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KLEPTOMANIA INVOLUNTARY STEELING DISORDER

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ABSTRACT

Kleptomania is an enigmatic pathological condition in which crime (theft) forms a part of its diagnostic criteria. Not surprisingly, it is commonly used by the defence counsel for mitigation of theft and related offenses, especially for repeat theft offenders. Kleptomania is described in both the medical and legal literature for centuries, dating back to the early 19th century when the Swiss physician Mathey who worked with the "insane" wrote of "an uncommon madness characterized by the aptitude to steal without motive and without necessity. This article reviews the literature for what is known about the clinical characteristics, family history, neurobiology, and treatment options for a person(s) with kleptomania. Like other impulse control disorders, kleptomania is characterized by an anxiety-driven to perform an act that is pleasurable at the moment but causes identifiable distress and dysfunction. Careful attention should be given to distinguishing kleptomania from an antisocial personality disorder. Unlike the later disorder, kleptomania is identified by the presence of guilt and remorse and the lack of theft motives such as monetary gain, personal use, stealing to impress someone, or stealing to support a drug habit. Here, we describe the demographic and clinical characteristics of 40 subjects meeting DSM-IV criteria for kleptomania. We conclude with advice for treatment options derived from the scant literature available.

INTRODUCTION

Kleptomania, also referred to as uncontrollable 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 many clinical samples advice that it is not uncommon. A recent study of adult psychiatric in-patients with multiple disorders revealed that 7.8% endorsed current symptoms consistent

with a diagnosis of kleptomania, and 9.3% had a lifetime diagnosis of kleptomania. A study of 102 adolescents hospitalized for a variety of psychiatric disorders found that 8.8% suffered from kleptomania. Because rates appear comparable 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 known that 4 (3.7%) suffered from kleptomania. In a study of 79 patients with alcohol dependence, 3 (3.8%) also reported symptoms dependable on kleptomania. Although these studies suggest that kleptomania is not a unique behaviour, this disorder remains poorly understood with little treatment data . Based on the frequent growth in kleptomania research, this article will detail what is currently known about the clinical characteristics, pathophysiology, and treatment of this disabling disorder.

History

Kleptomania has been specified in the medical and legal literature for centuries. Swiss physician Andre Matthey first used the term, 'klopemanie' to define thieves who impulsively stole unneeded items out of pure insanity . 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 determination. Due to the perception that such behavior only affected women, explanations at the end of the 19th century referred to uterine diseases or premenstrual tension as possible causes of kleptomania . In the early 20th century, the female reproductive system as the cause for this behaviour was discontinued along with virtually all clinical or research interest in the disorder. Kleptomania's ambiguous medical status was reflected again in the Diagnostic and Statistical Manual. The first Diagnostic and Statistical Manual of Mental Disorders (DSM-I 1962) contained kleptomania as a supplementary term rather than a formal diagnosis, but in the DSM-II (1968) kleptomania was omitted all together. It was later evoking in the DSM-III (1980) as an impulse-control disorder not elsewhere specified where it remains in the DSM-IV-TR (2000). In the past 15 years, however, has there been a body of scientific research to confirm kleptomania's status as a legitimate psychiatric disorder.

Table 1: Demographic characteristics in 40 subjects with DSM-IV – defined kleptomania.

Characteristic	Value
Gender, N (%)	
Male	15 (37.5)
Female	25 (62.5)
Age, y	
Mean (SD)	45.6 (11.1)
Range	20–68
Marital status, N (%)	
Single	11 (27.5)
Married or partnered	19 (47.5)
Divorced	10 (25.0)
Age at onset, y	
Mean (SD)	17.1 (11.9)
Range	5–55
Onset before age 11, N (%)	14 (35.0)
Course, N (%)	
Continuous	29 (72.5)
Episodic	11 (27.5)
No. of stealing episodes in the prior 2 weeks	
Mean (SD)	7.2 (10.3)
Range	0–30
Longest period without stealing, mo	
Mean (SD)	15.0 (42.1)
Range	0.1–240.0
Household income, $	
Mean (SD)	57,321 (52,405)
Range	0–250,000
Employment status, N (%)	
Full-time	16 (40)
Part-time	6 (15)
Unemployed	18 (45)

Of the 40 study participants, only 2 subjects (5.0%) had obtained medication treatment for kleptomania. They had been prescribed sertraline and fluoxetine, at unknown doses, with only lower benefits. Thirteen participants (32.5%) had received counseling specifically targeting kleptomania: 11 (27.5%) had been treated in individual psychotherapy and 2 (5.0%) in group psychotherapy. Two subjects (5.0%) undertook therapy to comply with a court order that followed an arrest. None of the subjects who received psychotherapy experienced any sustained enhancement in their symptoms.

