Introduction

The last decade has brought the impulse control disorders (ICDs) much-needed attention and has seen the accumulation of a modest body of clinical research results. Yet, clinicians wanting to provide cutting-edge pharmacological and psychotherapeutic care for these disorders have no up-to-date, comprehensive resource to consult. Given this unmet need, we have attempted to create a practical, authoritative clinical guide to the ICDs that summarizes the current state of knowledge.

An individual's disorder often both reflects and affects society. Thus, we wished not only to present the information and guidance needed to offer excellent clinical care but also to provide clinicians, policymakers, patients and families, and advocacy groups with information regarding societal aspects of ICDs. We therefore include companion chapters for each clinical disorder to discuss social factors affecting the onset or course of the disorder, legal system considerations, social costs (including familial and financial costs), and public health issues. We hope that these chapters will stimulate discussion regarding programs, laws, and public policies that can help prevent or treat various impulse control disorders or that can mitigate their widespread unfortunate social effects.

Each clinical chapter is organized into sections discussing:

- History of psychiatric attention to the disorder
- Diagnosis, both in DSM-IV and ICD-10
- Differential diagnosis
- Clinical picture, including the effects of symptoms on functioning
- Assessment instruments
- Prevalence
- Age at onset
- Natural history
- Effects of the disorder on quality of life
- Biological data that have treatment implications
- Comorbid conditions
- Treatments, both psychotherapeutic and psychopharmacological
- Self-help materials, when available

For many impulse control disorders, information on these topics is sparse or absent. To the extent possible, we present clinically useful information in detail, including resources for patients and families. In addition, Appendix I contains a treatment-planning guide for each disorder to help the clinician conduct the necessary evaluations and create a comprehensive treatment plan. Appendix II includes rating instruments that may be useful in defining each disorder's severity when the patient is first seen and in monitoring response to treatments.

The societal aspect chapters vary widely. The discussion of the social aspects of pathological gambling, for instance, explores financial and workplace impacts; relationship to crime; how federal and state governments, the gambling industry, the media and film industries, retailers, and even schools and community-based organizations encourage gambling; gambling's contributions to homelessness, domestic violence, and divorce; and, how these

unfortunate consequences could be mitigated by social interventions. A separate chapter discusses the intricate politics and economics of Indian gaming in the United States.

The chapter on the social aspects of kleptomania describes the legal system complexities surrounding the disorder. The companion chapter to compulsive buying disorder describes how advertising agencies, credit card issuers, the media, and retailers strive to "associate products we don't need with feelings we deeply desire" and so contribute to the problem of compulsive buying. This chapter lays out how a cultural focus on materialism promotes pernicious debt and degrades both interpersonal relationships and participation in civic life. The companion chapter regarding hypersexuality discusses the commercial sex industry and the health – including mental health – risks it entails for sex workers, as well as the substance abuse and legal problems they face.

Although not all behavior symptomatic of intermittent explosive disorder is physically violent, the disorder does account for a portion of the emotional and physical abuse suffered by many individuals. As a result, we have included a chapter that describes the epidemiology and health-related consequences of intimate partner violence and reviews the means to identify, educate, and treat the estimated 4.8 million women and 2.9 million men who are victimized in the United States each year. A second companion chapter describes the physical health and mental health consequences of violence against women, along with economic consequences and impact on the next generation. This chapter concludes with an exploration of primary, secondary, and tertiary prevention efforts that exist or could be created to diminish this evil.

Problematic Internet use may be the disorder of our time. To complement the clinical chapter on this topic, we included a chapter on the social effects of the virtual violence contained in video games and in so many venues on the World Wide Web. "Are we in danger of becoming desensitized to violence because our virtual lives are suffused with it?" is the important question that this chapter's authors explore.

Although pyromania accounts for only a small proportion of fire setting and arson, we have included a companion chapter reviewing the magnitude and costs of arson and the legal and community responses to it. The chapter also discusses how the legal and mental health systems interface and can collaborate to contain this sometimes lethal calamity.

