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PAPER

PSYCHIATRY & BEHAVIORAL SCIENCES; JURISPRUDENCE

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Personality Disorders and Criminal Responsibility in the Spanish Supreme Court*

ABSTRACT: The aim of this study is to determine how personality disorders (PDs) are viewed in relation to criminal responsibility (CR) within the jurisprudence of the Spanish Supreme Court**.** All sentences with PD from 2000 to 2006 were included. The most frequently occurring PDs are cluster B and nonspecific disorders, alongside another Axis I disorder. The Spanish Supreme Court admitted appeals on 50%, and sentencing criteria were changed in 25% of the cases. The most frequent outcome was in the first instance a minor reduction in CR and second full CR being upheld. The borderline PD and the comorbidity between a PD and an Axis I disorder are the variables associated with the decrease in CR. The assessment of CR in PD should be undertaken using the diagnosis as a base taking into account other elements, such as the type of PD, its seriousness, comorbidity, and relationship with the criminal behavior on trial.

KEYWORDS: forensic science, forensic psychiatry, criminal responsibility, personality disorder, volitional, cognitive capacities

The assessment of criminal responsibility (CR) is the result of the combination of psychological and psychiatric practice and legal regulations (1). The subjects with a mental pathology raise doubts concerning their CR in court proceedings. Many European state legislations clearly indicate that the mentally ill cannot be criminally prosecuted to the same degree as the mentally sane (2). In Spain, nobody can be regarded as totally CR, if they were not regarded as sane when acting in a delinquent manner. A verdict of guilty with complete CR can imply reclusion in a prison, while the absence of CR can imply acquittal and the imposition of security measures, such as admittance to a psychiatric hospital (3).

The assessment of CR depends on different factors, such as different legislations, the age of the subject, and measurement in different periods over time. Fazel and Grann (4) compared the psychiatric diagnoses of older offenders, referred by court for psychiatric assessment in Sweden, with younger offenders. The results indicated that older offenders were more likely to have dementia or an affective psychosis and less likely to be diagnosed with schizophrenia or a personality disorder (PD). Niveau and Sozonets (5) compared two psychiatric assessment samples carried out in Geneva in two different periods: 1973–1974 and 1997–1998. PD was the only variable influencing the researchers differently in the second period compared to the first period. In the second period, the PD diminished the risks of reducing the CR. It appears that the influence of PD on CR is limited (6). Unfortunately, very few studies examining PDs and their relationship with CR exist. However, PD constitutes a diagnosis worth considering, given its relationship with delinquent behavior. In fact, in the forensic and penitentiary areas (I. Idiaquez, J. Mansilla, L. Puig, A. Pujol, S. Mohíno, and JM. Roig-Fusté, Catalan Institute of Legal Medicine, Spain, personal communication), the prevalence of PD is higher than in the general population at large (7,8). Apart from antisocial PD, the symptoms of paranoid personality, passive-aggressive, and narcissistic behavior during adolescence are associated with an increased risk of committing violent acts against others in adolescence and early adulthood (9).

The factors behind delinquent behavior are as follows: first, "actus reus" or the delinquent act. Second, "mens rea" or the prevailing mental state at the time of committing the crime. Third, the relationship between the two at the moment. Determining the "mens rea" or mental state at the moment of committing a criminal act is a parameter for deciding the CR (10,11). In Spain, the current Penal Code has replaced the old term "alienated" with "psychic anomaly or alteration" (3,12). This new terminology allows for a PD to be included as a disorder that permits a possible modification of CR. Spanish legislation (3) highlights in two articles the circumstances that can modify CR. Article 20 of the Penal Code (3) states that a subject can be regarded as exempt from CR when committing a delinquent act, as a result of any psychic anomaly or alteration that impedes understanding the illegality of that act or when the subject acts in accordance with such a perception. Article 21 of the Penal Code highlights these aforementioned as causes when not all the requisites are met for exemption from CR.

In Spain, the assessment of CR requires a forensic evaluation of the psychic circumstances that can change it. CR in this case requires two elements. First, the capacity to understand the unjust nature of the committed act (cognitive capacity). Second, the capacity to modify ones behavior in concurrence with such an understanding (volitional capacity).

