ORIGINAL ARTICLE

Making Sense of Kleptomania: Clinical Considerations

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ABSTRACT

An understanding of the historical roots, clinical features and current diagnostic criteria of kleptomania would help in a better appreciation and assessment of this condition. One of the few psychiatric conditions that is defined by an illegal activity, kleptomania has been classified as one of the impulse control disorders under ICD-10 and DSM IV-TR. In terms of assessment, it is not sufficient merely to look at the operational criteria. One should take a complete history and probe for predisposing factors including childhood development and behaviour, previous relationships, losses, and habits. It is also necessary to detect current stressors and concomitant symptoms or disorders that may precipitate and perpetuate the condition. Some of the diagnostic criteria are based on subjective claim or report which may be unreliable. The use or value of the articles stolen is relative but may be easier to assess. As a guide, kleptomania should be a diagnosis by exclusion of other contributing disorders. When other contributing symptoms/disorders such as depression are present, care should be exercised before a diagnosis of kleptomania is made.

Keywords: depression, impulse control disorders, kleptomania, shoplifting, stealing

INTRODUCTION

In the history of psychiatry, similar clinical syndromes have been described or reported by different authors in different cultures, during different periods of time and given different names. On the other hand the same terms such as schizoaffective psychosis, schizophreniform psychosis, dysthymia and post traumatic stress disorder have either undergone changes from their past meaning, nomenclature and usage over time or may find themselves being applied to slightly different conditions. There is also a hierarchical approach in which a predominant disorder is diagnosed over the presence of concomitant symptoms from another disorder. The idea of co-morbidity is further recognised in associated symptoms and disorder. These observations point to the need to understand the origin of description of any psychiatric condition or use of psychiatric terminology over time. In the case of kleptomania, an understanding of its historical roots, clinical features and current diagnostic criteria would help in a better appreciation and assessment of this condition with treatment implications.

HISTORICAL AND CLINICAL ASPECTS

As early as the beginning of 19th century, it was noted that a small but distinct group of burglars either impulsively or compulsively stole objects that were either of no monetary value or need and which were easily obtainable by lawful means[1]. This behaviour was first described by Matthey in 1816 under the term "klopemanie"[1]. It was subsequently changed to "kleptomania" (klepto — to steal; mania — craze or stealing madness), a term which was coined in 1838 by 2 French physicians Jean Etienne Esquirol and CC Marc to describe shoplifting which was characterised as involuntary and irresistible[2]. Of course there had always been all kinds of stealing before that. But somehow the term kleptomania has more or less been reserved to refer to specific stealing from shops, stores and supermarkets. It is

also one of the few psychiatric conditions that is defined by an illegal activity.

Kleptomanic stealing is thought to be both impulsive and illogical. Apart from being used, the stolen goods are often hoarded, discarded or given away[3]. In other words they do not care about the value of the taken items. What excites them so intensely is the act of stealing itself. The thrill often comes from being able to pull the act of a theft in a very public setting without getting caught. Goldman remarked that "almost never does a patient come in complaining of the disorder" and "it is a very secretive thing, like bulimia"[4]. Kleptomania is frequently associated with a sense of remorse and guilt about what they have done[5,6]. This may be further shrouded in shame and in some instances, the kleptomaniac may present to the psychiatrist only years after the stealing as they find it too difficult to talk about their problem with their immediate families. It is estimated that shoplifting losses in the US could amount to 24 billion dollars, and it is possible that kleptomania may account for some of this loss[7]. The majority of reported cases involved females[8,9]. One explanation could be that while females are often married, older and tend towards kleptomania[10], men with impulse control problems tend towards pyromania, pathological gambling and explosive behaviour, have higher rates of paraphilic symptoms[3] and more frequently end up in jail.

In terms of co-existing psychopathology, McElroy *et al*[3] published an in-depth study of 20 cases of kleptomania and found that "all patients exhibited psychopathology in addition to kleptomania". In that study, 10 patients had a history of substance abuse, 12 suffered from bulimia, 16 had anxiety disorders, all had mood disorders, mostly major depression. Intense gratification was often felt during acts of stealing and appeared to be a component of kleptomania[3]. However, all the patients believed that their stealing was wrong, and most of the cases felt a sense of guilt, shame and embarrassment after the theft. Fishbain hypothesised that the act of stealing may have anti-depressant properties and could be a form of self treatment for their depression[11]. Deficiency in neurotransmitter serotonin is implied and has been thought to underlie the effectiveness of selective serotonin re-uptake inhibitors in the management of this condition alone[12,13] or in combination with other psychotropic agents[14,15].

