**Expert tip**

Prepare an exam-style essay on bipolar and related disorders. For part (a), the 'describe' part, decide what you need to include (and exclude). In the exam, you should spend no more than 12 minutes on this part. For part (b), the 'evaluate' part, choose a range of issues to include (three is a range). Choose two issues in addition to the named issue. You should spend no more than 18 minutes on part (b).

# Impulse control and non-addictive substance disorders

Revised

## Characteristics

### Definitions

People can be addicted to many things, not just drugs. People can be addicted to alcohol (alcoholics) and to nicotine (most smokers). However, the focus of attention here is on non-substance addictive disorders.

Simply, people can be addicted to anything, so what is the definition of an **addiction**?

An **addiction** is a condition produced by repeated consumption of a natural or synthetic substance, in which the person has become physically and psychologically dependent on the substance.

**Griffiths** (2005) believes there are six components that help define *any* addiction (even to coffee, chocolate and the internet):

- **Salience** – when an activity becomes the single most important activity in the person's life and dominates their thinking, feelings and behaviour.
- **Euphoria** – the experience people report when carrying out their addictive behaviour, such as a 'rush', a 'buzz' or a 'high'.
- **Tolerance** – where an increasing amount of activity is required to achieve the same effect.
- **Withdrawal** – the unpleasant feelings and physical effects that occur when the addictive behaviour is suddenly discontinued or reduced.
- **Conflict** – with those around them (interpersonal conflict), with other activities (job, schoolwork, social life, hobbies and interests) or from within the individual themselves (intrapsychic conflict).
- **Relapse** – chances of relapse are very high, even after a long time.

**Expert tip**

The syllabus does not include addictions to substances, so you do not need to know anything about drugs, alcoholism, physical dependence and associated terms.

**Impulse control disorders** have three typical features:

- before committing the act there is a growing tension
- during the act the person feels pleasure from acting, and often feels relief from the urge
- afterward the person may or may not feel guilt, regret or blame.

An **impulse control disorder** is a failure to resist a temptation, urge or impulse.

### Types of impulse control disorder

**Pyromania** is where a person has the urge to deliberately start a fire (and often to watch the fire or emergency services). Specifically, before setting the fire, the person must have felt some feelings of tension or arousal, must show that attraction to fire, must feel a sense of relief or satisfaction from setting the fire and witnessing it, and must not have other motives for setting the fire.

**Burton et al.** (2012) distinguished between fire-setting, arson and pyromania:

- **Fire-setting** includes both the accidental (e.g. falling asleep with a cigarette) and intentional setting of fires (with or without criminal intent).
- **Arson**, a subtype of fire-setting, is a criminal act in which one wilfully and maliciously sets fire to, or aids in setting fire to, a structure, dwelling, or property of another.
- People with **pyromania** engage in intentional and pathological fire-setting, but do not always commit the crime of arson.

Fire-setting is a behavior, arson is a crime, and pyromania is a psychiatric diagnosis.

**Kleptomania** is the repetitive, uncontrollable stealing of items not needed for personal use. Kleptomania is different from shoplifting because shoplifters plan the stealing of objects and usually steal because they do not have money to purchase the items.

Kleptomania has the following diagnostic criteria:

- recurrent failure to resist stealing impulses unrelated to personal use or financial need
- feeling increased tension right before the theft
- feeling pleasure, gratification or relief at the time of the theft
- thefts are not committed in response to delusions or hallucinations or as expressions of revenge or anger.

**Problem gambling** (a term now much preferred to *pathological* gambling) is where a person has to gamble to gain euphoria or relieve tension. This typically includes feelings of gratification or relief afterward. The term 'compulsive' is often used because compulsions are recurring actions that the individual has a need to carry out.

Blaszczynski and Nower (2002) identifed common influences in all problem gamblers: availability and access, classical and operant conditioning reinforcements, arousal effects and biased cognitive schemas. They outline three pathways into problem gambling:

- **Behaviourally conditioned** problem gamblers who gamble excessively as a result of poor decision-making strategies and bad judgements.
- **Emotionally vulnerable** problem gamblers who use gambling as a means of modifying mood states and/or to meet specific psychological needs.
- **'Antisocial impulsivist'** problem gamblers who have biological dysfunctions, either neurological or neurochemical. They are characterised by antisocial personality disorder and impulsivity.

**Now test yourself**

12 What are the typical characteristics of impulse control disorders?

**Answer on p. 198**

Tested

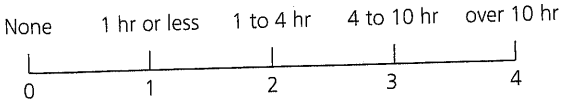
### Measure of impulse control disorder

The **kleptomania symptom assessment scale** or K-SAS (Grant and Kim, 2002) is an 11-item, self-rated scale designed to assess the change of kleptomania symptoms *during treatment*. It includes four main sections:

- four questions examine **urges/impulses** to steal
- three questions examine **thoughts** of stealing
- two questions ask about the degree of **emotional distress** immediately prior to and after the act of theft
- two questions examine emotional **distress** and **impairment** due to stealing.

