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Comparing the Best used Therapies for Clinical Disorders – Gender Bias among Kleptomaniacs

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Abstract

According to the American Psychology Association (2000), "kleptomania is an impulse control disorder characterised by a recurrent failure to resist encourages to steal things that are not needed for personal use or that have no monetary value (Criterion A). The individual is under increasing pressure just before the theft (Criterion B), but then enjoys elation, satisfaction, or relief afterward (Criterion C). The act of stealing is not motivated by vengeance or fury; it is not the outcome of hallucination or delusion (Criterion D); and it is not better explained by a behavioural disorder, a manic display, or a temperament that is anti-condition (Criterion E). It has long been believed that kleptomania is primarily a disease of affluent, Caucasian women. Very few studies have focused on males, persons of colour, or people from disadvantaged backgrounds, with a few significant exceptions. Criterion A may be an artefact of studying mostly affluent, white females, since it suggests that only individuals who can typically afford the stolen things may be seen as demonstrating kleptomania behaviour" (Cautela, 1966). People with kleptomania don't steal due to a lack of character traits like restraint or morality. Instead, it's a disorder in which sufferers lack the willpower to resist the urge to steal. There is a strong correlation between kleptomania and psychological distress. Many individuals try to make up the difference by reselling or donating the items in question or by deferring payment until a later date.

Keywords: Kleptomania, cognitive behavior therapy, disorder, gratification, relief, committing, theft, hallucination, ethnic minority, delusion.

Introduction

To reduce the personal and social costs of kleptomania, there is a need for education about the condition, compassion for individuals who suffer from it, and in-depth study into available treatments. Kleptomania has been a hotly contested topic since it was first used as a diagnostic word in the psychiatric vocabulary in 1838. It is debatable if it reflects a medical condition or a kind of unlawful and irregular behaviour that is more comparable to sociopathy. "Along with trichotillomania (compulsive hairs pulling), pyromania (compulsive fire lighting), and intermittent explosive disorder, kleptomania is included under the impulse control disorders not otherwise classified in the Diagnostic and Statistical Manuel of Mental Disorders (Cautela, 1966), Fourth Edition (DSM-IV). Kleptomania is characterised by a persistent inability to control urges to steal things that are not necessary for one's own use or for their financial worth, according to the DSM-IV. Like other disorders of impulse control, kleptomania is characterised by the need to engage in an action that, although enjoyable at the time, results in considerable suffering and dysfunction." This urge is anxiety-driven. It is important to differentiate between

kleptomania and antisocial personality disorder (Beck et al., 1988). Kleptomania is distinguished from the latter disease by the presence of shame and regret and the absence of theft objectives including monetary gain, personal usage, impressing someone, or stealing to fund a drug habit.

Defining Kleptomania

It is often described as a mental condition that results in an overwhelming impulse to steal that a person is unable to control (Abelson,1989). Stealing is a persistent neurotic need, particularly when there is no ulterior motivation. According to analysis of the data, kleptomania affects people of all socioeconomic backgrounds and seems to affect women more often than males. Up to 45% of patients are female.

Psychology has yet to reach an agreement about the causes and progression of kleptomania. The scarcity of research on the illness and the fact that kleptomania seems to be a relatively uncommon disease, with a projected incidence rate that ranges from 0.6 to 0.8%, make this situation worse, even if it is partly attributable to the normal theoretical disparities in viewpoint. However, when clinical populations are looked at, rates that are as high as 7.8% have been discovered. According to several studies, anything between 0% and 25% of shoplifters may have kleptomania (Bradford & Balmaceda, 1983). Others claim that kleptomania might be more prevalent than previously believed, but that it goes undiagnosed because of prejudice, concealment, or limited diagnostic criteria (Fullerton & Punj, 2004). Yet some people like to categorise kleptomania as an additional aspect of an obsessive condition, seeing it as a component of the affective spectrum disease. Finally, like compulsive gambling, some experts see kleptomania as an addictive spectrum condition. It is uncertain if kleptomania is a distinct yet co-morbid issue or an illness that is often diagnosed with many of the aforementioned other diseases.

Symptoms of kleptomania

The main symptom of involves one or more of the following:

a) The things aren't taken because they're needed or because they're valuable.

b) Before stealing, a person experiences stress or suspense, and shortly after, they feel joy, relief, or other good feelings.

c) After the “pleasant feelings pass, most kleptomaniacs experience remorse, humiliation, or regret.”

d) An individual with kleptomania steals unintentionally and acts alone. Kleptomaniacs often conceal their condition from their partners.

Additionally, first-order relatives of people with kleptomania have higher rates of affective as well as substance use disorders. There are also reports of social isolation, cognitive dysfunction, and high levels of perceived stress, all of which are linked to an increase in the frequency or intensity of kleptomania-related behaviours.

