

# Clinical Characteristics and Associated Psychopathology of 22 Patients With Kleptomania

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The current study was constructed to detail the demographic, phenomenological, family history, and treatment response data in a group of patients with kleptomania. Twenty-two subjects, drawn from an outpatient population, with uncontrollable urges to steal completed both a semistructured interview that focused on stealing behavior and the Structured Clinical Interview for DSM-IV (SCID). Fourteen women and eight men reported an average age of onset of 16 years and an average symptom duration of 21 years. Sixteen patients (73%) reported particular triggers for

their urges to steal. Seventeen subjects (77.3%) qualified for a lifetime axis I diagnosis and 9 (40.9%) qualified for a current axis I disorder other than kleptomania. These patients reported severe symptoms, with 15 subjects (68%) reporting intense shame or guilt following the thefts. We conclude that kleptomania is a distressing and disabling disorder associated with high rates of psychiatric comorbidity.

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**K**LEPTOMANIA, defined as the recurrent failure to resist the impulse to steal objects not needed for personal use or their monetary value, was first described almost two centuries ago.<sup>1</sup> Although kleptomania is recognized as a distinct psychiatric disorder with a possible prevalence of 0.6%,<sup>2</sup> it remains a poorly understood and under-recognized illness. Currently classified by DSM-IV as an impulse-control disorder, kleptomania is defined by three essential features: (1) failure to resist an impulse to steal unneeded objects; (2) an increasing sense of tension or arousal before committing the theft; and (3) an experience of pleasure, gratification, or release at the time of committing the theft.<sup>3</sup>

Although the studies are few in number, there is a growing body of literature on the phenomenology of kleptomania.<sup>2,4-7</sup> Patients with kleptomania have been described as predominately female, with stealing behavior starting during adolescence.<sup>1</sup> Little is known about the course of the disorder, but it appears to be chronic, with exacerbations and remissions.<sup>8</sup> Studies have reported that patients with kleptomania suffer from high rates of lifetime mood (36% to 100%),<sup>1,6</sup> anxiety (34% to 80%),<sup>1,8</sup> and substance use (22% to 50%) disorders.<sup>5,6</sup> A fragmented clinical picture emerges because of the

limited number of systematic studies of patients with rigorously diagnosed kleptomania.

The purpose of the present study was to construct a detailed demographic and phenomenological picture of patients with kleptomania by reporting stealing behavior, current and lifetime associated psychopathology, as well as family and treatment histories. Additionally, this study provides information on reported triggers to stealing behavior, time course from starting to steal and the development of kleptomania, methods used to resist urges to steal, and a retrospective look at the longitudinal course of the kleptomania symptoms.

## METHODS

Twenty-two subjects were recruited from two sources for an ongoing kleptomania phenomenology study: patients referred to the Impulse Control Disorders Clinic at the University of Minnesota and persons responding to media advertising (newspaper, radio, television) announcing available medication treatment for kleptomania symptoms. After complete description of the study to the subjects, written informed consent was obtained from all participants. The Institutional Review Board for the University of Minnesota approved both the study and the consent.

All subjects met DSM-IV criteria for kleptomania.<sup>3</sup> Whether subjects met DSM-IV criteria for kleptomania was determined by diagnostic interview (by the first author) without the use of a standardized instrument. To determine current comorbid psychiatric disorders, each subject was assessed with the Structured Clinical Interview for DSM-IV (SCID).<sup>9</sup>

We also administered a semistructured interview to elicit demographic data, lifetime comorbid psychiatric disorders, and information on the phenomenology, age of onset, course, associated features, treatment history, and response to treatment of the disorder. Because the SCID covers only certain DSM-IV disorders, a detailed interview assessing a history of impulse control disorders (including impulse control disorders not otherwise specified such as compulsive shopping, psychogenic excoriation, and sexual compulsions) was conducted. Severe personality disorders (e.g., borderline personality disorder, an-

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tisocial personality disorder) were assessed by clinical interview.

Prior treatment history for kleptomania was elicited on interview. Patients were asked about all outpatient, inpatient, and Shoplifters Anonymous treatments they had attended, the length of attendance, and their self-assessed response to those treatments with respect to stealing behavior and urges (full remission of symptoms, moderate improvement, slight improvement, no change, worsening of symptoms).

