

# Kleptomania: clinical characteristics and treatment

## Cleptomania: características clínicas e tratamento

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Jon E Grant,<sup>1</sup> Brian L Odlaug<sup>1</sup>

### Abstract

**Objectives:** Kleptomania, a disabling impulse control disorder, is characterized by the repetitive and uncontrollable theft of items that are of little use to the afflicted person. Despite its relatively long history, kleptomania remains poorly understood to the general public, clinicians, and sufferers. **Method:** This article reviews the literature for what is known about the clinical characteristics, family history, neurobiology, and treatment options for individuals with kleptomania. **Results:** Kleptomania generally has its onset in late adolescence or early adulthood and appears to be more common among women. Lifetime psychiatric comorbidity is frequent, mainly with other impulse control (20-46%), substance use (23-50%) and mood disorders (45-100%). Individuals with kleptomania suffer significant impairment in their ability to function socially and occupationally. Kleptomania may respond to cognitive behavioral therapy and various pharmacotherapies (lithium, anti-epileptics, and opioid antagonists). **Conclusions:** Kleptomania is a disabling disorder that results in intense shame, as well as legal, social, family, and occupational problems. Large scale treatment studies are needed.

**Descriptors:** Impulse control disorders; Pharmacotherapy; Comorbidity; Theft; Study characteristics [Publication type]

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### Resumo

**Objetivos:** A cleptomania, um transtorno incapacitante do controle dos impulsos, caracteriza-se pelo furto repetitivo e incontrolável de itens que são de pequena utilidade para a pessoa acometida por esse transtorno. Apesar de seu histórico relativamente longo, a cleptomania continua sendo pouco entendida pelo público geral, pelos clínicos e pelos que dela sofrem. **Método:** Este artigo revisa a literatura sobre o que se sabe a respeito das características clínicas, histórico familiar, neurobiologia e opções de tratamento para indivíduos com cleptomania. **Resultados:** A cleptomania geralmente tem seu início no final da adolescência ou no início da vida adulta, e parece ser mais comum em mulheres. A comorbidade psiquiátrica ao longo da vida com outros transtornos de controle de impulsos (20-46%), de uso de substâncias (23-50%) e de humor (45-100%) é freqüente. Indivíduos com cleptomania sofrem de prejuízo significativo em sua capacidade de funcionamento social e ocupacional. A cleptomania pode responder ao tratamento com terapia cognitivo-comportamental e com várias farmacoterapias (lítio, antiepilépticos e antagonistas de opióides). **Conclusões:** A cleptomania é um transtorno incapacitante que resulta em uma vergonha intensa, bem como problemas legais, sociais, familiares e ocupacionais. São necessários estudos de tratamento em ampla escala.

**Descritores:** Transtornos do controle de impulso; Farmacoterapia; Comorbidade; Roubo; Características de estudos [Tipo de publicação]

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<sup>1</sup> Department of Psychiatry, University of Minnesota School of Medicine, Minnesota, USA

### Correspondence

Jon E. Grant  
Department of Psychiatry  
University of Minnesota School of Medicine  
2450 Riverside Avenue, Minneapolis, MN 55454  
Phone: 612-273-9736; Fax: 612-273-9779  
E-mail: grant045@umn.edu

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## Introduction

Kleptomania, also referred to as compulsive shoplifting, may be a fairly common disorder that results in significant personal distress and legal consequences. Although no national epidemiological study of kleptomania has been performed, studies of kleptomania in various clinical samples suggest that it is not uncommon. A recent study of adult psychiatric inpatients with multiple disorders ( $n = 204$ ) revealed that 7.8% ( $n = 16$ ) endorsed current symptoms consistent with a diagnosis of kleptomania, and 9.3% ( $n = 19$ ) had a lifetime diagnosis of kleptomania.<sup>1,2</sup> A study of 102 adolescents hospitalized for a variety of psychiatric disorders found that 8.8% ( $n = 9$ ) suffered from kleptomania.<sup>3</sup> Because rates appear similar in adolescents and adults, this suggests that kleptomania may be a chronic disorder if untreated. These findings are consistent with prior studies. One study examining 107 patients with depression found that 4 (3.7%) suffered from kleptomania.<sup>4</sup> In a study of 79 patients with alcohol dependence, 3 (3.8%) also reported symptoms consistent with kleptomania.<sup>5</sup> Although these studies suggest that kleptomania is not a rare behavior, this disorder remains poorly understood with little treatment data.<sup>1</sup> Based on the recent growth in kleptomania research, this article will detail what is currently known about the clinical characteristics, pathophysiology, and treatment of this disabling disorder.