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There are three levels of psychic circumstances that can change the CR in Spanish Law. At the complete CR level, the understanding and willingness are not distorted or subject to deficiencies, alterations, or mental illness. At the partial CR level, a disturbance, deficiency, or mental illness exists that interferes with the superior psychic functions, although not completely canceling them out. There are two levels of partial CR: analogical mitigating circumstances and partial mitigating circumstances. Analogical mitigating circumstances require mild degree of diminished cognitive and volitional capacities, while partial mitigating circumstances require a severe degree of diminished cognitive and volitional capacities. Finally, at the non-CR level, the capacity to know and to act are annulled (13,14). Table 1 shows the CR possibilities according to cognitive and volitional capacities.

In Spain, absence of CR for psychic reasons includes the possibility of imposing "security measures." Spanish law takes "security measures" for some people declared insane, which can include restrictions of liberty or not. One of the measures in restrictions of liberty is commitment to a psychiatric hospital. Commitment of a subject to a psychiatric hospital is applied when the sentence would have included imprisonment, and the period of internment does not supersede the length of the sentence originally proposed. Measures without a restriction on liberty include outpatient psychiatric treatment, among others (3,13).

The Spanish Penal Code (3) does not determine types of disorders and their relationship with CR. With regard to CR, there is no standard regulation when it comes to PD. In the absence of such a distinction, the criteria of the Spanish Supreme Court jurisprudence are followed. This is the maximum and last court to resolve appeals, it establishes jurisprudence throughout the country, and the criminal chamber is responsible for all final appeals in criminal matters. Spanish Supreme Court jurisprudence demands the presence of an anomaly or psychic alteration which remarkably limits understanding of the illegal nature of the act, or to operate in conformity with this understanding and establish the relationship between the alteration and the delinquent behavior (15,16).

The aim of this study is to determine how PDs are viewed in relation to CR within the jurisprudence of the Spanish Supreme Court. First, to demonstrate the PD clusters and their comorbidity with other disorders. Second, to show the appeal admission rate and the change in CR criteria with respect to the court where the appeal has previously been heard. And third, describing the CR in relation to antisocial or borderline PD, and in those cases that include comorbidity with an Axis I disorder.

Methods

Sample and Procedure

This is a descriptive and retrospective study of sentences collected via the Spanish judicial database "La Ley." The sentences correspond with the criminal and military courts of the Spanish Supreme Court during the period from January 1, 2000, to October 31, 2006. Sentences included were those where the existence of a PD with or without an associated disorder was considered a proven fact. Sentences that only referred to Axis I disorders were excluded from the study. Mental retardation, included in Axis II of Diagnostic and Statistical Manual, Fourth Edition, Text Revision (DSM-IV-TR), has been considered as an Axis I disorder.

Of a total of 95 sentences studied, 86 (91%) appeals originated in criminal courts and nine (9%) in military courts. With regard to the offense, 29 (31%) were murder-related sentences, 18 (19%) sexual offenses, 18 (19%) crimes against public health, 11 (12%) crimes against property, eight (8%) injuries, five (5%) absence without leave, three (3%) fraud or falsification of public documents, two (2%) insulting a superior, and finally one (1%) disobedience against authority.

Analysis

To describe the sentences, variables are expressed as frequencies (%). The association between CR and clinical variables of interest was analyzed by means of the chi-square test**.** We also carried out a multiple logistic regression analysis to assess the independent role of the variables significantly related to the CR in the previous analysis. The level of significance proposed was $p < 0.05$. The data were analyzed through the 14.0 SPSS statistical package for Windows (SPSS Inc., Chicago, IL).

Results

Clinical Results

With regard to the cluster and PD type, of the 95 sentences studied, 86 (90%) presented either a specific or nonspecified type of PD while the remaining 9 (10%) indicated a comorbidity between two or more PDs. Table 2 indicates the frequency of the clusters and the type of PD. Sentences that included a cluster B were the most common (41%), with respect to those of clusters A (6%), cluster C (3%), and those that included a comorbidity between PD (10%). The sentences that included a cluster B appeared in similar proportion to those that included a nonspecific PD (40%). Minimal difference was found between the sentences that included a cluster A (6%) and those that included a cluster C (3%). The category of nonspecified PD (40%) differed significantly from clusters A (6%) and C (3%). The sentences that included a PD comorbidity (10%) appeared in almost similar proportion to those that included a cluster A (6%) and cluster C (3%), but were less frequent than those that included a nonspecific PD (40%).

In relation to the comorbidity with Axis I disorders, Table 3 illustrates the frequency of the type of Axis I disorders associated with PD in the sentences studied. The data show that substance abuse and mental retardation are the most common comorbid disorders. Differences exist between the sentences that indicated an Axis I disorder as well as a PD (58%), more than one Axis I disorder (7%) and those that presented no Axis I disorder (35%). Sentences that presented a PD associated with a single Axis I disorder were more frequent than those that presented no Axis I disorder and those that presented more than one Axis I disorder.

