
Impulsivity in Major Mental Disorders

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DEFINITION OF MENTAL DISORDER

The *Diagnostic and Statistical Manual of Mental Disorders*, fourth edition (DSM-IV; American Psychiatric Association [APA], 1994) acknowledges that "although this manual provides a classification of mental disorders, it must be admitted that no definition adequately specifies precise boundaries for the concept of 'mental disorder'" (p. xxi).¹ It goes on to state, however:

In DSM-IV, each of the mental disorders is conceptualized as a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is associated with present distress (e.g., a painful symptom) or disability (i.e., impairment in one or more important areas of functioning) or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom. (p. xxi)

DSM-IV's definition of "mental disorder" is consistent with my own (Coles, 1975, 1982) definition of "mental health" and "mental illness" as social value judgments that are based upon biological, sociocultural, and/or psychological data; of these two terms, the former represents a conjunctive concept and the latter a disjunctive concept. Perhaps the keys to the definitions, however, are DSM-IV's reference to "clinically significant" and my reference to "social value judgments." Moore (1975) noted:

"Insanity" and "mental illness" mean, and have historically meant "irrational"; to be insane, or to be mentally ill, is not to act rationally often enough to have the same assumption of rationality made about one as is made of most of humanity; and absent such an assumption of rationality, one cannot be fully regarded as a person. (p. 1493)

Thus, I have suggested (Coles, 1982) that not only is mental illness a social value judgment based upon biological, sociocultural, and/or psychological data; "it could also be the inference of irrationality that is made from [those] data" (p. 19).

Irrationality has traditionally been associated with emotionality, and "emotional illness" is a well-established euphemism for "mental illness." Both terms are often applied to individuals who appear to act without adequate consideration of the circumstances or the consequences—that is, to act without thinking, or "impulsively." It is not surprising, therefore, that "impulsive" should be a pejorative term.

CONSTRUCT EXPLICATION OF IMPULSIVITY

"Impulsivity" is a complex concept. It involves an impulse, the behavioral expression of that impulse, and the situation in which both occur.

Dickman (1990) has differentiated between two types of impulsivity, emphasizing the social evaluation or appraisal of the act: "functional impulsivity," the tendency to act without forethought when this tendency is optimal or beneficial; and "dysfunctional impulsivity," the tendency to act with absence of forethought when this tendency could be a source of problems. Whether an act is "optimal or beneficial" or "a source of problems" is a function of the situation, both social and physical, within which it occurs.

Athletes train themselves, and undergo endless series of repetitions of game actions and responses, in order to ensure that they can respond without thinking. But what happens if they should find themselves in a game situation in ordinary life—particularly if they are boxers or martial artists? Imagine, for example, that a martial arts expert is standing and talking in the coffee room at work when a female colleague—in a surprise move and in a dangerous sense of fun—jumps on his back, placing her arms around his shoulders and her head alongside his. Immediately he brings the back of his clenched fist into her face, breaking her nose. Is this an impulsive act? If so, is it an example of functional or dysfunctional impulsivity? There is no doubt that the act is the source of a problem for the female colleague. She receives a broken nose. It may also create social, and perhaps employment-related, problems for the martial artist. But is the consideration of those problems dependent on the circumstances?

Would that same act by our martial artist be evaluated in the same way if the attack had not been carried out by a female colleague, had not been initiated in a sense of fun, and had occurred in a dark lane late at night?

Use of the term "impulsivity" also reflects the extent to which the individual is considered to have exercised control of his or her impulses and/or actions. Both the pejorative and the control-related aspects of "impulsivity" are contained in the DSM-IV (APA, 1994) definition of "impulse-control disorders not elsewhere classified": in which it notes: "The essential feature of Impulse-Control Disorders is the failure to resist an impulse, drive, or temptation to perform an act that is harmful to the person or to others" (p. 609).

