

Rapid #: -22162447

CROSS REF ID: **383041**

LENDER: **LF0 (Flinders University) :: Main Library**

BORROWER: **VYQ (SUNY Upstate Medical) :: Main Library**

TYPE: Book Chapter

BOOK TITLE: Diagnostic ManualIntellectual Disability (DM-ID): A Textbook of Diagnosis of Mental Disorders in Persons with Intellectual Disability

USER BOOK TITLE: Diagnostic ManualIntellectual Disability (DM-ID): A Textbook of Diagnosis of Mental Disorders in Persons with Intellectual Disability

CHAPTER TITLE: Impulse control disorders not elsewhere classified

BOOK AUTHOR: Rifkin, Arthur; Barnhill, L. Jarrett; Fletcher, Ro

EDITION: 1st

VOLUME:

PUBLISHER: National Association for the Dually Diag

YEAR: 2007

PAGES: 483-495

ISBN: 9781572561250

LCCN:

OCLC #:

Processed by RapidX: 3/3/2024 6:30:26 PM

This material complies with Section 49 or Section 50 of the Australian Copyright Act

CHAPTER 26

Impulse-Control Disorders Not Elsewhere Classified

Arthur Rifkin, M.D.
L. Jarrett Barnhill, M.D.

This chapter covers Impulse-Control Disorders Not Elsewhere Classified. According to the *DSM-IV-TR*, these disorders represent "the failure to resist an impulse, drive, or temptation to perform an act that is harmful to the person or to others." Within this category are Intermittent Explosive Disorder, Kleptomania, Pyromania, Pathological Gambling, and Trichotillomania. For most of these disorders, "the individual feels an increasing sense of tension or arousal before committing the act and then experiences pleasure, gratification, or relief at the time of committing the act. Following the act there may or may not be regret, self-reproach, or guilt."

Intermittent Explosive Disorder

There is considerable debate about Intermittent Explosive Disorder (IED). Much of this discussion centers on its validity as a distinct syndrome versus a nonspecific form of affective-impulsive aggression. In spite of this controversy many clinicians find IED useful, especially for patients with aggressive behavior that was once classified as pathological aggression or episodic dyscontrol syndrome. Others do not find IED useful

because of the considerable heterogeneity inherent in any classification of aggressive behaviors. For these clinicians it is difficult to reliably differentiate IED from aggression associated with other neuropsychiatric disorders. In either case, the value of IED may be in defining a subset of aggressive behaviors that can be helpful in selecting treatment strategies.

Review of Diagnostic Criteria

IED includes behaviors that occur independently of other primary mental disorders. As a result, IED in many circumstances is made by exclusion.

Summary of DSM-IV-TR Criteria

In the *DSM-IV-TR*, IED is characterized by discrete episodes of impulsive aggression that has the potential to produce serious assaults or property destruction. The aggression must exceed the usual or expected intensity or threat-level of provocation or precipitating events. In addition, aggression associated with other mental disorders or substance use are excluded. Aggression associated with medical or known neurological conditions is excluded. The exclusion criteria are meant to limit het-

erogeneity, but make it difficult when these criteria are applied to patients with developmental disorders.

Issues Related to Diagnosis in People with ID

In contrast to normocognitive patients, individuals with ID are more apt to present with aggressive behaviors that are not directly related to diagnosable psychiatric disorders. The prevalence of such nonspecific aggressive behavior tends to vary inversely with the levels of ID, but directly in association with seizure disorders, developmental brain abnormalities, and environmental disorganization.

The following studies focus on the difficulty of trying to segregate aggression with and without comorbid mental disorders in individuals with IED:

1. Monopolis and Lion (1983) found a point prevalence of IED among 1.1% in a large sample of adults without ID. They also noted that only 1.8% of patients referred for treatment of aggression actually had IED. One confound in their study involved differences between *DSM-III* criteria and *DSM-IV-TR* criteria for IED. It was more difficult diagnosing IED using the *DSM-III* criteria. This difference will affect prevalence studies.
2. Zimmerman and colleagues surveyed 411 psychiatric outpatients without ID using *DSM-IV-TR* criteria. They noted that 3.8% met the criteria for current IED and 6.2% met lifetime criteria. It is difficult to gauge age of onset, temporal variability or chronicity from this data (Zimmerman, Mattia, Younken, & Torres, 1998).

