Asperger's Disorder and Murder

Donna M. Schwartz-Watts, MD

Little is known about the prevalence of violence and autistic spectrum disorders. This article reviews findings of current research on Asperger's disorder and violence. Criteria for diagnosing Asperger's disorder are given. Three cases are presented in which defendants with diagnosed Asperger's disorder were charged with murder. Specific symptoms in this disorder are discussed as they relate to issues of diminished capacity and criminal responsibility.

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Little is known about the prevalence of violence and autistic spectrum disorders. Many papers have dealt with the self-injurious behavior in such disorders. Even less is known about violence associated with Asperger's disorder, which was first described in 1944 by Hans Asperger.[1] It was not classified as a disorder in the DSM until 1994[2] (Table 1).

Asperger's disorder is considered by many to be a form of autism in which the patient has higher functioning. Generally, intellectual functioning is average to above average, and no language delay is present. Still, Asperger's disorder has many features in common with autism, including impairment in social interaction and restricted, repetitive, and stereotyped patterns of interests, behavior, and activity.

An Ovid Medline search for Asperger's and Violence yielded two journal articles. One was a case study of a 25-year-old who assaulted his mother[3] and the other described aggression and sexual offenses in an individual with Asperger's.[4] A review of articles from the *Journal of Autism and Developmental Disorders* from 1997 until the present revealed one article regarding Pervasive Developmental Disorders and aggression toward others.[5] The only study to date that attempts to correlate pervasive developmental disorders in forensic settings implied that 15 percent of juveniles evaluated in a forensic setting in Sweden had autistic spectrum disorders.[6] The prevalence of this disorder in a forensic setting is startling, given that the general prevalence of Asperger's disorder is 2.5 per 10,000.[7] This same review of epidemiologic studies in 2003 cited rates of aggression in autism as high as 38 percent.

This article discusses three defendants with diagnosed Asperger's disorder who were charged with murder. In each case, the defendant's diagnosis was related to his charge. In only one case did the defendant have a prior diagnosis of a pervasive developmental disorder. Therefore, the forensic psychiatrist was the first professional to make the diagnosis in the other cases, underscoring the need for forensic psychiatrists to gain expertise in this field.

Case Presentations

Sources of data for all three cases were legal records, hospital records, interviews of defendants, interviews of family members, and consultations. The first case involved a 22-year-old Hispanic male who was charged with the capital offense of murder of an 8-year-old boy. The defendant had a prior diagnosis of pervasive developmental disorder beginning at the age of 5 years. His family was in the military, and they moved often. Each time the defendant attended a new school, his teachers became aware of his impaired functioning and sent him for evaluation. His parents did not follow up with any treatments, although they were recommended. He was in special education classes in school and was often taunted by peers. Diagnosis was based on numerous medical records, an interview of the defendant, an interview of the defendant's family, neuropsychological testing, consultation with a psychologist specializing in the treatment of Asperger's disorder, and a neurologist experienced in the diagnosis and treatment of patients with autism. The defendant had average intelligence. He had stereotyped interests, including Game Boy games, weap-

Dr. Schwartz-Watts is Associate Professor of Psychiatry, Director of Forensic Services, Department of Neuropsychiatry, University of South Carolina School of Medicine, Columbia, SC. Address correspondence to: Donna M. Schwartz-Watts, MD, University of South Carolina School of Medicine, 15 Medical Park, Suite 102, Columbia, SC. E-mail: donnasw@gw.mp.sc.edu

Table 1 Diagnostic Criteria for 299.80 Asperger's Disorder[2]

A. Qualitative impairment in social interaction, as manifested by at least two of the following:
   1. Marked impairment in the use of multiple nonverbal behaviors such as eye-to-eye gaze, facial expression, body postures, and gestures, to regulate social interaction;
   2. Failure to develop peer relationships appropriate to developmental level;
   3. A lack of spontaneous seeking to share enjoyment, interests, or achievements with other people (e.g. by a lack of showing, bringing, or pointing out objects of interest to other people);
   4. Lack of social or emotional reciprocity.

