IMPULSE CONTROL DISORDER

BEHAVIORAL DEFINITIONS

1. A tendency to act too quickly without careful deliberation, resulting in numerous negative consequences.
2. Loss of control over aggressive impulses resulting in assault, self-destructive behavior, or damage to property.
3. Deliberate and purposeful fire-setting on more than one occasion.
4. Persistent and recurrent maladaptive gambling behavior.
5. Recurrent failure to resist impulses to steal objects that are not needed for personal use or for their monetary value.
6. Recurrent pulling out of one's hair resulting in noticeable hair loss.
7. Desire to be satisfied almost immediately and a decreased ability to delay pleasure or gratification.
8. A history of acting out in at least two areas that are potentially self-damaging (e.g., spending money, sexual activity, reckless driving, addictive behavior).
9. Overreactivity to mildly aversive or pleasure-oriented stimulation.
10. A sense of tension or affective arousal before engaging in the impulsive behavior (e.g., kleptomania, pyromania).
11. A sense of pleasure, gratification, or release at the time of committing the ego-dystonic, impulsive act.
12. Difficulty waiting for things—that is, restless standing in line, talking out over others in a group, and the like.

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LONG-TERM GOALS

1. Reduce the frequency of impulsive behavior and increase the frequency of behavior that is carefully thought out.
2. Reduce thoughts that trigger impulsive behavior and increase self-talk that controls behavior.
3. Learn to stop, listen, and think before acting.

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SHORT-TERM OBJECTIVES

1. Identify the impulsive behaviors that have been engaged in over the last six months. (1)
2. List the reasons or rewards that lead to continuation of an impulsive pattern. (2, 3)
3. Disclose any history of substance use that may contribute to and complicate the treatment of Impulse Control Disorder. (4)
4. Provide behavioral, emotional, and attitudinal information toward an assessment of specifiers relevant to a *DSM*

THERAPEUTIC INTERVENTIONS

1. Review the client's behavior pattern to assist him/her in clearly identifying, without minimization, denial, or projection of blame, his/her pattern of impulsivity.
2. Explore whether the client's impulsive behavior is triggered by anxiety and maintained by anxiety relief rewards; assess for bipolar manic disorder or ADHD.
3. Ask the client to make a list of the positive things he/she gets from impulsive actions and process it with the therapist.
4. Arrange for a substance abuse evaluation and refer the client for treatment if the evaluation recommends it (see the Substance Use chapter in this *Planner*).
5. Assess the client's level of insight (syntonic versus dystonic) toward the "presenting problems" (e.g., demonstrates good insight into the

diagnosis, the efficacy of treatment, and the nature of the therapy relationship. (5, 6, 7, 8)

problematic nature of the "described behavior," agrees with others' concern, and is motivated to work on change; demonstrates ambivalence regarding the "problem described" and is reluctant to address the issue as a concern; or demonstrates resistance regarding acknowledgment of the "problem described," is not concerned, and has no motivation to change).

6. Assess the client for evidence of research-based correlated disorders (e.g., oppositional defiant behavior with ADHD, depression secondary to an anxiety disorder) including vulnerability to suicide, if appropriate (e.g., increased suicide risk when comorbid depression is evident).

7. Assess for any issues of age, gender, or culture that could help explain the client's currently defined "problem behavior" and factors that could offer a better understanding of the client's behavior.

8. Assess for the severity of the level of impairment to the client's functioning to determine appropriate level of care (e.g., the behavior noted creates mild, moderate, severe, or very severe impairment in social, relational, vocational, or occupational endeavors); continuously assess this severity of impairment as well as the efficacy of treatment (e.g., the client no longer demonstrates severe impairment but the presenting problem now is causing mild or moderate impairment).

5. List the negative consequences that accrue to self and others as a result of impulsive behavior. (9, 10, 11)

9. Assign the client to write a list of the negative consequences that have occurred because of impulsivity (or assign "Recognizing the Negative Consequences of Impulsive Behavior" from the *Adult Psychotherapy Homework Planner* by Jongsma).

10. Assist the client in making connections between his/her impulsivity and the negative consequences for himself/herself and others.

11. Confront the client's denial of responsibility for the impulsive behavior or the negative consequences (or assign "Accept Responsibility for Illegal Behavior" from the *Adult Psychotherapy Homework Planner* by Jongsma).

6. Identify impulsive behavior's antecedents, mediators, and consequences. (12, 13)

12. Ask the client to keep a log of impulsive acts (time, place, feelings, thoughts, what was going on prior to the act, and what was the result); process log content to discover triggers and reinforcers (or assign "Impulsive Behavior Journal" from the *Adult Psychotherapy Homework Planner* by Jongsma).

