

Kleptomania: Clinical Features and Comorbidity in an Italian Sample

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Kleptomania, listed in DSM-IV as an impulse control disorder not elsewhere classified, is a psychiatric condition still poorly understood and subject of only a few systematic studies. The aim of this research was, therefore, to evaluate the clinical features and comorbidity of Italian patients with a DSM-IV diagnosis of kleptomania. Twenty outpatients with a lifetime diagnosis of kleptomania by DSM-IV criteria, were included in the study and underwent a specially designed semistructured interview and the Family History Research Diagnostic Criteria. The majority of

patients reported an early and abrupt onset and an episodic course of the disorder, with no gender preponderance. Lifetime comorbidity for other axis I disorders was high, in particular for mood, anxiety, and impulse control disorders. Family history also showed a high prevalence of psychiatric disorders. Our study indicates clear connections between kleptomania and different psychiatric disorders, the exact nature of which has yet to be clarified.

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KLEPTOMANIA, currently listed in DSM-IV¹ as an impulse control disorder not elsewhere classified, is defined as the recurrent failure to resist impulses to steal objects that are not needed for personal use or for their monetary value. The impulse is accompanied by an increasing sense of tension immediately before committing the theft, followed by an individual experience of pleasure, gratification, or relief at the time of committing it. The stealing is not committed to express anger or revenge, is not a response to delusions or hallucinations, and it is not better accounted for by a conduct disorder, a manic episode, or an antisocial personality disorder. The first symptoms may occur during adolescence or early adulthood, more frequently in women, with an episodic or continuous course throughout adulthood.^{2,3} In the latter case, although it is not always the rule, the patient may frequently encounter severe legal problems, with repeated arrests and consequent social impairment.^{4,5}

A few previous anecdotal reports and court cases are available,⁶⁻⁹ but the first clinical description of this peculiar psychopathological condition dates back to Matthey nearly two centuries ago.¹⁰ The proposed term "klopemanie" was subsequently modified by Marc and Esquirol,¹¹ melting the Greek terms *κλεπτειν* (to steal) and *μανια* (insanity). As Bleuler himself did at the turn of the century,¹² they underlined the absence of consciousness disturbances and the egodystonic nature of the kleptomaniac "urge."

Currently, kleptomania has no defined nosological position: in DSM-I¹³ it was not considered as a distinct diagnostic entity, being included only as

a supplementary term. In DSM-II¹⁴ it was totally ignored. No substantial differences were observed between the last three editions^{1,15,16} where it is always listed as an impulse control disorder not elsewhere classified. This situation may result from the fact that kleptomania has been considered for a long time as an uncommon condition⁴ and, therefore, has received no systematic study, being misdiagnosed or underestimated. This is probably due to different factors. First, the secretive nature of the disorder³: these patients feel a deep shame for stealing behaviors and are reluctant to speak about them. Most of them seek help or are referred to a therapist for a psychiatric interview only when arrested. However, some pathological shoplifters may never be arrested¹⁷ or accused by witnesses, in particular when they hold a prominent social position.¹⁸ In some cases, these patients may contact a psychiatric unit only for the onset of other mental disorders. Second, the insufficient accuracy in psychiatric evaluations and scant attention to operational diagnostic criteria may have provoked past selection bias. Due to these limitations, the largest collected sample was composed by 37 subjects, recruited during a period of 14 months through an advertisement in a daily newspaper.¹⁹

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Psychiatric comorbidity seems to be frequent in kleptomania, especially with mood disorders: this association has been observed in 36% of kleptomanic patients,³ but, if subsyndromal affective forms are included, this percentage grows up to 57%.^{2,3} Comorbidity for obsessive-compulsive disorder (OCD) is also frequent.³ Overlapping features are recurrence and persistence of impulses, the pervasive way of their onset, and the subsequent anxiety state which decreases after their accomplishment. However, at variance with OCD, impulses have a variable degree of resistance; moreover, the deriving action is pleasurable and it is not secondary to obsessive thoughts. From this point of view, kleptomania would belong to the so-called spectrum of OCD-related disorders along the impulsivity-compulsivity dimension.²⁰ Recently a high degree of association of kleptomania, OCD, and mood disorders, either as transversal, longitudinal, or familial comorbidity, has been described.²¹

