CASE REPORT

Fluoxetine-induced Kleptomania in a Patient with Depressive Disorder: A Case Report

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Abstract

Kleptomania is a disorder wherein the individual has an irresistible urge/impulse to steal things that are usually not of monetary value. Selective serotonin receptor inhibitors (SSRIs) are usually the first-line treatment of depressive disorders. Reports of depressed patients experiencing symptoms of kleptomania after administration of SSRI have been few. Here we present such a case of a female patient who exhibited symptoms of kleptomania following treatment with fluoxetine, an SSRI.

Keywords: Depression, Kleptomania, Selective serotonin receptor inhibitors.

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Background

Kleptomania is a disorder wherein the individual has an irresistible urge/impulse to steal things that are usually not of monetary value.[1] The overall prevalence of kleptomania is 0.6%, and the female to male ratio is estimated at 3:1.[2] Various studies have suggested the possibility of a link between kleptomania and mood disorders, especially depression.[3,4]

The selective serotonin receptor inhibitors (SSRIs) are usually the first-line treatment of depressive disorders. Research has shown that depressed patients experience symptoms of kleptomania during treatment with SSRIs.[5,6] As there are only few case reports of kleptomania treated with SSRIs, we present a case of depressive disorder who exhibited symptoms of emergent kleptomania during treatment with fluoxetine.

Case Description

We describe the case of a 40-year-old, married female hailing from Cuddalore, India, who presented to us with a new onset of behavior characterized by sudden urge to stealing things from provisional stores, appliance, and jewelry shops for the past 3 months. She gets the uncontrollable urge to steal and experience anxiety on attempting to suppress/control this urge. She would often take small items from the provisional stores. After performing the act of stealing, her anxiety would get relieved. However, she started feeling guilty about these acts of stealing and would keep it with herself, even though she never used them. She also felt an increased anxiety of being caught by shopkeepers or security guards. She was aware of her problem and tried to control it but was unable to do so. For the past 1 year she complained of low mood, easy fatigability, and decreased sleep and appetite. She was diagnosed as a case of depressive disorder by a psychiatrist and was on tablet fluoxetine 20 µg/day initially, which was hiked to 40 mg/day 4 months ago. No history of any other obsessive symptoms such as repeated cleaning, checking, or arranging things. No history of any psychotic symptoms such as delusions or hallucinations. No past history or family history of medical illnesses or substance use. On examination, she was conscious and oriented to time, place, and person. Her mood and affect were depressed and thought content revealed feelings of guilt and worthlessness, along with obsessive urge to steal things. No delusions/suicidal thoughts/perceptual abnormalities were elicited. She had no cognitive deficits and her grade of insight was 2. Depression rating was scored using Hamilton Depression Rating Scale and she had a score of 26 (very severe depression).

In view of the atypical emerging symptoms, she was admitted and investigations were done. Neuroimaging (computed tomography brain) was done and it was found to be normal.

Based on the history and findings, she was diagnosed as a case of kleptomania (probably drug induced) and major depressive disorder [according to Diagnostic and Statistical Manual of Mental Disorders – Fifth edition (DSM-5)].[1] Psychotherapy was initiated and tab fluoxetine was withheld. She was given tab imipramine 50 µg/day to control her depressive symptoms, which was later hiked to 75 µg/day, and she was discharged. Total resolution of urge to steal was observed in the next 2 weeks and her mood symptoms also improved. After discharge, she did not indulge in any shoplifting after visiting provisional stores in her hometown. During her review after a month, the Hamilton depression rating scale score was 6 (normal). She has been on regular monthly follow-up for 10 months. She is doing well and no further emergence of kleptomania symptoms was reported.

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Discussion

Literature review showed very few published reports on depressed patients experiencing symptoms of kleptomania during treatment with SSRIs. An article by Kindler et al., reported three patients with depression who developed kleptomania symptoms after starting treatment with SSRIs.[5] A recent Indian article has reported a patient with obsessive compulsive disorder, who developed symptoms of kleptomania while on fluvoxamine 100 µg/day.[6]

Kleptomania is a known side effect in patients treated with dopamine agonists for Parkinsonism, indicating a possible role of dopamine in impulse control disorders.[7] The SSRIs are known to have an action on the dopaminergic pathways through 5-hydroxy tryptamine 2C (5HT2C) receptor action. The 5HT2C receptors possess a unique ability to tonically regulate dopamine release from all three major pathways.[8] On the contrary, SSRIs are preferred treatment option for kleptomania.[9] Treatment with SSRIs can cause dopamine release at the initial phase, which can sensitize dopamine receptors which in turn can cause kleptomaniac symptoms. Alternatively, SSRIs alleviate symptoms of kleptomania via dopaminergic modulation rather than its action on serotonin.[8] Thus, there is a complex interplay between serotonin and dopamine in relation to kleptomaniac symptoms.

Conclusion

The present case report further emphasizes that symptoms of kleptomania may emerge from administration of SSRIs. These rare side effects of SSRIs are to be kept in mind while treating depressive disorders with this group of drugs. Moreover, the kleptomania symptoms can be embarrassing for the patient in a social situation. More research is required to establish the association between SSRI administration and kleptomania.

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