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Kleptomania or common theft – diagnostic and judicial difficulties

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Summary

First descriptions of kleptomania as a mental disorder date back to the nineteenth century. For the first time, kleptomania as an accompanying symptom rather than a formal diagnosis was included in the classification of psychiatric disorders of the American Psychiatric Association DSM-I in 1952. It was included in the International Classification of Diseases ICD-10 and classified under "habit and impulse disorders". Kleptomania is a serious disorder, as numerous thefts are impulsively carried out, carrying the risk of detection and consequently criminal liability. In Poland, we lack epidemiological data, however, it is estimated that 5% of those who commit theft are affected by kleptomania. People suffering from this disorder often do not seek a medical opinion so reviewing such cases is challenging for expert psychiatrists. The authors have proposed the term "kleptomania spectrum" for defining cases in which patients have an intense urge to steal, experienced a sense of tension from such an action, and relief following it, however, the criterion of theft of a superfluous object, without a profitable motive for themselves or others is not met.

Key words: psychiatry, kleptomania, forensic psychiatry

Introduction

According to ICD-10, kleptomania (KLM) is defined as a repeated failure to resist the impulse to steal object with no intention of personal use or monetary gain. The objects may be discarded, given away, or hoarded. This behavior is usually accompanied by a mounting sense of tension in the lead up to the action and a sense of relief during and immediately after it. Some effort is made to hide the act of stealing, but not all opportunities to do so are used. Theft is carried out alone. Between periods of theft, one may exhibit anxiety, depression, guilt, however, none of these prevents repetition of behavior [1, p. 179]. Diagnosis should be based on two criteria: 1) two or more thefts made without any financial motive directly for the person or others; 2) the person describes an intense urge to steal, with a sense of tension prior to the action and relief after it [2, p. 122–23]. According to DSM-5, people suffering from

KLM, despite the overwhelming impulse to steal, are usually able to refrain from illegal activities when significant and immediate consequences are evident (presence of a security guard, policeman or surveillance camera). KLM runs in three patterns: 1) short episodes of theft with long periods of remission; 2) longer periods of theft with short periods of remissions; and 3) chronic, continuous episodes of theft with low frequency fluctuations [3].

KLM was first described in 1816 by a Swiss physician Andre Matthey, who used the term *klopemanie* to describe thieves who impulsively steal unnecessary objects. Later, two French psychiatrists, Jean-Étienne Dominique Esquirol and Charles Chrétien Henri Marc changed the term to *kleptomanie*. According to them, a person with *kleptomanie* was "forced to steal" due to mental illness. Initially it was thought to be exclusively a female characteristic associated with uterus ailments or premenstrual syndrome [4, 5] as it was noted to occur during shopping (at that time the domain of women). The nineteenth century was a period of lush economic development with the first department stores being established which created enticing temptations and opportunities for misappropriation. Ladies touched by the affliction can be found throughout literature dating from this period (e.g., Agatha Christie's novel *Death on the Nile*) [6]. KLM was classified as a symptom of hysteria (such a diagnosis was given to Maria Konopnicka's daughter Helena, who committed a number of thefts at the house of a friend and when eventually brought to court was declared insane) [7].

KLM derives from the concept of monomania, introduced by Esquirol around 1810 [8], "which – to the detriment of forensic psychiatrists – is still applied among lawyers and laymen today" [9, p. 99]. In Polish psychiatric literature, Romuald Pląskowski in nineteenth century (1884) wrote in reference to KLM that this is "a pointless taking other people's belongings without any regard to value, usefulness or even personal need. Such misappropriation of property is made […] almost absentmindedly and could easily be detected by other people" [10, p. 471].

Twentieth century views strongly rejected earlier beliefs regarding the impact of a woman's reproductive system on the occurrence of this disorder. Historically, KLM was considered an affliction of Caucasian, upper or middleclass women [11–14]. Currently, KLM is acknowledged in both sexes, however, exhibited more frequently in women [15, 13], who account for approximately 75% of cases. It has been noted that first symptoms usually emerge before the age of 20, and in the US before the age of 18 [16].

Korzeniowski (1985) claims that although not everyone acknowledges the existence of KLM, the fact that thefts carried out by people who could easily afford to buy the stolen object supports the view that KLM is a specific pathological manifestation. The structure of a psychopathic personality with a tendency towards impulsive activities lies at the core of KLM. KLM does not include thefts committed by psychiatric patients (e.g., suffering from schizophrenia or dementia) [17].