For patients with ID and aggressive behavior:

1. Corbett (1979) found that 25% of 402 adults with Severe or Profound ID were diagnosed with "behavior/personality disorder."
2. In Denmark, using *ICD* criteria, Lund (1985) sampled 324 adults from the national register of 22,500 adults with ID and found that 19% of the men and 7% of women had "be-

havior disorders."

3. Ballinger, Ballinger, Reid and McQueen (1991) reported *ICD-9* diagnoses in 100 randomly selected adults with ID living in an institution. They found that 15% had "conduct disturbance" and 17% had "personality disorder." These studies may be compromised by selection bias since aggression can be a principle reason for residential placement
4. Eaton and Menolascino (1982) described *DSM-III* diagnoses in 168 consecutive referrals for mental health evaluation. They reported 25% of referrals had "personality disorder" but were not classified as Impulse-Control Disorder.
5. Russell and Tanguay (1981) presented data on 93 consecutive admissions to a unit for adolescents with ID. 33% of these patients presented with "behavior disorders."
6. King and associates (1994) found, using *DSM-III-R* criteria, that 12% of 251 psychiatric referrals of institutionalized patients with Severe ID presented with an "impulse control disorder."

These studies suggest that the interrelationship between impulse dyscontrol, mood dysregulation, and aggression is a complex one. For example, the combination of long-standing problems with affect and impulse regulation are common features of personality disorders. Although King et al. (1994) report that Impulse-Control Disorders are frequently encountered in patients with ID it can be difficult to differentiate personality and other disruptive behavior disorders. It is also apparent that clinicians need a means of sub-typing aggressive behavior to minimize diagnostic heterogeneity when possible.

The most difficult issue concerning Impulse-Control Disorders comes from an uncertainty whether such aggressive behavior represents a true disorder. The clinical heterogeneity of impulse dyscontrol and aggression is compounded by the gulf between individuals with Mild versus Severe ID. It seems prudent to consider IED/Impulse Control Disorders in dimensional terms and proceed to explore individual domains. This

approach may diminish the ambiguity noted in these studies.

There are also problems defining IED relying exclusively on a medical model. The referral for assessment or treatment is not based on a diagnosis of IED but more often the referring complaints cite aggressive behavior. Much of corroborating evidence focuses on the results of a functional behavioral analysis and is generally operationalized into specific target symptoms. Unfortunately this approach can minimize wide variations in the underlying pathophysiology – increases in target behaviors may not be considered as manifestations of a baseline exaggeration due to post-ictal changes due to an increasing seizure frequency or emerging Panic Disorder.

Robins and Guze (1970) addressed this problem by trying to fine tune psychiatric diagnosis by suggesting that data collection focus on eliciting or measuring groups of symptoms (syndromes). To be valid a syndrome requires not only symptoms that are consistently observed together, but that also follow a predictable course and display a common pathophysiology and response to treatment. Since few mental disorders have clear biological uniformity, clinicians rely on observable descriptions of symptoms that are then compared with established criteria (e.g. criteria for Schizophrenia or Bipolar Disorders). Unfortunately, the Impulse-Control Disorders in general, and IED in particular, lack this degree of internal consistency, especially for individuals with Severe ID.

Robins and Guze also assume that symptoms arise from abnormal brain, or cognitive or affective dysfunction. As we have seen, impulsivity, aggression, and IED are complex phenomena that are best understood from a comprehensive or biopsychosocial frame of reference. This model for diagnosis implies a reciprocal interaction between biological factors and the social ecology of the behavior. This transactional model supports the need for a dimensional approach. For example, individuals with Severe ID and comorbid developmental brain anomalies can have a much lower threshold for impulsive aggression such that stresses easily managed by normo-cog-

nitive individuals with less impairment can provoke severe aggression or destructive behavior. From this perspective, IED may have greater validity for individuals with Mild ID because clinicians can better judge the discontinuity between stress and aggressive behavior. Other approaches are needed for patients with Severe ID and for many it may be difficult to consider aggressive behavior as a discrete illness. This is the Achilles' heel for efforts to establish Impulse-Control Disorders as a valid diagnosis.