Behavioral Assessment Models

Psychoanalytic explanations of the aetiology of kleptomania have mostly been replaced by behavioural and cognitive-behavioral models, which are often complimentary to biological models. A psychobiological model of aetiology that blends neurochemistry with the behavioural theories of both operant and classical conditioning has been proposed by certain researchers (Abelson,1989). They contend that some people develop conditioning to respond to certain signals or stimuli (such as wanted objects) or feel drawn to stealing due to the pleasurable feeling it produces, both of which lead to alterations in the brain. Without the necessity for a precise diagnosis, this is generally complimentary to the behavioural and cognitive etiological explanations of kleptomania.

In reality, the use of functional evaluations, analyses of function, and operationally defined behaviours, which considerably diminish the need to depend on a single etiological model or precise diagnosis prior to initiating therapy (Hickey, 1998), is a particular strength of the cognitive and behavioural models. Kleptomania is frequently thought of as a collection of unwanted behaviours brought on by operant and response shaping, behavioural chaining, distorted thinking, and inadequate coping mechanisms. Once the underlying causes and perpetuating factors are understood, kleptomania can be treated within a behavioural framework.

The behavioural framework is the best tool for understanding how kleptomania behaviours emerge and are

maintained. Assume, for instance, that someone takes a certain object that has a strong linked meaning due to repeated pairings in the past (such as via commercials, knowing about the person's background, etc.). The acquisition of that physical thing, a sense of fulfilment, or any other pleasant emotion positively reinforces the stealing behaviour. Conversely, the behaviour is negatively reinforced when worry or other bad thoughts and emotions that preceded the theft lessen or vanish entirely. The risk that the behaviour will occur again is raised if this person receives little to no punishment or adverse consequences (Tibbetts, 1997). Stronger antecedents or signals inevitably become contingently associated with the behaviour as it persists, forming a powerful behavioural chain. Furthermore, if reinforcement of the stolen behaviours persists in the absence of any kind of deterrent consequences, ever more brazen and audacious stealing behaviours may develop.

Individuals with kleptomania eventually depend on stealing to get through difficult times and painful emotions, which serves to sustain the behaviour (by positive and negative reward) and reduce the number of accessible alternative coping mechanisms (McNeilly & Burke, 1998). The environment or the mind, such as with cognitions, may serve as both antecedents and consequences, according to cognitive-behavioral theory. The antecedent cognitions of a client were documented by certain psychologists. These cognitions included ideas like "I'm smarter than other people and can get away with it," "they deserve it," "I want to show to myself that I can do it," and "my family de- serves to have better things." Additional antecedents earlier in the behavioural chain, such as concerns about family, money, and job pressures, or depressive moods, all served as the catalyst for these thoughts. "Maintaining" cognitions, such as "score one for the 'little man' against the big companies" and "I knew I could get away with it," added reinforcement to stealing behaviours and included sentiments of pride. Even while emotions of regret were often felt after such thoughts, they arrived too late in the operating sequence to be effective punishment.

Behavioral and Cognitive-Behavioral Treatment Model

There haven't been any sizable controlled therapy trials for kleptomania to yet, despite the fact that medication is commonly used to treat many of the diseases that occur together with kleptomania behaviours. With varied degrees of success, SSRIs, antiepileptic drugs, and opiate antagonists have all been employed to treat kleptomania. However, pharmaceutical therapies typically come with unwanted side effects, which may discourage people from taking the prescription as prescribed. Pharmacological kleptomania therapy advocates retain an idiographic approach to kleptomania treatment, arguing that treatment should start with a knowledge of the specific subtype of kleptomania (Dannon et al., 1999).

Fortunately, an increasing amount of research points to the efficacy of using a number of basic behavioural strategies and cognitive-behavioral methods to treat kleptomania as well as co-occurring behaviour issues (Grant & Kim, 2002). These strategies include covert sensitization, shaping, behavioural chaining, solving issues, cognitive restructuring, as well as homework. Each of these strategies is implemented, formatted, and structured specifically for each person based on a comprehensive functional study. For instance, kleptomania-specific consequences (such as being arrested or going to jail) can be used as the aversive event in covert sensitization, which is a highly effective method of "pairing the imagined repercussions of stealing in the desire to steal" (McElroy et al., 1995). In this method, people speak aloud about the event in vivid detail while allowing their nervousness to build up until they reach a set end-point, such as serving time in prison or winning their case in court. The expression of thieving behaviours may be reduced via repeated pairings of unpleasant imagined outcomes, but only if they are combined with reward of proper behaviour.

Behavioural or cognitive-behavioral treatments are distinguished by features such as the scientist-practitioner paradigm and the systematic evaluation of therapy effectiveness (even if it mainly relies on self-report) (Haynes et al. 1997). A flexible self-report measure, Improvement Scaling has been used effectively in the evaluation and control of kleptomania. It is designed to measure mental shifts, actions, and desires as a result of therapy, and its psychometric properties seem appropriate. Thus, Improvement Scaling allows for the assessment of an individual's early treatment gains. Both the BDI-II and the BAI may be used to track changes in a person's level of sadness and anxiety.