TABLE 1—*Criminal responsibility and cognitive and volitional capacities.*

	Not Responsible	Partially Responsible					
Capacities	Full Mitigating Circumstances	Partial Mitigating Circumstances			Analogical Mitigating Circumstances		Completely Responsible
Cognitive	Annulled	Annulled	Diminished	Diminished	Normal	Diminished	Normal
Volitional	Annulled	Diminished	Annulled	Diminished	Diminished	Normal	Normal

TABLE 2—*Frequency of clusters and personality disorders.*

Cluster	Personality	*N* (%)	*N* (%)
A	Schizoid	1 (1)	6 (6)
	Schizotypal	1 (1)	
	Paranoid	4 (4)	
B	Histrionic	1 (1)	39 (41)
	Antisocial	20 (21)	
	Narcissistic	1 (1)	
	Borderline	17 (18)	
C	Avoidant	0 (0)	3 (3)
	Dependent	0 (0)	
	Obsessive-compulsive	3 (3)	
Not specified			38 (40)
>1 disorder			9 (10)
Total			95 (100)

Juridical Results

Prior to appeal, of the 95 sentences studied, the courts considered 51 (54%) as exhibiting full CR and the remaining, 44 (46%), were considered diminished responsibility. Of the sentences including a reduction in CR, analogical mitigating circumstances were applied to 37 (84%), and partial mitigating circumstances to seven (16%). In no case was full mitigating circumstances applied.

Of the 95 appealed sentences, the Supreme Court rejected 52 (55%) appeals and accepted the remaining 43 (45%). Of those that were admitted for appeal, 22 (51%) saw a change in the CR criteria from that established at a prior trial, while the remaining 21 (49%) saw no change. Therefore, of the 95 sentences studied, only 22 (23%) saw a change in criteria, leaving the remaining 73 (77%) without a change in CR.

Of the 22 sentences where there was a change in CR criteria, eight (36%) were as a result of PD, two (9%) mainly because of an Axis I disorder and the remaining 12 (55%) because of the presence of a comorbidity between a PD and an Axis I disorder. In this group, the sentences that included a comorbidity between a PD and an Axis I disorder were more frequent than those where the criteria was changed solely because of the identification of an Axis I disorder or those that changed criteria as a result of the identification of a PD alone.

After the revision of appeal cases heard by the Supreme Court, 37 (39%) saw complete CR maintained while a reduction in CR was taken into account in the remaining 58 (61%). Of the sentences that saw a reduction in CR, analogical mitigating circumstances were applied to 39 (67%), partial mitigating circumstances to 18 (31%), and full mitigating circumstances only to one (2%). It should be pointed out that in all the revised cases the Supreme Court reduced the CR, with the exception of one case where analogical mitigating circumstances were applied at the initial trial, while the Supreme Court considered it complete CR.

Forensic Results

Table 4 shows the levels of CR in 37 sentences that include antisocial or borderline PD. At the complete CR level, the sentences that include an antisocial PD are the most frequent. At the diminished CR levels, borderline PD cases are predominant. These differences showed statistical significance ($\chi^2 = 9.651$; df = 3; $p = 0.022$).

In the 95 studied sentences, we analyzed the contribution of a comorbid Axis I disorder diagnosis in the Spanish Supreme Court assessment of CR. The results showed a significant association between CR decrease and the presence of an Axis I disorder ($\chi^2 = 24.627$; df = 3; $p < 0.001$). Table 5 shows the levels of CR in sentences with and without Axis I comorbidity. We observed that the sentences with an Axis I associated disorder are predominant in the decrease in CR.

We carried out a multiple logistic regression analysis, taking into account CR as the dependent variable and both the kind of PD and the presence of an Axis I associated disorder as independent variables. In this case, CR was grouped into two options: a complete CR or any level of diminished CR. The only variable independently associated with CR was the presence of an Axis I disorder (odds ratio = 9.45; 95% confidence interval: 3.45–25.90; $p < 0.001$).

