## Case report

# A case of an adolescent girl with kleptomania: an unstoppable urge to steal

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**Summary**

Kleptomania was a rare impulse control disorder characterized by the recurrent inability to resist the urge to steal items not needed for personal use or monetary gain. Here was a case of a 17-years-old girl presenting with repeated stealing for the last 7 years which was not planned rather impulsive. Both pharmacological and psychological interventions were executed maintaining firm adherence and close monitoring. Considerable improvement of the patients was evident thereafter. The case gave a hopeful message to the mental health professionals to treat these patients more effectively in the future. More researches regarding the management of kleptomania was recommended to be carried out.

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### Introduction

Kleptomania is described in both the medical and legal literatures for centuries, dating back to the early 19th century when the Swiss physician Mathey who worked with the insane wrote of a unique madness characterized by the tendency to steal without motive and without necessity. He termed this condition as klopemania or a stealing insanity. The term klopemania changed to kleptomanie and described by the French physicians Marc and Esquirol as persons having irresistible and involuntary urges to steal.[1] It is easy to misdiagnose or over diagnose kleptomania because the majority of the condition's diagnostic criteria (recurrent failure to resist impulses to steal; increasing sense of tension immediately before committing the theft; and pleasure, gratification, or relief at the time of committing the theft) are based on self-reporting and it is difficult to test its reliability.

The condition is often undisclosed by patients and caused significant impairment and adverse consequences. Although it was previously explained psycho dynamically, there were attempts to introduce a neuropsychiatric model thus facilitating pharmacotherapy.[2] We here in described presentation, diagnosis and treatment of kleptomania in an adolescent girl.

### Case summary

A 17-years-old, married but separated, unemployed, female, brought to outpatient department of a tertiary care psychiatric hospital of Bangladesh by her family member with the complaints of repeated stealing for 7 years and staying out of home for 2 years. Initially she used to steal money from family members and neighbors. Eventually she stole ornaments, mobiles, cloths, money etc. from other people. She arrested by police for 2 times and humiliated several times for her act. She felt tension before committing the act and relived of tension followed by the theft with or without guilt or remorse. Most of the time her family member could afford those objects and she gave those to her maternal aunt. Her stealing behaviors were without the help of others, not in response to anger or vengeance and not for personal use or monetary value. These acts were not planned rather impulsive. She married at the age of 15 without permission from her family and separated within 3 months. Then she started to talk with several male friends and met with them. Sometimes she stayed outside of home. Her maternal grandfather had history of obsessive-compulsive symptoms but was not diagnosed. Her father left her mother when she was in womb. Her mother had to leave her frequently at her maternal grandparent home for job purpose. She was extrovert and manipulative. There was no history of manic or hypomanic episode, hallucination, delusion or substance use. She didn't take any treatment previously and no investigations was found. General examination and other systemic examination revealed no abnormality. On mental state examination, nothing abnormality was found. Regarding insight, patient said that she was suffering from mental illness and treatment was needed. Diagnosis was confirmed as kleptomania according to the diagnostic and statistical manual of mental disorders, fifth edition (DSM-5). The patient was commenced on a selective serotonin reuptake inhibitor (SSRI), sertraline 50 mg which was increased to 150 mg 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 systemic desensitization 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 behavior 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, most of the time she was able to resist the compulsion after 6 sessions. She only remained thoughts of stealing infrequently and agreed to continue ongoing treatment.

**Discussion**

Kleptomania is characterized by recurrent episodes of stealing. 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 DSM 5 classified kleptomania under disruptive, impulse control and conduct disorders.[3] The international classification of diseases (ICD) 10 classified the condition as pathological stealing (kleptomania) and as a disorder characterized by repeated failure to resist impulses to steal objects that were not acquired for personal use or monetary gain. The objects might instead be discarded, given away, or hoarded.[4]

The stealing mimics an obsession followed by a compulsion in that the urge to steal was experienced recurrently as a senseless and intrusive thought with increasing tension which was 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 was estimated to be about 0.3%-0.6% in the general population. However, the rate was 4%-24% in those arrested for shoplifting.[3] The prevalence varied widely because it was an uncommon disorder, the reluctance to seek treatment and the associated social stigma. It was reported to be commoner among females with a ratio of 3:1 with the average age at presentation for females being 35 years. Males presented later at an age of around 50 years. The onset of the illness might be in childhood or in adulthood but it was more common in adolescence. The three typical courses of the illness were 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 might last for years in some patients despite multiple convictions.[3] Although the exact pathophysiology of kleptomania was unknown, several theories had been proposed. Psychoanalytic and psychosexual theories explained kleptomania as a means of repossessing of losses in childhood such as neglect or abuse by parents, and sexual repression.[5] There was a high rate of comorbidity with mood and anxiety disorders in patients with kleptomania. It had been postulated that the response to SSRIs might be due to a common pathophysiology it shared with mood and anxiety disorders.[6,7]

This patient displayed the typical clinical pattern of kleptomania where the impulse to steal occurred 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 initiated on sertraline as SSRIs were useful in treating kleptomania. After proper psychoeducation to the patient and her family member supportive psychotherapy, exposure and response prevention and systemic desensitization was given. Thereafter, patient started to improve and agreed to continue the treatment.

**Conclusion**

This case report emphasized the presentation, etiology and intervention in managing kleptomania in adolescents. A comprehensive approach of both psychotherapy and pharmacotherapy tailored to the individual's need could contribute to positive outcome and improve quality of life.

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