# Kleptomania in Impulse Control Disorders, Obsessive-compulsive Disorder, and Bipolar Spectrum Disorder: Clinical and Therapeutic Implications

*Donatella Marazziti, MD*, Francesco Mungai, MD, Danielle Giannotti, MD, Chiara Pfanner, MD, and Silvio Presta, MD*

**Address**
*Department of Psychiatry, Neurobiology, Pharmacology, and Biotechnology, University of Pisa, via Rome 67, Pisa 56100, Italy.
E-mail: dmarazzi@psico.med.unipi.it

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This paper aims to critically review currently available data on kleptomania and to analyze the possible future evolution of clinical research and therapeutic strategies.

## Introduction

*Kleptomania*, a term deriving from the ancient Greek words κλεπτειν (to steal) and μανια (insanity), is defined in the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* (DSM-IV) [1] as the recurrent failure to resist impulses to steal objects not needed for personal use or their monetary value. It is classified within the category of impulse control disorders not elsewhere classified.

Apart from a few prior anecdotal reports, the first clinical description of kleptomania as a distinct psychopathologic condition date back to the early 19th century when Matthey [2] introduced the term *klopemanie* to indicate a condition characterized by the compelling impulse to steal a worthless or unneeded object. In 1838, Esquirol [3] coined the term *kleptomania*, which described the irresistible nature of this urge, and classified the disorder amongst the monomanias, such as arsonism, alcoholism, and impulsive homicide. They turned the focus on the egodystonic nature of the impulsive act, which was performed out of control. Bleuler [4], at the turn of the 20th century, underlined the lack of a straight association between kleptomania and other antisocial behaviors. Goldman [5] noticed the clinical differences between "proper" shoplifters and kleptomanic individuals, who displayed a compulsive pattern of stealing, were not motivated by conscious goal, and were characterized by a lack of antisocial traits.

However, in the *Diagnostic and Statistical Manual of Mental Disorders, Third Edition Revised* (DSM-III-R) [6], kleptomania was classified among the impulse control disorders (not elsewhere classified). According to DSM-IV criteria, the act of theft is preceded by an increasing sense of tension; during the theft the subject feels a sense of relief, pleasure, or gratification. The stealing is not an expression of revenge or anger, it is not determined by delusional symptoms or hallucinations, and it is not better accounted for by conduct disorder, a manic episode, or antisocial personality disorder. The kleptomanic urge is often abruptly experienced, and the theft is realized without premeditation—usually without collaboration with others or a complete consideration of the legal consequences.

## Epidemiology

Kleptomania has always been described as an uncommon disorder, which is consistent with that it has undergone no systematic studies, and it has been misdiagnosed or underestimated for a long time because of its secretive nature [5,7]. The insufficient attention of psychiatrists and the lack of operational diagnostic criteria provoked severe selection bias [8]; however, its legal aspects contribute to uncertainty in the definition of syndrome's boundaries.

Studies in the general population have not been performed, and those assessing the prevalence of kleptomania subjects amongst shoplifters have reported low rates of the disorder [9–13]. However, studies of clinical samples not selected for kleptomania revealed a higher rate of the disorder [14–16], although they suggest that kleptomania is more common than previously reported. It must be considered that a high percentage of people who steal are never caught [5] or may not be accused, especially when they hold a high social position [9], and this may determine an underestimation of the real proportion of the phenomenon.

Another area of great interest to researchers is gender differences. Although it has not been systematically assessed, available data suggest that the majority of the

subjects who meet criteria for kleptomania are women. With regard to gender-related differences, Guze [17] formulated the hypothesis related to impulse dyscontrol that men are more likely to develop an open antisocial behavior, such as pyromania, intermittent explosive disorder, and pathologic gambling, as a response to difficult environments, whereas women would be more likely to develop a less aggressive impulse disorder, such as kleptomania and trichotillomania. Medlicott [11] wrote that women who shoplift were more likely to be sent for psychiatric evaluation by the courts, whereas men were likely sent to prison, thus explaining consequently the higher number of women amongst psychiatric samples. Anyway, currently available data from highly selected groups of kleptomania subjects [7,18,19] seem to confirm a higher preponderance of women, with the only exception of the authors' group, who found no gender prevalence in a sample of 20 patients [20••].

Little is known about age at onset and course of kleptomania, although in several cases the first symptoms seem to begin in adolescence or early adulthood and may follow an episodic or a continuous course [8].

## Pathophysiology

No biologic studies have been specifically carried out in kleptomania patients [8]. Presently available literature offers several reports on how neurologic and medical conditions or pharmacologic agents can induce a kleptomania-like behavior [5]; however, the significance of these data, which suggest possible biologic substrates, is limited by the lack of systematic researches. The phenomenologic similarities with other obsessive-compulsive–related disorders may suggest common neurochemical dysfunctions, possibly involving the serotonergic transmission [21]. Marazziti *et al.* [22•], in preliminary data on the platelet serotonin transporter, reported dysfunction at this level in patients with diagnosis of obsessive-compulsive disorder (OCD) and related disorders, including a few kleptomania patients.