What constitutes "harm" is clearly open to interpretation. In the situation just described, we are inclined to refer to the action of the martial artist as "reflexive behavior"—that is, to say that the individual, his reflexes honed to a fine edge, responds "instinctively." We do so because his behavior is not an instantiation of a general tendency to act without thinking, but a specific tendency to respond to certain situations in a well-rehearsed way. His "impulsivity," being limited to those specific behaviors, is given a more positive label. The example of the martial arts expert therefore introduces another important aspect of "impulsivity": the boundaries of its content domain, or, in other words, the breadth of the behavior it covers.

We all have a variety of different impulses, and we vary in the way and extent to which we are able to control them. A person who cannot control the impulse to smoke may be perfectly capable of controlling his or her sexual impulses. A person who cannot control the desire to eat, and thus cannot control his or her weight, may have no trouble staying sober and away from alcohol. Impulse control—or the lack thereof—is not typically generic. Although, as noted by Webster and Jackson in Chapter 1, some patients and even nonpatients, when under stress, may exhibit impulsive actions in more than one area at the same time, or in several areas in succession.

I was testifying in a "dangerous offender" hearing a number of years ago. The offender in this case had just been released from jail, having served a 7-year sentence for rape, when he returned to the scene of his earlier crime and reoffended several times in a very similar way before being reapprehended. He was given a battery of psychological tests, and the results contained some common indications of "impulsivity." However, when he was described to the court as an impulsive individual, the judge interjected a question. For several days this man had sat calmly in court, listening to all kinds of nasty things being said about him, without as much as a restless change in position. He had not shouted out his objections, and he had certainly not lost control of his bowel or bladder functions. What had been meant when he had been described as "impulsive"?

DEFINITION OF IMPULSIVITY AND IMPULSE CONTROL

"Impulsivity" has not been comprehensively, clearly, or even consistently defined (Fink & McCown, 1993; Milich & Kramer, 1984; Parker, Bagby, & Webster, 1993). Most definitions, however, contrast impulsive behavior to planned behavior: "We may define the term impulse for our purposes as the generally unpremeditated welling-up of a drive toward some action that usually has the qualities of hastiness, lack of deliberation, and impetuosity" (Frosch, 1977, p. 296).

A review of *Webster's Third New International Dictionary* (1976) indicates that in common usage, in order to be called "impulsive" a person may manifest one of three quite different characteristics:

1. Acting momentarily, and in a way that is inconsistent with the prevailing behavior (i.e., manifesting behavior that can be described as whimsical, capricious, and even unpredictable); in this instance, behavior seems to represent a brief pulse or surge of energy, rather than a steady, consistent drive.
2. Generally acting, or being prone to act, with little apparent intellectual consideration of the appropriateness or consequences of so acting (i.e., manifesting behavior that could be described as spontaneous, impetuous, or rash).
3. Generally acting, or being prone to act, as if driven or compelled to act in a particular kind of way (i.e., manifesting behavior that appears to be more reflexive than volitional, and manifesting what might be called an "irresistible impulse").

The professional literature reflects three basic assumptions about the nature of impulsivity (Milich & Kramer, 1984): An impulsive response is rapid, undesirable, and/or error-prone; it is likely to occur in the presence of appealing stimuli; and/or it is likely to occur in the absence of strong cognitive control. There are two problems with each of these definitions, however. The first is deciding when an impulsive response is an undesirable symptom or sign of mental disorder, or a desirable feature of personality. In addition to the example of the martial arts expert given above, we have to consider the work of Eysenck, Pearson, Easting, and Allsopp (1985), who made a distinction between "impulsiveness" and "venturesomeness"; and the work of Parker et al. (1993), who identified two distinct dimensions of impulsivity, which they described as "cautious-spontaneous" and "methodical-disorganized." The second problem is determining whether impulsivity is the result of a strong impulse or of weak impulse control (Buss & Plomin, 1975). The implications of this distinction are as much therapeutic as they are definitional and conceptual.

IMPULSIVITY IN DSM-IV

Two observations spring readily from a cursory review of the signs and symptoms of mental disorders in DSM-IV (APA, 1994): The social maladjustment of mental disorders is identified in a number of ways, each of which could be considered to manifest an aspect of impulsivity; and the primary manifestation of social maladjustment is in aggressiveness and/or hostile behavior.

