

Naltrexone Treatment for Kleptomania: A Case Report



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Summary

Kleptomania is an impulse control disorder characterized by the recurrent failure to resist the impulse to steal unnecessary, worthless objects. Very little is known about its etiology, prevalence, and treatment. The disorder usually begins during puberty and persists until late adulthood. In some patients it may persist throughout an entire lifetime. Patients with kleptomania are likely to suffer from comorbid conditions such as mood disorders, and usually seek treatment for the comorbid psychiatric complaints, rather than kleptomania itself. The literature lacks sufficient knowledge and controlled studies about the treatment of kleptomania. Regarding treatment with SSRIs, there are some case reports and case series describing the use of mood stabilizers, antipsychotics, and opioid antagonists. Cognitive behavioral therapy has also been used for the treatment of kleptomania. This study presents a female patient whose kleptomaniac symptoms diminished after naltrexone treatment was added to her cognitive behavioral therapy and fluoxetine treatment. She also had comorbid major depressive disorder and obsessive-compulsive disorder.

Keywords: Kleptomania, naltrexone, comorbidity

INTRODUCTION

Kleptomania is a mental disorder characterized by the inability to resist the impulse to steal things that are of no value, and not needed for personal use. It is listed under the "Impulse Control Disorder, not elsewhere classified" in DSM-IV-TR (American Psychiatry Association 2007).. The number of individuals that seek treatment is limited, as it is a rare disorder and may result in social stigmatization; therefore, its etiology and incidence are not precisely known (Grant, 2006; Bayle et al., 2003; Durst et al., 2001; Chong et al., 1996). The incidence of comorbid kleptomania in patients with other psychiatric disorders is 7.8%, with a 9.3% lifetime incidence of kleptomania (Grant et al. 2005). Among a group of patients with depression, 3.7% had comorbid kleptomania (Lejoyeux et al., 2002) and 3.8% of patients with alcohol addiction had comorbid kleptomania (Lejoyeux et al., 2002). Among four clinical studies that evaluated the clinical features of patients

with kleptomania, 63% of 108 patients were female (Grant et al., 2002; Presta et al., 2002; Sarasalo et al., 1996; McElroy et al., 1991); however, this may have been due to the fact that females seek psychiatric help more often than males, and not because kleptomania occurs more frequently in females (Grant et al., 2002a).

Treatment strategies for kleptomania are scarce and have been described in just a few case reports and case series. As it is a rare clinical disorder, patients tend to hide their symptoms, and it is difficult to perform controlled studies with drugs in patients with kleptomania. Primarily, SSRIs (serotonin reuptake inhibitors) are used to treat kleptomania because it is conceptualized as a form of obsessive-compulsive disorder (OCD). SSRIs must be used at high doses, as suggested for OCD, because of the compulsive nature of kleptomania; however, findings concerning the efficiency of SSRIs for kleptomania are inconsistent (Mc Elroy ve ark. 1991, Grant ve Potenza 2004). In a case series of 20 patients with comorbid

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diagnoses in addition to kleptomania, only 2 patients responded to fluoxetine treatment, whereas 1 patient had partial response and 7 patients had no change in their symptoms (McElroy et al., 1991). Hocaoglu et al. (2004) reported 3 patients with kleptomania, of which 1 had comorbid OCD and 2 had comorbid major depression; all improved significantly following SSRI use. Trazodone, nortriptyline, clomipramine, amitriptyline, risperidone, quetiapine, lithium, and valproate are other agents used for the treatment of kleptomania (Grant et al., 2004; Kozian et al., 2003; Figgitt et al., 2000; Chong et al., 1996); however, the findings on lithium's efficacy are also inconsistent. Response to treatment was good in 1 of 2 patients treated with lithium only; however, no change in the symptoms of kleptomania was reported in 2 of 3 patients that received lithium augmentation treatment (McElroy et al., 1991).

The possible association between kleptomania and a spectrum of addiction disorders resulted in opioid antagonists becoming the target of researchers. As such, there are some case reports and 1 controlled study demonstrating the efficiency of opioid antagonists in adults and adolescents with kleptomania (Grant et al., 2009; Grant et al., 2002b). This study presents a patient with kleptomania whose symptoms diminished following the combined use of fluoxetine and naltrexone.

CASE

A 57-year-old married woman with 3 children and only a primary school education that was living with her husband and children was caught stealing children's underwear a few days prior to presenting to our outpatient clinic for treatment following the start of legal proceedings. She reported the following symptoms: loss of enjoyment; self-hatred; sleeplessness; stealing various things from shopping malls and markets, and regretting having done so afterwards. She reported that she began stealing 13 years earlier. She described her stealing behavior as follows: first, she has an urge to steal, followed by tension and then relaxation after stealing; sometimes she gave away the stolen items as gifts, sometimes she used them, sometimes she threw them in the garbage, and sometimes she returned them to the stores.

