

CHAPTER 18

DISORDERS OF IMPULSE CONTROL: EXPLOSIVE DISORDERS, PATHOLOGICAL GAMBLING, PYROMANIA, AND KLEPTOMANIA

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The disorders of impulse control are a group of clinical syndromes described in the third edition of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders (DSM III)*.¹ There are five categories of these disorders: the intermittent explosive disorder, the isolated explosive disorder, pyromania, kleptomania, and pathologic gambling. A sixth category, the atypical impulse control disorder, is also listed but reserved for conditions that clearly do not fall into the above; these "atypical" categories exist in many of the affective and thought disorder conditions described within the manual and allow for the diagnosis of unusual syndromes that may ultimately shape more specific clinical entities. This chapter will review briefly each of the existing clinical syndromes and comment on their diagnostic features and utility.

GENERAL COMMENTS

At the onset, it should be noted that the disorders of impulse control are a heterogeneous group of entities, quite different from each other and linked only by the common characteristics of (a) a failure to resist an impulse, drive, or temptation that gives rise to the act, (b) psychological tension that rises until the act is committed, and (c) some sense of relief or release upon completion of the act or a sense of gratification or pleasure during the act or thereafter. These characteristics are listed in the manual as inherent features of the impulse disorders, yet they pose certain problems for the practitioner, clinician, or forensic expert. For example, "failure to resist an impulse" is a controversial concept. Does this mean that the behavior is unpremeditated? Temper outbursts usually seem unpremeditated; but pyromania, shoplifting, and pathologic gambling involve degrees of willful planning and foresight. Thus the basic tenet of these disorders representing a capitulation to an impulse or a temptation is

problematic. The matter of there being an increased sense of tension before the impulsive act and an experience of pleasure or "release" during or after the commission of the act is also somewhat questionable. From the clinical standpoint, tension and release do not invariably occur. For example, persons exhibiting explosive temper outbursts may experience tension prior to their violence, but pleasure is rarely present during the act itself or thereafter; rage or guilt are common emotions as sequelae.

TERMINOLOGICAL DIFFICULTIES

On reviewing the disorders of impulse control, one is immediately struck with the different heritage of terms and the varying data bases surrounding the entities. The intermittent explosive disorder, for example, represents a transplant of the old "explosive personality" described in the second edition of the *Diagnostic and Statistical Manual (DSM II)*. The explosive personality was a rather sturdy entity most clinicians agreed upon.² Yet the characterologic terms posed contradictions for members of the American Psychiatric Association Task Force on Nomenclature who focused on observable behavior. An explosive personality was not always explosive; in fact, over a period of time it was rarely so. Virtually all explosive personalities interviewed by clinicians were "nonexplosive" at the time of their office visit (this is not to say that they were free of other characterologic traits). Therefore, how could one call this person explosive? Paranoid personalities, in contrast, seem to be more consistently paranoid, and schizoid individuals seem to be usually aloof. Obviously representing a rather statistical view of psychopathological base rates, such was the reasoning behind the deliberations resulting in the latest *Diagnostic and Statistical Manual*; the net result was to take the explosiveness of the explosive personality and redefine the latter as a disorder of impulse control. The term was also neurologized, so to speak, and made a limbic system disturbance. This reflected experience some task force members and consultants had with this disorder and with the study of aggression.

In juxtaposition to the intermittent explosive disorder, pathological gambling was introduced as an entirely fresh entity. Historically, there existed a literature on the topic of gambling, but it was predominantly found in case reports psychoanalytic in nature. A much larger and more scientific literature exists on the subjects of episodic dyscontrol,³ violence and aggression,⁴⁻⁶ and brain dysfunction,⁷⁻⁸ all of which helped shape the entity of the intermittent explosive disorder.

Pyromania and kleptomania had more traditional roots in the history of psychiatry, again mainly the focus of psychoanalytic interest. Because the two entities reflected observable behavior that had underpinnings of psychological dysfunction, they were itemized as disorders of impulse control.

Some entities among the impulse disorders seem more sensible than others in terms of reflecting clinical practice. Pyromaniac patients are not uncommonly seen in general psychiatric or forensic institutions, but kleptomaniacs are uncommon. Patients with the intermittent explosive disorder are often perceived as having behavior disturbances more appropriately the domain of the criminal justice system than the province of clinical psychiatry.

