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9 Eating and impulse-control disorders

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410 Chapter 9 Eating and impulse-control disorders Anorexia nervosa 1: overview Essence A condition most commonly seen in young women, in which there is marked distortion of body image, a pathological desire for thinness, and self-induced weight loss by a variety of methods. Significant mortality: 10– 15% (2/3 physical complications, 1/3 suicide). Epidemiology ♂:♀ = 1:10; mean age of onset: ♀ 16–17yrs (rarely >30yrs); ♂ 712yrs. Incidence 70.5% of adolescent and young women. Prognosis If untreated, this condition carries one of the highest mortality figures for any psychiatric disorder (10–15%). If treated, ‘rule of thirds’ (1/3 full re covery, 1/3 partial recovery, 1/3 chronic problems). Poor prognostic fac tors: chronic illness, late age of onset, bulimic features (vomiting/purging). Diagnostic criteria (ICD-10) • Low body weight—15% + below expected, BMI 17.5 or less (see Table 9.1). • Self-induced weight loss—avoidance of ‘fattening’ foods, vomiting, purging, excessive exercise, use of appetite suppressants. • Body image distortion—‘dread of fatness’: overvalued idea, imposed low weight threshold. • Endocrine disorders—HPA axis, e.g. amenorrhoea, reduced sexual interest/impotence, raised GH levels, raised cortisol, altered TFTs, abnormal insulin secretion. • Delayed/arrested puberty—if onset pre-pubertal. Table 9.1 Body mass index (BMI)* BMI is a ratio between weight and height and is more useful for predicting health risks than the weight alone (for adults aged 18+ yrs). BMI = Weight (in kg)/height (in m)2 Or BMI = Weight (in pounds) × 704.5/height (in inches)2 Women Men Interpretation Risk to health <19.1 <20.7 Underweight The lower the BMI, the greater the risk 19.1–25.8 20.7–26.4 Ideal weight Normal, very low risk 25.8–27.3 26.4–27.8 Marginally overweight Some risk 27.3–32.2 27.8–31.1 Overweight Moderate risk 32.3–44.8 31.1–45.4 Very overweight or obese High risk

> 44.8 45.4 Morbidly obesity Very high risk Note: BMI is less reliable for: children and teenagers (ranges are based on adult heights), competitive athletes and bodybuilders (muscle weight may skew the results), pregnant or nursing women, and people over 65yrs.

- The formula for BMI was developed by the Belgian statistician Adolphe Quetelet in the nineteenth century and is sometimes referred to as the 'Quetelet's formula'.

Anorexia nervosa 1: overview Differential diagnosis • Chronic debilitating physical disease, brain tumours. • GI disorders (e.g. Crohn's disease, malabsorption syndromes). • Loss of appetite (may be secondary to drugs, e.g. SSRIs). • Depression/OCD (features of which may be associated). Aetiology • Genetic Concordance MZ:DZ = 65%:32%, ♀ siblings: 6–10%. • Adverse life events No excess of childhood physical or sexual abuse (compared to psychiatric controls). • Psychodynamic models: • Family pathology—enmeshment, rigidity, over-protectiveness, lack of conflict resolution, weak generational boundaries. • Individual pathology—disturbed body image (dietary problems in early life, parents' food preoccupation, poor sense of identity). • Analytical model—regression to childhood, fixation on the oral stage, escape from the emotional problems of adolescence. • Biological: • Hypothalamic dysfunction—cause or consequence? • Neuropsychological deficits—reduced vigilance, attention, visuospatial abilities, and associative memory (reversible). • Brain imaging—CT: sulcal widening and ventricular enlargement (corrects with weight gain). Atypical eating disorders (ICD-10) • In >50% of eating disorder cases in the community, one or more of the key features may be absent, or all are present but to a lesser degree.1 • For atypical cases, the National Institute for Health and Care Excellence (NICE) recommends considering treatment for the eating disorder that it most closely resembles.2 1 Fairbairn CG, Cooper Z (2007) Thinking afresh about the classification of eating disorders. Int J Eat Disord 40(Suppl):S107–10. 2 National Institute for Health and Care Excellence (2017) Eating disorders: recognition and treatment. NICE guideline [NG69]. M https://www.nice.org.uk/guidance/ng69 [accessed 4 July 2018].