All items ask for an average symptom in the last 7 days. A maximum score is 44 and any reduction shows improvement. Typical questions are shown in Figure 9.

3. During the past week, how many hours (add up hours) were you preoccupied with your urges to steal?




9. During the past week, how much emotional distress (mental pain or anguish, shame, guilt, embarrassment) had your stealing caused you?

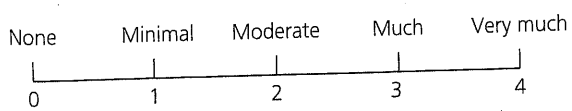



**Figure 9** Typical questions from the kleptomania symptom assessment scale (K-SAS)

**Evaluation**

- **Generalisations:** the features of addiction are said to apply to the addiction of anything (*strengths and weaknesses*).
- The K-SAS is a **psychometric test**. It is **reliable** and **valid**. It gathers **quantitative data** only. (*Strengths and weaknesses for all.*)

**Cross check**

Generalisations, page 68
Psychometric tests, page 89
Reliability, page 66
Validity, page 67

## Causes of impulse control and non-addictive substance disorders

**Biochemical causes:** when dopamine is released it gives feelings of pleasure and satisfaction. These feelings of satisfaction become desired, and to satisfy that desire the person will repeat the behaviours that cause the release of dopamine. This means that there is a complex relationship between physiological and psychological factors.

**Behavioural causes (positive reinforcement):** according to Skinner, positive reinforcement is when a behaviour is likely to repeated because of the addition of a reinforcing stimulus (a reward). If a person gambles and wins, the reward (and the thrill experienced) means the person is likely to repeat the behaviour. The thrill of stealing or setting fires and the release of dopamine explain why some people repeat this behaviour. The thrill (or high) is so intense that the person cannot resist and will do all they can to repeat the experience.

**Cognitive causes (feeling-state theory):** people often become addicted to something to reduce negative affect – to relieve anxiety and tension – or for positive affect – stimulation, relaxation and pleasure. The feeling-state theory (**Miller**, 2010) argues that disorders are created when intense positive feelings ('intense desire') become linked with specific behaviours (a 'triggering event'), and this creates a state-dependent memory or a 'feeling-state' (Figure 10).

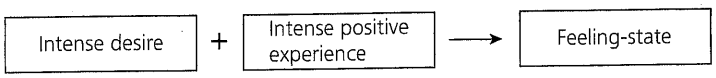



**Figure 10** Creation of the feeling-state

To generate the same feeling-state, the person compulsively repeats the same behaviour, even if it is detrimental. This re-enactment creates the impulse-control disorder (Figure 11).

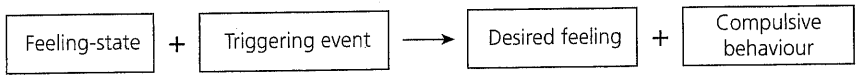



**Figure 11** Creation of the impulse-control disorder

'Feelings' refers to the total complex of sensations, emotions (physiological sensations) and thoughts related to an event (both positive and negative). There are three associated sets of beliefs:

- pre-existing negative beliefs that created the need to engage in a particular behaviour ('I'm a loser')
- positive beliefs that result from having an intense positive experience when performing the behaviour ('I'm a winner')
- negative beliefs that result when the behaviour becomes out of control (the ICD) ('I mess up everything').

This theory explains pyromania, kleptomania and gambling.

**Evaluation**

- The **behavioural** explanation is based on the work of Skinner and the **learning approach**. This is the nurture side of the **nature–nurture debate**. (*Strengths and weaknesses for all.*)
- However, the dopamine hypothesis is based on the **physiological and biochemical approaches** and the nature side of the **nature–nurture debate**. The dopamine hypothesis is **biological determinism** and **individual** rather than **situational**. (*Strengths and weaknesses for all.*)

**Cross check**

The learning approach, page 71
The biological approach, page 70
Nature–nurture debate, page 75
Determinism, page 90
Individual–situational debate, page 74

## Treating and managing impulse control and non-addictive substance disorders

**Biochemical treatments** such as selective serotonin uptake inhibitors (SSRIs) have been used to treat pyromania, kleptomania and sometimes gambling. Grant (2006) questions the use of SSRIs and suggests that other medications (such as opioid antagonists) have shown early promise in treating kleptomania. **Grant et al.** (2008) treated gamblers with the opiate antagonists nalmefene and naltrexone, which work by reducing the urge to engage in the addictive behaviour. The study invited 284 diagnosed problem gamblers and assigned half randomly to a 16-week course of nalmefene (or placebo) and the others to an 18-week course of naltrexone (or placebo). Using scores on a **Yale-Brown obsessive–compulsive scale** (see page 109) for gambling, Grant et al. found a significant reduction in urges to gamble.