These observations are consistent with Frosch's (1977) observation regarding the misuse of the term "acting out" as a pejorative rubric for all antisocial behavior, including behaviors that reflect problems with impulse control. It is also consistent with the general observation made by Zilboorg and Henry (1941) over 50 years ago that throughout history,

Every mental patient presents some form of unwillingness or inability to accept life as it is. Every mental patient either aggressively rejects life as we like it—and he was thought of as heretic, witch, or sorcerer—or passively succumbs to his inability to accept life as we see it—and he was therefore called bewitched. In the mind of the mentally healthy man, including the medical man, a mentally ill person still appears as an adamant rebel against our cultural common sense or a weakling who gives in to forces other than our cultural common sense. (pp. 523–524)

Scott (1958) referred to these two forms of "inability to accept life as it is" as "social maladjustment" and "failure of positive striving," respectively.

The different ways in which DSM-IV appears to identify social maladjustment could reflect a failure to adequately define the concept of impulsivity, indicative of attempts to refine and provide new operational definitions without effectively disposing of the old. It could also, however, simply be attributable to the disjunctive nature of the concept of social maladjustment.

Some of the terms and phrases that are used in DSM-IV (APA, 1994), and that on initial reading appear to be describing impulsivity, in fact relate to affect, mood, or emotion. The associated behavior is a direct reflection of a psychological condition, rather than an instrumental interaction with the environment, and requiring no planning. Examples include the "affective instability" of personality change due to a general medical condition (p. 171), the "affective lability" of dementia due to head trauma (p. 148), the "mood lability" and "lability of mood" of alcohol intoxication (p. 196) and manic episode (p. 328), and the "emotional lability" that is considered an associated feature/disorder of amphetamine-related disorders (p. 210). At the other extreme, there are references to a lack of control of behavior that is a purely biological phenomenon, with minimal association with any psychological state; this is the case with the elimination disorders, encopresis and enuresis. These clearly do

not qualify as examples of impulsivity in the strict sense of the term. The "irritability" of dementia due to Huntington's disease (p. 149) and manic episode (p. 328); the "irritable or anxious mood" of cannabis-related disorders (p. 215); the poor/low frustration tolerance of major depressive episode, indicated by "an exaggerated sense of frustration over minor matters" (p. 321); and the behavior that is "grossly out of proportion to any provocation or precipitating psychosocial stressor" (p. 610), listed as a characteristic of intermittent explosive disorder, are all similarly outside the current definition.

There is an important conceptual distinction to be made between impulsivity and overreaction. "Impulsivity" refers to the speed of the reaction (i.e., how long it takes for the person to react). "Overreaction" refers to the strength and duration of the reaction once it occurs. Although these may often be correlated, they are distinct and can occur independently. It would therefore be a mistake to assume that because a person reacts strongly (i.e., violently), that person is impulsive.

A more difficult decision surrounds the use of the phrase "disinhibition" in DSM-IV to describe a behavioral characteristic of dementia due to Pick's disease (p. 150) and symptom of injury to the frontal lobes, referred to under personality change due to a general medical condition (p. 171). The term is also used in DSM-III-R to describe a result of severe alcohol intoxication (APA, 1987, pp. 196-197). At a theoretical level, these conditions imply an underlying biological impairment of control, whereas impulsivity implies a psychological—and moral—failure to exercise control. For example, as noted earlier, DSM-IV has a major Axis I diagnostic category entitled "impulse-control disorders not elsewhere classified." This is considered in greater detail below and in Chapter 11. For present purposes, however, it should be repeated that the essential feature of this category of disorders is "*the failure to resist an impulse, drive, or temptation to perform an act that is harmful to the person or others*" (p. 609, emphasis added). This distinction, however, may be difficult to make in practice.

As illustrated by the earlier account of my testimony in a "dangerous offender" hearing, there is a similarly difficult distinction to be made between impulsivity as a general characteristic of the individual, and impulsivity as a failure to control specific impulses. Perhaps because behavior is invariably a reaction to the interaction of the individual with his or her environment, just as no one ever manifests complete control of all impulses in all situations, so no one can be expected to manifest a complete lack of control over all impulses in all situations.