## Case Vignette

Meg is a 49-year-old, married Caucasian female with three children. When she first began stealing at the age of 20, she would steal something once every few weeks from a store. This behavior continued throughout the next twenty-five years until the frequency of stealing increased to three or more times per week. Although gainfully employed throughout her life, she steals unnecessary items from retail stores and from friends. Upon entering a store, Meg reports an overwhelming urge to steal and feels the need to complete the theft before the tension will subside. After leaving the store, Meg feels guilty for having taken the item. These stolen objects, usually small items (e.g. cosmetics, hygiene products, magazines), are placed in boxes in her garage at home, never used. Her family does not know about her problem. She has never been caught, but she does not feel proud of this fact. She feels a sense of self-loathing on a daily basis. Detailed diagnostic assessment shows that Meg has no other psychiatric problems. Her family history is positive for both alcohol and substance use disorders.

## History

Kleptomania has been mentioned in the medical and legal literature for centuries.

Swiss physician Andre Matthey first used the term, 'klopemanie' to describe thieves who impulsively stole unneeded items out of pure insanity.<sup>6</sup> French physicians Jena Etienne Esquirol and C.C. Marc later changed the word to 'kleptomanie,' to describe behavior characterized by irresistible, involuntary urges. The person with 'kleptomanie' was therefore "forced to steal" due to a mental illness, not a lack of moral fortitude.<sup>7</sup> Due to the perception that such behavior only affected women, explanations at the end of the 19<sup>th</sup> century referred to uterine diseases or premenstrual tension as possible causes of kleptomania.<sup>7</sup> By the early 20<sup>th</sup> century, the female reproductive system as the cause for this behavior was discarded along with virtually all clinical or research interest

in the disorder.<sup>6</sup> Kleptomania's unclear medical status was reflected again in the Diagnostic and Statistical Manual. The first Diagnostic and Statistical Manual of Mental Disorders (DSM-I 1962) included kleptomania as a supplementary term rather than a formal diagnosis, but in the DSM-II (1968) kleptomania was omitted all together. It was later reintroduced in the DSM-III (1980) as an impulse-control disorder not elsewhere specified, where it remains in the DSM-IV-TR (2000).<sup>8-11</sup> Only in the last 15 years, however, has there been a body of scientific research to confirm kleptomania's status as a legitimate psychiatric disorder.

## Clinical characteristics

The DSM-IV-TR sets forth the following diagnostic criteria for kleptomania: 1) recurrent failure to resist impulses to steal objects that are not needed for personal use or for their monetary value; 2) increasing sense of tension immediately before committing the theft; 3) pleasure, gratification, or relief at the time of committing the theft; 4) the stealing is not committed to express anger or vengeance and is not in response to a delusion or a hallucination; and 5) the stealing is not better accounted for by conduct disorder, a manic episode, or antisocial personality disorder.<sup>11</sup>

Criteria #1 states that the stolen items are "not needed for personal use or their monetary value." In our case vignette, Meg fits this criterion by stealing inconsequential items. This criterion excludes from the diagnosis people who steal primarily in order to sell the items for money or out of need (e.g. stealing to feed starving family). Although case examples have often shown the peculiarity of the stolen items, the items themselves are not always peculiar and do not appear to have any significance in understanding the proposed pathophysiology of the disorder. Many individuals with kleptomania steal desirable and valuable items.<sup>12</sup> For some, the "rush" associated with the theft appears proportional to the monetary value of the item. For others, the value of the stolen objects increases over time, suggestive of tolerance. The stolen items are typically hoarded, discarded, returned to the store, or given away.<sup>13</sup>

Individuals with kleptomania describe the impulse to steal as "out of character," "uncontrollable," or "wrong". Although a sense of pleasure, gratification, or relief is experienced at the time of the theft, individuals will describe feelings of guilt, remorse, or depression soon afterwards.<sup>12</sup> Often due to this sense of shame, individuals with kleptomania present for treatment many years after the onset of stealing.<sup>13,14</sup> In a study of 22 kleptomaniacs, none of the 15 individuals had told their physician about their shoplifting. Instead, they sought treatment for depressive symptoms or anxiety. They reported fears that the physician would not treat them or that the physician would inform the police. None of the treating physicians screened for kleptomania.<sup>12</sup>