412 Chapter 9 Eating and impulse-control disorders Anorexia nervosa 2: physical consequences (See Fig. 9.1 and Box 9.1.) Cardiac complications • The most common cause of death (mortality rate 7–10%). • Findings may include: • Significant bradycardia (30–40bpm) and hypotension (systolic <70mmHg). • ECG changes (sinus bradycardia, ST-segment elevation, T-wave flattening, low voltage, and right axis deviation) may not be clinically significant, unless there are frequent arrhythmias (QT prolongation may indicate an i risk for arrhythmias and sudden death). • Echocardiogram may reveal a decreased heart size, decreased left ventricular mass (with associated abnormal systolic function), and mitral valve prolapse (without significant mitral regurgitation). These changes reflect malnutrition and are reversible. Nervous system Dermatological Cardiovascular Haematological Metabolic Renal Musculoskeletal Gastrointestinal (GI) Endocrine and Reproductive (Impaired concentration, cognitive performance, and peripheral neuropathy) (Dry skin, brittle hair, hair loss, lanugo body hair) (Low blood pressure, bradycardia arrhythmias, prolonged QTc, cardiomyopathy) (Anaemia, leucopenia, thrombocytopenia) (Hypokalaemia, hyponatraemia, hypoglycaemia, hypothermia) (Renal calculi, impaired renal function) (Myopathy, osteoporosis) (Prolonged GI transit - delayed gastric emptying, altered antral motility, gastric atrophy, decreased intestinal motility, constipation) (Amenorrhoea, infertility, low

birthweight of infant) Fig. 9.1 Physical consequences of anorexia nervosa.

Anorexia nervosa 2: physical consequences Amenorrhoea • Due to hypothalamic dysfunction (hypothalamic–pituitary–ovarian axis) with low levels of follicle-stimulating hormone (FSH) and LH, despite low levels of oestrogen [reversion to the pre-pubertal state occurs with LH response to gonadotrophin-releasing hormone (GnRH) blunted, leading to amenorrhoea]. • Consequences include reduced fertility, multiple small follicles in the ovaries, d uterine volume, and atrophy. • Note: weight loss, excessive exercise, and stress are also important. However, amenorrhoea can persist (in 5–44% of cases), even after recovery. Osteopenia Both cortical and trabecular bones are affected, and osteopenia persists despite oestrogen therapy. Contributing to bone loss are low levels of pro gesterone and d insulin-like growth factor-1 (IGF-1) levels. Treatment • No specific treatment exists; however, 1000–1500mg/d of dietary calcium and 400IU of vitamin D are recommended to prevent further bone loss and maximize peak bone mass. • Exercise and hormone replacement therapy (HRT), although of benefit in adult women, may be harmful for adolescents with anorexia nervosa (causing premature closure of bone epiphysis). Box 9.1 Physical signs • Loss of muscle mass • Dry skin • Brittle hair and nails • Callused skin over interphalangeal joints (Russell sign) • Pallor • Hypercarotinaemia (yellow skin and sclera) • Fine, downy, lanugo body hair • Eroded tooth enamel • Peripheral cyanosis • Hypotension and postural hypotension • Bradycardia • Hypothermia • Atrophy of the breasts • Swelling of the parotid and submandibular glands • Swollen, tender abdomen (intestinal dilatation due to reduced motility and constipation) • Peripheral neuropathy

414 Chapter 9 Eating and impulse-control disorders Anorexia nervosa 3: assessment Full psychiatric history (See Box 9.2.) • Establish the context in which the problems have arisen (to inform the development of a treatment plan). • Confirm the diagnosis of an eating disorder. • Assess the risk of self-harm/suicide. Full medical history • Focus on the physical consequences of altered nutrition (E Anorexia nervosa 2: physical consequences, p. 412). • Detail weight changes, dietary patterns, and excessive exercise. Physical examination • Determine weight and height (calculate BMI; see Table 9.1). • Assess for physical signs of starvation and vomiting (see Box 9.1). • Investigations (see Box 9.3) with special emphasis on high-risk findings (see Table 9.2). Box 9.2 Commonly reported psychiatric symptoms • Concentration/memory/decision-making problems • Irritability • Depression • Low self-esteem • Loss of appetite • Reduced energy • Insomnia • Loss of libido • Social withdrawal • Obsessiveness regarding food Box 9.3 Investigations • FBC Anaemia, thrombocytopenia, low white cell count (WCC), neutropenia • ESR Investigate raised ESR as may indicate physical cause • U&Es, phosphate, magnesium, bicarbonate, LFTs Raised urea and creatinine (dehydration), hyponatraemia,, hypokalaemic/ hypochloraemic metabolic alkalosis (from vomiting), metabolic acidosis (laxative abuse). Other abnormalities may include hypocalcaemia, hypophosphataemia, hypomagnesaemia, raised LFTs • Glucose Hypoglycaemia (prolonged starvation and low glycogen stores) • TFTs Low T3/T4, increased rT3 (euthyroid sick syndrome—hormonal replacement not necessary; reverts to normal on refeeding) • ECG Sinus bradycardia, raised QTc, signs of ischaemia, arrhythmias

