

Conceptualization and Treatment of Kleptomania Behaviors Using Cognitive and Behavioral Strategies

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Abstract

Kleptomania is a serious disorder that affects a small percent of the general population and a larger percent of the clinical population. It is frequently accompanied by other co-occurring problems, including depression, anxiety, obsessive-compulsive disorder, and substance abuse. Currently, little research on effective treatments exists; although behavioral and cognitive-behavioral treatments show great promise. Methods of behavioral assessments and intervention, as well future direction for research, are discussed.

Keywords: kleptomania, cognitive behavior therapy

Background

The DSM-IV-TR (American Psychological Association, 2000) classifies kleptomania as an impulse control disorder in which the essential feature is a recurring failure to resist impulses to steal items, even though those items are not needed for personal use or their monetary value (Criterion A). The individual experiences an increasing sense of tension just prior to the theft (Criterion B) and feels pleasure, gratification, or relief when committing the theft (Criterion C). The stealing is not committed in order to express anger or vengeance, is not done in response to a delusion or hallucination (Criterion D), and is not better accounted for by conduct disorder, a manic episode, or antisocial personality disorder (Criterion E). Historically, kleptomania has been considered a disorder seen mainly in white, upper- and upper middle-class women (Abelson, 1989; Goldman, 1991; Grant & Kim, 2002a, 2002b; McElroy, Hudson, Pope, & Keck, 1991; Sarasalo, Bergman, & Toth, 1996). With few exceptions (Kohn & Antonuccio, 2002; Wiedemann, 1998), comparatively little is known about males or individuals of ethnic minority or lower economic statuses. Given that, Criterion A may be an artifact of studying mainly upper-class, white females, because it presumes that only individuals who can otherwise afford the stolen items should be considered to be exhibiting kleptomania behaviors; recent research belies this notion (Kohn & Antonuccio, 2002; McElroy, Pope, Hudson, Keck, & White, 1991).

Prevalence & Diagnosis

A consensus about the origins and development of kleptomania has remained elusive to the field of psychology. Although this is due in part to the usual theoretical differences in perspective, it is exacerbated by a paucity of research into the disorder and because kleptomania appears to be a relatively rare problem, with an estimated prevalence rate ranging from 0.6 to 0.8% (Dannon, 2002; Goldman, 1992; Lepkifker, Dannon, Ziv, Iancu, Horesh, & Kotler, 1999). However, rates as high as 7.8% have been found when clinical populations are examined (Grant, 2006a). Different researchers have concluded that from none to a quarter of all shoplifters may suffer from kleptomania (Bradford & Balmaceda, 1983; Goldman, 1991; McElroy, Hudson, Pope, et al., 1991). Others suggest that kleptomania may be more common than previously thought, but is under-diagnosed due to secrecy, bias, or constricted diagnostic criteria (Abelson, 1989; Kohn & Antonuccio, 2002; McElroy, Pope, et al., 1991; McElroy, Keck, & Phillips, 1995; Murray, 1992). Some researchers have likened kleptomania to theft and refute the notion that there are psychological components involved (Bresser, 1979 as cited in Wiedemann, 1998). Others view kleptomania as part of an affective spectrum disorder (McElroy, Hudson, et al., 1991), and still others tend to classify kleptomania as more of an obsessive-compulsive disorder (Grant, 2006a; Tynes,

White, & Steketee, 1990). Finally, some researchers view kleptomania as an addiction spectrum disorder (Wiedemann, 1998), along the lines of pathological gambling. Because kleptomania is often diagnosed in conjunction with many of these other disorders, it is unclear whether it is a symptom of these other disorders or a separate but co-morbid problem. What is clear, however, is that symptoms of kleptomania rarely occur in isolation, and frequently occur in conjunction with other mental health problems. Additionally, there exist higher rates of affective and substance use disorders in first-order family members of individuals with kleptomania (Grant & Kim, 2002a) and reports of social isolation, dysfunctional cognitions, and high levels of perceived stress are also associated with increased frequency and/or intensity of kleptomania behaviors (Grant, Kim, & Grosz, 2003; Kohn & Antonuccio, 2002).

Behavioral and Cognitive-Behavioral Etiological and Assessment Models

Behavioral and cognitive-behavioral models of the etiology of kleptomania (e.g., Gauthier & Pellerin, 1982; Kohn & Antonuccio, 2002) have largely supplanted psychoanalytic models (e.g., Cupchik & Atcheson, 1983, as cited in McNeilly & Burke, 1998; Fullerton & Punj, 2004) and are generally complementary to biological models (e.g., Dannon, 2002; Grant, 2006a; Grant & Kim, 2002b; Kohn, Kalal, Kastell, & Viera, 2006). For example, Grant and Kim (2002b) propose a psychobiological model of etiology that combines neurochemistry with behavioral theories of classical and operant conditioning. They posit that certain individuals become conditioned to react to certain stimuli or cues (e.g., desired items) or to crave or desire stealing because of the rewarding sensation that follows it, both of which cause changes in the brain. This is largely complementary to the behavioral and cognitive etiological models of kleptomania, without the requisite need for an exact diagnosis.

