Study on the unexplainable diagnosis kleptomania

ASSIGN BUSTER

From a young age, we are taught to play nice, share with others, and not take possessions that don’t belong to ourselves. As we get older, we learn self-control, earning our keep, and protect our valuables from others. However, for some the moralistic guidelines, fear, embarrassment and guilt are not enough to prevent stealing from occurring daily.

The news is constantly broadcasting crimes of shoplifting, burglary, larceny, identify theft, robbery, and even plagiarism. These acts are all deliberate, whether spontaneous or planned, that involve taking something for personal or financial gain (Taylor, Kelly, Valescu, Reynolds, Sherman, & German, 2001). Although these crimes are easily understood and rather common, another type of stealing, kleptomania, presents an entirely different perspective.

Some individuals use the terms kleptomania and shoplifting synonymously. The National Association of Shoplifting Prevention found that one in every eleven adult have shoplifted at least once in their lifetime. They also found that more than thirteen billion dollars worth of goods are stolen from retailers in the United States each year (Grant, Odalaug, Davis, Kim, 2009). Roughly 0-8% of all shoplifters have kleptomania (Dannon, 2002). Although they share common characteristics, kleptomania is a much more relentless and atypical disorder.

Around for over two centuries, kleptomania is a distinct psychiatric disorder yet it remains poorly understood and unrecognizable to many clinicians. It is believed to affect only . 06 percent of the population. Although little is known about this disorder, kleptomania is a serious disorder, which causes

functional impairment. It is highly correlated with psychiatric hospitalizations and suicidal ideations (Grant & Kim, 2003).

Similar to other types of stealing, kleptomania is an impulse control disorder. Individuals with this mental disorder are unable to resist urges to engage in activities that could be harmful to themselves or others. The manifestation of kleptomania can occur across all age groups, but the mean onset is twenty years old (Dannon, 2002). It is different from other types of stealing in that these individuals do not steal for personal or monetary gain, but rather for leisure (Dannon, Aizer, & Lowengrub, 2006).

According to the Diagnostic and Statistical Manual IV, “ Kleptomania is the recurrent failure to resist impulses to steal items even though the items are not needed for personal use or for their monetary value. To be diagnosed the following five diagnostic criteria must be met: a rising tension immediately before the theft, pleasure or relief upon committing the theft, the theft is not motivated by anger or vengeance, or caused by a delusion or hallucination, and the behavior is not better accounted for by a conduct disorder, manic episode, or antisocial personality disorder. The objects are stolen despite the fact that they are typically of little value to the individual, who could have afforded to pay for them and often throws them away or discards them (American Psychiatric Association, 2000).”

Kleptomania is believed to affect two to three times more women and be related to menstruation and premenstration periods (Dannon, Aizer, & Lowengrub, 2006). It typically coexists with depression, anxiety, mood, chemical dependency, and eating disorders. Kleptomania can also coexist

with major depression, panic attacks, social phobia, anorexia nervosa, bulimia nervosa, substance abuse, and obsessive-compulsive disorder (Dannon, Aizer, & Lowengrub, 2006).

Kleptomania is linked with continual failed attempts to stop stealing. It may be specific to certain objects or settings. It is a solo act, where no collaboration is performed with others. The individual may steal from public places, stores, supermarkets, or from friends and family members. The items they steal typically have no value to them. They often secretly

donate, give away, or return the items they steal (Kleptomania, 2009).

Alike to other studies, researchers Grant and Kim found that most individuals with kleptomania steal household goods followed by groceries. Ironically, the least likely items they are to steal are books and music. The majority of participants reported stress and anxiety as being the cause of their stealing and sights and sounds as their least likely trigger. The large majority of these individuals claimed they resist the urge of stealing by thinking about getting caught. The least amount of participants admitted that shopping when stores are busy prevents them from resisting their urges to steal (Grant & Kim, 2002).

Although little is known about the etiology of kleptomania, various researchers believe it has a genetic component that may be transmitted among relatives (Grant & Kim, 2002). Some researchers believe it may be linked to the product of serotonin in the brain (Dannon, 2002). Others believe the onset is associated with head trauma, frontal lobe damage, dementia, and hypoglycemia (Dannon, Aizer, & Lowengrub, 2006).

