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Debate

Mental Competency of Kleptomania

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Abstract

In recent years, the courts have occasionally questioned the mental competency of repeat offenders with kleptomania. In such cases, essentially lawyers, rather than psychiatrists, take the lead role in determining the individual's mental competency. However, the most important evidence that lawyers can obtain is from psychiatrists, who can evaluate the accused and provide expert opinion in court. Here, mental competency in cases of kleptomania is discussed from the viewpoint of forensic psychiatry. First, the author points out that the concept itself is an ideal type and then presents a typical case of kleptomania based on the diagnostic criteria of kleptomania in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition. The scope of kleptomania is shown to be wider in medical practice than in legal practice and therefore the diagnostic criteria of kleptomania should be applied more rigorously in the courts in cases of habitual theft. The author concludes by discussing judicial judgements of mental competency and extenuation in cases of kleptomania.

Keywords：kleptomania, mental competency, extenuation, ideal type, forensic psychiatry

1.Introduction

In recent years, the courts have questioned the mental competency of repeat offenders with kleptomania. Although expert medical evaluation of mental competency in kleptomania is rarely conducted, lawyers make a show of questioning mental competency with written arguments and expert testimony. Precisely because mental competency in kleptomania has almost never been questioned, the courts are often thrown into confusion over these legal decisions. As a medical examiner for the Tokyo District Public Prosecutors Office, the author is frequently asked for an opinion on these written arguments. Although psychiatrists are expected not to comment directly in public on mental competency in court cases, their opinions are often sought in practice. Regardless, expert opinions from psychiatrists are the most important information for lawyers in such cases. As a psychiatrist engaged in evaluations, the author would like to take this opportunity to state their opinions on mental competency in kleptomania.

2. The concept of kleptomania

2-1.Kleptomania is an ideal type

Alongside many other psychiatric disorders, kleptomania does not correspond to a disease entity in physical medicine but does correspond to an ideal type in sociology6). A diagnosis of kleptomania is nothing more than a convention of using that term to refer to a condition that meets a certain number of characteristic features included in diagnostic criteria. Even the term “diagnosis” is not accurate, as a physical foundation common to this diagnosis has not been found (although some mechanism in the brain is presumed to exist, it is obviously not a standard that can be used in diagnosis). Even though some people are diagnosed with kleptomania, this does not necessarily prove that a disease called kleptomania in fact exists.

Kleptomania, pyromania, and a series of other impulse control disorders are considered “mental disorders that are not diseases” in German psychiatry classifications (the forensic psychiatric framework will be discussed later). In regard to mental disorders such as kleptomania and antisocial personality disorder in which a criminal act itself is defined as a characteristic, people with these characteristics are merely labeled by their diagnoses; these mental disorders do not constitute mental illness (i.e., they are not mental disorders that are diseases). It is

important to note that questions about "the presence and severity of the mental disorder that affected the criminal act" and "the mechanism of the crime", for which answers are frequently sought in expert evidence, lose their meaning when asked about this group of impulse control disorders. Attempting to answer these questions leads to a circular argument that goes, "The defendant has kleptomania, kleptomania is a disorder in the control of the impulse to steal, and therefore it greatly affected the crime" or "The crime stemmed from an impulse control disorder caused by kleptomania." Lawyers should be fully aware of this point.

Historically, mental competency evaluation for this group of mental disorders has conventionally considered there is full mental competency. The introduction of the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) cautions, "Even when diminished control over one's behavior is a feature of the disorder, having the diagnosis in itself does not demonstrate that a particular individual is (or was) unable to control his or her behavior at a particular time"1). While this statement is likely about impulse control disorders, merely meeting the diagnostic criteria for kleptomania does not enable an immediate conclusion to be drawn about mental competency. Incidentally, even in cases of schizophrenia and other "mental disorders that are diseases", the current overall trend in mental competency evaluation is not to directly link the diagnosis with mental competency but instead states that the degree to which decision-making by the full self was inhibited at the time of the crime must be examined carefully according to the mental disorder in question. The same is true of kleptomania and other impulse control disorders. In written arguments, lawyers often stress that a diagnosis of kleptomania equals limited mental competency, but this assertion does not consider the above.

2-2. The ideal type from the perspective of the DSM–5 diagnostic criteria

The definition of kleptomania has not changed much since DSM-III (1980). DSM-5 (2013) defines kleptomania according to the following diagnostic criteria2) (underline added by the author).

