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Treating kleptomania: cross-cultural adaptation of the Kleptomania Symptom Assessment Scale and assessment of an outpatient program

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Abstract

Background: Kleptomania is characterized by repetitive stealing and has severe consequences for patients. Stigma, a lack of standardized therapy and a limited number of assessment tools hinder advances in treatment. This study provides preliminary data on the Portuguese-language version of the Kleptomania Symptom Assessment Scale (P-K-SAS) and preliminary data on an outpatient program.

Methods: Experts in the field analyzed an initial P-K-SAS version, produced through translation/back-translation, in order to arrive at a final version. Eight patients currently on cognitive-behavioral therapy (CBT) and 10 patients under maintenance CBT were initially assessed, then re-assessed 6 months later.

Results: The mean P-K-SAS score was higher among patients initiating CBT than among those under maintenance CBT (21.1 ± 8.0 vs. 11.3 ± 7.5 ; Mann-Whitney $U = 15.0$, $P = .024$). The final version of the P-K-SAS presented excellent reliability (Cronbach's $\alpha = 0.980$; inter-item correlation, $0.638-0.907$).

Conclusions: The P-K-SAS presented solid psychometrics and seems ready for use in assessing the effectiveness of treatments for kleptomania. The findings suggest that kleptomania patients need follow-up treatment that goes beyond the traditional 12-session structure.

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1. Introduction

Kleptomania is an impulse control disorder characterized by recurrent failure to resist the impulse to steal objects, which are unnecessary for personal use, regardless of their monetary value. Patients report a subjective feeling of increased tension before the act, followed by pleasure, gratification, or relief after its completion. The stealing is not committed with an intention to express anger or exact vengeance on third parties; does not occur in response to a delusion or hallucination; and cannot be

better explained by a behavioral disorder, a manic episode or antisocial personality disorder [1].

Clinically, kleptomania is difficult to assess. Patients often reject a diagnosis of kleptomania, perceiving their behavior more as an expression of a moral deviation than a treatable condition, complicating the process of seeking professional help. People affected by this disorder usually have an impaired quality of life, incurring significant losses in social, family and professional functioning, as well as serious legal problems [2], isolating themselves because of embarrassment and shame, which further complicates the treatment-seeking process [3,4]. There is evidence that the disorder is not as rare as has been believed [2,3,5,6]. Probably underdiagnosed, the true prevalence of kleptomania in the general population remains unknown, but it has been estimated around 0.6–0.8% [5]. The age at onset varies, typically being between the late teens

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and early adult life [5,7], although rare cases have been reported in older individuals [8]. Two thirds of all individuals diagnosed with kleptomania are female [5,6,8].

The treatment of kleptomania combines psychopharmacological and psychotherapeutic approaches. The use of psychotropic drugs for the specific treatment of impulse control disorders is promising [2,9–11], albeit incomplete, so far the use of prescription medications has mostly focused on the treatment of the psychiatric comorbidities frequently seen in kleptomania [6,7]. An 8-week double-blind controlled trial showed that naltrexone was superior to placebo in the treatment of kleptomania [2]. However, the short follow-up period in that study and the chronic nature of this disorder leave open the question of whether the positive effects observed are maintained in the long term.

Most of the studies focusing on psychotherapeutic treatment of kleptomania have been based on case studies, with the use of behavioral therapy, psychotherapy, psychodynamic and cognitive-behavioral therapy [3,8]. The cognitive-behavioral therapy techniques most often cited as beneficial in the treatment of kleptomania are systematic desensitization, aversive therapy and covert sensitization [12–16]. In the example of pharmacological studies, the treatment time required for stabilization of patients was not specifically investigated and varied considerably between studies. In addition, none of the studies involving psychotherapeutic interventions made use of a control condition for comparison.

In addition to the methodological limitations outlined above, there is as yet no international criterion for evaluating the various models of treatment for kleptomania. The scales developed specifically for this purpose—including the Kleptomania Symptom Assessment Scale (K-SAS) and Yale-Brown Obsessive Compulsive Scale Modified for Kleptomania [2,9,11,17]—are in English. The K-SAS [11] appears to be particularly suitable for large-scale application for future international multicenter studies because it is a self-report questionnaire and is brief. It was adapted from the Gambling Symptom Assessment Scale [9,18]. The psychometric properties of the K-SAS have been evaluated [11] with a Cronbach's alpha value of 0.93 and a positive correlation with the Clinical Global Impressions Scale ($r = 0.85$, $P < .02$), as well as with the Global Assessment of Functioning ($r = 0.81$, $P < .05$).

