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Gender-Related Differences in Individuals Seeking Treatment for Kleptomania

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Abstract

Objective—Understanding variations in disease presentation in men and women is clinically important as differences may reflect biological and sociocultural factors and have implications for prevention and treatment strategies. Few empirical investigations have been performed in kleptomania, particularly with respect to gender-related influences.

Method—From 2001 to 2007, 95 adult subjects (n=27 [28.4%] males) with DSM-IV kleptomania were assessed on sociodemographics and clinical characteristics including symptom severity, comorbidity, and functional impairment to identify gender-related differences.

Results—Men and women both showed substantial symptom severity and functional impairment. Compared to affected men, women with kleptomania were more likely to be married (47.1% compared to 25.9%; $p=.039$), have a later age at shoplifting onset (20.9 compared to 14 years; $p=.001$), steal household items ($p<.001$), hoard stolen items ($p=.020$), and have an eating disorder ($p=.017$) and less likely to steal electronic goods ($p<.001$) and have another impulse control disorder ($p=.018$).

Conclusions—Kleptomania is similarly associated with significant impairment in women and men. Gender-related differences in clinical features and co-occurring disorders suggest that prevention and treatment strategies incorporate gender considerations.

Keywords

gender; impulse control disorders; kleptomania; phenomenology

INTRODUCTION

The impulse control disorder kleptomania is characterized by: 1) a recurrent failure to resist an impulse to steal objects that are not needed for personal use or their monetary value; 2) an increasing sense of tension immediately before committing the theft; 3) an experience of pleasure, gratification or release at the time of committing the theft; and 4) stealing that is not performed due to anger, vengeance, psychotic symptomatology, mania, or antisocial personality disorder.¹ Kleptomania is experienced by a broad range of psychiatric patient populations including 3.7% of depressed patients (n=107),² 3.8% of patients with alcohol dependence (n=79),³ 2.1% to 5% of individuals with pathological gambling,^{4–5} and 24% of those with bulimia.⁶ A recent study of psychiatric inpatients (n=204) with a range of

admitting disorders revealed that 7.8% (n=16) endorsed current kleptomania and 9.3% (n=19) met lifetime criteria.⁷

Recent health initiatives have highlighted the importance of understanding gender differences.⁸ In clinical samples, approximately two-thirds of kleptomania patients are women.^{9–13} Other impulse control disorders like pathological gambling are more common in men.¹⁴ Men with pathological gambling are typically more likely than affected women to be young, single, and living alone without children.¹⁵ As compared to men, women typically begin gambling later in life and the interval between the age of starting to gamble and developing a gambling problem is usually shorter for women,^{16–21} consistent with a “telescoping” progression. Whereas male gamblers report advertisements as eliciting urges to gamble, female gamblers more frequently report feelings of boredom or loneliness as triggers.^{16,18} Gender-related differences in the types of gambling preferred by recreational gamblers are reflected in the types of gambling problematic in female and male problem gamblers, respectively.^{20,22} These gender-related differences have implications for prevention and treatment of problem and pathological gambling.²⁰

Obsessive compulsive disorder (OCD), a disorder with phenomenological links to kleptomania,²³ exhibits an equal gender prevalence ratio, although clinically important gender-related differences exist. Men with OCD have an earlier onset, are more likely to remain single, and have comorbid social phobia.^{24–25} OCD subjects show gender-related differences in obsessions and compulsions – whereas men are more likely to report sexual and symmetry obsessions, women more frequently acknowledge aggression and contamination obsessions and cleaning rituals.^{24–25} Hoarding is a particularly difficult to treat behavior associated with OCD, and hoarding could have relevance to kleptomania as one possible outcome for stolen items. In some studies, hoarding in OCD has been found in male-predominant groups (e.g. those with early onset) whereas other studies have found female predominance.^{26–27}

Like pathological gambling, kleptomania is an impulse control disorder that has been conceptualized as lying along an impulsive-compulsive spectrum with OCD.^{28–29} The extent to which gender-related patterns observed in pathological gambling and OCD apply to kleptomania has not been systematically examined. To date, two small studies have examined directly gender-related differences in kleptomania and both focused predominantly on comorbidity. In one study of 20 subjects, men with kleptomania were less likely to suffer from a co-occurring eating disorder or bipolar disorder.¹¹ In another study of 20 subjects, men with kleptomania demonstrated higher rates of co-occurring paraphilias.¹⁰