A. Recurrent failure to resist impulses to steal objects even though the items are not needed for personal use or for their monetary value.

B. Increasing sense of tension immediately before committing the theft.

C. Pressure, gratification, or relief at the time of committing the theft.

D. The stealing is not committed to

express anger or vengeance and is not in response to a delusion or a hallucination. E. The stealing is not better explained by conduct disorder, a manic episode, or antisocial personality disorder.

In addition to explaining diagnostic criteria A through D (E is an exclusion criterion), let us describe (what the author considers to be) the prototype of kleptomania (or perhaps classic kleptomania). Below, we cover the points that should be asked about in an evaluation to diagnose kleptomania.

Criterion A is particularly important as it was prepared to distinguish kleptomania from typical theft (hereafter, recurrent theft that differs from kleptomania will be referred to as "habitual theft"). The first point of note is it involves "recurrent failure to resist impulses to steal objects" and not a recurrent impulse to steal objects themselves. The frequency of the theft impulse itself is irrelevant and need not be high. What recurs is the failure to resist impulses to steal. Confirming this requires asking, "What did you do and how hard did you try not to steal or not to go through with shoplifting (i.e., did you resist)?" It is an impulse and, by definition, arises suddenly. In addition, people with kleptomania understand well that what they are doing is wrong and that it is a senseless act that does not benefit them whatsoever. When they are arrested, they experience a loss of social standing firsthand. This is precisely why rational nature tries to resist the impulse to steal. Vigilance in daily life is an extension of this attempt by rational nature to resist impulses. Before the impulse to steal arises, people with kleptomania do what they can and remain vigilant so that they do not act on their impulse to steal when it arises or prevent the impulse from arising in the first place. For example, when they go out, they avoid being alone as much as possible, avoid taking a bag or purse, or wear clothing in which they cannot hide objects. Even then, they are unable to resist the impulse and end up stealing. That is criterion A. In prototypical kleptomania, people are unprepared before stealing and so are often detected. During the theft, they do not pay sufficient attention to their surroundings (the possibility of being arrested). In a particular case of kleptomania that the author diagnosed, the impulse to steal happened only infrequently (a few times a year), but being unable to resist completely, the person ended up stealing, and was detected and arrested almost every time. The rate of successful thefts may serve as an indicator of the severity of the kleptomania. Although there are issues with how to assess the success rate and what would serve as an object of comparison, it would be inversely

proportional to severity. Successful theft requires proper assessment of situations and control of impulses (if the success rate is too high, kleptomania is an unlikely explanation to begin with). The second point of note in criterion A is that the stolen objects are not needed for personal use or their monetary value. In kleptomania, gratification comes from the act of stealing itself; the stolen objects are meaningless in prototypical cases. In interviews, people with kleptomania are asked the following questions: "Are you selective about what you steal? If so, why do you steal what you steal?" "Do you have any personal use for the items you steal?" and "How much do you care about the items you steal?" In kleptomania, items are not stolen to be used, so they are thrown away, quietly returned, or stored away. Since items are not stolen for personal use, the types of items stolen typically vary greatly. Any item can be a target, and the person who steals it has no interest in it. It is not uncommon for patients with eating disorders (particularly bulimia) to also engage in theft, but they are typically drawn to foods to use in their binging. Criterion A excludes cases such as these. However, whether the stolen items are needed for personal use is often difficult to judge in practice. The author constantly encounters cases of habitual theft, in which people try to avoid or reduce criminal punishment (out of self-protection) by emphasizing that the stolen items were not needed for personal use or their monetary value or that they had no interest in the items. Even if that is not in fact the case, it is impossible to prove that none of the stolen items were for personal use. On the other hand, it is unlikely that all items stolen in habitual theft are for personal use or to be sold. Some items are surely discarded. Evaluating whether criterion A is met depends on whether the evaluation emphasizes that the items were stolen for personal use or were not used.