Impulsivity in Axis I Disorders

On Axis I, DSM-IV (APA, 1994) lists 16 major diagnostic categories, encompassing 337-374 specific diagnoses, depending on the status ac-

corded to subcategories. It is on Axis I that we find the various forms of dementia, for which it is noted:

Disturbances in executive functioning are a common manifestation . . . and may be related especially to disorders of the frontal lobe or associated subcortical pathways. Executive functioning involves the ability to think abstractly and to plan, initiate, sequence, monitor, and stop complex behavior. . . . Some individuals with dementia show disinhibited behavior, including making inappropriate jokes, neglecting personal hygiene, exhibiting undue familiarity with strangers, or disregarding conventional rules of social conduct. (pp. 135–136)

Also on Axis I are a number of disorders that are characterized by the failure to control specific impulses. These range from a failure to control "aggressive impulses," which is listed as an associated descriptive feature of dissociative amnesia (p. 478) and dissociative fugue (p. 482), and the "failure to resist aggressive impulses" in intermittent explosive disorder (p. 609), to the "failure to resist impulses to steal" of kleptomania (p. 612), "continu[ing] to gamble despite repeated efforts to control, cut back, or stop the behavior" of pathological gambling (p. 616), and the unsuccessful "attempts to resist the urge" that characterize Trichotillomania (p. 618). Intermittent explosive disorder, kleptomania, pathological gambling, and trichotillomania are disorders under the general heading of impulse-control disorders not elsewhere classified, mentioned earlier. In the introduction to this category, DSM-IV (APA, 1994) notes:

This section includes disorders of impulse control that are not classified as part of the presentation of disorders in other sections of the manual (e.g., Substance-Related Disorders, Paraphilic, Antisocial Personality Disorder, Conduct Disorder, Schizophrenia, Mood Disorders may have features that involve problems of impulse control). (p. 609)

In addition to the disorders just mentioned, the category includes pyromania and impulse-control disorder not otherwise specified.

Pyromania is somewhat of an anomaly in this context. Although it is identified in terms of a specific behavior (i.e., fire setting), the behavior is described as "deliberate and purposeful" (p. 614). As for the diagnosis of impulse-control disorder not otherwise specified, it is very generally defined: "This category is for disorders of impulse control that do not meet the criteria for any specific Impulse-Control Disorder or for another mental disorder having features involving impulse control described elsewhere in the manual (e.g., Substance Dependence, a Paraphilia)" (p. 621).

DSM-IV's reference to paraphilic in its description of impulse-control disorder not otherwise specified is interesting, since there is no explicit reference to impaired impulse control in the DSM-IV description of those conditions. The reference is to "recurrent, intense sexually arous-

ing fantasies, sexual urges, or behaviors" (p. 522), which "cause clinically significant distress or impairment in social, occupational, or other important areas of functioning" (p. 523). There are references to acting out "with a nonconsenting partner in a way that may be injurious to the partner" (p. 523); to the individual's being "subject to arrest and incarceration" (p. 523); and to the possibility that "acting out the paraphiliac imagery may lead to self-injury" (p. 523). However, there is no reference to impulsivity. Perhaps this is an indication of the status of impulsivity as a primary, if not universal, criterion of every mental disorder that is clearly antisocial and/or irrational—and, as such, a criterion that does not require explicit mention.

DSM-IV includes on Axis I, under the heading "disorders usually first diagnosed in infancy, childhood, or adolescence," a group of disorders that were on Axis II in DSM-III (APA, 1980) and DSM-III-R (APA, 1987) together with mental retardation and personality disorders. In DSM-III and DSM-III-R these disorders were listed under two major subcategories (pervasive developmental disorders and specific developmental disorders), with the latter further classified as academic skills disorders, language and speech disorders, or motor skills disorders. In DSM-IV (APA, 1994), the Axis I disorders usually first diagnosed in infancy, childhood, or adolescence are classified into nine major subcategories. As might be expected, given the fact that this category is based solely on the age at which a disorder is usually first diagnosed, all the adult types of impulsivity are represented.

