Culpability and Accountability: The Insanity Defense

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Key Points

- The insanity defense is an element of many legal systems, but not of all.
- The insanity defense is a topic of much debate; central issues include: the criteria of legal insanity, the reliability of forensic psychiatric and psychological assessments, and the helpfulness of neuroscience data for insanity evaluations.
- Many insanity criteria include both a knowledge/appreciation component and a control component; in brief, the question is: did the defendant know that what he was doing was wrong and/or could he control his conduct?
- Legal insanity is a legal matter. Meanwhile, in order to arrive at a conclusion about the defendant's sanity, mental health experts are asked to provide information about the mental state—in terms of psychopathology and its impact on the behavior—of the defendant. In some legal systems, the behavioral expert is allowed and/or explicitly asked to formulate a conclusion regarding the matter of legal insanity as well.
- Neuroscience may be helpful to diagnose a disorder, in particular neurological disorders such as a brain tumor or dementia. If neuroimaging is being used, in

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principle, it is advisable to also perform a neuropsychological evaluation in order to relate imaging findings to cognitive functioning. A neurological abnormality is not necessarily legally relevant.

Introduction

The insanity defense provides the possibility that a defendant who committed a crime is excused because of the presence of a mental illness at the time of the act (Meynen, 2016, 2021). Typically, it is not just the presence of a mental disorder, but its specific legally relevant influence that exculpates a defendant. Even though it may seem intuitive that, at least in some cases, a mental disorder excuses a person for his criminal conduct, the insanity defense is one of the most debated topics in criminal law.[1] In this chapter, we will consider the insanity defense by looking at some of the central issues under debate. The structure is as follows.

First, we address the legal framework of culpability and accountability as well as the ethical basis of the insanity defense. Next, we discuss the concept of mental disorder underpinning the insanity defense. Then we examine several influential legal criteria for insanity in the Western world. As we will see, these criteria often concern the defendant's lack of knowledge about the wrongfulness of the act and/or a lack of control over one's behavior. It will also become clear that there are many differences between legal systems regarding the insanity defense. Thereafter, we consider questions and concerns about the reliability and vulnerability of insanity assessments. Finally, we briefly discuss the role neuroscience and neuropsychology may play to increase the validity of insanity evaluations.

The Legal Framework of Culpability and Accountability

In Western criminal justice systems punishment is allowed only if a defendant is criminally responsible for an offense. Mental disorder can preclude criminal responsibility in most legal systems in at least two ways.

For most offenses it is not only required that the defendant committed a certain criminal act (*actus reus*—'wrongful act'), but also that he or she acted with a particular mental state (*mens rea*—'guilty mind'). The particular mental state

[1] Where we write he/his in this chapter, depending on the context, it also refers to she/her, and vice versa. On topics discussed in this chapter, see also Meynen (2016, 2021).

specified in the elements of the crime, for example 'recklessness' or 'intent', has to be proven beyond a reasonable doubt. It is possible that a mental disorder amounts to a so-called failure of proof defense, meaning that the required form of mens rea cannot be proven (Morse, 2011). An often-quoted, though a bit of an odd example, is the defendant who, under the influence of a psychotic delusion, believes that he is squeezing a lemon while actually choking somebody to death. This defendant does not act with the intent to kill, but merely with the (non-criminal) intent to squeeze a lemon. Mens rea for intentional homicide cannot be proven and the defendant will be acquitted.

More often, however, mental disorder is not an obstacle to prove the requisite mens rea. For example, a defendant under the influence of a persecutory delusion that police officers are plotting against her may act violently against a police officer. While this person has a severe mental disorder, she did act with the intention to harm the police officer. In this case, both actus reus and mens rea can be proven (e.g., intentional assault). However, due to the severe illness, the defendant may raise the insanity defense. The insanity defense is a so-called affirmative defense, meaning that the defendant does not deny the allegations (actus reus and mens rea), but offers a reason why he or she cannot be held responsible for this act (Morse, 2011). Most Western legal systems acknowledge insanity as an affirmative defense (Sinnot-Armstrong & Levy, 2011). However, Sweden and some states in the United States have abolished insanity as an affirmative defense. Mental disorders in these jurisdictions can only exculpate if the defendant did not act with mens rea due to the disorder (Morse & Bonnie, 2013).[2]