Criteria B and C should be viewed as inseparable aspects of a stream of events that are specific to kleptomania and not observed in typical theft. This is also why kleptomania is classified as an impulse control disorder. As with criterion A, people take great care in daily life to avoid stealing, but the impulse to steal is unpredictable and sudden. The impulse is usually triggered by being in a situation that enables theft, such as entering a store alone. People attempt to suppress the impulse with their rational nature, but the impulse becomes too great to suppress. Here, it becomes a battle between the impulse to steal, which seeks to carry out the theft, and rational nature, which seeks not to carry out the theft9). People must want, as soon as

possible, to be free of (to end) this unique heightened tension that arises immediately before the act. The moment that the impulse to steal wins the battle, the theft is carried out in a single stroke (without any consideration). During the theft, they experience an incredibly powerful sense of pleasure and a sense of relief from the rapid decrease in heightened tension. This stream of emotions that culminates in relief from tension constitutes a single set. This set arises in a short, densely packed amount of time immediately before and during the crime. Criterion C contains the words "pleasure" and "gratification", which the author understands as being similar to heightened sexual desire and the relief yielded by sex acts. Once the theft is carried out, the tension is immediately released and the pleasure does not last long. Instead, as if places have been switched, what manifests is the working of rational nature, the losing side. What is felt here is the guilt of having stolen again and the fear of being arrested if found out. This is completely different from the sense of tension before typical theft (taking care not to be discovered) and the relief of not being discovered (relief regarding the outcome). This difference must be confirmed in interviews. The difference with habitual theft can be clearly seen from the answers to the following questions: "What did you feel just before the theft?" "People would normally feel nervous before stealing, wondering if they could pull it off, and feel relieved afterwards if they weren't discovered. Did you feel like this, or did you feel something completely different?" "When do you feel relief from the tension? Is it just after the theft, or is it the relief of not having been discovered?"

Criterion D states that theft is not committed to express anger or vengeance and it is not in response to a delusion or a hallucination. While criterion A clearly states that the stolen objects are not stolen for their own sake, criterion D clearly states that the stealing is not in response to something or for any particular purpose. In cases like these, people sometime steal as an adolescent rite of passage (a dare) or as vengeance or the release of a grudge (e.g., against one's parents). In other cases, stealing may be an act of self-destruction. Kleptomania is different from these cases. The essence of kleptomania is that the impulse to steal and the act of stealing are not secondary but primary occurrences. This is precisely why the act of stealing is senseless. Questions must be asked from all angles, such as whether the theft served any purpose. Another question to ask is, "Does the stealing have any meaning to you or not? If it does, what meaning does it have?" In

prototypical cases, people will say "I don't know" or "It has no meaning", or they may give some contrived reason. On the other hand, many people who are arrested for habitual theft or other instances of theft (some of whom have amnesia) may also respond "I don't know." This response on its own means only that the true motive is unclear and does not meet criterion D. Whether this criterion is met in a particular case should be judged carefully with a view of the overall picture.

Prototypical cases of kleptomania, such as those described above, are extremely rare. The author has over 20 years of experience conducting pre-indictment simple psychiatric diagnostic evaluations for the Tokyo District Public Prosecutors Office. Despite conducting over 1,000 evaluations, he has made a diagnosis of kleptomania only a handful of times. Very few cases meet all of four diagnostic criteria. Indeed, medical professionals often say that almost no patients strictly meet the criteria12). The differences between cases of prototypical kleptomania and habitual theft may seem obvious, but while very few of the countless cases of shoplifting meet all four criteria for kleptomania, a fair few cases do meet some of the criteria. Although some assert that the line between kleptomania and habitual theft is not necessarily clear11), this is obvious if the concept of kleptomania is considered to be the ideal type. Rather than stating whether someone has kleptomania or not, all that can be said is the degree to which they have the characteristic features of kleptomania. Although this is the correct understanding, the distinction between kleptomania and habitual theft is not at all meaningless. How meaningful this distinction is depends on the situation in which the diagnosis is made.