The current study aims primarily to describe the process of translation and cross-cultural adaptation of the original, English-language, K-SAS for use in Brazil. As a secondary goal, we aim also to describe the profile of outpatients, determining whether the duration of treatment has an influence on the symptoms of kleptomania, as evaluated by the Portuguese-language version of the K-SAS, designated the P-K-SAS.

2. Methods

2.1. Structure, translation and adaptation of the K-SAS

The K-SAS [11] is a self-report scale consisting of 11 items designed to measure symptoms of kleptomania experienced in

the last 7 days. The score for each of the 11 items ranges from 0 to 4 points, with a maximum total score of 44 points. Items 1–4, respectively, measure the average severity of, frequency of, duration of and level of control over the impulse (to steal, exclusively); items 5–7, respectively, measure the average frequency of, duration of and level of control over thoughts related to theft (excluding other thoughts); items 8 and 9 measure the degree of emotion experienced before and during the act of stealing; item 10 investigates the suffering caused by theft; and item 11 addresses the personal problems (relationship, financial, legal, employment, medical and health problems) caused by the act of stealing. A total score ≤ 11 indicates remission.

The cross-cultural adaptation of the K-SAS was performed based on the methodological guidelines proposed by Reichenheim and Moraes [19] and applied by Kachani et al. [20] and Conti et al. [21]. According to those guidelines, the modification of the original instrument must be done critically, considering the cultural aspects of the target population so that the general meaning can transcend the literalness of the terms [22,23] but maintaining the initial quality and characteristics of the instrument [24,25].

The adaptation was performed in six consecutive steps:

1. A translator proficient in English translated the original English-language version of the instrument into Brazilian Portuguese.
2. The Portuguese-language version was back-translated into English by one of the co-authors (NH), who is an English native speaker, maintaining the original structure of the instrument with regard to the number of items, wording of instructions and response options.
3. The Portuguese-language version underwent a technical revision, based on the evaluation of the semantic equivalence between the back-translated version and the original, emphasizing the pursuit of referential and general meaning of the terms and words used in the instrument [10].
4. The revised Portuguese version was submitted to the evaluation of 12 specialists in the area of mental health (psychiatry, psychology, nursing and nutrition) to assess the degree of understanding and clarity of each item. We asked each specialist to answer using an adapted verbal numeric rating scale [21,22,26], with the following guideline: "How much of what was asked did you understand?" Responses were based on the Likert scale: 0—I did not understand anything; 1—I understood just a little; 2—I somewhat understood; 3—I understood almost everything, but I was unsure of some things; 4—I understood almost everything; and 5—I understood perfectly and have no uncertainties. It was established that the responses 0, 1, 2 and 3 would be considered indicators of insufficient understanding, in accordance with Conti et al. [21]. After completing the questionnaire, the specialists were asked to specify which aspects were not understood and to identify any inadequacies of language.

5. The Portuguese version was further revised on the basis of suggestions made by the specialists consulted. Specifically, items 8 and 9, which, in the original instrument, inquire about excitement and tension, respectively, before and during theft, were modified. In their original form, these items request that if a theft has not occurred in the last week, the patient estimate the excitement that would have been experienced if the theft had actually been committed. The experts suggested the separation of each of these items into two parts: a first part asking if a theft had been committed in the previous week and a second to be answered if the patient answers the first question in the negative. An initial version of the P-K-SAS, containing this adaptation, was tested in 18 patients in treatment.
6. The psychometric data obtained from the application of the initial version was analyzed, and a final version of the P-K-SAS was arrived at. The final version was applied to the same group of patients 6 months later, although three of those patients had been lost to follow-up. The patients were asked to rate the instrument, adopting the same procedure and evaluation criteria employed by the specialists in step 4.

