

# The girl who couldn't stop stealing

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Ms. B, age 14, has diagnoses of attention-deficit/hyperactivity disorder and oppositional defiant disorder. She has a habit of stealing that has worsened over the last year. How would you treat her?



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### CASE A lifelong habit

Ms. B, age 14, has diagnoses of attention-deficit/hyperactive disorder (ADHD) and oppositional defiant disorder, and is taking extended-release (ER) methylphenidate, 36 mg/d. Her mother brings her to the hospital with concerns that Ms. B has been stealing small objects, such as money, toys, and pencils from home, school, and her peers, even though she does not need them and her family can afford to buy them for her. Ms. B's mother routinely searches her daughter when she leaves the house and when she returns and frequently finds things in Ms. B's possession that do not belong to her.

The mother reports that Ms. B's stealing has been a lifelong habit that worsened after Ms. B's father died in a car accident last year.

Ms. B does not volunteer any information about her stealing. She is admitted to a partial hospitalization program for further evaluation and treatment.

### Which diagnoses would you consider for Ms. B?

- bipolar disorder
- substance use disorder
- kleptomania
- antisocial personality disorder

### EVALUATION Continued stealing

A week later, Ms. B remains reluctant to talk about her stealing habit. However,

once a therapeutic alliance is established, she reveals that she experiences increased anxiety before stealing and feels pleasure during the theft. Her methylphenidate ER dosage is increased to 54 mg/d in an attempt to address poor impulse control and subsequent stealing behavior. Her ADHD symptoms are controlled, and she does not exhibit poor impulse control in any situation other than stealing.

However, Ms. B continues to have poor insight and impaired judgment about her behavior. During treatment, Ms. B steals markers from the psychiatrist's office, which later are found in her bag. When the staff convinces Ms. B to return the markers to the psychiatrist, she denies knowing how they got there. Behavioral interventions, including covert sensitization, systemic desensitization, positive reinforcement, body and bag search, and reminders, occur consistently as part of treatment, but have little effect on her symptoms.

After 1 week in the partial hospitalization program, the psychiatrist asks Ms. B and her mother to complete the Kleptomania Symptom Assessment Scale

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#### Disclosure

The author reports no financial relationships with any company whose products are mentioned in this article or with manufacturers of competing products.

**Clinical Point**

Although impulsivity, instant reward-seeking behavior, and poor judgment can lead to stealing, they are not necessarily indicative of kleptomania

**Table 1**

**The Kleptomania Symptom Assessment Scale**

During the past week...

If you had urges to steal, on average, how strong were your urges?
How many times did you experience urges to steal?
How many hours were you preoccupied with your urges to steal?
How much were you able to control your urges?
How often did thoughts about stealing come up?
Approximately how many hours did you spend thinking about stealing?
How much were you able to control your thoughts of stealing?
On average, how much tension or excitement did you have shortly before you committed a theft?
On average, how much excitement and pleasure did you feel when you successfully committed a theft?
How much emotional distress (mental pain or anguish, shame, guilt, embarrassment) has your stealing caused you?
How much personal trouble (relationship, financial, legal, job, medical, or health) has your stealing caused you?
How many times did you steal?
<b>Source:</b> Reference 1

(K-SAS) (Table 1),<sup>1</sup> which is designed to evaluate the severity of symptoms of kleptomania. Differential diagnoses of mania, antisocial personality disorder, uncontrolled ADHD, and ordinary stealing are considered. Although the scale is designed to be filled out only by the patient, Ms. B’s mother also was asked to fill it out to the best of her knowledge about her daughter’s symptoms to obtain a comparison of externalizing symptoms. The K-SAS score reveals that Ms. B has daily urges to steal and has been stealing every day. Further evaluation reveals that Ms. B meets DSM-5 criteria for kleptomania (Table 2, page 51).<sup>2</sup>

**The author’s observations**

Risk-taking and novelty-seeking behaviors are common in adolescent patients. Impulsivity, instant reward-seeking behavior, and poor judgment can lead to stealing in this population, but this behavior is not necessarily indicative of kleptomania.

Kleptomania is the recurrent failure to resist impulses to steal objects.<sup>2</sup> It differs from other forms of stealing in that the objects stolen by a patient with kleptomania are not needed for personal use or for their monetary value. Kleptomania usually begins in early adolescence, is found in about 0.5% of the general population, and is more common among females.<sup>3</sup>

There are 2 important theories to explain kleptomania:

- **The psychoanalytical theory** explains kleptomania as an immature defense against unconscious impulses, conflicts, and desires of destruction. By stealing, the individual protects the self from narcissistic injury and disintegration. The frantic search for objects helps to divert self-destructive aggressiveness and allows for the preservation of the self.<sup>4</sup>

- **The biological model** indicates that individuals with kleptomania have a significant deficit of white matter in inferior frontal regions and poor integrity of the tracts connecting the limbic system to the thalamus and to the prefrontal cortex.<sup>5</sup> Reward system circuitry (ventral tegmental area–nucleus accumbens–orbital frontal cortex) is likely to be involved in impulse control disorders including kleptomania.<sup>6</sup>