2-3.The applicable scope of kleptomania in medicine and law

In medical practice in Japan, kleptomania is often diagnosed as comorbid with eating disorders (theft including food). Some medical professionals consider this to be a core group12). Here, there is no attempt to strictly apply criterion A. It is an eating disorder; therefore, if the stolen items include anything other than food, or if the food is stored away rather than eaten, these behaviors are interpreted as not being for personal use and are considered to meet criterion A of the definition of kleptomania. Furthermore, "recurrent failure to resist impulses to steal objects" is often read simply as "recurrent desire to steal". The presumption is that people are troubled by their impulses and naturally try to resist them; "failure to resist" is simply interpreted as being proven by the fact

of repeated arrests or committing crimes during probation. Worrying about being arrested and being on probation are not directly related to criterion A—what happens when people are put in that situation is crucial to judging criterion A. First, it is important to consider how they tried to resist the impulse to steal; recurrent failure to resist this impulse regardless of their attempts to resist is what satisfies criterion A. Criteria B and C are not viewed as two inseparable aspects of a single stream; instead, criterion B is considered a completely normal sense of heightened tension associated with the act of theft. This sense of tension is not relieved during the theft but only when far removed from the scene of the crime. Criterion C is reinterpreted as the relief of not being caught, the sense of accomplishment about a successful theft, or the sense of superiority of having gotten the better of someone. This feeling is a sense of relief and accomplishment about an outcome and would not arise in the case they were arrested (these feelings depend on the outcome of the theft and do not arise from the act of stealing itself). It is not the pleasure that comes from being released from impulse-born tension in one stroke that is peculiar to kleptomania. As for criterion D, patients with eating disorders often speak of the personal meaning of recurrent theft. In many cases, they steal to spite or trouble their parents or as an act of self-destruction born out of deep self-loathing.

Theft that accompanies eating disorders, and particularly bulimia, has long been a major problem in clinical practice. Essentially, it should be considered appropriate to attach "with theft" as a subgroup of, or an addition to, eating disorders and distinguish this theft from kleptomania, but theft accompanying eating disorders is currently not treated this way. In this case, recurrent theft observed in patients with eating disorders has to be viewed somewhat inevitably as approaching kleptomania. This viewpoint could be said to have quickly drawn attention to kleptomania in Japan. Patients shoplift food over and over and are arrested countless times. In medical practice, diagnostic criteria are applied to such patients loosely, and treatment proceeds with the diagnosis of kleptomania co-occurring with the eating disorder. The author does not oppose this expansion of the concept of kleptomania, which has become normal in medical practice, but rather considers it inevitable. Hereafter, we will signal this expanded concept of "kleptomania" using quotation marks to distinguish it from the original strict diagnosis. This expanded concept, of course, also includes the narrow definition of

kleptomania.

Expanding the concept of "kleptomania" does not pose any major problems. Habitual thieves, who never reflect on their acts and never change, do not show up in medical practice, and medicine is not the field for deciding whether to impose criminal punishment. This concept is used simply because it is useful in treatment, and it plays an important role as the ideal type of kleptomania6). Although facilities dedicated to treating addiction should include the narrow definition of kleptomania, the majority of them deal with "kleptomania", and a large percentage of patients to which it is applied are patients with eating disorders. As long as the concept of kleptomania does not exist in the real world but rather only as an ideal type, it may not be worth arguing whether strict diagnostic criteria are met if "kleptomania" is useful for treating patients. What matters is which diagnostic criteria are applied and how strictly they are applied in accordance with the situation and in the context in which "kleptomania" is used.

In the legal field, unlike in medical practice, these criteria must be applied strictly. "Kleptomania" is used in medicine but must have no place in law because the legal field is not concerned with treatment but instead must decide whether to impose criminal punishment or not. Kleptomania was originally conceptualized not for medicine but for law (the concept of monomania, as discussed later). The reason for the lack of major changes to the strict diagnostic criteria for kleptomania since 1980, when the DSM-III was published, is that relaxing the criteria even slightly would blur the distinction and boundary with habitual theft. In law, the people for whom the distinction with kleptomania matters most are criminals who do not show up in medical practice, who engage in theft habitually, and who never change their behavior. The diagnostic criteria for kleptomania were made with this distinction front and center.

How should the legal field deal with the problem of theft in patients with eating disorders? If viewed from the perspective of attending physicians and the patients themselves, it is easy to understand their concern that a guilty verdict risks delaying their return to society. If patients are found guilty, what little self-worth they have would erode further. One can easily understand the desire to hope that treatment may alleviate the problem. Therapeutically speaking, it is quite easy to understand the patient and those around them emphasizing "kleptomania", which poses a major quandary legally. The author has always felt that the most reasonable

solution may be to understand this not as a problem of mental competency but as a problem of extenuation. The decision to reduce a sentence is sometimes reached not only from the viewpoint of mental competency but also from that of extenuation. Let's discuss the issue of mental competency in kleptomania next.

