Kleptomania At A Glance

Kleptomania is an impulse control disorder characterized by repeated, failed attempts to stop stealing. It is often seen in persons who are chemically dependent or who have a coexisting mood, anxiety, or eating disorder. Although there is a tendency to describe a "compulsive need to steal" in those individuals with this diagnosis, controversy remains regarding how to determine if the person is suffering from this disorder or is simply using it as a way to escape complete responsibility for sociopathic (antisocial) behaviors.

TREATMENT

To date, no treatment has proven to be uniformly or consistently effective, however psychotherapies and medications have been helpful in some cases. Medications used include:

- Tricyclic Antidepressants
- SSRIs
- Trazodone
- Lithium
- Valproate
- Naltrexone
- Topiramate
- Tranylcypromine
- Carbamazepine

Specific therapies used to treat kleptomania include:

- Insight-Oriented
- Social Contingencies
- Aversive Conditioning
- Covert Punishing Contingencies
- Covert Sensitization
- Systematic Desensitization
- Assertiveness Training

Because there has been little demonstrable success with any single drug or psychotherapeutic intervention, it is likely that many clinicians use a combination of the above-mentioned treatments. Like other impulse disorders, the duration of treatment is most often long term.

Discussion

There are no rigorous published studies that evaluate controlled psychological or medical treatment studies of kleptomania. There are some reports of successful use of insight-oriented psychotherapies to treat kleptomania, but there also are reports of negative outcomes resulting from psychotherapeutic interventions. (Fishbain 1987; Goldman 1991; McElroy et al. 1991a).

Case reports suggest that different types of behavior therapy may be effective for some persons served. These therapies include alteration of social contingencies (Kraft 1970), aversive conditioning (Keutzer 1972), covert punishing contingencies (Guidry 1975), covert sensitization (Gauthier and Pellerin 1982; Glover 1985), systematic desensitization (Marzagão 1972), and assertiveness training (Wolpe 1958).

Similarly, case reports and case series suggest that medical treatments with antidepressant or mood-stabilizing properties may be effective in kleptomania. These treatments include tricyclic antidepressants (McElroy et al. 1991a); serotonin reuptake inhibitors such as fluoxetine, fluvoxamine, paroxetine, and sertraline (Chong and Low 1996; Feeney and Klykylo 1997; Kraus 1999; Lepkifker et al. 1999; McElroy et al. 1991a); trazodone (McElroy et al. 1989); lithium (Burstein 1992; Kindler et al. 1997; McElroy et al. 1991a; Rocha and Rocha 1992); valproate (Kmetz et al. 1997; McElroy et al. 1991a); and electroconvulsive therapy (Fishbain 1987).

It is important to bear in mind that kleptomanic symptoms have been reported with SSRI treatment (Kindler et al. 1997). Such persons often have bipolar disorders, including soft-spectrum disorders that are triggered or uncovered by the antidepressant. These persons' kleptomania may resolve with the addition of lithium (Kindler et al. 1997).

Kleptomania may respond to drugs effective in substance use disorders, including naltrexone (Grant 2005) and topiramate (Dannon 2003). In one open-label study, 9 of 10 subjects with kleptomania who received naltrexone (mean dosage: 145 mg/day) for 12 weeks were much (n = 2) or very much (n = 7) improved at the end of the trial (Grant and Kim 2002).1

Only case reports, two small case series, and one open-label study of pharmacotherapy have been conducted for kleptomania. Various medications—tricyclic antidepressants, SSRIs (Lepkifker et al. 1999), mood stabilizers, and opioid antagonists—have been examined for the treatment of kleptomania (Grant and Kim 2002c; McElroy et al. 1989). McElroy et al. (1991b) reported treatment response in half of persons served with the following single agents: fluoxetine, nortriptyline, trazodone, clonazepam, valproate, and lithium. Other successful monotherapies for kleptomania are fluvoxamine (Chong and Low 1996) and paroxetine (Kraus 1999). Combinations of medications have been reported effective: lithium plus fluoxetine (Burstein 1992), fluvoxamine plus buspirone (Durst et al. 1997), fluoxetine plus lithium, fluoxetine plus imipramine (McElroy et al. 1991b), and fluvoxamine plus valproate (Kmetz et al. 1997).

The findings from case reports have been inconsistent. Seven cases of fluoxetine, three of imipramine, two of lithium as monotherapy, two of lithium augmentation, four of tranylcypromine, and one of carbamazepine combined with clomipramine all failed to reduce kleptomania symptoms (McElroy et al. 1991b). Some evidence suggests that SSRIs may even induce kleptomania symptoms (Kindler et al. 1997). A case series found that kleptomania symptoms respond to topiramate (Dannon 2003). In another case series, the two subjects treated with naltrexone responded to medication (Dannon et al. 1999).

In the only open-label medication trial for kleptomania, naltrexone (mean effective dosage, 145 mg/day) resulted in a significant decline in the intensity of urges to steal, stealing thoughts, and stealing behavior (Grant and Kim 2002c). A lower dosage, possibly 50 mg/day, may be effective in younger people with kleptomania (Grant and

Kim 2002a). Opioid antagonists such as naltrexone may be effective in reducing both the urges to shoplift and the shoplifting behavior by reducing the "thrill" associated with shoplifting and thus preventing the positive reinforcement of the behavior. Antidepressants, particularly those that influence serotonergic systems (e.g., serotonin reuptake inhibitors), may also be effective in reducing the symptoms of kleptomania by targeting serotonergic systems implicated in impaired impulse regulation. If kleptomania represents both impaired urge regulation and inhibition of behavior, both opioid antagonists and antidepressants may play a pivotal role in controlling this behavior.[2]

Many different kinds of psychotherapy have been tried in the treatment of kleptomania. The success of these therapies exists only in case reports, with no published controlled trials of therapy. Psychoanalysis has resulted in some limited success for kleptomania symptoms, but usually with the addition of medication (Fishbain 1988; Schwartz 1992). Insight-oriented psychotherapy, however, has been unsuccessful in treating this disorder in 11 published cases (McElroy et al. 1991b). Behavioral therapies such as covert sensitization, exposure and response prevention, and conditioning have successfully treated some cases of kleptomania (Gauthier and Pellerin 1982; Glover 1985; Keutzer 1972).

Imaginal desensitization uses the idea of imagining the steps of stealing while maintaining a relaxed state. The person served then images the potential scene of stealing but also imagines his or her ability to not steal in that context. Undergoing fourteen 15-minute sessions over 5 days, two persons reported complete remission of symptoms for a 2-year period (McConaghy and Blaszczynski 1988). Learning to substitute alternative sources of satisfaction and excitement when urges to steal occur was successful in a woman treated weekly for 5 months who later reported 2 years of remitted symptoms (Gudjonsson 1987).

Further research is needed to determine the optimal psychotherapy to use and to evaluate the efficacy of the combination of medication and psychotherapy.[3]

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