PATHOLOGICAL STEALING IN LEARNING DISABILITY – A DIAGNOSTIC CHALLENGE?

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ABSTRACT

We would like to present a case of a man who we believe suffers from Pathological Stealing and discuss the inherent challenges in making such a diagnosis as well as the complexities in managing him.

Key Words: Pathological Stealing, Learning Disability

INTRODUCTION

Kleptomania is an irresistible urge to steal items of trivial value. The International Classification of Diseases (ICD-10) F63.2 defines Pathological Stealing (Kleptomania) as:-

A disorder characterized by repeated failure to resist impulses to steal objects that are not acquired for personal use or monetary gain. The objects may instead be discarded, given away, or hoarded. This behaviour is usually accompanied by an increasing sense of tension before, and a sense of gratification during and immediately after, the act. In Essence-People with this disorder are compelled to steal things of little value, such as pens, paper clips, paper and tape.

The cause of kleptomania is not known. Several theories suggest that changes in the brain may be at the root of kleptomania. Kleptomania may be linked to problems with a naturally occurring brain chemical (neurotransmitter) called serotonin. It may also be related to addictive disorders as stealing results in the release of dopamine (another neurotransmitter) which causes pleasurable feelings and some people seek this reward feeling out repeatedly. Further research is however needed to better understand the cause of kleptomania[1,2].

Therapy is usually directed towards impulse control as well as any accompanying mental disorders. Relapse prevention strategies for clear understanding of specific triggers should be used. Treatment may include psychotherapy, such as cognitive behavioural therapy (CBT). Recent studies have indicated that Fluoxetine and Naltrexone may be useful[3].

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CASE HISTORY

Mr X is a 34 year old Caucasian male with (F71.1) Moderate learning Disability with significant Impairment of Behaviour. He was initially diagnosed with (F20.0) Schizophrenia but this diagnosis was reviewed and subsequently revised to (F25.9) Schizoaffective Disorder. He has also been recently diagnosed as suffering from (F63.2) Pathological Stealing (Kleptomania).

At the time of writing, Mr. X has had 4 admissions to acute psychiatric care over the past 7 months. The first (Nov 2011) was under a 72 hour detention where he presented as increasingly paranoid, agitated and aggressive, believing that people were stealing from him. He was also noted to be carrying a knife, stealing from a local takeaway and raiding his neighbours' bins. He was subsequently place under a 28 day detention certificate following the expiry of the 72 hour detention. His mental state then improved and he was discharged on the 28/12/11.

He was readmitted to hospital on the 10/02/12 under a 28 day detention certificate after presenting with a 6 week history of paranoid delusions which were persecutory in nature, i.e. he believed that his neighbours were watching him and stealing from him. He broke into neighbour's car to steal a CD and when his neighbour confronted him with this, he accused the neighbour of stealing from him. He was found to be sleeping with a knife under his bed and threatened to attack anyone who confronted him. He had no insight and refused hospital admission and medication. He refused to believe he was mentally unwell and claimed to be possessed by other entities. He responded well to treatment and was discharged informally on the 06/03/12. He was however readmitted under a Short term detention certificate (28 day order) on the 27/03/12. He was brought in under police escort with a 2 week history of non-compliance with medication; he appeared to lack insight and refused to let carers into his home. His home was filled with stolen items taken from the local takeaway shops, neighbours bins and gardens.

He then very quickly settled in the ward and was discharged home with additional night time support but this proved futile as he was readmitted 7 days later with a similar presentation as his last admission. He was pre-

scribed Depakote 500mg bd, Simvastatin 40mg nocte, Aripiprazole 30mg mane, Levothyroxine 100mcg and Metformin 500mg bd. Mr X smokes 10 to 20 cigarettes a day.

He is a social drinker and has not used any illicit substances. He has never been charged or convicted of any offences. Mr X lives in his own tenancy. He receives support in the form of carers going into his own home 6 hours a day, 5 days a week.

DISCUSSION

Mr X is a 34 year old man with moderate learning disability and schizoaffective disorder. He lives in his own tenancy with support however has been admitted to our service on 4 occasions in the past year due to concerns about his nocturnal stealing, non compliance with medication, behavioural difficulties, vulnerability and psychosis. His taking of items includes; used oil drums, rubbish from neighbour's bins, out of date food, cups, toilet roll and more recently a CD from a neighbour's car. He clearly has an abnormal drive to steal but denies doing so. He is not able to express having an uncontrollable urge to steal nor does he admit to trying to resist the urge. He denies a release of built up tension or experiencing pleasure or gratification on stealing.

Mr X's behaviour can be described as pathological due to the impact that it has on the community, the risks that he places himself under and his inability to sustain community living because of it. However because he denies stealing, having an abnormal urge or having to resist the impulse to steal as well as receiving gratification or pleasure from it, makes it difficult for him to fulfil the ICD10 diagnostic criteria. We believe this presents inherent challenges that are common to individuals with learning disabilities due to their limited communication skills, which can lead to deficits in their ability to describe their internal world and experiences.

Nonetheless this diagnostic category best met Mr X's presentation, in addition to his other disorders; however we have to concede that he does not meet the full criteria as outlined in the ICD10.

Despite making the diagnosis and literature suggesting pharmaceutical options as well as psychological therapies, Mr X's case again proves challenging as he had a hypomanic episode on Selective Serotonin Reuptake Inhibitor (SSRI) medication and a trial of this class of drug would therefore present its own inherent risks. In relation to psychological therapies our colleagues in Psychology felt that CBT was not an option due to Mr X's denial of his symptoms and also his diminished cognitive ability to apply concepts that could be used to manage his thinking and behaviour. This together with his lack of motivation to change as well as lack of insight makes CBT an unsuitable option.

We have also considered behavioural options but these are unlikely to be successful considering that being admitted to hospital on 4 occasions has not resulted in any change to his behaviour. Again his lack of understanding and insight into how his behaviour puts him at risk causes concerns to others and merits readmission to hospital seems to be beyond his understanding.

It would be important to highlight that Mr X is on an antipsychotic at maximum dose and has been on previous antipsychotics with no change to this behaviour. He is also on a mood stabiliser and as previously stated has tried SSRI medication which precipitated a hypomanic episode. There have been reports in the literature of the use of Naltrexone and this maybe a viable next step for him.

We feel that further research is needed of this condition in people with a learning disability particularly focussing on treatment strategies.

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