The goal of the present study was to examine the clinical features of kleptomania in a large sample of men and women with kleptomania. Based on research in pathological gambling, OCD, and kleptomania, we hypothesized that: 1) kleptomania would be associated with significant clinical impairment in both men and women; and, 2) men and women would differ in clinical course, phenomenology, and co-occurring disorders (particularly eating, bipolar spectrum, and impulse control disorders like compulsive sexual behaviors). In the latter case, we specifically hypothesized that women as compared to men would: A) begin stealing later in life and show telescoping; B) more often report stealing items from shopping locations typically frequented by women (household stores) and less often from locations typically frequented by men (electronics good stores); C) less frequently acknowledge hoarding stolen items; D) more frequently acknowledge stealing to escape dysphoria or boredom; and E) more often report co-occurring eating disorders and less often report other impulse control disorders, particularly compulsive sexual behaviors.

METHODS

Subjects

Participants included 95 consecutive adults aged 18 years meeting current (past-year) DSM-IV criteria for kleptomania. Participants were recruited by advertisements and referrals and had participated in pharmacological studies (one completed³⁰ and one ongoing), a completed neuroimaging study,³¹ or an ongoing outpatient longitudinal study on impulse control disorders. Subjects were recruited over a 6-year period (2001–2007) at both a private psychiatric hospital and a public university medical center, and clinical characteristics of subgroups within this study have been previously reported.⁹ Subjects not suitable for treatment studies were included in the ongoing outpatient longitudinal study and were therefore included.

All subjects who contacted us for treatment were, therefore, included in this database if they meet the general inclusion criteria: 1) primary diagnosis of current DSM-IV kleptomania; 2) age 18 or older; and 3) able to be interviewed in person. The only exclusion criterion was the inability to understand and consent to the study. The studies were carried out in accordance with the Declaration of Helsinki. The Institutional Review Boards of the University of Minnesota and Butler Hospital approved the studies and the consent statements. Study participants provided voluntary written informed consent except in 17 subjects whose data was included via an IRB-approved chart review.³² No subject was court ordered to treatment.

Assessments

Diagnosis—The diagnosis of kleptomania was made using DSM-IV criteria in an unstructured clinical interview in the first 38 subjects and the Structured Clinical Interview for Kleptomania (SCI-K), which was added later, in the next 57 subjects. The SCI-K, which is based on DSM-IV criteria and includes exclusion criteria for stealing secondary to hypomania, mania, or antisocial personality disorder, has demonstrated excellent reliability and validity in a sample of psychiatric outpatients.³³

Clinical Characteristics—All subjects underwent a semi-structured interview (reported in previous studies)^{9,30–32} to assess clinical characteristics of kleptomania. Clinical questions assessed age at onset of shoplifting, frequency of shoplifting, intensity of the urges to shoplift, triggers to the behavior, locations of stealing, and whether the shoplifting resulted in arrest or conviction.

Severity of Kleptomania—Severity of shoplifting was assessed at initial evaluation using the Clinical Global Impression - Severity scale (CGI).³⁴ The CGI consists of a reliable and valid 7-item Likert scale used to assess severity in clinical symptoms. The CGI severity scale ranges from 1 = “not ill at all” to 7 = “among the most extremely ill.”

Subjects reported their symptom severity using the Kleptomania Symptom Assessment Scale (K-SAS), an 11-item self-report scale that has shown good reliability and validity in previous studies.³⁰ The K-SAS assesses shoplifting urges, thoughts, and behaviors during the previous seven days. Each item is rated 0 to 4 with a possible total score of 44 (higher scores reflect greater severity of kleptomania symptoms). Eighty-six of the 95 subjects completed the K-SAS at initial interview.

The Sheehan Disability Scale (SDS),³⁵ a 3-question, self-report measure, was used to assess the overall psychosocial interference due to shoplifting. The three questions examine the degree to which kleptomania symptoms interfere with work/school, social life and family

life/home responsibilities. The SDS was added later and therefore used in only a subset of the subjects (n=46).