Another thorny issue arises for clinicians treating patients with aggressive behaviors. Social pressures may result in attempts to medicalize aggression for purposes of community safety, gaining access to the health care system, or in forensic or criminal justice settings. These positions may not have a scientific evidence-base, especially for non-verbal individuals with impulsive, violent behavior.

Review of Research Applying to People with ID

King and associates provide one of the few large epidemiological studies of referrals for impulsive aggression in people with ID (King, DeAntonio, McCracken, J., & Forness, S., 1994). They studied 251 mental health referrals using data from multiple informants, past medical records, psychological tests, and behavioral data. Using modified *DSM-III-R* criteria, King et al. attempted to bypass problems in intentionality required for the diagnoses of Oppositional Defiant Disorder and Conduct Disorder (for example, disobedience motivated by spite or resentment) in nonverbal subjects with severe cognitive impairment. They grappled with the problem of organic cerebral dysfunction in patients with ID.

Following the lead of Menolascino (1970) and Szymanski (1988), King and his colleagues used the same criteria for a mental disorder as if the patient had no evidence of a physical (or neurological) impairment, unless there was some clear association, such as depression associated with hypothyroidism. Using these exclusion methods, the investigators reported that Impulse-Control Disorders were their

most common diagnosis, affecting 29% of the individuals reviewed.

The authors acknowledged, however, that their data did not constitute a representative sample. They also acknowledged that they had used no external confirmatory procedures to establish validity, nor had they made any effort to indicate reliability. Their work does suggest, nevertheless, that Impulse-Control Disorders might be quite common among people with ID.

Adaptation of Diagnostic Criteria

Aggressive episodes by a person with ID do not need to be "discrete" to qualify for

an IED diagnosis. Evaluation of whether the aggression is grossly out of proportion to psychosocial factors should include consideration of the person's developmental level. The presence of any mental disorder should exclude the diagnosis of IED unless the disorder seems separated from the aggression by comparative severity or temporal relationship. If the person has a mild Specific Phobia and severe aggression not confined to phobic situations, or if the aggressive episodes clearly preceded the other mental disorder, make the additional diagnosis of IED.

Intermittent Explosive Disorder

DSM-IV-TR Criteria	Adapted Criteria for Mild to Profound ID
A. Several discrete episodes of failure to resist aggressive impulses that result in serious assaultive acts or destruction of property.	A. Frequent episodes that last for at least two months of failure to resist aggressive impulses that result in serious assaultive acts or destruction of property.
B. The degree of aggressiveness expressed during the episodes is grossly out of proportion to any precipitating psychosocial stressors.	B. The degree of aggressiveness expressed during the episodes is grossly out of proportion to any precipitating psychosocial stressors and to the level of ID.
C. The aggressive episodes are not better accounted for by another mental disorder (e.g., Antisocial Personality Disorder, Borderline Personality Disorder, a Psychotic Disorder, a Manic Episode, Conduct Disorder, or Attention-Deficit/Hyperactivity Disorder,) and are not due to the direct physiological effects of a substance (e.g. a drug of abuse, a medication) or a general medical condition (e.g., head trauma, Alzheimer's disease).	C. The aggressive episodes are not better accounted for by any other mental disorder except if the other disorder is mild compared to the aggression, or is temporally unrelated to the aggression.

Kleptomania

Stealing is common in people with ID, but rarely does it appear unrelated to the individual's perceived need for personal use, monetary value, expressing anger, vengeance, or imitation. For individuals with ID, issues related to determining intent pose special problems in differential diagnosis. The differences between stealing and Kleptomania may largely disappear when confronted with nonverbal individuals with Severe ID.

Review of Diagnostic Criteria

Kleptomania consists of the recurrent failure to resist impulses to steal in the absence of need for personal use or monetary value; when the thefts do not express anger or vengeance; when they are not done as a response to a delusion or hallucination; and when it does not appear better accounted for by Conduct Disorder, a Manic Episode, or Antisocial Personality Disorder.

Summary of DSM-IV-TR Criteria

The essential feature of Kleptomania is stealing for no apparent reason. The sequence of urge, distress, compulsive action, and release from tension by acting on the impulse are not specific to Kleptomania. These features are also a part of a range of obsessive-compulsive spectrum disorders and addiction behaviors.

