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■ Little control over the negative behavior. Impulse control disorders are characterized by problems in the self-regulation of emotions and behaviors. 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. Core qualities of the impulse control disorders are as follows: ■ Repetitive or compulsive engagement in behavior despite adverse consequences. ■ Anxiety or craving experienced prior to engagement in impulsive behavior. ■ Relief or satisfaction during or after completion of the behavior. Mr. Baker is a 27-year-old married accountant who arrives at the outpatient psychiatry clinic complaining of difficulty in managing his anger. He has no prior psychiatric history, but reports that he has had difficulty controlling his temper since adolescence. He reports that he is easily angered by small occurrences, such as his wife’s failing to make coffee or a coworker’s forgetting a pen at work. He reacts quickly and in a volatile way, describing it as “going from 0 to 60 before I know it.” Mr. Baker feels that he is unable to control his anger; on several occasions he has thrown objects and destroyed property in fits of

rage, and has made threatening statements to his wife and coworkers in the past year. Because of these incidents, one coworker has recently threatened to pursue legal action. Mr. Baker describes these episodes as brief, lasting only 10–15 minutes, and feels embarrassed shortly after the episode has transpired. He is concerned he may lose his job because of his behavior, and he worries about the fate of his relationships. He rarely drinks alcohol, and denies any history of illicit drug use. What is his most likely diagnosis? Based on Mr. Baker’s history, his most likely diagnosis is intermittent explosive disorder. However, it is important to recognize that impulsivity is a common characteristic of other psychiatric diagnoses, and these must be ruled out prior to diagnosing a patient with this disorder. What would be your recommended treatment? Treatment for this disorder usually involves medications to treat impulsive aggression. These include selective serotonin reuptake inhibitors (SSRIs)— fluoxetine being the most studied—and mood stabilizers such as anticonvulsants and lithium. Individual psychotherapy is difficult and has limited efficacy given the nature of the disease and lack of individual control. However, cognitive-behavioral therapy (CBT) has been used in the treatment of anger management. Group therapy and/or family therapy may be useful to create behavior plans to help manage episodes. What are associated laboratory findings? In some impulsive individuals, cerebrospinal fluid testing shows low mean 5-hydroxyindoleacetic acid (5-HIAA) concentration. There may also be nonspecific electroencephalographic findings or abnormalities on neuropsychological testing.

Intermittent Explosive Disorder DIAGNOSIS AND DSM-5 CRITERIA ■ Recurrent behavioral outbursts resulting in verbal and/or physical aggression against people or property. 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. Patients may have a history of childhood physical or emotional abuse or head trauma. TREATMENT ■ Treatment involves use of SSRIs, anticonvulsants, or lithium. ■ CBT 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 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. IMPULSE CONTROL DISORDERS KEY FACT Low levels of serotonin in the CSF have been shown to be associated with impulsiveness and aggression. WARDS QUESTION Q: What conditions should be considered in the differential diagnosis for an adult with possible intermittent explosive disorder? A: Substance intoxication or withdrawal, antisocial or borderline personality disorders, neurologic disorders (e.g., TBI, seizures), ADHD, bipolar disorder, and psychotic disorders.

EPIDEMIOLOGY/ETIOLOGY WARDS QUESTION Q: What eating disorder is most commonly comorbid with kleptomania? A: Bulimia nervosa. An estimated 65% of patients with kleptomania also suffer from bulimia nervosa. ■ Occurs in 4–24% of shoplifters. TREATMENT Pyromania DIAGNOSIS AND DSM-5 CRITERIA KEY FACT Pyromania is the impulse to start fires, typically with feelings of gratification or relief afterward. EPIDEMIOLOGY/ETIOLOGY TREATMENT ■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. ■ 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. 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. ■ 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. ■ 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. 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.