Patients were asked about family history of psychiatric illness, alcohol use, substance use, and stealing behavior in first-degree relatives. Detailed information was elicited about relatives' patterns of alcohol use, substance use, and stealing. We did not use a standardized interview for family history. All family information was obtained through interviews with the subjects. Only when subjects were able to provide detailed information about first-degree relatives was that information included. No interviews of first-degree relatives were performed, and therefore a rigorous DSM-IV diagnosis of kleptomania of the relatives could not be made. Instead, based on detailed information, a first-degree relative was listed as having probable kleptomania if the described stealing behavior met DSM-IV criteria. Speculation about family members' psychiatric illnesses, substance use, or stealing behavior was not included in the family history data. Of the 144 first-degree relatives of the kleptomania subjects, family history data was obtained on 121 of the first-degree relatives, resulting in 23 relatives (16.0%) being excluded from data analysis.

Stealing behavior of each subject was assessed by the following: frequency of thefts and of urges to steal, the intensity of urges to steal during the week prior to initial assessment (using a 0 to 4 scale with 0 = no urges and 4 = extreme urges), the Global Assessment of Functioning (GAF) scale score,<sup>10</sup> and the Clinical Global Impression (CGI) severity scale (1 = not ill at all, 7 = among the most extremely ill).<sup>11</sup> The CGI was limited to kleptomania symptoms during the previous week. Patients also completed the Eysenck Impulsiveness Questionnaire, a 54-item self-report measurement of impulsiveness, venturesomeness, and empathy.<sup>12</sup>

### Data Analysis

Demographics, items stolen, reported triggers to stealing, methods to resist stealing, current and lifetime psychiatric diagnoses, family history, and treatment history were analyzed as frequencies. Age of onset and variables assessing severity of stealing symptoms (urge intensity and frequency, stealing frequency, GAF, CGI, Eysenck impulsiveness scores) were calculated as mean values accompanied by standard deviations.

To determine which variables predicted a shorter time course from the start of stealing to kleptomania (i.e., lag time), Spearman rho correlations were performed, except with age of onset, where a Pearson *r* correlation was performed. For each dichotomous variable analyzed (reported triggers to stealing: feeling lonely/depressed, boredom/ free time, stress/anxiety, none known; types of stealing behavior: from stores, family, work, friends, family history, gender), *t* tests (two-tailed) were performed to determine if the "no" group differed from the "yes" group with respect to lag time. To determine if any one variable predicted a shorter lag time while controlling for all other variables studied, linear regression analysis was performed.

Kleptomania subjects were compared, based on gender dif-

ferences, with normative means with regard to each subscale score of the Eysenck Impulsiveness Questionnaire. Between-group differences were tested using one-sample *t* tests (two-tailed) for continuous variables. Because there were significant multiple comparisons, we used a Bonferroni correction. Therefore, results which are statistically significant must be associated with a *P* value less than .0083. We do, however, include nonsignificant *P* values in reporting the data but stress that an appropriate alpha level is .0083.

## RESULTS

### Demographic Characteristics

Fourteen female (63.6%) and eight male (36.4%) subjects with kleptomania were studied. The age of the subjects at the time of presentation ranged from 13 to 68 years (mean age,  $37.0 \pm 15.6$ ). The sample included 20 Caucasians (90.9%), one Latino (4.5%), and one Asian-American (4.5%). Twelve (54.4%) of the subjects were married, five (22.7%) were single, four (18.2%) were divorced, and one (4.5%) was widowed. One (4.5%) had not yet completed high school, four (18.2%) had a high school diploma or General Equivalency Diploma, six (27.3%) had some college or trade school education, six (27.3%) had college degrees, and five (22.7%) had schooling beyond college.

### Clinical Characteristics

The reported mean age at onset of stealing behavior was  $16.4 \pm 9.5$  years (range, 3 to 35 years). The mean length of time between the first episode of stealing and onset of kleptomania was  $6.0 \pm 7.2$  years (range, 0 to 24 years). Five (22.7%) of the subjects progressed to kleptomania within 1 year of starting to stealing. One predictor of rapid progression to kleptomania (i.e., within 1 year of starting to steal) was a reported psychiatric illness (no particular form of familial psychopathology) in at least one first-degree relative (correlation coefficient =  $-0.510$ ; *P* = .015). Gender, current or prior history of a psychiatric illness in the patient, having the urge to steal provoked by various triggers, family history of substance use disorders, and family history of stealing were not predictors of rapid progression to kleptomania.