Although no systematic study is currently available, scattered data suggest the effectiveness of serotonergic drugs, such as selective serotonin reuptake inhibitors (SSRIs), trazodone and buspirone,^{3,22-26} tricyclics,^{3,27} benzodiazepines, and mood stabilizers,^{28,29} and even of electroconvulsive therapy.^{3,30-32} Paradoxically, some authors recently noted the emergence of kleptomania during SSRI treatment in depressed patients.³³

Given the paucity of available data, the aim of the present study was to assess the clinical features and comorbidity of a sample of Italian patients who had received a diagnosis of kleptomania.

METHODS

Twenty outpatients with a lifetime diagnosis of kleptomania according to DSM-IV criteria¹ were selected at the outpatient unit of the Dipartimento di Psichiatria, Neurobiologia, Farmacologia e Biotecnologie, Section of Psychiatry, University of Pisa, from larger cohorts of patients included in follow-up studies on mood and anxiety disorders. All patients gave their informed consent to participate in the study.

Patients were evaluated by two psychiatrists (D.M., S.P.), each with at least 10 years of postdoctoral clinical experience, who had received specialized training in the diagnosis and treatment of mood and anxiety disorders, in particular OCD and OCD-related disorders. The interview lasted approximately 1 hour, and in every evaluation the interviewer was blind to each patient's diagnosis. Data concerning family history were collected by two different investigators (C.P., S.P.), blind to the diagnosis of kleptomania. Each investigator underwent a training program in the use of the assessment instruments that included the direct observation of experienced raters and the direct supervision of interviews.

Demographic data (age, sex, educational level, employment) and other information (type of onset, illness course) were collected by a specially designed semistructured interview; the presence of axis I comorbidity was evaluated by means of the Structured Clinical Interview for DSM-IV³⁴; information regarding the presence of psychiatric disorders among first-degree relatives of the patients was obtained by means of the Family History Research Diagnostic Criteria.³⁵

To account for the limitations common to all retrospective studies, clinical data were reviewed by the interviewer team for the purpose of consensus agreement. When questions arose, patients were reapproached for further clarification. Patients' medical records were reviewed, and information was obtained from family members and also from physicians who had been consulted in the past.

Statistical Analyses

Data from this study were analyzed using the Stat View V statistical program (Macintosh, 1992): comparisons between patients on continuous variables were conducted using Student's *t* test and analysis of variance (ANOVA), and on categorical variables using chi-square analysis.

RESULTS

The patients with kleptomania had an equal gender distribution, with 10 (50%) patients being women and 10 (50%) men. Their age ranged from 19 to 68 years (mean \pm SD, 32.8 \pm 13.4). With regard to marital status, seven (35%) were married and 13 (65%) had never married; in this last group, a slight predominance of men was registered.

An analysis of social status showed that four (20%) patients had obtained a university degree, 11 (55%) a high school diploma, and five (25%) had completed 8 years of school; three (15%) were managers, four (20%) white collar workers, seven (35%) blue collar workers, two (10%) students, two (10%) unemployed, one (5%) housewife, and one (5%) retired.

The age at onset (mean \pm SD) of kleptomanic behaviors was 20.3 \pm 4.2 years, ranging from 12 to 28; seven of these patients reported the presence of kleptomanic urges at the time of the interview. The majority of the sample reported a sudden onset (90%) and an episodic course (85%) of the disorder.

All patients met DSM-IV criteria for at least one comorbid psychiatric disorder, with a high percentage of lifetime comorbidity for other axis I disorders, in particular OCD, bipolar disorders (type I and II), separation anxiety, panic disorder, bulimia, alcohol and tobacco abuse, simple phobias, OCD-related control disorders, such as body dysmorphic disorder, and impulse control disorders, such as pathological gambling and trichotillomania (Table 1).

