

Cambridge AS & A Level · Psychology 9990 · Notes

Impulse control disorders A2

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What you need to know

Impulse control disorders (ICDs) are the third disorder in the Clinical psychology option (Papers 3 and 4). You should be able to:

1. **Diagnose them with ICD-11:** the criteria for **kleptomania**, **pyromania** and **gambling disorder**.
2. **Describe the Kleptomania Symptom Assessment Scale (K-SAS):** what it asks, how it is answered and scored, and its strengths and weaknesses.
3. **Explain ICDs biologically:** the **dopamine** explanation.
4. **Explain ICDs psychologically:** the **behavioural** explanation (**positive reinforcement**) and the **cognitive** explanation (**Miller's feeling-state theory**).
5. **Describe biological treatment**, using the key study by **Grant et al. (2008)**, which treated gambling disorder with drugs and a placebo.
6. **Describe cognitive-behavioural therapies:** **covert sensitisation** (with a study such as **Glover, 1985**) and **imaginal desensitisation** (with a study such as **Blaszczynski and Nower, 2003**).
7. **Evaluate all of it**, using the issues, debates and methods the syllabus names: idiographic versus nomothetic, questionnaires, case studies, interviews, quantitative and qualitative data, objective and subjective data, application to everyday life, individual and situational explanations, nature versus nurture, reductionism versus holism, determinism versus free will and generalisations from findings.

Understand it

What an impulse control disorder is

Everyone has urges they resist. In an **impulse control disorder** a person **repeatedly fails to resist** a strong urge to do something harmful, even though they know the cost. The pattern is a cycle:

- **Before:** rising **tension or arousal** that the person can't settle.
- **During and just after:** **pleasure, excitement or relief**.
- **Later:** often guilt, shame, debt or legal trouble, but the urge returns.

The point is the **urge itself**, not a practical goal. A thief steals to gain something; a person with kleptomania steals for the relief of giving in to the urge.

ICD-11: the three disorders

Disorder	ICD-11 essential features
Kleptomania	Repeated failure to control strong urges to steal objects that are not needed for personal use or for their money value ; tension or arousal before the theft; pleasure, excitement, relief or gratification during and straight after; not better explained by another disorder (such as a manic episode), intellectual disability or intoxication
Pyromania	Repeated failure to control strong urges to set fires , with several acts or attempts; no apparent motive (not money, revenge , sabotage, a political point or wanting attention); persistent fascination with fire and things linked to it (watching fires, fire engines, firefighting equipment); tension or arousal before ; pleasure, excitement or relief while setting the fire, watching it or its aftermath; not better explained by another disorder, intellectual disability or intoxication
Gambling disorder	A persistent pattern of gambling (online or offline) showing all three of: impaired control (over when, how often, how much and when to stop); increasing priority over other interests and daily life; carrying on or escalating despite harm . The pattern usually lasts 12 months or more and causes significant distress or impairment (family, work, study, money)

ICD-11 places gambling disorder among the "disorders due to addictive behaviours", alongside substance addictions, while kleptomania and pyromania are classed as impulse control disorders. The syllabus groups all three here.

Pyromania is not arson. Fire-setting is any setting of fires; **arson** is a **crime** of deliberately damaging property by fire, usually with a motive; **pyromania** is a **psychiatric diagnosis** about the urge, with no motive. A person can have pyromania without committing arson, and most arsonists don't have pyromania.

Measuring kleptomania: the K-SAS

The **Kleptomania Symptom Assessment Scale (K-SAS)** is a **psychometric, self-report questionnaire** that measures **how severe** a person's kleptomania is.

- About a dozen **closed questions**, all about **the past week** (mark schemes list 12). They cover how **strong** the urges to steal were, **how often** they came, **hours** spent preoccupied with them, how well the person could **control** the urges and the thoughts, **tension or excitement before** a theft, **pleasure after** it, the **distress** and the **trouble** (money, work, legal, relationships) stealing caused, and **how many times** they stole.
- Each question has five fixed answers scored **0 to 4**. For example, how much were you able to control your thoughts of stealing this week: from complete control (0) to no control at all (4). Some questions ask for a band of hours, such as "1–4 hours".

- The scores are **added**: the **higher the total**, the more **severe** the symptoms. Because the questions cover one week, it can be repeated **before, during and after** treatment to track change.

Issue	Strength	Weakness
Quantitative and objective data	A number can be compared between people and before and after treatment, and scored the same way by anyone	It gives no qualitative data, so it can't say why the person steals
Validity	Its questions match the ICD-11 features (urges, tension before, relief after)	Some questions are ambiguous ("approximately how many hours"), some hour bands overlap , and each question has a different answer scale, which can confuse
Self-report and subjectivity	Only the person knows their urges and thoughts	It relies on recall of a whole week; stealing is a crime, so people may under-report
Idiographic versus nomothetic	Nomothetic : the same questions for everyone, so scores are comparable	Misses what is unique to one person's stealing; a case study gives that depth

Explanation 1: biological (dopamine)

Dopamine is the neurotransmitter of the brain's **reward pathway** (from the midbrain to the **striatum**, including the nucleus accumbens). It is released when we do something rewarding, and also when we **expect** a reward, most strongly when the reward is **uncertain**, as in gambling.

