IMPULSE CONTROL DISORDERS

INTERTMPETIVE EXPLOSIVE DISORDER (s. EPISODIC DISYCONTRL SYMPODROME) - sudden repeated, discrete episodes (violent physical behavior with minimal provocation in otherwise normal person → aggression toward persons (serious assaultive acts) or property (destruction of property).

- disorder begins in early childhood; men > women.
- precipitating events are absent or disproportionately insignificant when compared with extent of aggressive behavioral outburst.
- attendant preoccupation with fire setting, including: lighting, eating, biting, and shouting (including abusive and profane language); patient has clear consciousness, but cannot control behavior and may seem momentarily psychotic.
- can be confused with complex partial seizures; most affected adults have little evidence of structural brain damage (nonspecifically abnormal EEGs have been reported in some children).

EEG during attack remains normal!

- episode is followed by fatigue, amnesia, and sincere remorse.

ETIOLOGY
- disorder may best be considered characteristic symptom constellation deriving from multiple etiologies, rather than as distinct disorder.

Psychological etiologies - personality disorders (e.g. antisocial and borderline), psychotic disorders (schizophrenia), mood disorders (manic episodes), disruptive behavior disorders (e.g. conduct and attention deficit hyperactivity); Gilles de la Tourette's syndrome.

Organic etiologies - seizures (esp. temporal lobe), psychoactive substance intoxication, structural lesions with frontal lobe / ventromedial hypothalamus / amygdala dysfunction (trauma, infarct, tumor, hemorrhage, abscess), normal pressure hydrocephalus, CNS infection (herpes encephalitis), neurodegenerative disorders (Alzheimer's disease, Huntington's disease), metabolic disorders (hyperglycemia), hormone disturbances (androgen levels).

TREATMENT
- best aimed at underlying condition(s).
- incarceration, institutionalization, seclusion, restraint - control but not alter aggressive behaviors.
- behavior modification techniques - only modest success.
- medications - neuroleptics (most widely used agents!), mood stabilizers (e.g. LITHIUM), anticonvulsants (e.g. CARBAMAZEPINE!!!, PREVONTOX, VALPROIC ACID). β-blockers (e.g. PROPRANOLOL*), benzodiazepines (risk of tolerance or paradoxical disinhibition!), SSRIs *useful in brain damage

PSYCHOSURGERY (reserved for most dangerous and refractory cases).

KLEPTOMANIA - multiple episodes of impulsive stealing in presence of pertinent negatives; stealing is not:

(1) for financial gain or to satisfy personal need;
(2) expression of anger, retribution, or retaliation;
(3) in response to hallucination or delusion.

- individuals experience mounting sense of tension or anxiety before stealing episode.
- pleasure is derived from eating this internal tension and anxiety after gratifying impulse to steal, not from object(s) stolen! (it is common for objects stolen to be hidden).
- N.B. secondary gain plays no role!!!

- extremely rare disorder (females > males).
- treatment - anecdotal reports of psychoanalytic or behavioral therapeutic modalities.

PYROMANIA - multiple episodes of intentional fire setting in presence of pertinent negatives; fire setting is not:

(1) for financial gain (e.g. insurance reimbursement);
(2) act of sociopolitical insurrection;
(3) one of series of related criminal activities;
(4) act of vandalism or expression of retaliation or revenge;
(5) symptom of underlying psychotic disorder.

- individuals experience mounting sense of tension or anxiety before fire-setting episode, which sometimes may be in form of building sexual tension and excitement (pyrolagnia).
- relief of tension and anxiety, or sexual pleasure, is derived when fire-setting impulse is gratified as well as during aftermath of fire setting.
- individuals maintain obsessive preoccupation with fire (as in eating disorders - obsessive preoccupations with food).
- rare disorder; males > females; childhood onset is common.
- individuals lack empathic recognition of physical destructiveness of their actions.
- "treatment" most often occurs in penal institutions.

TRICHOTILLOMANIA - recurrent episodes of pulling out one's own hair → identifiable hair loss.

- scalp hair most commonly is involved.
- episodes are preceded by sense of increasing internal tension and anxiety; when impulse to pull has been gratified, individual experiences pleasurable sensation, or at least relief.
- hair pulling in this context does not typically induce pain!
- specific rituals related to hair disposition, including ingestion (trichophagy), may exist.
- usually begun in childhood; females > males.
- etiologic theories: self-stimulation in response to emotional deprivation; self-mutilation as form of self-punishment; habit disorder of childhood.

*useful in brain damage
PATHOLOGICAL GAMBLING

- *chronic, progressive, maladaptive gambling*, features:
  1. obsessional, cognitive preoccupation with gambling;
  2. impaired personal, social, educational, and occupational functioning as consequence of gambling;
  3. overly determined, *out-of-control* quality that drives, perpetuates, and escalates gambling despite derivative functional impairment and adverse consequences.

- patients often attempt unsuccessfully to stop gambling, lie or commit crime to enable gambling, jeopardize personal relationships and employment, and gamble with increasing amounts of money.
- may be viewed as variant of *addictive disorder*.
- as with alcohol consumption, some degree of gambling is viewed as falling within wide spectrum of normality.
- relatively common disorder (up to 3% American adult population!!!), men >> women.
- etiologic theories:
  a. psychoanalytic theories - various disturbances in psychossexual development.
  b. behavioral theories - exposure to behavior through others and ultimately "learning" it through powerful pattern of reinforcement.
  c. behavior may be propagated through activation of endogenous opioid systems.

Treatment

- earliest *individual modalities* tended to be conventional, *psychodynamic* approaches; recently, *behavioral techniques* (aversive and desensitizing models) have assumed more prominence.
- *group modalities* (such as Gamblers Anonymous).
- *pharmacotherapy* does not play significant role.

**Bibliography** for ch. “Psychiatry” — follow this [link]