Anorexia nervosa 3: assessment Table 9.2 Physical risk assessment in anorexia nervosa BMI Low risk: 15–17.5 Medium risk: 13–15 High risk: <13 Rate of weight loss

> 0.5kg per week = moderate risk 1.0kg per week = high risk Vital signs Low pulse (<40bpm i risk) Low blood pressure (especially if symptomatic) Temperature(<35°C i risk) Blood tests Low sodium (<130mmol/L: high risk) Low potassium (<3.0mmol/L: high risk) Raised transaminases Hypoglycaemia (blood glucose <3mmol/L) Raised urea or creatinine Low haemoglobin, neutrophils, platelets ECG Bradycardia (<40bpm i risk) Raised QTc (>450ms i risk), non-specific T-wave changes Source: data from Treasure, J (2009) A guide to the medical risk assessment for eating disorders. Section of Eating Disorders at the Institute of Psychiatry and the Eating Disorders Unit at SLaM. Available at M http://www.kcl.ac.uk/ioppn/depts/pm/research/eatingdisorders/resources/GUIDETOMEDICALRISKASSESSMENT.pdf [accessed: 4 Jul 2018].

416 Chapter 9 Eating and impulse-control disorders Anorexia nervosa 4: management General principles • Most patients will be treated as outpatients. • A combined approach is better: • Pharmacological Medication should not be used as sole treatment. • Psychological Anorexia nervosa-focused family therapy (indicated for children and young people); for adults, individual therapy, including adapted CBT (CBT-E),3 up to 40 sessions. • Dietetic counselling As part of multidisciplinary treatment. Criteria for admission to hospital (See Box 9.4 and Table 9.2.) • Inpatient management may be necessary for patients with rapid or excessive weight loss, failure of outpatient treatment, severe electrolyte imbalance (e.g. hypokalaemia or hyponatraemia), serious physiological complications, e.g. temperature <36°C, fainting due to bradycardia—PR <40bpm) and/or marked postural drop in BP, cardiac complications, significantly raised LFTs, marked change in mental status due to severe malnutrition, psychosis, or significant risk of suicide. • The location of any admission should be carefully considered— Management of really sick patients with anorexia nervosa (MARSIPAN) recommends that most patients with severe anorexia nervosa should be treated within a specialist eating disorder unit. • Admission goals of inpatient therapy should be fully discussed with the patient (and their family) and may include: • Addressing physical and/or psychiatric complications. • Supporting the patient to manage eating-disordered behaviours and thoughts and supporting them to follow an agreed menu plan. 3 CBT-Enhanced (CBT-E) and was developed by Christopher G Fairburn in the 1970s and 1980s, originally specifically for bulimia nervosa, but later for all eating disorders. The approach deals with both eating habits and other issues that do not directly involve eating (see Fairburn CG (2008) Cognitive behavior therapy and eating disorders. New York, NY: Guilford Press). Box 9.4 RCPsych (2014) College Report (CR189) MARSIPAN (Management of Really Sick Patients with Anorexia Nervosa), second edition • Written by the Royal College of Psychiatrists, the Royal College of Physicians, and the Royal College of Pathologists due to ‘concerns that patients with severe anorexia nervosa were being admitted to general medical units and sometimes deteriorating and dying because of psychiatric problems, such as non-adherence to nutritional treatment, and medical complications, such as re-feeding syndrome. Sometimes overzealous application of National Institute for Health and Care Excellence (NICE) guidelines led to death from underfeeding syndrome’. • Focuses on patients with a BMI of <15 • Contains guidance for clinicians on managing such patients Source: data from M http://www.rcpsych.ac.uk/files/pdfversion/CR189.pdf [accessed: 4 Jul 2018].