The Quality of Life Inventory (QOLI),³⁶ a reliable and valid 16-item self-administered rating scale, assesses the domains of health, work, recreation, friendships, love relationships, home, self-esteem and standard of living. Each domain generates a weighted satisfaction score based on importance and satisfaction ratings. Raw scores range from -6 to +6, with high quality of life corresponding to 3.6 to 6.0, average quality of life in the range of 1.6 to 3.5, low quality of life in the range of 0.9 to 1.5, and very low quality of life corresponding to -6 to 0.8. Because the QOLI was added later, QOLI data are available for 41 of the 95 subjects.

Comorbid Psychiatric Disorders—Each subject was evaluated with the Structured Clinical Interview for DSM-IV (SCID)³⁷ to assess current and lifetime comorbid disorders. These disorders were grouped in the following diagnostic categories: depressive (major depression, dysthymia), bipolar spectrum (bipolar I, bipolar II, cyclothymia), anxiety (generalized anxiety, post-traumatic stress, social phobia, and panic disorders), and eating disorders (bulimia nervosa, anorexia nervosa, binge eating disorder). SCID-compatible modules were used to examine current and lifetime rates of other impulse control disorders (pathological gambling, trichotillomania, pyromania, intermittent explosive disorder, compulsive buying, compulsive sexual behavior, and pathologic skin picking).⁷ Personality disorders were assessed using the SCID³⁷ in 43 subjects and by clinical interview assessing only antisocial and borderline personality disorders according to DSM-IV criteria in 56 subjects.

Statistical Analysis

Demographic and clinical variables were calculated as means, standard deviations, and frequencies. Between-group differences for men and women were examined using Pearson chi-square, Fisher's exact, t-tests (two-tailed), or Mann-Whitney test.

RESULTS

95 adults (n=27 [28.4%] males) with kleptomania were included in this study. Demographics and clinical characteristics of the total sample are presented (Table 1). For the entire sample, the mean age at shoplifting onset was 18.7 ± 12.3 [range 6 – 62] years. Mean age when subjects met DSM-IV criteria for kleptomania was 27.6 ± 12.8 [range 8 – 62] years. Subjects reported urges to steal a mean of 3.8 ± 2.4 days per week and a mean of 2.0 ± 1.8 thefts per week. A majority of subjects (n=65; 68.4%) had been arrested and a sizable minority (n=31; 32.6%) had received jail or prison time.

Compared to women, men were significantly younger at time of assessment (35.3 vs. 43.9 years; $p=.005$) and more likely to be single (59.3% vs. 27.9%; $p=.038$) (Table 1). Age at shoplifting onset was significantly earlier in men as compared with women (14.0 ± 6.2 years vs. 20.9 ± 13.8 years; $p<.001$). Although the lag time between starting to shoplift and developing kleptomania was shorter in women than in men, the difference was not statistically significant (9.88 ± 9.47 years in men vs. 7.45 ± 9.02 years in women; $p=0.28$). Overall clinical status (CGI scores) suggested more severe illness in men, although the between-sex difference was not statistically significant (5.22 ± 1.16 in men vs. 4.79 ± 0.97 in women; $p=0.070$). Severity of kleptomania (K-SAS scores) and social and occupational functioning (SDS scores) also did not differ significantly between men and women (Table 1). Similarly high proportions of men and women experienced lifetime suicide attempts (18.5% of men vs. 27.9% of women; $p=0.34$) and poor quality of life (QOLI scores of -0.35 ± 2.46 in men vs. 0.07 ± 2.38 in women; $p=0.59$). Men and women were similarly likely to

have been arrested (69.2% of men vs. 71.4% of women; $p=0.84$) or received a prison sentence (38.5% of men vs. 34.4% of women; $p=0.72$).

Similarities and differences were observed in the places of stealing and disposition of stolen items in men and women (Table 2). Men were more likely ($p<0.001$) to steal from electronic goods stores (e.g., stores selling cameras, computer items, etc) and women were more likely ($p<0.001$) to steal from household goods stores (e.g., stores selling kitchen wares, bed and bath accessories, etc). Women were more likely than men at $p=0.02$ to hoard the items they stole (50.0% compared to 22.2%). The primary triggers for stealing were seeing items that the person desired and stress, and the frequencies of acknowledgment of these and other triggers did not differ significantly between men and women (Table 3).

