

## Criminal Responsibility in Asperger's Syndrome

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**Abstract:** **Background:** Asperger's syndrome (AS) has been of much interest in the last two decades. Most people with AS are law abiding and are not involved in any violence. Over the years, however, there is increasing evidence of violent behavior and criminal acts committed by some people with AS. The characteristics of the link between AS and violation of the law requires identification and definition and the question regarding the criminal responsibility to be attributed to these offenders needs to be clarified. **Data:** We present three cases that illustrate how the special characteristics of this syndrome and particularly the inability to assess social situations and appreciate others' point of view constitute the main cause for the violent behavior and the criminal offences. For this specific behavior, the AS patients lack the criminal intent or the intent to cause harm (*mens rea*), which is essential for criminal responsibility. Thus it is reasonable to consider some AS sufferers not criminally responsible for their actions and unfit to stand trial. This approach has been accepted by the courts. **Conclusion:** It can be inferred that people with AS may not be criminally responsible despite not suffering from a psychotic illness.

### Introduction

Hans Asperger, a Viennese physician, described in 1944 a group of boys who had significant social problems but whose language and cognitive skills were normal (1). These children were pedantic and preoccupied with idiosyncratic interests. They were awkward with regard to their motor skills, similar to their fathers. These disorders had some similarity to Kanner's description, one year earlier, of infantile autism (2). Asperger published in German, therefore the interest in the disorder increased only after the important review by Lorna Wing in 1981 (3). In the English literature it was established as a disorder whose symptoms are lack of empathy, social isolation, intensive preoccupation with unique and unusual subjects, coordination disturbances and clumsy movement. The disorder was included in the DSM-IV (4) and the ICD-10 (5), emphasizing the sustained impairments in social interaction and the restricted repetitive patterns of behavior.

Asperger's syndrome (AS) tends to be more apparent in late puberty and early adulthood, due to the marked importance of social communication during this period of life. Thus, despite this being a neurodevelopmental disturbance which appears in

early childhood, most of its clinical expressions and the significant impairment it causes will appear at this stage, leading in many cases to relatively late diagnosis. Individuals with AS display a wide spectrum of behavioral responses to distress ranging from isolation and withdrawal to aggression and criminal behavior. In her first review, Wing (3) describes people suffering from AS who experienced bouts of violence and criminal behavior.

Over the years, following Wing's review, the descriptions of events relating AS to criminal behavior increased. This behavior may result from a change in routine or from running into a social situation which people with AS are unable to understand and, therefore, perceive as threatening. They display intense preoccupation with their special areas of interest and may react violently when disturbed or prevented from doing something related to these interests. They lack empathy and the ability to associate actions with their results (6, 7). They may be highly provoked by noise (8), and sometimes, in an attempt to be liked by others, they may be persuaded by these others to commit thefts, physical and sexual assaults, etc. (9).

The criminal behaviors described in the literature are of a large variety and are often strange, unusual

and bizarre to the extreme. They include physical and sexual assaults (10), arson (11, 12), harassing phone calls and theft of personal items (13), theft of personal items for the purpose of hoarding (14), attempted murder (15), murder (16) and, possibly, even serial murders (17). Their vandalism and assault is often directed against family members (18, 19).

In an attempt to assess the violence rate among people with AS, Ghaziuddin and colleagues (20) scanned the literature for events that were published. When using the widest possible definition of AS, they found 11 cases of violence out of a total of 197 reported cases of AS (i.e., 5.6%). Scragg and Shah (21) checked the rate of AS among patients hospitalized at a high security hospital and found it to be 1.5%, or, when using a wider definition of the syndrome, 2.3%. In a study in the ward for the criminally insane in Stockholm, Siponmaa and colleagues (22) found that of 135 youngsters who committed assault 30% may have fit the Pervasive Development Disorder diagnosis and, out of those, 4% fit the Asperger's syndrome diagnosis. These figures demonstrate that the rate of violence among people with AS is low and that there is no significant correlation between AS and violence.