The failure to control basic biological functions is seen in the creation of categories for feeding and eating disorders of infancy or early childhood and elimination disorders. Uncontrolled/uncontrollable behaviors that have the appearance of a physiological reflex, and for which many clinicians are inclined to infer an underlying neurological impairment, are represented by the category of tic disorders.

Attention-deficit and disruptive behavior disorders are identified in terms of their maladaptive features. Although clinicians frequently make the theoretical presumption that an organic impairment underlies these disorders also, the authors of DSM-IV have explicitly stated that the latest APA (1994) diagnostic and classificatory schemes are atheoretical. These disorders instantiate Scott's (1958) criterion of "social maladjustment," whereas his companion criterion of "failure of positive striving" can be seen to be the basis for distinguishing one of the pervasive developmental disorders, autistic disorder. These categories illustrate the pejorative use of "impulsivity."

Impulsivity in Axis II Disorders

Although impulsivity is encountered in a wide array of psychiatric disorders, it is a prominent characteristic of the Axis II personality

disorders (Lion & Penna, 1975); it is also widely considered to be a characteristic of the other major Axis II category, mental retardation.

The essential feature of a DSM-IV personality disorder is described as "an enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture and is manifested in at least two of the following areas: cognition, affectivity, interpersonal functioning, or *impulse control*" (p. 630, emphasis added).

In antisocial personality disorder, "a pattern of impulsivity may be manifested by a failure to plan ahead. . . . Decisions are made on the spur of the moment, without forethought, and without consideration of the consequences to self or others" (p. 646). In borderline personality disorder, "frantic efforts to avoid abandonment may include impulsive actions such as self-mutilating or suicidal behaviors" (p. 650). In histrionic personality disorder, an associated feature is as follows: "These individuals are often intolerant of, or frustrated by, situations that involve delay of gratification, and their actions are often directed at obtaining immediate satisfaction" (p. 656). Along with narcissistic personality disorder, the antisocial, borderline, and histrionic personality disorders are referred to as Cluster B disorders, having in common the feature of "wild," exaggerated, dramatic emotionality.

The Cluster A personality disorders—paranoid, schizoid, and schizotypal—are characterized by "weird" emotional withdrawal and odd behavior. They are suggestive of a less focused impulsivity.

The Cluster C personality disorders—avoidant, dependent, and obsessive-compulsive—have been described as "wary." They are characterized by anxious, resistive, and/or submissive behavior, and suggest overcontrol rather than a lack of control. For example, the essential feature of obsessive-compulsive personality disorder is said to be "a preoccupation with orderliness, perfectionism, and mental and interpersonal control," and individuals with this disorder "attempt to maintain a sense of control through painstaking attention to rules, trivial details, procedures, lists, schedules, or form to the extent that the major point of the activity is lost" (p. 669).

Almost by definition, the behavior of persons with mental retardation is expected to be impulsive. Because of the frequent association of mental retardation with underlying biological and neurological disabilities, it is often assumed that the behavior of a person with a mental retardation is beyond control. Because of their limited ability for abstract thinking and the consideration of events beyond the present, acting without thinking is considered to be characteristic of them. It is also thought that persons with mental retardation may lack the adaptive social skills that are necessary to express their feelings and emotions in a socially appropriate manner, and that they lack the social power to adjust and control their environment in such a way as to ensure that it does not create problems for them.

Although some of these stereotypes may be true of some people with

mental retardation, they may be misleading in other cases, as DSM-IV points out: "No specific personality and behavioral features are uniquely associated with Mental Retardation. Some individuals . . . are passive, placid, and dependent, whereas others can be aggressive and impulsive" (p. 42). Indeed, "behaviors that would normally be considered maladaptive (e.g., dependency, passivity) may be evidence of good adaptation in the context of particular individual's life (e.g., in some institutional settings)" (p. 40). In DSM-IV's conceptualization, therefore, a person with mental retardation may fall into either of Zilboorg and Henry's (1941, pp. 523–524) categories of mental disorder: The person "either aggressively rejects life as we like it" or "passively succumbs to his [or her] inability to accept life as we see it."