High proportions of both men and women acknowledged current depressive disorders (36.8% of women and 25.9% of men had major depressive disorder), impulse control disorders other than kleptomania (14.7% of women and 11.1% of men had compulsive buying), and anxiety disorders (8.8% of women had posttraumatic stress disorder, 4.4% of women had generalized anxiety disorder, and 14.8% of men had generalized anxiety disorder). The most significant difference among current disorders reported by men and women was among other impulse control disorders (51.9% of men vs. 26.5% of women; $p=0.018$), with this difference being most attributable to current intermittent explosive disorder (11.1% of men vs. 0% of women; $p=.021$) and compulsive sexual behaviors (14.8% of men vs. 4.4% of women; $p=0.098$). With respect to lifetime comorbidity, the most significant between-group differences were observed for eating disorders (19.1% of women vs. 0% of men; $p=.017$) (8 [11.8%] of the women with kleptomania had binge eating disorder; 3 [4.4%] had bulimia nervosa, and 2 [2.9%] had anorexia nervosa) and bipolar spectrum disorders (13.2% of women vs. 0% of men; $p=0.056$) (8 [11.8%] of the women had bipolar I disorder and 1 [1.5%] had bipolar II disorder).

DISCUSSION

The present study is the largest to date to examine the characteristics of individuals with kleptomania and gender-related differences in their clinical features. The sample contained twice as many women as men, consistent with findings from smaller studies.^{10–13} The findings of substantial clinical impairment across gender groups highlights the need for improved identification and treatment strategies for individuals with kleptomania. Identified gender differences in phenomenology and co-occurring disorders emphasize the need to consider optimizing these approaches for men and women, respectively.

Hypothesis One

The findings support our first hypothesis that kleptomania would be associated with clinical impairment in both men and women. Kleptomania symptoms for both women and men were generally severe. The mean SDS scores in the study suggest significant functional impairment for both women and men. The average scores on the SDS for individuals with kleptomania were three times greater than those reported in pathological gambling,³⁸ twice those found in individuals with posttraumatic stress disorder,³⁹ one and a half times greater than those reported in substance use disorders,⁴⁰ and similar to those in major depressive disorder and OCD.^{40,41} The overall quality of life of individuals with kleptomania was very low in both women and men, and was notably lower than those reported for individuals with substance use disorders⁴² or pathological gambling.⁴³

Given the severity of impairment and the low quality of life in individuals with kleptomania, it is not surprising that a substantial portion of subjects (25.3%) report having attempted suicide. Consistently, a prior study found that 36% of subjects with kleptomania

acknowledged suicidal behaviors.⁴⁴ The frequency of suicide attempts seen in this study is approximately 6 to 24 times higher than that observed in the United States general population.^{45,46} Although the percentage of individuals with kleptomania reporting attempted suicide is comparable to that in bipolar disorder (27% – 34%),^{47,48} it is higher than those reported in major depression (16.5%)⁴⁹ and panic disorder (16.5%).⁵⁰

Legal problems (arrest and incarceration) were common in both women and men. The majority of subjects (66.3%) had been arrested at least once and 32.6% had served jail time for their shoplifting. These percentages are consistent with those for arrest (64% – 87%) and incarceration (15% – 23%) in smaller samples (n=20–40) of individuals with kleptomania.^{10,12,13} These legal repercussions can generate significant individual emotional distress and represent substantial financial costs to the economy and legal system.¹³ The findings highlight the need for effective interventions (e.g., treatment of kleptomania) within correctional settings and the importance of clinical interfacing with components of the legal system (court, probation) in the care of patients with kleptomania.

Hypothesis Two

Our second hypothesis - that men and women would differ in clinical course, phenomenology, and co-occurring disorders – was supported. Some of the differences are similar to those seen in OCD, substance dependence, and other impulse control disorders such as pathological gambling.

Hypothesis 2A: Age at Onset of Shoplifting and Telescoping—Men with kleptomania, like men with pathological gambling or OCD,^{24,51} have symptom onset (begin shoplifting) during puberty, at an age significantly younger than is seen in women. Like other risk taking behaviors (gambling, substance use), shoplifting may require early intervention, particularly in adolescent males, and empirically validated approaches (e.g., educational programs in schools, treatment) within this population warrant investigation. An improved understanding of how shoplifting aggregates with other risk behaviors and the specific environmental and genetic factors underlying shoplifting, including the role of sex hormones during adolescent development, would inform these efforts.