3. Mental competency

This section refers to and cites "Psychological Evaluation and Judgment" by Muramatsu and Uemura8). Kleptomania has historically been included in monomania, or extreme enthusiasm or zeal for a subject or idea in an otherwise sound mind. Known examples of monomania include theft, fraud, arson, counterfeiting, and murder. Historical legal views of monomania are as follows8) (underline added by the author).

a. Monomania is usually nothing more than criminal desire that has intensified to become so dominant that it cannot be restrained by the wholeness of the soul.
b. The degree to which such a disorder exists, the degree to which so-called monomania is not resistible, and the degree to which decision-making by the full self is eliminated are matters of fact.
c. In practice, monomania is not considered cause for legal discharge, but this is just.

Although these are historical views, these basic principles do not need to be greatly changed today, with no particular circumstances that require such changes. We must be especially careful about any kind of legal discharge in the case of mental disorders that are defined in terms of criminal acts. Although monomania is called impulse control disorder today, pathological arson (pyromania) is included in the same group, and we cannot overlook that lust murder was also once included here. Diagnostic criteria B and C in kleptomania, which are characteristic of kleptomania, are also listed for pyromania. As such, kleptomania and pyromania are grouped together as a single type of impulse control disorder, namely, habit and impulse disorders. Given this background, the author agrees with not considering monomania as cause for legal discharge in practice. Although coming from a different perspective, Takemura, who stresses "kleptomania", is of the same opinion12). "Kleptomania" should be treated in principle as full mental competency and, fundamentally, the presence of extenuating circumstances should be examined (see the following section for details).

Still, some may ask critically why a

diagnosis of kleptomania alone implies full mental competency. If mental competency in people diagnosed with kleptomania is to be debated, it would theoretically be valid to think as follows. Within the German forensic psychological framework of the four categories of mental disorders—pathological mental disorders, profound consciousness disturbance, mental deficiency, and other severe mental abnormalities—kleptomania, like personality disorders, is classified under "other severe mental abnormalities"10). "Other mental abnormalities" refers to mental disorders that are not diseases and is viewed as quantitative deviations for which there is no clear boundary with a normal mental state. This is why competency emerges (i.e., mental competency is present). For this group, "mild" abnormalities are beside the question; level of competency needs to be judged only in "severe" cases. Normative severity (not the same as medical severity)—in other words, the indicator for judging the degree of competency to be tried (complete or limited)—is demonstrated in the previously stated underlined historical view. This is a matter of fact and therefore should be judged subjectively by lawyers and no one else. However, to provide an advisory opinion as a psychiatrist, the author feels that when someone is diagnosed with "kleptomania", the following must be examined closely. As stated previously, because kleptomania is a mental disorder defined by a criminal act, the bar must be set quite high in legal practice.

1) Are the diagnostic criteria for the narrow definition of kleptomania indisputably met?
2) How careful is the person to resist the impulse to steal in their daily life?
3) How frequently does the person steal, and at what rate do they succeed?
4) How prepared, calculated, and purposeful is the person in regard to the crime?
5) Does the person have deep remorse and guilt about the act rather than regret about the outcome (i.e., wishing they had not been caught)? Do those feelings manifest not only through a confession but through actions?

The purpose of point 1) is to confirm that the person does not have "kleptomania" that is loosely used in medical practice but rather kleptomania according to the narrow definition. "Kleptomania", which is not the same as kleptomania, is beside the question. Furthermore, since kleptomania must be proven to be "severe", the following conditions are added. Point 2) potentially confirms that the person has difficulty controlling impulses to steal regardless of whether

they take sufficient care in daily life to avoid stealing. The declaration "I was careful not to steal" is insufficient here, and the only reliable basis for evaluation is specific actions and rituals carried out in daily life. Point 3) does not involve citing specific figures, but instead a high theft success rate indirectly demonstrates that the person does not resist the impulse to steal in daily life and that they pay sufficient attention to their surroundings during the crime. The lower the theft success rate, the more comprehensively it shows a major problem with impulse control. The success rate is more important than the frequency of theft, but a particularly high frequency may indicate that the person will not resist the impulse to steal in the first place. Assessing the frequency and success rate of theft involves the problem of uncertainty about how much the person's self-reporting can be believed. Point 4) seeks to determine whether the crime involved a planning stage and how carefully the crime was executed. A higher degree of care in planning and execution demonstrates a higher level of decision-making by the self. This aspect should be absent in "severe" cases of kleptomania. Point 5) assesses the presence of the rational nature that lost its battle with the impulse to steal. A more prominent contrast between an extremely high level of reasoning and an even greater impulse to steal probably indicates limited competency. The author feels that these are the five points that should be considered when evaluating mental competency in kleptomania. Arguing for a limited degree of competency requires that all of these points be met. The author has not yet experienced any such cases and cannot say how many cases there are, but feels that there are almost none. From this viewpoint, the principle of not considering kleptomania cause for legal discharge is correct.