- Setting a fire, stealing or placing a bet releases dopamine, so the act **feels good** and the brain learns to want it again.
- With repetition, the striatum's response **weakens** (fewer receptors, less dopamine). Ordinary pleasures feel flat, so the person needs **more** of the behaviour to feel the same reward. This is called **reward deficiency**, and it keeps the disorder going.

Evidence for: some patients with **Parkinson's disease** given drugs that **boost dopamine** (dopamine agonists) develop impulse control problems such as compulsive gambling, which often ease when the dose is lowered. Drugs that reduce the reward signal (Grant et al., below) cut urges. **Evidence against**: much of the research is **correlational**, so different dopamine activity could be a **result** of the behaviour rather than its cause; dopamine doesn't explain **why** one person steals and another sets fires; and drugs acting on **serotonin** (SSRIs) also help some patients, so dopamine is not the whole story.

Explanation 2: behavioural (positive reinforcement)

Operant conditioning (Skinner): a behaviour followed by a **reward** becomes more likely. That is **positive reinforcement**.

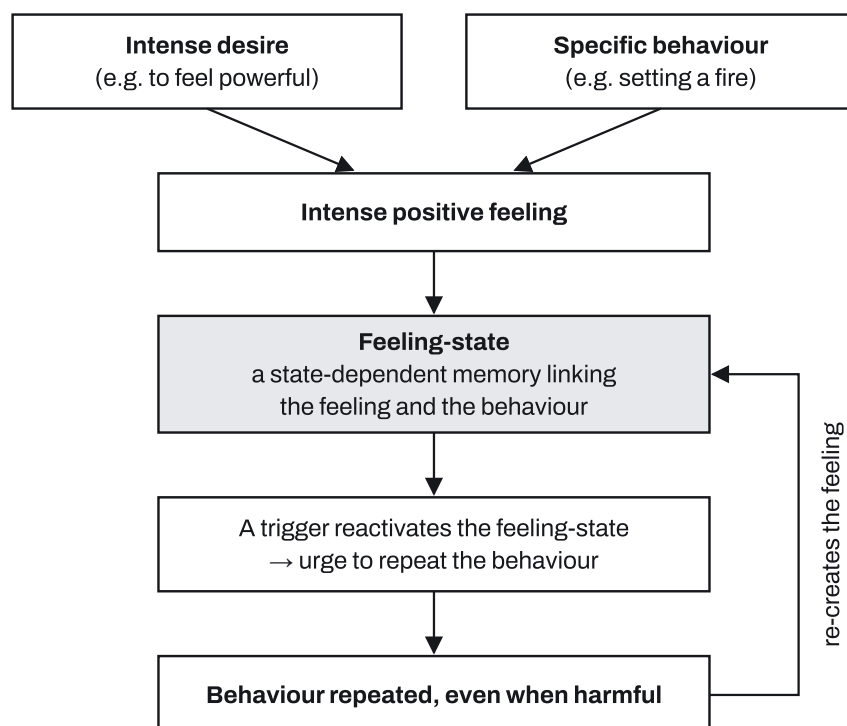
- **Gambling**: the reward is the **win** (money) and the excitement. Wins come on a **partial (variable-ratio) schedule**: after an unpredictable number of bets. Behaviour learned this way is the hardest to **extinguish**: after a losing run the gambler keeps going because the next bet **might** win. **Near misses** feel almost like wins and add to this.
- **Kleptomania and pyromania**: the reward is the **thrill**, the excitement of getting away with it or of watching the flames.
- The **relief** of tension after giving in is **negative reinforcement**: something unpleasant is removed, which also makes the act more likely next time.

Explanation 3: cognitive (Miller's feeling-state theory)

Miller (2010) argued that an ICD starts when an **intense positive feeling** becomes **linked** with a **specific behaviour**.

1. A person who wants a feeling intensely (for example to feel **powerful, successful** or **in control**, often because they think badly of themselves) does a behaviour at a moment when it gives that feeling strongly.
2. The feeling and the behaviour are stored **together** in memory as one unit, a **state-dependent memory** that Miller called a **feeling-state**. It holds the **emotions, thoughts** and **physical arousal** of that moment.
3. Later, when anything **triggers** the feeling-state, it brings back the desire, and the person **repeats the behaviour** to re-create the feeling, even when it harms them. That repetition is the impulse control disorder.

For example, a teenager who feels ignored lights a fire, watches people rush to it, and feels powerful for the first time in months. "Power" and "fire" become one feeling-state; whenever she feels small again, the urge to light a fire returns.



Miller supported the theory with **case studies**, such as **John**, a 35-year-old compulsive gambler (poker), whose urge to gamble faded after a therapy that targeted his gambling feeling-state.

Key study: Grant et al. (2008), treating gambling disorder with drugs

Background: **opioid antagonists** block the brain's opioid receptors, which **reduces the dopamine** reward signal, so urges and cravings should weaken.

Aim: to find out which patients with gambling disorder respond to opioid antagonists and which respond to a placebo.