KLM, as an accompanying symptom – not a formal diagnosis – was for the first time included in the American Psychiatric Association's classification of psychiatric disorders DSM-I in 1952. In DSM-II (1968), it was completely overlooked only to return in 1980 as a separate disorder during the revision of DSM-III [4].

The International Classification of Diseases, ICD-10, included KLM in the group “Habit and impulse disorders” (F63) [18]. This group includes: pathological gambling (F63.0) – frequent, repeated episodes of gambling despite negative social consequences; pathological fire-setting (pyromania) (F63.1) – multiple acts of setting fire to property or other objects, without apparent motive, and a persistent preoccupation with subjects related to fire and burning; pathological stealing (KLM) (F63.2) – frequent impulses to steal objects; trichotillomania (F63.3) – noticeable hair-loss due to a recurrent failure to resist impulses to pull out hair. According to Ebert (1999), common features of above-mentioned disorders are: 1) no resistance to specific actions; 2) mounting tension and agitation are followed by a sense of relief or gratification during and immediately after the act; 3) impulsive actions are usually repeated and lead to negative psychosocial consequences [19].

In the 1960s, T. Bilikiewicz reverted to debates dating back to the first half of the twentieth century over the presence of an entity in impulsive disorders (Emil Kraepelin’s *Impulsives Irressein*) which would be a form of constitutional psychopathy (so-called impulsive psychopaths) [20]. The classification of an impulsive behavior as mental disorder is determined by intensity. Descriptions of KLM usually derive from individual cases, although McErloy et al. and Prest et al. described a group of KLM sufferers and observed a higher likelihood of mood disorders than in the control group [21, 22]. Bayle et al. suggest that habitual behavior – such as KLM – has an antidepressant effect: when the patient starts stealing, the mood improves. Typically, depression preceded the theft [as cited in: 23]. Bayle et al. compared a group of KLM sufferers with a group of healthy persons and a group with dependencies on alcohol and other substances – they observed more pronounced mood disorders, increased nicotine dependence and a higher impulse rate in the group of KLM sufferers [24].

KLM is a rare disorder diagnosed in 0.3–0.6% of the population, with a female-male ratio of 3:1. Only 0.4% of students met KLM criteria [16].

The etiology and pathogenesis of KLM are still under discussion. Studies showed a serotonergic dysfunction of prefrontal cortex which led to formulating a hypothesis that patients with KLM have a weak decision-making process [25]. At the same time, neuroimaging techniques have shown a reduction in micro-areas of the white matter of the ventromedial frontal regions of the brain in people with KLM compared to the control group [26].

Different psychological theories are under consideration: the theory of learning, the theory of addiction, psychodynamic and biological theories [27, 28]. To date, none of those theories has gained any significant advantage over the other. Epidemiological data are also lacking. Some authors suggest that these disorders have an early onset (childhood or adolescence; [28]). The gender split varies depending on the type of disorder. The common feature of all disorders in this group is the chronic nature coupled with exacerbations and remissions. KLM also accompanies other mental illnesses and disorders (20–46% other impulse control disorders [29], 23–50% substance abuse [23, 29], 45–100% mood disorders [21, 30].

In the pharmacological treatment of KLM the following medications are recommended: antidepressants (SSRI), mood stabilizers (lithium, valproic acid), anti-epileptic

medications (topiramate), and opioid antagonists (naltrexone) [16]. Psychotherapy of KLM mainly comprises of cognitive-behavioral techniques [31].

KLM should be distinguished from mere shoplifting. Studies show that approximately 64–82% of KLM sufferers have been stopped "in the act" [30, 32]. It is estimated that KLM accounts for about 5% of those who thieve. This data may well be underestimated, as KLM sufferers are often not under medical care. Studies on the legal consequences of KLM revealed that 68% faced arrest, 36% were arrested but found not guilty, 20% were convicted and imprisoned; 10% were convicted but not imprisoned [26].

There are no epidemiological and clinical data, and cases of KLM are often treated as casuistry. KLM patients are highly stressed, ashamed of what they are doing, but seeking medical help is often seen as a last resort. Treatment is also problematic. There are no controlled clinical trials. Hence KLM cases are difficult to judge in forensic psychiatric rulings. To illustrate these difficulties, we cite several case studies compiled by one of the authors.

Case study I.