Symptoms of kleptomania often originate between late adolescence and early adulthood. In rare cases, it can begin as early as childhood or as late as adulthood (Kleptomania, 2009).

Risk factors play a significant role in the progression of kleptomania. Individuals that have blood relatives with kleptomania, mood disorders, addictions, obsessive compulsive disorder, or excessive life stressors are at a significant risk for developing kleptomania (Dannon, Aizer, & Lowengrub, 2006). The preceding studies provide added support.

Grant and Kim performed a study in 2002 to examine the similarities of the onset and family history of kleptomania. Grant found that the participants reported an average onset of sixteen years. However, most individuals were not diagnosed with their disorder until roughly six years from onset and symptoms were found to last twenty-one years on average. The study found that the only predictor of developing kleptomania in one year of onset was a family history of prior psychiatric illness. Nevertheless, little is known about the biological aspect of kleptomania; therefore, it warrants further evaluation (Grant & Kim, 2002).

A second study based on gender related differences in individuals seeking treatment for kleptomania offers further analysis. The study found that both men and women diagnosed with kleptomania have relatively severe symptoms and functional impairments. In fact, individuals with kleptomania had three times greater symptoms than those reported in pathological gambling, twice of those found in individuals with post traumatic stress disorder, and one and a half times those reported in substance abuse

disorders. The intensity of the symptoms were comparable to those who are diagnosed with obsessive compulsive disorder and major depressive disorders (Grant & Potenza, 2008).

The study went on to find that women with kleptomania were more likely to be married (47. 1%), begin shoplifting at a later age (20. 9 years old), have comorbid disorders of depression (55. 6%), steal house-hold goods from stores (60. 35), and hoard items they stole (50%). Fewer men were found to be married (25. 9%), and their onset of stealing occurred earlier (14 years old). Men reported having more comorbid impulse-control disorders (51. 9%), stealing from electronic-goods stores (48. 1%), and giving items away (40. 7%). Lastly, women rated the sight of an item (38. 2%) as their trigger for stealing, while men rated anxiety/stress (37. 0%) as their leading motive for stealing. The lowest rated trigger for both men and women was low self-esteem (Grant & Potenza, 2008).

A third study, which focused on one’s perception of symptoms, provides further investigation on the characteristics of kleptomania. There is no question that an individual with kleptomania experiences urges to steal and shame thereafter. However, this study found a correlation between the intensity of symptoms and perceived stress. The more powerful and plentiful the symptoms are, the more kleptomaniacs’ are to view their lives as erratic and unmanageable. The sooner treatment is offered to individuals with kleptomania, the less their perceived stress will be. As a result of reducing their perceived stress, they will reduce the actual stress in their lives and live healthier lifestyles (Grant, Kim & Grosz, 2003).

Although only . 06 percent of the population is reported to have kleptomania, it is thought to be under reported (Dannon, Aizer, & Lowengrub, 2006; Kohn, 2006). Grant performed a study that identified rates as high at 7. 8 percent (Grant & Kim, 2002). Individuals with kleptomania experience a plethora of symptoms that are unique to themselves. After recognizing the symptoms, individuals with kleptomania should determine why they are engaging in these high risk behaviors.

Why individuals steal is based on a variety of objectives and motives. Young children steal items because they lack an understanding. They cannot comprehend that items cost money and in order to receive items they need to pay for them. As they approach school age, children are taught right versus wrong and that they should not take things that do not belong to themselves. As children approach adolescents, they should fully understand they cannot take things without asking permission or paying for the items. At the point of adolescents and adulthood, individuals know stealing is wrong, yet many still engage in this criminal behavior. Peer pressure, modeling, financial difficulties, a lack of self-control, trying to feel a void, suppress other tribulations or defiance could all be functions of stealing (Tynan, 2008)

The function of kleptomania is unique from all other forms of stealing. Individuals with this disorder steal, not for personal or monetary gain, but rather for the thrill. These individuals are typically financially well off and see no value in the items they are taking (Kleptomania, 2009).

Self-report measures can be a useful technique to identify the antecedents and consequences of the behavior and the correlations with other disorders.

The Beck Depression Inventory-II and the Beck Anxiety Inventory can help identify the harshness of each co-morbid disorder. Clinical discussions and evaluations regarding the Abstinence Violation Effect could also help in identifying a person’s perception of the loss of control over their behaviors (Kohn, 2006).