B. Restricted repetitive and stereotyped patterns of behavior, interests, and activities, as manifested by one of the following:
   1. Encompassing preoccupation with one or more stereotyped and restricted patterns of interest that is abnormal, whether in intensity or focus;
   2. Apparently inflexible adherence to specific, nonfunctional routines or rituals;
   3. Stereotyped and repetitive motor mannerisms (e.g. hand or finger flapping or twisting, or complex whole-body movements);
   4. Persistent preoccupation with parts of objects.

C. The disturbance causes clinically significant impairment in social, occupational, or other important areas of functioning.

D. There is no clinically significant general delay in language (e.g., single words used by age 2 years or communicative phrases used by age 3 years).

E. There is no clinically significant delay in cognitive development or in the development of age-appropriate self-help skills, adaptive behavior (other than social interaction), and curiosity about the environment in childhood.

F. Criteria are not met for another specific Pervasive Developmental Disorder or Schizophrenia.

ons, and Legos. At the time of the crime, he was homeless. Three months prior to the incident, he was hospitalized with a Tylenol overdose. His parents did not allow him to return home. Unbeknownst to them, he slept in their backyard in a tool shed. He was employed at a local sandwich shop before the incident and he worked on the day of the incident. After work, he walked to a nearby grocery store and purchased two beers. He drank them while walking. As he neared an area where he planned to stay for the evening, he was approached by an 8-year-old on a bicycle who asked him about Game Boy games. He stated that he asked the boy to leave him alone and that the boy ran over his foot with his bicycle. He remembered pulling out his gun (which he always kept on his person for protection) and shooting the boy.

The second case involved a 35-year-old Pakistani male who was charged with murdering a neighbor who entered his apartment while the defendant was on the telephone with a friend, who overheard the ensuing argument. The defendant attempted to reason with the neighbor, who was alleging the defendant owed him money for a grill. The victim struck the defendant about the face, hitting his glasses. The defendant retreated to his bedroom where he kept guns. The victim followed. The defendant shot the victim repeatedly, emptying a .38-caliber revolver. He then got another gun from his bedroom and fired another shot into the victim's head. The defendant had no prior diagnosis of any pervasive developmental disorders. When he was a child, his parents had taken him to neurologists and psychiatrists, who failed to render a diagnosis. Yet his parents maintained that something was wrong with him. Diagnosis was based on interviews with the defendant, his family, neuropsychological testing and a consultation from a Neurologist experienced with the diagnosis of autism. The defendant was a "savant" in mathematics. He had numerous stereotyped, repetitive interests, including collecting items in multiples of two such as: health club memberships, bicycles, refrigerators, textbooks for his classes, guns, and jobs. He spent numerous hours studying World War II and knew many esoteric facts about Adolf Hitler. He was often taunted by others and had very few friends.

The third case involved a 20-year-old Spanish-American who was charged with murdering his girlfriend's father. The victim had phoned the defendant and asked him to pick up personal belongings left at the victim's beach house. The defendant stated that he had forgotten a belt and that the victim walked to his car to return the belt. The defendant pulled a shotgun out of the trunk as the victim approached and shot him. The defendant had not had a previous diagnosis of an autistic spectrum disorder, although he had undergone numerous psychiatric treatments and was given a diagnosis of and treated for Schizoaffective Disorder by a psychiatrist at the time of the offense. The diagnosis was based on an interview of the defendant and his parents and consultation with a psychiatrist specializing in the research, diagnosis, and treatment of autism. Neither neuropsychological testing nor neurological examination confirmed the diagnosis.

Diagnostic Challenges

The diagnosis was not difficult to obtain in the defendant in Case 1. The case was tried as a capital offense, and there were numerous investigators who

were able to retrieve important medical records and obtain collateral interviews with peers, teachers, and employers. The defendant was also sent for court-ordered forensic evaluation to determine his competency to stand trial and criminal responsibility. All parties involved agreed on the diagnosis. Consultations obtained also confirmed the diagnosis.

