

Kleptomania: An impulse control disorder?

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Received 8 June 2001; accepted for publication 4 July 2001

Kleptomania – the inability to resist the impulse to steal objects, not for personal use or monetary gain – is currently classified in psychiatric nomenclature as an impulse control disorder. However, the principal effects of the theft are repetitive intrusion thoughts, and inability to avoid the compulsion to perform the theft, and the relief of tension following the act could suggest that kleptomania may be a form of obsessive–compulsive spectrum disorder. Kleptomania as an obsessive–compulsive variant with other psychiatric disorders has led to the use of serotonin reuptake inhibitors (SSRIs), other antidepressants, mood stabilizers, and opioid receptor antagonist medications for pharmacological management together with cognitive behavioral therapy (CBT), with favorable results. (Int J Psych Clin Pract 2002; 6: 3–7)

Keywords

**kleptomania
obsessive–compulsive spectrum**

**impulse control
SSRI**

INTRODUCTION

The aim of this article is to review the diagnostic and therapeutic approaches to kleptomania. Since the nineteenth century the definition of this condition has been modified and adapted by clinicians and researchers to fit contemporary psychiatric classifications and models of treatment. Kleptomania was classified in the DSM-IV of the American Psychiatric Association as an impulse control disorder not elsewhere classified,¹ and the International Classification of Diseases of the World Health Organization classified it under the heading of 'habit and impulse disorders',² together with pathological gambling, pyromania and trichotillomania. Both classifications are based on recurrent failure to resist the impulse to steal despite the ego-dystonic nature of the impulse and awareness that the act is wrong.

The etiological approach (psychological and biological) accommodates the contribution of unbalanced CNS neurotransmitters, as in trichotillomania and obsessive compulsive disorder (OCD), and hence the possibility of treatment by various psychotropic medications.

Kleptomania is generally believed to be a rare clinical condition. Clinical manifestations can occur at different ages from adolescence to mid-life, the mean age at onset being 20, although late onset (a 77-year-old woman) has been reported.³ Late diagnosis following many years of suffering is the rule.⁴ The prevalence of kleptomania in the general population is hard to assess; it is thought to be between 0.6 and 0.8%.⁵ Estimates of true cases of kleptomania range from zero to 8% of all shoplifters.^{6,7}

The syndrome is known to afflict four times as many women as men,⁸ and some researchers see an association between kleptomaniac acts and menstruation⁹ or premenstrual tension.¹⁰ The pathological thief differs from ordinary thieves in that the act of stealing is performed in order to achieve emotional relaxation and not personal gain. Tension is experienced before the act and in attempting to resist the impulse. Pathological stealing is impulsive and repetitive, resembling OCD in featuring a struggle to oppose the drive – a struggle that evokes anxiety and tension. Patients typically suffer from emotional distress and impaired functioning in social and occupational areas.

Kleptomania appears to be comorbid with other psychiatric conditions, most notably mood disorders, anxiety disorders, eating disorders and abuse of alcohol and other psychoactive substances.¹¹ Hudson and Pope proposed a relationship between kleptomania and mood disorders, OCD, eating disorders, and panic disorders, terming them 'affective spectrum disorders'.^{13,14} McElroy and colleagues^{12,15,16} and Hollander and Wong¹⁷ suggested that the syndrome is associated with strong compulsive and impulsive features and hence consider it a variant of (within the spectrum of) the obsessive-compulsive disorders, together with pathological gambling, compulsive buying, pyromania, nail biting and trichotillomania. The 'obsessive-compulsive spectrum' and 'affective spectrum' disorders and the phenomenological resemblance to other impulse control disorders suggests that medications that have proved to be beneficial for such disorders will be of help in treating kleptomania. The core fault in these

disorders is at the level of brain neurotransmitters, with the main focus of research and therapeutic interest on serotonin levels.