Pathological gambling, however, is probably the most questionable construct, at least in theory, when offered as a defense of insanity. To some extent, the entity is similar to the term pathologic intoxication in *DSM II*, now called

idiosyncratic alcohol intoxication in *DSM III*. Here, the prefix "pathologic" denoted a qualitatively different form of behavior characterized not by simple drunkenness but by a form of intoxication liberated by minimal alcohol intake and involving central nervous system manifestations.

Most critics skeptical of the term pathological gambling ask, "What, then, is normal gambling?" The question is not easy to answer from the viewpoint of clinical medicine; it would appear that pathological gambling is simply a losing form of gambling, representative of bad luck coupled with a driven compulsion that can be observed. Suffice it to say that the fate of this term for any future manual is unclear.

The disorders of impulse control are not the only entities to suffer from inconsistencies in diagnostic rigor. Some personality disorders are just as variable. For example, the avoidant personality is described almost poetically in *DSM III* as a disorder "in which there is a hypersensitivity to potential rejection, humiliation, or shame; an unwillingness to enter into relationships unless given unusually strong guarantees of uncritical acceptance; social withdrawal in spite of a desire for affection and acceptance; and low self-esteem." In sharp contrast, the antisocial personality has numerous qualifying parameters such as "truancy (positive if it amounted to at least five days per year for at least two years, not including the last year of school)" or "inability to sustain consistent work behavior as indicated by . . . too frequent job changes (e.g., three or more jobs in five years not accounted for by nature of job or economic or seasonal fluctuation)."

The lesson to be learned here is that the criteria for some diagnoses in the manual are very hard, some quite soft. The same is obviously true with the disorders of impulse control. As will be seen from the diagnostic criteria for all the disorders of impulse control, other major psychopathology has to be excluded; affective, thought, behavior, and personality disorders should **not** be the basis for the specific impulse disorder. In other words, a patient's kleptomaniac activities should not be due to a schizophrenic disorder in which he or she may be delusional and hence steal articles of some delusionally symbolic worth. Kleptomania should not be due to antisocial propensities in which stealing is part of a criminal's life, and the intermittent explosive disorder should not be due to a conduct disturbance, such as an attention deficit disorder in which there is generalized impulsivity. In clinical practice, however, these distinctions are difficult to make, and the forensic expert may indeed see a patient who engages in kleptomaniac activities and who has a history of schizophrenia but who is not actively psychotic at the time of the commission of the kleptomaniac act. The same is true of pyromania; mental retardation may coexist, or the patient may have schizoid traits. The differential diagnosis may thus be problematic. Psychological testing may be useful to detect or to substantiate an underlying thought disorder, organicity, or other major psychopathology.

INSANITY DEFENSE ISSUES

Little objective data exist on the matter of how often the disorders of impulse control are used as the basis for an insanity defense. Ratner and Shapiro⁹ have indicated the successful use on a few occasions of episodic behavior disorders³ as legal exculpation for violent crime. The term episodic behavior disorder is, however, not synonymous with any particular disorder of impulse control but is an all-inclusive description of a wide range of behaviors that include affective,

thought, and behavior disturbances. These are all paroxysmal in nature, thought to be epileptoid in etiology. Pyromania and kleptomania are rather distinctive clinical entities, and both have been used as the basis for insanity pleas, though precise statistics are not available with respect to frequency of such use. Pathological gambling is so subtly different from "nonpathologic" gambling that one might wonder about its viability for an insanity defense. Yet McGarry¹⁰ indicates that the term has served as a basis for insanity pleas at trial court level in three states and in two federal jurisdictions. Furthermore, the plea has led to insanity acquittals in two states and a hung jury in two others. Although McGarry is tolerant of the clinical entity of pathological gambling, he feels it illogical to assume that the lack of volitional control over the isolated act of gambling is the same as the lack of such control over the criminal acts carried out in the service of the impulse to gamble. McGarry is thus critical of the exculpatory use of the term and forecasts that such use will ultimately not be sustained by the appellate courts of this country.