In fact, a particular strength of the cognitive and behavioral models is the use of functional assessments, functional analyses, and operationally defined behaviors (e.g., Haynes, Leisen, & Blaine, 1997; Haynes & O'Brien, 1990) that greatly reduce the need to rely on a singular etiological model or specific diagnosis prior to beginning treatment (Hickey, 1998). Often, kleptomania is conceptualized as a set of unwanted behaviors which are the result of operant and respondent conditioning, shaping, behavioral chaining, distorted cognitions, and impoverished coping skills (e.g., Gauthier & Pellerin, 1982; Kohn & Antonuccio, 2002), all of which are treatable within a behavioral framework once the underlying functions and maintaining consequences are identified.

The behavioral framework is ideal for conceptualizing the development and maintenance of kleptomania behaviors. For example, assume an individual steals some item that has a strong associated meaning through repeated pairings in the past (e.g., through advertisements, learning history of the individual, etc). The stealing behavior is positively reinforced through the gain of that tangible item, sense of gratification, or other positive emotion; it is also negatively reinforced when preceding anxiety or other negative thoughts and feelings decrease or are completely eliminated. If this individual experiences minimal or no negative consequences or punishment, then the likelihood that the behavior will reoccur is increased. As the behavior continues to occur, stronger antecedents or cues become contingently linked with it, in what ultimately becomes a powerful behavioral chain. Additionally, ever more bold and daring stealing behaviors may be shaped if reinforcement of the stealing behaviors continues to occur in the absence of any type of punishing consequences. Eventually, individuals with kleptomania come to rely upon stealing as a way of coping with stressful situations and distressing feelings, which serve to further maintain (via positive and negative reinforcement) the behavior and decrease the number of available alternative coping strategies. According to cognitive-behavioral theory, both antecedents and consequences may either be in the environment or in the mind, as with cognitions. For example, Kohn and Antonuccio (2002) described a client's antecedent cognitions, which included thoughts such as "I'm smarter than others and can get away with it"; "they deserve it"; "I want to prove to myself that I can do it"; and "my family deserves to have better things." All of these thoughts were precipitated by additional

antecedents further back in the behavioral chain that were thoughts about family, financial and work stressors, or feelings of depression. "Maintaining" cognitions provided additional reinforcement for stealing behaviors and included feelings of vindication and pride, for example: "score one for the 'little guy' against the big corporations" and "I knew I could get away with it". Although those thoughts were often followed by feelings of remorse, this came too late in the operant sequence to serve as a viable punisher.

Self-report questionnaires can be useful adjuncts to a functional assessment examining the antecedents, consequences, and correlates of kleptomania behavior, particularly given the high comorbidity rate of affective, impulse control, substance use, and obsessive-compulsive disorders (Grant, 2006a). Measures such as the Beck Depression Inventory-II (BDI-II; Beck, Steer, & Brown, 1996) and the Beck Anxiety Inventory (BAI; Beck & Steer, 1993) can help identify the severity (i.e., dimensional aspects) of depressive and anxiety symptoms. Discussions of the Abstinence Violation Effect (AVE; e.g., Larimer, Palmer, & Marlatt, 1999) may also help to elicit dysfunctional cognitions. Research indicates that among shoplifters, individuals who experience stable, global feelings of shame (e.g., "I'm a bad person") are more likely to continue stealing; whereas those who experience situation-specific feelings of shame (e.g., imagining getting caught stealing when one is an otherwise "good" person) are more likely to stop (Tibbetts, 1997). Finally, circumstances that may decrease motivation for change (Miller & Rollnick, 2002), including personality disorders such as antisocial personality disorder (e.g., Grant & Kim, 2002b; Kohn & Antonuccio, 2002) should be identified and appropriately addressed.