Studies using clinical samples have consistently reported that the majority (approximately two-thirds) of kleptomania patients are women.<sup>12,14-16</sup> Without epidemiological data, however, the true percentage of men and women with kleptomania remains unknown. Some have suggested that greater numbers of females seek treatment for kleptomania because men are more likely to be sent to jail if caught shoplifting.<sup>12,17</sup>

Gender aspects of kleptomania, however, have received little research focus. One study found that men with kleptomania are more likely to have a history of birth trauma.<sup>15</sup> Men with kleptomania also appear less likely to suffer from a co-occurring

eating disorder or bipolar disorder,<sup>15</sup> but they appear to have higher rates of co-occurring paraphilias.<sup>14</sup>

For both men and women with kleptomania, lifetime psychiatric comorbidity with other impulse control (20-46%),<sup>17,18</sup> substance use (23-50%)<sup>12,14</sup> and mood (45-100%)<sup>14,15,18,19</sup> disorders are common. Personality disorders are also common in kleptomania. A study involving 28 individuals with kleptomania revealed that 12 (42.9%) met DSM-III-R criteria for at least one personality disorder, and two (14.3%) met criteria for two personality disorders. Paranoid (17.9%), borderline (10.3%) and schizoid (10.7%) personality disorders were the most common.<sup>20</sup>

Individuals with kleptomania suffer significant impairment in their ability to function socially and occupationally. Many patients report intrusive thoughts and urges related to shoplifting that interfere with their ability to concentrate at home and at work.<sup>12</sup> Others report missing work, often in the afternoon, after leaving early to shoplift. With the functional impairment that individuals with kleptomania experience, it is not surprising that they also report poor quality of life. In the only study to systematically evaluate quality of life using a psychometrically sound instrument (Quality of Life Inventory), patients with kleptomania, independent of comorbidity, reported significantly poorer life satisfaction compared to a general, non-clinical adult sample.<sup>21</sup> Some patients have even considered suicide as a means by which they could stop themselves from shoplifting.

In addition to the emotional consequences of kleptomania, many patients with kleptomania have faced legal difficulties due to their behavior. Studies have reported that 64% to 87% of kleptomania patients have a history of being apprehended.<sup>16,19</sup> In fact, one study found that patients reported a mean number of lifetime apprehensions of approximately 3 per patient.<sup>22</sup> Although most apprehensions do not result in jail time, early evidence suggests that 15% to 23% of kleptomania patients have been jailed for shoplifting.<sup>19,22</sup>

### Family history

Data is limited on the family history and possible genetics of kleptomania. In the only family history study of kleptomania to use a control group, a significantly higher number of first degree relatives of kleptomania subjects suffered from alcohol use disorders compared to controls.<sup>18</sup> No other significant differences in family history were noted between the groups. High rates of mood disorders, alcohol use disorders, and kleptomania in the first-degree relatives of individuals with kleptomania have also been reported.<sup>12,15,17,18</sup>

### Neurobiology

Although individuals with kleptomania report an inability to resist their urge to shoplift, the etiology of this uncontrollable behavior is unclear. Serotonergic dysfunction in the ventromedial prefrontal cortex has been hypothesized to underlie the poor decision-making seen in individuals with kleptomania.<sup>23</sup> One study examined the platelet serotonin transporter in 20 patients with kleptomania. The number of platelet 5-HT transporters, evaluated by means of binding of 3H-paroxetine, was lower in kleptomaniac subjects compared to healthy controls<sup>24</sup> thereby suggesting some nonspecific serotonergic dysfunction.

One study of neurocognitive functioning in 15 women diagnosed with kleptomania revealed, as a group, no significant deficits in tests of frontal lobe functioning when compared to normative values. Those individuals with greater kleptomania symptom severity, however, had significantly below-average scores on at least one measure of executive functioning.<sup>25</sup> Significantly

higher rates of cognitive impulsivity (measured by the Barratt Impulsiveness Scale, 10<sup>th</sup> version) were found in 11 subjects with kleptomania when compared to a control group of psychiatric patients without kleptomania.<sup>17</sup>

Case reports and neuroimaging studies provide additional clues as to a possible etiology for kleptomania. Damage to the orbitofrontal-subcortical circuits of the brain has been reported to result in kleptomania.<sup>26</sup> Neuroimaging techniques have demonstrated decreased white matter microstructural integrity in the ventral-medial frontal brain regions of kleptomaniacs compared to controls.<sup>27</sup> These images are consistent with findings of increased impulsivity in kleptomaniacs.<sup>17</sup> These studies also support the hypothesis that at least some individuals with kleptomania may not be able to control their impulse to steal.