Table 2: Lifetime psychiatric co morbidities in 40 subjects with DSM-IV- Defined kleptomania.

Comorbidity	N (%)
Major depressive disorder	14 (35.0)
Attention-deficit/hyperactivity disorder	3 (7.5)
Generalized anxiety disorder	2 (5.0)
Obsessive-compulsive disorder	2 (5.0)
Compulsive shopping disorder	1 (2.5)
Anorexia nervosa	1 (2.5)
Bulimia nervosa	1 (2.5)
Dissociative disorder not otherwise specified	1 (2.5)
Cannabis abuse	2 (5.0)
Methamphetamine abuse	1 (2.5)
Cocaine abuse	3 (7.5)
Alcohol abuse	3 (7.5)
No psychiatric comorbidity	6 (15.0)

Thirty-one subjects (77.5%) had been under arrest for shoplifting. The mean number of arrests for the group was 2.4 (median = 2; range, 0 to 10), and 7 subjects (17.5%) had served jail time.

Almost every subject (N = 39, 97.5%) had actively lied about their kleptomanic behavior to spouses and close family members. Nineteen subjects (47.5%) felt that hiding this consuming problem from loved ones led directly to deterioration of those relationships. For 17 subjects (42.5%), kleptomanic behavior seriously impaired work productivity through work time wasted dealing with the urges, the guilt that follows the theft, and the personal and legal consequences of the behaviour.

Clinical characteristics

The DSM-IV-TR sets first the following diagnostic criteria for kleptomania:

1. Frequent failure to resist impulses to steal objects that are not important for personal use or for their monetary value;
2. Enhancing sense of tension immediately before committing the theft;
3. Pleasure, gratification, or relaxation at the time of committing the theft;
4. The stealing is not committed to show anger or vengeance and is not in response to a delusion or a hallucination; and
5. The stealing is not better considered for by conduct disorder, a manic episode, or antisocial personality disorder.

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 removes 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 distinctiveness 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 costly items . Individuals with kleptomania explain the impulse to steal as "out of character," "uncontrollable," or "wrong". Although a sense of pleasure, gratification, or relief is sophisticated at the time of the theft, persons will describe feelings of guilt, remorse, or depression soon afterwards. Often due to this sense of shame, persons with kleptomania present for treatment many years after the onset of stealing . In an analysis of 22 kleptomaniacs, none of the 15 individuals had expressed their physician about their

shoplifting. Instead, they sought treatment for depressive symptoms or anxiety. They reported fears that the physician would not cure them or that the physician would complain the police. Studies using clinical samples have frequently reported that the majority (approximately two-thirds) of kleptomania patients are women. Without epidemiological data, however, the accurate 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. Gender aspects of kleptomania, however, have acquired little research focus. One elucidated that men with kleptomania are more likely to have a history of birth trauma. Men with kleptomania also appear less likely to suffer from a co-occurring eating disorder or bipolar disorder, but they appear to have higher rates of co-occurring paraphilias.

For both genders with kleptomania, lifetime psychiatric comorbidity with other impulse control (20-46%). substance use (23-50%) and mood (45-100%) disorders are frequent. Personality disorders are also frequent in kleptomania. A study involving 28 individuals with kleptomania showed 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 typical. Individuals with kleptomania suffer important impairment in their ability to function socially and occupationally. Many patients report intrusive thoughts and urges related to shoplifting that mediate with their ability to concentrate at home and at work . With the functional impairment that person 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. Some patients have even considered suicide as a means by which they could control themselves from shoplifting.

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

Family history

Data is restricted on the family history and possible genetics of kleptomania. In the only family history study of kleptomania to use a restricted group, a significantly higher number of first degree relatives of kleptomania subjects suffered from alcohol use disorders compared to controls. No other important 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 complained.