Table 1. Lifetime Comorbid DSM-IV Diagnoses in Kleptomania

Diagnoses	N	%
Mood disorders		
Bipolar I disorder	4	20
Bipolar II disorder	8	40
Unipolar depression	3	15
Anxiety disorders		
OCD	12	60
Separation anxiety disorder	6	30
Panic disorder	6	30
Simple phobia	4	20
School phobia	2	10
Generalized anxiety disorder	1	5
Social phobia	1	5
Eating disorders		
Bulimia	5	25
Anorexia nervosa	2	10
Substance abuse		
Alcohol abuse	5	25
Tobacco abuse	5	25
Benzodiazepine abuse	4	20
Stimulants abuse	3	15
Caffeine abuse	3	15
Opioid abuse	2	10
Impulse control disorders		
Pathological gambling	4	20
Trichotillomania	4	20
Explosive intermittent disorder	4	20
Sexual compulsions	3	15
Self-injurious behaviors	2	10
Pyromania	1	5
Body dysmorphic disorder	5	25
Attention deficit hyperactivity disorder	3	15
Tic disorder	3	15

A gender-related comparison of the comorbidity patterns showed that birth trauma was significantly more frequent in men than in women, while bipolar I disorder and bulimia were more likely to occur in women than in men (Table 2). Of note, three of the four male patients with a history of birth trauma showed a continuous course of the illness and had OCD.

We did not detect any cluster of disorders, except for impulse control disorders that tended to be grouped with OCD.

We also evaluated the presence and characteristics of the family history of psychiatric disorders. Here, too, a high prevalence of mood disorders, both unipolar and bipolar (type I and II), OCD, alcohol abuse, panic disorder, and a few others were observed (Table 3).

When we compared kleptomanic patients with comorbid bipolar disorder to those with comorbid OCD, while excluding the six patients who had

both conditions, we did not find any significant difference in clinical features of kleptomania, sociodemographic status, or family history. Similarly, a comparison of 20 patients (10 male and 10 female; mean age \pm SD, 33.8 ± 11.4 years) affected by OCD with 20 (10 male and 10 female; mean age \pm SD, 37.4 ± 13.1 years) suffering from bipolar disorder only, did not detect any difference at the level of the sociodemographic status. We observed only a trend towards a lower rate of marriage in OCD patients (15 of 20 never married) and a lower occupational level, as compared with the high educational level, again in OCD patients.

DISCUSSION

Any analysis of our report should take into account some methodological limitations: (1) the small number of patients; (2) the possibility of selection bias, due to the characteristics of the setting, mainly devoted to the treatment of resistant and refractory cases; and (3) the potential unreliability of anamnestic recall in a retrospective study. However, the condition of blindness of the investigators to the diagnosis and the fact that family history was collected by a second member of the research group blind to the diagnosis of kleptomania should have minimized this potential bias. The results of the present study confirm previous findings^{3,4} and add some interesting new data with regard to characteristics of kleptomania.

As already mentioned,^{36,37} there would appear to be an important link between kleptomania and mood disorders, in particular bipolar illness, and some childhood and adult anxiety disorders, such as separation anxiety disorder, panic disorder, and OCD. We found a high degree of comorbidity with mood disorders, both unipolar and bipolar, type I and II. To better understand the relationship between kleptomania and mood disorders, the frequency or intensity of the kleptomanic condition should be related to mood variations with exacerbations occurring during hypomanic periods or mixed states^{3,26}: during these phases, it may be that kleptomanic behavior becomes simply a symptom and loses its egodystonic nature after giving in to the urge. In fact, the feeling of mood elation during the kleptomanic urge is generally very similar to that of hypomanic phases and is often followed by a “depressive” state with a sense of guilt, depressed mood, and fatigue.¹⁰ Furthermore, the act of stealing has been reported to have a quasi “therapeutic” effect on depressive symptoms in the case of some