In pathological gambling or substance use disorders, women more rapidly progress to addiction after starting a behavior (i.e. the “telescoping phenomenon”).^{18,20,52} Although there was no statistically significant difference between the groups in progression from age at onset of shoplifting to having kleptomania, women as compared to men reported a numerically shorter timeframe (approximately 7 years from onset of shoplifting in women compared to approximately 10 years in men). These values are reminiscent of those found in studies suggesting telescoping in problem gambling; e.g., one study found mean durations between age at gambling onset to developing a problem of 7.29 years in women and 9.99 years in men.²⁰ As such, the findings suggest that telescoping might occur with kleptomania as with other disorders characterized by impaired impulse control, and that a larger sample might detect statistically significant differences in progression between women and men. Further investigation is needed to confirm this impression.

Hypothesis 2B: Locations of Stealing—Our hypothesis that women would be significantly more likely to shoplift from locations frequented by women was supported, and differences in patterns of shoplifting could reflect differences in motivations to steal. Women were more likely to report shoplifting from stores selling household items (e.g., kitchen items, bed and bathroom accessories). In contrast, men with kleptomania were more likely to steal from electronic stores (e.g., computer accessories, video games), and the items they stole tended to be more expensive and under tighter security. Among problem

gamblers, sex differences in types of gambling reported as problematic have been reported, with women frequently reporting problems with non-strategic forms like slot machines and men with strategic forms like card or sports gambling.²⁰ This pattern is reflected more in the gambling preferences than in the gambling behaviors of recreational gamblers,⁵³ suggesting that the gambling-form-related motivations are poorly controlled in problem gamblers in a gender-specific manner. A similar finding for kleptomania is suggested, intimating a phenomenological link in gender differences across impulse control disorders. Potential mediating factors (e.g., male risk-taking) as related to these sex differences in impulse control disorders warrant further investigations. The findings have clinical implications with respect to treatment; e.g., development of exposure/response-inhibition therapies might benefit from considering gender differences in locations of stealing and motivations for stealing.

Hypothesis 2C: Hoarding of Stolen Items—Although hoarding has been examined in association with OCD and other psychiatric disorders,⁵⁴ it has not been studied in kleptomania. As with hoarding in OCD,⁵⁵ individuals with hoarding and kleptomania may constitute a distinct group with clinically relevant features. For example, individuals with hoarding score high on measures of impulsivity⁵⁶ as do individuals with kleptomania.⁴⁴ Consistently, a study of impulse control disorders in individuals with OCD found that the presence of an impulse control disorder was most robustly associated with hoarding obsessions and compulsions.⁵⁷ As hoarding symptoms in OCD can be used to guide selection of effective therapies,^{27,55} more research is needed to examine the clinical utility of identifying hoarding in kleptomania with respect to treatment selection and outcome. Given the finding of women more frequently reporting hoarding, such considerations seem particularly applicable to women's health.

Hypothesis 2D: Motivations for Stealing—Cues for stealing and disposition of items had previously not been examined systematically in kleptomania. Similar proportions of men and women with kleptomania acknowledged each of the cues examined. Both gender groups reported that the sight of an object was a prominent cue for shoplifting urges, and both groups reported that anxiety or stress often elicited urges to steal. These findings share similarities and differences with other impulse control disorders. Although visual triggers are also common in both men and women with pathological gambling,^{16,18,20} women with gambling problems more commonly report that feeling bored or lonely leads to gambling (citing gambling as a means of escaping from states of depression), whereas men usually report urges to gamble unrelated to mood.^{18,20} Thus, our hypothesis that men and women would differ on stealing in relationship to feelings of dysphoria or boredom was not supported. The findings that individuals with kleptomania have multiple triggers and that there are no apparent gender differences have clinical relevance. For example, cognitive behavioral therapies that include strategies on identifying cues and coping with urge states should consider the relative frequencies of specific cues among women and men in general.