TREATMENT STRATEGIES

Although recognized for over a century, the etiology of kleptomania is still unclear, so that various therapeutic strategies have been proposed for its treatment, including psychoanalytic-oriented psychotherapy,^{18,19} behavioral therapy²⁰ and pharmacotherapy.

Antidepressants, mainly from the group of selective serotonin re-uptake inhibitors (SSRIs), became the treatment of choice, as in other impulse control disorders (trichotillomania, pathological gambling, binge-eating, compulsive buying). This therapeutic strategy is based on the assumption that the biological etiology of these disorders stems from different levels of serotonin in brain synapses, and that the therapeutic effectiveness of this strategy will apply also to kleptomania as well as to the vast majority of its comorbid psychiatric disorders.

PSYCHOLOGICAL INTERVENTIONS

Various interpretations of the dynamics of kleptomania have been suggested. A current social approach suggests that kleptomania is a consequence of consumerism and the abundance of commodities in modern society;²¹ and that this might explain its predominance among women. Psychoanalysts interpreted the syndrome as a reflection of unconscious ego defense against anxiety, forbidden instincts or wishes, unresolved conflicts or prohibited sexual drives,²² fear of castration, sexual arousal,²³ sexual gratification and orgasm during the act of stealing.²⁴

Symbolic meaning has been attributed to the act itself, the object stolen, and the victim of the theft, and some have concluded that kleptomania is "a delinquent expression of a neurotic nature."¹⁸ The stealing has been considered as a symbol of sexual impulse or as symbolic substitution for masturbation.⁹

Cognitive-behavioral therapy has largely replaced the psychoanalytic and dynamic approach in the treatment of kleptomania. Several behavioral strategies have been shown to be effective in a number of cases reported in the literature: among them, covert sensitization using aversive imagery of nausea and vomiting,²⁰ aversion therapy²⁵ such as aversive breath-holding (until mildly painful) whenever an urge to steal or an image of it is experienced,²⁶ and systematic desensitization.²⁷ Gudjonsson claimed that the provision of alternate sources of satisfaction was more likely than aversive conditioning to help the patient overcome comorbid depression and the need for excitement and pleasure presumably achieved through the stealing.¹⁰ In some cases combination strategies such as combined covert sensitization with exposure and response prevention were used.^{26,27}

PHARMACOLOGICAL INTERVENTIONS

There have been no controlled studies of the psychopharmacological treatment of kleptomania. This may be due to the fact that the phenomenon is rare and it is difficult to obtain a large enough sample. Current knowledge of psychopharmacological treatment of kleptomania is derived from case reports or from material collected from group series.

The close resemblance between kleptomania and affective disorders has led to treatment with antidepressants and ECT, lithium, and valproic acid.¹⁶ The presumed involvement of serotonergic systems in a broad range of disorders tentatively linked to obsessive-compulsive disorders such as kleptomania²⁸ has led Marazziti and colleagues²⁹ to investigate platelet paroxetine binding in patients with OCD-related disorders. The results suggest a shared abnormality at the level of the presynaptic 5-HT transporter. In resistant cases, augmentation with buspirone, or in combinations with benzodiazepines such as diazepam or alprazolam, have been found useful in ameliorating the kleptomaniac drives.

Several recent case reports suggest that SSRIs are effective in the treatment of disorders in the OCD spectrum and especially in kleptomania. Among the SSRIs, fluoxetine, whether as a sole medicament or in combination with other medications, is most often cited as having a beneficial effect. The largest documented case series, reporting the result of biological treatment in 20 kleptomaniac patients,¹² reported two cases of good response to fluoxetine as a single-drug treatment, with lasting remission, although seven patients in the same series did not respond to fluoxetine. Fluoxetine was effective in combination with imipramine (one case) and in combination with lithium (one case), but in another case the latter combination was not effective. Schwartz also reported a case of kleptomania successfully treated with 80 mg of fluoxetine per day, replacing previous ineffective trial treatment with phenelzine, which had also caused severe hypotension.³⁰ Fluoxetine in combination with lithium was also reported to be effective by Burstein, in a case in which no response had been achieved in previous treatment trials with fluoxetine or clomipramine as sole drug.³¹

