

Kleptomania: Making Sense of the Nonsensical

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Objective: Kleptomania, or the irresistible impulse to steal unneeded objects, is a poorly understood disorder. The objectives of this paper are to critically review and integrate existing data and to make suggestions for further research. **Data Collection:** Information was gathered by reviewing the English-language literature on kleptomania. Cases were chosen for review that approximated the diagnosis as defined in DSM-III-R. These cases were analyzed in terms of their relationship to previous theories about the disorder, and larger relevant studies were examined. Using the data organized into a table, the author explores areas of convergence and disagreement and discusses the methodological difficulties of the different studies. **Findings:** Kleptomania is more common than previously thought. The "typical" individual with kleptomania is a 35-year-old woman who began to steal when she was 20 years old. Her thefts bring both relief and guilt. She probably has not sought treatment on her own but suffers from a necessary, pervasive, repetitive, and self-destructive act. She may have a history of sexual dysfunction or sexual preoccupation and may be unhappily married to an emotionally unsupportive husband. She has been labile and dysphoric for many years and may have a personality disorder. She has probably had a tumultuous, stressful childhood and may dissociate. **Conclusions:** The author proposes a biopsychosocial model of the etiology of kleptomania based on data from the literature. This model emphasizes possible childhood abuse as a precipitating factor in later development of kleptomania. More complete research is needed in the study of kleptomania.

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Yet I lusted to thieve and did it compelled by no
hunger, nor poverty.

—St. Augustine, *Confessions*, 370 A.D.

Kleptomania, or the irresistible impulse to steal unneeded objects, is a poorly understood disorder. Despite the strange and seemingly meaningless behavior that characterizes it, kleptomania has received little empirical attention. This is surprising in view of the fact that kleptomania may account for a substantial proportion of the staggering 40 billion dollars in business losses attributed to shoplifting each year (1). Additionally, people with kleptomania suffer the pain and humiliation of repeated arrests.

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DSM-III-R classifies kleptomania as an impulse control disorder. The symptoms may begin in childhood and can continue intermittently throughout adulthood. DSM-III-R (pp. 322-323) describes the disorder as follows:

The essential feature . . . is 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, discarded, 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 . . . , it is 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 between the stealing and anger or vengeance.

The diagnosis is not made if the stealing is due to Conduct Disorder or Antisocial Personality Disorder.

The term "kleptomania" (Greek for "stealing madness") did not appear until 1838 (2). However, court cases, personal accounts, and anecdotal reports throughout the ages have underscored the curious nature of

this type of stealing (2–8) and have contributed to the current *DSM-III-R* nosology. In 1799, for example, a wealthy woman appeared before a British magistrate charged with the theft of a piece of lace (3). Some years later, according to Ray (4), Benjamin Rush remarked on the otherwise high moral character of afflicted individuals and further commented on the theft of a seemingly unneeded object. Esquirol, in describing the monomanias, discussed illnesses characterized by involuntary, irresistible actions (6). According to Gibbens and Prince (7), Esquirol and Marc coined the term “kleptomania” in 1838 to describe the behavior of several kings who stole worthless items.

Many modern writers have commented on kleptomania, and several psychoanalytic theories have been proposed to explain it. *DSM-I*, published in 1952, included “kleptomania” as a supplementary term because it was not yet considered a distinct diagnostic entity (2). The disorder was left out of *DSM-II* entirely. It found its way back into *DSM-III* and *DSM-III-R* as an impulse control disorder. (There is no substantial difference between the *DSM-III* and *DSM-III-R* definitions.)

This paper focuses on kleptomania or kleptomania-type disorders as opposed to stealing for profit, a distinction that has often been blurred in the literature. Perhaps because there seems to be no consistent theory regarding most aspects of the disorder and there is much theoretical overlap, many terms have been used to describe a variety of behaviors. For the sake of clarity, the terms “shoplifting” and “stealing” are used here to refer to a broad range of behaviors that include both kleptomania and theft for profit. “Kleptomania,” however, is used to refer to a disorder approximating the *DSM-III-R* definition. Although the term “nonsensical stealing” does not necessarily match the *DSM-III-R* definition of kleptomania, it approximates the type of peculiar behavior seen in the disorder and will be used in this capacity.

The goals of this paper are 1) to provide a critical review of the literature on kleptomania, 2) to integrate existing data on kleptomania and kleptomania-type disorders and propose an etiological model, and 3) to offer suggestions for a more definitive, comprehensive study of the disorder.

EPIDEMIOLOGY AND DEMOGRAPHICS

Kleptomania has been recognized for more than 150 years as a comparatively rare clinical condition. Table 1 summarizes the published English-language case studies approximating the *DSM-III-R* definition of kleptomania. Included in the table are categories that represent potential areas of disagreement and controversy as well as other important variables. Excluded from the table are cases that did not clearly conform to *DSM-III-R* criteria. The few larger studies of stealing (21–27) are discussed in the text. The difficult methodological problems inherent in a retrospective review of cases will be addressed in the discussion.