INTERMITTENT EXPLOSIVE DISORDER

Clinical Features

This condition refers to patients who have sudden and paroxysmally recurring outbursts of impulsive violence. The outbursts come on without clear warning and remit quickly; in common parlance, the term "temper" would be used to describe the rage attacks. Patients who demonstrate the intermittent explosive disorder overrespond to stimuli and react to some social situations with all-or-none behavior. They have difficulties with the modulation of anger and become physically aggressive toward persons or property. Between the outbursts of rage, they often appear calm, peaceful, and even reflective. The diagnostic criteria of the illness are excerpted below from the current *Diagnostic and Statistical Manual*.¹

Diagnosis

- A. Several discrete episodes of loss of control of aggressive impulses resulting in serious assault or destruction of property.
- B. Behavior that is grossly out of proportion to any precipitating psychosocial stressor.
- C. Absence of signs of generalized impulsivity or aggressiveness between episodes.
- D. Not due to Schizophrenia, Antisocial Personality Disorder, or Conduct Disorder.

Etiology, Pathogenesis, Dynamics

The above features are purely descriptive. As previously mentioned, there is little statistical or systematic empirical basis for this disorder, and the qualifying parameters are clinical descriptions. Men are more likely to demonstrate this disorder than are women. The complications of the illness seem rather obvious and include penal incarceration and hospitalization. The disorder commonly

makes its appearance in the second or third decade of life. No clinical course is outlined in *DSM III*.

The neurological flavoring of the diagnosis has already been alluded to with regard to the biology of aggression. In this matter of temper, some clinical data have suggested that organic factors play a role in some expressions of aggression in man, especially paroxysmal outbursts in intermittent explosive disorders. Thus in *DSM III*, certain neurologic features are described as important. These include historical antecedents to temper outbursts, such as head injuries or hyperactivity, or predisposing factors such as perinatal trauma and encephalitis. Evidence of organic brain dysfunction or actual seizure states manifested by alterations in consciousness, confusion, or memory deficits are relevant. Inasmuch as epilepsy is often accompanied by subjective symptoms like changes in taste or smell, followed by drowsiness or amnesia, these symptoms are also mentioned in the manual. Laboratory tests may be of value in the diagnosis of the intermittent explosive disorder. A sleep electroencephalogram (EEG) may reveal paroxysmal discharges or a spike focus indicative of brain dysfunction. Neurologic examination for "soft signs" and psychological tests for organicity may detect underlying cortical dysfunction that plays a role in the patient's aggressive outbursts. In summary, the etiology of the intermittent explosive disorder is seen as partially organic and its pathogenesis reflective of central nervous system dysfunction.

Many conditions mimic this disorder. The differential diagnosis thus includes the antisocial personality, dissociative disorders, psychotic disorders, attention deficit disorder, and an organic brain syndrome.

Despite little knowledge about this disorder, its inclusion in *DSM III* is extremely important and acknowledges that aggression may be a subject for study by clinicians. Psychiatrists have long been reluctant to study violent patients and have relegated them to the disciplines of criminology and sociology. Thus it may facilitate the understanding of aggression to include the intermittent explosive disorder among conventional mental disease entities.

The only existing literature on the intermittent explosive disorder pertains to the matter of precision of diagnosis, using official nomenclature. Monopolis and Lion¹¹ have studied 20 cases of the disorder among 830 admissions to a general psychiatric unit over a 2-year period (an incidence of 2.4 percent). Cases of intermittent explosive disorder were found to be diagnosed principally in reference to the basic diagnostic criteria cited in this chapter. With the exception of the EEG, few clinicians used neurologic indices for identifying their cases, despite the manual's emphasis of these organic factors as associated features of the disorder.

A number of authors have studied what is tantamount to the intermittent explosive disorder without calling it by that name. Monroe³ has devoted a portion of his monograph on episodic behavior disorders to a description of patients who have recurring repetitive outbursts of temper or atypical mood or thought disorders reflective of limbic system dysfunction. Bach-y-Rita and coworkers¹² have described patients with recurring outbursts of rage and drawn attention to recurring clinical features of these individuals.