From a psychodynamic point of view, psychologic and psychosexual theories attempted to explain the causes of kleptomania, and considered the relationships with anxiety, depression, and sexual disturbances [5]. The kleptomanic act may be interpreted as the result of a risk-taking behavior performed by a depressed subject with an antidepressant significance [23], as a symptom of stress in an otherwise non-pathologic individual [24], or, on the contrary, as a way of relief from stressful conditions [25,26•]. Some analytic theorists have hypothesized that the theft was to consider for its intrapsychic profit, because the stolen objects were not for their economic value, assuming sometimes a sexual meaning [27].

The association between kleptomania and other impulse control disorders, such as fetishism [28], has been also described, but this finding was not confirmed by others [10].

## Comorbidity

Available literature reveals a range of associated conditions that have been documented in several case reports and case series, although no controlled studies have been conducted specifically on this topic.

McElroy *et al.* [7], while considering the lifetime and current comorbidity of 20 consecutive kleptomania inpatients and outpatients, reported that all subjects met also DSM-III-R for at least one psychiatric disorder, and 17 patients met criteria for four or more disorders. All subjects had previously consulted a psychiatrist for different symptoms—eight patients for mood disorders, eight for eating disorders, and four for anxiety disorders. They noted that the patient generally did not express kleptomania symptoms until arrest, or when the symptomatology was reduced by the treatments administered for the other disorder. This underlies that kleptomania is considered the most debilitating or humiliating of their symptoms, even in the presence of other severe psychiatric disorders. It is worth noting that 20 patients met DSM-III-R for a lifetime diagnosis of a major mood disorder, and many of them reported changes in their kleptomania behavior related to their mood switches (*eg*, the rush or the thrill experienced with stealing associated with a relief of their depressive or manic symptoms).

Other associated disorders were bulimia nervosa, OCD, alcohol or drug abuse, and a variety of psychopathologic symptoms belonging to the obsessive-compulsive spectrum, such as compulsive shopping, hoarding, exercising, and sexual activity. Paraphilic symptoms, such as egodystonic urges for sexual intercourse with children or sadistic fantasies, were reported in several male subjects.

Another study described personality traits, psychiatric characteristics, and comorbidity of a series of kleptomania patients recruited from a community-based sample by advertisement in a daily newspaper and not through the medical or legislative system [19]. The sample, which is the largest collected to date, was composed by 37 individuals; two thirds were women. After establishing the diagnosis of kleptomania and the exclusion of antisocial personality disorder, a comprehensive and structured interview was administered to the patients to detect other psychiatric or somatic diseases. The ensuing findings showed that kleptomania patients scored within or above the mean for a standard population on the following items: low socialization levels, muscular tension, psychic and somatic anxiety, impulsivity, and monotony avoidance. Gender difference was not relevant, except for the tendency to exhibit more impulsivity and less muscular tension in men. Current psychiatric problems were reported by the 81% of the sample, of which one third had a long history of suffering; 54% had a positive family history for psychiatric disorders, 46% were currently receiving a psychiatric treatment, and 56% had taken psychotropic drugs, mainly for mood, anxiety, and sleeping disorders. In addition, 43% of the patients reported problems related to food

intake and body weight—one fulfilled criteria for a current episode of anorexia nervosa and three other subjects had history of eating disorder. Alcohol-related problems were common in terms of misuse and abuse; 32% of the patients showed suicidal behavior in the past.

In agreement with a previous study, the authors' reported at least one comorbid psychiatric disorder in a sample of 20 in- and outpatients with a DSM-IV diagnosis of kleptomania. The lifetime comorbidity for Axis I disorders in association with kleptomania was relevant for bipolar disorder, alcohol abuse, separation anxiety, panic disorder, OCD, and other impulse control disorders, such as pathologic gambling and trichotillomania [20••].

Lejoyeux *et al.* [29] evaluated the frequency of impulse control disorders in a population of depressed individuals, and found that those patients with kleptomania had a higher number of previous depressive episodes. They also noted that patients with a diagnosis of an impulse control disorder showed a higher comorbidity rate of bipolar disorder.

## Therapeutic Strategies

Despite the large number of case reports that kleptomania responded favorably to different psychologic or pharmacologic treatments, no controlled studies, which aim to evaluate the real effectiveness of the different therapeutic strategies, are available.

A few cases reported that covert sensitization, a psychotherapeutic technique used to stop unwanted behaviors, was effective in reducing kleptomania symptoms. Gauthier and Pellerin [30] noted an improvement in frequency, duration, and intensity of kleptomanic urges in a patient with a shoplifting history of 4 years, which persisted along a follow-up of 14 months. Another patient with a history of daily compulsive shoplifting that lasted for 14 years maintained the control on kleptomanic symptoms at 19 month follow-up, and showed a simultaneous improvement in self-esteem and socialization [31].