Table 1 shows that 22 of the 26 patients described in published reports did not seek voluntary treatment. They were either coerced into treatment by those who caught them or referred by the courts after apprehension. There is no information on this point about one case. Because most cases of kleptomania are identified through court-ordered evaluations of shoplifters, the rate of the disorder in the general population is unknown. There is disagreement regarding the rate among shoplifters. In one study of 338 arrested shoplifters (25), only 13 (3.8%) were considered to have displayed a “compulsive behavior pattern” that the authors called “kleptomania.” Bradford and Balmaceda (26) found that two (4%) of 50 shoplifters met criteria for kleptomania approximating those of *DSM-III-R*, and Medlicott (14) found similarly diagnosed kleptomania in five (10%) of 50 people arrested for thefts of various kinds. Yates (21) found nonsensical stealing in 15 (15%) of 101 arrested shoplifters but did not specify whether these patients met the criteria for kleptomania. Another study (24) found “nonrational” stealing (stealing not motivated by conscious goal) in 32 (24%) of 132 arrested shoplifters. On the other hand, several authors of larger studies of people arrested or convicted of shoplifting (23, 27) failed to identify any subjects with kleptomania. This wide range of kleptomania rates probably reflects both the sampling and definitional difficulties inherent in the identification of the disorder.

Kleptomania may be more common than these statistics suggest. Indeed, studies of clinical samples not selected for kleptomania (28–31) found relatively high rates of the disorder. Hudson et al. (29), for example, found that 24% of a group of patients with bulimia met *DSM-III-R* criteria for kleptomania. Based on extrapolation of the rate of bulimia from prevalence studies of bulimia in a large nonreferred adolescent population (2.5%) (32), the rate of kleptomania is at least six per 1,000 persons. These data must be interpreted with great caution because the relationship between eating disorders and kleptomania is unclear. Furthermore, an estimate of the rate of kleptomania based on the comparison of two unrelated studies may not be reliable. Nonetheless, these data suggest that kleptomania occurs far more frequently than previously thought.

There are additional reasons for believing that kleptomania may be more extensive than earlier studies suggest. A high percentage of people steal, and most are never caught (16, 33, 34); those who witness a theft rarely report it. Arieff and Bowie (25) noted the possibility that no arrest is made when an accused shoplifter is a prominent social figure. Moreover, individuals with kleptomania tend to be ashamed of their behavior and hesitant to share their secret with anyone, including therapists. Thus, shoplifters in general and those with kleptomania specifically may escape detection. The disorder, even if rare, most certainly is a source of both tremendous economic loss for

TABLE 1. Case Reports of DSM-III-R Kleptomania in the Literature

Author	Sex	Age (years)	Age at Onset (years)	Referral Source	Sexual Preoccupation/Dysfunction/Perversion	Relief or Pleasure ^a	Guilt ^a	History of Affective or Anxiety State	Symptoms Associated With a Personality Disorder
Fishbain (9)	F	57	20	Self	Yes	Both	— ^b	Depression	Histrionic
Turnbull (10)	F	29	6	— ^c	Yes	Both	Yes	— ^b	— ^b
Keutzer (11)	F	— ^b	— ^b	— ^c	Yes	— ^b	— ^b	Depression	Shy
	M	25	14	— ^b	Yes	— ^b	No	— ^b	— ^b
	F	25	— ^d	Self	Yes	— ^b	No	Psychotic depression, anxiety	— ^b
Elizur and Jaffe (12)	F	25	6	Self	Yes	Relief	Yes	— ^b	Compulsive, labile
Coid (13)	F	54	— ^b	Courts	Yes	Relief	Yes	Depression, anxiety	— ^b
Medlicott (14)	M	52	14	Courts	— ^b	Relief	— ^b	— ^b	— ^b
	M	59	— ^b	Courts	— ^b	Relief	— ^b	— ^b	Passive, unsuccessful
	M	68	48	Courts	— ^b	Relief	— ^b	— ^b	— ^b
	M	47	— ^b	Courts	— ^b	— ^b	— ^b	— ^b	— ^b
Gauthier and Pellerin (15)	F	44	44	Courts	— ^b	Both	Yes	— ^b	— ^b
	F	30	26	Courts	— ^b	— ^b	Yes	— ^b	— ^b
Russell (16)	F	17	17	Courts	— ^b	— ^b	— ^b	— ^b	— ^b
McConaghy and Blaszczyński (17)	F	19	9	Courts	Yes	Pleasure	— ^b	— ^b	Hysterical
	F	39	23	Courts	— ^b	— ^b	— ^b	Depression	— ^b
Davis (18)	F	53	35	Courts	— ^b	Relief	— ^b	— ^b	— ^b
	F	42	— ^b	Courts	— ^b	— ^b	— ^b	Depression, anxiety	Passive-dependent
	F	48	— ^b	Courts	— ^b	— ^b	— ^b	Depression, anxiety	— ^b
	F	40	— ^b	Courts	— ^b	— ^b	— ^b	Depression, anxiety	Lability
	F	40	— ^b	Courts	— ^b	— ^b	— ^b	Depression, anxiety	Lability
Gudjonsson (19)	F	31	— ^b	Courts	— ^b	— ^b	— ^b	Depression, anxiety	Lability, obsessive-compulsive, dependent
	F	31	— ^b	Courts	— ^b	— ^b	— ^b	Depression, anxiety	Obsessive-compulsive
McElroy et al. (20)	F	— ^c	— ^b	Courts	Yes	Both	— ^b	Depression, anxiety	— ^b
	F	23	20	Courts	— ^b	Both	Yes	Bulimia	— ^b
	F	35	20	Courts	— ^b	Both	No	Bulimia, major depression	— ^b
	F	19	16	Courts	— ^b	— ^b	— ^b	Bulimia, major depression	— ^b

^aDuring or associated with the act of stealing.
^bNo information was available.
^cCoerced into treatment after apprehension by peer or store owner.
^dChildhood.
^eMiddle-aged when treated; thefts began 20 years earlier.

the community (1) and emotional trauma for those afflicted.

