

Kleptomania

Emerging therapies target mood, impulsive behavior

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Kleptomania is a secretive disorder that is often overlooked in clinical practice. Research is limited, but these clinicians have experience in treating patients unable to control the impulse to steal. Here is the approach that works for them.

What *is* kleptomania? An independent illness, a symptom of other psychiatric disorders, or merely criminal behavior? Kleptomania—a disorder defined by an inability to resist the impulse to steal—is one of psychiatry’s most poorly understood diagnoses, even though it has been recognized in the literature for almost 200 years.

Kleptomania causes notable distress and impaired functioning.¹ People with kleptomania often suffer from comorbid mood, anxiety, substance use, and other impulse-control disorders.¹⁻⁴ They experience the humiliation of repeated arrests, which leads to guilt, depression, and even suicide.^{1,5} Yet kleptomania usually goes undiagnosed and untreated, despite a lifetime prevalence as high as 0.6%.⁶

Case report: ‘I’m a thief’

“I’m a thief,” began Susan, age 39. “I steal something four or five times every week. I steal from grocery stores and clothing stores. Sometimes I might steal something like vanilla extract; other times an expensive men’s tie. I probably steal \$200 worth of items every week.

“You probably won’t believe this, but I don’t want or need the stuff I take. I have plenty of money. I have no idea why I take the things I do. That’s why I’m so depressed. What kind of person does something like this?”

The urge to steal “I was probably 14 when I started stealing. I would go to stores with my mother. When I saw certain objects, I would get urges to steal them. The odd thing was

Box

MYTHS AND FACTS ABOUT KLEPTOMANIA

Myth

Fact

Only little old ladies are kleptomaniacs.

Men and women of all ages suffer from kleptomania. Most patients report that the disorder began in adolescence.

It's just a phase kids go through.

Parents of adolescents might see stealing as a phase. In many cases this might be true, but stealing may also suggest an underlying psychopathology.

People who steal are "bad."

People with kleptomania steal because of urges to steal, not because of moral weakness. Treatment, not judgment, is the appropriate response.

that the items I stole were so ridiculous. I remember stealing key chains for several months, maybe three or four times a week. When I got older, things got worse. I was having urges more often, and so I needed to steal more often.

"My entire life has been torment. Each day I worry about having the urges, and then I worry about being caught stealing. I can't relax. I've been married for 17 years, and I haven't told my husband. My secrecy is tearing our marriage apart. My husband thinks I'm having an affair because I've distanced myself emotionally from him."

Susan described urges to steal almost every day. When the urges were mild, she could resist them. Other days they were severe, and Susan felt unable to control her behavior. At work, her urges distracted her from completing projects, and her performance suffered. The urge to steal would often compel Susan to leave work early so she could get to a store.

Calm, then guilt "Every time I steal something I feel both a thrill and a great sense of calm," she said. "It feels good. The problem is that almost immediately after each theft, I feel guilty and ashamed. After I steal, I usually donate the items

to the Salvation Army, throw them away, or give them away as gifts."

Drug trials We started treating Susan with the selective serotonin reuptake inhibitor (SSRI), citalopram. She reported notable improvement in her mood after 3 weeks on a dosage of 60 mg/d and she had been attending weekly psychotherapy, although her stealing continued unchanged. The addition of naltrexone, 200 mg/d for 2 weeks, decreased the frequency of Susan's stealing and reduced her urges to steal, but her symptoms continued to interfere significantly with her overall functioning.

We then added the atypical antipsychotic quetiapine, 100 mg bid, and Susan's urges to steal and stealing behavior went into remission within 3 weeks. She has refrained from stealing for the last 9 months.



Cut

Table 1

SCREENING TEST FOR KLEPTOMANIA

	Yes	No
1. Do you steal or have urges to steal?	<input type="radio"/>	<input type="radio"/>
2. Do thoughts of stealing or urges to steal preoccupy you? That is, do you often think about stealing or have urges to steal and wish the thoughts or urges occurred less often?	<input type="radio"/>	<input type="radio"/>
3. Do you feel tense or anxious before you steal or when you have urges to steal?	<input type="radio"/>	<input type="radio"/>
4. Do you feel pleasure or a sense of calm when you steal something?	<input type="radio"/>	<input type="radio"/>
5. Has the stealing or urges to steal caused you much distress?	<input type="radio"/>	<input type="radio"/>
6. Has the stealing or urges to steal significantly interfered with your life in some way?	<input type="radio"/>	<input type="radio"/>

A patient who answers "yes" to questions 1 through 4 and to question 5 or 6 is likely to have kleptomania.

Adapted from DSM-IV criteria, American Psychiatric Association, 2000

Making the diagnosis

In our clinic, we have treated more than 50 patients with kleptomania. Rather than coming to us through the criminal justice system, they are usually self-referred. Often they contact us after discovering on the Internet that we specialize in treating persons with this disorder.