Even though these individual steal for the thrill, they experience many legal repercussions (Grant, Odalaug, Davis, Kim, 2009). Alike to stealing, kleptomaniacs are aware stealing is wrong and senseless. They usually do not take into account the repercussions of the crime before committing it unless there are immediate possibilities of arrest. Before the initial act they feel tension and fear being apprehended. During the crime, they feel gratitude and pleasure. Following the crime they experience feelings of guilt, shame, and depression (Kleptomania, 2009). The following studies offer additional support.

Out of the one hundred and one adults with kleptomania studied, 74% reported being stopped by store security on at least one occasion, 69% reported being arrested, 37% reported being arrested but not convicted, and 21% of the participants reported being convicted with incarceration after their conviction. The remaining 27% of the participants reported they were never stopped by store security or arrested (Grant, Odalaug, Davis, Kim, 2009). The results indicate the kleptomania is a pathological behavior that results in significant legal repercussions, personal distress, and functional impairment (Grant, Kim, McCabe, 2006).

A second study found that 64%-87% of individuals with kleptomania have been arrested at some point in their life. It went on to mention that individuals who have kleptomania have often been arrested multiple times, with some reporting over 10 lifetime arrest. They found that 15-23% of individuals seeking treatment have spent time in jail as a result of shoplifting (Grant & Kim, 2002).

Since arrest and incarceration takes an emotional toll on these individuals, clinicians need to place a significant emphasis on behavioral and emotional consequences (Grant, Odalaug, Davis, Kim, 2009). Shoplifting most commonly begins in late adolescence or early adulthood, and for most people with kleptomania, it appears that it may take several years to meet the DSM-IV criteria for kleptomania (Grant, Odalaug, Davis, Kim, 2009). As a result, early recognition and prevention efforts for individuals who are caught shoplifting may prevent the development of kleptomania.

Given that individuals who have kleptomania rarely seek medical assistantance, this disorder is difficult to diagnose. Physical and psychological evaluations are performed to make sure nothing is physically wrong with the individual causing the triggering of symptoms. Preliminary psychological evaluations may detect signs and symptoms of poor parenting, conflicts in relationships, or acute stressors (Kleptomania, 2009). It is difficult for medical doctors to diagnose kleptomania because these individuals may have patterns of stealing restricted to specific objects and/or events. When kleptomania is diagnosed it typically occurs when individuals seek treatment for other disorders such as: depression, bulimia, emotional instability, or dysphoria (Grant & Kim, 2002).

Since there is no specific test to determine if an individual has kleptomania or not, a list of questions and situations are implemented to evaluate the responses of the individual. First, the individual would be asked questions regarding their medical history to see if they have any other diagnosis. Next their family history, consumption of alcohol and drugs, and current medications would be evaluated. Subsequently, they would be asked more personal questions. Common questions asked determine at what age the first experience of stealing occurred, how often the feelings occur, have they ever been caught, what types of items do they steal, do they need these items, who do they steal from, and what do they do with the items they steal. Additional questions may revolve around the triggers that urge them to steal and how stealing affects other areas of their life (Kleptomania, 2009).

After a clinician assesses the physical and psychological evaluation and clinical interview, they would compare their client's responses to that of the DSM-IV. As previously mentioned, in order to be diagnosed with kleptomania, an individual must possess the following symptoms: an inability to resist urges to steal objects that are not needed for personal or monetary gain, the feelings of increased tension leading up to an event, the feelings of relief and gratification proceeding the theft, not committed because of revenge or anger, not performed during hallucinations or delusions, and not related to manic episodes, bipolar disorder, or other mental health disorders (American Psychiatric Association, 2000). In order to be diagnosed as having kleptomania, the individual must meet all the criteria.

Currently, psychiatrists are using the Structured Clinical Interview for the DSM-IV (SCID) to identify individuals with kleptomania. It is a widely used diagnostic instrument, but it lacks specific assessments to successfully identify all cases of kleptomania. Therefore, Grant, Kim, and McCabe developed a comparable Structured Clinical Interview for Kleptomania (SCI-K). During their study, 112 individuals with multiple disorders, seeking psychiatric outpatient therapy, were administered the interview. The SCI-K took on average twenty minutes to administer and was well received by all the participants. Consequently, the Structured Clinical Interview for Kleptomania was found to have excellent reliability and validity in diagnosing kleptomania in these participants. Although this study needs to be replicated with a larger and more diverse population, it shows much promise (Grant, Kim, and McCabe, 2006). Based on the results of this study and future studies to come, kleptomania may one day be easier to distinguish and treat.