CONCEPTUAL AND RESEARCH IMPLICATIONS

A complete lack of behavior control is rarely, if ever, observed in a conscious person, regardless of whether he or she has an Axis I mental illness, a personality disorder, or mental retardation. With the obvious exceptions of delirious and comatose individuals, and possibly those with a physiologically based incontinence of bladder or bowel functions, the expression of a socially unacceptable impulse invariably reflects some control. Impulsivity is therefore a matter of degree: A person is more or less impulsive, and can only be described as "impulsive" or "not impulsive" with considerable loss of information.

DSM-IV's descriptions of mental disorders highlight another important point. Impulsivity can be an "essential feature" of a disorder, an "associated feature," or merely a reaction that some people may show to a disorder. Although DSM-IV explicitly distinguishes between the first two, it fails to explicate its recognition of the last. For example, with regard to intermittent explosive disorder, it states: "Signs of generalized impulsivity or aggressiveness *may* be present between explosive episodes. Individuals with narcissistic, obsessive, paranoid, or schizoid traits *may* be especially prone to having explosive outbursts of anger when under stress" (p. 610, emphasis added). Compare this to the more definitive statement with regard to the gender of individuals with reading disorder: "From 60% to 80% of individuals diagnosed with Reading Disorder are males. Referral procedures *may* often be biased towards identifying males, because they more frequently display disruptive behaviors in association with Learning Disorders" (p. 49).

In failing to fully take into account individual differences in reaction to disorders, DSM-IV illustrates its failure to develop the interactional model that its multiaxial classification demands. Recognition that people react differently to their disorders inevitably leads to clinical syndromes' being considered *the product of an interaction among Axis I, Axis II, Axis III, and Axis IV conditions*, rather than an indication of one of those conditions.

DSM-III (APA, 1980) brought us to the point where we need empirical research to determine whether, for example, intermittent explosive disorder only occurs in individuals who have an Axis II diagnosis in which narcissistic, obsessive, paranoid, and/or schizoid traits are prominent; an Axis III medical diagnosis of a neurological impairment; and an Axis IV psychosocial or environmental problem indicative of a high level of premorbid/perimorbid stress. DSM-III-R and DSM-IV have added little in this regard. However, the treatment implications of such a conceptualization are considerable.

THERAPEUTIC IMPLICATIONS

People in a patient's community, and even in society at large, usually do not care how or why the person acts in an uncontrolled and/or unpredictable manner—only that he or she does behave in such a manner. There are two basic ways in which individuals can exercise control over their impulsive behavior: internally (i.e., by using defense mechanisms such as repression, suppression, and/or reaction formation, in addition to such cognitive strategies as reframing) or externally (i.e., by putting themselves or being put in a situation in which it is very difficult to act out—either because there is little in their environment to stimulate their impulses, or because there are controlling features in the environment that cannot be overlooked or ignored, such as the proverbial "police officer at the shoulder").

The clinical emphasis is invariably on internal control—perhaps based on the premise that the only real control is self-control—and, in particular, on control through the elimination of the psychological impulse. However, for those people who, for whatever reason, cannot establish some form of internal control, external controls can fill the gap. Consider, for example, people who reinforce their "will" to diet or to abjure alcohol by putting physical distance between themselves and the physical source of their addictive substances. The dieter will study at the library, rather than at home where the refrigerator is handy. The reforming alcoholic will stay away from bars.