Another area of uncertainty concerns gender. Anecdotal case reports and some studies (18, 21) seem to agree with the longstanding belief that kleptomania occurs primarily in women. One study (27), however, contradicted that belief. In addition, Medlicott's study of 50 thieves (14) revealed that four of the five identified as having kleptomania were men. Of the 26 case studies listed in table 1, five were men and 21 were women. Similarly, Yates (21) found that 80% of people who engaged in nonsensical shoplifting were women.

The literature clearly suggests that the majority of those identified as having kleptomania are women. One reason may be that women are more likely than men to present for psychiatric evaluation (26). Indeed,

table 1 shows that all three of the subjects who referred themselves were women. In addition, the courts may be likely to send male shoplifters to prison while sending female shoplifters for psychiatric evaluation. Medlicott (14), for example, reported the case of a male patient who was imprisoned for 14 years for the repetitive thefts of bicycles and trucks that he abandoned shortly after stealing. Thus, for several reasons, it is possible that men who shoplift do not enter the population of people referred for evaluation.

Another possibility is that kleptomania is truly more common among women. Guze (35) has shown that male and female felons from similar difficult environments may develop quite differently. Men may develop more overtly antisocial behavior, but women develop other symptoms, such as hysteria. Men and women with impulse control problems may manifest these

TABLE 1 (continued)

Family History	Precipitant	Marital Status
Postpartum depression in mother	Yes	Married twice
Mother ineffectual, with somatic complaints; father absent	— ^b	Single
— ^b	Yes	Married
— ^b	Yes	Single
Depression in, suicide attempts by mother; father absent	— ^b	Single
Psychotic mother; weak father	— ^b	Married
Denied	Yes	Married twice
— ^b	— ^b	Single
— ^b	Yes	Married
— ^b	— ^b	Married
— ^b	— ^b	Married
— ^b	— ^b	Married
— ^b	— ^b	Married
— ^b	Yes	Single
— ^b	— ^b	Single
— ^b	Yes	Married
— ^b	Yes	Separated
— ^b	Yes	Married
— ^b	Yes	Married twice
— ^b	Yes	Married
— ^b	Yes	Single
— ^b	Yes	Married
Weak mother; cruel stepfather	Yes	Married
Major depression in mother	— ^b	Single
Major depression in grandmother; alcoholism in father; kleptomania, alcoholism, and bulimia in sister	— ^b	Married
Major depression in mother	— ^b	— ^b

problems differently. Men seem to have a relative monopoly on the more aggressive acts of impulse such as pyromania, intermittent explosive disorder, and pathological gambling. Kleptomania and trichotillomania, the less overtly destructive impulse disorders, may be more common in women.

The mean±SD age at the time of evaluation for the women with kleptomania shown in table 1 was 35±12.6 years (range=17–57), for the men it was 50±16.1 (range=25–68), and for both sexes it was 38±14.3. The mean±SD age at onset for the women was 20±12.5 (range=6–44). (The data are insufficient to determine the mean age at onset for the men.) Although some individuals with kleptomania have been arrested numerous times, the typically long period of time between onset and presentation seems to reinforce the belief that kleptomania is a behavior that is extremely difficult to extin-

guish without help and that it is difficult to detect. The traditional notion of kleptomania first developing in a middle-aged woman in response to a loss, such as a child's leaving home, may be faulty. Instead, symptoms of kleptomania may return under these circumstances. It seems clear that the disorder is a pattern that is established early on.

Most of the individuals shown in table 1 were married (N=16) or separated (N=1). This supports Yates's data on marital status in 101 individuals with nonsensical shoplifting (21): 73% were married. There are few data on other demographic variables, such as social class, rural and urban distribution, race, and religion. Schlueter et al. (24), however, found that "non-rational" shoplifters were more likely to be of faiths other than Catholic or Protestant and tended to be well educated. They also found no significant difference in race between the "nonrational" thieves and ordinary thieves. Sampling difficulties undoubtedly affected the reliability of these data.

ETIOLOGY, CHARACTERISTICS, AND CLASSIFICATION

Psychological and Psychosexual Theories

Much of the literature regarding the causes of kleptomania focuses on its relationship to anxiety, depression, or sexual disturbances (10, 16, 21, 25, 36). According to Ellenberger (37), Janet felt that the need for stimulation resulted in artificial methods to increase psychological tension. In 1911, Janet discussed the case of a depressed woman who was able to relieve her symptoms through the stimulation provided by shoplifting. The need for stimulation is also echoed in Fishbain's case of a depressed woman who masturbated during shoplifting (9). Fishbain concluded that depression was a stimulus to risk-taking behavior (kleptomania), which had an antidepressant effect. Roy (36) felt that the new onset of shoplifting in an otherwise normal man was a symptom of stress, but others (13, 38) have considered the function of kleptomania to be symptom relief. Although this theory does not explain why these patients choose theft as a relief mechanism, this model seems, at least in part, valid. Indeed, all 13 of the individuals for whom such information was reported in table 1 experienced relief of tension or both relief and pleasure from stealing.