Depressive affect and mood were noted during her mental examination. She was preoccupied with the stealing behavior she could not resist, which made her anxious. Her thought content was depressive and she had doubt and contamination obsessions. Anergy, anhedonia, control compulsions, poor social functionality, and a decrease in the need for sleep, appetite and sexual desire were noted. The patient was diagnosed with OCD and major depressive disorder, based on a SCID-I interview, and kleptomania, based on DSM-IV TR criteria. Kleptomania started 13 years ago, while OCD three

years and depression started one year ago. No mental disorder was found in the family.

Her Hamilton Depression Rating Scale (HAM-D) and Yale Brown Obsession Compulsion Scale (YBOCS), scores were 27 and 30 respectively, at the beginning of the treatment. Fluoxetine 20 mg d⁻¹ was initiated based on comorbid OCD and the patient began a CBT program administered by her clinical psychologist. The fluoxetine dose was gradually increased to 60 mg d⁻¹. Her obsessive-compulsive symptoms partially improved after using the drug for 3 months; however, the symptoms of kleptomania remained unchanged. As such, lithium 600 mg d⁻¹ was added to her treatment. News that her daughter was moving to her town increased her anxiety that people would learn of her illness. Thus, outpatient treatment was terminated and she was admitted to the open psychiatry clinic. Her depressive and obsessive-compulsive symptoms regressed during her hospitalization and her total HAM-D and YBOCS scores decreased to 18 and 14, respectively. Although she did not exhibit any stealing behavior while hospitalized, in response to abstaining from shopping malls and stealing, syncope of a convulsive nature began.

Her new state and these symptoms were related to the request from the court for a state disclosure report of the stealing behavior, which resulted in her psychiatric presentation, from the Department of Psychiatry of EUTF. Lithium was discontinued due to symptoms of lithium intoxication. The patient was discharged for follow-up at the outpatient clinic following 2.5 months of hospitalization, during which time she was administered fluoxetine 80 mg d⁻¹ and CBT. HAM-D and YBOCS scores at discharge were 9 and 10, respectively. Her treatment was reassessed due to resumption of intense impulsive stealing symptoms, whereas she did not steal anything while hospitalized.

CBT was continued on an outpatient basis, and fluoxetine was decreased to 60 mg d⁻¹ and naltrexone 50 mg d⁻¹ was added to the treatment. Her Kleptomania Symptom Assessment Scale (K-SAS) (Grant 2002c) score was 35 at the beginning, versus 16 at the evaluation performed after 6 weeks. Her desire to steal and her thoughts about this desire were reasonably decreased and her ability to control her stealing behavior was rather increased; however, her feelings of guilt attributed to the ongoing legal process continued. Her liver function tests were checked regularly during the treatment period. She reported that the impulse to steal was greatly diminished, and her behavior of abstinence ended at the evaluation performed 16 weeks after the addition of naltrexone to the treatment. Her K-SAS score decreased to 12, and whereas her General Assessment of Functioning Scale total score was 45 at the beginning of treatment, it was 70 at the last evaluation.

DISCUSSION

Fluoxetine was chosen for treatment in the presented kleptomania case primarily because of comorbid OCD and major depressive disorder. Accompanying diagnoses complicate both stealing behavior and treatment of kleptomania (Çaliyurt et al., 2009; Grant et al., 2008). The primary difficulties associated with the treatment of the presented case were that she was caught stealing and subjected to legal proceedings, had intense feelings of guilt accompanying the depression associated with her stealing behavior, the presence of obsessions and compulsions, and presentation for treatment 13 years after the onset of the symptoms of kleptomania.

Reports of the efficacy of opioid antagonists in the treatment of kleptomania are promising. The stealing impulse was significantly reduced following naltrexone treatment in 8 of 10 patients and completely extinguished in 2 patients that had kleptomania only (Grant et al., 2002c). In a retrospective study of 17 kleptomania patients, of which 7 had comorbid mood disorders or an anxiety disorder, the impulse to steal decreased in >75% of the patients, and 40% stopped stealing (Grant 2005). Another study reported that 2 patients that developed kleptomania following head trauma and were non-responsive to antidepressant treatment significantly improved with combined treatment of antidepressants, CBT, and naltrexone (Aizer et al., 2004).

The results of the first and only, double-blind placebo-controlled study of 25 patients for 8 weeks, on the efficacy of naltrexone for the treatment of kleptomania verified that it significantly reduces the impulse to steal and stealing behavior with a mean dose of 116.7 ± 44.4 mg d⁻¹ (Grant, 2009). Opioid receptor antagonists were reported to be effective for pathological gambling, which is a pleasure-related disorder (Kim et al., 2001a, 2001b). Naltrexone inhibits dopamine neurons in the ventral tegmental region and neutralizes the effect of dopamine, which plays a role in the regions associated with desire and pleasure in the nucleus accumbens and basal brain (Kim, 2001b). It is thought that naltrexone decreases the urge related to stealing behavior along this pathway (Kim 1998). It was also reported that endorphins and GABA play a role in impulses and impulse-related behaviors in impulse control disorders; however, the mechanism of action of opioid receptor antagonism in the treatment of kleptomania is not completely understood (Grant et al., 2009).