In our experience, kleptomania typically goes undiagnosed in clinical settings, in part because patients are ashamed and embarrassed to discuss their symptoms with physicians unless specifically asked.¹ If left untreated, however, kleptomania frequently becomes chronic.⁴ If persons with kleptomania are to seek treatment, it is important that family, friends, and mental health professionals understand the myths and facts about this disorder (*Box*).

To make the diagnosis, we use the simple screening instrument shown in *Table 1*.⁷ In general, because of high comorbidity with certain disorders, we screen every patient presenting to our clinic with a mood, substance use, anxiety, or eating disorder, or who has a problem with impulse control. Kleptomania is likely if the patient answers “yes” to questions 1 through 4 and to question 5 or 6. Stealing may be a symptom of several other psychiatric disorders, however, and misdiagnosis is fairly common (*Table 2*).^{6,8}

Data suggest that the female-to-male ratio in kleptomania is approximately 2:1, with onset in adolescence. Typical individuals with kleptomania steal because they have urges to steal, often triggered by specific stimuli such as the sights and sounds of stores or feelings of loneliness or stress.¹ Most patients with kleptomania are fairly specific about the types of stores from which they steal and the items they steal, and most hoard stolen items.¹

Although many patients with kleptomania function quite well, others are severely debilitated in social and occupational realms. In a series of 22 patients with kleptomania:

- 64% had been apprehended

- 23% had served jail time
- 27% had been hospitalized because of their kleptomania symptoms
- 18% had considered or attempted suicide because of the distress associated with their kleptomania.¹

Treatment recommendations

Patient history With patients who steal, we begin by identifying the motivation behind the stealing. Most patients with kleptomania report urges to steal. Some of these patients may have comorbid depression; for them, stealing makes them feel

Table 2

DIFFERENTIAL DIAGNOSIS: DISORDERS THAT MAY INVOLVE STEALING

Misdiagnosis

How to distinguish from kleptomania

Bipolar disorder

Patients with bipolar disorder may steal as a result of the impulsivity of mania. In fact, the diagnostic criteria for kleptomania require the exclusion of mania as the cause of stealing.⁷ Patients with bipolar disorder report an elevated, expansive, or irritable mood while stealing. Patients with kleptomania tend to report a depressed mood when not stealing

Borderline personality disorder

Unlike patients with borderline personality disorder, patients with kleptomania do not report long histories of unstable relationships or negative self-image; inappropriate anger and “psychotic-like” symptoms are rare in patients with kleptomania

Antisocial personality disorder (ASPD, or conduct disorder)

Patients with kleptomania suffer intense shame and guilt, unlike those with ASPD. Also, most patients with kleptomania do not report other illegal or antisocial behavior.

Eating disorders

Data suggests that about one-third of patients with an eating disorder also steal.^{6,8} Patients with kleptomania, however, do not have disordered eating patterns or distorted body images common to patients with eating disorders.

less depressed. Anger or irritability may point to borderline personality disorder. Stealing for the enjoyment of risk may suggest bipolar disorder.

Many patients with kleptomania have comorbid mood, substance, or anxiety disorders. Treating these other symptoms while ignoring the symptoms of kleptomania may be unsuccessful. Comorbidity also may influence the choice of medication.

Medical assessment Case reports have associated the onset of kleptomania with a variety of medical conditions, including presenile cortical atrophy in a 25-year-old, a parietal tumor that caused blackouts and obliterated any memory of stealing episodes, narcolepsy, and an insulinoma that caused severe hypoglycemia.⁹ The relationship of these conditions with the onset of kleptomania is unclear, but the reports suggest that medical causes—although unlikely—should be ruled out before you consider kleptomania as a psychiatric illness.

Patient education Persons with kleptomania often feel that no one else has the same problem. They do not think of their behavior as being an illness. It is helpful to explain that kleptomania is treatable and to connect patients with educational books, self-help groups, and Web sites providing information and support (see “Related resources,” page 49).

Cognitive-behavioral therapy (CBT) Although the evidence is quite limited, covert sensitization, exposure and response prevention, and imaginal desensitization have all been shown effective in case reports.¹⁰

What medications are effective?

Only case reports, a case series of five subjects, and a single open-label treatment study involving 10 subjects with kleptomania have been done.