The features found in kleptomania such as recurrent impulses to steal, build up of tension if these impulses are resisted and relief after the act bear some resemblance to obsessive compulsive symptoms[16]. In addition, some patients with kleptomania also report hoarding the stolen items[3] which can be found in individuals with obsessive compulsive disorder (OCD). However, there are several differences between kleptomania and OCD. First, patients with kleptomania sometimes report a craving before the act of stealing and experience of pleasure or gratification following the act. This hedonic quality is usually not found in patients with OCD who often experience distress and anxiety accompanying their symptoms[17]. Second, patients with OCD generally are harm avoidant with compulsive behaviours to avert the perceived harm whereas individuals with impulse control disorder may be novelty seeking[18].

Kleptomania has been classified as one of the impulse control disorders under ICD-10[19] and DSM IV-TR[20], a category that also includes pathological gambling, trichotillomania, intermittent explosive disorder and pyromania. These conditions share some broad features such as the failure to resist an impulse to perform an act, an increasing sense of arousal prior to committing or engaging in the act as well as an experience of either pleasure, gratification or release of tension at the time of committing the act[21]. William Cupchik believe that the roots of kleptomania lie in the personal history. From his experience in treating shoplifters he says, "In most cases, the person suffered a traumatic event long ago, most often related to loss"[4]. He described a "hard working religious woman" who was arrested for stealing 3 dresses from a fashionable department store and later led the police to her walk-in closet with 200 dresses still with price tags on. Her mother was a dressmaker who became sick and poor and had to exchange her own dresses for food or money. Some consider kleptomania to be a kind of behavioural addiction. This is in view of the clinical features which have some similarities with substance use disorders including repeated urge to engage in behaviour known to be counter-productive, mounting tension until it is completed, rapid temporary switching off of tension by completing the behaviour, gradual return of the urge, syndrome specific external and internal cues, secondary conditioning of the urge to external and internal cues[22]. There is also

evidence of co-existence of substance use disorders (up to 50%)[3,23] in kleptomania and individuals with kleptomania are associated with first degree relatives with substance use disorders including alcohol use disorders[24].

Having reviewed some aforementioned descriptions and postulations, kleptomania may be considered a heterogeneous group of pathological stealing with different related clinical models. Some cases may be related to the "affective spectrum disorders" associated with depressive illness, others possibly related to obsessive-compulsive disorder, impulse control disorders, or even a type of behavioural addiction. The condition is thought to spring from a common underlying disturbance which may be related to serotoninergic dysfunction based on treatment agents[21] or neuroanatomical findings[25].

ICD AND DSM CRITERIA

Kleptomania first appeared in ICD-9 under Compulsive Conduct Disorder while other solitary stealing comes under Unsocialised Disturbance of Conduct[26]. In ICD-10 it is listed as Pathological Stealing [Kleptomania][19]. The term appeared in DSM-I27 as a supplementary term rather than as a distinct diagnosis. However it was left out in DSM-II[28]. It reappeared in DSM-III as an Impulsive Control Disorder not elsewhere classified and has remained so in the current DSM-IV-TR[29]. As for its diagnostic criteria there seems to be a consensus of the main operational criteria between ICD-10 and DSM-IV-TR.

ICD-10[19]

The disorder is characterised by repeated failure to resist impulses to steal objects that are not acquired for personal use or monetary gain. The objects may instead be discarded, given away, or hoarded.

Diagnostic Guidelines

There is an increasing sense of tension before, and a sense of gratification during and immediately after, the act. Although some effort at concealment is usually made, not all the opportunities for this are taken. The theft is a solitary act, not carried out with an accomplice. The individual may express anxiety, despondency, and guilt between episodes of stealing from shops (or other premises) but this does not prevent repetition. Cases meeting this description alone, and not secondary to one of the disorders listed below, are uncommon.

a. No psychiatric disorders, pre-planned, obvious motive of personal gain;

b. Due to organic disorder e.g. memory disturbance and intellectual deterioration;

c. Depressive disorder with stealing.

DSM-IV-TR[20]

A. Recurrent failure to resist impulse to steal objects that are not needed for personal use or for their monetary value;

B. Increasing sense of tension immediately before committing the theft;

C. Pleasure, gratification, or relief at the time of committing the theft;

D. The stealing is not committed to express anger or vengeance and is not in response to a delusion or a hallucination;

E. The stealing is not better accounted for by Conduct Disorder, a Manic Episode, or Antisocial Disorder.

Assessment Considerations

In mental disorder, unlike medical disease, there is usually no specific aetiology or demonstrable pathology. Diagnosis depends on history of predisposing, precipitating and propagating biopsychosocial factors. Subjective complaint or experience must preferably be corroborated by observed behaviour or objective evidence.