For trichotillomania, skin-picking disorder, and nail biting – ICDs that can be associated with significant medical consequences – we include contributions from nonpsychiatric medical experts to complement the clinical chapters and to provide more thorough reviews. Hence, dermatological perspectives are discussed in two chapters that complement the trichotillomania and skin-picking–disorder chapters, and a dentist's clinical perspective is presented to complement the chapter on nail biting.

Finally, because nonprofit resource, support, and advocacy groups frequently provide patient and public education, and because they can attract public attention and research funding to a given disorder, we include a chapter describing a successful effort to create a nonprofit organization, the Trichotillomania Learning Center. This narrative contains many rarely discussed and extremely helpful points for anyone who chooses to follow the author's courageous example.

Our book contains the distilled knowledge of a distinguished group of international experts from the fields of psychiatry, medicine, public policy, and the law, in addition to other disciplines pertinent to understanding and managing impulse control disorders. We are deeply grateful to our contributing authors. They have helped us create a book that we think readers will find is a comprehensive resource regarding disorders that are costly and painful for the afflicted individual and for society at large but that too often are underestimated, underdiagnosed, and undertreated.

Section I

Acquisitive Impulses

1

Compulsive Buying: Clinical Aspects

Donald W. Black, MD

History

Shopping is a major leisure activity for most people in the United States and other developed countries (Farrell 2003). Kowinski (1985) has pointed out that the enclosed shopping mall is a central element in U.S. society, where more time is spent than anywhere else outside of home or work. Shopping experiences provide pleasure and relaxation; yet, for some, excessive shopping is an irresistible and costly way of life (Elliott 1994). These are the compulsive buyers whose lives are organized around a variety of shopping experiences and whose behavior has prompted concerns that it can lead to a clinical disorder.

Examples of profligate spending have been described for centuries, although these reports mainly involve the wealthy and powerful. Marie Antoinette, queen of France during the turbulent time before the revolution, was known for her extravagance (Castelot 1957; Erickson 1991). Mary Todd Lincoln, wife of President Abraham Lincoln, had spending binges that greatly distressed her husband (Baker 1987). Publisher and magnate William Randolph Hearst had an insatiable appetite for art and antiques that nearly drove him to bankruptcy during the Great Depression of the 1930s (Swanberg 1961). Jacqueline Kennedy Onassis, known for her personal charm and great fashion sense, was an obsessive shopper whose uncontrolled behavior dismayed both of her husbands (Heymann 1989). Even the late Princess Diana, a clotheshorse and media star, was widely reported to have an intense interest in shopping and spending (Davies 1996). Whether these individuals had a compulsive buying disorder (CBD) is a matter of debate, yet all were observed to have episodes of excessive and sometimes senseless spending that contributed to their financial downfall or personal problems and, in the case of Marie Antoinette, may well have cost her her life.

Apart from these accounts, the first clinical description of compulsive buying dates to 1915, when German psychiatrist Emil Kraepelin (1915) wrote about "buying maniacs," or "oniomanics," otherwise ordinary persons with uncontrolled shopping and spending behavior. He was later quoted by Swiss psychiatrist Eugen Bleuler (1930) in his *Lehrbuch der Psychiatrie* (*Textbook of Psychiatry*):

> As a last category, Kraepelin mentions the buying maniacs (oniomaniacs) in whom even buying is compulsive and leads to senseless contraction of debts with continuous delay of payment until a catastrophe clears the situation a little – a little bit never altogether because they never admit all their debts. According to Kraepelin, here, too, it always involves women. The usually frivolous debt makers and who in this way wish to get the means for pleasure naturally do not belong here. The particular element is impulsiveness; they cannot help it, which sometimes even expresses itself in the fact that not withstanding a good school intelligence, the patients are absolutely incapable to think differently and to conceive the senseless consequences of their act, and the possibilities of not doing it. They do not even feel the impulse, but they act out their nature like the caterpillar which devours the leaf. (p. 540)

Both Kraepelin and Bleuler considered "oniomania" an example of a *reactive impulse*, or *impulsive insanity*, and placed it alongside kleptomania and pyromania. They appear

to have been influenced by French psychiatrist Jean Esquirol's (1838) earlier concept of *monomania*, a term he used to describe persons with a pathological preoccupation who otherwise functioned well.

