SAGE reference

# The SAGE Encyclopedia of Abnormal and Clinical Psychology

## Impulse Control Disorders: Treatment

Contributors: Roxanne James & Dan J. Stein
Edited by: Amy Wenzel
Book Title: The SAGE Encyclopedia of Abnormal and Clinical Psychology
Chapter Title: "Impulse Control Disorders: Treatment"
Pub. Date: 2017
Access Date: April 12, 2017
Publishing Company: SAGE Publications, Inc.
City: Thousand Oaks,
Print ISBN: 9781483365831
Online ISBN: 9781483365817
DOI: http://dx.doi.org/10.4135/9781483365817.n713
Print pages: 1776-1778

Impulse control disorders have been recognized within the area of psychiatry since 1838, when Jean Etienne Esquirol first defined these disorders as “monomanias” characterized by an individual fixating on an irrational action or desire, which is pursued without deviation to derive emotional gratification. Subsequent research directions, including work based in psychodynamic, cognitive behavioral, and neurobiological models, have also focused on the idea that a broad range of different diagnostic entities are characterized by impulsive traits.

The development of treatments for the impulse control disorders is an important area of research; however, the research base is at an early stage, with relatively few randomized controlled trials (RCTs), typically with relatively small sample sizes, having been undertaken, particularly in kleptomania, pyromania, and other specified conditions. However, a growing evidence base of psychotherapeutic and pharmacological interventions for these conditions has emerged. At the same time, this research has been influenced by concepts from the psychodynamic, cognitive behavioral, and neurobiological literature, emphasizing that these conditions may overlap insofar as they are all characterized by underlying impulsive traits, which may be targeted during treatment. Prior to beginning treatment, it is important to establish diagnosis, so this entry begins with a discussion of diagnosis and evaluation of impulse control disorders and then focuses on evidence-based treatment approaches, particularly as applied to intermittent explosive disorder (IED), kleptomania, and pyromania.

## Diagnosis and Evaluation

The *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision* (*DSM-IV-TR*), described a number of conditions characterized by impulsive symptoms (e.g., various personality disorders) and also emphasized that impulse control disorders not elsewhere classified in the manual are characterized by (a) rising tension prior to the impulsive act, (b) gratification on completion of the act, and (c) relief from tension on completion of the act. The *DSM-IV-TR* impulse control disorders not elsewhere classified include IED, kleptomania, pathological gambling, pyromania, and trichotillomania.

The *DSM-5* and the *International Classification of Diseases, 11th Revision* (*ICD-11*), have taken somewhat different approaches to the classification of the *DSM-IV-TR* impulse control disorders. In the *DSM-5*, the category of “Disruptive, Impulse-Control and Conduct Disorders” includes IED, kleptomania, and pyromania, but pathological gambling has been moved to the “Substance-Related and Addictive Disorders” chapter and trichotillomania has been classified in the “Obsessive-Compulsive and Related Disorders” chapter. This reflects a view that key underlying mechanisms in pathological gambling are related to those involved in substance use disorders (e.g., impulsivity across these conditions may reflect disruption in reward processing key) and that underlying mechanisms in trichotillomania are related to those involved in obsessive-compulsive and related disorders (e.g., symptoms across these conditions may reflect disruption in grooming behavior).

In contrast, the *ICD-11* retains impulse control disorders in a single chapter that includes IED, kleptomania, pathological gambling, and pyromania. This decision reflects a view that research on these conditions is still at an early stage, so that definitive delineation based on psychobiological mechanisms may be premature. Instead, the *ICD-11*, which is often used by nonspecialist clinicians, puts significant emphasis on clinical utility; having IED, kleptomania, pyromania, and pathological gambling in the same category encourages clinicians to use similar diagnostic and treatment approaches across these conditions. In contrast, the clinical approach to trichotillomania is arguably influenced more by the evidence base on the

psychotherapy and pharmacotherapy of the obsessive-compulsive and related conditions.