Table 2. Gender Distribution of Comorbidity Patterns in Kleptomania

	Men		Women		<i>P</i>
	N	%	N	%	
Mood disorders					
Bipolar I disorder	0	0	4	20	.02*
Bipolar II disorder	5	25	3	15	.36
Unipolar depression	1	5	2	10	.53
Anxiety disorders					
OCD	6	30	6	30	1
Panic disorder	2	10	4	20	.32
Separation anxiety disorder	3	15	3	15	1
Simple phobia	3	15	1	5	.27
School phobia	2	10	0	0	.13
Generalized anxiety disorder	0	0	1	5	.30
Social phobia	0	0	1	5	.30
Eating disorders					
Anorexia nervosa	1	5	1	5	1
Bulimia	0	0	5	25	.01*
Impulse control disorder					
Pathological gambling	3	15	1	5	.26
Trichotillomania	3	15	1	5	.26
Pyromania	1	5	0	0	.30
Explosive intermittent disorder	2	10	2	10	1
Sexual compulsions	1	5	2	10	.53
Self-injurious behaviors	0	0	2	10	.14
Substance abuse					
Alcohol abuse	1	5	4	20	.12
Opioid abuse	1	5	1	5	1
Stimulants abuse	0	0	3	15	.06
Benzodiazepine abuse	1	5	3	15	.26
Caffeine abuse	1	5	2	10	.53
Tobacco abuse	2	10	3	15	.61
Body dysmorphic disorder	2	10	3	15	.61
Birth trauma	4	20	0	0	.02*
Attention deficit hyperactivity disorder	2	10	1	5	.53
Tic disorder	2	10	1	5	.53

*Significant, $P < .05$.

patients with comorbid bipolar disorder.³³ In addition, some kleptomaniac shifts in depressed patients treated with SSRIs been reported.^{27,28} The clear identification of the syndrome's boundaries would seem necessary in order to confirm diagnostic validity and, thus, to differentiate a true kleptomaniac urge from abnormal behaviors related to changes of mood polarity. We would stress that all of our bipolar patients reported feeling a distinct difference between the kleptomaniac impulses and similar abnormal behaviors that occurred during phases of mood elation.³⁷ Those with bipolar comorbidity often showed a tendency towards an episodic course of kleptomania, but with no correlation between intraepisodic mood polarity and illness exacerbations. Furthermore, as with several bipolar patients, the onset of kleptomaniac exacerbations was, in 90% of cases, sudden.

Apart from mood disorders, we observed more frequent comorbidity for OCD, panic disorder, separation anxiety disorder, body dysmorphic disorder, and other impulse control disorders, such as pathological gambling and trichotillomania. Interestingly, multiple impulse control disorders appear to be comorbid with OCD, while we did not observe other clusters of symptoms, probably for the small sample size. Almost all of our patients showed a high degree of association of different psychopathological entities, often more than two disorders; this might suggest that kleptomania represents a nonspecific condition reflecting the a "heavy" presence of psychopathology.^{38,39}

Furthermore, while men showed a general tendency towards high comorbidity rates, significance was reached in female patients only with regard to bipolar I disorder and bulimia. On the

Table 3. Familial Comorbidity in Kleptomania

	N	%
Mood disorders		
Unipolar depression	7	35
Bipolar I disorder	5	25
Bipolar II disorder	5	25
OCD	5	25
Alcohol abuse	3	15
Panic disorder	2	10
Anorexia nervosa	2	10
Hypochondriasis	1	5
Opioid abuse	1	5
Schizophrenia	1	5
Kleptomania	1	5

other hand, four of 10 males reported a personal history of birth trauma and three showed an early onset and a continuous course of kleptomania associated with OCD; this is in agreement with previous findings in "pure" OCD patients.³⁸

Among the first-degree relatives of our sample, a positive family history for mood and certain anxiety disorders, such as OCD and panic disorder, was observed. Interestingly, one proband (a male) had a family member (a male) with both kleptomania and panic disorder and he had multiple diagnoses, in particular OCD, bipolar disorder,

panic disorder, explosive intermittent disorder, and trichotillomania.

It is of particular interest that similar findings, in terms of comorbidity and family history, have been described recently for compulsive shopping.^{40,41} These similarities may be explained by common neurochemical dysfunctions, possibly located in central serotonergic transmission. Preliminary data on the platelet serotonin transporter have shown the presence of dysfunction at this level in patients suffering both from OCD and OCD-related disorders, including kleptomania.⁴²

Our study suggests that kleptomania is a condition that usually emerges in comorbidity with other psychiatric disorders and opens the question of whether it is truly autonomous or represents a nonspecific symptom of underlying (and primary) psychopathological entities. This might explain the wide range of psychiatric disorders encountered in our patients, although it cannot be ruled out that specific clusters of diagnoses might exist and contribute to different symptomatological expressions. Future studies in larger samples of patients are thus necessary to answer this question, which could direct therapeutic choices.

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