Anorexia nervosa 4: management Refeeding syndrome (See Box 9.5.) • Characterized by severe electrolyte disturbances (principally low serum concentrations of phosphate, magnesium, and potassium) and metabolic abnormalities while undergoing refeeding, whether orally, enterally, or parenterally. • Other clinical features include cardiac complications (heart failure, arrhythmias), renal impairment, and liver function abnormalities. • Preventable, treatable, under-recognized; can be fatal. Inpatient management • If at high risk of refeeding syndrome, review or consult with professionals with expertise in this area (e.g. dietitian, eating disorder psychiatrist, physician with expertise in nutrition) to commence the patient on an appropriate menu plan (may start with lower calorie intake and increase over 10 days and be further adapted to reduce the risk of refeeding syndrome). • If at high risk of refeeding syndrome, prescribe thiamine, Vitamin B Compound Strong, and a multivitamin, and consider daily bloods [full blood count (FBC), U&Es, LFTs, phosphate, magnesium, glucose) and ECGs for the first 10 days, reducing in frequency thereafter if within the normal range. • If blood monitoring detects a reduction of phosphate, magnesium, and potassium serum levels, consider supplementation (in line with local guidance) and review dietetically. • If signs of refeeding syndrome are detected, including electrolyte disturbances/cardiac symptoms or signs/ ECG changes, review medically and consult with senior medical colleagues with expertise in this area. Box 9.5 Criteria for determining people at high risk of developing refeeding problems Patient has one or more of the following: • BMI <16kg/m2 • Weight loss >15% within the last 3–6 months • Little or no nutritional intake for >10 days • Low levels of potassium, phosphate, or magnesium prior to feeding Or patient has two or more of the following: • BMI <18.5kg/m2 • Weight loss >10% within the last 3–6 months • Little or no nutritional intake for >5 days • History of alcohol abuse or drugs, including insulin, chemotherapy, antacids, or diuretics Source: data from NICE Clinical Guideline (CG32) Nutrition support for adults: oral nutrition support, enteral tube feeding and parenteral nutrition. Feb 2006. M https://www.nice.org.uk/ guidance/cg32 [accessed: 4 Jul 2018].

418 Chapter 9 Eating and impulse-control disorders Bulimia nervosa Essence Characterized by recurrent episodes of binge eating, with compensatory behaviours and overvalued ideas about ‘ideal’ body shape and weight. Often there is a past history of anorexia nervosa (30–50%) and body weight may be normal. Epidemiology Incidence 1–1.5% of women, mid-adolescent onset, and presentation in early 20s. Aetiology Similar to anorexia nervosa, but also evidence for associated personal/ family history of obesity and family history of affective disorder and/or substance misuse. Possible ‘dysregulation of eating’, related to serotonergic mechanisms [possible supersensitivity of 5-hydroxytryptamine 2C (5-HT2C) due to d5-HT]. Prognosis Generally good, unless there are significant issues of low self-esteem or evidence of a severe personality disorder. Diagnostic criteria (ICD-10) • Persistent preoccupation with eating (see Box 9.6). • Irresistible craving for food. • ‘Binges’—episodes of overeating (see also Box 9.7). • Attempts to counter the ‘fattening’ effects of food (self-induced vomiting, abuse of purgatives, periods of starvation, use of drugs, e.g. appetite suppressants, thyroxine, diuretics). • Morbid dread of fatness, with imposed ‘low weight threshold’. Box 9.6 The SCOFF questions Useful as a screening tool for eating disorders in primary care. Sensitivity is low, and a score of 2+ ‘yes’ answers indicates that a further, more de tailed history is indicated, before considering treatment or referral. • Do you make yourself Sick because you feel uncomfortably full? • Do you worry you have lost Control over how much you eat? • Have you recently lost more than One stone in a 3-month period? • Do you believe yourself to be Fat when others say you are too thin? • Would you say that Food dominates your life? Reprinted from Morgan JF, Reid F, and Lacey JH (1999) The SCOFF questionnaire: assessment of a new screening

tool for eating disorders. Br Med J 319: 1467–8 with permission from the BMJ Publishing Group Ltd.

