



Kleptomania and Potential Exacerbating Factors: A Review and Case Report

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ABSTRACT

Kleptomania is an impulse control disorder that can cause significant impairment and serious consequences. Often, the condition is kept secret by the patient, and usually help is sought only when confronted by the legal consequences of the impulsive behaviors. Historically, kleptomania has been viewed from a psychodynamic perspective, and the mainstay of treatment has been psychotherapy. Recently, attempts to explain kleptomania within a neuropsychiatric paradigm have highlighted the possible links between mood disorders, addictive behaviors, and brain injury with kleptomania. These associations with kleptomania can be extrapolated to pharmacological strategies that can potentially help in treating kleptomania. A case of kleptomania, which was potentially exacerbated by multiple factors, will be reviewed. Treatment modalities used in this case, including the use of the Yale-Brown Obsessive Compulsive Scale as a surrogate marker to gauge response to treatment, will be discussed.

INTRODUCTION

Kleptomania is characterized by recurrent episodes of compulsive stealing. Stealing commonly occurs in the form of shoplifting. The items involved are usually of trivial value and are not needed by the individual stealing them. The compulsions to steal are ego dystonic and upsetting to the patient.

The term *kleptomania* was coined by the French psychiatrists Esquirol and Marc in the 19th century.¹ From as far back as 1878, cases of kleptomania in America have been reported in the literature.² Few patients voluntarily seek help due to embarrassment and fear of legal consequences. The *Diagnostic and Statistical Manual, Fourth Edition, Text Revision, (DSM-IV-TR)* lists kleptomania with the impulse control disorder, not otherwise specified (NOS) category along with pyromania, trichotillomania, intermittent explosive disorder, and pathological gambling. The diagnostic criteria for kleptomania are listed in Table 1.³

LITERATURE REVIEW

The prevalence of kleptomania in the general population is

TABLE 1. Diagnostic criteria for kleptomania⁹

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

Increasing sense of tension immediately before committing the theft.

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

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

The stealing is not better accounted for by conduct disorder, a manic episode, or antisocial personality disorder.

approximated at 0.6 percent. In those arrested for shoplifting, the prevalence of kleptomania is 3.8 to 24 percent. The female to male ratio is estimated at 3:1. The onset is usually in adolescence, and the average age for presentation for treatment is 35 years for women and 50 years for men.^{1,4,5}

Kleptomania is rarely brought to medical attention voluntarily. Patients usually present for treatment by legal mandate due to repeated shoplifting. Men are more likely to be sent to prison instead of being referred to treatment.⁴

A study involving 20 kleptomania patients found a high association with major depression and, to a lesser extent, anxiety and eating disorders. All of the patients in the study had a lifetime diagnosis of depression; 16 had a lifetime diagnosis of an anxiety disorder; and 12 had a lifetime diagnosis of an eating disorder.⁶

Kleptomania and other impulse control disorders seem to be more prevalent among those with psychiatric disorders. In a study of 204 psychiatric patients admitted for inpatient treatment, 31 percent of the patients were identified with a current impulse control disorder and 7.8 percent with kleptomania.⁷ A report that identified 11 patients with kleptomania compared them to a group of patients with alcoholism and

to a group of non-psychotic psychiatric patients. The patients with kleptomania had significantly higher levels of impulsivity that distinguished them from both comparison groups. The patients with kleptomania were also found to have high rates of substance abuse and mood disorders.⁸

The pathophysiology of kleptomania is unknown. Psychoanalytic theories link compulsive stealing to childhood trauma and neglectful or abusive parents, and stealing may symbolize repossessing the losses of childhood.^{1,4} Kleptomania has also been linked to psychosexual issues such as sexual repression and suppression.^{1,4} Neuropsychiatric factors are also thought to play a role in kleptomania. The disorder appears to be highly associated with mood disorders and anxiety spectrum disorders.^{6,9} Reports of kleptomania responding to selective serotonin reuptake inhibitors (SSRIs) suggests a common pathophysiology with mood and anxiety disorders.^{9,10}

Kleptomania may also be regarded as a form of addictive behavior and has been shown to be associated with other substance use disorders (e.g., alcohol and nicotine).⁸ Naltrexone, an opiate antagonist used to treat addictive behaviors, has been shown to reduce kleptomania symptoms.¹¹⁻¹³ A double-blind, placebo-controlled study of 25 patients who were administered naltrexone showed significant improvement in kleptomania.¹⁴ Topiramate, an anticonvulsant drug, has been shown to be effective in impulse control disorders, and recently topiramate demonstrated efficacy in treating binge eating.¹⁵ Again, this has been extrapolated to kleptomania with encouraging results in small case series.^{16,17} Additionally, there are case reports in the literature documenting kleptomania responding to lithium, valproate, trazodone, and electroconvulsive therapy.^{1,4,5,9}