Issues Related to Diagnosis in People with ID

The *DSM-IV-TR* criteria requires that the clinician establish the sequence of events leading to the act of stealing. It can be exceedingly difficult to determine state of motivation and release of tension by stealing since many people with Moderate to Severe ID have an impaired ability to report subjective states. Even in individuals with sufficient verbal ability to express subjective feelings, self-monitoring of motivational states may be impaired. Also, the concept of defining Kleptomania by the release of tension adds an unnecessary complication to describe a disorder concerning stealing for no apparent benefit adds a level of

inference about one's understanding of ownership, value, and conflict between personal need gratification and societal rules.

Review of Research Applying to People with ID

No studies or case reports have appeared concerning Kleptomania and ID.

Summary of Limitations in Applying DSM-IV-TR Criteria to People with ID

Determining motivation in people across the ID spectrum presents many difficulties. Unfortunately, attempts to eliminate motivational states due to difficulty making reliable clinical distinctions could render our current concept of Kleptomania meaningless. Motivation is central to differentiating Kleptomania from stealing. A similar problem relates to the need to elicit the sequence of tension, distress driven urges, faulty inhibition of these impulses, and gratification through release in nonverbal patients who lack insight into their behavior. We can assume that tension reduction can serve as an intrinsic, negative reinforcement that allows the individual to escape an unpleasant affective state. Viewed from this vantage point, Kleptomania is like other repetitive behaviors, including other compulsive spectrum behaviors. Clinicians would need to consider the adverse effects of a primary mental disorder such as Depression or Mania on both the intensity of urges or level of impulse regulation.

The exclusion of stealing, hoarding, and other impulsive-compulsive behaviors, or interpersonal issues such as stealing for personal use, anger, vengeance is also problematic for patients with Severe ID.

Adaptation of Diagnostic Criteria

It is difficult to apply the following criteria to individuals with Severe ID:

1. Level of ID: "Recurrent failure to resist impulses to steal objects that are not needed for personal use or for their monetary value," would have limited relevance for people who lack an understanding of ownership and rules.

2. Differentiating affective state, motivation, and behaviors in nonverbal individuals: to “stealing is not committed to express anger or vengeance,” add: “or, if it comes from cognitive impairment it is not committed in the absence of cognitive awareness of ownership or rules against stealing.”
3. Nature of the relationship between Kleptomania and other psychiatric disorders where stealing might be prominent: OC spectrum, hoarding, or stealing “is not in response to a delusion or a command hallucination to steal,” or “not better accounted for by Conduct Disorder, a Manic Episode, or Antisocial Personality Disorder.” The

presence of another mental disorder does not necessarily disqualify the diagnosis of Kleptomania.

Comment: The adapted criteria differ from the *DSM-IV-TR* in several ways. They remove the criteria concerning tension and relief. The *DSM-IV-TR* excludes the diagnosis of Kleptomania if the stealing is better accounted for by Conduct Disorder, Mania, or Antisocial Personality Disorder. The adapted criteria include all the mental disorders as possible exclusionary facts, but only if there are clear indications of a direct relationship to stealing. These criteria thus widen and restrict the previous criteria.

Kleptomania

DSM-IV-TR Criteria	Adapted Criteria for Mild to Severe ID
A. Recurrent failure to resist impulses to steal objects that are not needed for personal use or for their monetary value.	A. No adaptation.
B. Increasing sense of tension immediately before committing the theft.	B. This criterion is not necessarily present because of difficulty in expressing such feelings.
C. Pleasure, gratification, or relief at the time of committing the theft.	C. This criterion is not necessarily present because of difficulty in expressing such feelings.
D. The stealing is not committed to express anger or vengeance and is not in response to a delusion or a hallucination.	D. The stealing is not committed to express anger or vengeance and is not in response to a delusion or a hallucination, or, if it comes from cognitive impairment—e.g., because of a lack of awareness of the concept of ownership—it is not committed in the absence of cognitive awareness of ownership or rules against stealing.
E. The stealing is not better accounted for by Conduct Disorder, a Manic Episode, or Antisocial Personality Disorder.	E. No adaptation.

Pyromania

Pyromania is a rare disorder in the general population. The prevalence among individuals with ID is largely unknown in part due to access to fire making materials. As with all disorders in this category, Pyromania requires the sequence of arousal before the act and relief after the act. Eliciting this sequential data may be difficult to ascertain in individuals with Moderate to Severe ID.