Despite this early work, CBD attracted little attention except for rare clinical case presentations in the psychoanalytic literature (Krueger 1988; Lawrence 1990; Stekel 1924; Winestine 1985). Interest was rekindled in the late 1980s and early 1990s through a convergence of events. Consumer behavior researchers showed the disorder to be widespread (Elliott 1994; Magee 1994; O'Guinn and Faber 1989), and a report appeared in the psychiatric literature describing three women and their response to antidepressant medication (McElroy et al. 1991). Three independent clinical case series followed on the heels of this report, involving a total of 90 subjects (Christenson et al. 1994; McElroy et al. 1994; Schlosser et al. 1994); the results were remarkably similar, even though the methods differed. These reports painted a picture of a definable, persistent clinical disorder that mainly affected women in early to mid-adulthood, many of whom had substantial psychiatric comorbidity.

Diagnosis and Classification

Compulsive buying disorder is not included in contemporary diagnostic systems, such as the *Diagnostic and Statistical Manual of Mental Disorders–Text Revision* (DSM-IV-TR) (American Psychiatric Association 2000) or the *International Classification of Diseases*, 10th edition (World Health Organization 1992), yet several definitions have been proposed. Following in the tradition of criteria-based diagnoses, McElroy et al. (1994) developed an operational definition that emphasizes cognitive and behavioral aspects of the disorder as well as associated impairment from marked subjective distress, interference in social or occupational functioning, or financial/legal problems; in addition, mania and hypomania have to be ruled out. These criteria have become standard in CBD research, although neither their reliability nor validity has been established. Although there is ample evidence of serious harm caused by compulsive buying and significant evidence of comorbidity, some writers have decried attempts to categorize CBD as an illness, attempts they see as part of an unfortunate trend toward "medicalizing" behavioral problems. This stance ignores the reality of CBD and trivializes and stigmatizes attempts to understand or treat it (Lee and Mysyk 2004).

Although DSM-IV-TR does not mention CBD, the disorder can be placed in the category "impulse control disorder not otherwise specified (Code 312.30)." The impulse control disorders share an inability to resist an "impulse, drive, or temptation to perform an act that is harmful to the person or to others" (American Psychiatric Association 2000, p. 663), symptoms that appear to describe CBD. The degree of harm caused by compulsive buying can vary widely. Most obvious is financial harm and distress; however, occupational, interpersonal, marital, social, and spiritual distress have all been reported (Christenson et al. 1994; Lejoyeux et al. 1997; Schlosser et al. 1994).

Other definitions have come from consumer behavior researchers or social psychologists. Faber and O'Guinn (1992) defined the disorder as "chronic buying episodes of a somewhat stereotyped fashion in which the consumer feels unable to stop or significantly moderate his behavior" (p. 738). Edwards (1993), another consumer behaviorist, suggests that compulsive buying is an "abnormal form of shopping and spending in which the afflicted consumer has an overpowering uncontrollable, chronic and repetitive urge to shop and spend (that functions) . . . as a means of alleviating negative feelings of stress and anxiety" (p. 67). Dittmar (2004) describes three cardinal features: irresistible impulse, loss of control, and carrying on despite adverse consequences. Some consumer behavior researchers consider CBD part of a spectrum of aberrant consumer behavior that includes pathological gambling, shoplifting, and credit abuse (Budden and Griffin 1996).

The appropriate classification of CBD remains elusive, a fact reflected by the many terms used to describe the condition: compulsive shopping, addictive shopping, shopaholism,

compulsive buying, and even mall mania. McElroy et al. (1991) had suggested that compulsive shopping behavior might be related to "mood, obsessive-compulsive or impulse control disorders." Hollander (1993) later described a spectrum of disorders that he has related to obsessive-compulsive disorder, including CBD, while Lejoyeux et al. (1996) linked it to the mood disorders. Others (Glatt and Cook 1987; Goldman 2000; Krych 1989) have linked CBD to the addictive disorders, grouping it with alcohol and drug dependence. Other investigators have followed in the tradition pioneered by Kraepelin and Bleuler, classifying CBD as a disorder of impulse control. The relationship of CBD to other impulse control disorders was also recognized by Wilhelm Stekel (1924), an early follower of Freud, who proposed that inordinate buying was an incomplete or atypical form of kleptomania (Maier 1997).