Impulse control disorders can present as neuropsychiatric sequelae of head trauma and traumatic brain injury.¹⁸ New onset kleptomania has been reported in two cases of closed

head trauma.¹⁹ Brain disorders, such as epilepsy¹⁷ and frontotemporal dementia¹ have been reported to cause kleptomania. Kleptomania has also been reported as paradoxical side effect of SSRIs in three patients.²⁰

Various psychotherapeutic techniques alone and in combination with psychotropic medications have been reported to improve compulsive stealing.^{1,4,9} Desensitization was effective in a small study of three patients with impulse control disorders: two shop-lifters and one binge eater.²¹ In a study of 28 patients with compulsive buying (a condition closely related to impulse control disorders), cognitive behavioral therapy (CBT) was found to be effective in reducing the compulsions to buy.

CASE REPORT

Presentation. A 54-year-old Caucasian woman presented to the author's psychiatric clinic initially for treatment of attention and concentration issues. Her history included dyslipidemia, major depressive disorder (MDD), attention deficit hyperactivity disorder (ADHD), which was diagnosed in childhood, and posttraumatic stress disorder (PTSD) due to a motor vehicle accident (MVA). The MVA occurred five years previously, and the accident was severe; the patient's husband and another passenger died, and the patient, who was the driver, was disabled due to the physical injuries sustained.

The patient was hospitalized once in her early 20s for depression. Substance abuse history was positive for alcoholism, which was now in remission. The patient reported her childhood as significant for a violent and chaotic home life due to parental discord and alcoholism. Family history included an alcoholic father. The patient completed high school and worked in retail until disabled by the MVA. Her current medications were pravastatin 40mg daily and venlafaxine 150mg daily.

Course of illness and treatment. On initial presentation,

the patient was concerned with attention and concentration problems. She reported that she was attempting to take college classes but was struggling to maintain attention and concentration in class. She reported her mood as euthymic and that she was abstinent from alcohol. History and clinical presentation were not suggestive of psychosis, mania, or a personality disorder. Her symptoms were consistent with ADHD, and treatment was initiated with methylphenidate 10mg daily. Methylphenidate was selected because the patient reported being prescribed the medication previously, with good results, for her ADHD. At the follow-up appointment four weeks later, the patient reported improvement in attention and concentration and did not report any adverse medication effects.

At the next medication management appointment four weeks later, the patient spontaneously reported a history of behaviors consistent with kleptomania since adolescence. The patient reported that the severity and frequency of the behaviors had escalated over the past five years, but that she, as of yet, had never been caught stealing. The patient reported that the stealing behaviors began at age 15, and that initially she would steal unneeded items from large stores every 3 to 4 weeks. She reported that excitement and tension would build up while thinking about stealing; eventually, she would steal and feel an immediate sense of relief, quickly followed by guilt and shame. Afterward, she would discard the items for fear of being discovered. In late adolescence, the patient reported that she started to drink heavily and by early adulthood developed alcoholism. The patient reported that she did not steal when intoxicated.

The patient reported that she had been hospitalized for a concussion and multiple fractures following the MVA in which her husband died. She had been told at that time that her brain imaging tests were normal. The patient reported that following the

discharge from the hospital, she stopped drinking alcohol and had remained abstinent for the last five years. She also reported that, since the accident, her symptoms of kleptomania worsened to multiple episodes of stealing per week and sometimes daily.

With agreement from the patient, the team initiated treatment for her symptoms of kleptomania. The Yale-Brown Obsessive Compulsive Scale (Y-BOCS)²² was administered to the patient. The Y-BOC questionnaire

The Y-BOCS is not a validated questionnaire for kleptomania and is not indicated for use in kleptomania. However, in attempting to objectively gauge improvement in the patient, the team decided to use the Y-BOCS as a surrogate marker for the intensity of the compulsions as they related to her symptoms of kleptomania.

includes 10 questions rated on a Likert-type scale,^{22,24} and severity is rated as subclinical 0 to 7; mild 8 to 15; moderate 16 to 23; severe 24 to 31; and extreme 32 to 40. The patient's initial score was 33.