To the best of our knowledge the present study is the first to report the use of naltrexone for the treatment of kleptomania in Turkey. Although it is not possible to directly infer the efficacy of naltrexone as a single agent, as it was used in addition to fluoxetine and CBT in the presented case, it may be a good choice for patients resistant to treatment. Additional controlled studies on the use of naltrexone for the treatment of kleptomania are necessary to more clearly discern its effectiveness.

REFERENCES

- Aizer A, Lowengrub K, Dannon PN (2004) Kleptomania after head trauma: two case reports and combination treatment strategies. *Clin Neuropharmacol*, 27: 211-5.
- American Psychiatric Association (2007). *Diagnostic and Statistical Manual of Mental Disorders*
- 4th Ed, Revised Whole Text (DSM-IV-TR), American Psychiatric Association, Washington DC, 2000, Köroğlu E (Translated Ed.), Hekimler Yayın Birliği.
- Baylé FJ, Caci H, Millet B et al. (2003) Psychopathology and comorbidity of psychiatric disorders in patients with kleptomania. *Am J Psychiatry*, 160: 1509-13.
- Chong SA, Low BL (1996) Treatment of kleptomania with fluvoxamine. *Acta Psychiatr Scand*, 93: 314-5.
- Çaliyurt O, Tamam L (2009) Kleptomanide Tedavi Seçenekleri. *Psikiyatride Güncel Yaklaşımlar*, 1: 1-10.
- Durst R, Katz G, Teitelbaum A et al. (2001) Kleptomania: diagnosis and treatment options. *CNS Drugs*, 15: 185-95.
- Figgitt DP, McClellan KJ (2000) Fluvoxamine. An updated review of its use in the management of adults with anxiety disorders. *Drugs*, 60: 925-54.
- Grant JE (2006) Understanding and treating kleptomania: new models and new treatments. *Isr J Psychiatry Relat Sci*, 43: 81-7.
- Grant JE, Odlaug BL (2008) Kleptomania: Clinical Characteristics and Treatment. *Revista Brasileira de Psiquiatria*, 30: 11-5.
- Grant JE, Kim SW (2002a) Clinical characteristics and associated psychopathology of 22 patients with kleptomania. *Compr Psychiatry*, 43: 378-84.
- Grant JE, Kim SW (2002b) Adolescent kleptomania treated with naltrexone—a case report. *Eur Child Adolesc Psychiatry*, 11: 92-5.
- Grant JE, Kim SW (2002c) An open-label study of naltrexone in the treatment of kleptomania. *Journal of Clinical Psychiatry*, 63: 349-56.
- Grant JE, Kim SW, Odlaug BL (2009) A double-blind, placebo-controlled study of the opiate antagonist, naltrexone, in the treatment of kleptomania. *Biol Psychiatry*, 65: 600-6.
- Grant JE, Levine L, Kim D et al. (2005) Impulse control disorders in adult psychiatric inpatients. *Am J Psychiatry*, 162: 2184-8.
- Grant JE, Potenza MN (2004) Impulse control disorders: clinical characteristics and pharmacological management. *Ann Clin Psychiatry*, 6: 27-34.
- Grant Jon E (2005) Outcome Study of Kleptomania Patients Treated With Naltrexone: A Chart Review. *Clinical Neuropharmacology*, 28: 11-4.
- Hocaoglu Ç, Kandemir G (2004) Kleptomani Tedavisinde Seçici Serotonin Gerilim Engelleyicisi (SSRI) Kullanımı: Üç Olgunun Sunumu. *Klinik Psikofarmakoloji Bülteni*, 14: 204-8.
- Kim SW (1998) Opioid antagonists in the treatment of impulse-control disorders. *J Clin Psychiatry*, 59: 159-64.
- Kim SW, Grant JE (2001a) An open naltrexone treatment study in pathological gambling disorder. *Int Clin Psychopharmacol*, 16: 285-9.
- Kim SW, Grant JE, Adson DE et al. (2001b) Double-blind naltrexone and placebo comparison study in the treatment of pathological gambling. *Biol Psychiatry*, 49: 914-21.
- Kozian R, Otto FG (2003) Pharmacological treatment of kleptomania—review. *Psychiatr Prax*, 30: 216-20.
- Lejoyeux M, Arbaretaz M, McLoughlin M et al. (2002) Impulse control disorders and depression. *J Nerv Ment Dis*, 190: 310-4.
- Lejoyeux M, Feuché N, Loi S et al. (1999) Study of impulse-control disorders among alcohol-dependent patients. *J Clin Psychiatry*, 60: 302-5.
- McElroy SL, Pope HG Jr, Hudson JI et al. (1991) Kleptomania: a report of 20 cases. *Am J Psychiatry*, 148: 652-7.
- Presta S, Marazziti D, Dell'Osso L et al. (2002) Kleptomania: clinical features and comorbidity in an Italian sample. *Compr Psychiatry*, 43: 7-12.
- Sarasalo E, Bergman B, Toth J (1996) Personality traits and psychiatric and somatic morbidity among kleptomaniacs. *Acta Psychiatr Scand*, 94: 358-64.