



"ASSESSMENT FOR IMPULSE DISORDERS"

This .pdf document contains the course materials you must read.

Simply keep scrolling down and read every page. To receive CEU credit after reading this file, please follow the directions at the end of the course.

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**PeachTree Professional Education, Inc.
Richard K. Nongard, LMFT/CCH
15560 N. Frank L. Wright Blvd, #B4-118
Scottsdale, AZ 85260**

Voice: (800) 390-9536

Fax: (888) 877-6020

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ASSESSMENT FOR IMPULSE DISORDERS

3 CEU Credit Hours

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Course Description:

Understand the diagnostic characteristics of the 5 Impulse Disorders as outlined in the DSM, including rule-outs. Case examples help differentiate between criminal and psychiatric behaviors.

Course Objectives:

At the conclusion of this course, the professional will be able to:

- 1) Describe the essential diagnostic features of each DSM-IV impulse disorders
- 2) Understand possible rule-outs, including conditions which are actually social rather than psychiatric in nature.
- 3) Describe the cycle of impulsivity as outlined in the DSM-IV.
- 4) Assess client condition in context of cycles of impulsivity outlined in the DSM-IV.
- 5) Define Impulse Disorders NOS and cite examples from clinical experience.

Purpose of this course:

The purpose of the course is to assist mental health counseling professionals in assessing clients in all settings, (in-patient, outpatient and criminal justice) who may be affected by impulse disorders.

Course Outline:

Part 1: Course organization, Documentation and Introduction.

Part 2: Reading of the course materials (this document)

Part 3: Administration and Completion of the Evaluation of Learning Quiz

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3 Clock Hours / CE Credits

If you ever have any questions concerning this course, please do not hesitate to contact **PeachTree at (800) 390-9536**.



Your instructor is **Richard K. Nongard**,
a Licensed Marriage and Family Therapist, Certified Clinical
Hypnotherapist and a Certified Personal Fitness Trainer.

PeachTree Professional Education, Inc.
15560 N. Frank L. Wright Blvd, #B4-118
Scottsdale, AZ 85260

Voice: (800) 390-9536
Fax: (888) 877-6020
www.FastCEUs.com

Assessment of Impulse Disorders

A 3-hour Continuing Education Course

INTRODUCTION

To qualify for continuing education credit, the professional taking this course must read not only this material, but must also refer to the Impulse Disorders section of the DSM-IV, including the 'Not Otherwise Specified' section.

In the **DSM-IV-TR**, this will be found on **pages 663-677**.

It is acceptable to use a DSM-IV to complete this course rather than a TR. Simply check the table of contents of the DSM-IV for the Impulse Control Disorders section.

It is not acceptable to use a DSM-III-R or earlier version of the DSM to complete this course.

The DSM-IV is a remarkably interesting book. It is a guide to diagnosis and understanding of human condition, with a great many sections designed to help clinicians develop an orderly understanding of psychiatric conditions.

Impulsivity is a characteristic of many psychiatric conditions listed in the DSM-IV. As a behavior and a criterion for the diagnosis of a specific condition, impulsivity can be found across a broad spectrum of Axis-I and Axis-II diagnoses, including personality disorders, addictive diseases, psychotic disorders and mood disorders.

However, in this continuing education course, as we attempt to find solutions for clients who manifest problems related to impulsivity, we will only address those patients who have received a diagnosis of a specific Impulse Disorder, such as Trichotillomania, Pathological Gambling, Intermittent Explosive Disorder, Pyromania and Kleptomania.

This course is designed to overview the diagnostic criteria for each disorder and to assist clinicians in identifying the major issues in defining impulsivity.

Section ONE

An Overview of the DSM-IV Specified Impulse Disorders

Diagnostic Features, Rule-Outs and Case Examples

According to the DSM-IV:

Intermittent Explosive Disorder is characterized by discrete episodes of failure to resist aggressive impulses, resulting in serious assaults or destruction of property. The degree of aggressiveness is grossly out of proportion or any provocation or stressor. The individual may describe the aggressive episodes as "spells" or "attacks".