The various violent assaults and certainly the more severe ones raise the question of whether there is a direct causal link between the violent behavior and the psychopathology of AS and, if so, what is the extent of those people's criminal responsibility and their ability to stand trial and be penalized for their actions? All that considering the fact that AS is a psychiatric disorder rooted in deficient empathy and an inability to communicate normally with others. However, people suffering from AS are not psychotic. They have adequate cognitive abilities and therefore are capable of understanding and knowing the law. To date very few publications have attempted to deal with these topics.

Murrie and colleagues (17) (15) published a series of six case studies that include arson, physical and sexual assault, voyeurism and attempted murder. The authors examined the influence of typical AS symptoms and of deficient empathy on criminal activity. They suggest viewing this deficiency as a basis for arguing that the person is not criminally responsible due to mental deficiency. Barry-Walsh and

Mullen (23) published five case studies of arson and assault. They view these actions as stemming directly from the person's mental pathology. They claim that people with AS cannot understand the implications of their deeds and how they impact others and therefore do not understand that the action is forbidden. In addition, since the legal hearing involves a proceeding that is all based on innumerable complex social codes, these people are incapable of dealing with it at an adequate level and of protecting themselves. Therefore they suggest reconsidering these people's criminal responsibility and their ability to stand trial. While they realize that it is easier to make this claim for lighter cases, they still recommend that psychiatrists and the courts take these facts into consideration. However, to the best of our knowledge the courts have not yet taken a clear stand with regard to the criminal responsibility and fitness to stand trial of people with AS.

We present three cases of people who were hospitalized in our facility following violent assaults that were suspected to be caused by psychotic states. We diagnosed these people with AS. We examine to what extent their violent behavior resulted directly from AS and how this impacted the expert psychiatric opinions presented to the courts. We also examine the legal precedent established by these cases.

### Case 1

TN, 30 years old, his early development is described as being normal. He attended a regular preschool and started first grade in a regular school, but was kept a grade behind due to low academic achievements and difficulties in reading comprehension. The learning difficulties reappeared over the years despite TN's high level of motivation. He was described already in first grade as having behavioral problems, unstable social relations, a low frustration threshold, temper tantrums and displaying unacceptable behavior, like walking out of the classroom in the middle of class. In second grade he started attending boarding school. He changed boarding schools several times due to adjustment difficulties and particularly due to inability to integrate socially. He also had learning difficulties and at age 15 was diagnosed with dyslexia, borderline intelligence and attention deficit disorder. In adulthood he tried to

work in gardening but did not persist beyond three months as a result of adjustment difficulties and misunderstandings with his employers.

Throughout his life span TN has been described as someone whose behavior is lacking in social conventions. Living with him has meant living in constant terror. He has had frequent furious outbursts directed towards his family and other people and was verbally and physically abusive. In one such incident he pushed his mother, causing her to fracture her pelvis. He uttered threats, cursed, broke dishes and furniture and punched the walls. The motive was usually his feeling of being misunderstood, not having his wishes fulfilled or feeling offended.

Starting at a young age TN was treated at a mental health clinic. He was diagnosed with borderline personality disorder and underwent psychotherapy. A variety of treatments were tried and it was suggested that he undergo drug treatment, but he refused.

At age 27 TN fell in love with a young woman from an employment agency who had interviewed him for a job. In his words, "our eyes met." Three days after the interview he returned to the employment agency carrying a wooden heart and confessed his love to the young woman. She asked him to leave. A few months later he started harassing her with phone calls and with visits to the employment agency. During those visits he would just stand there and stare at her for a few minutes without uttering a word. Once, when she was away from the office, he told her colleague of his intentions to kill her because she offended him. Throughout this period TN did not receive any treatment. He severed the few social connections he had, withdrew into his home and focused on watching TV sports programs. His outbursts became more frequent and more violent. He claimed that his mother abused him sexually and that he was terminally ill. He ate and drank very little, did not sleep and wandered around alone on the streets.