42-year-old man was charged with stealing food products and domestic chemicals in October 2014. He entered into the shop with the intent to steal, thus was in violation of Article 278, paragraph 1 of the Polish Penal Code. He completed a secondary, vocational education with passed matriculation exams. At that time, he started studying an internal security course as an external student. He re-sat grade II at elementary school. As a minor, he was not institutionalized nor in care. He has never been in a penitentiary. Previously, he worked in sales, currently and for the last 7 years in the prison services and at the same time for the last 4 years as a store security guard. He was not drawing any form of disability benefit. He had never performed military service as he was home-carer for his grandparents. He lives with his wife and 11-year-old daughter. The 12 year marriage is stable and working out well. The subject is the youngest of 3 siblings. His sister suffers from schizophrenia. He denies any severe somatic disorders, operations, head injuries, loss of consciousness, meningitis or epilepsy. He has been receiving psychiatric treatment since November 2014, taking trazodone and hydroxyzine. He argues: "It all started in childhood"; "Being aware that he was in the lion's den he was still unable to talk about it"; "Had he sought specialist help sooner he could have avoided the problems". He rarely goes shopping alone to avoid temptation. He has never been hospitalized in a psychiatric ward. He denies ever self-harming or having suicide attempts. He negates any problem with alcohol or drug abuse. He has never been jailed to sober up. Medical records show that he is diagnosed with habits and impulse control disorder (kleptomania). For the last four years he has felt the compulsion to steal small items – a desire that intensified over the weeks leading up to seeking medical care. The patient, seeking relief, committed a few minor thefts. He is aware that this is unacceptable behavior, but the compulsion to act was stronger. He sought psychiatric and psychotherapy treatment. Experts failed to find any significant deviations from the norm either psychologically or in somatic

state. He was not diagnosed with mental illness at the time of the crime, nor found to be mentally disabled or suffer from any other mental disorder which would affect his ability to recognize, even partially, the significance of the committed act or influence his behavior (no cause to apply Article 31, paragraph 1 or Article 31, paragraph 2 of the Polish Penal Code). His sanity, which was tested during the course of the proceedings, raised no doubts on his ability to participate in the judicial process.

Case study II.

43-year-old woman was accused under Article 278, paragraph 1 and Article 288, paragraph 1 of the Polish Penal Code of stealing clothing from 5 shops at a shopping mall, together with a minor (her daughter), in October 2013. The allegation also included an act of damage to the fastening of a skirt as well as the material itself. Educated at secondary level, without completion of a diploma, she previously studied at a vocational school. No school year repetition. As a minor, she had no legal record nor was ever under the custody of any institution. Although previously stopped for shoplifting by the police she never faced charges. Previously employed as a seamstress for approximately 3–4 years. She has a16-year-old daughter who requires special care. Her first marriage lasted 5 years before her husband died, of this relationship she has a 22-year-old son. She has a 16-year-old daughter and a 10-year-old son from a later relationship that dissolved due to "irresponsible partner". Her second marriage, from which there were no children, broke down as a result of her husband's alcohol abuse and bullying. She lives with her parents and children. When aged 38 she underwent surgery for ovarian cancer. At the age of 7 she suffered a head injury – her friend pushed her, but she has no recollection of details. For several weeks (before the test), she reported instances of unconsciousness – "turning off and lost in thought". She is aware that this lasts few seconds. "Darkness in front of my eyes and I can't see anything". She denies epilepsy. Hospitalized on three occasions at psychiatric institutions due to personal issues, for example, her son had a serious accident when his friend shot him with an arrow in the eye. She blames herself for not keeping him safe, her mood is lowered. She is treated psychiatrically at a mental health clinic and by a private practitioner. She is taking amitriptyline, quetiapine and valproic acid. During her assessment, the patient was referred to a psychiatric day ward. She had attempted suicide on two occasions by overdosing. In the past, she self-harmed by "biting her veins". She denies alcohol abuse or drug use. She has been treated in Mental Health Clinic since 2004 (anxiety and depressive disorder, addiction to benzodiazepines, psychopathic personality and kleptomania). She has been prescribed: sertraline up to 150 mg/day; perazine 200 mg/day; valproic acid 1,300 mg/day. Since December 2012, symptoms characteristic for kleptomania have been reported. She has also been treated under private psychiatric medical care since 2013 (anxiety and depressive disorder, affective decompensation response – adjustment disorder, history of impulse control disorder). In addition to psychiatric treatment, she remains under the care of a psychologist. In 2013, she was hospitalized for four weeks in a psychiatric ward (anxiety and depressive disorder, emotionally unstable personality disorder, addiction to benzodiazepines). Experts