Review of Diagnostic Criteria

Pyromania involves the setting of fires repeatedly, directly due to a fascination with fire, which can also be expressed by observing fires set by someone else. The fire setting is not accounted for by other disorders.

Summary of DSM-IV-TR Criteria

The essential features of Pyromania are the repeated setting of fires, with arousal before the act and relief afterward. The motivation for fire setting is partly intrinsic (elation of setting and escape from distressing urge to set fires). Other factors include: an expression of anger-rage; wish for revenge; psychosis, or impaired judgment during episodes of delirium or dementia. As a result, Pyromania is distinguished from playing with fire, fascination with watching fires, or arson for profit. Differences arise in both motivation, impulse control, developmental course of fire play or the level of instrumental or goal directed behaviors associated with arson or fire setting.

Issues Related to Diagnosis in People with ID

The diagnosis of Pyromania requires a determination of the person's motivation. Unfortunately there are serious limitations in our ability to elicit relevant information to establish motivation in individuals with limited cognitive and verbal skills, and little capacity for insight or self-reflection. The differential diagnosis of intentional fire setting requires an awareness of goal-direction, experimentation, such as playing with matches; a response to a delusion or a hallucination; or from impaired judgment (a person with ID might not understand the consequences of fire setting). Access to fire setting materials may reflect inadequate vigilance or supervision by caregivers.

Review of Research Applying to People with ID

Lewis and Yarnell (1951) provide the most comprehensive review of fire setting. Their observations draw from 1,145 cases of fire setters. The number of individuals with Pyromania is uncertain. In their data, 70% of adult fire setters had below normal intelligence (IQ and adaptive scores not defined)

1. Most of the fire setters had a history of antisocial behavior and impulsive acts.
2. Ten percent had a Psychotic Disorder.
3. Many had antisocial personalities.
4. Forty percent of the adult males had no apparent motive, and 30% set fires for revenge or jealousy.
5. Five percent initiated the act in order to put out the fires and receive praise. (Lewis & Yarnell, 1951)

There have been no definitive epidemiological studies of Pyromania in people with ID using *DSM* or *ICD* criteria. Such studies would have to deal with formidable methodological problems, especially distinguishing Pyromania from other compulsive behaviors, or in giving up fascination with fire, accidental fires, fire setting as a deliberate act. It may be even more difficult to understand gender differences noted by Lewis and Yarnell and relationship to abuse-neglect, level of ID, unrecognized disorders, or associated brain disorders.

Summary of Limitations in Applying DSM-IV-TR Criteria to People with ID

The diagnosis of Pyromania requires establishing the role of urge/arousal and gratification. Assessing these states can be difficult in people with limited means of expressing themselves, and it seems speculative to describe a condition by such a motivation. It would be preferable to limit the criteria to those describable with fewer assumptions.

Adaptation of Diagnostic Criteria

DSM-IV-TR Criterion B ("Tension or affective arousal before the act") and Criterion D ("Pleasure, gratification, or relief when setting fires, or when witnessing or participating in their aftermath") do not apply to individuals with ID more severe than Mild ID. People with ID who set fires *because of their ID*, may not realize that matches burn certain materials, should be classified differently. The therapeutic task with such people is either education or restriction from access to the means of fire setting, whereas the therapeutic task for other

people who set fires consists of dealing with the desire to set fires despite a knowledge of its dangerousness.

DSM-IV-TR Criterion E includes the restriction that the fire setting is not in response to a delusion or hallucination, and Criterion F stipulates the restriction that the behavior is not better accounted for by Psychotic Disorder, Conduct Disorder, a Manic Episode, or Antisocial Personality Disorder. Such exclusions may be difficult in individuals with Severe ID.