Treatment

Unlike case reports for the treatment of kleptomania or pathologic gambling, little literature exists for the specific treatment of the intermittent explosive disorder. But there is a vast literature pertaining to the treatment of aggressive

individuals, many of whom do not have a crisply defined intermittent explosive disorder yet suffer from aggressive tempers. Treatment for the specific intermittent explosive disorder relies upon drugs and psychotherapy. In regard to drugs, a variety of pharmacologic agents have been used, most with the rationale that outbursts of temper reflect an epileptoid disorder, hence the drug of choice is an anticonvulsant.¹³ Most recently, carbamazepine has been used as an agent to control limbic system kindling and temper.¹⁴ Lion¹⁵ has described the basic strategy underlying the psychotherapeutic treatment of impulsive aggression and indicates that there are two strategies in the treatment of such patients. First, these patients need to be aware of anger as it builds up so that they can identify it as early as possible and verbalize their feelings. Impulsive patients generally have an impoverished affective awareness and tend to translate the premonitory mood associated with physical violence into some kind of adverse behavior such as drinking, often to quench the incipient rage. The drinking, in turn, exacerbates the violence. Second, Lion emphasizes the need to teach people to fantasize the outcome of a violent act. Cognitive appreciation for the sequelae of an aggressive outburst is an essential prerequisite for violence-prone patients' control of their impulsivity. These patients tend to act first and think afterward and need to be retrained to reflect on the consequences of their violence. Psychodynamic factors are also important because patients with violent tempers are sensitive to conflicts over sexuality, body size, or territoriality.

Patients manifesting the intermittent explosive disorder often become convicted of criminal assault. Many see little need for any kind of psychiatric treatment and perceive their temper outbursts as simply a part of their personality. Court-mandated therapy is thus a useful means of propelling them into a treatment program which may ultimately attenuate their violent propensities. Lion and coworkers¹⁶ have described outpatient group psychotherapy as a useful modality of treatment for these patients.

ISOLATED EXPLOSIVE DISORDER

Clinical Features

This disorder will be mentioned only briefly because it is so rare. The disorder refers to a single outburst of rage, an outburst of catastrophic proportions but one which cannot be classified as psychotic. The diagnosis would seem to be a difficult one to make, though anecdotally many clinicians recall hearing of patients who have "gone amok" and committed a heinously violent act such as a mass murder. The condition has been described by Menninger¹⁷ in his accounts of the "third order of dyscontrol" and, earlier, by Wertham,¹⁸ who used the expression "catathymic crisis." Both authors refer to a single and isolated assaultive or destructive rage which may build up over a period of time within the individual and then erupt into overt behavior. Megargee¹⁹ has described the "overcontrolled" personality who is very rigid and guarded and who is prone to an unmodulated and explosive outburst of rage. Formal literature on the forensic aspects of the isolated explosive disorder is lacking.

The diagnostic criteria for this condition are excerpted below from *DSM III*¹:

Diagnosis

- A. A single, discrete episode in which failure to resist an impulse led to a single, violent, externally directed act that had a catastrophic impact on others.
- B. The degree of aggressivity expressed during the episode was grossly out of proportion to any precipitating psychosocial stressor.
- C. Before the episode there were no signs of generalized impulsivity or aggressiveness.
- D. Not due to Schizophrenia, Antisocial Personality Disorder, or Conduct Disorder.

Etiology, Pathogenesis, Dynamics

Little is known or has been described regarding the above factors in this disease process. Although the violent act is often bizarre or senseless and typically involves victims unknown to the assailant, isolated accounts of this disorder often reveal that the perpetrator was under great emotional stress. He may have translated an intolerable intrapsychic crisis into an isolated behavioral act which represented the ultimate discharge of murderous rage without evidence or development of a psychosis. These accounts, however, are speculations after the fact; the isolated explosive disorder has not been sufficiently studied to validate any recurring dynamics or etiological factors. As such, its appearance in *DSM III* could be regarded as tentative.

Treatment

No specific therapy is identified for the disorder; because the outburst of violence occurs just once, treatment obviously would be dictated by the specifics of the individual case, and hospitalization would seem to be in order to reach appropriate clinical understanding.

PYROMANIA

Clinical Features

This condition refers to patients who feel compelled to set fires repeatedly and for no monetary or overtly retributive gain. The fire setting is a highly symbolic act in the mind of the fire setter and, unlike arson, is a seemingly purposeless act that is carried out impulsively. There appear to be no clearly associated psychiatric disturbances in these patients. The diagnostic criteria of the illness are excerpted below from *DSM III*.¹

Diagnosis

- A. Recurrent failure to resist impulses to set fires.
- B. Increasing sense of tension before setting the fire.