Fluvoxamine, the second SSRI studied in cases of kleptomania, was found to be efficient in one case following failure to respond to psychodynamic and behavioral therapy, and to several previous psychopharmacological trials with amitriptyline, imipramine, nortriptyline, fluoxetine, and lithium.³² The third SSRI reported to be beneficial in treating kleptomania is paroxetine. In a case reported by Lepkifker and colleagues, paroxetine at 20 mg/day for 3 months reduced kleptomaniac drives when used in combination with alprazolam.⁵ All of the five patients in the series benefited from SSRIs (the other four received fluoxetine). In another case reported by Dannon et al, paroxetine was used successfully together with naltrexone.³³ Interestingly, the paradoxical emergence of kleptomania during SSRI treat-

ment of depression has been reported in three cases.³⁴ Kraus reported a favorable response to paroxetine in a kleptomaniac patient with a long history (>10 years) of multiple drug treatment, who was first diagnosed as suffering from kleptomania with comorbid major depression following a suicidal attempt.³⁵ He concluded that kleptomania as an obsessive-compulsive spectrum disorder may share a serotonin-related dysfunction, and paroxetine may prove effective in treatment.

Trazodone produced a good response in treating kleptomaniac symptoms in four cases, with no response in two other cases.¹² Imipramine was not successful as a sole treatment (three trials), nor was desipramine (one trial), unlike nortriptyline, which proved efficient in one case with full remission. Imipramine combined with fluoxetine proved beneficial (one case) and a good remission was achieved when combined with fluoxetine (one case). Amitriptyline in combination with perphenazine was reported to be beneficial by Fishbain.³⁶

Monoamine oxidase (MAO) inhibitors were suggested as a possible option in treating kleptomania by Priest and colleagues.³⁷ They hypothesized that reversible and selective MAO-A inhibitors should be considered in these cases, but as yet no clinical data are available. Data from the largest and best-documented report of 20 patients published by McElroy and colleagues do not give much support to this hypothesis, as tranylcypromine proved unsuccessful in five trials, and only proved beneficial in one trial, when combined with trazodone.¹²

The same group used lithium as a sole treatment for kleptomania in four cases.³² In one case remission was reported, but the other three showed no response. Lithium in combination with fluoxetine resulted in improvement in two cases, but another trial found no improvement with this combination, nor did the combination of lithium with imipramine bring a relief in symptoms.¹² A case report by Kmetz and colleagues indicates that valproic acid in combination with fluvoxamine was effective in a patient suffering from kleptomania with comorbid mixed mania.³⁸ Another mood stabilizer, carbamazepine, in combination with clomipramine failed to ameliorate kleptomaniac symptoms.¹²

Opioid antagonists are considered useful in reducing urge-related symptoms, which are a core element of impulse control disorders; hence, their use in substance abuse as well as in impulse control disorders. The most commonly used drug is naltrexone, a long-acting competitive opioid antagonist principally of μ , but also of κ and λ opioid receptors. A preliminary case series published by Kim³⁹ found that naltrexone at dosage levels ranging from 100 to 200 mg/day was efficient in promptly reducing urges and that it was well tolerated in 15 patients diagnosed as suffering from impulse control disorder – including one case of kleptomania. The kleptomaniac patient had comorbid OCD symptoms and a significant decrease was reported in her stealing urges within several days of treatment with naltrexone (100 mg/day), with complete

remission at 150 mg/day. The main side-effects reported were gastrointestinal (diarrhea and nausea). No hepatic side effects or liver enzymatic changes have been reported, but because naltrexone poses a potential hepatic risk at high dosages, it should be prescribed only after preliminary tests to evaluate liver enzyme.³⁹ The curative effect of naltrexone is attributed to the reduction of urge symptoms, similar to the diminution of urge symptoms associated with alcoholism following naltrexone treatment. Dannon et al reported significant improvement in two kleptomaniac patients (one suffering from concurrent OCD and the other a pathological gambler) who received naltrexone for the treatment of kleptomania (as monotherapy or as an augmentation to paroxetine).³³