Behavioral and Cognitive-Behavioral Treatment Model

Although many of the disorders that co-occur with kleptomania behaviors are frequently treated with medication, to date there have been no large-scale controlled treatment studies for kleptomania. Selective Serotonin Reuptake Inhibitors (SSRIs), antiepileptics, and opioid antagonists have all been used to treat kleptomania with varying results (Burstein, 1992; Dannon, 2003; Dannon, Iancu, & Grunhaus, 1999; Grant & Kim, 2002b; Kraus, 1999). However, pharmacological interventions are frequently accompanied by side effects (e.g., Antonuccio, Danton, DeNelsky, Greenberg, & Gordon, 1999; Dalfan & Stewart, 2001; Grant & Kim, 2002b; Kindler, Dannon, Iancu, Sasson, & Zohar 1997), which individuals may find disagreeable, leading to poor compliance with the medication (e.g., Dannon, 2003; Dannon, et al., 1999). Proponents of pharmacological treatments of kleptomania behaviors maintain an idiographic stance to the treatment of kleptomania suggesting that "[t]reatment should begin with understanding the particular subtype of kleptomania" (Grant, 2006a, p.85).

Fortunately, a growing body of research suggests the effectiveness of using several fundamental components of behavior and cognitive-behavioral approaches to treat kleptomania and co-occurring behavior problems (e.g., Gauthier & Pellerin, 1982; Glover, 1985; Grant, 2006a; Kohn & Antonuccio, 2002), including covert sensitization, shaping, behavioral chaining, problem-solving, cognitive restructuring, and homework (O'Donohue, Hayes, & Fisher, 2003). A thorough functional analysis drives the unique implementation, format, and structure of each of these techniques for each individual (Haynes & O'Brien, 1990; Kanfer & Saslow, 1965; Kohn & Antonuccio, 2002). For example, covert sensitization, the "pairing of imagined consequences of stealing with the desire to steal" (Goldman, 1991, p. 993), can use kleptomania-specific consequences (e.g., getting arrested, going to jail), rather than the commonly used images of nausea or vomiting (e.g., Cautela, 1966, Glover, 1985) as the aversive event, with high rates of success (Gauthier & Pellerin, 1982; Kohn & Antonuccio, 2002). In this approach individuals describe the scenario aloud, in vivid detail, allowing their anxiety to increase until they reach a predetermined end-point, such as spending time in jail or the conclusion of a court trial. Repeated pairings of aversive imagined consequences can lead to a decrease in expressed stealing behaviors, but also must be accompanied by reinforcement of appropriate behaviors.

A hallmark of behavioral and cognitive-behavioral interventions is the use of the scientist-practitioner model, and the systematic measurement of treatment progress which, albeit, relies largely on self-report. As such, an individual's initial treatment gains can be assessed using Improvement Scaling (IMS; Smith, Cardillo, Smith, & Amezaga, 1998), a versatile self-report measure tailored to each client's treatment goals that has been successfully utilized in the assessment and treatment of kleptomania (Kohn & Antonuccio, 2002). The Kleptomania Symptom Assessment Scale (K-SAS; Grant, 2006b) a self-report measure, appears to have adequate psychometric properties, and is designed to assess change in cognitions, behaviors, and urges during treatment. The BDI-II (Beck, et al., 1996) and BAI (Beck & Steer, 1993) can also be used to gauge increases and decreases in depressive and anxiety symptoms.

Conclusion and Implications

Although behavior and cognitive-behavioral theories have much to add to our knowledge of kleptomania, research regarding kleptomania is still in its early stages. Few behaviorists appear to be investigating or treating kleptomania, as such, the bulk of the research has occurred in the area of prevalence estimates and biological etiology and treatment of kleptomania. Historically, kleptomania has been considered a disorder mainly seen in white, upper- and upper middle-class women. It is possible that the current criteria for kleptomania only capture a limited segment of the population (e.g., upper middle class, white women) and ostensibly ignores others that may be suffering from kleptomania, but instead are labeled as criminals (e.g., lower SES, males). Therefore, we suggest that researchers continue to examine the characteristics of those diagnosed with kleptomania, while not constraining themselves to the current, commonly accepted criteria. Including kleptomania in future Catchment or large population studies can help to provide more information about the disorder in an empirical, less self-selected manner. Moreover, although psychotropic interventions have shown some success, to date cognitive-behavioral interventions appear credible, effective, and safer, due of their lack of side effects, and thus should be considered the first line of treatment for kleptomania (Antonuccio, Burns, & Danton, 2002).

The idiographic nature of behavioral interventions, combined with the nomothetic nature of behavioral principles (e.g., Haynes & O'Brien, 1990), makes behavioral and cognitive-behavioral interventions highly advantageous for individuals struggling with kleptomania behaviors. Behaviorists have a powerful etiological and treatment theory but only a small amount of evidence currently exists in the published literature. Future research should continue to delineate the use of a functional analysis and assessment in the treatment of kleptomania, providing more detailed guidance for clinicians and researchers in the field.

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