2.2. Participants

Patients who sought treatment for kleptomania were recruited from among those enrolled in the Impulse Control Disorders Outpatient Unit at the University of São Paulo Institute of Psychiatry, São Paulo—Brazil. The program is offered free of charge. Patients either seek treatment independently or are referred from other health care facilities; those meeting the criteria for a diagnosis of an impulse control disorder are enrolled. For the present study, we approached all patients who were in treatment for kleptomania ($N = 18$), eight initiating cognitive-behavior therapy (CBT), less than 20 sessions, and 10 patients in maintenance CBT, more than 20 sessions. All of the patients approached agreed to participate in the study and gave written informed consent.

We collected demographic data related to gender, age, ethnicity, marital status, level of education and employment status. To evaluate the clinical status of kleptomania patients, the P-K-SAS was used. Eighteen patients completed the initial version, which was evaluated for its psychometric validity. Six months later, the final version was applied to the same patients, except for three patients who were lost to follow-up.

2.2.1. The kleptomania outpatient program

The kleptomania CBT program involves 20 individual weekly sessions. This is referred to as the initial treatment phase, after which patients continue to receive treatment sessions at variable frequencies (every 2 weeks or monthly) until they are able to go at least 6 months without stealing. This is referred to as the maintenance treatment phase. [Table 1](#) summarizes the structure of the initial treatment.

The maintenance treatment phase aims to do the following: prepare the patient for gradual withdrawal from the program

with the strengthening and improvement of techniques developed during the program, addressing questions and difficulties; strengthen and solidify response prevention (directed to the possibility of relapse and expanding the repertoire, with application of techniques and problem solution); and evaluate the patient during an extended period of post-treatment follow-up, including application of the P-K-SAS.

2.3. Statistical analysis

The demographic profile and P-K-SAS scores of patients undergoing initial and maintenance treatment were compared. Because of the small sample size, which did not allow testing for normality of continuous variables, a non-parametric analysis was chosen. The Mann-Whitney U test and chi-square test were used for comparison of continuous and categorical variables, respectively. The level of significance was set at 5%. For all statistical analyses, we used the SPSS program, version 14.0 (IBM, Armonk, NY, USA).

The validity of versions 1 and 2 of the P-K-SAS was assessed by analyzing the correlation matrix between items and reliability analysis using Cronbach's alpha.

3. Results

[Table 2](#) shows a summary of the demographic profile of the sample. During the implementation of the initial version of the P-K-SAS, eight patients were in the initial treatment phase. Of those, seven had had ≤ 3 sessions and one had had 16 sessions (median, 1 session). In the group of patients undergoing maintenance treatment, the number of sessions completed ranged from 39 to 94 (median, 80). There was no significance between the two groups regarding the demographic profile. The total score on the initial version of the P-K-SAS was significantly higher for individuals in the initial treatment phase ([Table 2](#)).

The fifteen patients who remained in treatment (four in the initial phase and 11 in the maintenance phase) were reassessed with the final version of the P-K-SAS. The mean P-K-SAS score for the four patients who had not yet completed the initial phase of treatment was 20.3 ± 14.4 , compared with 8.9 ± 13.2 for the 11 individuals who were already in the maintenance phase. This difference was not statistically significant ($Z = -1.049$, $P = .343$).

3.1. Verbal comprehension of the P-K-SAS

For both mental health specialists and patients, the items proved easy to understand (scores on the comprehension Likert scale: mean = 4.3, SD = 1.1, mean = 4.1, SD = 1.7, respectively).

3.2. Evaluation of the instrument

[Tables 3 and 4](#) show the consistency analysis of the two versions of the P-K-SAS. The correlation between items was generally high, but we identified problems with items 4, 8

Table 1

Structure of the initial treatment phase of the kleptomania cognitive–behavioral therapy regimen of the Integrated Outpatient Program for Impulse Control Disorders, University of São Paulo Institute of Psychiatry, São Paulo, Brazil.