Pyromania

DSM-IV-TR Criteria	Adapted Criteria for Mild ID	Adapted Criteria for Moderate, Severe, and Profound ID
A. Deliberate and purposeful fire setting on more than one occasion.	A. No adaptation.	A. No adaptation.
B. Tension or affective arousal before the act.	B. No adaptation.	B. The criterion does not apply.
C. Fascination with, interest in, curiosity about, or attraction to fire and its situational contexts (e.g., paraphernalia, uses, consequences).	C. No adaptation.	C. No adaptation.
D. Pleasure, gratification, or relief when setting fires, or when witnessing or participating in their aftermath.	D. No adaptation.	D. The criterion does not apply.
E. The fire setting is not done for monetary gain, as an expression of sociopolitical ideology, to conceal criminal activity, to express anger or vengeance, to improve one's living circumstances, in response to a delusion or hallucination, or as a result of impaired judgment (e.g., in dementia, Mental Retardation, Substance Intoxication).	E. No adaptation.	E. The criterion does not apply.
F. The fire setting is not better accounted for by Conduct Disorder, a Manic Episode, or Antisocial Personality Disorder.	F. No adaptation.	F. The fire setting is not better accounted for by Conduct Disorder, a Manic Episode, or Antisocial Personality Disorder, or for individuals with ID, by any other mental disorder.

Pathological Gambling

This disorder must be extremely rare in people with ID, because gambling requires a degree of access to money and the ability to negotiate the mechanics of gambling. No liter-

ature exists concerning this disorder in people with ID. It seems plausible that a person with Mild ID could have such a disorder. If a person with Mild ID were to engage in Pathological Gambling, the *DSM-IV-TR* criteria can apply.

Pathological Gambling

<i>DSM-IV-TR</i> Criteria	Adapted Criteria for Mild ID	Adapted Criteria for Moderate, Severe, and Profound ID
<p>A. Persistent and recurrent maladaptive gambling behavior as indicated by five (or more) of the following:</p> <ul style="list-style-type: none"> (1) Is preoccupied with gambling (e.g., preoccupied with reliving past gambling experiences, handicapping, or planning the next venture, or thinking of ways to get money with which to gamble) (2) needs to gamble with increasing amounts of money in order to achieve the desired excitement (3) has repeated unsuccessful efforts to control, cut back, or stop gambling (4) is restless or irritable when attempting to cut down or stop gambling (5) gambles as a way of escaping from problems or of relieving a dysphoric mood (e.g., feelings of helplessness, guilt, anxiety, depression) (6) after losing money gambling, often returns another day to get even ("chasing" one's losses) (7) lies to family members, therapist, or others to conceal the extent of involvement with gambling (8) has committed illegal acts such as forgery, fraud, theft, or embezzlement to finance gambling (9) has jeopardized or lost a significant relationship, job, or educational or career opportunity because of gambling (10) relies on others to provide money to relieve a desperate financial situation caused by gambling <p>B. The gambling behavior is not better accounted for by a Manic Episode.</p>	<p>A. No adaptation.</p> <ul style="list-style-type: none"> (1) No adaptation. (2) No adaptation. (3) No adaptation. (4) No adaptation. (5) No adaptation. (6) No adaptation. (7) No adaptation. (8) No adaptation. (9) No adaptation. (10) No adaptation. <p>B. No adaptation.</p>	<p>A. The criterion does not apply.</p> <p>B. No adaptation.</p>

Trichotillomania

Trichotillomania is a form of repetitive "grooming" behavior that involves pulling one's hair. The diagnosis requires establishing a sequence of increased tension before the act and relief afterward. These criteria seem too difficult to ascertain with adequate validity in people with ID.

The *DSM-IV-TR* criteria exclude Trichotillomania if the behavior is better accounted for by another mental disorder or a general medical condition, such as a dermatological condition. The adapted criteria in this chapter exclude this restriction.

Review of Diagnostic Criteria

Trichotillomania consists of the recurrent pulling out of one's hair, anywhere on the body.

Summary of DSM-IV-TR Criteria

The essential feature of Trichotillomania consists of the individual pulling out his or her own hair, to the point of producing noticeable hair loss. There is a critical role for the sequence of tension before the act or during the individual's attempts to resist the act, and relief after an episode of pulling. Variable levels of insight into the situations that trigger Trichotillomania, sense of distress caused by the symptoms, and success inhibiting the behaviors through standard response prevention techniques suggest considerable heterogeneity. Exclusion criteria include other psychiatric disorders that better account for the symptoms.

Issues Related to Diagnosis

in People with ID

Two issues confound the diagnosis of Trichotillomania in people with ID: (a) self-injurious behavior commonly occurs in people with ID, much more so than it does in others, and self-injurious behavior can include hair pulling; and (b) assessing subjective states of painful arousal and gratification appears difficult in people with ID.