Bulimia nervosa Physical signs • May be similar to anorexia nervosa (E Anorexia nervosa 2: physical consequences, p. 412), but less severe. • Specific problems related to ‘purging’ include: • Arrhythmias. • Cardiac failure (sudden death). • Electrolyte disturbances [dK+, dNa+, dCl–, metabolic acidosis (laxatives) or alkalosis (vomiting)]. • Oesophageal erosions. • Oesophageal/gastric perforation. • Gastric/duodenal ulcers. • Pancreatitis. • Constipation/steatorrhoea. • Dental erosion. • Leucopenia/lymphocytosis. Investigations As for anorexia nervosa (E Anorexia nervosa 3: assessment, p. 414). Differential diagnosis • Upper GI disorders (with associated vomiting). • Brain tumours. • Other mental disorders, e.g. personality disorder, depression, OCD. • Drug-related i appetite (E Weight gain with psychiatric medication, p. 1000). • Other causes of recurrent overeating (e.g. menstrual-related syndromes, E Menstrual-related disorders, p. 488; Kleine–Levin syndrome, E Hypersomnia 3: other causes, p. 452). Comorbidity • Anxiety/mood disorder. • ‘Multiple dyscontrol behaviours’, e.g. cutting/burning, overdose, alcohol/drug misuse, promiscuity, other impulse disorders (E Impulse- control disorders 1, p. 422; E Impulse-control disorders 2, p. 424; E Impulse-control disorders 3, p. 428). Box 9.7 Binge eating disorder (DSM-5; ICD-11) Increasingly recognized as a diagnosis, although not in ICD-10. • Recurrent episodes of binge eating (1+/week) without compensatory behaviours of bulimia and 3+ of: eating more rapidly; eating until uncomfortably full; eating large amounts when not hungry; eating alone due to embarrassment; feeling disgusted, depressed, or guilty after • Treat with guided self-help and up to 20 sessions of adapted CBT (CBT-E, E Anorexia nervosa 4: management, p. 416)

420 Chapter 9 Eating and impulse-control disorders Treatment • General principles: • Full assessment (as for anorexia nervosa, E Anorexia nervosa 3: assessment, p. 414). • Usually managed as an outpatient. Admission for suicidality, physical complications, extreme refractory cases, or if pregnant. • Combined approaches improve outcome. • Pharmacological: • Medication should not be used as sole treatment. • Most evidence for high-dose SSRIs (fluoxetine 60mg). • Psychotherapy: • Guided self-help as a first step; CBT adapted for eating disorders (CBT-E, E Anorexia nervosa 4: management, p. 416), up to 20 sessions. • Family therapy for children and young people.

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422 Chapter 9 Eating and impulse-control disorders Impulse-control disorders 1 Impulse-control disorders (ICDs)4 are disorders in which a person acts on a certain impulse that is potentially harmful, but to which they cannot resist. There is usually an increasing sense of arousal or tension prior to commit ting or engaging in the act and an experience of pleasure, gratification, or release of tension at the time of committing the act (unlike OCD where acts are not in themselves pleasurable). DSM-5’s ‘Disruptive, impulse- control, and conduct disorders’ now includes: oppositional defiant disorder, intermittent explosive disorder, conduct disorder, antisocial personality disorder, pyromania, and kleptomania. Gambling disorder is moved to the ‘Substance-related and addictive disorders’ section, and trichotillomania and excoriation disorder are in a new ‘Obsessive-compulsive and related disorders’ category. ICD-11 follows similar lines but retains pyromania, kleptomania, and intermittent explosive disorder within ‘Impulse control disorders’, with the addition of compulsive sexual behaviour disorder (CBSD). Gambling disorder moves to

‘Disorders due to addictive behav iours’, with a new category—gaming disorder. (See Box 9.8.) Pathological fire-setting/pyromania (ICD-10/11; DSM-5) Multiple episodes of deliberate, purposeful fire-setting, leading to property damage, legal consequences, and injury or loss of life. Rare in children; more common in male adolescents, particularly those with poor social skills and learning difficulties. Clinical features • Tension or affective arousal before the act. • Fascination with, interest in, or attraction to fire and its situational contexts. • Pleasure, gratification, or relief when setting fires or when witnessing or participating in the aftermath. • Evidence of advance preparation. • Indifference to consequences on property or life. • Not for financial gain, to express sociopolitical ideology, to conceal criminal activity, as an expression of anger or vengeance, to improve one’s living circumstances, due to delusions or hallucinations, or as a result of impaired judgement. Differential diagnosis Conduct disorder, ADHD, adjustment disorder, other major affective or psychotic disorder. Comorbidity Substance misuse, past history of sexual or physical abuse, antisocial personality disorder. Treatment Should address any underlying or comorbid psychiatric dis order. Psychotherapeutic intervention may be helpful (e.g. CBT). Pathological stealing/kleptomania (ICD-10/11; DSM-5) Failure to resist impulses to steal items that are not needed for their per sonal use or monetary value. Usually women, mean age 36yrs, mean dur ation of illness 16yrs (often childhood onset). 75% of stealing in the United States (USA). 4 Dell’Osso B, Altamura AC, Allen A, et al. (2006) Epidemiologic and clinical updates on impulse control disorders: a critical review. Eur Arch Psychiatry Clin Neurosci 256:464–75.