Kleptomania is characterized by the recurrent failure to resist impulses to steal objects that are not need for personal use or monetary value. The stealing is not done to express anger or vengeance, nor in response to a delusion or hallucination. They will often give the stolen items away, or they may hoard them or even surreptitiously return them. Generally, these individuals will avoid stealing when immediate arrest is probable, but they do not usually preplan the thefts or fully take into account the chances of apprehension. The stealing is done on their own, without assistance or collaboration with others.

Pyromania is characterized by a pattern of fire setting for pleasure, gratification, or relief of tension. There are generally multiple episodes of deliberate and purposeful fire settings. They have a general fascination with fire, are often 'fire watchers', may set off false alarms, and may spend a lot of time around the local fire department. The fires are not set for monetary gain, vengeance or as a result of hallucinations, nor from impaired judgment.

Pathological Gambling is characterized by recurrent and persistent maladaptive gambling behavior, which disrupts personal, family or vocational pursuits. Manic episodes do not qualify as pathological gambling. A preoccupation with gambling is present (reliving past experiences, planning the next venture, trying to come up with more money to gamble with), and the gambler seeks the 'action' experience even more than the money itself, or they may see gambling as an 'escape' from their

everyday life and problems. Desperation for money to gamble with may lead to antisocial and/or illegal behavior.

Trichotillomania is characterized by the recurrent pulling out of one's hair for pleasure, gratification, and relief of tension, which results in noticeable hair loss, most commonly from the scalp, eyebrows and eyelashes. The hair pulling can occur not only during stressful situations, but also during periods of relaxation and distraction. The related tension characteristic is sometimes associated with attempts to resist the urge to pull the hair, rather than the typical impulse disorder tension buildup preceding an action.

Impulse Disorders Not Otherwise Specified (NOS) permits professionals to use the coding of impulse disorders when an individual does not meet the criteria for a specific disorder, yet still manifests the characteristics of an impulse disorder condition.

Intermittent Explosive Disorder

Many clients come to us with a diagnosis of impulse disorder. Those working in criminal justice or mental health settings likely see the Intermittent Explosive Disorder diagnosis more than any other impulse disorder.

The chief characteristic and feature of an impulse disorder is the person taking a behavioral action to meet a specific psychological, emotional, or physical need.

It is my contention that the diagnosis of Intermittent Explosive Disorder (IED) is overused, and that many individuals are diagnosed with IED simply because it seems we need a diagnosis to justify the work that we do, or to get paid for our time. I further believe that many of these aggressive clients are done a terrible disservice when given an IED diagnosis because it works to abdicate them of their personal responsibility for their own actions.

Let's look at a specific case.

The case of Johnny

Johnny is a 9-year-old boy. As everyone knows, nine year old boys can certainly be quite rowdy, boisterous and even aggressive. Johnny's behavior, however, was outside the standard deviation of normal boyhood behavior. His aggression manifested with incredibly powerful physical outbursts, directed particularly towards his mother, during times of stress in the family.

Johnny's mother first noticed these emotional extremes early on in his childhood. His Terrible Two's tantrums seemed to be worse than those of her other children. When he was five and six and did not get his way, the anger Johnny directed towards his mother seemed to be far more intense than that of the average child.

Now at nine, he was repeatedly in trouble at school for verbally lashing out at his teachers. He was particularly angry with his homeroom teacher for regularly consulting with his mother about his missing homework assignments.

At three years of age, Johnny's father, a substance abuser, began a long period of incarceration, leaving Johnny's mother to care for Johnny and his two siblings on her own. Johnny's father was arrested at home in the presence of all of the children. Johnny's mother was not an innocent-bystander and was involved with her husband in producing methamphetamine for sale and distribution. However, she was not held legally accountable for the activities that she had participated in with her husband. Consequently, Johnny's older siblings blamed their mother for their father's long incarceration.