In this state he arrived for an examination at an outpatient psychiatric clinic. The initial impression was that he suffered from unspecified personality disorder and from a manifold psychotic state. He was offered a drug treatment regime, but the following day he contacted the young woman again and, as a result, was arrested and taken for observation to a psychiatric hospital. There the lack of judgement af-

fecting his behavior was observed, especially with regard to the women in the ward whom he constantly harassed. In addition he manifested a low irritability threshold, difficulty in repelling gratification and bizarre contents with sexual connotations that focused on his mother. The conclusion was that he suffered from a psychotic state and expert psychiatric opinion to that effect was presented to the courts. As a result he was hospitalized under court order in a closed ward in our institution.

The diagnosis at our hospital was based on repeat examinations, previous medical records and several interviews with the patient and with his family conducted by a psychiatrist experienced in the diagnosis and treatment of patients with autism spectrum. We didn't find any psychotic symptoms. We found, however, clumsiness, difficulty to communicate and keep eye contact with others, a propensity to recite certain things repeatedly regardless of the topic of conversation, obsessive preoccupation with restricted thought contents and an inability to understand others and to form a normal social connection in a suitable manner. His complete lack of understanding of social codes was particularly remarkable. His thought process was inflexible and very concrete. He was impulsive and incapable of controlling urges to seek satisfaction. There were many angry outbursts mostly caused by his inability to interpret social situations correctly. It was clear that his social judgement was lacking while his perception of reality was in order. Sensory motor skills were very weak. His cognitive skills were normal, but he had difficulty with attention and with abstraction and space cognition. His verbal ability was fairly normal.

By generally accepted criteria, the combination of these findings match the diagnosis of Asperger's syndrome.

TN was diagnosed with AS and Attention Deficit Disorder (ADD). In the expert psychiatric opinion we presented to the courts we argued that when he committed the illegal acts (harassing the young woman) TN suffered from AS and his actions stemmed from his mental state with its accompanying handicap and from severely damaged social judgement. He was incapable of correctly understanding and interpreting the messages he received from the women he harassed and their rejection of his courtship. Therefore, his reactions were abnor-

mal and he was unable to understand their implications. Formally, TN is capable to stand trial and is able to follow the legal process. However, with regard to the offences he is charged with, which involve social judgement, he may know that "it is wrong to harass someone" but he may not realize that this is what he was doing. Thus, there is no justification to prosecute TN. He should not be prosecuted for the offences he is charged with since his actions stemmed from his illness and were committed without criminal intent.

Our recommendation was accepted by the courts and TN was sent back to our institution for continued hospitalization under court order.

## Case 2

PK, 22 years old and the youngest of six siblings, was born following a normal pregnancy and birth. During his early life his development is described as normative. He attended school and was a good student, although socially there were always some problems. He had difficulties integrating, very few friends and a tendency to seclusion. In adulthood he attended a variety of educational and training programs, but could not complete any of them due to social difficulties. He was drafted into the army for compulsory service, but after a short period of time he deserted, was sentenced, jailed and released from the army due to mental problems. Since then he has been unemployed, has been living with his parents and has been financially supported by them. It was suggested to the parents multiple times that, due to PK's social difficulties, he should undergo psychological testing, but they refused.

While PK was staying with his parents there were repeated incidents of aggression during which he attacked family members and in particular one of his sisters, both verbally and physically. This led to a restraining order that banned PK from his parents' home. Disregarding the order, PK returned to his parents' home where he physically assaulted his sister and father. Police arrested him and following a judge's decision he was admitted to a psychiatric hospital for examination. During his hospitalization he underwent a number of psychiatric tests including an examination by a psychiatric expert in diagnosis and treatment of people with autism spectrum. The

family was interviewed as well. No evidence was found for a psychotic state during these examinations or previously; however, there was clear indication of a total lack of understanding of social codes of behavior and of an inability to understand and interact with other people in an appropriate and socially acceptable manner. He showed no interest whatsoever in social interaction and a nearly complete lack of ability to empathize. At the time of admission he displayed a high level of preoccupation with routines, procedures and ceremonies. During examinations he avoided eye contact, used a monotone voice and a limited affect and kept repeating things over and over while ignoring the examiner's questions.