The disorder in the defendant in Case 2 was not difficult to diagnose because of his extraordinarily circumscribed, idiosyncratic interests in math, World War II, numbers, and television shows. All consultants in the case were able to confirm the diagnosis. The defendant's forensic interview was videotaped, making the presentation of his symptoms clear.

The defendant's disorder was difficult to diagnose in Case 3. His presenting symptom was intolerance and oversensitivity to a specific noise. As a child, he was unable to tolerate the noise of his parents talking on a telephone downstairs. On hearing this noise, he would become aggressive toward others and bang his head against the wall. His parents eventually attempted to construct a soundproof room. He had numerous idiosyncratic collections as a child, most notably of tire stem valves from bicycles or cars. He had impaired relationships with very few friends, and the two he had were described as "Gothic." His illness was complicated by severe substance abuse, including crack and alcohol. Neither the neuropsychological nor the neurological consultation was able to confirm the diagnosis. The forensic examiner videotaped an interview with the defendant, and the tape was sent to a prominent psychiatrist, known for his expertise in researching, diagnosing, and treating autism. The tape enabled the consultant to confirm the diagnosis.

Forensic Opinions

In Case 1, both the court-ordered forensic psychiatrist and the retained forensic psychiatrist agreed that the defendant's disorder was related to his charge. The defendant experienced "tactile defensiveness" that immediately preceded his violent outburst. Neurological examination revealed that the defendant had an oversensitivity to touch on his hands and feet. Also, the defendant's fascination with and collection of guns and swords was consistent with his stereotyped interests. The defendant in this case was not given the death penalty but was sentenced to life in prison. He has been seen in follow-up and has had a fair adjustment to incarceration. He is housed in a unit with other mentally disordered inmates.

In Case 2, the defendant also described oversensitivity to having his glasses touched. Collateral interviews from colleagues at work verified that the defendant became irritable whenever his head or glasses were touched. More important in this case, the defendant was unable to appreciate the "overkill" of his victim. When asked why he retrieved a second gun and shot the victim in the head, the defendant replied he has seen an episode of "America's Most Wanted," involving a shooting in a beauty shop in which the victim was not dead after being shot numerous times. The defendant stated he that had also seen many horror movies in which people were able to attack after being shot. During the defendant's jury trial, the judge directed a verdict of self-defense and the defendant was acquitted of all charges.

In Case 3, the defendant had difficulty recognizing the facial expression and nonverbal cues of his victim, a feature common in Asperger's disorder.[8,9] He consistently stated that his victim looked as if he was going to harm him and that he was defending himself. He was convicted of murder and sentenced to life in prison. The judge would not allow psychiatric testimony during his trial. He is presently housed in a unit for mentally disordered offenders.

Conclusions

Each of these cases illustrates the difficulty encountered by forensic psychiatrists in diagnosing Asperger's disorder. There is a paucity of experts in the field, and the disorder is extremely rare. Complicating these factors is the numerous previous psychiatric or neurological visits that either result in misdiagnosis or no diagnosis. Even consultants experienced in the field have difficulty diagnosing the illness in less traditional cases.

The importance of an accurate diagnosis is evident in each of these cases. The illnesses of the defendants were related to their crimes. In jurisdictions in which diminished capacity is used for defenses or mitigation, accurate diagnosis is critical. How often do forensic psychiatrists include questions about interests, social impairments, and language development in interviews? Persistence is sometimes necessary in obtaining a diagnosis as well. Although some findings on neurological or neuropsychological testing can as-

sist in confirming a diagnosis, these findings are not always present. The need for consultation with experts in the field is perhaps the most important vehicle for obtaining an accurate diagnosis.

Finally, these cases illustrate the need for forensic psychiatrists to research the relationship between pervasive developmental disorders and violence.

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