Method: data from **two double-blind, placebo-controlled trials** with **284** people with gambling disorder:

Trial	Drug	Length
1	nalmefene	16 weeks
2	naltrexone	18 weeks

The trials were run at the **University of Minnesota** and at **out-patient treatment centres**. Participants were **randomly** given the drug or a **placebo** (a pill with no active drug). **Double-blind:** neither the participants nor the researchers knew who had which, so neither expectations nor researcher bias could explain the results. Gambling severity was measured with a version of the **Yale-Brown Obsessive Compulsive Scale for gambling (PG-YBOCS)**.

Results:

- Those on the **drugs** improved more than those on **placebo**.
- Those with a **family history of alcoholism** responded **best** to the drugs.
- **Higher doses** of nalmefene gave a bigger reduction in symptoms.
- **Younger** participants were more likely to respond to the **placebo**.

Conclusion: opioid antagonists can treat gambling disorder, especially in people who may be genetically inclined to respond to them.

Evaluation: random allocation, a **placebo control** and **double-blinding** make it a valid test of the drugs; the large sample and two trials give reliable, **quantitative** results. But drug treatment only reduces **urges**: it doesn't teach the person anything, side effects (such as nausea) make some stop, and urges may return when the drug stops. Using **several locations** gives a more varied, generalisable sample (students near a university and patients at treatment centres), but people at each site may differ, which could affect the results.

Treatment 2: covert sensitisation

A **cognitive-behavioural** therapy based on **classical conditioning**. The patient **imagines** doing the impulsive behaviour and pairs it, in imagination, with something **unpleasant** (an **aversive** stimulus, such as nausea, vomiting or being caught). The behaviour becomes linked with the unpleasant feeling, so the urge weakens.

- **Covert** means it happens in the **imagination**, not in real life (overt aversion therapy would use real, unpleasant stimuli). It does **not** mean the patient doesn't know.
- **Sensitisation** means the patient becomes **more** sensitive (averse) to the behaviour. **Desensitisation** is the opposite.
- No pictures are shown: **imagery** means imagining.

Study: Glover (1985), covert sensitisation for kleptomania

- **Participant:** a **56-year-old married woman** who had **shoplifted every day for 14 years**. It is a **case study**.
- **Procedure:** after an **interview**, the therapist chose imagery of **nausea and vomiting**. In each scene she imagined approaching an item in a **supermarket** to steal it and feeling **more and more sick**, then **vomiting** as she picked it up, with **other shoppers staring** at her. The sickness **stopped** as soon as she **put the item back** and **walked out**. She had **4 therapy sessions**; **muscle relaxation** was used in the first **2** to help her imagine vividly. She then used the imagery herself whenever she felt tempted.
- **Results:** at a **19-month follow-up** she had stopped stealing apart from **one lapse**, and her **self-esteem** and **social life** had improved.
- **Evaluation:** rich, in-depth, **qualitative** detail and a long follow-up show a lasting effect; she practised in real shops, so it applied to everyday life. But it is **one** woman, so it may not **generalise** to men, younger people or other ICDs, and her improvement relied partly on her own reports.

Treatment 3: imaginal desensitisation

Also a **cognitive-behavioural** therapy, but it works the **opposite** way. The urge is kept going by **arousal**: once the person starts the chain of behaviour, the tension pushes them to finish it, and finishing it brings relief. Imaginal desensitisation teaches them to stay **calm** through the chain in imagination, so the drive to complete it **weakens**. A person can't be relaxed and highly aroused at once.

1. Identify the person's usual **sequence** from first urge to the act.
2. Break it into **4–6 scenes** (for a gambler: feeling the urge, planning, arriving at the venue, the excitement of playing, second thoughts, the pull fading).
3. Teach **progressive muscle relaxation** (tensing and relaxing each muscle group) at the start of each session.
4. The person **imagines** each scene, feels the urge, then imagines **leaving** without acting on it, while staying **relaxed**.
5. Practise at **home** with **recorded** instructions and keep a **log** of urges, thoughts and feelings.

Blaszczynski and Nower (2003) described the technique working well with gamblers, illustrated with **Mary**, a **52-year-old** gambler, who learned to imagine her typical gambling scenes while relaxed and found her urge to gamble decreased.

	Covert sensitisation	Imaginal desensitisation
Aim	make the behaviour unpleasant	make the urge weaker and the person calm
What is imagined	the behaviour plus an aversive consequence (vomiting)	the trigger scene, then walking away relaxed
Relaxation	not the core of it (Glover used it only to aid imagery)	central : progressive muscle relaxation
Learning principle	classical conditioning (pairing with something unpleasant)	reducing arousal (relaxation replaces tension)

Evaluation of both: no medication, so no side effects or dependence; the patient can use the technique **anywhere, at any time** when tempted; skills last after therapy ends. But both need a person who can **imagine vividly**; what works in the therapy room may not **transfer** to a real shop, fire or casino; they need motivation and honest reporting of urges; and evidence comes mostly from **case studies**.