This social situation reflects numerous family problems ranging from addiction to unstable living environments and financial difficulties derived from illegal drug use. It is interesting to note that while Johnny did manifest aggressive behaviors particularly towards his homeroom teacher and others, his bursts of physical violence were generally directed towards his mother. By the time he was finally hospitalized at 9 years old, Johnny had physically harmed his mother enough to require medical attention on two separate occasions.

As we look at this case, there is no doubt that Johnny is impulsive. But as clinicians, in the assessment process we must ask if Johnny really meets the diagnostic criteria for Intermittent Explosive Disorder.

The criteria in the DSM-IV, found on page 667, requires three things:

- 1) The inability to resist aggressive impulses,
- 2) An exaggerated aggressive response,
- 3) The aggressive episode is not better accounted for by another mental disorder, psychotic disorder, conduct disorder or attention defect hyperactivity disorder and are not due to the direct effects of a substance or a general medical condition.

Johnny is certainly an impulsive boy and will likely benefit from interventions designed to reign in his impulsivity. But, Johnny's primary target is always his mother. Although he acts aggressively towards peers and others, he appears to be able to resist impulsive physical aggression in the school. The only time Johnny has brought physical assault or destruction of property has been in the context of his relationship with his mother.

What this tells me is that while Johnny may be an impulsive boy, the impulsivity is a symptomatic feature of his psychosocial environment, rather than the manifestation of the psychiatric disease known as Intermittent Explosive Disorder.

The fine line in our assessment process is sometimes difficult to place. Little Johnny may begin to manifest all of the features of Intermittent Explosive Disorder later in life. But I think that in this case, at least so far, the aggressive episodes actually are better accounted for by some explanation other than IED.

When I put myself in the shoes of that nine-year-old boy, I think that considering the circumstances, I might act the same way he has acted. Why? Because it's just not normal for a 9-year-old boy to have to deal with the emotional and social ramifications of a missing parent due to drug use and drug dealing.

Through my work in the criminal justice system, I have seen many aggressive clients who harmed other individuals or who threatened them or in one way or another crossed the line, and were subsequently labeled as Intermittent Explosive Disordered. I believe this was often an incorrect diagnosis.

For example: Bob, the alcoholic car thief, punches an old man who will not get out of his car when Bob tries to carjack it. This is not a manifestation of Intermittent Explosive Disorder. Bob did not strike this specific target because he was unable to resist his aggressive impulses. Bob hit this man because he was not getting what he wanted (the man's car).

I believe that clients who are misdiagnosed as Intermittent Explosive Disordered individuals are set up to fail in the criminal justice and mental health system. For reasons that should be obvious, they simply do not respond to therapy, psychotropic medications and support services like truly impulsive clients do.

Let's look at another case.

The Case of Joey

Joey is a 17-year-old high school Junior. He has a history of psychiatric hospitalizations with prior diagnoses of both Conduct Disorder and Bipolar Disorder. As he entered late adolescence, Joey became behaviorally more and more difficult to manage. For no apparent reason, he often poked, punched, hit and terrified classmates sitting next to him. In the halls of the alternative school he attends, he randomly walks up to other students and pushes their books to the floor, with no perceptible provocation. This aggressive action frequently results in the destruction of property.

Joey lives with his grandmother, and is aggressive towards her as well. He takes advantage of her financially and has verbally and physically assaulted her numerous times.

The most recent explosive episode occurred in a convenience store. Joey was asked to provide identification showing he was over age 18, and since he could not do this, the clerk refused to sell him cigarettes. Joey responded by knocking over the cigarette rack and pulling down a display of cola products. As he left the store laughing, he kicked another customer's car in the parking lot, leaving a dent in the door.

Unlike our first example, Joey is unable to resist his physically aggressive impulses. The degree of his responses is

grossly out of proportion to the precipitating social stressors, and his aggressiveness and impulsivity is not directed towards any one particular individual.