The chances of success of raising the insanity defense depend on the substance of the defense in the particular jurisdiction the defense is raised. For example, until recently, in Norway psychosis was a sufficient (and necessary) reason for legal insanity, but usually jurisdictions require that, in addition to the requirement of mental disorder, certain criteria for insanity are met. The formulation of these criteria varies across jurisdictions (see section "Legal Criteria for Insanity in the Western World"). Self-induced mental disorder due to, for example, the voluntary ingestion of illegal substances resulting in a psychosis usually precludes a successful insanity defense ('prior fault' or 'culpa in causa') (Dimock, 2011).

Typically, a successful defense of insanity does not lead to an outright acquittal. While *punishing* a defendant who is not responsible is precluded in Western criminal justice systems, usually some form of *preventive detention* is allowed

[2] This approach has received criticism for being unfair.

when the defendant is presumed dangerous due to mental disorder.[3] Treatment of the disorder should reduce the risk of recidivism to acceptable levels (Chapters 25 and 29). In a way, therefore, the mental illness constitutes a double-edged sword for defendants. On the one hand, they are exculpated for their crime, but on the other hand, they may be sentenced to (indefinite) treatment until risk levels have sufficiently decreased (the specific regulations vary across jurisdictions).

In order to support the fairness of the insanity defense, people tend not only to refer to legal matters, but also to ethical considerations (Chapter 31). For instance, Bonnie writes: "The insanity defense, in short, is essential to the moral integrity of the criminal law" (1983). This moral perspective highlights that it is not morally justified to blame and punish people if they do not *deserve* such blame and punishment because they were not actually responsible for their actions.

Mental Disorder

The insanity defense predates psychiatry as a medical specialty. Historically, various criteria for insanity have been used (Robinson, 1996). One well-known criterion in the Western world is the so-called wild beast test. According to this criterion, a defendant "must be a man that is totally deprived of his understanding and memory, and doth not know what he is doing, no more than an infant, than a brute, or a wild beast; such a one is never the object of punishment" (Robinson, 1996, p. 134). Notably, this criterion for insanity does not refer to any (specific) mental disorder or deficiency—so, to psychopathology. Rather, it refers to children and wild beasts as non-rational beings, but not to pathological categories. Nowadays, however, the standards for insanity tend to refer to some form of mental disorder or deficiency, though the formulations vary.

An important question—and issue of debate—is to which extent such a reference to mental disorder or deficiency refers to the medical domain or whether it is a legal notion. Until recently, in Norway, the 'medical principle' has been used (for instance in the Breivik case [Melle, 2013][4]): insanity was merely about the presence of a psychotic disorder at the time of the crime, and the psychotic disorder was considered to refer to the ICD-system, The International Classification

[3] The apparent assumption in various Western legal systems that there is a special connection between being not responsible due to mental disorder and being dangerous is, at least to some extent, challenged in Bijlsma et al. (2019).

[4] On 22 July 2011, in Norway, Anders Breivik killed 77 people, many of whom were youths attending a summer camp. Initially, psychiatrists considered him psychotic and legally insane, but eventually the court considered him sane.

of Diseases (currently, the 11th edition), which is a medical classification system (Syse, 2014; Gröning et al., 2020).[5] However, in the United States, according to Stephen Morse, the situation is different:

> The criminal law can, but need not, turn to scientific or clinical definitions of mental abnormality as legal criteria when promulgating mental health laws. The Supreme Court has reiterated on numerous occasions that there is substantial dispute within the mental health professions about diagnoses, that psychiatry is not an exact science, and that the law is not bound by extra-legal professional criteria. The law often uses technical terms, such as "mental disorder," or semi-technical qualifiers, such as "severe," but non-technical terms, such as "mental abnormality," have also been approved. Legal criteria are adopted to answer legal questions. As long as they plausibly do so, they will be approved even if they are not psychiatric or psychological criteria. (Morse, 2011, p. 894)

Apparently, the notion 'mental disorder' does not necessarily refer to medical criteria, at least not in the US context. Apart from this issue, it is good to realize that, ultimately, it is the court or jury that decides whether the criteria for insanity have been fulfilled. This is particularly relevant in cases where the experts disagree about the presence of a mental disorder, then the court or jury will take a prominent role in the decision.