Issues and debates

Debate	How it applies to ICDs
Nature versus nurture	Dopamine is nature (a person may be born with a stronger or weaker reward response), though the response also changes with experience. Positive reinforcement and feeling-states are nurture : learned from experience. Grant's finding that a family history of alcoholism predicted drug response suggests a biological part too.
Reductionism versus holism	Dopamine reduces an ICD to one neurotransmitter; positive reinforcement reduces it to rewards. Miller's theory is more holistic : it combines emotions, thoughts, physical arousal and memory, and the person's view of themselves. Drugs are reductionist; therapies treat the person's thinking and situation.
Determinism versus free will	Dopamine and reinforcement suggest the person's behaviour is determined by biology or past rewards. But a person can choose to avoid triggers (casinos, certain shops), and the therapies assume they can learn to resist: some free will .
Individual versus situational	Dopamine and feeling-states are individual ; reinforcement is situational (gambling venues and websites supply the rewards), though people choose to go there.
Application to everyday life	Explanations point to treatments: drugs for dopamine; covert sensitisation or imaginal desensitisation to break learned links; limiting gambling sites' payouts reduces reinforcement.
Idiographic versus nomothetic	ICD-11 criteria, the K-SAS and Grant's trials are nomothetic ; Glover, Mary and John are idiographic case studies: deep but hard to generalise.
Generalisations from findings	Grant's trials were on gambling only, so may not apply to pyromania or kleptomania; one case study can't stand for everyone with an ICD.

Debate	How it applies to ICDs
Methods	Questionnaires (K-SAS) and interviews give self-report data that people may distort, since stealing and fire-setting are crimes; observation of behaviour is more objective.

Key facts and formulas

There is no formula list in the 9990 exam. "Learn it" means you must remember it.

Fact	Status
ICD-11 kleptomania: repeated failure to resist urges to steal objects not needed for personal use or money value; tension or arousal before; pleasure, excitement or relief during and after; not due to another disorder	Learn it
ICD-11 pyromania: repeated failure to resist urges to set fires (several acts); no motive such as money or revenge; fascination with fire; tension or arousal before; pleasure or relief during and after	Learn it
ICD-11 gambling disorder: impaired control, increasing priority, continuing despite harm; usually 12 months; significant distress or impairment	Learn it
K-SAS: self-report questionnaire about the past week (urges, thoughts, control, tension before, pleasure after, distress, trouble, thefts); each answer scored 0–4; higher total = more severe kleptomania	Learn it
Dopamine: reward pathway to the striatum; released by rewarding and uncertain acts; repetition weakens the response (reward deficiency)	Learn it
Positive reinforcement: a rewarded behaviour is repeated; gambling wins on a partial (variable-ratio) schedule resist extinction	Learn it
Miller (2010) feeling-state: intense positive feeling linked with a specific behaviour forms a state-dependent memory; triggers make the person repeat the behaviour	Learn it
Grant et al. (2008): 284 people with gambling disorder, two double-blind placebo-controlled trials, nalmefene 16 weeks and naltrexone 18 weeks; drugs beat placebo; family history of alcoholism predicted the best response	Learn it
Glover (1985): 56-year-old woman, daily shoplifting for 14 years; imagined nausea and vomiting while stealing; 4 sessions; free of stealing apart from one lapse at 19 months	Learn it
Imaginal desensitisation: progressive muscle relaxation, then imagine the trigger scenes and leaving without acting, staying relaxed; home practice with recordings	Learn it
Percentage change = $\frac{\text{old} - \text{new}}{\text{old}} \times 100$	Learn it

How to do it

We have tagged 45 questions on this topic, from 2021 to 2026 (Papers 3 and 4; 32 different questions, as variants repeat them). 22 of them have parts of more than one type, so the counts add up to 84. Questions before 2024 follow the old syllabus (Griffiths' components of addiction, "non-substance addictive disorder", Glover dated 2011): learn the current content, and use those questions for the skill they test.

Question type	Questions
Explain a strength or weakness of a treatment, measure, theory or study	18
Suggest a way to measure a disorder or a treatment's effect	9
Describe a psychological treatment or its study	9
Plan a study and justify its choices	9
Explain a disorder or state its ICD-11 criteria	8
Describe and evaluate in an essay, with a named issue	6
Discuss strengths and weaknesses with a conclusion (5 marks)	6
To what extent do you agree essay (12 marks)	5
Recall and explain Grant et al. (2008)	3
Outline Miller's feeling-state theory	3
Outline Griffiths' components of addiction (old syllabus)	3
Apply ICD-11 criteria to a person	2
Apply or suggest a treatment for a person or disorder	2
State a K-SAS question	1

1. Explain a strength or weakness of a treatment, measure, theory or study (18 questions)

Usually 2 marks a point: the point (1), then apply it to the **named disorder or study** (1). A point that could fit any topic needs linking to the disorder before it earns full marks (March 2025 report).

- **Imaginal desensitisation for pyromania:** he may not be able to **imagine** the arousal of lighting a fire vividly enough; he may not be **honest** about how strong his urges still are, to hide his fire-setting; calm in the therapy room may not **transfer** when he sees matches or a fire. Don't give covert sensitisation's weaknesses, or a bare "time-consuming" (March 2026 report).
- **Psychological treatments for kleptomania:** usable **anywhere, any time** (she can call up the imagery when tempted in a shop); **no medication**, so no dependence on drugs; the same learning principles apply to other ICDs. **Why drugs may not work for kleptomania:** pills may not be taken, they reduce urges rather than the cause, and no drug directly stops someone stealing (June 2022 report).