Hypothesis 2E: Co-Occurring Disorders—Our hypothesis that women would more frequently acknowledge eating disorders and men more frequently impulse control disorders like compulsive sexual behaviors was partially supported. Lifetime eating disorders were more frequently reported by women with kleptomania as compared to affected men, although frequencies of current eating disorders did not differ significantly between women and men. This finding appears largely attributable to the change from an 11.8% lifetime rate of binge eating disorder to 0% at the time of presentation for kleptomania treatment. Although this pattern might be in part attributable to general gender differences in eating disorders and developmental changes in eating behaviors and disorders in women, it might also represent “switching” of excessive or impulsive patterns of eating for similar patterns of

stealing. Consistent with the “switching” of behaviors hypothesis, all 8 women with binge eating disorder reported that shoplifting worsened when they stopped their bingeing. Four of the women received gastric bypass surgery for obesity resulting from binge eating disorder and reported that shoplifting increased dramatically after surgery. A similar but less striking pattern was seen for compulsive buying in women in this sample (23.5% lifetime frequency; 14.7% current frequency). It was not uncommon for women to report that their shoplifting increased when finances worsened and the purchase of desired items became less feasible. Thus, the findings suggest a complex relationship among multiple impulse control and eating disorders in women, and a more complete understanding of the temporal progressions and inter-relationships would help clinicians target interventions.

Current impulse control disorders, particularly in the domains of aggression and sex, were more frequently acknowledged by men as compared to women. Men were more frequently acknowledged intermittent explosive disorder (11.1% compared to 0% in women) and compulsive sexual behavior (14.8% compared to 8.8% in women), and the higher proportion of men reporting these disorders is consistent with prior reports from clinical and community samples.^{58,59} These findings suggest that men with kleptomania have more deficits in control over behavior than do women. Although the etiology is not precisely known, neurobiological (e.g., hormonal influences) and sociocultural (e.g., the possibility that both violent outbursts and disinhibited sexual behavior are more socially tolerated in men) factors are likely involved. Given the associated legal and economic costs of aggression,⁵⁸ as well as the health risks and costs of sexually transmitted diseases, the present findings highlight the need for targeted prevention and treatment strategies for aggressive and sexual behaviors in men with kleptomania.

In general, lifetime and current co-occurring disorders were common in this sample, with particularly frequent acknowledgment of other impulse control disorders (47.4% lifetime and 33.7% current) and major depressive disorder (38.9% lifetime and 33.7% current) in both women and men. These results are consistent with a previous study which found that 45% of individuals with kleptomania suffered from lifetime rates of both impulse control disorders and major depressive disorder.⁴⁴ Bipolar disorder was relatively frequently acknowledged, particularly by women. The extent to which bipolar disorder shares a common neuropathophysiology with impulse control disorders, as suggested from other studies,⁶⁰ requires further investigation. As treatment strategies for bipolar disorder have shown efficacy in reducing gambling and manic symptoms in individuals with co-occurring pathological gambling and bipolar disorders,⁶¹ similar strategies warrant investigation in kleptomania, particularly women.

Limitations and Strengths

This study has multiple limitations. Although our sample was recruited from treatment-seeking individuals in both the Midwest and the northeastern United States, its representativeness to other geographic locations and samples (e.g., non-treatment-seeking or community-based ones) is not known. Data regarding age at onset were collected retrospectively and may be subject to recall bias. Data regarding arrests and jail time were not confirmed with legal documents and therefore may over- or under-estimate actual rates. Although limitations exist, the study has multiple strengths, including the sample size, the use of standard, reliable and valid measures, and the examination of previously unstudied, clinically relevant questions in kleptomania.

Conclusions and Future Directions

This study identifies important sex differences in kleptomania. A more complete understanding of how kleptomania may present differently in men and women should

facilitate early detection and timely treatment. Epidemiological and longitudinal studies of kleptomania that incorporate gender considerations are needed to investigate clinical features and the course of illness in community samples. Studies are also needed to elucidate the neurobiological and psychosocial factors that contribute to gender differences in kleptomania.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

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Focus Points

- Kleptomania is associated with substantial clinical impairment across gender groups and highlights the need for improved identification and treatment strategies.
- Women with kleptomania have later age of onset of the disorder, have greater likelihood of hoarding items and have higher rates of co-occurring eating disorders.
- Gender-related differences in clinical features and co-occurring disorders suggest that prevention and treatment strategies incorporate gender considerations

Learning Objectives

Upon the completion of this lecture the participants will be able to:

- Understand the clinical features of kleptomania
- Appreciate how gender influences the clinical presentation of kleptomania
- Be aware of the gender differences in the social and functional problems associated with kleptomania

Needs Assessment

Kleptomania appears to be a fairly common disorder, and gender-related differences in kleptomania may have implications for prevention and treatment. This is the first study to examine a large sample of men and women with kleptomania and thereby provides needed information about the role of gender in this disorder.