Review of Research Applying to People with ID

Most research data for Trichotillomania in people with ID come from case studies or small treatment studies. A systematic evidence base is lacking, and most treatment studies extrapolate from those of normocognitive patients. It is evidence from these case studies that Trichotillomania is a heterogeneous condition and that there are significant boundaries problems with Complex Tics, other compulsive spectrum disorders (including Body Dysmorphic Disorder, stereotypies, and some forms of self-injurious behavior.) Many of these case reports fail to report tension and gratification related variables.

A survey of habit disorders in people with ID living in a section of England found Trichotillomania in 5% of the sample, compared with 13% with Bruxism, 16% with a Tic Disorder, and 32% with Stuttering (Long, Miltenberger, & Rapp, 1998) (Strength of evidence: V). The increased prevalence of Tic Disorders suggests that Trichotillomania has a complex neurobiology that is broader than other impulse Control Disorders.

Litt (1980) (Strength of evidence: V) described a 5-year-old with ID whose hair pulling emerged in the context of a threatened loss or injury (or both) to a beloved grandfather. A dysfunctional mother-child relationship served as a predisposing factor. This child improved when the therapist helped the mother clarify with the child the traumatic event affective response to the impending losses. In this context, the hair pulling might represent a stress reaction and improved with treatment.

Dech and Budow (1991) (Strength of evidence: V) described Trichotillomania in a 17-year-old female with Prader-Willi syndrome. The *DSM-IV-TR* diagnosis of Trichotillomania requires dealing with skin picking and other compulsive behaviors that are associated with the behavioral phenotype of PWS. This study also presents an interesting disconnection between hair pulling and other symptoms: the patient showed a marked improvement in weight control and only a

moderate improvement in hair pulling, suggesting that identifying the hair pulling as a separate category has merit.

Ghaziuddin, Tsai, and Ghaziuddin (1991) (Strength of evidence: V) described an 11-year-old boy with Autistic Disorder, ID, and hair pulling, who was successfully treated with haloperidol. The authors pointed out that this patient lacked symptoms of Obsessive-Compulsive Disorder (OCD). The disconnection between Autism, classic OCD, and Trichotillomania suggests a different but probably overlapping neurobiology and further suggests tension and relief may not be a necessary aspect of Trichotillomania in people with developmental disorders.

Maguire, Piersel, and Hauser (1995) (Strength of evidence: V) described Trichotillomania in a 46-year-old woman with Profound ID, successfully treated with a presentation of alternative behaviors and the wear-

ing of padded hand mitts. Miltenberger, Long, Rapp, Lumley, and Elliot (1998) Strength of evidence: V) described a person with ID with severe hair pulling and suggested that self-stimulation, rather than relief of tension, lay behind the behavior. These studies confirm that hair pulling occurs in people with ID, but may not meet the criteria for Trichotillomania. The clinician must deal with the overlap between Trichotillomania and other forms of stereotypies and self-injurious behaviors. This study indicates that Trichotillomania occurs in people with ID.

These studies provide examples of behavioral and pharmacological nonrandomized-treatment-outcome studies (Long & Miltenberger, 1998) (Strength of evidence: V). The paucity of controlled versus small clinical programs prevents generalizing about treatment response as a validation criterion for the diagnosis.

Trichotillomania

DSM-IV-TR Criteria	Adapted Criteria for Mild to Moderate ID	Adapted Criteria for Severe to Profound ID
A. Recurrent pulling out of one's hair resulting in noticeable hair loss.	A. No adaptation.	A. No adaptation.
B. An increasing sense of tension immediately before pulling out the hair or when attempting to resist the behavior.	B. This criterion might not apply because of the individual's inability to express feelings.	B. This criterion does not apply.
C. Pleasure, gratification, or relief when pulling out the hair.	C. This criterion might not apply because of the individual's inability to express feelings.	C. This criterion does not apply.
D. 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).	D. 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). In people with ID, however, the disturbance might occur in the presence of other mental disorders, including other types of self-injurious behavior.	D. No adaptation.

Summary of Limitations in Applying DSM-IV-TR Criteria to People with ID

There is very limited comparison data between Trichotillomania and hair-pulling in individuals with Severe ID. Some of this shortfall grows out of problems eliciting self-reports of sequential arousal/behavior/release from individuals with severe cognitive impairment. As a result hair pulling may represent a better operationalization, but may not meet the various criteria for Trichotillomania. It seems unwise to base the diagnosis of Trichotillomania on tension before and relief after the act. It also seems unhelpful to exclude the diagnosis of Trichotillomania in the presence of other mental disorders, because it is not known whether hair pulling exists in different disorders.