- **Self-report for gambling or pyromania:** weaknesses: answers may be **dishonest** or **socially desirable** to hide how much they gamble or that they set fires (crimes); open answers need interpreting; closed answers miss individual differences. Strengths: shows **how severe** the problem is, so a treatment can be chosen; helps understand features such as the tension before an act.
- **The K-SAS:** ambiguous wording ("approximately how many hours"), **overlapping** hour bands, a different answer scale for each question, reliance on **recall** of a week, no **qualitative** "why". A bare "social desirability" is about the person, not the K-SAS, and earns 0.
- **Grant et al.:** **placebo control** gives a baseline, so the drug's effect on gambling can be separated from expectations; participants act as if they might be on nalmefene or naltrexone. **Several locations:** a wider, more generalisable sample (university versus treatment centres) but people may differ between sites.
- **One study or case study (Miller's John, Glover):** one person can't represent everyone; one study gives little support; the theory may not fit every ICD; feeling-states is only one explanation. Cultural differences earn nothing here.
- **Glover** (strength and weakness): in-depth, qualitative, 19-month follow-up, practised in real shops; but one woman, so poor generalisability. Ethics is not a weakness: she asked for treatment and consented (June 2023 report).
- **Face-to-face interview for kleptomania:** the therapist can **follow up** answers and build **trust**, so a patient may admit thefts she would hide on a form; but she may still lie, and it takes the therapist's time.
- **Why Miller's theory is holistic** (2): define holism (the whole person, the parts working together) (1), then say why: it combines **emotions**, **physical arousal** and the **memory** of them, not one part alone (1).

2. Suggest a way to measure a disorder or a treatment's effect (9 questions)

Name the method (1) and say **exactly what you would record** for this disorder (1).

- **"Other than self-report":** questionnaires and interviews are self-reports and score 0 (March 2025 report). Use an **observation** (covert, structured, with consent where needed: count how many times a week the person gambles, or how long they spend at a slot machine), a **case study**, or an **experiment** (expose a person to a fire-setting or gambling cue and record whether they resist). "I would observe a gambler" earns nothing (June 2021 report).
- **Effect of covert sensitisation by online questionnaire:** closed questions ("Since treatment, how often have you wanted to take something from a shop? never / sometimes / often") and open ones ("Describe how you feel now when you are in a shop where you used to steal"), or the **K-SAS before and after** treatment.
- **Reliability of the K-SAS:** **test-retest** (the same person takes it twice, close together, and the scores should match) or **split-half** (scores on the two halves should correlate strongly). Inter-rater reliability scores 0, because there is no rater.
- **Supporting Miller other than by a case study:** a **questionnaire** for many people with ICDs rating how intense a remembered positive feeling was when the behaviour began; an **interview** by a trained clinician about feeling-states; an **observation** of how often the behaviour happens after a trigger.

3. Describe a psychological treatment or its study (9 questions)

2 marks = a detailed outline, 1 = partial; 4-mark versions need more detail of the study (sample, sessions, procedure, results).

- **Imaginal desensitisation features** (1 each): progressive muscle relaxation; **imagining** the trigger situation; imagining **leaving** it in a relaxed state. Writing about covert sensitisation (nausea) or saying images are shown scores 0 (March 2026 report).
- **Covert sensitisation / aversive imagery**: pair the imagined behaviour with an imagined unpleasant stimulus, e.g. Glover's vomiting. Imagery is imagining, not looking at pictures (June 2022 report).
- **Glover**: sample, the nausea-and-vomiting imagery and when it stopped, 4 sessions with relaxation in the first 2, 19-month result (June 2023 report). Focus on the **treatment** rather than the history (March 2021 report).
- **Two differences** between the therapies: give each as a contrast, not one description then the other (November 2021 report). Use the comparison table.

4. Plan a study and justify its choices (9 questions)

Since 2024: (a) plan [10], (b)(i) the psychology it is based on [4], (b)(ii) how two features shaped the plan [4], (c) three 2-mark reasons, each applied. To 2023: design [10] plus psychological **and** methodological evidence [8] (only one kind caps it at 5). See the research-methods note for method features.

1. **Use the named method and disorder**: an observation question needs an observation, and a question on one disorder needs participants with that disorder, not another (March 2023 report).
2. **Specific features**: for a questionnaire, technique (paper and pencil, online or postal), format (open, closed), **example questions about the disorder**, rating scale, scoring; for an observation, structured, covert or overt, controlled or naturalistic (a casino, a lab with no real money), **behavioural categories**, two observers for **inter-rater reliability**. Then sample, ethics, hypothesis, data.
3. **Make it specific**: "Since treatment, your urges to set a fire have been: very strong / strong / weak / very weak"; for a drug study, say which drug and which ICD, such as nalmefene for gamblers (June 2022 report).
4. **(b)(i)**: imaginal desensitisation's steps, covert sensitisation with Glover, the ICD-11 criteria, or Grant's design. There is no "pyromania version" of the K-SAS. Writing "a questionnaire like the K-SAS" is not enough, and an acronym needs its full name first: describe your own questions (March 2025 report).
5. **(c)**: quote your own plan in each reason ("online, so a gambler answers alone and admits how much he gambled").

5. Explain a disorder or state its ICD-11 criteria (8 questions)

2 marks: one criterion (1) with detail or an example (1).