PK made no attempt to explain his assaults on his father and sister and was incapable of comprehending the damage he caused them, both physical and emotional. His thought process was inflexible, concrete and persevering. He required clear direction in order to understand how to behave: "Maybe if the judge had explained to me that it was not permitted to beat up people, I wouldn't have done it."

PK was unable to grasp the nature of activities within the ward, and he made no effort to identify and remember his caretakers. He required concrete explanations and constant mediation in social interactions. His social judgement was clearly deficient, although his reality testing was in order.

According to his family, PK had been in this state since early childhood. In a conclusive psychological examination his intelligence quota was found to be medium-low (87.50). He had difficulties with visual memory and deficient graphomotoric ability, while his verbal ability was normal.

In view of our findings he was diagnosed with Asperger's syndrome. In our expert opinion to the court we claimed that as a result of his disorder, PK was not able to properly understand and interpret his sister's and parents' messages and therefore his reactions were aberrant. He was unable to comprehend their implications and while committing those transgressions his social judgement was deficient. Therefore, we recommended to halt the court procedures in his case and instead to continue his hospitalization in a psychiatric hospital by court order. The courts accepted our recommendations.



### Case 3

At 38 years of age, RE is married with no children. He is the middle child of three siblings and was born following a normal pregnancy and delivery. His psychomotoric development was delayed and from the age of four he had been in occupational therapy and had taken part in special gymnastics classes. He started talking at one year and walking at 17 months. He suffered severe separation anxiety when in the company of other children. Until the age of 10 he suffered from enuresis. As early as daycare it was suggested to put him into a special education program, due to his difficulties integrating into a social environment. Despite that, he attended a regular school where he proved to be a mediocre student and was moved to a special education class due to learning difficulties. Throughout school he was isolated and experienced difficulties integrating and getting used to the social environments. Still, he graduated high school with a full matriculation diploma and enlisted in the army where he completed his round of duty, serving in a clerical position. Thereafter he worked at a number of clerical positions, all of them lasting between one and two years. He was released from all those jobs because of dissatisfaction with his skills and due to his inability to work in a team. In contrast to the events, RE remembers this as one of the best periods in his life and boasts about his ability to remember numbers and names better than anyone else. During the two years preceding his hospitalization RE worked in a candle-making factory.

At the age of 27 RE married a woman suffering from schizophrenia to whom he was introduced by friends. In the relationship between them he was always detached and distant and as far as RE is concerned he got married "because this is the proper thing to do." He used to hoard large amounts of newspapers in his home and if his wife threw them away he would assault her physically. This resulted in his first arrest; however, the charge was dropped and the legal process was stopped.

During this period RE started harassing people by phoning them. He described this as an urge and was sent for psychiatric ambulatory treatment. He was diagnosed as suffering from obsessive-compulsive disorder and borderline personality disorder and was treated with various anti-anxiety anti-de-

pression drugs. There was, though, no improvement or any change in his condition. His continued harassment of people on the phone resulted in several harassment and uttering threats charges. Repeated psychiatric examinations did not find any evidence of active psychotic disorder and he was sentenced to house arrest. While he was under house arrest his agitation increased, he continued calling and harassing the girl he had previously harassed and was aggressive at home. His family requested his hospitalization in a psychiatric hospital and both RE and the court agreed.