In terms of diagnostic criteria, there are commonalities and differences in details between the two major classification systems. With regard to commonalities, both ICD-10 and DSM IV-TR stipulate the recurrent nature of the impulse, failure to resist the impulse, stealing of items not for personal use of monetary gain, and sense of tension with relief or gratification following the act of stealing. It helps to scrutinise the operational criteria closely. To begin with, the number of episodes to qualify for recurrent is not stated in both clinical diagnostic criteria, i.e. how many episodes of such shoplifting would be considered as repeated or recurrent failure to resist impulses? Presumably more than one episode can qualify as recurrent and this is precisely stated as "two or more thefts" in the ICD-10 Diagnostic Criteria for Research

version[30] but not within the clinical descriptions and diagnostic guidelines[19,20]. In terms of failure to resist impulses, it is not always easy to determine whether one could not or would not resist. Is there any attempt or effort to control or avoid the impulse, for instance not entering the shop, store or supermarket alone and when there is no intention to buy something? With regard to impulse, and not withstanding that kleptomania is grouped under the impulse control disorders, how do we view patients who may experience the thought or image of shoplifting which can still lead to the act of stealing? Do we classify this as more obsessional rather than impulsive urge? Furthermore, enquiry needs to be made about whether it is a specific impulse that leads to kleptomania or part of general impulsivity that results in multiple-impulse control disorders. In the former it is possible to have developed through some sort of operant conditioning based on previous consequences and in the latter, it may involve personality traits or factors that are inherent or pervasive. In both cases, past history including development, habits, ways of coping with stress, and underlying psychopathology need to be inquired and explored. If the impulse is preceded by rising tension does it occur before entering the premise or on browsing the goods? What are the triggers? Is the sequence of response recognised and precautions taken? With regard to the intention of use of objects taken, it is important to note that the intentions may differ for different items and across time for different episodes.

There are several differences in details between ICD-10 and DSM-IV-TR. First, ICD-10 elaborated on the fact that the stolen items in kleptomania are often discarded, given away or hoarded to reinforce the notion that the stolen items are not acquired for personal benefit or monetary value. Second, ICD-10 also mentioned that not all opportunities at concealment are made and usually the act of stealing is done without an accomplice pointing to the lack of planning and personal nature of the condition. Third, ICD-10 further mentioned that internal psychological responses following the act may include anxiety, despondency and guilt which do not prevent the recurrence of the stealing. The experience of guilt and shame may explain why often the condition is not discovered earlier leading to long duration of similar behaviours with delays in diagnosis. These 3 features are not elaborated in DSM IV-TR. Fourth, DSM-IV-TR included pleasure as a possible feeling state following the act of stealing pointing to the nature of impulsive control disorder whereby individuals may sometimes get the thrill and hence develop more craving for such sensations. Fifth, ICD-10 and DSM-IV-TR differ in their explicit mention of conditions to be excluded before a diagnosis of kleptomania is made. ICD-10 specifically mentions that cases meeting the description and not in the context of other psychiatric conditions are uncommon. ICD-10 cautions that recurrent shoplifting with premeditated motives for personal gain, organic conditions with memory disturbances and affective conditions such as depression need to be excluded. On the other hand, DSM-IV-TR stated that the act of stealing must not due to personal reasons (anger, vengeance) or secondary to psychotic experiences, affective conditions such as mania, behavioural or personality disorders (such as conduct or antisocial personality disorder). One of the most difficult aspects is the question of the "act of theft" or the commission of the "act of theft". It is not clear what is exactly meant by the "act", that is, what is included in the beginning and the end of the "act". The act could mean "intention of taking (with or without concealing) with no intention to pay" or the intention of stealing and to escape undetected. In other words does the "act" begin with stealing and end in successful escape or arrest and when exactly is the pleasure or gratification experienced and how enduring is it?

As for management, it depends on the theoretical formulation of the disorder. There is currently no definitive treatment for kleptomania which is based largely on case reports and small open label trials. A combination of medications and psychotherapy is presently an accepted approach to help control the impulses and prevent relapses. However, there is no single medication that has clearly superior efficacy, and oftentimes medications may target co-morbid conditions like depression. The most commonly used drugs are selective serotonin reuptake inhibitors[12–14]. Some authors have reported a measure of success with other classes of medications such as topiramate[15] and naltrexone[31]. Cognitive behavioural techniques[14] and psychoeducational group counselling[32] may also help the patient to develop adaptive ways to resist their impulses to a certain extent.

CONCLUSION

This paper may raise more questions than answers

to the assessment of kleptomania but it would have achieved its purpose if it stimulates or provokes us to think deeper about the phenomenology of kleptomania. In sum, in terms of assessment, it is not sufficient merely to look at the operational criteria. One should take a complete history and probe for predisposing factors, including childhood development and behaviour, previous relationships, losses, and habits. It is also necessary to detect current stressors and concomitant symptoms or disorders that may precipitate and perpetuate the condition. It is important to remember that some of the criteria are based on subjective claim or report which may be elusive, unreliable, difficult to confirm and may be malingered or mimicked through reading and coaching. The use or value of the articles stolen is relative but may be easier to assess. As a guide, kleptomania should be a diagnosis by exclusion of other contributing disorders. In line with the diagnostic criteria of ICD-10 and DSM-IV-TR, when other contributing symptoms/disorders such as depression are present, care should be exercised before a diagnosis of kleptomania is made.

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