IMPULSE CONTROL DISORDERS

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The behaviors violate the rights of others and/or conflict with societal norms.

Impulse control disorders are not caused by another mental disorder, medical condition, or substance use.

OCD is a big differential diagnosis

OF THE QUALITIESCORE CONTROL DISORDERS IMPULSE FOLLOWS:ARE AS

- Repetitive or compulsive engagement in behavior despite adverse consequences.
- Little control over the negative behavior.
- Anxiety or craving experienced prior to engagement in impulsive behavior.
- Relief or satisfaction during or after completion of the behavior.

PROCESS:

- Impulse:
  - They feel an impulse that driving them to do Sth
- Tension :
  - They know they should not be doing it
- Pleasure:
- Relief:
  - Ok,I have done it
- Guilt/no guilt:

TYPES OF IMPULSE CONTROL DISORDERS

1 Intermittent explosive disorder

2 Kleptomania

3-Pyromania

4-Gambling disorder

5-Trichotillomania

DISORDER INTERMITTENT EXPLOSIVE

- ✓ Recurrent behavioral outbursts resulting in verbal and/or physical aggression against people or property.

DSM-5 diagnosis and criteria

- Either:
- Frequent verbal/physical outbursts (that do not result in physical damage to people, animals, or property) twice weekly for 3 months
- Or:
- Rare (more than three times per year) outbursts resulting in physical damage to others, animals, or property.
- Outbursts and aggression are grossly out of proportion to the triggering event or stressor.
- Outbursts are not premeditated and not committed to obtain a desired reward.
- Aggressive outbursts cause either marked distress or impairment in occupational/ interpersonal functioning, or are associated with financial/legal consequences.
- Aggression is not better explained by another mental disorder, medical condition, or due to the effects of a substance (drug or medication).

EPIDEMIOLOGY/ETIOLOGY

- ■More common in men than women.
- ■ Onset usually in late childhood or adolescence.
- ■ May be episodic, but course is generally chronic and persistent.
- ■ Genetic, perinatal, environmental, and neurobiological factors may play a role in etiology.
- Low levels of serotonin in the CSF have been shown to be associated with impulsiveness and aggression.

DIFFERENTIAL DIAGNOSIS

- **Medical: Brain tumors, endocrine disorders, degenerative disorders**
- **Psychatric : Antisocial personality disorder, Borderline presonality disorder, schizophrenia, substance intoxication**

treatment

- ■Treatment involves use of SSRIs, anticonvulsants, or lithium.
- ■ CBT (cognitive behavioral therapy)has been shown to be effective and is often used in combination with medications.
- ■ Group therapy and/or family therapy may be useful to create behavior plans to help manage episodes

KLEPTOMANIA
(AN IMPULSE TO STEAL)

DIAGNOSIS AND DSM-5 CRITERIA

- Failure to resist uncontrollable urges to steal objects that are not needed for personal use or monetary value.
- Increasing internal tension immediately prior to the theft.
- Pleasure or relief is experienced while stealing; however, those with the disorder often report intense guilt and depression.
- Stealing is not committed to express anger/vengeance and does not occur in response to a delusion or hallucination.
- Objects stolen are typically given or thrown away, returned, or hoarded.

EPIDEMIOLOGY/ETIOLOGY

- ■ Three times more common in women than men, though rare in the general population.
- ■ Higher incidence of comorbid mood disorders, eating disorders (especially bulimia nervosa), anxiety disorders, substance use disorders, and personality disorders.
- ■ Higher risk of OCD and substance use disorders in family members.
- ■ Illness usually begins in adolescence and course is episodic.

65% of patients with kleptomania suffer from bulimia nervosa.

TREATMENT

- Treatment may include CBT (including systematic desensitization and aversive conditioning) and SSRIs.

- There is also some anecdotal evidence for the use of naltrexone, which blocks reward pathways mediated by endogenous opioids.

PYROMANIA

Pyromania is the impulse to start fires,typically with feelings of gratifucation or relief afterward.

DIAGNOSIS AND DSM-5 CRITERIA

- At least two episodes of deliberate fire setting.

- Tension or arousal experienced before the act; pleasure, gratification, or relief experienced when setting fires or witnessing/participating in their aftermath.

- Fascination with, interest in, curiosity about, or attraction to fire and contexts.

- Purpose of fire setting is not for monetary gain, for expression of anger or vengeance, to conceal criminal activity, or as an expression of sociopolitical ideology. It is not in response to a hallucination, delusion, or impaired judgment (intoxication, neurocognitive disorder).

- Fire setting is not better explained by conduct disorder, a manic episode, or antisocial personality disorder.

Must rule out arson. (criminal act/set fires with CRIMINAL intent)

EPIDEMIOLOGY/ETIOLOGY

- Rare disorder but much more common in men.
- Most begin to set fires in adolescence or early adulthood.
- High comorbidity with mood disorders, substance use disorders, gambling disorder, and conduct disorder.
- Episodes are episodic and wax and wane in frequency.

PHYSICAL AND PSYCHIATRIC PRESENTING SYMPTOMS

- Many watch fires in their neighborhood and/or set off fires alarms.
- Lack remorse for the consequences of their action, and show resentment toward authority figures.
- May become sexually aroused by the fire.

TREATMENT

Most don't go into treatment and symptoms will remain chronic.

While there is no standard treatment, CBT, SSRIs, mood stabilizers, and antipsychotics have all been used.

Because no treatment has been proven to be beneficial, incarceration may be indicated.