**Comorbidity.** Kleptomania often is comorbid with substance use disorder (SUD), obsessive-compulsive disorder (OCD), and compulsive shopping, as well as depression, anxiety disorders, bulimia nervosa, and impulse control and conduct disorders.<sup>3,6</sup>

Kleptomania shares many characteristics with SUD, including continued engagement in a behavior despite negative consequences and the temporary reduction in



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urges after the behavior's completion, followed by a return of the urge to steal. There also is a bidirectional relationship between OCD and kleptomania. Individuals with both disorders frequently engage in excessive and unnecessary rituals even when it is ego-dystonic. First-degree relatives of kleptomania patients have high rates of SUD and OCD.<sup>3</sup>

Serotonin, dopamine, and opioid pathways play a role in both kleptomania and other behavioral addictions.<sup>6</sup> Clinicians should be cautious in treating comorbid disorders with stimulants. These agents may help patients with high impulsivity, but lead to disinhibition and worsen impulse control in patients with low impulsivity.<sup>7</sup>

### TREATMENT Naltrexone

The psychiatrist discusses pharmacologic options to treat kleptomania with Ms. B and her mother. After considering the risks, benefits, adverse effects, and alternative treatments (including the option of no pharmacologic treatment), the mother consents and Ms. B assents to treatment with naltrexone, 25 mg/d. Before starting this medication, both the mother and Ms. B receive detailed psychoeducation describing naltrexone's interactions with opioids. They are told that if Ms. B has a traumatic injury, they should inform the treatment team that she is taking naltrexone, which can acutely precipitate opiate withdrawal.

Before initiating pharmacotherapy, a comprehensive metabolic profile is obtained, and all values are within the normal range. After 1 week, naltrexone is increased to 50 mg/d. The medication is well tolerated, without any adverse effects.

#### What laboratory test is important to use in monitoring a patient taking naltrexone?

- renal function test
- liver function test
- complete blood count
- fasting lipid profile

**Table 2**

### DSM-5 criteria for kleptomania

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 a hallucination

The stealing is not explained by conduct disorder, a manic episode, or antisocial personality disorder

Source: Reference 2

### The author's observations

Behavioral interventions, such as covert sensitization and systemic desensitization, often are used to treat kleptomania.<sup>8</sup> There are no FDA-approved medications for this condition. Opioid antagonists have been considered for the treatment of kleptomania.<sup>7</sup>

Mu-opioid receptors exist in highest concentrations in presynaptic neurons in the periaqueductal gray region and spinal cord and have high affinity for enkephalins and beta-endorphins. They also are involved in the reward and pleasure pathway. This neurocircuit is implicated in behavioral addiction.<sup>9</sup>

Naltrexone is an antagonist at  $\mu$ -opioid receptors. It blocks the binding of endogenous and exogenous opioids at the receptors, particularly at the ventral tegmental area. By blocking the  $\mu$ -receptor, naltrexone inhibits the processing of the reward and pleasure pathway involved in kleptomania. Naltrexone binds to these receptors, preventing the euphoric effects of behavioral addictions.<sup>10</sup> This medication works best in conjunction with behavioral interventions.<sup>8</sup>

Naltrexone is a Schedule II drug. Use of naltrexone to treat kleptomania or other impulse control disorders is an off-

### Clinical Point

There are no FDA-approved medications for kleptomania; however, opioid antagonists have been considered for this indication

## Clinical Point

**Naltrexone works best in conjunction with behavioral interventions**

### Related Resources

- Grant JE, Kim SW, Odlaug BL. A double-blind, placebo-controlled study of the opiate antagonist, naltrexone, in the treatment of kleptomania. *Biol Psychiatry*. 2009;65(7):600-606.
- Grant JE. Outcome study of kleptomania patients treated with naltrexone: a chart review. *Clin Neuropharmacol*. 2005;28(1):11-14.

#### Drug Brand Names

Methylphenidate ER • Concerta      Naltrexone • Revia

label use of the medication. Naltrexone should not be prescribed to patients who are receiving opiates because it can cause acute opiate withdrawal.

Liver function tests should be monitored in all patients taking naltrexone. If liver function levels begin to rise, naltrexone should be discontinued. Naltrexone should be used with caution in patients with pre-existing liver disease.<sup>11</sup>

### OUTCOME Marked improvement

Ms. B's K-SAS scores are evaluated 2 weeks after starting naltrexone. The results show a marked reduction in the urge to steal and in stealing behavior, and Ms. B's mother reports no incidents of stealing in the previous week.

Ms. B is maintained on naltrexone, 50 mg/d, for 2 months. On repeated K-SAS scores, her mother rates Ms. B's symptoms "very much improved" with "occasional" stealing. Ms. B is discharged from the intensive outpatient program.

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## Bottom Line

Naltrexone, used in conjunction with behavioral interventions, can safely reduce urges to steal and stealing behavior in patients with kleptomania. Hepatic transaminases should be checked regularly in patients taking naltrexone.