The subjects in this study generally had severe symptoms. All subjects reported stealing because they had urges to steal. On average, the subjects stole  $2.3 \pm 1.5$  times per week and had urges to steal  $3.7 \pm 1.6$  days per week. The subjects had an average CGI severity score  $5.82 \pm 1.05$  and an average urge score of  $3.44 \pm 1.25$  (scale of 0 to 4).

Six subjects (27.3%) reported that their stealing had resulted in psychiatric hospitalization, and four (18.2%) had considered suicide to stop themselves from stealing. In terms of overall functioning, the average GAF score was  $51.55 \pm 7.91$ . All 22 subjects (100%) reported trying unsuccessfully to stop stealing, with the average period of abstinence from stealing being  $20.7 \pm 23.0$  days. Twenty-two subjects (100%) reported increased urges to steal when trying to stop their behavior. Four subjects (18.2%) reported never having a day without symptoms. The inability to stop a behavior that no subject wanted to engage in led to feelings of shame and guilt in 17 (77.3%) of the subjects. Of the 12 married subjects, only five (41.7%) had told their spouses about their behavior due to the shame and guilt. The severity of symptoms did not differ significantly between male and female subjects.

On the Eysenck Impulsiveness Questionnaire, the average subscale scores for the male subjects did not differ significantly from the normative means: impulsiveness =  $13.20 \pm 3.90$  (normative mean,  $8.76 \pm 4.32$ ;  $t = 2.547$ ;  $P = 0.064$ ); venturesomeness =  $12.40 \pm 2.19$  (normative mean,  $10.61 \pm 3.22$ ;  $t = 1.827$ ;  $P = .142$ ); empathy =  $9.20 \pm 3.70$  (normative mean,  $11.22 \pm 3.51$ ;  $t = -1.220$ ;  $P = .289$ ). With respect to the female subjects, the average impulsiveness score ( $11.42 \pm 4.38$ ) was not significantly greater than the normative mean ( $8.17 \pm 4.44$ ;  $t = 2.568$ ;  $P = .026$ ). The female score on the venturesomeness subscale ( $10.42 \pm 3.50$ ) did not differ significantly from the normative mean ( $8.32 \pm 3.83$ ;  $t = 2.074$ ;  $P = .062$ ), nor did the empathy score ( $14.25 \pm 3.33$ ; normative mean,  $14.26 \pm 3.12$ ;  $t = -0.010$ ;  $P = .992$ ).

The subjects reported stealing from several different places. Sixteen subjects (72.7%) reported that their first theft had been in a store, while three subjects (13.6%) reported first stealing from a friend and three (13.6%) reported stealing from a relative the first time. Currently, all 22 subjects (100%) reported stealing from stores. With respect to types of stores, 11 subjects (50.0%) reported stealing from department stores, 10 (45.5%) from grocery stores, eight (36.4%) from clothing stores, and four (18.2%) from houseware stores. On average, subjects reported stealing from  $1.5 \pm 0.6$  types of stores. In addition, eight (36.4%) subjects stole from friends, six (27.3%) stole from work,

and five (22.7%) stole from relatives. Only four subjects (18.2%) reported that there was a change in whom they stole from over the course of the illness.

The actual items stolen were also varied (Table 1). All 22 subjects (100%) reported that they could afford the items they stole. Additionally, all 22 subjects (100%) reported that in the majority of cases, they did not understand why they stole the particular items they did. Fifteen subjects (68.2%) reported that the items they steal have changed over the course of their illness—all 15 subjects reported that the value of items had increased over the years.

Nineteen subjects (86.4%) reported that they kept the items they stole; in fact, 12 of the 19 subjects (63.2%) reported hoarding particular items. Thirteen subjects (59.1%) gave away the items they stole. Four subjects (18.2%) returned items, while one (4.5%) routinely discarded the stolen items. On average, each subject reported  $1.7 \pm 0.7$  different methods of disposing of the stolen items. Only three subjects (13.6%) reported that what they did with the items changed over the course of the illness.