References

- Ballinger, B., Ballinger, C., Reid, A., & McQueen, E. (1991). The psychiatric symptoms, diagnosis, and care needs of 100 mentally handicapped patients. *British Journal of Psychiatry*, 158, 251-254.
- Corbett, J. (1979). Psychiatric morbidity and mental retardation. In R. Snaith (Ed.), *Psychiatric illness and mental handicap*. London: Gaskell.
- Dech, B., & Budow, L. (1991). The use of fluoxetine in an adolescent with Prader-Willi syndrome. *Journal of the American Academy of Child & Adolescent Psychiatry*, 30(2), 298-302.
- Eaton, L., & Menolascino, F. (1982). Psychiatric disorders in the mentally retarded: Types, problems, and challenges. *American Journal of Psychiatry*, 139, 1297-1303.
- Ghaziuddin, M., Tsai, L. Y., & Ghaziuddin, N. (1991). Brief report: Haloperidol treatment of trichotillomania in a boy with autism and mental retardation. *Journal of Autism & Developmental Disorders*, 21(3), 365-371.
- King, B. H., DeAntonio, C., McCracken, J., Forness, S., & Ackerland, V. (1994). Psychiatric consultation in severe and profound mental retardation. *American Journal of Psychiatry*, 151, 1802-1808.
- Lewis, N., & Yarnell, H. (1951). Pathological firesetting (pyromania). *Nervous and Mental Disease Monograph*, 82, 8-26.
- Litt, C. J. (1980). Trichotillomania in childhood: A case of successful short-term treatment. *Journal of Pediatric Psychology*, 5(1), 37-42.
- Long, E. S., & Miltenberger, R. G. (1998). A review of behavioral and pharmacological treatments for habit disorders in individuals with mental retardation. *Journal of Behavior Therapy & Experimental Psychiatry*, 29(2), 143-156.
- Long, E. S., Miltenberger, R. G., & Rapp, J. T. (1998). A survey of habit behaviors exhibited by individuals with mental retardation. *Behavioral Interventions*, 13(2), 79-89.
- Lund, J. (1985). The prevalence of psychiatric morbidity in mentally retarded adults. *Acta Psychiatrica Scandinavica*, 72, 563-570.
- Maguire, K. B., Piersel, W. C., & Hauser, B. G. (1995). The long-term treatment of trichotillomania: A case study of a woman with profound mental retardation living in an applied setting. *Journal of Developmental & Physical Disabilities*, 7(3).
- Menolascino, F. (1970). Down's syndrome: Clinical and psychiatric findings in an institutionalized sample. In F. Menolascino (Ed.), *Psychiatric approaches to mental retardation*. New York: Basic Books.
- Miltenberger, R. G., Long, E. S., Rapp, J. T., Lumley, V., & Elliott, A. J. (1998). Evaluating the function of hair pulling: A preliminary investigation. *Behavior Therapy*, 29(2), 211-219.
- Monopolis, S., & Lion, J. R. (1983). Problems in the diagnosis of intermittent explosive disorder. *American Journal of Psychiatry*, 140(9), 1200-1202.
- Robins, E., & Guze, S. B. (1970). Establishment of diagnostic validity in psychiatric illness: Its applications to schizophrenia. *American Journal of Psychiatry*, 126, 983-987.
- Russell, A., & Tanguay, P. (1981). Mental illness and mental retardation: Cause or coincidence. *American Journal of Mental Deficiency*, 83, 570-574.
- Szymanski, L. (1988). Integrative approach to diagnosis of mental disorders in retarded persons. In J. Stark, F. J. Menolascino, M.

- H. Alberelli, & V. C. Gray (Eds.), *Mental retardation and mental health: Classification, diagnosis, treatment, services*. New York: Springer-Verlag.
- Zimmerman, M., Mattia, J., Younken, S., & Torres, M. (1998). *The prevalence of DSM-IV impulse control disorders in psychiatric outpatients* (APA New Research Abstracts No. 265). Washington, DC: American Psychiatric Association.