Depressive states and tension are often reported as precursors to many kinds of theft (18, 21, 26). Yates (21) found depression in 80% of those who engaged in nonsensical shoplifting. Indeed, table 1 reveals that 13 of the 14 individuals for whom a history of affective or anxiety states were reported had states of depression or depression and anxiety. Unfortunately, in the majority of cases reported, neither the severity of the depressive or anxiety state nor the length of the episode was specified. In most cases, however, no mention was

made of hospitalization; most cases seem to have involved outpatient evaluation and treatment. There is descriptive evidence, however, that the individuals suffered from a spectrum of affective states ranging from dysthymia to psychotic depression. This range of mood raises the question of the length of time the person has experienced anxiety or depression—i.e., whether an acute, chronic, or recurring mood disorder is more likely to be associated with kleptomania. This information is not found in most case descriptions. Further evidence supportive of an association between kleptomania and depression, however, comes from studies of subjects with bulimia (28–31). McElroy et al. (20), noting that both the impulse to steal and bulimic behavior ceased with antidepressant therapy, highlighted the possible link between kleptomania and depression. Although some have felt that depression might have been a response to an approaching trial, Davis (18) noted that depression predated arrest.

The same ambiguity in the literature holds true for acute environmental precipitants to stealing, which may or may not be sequentially related to the onset of affective or anxiety states. All 14 of the individuals in table 1 for whom the data were available reported precipitants to their stealing behavior. Cupchik and Atcheson (1), in discussing thievery among “upstanding” citizens (some of whom may have had kleptomania), formulated the loss-substitution-by-shoplifting hypothesis based on the recollections of individuals who had recently been arrested. These authors maintained that in a large percentage of patients the theft was an effort to obtain symbolic compensation for an actual or anticipated loss. The study, like most others, was retrospective and uncontrolled.

With a few exceptions, the literature is vague in its description of precipitants and stressors and in its methodology. Many cases were retrospective and not the result of longitudinal exploration. Vague terms like “social isolation” (21) were used in descriptions. However, since there was a disparity between age at onset and age at evaluation, the information about the precipitant to the latest theft seems of limited value. The chronicity of the depression and/or tension and the importance of acute precipitants in disorders that are chronic are unclear. The chances seem good that individuals with kleptomania have experienced one precipitant after another for many years and have existed in a chronic depressed or anxious state for many years. Indeed, Yates (21) suggested that nonsensical shoplifting may be associated with an accumulation of stressors over time. Few, if any, authors who noted objective precipitants in their subjects explored the intrapsychic mechanisms that were stimulated by these precipitants. Since the materials stolen were not for their economic value, one plausible hypothesis is that the theft was for intrapsychic profit. As shown later in this paper, analytic theorists have advocated this idea. Most of the case descriptions in the literature, however, fail to identify the patient’s thoughts or associations just before the theft.

Fenichel (39) believed that kleptomania can have direct sexual significance. Other early drive theorists felt that kleptomania involved “doing a forbidden thing secretly” and likened the behavior to a sexual act. Wittels (40, 41), for example, observed that stealing was the sex life of the person with kleptomania and that his or her real sex life was underdeveloped. According to Elizur and Jaffe (12), Stekel felt that kleptomania was analogous to a perversion. The stolen objects have also been considered to have other sexual significance. Fenichel (39) suggested that the objects stolen by individuals with “perverse” kleptomania are actually their fetishes. Wise (42) commented that kleptomania and other impulse disorders have been associated with fetishistic behavior. Bradford and Balmaceda (26), however, failed to find evidence of “sexual deviation” in their two subjects with kleptomania.

No information was given concerning sexual preoccupations, behaviors, or dysfunction for 17 of the 26 patients in table 1. In the nine studies reporting such information, the patients reported experiences such as vaginismus, nonarousal, promiscuity alternating with abstinence, and a preoccupation with sterility. Some reported orgasm or sexual excitement during thefts (9–13, 16, 19). In the light of the absence of information on the majority of patients, it is unwise to make firm conclusions. Certainly, there are also biases built into this information. Indeed, an author treating several patients with kleptomania, one of whom has a strange sexual behavior, is more likely to report this case rather than the others. The data, however, suggest an association between kleptomania and sexual abnormalities. Several authors (4, 43–46) have argued that kleptomania is more prevalent during menstruation or pregnancy, but these observations have not been duplicated (12, 27) and are not considered valid.

The psychoanalytic literature suggests that kleptomania is a symptom of an underlying conflict. Noting the presence of depression and disturbed sexuality, analysts proposed mechanisms they felt could explain the disorder. Fenichel (39) and others (41, 43, 47–50) discussed kleptomania and other forms of stealing as the gratification of id impulses and as an expression of infantile needs. Abraham (51) traced kleptomania back to the child’s feelings of neglect concerning proofs of love: in stealing, the child finds a substitute pleasure for a lost pleasure and simultaneously takes revenge on those who caused the suffering. Unfortunately, there are no modern data available to refute or confirm these earlier psychoanalytic findings. Indeed, most modern case reports of kleptomania are essentially devoid of important details such as associations and transference phenomena. Family data are also scarce. Such information would theoretically reflect the nature of the individual’s psychosexual development and could be used to refute or confirm analytic theory. Of the 26 case studies summarized in table 1, family characteristics were dealt with in only nine. In one case, the subject’s mother was psychotic, in four cases the mother was depressed, and in two cases the

mother was ineffectual or absent. Absent or weak fathers were reported in three of the nine cases. One case described a cruel stepfather and one described an alcoholic father. These data are undoubtedly incomplete, and little can be said conclusively about family characteristics, but these findings may lend support to the idea that kleptomania is related to depression.