A number of psychiatric examinations and psychomotor tests were performed during RE's hospital stay and his family was interviewed. No evidence was found of a psychotic disorder. His mood seemed euthimic with limited affect. He avoided communicating with others and showed complete indifference to goings-on around him. He did not integrate at all into the ward's activities. His only contact was with his mother and he even ignored his wife when she came to visit him. He displayed clearly a lack of understanding of social behavior codes, an inability to comprehend others and to communicate with them in an appropriate and socially acceptable manner. When he was asked the reason for harassing people he claimed that he was jealous of his friends who had settled in appropriate jobs while he couldn't achieve that. He also mentioned that he was interested in a friend of the girl whom he had harassed by phone and had believed that he could reach her in this manner. He had difficulty understanding that he hurt these people by his behavior. In addition, it was evident that he suffers from severe motoric clumsiness as well as from deficient coordination, multiple perception difficulties and deficient space cognition, difficulties in holding a pencil and writing and in using cutlery. His perception and graphomotor skills were at the level of an eight-and-a-half-year-old. The verbal skills were completely normal and so was his memory. He could remember many marginal details from various periods in his life.

In view of all these findings and following the examination of a psychiatrist specializing in diagnosis and treatment of people with disturbances in the autism spectrum, RE was diagnosed with Asperger's syndrome. In the expert opinion that we presented to the court, regarding the charges of harassment and

uttering threats, for which he was being tried, we stated that he suffers from Asperger's syndrome and that all his actions stemmed from his mental condition and limitations which included severe deficiency in social judgement. He was incapable of correctly perceiving and interpreting the messages passed on to him from the people he harassed by phone and therefore his reactions were aberrant and he could not understand the implications of his deeds. Thus we concluded that he has no understanding of the transgressions he was charged with and which are related to social judgement. He should not be tried for these transgressions and should not be held responsible for them since his actions resulted from his illness and without his awareness of wrong-doing.

Due to the significant improvement in his condition that occurred during hospitalization and in view of his full cooperation in the treatment program, which included training and learning of social skills, we recommended that the court decide to continue his treatment in an ambulatory framework and by court order. The court accepted our recommendation and RE was released from hospital to ambulatory treatment.

## Discussion

Criminal responsibility is defined by the existence of two components: criminal act (*actus reus*) and criminal intent or intent to cause harm (*mens rea*). In order to prove the criminal responsibility of an offender in a criminal case the prosecution has to show that both components exist. The present standard for the defense of mental illness in most Anglo-American jurisdictions is based on the M'Naughten rules: "A person is not responsible for criminal conduct if at the time of the act he was laboring under such a defect of reason, from disease of the mind, as not to know the nature and quality of the act he was doing, or if he did know it, that he did not know he was doing what was wrong" (24). The 1994 amendment of the Israeli law is based on the cognitive incapacity of the M'Naughten rules but an additional criterion was added for incapacity, namely the offender's inability to control his or her behavior in order to avoid the criminal act. This is termed the volitional test (25).

In the various insanity defense standards evidence of mental disorder may be used to show that the accused lacked the *mens rea*, the criminal intent for the crime with which he is charged. It is generally agreed that a mental illness sufficient to nullify the *mens rea* necessary for a crime should completely remove criminal responsibility (26).

People suffering from AS display rigid behavior patterns and preference for order, discipline, organization and rules and regulations. The majority of AS sufferers is law abiding and is not involved in any violent activities (7, 27). Only a minority among them are involved in violent activities for which their criminal responsibility may be challenged.

The three cases presented in this article are characterized by repeated acts of aggression and injury to others, especially to people who are close to the subject. We put forward that these actions are expressions of the disability caused by the disorder itself and that this should be taken into account when weighing the person's criminal responsibility and his or her ability to stand trial. When we examine the motive for aggressive behavior in all three cases we find that the disorder is a major contributor.

The primary problem of these AS cases is their inability to interpret correctly social situations and social messages. Therefore TN was convinced that a woman fell in love with him just because their eyes happened to meet. He then went on to interpret all her attempts to reject him as expressions of love and viewed this as a genuine and complete relationship. PK also found it difficult to comprehend social codes and messages as well as the physical and emotional damage he caused his family. He assaulted them repeatedly whenever he felt the treatment he received to be improper or when he perceived their behavior towards him as being hostile. RE was incapable of understanding that his repeated phone calls caused those people much aggravation and that they really meant it when they told him to stop the harassment. He was even convinced that phoning a girl's friend repeatedly was a legitimate way to court the girl.

