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Changes in impulse control disorder features in a present kleptomania patient and importance of rational treatment strategy on social dangerousness: a case report

Summary

The argument of the present article is the case of a 52 year-old male suffering from compulsive disorders (cocaine addiction, gambling, kleptomania) since adolescence, with behavioural and clinical features changing over time and poorly influenced by pharmacological treatments.

At present the patient shows kleptomanic behaviour pharmacologically treated with antipsychotics, antidepressants and anxiolytics. No specific treatment for compulsive spectrum appears to have been effected along the clinical history of the patient.

In agreement with international literature, according to which Pathological Gambling, Kleptomania and Substance Abuse share elements of both Obsessive-compulsive Disorder spectrum and affective spectrum disorders, the authors hypothesized for the case a not specific pharmacological treatment which might in time have led an evolution of the disorder symptoms to other forms of Impulse Control Disorders, with severe implications for his social dangerousness.

The analysis of the case suggests that a specifically targeted therapy, also included in the general legal system organization, may be effective to contain such an evolution in patients with Impulse Control Disorders.

Specific measures are thus needed for the rehabilitation of clinically similar subjects and for the recovery of their mental functions and normal behaviour.

Key words

Impulse control disorder • Compulsive disorders • Kleptomania • Gambling • Cocaine addiction • Social dangerousness • Treatment strategy

Introduction

The term Kleptomania (KL) was coined by French psychiatrists Esquirol and Marc in the 19th century [1]. From as far back as 1878, cases of KL in America have been reported in literature [2]. Over a decade of study and scientific developments have led a DSM-V [3] task force to consider two important changes: separating Pathological Gambling (PG) from Impulse Control Disorders (ICDs); creating a new autonomous category, Disruptive, Impulse-Control, and Conduct Disorders, which consist of illness manifested in behaviours that violate the rights of others (e.g., aggression, destruction of property) and/or that bring the individual into significant conflict with societal norms or authority figures. This category includes oppositional defiant disorder, intermittent explosive disorder, conduct disorder, antisocial personality disorder (which is described in the chapter "Personality Disorders"), pyromania, KL and other specified and unspecified disruptive, impulse-control, and conduct disorders.

KL is a disorder in which the individual impulsively steals even though there is not need to do so (i.e., the individual has money to pay for the stolen items or does not need the stolen goods). Like other ICDs, KL is characterized by an anxiety driven urge to perform an act that is pleasurable in the moment but causes significant distress and dysfunction [4]. Individuals

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with KL experience an increasing sense of tension immediately before committing the theft and gratification or release at the time of committing the theft [3]. Furthermore, the stealing is not committed to express anger or vengeance [3], it is not done in response to a delusion or hallucination, and it is not better explained by conduct disorder, manic episode, or antisocial personality disorder. Stealing commonly occurs in the form of shoplifting. KL occurs in about 4-24% of individuals arrested for shoplifting [1 4 5 6]. Nevertheless, KL is thought to account for 5% of shoplifting in the U.S. [7], about $500 million annual loss. Its prevalence in the general population is very rare, at approximately 0.3-0.6%, but it's possible that it is underestimated because of the embarrassment resulting in KL, it is often kept secret and thus goes undiagnosed [4]. An interesting study of college students (n = 791) found that although 28.6% reported having stolen an item in his/her lifetime, only 0.4% met criteria for KL [8]. Although KL is frequently encountered in patients with psychiatric disorders, isolated KL is a relatively rare condition [9]. KL is experienced by a broad range of psychiatric patient populations including 3.7% of depressed patients (n = 107) [10], 3.8% of patients with alcohol dependence (n = 79) [11], 2.1% to 5% of individuals with Pathological Gambling [12 13], and 24% of those with bulimia [14].

Some health initiatives have highlighted the importance of understanding gender differences [15]. Females outnumber males at a ratio of 3:1 [1 4 5 6]. In clinical samples, approximately two-thirds of KL patients are women [7 16 17 18 4].

Other ICDs like PG are more common in men [19]. Men with PG are typically more likely than affected women to be young, single and living alone without children [20]. Whereas male gamblers report advertisements as eliciting urges to gamble, female gamblers more frequently report feelings of boredom or loneliness as triggers [17 21].