Stage	Method	Goal
1 (sessions 1 to 3)	Psycho-education	Clarify symptoms and enhance diagnostic acceptance
2 (session 4)	Motivational interviewing	Identify the stage of readiness for behavioral change and foster commitment to therapy
3 (sessions 5 to 7)	Self-assessment of stealing behavior, desire to steal and emotional triggers involved	Identify environmental factors that reinforce stealing
4 (sessions 8 to 10)	Cognitive restructuring	Identify cognitive and emotional triggers of stealing and other impulsive behaviors
5 (sessions 11 to 12)	Emotions coping skill training	Focus on bodily signs of emotional triggers and problem solving training
6 (sessions 13 to 15)	Life-line technique	Construct two parallel linear progressions: one biographical and another for kleptomania symptoms. Identify the evolving pattern of symptoms throughout life
7 (session 16)	Reflecting upon kleptomania and its consequences	Enhance awareness and provide closure by writing letters ^a to family, loved ones, or to kleptomania itself reporting on feelings and consequences experienced as a result of stealing
8 (session 17)	Relapse prevention	Identify high-risk situations and establish preventative strategies.
9 (sessions 18 to 20)	Assessment of process, outcome and continuing needs	Assess positive and negative aspects; establish goals and stimulate adherence to the maintenance phase

^a The letters work as a means to promote reflection, and patients are assured that the letters are not meant to be sent or exposed outside the sessions.

and 9 in the initial version. Item 8 in particular presented negative correlations with other scale items.

Although the Cronbach's alpha of the initial version was high (0.897), the item–total correlations of items 4 and 8 were below 0.400 and the alpha of the total scale showed a tendency to increase when they were excluded. The three items were reviewed, especially items 8 and 9, which in the initial version had been broken down into two sub-items to facilitate understanding according to the experts' suggestion, had their texts revised and were then returned to the original format. The final version of the scale had an even higher Cronbach's alpha (0.980), with item–total correlations equally high for all items. The deletion of item 9 resulted in an uptrend in the alpha of the

scale, albeit of negligible magnitude; considering the good indices of item–item and item–total correlation, we decided to keep item 9 in the scale.

4. Discussion

Through a rigorous process of translation and adaptation, we arrived at a valid and reliable version of the P-K-SAS for evaluating kleptomania patients. The data from the evaluation of the P-K-SAS show that the benefit that kleptomania patients gain from treatment is dependent upon the amount of treatment received.

Table 2

Demographic and clinical profile of kleptomania patients ($N = 18$).

Characteristic	Initial treatment	Maintenance treatment	Total	Statistic	<i>P</i>
	(≤ 20 sessions)	(>20 sessions)			
	($n = 8$)	($n = 10$)			
Gender, n (%)					
Male	5 (62.5)	2 (20.0)	7 (38.9)	$\chi^2 = 1.82$.177
Female	3 (37.5)	8 (80.0)	11 (61.1)		
Age (years), mean [SD]	32.5 [15.9]	36.8 [12.7]	34.9 [13.9]	$U = 26.0$.222
Ethnicity, n (%)					
White	7 (87.5)	8 (80)	15 (83.3)	$\chi^2 < 0.001$	1.000
Other	1 (12.5)	2 (20)	3 (16.7)		
Marital status, n (%)					
With partner	6 (75.0)	4 (40.0)	10 (55.6)	$\chi^2 = 1.02$.314
Without partner	2 (25.0)	6 (60.0)	8 (44.4)		
Years of education, mean [SD]	14.9 [5.2]	15.3 [5.5]	15.1 [5.2]	$U = 39.5$.931
Employment status, n (%)					
Employed	2 (25.0)	6 (60.0)	8 (44.4)	$\chi^2 = 1.02$.314
Unemployed	6 (75.0)	4 (40.0)	10 (55.6)		
P-K-SAS score, mean [SD]	21.1 [8.0]	11.3 [7.5]	16.2 [9.0]	$U = 15.0$.024

P-K-SAS: Portuguese-language version of the Kleptomania Symptom Assessment Scale.

Table 3
Correlation matrix for the Portuguese version of the Kleptomania Symptom Assessment Scale.