Hollander and Allen (2006) have suggested that CBD be included in a new diagnostic category that combines behavioral and substance addictions. In this model, "behavioral addictions" include pathological gambling, kleptomania, pyromania, CBD, Internet addiction, and compulsive sexual behavior. The National Institute on Drug Abuse considers behavioral addictions to be relatively pure models of addiction because they are not contaminated by the presence of an exogenous substance (Holden 2001).

Differential Diagnosis

Ruling out bipolar disorder as the cause of excessive shopping and spending is essential. A manic patient's unrestrained spending typically corresponds to manic episodes and is accompanied by euphoric mood, grandiosity, unrealistic plans, and often a giddy, overly bright affect. The pattern of shopping and spending in the person with CBD lacks the periodicity seen in bipolar patients and points to an ongoing preoccupation (Kuzma and Black 2006). Although unlikely, clinicians should also rule out medical causes (e.g., neurological disorders, brain tumors).

Compulsive buying disorder must be distinguished from normal buying behavior, although the distinction is sometimes arbitrary. Frequent shopping does not by itself constitute evidence of the presence of CBD. For the person with CBD, the frequent shopping and spending has a compulsive and difficult-to-resist quality and leads to deleterious consequences. Although normal buying can also sometimes exhibit a compulsive quality, particularly around special holidays or birthdays, the pattern neither persists nor leads to distress or impairment. Persons who receive an inheritance or win a lottery may experience shopping sprees as well. The clinician needs to exercise judgment in applying the diagnostic criteria of McElroy et al. (1994) and be mindful of the need for evidence of resultant distress or impairment.

Clinical Picture

A distinct clinical picture of the compulsive shopper has emerged. Four distinct phases of CBD have been described, including: (1) anticipation; (2) preparation; (3) shopping; and (4) spending (Black 2007). In the first phase, the person with CBD experiences a thought or preoccupation either with having a specific item or with the act of shopping itself. This leads the individual to prepare for shopping and spending, e.g., deciding on when and where to go, how to dress, and even which credit cards to take. This phase is followed by the actual shopping experience, which many individuals with CBD describe as intensely exciting; some even describe experiencing a sexual feeling (Schlosser et al. 1994). The act is completed with the purchase, often followed by a sense of letdown or disappointment with oneself (Koran et al. 2006).

Perhaps the most important symptom is preoccupation with shopping and spending. This typically leads to spending many hours each week engaged in these behaviors (Christenson et al. 1994; Schlosser et al. 1994). Although it could be argued that a person could

be a compulsive shopper and not spend, confining the interest to window shopping, this pattern is very uncommon in the author's experience. Persons with CBD often describe increasing anxiety that is relieved only when a purchase is made.

Compulsive buying disorder behaviors occur all year but can be more problematic during the Christmas holidays and others, as well as around the birthdays of family members and friends. Schlosser et al. (1994) reported that subjects showed a range of behaviors after a purchase: returning the item, failing to remove the item from the package, selling the item, or even giving it away. Compulsive shopping tends to be a private pleasure, and individuals with CBD typically shop alone (Schlosser et al. 1994). Compulsive shopping can occur in any venue: high-fashion department stores and boutiques, consignment shops, garage sales, or catalogs (Christenson et al. 1994). Dittmar (2007) has documented how CBD has gained a strong foothold in online buying.