In our first example, the young boy always directed his assaults at his mother, but Joey manifests a random pattern of assaultiveness against not only family and peers, but even people and objects which have little or no relationship to him at all.

To me, it's clear that Joey manifests the characteristics of Intermittent Explosive Disorder right out of the DSM-IV. The moment Joey strikes somebody, destroys something or inflicts damage - even against those things or people with whom he has no relationship - he feels a sense of relief. This is the major characteristic of the impulse disorder diagnosis.

The action taken relieves emotions and feelings of tension. Impulse disordered clients manifest their behaviors not because they intentionally want to harm a specific person, get vengeance over a specific person or define their status over a specific person, but simply because when they take the action it brings them psychological, emotional, social or spiritual relief from a stressor defined within their psyche.

Kleptomania

The Kleptomaniac is characterized by the inability to resist the urge to steal things. There are a lot of people on probation who would like to be labeled a kleptomaniac. However, the majority of people who steal things - even those who steal things repeatedly and even those people who steal things of little monetary value - do so not because they suffer from a psychiatric disease, but simply because they are criminals.

I heard a tacky joke years ago that went something like this:
How do you know the toothbrush was invented in Oklahoma?

Answer: Because if it had been invented anywhere else, it would have been called a 'teethbrush'.

Now, I'm only picking Oklahoma as humorous example since I grew up there, not because I don't like the state or people. So, just for this example, let's say I'm from Oklahoma and because I'm from Oklahoma, I don't have any teeth. But every time I go to the convenience store or the grocery store, I find myself unable

to resist the urge to steal toothpaste. When I steal a tube of toothpaste or a tube of dental floss, which I obviously do not need and will not use, I feel a sense of power or control or relief from emotional stressors or in some way or another. When I get away with that theft, it restores my emotions to a state of equilibrium. If this scenario were true, I would appear to meet the criteria for Kleptomania.

In another example, let's say I do have all of my teeth, and in fact, I am quite proud of my teeth. In the past, I had a tremendous amount of dental work done to make my teeth perfect. But now that I am unemployed and my entitlement programs cover only basic food products and not hygiene concerns, whenever I'm at the grocery store I also steal a tube of toothpaste and some dental floss.

This thievery is not designed to meet a psychological need for the restoration of emotional equilibrium. Instead, I believe that I need the toothpaste, and I'm just short two bucks and I don't think that stealing the inexpensive toothpaste will actually hurt anyone else.

In the first example, we have a Kleptomaniac. In the second example, we simply have a thief.

Trichotillomania

Trichotillomania is a recurrent desire to pull out body hair. When Trichotillomaniacs pull out body hair from their head, arms, and legs or wherever, it brings them a sense of relief and restores them to a state of psychological equilibrium. It is important to note that the diagnosis of Trichotillomania is predicated upon a sufficiently noticeable amount of hair being pulled out.

One of the early manifestations of impulsive behaviors seen in children is Trichotillomania. Unfortunately, this may only be the beginning of the impulse disorders that may plague them throughout their lifetime.

It's probably normal for all of us at one point or another to respond emotionally by tugging on our hair, illustrating "pulling our hair out", or to even pluck our eyebrows, but it is abnormal to pull out enough body hair for it to be noticeable and cause problems. In children, this can be particularly grotesque and can cause them tremendous social difficulties.

Trichotillomania scars the body and over time, it can actually cause dermatological damage.

Pathological Gambling

The fourth impulse disorder specified in the DSM-IV is pathological gambling. It is important to note that pathological gambling is not in the "addiction" section of the DSM-IV. It is not wedged between alcoholism and heroin addiction. In the arena of pop-psychology, "gambling addiction" has become a popular term, and when it is used, we generally understand the behaviors that are being described. Nevertheless, pathological gambling is actually an impulse disorder, and not an addictive disease.