- **Pyromania**: repeated, failed attempts to resist setting fires, **plus** tension before and relief after, or fascination with fire, or no motive. "Setting fires" alone gets 1; firefighters do not have pyromania (June 2021 and June 2023 reports).

- **Kleptomania**: the urge to steal objects not needed or not stolen for their value, **plus** tension before and **relief** after. "Pleasure" alone doesn't separate it from ordinary theft (November 2022 report).
- **Gambling disorder** (two criteria): impaired control, increasing priority, continuing despite harm, distress or impairment. Features that fit any ICD or any addiction score 0 (March 2025 report).

6. Describe and evaluate in an essay, with a named issue (6 questions)

Paper 3: (a) describe [6 or 8], (b) evaluate [10] including a named issue (nature versus nurture three times; also self-reports, quantitative data).

1. **(a)**: describe **exactly** what is asked: explanations (dopamine, positive reinforcement with schedules **explained**, Miller), treatments (Grant, covert sensitisation, imaginal desensitisation steps) or diagnosis and the K-SAS. Use an example ICD in each (pyromania for feeling-states works well). Symptoms when causes are asked earn nothing (June 2021 report), and describing only one of two named items caps the part at 4.
2. **(b)**: issue by issue, applying each issue to **every** item, not many issues per item (March 2021 report). Named issue first, then two or three more from the "Issues and debates" table.
3. **Analyse**: say **why** an explanation is nurture, and what follows ("if it is learned, limiting gambling payouts could stop it being learned"). Bare labels stay in the bottom levels (June 2021 report). Evidence (Parkinson's patients, Grant's results) lifts a point.

7. Discuss strengths and weaknesses with a conclusion (5 marks) (6 questions)

Old Paper 4: 1 mark per point about the named thing (at least two each side, up to 4), plus 1 for a **conclusion** that is a reasoned judgement, not a summary (June 2022 report). Relate every point: dishonesty matters because the therapist then misjudges how often this patient steals (June 2021 report).

- **Covert sensitisation**: self-applied anywhere, no drugs, Glover's lasting result; but needs vivid imagery, unpleasant, evidence is case studies.
- **Generalising from Glover**: the principle (conditioning) is universal; but one 56-year-old woman with one ICD.
- **Questionnaires for kleptomania**: quick, comparable scores; but dishonesty about crimes, no "why".

8. To what extent do you agree essay (12 marks) (5 questions)

Old Paper 4: argue **both** sides with research, then judge. Description alone earns nothing (June 2023 report).

- **"All ICDs are caused by high dopamine"**: agree (reward pathway, Parkinson's evidence, objective measures); disagree (correlation, doesn't explain why one ICD rather than another, positive reinforcement and Miller also explain them).
- **"Case studies reveal most"**: agree (depth, Glover, John); disagree (the K-SAS compares many people, individual differences, nomothetic drug trials like Grant).
- **"Behavioural explanations are too reductionist"**: precise and testable, and lead to therapy; but ignore biology and thinking (Miller is more holistic).

- **"Psychometric measures give no useful information":** argue about psychometrics in general, using the K-SAS as one example (June 2021 report).

9. Recall and explain Grant et al. (2008) (3 questions)

- **Drugs: nalmefene and naltrexone** (1 each; "opioid antagonists" alone scores 0). **Lengths: 16 and 18 weeks.**
- **Double-blind** (2): neither participants nor researchers know who has the drug (1), so a gambler on nalmefene or on the placebo can't tell which (1). **Placebo-controlled** (2): a group gets an inactive pill (1) for comparison with the drug group (1).
- **No double-blind:** participants who know they're on the placebo may change their gambling (participant bias), or researchers may treat groups differently (experimenter bias).
- **Why a placebo** (2): to see if the drug works better than a pill with no active drug (1), applied to nalmefene or naltrexone for gambling (1).

10. Outline Miller's feeling-state theory (3 questions)

2 marks: an intense positive feeling becomes linked with a specific behaviour (1); this forms a **feeling-state** (state-dependent memory) that the person re-creates by repeating the behaviour, even when harmful (1). Full marks need what the feeling-state **is**. A quick diagram helps.

11. Outline Griffiths' components of addiction (old syllabus) (3 questions)

Not on the 2024–2026 syllabus. Griffiths named six components: **salience** (it dominates thinking, feeling and behaviour), **mood modification** (a buzz or escape), **tolerance** (more needed for the same effect), **withdrawal** (unpleasant feelings on stopping), **conflict** (with others or within oneself) and **relapse** (falling back into the old pattern). Name the component (1) and say what it means (1) (June 2021 report).

12. Apply ICD-11 criteria to a person (2 questions)

1. **Reason to diagnose** (2): pick a detail from the scenario (1) and name the criterion it meets (1).
2. **Reason not to** (2): only **one** act (the criteria need repeated acts); a **motive** (money, revenge, anger at someone); another disorder explains it better. Time or duration is not credited.
3. **Other diagnostic problem** (2): the person may hide or play down fire-setting or theft because it is **illegal**; there may be **mixed** motives. Link it to the disorder; restating "meets some criteria" earns nothing.