4. The problem of extenuation

Although judgments about extenuation, like mental competency, are left for the legal field to decide, the author would like to state the opinion of the medical side, which engages in treatment. Here, the focus will be on "kleptomania". Did the theft have a purpose? If it did have a discernible purpose, did it involve the object stolen or the act of theft itself? While these questions also concern the diagnostic criteria for determining whether the person has kleptomania, this question is difficult to assess (as described above), ultimately leading to debate about how much the concept of kleptomania can be expanded. Regardless of whether the purpose of the theft was the object stolen or something psychological, the personal meaning of the purpose must

be evaluated in a social context. For example, in some cases where recurrent theft with a grudge against the world gives people a sense of superiority, they have a warped view of society stemming from factors such as an unhappy upbringing (abusive parents), difficult living environment (economic hardship or spousal abuse), betrayal by someone close, or recurrent failures in employment. While the act of theft itself should be condemned, society that has created the warped impulses behind the crime should also take some of the blame.

Extenuating circumstances are likely to exist for patients undergoing treatment at medical institutions. It is necessary to prove that the rational side of their personality is dominant or that they are trying to quit stealing however they can. What must be noted here is that some people enter medical institutions merely in the hope of avoiding criminal punishment. Extenuation depends on whether they are truly remorseful about their theft or whether they are attempting to avoid punishment.

Many patients with eating disorders who frequently shoplift seem to have extenuating circumstances. Arguing over context of mental competency in such cases can in fact cause the issue of extenuation to go unlooked and lead to an unexpectedly harsh sentence. This outcome is incredibly unfortunate for the medical professionals who have supported the patient thus far. The author believes that extenuation, rather than mental competency, should be proactively assessed in "kleptomania" in order to reduce the incidence of these unfortunate cases as much as possible.

5. Conclusion

While the connotations of the current definition and construct of kleptomania remain as they always have, its denotations clearly continue to expand. This trend is associated with the academic situation surrounding kleptomania. Grant et al, who have published many research papers in this field, attempt to approximate "kleptomania" with gambling disorder. Their self-administered Kleptomania Symptom Assessment Scale (K-SAS) is a nearly unaltered conversion of an assessment of symptoms in gambling disorder4), and the validity and reliability of the Japanese version of the K-SAS was recently reported3). Grant et al emphasize the obsessive feature of "kleptomania" over the impulsive feature5). In contrast, Takemura, the preeminent Japanese authority on the subject, stresses that theft accompanying eating disorders is the core of "kleptomania" and treats it by viewing it as an addiction disorder12). Whether "kleptomania" is framed as

obsessive-compulsive disorder or an addiction disorder, both stress that "kleptomania" is more common than previously thought (i.e., is not at all rare) and attempt to remove it from the list of impulse control disorders. This academic trend relates to the connotations of the concept of kleptomania and should be followed carefully. Regardless of whether the concept of kleptomania should be revised, what remains the same is that it falls under "other mental abnormalities". This recognition is what is most important in forensic psychiatry. In evaluations, the question of kleptomania cannot be answered with a psychiatric diagnosis alone; a normative judgment as to "whether it is severe" is also needed. Incidentally, the K-SAS developed by Grant et al is a self-administered, subjective assessment that focuses on the strength, frequency, and degree of control over the impulse to steal and on the subjective anguish the impulse causes, and the subjective nature of the scale precludes its use in forensic psychiatric assessment. In the future, K-SAS evaluations may be used as evidence of "severe kleptomania" in the legal field, a possibility that requires caution.

The author's hope is that the sharing of several views between psychiatrists and lawyers, both of whom are involved in judging mental competency, can avoid needless confusion in court.

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