The pathophysiology of KL is unknown. Psychoanalytic theories link compulsive stealing to childhood trauma and neglectful or abusive parents and stealing may symbolize repossessing the losses of childhood [1 5]. KL has also been linked to psychosexual issues such as sexual repression and suppression [1 5].

KL may also be regarded as a form of addictive behaviour and has been shown to be associated with other substance use disorders (e.g., alcohol and nicotine) [22]. Naltrexone, an opiate antagonist used to treat addictive behaviours, has been shown to reduce KL symptoms [23-25]. Impulse control disorders can manifest as neuropsychiatric sequelae of head trauma and traumatic brain injury [26]. New onset KL has been reported in two cases of closed head trauma [27]. Brain disorders, such as epilepsy [28] and fronto-temporal dementia have been reported to cause KL.

KL is rarely brought to medical attention voluntarily. Patients usually present themselves for treatment by legal mandate due to repeated shoplifting. KL behaviour carries serious legal consequences: approximately 2 million Americans are charged with shoplifting annually [29]. If KL accounts for 5% of these, this translates into 100,000 arrests. Prior studies of clinical samples of individuals meeting criteria for KL have reported that 64-87% of individuals with KL have been arrested [7 16]. These same studies of clinical samples further indicate that 15-23% of individuals seeking treatment for KL have spent time in jail or prison as a result of shoplifting [7 30]. These high arrest and incarceration rates not only result in emotional distress, but also cause substantial financial costs to the economy and legal system [4]. While research has focused on how pathological gambling, another impulse control disorder with phenomenological links to KL [31], contributes to unlawful behavior [32 33], there has been limited research focusing on how KL relates to criminality.

Being ICDs very threatening, the assessment of social dangerousness once the individual enters the judicial circuit is frequent. In these cases, in order to assess the potential of recurrence, subjects undergo psychiatric evaluation. The question to the expert is to evaluate the risk of recurrence of the offender before the same is returned to the community. For this reason it is very important for the evaluator to have theoretical and practical references on the evaluation criteria of dangerousness and possible treatments in similar cases.

In order to elicit thought about these problem, we describe the interesting case of a subject that has numerous ICDs with KL as the disorder most recently manifested. The social dangerousness will be evaluated considering the evolution of the clinical symptomatology that, in this case, has increased in levels.

This paper aims to focus on the possible beneficial impacts of a targeted treatment strategy on social dangerousness for individuals affected by ICDs to avoid disorder features evolution and to lower the rate of recurrence of the offender.

Case report

The case is a 52 years old male, affected by compulsive behavior (cocaine abuse, PG, KL) from early adolescence. He came to our attention as a result of legal consequence for repeated theft.

Familiar case-history: father is a retired executive officer, described as shy and absent due to his tight working schedule. The patient has developed an almost obsessive competition towards the father, even considering the latter a figure of reference. Mother is an ex secretary, housewife at present, whom the patient defined as "perfect". He is the first born of three siblings. He excluded neuro-psychiatric disorders in his ancestors.