Some authors (12, 39, 52) focused not only on the act but on the specific, symbolic meaning of the objects stolen and their relationship to fixation points. An oral fixation would mean that the stolen object represents mother's milk, anal fixation is linked to the hoarding and collecting of goods, and phallic fixation results in penis envy or castration fears—the stolen object represents a penis. Wittels (40) theorized that individuals with kleptomania take "love in the shape adequate to their libidinal understanding." Perhaps, therefore, they can be either oedipal or pre-oedipal; it is quite difficult to arrive at a determination of the primitiveness of the defenses of individuals with kleptomania from available data. However, personality traits (discussed later in this paper) may provide some additional information. There is not enough information to know whether a given person both hoards and discards or what the significance of keeping the stolen objects would be. It would be interesting to know whether one person stole only one type of article, but this cannot be gleaned from the available data.

With a slow shift away from traditional drive theory, some writers have chosen to see kleptomania itself as defensive (49, 53–55). Rado (53), in discussing castration anxiety in women, considered the "fight" defense as the primary source of pleasure in kleptomania. According to this view, the woman, overcome by castration fear, acquires a penis to strengthen her "tottering phallic position." Menaker (49), in a study of 12 boys who stole, felt that the only defense against the strong passive-receptive wish is the opposite wish to grab, steal, or tear away. In general, these authors were moving away from the notion of theft as having a primarily sexual meaning to a model of theft as defensive.

Although these analytic writers discussed theft and not kleptomania specifically, they seemed to consider the two to have the same meanings and causes. Yates (21), however, has shown that there are many important differences between stealing for obvious profit and nonsensical stealing. For example, she said, those who steal for profit tend to have, among other things, far more "anti-social and delinquency-prone personalities," whereas individuals with kleptomania tend to be depressed and socially isolated. There appears to be a difference in character that goes unexplained by early analytic cases. One wonders why the thief and the kleptomaniac are discussed interchangeably when they may, in fact, develop so differently. Guze (35), however, pointed out that male and female felons growing up in similar tumultuous environments may develop different symptoms as adults. It remains unclear, however, whether it is accurate to draw conclusions about

the individual with kleptomania from the psychoanalysis of other kinds of thieves.

In this light, other writers view kleptomania as a form of psychopathy or related to it (12, 40, 41, 46, 54). Wittels (40) believed that individuals with kleptomania enter treatment only when threatened by the law and abruptly abandon treatment once they have been acquitted. Elizur and Jaffe (12) saw kleptomania as a neurotic conflict in a person with elements of an antisocial character formation. The notion of guilt and remorse has prompted several writers to comment on the role of the superego in stealing, the presence or absence of guilt, and the presence or absence of symbolism in stealing acts. Some (56, 57) have felt that theft results from a hypertrophied superego, which ultimately results in incarceration or other punishment. Moore's "episodic" shoplifters (22) stole items used for self-punishment. Castelnuovo-Tedesco (58), in describing an ordinary thief as a kleptomaniac, maintained that stealing is done with superego approval based on primitive ethical premises, but other authors (12, 41, 49) felt that the superego is underdeveloped in kleptomania.

Those theories which view the individual with kleptomania as having an antisocial character seem particularly narrow. Indeed, the drive to steal in kleptomania may be no more antisocial than the need to lie to the physician about the quantity of food intake in anorexia nervosa. Moore's shoplifters (22) responded with "quiet compliance" when detected. Furthermore, they felt that their acts were illegal and morally wrong. The data in table 1 also seem to contradict the idea that kleptomania is simply antisocial. Of the nine subjects for whom such information was reported, six expressed guilt regarding the act of theft. (Yates's finding of a lack of antisocial traits in her patients [21] seems to support these findings.) Of course, these observations are based on limited data, and it is possible that the expression of guilt could have been a ploy to escape further legal action. There is no information, however, on those who are not apprehended, and it is possible that patients who have been caught reflect a different subgroup of individuals with kleptomania. Perhaps these patients have a more hypertrophied or punitive superego and "set themselves up" to get caught more easily than those whose superegos are underdeveloped. Testing this hypothesis would present difficult methodological problems.

The issue of personality is briefly mentioned in *DSM-III-R*, as is the idea that kleptomania sometimes, but not invariably, is associated with personality disorders. In some ways, the question of personality may be rooted in the question of whether kleptomania exists as a monomania or as one of the pathological signs in an otherwise normal person. The literature seems to suggest that there can often be associated personality symptoms. Table 1 reveals that many of the reported cases had such symptoms. Ten of the reports described characteristics consistent with personality disorders. These included compulsiveness, dependency, lability,

hysteria, and histrionics—most considered to be more primitive traits. Unfortunately, as with many other categories, nothing is known about the 16 cases that did not report personality characteristics, making generalizations difficult. In addition, the lack of a reliable longitudinal evaluation in many of the cases makes a diagnosis of personality disorder tenuous. However, many of the symptoms seem more consistent with a character disorder than symptoms of, for example, a depressive episode. Additionally, individuals with kleptomania and nonsensical shoplifting reported tumultuous and unusually stressful childhoods (concentration camp survival, for example), marital turmoil, social isolation, and lack of self-esteem (11, 12, 16, 18, 19, 21, 22), making associated personality difficulties all the more possible.