Table 1
Demographics and Clinical Characteristics of 95 Women and Men with Kleptomania

	Total Sample (n=95)	Women (n=68)	Men (n=27)	Statistic	df	p-value
Age						
Mean ($\pm$ SD), [range], years	41.5 (13.6) [18,68]	43.9 (13.5) [18,68]	35.3 (12.0) [18,57]	2.904t	93	0.005
Ethnicity, n (%)						
Caucasian	88 (92.6)	64 (94.1)	24 (88.9)			
African American	3 (3.2)	1 (1.5)	2 (7.4)			
Latino/Hispanic	1 (1.1)	1 (1.5)	0 (0)	f	n/a	0.465
Asian	2 (2.1)	1 (1.5)	1 (3.7)			
Native American	1 (1.1)	1 (1.5)	0 (0)			
Marital Status, n (%)						
Single	35 (36.8)	19 (27.9)	16 (59.3)			
Married	39 (41.1)	32 (47.1)	7 (25.9)	f	n/a	0.038
Widow/Separated/Divorced	21 (22.1)	17 (25.0)	4 (14.8)			
Education, n (%)						
High school grad or less	30 (31.6)	23 (33.8)	7 (25.9)			
At least some college	65 (68.4)	45 (66.2)	20 (74.1)	0.777c	1	0.378
Age at onset of shoplifting, mean $\pm$ SD [range], years	18.7 (12.3) [6,62]	20.9 (13.8) [8,62]	14.0 (6.2) [6,32]	3.310t	88,448	0.001
Frequency of shoplifting (days per week), mean $\pm$ SD, [range]	2.05 (1.78) [0.25,7]	2.06 (1.86) [0.25,7]	2.05 (1.65) [0.25,7]	0.021t	77	0.983
Subjects who had been arrested, n (%)	63 (66.3)	45 (71.4)	18 (69.2)	0.043c	1	0.836
Subjects who had received jail or prison terms, n (%)	31 (32.6)	21 (34.4)	10 (38.5)	0.129c	1	0.719
History of suicide attempt, n (%)	24 (25.3)	19 (27.9)	5 (18.5)	0.909c	1	0.340
Time from first theft to meeting kleptomania criteria, Mean ($\pm$ SD) [range], years	7.97 (10.02) [0, 40]	7.45 (9.02) [0,39]	9.88 (9.47) [0,40]	-1.081t	77	0.283
Clinical Global Impression score (severity), Mean ($\pm$ SD) [range]	4.92 (1.04) [3,7]	4.79 (0.97) [3,7]	5.22 (1.16) [3,7]	-1.835t	93	0.070
K-SAS total score, Mean ($\pm$SD) [range]	25.7 (6.06) [13, 41]	25.7 (5.96) [13,41]	25.8 (6.40) [16,41]	-0.100t	84	0.921

	Total Sample (n=95)	Women (n=68)	Men (n=27)	Statistic	df	p-value
SDS mean score, Mean $\pm$ SD, [range]	14.9 (6.27) [0, 27]	15.4 (2.12) [0, 27]	14.5 (2.43) [8, 27]	1.226t	44	0.227
QOLI, Raw Score Mean $\pm$ SD, [range]	-0.1 (2.42) [-3.4, 5.7]	0.07 (2.38) [-3.4, 3.6]	-0.35 (2.46) [-3.1, 5.7]	0.538t	39	0.594