Further imaging and neuropsychological assessments in a large sample may assist in further elucidating the etiology of this disorder.

### Treatment

Although pharmacotherapy and psychotherapy have shown some early promise in treating kleptomania, only a small number of subjects have been examined. Small case series and case reports constitute the majority of published treatment data. Currently, there are no medications approved by the Food and Drug Administration (FDA) in the United States to treat kleptomania. Case reports examining the efficacy of pharmacotherapy for kleptomania have found a variety of promising treatments: paroxetine,<sup>28</sup> fluvoxamine,<sup>29</sup> escitalopram,<sup>30</sup> a combination of sertraline and the stimulant methylphenidate,<sup>31</sup> imipramine in combination with fluoxetine;<sup>32</sup> and valproic acid.<sup>33</sup> Unfortunately, for every successful case report, there have been other reports demonstrating the ineffectiveness of these medications for kleptomania.<sup>14</sup>

Case series have also been reported in kleptomania. In one case series, 5 subjects with kleptomania reported the efficacy of fluoxetine (4 individuals) and paroxetine (1 individual).<sup>34</sup> A case series of three kleptomaniacs resulted in complete remission of kleptomania symptoms after two months on a combination of topiramate 100 mg/day and citalopram 30 mg/day for a 28-year-old female; topiramate 100 mg/day and paroxetine 60 mg/day for a 32-year-old female; and topiramate 150 mg/day for an 18-year-old male.<sup>35</sup> Lithium administered alone was helpful for only one out of four reported cases, but caused a significant decrease in kleptomania symptoms when augmented with fluoxetine in the case of a 40-year-old female.<sup>36</sup> A case series of two patients suffering from kleptomania treated with naltrexone (50 mg/day and 100 mg/day) reported remission of both urges to steal as well as the stealing behavior.<sup>37</sup>

There have been only two small, open-label trials of medication for kleptomania. One trial examined escitalopram in the treatment of kleptomania. Of 20 subjects treated with open-label escitalopram, 79% reported improvement in stealing behavior. Those who responded to open-label escitalopram were randomized to continue medication or to receive a placebo. The double-blind phase found that 43% of those on medication and 50% of those assigned placebo failed to maintain their response (no statistical difference between these rates), thereby suggesting that no true drug effect occurred.<sup>38</sup>

In another open-label study, 8 out of 10 individuals with kleptomania treated with naltrexone for 12 weeks reported a significant reduction in urges to steal with 20% reporting complete remission of symptoms.<sup>22</sup> The mean effective dose of naltrexone was 145 mg/day. A retrospective, longitudinal study of naltrexone over a three-year period involving 17 individuals with kleptomania treated with naltrexone as monotherapy resulted in 76.5% of subjects reporting reduction in urges to steal, 41.1% ceasing to steal, and 52.9% of subjects rated on the Clinical Global Severity Scale as "not ill at all" or "very mild" in regards to kleptomania symptom severity by the investigator.<sup>39</sup>

Various forms of behavioral, psychoanalytic, psychodynamic, and cognitive-behavioral therapy (CBT) have also been reported as beneficial in treating kleptomania. Cognitive-behavioral therapeutic treatments such as systematic desensitization, aversion therapy, and covert sensitization have all been shown to have benefit in the treatment of kleptomania.<sup>40</sup> There have been no controlled studies of any psychotherapy for kleptomania. Combination treatments using CBT with medication have shown benefit to individuals in case reports. A 43-year-old gentleman with blunt-trauma to the frontotemporal region of the head which resulted in kleptomania-like symptoms was treated with citalopram and CBT and reported remission of all kleptomania symptoms.<sup>41</sup> A 77-year-old woman with late-onset kleptomania (age 73 years) reported cessation of all stealing with a combination of CBT, sertraline 50 mg/day, self-talk, and a self-imposed ban on shopping.<sup>42</sup>

### Conclusion

Kleptomania, a largely unrecognized disorder, presents as a chronic illness for many individuals and causes significant psychological, social and legal repercussions. Since presentation specifically for kleptomania is quite rare, it is important that clinicians recognize the disorder and screen patients appropriately. Various treatments have been helpful in case studies and small treatment studies but more research examining etiology and treatment is needed.

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