Initial treatment consisted of increasing venlafaxine, a serotonin norepinephrine reuptake inhibitor (SNRI), to 225mg daily and discontinuing methylphenidate. At follow up three weeks later, there was no change her symptoms. A trial of naltrexone 50mg daily was started, and cognitive behavioral therapy (CBT) was initiated. The patient discontinued the naltrexone after two weeks due to intolerance (e.g., patient reported feeling groggy, sedated, and cognitively slowed). However, the patient perceived a reduction in the kleptomania symptoms, which she felt was related to the psychotherapeutic techniques. Y-BOCS score at this follow up was in the moderate range at 20. CBT was continued and topiramate therapy was initiated. Topiramate 100mg at bedtime was recommended to the patient, and she was instructed to titrate to the recommended dose of 100mg with weekly 25mg increments. The

treatment team decided to gauge her response to topiramate at the next follow-up visit to determine whether the topiramate dosage should be increased or maintained at 100mg. At follow-up visit four weeks later, the patient reported tolerating topiramate well with significant improvement in symptoms and no stealing during those four weeks. Topiramate was maintained at 100mg, and at her next follow-up visit six weeks later, she reported continuing to refrain from stealing. The Y-BOCS score was

further decreased to the mild score of 12. Venlafaxine was maintained through the course of treatment for depressive symptoms.

Psychotherapeutic interventions included CBT and insight-oriented therapy, and were administered to the patient at each visit. The patient was asked to chart compulsive behaviors in a diary. The patient also engaged in desensitization by imagining situations in which she might steal and utilizing relaxation techniques to reduce the tension she experienced in these settings. Conditioning was also employed—the patient was instructed to imagine the negative consequences of shoplifting (e.g., embarrassment, legal ramifications) and couple the negative emotions with the compulsion to steal. Other behavioral techniques included the avoidance of shopping alone or shopping in large chain retailers. Psychoeducation was utilized to enable the patient to better understand the condition in the context of depression, anxiety, past trauma, and addictive behaviors. The patient was followed by the treatment team for approximately 12 months, with zero instances of shoplifting reported by termination date.

DISCUSSION

The treatment team in the case report described here used the Y-BOCS²² to rate the symptoms of kleptomania in the patient. Y-BOCS is a validated questionnaire that rates the severity of symptoms in obsessive compulsive disorder and was used in a study of patients with compulsive buying to follow changes in the compulsions.²³

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This report illustrates the multiple neuropsychiatric issues that may accompany and possibly complicate kleptomania. Our patient presented with a history of addiction, childhood and psychological trauma, depression, and head trauma (concussion). To the best of our knowledge, this is the first report describing the exacerbation of preexisting kleptomania. The worsening of symptoms was reported by our patient to consist of stronger and more frequent compulsions to steal. This was reflected by an increase in stealing to an almost daily pattern while previously the frequency was every 3 to 4 weeks. The feelings of guilt, shame, and helplessness intensified and caused a worsening of depression.

Kleptomania developing after head trauma has been reported in the literature.¹⁹ We were unable to obtain records of the brain imaging performed at the time of the patient's MVA despite multiple attempts. This unfortunately will preclude any causal link between the head trauma and the worsening of kleptomania in this case. While it cannot be completely ruled out that the head trauma may have contributed to the worsening of the

patient's kleptomania, it is most likely that the exacerbation of her kleptomania following the MVA was multifactorial.

An important factor that should be considered in this case is the trauma and depression caused by the death of the patient's husband in the MVA. It is feasible that maintaining and increasing venlafaxine in the patient may have mitigated the worsening effects of depression on kleptomania.

Another potential exacerbating factor is the patient's abstinence from alcohol following the MVA, which may have resulted in the loss of the anxiolytic effects of alcohol and contributed to an increase in the compulsions to steal.

In addition to psychotherapy and medications, the following methods were found to be helpful in controlling the symptoms: close follow up, charting of the behaviors in diary, and utilizing the Y-BOCS at follow-up visits. These methods provided the patient with positive reinforcement and motivated her to continue treatment.

The patient in this report benefited from the systematic use of medications that have been shown in the literature as described earlier to be potentially beneficial in kleptomania. This patient did not respond to a SNRI and did not tolerate naltrexone, but did respond well to topiramate at 100mg daily. A reasonable paradigm for psychopharmacology in kleptomania can consist of the following: start with a SSRI or SNRI and titrate to the recommended dosage and duration. If the response is inadequate, a trial of naltrexone or topiramate should be considered.⁵ The average effective dose of naltrexone in a placebo-controlled study for kleptomania was 116mg daily, with a range of 50 to 150mg.¹⁴ Topiramate was effective for impulse control disorders (binge eating) and kleptomania in the range of 200 to 400mg daily.^{15,16} Our patient responded to topiramate at the lower dose of 100mg daily.

Finally, all patients with kleptomania can potentially benefit

from a trial of psychotherapeutic interventions.

CONCLUSION

Clinicians should routinely inquire about urges to steal during the general psychiatric interviews with their patients. Patients with a history of trauma, head injury, or substance abuse should also be screened for kleptomania. It is essential to approach kleptomania in a nonjudgmental manner and to reinforce confidentiality due to patients' fear of legal consequences. Increased awareness and screening by clinicians may increase the number of patients seeking help. Individuals who suffer from this condition can reasonably expect a reduction and possible remission of symptoms with a combination of psychotherapy and psychopharmacology.

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