- C. An experience of either intense pleasure, gratification, or release at the time of committing the act.
- D. Lack of motivation, such as monetary gain or sociopolitical ideology, for setting fires.
- E. Not due to an Organic Mental Disorder, Schizophrenia, Antisocial Personality Disorder, or Conduct Disorder.

Etiology, Pathogenesis, Dynamics

A large and descriptive literature exists on pyromania, mostly psychoanalytic in nature, highly theoretical, and based on isolated case reports. Freud²⁰ linked fire setting to enuresis and later saw the act as a masturbatory equivalent, and Fenichel²¹ more explicitly identified pyromania with urethral eroticism. Other early writers, like Stekel,²² described what they felt to be an association between fire setting and sadism or homosexuality. Later investigators who interviewed children fire setters commented more globally on the extensive family pathology present in the cases they saw and reported that fire setting often occurred after the child witnessed parental infidelity or sexual intercourse between parents.^{23,24} Yarnell²⁵ found that latency age children (ages 6 to 12 years) who set fires had fantasies about burning a family member who had either withheld love from them or was a rival for the love of the parents. They set fires in or close to their home. Associated behavior problems among this group of children included running away, truancy, stealing, aggression, and learning disabilities. Enuresis was frequently present.

Incidence and prevalence statistics vary widely in different published series. The term "fire setting" is often used interchangeably with "pyromania," thus confusing the data. In a heterogeneous series of 1145 fire setters seen in a variety of clinical settings by Lewis and Yarnell,²⁶ these authors found that two thirds of the individuals were men over the age of 16, and only 13 percent were girls or women. The peak incidence was at the age of 17. Monkemoeller²⁷ reported that 37 percent of his series of fire setters were females. Vandersall and Wiener²⁸ reported that among 660 children seen in an outpatient clinic, 2.1 percent were fire setters; whether these children set fires for revenge or money or were pyromaniacs is unknown. In looking at Lewis and Yarnell's data,²⁶ it appears that about 40 percent of their series represented true pyromaniacs.

Much attention has been given to the clinical triad of enuresis, pyromania, and cruelty to animals as indicative of future criminal violence; however, more recent empirical data²⁹ has shown this triad to have no predictive value.

Neurological impairment accompanied by poor academic achievement and borderline intellectual functioning has been described among fire setters as a whole.³⁰ Kuhnley and coworkers³¹ reported a high frequency of attention deficit disorder among fire setting children. Vandersall and Wiener²⁸ noticed that school failure was common, and Yarnell²⁵ and Lewis and Yarnell²⁶ remarked that fire setters may have below normal intelligence.

Pyromaniac patients have been observed by some clinicians to be regularly present at neighborhood fires and find particular fascination with fire-fighting apparatus. They may become involved in setting off false alarms. In Lewis and Yarnell's²⁶ series of firesetters, 5 percent were reported to have set the fire

merely to extinguish it themselves or to watch it extinguished, hence drawing attention to the often-cited association between firemen and pyromaniacs. In fact, no data exist regarding the representation of firemen among either general fire setters or true pyromaniacs. Sexual satisfaction or masturbation or orgasm during the watching or setting of fires is rarely present.

A number of behaviors mimic true pyromania and thus need to be considered in the differential diagnosis. These would include normal play behavior by children, conduct disorders, antisocial personality, and criminal arson.

Treatment

Pyromaniac people as a group are usually resistant to treatment because of their poor motivation, denial, lack of insight, and resistance to assuming responsibility for their actions. They are also very passive, and it is difficult in therapeutic work to confirm the psychodynamics that are presumed to underlie the etiology of the behavior. The use of intensive individual psychotherapy has been reported by Macht and Mack,³² however, no follow-up data have been reported.