Initial version (<i>N</i> = 18)	Item 1	Item 2	Item 3	Item 4	Item 5	Item 6	Item 7	Item 8	Item 9	Item 10
Item 2	0.402	–								
Item 3	0.415	0.483	–							
Item 4	0.075	0.733	0.094	–						
Item 5	0.707	0.732	0.634	0.398	–					
Item 6	0.434	0.832	0.635	0.631	0.805	–				
Item 7	0.719	0.701	0.387	0.477	0.862	0.663	–			
Item 8	0.328	–0.235	0.246	–0.487	0.175	0.014	0.027	–		
Item 9	0.694	0.225	0.173	0.181	0.333	0.209	0.477	0.093	–	
Item 10	0.863	0.522	0.389	0.409	0.709	0.660	0.754	0.218	0.720	–
Item 11	0.572	0.533	0.436	0.237	0.566	0.629	0.664	0.173	0.340	0.616
Final version (<i>n</i> = 15)	Item 1	Item 2	Item 3	Item 4	Item 5	Item 6	Item 7	Item 8	Item 9	Item 10
Item 2	0.899	–								
Item 3	0.920	0.922	–							
Item 4	0.794	0.873	0.794	–						
Item 5	0.945	0.941	0.926	0.851	–					
Item 6	0.931	0.937	0.961	0.793	0.977	–				
Item 7	0.846	0.863	0.849	0.743	0.910	0.912	–			
Item 8	0.833	0.798	0.834	0.600	0.805	0.835	0.839	–		
Item 9	0.713	0.658	0.718	0.473	0.756	0.789	0.885	0.899	–	
Item 10	0.890	0.924	0.874	0.893	0.928	0.909	0.947	0.796	0.752	–
Item 11	0.688	0.714	0.667	0.721	0.737	0.736	0.897	0.638	0.733	0.907

The demographic profile of the sample indicated a high level of unemployment (55.6%), despite the fact that the mean level of education was high (at least some college) in the sample and that its constituents were in their economically productive years (≈ 35 years of age). This provides evidence

Table 4
Reliability analysis of the Portuguese-language version of the Kleptomania Symptom Assessment Scale.

Item–total statistics	Adjusted item–total correlation	Cronbach's alpha if item deleted
Initial version: Cronbach's alpha = 0.897 (<i>N</i> = 18)		
Item 1	0.778	0.879
Item 2	0.681	0.887
Item 3	0.538	0.896
Item 4	0.363	0.900
Item 5	0.853	0.875
Item 6	0.783	0.883
Item 7	0.831	0.878
Item 8	0.132	0.909
Item 9	0.503	0.895
Item 10	0.853	0.873
Item 11	0.680	0.887
Final version: Cronbach's alpha = 0.980 (<i>n</i> = 15)		
Item 1	0.923	0.977
Item 2	0.928	0.977
Item 3	0.922	0.977
Item 4	0.809	0.980
Item 5	0.960	0.976
Item 6	0.963	0.976
Item 7	0.954	0.976
Item 8	0.859	0.979
Item 9	0.799	0.981
Item 10	0.966	0.976
Item 11	0.802	0.980

of the degree of professional and social impairment caused by this serious disorder, with consequent impairment of quality of life. These findings are consistent with those of previous reports of clinical samples of patients with kleptomania.

The P-K-SAS scores obtained from patients in initial treatment were consistent with those reported in other studies [27,28], confirming the suitability of this version of the K-SAS. The division of the instrument evaluation process into two parts contributed to more rigorous refinement of the instrument. Although the initial version produced satisfactory data, there was a clear gain in psychometric robustness when the final version was applied. The finding that patients who had been in treatment longer scored lower on the P-K-SAS is indirect evidence of its sensitivity to change in patient clinical status and is further evidence of the validity of the translated version. Although, in the second with the P-K-SAS this difference between patients in initial and maintenance treatment was not statistically significant, probably due to the small sample size.

This study has important limitations that should be noted, not the least of which is the small sample size. The Impulse Control Disorders Unit offers treatment programs for a wide range of impulse control disorders, including pathological gambling, compulsive shopping and Internet abuse, all of which are in high demand and have waiting lists. Despite its being the only program of its kind in Brazil and having been promoted in the mass media, lay press and special-interest publications, the kleptomania program still has immediately available vacancies, probably reflecting the stigma and difficulty patients face when seeking treatment. In addition, we unfortunately did not arrange two applications at different times of the same version of the P-K-SAS. Therefore,

specific data on its sensitivity to change in status of kleptomania symptoms need to be obtained in future studies.

On the other hand, the P-K-SAS showed robust psychometrics and can now be used in studies assessing the severity of kleptomania and its responses to treatment. The fact that significant reductions in scores were obtained in the maintenance treatment phase suggests that kleptomania is a serious condition that can require long-term treatment, possibly more than the 12 sessions proposed by the standard models for treatment of conditions involving habit and impulse control.

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