The aspects that enable these people to commit assault, often a serious one, namely the inability to assess social situations and to appreciate others' point of view, are central to AS. People with AS are unable to perceive other people's needs, desires or distress due to their inability to interpret correctly

other people's behavior (28). There is no understanding whatsoever on the AS subjects' part of the implications and repercussions of their actions. This is an important factor that distinguishes between people suffering from antisocial personality disorder and people with AS. Both seem to be lacking in empathy, but the latter do not have the ability to manipulate, to charm and to exploit other people. Often it is the AS sufferers who are being exploited. Also frequently, people with antisocial personality disorder understand very well the repercussions of their violent and criminal actions, while people with AS have a hard time grasping this (18). In all the described AS cases there is no criminal behavior other than that which is related to the disorder. There is no history of alcohol or drug abuse and there are no other criminal offences. When people with AS are charged with offences they are quick to confess since they do not feel any guilt and are convinced that their actions were suitable to the situation. In addition they are very honest and true people and they are not aware of the social and legal implications of their confession.

Currently, the law decrees that a person is not criminally responsible and cannot stand trial when it is clear that the criminal act was done while being in a psychotic state and under the influence of the psychosis. It is agreed that at such time the person's judgement is deficient and the person cannot grasp the severity and the consequences of his actions. The courts even accept a defense of general irresponsibility in cases of severe cognitive disability. As with most AS patients, in the cases presented above, the subjects are not in a psychotic state and their cognitive abilities are within the normal range. Still, we claim that they are not criminally responsible for their actions and cannot stand trial.

The cases discussed above demonstrate that the behavior stems directly from the disorder and that it is the disorder that causes these people to act in such a destructive manner and with such lack of judgement. It is especially in the social sense that their judgement is deficient to a degree that inhibits their ability to understand that what they were doing was wrong. Thus, when presenting our expert opinion to the courts in these three cases, we argued that they were not criminally responsible for their actions and, in line with Barry-Walsh and Mullen's opinion (23) that they could not understand the essence of the

charges brought against them, that they could not understand the circumstances of a trial and the many social messages and codes related to it. They could not cope with all these requirements as well as defending themselves and, therefore, we concluded that they were not fit to stand trial.

The court's acceptance of the recommendations of our expert opinion established a legal precedent. Therefore, when people with AS commit criminal acts stemming from and motivated by their disorder, it is reasonable to consider them not criminally responsible for their actions and not fit to stand trial and be punished. This is not a sweeping recommendation. Every case should be considered on its own merit while taking into account the type of crime, its severity and its direct connection to the disabilities caused by the disorder. Hence it may be inferred that people suffering from AS are not criminally responsible even though they do not suffer from a psychotic illness.

The decision to exempt AS sufferers from criminal responsibility and from standing trial and to require that they receive professional treatment under psychiatric care is of great importance from the treatment point of view as well. Our own experience and the experience of others (18) show that while we cannot free AS patients from their disorder, it is certainly possible to teach them compassionate behavior so as to prevent them from causing damage to others and to help them function in a more socially acceptable manner. This will benefit both the AS patients and others around them, as Simblett and Wilson (18) described:

"It was only by making the diagnosis of Asperger's syndrome and emphasizing acceptance and containment of their peculiar handicap that they were able to make headway of sorts."

It is possible to attain significant improvement in the behavior of AS sufferers and in their relationship with their surroundings by combining the teaching of social skills and of behavioral and cognitive elements with training and follow-up of the support system.

## Epilogue

The three patients presented, following their diagnosis with AS, were treated mostly by educating them

about their disorder, both during their hospitalization and after their release. They were taught social skills with emphasis on codes of behavior and on the kinds of behavior that are permissible and those that are prohibited. Currently all three live within the community with their families and in a one-year follow-up they do not show signs of aggressive behavior.

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