Treatment and management of impulse control disorders

Lesson 3.3.3 | Clinical psychology

Core ideas

Cognitive behavioural therapy can help people recognise triggers, challenge thinking patterns and plan safer responses to urges.

Behavioural strategies may include delaying the response, avoiding high-risk cues, practising alternative behaviours and reducing reinforcement for the impulsive act.

Some management plans use medication to target mood, anxiety, reward or impulse-control difficulties, depending on the person and diagnosis.

Relapse prevention focuses on recognising warning signs, planning support and preparing for situations where urges are likely.

Family or social support can reduce opportunities for harmful behaviour and make coping plans easier to follow.

Treatment should consider severity, risk, motivation, access, side effects, co-occurring disorders and whether the plan fits the person's daily life.

Key terms

CBT: A talking therapy that works on thoughts, beliefs and behaviour.

Trigger management: Planning how to reduce or cope with cues that increase urges.

Response prevention: Stopping or delaying the usual impulsive behaviour after an urge.

Coping strategy: A planned action used to manage urges or stress.

Relapse: A return of harmful behaviour after improvement.

Relapse prevention: Planning to reduce the chance of symptoms returning.

Adherence: How far a person follows a treatment plan.

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Co-occurring disorder: Another disorder present at the same time.

Opioid antagonist: A drug that blocks opioid receptors; used in the Grant gambling trials.

PG-YBOCS: Yale-Brown Obsessive Compulsive Scale modified for pathological gambling.

Covert sensitisation: An imagery-based procedure linking an unwanted act with unpleasant imagined consequences.

Imaginal desensitisation: An imagery-based method intended to reduce arousal and improve responses to triggering situations.

Further detail and evidence

Key study - Grant et al. (2008): because responses to opioid antagonists differed, the study examined which clinical characteristics predicted improvement. It pooled 284 adults with pathological gambling from two double-blind placebo-controlled trials: 16 weeks of nalmefene and 18 weeks of naltrexone.

Grant method: 214 received active medication and 70 placebo after random allocation within the original trials. Repeated PG-YBOCS ratings measured gambling urges and behaviour. Response meant at least a 35% score reduction maintained for a month by the endpoint.

Grant findings: family history of alcohol problems was the clearest predictor of response to active medication. Stronger urges at higher doses and younger age in the placebo group were weaker trends. The analysis identifies predictors, not proof that family history causes medication response.

Required psychological treatments include covert sensitisation: the person imagines the unwanted act paired with unpleasant consequences (illustrated by Glover's 1985 kleptomania case). Imaginal desensitisation pairs imagined triggering situations with reduced arousal and alternative responses (illustrated by Blaszczynski and Nower, 2003).

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Opioid antagonists block opioid receptors and may reduce the rewarding impact or urge associated with gambling. They are not dopamine-receptor blockers. Grant investigated predictors of improvement in trials of two such medicines, rather than directly measuring a dopamine mechanism.

Covert sensitisation uses imagined unwanted behaviour followed by imagined aversive consequences. Glover's kleptomania case illustrates pairing theft imagery with unpleasant responses to weaken attraction. Imaginal desensitisation rehearses urge-triggering scenes while practising a calmer alternative response, illustrated by Blaszczynski and Nower.

Applying the ideas

For a learned trigger, a psychological intervention changes the association or response without requiring the person to carry out the harmful act. A later reduction in urges and acts is relevant to effectiveness; follow-up is needed to assess persistence. Case improvement cannot exclude spontaneous change, expectancy or concurrent support.

Evaluation and connections

Grant evaluation: blinding and placebo control reduce expectancy bias. Pooling trials increases sample size but combines different drugs, durations and samples; clinical exclusions restrict generalisation. Informed consent and monitoring of adverse effects matter. Distinguish opioid-antagonist treatment from a claim that the study directly tested dopamine levels.

Compare biological treatment and cognitive-behavioural approaches using effects on urges and behaviour, side effects, durability, ethical consent and individual needs. Case evidence gives detail but cannot alone establish that treatment caused improvement.

Grant's pooled analysis concerns selected treatment-seeking adults with gambling problems. Findings should not be transferred automatically to pyromania or kleptomania. A predictor measured before treatment can support personalisation, but association does not show causation. Compare drug adverse effects with the distress, engagement and skill demands of imagery-based therapy.