concluded there were no significant deviations in the patient's psychological and somatic state. They did not recognize psychiatric illness, mental retardation or other mental disorders which would affect her comprehension of actions or ability to control behavior at the time of the crime (no cause to apply Article 31, paragraph 1 or Article 31, paragraph 2 of the Polish Penal Code). It was concluded that patient's sanity during the evaluation proceedings was not in doubt.

Case study III.

58-year-old woman was accused of stealing goods from a supermarket in April and May 2010, i.e., violations under Article 278, paragraph 1 of the Polish Penal Code. Analysis of the National Criminal Register showed 13 records during the years 2007–2010 (Article 278 of the Polish Penal Code). She has a secondary education and is retired since 1997. Previously employed for 27 years in personnel department. She never had to re-sit a year at school. She is a widow and has 2 children aged 35 and 32. She was the youngest of 11 siblings. Her mother was treated psychiatrically, however, the accused was unaware of the reason. No one in the family had ever attended any school for pupils requiring special needs. As a minor, she was never in foster care, or up before a court. As an adult, she had on many occasions been penalized "for the same". "This is kleptomania … I have to calm down … take it, then I feel relief … I load my bag with whatever catches my eye, not that I see that well at the time". She has never been in a penitentiary institution. She claims to have suffered from tuberculosis. She has never undergone any serious operation or suffered head injuries or epilepsy. At the age of 6 she suffered from meningitis. She has been undergoing psychiatric treatment due to depression since 1991. "I don't have a life. All I want to do is cry … I can't sleep, can't eat". Current treatment: clomipramine, clonazepam, mianserin, chlorprothixene. She has been treated in psychiatric hospitals on several occasions – most recently two years ago. She has attempted suicide twice by overdosing. She denies self-harming. She has problems with her memory, difficulties to recall names. She believes she has a 10 year addiction to clonazepam. She takes two tablets and sometimes 3–4 tablets per day. She denies alcohol abuse. She has never been jailed to sober up. She denies drug, adhesive or solvent abuse. Medical records show that she was treated at a psychiatric hospital in 1998 (depressive episode), 2004 (recurrent depression), twice in 2005 (depressive episode; recurrent depressive disorder, addiction to benzodiazepines), in 2007 (personality disorders), in 2009 (adjustment disorder). Tomography results (in March 2010) show moderate cortical and subcortical atrophy, without any deviations. She has been treated at the same clinic since 2010 (recurrent depressive disorder, kleptomania, addiction to benzodiazepines). Previously, she underwent treatment in another city. Medical notes (history of illness) from 2010–2011: "Four years ago her husband died and then it revealed itself, when the patient walked around the shops she felt the compulsive need to steal something, as it provided relief. Earlier she had such tendencies, but over the 4 years this compulsion significantly increased … the patient claims she would like to stop walking around the shops and stealing, and she is determined to participate in regular meetings … during

the last 2.5 months, on 2 to 3 occasions she has stolen from a shop; Before today's appointment she was in a drugstore where she was caught for theft and fined PLN 200. She had arrived early for the appointment, she was a little tense, so she went in and stole a children's tea – this calmed her down". Her mental state showed deviation from the norm: "thought processes scattered, depressed mood, crying. Psychomotor drive slightly lowered, dull, somewhat unsettled. Organically impoverished, consistent personality. Dependence on benzodiazepines". No significant deviations from the norm in somatic condition were observed. Experts did not acknowledge finding a psychological disorder or mental retardation at the time of the crime. They diagnosed mental disorders in the form of organic personality disorder and mood disorder, kleptomania and addiction to benzodiazepines. The features of organic CNS lesions were indicated by the results of a clinical trial and moderate cortical and subcortical atrophy of the brain found in CT in 2010. The decisive factor in the opinion on sanity of the patient was based on the motivational process. During the investigation the patient indicated that she was stealing impulsively without intention to profit. This was supported by previous judicial-psychiatric assessment (included in the file) and medical records (she shoplifted while waiting for a therapy with a psychologist). The experts did not issue an unambiguous opinion, pointing out alternatives to the Court. If court proceedings prove the motivation of the accused woman was influenced by impulse control disorder, then the ability to control her behavior was very limited (Article 31, paragraph 2 of the Polish Penal Code). Such findings were confirmed by experts in 2007 and 2009. However, if court proceedings prove the accused was motivated by material profit, then the accused cannot be seen to have a substantially reduced ability to recognize the act of theft or control her behavior (no cause to apply Article 31, paragraph 1 or Article 31, paragraph 2 of the Polish Penal Code). Such doubts were reported by forensic psychiatric experts in 2010 (manipulation, insincerity, recent thefts did not correspond to the criteria of kleptomania). The experts considered non-material motivation, related to impulse control disorder, and substantially reduced ability to control her behavior, as more probable (Article 31, paragraph 2 of the Polish Penal Code). The accused was allowed to participate in the proceedings. Her sanity during the proceedings did not raise doubts.