In our audio home study continuing education course titled "Addiction Answers," I address the subject of defining the differences between true addiction and what pop-psychology has labeled as addiction. Although 12-Step programs, support groups and other interventions that are useful with the addicted client may also be useful with the pathological gambler, a person cannot become physiologically addicted to a specific behavior. Classic addictions require not only a psychological obsession, but also a physical craving.

In our profession, a small minority wants to ascribe all human behaviors to nothing more than our brain chemistry. These folks have attempted to make a case that a pathological gambler's brain chemistry actually changes when they roll the dice. This, they claim, is why they are unable to control their behaviors. It is my personal opinion that such extrapolations and explanations of human behavior based solely on human biology do our clients a true disservice.

As we talk about impulse disorder interventions, we find that the most successful ones are predicated on the client's acceptance of responsibility for their own actions, rather than assigning the responsibility to their brain chemistry. The pathological gambler can suffer tremendous consequences socially, vocationally and legally because of their behavior. And of course, depending on the jurisdiction where a person lives, the behavior itself may actually be a crime.

It is also important to note that the majority of people at a casino are there for entertainment. The majority of people who play cards with their friends on the weekend are doing so to meet a social need. Because a person gambles does not mean they

meet the diagnostic criteria for impulse disorder. When the behavior impairs their ability to function and they are unable to resist the impulse to gamble and gambling meets a specific psychological need - restoring them to psychological equilibrium - then we have the diagnosis of impulse disorder.

Pyromania

The fifth impulse disorder defined in the DSM-IV is Pyromania. The pyromaniac starts fires because when they see a building, structure, or object burn, it meets a psychological need; it restores them to a state of equilibrium. Let us look at two examples.

Bill owns (by way of a mortgage) an office building. As long as the occupancy rate for the office building is at least 50%, he can cover his mortgage with the rental payments he receives. Business has been good for Bill, and his building has a 90% occupancy rate because he has two large tenants. But, when one of the tenants goes out of business, the occupancy rate falls to 40%. Now Bill is unable to cover his mortgage payments. Unable to procure new tenants in a shaky economy, Bill begins to run out of money and face the prospect of bankruptcy.

Late one night while looking at his property, Bill sees that no one is around, and he pours the gasoline from the canister in the back of his pickup truck around the edge of the building and starts it on fire. Bill is able to collect the insurance money for the fire damage to his property. This is not pyromania. This is arson and insurance fraud. It is not psychiatric illness.

However, let us look at another example. Peter is an 11-year-old boy who has started numerous fires in public places over the years. Interestingly enough, his father is the fire Chief in a large metropolitan area. He came to us for treatment after burning down a 1.2 million dollar building, which caused several serious injuries. Peter had no relationship to the owner of the building or any of the tenants. Before starting the fire, he had never even seen the building before. In this example, we see that the criteria for pyromania are met via the randomness of the act and through the psychological restoration to equilibrium, rather than the financial gain that characterizes the simple arsonist.

Impulse Disorders Not Otherwise Specified

The DSM-IV gives us a sixth area of impulse disorders for those individuals who may manifest the general characteristics of an impulse disorder, but engage in behaviors that are not specifically described in any of the previous five sections.

I once worked with a sixteen-year-old boy in a residential treatment facility who compulsively masturbated an average of five to seven times a day. This obsessive/compulsive sexual behavior carried with it many of the characteristics found in the impulse disorder section. The psychiatrist with whom I did the assessment diagnosed the kid as an 'Impulse Disorder Not Otherwise Specified', so that a treatment plan could be established focusing on his inability to resist the urge to find physical and emotional gratification through his sexual behavior.

It is my contention that the majority of self-mutilators fit the criteria for borderline personality disorder. However, some may actually manifest characteristics more typical of the impulse-disordered individual, and a diagnosis of ID-NOS may be appropriate.

Section TWO

The Cycle of Impulsivity

It is interesting to me that our profession so often overlooks the Impulse Disorder section. It is not a familiar diagnosis for most of us. Nevertheless, these five disorders are commonly seen in the patients we work with.