Once the disorder is evaluated and confirmed by a clinician, treatment and coping methods are implemented. Although treatment is needed for individuals with kleptomania, most fail to receive treatment and the pharmacological treatment is limited due to the lack of controlled trials (Dannon, Aizer, & Lowengrub, 2006). As a result, psychiatrists have little scientific data on which to base their recommendations.

Although there are few studies and limited research, there are a plethora of medications and therapies used to help individuals with mental health disorders. The five most common types of medications are antidepressants, mood stabilizers, benzodiazepines, anti-seizure, and addiction medication.

Antidepressants are the most common type of medication used to treat kleptomania (Kleptomania, 2009; Dannon, 2002; Dannon, Aizer, & Lowengrub, 2006). They consist of selective serotonin reuptake inhibitors that help to reduce impulses to steal. These medications have also been found to successfully treat other impulse control disorders such as trichotillomania, pathological gambling, binge-eating, and compulsive buying (Dannon, 2002). Antidepressant medications include: fluoxetine, fluoxamine, paroxetine, naltrexone and (Kleptomania, 2009).

Fluoxetine has been cited by many studies as being the most beneficial to treat the symptoms associated with kleptomania. Fluvoxamine was the second most successful drug in treating symptoms associated with impulse-control disorders when psychodynamic and therapy failed. When used in combination with other medications for an average of three months, paroxetine was found successful in reducing urges to steal. Lastly, naltrexone, the most recent drug tested, was found to reduce associated symptoms of kleptomania when used in combination with paroxetine (Dannon, 2002).

Mood stabilizers are the second type of medication that could be useful in treating kleptomania. The roles of these medications are to even out mood so that stealing is not triggered. The most common mood stabilizer used to treat kleptomania is lithium (Kleptomaniam 2009).

Following, Benzodiazepines are used to control the central nervous system. Their effectiveness varies, but caution needs to be taken for these drugs can be very habit forming if taken in high doses or over a long period of time.

These tranquilizer type medications include clonazepam and alprazolam (Kleptomania, 2009).

The fourth group of medication used to treat kleptomania is anti-seizure medications. This type of medication is not only used to treat seizures, but have also been found to benefit certain mental health disorders. Anti-seizure medications include topiramate and valproic acid (Kleptomania, 2009).

Lastly, addiction medications are used to reduce the symptoms associated with kleptomania. These medication block parts of the brain that feels urges to steal and pleasure when stealing (Kleptomania, 2009). All of the previous listed medications are possible treatments for kleptomania, but should not be used alone.

Grant and Kim conducted a study to test this theory. They found that 60% of the individuals in their study attempted to get help at some point in their life for kleptomania. Since kleptomania is difficult to diagnose, physicians prescribed anxiety and depression medications to treat the symptoms that these individuals demonstrated. Of the medications prescribed, no individual felt a decrease in their kleptomania urges and symptoms. This study supports the previous claim, stating that medication alone is not proven to reduce the symptoms of

kleptomania (Grant & Kim, 2002).

Therapy should be used in accompaniment of medication to relieve symptoms associated with kleptomania. The direction of therapy for kleptomania typically revolves around impulse control and accompanying

mental disorders. However, there is a discrepancy between which therapies are used most frequently and which are most beneficial. Therapies typically implemented are cognitive behavioral therapy and psychoanalytic therapies such as covert sensitization, aversion therapy, and systematic desensitization. According to a study by Antonuccio, Burn, and Danton, cognitive-behavioral interventions are the most plausible and efficient treatment for kleptomania and have the least number of side effects (Antonuccio, Burns, & Danton, 2002). The Mayo Clinic concurs mentioning that cognitive behavioral therapy has shown much success in relieving the symptoms related to kleptomania. In addition, they mention that cognitive behavioral therapy helps individuals with kleptomania identify unhealthy negative thoughts and behaviors and replace them with healthy positive associations (Kleptomania, 2009).