The diagnostic criteria for kleptomania

- Recurrent failure to resist impulses to steal objects that are not needed for personal use or for their monetary value
- Increasing sense of tension immediately before committing the theft
- Pleasure, gratification, or relief at the time of committing the theft
- The stealing is not committed to express anger or vengeance and is not in response to a delusion or a hallucination
- The stealing is not better accounted for by conduct disorder, a manic episode, or antisocial personality disorder

CASE REPORTS

Case 1

A 45-year-old, divorced Chinese male was arrested three times in the same year for the same charges and evaluated specifically with regard to kleptomania. He had attained the GCE 'A' Level qualifications and lost his job. In past he has been diagnosed with conduct disorder, alcohol dependence, depression, and antisocial personality disorder. He had started shoplifting from the age of 29. The diagnosis of kleptomania had been advised a few times but not established because of the lack of validation of his self-reported history of kleptomaniac pattern of stealing and the presence of other diagnoses that are assumed to inhibit kleptomania according to the criteria. What further complexes the diagnostic issue was that he was likely to have been intoxicated by alcohol at the material time. He gave a history of stealing for fun together with colleges during his teenage. He started stealing again in his late twenties, executing the act more times than he was caught and he was a prisoner for shoplifting items that he had no personal use for. However, the house had been sold after his divorce, and his ex-wife could only verify seeing many electronic and stationery items that were never used and said that he claimed they had been given to him by people who unpaid his money. He also reported that he only stolen on impulse and not from

premeditation; he noticed tension prior to, and satisfaction after, shoplifting. In order to confirm his history, details of his past criminal records of theft were requested from the Investigating Officer in charge of his case, and they were fairly logical with what he reported. This case is interesting in that even though he had been diagnosed with behavioural disorder and antisocial personality disorder, there was no proof that these conditions counted for all his acts of stealing, and that there were distinctly different types of stealing at different points in his life. He was lastly diagnosed with antisocial personality disorder, alcohol dependence and kleptomania, and it was come to an end that kleptomania contributed to only some of his offences.

Case 2

A 46-year-old, married Chinese male, who had achieved the GCE 'A' Level qualifications and worked part-time, started stealing in after his adolescence and had several confidence for theft. He had also been formerly diagnosed with OCD (repeated checking and washing secondary to compulsions of pathological doubt and contamination) and kleptomania. His index infraction included stealing several cash cards at different points of time. He stated that he had a sudden urge to steal cash cards upon seeing unlocked cars, accompanied by heightened anxiety and then getting a sense of satisfaction and gratification after the completion of theft. These acts were not premeditated. He declared that he would feel ashamed of himself after his acts and would place the cash card(s) either in a box or a card holder at home. His family members accepted that they had found a box and card holder containing more than 100 cash cards. Out of several stolen cash cards, he had transferred the cash value of one card into his bank account. Stealing items for their financial value excludes the diagnosis of kleptomania; this case highlights the point that kleptomaniacs can have acts of stealing that are not considered for by the laid diagnostic criteria. It also signifies a complex relationship between impulse control disorders and OCD, heterogeneity within the impulse control disorders, and a complicated overlay between impulsivity and compulsivity.

Case 3

A 60-year-old, divorced Indian woman who had finished Primary 6 education and had various manual jobs, initiated shoplifting from the age of 30. She had multiple dogmas of theft and several remand admissions. She was diagnosed with frequent depression. She reported acts of stealing both during and after her depressive episodes. The acts of stealing were typically due to failure to withstand the tension and strong urge to take the items

without paying and feeling satisfied after taking them. She stated that the acts of shoplifting aided to lift her mood temporarily during the depressive episodes. However, she would later feel blameworthy, which subsided when she either threw away or gave the items to others. Regarding her shoplifting behaviours when she was not suffering from depressive episodes, she stated she could identify that her mood would be marginally low during those times but she was still capable to function normally. The diagnostic criteria for kleptomania do not forbid depressive disorders as a contributory factor for the diagnosis of kleptomania. This case clarifies that depressive disorder is closely linked to kleptomania and makes us think whether kleptomania may symbolize another form of affective spectrum disorder.

Neuron biology

Although individuals with kleptomania complain an inability to withstand their urge to shoplift, the aetiology of this uncontrollable behaviour is unclear. Serotonergic dysfunction in the ventromedial prefrontal cortex has been hypothesized to underlie the poor decision-making seen in individuals with kleptomania . One study investigated the platelet serotonin transporter in 20 patients with kleptomania. The number of platelet 5-HT transporters, assessed by means of binding of 3H-paroxetine, was lower in kleptomaniac subjects correlated to healthy controls thereby suggesting some nonspecific serotonergic dysfunction. One study of neurocognitive functioning in 15 females was diagnosed with kleptomania revealed, as a group, no significant blemish 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 administrative functioning . Significantly higher rates of cognitive impulsively (measured by the Barratt Impulsiveness Scale, 10th version) were found in 11 subjects with kleptomania when compared to a control group of psychiatric patients without kleptomania. Case reports and neuroimaging analysis provide additional clues as to a possible aetiology for kleptomania. Damage to the orbitofrontal-subcortical circuits of the brain has been announced to result in kleptomania. Neuroimaging techniques have determined decreased white matter micro structural integrity in the ventral-medial frontal brain regions of kleptomaniacs correlated to controls. These images are logical with findings of increased impulsivity in kleptomaniacs. These studies also support the assumption 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 help in further elucidating the aetiology of this disorder.