Various triggers were reported as provoking the urge to steal (Table 2). Approximately half (45.5%;  $n = 10$ ) of the subjects reported that stress or anxiety triggered the urge to steal. Other strong triggers included boredom, feeling sad or depressed, or seeing certain items in a store. Six subjects (27%) could identify no known trigger to the stealing urges; these subjects reported often waking in the morning with an urge to steal. Among those subjects who reported having a trigger to their stealing behavior, there was an average of 1.8 triggers per subject. Subjects reported multiple ways in which they attempted to control the urges to steal (Table 2).

**Table 1. Items Stolen by 22 Patients With Kleptomania**

Items Stolen	N	%
Household goods	13	59.1
Groceries/food	10	45.5
Clothing	8	36.4
Tools/mechanical	7	31.8
Games/toys/sports	5	22.7
Toiletries	4	18.2
Books/music	1	4.5

**Table 2. Triggers to Stealing Behavior/Urges and Methods of Resisting Urges in 22 Patients With Kleptomania**

	N	%
Trigger to stealing behavior/urges		
Stress/anxiety	10	45.5
Feeling lonely/depressed	8	36.4
Seeing certain items	7	31.8
Boredom/free time	7	31.8
No known triggers	6	27.3
Sights/sounds of stores	5	22.7
Method of resisting urges		
Thinking about getting caught	18	81.8
Avoid going to stores	14	63.6
Shopping with friends/family	7	31.8
Not leaving the house	5	22.7
Shopping when stores are busy	4	18.2

Fourteen subjects (63.6%) reported a history of being apprehended (average of  $2.6 \pm 1.6$  times per subject), and five (22.7%) reported having been jailed (average of  $1.6 \pm 0.6$  times per subject). Eleven of the 14 subjects apprehended (78.6%) reported that their urges to steal were virtually abolished after the apprehension, but only for an average of  $3.5 \pm 3.9$  days.

Fourteen probands (63.6% of total subjects) reported at least one first-degree relative with a history of a mood disorder. Seven probands (31.8%) had at least one first-degree relative with either alcohol abuse or dependence. Seven probands (31.8%) also reported at least one first-degree relative who had symptoms consistent with probable kleptomania.

#### Current Comorbidity

Table 3 summarizes the current DSM-IV axis I diagnoses of these subjects. The most common current comorbid axis I disorders were mood disorders ( $n = 8$ ; 36.4%). Four subjects (18.2%) were diagnosed with an impulse-control disorder. Substance use disorders were also diagnosed in four subjects (18.2%). Thirteen subjects (59.1%) had no other axis I disorder comorbid with kleptomania. Two subjects (9.1%) had borderline personality disorder as assessed by diagnostic interview. No one had antisocial personality disorder.

#### Lifetime Comorbidity

Table 3 also summarizes lifetime comorbidity of DSM-IV axis I disorders, including other impulse control disorders that were screened for by SCID and by detailed clinical interviews. Sixteen sub-

jects (72.7%) had at least one lifetime axis I disorder other than kleptomania. The most common lifetime comorbid disorders were mood disorders (59.1%;  $n = 13$ ), impulse-control disorder (45.5%;  $n = 10$ ), anxiety disorder (36.4%;  $n = 8$ ), and substance use disorders (36.4%;  $n = 8$ ).

#### Treatment History

In terms of prior treatments, 15 (68.2%) subjects had previously sought medication treatment. None of the 15 subjects told their treating physician about the kleptomania symptoms; instead medication was sought for anxiety or depressive symptoms. Of note, no treating physician had screened for kleptomania symptoms. Eight of the 15 subjects (53.3%) had tried fluoxetine (mean dose, 50 mg/d for 5.3 weeks). Six of the eight (75%) taking fluoxetine reported no change in kleptomania symptoms, while two (25%) reported moderate improvement. Four of the 15 subjects (26.7%) reported a trial of sertraline (mean dose, 88 mg/d for 8.3 weeks). All four reported no change in kleptomania symptoms. Other medication trials included citalopram (tried by three patients; mean dose, 43