Like earlier analytic writers, many object relations theorists did not seem to distinguish between kleptomania and stealing for profit. Object relations models emphasize internal representations of the infant's relationships with its objects as well as the importance of id desires and affective states (59). Castelnuovo-Tedesco (58), for example, felt that stealing and kleptomania represent "a way of controlling a frightening and dangerous object and rendering it harmless by reinstating a long-lost but greatly cherished sense of omnipotence." There does seem to be an attitude of omnipotence in some patients (18), but this does not always appear to be conscious. Indeed, the fact that the individual may steal in plain view of others may reflect this attitude. Winnicott (60), although not discussing kleptomania specifically, felt that the child who steals is looking for the mother over whom he or she has rights. The mother becomes the object that the child is ready to find.

Self theory is concerned with deficits in the structure of the self as opposed to the conflict resolution associated with drive theory (59). Kligerman (61), for example, in response to Castelnuovo-Tedesco (58), discussed stealing and kleptomania in terms of the narcissistic vulnerabilities found in disorders of the self. He postulated that stealing can be a response to narcissistic injuries and can help prevent fragmentation of the self. Both of these authors also questioned whether all stealing, including ordinary theft, is symbolic and psychopathological. Castelnuovo-Tedesco concluded that the act of stealing has many meanings and functions, all of which are restitutive. Tolpin (62) saw his patient's kleptomania as an attempt to counter an inadequate formation of her nuclear self. However, his patient's clinical picture was complicated by her ongoing substance abuse.

Several authors (63–65), perhaps noting its repetitive, irresistible, and seemingly meaningless patterns, have likened kleptomania to or considered it a part of an obsessive-compulsive disorder. Laughlin (64), however, pointed out the differences between the two disorders, including the propensity to act out in kleptomania. The behavior in obsessive-compulsive disorder is not an end in itself but is instead intended to produce

or prevent some future event or situation. Furthermore, *DSM-III-R* points out that the act of kleptomania may bring intense gratification—an experience that helps differentiate the impulse disorders from obsessive-compulsive disorder. This seems to be an important distinction because obsessive-compulsive disorder is noteworthy for its ego dystonicity and its sense of relief rather than gratification. An examination of table 1, however, reveals that in the 13 cases reporting symptoms of relief and/or gratification from the stealing act, six reported relief, six reported both pleasure and relief, and one reported only pleasure. Thus, stealing does not appear to be strictly pleasurable and many subjects with kleptomania seem to obtain relief from the act, implying that a relationship might exist between kleptomania and obsessive-compulsive disorder.

In summary, analysts and other dynamic psychotherapists have suggested many mechanisms to explain both the developmental origins and behavior of the person with kleptomania. There appears to be some agreement regarding the types of symptoms seen in the disorder but little agreement about causation. Most theories do not seem specific for kleptomania and can be used to describe a multitude of disorders. Furthermore, there has been little integration of the various schools of thought. It must be noted that most seem to ignore the intensity of the symptoms and fail to explain the tremendous, uncontrollable drive to repeat what most certainly is self-destructive, masochistic behavior—behavior that overpowers, controls, and imprisons. Not all theorists feel that acts of self-destruction are adequately explained by traditional analytic tenets. Simpson and Porter (66), for example, felt that "self-destructive activities were not primarily related to conflict, guilt, and superego pressure, but to more primitive behavior patterns originating in painful encounters with hostile caretakers during the first years of life."

Biological Considerations

A number of reports suggested that kleptomania-type behavior can be organically precipitated by neurological conditions (67–71), medication effects (72), and other medical conditions (73). Mendez (67) described a 71-year-old man with dementia and left frontal and right parietotemporal hypolucency who started stealing objects when he was 66 years old. Khan and Martin (68) reported the case of a 25-year-old man with presenile cortical atrophy (particularly frontal) who stole cigarette stubs and broken saucers as well as objects of greater value. Chiswick (69) described a middle-aged woman who, 2 years before a nonsensical stealing episode, had a right parietal mass accompanied by apathy and depression. She could not recall her stealing episode and had continued blackouts. She was effectively treated with amitriptyline, phenytoin, and psychotherapy. Chiswick considered psychomotor attacks as the cause of the stealing but felt that depression was the likely precipitant. Bleuler (45) discussed a disturbance in consciousness in his patients with klep-

omania, as did Bradford and Balmaceda (26), who found that 12% of a group of shoplifters described a dissociative state. According to Elizur and Jaffe (12), Stekel felt that kleptomania necessitated a fugue state. Zoric et al. (70) described nonsensical shoplifting in a woman who suffered from narcolepsy. Moak et al. (71) speculated that lower levels of biogenic amines and rates of synthesis in the elderly lead to a decline in reciprocal inhibition and may cause stealing. Todd (72) described a woman on "calmative" medication with no previous criminal record who stole food from a store for no apparent reason. Segal (73) described unwitting shoplifting by a person with severe hypoglycemia secondary to an insulinoma.

