

Editorial: Impulse Control Disorders: Does the DSM-IV Classification Really Explain Everything About This Type of Disorder?

Impulse control disorders are so named because of their essential feature, which is the failure to resist an impulse, drive, or temptation to perform a harmful act which is experienced as anxiolytic or even as pleasurable. Whether the diagnosis is that of pathological gambling, kleptomania, pyromania, trichotillomania, intermittent explosive disorder, binge eating or compulsive buying, the affected individual is unable to voluntarily control, cut back, or stop the pathological behavior. Of late this group of disorders are being detected and diagnosed more frequently in daily clinical practice. Although research shows that Impulse Control Disorders comprise up to 10% percent of psychiatric diagnoses, they remain underdiagnosed or neglected by clinicians or patients' families, and even by the patients themselves. The narrow perspective of the patient-family-therapist triangle sees these disorders as personal behavioral problems, which do not require medical help.

The aims of this special section are as follows:

- To explain the importance of Impulse Control Disorders in clinical practice;
- To demonstrate the neurocognitive changes and to explore the possible underlying pathologies;
- To supply general information about pathological gambling and kleptomania in order to find better classifications and future treatment regimens;
- To explore the genetic and environmental factors in these disorders;
- To present different impulsive behaviors such as stalking and malingering in general and psychiatric populations;
- Finally to remember our role as therapists and

our behavior in relation to this specific type of patient.

In the first article Kertzman et al. explore the neurocognitive characteristics of impulsivity. They review their experiences and research in other countries in this field, which suggest that impulse control disorders could be related to either addictive disorders or to obsessive-compulsive spectrum disorders.

The papers by Grant and Dannon et al. give the clinical perspective of the neurocognitive theory.

Grant discusses the phenomenon of kleptomania in order to arrive at clearer perspectives in diagnosis and treatment. Dannon et al. present the family psychiatric perspective of pathological gamblers and discuss commonly found dual or secondary psychiatric diagnosis in pathological gamblers and their families.

Hemmings et al. compare the genetic findings of trichotillomania with obsessive-compulsive disorder in South African population. This article is one of the pioneer studies in this field. Their investigation provides preliminary evidence for the involvement of *5-HT_{2A}* in the molecular aetiology of trichotillomania and supports the need for further replication in a larger dataset. The present data are consistent with previous findings that *5-HT_{2A}* plays a role in mediating impulse dyscontrol.

Mester et al. present an overview of stalking, a subject that is attracting intense attention in medical and legal communities, especially during the last two decades, because of the dangerous behavior of the violent stalkers and the physical and mental injury often caused to victims. This paper includes an appendix with clinical vignettes, which describe various interventions useful for dealing with the different types of stalkers.

Kertzman et al. discuss the use of modern computerized neurocognitive tests and present a research study centered on the detection of malingering using a new test for this group which is particularly user-friendly since it is quick, non-verbal and self-administered.

Three studies appear in this issue that are not directly linked to impulse control disorders but have been included for some common issues. Aviv et al. present the first study in Israel to our knowledge of sexual relations between patients and their therapists. The study is impressive in having approached all members of the Israel Psychiatric and Psychological Association with a 50% response rate. The design chosen was "indirect," in that therapists were not asked about their own behavior, which may have resulted in underreporting, but asked them to count the number of their patients who had had sexual relations with the previous therapist. Findings were similar to studies in the U.S., in that 91% of exploited patients were female, 4% were minors, 75% were evaluated as having been harmed by the relations, 4% required hospitalization and 6% attempted suicide, 6% had lodged complaints with an ethics committee and 2% with the police.

Gelkopf et al. studied comorbidity in 151 attendees at a Methadone Maintenance Treatment center and found that most had comorbid psychiatric disorders, usually anxiety and depression. The presence of comorbid axis I disorders was associated with longer attendance at the clinic, and they suggest on the basis of their interviews that 45–63% of the anxiety and depression disorders were secondary to drug-use.

Ashkar et al. carried out a retrospective study of the files of 175 adults who were hospitalized in Nahariya General Hospital following a suicide attempt. They found the incidence among Arab-Israelis to be higher than Jewish-Israelis (24.4 versus 11.0 per 100,000 population), and the Arab sample to be predominantly young females, while the Jews were older. The authors' awareness of the limitations of the sampling and possible understanding of the interethnic differences are worth reading.

Impulse control disorders are associated with high rates of anxiety and affective disorders, which lends support to the idea that anxiety rather than a desire for immediate gratification drives the

maladaptive behavior. Indeed, a central defining characteristic of impulse control disorders is the inner psychological tension, which precedes the "impulsive" behavior and the sense of relief or pleasure, which follows the behavior. The presence of this cycle of inner tension and subsequent symptom resolution is essential to the diagnosis of the impulse control disorders and distinguishes this set of disorders from pharmacological addiction where the desire for immediate gratification (reward) rather than anxiety is thought to drive the drug seeking behavior.

In the field of impulse control disorders, there is a broad choice of pharmacotherapeutic treatment options which reflects the diversity of related DSM-IV axis I comorbid diagnoses. Multiple studies (1–3) have shown SSRIs to be beneficial in the treatment of pathological gambling, kleptomania, binge eating, compulsive buying, and intermittent explosive disorder. Other agents which have been shown to be useful include lithium for pathological gambling (4, 5) and trichotillomania (6), valproate for intermittent explosive disorder (7), and topiramate for pathological gambling (8) and hoarding, compulsive buying (9). Preliminary studies have shown naltrexone to be useful in reducing the urges associated with pathological gambling (10) and kleptomania (1).

Impulse control disorders may have devastating psychosocial, legal and financial consequences. It is easy to miss the diagnosis of impulse control disorders because: 1) there may be no outward physical signs of the disorder; 2) affected individuals may be reluctant to request treatment either because of embarrassment or lack of insight into their problem, and frequently it is a family member who initiates the psychiatric referral. It is therefore incumbent on the mental health professional to play an active role in screening patients for the presence of impulse control disorders. Careful screening is the key to early intervention, and treatment of the impulse control disorder can lead to significant improvement in the patient's quality of life. This group of disorders is a major and expanding problem whose prevention and treatment requires the intervention of multidisciplinary teams including mental health workers, community social workers, police, the courts and legislators.

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