Kleptomania: An Overview

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Kleptomania is an irresistible impulse to steal unneeded objects, which appears to spare no segment of the population. Indeed, stories of the theft of easily affordable items among Hollywood stars and other high-profile people are not uncommon.

A recent review of the literature revealed that the typical person suffering from kleptomania might have the following profile: a 35-year-old married female who has been apprehended for the theft of items she could easily afford and did not need. Her stealing began at age 20, although it may have started sooner, and she has been caught several times. A search of her house revealed numerous cans of food that she never uses. Her stealing brings relief from tension. She may force herself to remain indoors for fear that she will resume her stealing. Although perhaps feeling entitled about the thefts, she feels guilty but almost never seeks treatment on her own.

Because of guilt or shame, or perhaps because she is fearful of losing the opportunity to steal, she feels compelled to keep the habit a secret. She appears to suffer from a necessary, repetitive, and seemingly self-destructive act. A personal history reveals that she may be unhappily married and may have sexual difficulties. She has felt dysphoric and moody for many years. The chances appear good that she has had a stressful and tumultuous childhood. Additionally, she may have a personality disorder.

The symptoms may begin in childhood and can continue intermittently throughout adulthood. DSM-III-R describes the disorder as follows:

...a recurrent failure to resist impulses to steal objects not needed for personal use or their monetary value; the objects taken are either given away, returned surreptitiously, or kept and hidden. Almost invariably the person has enough money to pay for the stolen objects. The person experiences an increasing sense of tension immediately before committing the act and intense gratification or relief while committing it. Although the theft does not occur when immediate arrest is probable, it is not preplanned, and the chances of apprehension are not fully taken into account. The stealing is done without long-term planning and without assistance from, or collaboration with, others. Further, there is no association...
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for women (onset, age 20) and 50 for men (age of onset unknown). The typically long period between onset and presentation seems to reinforce the belief that kleptomania is a behavior that is extremely difficult to self-extinguish and that it is difficult to detect. However, it seems clear that the disorder is a pattern that is established early on.

PSYCHOLOGICAL MODELS OF ETIOLOGY

Depressive states and tension are frequently reported as precursors to many kinds of theft. Yates found depression in 80% of those who engaged in nonsensical shoplifting. There is descriptive evidence that those with the disorder suffer from a spectrum of affective states, ranging from dysthymia to psychotic depression that may have been chronic.

Underscoring the apparent link between kleptomania and affective illness, some researchers have noticed an association between bulimia, kleptomania, and depression. Since those with the disorder experience symptoms of anxiety and depression, several authors have commented that the act of kleptomania is an antidepressant, helping temporarily to resolve feelings of tension, with the behavior acting also as a stimulant.

Many writers have traditionally likened the stealing behavior to a sexual act or felt that the objects stolen represented fetishes. Although a controversial topic, a recent review found that sexual preoccupations or maladaptive sexual behaviors or intrusive thoughts may not be rare. Many also felt that the items taken were symbolic representations of psychosexual fixations.

In proposing etiological models, analytic writers felt that kleptomania and other forms of stealing were attempts to gratify id impulses, used as expressions of infantile needs, or as restitution for a lack of early love. Ego psychology saw a woman's kleptomania as defensive, representing a fight against castration anxiety, or as a defense against passive longings and wishes in boys. Confirmation of these more historic formulations is difficult because most contemporary case reports of kleptomania lack important information about associations and transference phenomena, as well as family data. Although these analytic writers discussed theft and not kleptomania specifically, they seemed to consider the two to have the same meanings and causes, although there may be some important differences.

Yates suggests, for example, that those who engage in theft for obvious material profit have characteristics more consistent with antisocial personalities, while individuals who steal nonsensically are socially isolated and depressed. Cupchik and Acheson, in discussing thievery among "upstanding" citizens (some of whom may have been suffering from kleptomania), felt that theft was an effort to obtain symbolic compensation for an actual or anticipated loss.

Some writers have chosen to see people suffering from kleptomania as having either an antisocial character formation or underdeveloped superego, while others felt that the superego was hypertrophied with the behavior ultimately resulting in arrest or self-punishment. Recent data suggest that a significant proportion of these patients express guilt or remorse regarding their behavior and do not exhibit antisocial traits.