Compulsive buyers are mainly interested in consumer goods such as clothing, shoes, crafts, jewelry, gifts, makeup, and compact discs/DVDs (Christenson et al. 1994; Mitchell et al. 2006; Schlosser et al. 1994). Research has not identified gender-specific buying patterns, but in the author's experience men with CBD tend to have a greater interest than women in electronic, automotive, and hardware goods. Compulsive shoppers often display a great fashion sense and have an intense interest in new clothing styles and products. They may report buying a product based on its attractiveness or because it was a "bargain" (Frost et al. 1998). Individually, items purchased tend not to be large or expensive, but many compulsive shoppers will buy in quantity, so that spending rapidly escalates. During a typical episode, compulsive shoppers have reported spending an average of $110 (Christenson et al. 1994), $92 (Schlosser et al. 1994), or $89 (Miltenberger et al. 2003). Compulsive buying disorder has little to do with intellect or educational level and has been observed to occur in mentally retarded persons (Otter and Black 2007).

Several writers have emphasized the emotional significance of the types of objects purchased, which may address personal and social identity needs (Dittmar 2007; Richards 1996). Richards (1996) stressed the role of clothing in developing a feminine identity and noted that voids in one's identity have their roots in failed parent–child interactions. Krueger (1988) observed that emotionally deprived persons unconsciously replace what is missing with objects in an attempt to "fill the emptiness of depression and the absence of self-regulation" (p. 582). These explanations for compulsive buying behaviors may apply to some, but certainly not all, persons with CBD. One study found that self-image concerns were more closely linked to the motivations underlying CBD in women than in men (Dittmar and Drury 2000).

Miltenberger et al. (2003) reported that negative emotions, such as anger, anxiety, boredom, and self-critical thoughts, were the most common antecedents to shopping binges; euphoria or relief of negative emotions has been the most common immediate emotional reaction (Elliott, Eccles, and Gournay 1996). Lejoyeux et al. (1996) concluded that for some persons "uncontrolled buying, like bulimia, can be used as a compensatory mechanism for depressive feelings" (p. 1528). Faber and Christenson (1996) commented on the close relationships among shopping, self-esteem, and negative emotions. Faber and O'Guinn (1992) concluded that shopping behavior is likely to become problematic when it provides a sense of recognition and acceptance for people with low self-esteem, allowing them to act out anger or aggression while providing an escape from day-to-day drudgery.

Natarajan and Goff (1991) have identified two independent factors in CBD: (1) buying urge or desire and (2) degree of control over buying. In their model, compulsive shoppers combine high urge with low control. This view is consistent with clinical reports that compulsive buyers are preoccupied with shopping and spending and despite trying to resist their urges, often have little success (Black 1996; Christenson et al. 1994; Marks 1990). For example, in the study of Christenson et al. (1994), 92% of persons with the disorder described often unsuccessful attempts to resist buying. Subjects indicated that the urge to

buy resulted in a purchase 74% of the time. Typically, one to five hours passed between initially experiencing the urge to buy and the eventual purchase.

Income has relatively little to do with CBD because persons with a low income can be as preoccupied with shopping and spending as wealthier individuals (Black 2001; Dittmar 2007); level of income may lead one person to shop at a consignment shop, while the other shops at a high-end boutique. Koran et al. (2006) found that, compared with other respondents, individuals with CBD were more likely to report an income under $50,000; less likely to pay off credit card balances in full; and gave maladaptive responses regarding their consumer behavior. In this study, compulsive buyers engaged in "problem shopping" more frequently and for longer periods, and were more likely than other respondents to feel depressed after shopping, to make senseless and impulsive purchases, and to experience uncontrollable buying binges. These data are partially compatible with the findings of Black et al. (2001), who divided a sample of individuals with CBD into quartiles from most to least severe based on their Compulsive Buying Scale score (Faber and O'Guinn 1992). Greater severity was associated with lower gross income, a lower likelihood of having an income above the median, and spending a lower percentage of income on sale items. Subjects with more severe CBD were also more likely to have comorbid Axis I or Axis II disorders. These results suggest that more severe buying disorders occur in psychologically distressed persons with low incomes who have an impaired ability to control or to delay their urges to make inappropriate purchases.

Wealth does not protect against CBD either because the presence of CBD may cause or contribute to interpersonal, occupational, marital, or spiritual problems, even when it does not create financial problems. Many compulsive buyers who seek treatment have incomes well in excess of $100,000 (A. Benson, personal communication, 2008).