Discussion

The results indicate that the most frequently occurring PDs in the sentences studied are antisocial, borderline, and nonspecified PD. The majority of these were associated with another Axis I disorder, in particular those associated with substance abuse. In court resolutions prior to appeal at the Spanish Supreme Court where PD was taken into account, either total CR or a slight reduction in CR, meaning analogical mitigating circumstances and exceptionally partial mitigating circumstances, was applied. The

TABLE 3—*Frequency of types of Axis I disorder associated with a personality disorder (PD).*

	Type		*N* (%)	*N* (%)
PD with 1 Axis I disorder	Alcohol abuse and/or dependence		10 (18)	55 (58)
	Multiple drug use		31 (56)	
	Pathological gambling		1 (2)	
	Mental retardation*		9 (16)	
	Delusional disorder		1 (2)	
	Psychotic episode		1 (2)	
	Adaptive disorder		1 (2)	
	Post-traumatic stress disorder		1 (2)	
PD with >1 Axis I disorder	Depressive disorder	Generalized anxiety disorder	1 (14)	7 (7)
		Obsessive-compulsive disorder	1 (14)	
	Substance abuse and/or dependence	Delusional disorder	1 (14)	
		Schizophrenia	1 (14)	
		Mental retardation*	1 (14)	
		Anorexia nervosa	1 (14)	
		Generalized anxiety	1 (14)	
PD without an Axis I disorder				33 (35)

*To be considered as an Axis I diagnostic.

TABLE 4—*Levels of criminal responsibility (CR) in antisocial and borderline personality disorder (PD).*

	PD	
	Antisocial	Borderline
CR	*N* (%)	*N* (%)
Complete	11 (85)	2 (15)
Analogical mitigating	6 (40)	9 (60)
Partial mitigating	2 (25)	6 (75)
None	1 (100)	0 (0)

TABLE 5—*Levels of criminal responsibility (CR) in sentences with and without Axis I comorbidity.*

	Personality Disorder	Personality Disorder with Axis I
CR	*N* (%)	*N* (%)
Complete	24 (65)	13 (35)
Analogical mitigating	7 (18)	32 (82)
Partial mitigating	2 (11)	16 (89)
None	0 (0)	1 (100)

Spanish Supreme Court rejected appeals in half of the sentences. Of the admitted appeals, the CR criteria were changed in 50%, mainly because of comorbidity between PD and an Axis I disorder. It seems that the Spanish Supreme Court hardly modified the CR criteria in the PD in regard to the resolutions passed by previous trials. From the results, it can be deduced that the Spanish Supreme Court jurisprudence indicates that PD reduces CR slightly, especially if the PD is accompanied by an Axis I disorder. The results correspond to those of Niveau and Sozonets (5) and Rudnick and Levy (6), who indicate that the relationship between PD and a reduction in CR is weak. Other authors (17) have indicated that PDs are not a legal criteria for establishing a lack of CR. The seriousness of the PD should be considered in any assessment of CR. Other lines of investigation attempt to clarify whether PD are mental disorders or not (18). Thus, some authors accept the idea that Axis I (psychotic) disorders annul CR, but in antisocial or borderline PD there are some doubts, because the subjects are conscious of their actions (19). In fact, the majority of sentences that included an antisocial PD in our study show complete CR**.** However, in the sentences that included borderline PD, the Spanish Supreme Court accepted a diminished CR**.** For some authors on the contrary, the PD do not satisfy the no CR criteria, and only serious Axis I disorders can be considered as non-CR (17,20). Nevertheless, other more restrictive authors (e.g. [21]) have suggested that the Axis I diagnosis, schizophrenia, should not be associated with a lack of CR. Kröber and Lau (2) conclude that mental illness and moderate intoxication, sexual deviation, and PD do not annul the capacity to understand situations. In agreement with Nedopil (21), the individual psychopathology of a subject with respect to delinquent behavior is more important than the clinical diagnosis per se. The CR in subjects with psychotic disorders depends on the cognitive alteration and the volition derived from the disorder. In this sense, evaluating the CR in a subject who commits a crime as a result of a delusional disorder is not the same as evaluating it in a residual schizophrenic with a minor personality alteration.

In agreement with some authors (8), the difficulty in assessing the CR in PD is that these do not cause the cognitive and volitional capacities to deteriorate considerably. Thus, people with a PD are seldom considered as having no CR. The important factor in assessing CR is the study of cognition and volitional capacity in the disorders. In forensics, valid and reliable systems for evaluating cognition and volitional capacity do not exist. Grinage (22) explains volitional capacity via concepts, such as impulsive control and compulsive behavior. In determining the control of impulses, the ego-syntonic and ego-dystonic behavior should be considered. If an impulse is in harmony with the individual (ego-syntonic), there is no intention in the individual to resist such an impulse. In ego-dystonic impulses, the volition is impaired, while in the ego-syntonic impulse it is intact. In psychosis or mania, the conduct is ego-syntonic, but a cognitive dysfunction exists. Neurotic disorders are ego-dystonic whereas PDs have ego-syntonic symptoms (23).