The literature suggests that impulse control disorders are underdiagnosed and undertreated; however, once a diagnosis has been made, it may be useful to assess symptom severity using standardized symptom measures (e.g., the Massachusetts General Hospital Hairpulling Scale; the Southern Oaks Gambling Screen). Impulse control disorders are characterized by substantial comorbidity with one another, as well as with mood, anxiety, and substance use disorders; it is therefore important for clinicians to screen for these common mental health disorders and their key symptoms (including suicidal ideation) in any patient presenting with an impulse control disorder. Traumatic or stressful events are common precipitants of an increase in impulsive behavior, so a careful and comprehensive developmental and psychiatric history is needed in all patients.

## Treatment Principles

As noted earlier, there is a growing evidence base of RCTs on the pharmacotherapy and psychotherapy of some impulse control disorders. That said, the literature is at an early stage, and there are a number of important gaps. One key gap is the combined use of pharmacotherapy and psychotherapy. In the absence of evidence, expert consensus is that in many impulse control disorders it may well be useful to use both modalities, perhaps in a sequenced fashion. Psychotherapy may be useful early in treatment—for example, in establishing a therapeutic relationship, in providing key psychoeducational principles, and in setting up ground rules for addressing impulsive behaviors (e.g., removing access to credit in patients with pathological gambling, refraining from entering retail stores alone for those with kleptomania). Pharmacotherapy may be useful as treatment progresses—for example, in tackling key symptoms or comorbid disorders (e.g., depression).

Indeed, a broad range of pharmacotherapies have been utilized in impulse control disorders, including serotonergic antidepressants (addressing affective alterations), opioid agents (addressing behavioral addiction), and glutamatergic medications (addressing cognitive dyscontrol). However, as of 2016, the U.S. Food and Drug Administration has not approved any drugs for the treatment of these conditions. The largest body of evidence is for selective serotonin reuptake inhibitors (SSRIs). These have proven effective in a number of studies (e.g., of IED), although other findings have been disappointing (e.g., studies of SSRIs in trichotillomania have been negative). Although there is a paucity of studies on patients with impulse control disorder and comorbid depression or anxiety disorders, these agents may be particularly useful in this population, given their efficacy in primary depression and anxiety. The possibility of increased impulsivity in some patients, particularly those with comorbid bipolar disorder, should be borne in mind.

### Pharmocotherapy

#### *Intermittent Explosive Disorder*

Early work on the pharmacotherapy for the treatment of IED focused on SSRIs. Emil Coccaro and colleagues, for example, conducted a double-blind randomized trial on 100 individuals to determine whether fluoxetine affected IED. The results revealed that full and partial remission of aggression was noted in 46% of the individuals, with a superior response rate to placebo. A review of randomized trials of SSRIs concluded that there was evidence that SSRIs were able to assist in the treatment of IED by reducing aggression. A range of other medications have

been studied in IED, including lithium and anticonvulsant agents, but with somewhat mixed findings. There also has been some work on omega-3 and omega-6 fatty acids in IED, but again, further work is needed to demonstrate efficacy.

#### *Kleptomania*

There are few if any RCTs of pharmacotherapy in kleptomania. Antidepressants have been used clinically. A review of case reports and series of these agents in kleptomania reveals mixed findings, with some patients responding but with a minority of patients also experiencing an exacerbation of symptoms. Naltrexone, an opioid antagonist, may decrease impulsivity in kleptomania, perhaps due to inhibitory effects on dopaminergic neurons involved in reward neurocircuitry.

#### *Pyromania*

This is another impulse control disorder that has received little systematic attention from researchers. The literature is limited to a number of case reports and series. These suggest that antidepressants may be useful in some cases.

#### *Other Specified Disruptive, Impulse Control, and Conduct Disorders*

The pharmacotherapy of these conditions is not well studied, although there is anecdotal evidence that SSRIs may be useful for compulsive sexual behavior.