The two main possible pathophysiological explanations offered for the efficacy of naltrexone in treating kleptomania are: (1) naltrexone inhibits dopamine release in the nucleus accumbens through the disinhibition of GABA input to the dopamine neurons in the ventral tegmental area,^{39,40} or (2) naltrexone may probably reduce urges as well as the subjective experience of pleasure observed in impulse control disorders.

Clonazepam and alprazolam have been reported to produce partial success in treating kleptomania.^{5,12}

The positive results obtained following ECT in two published cases¹² may be due to its treatment of associated comorbid major depression. In general, ECT should probably be reserved for resistant cases with comorbid depression.

SUMMARY

SSRIs seem to be the most promising group of drugs in the treatment of kleptomania (19 out of 30 cases of successful drug treatment reported in the literature). Fluoxetine as sole treatment was successful in nine cases; in combination with lithium, in two cases; in combination with imipramine, in one case; and in combination with alprazolam, in one case. Paroxetine resulted in remission when used as sole treatment in one case, in combination with naltrexone in one case, and in combination with alprazolam in one case. Fluvoxamine as sole treatment was used successfully in one case, in combination with buspirone in one case, and in combination with valproic acid in one other case.

Positive results were obtained with cyclic antidepressants in four cases. In two cases, the agent was amitriptyline, used in combination with ECT in one case and with perphenazine and ECT in the other. Successful results were also obtained with other cyclic antidepressants: protriptyline with ECT (one case) and nortriptyline (one case). Trazodone produced a positive outcome in two cases, in combination with tranylcypromine in one case, and alone in another case (a partial response).

Mood stabilizers have been reported as having a positive outcome in only two trials: one with lithium, the other with valproic acid. Benzodiazepines partially relieved kleptomaniac behavior when used alone in one case (diazepam).

However, full remission was achieved when this group of medications was used in combination with fluoxetine (one case) and paroxetine (one case).

Naltrexone, the most recent drug tested in kleptomania and other impulse control disorders, proved successful as sole treatment in two cases and in combination with paroxetine in one other case.

CONCLUSIONS

Kleptomania is probably more common than generally believed. It seems to be more common in women than in men, and is mostly comorbid with other psychiatric disorders. The approach toward kleptomania has changed over the last decades, and it is now regarded as an impulse-control disorder and considered to belong to the obsessive-compulsive spectrum psychopathology. Interventions have therefore shifted away from psychodynamic therapy toward biological treatments, conjoined with behavioral or cognitive psychotherapy. The SSRI group of drugs seems the most beneficial pharmacological treatment. A few case reports have also shown other antidepressants to be beneficial in ameliorating symptoms. The more the utility of drug treatment in kleptomania is recognized, the greater the chance to help sufferers and gain more precise

knowledge as to which medications should be used and in what combinations. The SSRI group – fluoxetine, fluvoxamine, paroxetine, and others – has been shown to be most effective in treating kleptomania and should be seriously considered as a first treatment option in new cases, followed by the recently approved successful treatment with opioid receptor antagonists. These treatment modalities could give a further insight into the pathophysiology and clinical management of kleptomania as well as other impulse control disorders.

KEY POINTS

- Kleptomania is a more common disorder than reported in psychiatric literature
- Kleptomania is not only an impulse control disorder but also an obsessive compulsive spectrum disorder
- There are various treatment modalities in kleptomania
- Treatment is successful in most of the cases
- Comorbid psychiatric diagnosis is the main reason for the patient to come to the psychiatrist

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