This is consistent with Dickman's (1990) differentiation between functional and dysfunctional impulsivity, which emphasizes the social evaluation or appraisal of the act. This distinction makes the definition of an impulsive act dependent not only upon its outcome, but also upon the situation in which the behavior occurs. In some cases, the professional therapist becomes a crucial part of that environment:

We can point out and clarify the existence of a defect; we may try to repair it, patch it, or offer a replacement; we cannot interpret it. Therefore, in the classic mode of supportive technique, we must work within the patient's psychic apparatus, accept what he has, evaluate his resources—especially [those] that

may be brought into the service of control—and try to utilize them where possible and to strengthen them if there is sufficient time. If such resources are limited or lacking, we may have to lend the patient our own ego operations to help meet this lack; in such instances, therapists must sometimes accept such patients as a lifelong commitment. (Frosch, 1977, pp. 311)

For some disorders, the choice between internal and external control of impulsivity is absolute and categorical. Consider the example of criminal sex offenders. Prior to committing a sexual offence, individuals are allowed to have as many lascivious or licentious thoughts as they wish. Their fantasy life is their own, and as long as they do not act on it, particularly with an unwilling partner or in an inappropriate situation, it is of no concern to anybody else. But once they have acted out their fantasies in an inappropriate manner, and have been placed in a treatment facility, it is the absence of the thoughts that will determine when they can be safely returned to the community. No matter how strong their behavioral controls, and no matter how firm their resolve not to act impulsively, they will be subjected to absolute environmental control and detained in a correctional facility, away from the sources of satisfaction for their impulses, as long as they have the socially unacceptable sexual fantasies. The criteria for discharging a convicted sexual offender into the community are far higher than the criteria that a nonoffender has to meet in order to stay in the community.

A similar kind of rigidity can be seen in the approach to impulsivity that is considered to be a personality trait:

Insofar as "impulsiveness" would appear to be a trait of personality (Eysenck, 1993), it would seem very important indeed that the therapeutic aim be established as one of "management" rather than "cure". This means that, to an extent, the therapist must undertake something of a role as teacher or model. The purpose must be one of helping persons identify sources of stress and of assisting them strengthen their tolerance to these events. This means assisting them find ways of releasing tensions that are acceptable to them and to other members of society. . . . Clients frequently need assistance in isolating the kinds of experiential and emotional states that predispose them to untoward impulsive actions. The same can be said of analysis of precipitating events, [which are] sometimes called "triggers". (Mittler, 1994, pp. 37-38)

The current attitude toward the treatment of impulsivity in sex offenders and in personality-disordered individuals reflects the old, univariate, disease-based model of causality, rather than the new, multivariate, behavioral model that is advocated by DSM-III (APA, 1980), DSM-III-R (APA, 1987), and DSM-IV (APA, 1994). When it comes to the development of an interactive, multivariate model for diagnosis and treatment, the American Association on Mental Retardation (1992) is leading the way. And it is a very optimistic way.

In cases where impulsivity is to be attributed to limited intellectual

functioning, it may be beneficial to think of the persons in terms of their mental age rather than their intelligence quotient. The concept of a low intelligence quotient carries with it an implicit assumption of an underlying, irreversible, neurological impairment, with a corresponding impediment to learning and behavioral change. However, young children, even very young children, can learn and acquire simple skills if the information is presented to them at a level and in a way that they can understand.

Camp (1977) suggested that aggressive boys have problems inhibiting impulsive behavior because they have not learned the adequate use of verbal mediation processes. Camp, Blom, Herbert, and van Doornick (1977) consequently developed a training program called "Think Aloud," which is designed to help aggressive boys gain control of their impulsive response styles through verbal mediation procedures. Dodge and Newman (1981) have suggested that aggression in young boys is sometimes attributable to their responding before they have given adequate attention to available social cues; this too can be corrected through education.

A FINAL COMMENT

Consideration of the meaning of "impulsivity"—its construct explication—should not be dismissed as a purely semantic issue. There is a story of a small community in the interior of British Columbia that has two churches. The difference between them is purely semantic. One says, "There is no hell"; the other says, "The hell there ain't!" The story is probably apocryphal, but its message is not.

A solution has never been found to a problem that was never defined. One of the major purposes of classifying disorders is to facilitate their treatment. Until the concept of impulsivity is clearly defined, the APA classification of its disorder(s) cannot be clear, and the DSM guidelines for treatment will consequently range from nonexistent to confused.

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NOTE

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