Case study IV.

28-year-old woman was accused of two thefts in March and June 2012 (at a supermarket she put cold meats into her handbag; at a wholesaler's she was stopped while trying to leave with unpaid goods (shaver, vodka)), i.e., violations under Article 278, paragraph 1 of the Polish Penal Code. She has vocational education – gardener. She had never worked "due to illness". When asked about her marital status responded with "married-single". "She has a partner – she is bringing up his two children and she has one child of her own. "She does not know" the child's age. The patient claims to have three siblings, however, does not know in which order they were born. As a minor, she was never in foster care or any correction centre. There is no past record of penal punishment and now she is facing her first criminal case. In the family, "almost

everyone" is treated for schizophrenia, e.g., her mother's brother, and her mother "is screwed up". When asked about past serious illnesses she refers to a brain tumor, epilepsy and kleptomania. She underwent surgery of the brain tumor at a military hospital. She denies having had any head injuries. She suffers from "tonic-tonic seizures" 4 to 5 times per week with loss of consciousness. She is treated with topiramate and carbamazepine. She has received psychiatric treatment, but cannot recall why. She suffers memory issues, "I have the right not to remember, I've had a brain surgery". A psychiatrist has prescribed her "Asertin and something else to get rid of tension". She has never been hospitalized in a psychiatric unit. She confirms suicide attempts but "doesn't remember" overdosing. She denies self-harming, alcohol or drug abuse. She has never been picked-up for being under the influence. She denies glue or any other solvent abuse. Medical records show that she has been under public mental care treatment since 2010 (organic personality and mood disorders, epilepsy, condition after brain surgery). A neuropsychological test conducted in 2012 unequivocally confirmed CNS lesions (Benton test), contact with the patient was impaired, significant difficulties were observed in her ability to concentrate and the patient demonstrated inadequate emotional responses. Conclusions: secondary cognitive dysfunction and personality and mood disorders. Experts assessed her mental condition: "Maintained, although sometimes difficult, verbal contact. Clear awareness. Auto – and allopsychic orientation preserved. Consistent, rambling thought process. Aligned psychomotor drive. No acute psychopathology in terms of hallucinations or delusions. Blunted affect. During testing the patient sometimes demonstrated irritancies, affective strain. Intellect – within the broad standard. Organically impoverished, consistent personality. Deviations to somatic condition – postoperative scar in the right temporal area. Tattoo on the left forearm". Experts concluded that they are unable to provide an opinion in terms of the patient's mental health and sanity on the basis of a single forensic psychiatric examination. Her mental state raised numerous doubts. The patient herself did not respond with answers to a vast number of questions although this was perceived as her reluctance to cooperate rather than the impact of cognitive impairment. During the examination she was irritable and affectively tense. A suspicion arose that the patient might be aggravating her mental condition (mainly cognitive functioning). In order to reach a higher level of objectivity, it was recommended to continue psychiatric observations of the patient's mental state, behavior, social relations etc. over an extended period at a forensic psychiatric institution.

Discussion

Although KLM is a popular term in social and cultural life, the actual ratio of occurrence in the population is relatively low in comparison to other mental disorders. KLM sufferers face the risk of falling into legal conflict. Depending on the value of the misappropriation it could potentially lead the KLM suffer onto a path of misdemeanor or crime. Few people diagnosed with KLM in conclusion to a forensic psychiatric examination are charged and brought before a court of law. In the vast adjudicatory experience of one of the authors, the issue of KLM has surfaced in barely a handful

of cases throughout the last decade – the four examples outlined above. The vast majority of shoplifting cases are not related to KLM. It seems that many people accused of shoplifting who are experiencing KLM do not reveal the condition and vice versa – people who do not suffer from KLM declare to have symptoms hoping for mitigating circumstances during a forensic psychiatric examination. Many people who misappropriate items either are not caught red-handed or steal items of little value to avoid prosecution. Others, who have previously managed to avoid legal consequences of their theft have undertaken therapy to avoid future temptation to steal.