Physiological and pathological case-history: his psychosomatic growth was regular. Since he was 18 until about 40 years old, he regularly inhaled about 1-2 grams of cocaine a day, and then he passed to a sporadic use of the substance. In remote pathological case-history there emerge two previous car crashes, at 16 and 21 respectively, after which he suffered from cranial traumatisms with no relevant consequences. No hospitalizations and/or other kinds of pathologies were mentioned.
Educational and working case-history: at 19 he got a diploma in classical studies with the highest marks, and then at 29 he graduated in electronic engineering with mark 103/110. From 14 to 17 he played football in regional teams. From 29 to 32 he worked at the university. SG was then hired in an international company as manager. He resigned at 40 after about one and a half year of leave, concentrating on private practice.
Sentimental experiences: the patient reported he had been living with one woman for 6 years, and then with another (up to now) who had a 19 year-old son from a previous relationship, and with whom he has a 6 year-old daughter.
Psychiatric case-history: it started when he was about 18 with an impulse control disorder, inhaling 1-2 grams of cocaine every day. At 20, the patient started gambling, introduced by a friend, till it became a real obsession at about 28-29. He reported that gambling was not a pleasure, but an irresistible impulse. He could not bear waiting and wanted to know immediately whether he had won or lost, preferring the "mechanical" games (slot machines). The patient showed both compulsive disorders until he reached 40. Later, in 2001-2002, he suffered from depression for about two years. During this phase, he developed an attraction towards shoplifting, after noticing a woman who had put two chunks of cheese in her bag in a supermarket. In such occasion the patient remembers he felt a strong strain thinking about the risk that the woman had taken and about the humiliation she could have undergone if caught. In about a week's time he started shoplifting. His KL behavior changed over time: at the beginning, in fact, he preferred taking things of small value, big things that did not interest him and that he hid badly with the intent of being caught. If this did not happen, he went back to the place and got other objects until the guards or the clerks noticed him. Later though, he started choosing more valuable objects, often breaking the anti-theft badges with a tool. The patient voluntarily started psychotherapy and drug treatment in 1999 on a three days a week basis for two years. He got over his gambling compulsion in 2001.
On the contrary, the drugs prescription (Haloperidol 2 mg/die) gave scarce results on KL behaviour. In 2003, at the appearance of KL, he spent 4 months in a psychiatric clinic with no relevant results. At the same time he was treated by his psychologist and by a health care assistant of reference. At present, the patient is treated by a psychiatrist at public Mental Health Department and he stopped stealing (8 months without episodes). The same doctor told him, in case of compulsion, to write his emotional state in a diary describing the feeling. This helps the patient to understand the reasons that lead him in that direction and to acquire a wider awareness of his actions. Nevertheless, the patient reports about two episodes in which he stole some goods (a pair of shoes and two t-shirts), but that he then paid with no consequences after clarifying the issue with the sales manager. Currently he is taking anxyolitic treatment (Lorazepam, 2,5 mg x 3), antidepressant treatment (Amitriptyline, 30 mg in the morning and 40 mg in the evening) and antipsychotic treatment (Olanzapine, 10 mg). A MRI exam gave negative results for pathological any reports.
Judicial history: his first jail detention was in 2007 for six months, the last and most recent in 2012 for about 100 days. At present there are 27 proceedings against the patient.
Forensic-psychiatricevaluation: the patient underwent three different reports, the first two in 2008 in relation to aggravated theft of three chunks of Parmersan cheese and one chunk of ham, as well as escape from house arrest, and the third in 2010 for having stolen clothing items for a commercial value of 569,00 Euros. All the reports ended by recognizing the patient a mental semi-insanity and the acknowledgement of social dangerousness. This last aspect in particular was evaluated in two of the three reports, considering the reiteration of the offence probable in consideration of his clinical history. A therapeutic support was then suggested in a local Mental Health Centre, i.e. therapeutic community, with drugs and psychological treatment. In the third report, on the contrary, reference was made regarding internal and external predictability indicators, with possibility of a potential new feedback compliance to specific psycho-pharmacological treatment, carried out in a therapeutic community specialized for the treatment of obsessive-compulsive disorders.

Discussion

The case is an example of ICD in which behaviours have changed over time and were resistant to psychotherapy practiced; the patient was also treated with low doses of drugs. He has transitioned from substance abuse, to PG, and then to KL. These behaviours have produced familiar, economic and legal consequences for the subject who, especially since he began to manifest KL, was involved in many court cases, that led him to serve periods of restriction.