The data available must be interpreted with caution—it is, for example, difficult to know whether the given localizations of lesions were specifically responsible for the stealing. Obvious pathology in one part of the brain can affect other distant areas. Additionally, data that describe parietotemporal lesions may be suggestive of temporal lobe epilepsy. Indeed, many of the symptoms described can be attributed to temporal lobe epilepsy—altered sexuality, dissociative phenomena, depression, and anxiety. However, like most hypotheses regarding kleptomania, there are not yet enough clinical data to support or refute these ideas.

There are not enough data to know whether these organically ill patients have had the same developmental and psychological characteristics and circumstances that seem to be more frequent in those with the "naturally occurring" form of kleptomania. Although the cases lack obvious signs of relief or gratification, they may nonetheless be reflective of a biological substrate that bypasses the developmentally driven features of a person suffering from kleptomania.

Behavioral Models

Unfortunately, data regarding behavioral models are scarce because many behavioral researchers are not concerned with etiology. Indeed, all of the reports found in the literature focused almost exclusively on treatment. Glover (74), however, suggested that her patient's positive response to a trial of covert sensitization implicitly supports a cognitively mediated model of compulsive shoplifting. The development of an etiological model based on response to treatment, however, must be made with caution.

TREATMENT AND PROGNOSIS

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. Aversive behavioral treatment, which pairs an aversive consequence of stealing with the desire to steal, has been used. Keutzer (11) had her patient hold her breath when she thought of stealing to rid her of the desire to steal; this treatment was successful at

10-week follow-up. A more lengthy follow-up period may have been helpful in determining the efficacy of this form of treatment.

Covert sensitization pairs an imagined consequence of stealing with the desire to steal. To treat a woman who had stolen daily for 14 years, Glover (74) had the patient associate images of nausea and vomiting with the desire to steal. At 19-month follow-up this patient had had only one episode of stealing. Gauthier and Pellerin (15) also reported successful use of this technique at long-term follow-up.

Although much of the theoretical groundwork has been provided by the psychoanalytic community, there is little well-organized information regarding the efficacy of long-term insight-oriented psychotherapy. Psychoanalysts and other psychodynamic therapists have claimed success by treating kleptomania and other forms of stealing as a symptom of an underlying conflict (47, 48). It is not at all clear whether treatment successes are specific for kleptomania, especially because the definitions of the disorder in these reports are so murky and variable.

Fishbain (9) used several forms of treatment to cure his patient of kleptomania. He used insight-oriented and supportive therapies for the patient's "risk-taking" behavior and her guilt feelings related to the effect of her kleptomania on her family, respectively. He also prescribed medication for depression and behavioral modification for the actual stealing. He noted that depression and stealing returned on discontinuation of antidepressant medication. These results seem to indicate that an appropriate treatment for kleptomania is antidepressant therapy, but other authors (17, 19) reported no cessation of kleptomania with antidepressants. McElroy et al. (20) found that administration of serotonergic agents resulted in complete or partial cessation of stealing in three patients with both bulimia and kleptomania. McElroy et al. concluded that because appetite, impulsivity, and mood can be affected by serotonergic pathways, these drugs may be helpful in the treatment of these conditions.

Although many methods have been used to treat kleptomania, perhaps the most common is the self-imposed banning of all shopping in an attempt to prevent theft. Although there have been several reports of this self-treatment (17, 19, 20, 74), it may be far more common than reported because individuals with kleptomania can impose such "treatment" on themselves without having to seek professional help.

DISCUSSION

Methodological Difficulties

The compiling of data for table 1 was complicated by a lack of complete information. This incompleteness may be a reflection of the individual authors' attempts to illustrate one or two points about a partic-

ular case. Many of the anecdotal reports are based on short-term interviews rather than longitudinal encounters. Secret characteristics, early trauma, and repressed precipitants, therefore, may not be reflected. This lack of data undoubtedly affects reliability. Additionally, the phenomenon of underreporting important details may be a reflection of the covert actions and secret nature of the individual with kleptomania rather than the deficiency of the reporting authors. Also, most of the cases in table 1 were referred from courts. These are characteristics of patients who were caught; the table tells us nothing about those who elude apprehension. Furthermore, many of these cases were undoubtedly chosen for review and publication on the basis of characteristics such as sexual dysfunction. It is not known whether the authors cited excluded cases without these interesting features.

On the other hand, the analysis of these cases is meant to give an overview of available data. Despite the various limitations that bias each reported case, it is hoped that the information gleaned can be of assistance in determining more about this mysterious illness and can prompt further thought.

Integration of Existing Data

Although there is no unified psychological theory regarding kleptomania's etiology, the small amount of information available affords us a basis on which we can hypothesize about the disorder. It would appear that the average person suffering from kleptomania is a 35-year-old married woman who has been apprehended for the theft of objects she could easily afford and does not need. Her stealing began at age 20 and she has been caught several times. A search of her house reveals piles of unopened packages of stockings and cans of jam. Her acts of theft bring her great relief from tension, and she may attempt to force herself to remain indoors for fear that she will steal. Despite her sense of entitlement about the thefts, she feels remorse and almost never seeks treatment on her own. Perhaps because of guilt or shame or because she is fearful of losing the opportunity to steal, she feels compelled to keep it a secret. She seems to suffer from a powerfully necessary, pervasive, repetitive, and ultimately self-destructive act. A personal history reveals that she is unhappily married, may have sexual difficulties, and has been dysphoric and moody for many years. She very likely has had a tumultuous and stressful childhood. Furthermore, she may have a personality disorder.