13. Explore the client's past experiences to uncover his/her cognitive, emotional, and situational triggers to impulsive episodes.

7. Participate in imaginal exposure sessions to decrease the urge to act impulsively. (14, 15)

14. Assist the client in composing a script describing a typical situation in which impulsive behavior occurs, the urge to act, physical symptoms, expected negative consequences, and, finally, resisting the urge.

15. Use the client's script in an imaginal exposure session in which the client is relaxed and the script is read repeatedly.

8. Participate in an *in vivo* exposure treatment procedure. (16, 17, 18, 19)

16. Direct and assist the client in construction of a hierarchy of feared internal and external impulsive behavior cues.

17. Assess the nature of any external cues (e.g., persons, objects, and situations) and internal cues (thoughts, images, and impulses) that precipitate the client's impulsive actions.

18. Select initial exposures (imaginal or *in vivo*) to the internal and/or external impulsive behavior cues that have a high likelihood of being a successful experience for the client; include response prevention and do cognitive restructuring within and after the exposure (see *Mastery of Obsessive-Compulsive Disorder* by Kozak and Foa; or *Treatment of Obsessive-Compulsive Disorder* by McGinn and Sanderson).

19. Assign the client a homework exercise in which he/she repeats the exposure to the internal and/or external impulsive behavior cues using response prevention and restructured cognitions between sessions and records responses (or assign "Reducing the Strength of Compulsive Behaviors" in the *Adult Psychotherapy Homework Planner* by Jongsma); review during next session, reinforcing success and providing corrective feedback toward improvement (see *Mastery of Obsessive-Compulsive Disorder* by Kozak and Foa).

9. Verbalize a clear connection between impulsive behavior and negative consequences to self and others. (10, 20)

10. Assist the client in making connections between his/her impulsivity and the negative consequences for himself/herself and others.

20. Reinforce the client's verbalized acceptance of responsibility for and connection between impulsive behavior and negative consequences.

10. Before acting on behavioral decisions, frequently review them with a trusted friend or family member for feedback regarding possible consequences. (21, 22)

21. Conduct a session with the client and his/her partner to develop a contract for receiving feedback prior to impulsive acts.

22. Brainstorm with the client who he/she could rely on for trusted feedback regarding action decisions; use role-play and modeling to teach how to ask for and accept this help.

11. Utilize cognitive methods to control trigger thoughts and reduce impulsive reactions to those trigger thoughts. (13, 23, 24)

13. Explore the client's past experiences to uncover his/her cognitive, emotional, and situational triggers to impulsive episodes.

23. Teach the client cognitive methods (thought-stopping, thought substitution, reframing, etc.) for gaining and improving control over impulsive urges and actions.

24. Use the cognitive restructuring process (i.e., teaching the connection between thoughts, feelings, and actions; identifying relevant automatic thoughts and their underlying beliefs or biases; challenging the biases; developing alternative positive perspectives; testing biased and alternative beliefs through behavioral experiments) to assist the client in replacing negative automatic

thoughts associated with education and his/her ability to learn.

12. Use relaxation exercises to control anxiety, urges, and reduce consequent impulsive behavior. (25, 26, 27)

25. Teach the client relaxation skills (e.g., progressive muscle relaxation, imagery, diaphragmatic breathing, verbal cues for deep relaxation), how to discriminate better between relaxation and tension, as well as how to apply these skills to coping with situations associated with impulsive urges (e.g., see *Progressive Relaxation Training* by Bernstein and Borkovec).

26. Assign the client homework each session in which he or she practices relaxation exercises daily for at least 15 minutes and applies the technique to impulsive trigger situations; review the exercises, reinforcing success while providing corrective feedback toward improvement.

27. Assign the client to read about progressive muscle relaxation and other calming strategies in relevant books or treatment manuals (e.g., *The Relaxation and Stress Reduction Workbook* by Davis, Robbins-Eshelman, and McKay; *Mastery of Your Anxiety and Worry—Workbook* by Craske and Barlow).

13. Utilize behavioral strategies to manage urges for impulsive action. (28, 29, 30)

28. Teach the use of positive behavioral alternatives to cope with impulsive urges (e.g., talking to someone about the urge, taking a time out to delay any reaction, calling a friend or family member, engaging in physical exercise, leaving credit cards with a family member, creating needed item shopping lists to avoid impulsive buying, avoiding use of police and fire scanners, etc.).

29. Review the client's implementation of behavioral coping strategies to reduce urges and tension; reinforce success and redirect for failure.

30. Teach the client covert sensitization in which he/she imagines a negative consequence (e.g., going to jail) whenever the desire to act impulsively appears (e.g., the desire to steal); assign as homework; review, reinforcing success and problem-solving obstacles until internalized by the client.