According to another study conducted by Dannon, he states that cognitive-behavioral therapy has mostly replaced psychoanalytic and dynamic approaches (Dannon, 2002). He found that covert sensitization, aversion therapy, and systematic desensitization have proven beneficial for individuals with kleptomania. Covert sensitization encourages the individual to picture themselves stealing and then being caught stealing. Aversion therapy encourages the individuals to engage in painful techniques to replace their urges of stealing. Systematic desensitization promotes relaxation techniques to control the urge to steal (Kleptomania, 2009).

Aside from pharmacological, cognitive-behavioral, and psychoanalytic therapies, the Mayo Clinic offers additional coping and support strategies. Individuals with kleptomania need to educate themselves on the factors,

treatment, and triggers of kleptomania and stick to their treatment plan. The more precise they are in following their medication guidelines and attending their therapeutic sessions, the better off they will be at fighting this disorder. They need to find out their triggers and find appropriate ways to manage their urges. Individuals with kleptomania could benefit from relaxation and stress management techniques. Meditation and yoga could help them focus their energy in a positive way. Ultimately, they need to stay focused on their goal (Kleptomania, 2009). Kleptomania is a serious disorder and with it comes many drawbacks. If all else fails, there are support groups based on twelve-step programs. Being part of a group and understand " You are not alone" has been proven to benefit many individuals with mental disorders (Kleptomania, 2009).

Similar to many impulse-control disorders, it is not uncommon for individuals with kleptomania to relapse. It is essential that individuals closely follow their treatment plans. If they feel triggers and urges to steal, they need to contact their mental health provider, a reputable support group, or if on probation, let their probation officer know (Kleptomania, 2009).

The prognosis for kleptomania is fair. The best preventative measure is correcting acts of

stealing in childhood. When parents first recognize their child is stealing, they should discuss and explain why stealing is wrong. As children begin to understand why stealing is wrong, they should be taught ownership and appropriate ways of getting items without taking them. By modeling appropriate behaviors and praising children for their honest behavior,

stealing could be corrected before it becomes overwhelming and unmanageable (Zolten & Long, 2006).

Research has found that amongst shoplifters, individuals who experience constant, universal feelings of embarrassment and guilt are more likely to continue stealing. Individuals who experience situation-specific feelings of humiliation are more likely to discontinue their behaviors associated with stealing (Kohn, 2006).

Early detection and treatment are the best defenses to help symptoms of kleptomania become manageable (Kleptomania, 2009). If left untreated, kleptomania can lead to relentless psychological, legal, and monetary problems (Kleptomania, 2009). Individuals may live in constant guilt and humiliation. As a result of this disorder, individuals can experience arrest, imprisonment, depression, alcohol and substance abuse, eating disorders, anxiety, compulsive gambling or shopping, suicidal ideations, and social isolation. The Mayo Clinic suggests that, " A healthy upbringing, positive relationships, and a manageable way to deal with acute stress may lower the prevalence of kleptomania and coexisting disorders" (Kleptomania, 2009).

Kleptomania has been around for nearly two decades, but still little is known about the causes, diagnosis, and treatment of such a severe mental disorder. For years many clinicians believe that the onset of kleptomania was largely due to a family history, the presence of other psychological disorder or unmanageable life stressors. Clinicians continually used a widely respectable diagnostic tool, the Structured Clinical Interview for the DSM-IV (SCID), to identify symptoms related to kleptomania. Once they were able to

recognize associated symptoms, they perpetually prescribe medication to reduce and alleviate the symptoms.

With the advancements in technology and vast psychological studies, the causes, diagnosis, and treatment of kleptomania have been questioned. A shift in research has drifted away from the traditional genetic characteristics and directed their focus on head injuries and brain pathological as being possible causing of kleptomania. Researchers Grant, Kim, and

McCabe opened doors to a more effective and efficient diagnostic tool doubting the reliability and practicality of the Diagnostic and Statistical Manual. Study after study, found the fewer side effects and the more manageable approach associated with cognitive behavioral therapy has lead to greater success in treating symptoms related to kleptomania. The point being, more research and further investigation into the etiology, biology, diagnostic measures and treatment is warranted. Hopefully in the years to come, kleptomania will no longer be known as the unexplainable disorder, but rather one that has answers.