For those who struggle with kleptomania behaviours, behavioural and cognitive-behavioral therapies are quite helpful due to the idiographic character of behavioural interventions and the nomethetic character of behavioural principles. Although behaviourists have a strong aetiology and treatment theory, there is presently very little supporting data in the scientific literature. Future studies should continue to outline how to treat kleptomania

using a functional analysis and evaluation, giving doctors and investigators in the area more precise instructions (Kanfer & Saslow, 1965).

There is evidence that points to some possible causes:

a) Neurotransmitters are specialist chemicals that assist your brain connect with one another and regulate various processes. Some people who experiment with medicines that alter neurotransmitters in the brain develop a compulsive need to steal. Since this is a rare occurrence, further investigation into its cause is warranted.

b) For some professionals, kleptomania isn't a mental illness in and of itself, but rather a sign of another condition. Anxiety, depression dietary addictions, and substance use disorders are common in people with kleptomania. They have a higher suicide and self-harm rate.

c) Genetics: It is unclear if kleptomania may run in families or whether a family history of the disorder enhances one's risk of acquiring the disorder. Although persons with kleptomania often report a history of other mental health issues in their families, such as anxiety, mood, and substance abuse disorders, this is not definitive evidence that kleptomania is hereditary.

Some situations may be the consequence of abuse, neglect, or trauma experienced as a youngster. According to this hypothesis, theft might stand in for recovering lost childhood possessions.

5 requirements are required to be met for patient diagnosed with kleptomania:

a) The stolen objects weren't taken because someone required them or needed anything important to barter for them or exchange for money, despite several fruitless efforts to stop the theft.

b) Feeling tense or eager before committing a theft.

c) Experiencing "high" or favourable feelings just after stealing, like relief or joy.

d) “The act of theft is not motivated by an emotional reaction (done out of retaliation or anger) and is not taking pace as a result of a delusion or a hallucination.”

Tests Conducted to Diagnose Kleptomania

Tests may be suggested by medical professionals to rule out further problems. The best person to inform you if and why tests are advised for your particular instance is your healthcare practitioner.

Management of Treatment

“There is no established method for treating kleptomania, and there is little data on the most effective therapies. This is partially due to the fact that persons with kleptomania seldom seek therapy on their own, making it more difficult to investigate potential therapies” ((Larimer et al., 1999). 2 therapies major groups are:

Medication: Opioid inhibitors, which block the psychotropic properties of opioid drugs, are often used as a first therapy. Their usefulness is supported by research. These medications take away the high one gets from stealing, which might help someone control their impulses. Other possible therapies include antidepressants, seizure medications, or lithium (Antonuccio et al., 2002).

Psychotherapy, also known as behavioural therapy or mental health treatment, involves working with a patient to identify problematic patterns of conduct and developing plans for altering or eliminating them. Many different types of talk therapy, such as hypnosis, therapy in groups, and cognitive behavioral therapies (CBT), are used to treat kleptomania. General practitioners have a unique chance to test for this condition, assisting in the prevention of symptoms that are usually lifelong. Inserting a neutral inquiry regarding any current or previous legal issues during the social history gathering may be enough to provide clues to the diagnosis and trigger a referral to a psychiatrist. If you have "recurrent, unsettling cravings to steal things that are not yours," (Antonuccio et al., 2002). ask further questions. There is a strong need for research comparing different psychotherapy and drug treatment modalities for this disorder (Larimer et al., 1999). To compare the relative efficiency of different medicines, especially serotonergically active ones that have been shown beneficial in treating other impulse control disorders, double-blind, placebo-controlled studies should be carried out.

The data point to a predominance of females, a young age at commencement, and most often a continuing course. Other gender-based variations are not seen. As seen by the high rates of arrest and jail, kleptomania may have severe implications on one's personal and professional life as well as major legal repercussions. Because kleptomaniacs seldom seek psychiatric treatment for the illness.

Conclusion

Even while behaviour and executive functions-behavioral theories have a lot to teach us about kleptomania, research on the disorder is still in its infancy. The majority of research on kleptomania has focused on biological aetiology, therapy, and prevalence estimates since few behaviourists seem to be studying or treating the condition. The condition of kleptomania has traditionally been associated with white, upper- or upper middle-class females. It's likely that the existing definition of kleptomania only encompasses a small portion of society (for example, middle-income, wealthy white women) and seemingly excludes those who could be experiencing the disorder but are instead classified as criminals (for example, lower SES, males). As a result, we recommend that researchers keep looking into the traits of people who have been diagnosed with kleptomania without being limited by the present, widely used criteria. Future Catchment and large population studies that include kleptomania might contribute to the development of more empirical, less self-selected knowledge on the condition. Furthermore, while pharmacological approaches have had some success, to date, because to their lack of side effects, cognitive-behavioral interventions look believable, successful, and safer and should be thought of as the first line of therapy for Kleptomania.

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