Identification and Assessment

In clinical practice, few patients refer themselves for treatment for a compulsive buying disorder. When CBD is a presenting problem, the patient has typically been referred by a financial counselor, lawyer, law enforcement officer, family member, or spouse (Black 2000). More frequently, compulsive buying reveals itself in the course of ongoing treatment. Some patients will begin to talk openly about the problem; with others, it emerges in the context of financial independence and responsibility issues, relationship problems, difficulties at work, or parenting problems. Compulsive buying may also present itself indirectly: a patient might wear something new or different to every session, arrive with shopping bags week after week, repeatedly give gifts to the therapist, or fall behind in paying the bill (Benson 2000).

Compulsive buyers are largely secretive about their disorder because it is a source of great shame, perhaps even more so than alcoholism or drug abuse. The latter are commonly thought of as diseases, or at least are recognized as serious problems requiring treatment. Compulsive buyers, on the other hand, worry that they will be considered materialistic and vacuous – judgments that likely reflect their self-perceptions (Benson 2000).

The diagnostic process begins with relatively nonintrusive inquiries, followed with more detailed inquiries regarding the person's shopping attitudes and behaviors (Black 2000). For general screening purposes, the clinician might ask:

- "Do you feel overly preoccupied with shopping and spending?"
- "Do you ever feel that your shopping behavior is excessive, inappropriate, or poorly controlled?"
- "Have your shopping desires, urges, fantasies, or behaviors ever been overly time consuming, caused you to feel upset or guilty, or led to serious problems in your life such as financial or legal problems or the loss of a relationship?"

Positive responses can be followed up with more detailed inquiries, such as how frequently the behavior occurs, what the individual prefers to buy, and how much money is spent. Attitudes and behaviors following purchases are also important to explore.

This exploration should be followed by a thorough assessment of the patient's psychiatric history, including medications, psychotherapy, and hospitalizations. This assessment is important because most compulsive buyers have a history of psychiatric comorbidity, and the presence of a disorder, such as major depression or panic disorder, may suggest a particular treatment strategy or approach or provide information that may be useful in counseling the patient. Taking a history of physical illnesses, surgical procedures, drug allergies, or medical treatment may help rule out medical causes of the compulsive buying, as noted earlier.

A family history should be obtained. Compulsive buying runs in some families (typically female relatives), and these families are often troubled by depression, alcoholism, or drug addiction (Black et al. 1998). Having grown up in a dysfunctional home in which one or more family members had a mental illness or an addictive disorder may have contributed to the patient's CBD. On the other hand, the patient may have learned inappropriate buying and spending behavior from his or her parent or other relatives.

The patient's social and personal history should be explored, including family life, history of childhood development, possible history of abuse, educational background, occupational history, intimate relationships and marriages, children, and finances or legal problems related to the disordered buying. This information will help in planning a comprehensive approach to the patient's problems.

Several instruments have been developed to either identify CBD or rate its severity. Canadian researchers developed the Compulsive Buying Measurement Scale (Valence, D'Astous, and Fortier 1988). These investigators selected 16 items thought to represent four basic dimensions of compulsive buying (tendency to spend, urge to buy or shop, post-purchase guilt, and family environment). A reliability analysis led to deleting three items representing family environment. A modified version of the scale, tested by German researchers (Scherhorn, Reisch, and Raab 1990) as the Addictive Buying Scale (ABS), had high reliability and construct validity. Like the Canadian instrument, the ABS discriminated normal from compulsive buying behavior.

The Compulsive Buying Scale (CBS) was developed by Faber and O'Guinn (1992) to distinguish normal from pathological buyers. They began with 29 items, each item reflecting important characteristics of compulsive buying derived from earlier work, and rated each item on a 5-point scale. Logistic regression analysis identified seven items representing specific behaviors, motivations, and feelings that together correctly classified 88% of the individuals tested. Many researchers consider the CBS a useful tool for identifying compulsive buyers and rating CBD severity.

Edwards (1993) developed a 13-item scale to assess important experiences and feelings about shopping and spending. The items were selected to measure dimensions of tendency to spend, frequency of shopping, spending feelings and experiences while shopping, impulsivity while shopping, unplanned purchasing, post-purchase guilt, and dysfunction resulting from spending. The scores can be used to classify consumers according to their level of compulsiveness in buying.