A combination of insight-oriented and pharmacologic treatment, for the patient's "risk-taking" behavior associated with depressive symptoms, proved effective, but a relapse of depression and stealing behavior was noted after the discontinuation of antidepressants [23].

No improvement in kleptomanic symptoms in a group of 11 patients (of a total of 20) undergoing insight-oriented psychotherapy was observed [7]. In addition, 10 of 18 patients receiving treatment with antidepressants, described a partial or complete remission of impulsive and behavioral symptoms related to stealing. Several patients suffered a relapse when treatment was discontinued and a remission at its re-introduction; this finding is consistent with the opportunity and the effectiveness of pharmacologic treatments in kleptomania patients with bipolar comorbidity.

McElroy *et al.* [32] also described three kleptomania patients with a concurrent diagnosis of bulimia nervosa treated with fluoxetine, trazodone, and tranylcypromine who demonstrated a partial or complete remission of symptoms. While analyzing the comorbidity with mood or eating disorders of these cases, the authors concluded that different types of kleptomania may exist that may not respond to conventional pharmacologic treatment.

A positive response to lithium therapy of a bipolar patient with a concurrent diagnosis of kleptomania was reported in 1992 [33].

Chong and Low [34] treated a 38-year-old kleptomania patient, who had suffered from compulsive checking and rumination since adolescence, with fluvoxamine. The patient had been previously treated with behavioral therapy, psychotherapy, clomipramine, imipramine, and lithium, administered singularly, at therapeutic dosage and for an adequate period. He showed no improvement in obsessive-compulsive or kleptomania symptoms. The dose of fluvoxamine was titrated up to 300 mg per day, and the patient showed, during a period of 9 months, a significant decrease in his rumination and checking, as well as complete control on the occasionally present urges to steal.

Kmetz *et al.* [35] reported a case of a 36-year-old married mother who met DSM-IV for kleptomania and bipolar disorder, mixed state, and was treated with fluoxetine in combination with valproate. After 8 months, she reported mild mood swings and a remission of stealing urges and behavior, thus suggesting that bipolar disorder and kleptomania may be related and may respond to a mood stabilizer.

In a recent study on 10 subjects who met DSM-IV criteria for kleptomania, during a Structural Clinical Interview, naltrexone was administered for 12 weeks in an open-label study. Naltrexone reduced urges to steal and stealing behavior significantly, within 11 weeks of treatment, and improved social and occupational functioning [36•].

Although no systematic study is currently available, some data suggest the effectiveness of tricyclic antidepressants, in particular amitriptyline [26•], imipramine, or nortriptyline [7], and benzodiazepines, such as clonazepam. The efficacy of buspirone augmentation during fluvoxamine treatment has also been reported [37]. However, no treatment response was obtained with non-reversible monoaminooxydase inhibitors, such as tranylcypromine [32,33], or, in one patient only, with desipramine [33]. Some authors have noted recently the emergence of kleptomania during selective serotonin reuptake inhibitor treatment in depressed patients [38]. Finally, the efficacy of electroconvulsive therapy has been reported in some cases [7,39,40].

## Conclusions

The available literature suggests that kleptomania is a heterogeneous condition that would seem to be related to mood disorders and OCD-related disorders.

McElroy *et al.* [8] have suggested that kleptomania, compulsive buying, and binge-eating disorders would be parts of the so-called "affective spectrum disorders," which share a common pathophysiologic alterations, possibly at

the level of the serotonergic system [15,22•]. This hypothesis is mainly based on the observations of high comorbidity rates, particularly with bipolar disorder [8], where the "rush" associated with kleptomanic stealing would resemble hypomania, and it may provide a possible explanation for the positive response to mood-stabilizers shown by kleptomania subjects.

Kleptomania has been considered also a variant of OCD or strictly linked to OCD-spectrum disorders [21,41,42], on the basis of the similarities between the impulse to steal and obsessions or compulsions typical of OCD. The impulse to steal, like an obsession, is experienced as senseless, intrusive, and associated with an increasing tension or anxiety, and the stealing itself is described as uncontrollable and a tension or anxiety release. However, some phenomenologic differences between these conditions do exist, that is, kleptomania is generally associated with a more impulsive behavior and seems to respond to heterogeneous drugs, whereas OCD is generally accompanied by a compulsive behavior and its response to drug treatment is mainly restricted to serotonin reuptake inhibitors [41,42].

An alternative model underlies the similarities between the impulse to steal experienced by the patient and the irresistible impulse of craving to drink or use drugs and followed, in both cases, by a sense of "high" [43].

Further studies are needed to clarify whether or not kleptomania is a real, autonomous disorder, or a symptom or a variant of other major pathologies. In any case, because it may constitute a significant public health problem given the wider occasions to steal available nowadays, it would be important to improve its recognition and diagnosis, as well as to define possible therapeutic strategies.

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