There are little data available to...
Kleptomania

make a more definitive determination regarding a possible association between kleptomania and personality disorders. Those suffering from kleptomania and those who engage in nonsensical shoplifting, however, report tumultuous and unusually stressful childhoods (concentration camp survival, for example), marital turmoil, social isolation, and lack of self-esteem, making associated personality difficulties perhaps more likely.

Self-psychology and object relations theorists have also offered commentary on the disorder. Castelnuovo-Tedesco, for example, felt that stealing and kleptomania were a way of controlling a frightening and dangerous object and rendering it harmless by reinstating a long-lost but greatly cherished sense of omnipotence. Kligerman saw stealing and kleptomania as a response to narcissistic injuries and as a way to prevent fragmentation of the self.

Kleptomania has also been likened to or considered to be part of an obsessive compulsive disorder (OCD). While DSM-III-R points out that the act of kleptomania may bring intense gratification—an experience that helps differentiate the impulse disorders from OCD—stealing does not appear to be strictly pleasurable and many patients seem to obtain relief from the act, implying that a relationship might exist between kleptomania and OCD.

Based on the apparent uncontrollable drive to repeat what most certainly is an ultimately self-destructive behavior, coupled with other characteristics of those suffering from the disorder, it has recently been suggested that early traumatic experiences may play a role in the development of kleptomania. It has been theorized that the act itself may condition an opiate response, used by the person, for example, to modulate affective states.

**BIOLOGIC AND BEHAVIORAL THEORY**

The literature seems replete with reports suggesting that kleptomania-type behavior can be organically induced. Indeed, medication effects, tumors, dementias, and epilepsy can mimic kleptomania. Mendez, for example, reports a case of a man with dementia and brain lesions who began to steal at age 66.

Other disturbances suggestive of dissociation have also been described. Bleuler, for example, discussed a disturbance in consciousness in his population of patients, as did Bradford and Balmaeda, who found that 12% of a group of shoplifters described a dissociative state. Further study and isolation of brain areas affected may help researchers isolate neurological pathways responsible for the illness' biological substrate.

Since behavioral therapists rely most heavily on outcome and not etiology, few models exist. One author, however, has suggested that her patient's positive response to a trial of covert sensitization implicitly supports a cognitively mediated model of compulsive shoplifting.

**CLINICAL MANAGEMENT**

Because most available data on kleptomania focus on describing the phenomenon, very few reports of successful treatment exist and long-term follow-up is lacking. A variety of techniques, medications, and psychotherapies have been used with inconsistent response.

Behavioral techniques such as covert sensitization have been used with success. Glover, coupling images of nausea and vomiting with a desire to steal, successfully treated a woman who had stolen daily for 14 years.

Pharmacotherapy has met with mixed results. McElroy and colleagues, however, reported that 10 of 18 patients with kleptomania treated with a variety of antidepressants found at least partial relief of their urges and behavior. Combinations of psychotherapy, medication, and behavioral treatment may have the best chance for effective long-term results.

Perhaps the most common method of treatment is the self-imposed banning of all shopping by the patient in an attempt to prevent theft. It may be far more common than reported, since persons suffering from kleptomania can impose such treatment on themselves without having to seek help.

**CONCLUSION**

Our understanding of this complex behavior appears to be in its infancy. Despite the limitations inherent in developing a more complete understanding of the disorder, it appears that a variety of psychological and perhaps even physiological mechanisms are employed at various levels of consciousness. A more complete biological, behavioral, and developmental understanding of the disorder would help alleviate both tremendous cost to the public and untold human suffering. The covert nature of the illness and the hesitation of those afflicted to come forward make obtaining a large sample difficult.

The detection of kleptomania, like the detection of other sensitive issues, may necessitate a lengthy, alliance-based psychotherapy. During the clinician's initial inquiry regarding a history of secretive, impulsive, or compulsive behavior, the patient's first answer is often negative. It is not until later in the therapy, when a therapeutic alliance has been established, that the patient feels free to disclose. Nonetheless, a nonjudgmental inquiry during the evaluation proc-
ess may allow the patient to bring it up at a later date.

REFERENCES