Treatment

Although pharmacotherapy and psychotherapy have shown some initial promise in treating kleptomania, only a small number of subjects have been observed. Small case series and case reports comprise the majority of published treatment data. Currently, there are no medications approved by the Food and Drug Administration (FDA) in the United States to cure kleptomania. Case reports investigating the efficacy of pharmacotherapy for kleptomania have found a variety of promising treatments: paroxetine, fluvoxamine, escitalopram a combination of sertraline and the stimulant methylphenidate, imipramine in combination with fluoxetine; and valproic acid. Regrettably, for every successful case report, there have been other reports demonstrating the ineffectiveness of these medications for kleptomania. In one case series, 5 subjects with kleptomania reported the potency of fluoxetine (4 individuals) and paroxetine (1 individual).

A case series of three kleptomaniacs ensued 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. Lithium administered alone was advantageous for only one out of four reported cases but caused a significant decrease in kleptomania symptoms when improved with fluoxetine in the case of a 40-year-old female. A case series of two patients suffering from kleptomania treated with naltrexone (50 mg/day and 100 mg/day) reported acquittal of both urges to steal as well as the stealing behaviour. There have been only two small, open-label trials of medication in a chart for kleptomania. One trial inspected escitalopram in the treatment of kleptomania. Of 20 subjects treated with open-label escitalopram, 79% reported enhancement in stealing behaviour. Those who responded to open-label escitalopram were randomized to prolong medication or to receive a placebo. The double-blind phase found that 43% of those on medication and 50% of those allowed placebo failed to maintain their response (no statistical difference between these rates), thereby advising that no true drug effect occurred. In another open-label study, 8 out of 10 individuals with kleptomania treated with naltrexone for 12 weeks reported a noticeable reduction in urges to steal with 20% reporting complete remission of symptoms. The mean effective dose of naltrexone was 145 mg/day. A retrospective&longitudinal study of naltrexone over a three-year period including 17 individuals with kleptomania treated with naltrexone as monotherapy resulted in 76.5% of subjects reporting reduction in urges to steal, 41.1% preventing 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. Various forms of behavioural, psychoanalytic, psychodynamic, and cognitive-behavioural therapy (CBT) have also been reported as useful in treating kleptomania. Cognitive-behavioural therapeutic treatments such as systematic desensitization, aversion therapy, and covert sensitization have all been shown to have an advantage in the treatment of kleptomania . There have been no restricted studies of any psychotherapy for kleptomania. Combination treatments using CBT with medication have shown benefit to individuals in their case reports. A 43-year-old gentleman with blunt-trauma to the front temporal region of the head which resulted in kleptomania-like symptoms was treated with citalopram and CBT and reported remission of all kleptomania signs. A 77-year-old woman with late-onset kleptomania (age 73 years) reported compulsion of all stealing with a combination of CBT, sertraline 50 mg/day, self-talk, and a self-imposed ban on shopping.

CONCLUSION

Kleptomania has a number of victims: the patient, the family, the person or institution stolen from, and society at large, which acquires a burdened legal system and an inflated price of goods. Given the secrecy and humiliation that surround it, kleptomania often goes undiagnosed. General medical practitioners have a unique opportunity to diagnose for this illness, thus helping to prevent what is commonly a lifetime of symptoms. While collecting the social history, inserting a neutral question about any present or past legal problems may be sufficient to present clues to the diagnosis and prompt a psychiatric referral. Additional questions could look into “frequent, disturbing urges to take things that don't belong to you.” Empathy, careful diagnosis, and primary intervention are crucial if we are to diminish the considerable personal, legal, and economic costs of kleptomania. Research comparing many psychotherapies and medication approaches to treating this disorder is clearly needed. Double-blind, placebo-controlled trials should be conducted to test the relative effectiveness of various medications; particularly serotonergically potent drugs that have been shown to be effective in other disorders of impulse control.

Drug names: buspirone (BuSpar and others), escitalopram (Lexapro), fluoxetine (Prozac and others), lithium (Lithobid, Eskalith, and others), naltrexone (Revia and others), sertraline (Zoloft), topiramate (Topamax), trazodone (Desyrel and others), valproic acid (Depakene and others).

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