Kleptomania: a case report from Sri Lanka

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Summary

Kleptomania is a relatively uncommon disorder characterised by repeated episodes of stealing with symptoms being of an obsessive nature, while at the same time displaying a lack of impulse control.

We report a case successfully managed with pharmacotherapy and psychotherapy.

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Introduction

Kleptomania, first described by French psychiatrists Esquirol and Marc in the 19th century is a rare disorder and is classified as an impulse control disorder (1). The condition is often undisclosed by patients and cause significant impairment and adverse consequences. Although it was previously explained psychodynamically, there are attempts to introduce a neuropsychiatric model thus facilitating pharmacotherapy (2). We report a case of kleptomania managed successfully by psychotherapeutic and pharmacological methods.

Case report

A 23 year old female reported stealing behaviours since the age of 15 years. She stole money when she was presented with an opportunity and without premeditation despite having no financial difficulties. The impulse to steal arose upon seeing money. She had difficulty in controlling these impulses. The increased tension just before the theft was followed by a sense of relief and pleasure after stealing. She did not have the impulse in the presence of others. At times she tried to resist the urge. Although there was some degree of shame and guilt, she did not feel persistent and unbearable guilt about stealing. She stole small amounts of money once or twice a month. Her behaviour was not detected until recently. After an act of stealing was discovered she had to leave her work place.

She developed persistent sadness, lack of interest in usually pleasurable activities, poor sleep and reduced appetite which resulted in presenting to psychiatric services. She harboured intense feelings of guilt, shame and worthlessness. She felt guilty about life in general as well as about the compulsive acts of stealing that she had carried out in the past. She had no obsessive compulsive behaviours or psychotic features. Her childhood was uneventful with no sexual or physical abuse and there were no features of conduct disorder. No conflicts were reported in her family. She was an introverted person who did not share her thoughts and feelings. She did not have borderline or antisocial personality traits.

The patient was commenced on a Selective Serotonin Reuptake Inhibitor (SSRI), fluoxetine 20 mg which was increased to 40mg a day. Initially a benzodiazepine was added due to insomnia. Exposure and response prevention techniques were used in her management: she was exposed to money kept at random places, at home, without her prior knowledge. This was done after educating the patient and her parents about exposure and response prevention. The techniques of covert desensitisation were also used to further strengthen her ability to resist the impulses.

A major component of management involved dealing with family members who expressed a high level of emotions regarding her symptoms. Her feelings of guilt and abandonment subsequent to the discovery of stealing behaviour and the social consequences were dealt with supportive psychotherapy.

The patient initially found the thought to steal difficult to resist. However, with repeated exposure to money, she was able to resist the compulsion completely after 12 sessions. She only developed thoughts of stealing infrequently. After completion of the course of therapy she was reviewed monthly. Currently, after six months of treatment, she remains well with no recurrence of symptoms.

Discussion

Kleptomania is characterised by recurrent episodes of stealing, commonly in the form of shoplifting. The items that are stolen are of trivial value and not often needed by the person who steals them. The patient recurrently fails to resist the impulse to steal objects. The thought is often egodystonic and is upsetting to the patient. The stealing is abrupt, without premeditation and no others are involved. The person is often aware that the act is wrong and senseless and attempts to resist it. They do not think of possible detrimental outcomes at the time of stealing. However, the person feels depressed or guilty about the thefts afterwards.

The Diagnostic and Statistical Manual, Fourth Edition, Text Revision, (DSM-IV-TR) lists kleptomania in the 'impulse control disorder, not otherwise specified (NOS)

category', along with pyromania, trichotillomania, intermittent explosive disorder, and pathological gambling (3). The DSM 5 classifies kleptomania under 'disruptive, impulse control and conduct disorders' (4). The ICD-10 classifies the condition as pathological stealing (kleptomania) and as a disorder 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 (5).

The stealing mimics an obsession followed by a compulsion in that the urge to steal is experienced recurrently as a senseless and intrusive thought with increasing tension which is relieved upon stealing. Hence, although classified as an impulse control disorder has features compatible with an obsessive compulsive spectrum disorder as well.

The prevalence of kleptomania is estimated to be about 0.3%-0.6% in the general population. However, the rate is 4%-24% in those arrested for shoplifting (4). The prevalence varies widely because it is an uncommon disorder, the reluctance to seek treatment and the associated social stigma. It is reported to be commoner among females with a ratio of 3:1 with the average age at presentation for females being 35 years. Males present later at an age of around 50 years.

The onset of the illness may be in childhood or in adulthood but it is more common in adolescence. The three typical courses of the illness are sporadic with brief episodes and long periods of remission; episodic with protracted periods of stealing and periods of remission; and chronic with some degree of fluctuation. The condition may last for years in some patients despite multiple convictions (4).

A study of 20 patients with kleptomania reported high comorbidity rates with all 20 of them having a life time diagnosis of depressive disorder, 16 had anxiety disorders and 12 had a life time diagnosis of eating disorder (6).

Although the exact pathophysiology of kleptomania is unknown, several theories have been proposed. Psychoanalytic and psychosexual theories explain kleptomania as a means of repossessing of losses in childhood such as neglect or abuse by parents, and sexual repression (1).

There is a high rate of comorbidity with mood and anxiety disorders in patients with kleptomania. It has been postulated that the response to SSRIs may be due to a common pathophysiology it shares with mood and anxiety disorders (7, 8). Kleptomania is also classified as an addictive disorder because of its common coexistence with substance use disorders; also, patients treated with naltrexone have shown significant improvement. (8, 9). Kleptomania has been reported secondary to neurotrauma, epilepsy and fronto-temporal dementia.

This patient displayed the typical clinical pattern of kleptomania where the impulse to steal occurs only upon the sight of the object. The thought was intrusive, recurrent and senseless and caused a great distress to the

patient which was relieved upon stealing. Her symptoms were compatible with the impulse control and obsessive definitions of the disorder. The patient had a depressive episode, in keeping with the pathophysiological theory of common pathways with mood and anxiety disorders. She did not have a family history of kleptomania or obsessive compulsive disorder. The patient was initiated on fluoxetine as SSRIs are useful in treating depression as well as kleptomania. Cognitive behaviour therapy was initiated as it has more robust evidence in the maintenance of anxiety disorders, though not specifically for kleptomania.

Declaration of interest

None declared

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