In Spain, the current Penal Code of 1995 (3) stipulates the CR for those subjects who have the capacity to understand the illegality of the act (cognitive capacity) and whose capacity to act (volitional capacity) conforms to this understanding. As a result, it is the legal criteria and not the psychiatric diagnosis that determines the CR. In this way, our results prove that the Supreme Court's tendencies in the assessment of CR are basically as follows: first, in general, PD is not reason enough to reduce the CR. Second, the CR is only reduced in PD comorbidities when an Axis I disorder is present. Third, antisocial PD is not considered a reason for reducing the CR. Fourth, only borderline PD is considered by the Supreme Court to reduce the CR.

In the forensic assessment, it is necessary to consider the psychological impact the disorder produces in the subject. The forensic assessment implies the study of the cognitive and volitional capacities of a subject with PD with regard to a specific act in a chronologically determined moment. To do this, four criteria are used. First, the qualitative criteria that establish the type of disorder, the impact on the mental functions, and their repercussion on behavior. Second, the quantitative criteria that establish the intensity or degree of alteration in the cognitive and volitional faculties of a subject. Third, the chronological criteria that establish the degree of permanence of the disorder. And finally, the causal criteria that establish the relationship between the disorder and the delinquent behavior (14).

Fennig et al. (24) establish three criteria for evaluating the CR in subjects with PD in murder cases. First, establishing whether the individual suffers from a severe mental disorder. It is necessary to establish a PD diagnosis on the basis of DSM-IV-TR and International Statistical Classification of Diseases and Related Health Problems, 10th Revision (ICD-10). Also, determining whether the disorder is severe in all sections. If necessary, multiple sources of information throughout the individual's life are used, as well as a psychological test. Second, demonstrating that the subject has reduced capacity to understand or to control his or her actions. Third, explaining coherently whether the action results from a relationship of dependency with the pathology, rather than merely being a chain of antisocial behaviors.

The presented results are difficult to compare with those of other studies, given that almost no research has been undertaken to date concerning CR and PD. Another limitation is that of the retrospective study of databases, given that there is not sufficient information available concerning how the PD has been evaluated. Other unresolved questions include the reasons why only half the PD-related sentence appeals were admitted for hearing by the Spanish Supreme Court.

Future research should look into the relationship between the dimensions of PD, CR, and violence. Nestor (25) indicates that there are four related fundamental personality dimensions: impulse control, affect regulation, narcissism, and paranoid cognitive personality style. Low impulse control and affect regulation

increase the risk of violence with substance abuse disorders. Paranoid cognitive personality style and narcissism increase the risk in subjects with schizophrenia and in individuals with PD. The comorbidity of the paranoid, antisocial, and impulsive PD with psychosis increases the risk of violence (26). Palermo (27) suggests that a person with a decompensated PD who commits a crime could possibly be considered not legally responsible. The court would determine whether at the time of the offense the PD may have crossed over to a psychotic state of mind that impaired understanding and volitional capacity. Palermo (27) also suggests that a person with a borderline PD, with emotional and behavior instability characteristic, may occasionally undergo micro-psychotic periods with conduct disorganization during severe stress, and may commit crime during these periods. Our results seem to be in agreement with this point of view.

Dressing et al. (28) conclude in their study that in 15 European Union member states, differences and similarities in legislation in the placement and treatment of mentally ill offenders exist. The highest level of agreement across the member states is in schizophrenia and other psychotic disorders. The widest ranging is the inclusion of addiction, neurotic, and PDs (28).

The results of the study concluded that the Spanish Supreme Court jurisprudence indicates that PD can be regarded as the necessary cause or trigger, but not sufficiently to reduce CR. The CR in PDs varied in relation to the PD type, its seriousness, its comorbidity with Axis I disorders, the level of influence on the volitional capacity, the type of delinquent behavior, and the specific circumstances. The evaluation of CR is the result when combining the legal system and clinical practice (1). The assessment of the psychic alteration as a possible cause for modification of the CR is not resolved with diagnose alone. The psychological effect that the disorder produces in the cognition and/or volition of a subject in relation to a specific behavior should also be evaluated. The psychological effect has to consist of a disturbance of a subject's psychic faculties that impedes them being aware of and orienting their behavior according to this awareness.

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