13. Apply or suggest a treatment for a person or disorder (2 questions)

- **Imaginal desensitisation for a named person** (4): relaxation first, then the person imagines **their own** steps (buying matches, choosing a place, striking one), then imagines **leaving** while relaxed; home practice; arousal falls, so the urge weakens. Covert sensitisation or digging into childhood earn 0.

- **Another treatment for pyromania (2): covert sensitisation** with the aversive pairing and Glover, or **drugs**: SSRIs used for pyromania and kleptomania, or Grant's opioid antagonists, which reduce urges. Cognitive restructuring is a depression treatment and scores 0 (March 2026 report).

14. State a K-SAS question (1 question)

2 marks: a question in its K-SAS form (1) **with** its fixed answer scale (1), e.g. "During the past week, how much tension or excitement did you feel just before stealing?" answered on a 0–4 scale from none to extreme.

Worked examples

Example 1

Lukas, 34, earns a good salary as an accountant. For two years he has taken small items from hardware shops (packets of screws, tape measures) that he has no use for. In the shop he feels tension building until he slips something into his pocket; outside, he feels a rush of relief. He leaves the items in his car boot. Lukas also has spells of very high mood, little sleep and reckless spending.

- (a) Using the ICD-11 diagnostic criteria for kleptomania, suggest one reason why Lukas may be diagnosed with kleptomania. [2]
- (b) Suggest one reason why a doctor may not diagnose Lukas with kleptomania. [2]
- (c) Suggest how the effectiveness of a treatment for Lukas could be measured, other than by self-report. [2]
- (a)** He steals things he has no use for and doesn't need, such as tape measures he leaves in his car **(1)**, which meets the criterion that the objects are not stolen for personal use or for their value; he also feels tension before and relief after, another criterion **(1)**.
- (b)** His spells of very high mood, little sleep and reckless spending could be manic episodes **(1)**. ICD-11 says kleptomania is not diagnosed if the stealing is better explained by another disorder, such as a manic episode, so the doctor would need to rule this out **(1)**.
- (c)** A structured observation, with Lukas's consent, by a trained observer who goes shopping with him **(1)**, counting each time he picks up an item he doesn't intend to buy and each time he pockets one, on visits before and after treatment **(1)**.

Example 2

A psychologist tests a new drug for gambling disorder in a double-blind trial. 40 participants are randomly allocated: 20 take the drug and 20 take a placebo for 12 weeks. On a gambling-severity scale, the drug group's mean score falls from 26 to 14 and the placebo group's from 25 to 20.

- (a) Calculate the percentage fall in the mean score for each group, to 1 decimal place. [2]
- (b) Explain why a placebo group was used in this trial. [2]

(c) Explain one weakness of drug treatment for gambling disorder compared with imaginal desensitisation. [2]

(a) Drug: $\frac{26 - 14}{26} \times 100 = 46.2\%$ (1). Placebo: $\frac{25 - 20}{25} \times 100 = 20.0\%$ (1).

(b) Some people improve just because they believe they are being treated, so the placebo group gives a baseline (1): the drug's real effect on gambling is the extra fall beyond the placebo group's 20.0%, not the whole 46.2% (1).

(c) The drug reduces the urge only while it is taken; it teaches no skill (1), so when the gambler stops the pills the urges may return, whereas imaginal desensitisation teaches relaxation he can use in a betting shop for life (1).

Example 3

(a) Describe the biological explanation (dopamine) and the behavioural explanation (positive reinforcement) of impulse control disorders. [6]

(b) Evaluate the biological explanation (dopamine) and the behavioural explanation (positive reinforcement) of impulse control disorders, including a discussion of reductionism versus holism. [10]

(a) *Dopamine.* Dopamine is the neurotransmitter of the brain's reward pathway, which runs to the striatum. It is released when a person does something rewarding, and when they expect a reward, especially an uncertain one. For a person with pyromania, setting a fire releases dopamine, so the act feels good and is wanted again. With repetition the striatum responds less (reward deficiency), so ordinary pleasures feel flat and more fire-setting is needed for the same high, which keeps the disorder going.

Positive reinforcement. In operant conditioning, a behaviour followed by a reward becomes more likely. For a gambler the reward is winning money and the excitement; for kleptomania and pyromania it is the thrill. Gambling wins come on a partial, variable-ratio schedule, after an unpredictable number of bets, so the gambler keeps playing because the next bet might win, and the behaviour is very hard to extinguish.

Why it reaches the top level: both explanations accurate, with terms (reward pathway, striatum, variable-ratio), each linked to a named ICD.

(b) *Reductionism versus holism (the named issue).* Both explanations are reductionist. The dopamine explanation reduces the disorder to one neurotransmitter, and positive reinforcement reduces it to a history of rewards. This makes them precise and testable: dopamine-boosting drugs given for Parkinson's disease have produced compulsive gambling, which supports the biological explanation. But neither explains why one person steals and another sets fires, or why most people who gamble never develop a disorder. Miller's feeling-state theory is more holistic, combining emotions, thoughts, physical arousal and the person's view of themselves, which suggests a full account needs more than either explanation alone.

Nature versus nurture. Dopamine is mainly nature, though the reward response also changes with repeated behaviour; reinforcement is nurture. Each explanation is the other's missing half: a person may be born with a strong dopamine response (nature), but it is the wins they experience (nurture) that teach them to gamble.

Application to everyday life. The dopamine explanation led to drugs such as nalmefene, which Grant et al. found beat a placebo for gambling disorder. Reinforcement suggests limiting gambling sites' payouts, and therapies that remove the reward, such as covert sensitisation, which made stealing unpleasant in Glover's case.

Evidence. Dopamine findings are largely correlational, so changed dopamine activity may be a result of gambling, not its cause.

Why it reaches the top level: issue by issue, the named issue first and in detail, both explanations compared within each issue, with evidence (Parkinson's, Grant, Glover) and a judgement.

Common mistakes

- **Confusing pyromania with arson, or with stealing or gambling,** or writing only "setting fires" (June 2021 and June 2023 reports).
- **Calling pleasure alone the sign of kleptomania:** any thief enjoys getting away with it; give tension before and relief after (November 2022 report).
- **Giving features that fit any ICD or any addiction** when gambling disorder is asked (March 2025 report).
- **Mixing up covert sensitisation and imaginal desensitisation,** saying covert means the patient doesn't know, or that pictures are shown (November 2021, June 2022 and March 2026 reports).
- **Using self-reports when the question says "other than self-report",** or a vague "I would observe a gambler" (June 2021 and March 2025 reports).
- **Generic points:** "people may lie" or "it is time-consuming" without linking to the disorder or saying why (June 2022, March 2025 and March 2026 reports).
- **Labelling debates without explaining them,** or listing many issues per explanation instead of comparing (March 2021 and June 2021 reports).
- **Describing symptoms or treatments when causes are asked,** or serotonin instead of dopamine for the biological explanation (June 2021 and June 2023 reports).
- **Treating ethics as Glover's weakness:** she asked for help and consented (June 2023 report).
- **In plans, using the wrong method or disorder,** or writing "a questionnaire like the K-SAS" without saying what it asks (March 2023 and March 2025 reports).
- **Suggesting cognitive restructuring for an ICD:** it treats depression (March 2026 report).

How to get the marks

- **"Identify", "state":** exact facts: drug names, trial lengths, ICD-11 criteria, relaxation plus imagined scenes.
- **"Outline" or "explain what is meant by"** (2 marks): the point plus a criterion, detail or example.
- **"Explain" or "suggest"** (2 marks a point): the point (1) applied to the named disorder, study or person (1).
- **"Other than ...":** read what is excluded and pick a different method or treatment.
- **Scenario questions:** quote the person's details and name the matching criterion in each answer.

- **"Describe" in an essay:** exactly the named items, with terms and an example ICD; no evaluation.
- **"Evaluate":** issue by issue, the named issue first, every item compared, evidence, a short judgement.
- **"Discuss ... conclusion"** and **"To what extent"**: both sides, then a judgement reached by reasoning, not a summary.
- **Plans:** the named method and disorder, specific features with example questions, then the knowledge linked feature by feature.

Quick check

1. Which diagnosis fits, if any? (a) Ines has set fire to three cars belonging to her former partner because she is furious with him. (b) For 14 months Raj has been unable to cut down on online betting, has dropped football and friends to bet, and keeps betting after losing his savings. (c) Joel takes electronics from shops and sells them online.
2. In a hypothetical trial, a patient's gambling-severity score falls from 32 to 20 after imaginal desensitisation. Calculate the percentage fall.
3. A slot machine pays out on average once every 8 spins, at unpredictable points. How many wins would a player expect, on average, in 40 spins, and why does this schedule make gambling hard to stop?
4. Name the treatment: (a) a patient imagines retching as he reaches for a lighter; (b) a patient relaxes her muscles, imagines walking into a casino and feeling the pull to play, then imagines walking out calm.
5. A student writes: "One weakness of the K-SAS is social desirability." Why does this score 0, and what weakness of the K-SAS would score?

Answers

1. (a) **Not pyromania**: she has a **motive** (revenge), and the criteria require no apparent motive. (b) **Gambling disorder**: impaired control, increasing priority and continuing despite harm, for over 12 months. (c) **Not kleptomania**: he steals for **money**, and kleptomania involves objects not needed or taken for their value.
2. $\frac{32 - 20}{32} \times 100 = 37.5\%$.
3. $40 \div 8 = 5$ wins on average. Because the wins come at unpredictable points (partial, variable-ratio reinforcement), the player never knows if the next spin will win, so stopping after losses is hard and the behaviour resists extinction.
4. (a) **Covert sensitisation** (imagined aversive stimulus paired with the behaviour). (b) **Imaginal desensitisation** (relaxation, imagined trigger, leaving calm).
5. Social desirability is a problem with the person answering, not with the K-SAS itself. A K-SAS weakness: some hour bands overlap (such as 1–4 and 4–10 hours), so a person who spent 4 hours could tick either, making scores inaccurate.

Past questions to try

- [9990/32/M/J/25 Q1](#): applying imaginal desensitisation step by step to a named person with pyromania.
- [9990/42/M/J/24 Q2](#): a K-SAS question, testing its reliability and its weaknesses.
- [9990/32/O/N/24 Q4](#): describing and evaluating positive reinforcement and Miller, with nature versus nurture.
- [9990/42/O/N/25 Q9](#): planning a questionnaire study on pyromania and justifying it.