**Table 3. Current and Lifetime DSM-IV Diagnoses in 22 Patients With Kleptomania**

Diagnosis	Current		Lifetime	
	N	%	N	%
Mood disorders				
Major depressive disorder	7	31.8	10	45.5
Bipolar disorder	1	4.5	2	9.1
Depressive disorder NOS	0	0	1	4.5
Anxiety disorders				
Obsessive-compulsive disorder	1	4.5	2	9.1
Generalized anxiety disorder	1	4.5	2	9.1
Panic disorder	0	0	3	13.6
Social phobia	0	0	1	4.5
Substance use disorders				
Alcohol dependence	4	18.2	4	18.2
Other abuse/dependence	2	9.1	3	13.6
Alcohol abuse	0	0	1	4.5
Eating disorders				
Anorexia nervosa	1	4.5	0	0
Binge eating disorder	0	0	3	13.6
Impulse-control disorders				
Compulsive sexual behavior	2	9.1	1	4.5
Compulsive buying	1	4.5	2	9.1
Skin picking	1	4.5	2	9.1
Pathological gambling	0	0	3	13.6
Trichotillomania	0	0	2	9.1
Pyromania	0	0	1	4.5
Intermittent explosive disorder	0	0	1	4.5



mg/d for 4.5 weeks), paroxetine (tried by two patients; mean dose, 60 mg/d for 4.0 weeks), and fluvoxamine (tried by two patients; mean dose, 225 mg/d for 6.5 weeks). None of the subjects taking citalopram, paroxetine, or fluvoxamine reported changes in kleptomania symptoms.

Seven subjects (31.8%) had undergone some form of outpatient therapy treatment (group therapy or individual therapy). Although the majority ( $n = 4$ ; 57.1%) reported no response to outpatient treatment, approximately one fourth (28.6%;  $n = 2$ ) of the subjects engaged in therapy reported slight improvement in kleptomania symptoms (by patients' subjective reports). One subject who received therapy (14.3% of those receiving therapy) reported a worsening of kleptomania symptoms after starting individual therapy

## DISCUSSION

This study examined the characteristics of a large group of patients with kleptomania. The results show that stealing behavior began in adolescence. The majority of the subjects in this sample were female (the female-to-male ratio was 1.8:1), supporting the impression from the literature that kleptomania is more common in females.<sup>1,4</sup> Although there were more women represented in this study, the demographic or phenomenological picture of kleptomania in the men did not differ significantly from that seen in the women.

The results also show that, although stealing began in adolescence, the average age for the onset of kleptomania was approximately 6 years after starting to steal (range, 0 to 24 years). Why some subjects steal for years before it results in uncontrollable urges to steal and others develop a problem almost immediately is still unclear. A family history of psychiatric illness was the only predictor of developing kleptomania within 1 year of beginning to steal. Whether there is some biological determinant of the progression to kleptomania is unknown. Gender, type of stealing behavior, frequency of stealing, and specific triggers to stealing do not seem to predict who is more likely to develop kleptomania in a shorter time span.

The subjects stole a range of items and stole from various locations. The majority of the subjects stole from stores. This finding is consistent with the activity of subjects with kleptomania found in other studies.<sup>6</sup> Furthermore, our finding

that subjects stole from 1.5 types of stores suggests that once a subject with kleptomania engages in a particular stealing activity, he or she tends not to steal from multiple locations. Patients with kleptomania tend to be specific in what they steal and from whom.

These results also show that although the type of items stolen did not change over the course of the illness, the expense of particular types of items increased. Patients reported that this increase was necessary to relieve the worsening sense of anticipatory tension they experienced shortly before thefts. After years of stealing, they needed more expensive items to relieve their anxiety. What this finding tells us about the progression of kleptomania and the possible neurochemistry of impulsivity has yet to be elucidated.

The majority of our subjects appeared to have significant family histories of psychiatric illnesses, substance use disorders, and kleptomania. The finding of high rates of mood and substance use disorders in first-degree relatives is consistent with the literature.<sup>6</sup> However, our finding that approximately 32% of our probands had at least one first-degree relative with kleptomania is considerably higher than previously reported.<sup>6</sup> Although, there are no controlled family history studies or genetic studies of kleptomania, our finding of a relatively high rate of kleptomania in first-degree relatives may simply suggest a common pathophysiological disturbance that manifests itself as either an impulse disorder or mood disorder. This rationale would be consistent with the hypothesis of kleptomania as an affective spectrum disorder.<sup>1,13</sup> Although the connection between kleptomania and familial alcohol abuse has not been studied, the high rate of alcohol abuse in first-degree relatives of our probands is consistent with studies of alcoholic families. Relatively high levels of behavioral disinhibition differentiate the children of alcoholics from nonalcoholics.<sup>14</sup> Just as general behavioral disinhibition may be familial, the development of kleptomania may be similarly affected by this behavioral trait. The exact influence of genetics and environmental risk factors is, however, just beginning to be explored.