Other scales have not found wide use. Lejoyeux et al. (1997) developed a 19-item questionnaire to tap the basic features of CBD, but its psychometric properties have not been reported. Weun et al. (1998) developed the Impulse Buying Tendency Scale to assess the proclivity for impulse buying, which they distinguish from compulsive buying. Ridgeway et al. (2008) have developed the Compulsive-Impulsive Buying Scale, which measures compulsive buying as a construct incorporating elements of both an obsessive-compulsive and an impulse control disorder. The scale appears to be reliable and valid, and it performs

Table 1.1 Prevalence surveys of compulsive buying disorder

Study	Location	Diagnostic Method	Sample Size	Setting	Findings
Faber and O'Guinn 1992[1]	Illinois	CBS	292	General population	1.8%–8.1%
Dittmar 2005	England	CBS	194	General population	13.5%
Neuner et al. 2005[2]	Germany	ABS	1527/1017	General population	6.5%–8%
Koran et al. 2006[1]	United States	CBS	2513	General population	1.4%–5.8%
Magee 1994	Arizona	CBS	94	College students	16%
Hassay and Smith 1996	Manitoba, Canada	CBS	92	College students	12%
Roberts 1998	Texas	CBS	300	College students	6%
Dittmar 2005	England	CBS	195	Adolescents	44.1%
Grant et al. 2005	Minnesota	MIDI	204	Psychiatric outpatient clinic	9.5%

CBS = Compulsive Buying Scale; ABS = Addictive Buying Scale; MIDI = Minnesota Impulsive Disorders Interview.
[1] The study used conservative and liberal cut points with the CBS.
[2] The study involved interviews with East and West Germans from 1991 to 2001.

well in correlating with other theoretically related constructs. These instruments will be of interest mainly to researchers.

Monahan, Black, and Gabel (1995) modified the Yale Brown Obsessive-Compulsive Scale to create the YBOCS-Shopping Version (YBOCS-SV). The 10-item scale rates time involved, interference, distress, resistance, and degree of control for both cognitions and behaviors typical of CBD, yielding a score ranging from 0 to 40. The scale had adequate inter-rater reliability and was valid in measuring both severity and change during a clinical trial. Persons with CBD had a mean score of 21 (range 18–25) compared with a mean of 4 (range 1–7) for normal buyers.

Christenson et al. (1994) developed the Minnesota Impulsive Disorders Interview, a semistructured interview to assess the presence of CBD, kleptomania, trichotillomania, intermittent explosive disorder, compulsive sexual behavior, pathological gambling, and compulsive exercise. The instrument had a sensitivity of 100% and a specificity of 96.2% for CBD when compared with the diagnostic criteria of McElroy et al. (1994) (Grant et al. 2005).

Shopping logs or diaries may be helpful in understanding and treating persons with CBD. Patients can record their shopping experiences, accompanying mood, and the outcome (e.g., money spent, item purchased). This description of the patient's buying behavior may be helpful during treatment, for example, in a medication or behavior therapy trial (Benson 2006; Bernik et al. 1996; Black et al. 1997). The use of a daily log may be therapeutic as well by fostering the patient's awareness of the extent of the problem.

Prevalence

Prevalence surveys relevant to CBD have produced rates that range from 1.4% to 44%, the differences likely resulting from the populations examined and the research methods used (Table 1.1). In general, adolescents and college students had higher rates of CBD than general adult populations.

In perhaps the most widely cited study, Faber and O'Guinn (1992) estimated the prevalence of CBD at between 1.8% and 8.1% of the general population based on a mail survey in which the Compulsive Buying Scale (CBS) was returned by 292 individuals from a sample selected to approximate the demographic makeup of the general population of Illinois. The high and low prevalence estimates reflect different score thresholds set for CBD. The higher figure is based on a probability level of 0.70 (i.e., two standard deviations above the mean), while the lower figure is based on a more conservative probability level of 0.95 (i.e., three