Impulse-control disorders 1 Clinical features • Recurrent failure to resist impulses to steal objects that are not needed for personal use or their monetary value. • Increasing sense of tension immediately before committing the theft. • Pleasure, gratification, or relief at the time of committing the theft. • The stealing is not committed to express anger or vengeance and is not in response to a delusion or a hallucination. • The stealing is not better accounted for by a conduct disorder, a manic episode, or an antisocial personality disorder. Differential diagnosis Shoplifting (usually well-planned, motivated by need or financial gain), antisocial personality disorder, OCD, depression. Comorbidity Eating disorders, substance abuse, depression. May be pre cipitated by major stressors (e.g. loss events). Treatment SSRIs (e.g. fluoxetine); psychotherapy (e.g. CBT, family therapy). Intermittent explosive disorder (DSM-5; ICD-11) DSM-5 (and now ICD-11) recognizes intermittent explosive disorder (IED) in individuals who have extreme explosive behaviours out of proportion to the actual trigger (e.g. a person who feels insulted by a coworker may go into the lunch area, rip down cabinets, throw the chairs, and only later feel guilty and embarrassed). Life prevalence 2–11%; occurs most often in young men. Episodes are typically infrequent [unlike ICD-10’s emotionally unstable personality disorder (EUPD)-impulsive subtype] and last 20min or less. Associated symptoms: tingling, tremor, palpitations, chest tightness, head pressure, hearing an echo. Clinical features • Several discrete episodes of failure to resist aggressive impulses that result in serious assaultive acts or destruction of property. • The degree of aggressiveness expressed during the episodes is grossly out of proportion to any precipitating psychosocial stressors. • Not due to another disorder or substance use. Differential diagnosis ADHD, bipolar disorder, conduct disorder, person ality disorder (antisocial), oppositional defiant disorder. Treatment Evaluate and treat comorbid disorders. IED is challenging to treat, and most efforts are focused on minimizing aggression. There is some evidence for the use of mood stabilizers (lithium, semisodium valproate, maybe carbamazepine), phenytoin, SSRIs, β-blockers (especially if brain in jury is present), α2-agonists (clonidine), and antipsychotics.

424 Chapter 9 Eating and impulse-control disorders Impulse-control disorders 2 Pathological gambling disorder (ICD-10)/gambling disorder (DSM-5; ICD-11) Persistent and recurrent maladaptive patterns of gambling behaviour that may lead to significant personal, family, and occupational difficulties.5 The disorder is felt to start in adolescents where the prevalence is 4–7%. Prevalence in adults is reported to be around 1–3%, whereas around 80% of the general population consider themselves 'recreational gamblers'. Diagnostic criteria • Preoccupation with gambling (thinking of past gambling experiences, planning the next experience, or thinking of ways to get money to gamble). • Needing to gamble with larger amounts of money to get the same feeling of excitement. • Unsuccessful attempts to stop gambling or to cut down. • Restlessness or irritability when trying to cut down or stop gambling. • Gambling to escape from problems or to relieve feelings of anxiety, depression, or guilt. • Chasing losses (return after losing to get even). • Lying to family or friends about gambling. • Committing illegal acts to finance gambling. • Has lost or jeopardized a significant relationship, job, career, or educational opportunities because of gambling. • Relies on family or friends for money to relieve financial problems caused by gambling. • The gambling behaviour is not better accounted for by a manic episode. Box 9.8 The rise of 'behavioural addiction' 'Addiction' is not a unitary construct but incorporates a number of fea tures, including: repetitive engagement in behaviours that are rewarding (at least initially), loss of control, persistence despite negative functional consequences, and physical dependence (E The dependence syndrome, p. 574). Whether certain disorders, characterized by maladaptive, re petitive behaviours, such as kleptomania, compulsive sexual behaviour, trichotillomania (hair pulling disorder), skin picking disorder, gambling disorder, and gaming disorder, should be regarded as 'behavioural addic tions', 'impulse-control disorders', or 'compulsive behaviour disorders' remains controversial. The myriad of other proposed specific 'behav ioural addictions' (e.g. food, sex, porn, the Internet, mobile phones, work, exercise, shopping, plastic surgery, tanning, dancing) is overwhelming. Most commentators agree that research into the aetiology, phenomen ology, comorbidity, neurobiology, and treatment of such conditions is the only way to meaningfully settle such issues and to lay the foundations for future diagnostic classification systems. 5 Grant J, Potenza E, Marc N (2004) Impulse control disorders: clinical characteristics and pharma cological management. Ann Clin Psychiatry 16:27–34.