So far, uses of tricyclic antidepressants (imipramine, nortriptyline), SSRIs (fluoxetine, fluvoxamine, paroxetine), the opioid antagonist naltrexone, and mood stabilizers (lithium, valproate) have met with varying degrees of success. Strategies targeting urge and behavior reduction and mechanisms for coping with urges and behavior (e.g., cognitive-behavioral therapies) may represent important adjunctive components.^{2,11-17}

No medications are FDA-approved for treating kleptomania. Therefore, it is important to inform patients of

any off-label use of medications for this disorder, as well as the empirical basis for considering pharmacologic treatment. **SSRIs** Only case reports exist on the use of SSRIs in treating kleptomania. The disorder may share a common pathology with pathologic gambling, and in our clinical experience appears to respond to similar treatments.¹⁸ We draw on research of pathologic gambling as well as our clinical experience in choosing SSRIs as first-line treatment, especially for patients with significant mood symptoms.¹⁹

We suggest titrating SSRIs to the maximum recommended dosage. As in the treatment of pathologic gambling, dosages of SSRIs required to treat kleptomania symptoms appear to be higher than average dosages required to treat depressive disorders. An SSRI should not be considered ineffective unless it has been tried for at least 10 to 12 weeks and the highest dosage tolerated or recommended by the manufacturer has been reached.

Response to SSRIs usually is characterized by decreased thoughts about stealing, decreased stealing behavior, and improvement in social and occupational functioning. If an SSRI is only partially

effective, we consider augmentation with naltrexone, bupirone, or a mood stabilizer.

Naltrexone Patients taking naltrexone often report less-intense urges to steal. The urges may not disappear but are often sufficiently reduced so that the patient can resist them more easily. Patients also report that the thrill associated with stealing is reduced or eliminated.

Naltrexone was used in the first medication study of kleptomania and showed a significant decline in the intensity of urges to steal, stealing thoughts, and stealing behavior. Average dosage was 150 mg/d;¹¹ a reduced dosage (e.g., 50 mg/d) may work in adolescents with kleptomania.²⁰

Nausea as a side effect can be reduced by starting patients on 25 mg/d for the first 3 or 4 days and possibly adding ondansetron, 4 to 8 mg/d. Nausea and diarrhea are usually mild and resolve within the first week. Clinically, most patients respond to naltrexone within 2 weeks. After that, the dosage usually needs to be adjusted.

In patients with comorbid depression, augmentation with an SSRI may prevent worsening of untreated depressive symptoms. It is prudent to obtain liver function tests prior to naltrexone administration and again 3 to 4 weeks after

SSRIs are a reasonable first-line treatment, especially for patients with significant mood symptoms

starting the drug.²¹ Repeat testing should be performed at 2- to 4-week intervals for the next 2 months, then once a month for the following 3 months. After 6 months, testing three to four times a year is usually sufficient.

Nonsteroidal analgesics should not be used with high dosages of naltrexone (>50 mg/d), as concurrent use may increase the risk of hepatic transaminase elevation.²¹

Mood stabilizers Responses to lithium and valproate have been described in two case reports of patients with kleptomania.^{14,15} In the case of valproate, the effective dosage was 2,000 mg/d, whereas lithium reduced stealing urges at a serum level of 0.5 mEq/L.

Although it would be premature to recommend the use of mood stabilizers, their possible benefit may be related to their efficacy in bipolar disorder treatment and the existence of features (e.g., impulsivity) shared by kleptomania and bipolar disorder.

Atypical antipsychotics Although there is no evidence that atypical antipsychotics are useful in kleptomania, augmenting an SSRI with an atypical neuroleptic may be beneficial. Atypical antipsychotics have been explored as augmenting agents in the treatment of nonpsychotic disorders and behaviors, including pathologic gambling and obsessive-compulsive disorder.

The role of psychotherapy

Cognitive-behavioral therapy Based on the evidence of its effectiveness in treating pathologic gambling, CBT may hold promise as monotherapy for mild cases of kleptomania.

Combination therapy Combined pharmacologic and behavioral therapy may be the optimal treatment strategy for kleptomania. In our experience, patients who respond only partially or fail to respond to pharmacotherapy alone are more likely to find relief with a combination of drug and cognitive-behavioral therapies.

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Related resource

- ▶ Goldman MJ. *Kleptomania: the compulsion to steal—what can be done?* Far Hills, NJ: New Horizon Press, 1998.
- ▶ Shoplifters Alternative <http://www.shoplifters.org>
- ▶ Impulse Control Disorders Clinic, University of Minnesota <http://www.med.umn.edu/psychiatry/research/impulse.htm>

DRUG BRAND NAMES

Citalopram • Celexa	Nortriptyline • Aventyl, Pamelor
Fluvoxamine • Luvox	Paroxetine • Paxil
Imipramine • Tofranil	Quetiapine • Seroquel
Naltrexone • Revia	Valproic acid • Depakote

DISCLOSURE

The authors report no affiliation or financial arrangement with any of the companies whose products are mentioned in this article.

Kleptomania is a secretive disorder that requires careful screening for its diagnosis. Though evidence is limited, SSRIs are often effective, and naltrexone is a reasonable option for patients with intense urges to steal. Combination pharmacologic and behavioral therapy may be the most effective treatment.

BottomLine