c = Chi Square

f = Fisher's Exact Test

t = Students t-test

CGI=Clinical Global Impression scale

K-SAS= Kleptomania Symptoms Assessment Scale

SDS=Sheehan Disability Scale

QOLI=Quality of Life Inventory

Table 2

Gender Differences in Places Stolen From and Disposition of Items

	Total Sample (n=95)	Women (n=68)	Men (n=27)	p-value ^I
Places Stolen From				
Clothing Store	51 (53.7)	41 (60.3)	10 (37.0)	0.067
Household goods store	40 (42.1)	39 (57.4)	1 (3.7)	<0.001
Grocery Store	35 (36.8)	26 (38.2)	9 (33.3)	0.814
Electronic goods store	18 (18.9)	5 (7.4)	13 (48.1)	<0.001
Friends' homes	15 (15.8)	9 (13.2)	6 (22.2)	0.351
Work	14 (14.7)	8 (11.8)	6 (22.2)	0.211
Relatives' homes	7 (7.4)	4 (5.9)	3 (4.4)	0.401
Gift Shops	4 (4.2)	3 (4.4)	1 (3.7)	1.000
Disposition of Items				
Kept	74 (77.9)	56 (82.4)	18 (66.7)	0.108
Hoarded	40 (42.1)	34 (50.0)	6 (22.2)	0.020
Given away	29 (30.5)	18 (26.5)	11 (40.7)	0.218
Returned	16 (16.8)	14 (20.6)	2 (7.4)	0.102
Discarded	11 (11.6)	6 (8.8)	5 (18.5)	0.283

^I Fisher's Exact Test

Table 3

Triggers to Stealing in 95 Women and Men with Kleptomania

	Total Sample¹ (n=95)	Women (n=68)	Men (n=27)	p-value²
Sight of an item	35 (36.8)	26 (38.2)	9 (33.3)	0.814
Anxiety/stress	31 (32.6)	21 (30.9)	10 (37.0)	0.630
Boredom	19 (20.0)	13 (19.1)	6 (22.2)	0.779
None	13 (13.7)	10 (14.7)	3 (11.1)	0.752
Feeling sad/depressed/lonely	11 (11.6)	6 (8.8)	5 (18.5)	0.283
Low self-esteem	3 (3.2)	3 (4.4)	0 (0)	0.556

¹Subjects may have reported more than one trigger²Fisher's Exact Test

Table 4

Co-Occurring Disorders in 95 Women and Men with Kleptomania

	Total Sample (n=95)	Women (n=68)	Men (n=27)	Statistic	Df	p-value
Current Comorbid Disorders, n (%)						
Any depressive disorder	32 (33.7)	25 (36.8)	7 (25.9)	1.016c	1	0.313
Any bipolar spectrum disorder	7 (7.4)	7 (10.3)	0 (0)	f		0.185
Any anxiety disorder	16 (16.8)	12 (17.6)	4 (14.8)	0.111c	1	0.739
Alcohol abuse/dependence	7 (7.4)	5 (7.4)	2 (7.4)	f		1.000
Drug abuse/dependence	6 (6.3)	3 (4.4)	3 (11.1)	f		0.347
Any eating disorder	1 (1.1)	1 (1.5)	0 (0)	f		1.000
Any other impulse control disorder	32 (33.7)	18 (26.5)	14 (51.9)	5.574c	1	0.018
Attention deficit hyperactivity disorder	5 (5.3)	2 (2.9)	3 (11.1)	f		0.137
Lifetime Comorbid Disorders, n (%)						
Any depressive disorder	37 (38.9)	28 (41.2)	9 (33.3)	0.500c	1	0.480
Any bipolar spectrum disorder	9 (9.5)	9 (13.2)	0 (0)	f		0.056
Any anxiety disorder	20 (21.1)	15 (22.1)	5 (18.5)	0.146c	1	0.703
Alcohol abuse/dependence	28 (29.5)	21 (30.9)	7 (25.9)	0.228c	1	0.633
Drug abuse/dependence	15 (15.8)	11 (16.2)	4 (14.8)	0.027c	1	0.870
Any eating disorder	13 (13.7)	13 (19.1)	0 (0)	f		0.017
Any other impulse control disorder	45 (47.4)	30 (44.1)	15 (55.6)	1.014c	1	0.314
Attention deficit hyperactivity disorder	6 (6.3)	3 (4.4)	3 (11.1)	f		0.347
Any personality disorder	18 (18.9)	15 (22.1)	3 (11.1)	f		0.261

c = Chi Square

f = Fisher's Exact Test