Impulse-control disorders 2 Comorbidity Highly comorbid with mood disorders (both depression and bipolar), substance abuse or dependence. Other associations seen with ADHD, other impulse-control disorders, and personality disorders (espe cially cluster B DSM-5). Treatment Exclusion and treatment of any comorbid psychiatric dis order. Proposed specific treatments to control addictive behaviour in clude SSRIs (e.g. fluoxetine, fluvoxamine, paroxetine, citalopram), lithium, clomipramine, and naltrexone. CBT may also help reduce preoccupation with gambling. Trichotillomania (ICD-10/11; DSM-5) Recurrent pulling of one's own hair, exacerbated by stress or relaxation (e.g. reading, watching TV).6, 7 Feelings of tension are relieved by pulling hair. Usually involves the scalp but may include eyelashes, eyebrows, axillae, and pubic and any other body regions. In children, ♀ = ♂, often with a limited course. In adults, ♀ (3.4%) > ♂ (1.5%), with a chronic or episodic course. Lifetime prevalence rate of 1–2%. Clinical features • Recurrent pulling out of one's hair, resulting in noticeable hair loss. • An increasing sense of tension immediately before pulling out the hair or when attempting to resist the behaviour. • Pleasure, gratification, or relief when pulling out the hair. • The disturbance is not better accounted for by another mental disorder and is not due to a general medical condition (e.g. a dermatological condition). • The behaviour causes clinically significant distress or impairment in social or occupational functioning.

Associated features Examining hair root, pulling strands between teeth, trichophagia (eating hairs), nail biting, scratching, gnawing, excoriation. Differential diagnosis OCD, psychotic disorder (e.g. delusional parasitosis, tactile hallucinations/formication), Tourette's syndrome, per vasive developmental disorder (e.g. autism), stereotyped behaviour, body dysmorphic disorder, factitious disorder. Comorbidity OCD, excoriation disorder, depressive disorder, general ized anxiety disorder, personality disorder. Treatment Address any comorbid disorder. Treat any secondary med ical complications (e.g. infection). CBT/behavioural modification (substitu tion, positive/negative reinforcement) is key to treatment. There is some evidence for the use of SSRIs, clomipramine, pimozide, risperidone, and lithium. Excoriation (skin picking) disorder (DSM-5; ICD-11)7 Recurrent skin picking resulting in skin lesions, associated with repeated at tempts to decrease or stop behaviour, significant distress or impairment of social/occupational/or other areas of functioning. Not due to use of 6 Walsh KH, McDougle CJ (2001) Trichotillomania: presentation, etiology, diagnosis and therapy. Am J Clin Dermatol 2:327–33. 7 Stein DJ, Grant JE, Franklin ME, et al. (2010) Trichotillomania (hair pulling disorder), skin picking disorder, and stereotypic movement disorder: toward DSM-V. Depress Anxiety 27:611–26.

426 Chapter 9 Eating and impulse-control disorders substances, a medical condition, or other mental disorder (e.g. delusions or tactile hallucinations in a psychotic disorder, attempts to improve a perceived defect or flaw in appearance in body dysmorphic disorder, stereotypies in stereotypic movement disorder, or intention to harm one self in non-suicidal self-injury). In general population, ♀:♂ 3:1, with 1–1.4% lifetime prevalence. More common in individuals with OCD and their first- degree relatives. Differential diagnosis/comorbidity/treatment As for trichotillomania (E Trichotillomania (ICD-10/11; DSM-5), p. 425) Course Usual onset during adolescence, may begin with a dermato logical condition such as acne. Sites of skin picking may vary over time. Course is chronic, with some waxing and waning if untreated.