### Psychotherapy

#### *Cognitive Behavioral Therapy*

There is a growing evidence base on the use of cognitive behavioral therapy (CBT) for impulse control disorders. CBT interventions modified for impulse control disorders often focus on the identification of triggers that precipitate the unwanted behaviors, and subsequent desensitization to these triggers, to reduce the tension that cause the acting-out behavior. Interventions are aimed at addressing the cognitive distortions found in impulse control disorders, as well as the impulsive behavior with which the individual presents, whether firesetting, shoplifting, or an aggressive outburst. The modification of impulsive behavior is achieved through either systematic relaxation or imaginal exposure, as well as the completion of homework tasks, aimed at increasing the individual's sense of autonomy and control. CBT has been found efficacious in wait list controlled trials of IED as well as in the *DSM-IV-TR* impulse control disorders pathological gambling and trichotillomania. Further work is needed to fully dismantle the most efficacious components of CBT in impulse control disorders.

#### *Dialectical Behavior Therapy*

Dialectical behavior therapy (DBT), which has its roots in CBT, was initially developed for the treatment of borderline personality disorder. Subsequently, there has been a good deal of interest in adapting this therapy for use across a range of settings and for a variety of disorders, including impulse control disorders. The main aim of DBT is to assist individuals to change behavioral patterns that are considered maladaptive by reducing emotional dysregulation and allowing these individuals to actively affect the dynamic between internal processes and the external environment. Specifically, this intervention focuses on increasing

the mindfulness of individuals, their ability to engage in reality testing, effective ways to tolerate distress, and the ability of individuals to regulate their emotional state. To date, however, there are few data on DBT in impulse control disorders. Although schema-focused and psychodynamic interventions may also address emotion regulation, these have not been systematically studied in impulse control disorders.

***See also***Cognitive Behavioral Therapy; Dialectical Behavior Therapy; Intermittent Explosive Disorder; Kleptomania; Psychopharmacology; Pyromania

Roxanne JamesDan J. Stein
http://dx.doi.org/10.4135/9781483365817.n713
10.4135/9781483365817.n713

**Further Readings**

Coccaro, E. F., Lee, R. J., & Kavoussi, R. J. (2009). A double-blind, randomised, placebo-controlled trial of fluoxetine in patients with intermittent explosive disorder. Journal of Clinical Psychiatry, 70(5), 653–662. doi:http://dx.doi.org/10.4088/JCP.08m04150
Dannon, P. N. (2002). Kleptomania: An impulse control disorder? International Journal of Psychiatry in Clinical Practice, 6, 3–7.
Driessen, E., Van, H. L., Don, F., Peen, J., Kool, S., Westra, D., … Dekker, J. J. M. (2013). The efficacy of cognitive-behavioural therapy and psychodynamic therapy in outpatient treatment of major depression: A randomized clinical trial. American Journal of Psychiatry, 170(9), 1041–1049.
Durst, R., Katz, G., Teitelbaum, A., Zislin, J., & Dannon, P. N. (2001). Kleptomania diagnosis and treatment options. CNS Drugs, 15(3), 185–195.
Gabbard, G. O., Gunderson, J. G., & Fonagy, P. (2002). The place of psychoanalytic treatments within psychiatry. Archives of General Psychiatry, 59, 505–510.
Gesch, C. B., Hammond, S. M., Hampson, S. E., Eves, A., & Crowder, M. J. (2002). Influence of supplementary vitamins, minerals and essential fatty acids on the antisocial behaviour of young adult prisoners: Randomised, placebo-controlled trial. British Journal of Psychiatry, 181, 22–28.
Grant, J. E., Donahue, C. B., & Odlaug, B. L. (2011). Treating impulse control disorders: A cognitive behavioural therapy program (Therapist Guide). New York, NY: Oxford University Press.
Grant, J. E., & Potenza, M. N. (2012). The Oxford handbook of impulse control disorders. New York, NY: Oxford University Press.
Hoffmann, S. G., Asnaani, A., Vonk, I. J. J., Sawyer, A. T., & Fang, A. (2012). The efficacy of cognitive behavioural therapy: A review of meta-analysis. Cognitive Therapy Research, 36, 427–440.
McKay, M., Wood, J., & Brantley, J. (2004). The dialectical behavior therapy skills handbook. Oakland, CA: New Harbinger.