The history showed two previous cranial trauma, without apparent consequences to neuroimaging and neuropsychological function measured with neuropsychological tests. The assessment has therefore focused on the psychiatric profile. This showed the presence of mood swings, narcissistic traits of personality and obsessiveness.
The clinical picture seems to have developed very early in the life of the individual and seems to recall the OCD spectrum.
Kleptomania has been linked heuristically to three groups of disorders in efforts to explore potential treatment approaches: (1) the "affective" spectrum; (2) the "obsessive-compulsive" spectrum, and (3) the "impulse control" disorders. Hudson and Pope proposed the existence of "affective spectrum disorders" and asserted a relationship between mood disorders and kleptomania, OCD, eating disorders, and panic disorder [34 35 36]. A link between KL and affective disorders was supported by the high rate of comorbid affective disorders in KL patients. Joined by McElroy, these authors based their theory on: (1) phenomenological similarities, including harmful, dangerous, or pleasurable behaviours, impulsivity, and affective symptoms and dysregulation; (2) similar onset in adolescence or early adulthood and episodic and/or chronic course; (3) high comorbidity of KL and mood disorders, and similar comorbidity with other psychiatric disorders; (4) elevated familial rates of mood disorder; (5) possible abnormalities in central serotonergic and noradrenergic neurotransmission; and (6) response to mood stabilizers and antidepressants [36]. McElroy and colleagues [7 35 37] and Hollander and Wong [38] suggested that KL is associated to strong compulsive and impulsive features and hence should be considered as lying within the "obsessive-compulsive spectrum" along with pathological gambling, compulsive buying, pyromania, nail biting and trichotillomania.
According to this model, PG, KL and substance abuse share elements of both OCD spectrum and affective spectrum disorders, due to high comorbidity with mood disorders, to presence of compulsive and impulsive features, to relief from depression or manic symptoms, after stealing. In particular, KL and PG share typical features, such as repetitive or compulsive engagement in a behaviour despite adverse consequences, diminished control over the problematic behaviour, an appetitive urge or craving state before engagement in the problematic behaviour, and hedonic quality during the performance of the problematic behaviour.
Pharmacologically, the patient was treated with antipsychotics, antidepressants and anxiolytics in low doses. No specific treatment for compulsive spectrum appears to have been practiced. Because KL is as a form of Disruptive, Impulse-Control, and Conduct Disorder, so far evidence suggests that the initial pharmacological treatment should be with serotonin-enhancers such as selective serotonin reuptake inhibitors (SSRIs). Among these, some case reports suggest the use of Fluoxetine, Paroxetine and Fluvoxamine [7 39 40 41]. Subsequent studies, however, did not confirm the adequacy of such therapeutic agents, but rather they put out their unsuitability as, paradoxically, themselves activating kleptomanic behaviour. Others studies suggest that lithium, valproate and topiramate can have good results in the treatment of KL [42 43]. Also, the use of opioid antagonists (naltrexone) gave good results, because of the possible relationship between KL and addictive disorders [44].
The patient was treated with a course of Freudian analysis. Nevertheless, only cognitive behavioural therapy (CBT) has shown to be effective for KL [45 46] and PG [47]. Relying on the feelings of guilt, shame and helplessness experienced by the patient, cognitive behavioural therapy can help the patient to learn to relax, cope with stress, combat negative thoughts and prevent harmful behaviours. The CBT treatment for many ICDs is often composed of steps particularly focused on stress reduction skills and emotion regulation and distress tolerance skills [48]. In addition the patient could find support with other people who are trying to control impulsive behaviours (for example Gamblers Anonymous) [49].
For what concerns legal medicine issues, there are interesting implications for the social dangerousness and, therefore, the opportunity to choose the specific safety measures. The assessment of social dangerousness must also take into account the dynamic and evolutionary characteristic of the disorder. In the present case, in fact, the disease originated as substance abuse, transformed into PG and after into KL. This suggests possible further development towards forms at greater risk (e.g. pyromania).
It must be noted that, at the moment, drug treatment and therapeutic result are not suitable for a satisfying management of the "symptoms" of the subject.
It must be also added the fact that the risk assessment can't be based only on the consideration of individual psychopathological features, but it must also take into account social, environmental and cultural contexts in which the subject is inserted, potentially influencing the imbalanced behavioural, the lack of a specific and valid treatment by the psychiatric services and the availability of valid replacement or alternative solutions.
Based on these considerations a severe social dangerousness may be not recognized in the case subject, despite the objective risk he can repeat preceding illegal conducts and he reported to have tried two other thefts in recent months.

Conclusions

The case suggests the necessity of targeted therapy

in KL, in order to contain the evolution of symptoms in other forms of ICDs. If KL is conceptualized as belonging to OCD spectrum disorders, then it would be logical to treat patients using the same psychopharmacological regimens that are known to be effective for OCD. Both KL and PG patients may benefit from the wealth of treatment options now available for mixed affective and obsessive states, based on the association of agents of different pharmacological classes, such as antidepressants (mostly SSRIs), antipsychotics, mood stabilizers. The findings highlight the need for effective interventions within correctional settings and the importance of clinical interfacing with components of the legal system in the care of patients with ICDs. Hence the need to implement specific measures aimed at the rehabilitation of the subject and the recovery of his mental and social behavioural functions.

Conflict of interest

None.

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