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428 Chapter 9 Eating and impulse-control disorders Impulse-control disorders 3 Gaming disorder (ICD-11)8 Classified under 'Disorders due to addictive behaviours' in ICD-11, to gether with gambling disorder, gaming disorder is characterized by a pattern of persistent or recurrent gaming behaviour ('digital gaming' or 'video- gaming'), which may be online (i.e. over the Internet) or offline. Current epidemiological studies estimate prevalence as 71–27%, but there are marked differences in diagnostic methods used and populations studied— more research is definitely needed. Diagnostic criteria • Impaired control over gaming (e.g. onset, frequency, intensity, duration, termination, context); • Increasing priority given to gaming, to the extent that gaming takes precedence over other life interests and daily activities; and • Continuation or escalation of gaming despite the occurrence of negative consequences. • The behaviour pattern is of sufficient severity to result in significant impairment in personal, family, social, educational, occupational, or other important areas of functioning. • The pattern of gaming behaviour may be continuous or episodic and recurrent. The gaming behaviour and other features are normally evident over a period of at least 12 months in order for a diagnosis to be assigned, although the required duration may be shortened if all diagnostic requirements are met and symptoms are severe. Comorbidity Depression, ADHD, alcohol misuse, anxiety, and lack of psy chosocial supports. Treatment Address any comorbid disorder. Counselling and CBT/be havioural modification are key to specific interventions. Some evidence for use of bupropion. Self-help (12-Step Programme) such as through

On-line Gamers Anonymous (M http://www.olganon.org/home). Compulsive sexual behaviour disorder (ICD-11) Grouped with the other ‘Impulse control disorders’ in ICD-11, CSBD is characterized by ‘a persistent pattern of failure to control intense, re petitive sexual impulses or urges resulting in repetitive sexual behaviour.’9 Community prevalence is estimated at 72% in young adults, but more re search is needed into the aetiology and management. Diagnostic criteria • Repetitive sexual activities becoming a central focus of the person’s life to the point of neglecting health and personal care or other interests, activities, and responsibilities. • Numerous unsuccessful efforts to significantly reduce repetitive sexual behaviour. 8 van Rooij AJ, Ferguson CJ, Colder Carras M, et al. (2018) A weak scientific basis for gaming dis order: Let us err on the side of caution. J Behav Addict 7:1–9. 9 Walton MT, Bhullar N (2018) Compulsive sexual behavior as an impulse control disorder: awaiting field studies data. Arch Sex Behav 47:1327–31.

Impulse-control disorders 3 • Continued repetitive sexual behaviour despite adverse consequences or deriving little or no satisfaction from it. • The pattern of failure to control intense sexual impulses or urges and resulting repetitive sexual behaviour is manifested over an extended period of time (e.g. 6 months+) and causes marked distress or significant impairment in personal, family, social, educational, occupational, or other important areas of functioning. • Distress that is entirely related to moral judgements and disapproval about sexual impulses, urges, or behaviours is not sufficient to meet this requirement. Important exclusions • High sex drive without impaired control, distress, or impairment. • High levels of sexual interest and/or behaviour in adolescents. • Psychological distress regarding one’s sexuality. • Self-reported ‘sex addiction’/‘porn addiction’ where behaviours are secondary to other psychological problems (e.g. anxiety, depression). • Behaviours symptomatic of mental disorder (e.g. bipolar disorder, ID). • Behaviours due to a medical condition (e.g. dementia/brain injury), medication (e.g. treatment of Parkinson’s disease), or illicit substances. Comorbidity Depressive and anxiety symptoms, high levels of stress, low self-esteem, social anxiety disorder, ADHD, compulsive buying, patho logical gambling, and kleptomania. Treatment Psychodynamic therapy and CBT have shown benefit, combined with group, family, or couple’s therapy. Limited evidence for pharmacotherapy—SSRIs (e.g. citalopram) may reduce sexual desire, with possible naltrexone augmentation. Support groups [e.g. Sex Addicts Anonymous (SAA), M http://saauk.info/en/) offer a 12-Step program].

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