The current and lifetime prevalence of other psychiatric disorders raises several questions about the nosology of kleptomania. Our finding that approximately 73% of the subjects had a lifetime

history of psychiatric illness is consistent with the literature findings of high rates of associated psychopathology, particularly major depressive disorder.<sup>1,6</sup> Our results differ from the literature, however, in several important respects. First, the rates of lifetime and current bipolar disorder in our sample were only 9% and 4.5%, respectively. Unlike the literature that equates kleptomania with manic or hypomanic states,<sup>13</sup> our results do not support a link between kleptomania and bipolar disorder. Similarly, previous studies have found high rates of current and lifetime anxiety disorders, particularly obsessive compulsive disorder (OCD).<sup>1,6</sup> Our results showed only a 36% lifetime rate of anxiety disorders (9% OCD) and a 9% current comorbidity with anxiety disorders. Many investigators have argued that kleptomania should be thought of as an OCD spectrum disorder, and support this point by citing similarities in phenomenology and increased rates of comorbidity between kleptomania and OCD.<sup>15</sup> The results of this study, however, do not support the comorbidity between kleptomania and OCD. Instead, the lifetime comorbidity with impulse control disorders argues for its current nosological status.

Although current treatment strategies are based only on case reports, there is some evidence that symptoms of kleptomania may respond to various treatment approaches: psychoanalysis, insight-oriented psychotherapy, combined covert sensitization with exposure and response prevention, and pharmacotherapy.<sup>6,16-23</sup> An understanding of the phenomenology of kleptomania may therefore have treatment implications. Virtually no subject in this study found significant symptom relief with the available pharmacological or therapeutic treatments. While a small number of case reports cite improvement using tricyclic antidepressants, selective serotonin reuptake inhibitors (SSRIs), lithium, or valproate,<sup>6,19-23</sup> there are no data concerning either effective dosages or duration of medication trials. Although the lack of response to previous medication and outpatient therapy in our sample may reflect a selection bias (e.g., patients who improved with other treatments would not have sought assistance in our clinic), this finding argues for further studies both of pharmacotherapy and of psychotherapy in treating this disorder. Additionally, the fact that certain triggers to stealing urges

or behavior exist may prove useful in devising cognitive behavioral therapies to treat this disorder.

### *Limitations*

This study's findings are affected by several methodological limitations. First, the patients were recruited by referrals or advertisements for medication treatment. This form of recruitment may limit the study sample to only those who are really motivated for medication treatment. What this means, in terms of addictions and human behavioral change, is that our subjects may include only those in the preparation (action) phase or the maintenance/relapse prevention phase, not the denial or precontemplation and contemplation phases.<sup>24</sup> Thus, our study sample may not represent all people suffering from kleptomania.

The second limitation is that the interviews were performed by non-blind investigators. Nonetheless, the rates of associated psychopathology were so striking that they seem unlikely to be purely artifactual. Although not every aspect of this sample is generalizable to all patients with kleptomania, they may well describe a significant number or a meaningful subset of those with the disorder.

Additionally, the data concerning family history of mood disorders, kleptomania, and substance use must be interpreted cautiously because the family members were not directly interviewed. The investigators also failed to use a standard interview to collect family history. This lack of a standard interview may have resulted in an underestimation of the prevalence of psychiatric disorders within the family. Thus, further studies are needed to analyze the relationship between family history and kleptomania.

Finally, there are limitations concerning the treatment history data of these subjects. None of the subjects who had previously sought treatment had disclosed their kleptomania to their treating physicians. Thus, the treatment could not be targeted to the kleptomania symptoms and may therefore have been underdosed.

### *Conclusion*

Kleptomania appears to be a disorder associated with significant personal distress and associated psychopathology. These findings must be considered preliminary. Further investigation into the phenomenology, course, biology, family history, and response to treatment of kleptomania appears warranted.

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