Psychiatric hospitalization may provide the needed protective environment to treat underlying psychopathology and may help the patient cope with destructive urges. According to published accounts of case reports, outpatient treatment and probation supervision for long periods are necessary in order to prevent recurrences of the pyromaniac activity.³²⁻³⁵

KLEPTOMANIA

Clinical Features

This condition refers to individuals who experience an impulse to steal objects that they neither need nor wish to keep or to sell. Although kleptomaniacs break the law in the commission of their acts, they are not antisocial. The object stolen is often one of symbolic significance to the patient. Kleptomaniacs usually act alone and without accomplices. They steal objects such as books, undergarments, or even food, although they carry money with them. Some kleptomaniac patients are reported to return the stolen item secretly or to dispose of it, but most evidently keep such items. As in the case of pyromania, no consistent psychiatric disorders are associated with this group of patients. The diagnostic criteria of the illness are excerpted below from *DSM III*.¹

Diagnosis

- A. Recurrent failure to resist impulses to steal objects that are not for immediate use or their monetary value.
- B. Increasing sense of tension before committing the act.
- C. An experience of either pleasure or release at the time of committing the theft.

- D. Stealing is done without long-term planning and assistance from, or collaboration with, others.
- E. Not due to Conduct Disorder or Antisocial Personality Disorder.

Etiology, Pathogenesis, Dynamics

Kleptomania, like pyromania, has been primarily the focus of psychoanalytic writers who have studied isolated causes and reported on psychodynamic considerations. Thus Wimmer³⁶ talked of the role of hunger and orgasm among the kleptomaniac patients, and Abrahamson³⁷ classified the disease as a neurotic entity, similar to nymphomania or pyromania. Anna Freud³⁸ considered stealing as rooted in the early "oneness" between mother and child.

Winer and Pollock³⁹ have described the repetitive course of kleptomania, pointing out that the urge to steal waxes and wanes within an individual and may be a function of his or her internal conflicts. Other workers^{40, 41} have described autonomic sensations that accompany the shoplifting episodes such as anxiety, perspiration, or dyspnea, although it would seem that such symptoms are quite nonspecific and common to any endeavor that has legal consequences for the individual concerned. Remorse or guilt following an episode of kleptomania has been described, but this would also seem to suffer from the same criticisms as above.

The terms "kleptomania" and "shoplifting" have been used synonymously (but erroneously) as though the two were the same entities. Thus it is difficult to discern in the published literature which statistics apply to true kleptomaniac patients and which to criminal shoplifters. Arieff and Bowie⁴² indicated that in a 5-year period, 77 percent of shoplifting cases studied in a psychiatric hospital had a psychiatric diagnosis (psychoneurosis, mental deficiency, psychosis, or organic disorder). Meyers⁴⁰ emphasized the marked disturbance in the sexual lives of shoplifters, as well as the presence of somatic symptoms and signs such as headache, respiratory symptoms, or gastrointestinal disturbances. In a 5-year study of female shoplifters brought to court, Gibbens, Palmer, and Prince⁴³ found that about 15 percent had a history of previous inpatient mental treatment. Schizophrenia, depression, manic-depressive illness, psychotherapy, and alcoholism were the most common diagnoses. Meyers⁴⁰ observed that the majority of male shoplifters were single and that female offenders were married. Men stole books much more frequently than did women.

The main condition that plays a role in the differential diagnosis is a criminal stealing in which there is obvious gain and clear planning. Conduct disorders and the antisocial personality must also be considered in the differential diagnosis.

Treatment

Unfortunately, the available literature on kleptomania usually consists of single case reports or small series of cases.⁴⁴⁻⁴⁷ No systematic studies have been undertaken. On the basis of clinical knowledge about the tendency for kleptomaniacs to repeat the act, some form of court-mandated psychiatric treatment would seem warranted.

PATHOLOGICAL GAMBLING

Clinical Features

This condition refers to compulsive involvement in gambling with concomitant deterioration in personal and social functioning. The gambler gives up all else in life and concentrates mainly on winning or gaining restitution of debts incurred through gambling. Pathological gamblers are unable to stop their activities but spiral ever downward to the point of confrontation by legal authorities. The diagnostic criteria of the illness are excerpted below from *DSM III*.¹

Diagnosis

- A. The individual is chronically and progressively unable to resist impulses to gamble.
- B. Gambling compromises, disrupts, or damages family, personal, and vocational pursuits, as indicated by at least three of the following:
 - 1. arrest for forgery, fraud, embezzlement, or income tax evasion due to attempts to obtain money for gambling.
 - 2. default on debts or other financial responsibilities.
 - 3. disrupted family or spouse relationship due to gambling.
 - 4. borrowing of money from illegal sources (loan sharks).
 - 5. inability to account for loss of money or to produce evidence of winning money, if this is claimed.
 - 6. loss of work due to absenteeism in order to pursue gambling activity.
 - 7. necessity for another person to provide money to relieve a desperate financial situation.
- C. The gambling is not due to Antisocial Personality Disorder.