Having an understanding of the nature of impulse disorders is essential for those working with in-patient, outpatient, criminal justice, or mental health settings.

The individual criteria established are fairly specific for each of the five listed impulse disorders, but I want to take a minute to more thoroughly discuss the general five-stage cycle of impulsivity as outlined in the DSM-IV.

Stage 1 - Awareness

The first stage is awareness. This can be a conscious awareness or it may be a subconscious awareness that things are changing internally. Something, definable or not, is different - emotionally, socially, psychologically or spiritually.

Stage 2 - Tension

This awareness creates the second stage, which is an increase in tension or arousal. This tension may be felt emotionally, socially, psychologically and/or spiritually.

Stage 3 - Action

The third stage of the impulse disorder cycle is a specific action taken with the intention to decrease the tension experienced in the previous stage. These kinds of actions may include fire starting, hair pulling, gambling, assault, or some other action not otherwise specified.

Stage 4 - Relief

When the action is taken, the client enters the key fourth stage of the impulse disorder cycle, known as the relief stage. Following the action, the person feels instant gratification from an emotional or psychological perspective. This is their reward. The minute they engage in a specific

behavior it brings about a sense of relief, restoring them to a state of equilibrium.

This occurs without or despite knowledge or understanding that the long-term consequences of their impulsive behavior will likely outweigh any perceived benefits.

Stage 5 - Withdrawal

After the relief stage, clients then enter the fifth and final stage that I call withdrawal. This is not withdrawal in the context of addiction where there is physical or emotional withdrawal, but rather where they enter a period of evaluation to determine whether or not they have been truly gratified by the action. For the impulse disordered individual the answer is usually no. They may even discover feelings of regret, self-reproach or guilt.

Their relief is usually short lived or unsatisfactory, and so they reenter the first stage - the awareness of a state of disequilibria - and the cycle replicates itself, again and again.

This cycle of impulsivity is a useful guide for clinicians because it allows us to see and evaluate more specifically the areas where our clients are experiencing the most difficulty related to their impulse behavior.

This knowledge helps us to create targeted interventions that are more effective at arresting the destructive cycle.

Conclusion

Although this course has been short, we hope it has been useful to you by:

- 1) meeting your need for documentation of 3 hours of continuing education credit;
- 2) providing a practical guide for understanding the context of impulsive behavior in psychiatry;
- 3) offering useful information for helping you to differentiate between criminal behavior and psychiatric behavior.

THANK YOU FOR PARTICIPATING IN THIS COURSE

To receive continuing education credit for this course, you must also read the entire Impulse Disorders section from the DSM-IV or the DSM-IV-TR.

You must also complete and return the Evaluation of Learning Quiz and the appropriate fee, either online or by fax or mail. (Instructions are on the next page.)

We always appreciate constructive input from our customers - even when it is 'negative', so please feel free to fill in the "Additional Comments" section of the 'Grade This Course' evaluation when you submit your quiz and payment.



Richard K. Nongard, LMFT, CCH, CPFT
Executive Director

"Assessment for Impulse Disorders"

3 Continuing Education Clock Hours

Procedures to Receive CEU Credit:

- This document contains all of the course materials you needed to read.
- Now you must complete the required True/False Evaluation of Learning Quiz and submit it to our office along with your payment, in order to obtain your CEU certificate.

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Go back to www.FastCEUs.com and click the "QUIZ & PAY" button for this course.

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Print the Quiz and Payment forms on the next few pages of this document, and complete the requested information.

Our 24-hour secure Fax number is **(888)-877-6020**.

If you fax your quiz and payment to us, please do NOT also mail it. We process faxes within approximately 4 business hours after receiving them. Faxes submitted late in the day or after hours will be processed the next business morning. However, all certificates are dated the date we receive your course quiz and payment.