In general, theorists have seemed to focus on the unusual symptoms of kleptomania rather than examining the overall clinical picture. In examining the data available to us, many of the details presented here seem to raise the possibility of the role of early sexual or physical trauma. Indeed, many of the characteristics found in those who have been sexually abused (75, 76) seem to correspond well with the traits of those who have kleptomania. Several statistics illustrate this point. In a study of sexually abused women, Herman

(76) discovered that, like women with kleptomania, many women who had been sexually abused as children complained of major depressive symptoms in adult life and suffered from alternating sexual promiscuity and abstinence. Like those with kleptomania (10, 11, 15, 17–19), sexually abused women developed stormy and tormented relationships, often with exploitative men. They often felt unvalued by their husbands, and many had relationships with older men. More than half complained of sexual impairment—a phenomenon found with some regularity in individuals with kleptomania. Indeed, there are many examples of sexual preoccupations and intrusive sexual fantasies in kleptomania that correspond to those of sexually abused women. Herman (76) stated that some sexually abused women “so thoroughly associated sex with the feeling of being dominated and controlled that they were unable to relax.” Similarly, Turnbull (10) reported the case of a woman with kleptomania who was passive during sex and had fantasies of being beaten by an older woman, which led to orgasm. Dissociative phenomena, which have been described in those with kleptomania, are also seen with regularity in those suffering from early abuse (75).

Another relevant phenomenon, which perhaps has stood in the way of our more fully understanding the illness, is the secretiveness of the behavior in kleptomania. Indeed, by its very nature, kleptomania is covert and secretive—much like its sufferers. Could this be a reflection of the secrets (either conscious or unconscious) that those who have been abused keep?

If the literature is accurate, individuals with kleptomania appear to suffer from many abuses—in childhood, marriage, and relationships. This may give us some clues as to the origins of the compulsive, addictive symptoms. Van der Kolk (77), for example, felt that trauma can be repeated on many different levels, including behavioral, emotional, physiological, and neuroendocrine, and that it is associated with physiological hyperarousal and the compulsion to repeat the trauma.

According to both animal and human studies (77), those who have been exposed to severe stress will experience large increases in endogenous opiates and catecholamines in response to subsequent stress. This chemical shift can produce relief, dependence, and withdrawal resembling the response to exogenous opioids. The victims neutralize their hyperarousal, which interferes with their ability to make rational decisions, by a variety of addictive behaviors, including compulsive reexposure to situations reminiscent of the trauma, such as abusive relationships. Applied to kleptomania, Van der Kolk's theory could posit that the stimulus of theft may condition an opioid response. Kleptomania may be the mechanism by which the person attempts to modulate affective states, gain relief from hyperarousal, and prevent withdrawal from the addiction (kleptomania).

Individuals who have been traumatized may show an initially good social adjustment but become socially

isolated or aggressive when emotionally aroused. They also can respond inappropriately to sexual arousal (77). This might help to explain the bizarre sexual behavior and ideation of some individuals with kleptomania as well as their isolation and aggression (theft).

Although the reminiscence of original trauma in kleptomania may be in a tumultuous marriage, perhaps the theft itself can serve as a representation of the trauma—such as “stealing” the father from the mother during the father’s exploitation of oedipal longings or the compulsion to repeat receiving inappropriate and dangerous “gifts” from the father. It may also represent an identification with the aggressor—the woman with kleptomania may become like the person who robbed her of her childhood. Thus, it is possible that kleptomania is a self-abusive behavior that is used in the service of modulating affective states and as a coping mechanism. Perhaps the act itself is a repetitive trauma. Each theft elicits a necessary physiological response, the positive reward of which becomes learned and repeated and is representative of a dynamic reenactment. In the sexually abused, these adaptive behaviors ultimately perpetuate chronic feelings of helplessness, a sense of being bad, and a sense of loss of control (77). These feelings and behaviors can lead to great social and personal suffering (77)—traits that those with kleptomania are well acquainted with.

CONCLUSIONS

A more complete biological, behavioral, and developmental understanding of kleptomania would help alleviate both tremendous cost to the public and untold human suffering. Future research seems to be dependent on the collection of a larger group of individuals with the illness. Certainly, prospective studies would be desirable. Due to the covert nature of the illness and the hesitation of those afflicted to come forward, obtaining a large group presents the clinician with a challenging task. Prevalence studies using an inventory designed to detect other impulse disorders (78) have been successful and may be an important first step in studying the illness.

If study groups are selected from the courts, more complete, longitudinal evaluations should be performed. Once a population can be identified, sexual abuse inventories should be used (79), results of medication trials should be recorded, and evidence of dissociation and other necessary information should be gathered (80). Controlled studies comparing subjects with kleptomania with other thieves as well as with a variety of nonforensic populations and subjects with other types of impulse control disorders should be conducted.

Therapists need to improve their ability to detect all of the secretive impulse disorders—a task that requires patience. Indeed, the detection of kleptomania, like the detection of other sensitive issues, may necessitate a lengthy, alliance-based psychotherapy. The initial answer to a therapist’s questions about a history of se-

cretive, impulsive, or compulsive behavior is often negative. It is not until later in the therapeutic process, when a firm therapeutic alliance has been established, that the patient feels free to disclose such behavior. A nonjudgmental inquiry during an initial evaluation may allow the patient to bring it up at a later date.

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