In three out of the four presented cases, KLM was diagnosed and medical treatment advised although the stolen objects were acknowledged as commonly useful items. It seems that when a person with characteristic psychological features and intrapsychic experiences steals useful items, the KLM spectrum should be recognized rather than full-blown KLM. A separate issue is the problem of belief in declared motivations to act. Motivation is judged by forensic experts and the court. The court does not have to agree with the forensic analysis during the inquiry hearing.

Obvious preparation for theft (e.g., early arrival at the shop, checking the quality of security monitoring, carrying items out in bags lined with aluminum foil) excludes KLM. When a KLM perpetrator walks into a shop without prior preparation, his/her behavior during the theft differentiates emotional and material motivation. The KLM sufferer behaves more chaotically, has affective tension and the stolen object, more often than not, does not appear to be well hidden. A common thief when stealing from a shop usually steals more than one item, keeps them well hidden and remains calm so as not to draw attention to himself/herself.

Above, we presented four different case studies which were diagnosed – potentially prematurely – with KLM. They were presented according to increasing complexity of diagnostic and medical problem. Case study I refers to a "pure" KLM spectrum; II – KLM spectrum with comorbid personality disorders and addiction to benzodiazepines; III – KLM spectrum in individuals with organic CNS lesions and addiction to benzodiazepines; and IV – KLM spectrum comorbid with CNS damage and epilepsy after brain surgery due to brain tumor. While judicial rulings on cases I and II do not seem to raise doubts (no significant mental restrictions were found), there are serious concerns relating to the remaining ones. In case III, an alternative opinion was proposed, and in case IV the experts requested further psychiatric observation. KLM symptoms may be more difficult to diagnose when accompanied by other mental disorders, especially more severe than impulse control disorder (e.g., organic mood or personality disorder, mental illness), or neurological disorders (epilepsy with absence seizures). Case III, examined by different teams of experts, evoked various opinions (lack of diminished accountability or significantly diminished accountability). It seems that the decisive factor on which the experts based their observations was their belief in the sincerity of responses provided by the patient. The presence of impulse control disorder in a person with significant organic CNS damage may result in misplaced judgment even if all KLM criteria are not met.

In none of the presented cases, the two KLM criteria according to ICD-10, were met. Although patients had an intense drive to steal, experienced tension before such

an action and relief after it, the criterion of theft of a completely superfluous object, without tangible motive of profit for themselves or others, remains unmet. Therefore, *de facto*, those persons did not meet the diagnostic criteria of KLM. Therefore, in none of the above opinions did the forensic experts diagnose KLM.

Conclusions

1. KLM is a popular term in social and cultural life, however, its actual prevalence in the population is relatively low in relation to other psychiatric disorders.
2. KLM is associated with the risk of falling into a legal conflict.
3. Few people diagnosed with KLM face being brought to trial as a result of forensic psychiatric examination.
4. Many people accused of shoplifting who actually suffer from KLM do not reveal the disorder and vice versa – persons not suffering from KLM proclaim symptoms, in hope of providing mitigating circumstances.
5. For complete and comprehensive KLM diagnosis, in addition to the clinical trial, the following procedures should be carried out:
6. neuroimaging (CT, NMR) – to determine possible organic lesions in the CNS
7. psychological examination, including impulse evaluation tests (e.g. Baratt, Eysenck or Dickman test).
8. The authors propose the term “kleptomania spectrum” for defining cases in which patients had an intense urge to steal, experienced tension before such an action and relief after it, however, the criterion of theft of a superfluous object, without a profitable motive for themselves or others remains unfulfilled.
9. Research suggests that KLM is most likely to be associated with personality disorders, drug dependence or organic CNS damage.
10. None of the above cases have met the KLM ICD-10 criteria.
11. The authors propose to rule a substantially reduced ability of the accused to control his/her behavior when KLM is accompanied by significantly manifested features of organic CNS damage and/or severe impulse control disorder.

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