14. List instances where "stop, listen, think, and act" has been implemented, citing the positive consequences. (31, 32)

31. Using modeling, role-playing, and behavior rehearsal, teach the client how to use "stop, listen, and think" before acting in several current situations.

32. Review and process the client's use of "stop, listen, think, and act" in day-to-day living and identify the positive consequences.

15. Describe any history of manic or hypomanic behavior related to a mood disorder. (33)

33. Assess the client for a mood disorder that includes manic episodes with a lack of judgment over impulsive behavior and its consequences (see the Bipolar Disorder—Mania chapter in this *Planner*).

16. Identify situations in which there has been a loss of control over aggressive impulses resulting in destructive or assaultive behavior. (34)

34. Explore the client's history of explosive anger management problems; include this as presenting problem if there have been several such episodes of aggressiveness grossly out of proportion to any precipitating psychosocial stressor (see the Anger Control Problems chapter in this *Planner*).

17. Comply with the recommendations from a physician evaluation regarding the

35. Refer the client to a physician for an evaluation for a psychotropic medication prescription.

necessity for psychopharmacological intervention. (35, 36)

36. Monitor the client for psychotropic medication prescription compliance, side effects, and effectiveness; consult with the prescribing physician at regular intervals.

18. Implement a reward system for replacing impulsive actions with reflection on consequences and choosing wise alternatives. (37, 38)

37. Assist the client in identifying rewards that would be effective in reinforcing himself/herself for suppressing impulsive behavior.

38. Assist the client and significant others in developing and putting into effect a reward system for deterring the client's impulsive actions.

19. Learn and implement problem-solving skills to reduce impulsive behavior. (39, 40)

39. Teach the client problem-resolution skills (e.g., defining the problem clearly, brainstorming multiple solutions, listing the pros and cons of each solution, seeking input from others, selecting and implementing a plan of action, evaluating outcome, and readjusting plan as necessary).

40. Use modeling and role-playing with the client to apply the problem-solving approach to his/her urge for impulsive action (or assign "Problem-Solving: An Alternative to Impulsive Action" from the *Adult Psychotherapy Homework Planner* by Jongsma); encourage implementation of action plan, reinforcing success and redirecting for failure.

20. Read recommended material on overcoming impulsive behavior. (41)

41. Recommend the client read material on coping with impulsive urges (e.g., *Stop Me Because I Can't Stop Myself: Taking Control of Impulsive Behavior* by Grant and Fricchione; *Overcoming Impulse*

Control Problems: A Cognitive-Behavioral Therapy Program—Workbook by Grant, Donahue, and Odlaug).

21. Attend a self-help recovery group. (42)

42. Refer the client to a self-help recovery group (e.g., 12-step program, ADHD group, Rational Recovery, etc.) designed to help terminate self-destructive impulsivity; process his/her experience in the group.

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DIAGNOSTIC SUGGESTIONS

Using DSM-IV/ICD-9-CM:

Axis I:	312.34	Intermittent Explosive Disorder
	312.32	Kleptomania
	312.31	Pathological Gambling
	312.39	Trichotillomania
	312.30	Impulse Control Disorder NOS
	312.33	Pyromania
	310.1	Personality Change Due to Axis III Disorder
	______	______________________________
	______	______________________________
Axis II:	301.7	Antisocial Personality Disorder
	301.83	Borderline Personality Disorder
	799.9	Diagnosis Deferred
	V71.09	No Diagnosis
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Using DSM-5/ICD-9-CM/ICD-10-CM:

ICD-9-CM	ICD-10-CM	*DSM-5* Disorder, Condition, or Problem
312.34	F63.81	Intermittent Explosive Disorder
312.32	F63.81	Kleptomania
312.31	F63.0	Gambling Disorder
312.39	F63.2	Trichotillomania
312.9	F91.9	Unspecified Disruptive, Impulse Control, and Conduct Disorder
312.89	F91.8	Other Specified Disruptive, Impulse Control, and Conduct Disorder
312.33	F63.1	Pyromania
310.1	F07.0	Personality Change Due to Another Medical Condition
301.7	F60.2	Antisocial Personality Disorder
301.83	F60.3	Borderline Personality Disorder

Note: The ICD-9-CM codes are to be used for coding purposes in the United States through September 30, 2014. ICD-10-CM codes are to be used starting October 1, 2014. Some ICD-9-CM codes are associated with more than one ICD-10-CM and *DSM-5* Disorder, Condition, or Problem. In addition, some ICD-9-CM disorders have been discontinued resulting in multiple ICD-9-CM codes being replaced by one ICD-10-CM code. Some discontinued ICD-9-CM codes are not listed in this table. See *Diagnostic and Statistical Manual of Mental Disorders* (2013) for details.