**Cross check**

Strengths and weakness of drugs, page 96

### Cognitive–behavioural treatments

**Covert sensitisation** involves an aversive stimulus in the form of anxiety-producing imagery (such as being caught or feeling nauseous) being paired with the undesirable behaviour to change that behaviour. It is covert because it involves imagery about the undesired behaviour rather than the actual behaviour (which would be overt).

**Glover** (1985, 2011) reported the case of a 56-year-old woman who had been stealing from shops every day for 14 years. Every morning on awakening she would have the obsessive thought that she must shoplift later that day. Glover decided to use imagery of nausea and vomiting paired with the act of stealing. As she imagined approaching the item to steal, she would imagine vomiting which would attract the attention of other shoppers. The vomiting would cease as she replaced the article and left the shop. At her final appointment, 19 months after completion of covert sensitisation, she had not once lapsed into stealing.

Similarly, Kohn and Antonuccio (2002) used kleptomania-specific covert sensitisation (images of getting arrested, going to court and spending time in jail) successfully.

**Imaginal desensitisation** involves teaching progressive muscle relaxation and then the person *visualises* themselves being exposed to the situation that triggers the drive to carry out the impulsive behaviour. The aim is to reduce the strength of the drive. **Blaszcznski and Nower** (2003) found this technique was particularly effective with gamblers. There are six steps in a typical treatment sequence:

1. Initiating the urge.
2. Planning to follow through on the urge.
3. Arriving at the venue.
4. Getting arousal and excitement with the behaviour.
5. Having 'second thoughts' about the behaviour.
6. Decreasing the attractiveness of the behaviour.

Sessions are initially conducted with the therapist but can then be conducted at home. The 'home' pack includes:

- Tape 1 so the client can listen to the imaginal desensitisation process.
- Handout 1: a table to be completed regarding situations, feelings and thoughts that trigger the need to carry out the behaviour.
- Handout 2: a script for conducting progressive muscle relaxation.
- Handout 3: a sheet to record each day the number of times Tape 1 is listened to.

At the end of the programme the client should report a significant reduction in the frequency and intensity of urges to act on impulse.

**Expert tip**

In the Blaszcznski and Nower study, the client is conducting and recording details of their own therapy. Think about the advantages and disadvantages of a client conducting their own therapy at home.

**Impulse control therapy** is outlined by **Miller** (2010). Based on his theory of feeling-states, he believes that both cognitive *and* behaviour change is necessary to control the disorder. Miller proposed the **impulse-control disorder protocol** (ICDP) developed from EMDR. EMDR is eye-movement desensitisation and reprocessing, which was originally devised by Shapiro (1998) to treat post-traumatic stress disorder (PTSD). EMDR treatment involves identifying the traumatic image, identifying the negative feelings and beliefs associated with the image, and then using eye movements to process the image and feelings and install positive beliefs and feelings.

Miller outlines a 12-step process summarised as:

- identifying the specific aspect of the compulsive behaviour that has the most emotional intensity
- identifying the specific positive feeling (and physical sensations) associated with this behaviour and calculating its PFS* rating
- forming an image linking the behaviour, feelings and sensations
- performing eye movements (EMDR)
- setting homework and conducting follow-up sessions

* Baseline and progress can be assessed using the **positive feelings scale** (PFS) with 10 being the most positive feelings.

Miller cites the case study of 'John', a 35-year-old male with a gambling problem who had lost more than $1,000,000 playing poker. John's 'feeling-states' were identified, e.g. a time when he won $16,000 and felt excitement. His PFS was rated as 10. John followed the 12-step process and in his follow-up interview 3 months later he reported that his poker compulsion had not returned.

**Evaluation**

- The biological treatments are **reductionist** (*strengths and weaknesses*) but so are the cognitive-behavioural treatments.
- Biochemical treatments are based on the **physiological and biochemical approaches** (*strengths and weaknesses*) and the nature side of the **nature–nurture** debate.
- Biological treatments are **biological determinism** and **individual** rather than **situational**. The two **case studies** reported here have many strengths and weaknesses.

**Cross check**

Reductionism, page 89
Nature–nurture debate, page 75
Determinism, page 90
Individual–situational debate, page 74
Case studies, page 51

**Expert tip**

Prepare an exam-style essay on impulse control and non-addictive substance disorders. For part (a), the 'describe' part, decide what you need to include (and exclude). In the exam, you should spend no more than 12 minutes on this part. For part (b), the 'evaluate' part, choose a range of issues to include (three is a range). Choose two issues in addition to the named issue. You should spend no more than 18 minutes on part (b).

# Anxiety disorders

Revised

## Characteristics

### Definitions and types

Some people have **generalised anxiety disorder**, meaning they might have a 'panic attack' but do not know its cause. The characteristics of generalised anxiety disorder are as follows:

- Excessive, uncontrollable and often irrational worry, which interferes with daily functioning.
- Physical symptoms of headaches, nausea, numbness in hands and feet, muscle tension, difficulty swallowing and/or breathing, trembling, twitching and sweating.

**Anxiety** is a general feeling of dread or apprehensiveness accompanied by various physiological reactions such as increased heart rate, sweating, muscle tension, and rapid and shallow breathing.