Etiology, Pathogenesis, Dynamics

Most of the older literature pertaining to gambling comes from psychoanalytic writers. Very small series or isolated case reports form the bulk of these descriptions. Freud⁴⁸ viewed gambling as a repetition of the childhood compulsion to masturbate, and Bergler⁴⁹ commented on the gambler's unconscious desire to lose. Other writers have talked in general terms about the unconscious determinants of winning or losing or the need to appease others or to be appeased by luck.

Writing about current views of gambling, Custer⁵⁰ based his experience on a Veterans Administration service for compulsive gamblers. He felt that only a minority of the treated population were neurotic. However, precise figures on this aspect of diagnosis are lacking. Moran⁵¹ described neurotic, impulsive, and psychopathic gamblers in a survey of 50 pathological gamblers referred for psychiatric treatment.

Pathological gambling is more common among men than among women.¹ Pathological gambling and alcoholism are more common in the fathers of men and in the mothers of women with the disorder than in the general population.¹ Custer⁵² estimates that there are several million "compulsive" gamblers in the United States. No other data are available for the specific disorder of pathological gambling; the demographics of gambling in general have been studied, one source being a 1975 survey done at the University of Michigan, cited by Custer,⁵⁰ and another cited by Moran.⁵³

The stages of the development of the pathological gambler have been described by Dupouy and Chatagnon⁵⁴ as consisting of initiation, habituation, suffering, and impairment. The authors discuss the fact that most gamblers are introduced to this activity by friends or relatives. Petty gambling usually starts in early adolescence. Serious gambling begins around age 17. According to Custer,⁵² there appear to be three phases in the development of pathological gambling: (1) *Winning phase*—the gambler wins at the beginning of his career. (2) *Losing phase*—eventually he or she experiences failures. In order to make up for the losses, the gambler starts betting amounts of money that deplete personal resources and he or she becomes increasingly indebted to others. Excuses and lying are frequent. Work attendance and productivity are diminished. Family relationships deteriorate. The pressure of lenders increases. (3) *Desperation phase*—over time, occupational, family, social aspects of the gambler's life deteriorate further. Eventually the inability to pay excessive debts leads to illegal activities, such as forgery, embezzlement, income tax evasion, fraud, or robbery. It may take from 1 to 20 years to reach this stage of desperation, but the average is 5 years.

According to Lesieur,⁵⁵ as options diminish, the compulsive gambler becomes entrapped in an extremely powerful and panic-ridden state that leads with certainty to personal downfall.

Forensic experts may have difficulty distinguishing pathological gambling from "nonpathological" gambling. In the former, the patient usually has no antisocial history and has a good work history until such time as the gambling takes hold. Predatory or psychopathic traits are absent, and the patient usually is conscientious in all other areas of life. Other differential diagnoses include malingering and conduct disorder. Some patients develop a true euphoria as they gamble and do not eat or sleep; in time, the full-blown clinical picture of mania is seen. Thus affective disorders, such as manic-depressive disorder, are in the differential diagnosis.

Treatment

A host of techniques has been used with pathological gamblers, including psychoanalysis,⁴⁹ group therapy,⁵⁶ and isolated case reports of behavior modification paradigms.^{57, 58} The program developed by Custer consists of inpatient treatment with outpatient follow-up. Hospitalization lasts 3 to 4 weeks and consists of various psychosocial treatment modalities.^{50, 52}

Pathological gambling is a chronic and incapacitating psychosocial disorder that requires long-term intervention. Modeled after other addiction treatments, Gamblers Anonymous (GA) was founded in Los Angeles in 1957. It is a self-help organization of pathological gamblers helping each other with abstinence.⁵⁹ Pokorny⁶⁰ found that spouses played a crucial role in the illness of pathological

gambling and affected the outcome of therapy. Gam-Anon and Gam-a-Teen provide gamblers' spouses and children opportunity for therapy.

Once identified as a pathologic gambler, the individual patient requires some form of court supervision in order to remain in treatment.

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