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EVALUATION OF LEARNING QUIZ - PAGE 1 of 4

PRINT & FAX or MAIL THIS PAGE AND THE ANSWERS PAGES TO OUR OFFICE

*** * * * OR * * * ***

You may complete and submit this information **ONLINE** by following this link:

<https://www.fastceus-store.com/quizzes/index.php?extension=impulse>

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Assessment for Impulse Disorders

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EVALUATION OF LEARNING QUIZ - PAGE 2 of 4

Course Title: "ASSESSMENT for IMPULSE DISORDERS"

3 Hours of Approved Continuing Education Credit

The purpose of the following Evaluation of Learning questions is to:

- A.) Verify that you have read the required course materials
- B.) Demonstrate an understanding of the practical application of the course materials
- C.) Officially document your participation and completion of this course

➞ ANSWER THE FOLLOWING 20 T/F EVALUATION QUESTIONS.

- T F** 1. I have read the required .pdf text file for this course.
- T F** 2. I have read the required DSM selection for this course.
- T F** 3. Impulsivity is a characteristic of many psychiatric conditions listed in the DSM-IV.
- T F** 4. Intermittent Explosive Disorder is characterized by discrete episodes of failure to resist aggressive impulses.
- T F** 5. Kleptomania is characterized by the recurrent failure to resist impulses to steal objects that are not need for personal use or monetary value.
- T F** 6. Pyromania is characterized by a pattern of fire setting for pleasure, gratification, or relief of tension.
- T F** 7. Trichotillomania is characterized by the recurrent pulling out of one's hair for pleasure, gratification, and relief of tension, which results in noticeable hair loss.
- T F** 8. The diagnosis of Trichotillomania is predicated upon a sufficiently noticeable amount of hair being pulled out.
- T F** 9. Classic addictions require not only a psychological obsession, but also a physical craving.
- T F** 10. The majority of people at a casino are there because they are gambling addicts.
- T F** 11. Some self-mutilators actually manifest characteristics more typical of the impulse-disordered individual, and a diagnosis of ID-NOS may be appropriate.

The Evaluation Quiz is continued on the next page →

EVALUATION OF LEARNING (Continued) PAGE 3 of 4**Course Title: "ASSESSMENT for IMPULSE DISORDERS"****3 Hours of Approved Continuing Education Credit**

- T F** 12. Our profession pays close attention to the diagnosis of impulse disorder.
- T F** 13. The third stage of the impulse disorder cycle is a specific action taken with the intention to decrease the tension experienced in the previous stage.
- T F** 14. Amok is characterized by an episode of acute, unrestrained violent behavior for which a person claims amnesia.
- T F** 15. Reliable information of the prevalence of IED is readily available and published in the DSM-IV.
- T F** 16. Pyromaniacs usually start fires for the insurance money.
- T F** 17. Distortions in thinking are rarely present with the pathological gambler.
- T F** 18. Medical conditions can cause alopecia.
- T F** 19. An equal number of male and female children manifest Trichotillomania.
- T F** 20. Lifetime rate of Trichotillomania is about 6.5% of the general population.

GRADE THIS ONLINE COURSE! – Page 4

It is helpful to us to have you return this form via snail mail or fax, if you're not completing the Quiz & Payment info Online. Thank-you!

Participant Assessment of Home Study CEU Course

"ASSESSMENT FOR IMPULSE DISORDERS"

3 Credit Hours

Please Rate the Following Statements from 1-5

(1 being the Lowest, 5 being the Highest.)

- _____ 1. I found the PeachTree Online Home Study Course Instructions simple to follow.
- _____ 2. I found the PeachTree Online Home Study Course materials to be of professional quality, and easy to read.
- _____ 3. I found the PeachTree Online Home Study Course materials to be of educational value, relative, and useful to my counseling practice.
- _____ 4. I completed the 3 Hour PeachTree Online Home Study Course in approximately 3 hours.
- _____ 5. I would take another PeachTree Online Home Study Course, and/or recommend them to a co-worker.

ADDITIONAL COMMENTS: