



Focusing on Symptoms Rather than Diagnoses in Brain Dysfunction: Conscious and Nonconscious Expression in Impulsiveness and Decision-Making

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Symptoms and syndromes in neuropathology, whether expressed in conscious or nonconscious behaviour, remain imbedded in often complex diagnostic categories. Symptom-based strategies for studying brain disease states are driven by assessments of presenting symptoms, signs, assay results, neuroimages and biomarkers. In the present account, symptom-based strategies are contrasted with existing diagnostic classifications. Topics include brain areas and regional circuitry underlying decision-making and impulsiveness, and motor and learned expressions of explicit and implicit processes. In three self-report studies on young adult and adolescent healthy individuals, it was observed that linear regression analyses between positive and negative affect, self-esteem, four different types of situational motivation: intrinsic, identified regulation, extrinsic regulation and amotivation, and impulsiveness predicted significant associations between impulsiveness with negative affect and lack of motivation (*i.e.*, amotivation) and internal locus of control, on the one hand, and non-impulsiveness with positive affect, self-esteem, and high motivation (*i.e.*, intrinsic motivation and identified regulation), on the other. Although

presymptomatic, these cognitive-affective characterizations illustrate individuals' choice behaviour in appraisals of situations, events and proclivities essentially of distal perspective. Neuropathological expressions provide the proximal realities of symptoms and syndromes with underlying dysfunctionality of brain regions, circuits and molecular mechanisms.

Keywords: Symptom; Decision-making; Diagnosis; Substrates; Impulsiveness; Expression; Nonconscious; Conscious; Neuropathology

INTRODUCTION

Efforts to describe and understand symptom profiles over diagnostic constraints and disorder categorizations remain bedeviled by the straightjackets of existing criteria, instruments and classifications. In focussing upon a "symptom strategy", it is implicitly concluded that the presenting symptoms, signs, assay results, neuroimages and biomarkers are themselves the targets for attempts to grapple with the neuropathology of brain disease states. Thus, the contributions of conscious and noncon-

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scious processes to cognitive, affective and motor expressions of behavioural dysfunctionality and the underlying neural substrates await elucidation.

Functionality and Dysfunctionality

So-called 'everyday memory failures', *e.g.*, forgetting to put on a tie for a formal public occasion, have given rise to conceptualizations such as a breakdown of "unity of consciousness" and the "unity model of memory failure" (Gennaro *et al.*, 2006). These notions suggest that although poor encoding retention or retrieval may result in memory failure, problems of forgetting may result from disruptions of the "unity of consciousness", brought about by practical, undramatic events on a daily basis. Emotional states, stressful situations and personal cognitive appraisals may imbue the "unity of consciousness" breakdowns with more sinister, neuropsychiatric aspects, distinct from memory *per se* (Reason, 1984). Current notions of memory processes distinguish explicit memory, *e.g.*, declarative memories that support the ability to recognise and/or recall events consciously, from implicit memory, *e.g.*, non-declarative memories inaccessible to conscious report yet inferred from performance improvements due to previous experience of the task; the latter normally is preserved in amnesia (Verfaellie *et al.*, 2006). However, recently Chun (2005) discussed evidence of an impairment in implicit memory in the transient amnesia of healthy volunteers administered midazolam (an anti-anxiety benzodiazepine producing amnesia for surgical procedures by blocking the encoding of new information despite subjects remaining alert and performing the task normally (Polster *et al.*, 1993). It was shown that midazolam impaired implicit relational memory while allowing non-relational memory to be preserved (Hirshman *et al.*, 1999). In addition, the involvement of contextual cuing variables in implicit memory under conditions of brain damage offers further complexity for implications of states of consciousness in cognition (Chun and Phelps, 1999; Manns and Squire, 2001; Chun and Jiang, 2003; see also Rosenbaum *et al.*, 2007).

From a parallel perspective, Le Moal *et al.* (2008) have addressed issues arising from the applications of animal models in behavioural pathology. They discuss the consequences of introducing medical

models and the various procedures inherent to diagnosis into psychiatry, on the one hand, and collection and assembly of symptoms and syndromes, on the other. A major constraint in many cases appears to be the absence of reliable and valid laboratory data (neuroimaging may lack the status of a reliable marker) (Rutter *et al.*, 2001; 2006). Most animal models appear not to fit the clinical features and, above all, the clinical realities. Pathological traits or phenotypes characterise the co-existence of different modular components, each a symptomatic expression of dysfunction within a given functional system (Petronis, 2004). The notion, derived from animal and/or human research, that neuropathological traits present multi-symptom sets, essentially syndromes, within distinct intertwined behavioural and biological levels or conglomerations provides plausible logic for a disease (Piazza and LeMoal, 1996).

Biological defects co-exist with pathobehavioural trait characteristics as signatures of different neurobiological systems (Rapp and Amaral, 1992). The case may be illustrated with regard to the condition labelled 'psychopath', referring to individuals showing antisocial personality disorder, characterised by inability to develop emotional involvements and recurrent infringements of the rights of others (Hare *et al.*, 1978; Veit *et al.*, 2002). These individuals lack the ability to anticipate punishment and show autonomic conditioning deficiencies (Lykken, 1957; Hare and Quinn, 1971; Lilienfeld and Andrews, 1996). Recently, Birbaumer *et al.* (2005) examined cerebral, peripheral and subjective correlates of fear conditioning in ten criminal psychopaths and ten healthy volunteers through application of an aversive differential Pavlovian delay conditioning paradigm with neutral faces as conditioned stimulus and painful pressure as unconditioned stimulus. They found that healthy volunteers showed differential activation of the limbic-prefrontal circuit, consisting of amygdala, orbitofrontal cortex, insula and anterior cingulate cortex, during acquisition of fear and successful verbal and autonomic conditioning, as assessed with functional magnetic resonance imaging. Conversely, the psychopaths (indexed with the Hare Psychopathy Checklist-Revised) showed no significant activity in this circuit and no conditioned skin conductance and

emotional valence ratings, despite contingency and arousal ratings being normal. They concluded that the lack of anticipation of aversive events by the psychopaths was due to the dissociation of emotional and cognitive processing in the brain, confirming observations that disruptions of the orbito-frontal cortex of the frontolimbic circuit result in "acquired sociopathic" manifestations (Anderson *et al.*, 1999; Damasio, 2000).

Similarly, Geyer (2008) discusses aspects of the neurobiological substrates, constructs and mechanisms underlying the development of animal models to mimic diagnostic syndromes in the search for models of specific symptoms. The development of cross-species methodology has offered particular utility for deriving the symptom/presymptom profiles originating from brain abnormalities (Vallee *et al.*, 1997; 1999; Lemaire *et al.*, 2000; Bateson *et al.*, 2004). Prepulse inhibition (PPI), a sensory gating procedure of established applicability in studying symptom profiles (Braff and Geyer, 1990), was shown to be reduced in schizophrenic and manic bipolar patients (Braff *et al.*, 2001; Perry *et al.*, 2001). PPI deficits interacted with strain in animal models and antipsychotic medication in humans (Olivier *et al.*, 2001; Powell and Geyer, 2002; Cilia *et al.*, 2005; Geyer, 2006; Swerdlow *et al.*, 2006; Csomor *et al.*, 2008; Young *et al.*, 2007). Illustrations of more or less valid cross-species models, specific animal paradigms that parallel pre-cognitive - cognitive expressions and development of novel human models of neuropsychiatric symptoms are outlined and discussed together with genetic predispositions (Palmer *et al.*, 2000; Geyer *et al.*, 2002).

Verhoeven and Tunier (2008) discussed the genetic underpinnings of schizophrenia from the perspective of a broad clinical phenotype regarding developmental issues, symptoms and co-morbidity (Verhoeven and Tunier, 2001; Wijers *et al.*, 2005; Cuesta *et al.*, 2007). The long-lasting debate regarding symptom categorization in order to facilitate further insights into disease etiology and neuropathology has resulted in the development of criteria for diagnosing disorders; yet, there exists a remarkable surfeit of precise symptomatic boundaries and a vagueness regarding systems that may offer validity for genetic and other biological research (Rosenman *et al.*, 2003; Matsuura *et al.*, 2004;

Serretti and Olgiati, 2004). Thus, for example, the search to identify linkages between schizophrenia and one or more genes has yielded few reliable findings. Verhoeven and Tunier (2008) discuss the search for candidate genes, *e.g.*, *DISC1* (Ekelund *et al.*, 2001; Hwu *et al.*, 2003; Sachs *et al.*, 2005) and the 22q11 deletion syndrome (Shprintzen *et al.*, 1978; Shprintzen, 2000; Schaer *et al.*, 2006; Williams *et al.*, 2007). From the case of the 22q11 deletion syndrome, psychotic symptoms emerge from a context of brain anomalies, an interaction of somatic abnormalities and specific neurocognitive deficits whereas in the Prader-Willi syndrome (Verhoeven and Tunier, 2006), a hypothalamic disorder which is expressed by psychotic symptoms that may resemble schizophrenia. Children presenting the 22q11 deletion syndrome exhibited a neuropsychological profile of relative verbal strength versus visuospatial and perceptual deficits (Swillen *et al.*, 1999; Lajiness-O'Neill *et al.*, 2006) as well as an impaired short term verbal memory (Majerus *et al.*, 2007), whereas at later age significant impairments in visuoperceptual ability, problem solving and planning are present (Henry *et al.*, 2002). Verhoeven *et al.* (2007) have described a group of adults displaying 22q11 syndrome and psychotic features together with verbal and performance IQ discrepancies and impairments in visuoperceptual ability and comprehension of abstract and symbolic language. They discuss too the putative existence of a susceptibility locus for schizophrenia and bipolar disorder on chromosome 15q26 (Vazza *et al.*, 2007). Finally, it was concluded, not only that schizophrenia is a highly variable disease, but that the genetic samples are even more heterogenous.

Decision-making and Impulsiveness

The notion that decision-making represents a rational and conscious process, *e.g.*, decisions of the type that are unpleasant in the short-term may offer long-term advantages, relatively removed from implicit or emotional considerations, may be questionable (*e.g.*, Bechara *et al.*, 1994; Damasio, 1998). Decision-making may be assisted by emotion-related stimuli, "somatic markers", that may occur prior to complete consciousness regarding the suitability of the choice. Confronted by the Iowa Gambling Task (IGT) (Bowman *et al.*, 2005),

healthy subjects select cards from all four decks but learn quickly to rely on the advantageous decks, displaying greater anticipatory skin conductance responses (SCRs) prior to selecting a card from the disadvantageous decks; this observation is consistent with the somatic marker hypothesis. Thus, individuals are offered choices between card decks that yield high monetary rewards but higher losses (*i.e.*, the disadvantageous decks) or decks with low rewards but lower penalties. Although each deck is linked to a specific schedule of "win-lose" ratios, it is not possible to make an exact calculation of deck payoffs with the consequence that players are confronted with conflicts between playing from decks with risky high rewards or from those associated with low rewards and low punishment. Patients with ventromedial prefrontal cortex damage choose more from the disadvantageous decks in the IGT (Bechara *et al.*, 1997; 2000; 2005; Manes *et al.*, 2002), which implies the involvement of this region in mediating a sensitivity for future consequences of current actions (Bechara *et al.*, 1996). Recently, Gutbrod *et al.* (2006) tested whether or not explicit, conscious memory was necessary for acquisition of a strategy allowing the performance of advantageous responses, using the IGT procedure and measuring skin conductance responses concomitantly. Accordingly, five amnesic patients with damage to the basal forebrain and orbitofrontal cortex and six amnesic patients with damage to the medial temporal lobe or the diencephalon were compared with eight healthy controls. They observed that the healthy controls acquired a preference for advantageous choices and generated large SCRs to high levels of punishment over 100 trials; the anticipatory SCRs to disadvantageous choices by the controls were greater than to the advantageous choices. On the other hand, nine out of the eleven amnesic patients performed the IGT at chance level and did not exhibit the differential SCRs to advantageous and disadvantageous choices, nor was anticipatory SCR magnitude linked to performance. The authors concluded that the acquisition of strategic preference in decision-making, whether regarding advantageous or disadvantageous choices, places demands upon a functioning explicit memory that remembers the outcome of previous trials in a punishment reinforcement situation. Thus, the linkage of stimu-

li and their particular outcomes appears a necessary prerequisite for learning in emotionally-charged decision-making situations (Ptak *et al.*, 2001; Hinson *et al.*, 2002; Tomb *et al.*, 2002; Clark *et al.*, 2004; Denburg *et al.*, 2005; Fellows and Farrah, 2005).

Several disorders, in which immediate gratification is given a higher priority than long-term goals in decision-making, are characterised by high levels of impulsiveness and poor decisions, including attention deficit hyperactivity disorder (ADHD), psychopathy, substance-abuse disorders, eating disorders and certain personality disorders (*e.g.*, Bulik *et al.*, 1997; Petry *et al.*, 1998; Bechara *et al.*, 2001; Lynskey and Hall, 2001; Mitchell *et al.*, 2002). Under the influence of alcohol, normally healthy individuals frequently make impulsive choices without regard for the future consequences of these choices; intoxication may induce gamblers to persist with higher wagers (Kyngdon and Dickerson, 1999) but may also induce less impulsiveness (Ortner *et al.*, 2003), although willingness to gamble is elevated by alcohol across all individuals (Breslin *et al.*, 1999). Furthermore, the acute effects of alcohol on executive functioning vary differentially with the descending curve linked to executive functioning impairments (Pihl *et al.*, 2003). Psychopathic individuals and substance abusers, both displaying high levels of impulsiveness (Palomo *et al.*, 2007), showed impaired performance on the IGT (Grant *et al.*, 2000; Bechara and Damasio, 2002; as well as above). Recently, Balodis *et al.* (2006) assessed the performance of 127 male undergraduate students on the IGT, the Newman Perseveration task, measuring impulsiveness, and Barratt's Impulsiveness Scale (BIS) under alcohol intoxication or not. They obtained unimpaired performance of the IGT by the intoxicated group, concluding that individual characteristics rather than the direct action of alcohol induce a greater influence on decision-making. Nevertheless, impulsiveness is a diagnostic criterion for mania (American Psychiatric Association, 1994; Swann *et al.*, 2003; 2004; 2005); it follows therefore that this notion together with risky decision-making may be associated with bipolar disorder (Rubenzstein *et al.*, 2000; Murphy *et al.*, 2001; Blumberg *et al.*, 2003; Frangou *et al.*, 2003). Christodoulou *et al.* (2006)

investigated twenty-five remitted bipolar disorder patients who completed the BIS, the Hayling Sentence Completion task and a computerized version of the IGT. They found that higher scores on the BIS attentional and non-planning subscales were associated with more errors on the Hayling Sentence Completion task and less advantageous choices in the IGT. Despite the limitations of all the patients being under medication and no healthy controls being included, they concluded that impulsiveness, response inhibition and decision-making in bipolar disorder may be manifestations of possible ventral prefrontal cortical dysfunction.

Impulsiveness Relative to Affect, Motivation, Self-esteem and Locus of Control

Individuals expressing higher levels of impulsiveness often display deficits over a variety of executive function tests (Dolan and Park, 2002; Rogers, 2003), cognitive tasks requiring response control (Potter and Newhouse, 2004) and cognitive flexibility (Mungas, 1988; Barratt *et al.*, 1997). Keilp *et al.* (2005) found that performance of executive function, verbal fluency, tasks requiring decision-making against time, reaction time to paired words and paired faces memory tasks, the Go-No Go task, the time estimation task and response bias on the continuous performance task correlated substantially with the self-reported scores on Barratt's Impulsiveness Scale. Performance on the Go-No Go task is the strongest correlate for self-rated impulsiveness whereby decision-making and response-organisation tasks under pressure of time give stringent tests of the trait. Archer *et al.* (2008) described studies assessing the influence of affective personality upon stress, motivation, self-esteem, optimism, depression and anxiety and locus of control in different populations, and the predictive relationships between positive affect, negative affect, self-esteem, intrinsic motivation and depression (Beck's BDI) within and across estimations of cognitive-emotional expressions, as assessed with regression analysis. In the present account, the findings of three self-report studies designed to investigate the predictive relations, using regression analyses, between self-rated impulsiveness, affect, motivation, self-esteem and locus of control are described.

In three studies, 167 high school students, 83

female and 84 male, with a mean age of 18.41 years (SD = 3.70; range = 16 to 19) and 194 high school students, 101 female and 93 male, with a mean age of 18.47 years (SD = 3.75; range = 16 to 19) and from the south-east (Kalmar) of Sweden and 321 middle-to-high school pupils, 241 female and 80 male (age range 12 - 18 years), from the Greater Gothenburg region (Sweden) participated. Choice of participant in studies 1 and 2 was determined by the presence of these individuals in a situation (university studies) in which high academic performance was of central importance, this particular population of individuals was thereby considered relevant due to the stress experience associated with motivational levels focused upon high achievement. Choice of participant for study 3 was determined by willingness of the participants to complete the questionnaires regarding PANAS, Stress and Energy, Dispositional optimism, Rosenberg's Self-esteem and Barratt's Impulsiveness Scale (modified to take into account the ages of the younger subjects). The students belonged to different educational programs, including social sciences, health care, vehicles, humanities, business, and pure science.

Instruments and Procedure

Positive affect and negative affect scale (PANAS). The PANAS-instrument provides a self-estimation of affect, both positive and negative. It consists of 10 adjectives for the NA dimension and 10 adjectives for the PA dimension. The test manual (Watson *et al.*, 1988a,b) postulates that the adjectives describe feelings (Affect) and mood level. Participants were instructed to estimate how they felt during the last few days. The response alternatives were presented on a five-grade scale that extended from 1 = not at all to 5 = very much. For each participant the responses to the 10 negatively-charged adjectives were summated to provide a total NA-result for NA affect, and similarly the responses to the positively-adjectives were summated to provide a total PA-result for PA affect. The PANAS instrument has been validated through studies analyzing conditions associated with general aspects of psychopathology (Huebner and Dew, 1995), as well as a multitude of other expressions of affect (Watson and Clark, 1984). Previous

studies (Norlander *et al.*, 2002; Bood *et al.*, 2004; Palomo *et al.*, 2004) have modified and developed the PANAS instrument further through a subject-response based derivation of the four types of affective personality (see Design). This procedure was implemented in the present study through dividing the results on the PA-scale into two parts thereby distributing the participants into one group with high PA and another group with low PA (*cut-off point* = 53.2%). The same procedure was implemented for the participants' responses on the NA-scale (*cut-off point* = 48.9%). Following this, the results from these two scales were combined according to the procedure that assigned each one of the participants into one of the four affective personality groups, as follows: individuals showing high PA and low NA ("Self-fulfilling"), high PA and high NA ("High affective"), low PA and low NA ("Low affective") and low PA and high NA ("Self-destructive").

Locus of Control. Locus of Control was measured using a modified version according to Millet and Sandberg (2003; Millet, 2005) using an abbreviated version of the Rotter scale (1966) as developed by, for example Andersson (1976), for use mainly in Swedish work settings. The scale has a minimum score of 8 and a maximum of 40, with a lower score representing an external locus of control orientation and a higher score representing an internal locus of control orientation. Several empirical studies have shown that perceived control is strongly correlated with rehabilitational outcomes, not least empowerment (Tseng, 1970; Levenson, 1974; Partridge and Johnston, 1989; Erbin-Roesemann and Simms, 1997). Possible considerations pertaining to cross-confounding with other constructs appear to have been rebutted by Lefcourt (1991).

Situational Motivation Scale (SIMS). The SIMS instrument was designed to provide an estimation of the constructs (factor), intrinsic motivation, identified regulation, external regulation and amotivation (*cf.*, Deci and Ryan, 1985; 1991) in both field and laboratory settings. Guay *et al.* (2000) have shown that SIMS is composed of four internally consistent values (Cronbach's α) for each factor, showing:

intrinsic motivation = 0.95, identified regulation = 0.80, external regulation = 0.86 and amotivation = 0.77, with self-report internal consistency scales in the 0.70-0.80 range acceptable for research purposes. The construct validity of SIMS has been shown to be supported by correlations with other constructs, *e.g.*, perceived competence, concentration and behavioural intentions. The present version of SIMS included four items for each factor, *e.g.*, *intrinsic motivation*: "Because I think this activity is interesting", *identified regulation*: "Because I am doing it for my own good", *external regulation*: "Because I am supposed to do it", and *amotivation*: "I do this activity but I am not sure it is worth it", with seven response alternatives [1 = not at all, 2 = very little, 3 = a little, 4 = moderately, 5 = enough, 6 = a lot, 7 = exactly] that provided eigenvalues of 5.70, 2.63, 1.33, and 0.73, for each factor, respectively. Guay *et al.* (2000) have shown both that perceived competence, concentration and behavioural intentions of future persistence toward the activity were associated with SIMS factors according to the self-determination continuum and specific and positive interrelations between Academic Motivation Scale factors (*cf.*, Vallerand *et al.*, 1989) and the SIMS factors.

Rosenberg's Self-esteem Scale (SES). The SES instrument is a self-estimation, 10-item questionnaire which has been constructed to measure the extent to which individuals consider themselves "sufficiently functional", particularly in adolescents and young adults (Rosenberg, 1965). Self-esteem is measured using ten items (statements, each item rated on a four point Likert scale) concerned with feelings about oneself and one's attitude towards one's resources, relations to others and achievements, whereby half of the statements express positive aspects about self and half express negative aspects. The participants were required to respond with the number that they considered to fit the degree to which they agreed with the statement or disagreed with the statement, whereby 1 = "agree completely" and 4 = "disagree completely". For example, statements like "I can do things as well as anybody else", or "I wish that I had more respect for myself", or "On the whole I am satisfied with myself" were included.

Barratt's Impulsiveness Scale (BIS-11, modified and translated). The present modified, Swedish version BIS-11 instrument is a self-estimation 25-item questionnaire that assesses impulsiveness (Patton *et al.*, 1995). Participants respond to statements on a 4-point scale, "Never" - "Sometimes" - "Often" - "Always", whereby 16 out of the 25 items express impulsiveness, such as "I do things without consideration", or "I act impulsively", and, conversely, 9 out of 16 items express non-impulsiveness, such as "I have good self-control", or "I plan for the future". Nine of the twenty-five items are scored formulated to express 'non-impulsiveness' thereby providing a reverse order, avoiding response bias, and sixteen items provided direct scores of impulsiveness. According to the factor analysis study by Li and Chen (2007), BIS items may be chosen to produce three factors, inability to plan, lack of self-control and sensation/novelty seeking, that are tangential to the three subscales, nonplanning, motor and cognitive impulsiveness. BIS has been translated into several different languages with test-retest reliability ranging from 0.71 to 0.89 (Fossati *et al.*, 2001; Someya *et al.*, 2001).

Procedure. Participants (except in Study 3 wherein the instruments were sent out over the internet) were assembled in groups of 5 to 6 participants (within each respective testing environment) before receiving instructions followed by the questionnaires. They were provided with an envelope containing the questionnaire with all the instruments and were instructed to complete these quietly and independently. In each study, the amount of time allocated to the participants was 20-30 minutes. All instructions and questionnaires were in Swedish and all the participants were guaranteed anonymity and assured that their collaboration was on a voluntary basis. First, the participants completed a background sheet providing information concerning age, sex, education, physical exercise, use of medicine, etc. After this, they completed all the other instruments, including PANAS, Locus of Control, SES, SIMS and BIS (as arranged within each respective Study).

RESULTS AND DISCUSSION

Regression analyses indicated that Impulsiveness was predicted by negative affect ($\beta=0.22$) and amotivation ($\beta=0.15$), and was counterpredicted by internal locus of control ($-\beta=0.17$) in Study I; it was predicted by amotivation ($\beta=0.27$) in Study II; and, it was predicted by negative affect ($\beta=0.33$) and counterpredicted by positive affect ($\beta=-0.29$) in Study III. Table I presents the standardized weights from linear regression analysis with (a) Impulsiveness in Study I [$F_{(9,157)}=5.26$, $p < 0.001$; Adjusted $R_2=0.187$], (b) Study II [$F_{(6,187)}=3.34$, $p < 0.01$; Adjusted $R_2=0.069$], and (c) Study III [$F_{(4,316)}=24.69$, $p < 0.001$; Adjusted $R_2=0.228$], respectively, as dependent variable and Positive and Negative affect, internal and external locus of control, self-esteem, intrinsic motivation, identified regulation, external regulation and amotivation as independent variables.

Regression analyses indicated that Non-impulsiveness was predicted by positive affect ($\beta=0.17$), self-esteem ($\beta=0.19$), intrinsic motivation ($\beta=0.20$) and identified regulation ($\beta=0.20$) in Study I; it was predicted by positive affect ($\beta=0.20$), and counterpredicted by amotivation ($\beta=-0.15$) in Study II; and, it was predicted by positive affect ($\beta=0.50$) and internal locus of control ($\beta=0.17$) in Study III. Table II presents the standardized weights from linear regression analysis with (a) Non-impulsiveness in Study I [$F_{(9,157)}=11.64$, $p < 0.001$; Adjusted $R_2=0.366$], (b) Study II [$F_{(6,187)}=3.70$, $p < 0.01$; Adjusted $R_2=0.078$], and (c) Study III [$F_{(4,316)}=34.09$, $p < 0.001$; Adjusted $R_2=0.293$], respectively, as dependent variable and Positive and Negative affect, internal and external locus of control, self-esteem, intrinsic motivation, identified regulation, external regulation and amotivation as independent variables.

The present findings from three studies, carried out on relatively young or adolescent, relatively healthy, nonclinical individuals, implicate markedly the predictive associations between impulsiveness with negative affect and lack of motivation (*i.e.*, amotivation) and an absence of internal locus of control, on the one hand, and non-impulsiveness with positive affect, self-esteem, a high level of motivation (*i.e.*, intrinsic motivation and identified

regulation) and internal locus of control, on the other hand. One notion of 'impulsiveness versus restraint' views impulsiveness and anxiety at opposite dimensional poles with impulsiveness occurring when anxiety is low, and vice versa, whereas others conceptualize several different dimensions of impulsiveness-restraint, particularly in the context of brain function (Epstein, 1994; Sloman, 1996; Metcalfe and Mischel, 1999; Bechara, 2005; Carver, 2005). Much evidence suggests that high levels of, or unrestricted impulsiveness, are associated with adventuresome decision-making in a

range of situations studying neural correlates of and brain regions associated with risk-taking behaviour (e.g., Sanfey *et al.*, 2003; Hsu *et al.*, 2005; DeMartino *et al.*, 2006; Huettel *et al.*, 2006; Weller *et al.*, 2007). A variety of decisions, unexplainable solely on the basis of rational imperatives, may be influenced markedly by affective state, e.g., by the emotion of 'regret' in guiding choice behaviour (Bell, 1982; Gilovich and Melvec, 1994; Byrne, 2002; Coricelli *et al.*, 2005) with the involvement of orbitofrontal cortex-amygdala circuits seeming to characterise anticipation of regret (Mellers *et al.*, 1999;

Table I Standardized weights from linear regression analysis with Impulsiveness in (a) *Study I* [$F_{(9,157)}=5.26$, $p < 0.001$; Adjusted $R_2=0.187$], (b) *Study II* [$F_{(6,187)}=3.34$, $p < 0.01$; Adjusted $R_2=0.069$], and (c) *Study III* [$F_{(4,316)}= 24.69$, $p < 0.001$; Adjusted $R_2=0.228$], respectively, as dependent variable and Positive and Negative affect, internal and external locus of control, self-esteem, intrinsic motivation, identified regulation, external regulation and amotivation as independent variables.

(a) **Impulsiveness: Study I**

Predictor variable	Standardized Beta (β)
Amotivation	0.22**
Negative affect	0.15*
Internal locus of control	-0.17*

* $p < 0.05$, ** $p < 0.01$. Predictor variables: Positive affect, intrinsic motivation, identified regulation, external regulation, external locus of control and self-esteem were non-significant.

(b) **Impulsiveness: Study II**

Predictor variable	Standardized Beta (β)
Amotivation	0.27**

** $p < 0.01$, *** $p < 0.001$. Predictor variables: Positive and negative affect, intrinsic motivation, identified regulation, external regulation, internal and external locus of control and self-esteem were non-significant.

(c) **Impulsiveness: Study III**

Predictor variable	Standardized Beta (β)
Negative affect	0.33***
Positive affect	-0.29***

* $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$. Predictor variables: External locus of control almost reached significance, $\beta = 0.11$, $p=0.6$, but internal locus of control was non-significant.

Coricelli *et al.*, 2005). Additionally, affective appraisals and their eventual consequences may modulate particular mechanisms of cognitive-emotional control of choice processes, involving reinforcement or avoidance of the experienced behaviour, with selective activations of their underlying neural circuits (Bechara *et al.*, 1999; Peters and Slovic, 2000; Rustichini, 2005; Frank and Claus, 2006; LaBar and Cabeza, 2006; Steidl *et al.*, 2006; Coricelli *et al.*, 2007; Koenigs and Tranel, 2007). Against this conceptual and neuropathological context, it appears remarkable, that in three different

analyses of reasonably healthy and normal individuals, to observe significant associations between high expressions of impulsiveness with negative emotions, almost nonexistent motivation (amotivation) and lack of ability to explain/expect events from one's own ability and efforts, which ought to provide a frighteningly disadvantageous prognosis for this substantial portion of the young population studied. Conversely, expressions of non-impulsiveness enjoyed strong causal links with positive affect, high levels of quality motivation, personal self-esteem and the expectancy of internal locus of

Table II Standardized weights from linear regression analysis with Non-impulsiveness in (a) *Study I* [$F_{(9,157)}=11.64$, $p < 0.001$; Adjusted $R_2=0.366$], (b) *Study II* [$F_{(6,187)}=3.70$, $p < 0.01$; Adjusted $R_2=0.078$], and (c) *Study III* [$F_{(4,316)}=34.09$, $p < 0.001$; Adjusted $R_2=0.293$], respectively, as dependent variable and Positive and Negative affect, internal and external locus of control, self-esteem, intrinsic motivation, identified regulation, external regulation and amotivation as independent variables.

(a) **Non-impulsiveness: Study I**

Predictor variable	Standardized Beta (β)
Positive affect	0.17*
Self-esteem	0.19*
Intrinsic motivation	0.20*
Identified regulation	0.20*

* $p < 0.05$, ** $p < 0.01$. Predictor variables: Negative affect, external regulation and amotivation, internal and external locus of control were non-significant.

(b) **Non-impulsiveness: Study II**

Predictor variable	Standardized Beta (β)
Positive affect	0.20**
Amotivation	-0.15*

* $p < 0.05$, ** $p < 0.01$. Predictor variables: Negative affect, intrinsic motivation, identified regulation and external regulation were non-significant.

(c) **Non-impulsiveness: Study III**

Predictor variable	Standardized Beta (β)
Positive affect	0.50***
Internal locus of control	0.17***

* $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$. Predictor variables: Negative affect and external locus of control were non-significant.

control, all characteristics ensuring advantageous prognosis for successful choice behaviour and optimal decision-making.

According to Kalenscher *et al.* (2006), impulsiveness and self-control represent two antagonistic choice patterns with diametrically opposing outcomes, and yet present dispositions that govern future consequences of behaviours performed (Ainslie, 1975; Logue, 1988). As discussed above, the orbitofrontal and prefrontal regions appear intimately involved (*e.g.*, Dolan, 2007), although the notion that several other regions, such as the lateral prefrontal area and posterior parietal cortex, contributing for example to economical and rational planning, and time-reward trade-offs, offer different competing decision-making networks is also plausible (McClure *et al.*, 2004; Tanaka *et al.*, 2004; Sanfey *et al.*, 2006). The neuropharmacology of impulsiveness in decision-making implies some influence of dopaminergic neurotransmission whereby raclopride (DA D₂ antagonist) and flupenthixol and haloperidol (DA D₁/D₂ antagonists), but not SCH 23390 (DA D₁ antagonist) increased impulsive choice behaviour (Evenden, 1999; Cardinal *et al.*, 2000; Wade *et al.*, 2000). Additionally, serotonergic contributions have been well-documented in different species (Bizot *et al.*, 1999; Wolff and Leander, 2002). Winstanley *et al.* (2005) dissociated between serotonergic and dopaminergic modulation of rat medial prefrontal cortex and medial orbitofrontal cortex using microdialysis. Serotonin efflux was seen in the former not the latter, with increased 5-HT levels only under free-choice, but not under rewarded forced choice, conditions. Similarly, increased dopaminergic efflux in the medial orbitofrontal cortex was seen only after free choice conditions with increased DA efflux in the medial prefrontal cortex under both free and forced choice conditions. It was suggested that serotonin levels were associated with choice behaviour, not processing of response-outcome contingencies; on the other hand, DA levels in the medial orbitofrontal cortex were associated with choice behaviour with medial prefrontal cortex DA levels associated with response-outcome reward expectancies.

Several lines of evidence implicate serotonergic involvement in different expressions of impulsiveness: fighting and assault (Coccaro *et al.*, 1997),

domestic violence (George *et al.*, 2001), suicidal behaviours (Ågren, 1980), low-lethality suicide attempts (Placidi *et al.*, 2001), patients with anger attacks (Fava *et al.*, 2000) and impulsive aggression among men (Cleare and Bond, 1997), generally relating to low serotonin function/availability (Evans *et al.*, 2000; Walderhaug *et al.*, 2002; Dolan and Anderson, 2004; Frankle *et al.*, 2005). Dolan *et al.* (2001) found low serotonin function associated with elevated impulsiveness and aggression, as well as to higher anxiety, but also to poorer executive function (Dolan *et al.*, 2002). Low serotonin functioning/efficacy, linked with low platelet monoamine oxidase (MAO) activity and the short (*S*)-allele of the serotonin transporter gene promoter region polymorphism (5-HTTLPR), has been linked to neuropathological aspects of impulsiveness (Schalling *et al.*, 1988; Hallikainen *et al.*, 1999; Gerra *et al.*, 2004; Baca-Garcia *et al.*, 2005; Clark *et al.*, 2005; Paaver *et al.*, 2006). Recently, Paaver *et al.* (2007) showed that low platelet MAO activity together with the carriage of the *S*-allele of the 5-HTTLPR were both associated with a higher error-rate and a more impulsive performance on a visual comparison task. Moreover, platelet MAO and the 5-HTTLPR *S*-allele had an interaction effects on the self-reported impulsiveness scale (BIS-11, above), *i.e.*, subjects with low platelet MAO activity carrying the *S*-allele of 5-HTTLPR showed the highest mean score for self-reported impulsiveness. Taken together, the consensus from several lines of evidence makes plausible links between serotonergic functioning and impulsiveness (Carver and Miller, 2006).

Motor and Learned Expressions: Explicit and Implicit Processes

Movement disorders and/or motor expressions of neuropsychiatric symptoms may be associated generally with neurological disease states but nevertheless the accounts rendered below serve to illustrate the utility of maintaining neurologic perspectives on psychiatry, and vice versa. DA, whether in nigrostriatal or mesolimbic pathways, contributes diversified multifunctional influences regarding motor behaviour, cognition, emotion and motivation. Gerlach *et al.* (2008) discuss the associations of the movement disorders with a broad spectrum of disorders defined

by inability to initiate movement, with hypokinetic disorders at one end of the scale, and conditions encompassing an exaggeration of motor behaviours, hyperkinetic disorders, at the other end of the scale; the former case was exemplified by Parkinson's disease and similar neurodegenerative conditions and the latter by a constellation of disorders such as Huntington's Chorea and Hemiballism but also other neuropsychiatric conditions like Tourette's syndrome, Lesch Nyhan's disease, ADHD and schizophrenia, often DA-glutamate interactions providing central features. All these disorder conditions directly or less directly reflect dysfunctional DA systems as the underlying pathophysiology in neuroanatomical, neurohumoral and neurobehavioural terms (Albin *et al.*, 1989; Mink, 2001; Biederman and Faraone, 2005; Carlsson, 2006; Björklund and Dunnett, 2007; Iversen and Iversen, 2007; Schultz, 2007; van der Kooij and Glennon, 2007). One fundamental issue highlighted in this account pertained to utility of distinctions between psychiatry and neurology but rather the further development of neurobiological approaches. It seems remarkable that several motor features associated, *e.g.*, with Tourette's syndrome, Lesch-Nyhan disease, schizophrenia and ADHD, involve multiple features of dopaminergic dysfunction (*e.g.*, Girault and Greengard, 2004; Cortese *et al.*, 2005).

Kostrzewa and co-workers (2007) maintained this broad neurobiological theme in exploring DA-receptor sensitivity in relation to stereotypic motor behaviours, in particular vacuous chewing movements (VCMs) and locomotion. They presented a series of results illustrating the influence of lesioning presynaptic terminals (*e.g.*, applying postnatal 6-hydroxydopamine) or prolonged receptor antagonist action combined with acute administrations of DA D₁ or DA D₂ agonist to elicit the behavioural responses. They suggested that DA receptor sensitivity and stereotypy may reflect receptor subsensitivity and/or modulation by receptor co-sensitization of another phenotype.

Youdim (2008) reviewed the iron-deficiency syndrome, a condition described by defective brain dopaminergic-opiate system functioning with regard to circadian behaviours, cognition and the neurohumoral alterations associated with its neuropathology (Hallgren and Sourander, 1958; Werkman *et al.*,

1964; Dallman *et al.*, 1975; Youdim and Green, 1977; Ben-Shachar *et al.*, 1986; Lozoff and Brittenham, 1986; Yehuda and Youdim, 1984; Yehuda *et al.*, 1986; Youdim *et al.*, 1986; 1989; 2000; Youdim and Yehuda, 2000). Recent studies have established that the cognitive impairments may be associated with neuroanatomical damage and zinc metabolism in the hippocampus as a result of iron-deficiency (Shoham *et al.*, 1996; Shoham and Youdim, 2000; Zecca *et al.*, 2004). In consensus, these studies and several other studies aimed at symptom definition and drug therapy, have prompted the development of the fashionably plausible contention, "dirty drugs for dirty diseases", currently an appealing concept in drug development, through descriptions of neurotoxic events, *e.g.*, oxidative stress, excitotoxicity, inflammatory processes, brain iron dysregulation, etc. in the neurodegenerative disorders and the new therapeutic strategies under development. Here, candidate drugs have been designed to act on multiple neural and biochemical targets, combining cholinesterase inhibition, monoamine oxidase inhibition, iron chelation, inhibition of glutamate release and anti-apoptotic neurorescue activity. These diverse activities were tested over a variety of animal and *in vitro* models as well as in transgenic mice. Thus, by exemplifying the iron-deficiency syndrome from functional and neurochemical perspectives the notion of multiple neurotransmitter systems underlying symptom-profiles was illustrated.

Beninger and Banasikowski (2008) reviewed DA D₃ receptor modulation of the effects of self-administered drugs on reward-rich and lean schedules, in reinstatement tests, second order schedules and acquisition and expression of conditioned place preference (CPP) and conditioned activity (Aujla and Beninger, 2004; 2005; Xi *et al.* 2006; Vazquez *et al.*, 2007). They discuss the acquisition and expression of incentive learning in relation to the role of DA (*cf.*, Beninger, 1983). Thus, a consensus of evidence highlights the position that DA acting via D₁-like and D₂ receptors is critical for acquisition. Using a conditioned activity procedure based on cocaine it was found that DA D₂ and DA D₃ receptors function differently, presenting a double dissociation with D₂ receptors necessary for *establishment*, but not *expression* (initial), of conditioned

activity; conversely, D₃ receptors were necessary for *expression* but not *establishment*. Results imply that Drd3 exert a greater influence upon the expression than in the establishment of the CPP or conditioned activity. Although the mechanism through which Drd3 modulates control of responding by conditioned incentive stimuli awaits elucidation, it has been found that the population of these receptors in the nucleus accumbens increases during conditioning.

Dopaminergic involvement is implicated in complex cognition, *e.g.*, DA D₁ and D₃ receptors are involved in working memory and other aspects of prefrontal function (Williams and Goldman-Rakic, 1995; Glickstein *et al.*, 2002; Di Cara *et al.*, 2007). Recently, Lane *et al.* (2008) studied prefrontal executive functioning and DA D₁, D₃, 5-HT_{2A} and 5-HT₆ receptor gene variations in 216 healthy Han Chinese adults using the Wisconsin Card Sorting Test and genotyping for the four genetic variations. There was a significant difference in perseverative errors among the genotypes D₃ Ser9Gly, 5-HT_{2A} T102C and 5-HT₆ T267C but not D₁ A-48G, suggesting that these polymorphisms may contribute to prefrontal executive cognition. Symptoms derived from dysfunctioning in cognitive systems appear central to many expressions of neuropathology. The liability for cognitive deficits, including impairment of episodic memory, the explicit, conscious memory for spatial and temporal contexts of personally experienced events, associated with chronic, heavy alcohol abuse has been well documented (Horner *et al.*, 1999; Fox *et al.*, 2000; Sullivan *et al.*, 2000; Goldstein *et al.*, 2004). It has been shown too that acute alcohol consumption significantly reduces conscious recollection (Curran and Hildebrandt, 1999; Duka *et al.*, 2001). Aspects of explicit, conscious memory processes may be impaired in other respects. For example, models of working memory employ a central executive (*cf.*, Baddeley and Hitch, 1974; Baddeley, 2003), purported to own similar properties to executive functioning, *e.g.*, abstract thinking and planning, which is defective in chronic alcoholism (Ambrose *et al.*, 2001; Brokate *et al.*, 2003; Fama *et al.*, 2004; Oscar-Berman *et al.*, 2004; Zinn *et al.*, 2004). Since executive functioning appears to contribute

importantly to episodic memory (Kramer *et al.*, 2005; Davidson *et al.*, 2006), defective executive functioning in chronic alcoholism ought to result in episodic memory deficits. Recently, Pitel *et al.* (2007) assessed episodic memory (tasks measuring learning, storage, encoding and retrieval, contextual memory and autoegetic consciousness components) and executive functioning (tests of organisation, inhibition, flexibility, updating and integration capability) in forty recently detoxified alcoholic inpatients and fifty-five group-matched healthy controls. They found that the alcoholic patients displayed impaired cognitive and learning abilities compared with the healthy control, including both encoding and retrieval processes, contextual memory and autoegetic consciousness, the phenomenon underlying remembering in the sense of self-recollection in the 'mental re-enactment' of previous events at which the individual was present (*cf.*, Gardiner, 2001), thereby involving episodic memory. It is distinguished from noetic consciousness, which ensures awareness of the past that is limited to feelings of familiarity of knowing, and is identified with semantic memory, involving general knowledge. One approach to episodic memory utilising 'first-person' reports of remembering thereby allowing the most elusive aspect of consciousness, its subjectivity, can be investigated scientifically. The alcoholic subjects showed deficits in each of the executive tasks applied. Pitel *et al.* (2007) concluded that these patients with chronic alcoholism presented genuine deficits of episodic memory distinct from the eventual consequences of executive dysfunctioning, implying an association with neuroimaging studies involving hippocampal atrophy in chronic alcoholism (Agartz *et al.*, 1999; Bleich *et al.*, 2003; Beresford *et al.*, 2006).

The pursuit of a symptom rationale preliminary to the neuropathology of disorder ought necessarily to be linked with analyses of biomarkers, in the present case in the particular context of cognition and the plasticity incorporated in the biochemistry of neuronal events. Sutton and co-workers (*e.g.*, Sutton *et al.*, 2004; 2006; Sutton and Schuman, 2005; 2006) have demonstrated that mode of neurotransmission may exert much influence on ongoing protein synthesis in dendrites, posing the ques-

tion: how does one maintain the stability of activation in neural circuits? Recently, it was described that local dendritic protein synthesis was implicated in many types of synaptic plasticity with regard to how neurotransmission affects ongoing protein synthesis in dendrites. Thus, the tetrodotoxin-blockade of intrinsic action potential mediated network activity in cultured hippocampal neurons inhibited the dendritic synthesis of a fluorescence translation reporter, with ongoing spontaneous neurotransmitter release bidirectionally regulating dendritic protein synthesis. Sutton *et al.* (2007) identified eukaryotic elongation factor-2 (eEF2), catalyzing ribosomal translocation during protein synthesis, a biochemical sensor in dendrites specifically and locally tuned to the quality of neurotransmission. The phosphorylation of eEF2 at Thr56 inhibits its activity thereby inhibiting protein synthesis (Redpath *et al.*, 1993). The phosphorylation of eEF2 is stimulated by strong activation of ionotropic glutamate receptors (Chotiner *et al.*, 2003), and regulated in isolated synaptic biochemical fractions (Scheetz *et al.*, 2000; Carroll *et al.*, 2004). Sutton *et al.* (2007) have shown that intrinsic action potential (AP)-mediated network activity in cultured hippocampal neurons maintains eEF2 in a relatively dephosphorylated (active) state whereas spontaneous neurotransmitter release (miniature neurotransmission) promotes markedly the phosphorylation (and inactivation) of eEF2. They indicate that eEF2 is a biochemical sensor that couples miniature synaptic events to local translational suppression in neuronal dendrites. Note that strong NMDA receptor stimulation induces several biochemical changes that promote translation initiation (Kelleher *et al.*, 2004; Gong *et al.*, 2006).

A symptom-based strategy presupposes the operational assessment of presenting symptoms along with available measures of biomarkers, neuroimaging, etc., in characterizations of neuropathological states; as yet, much effort has been squandered within the constraining enclosures of diagnostic labyrinths. The present treatise attempts to explore neuropathological expressions of ongoing proximal realities of symptoms and syndromes with underlying dysfunctionality of brain regions, circuits and molecular mechanisms.

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