Legal Criteria for Insanity in the Western World

Arguably, the most well-known criterion for legal insanity in the Western world is the M'Naghten rule. It was established in 1843, in the aftermath of the case of Daniel M'Naghten. He suffered, it is assumed, from a paranoid delusion for some time: he believed that the British political party of the Tories was behind the problems in his life. At some point he tried to assassinate the Tory Prime Minister, Sir Robert Peel. But, presumably because of a mistake, he shot—and killed—his secretary, Edward Drummond, instead. M'Naghten was acquitted by reason of insanity, but this result led to an uproar. It would not be the last insanity verdict that led to public upheaval. Judges were then asked to formulate the criteria for legal insanity. This was their response to this question:

> At the time of committing the act, the party accused was labouring under such a defect of reason, from disease of the mind, as not to know the nature and quality of the act

[5] See the English translation of the Breivik verdict Lovdata TOSLO-2011-188627-24E.

> he was doing; or if he did know it, that he did not know what he was doing was wrong (M'Naghten)[6]

So, if the defendant, due to a disease of the mind, did not know the nature, quality, or wrongfulness of the act, he is legally insane. The standard is currently being used in England and Wales and in many states in the United States. However, there is debate about this standard. The standard is generally considered to cover at least in part what people feel to be relevant for legal insanity. According to many scholars, if a person fulfills the criteria of the standard, the person should be considered insane. Still, many are worried that the criterion for insanity is too narrow (Meynen, 2016; Moratti & Patterson, 2016; Sinnot-Armstrong & Levy, 2011; Slobogin, 2018). Mental illnesses may not only lead to insanity, it is argued, because they affect a person's knowledge—the M'Naghten rule is all about the defendant's knowledge—but also by affecting the person's behavioral control. For instance, a defendant may have been forced to do something by an auditory command hallucination, which she could not but obey. She may still have known the nature and quality of the act and she may even have felt that the act was wrong, but she could not disobey the command. In a way, the commanding voice 'hijacked' her behavioral control: she was 'made to do' what she did by a psychopathological phenomenon. Still, this person cannot be found legally insane under M'Naghten. Meanwhile, many may feel that this person should also be a candidate for the insanity defense because her *behavior* was to such a large degree determined by a psychopathological phenomenon (the voice). Many countries and jurisdictions therefore have added a 'control element' to the 'knowledge' part. An example is the Model Penal Code insanity test, which is used in a minority of US states. It reads as follows:

> a person is not responsible for criminal conduct if at the time of such conduct as a result of mental disease or defect he lacks substantial capacity either to appreciate the criminality (wrongfulness) of his conduct or to conform his conduct to the requirements of the law.[7]

In this standard we recognize the component of appreciating the wrongfulness (echoing a part of M'Naghten), but there is a second element referring to one's behavioral control. The Model Penal Code standard acknowledges that the effects of mental illnesses may be such that, although the person recognizes that what he is doing is wrong, the person could not control his behavior in accordance with

[6] M'Naghten's Case, 10 Cl. & Fin. 200, 8 Eng. Rep. 718 (H.L. 1843).

[7] Model Penal Code (American Law Institute 1985).

such knowledge. There are many more countries that have standards consisting of these two components—knowledge/appreciation and control—for instance Germany (German Penal Code (*Strafgesetzbuch*), section 20), Italy (Messina et al., 2019), and China (Zhao & Ferguson, 2013).

In Norway, until 2020, a very different insanity criterion was used. As, Løvlie writes, "The Norwegian Penal Code section 20, first paragraph letter b, has a specific reference: 'To be liable for punishment the offender must be accountable at the time of the act. The offender is not accountable if, at the time of the act, he/she is […] psychotic […]'" (Løvlie, 2019, p. 81). This criterion deviates from both standards we discussed—M'Naghten and the Model Penal Code test—in two ways. First, it does not stipulate a specific effect of the mental illness. While M'Naghten refers to effects on knowledge and the Model Penal Code test refers to effects on appreciation and control, the Norwegian standard merely mentions the illness. Second, while both earlier mentioned standards refer to mental disease *in general*, the Norwegian Penal Code specified a type of disorder: psychosis. Psychosis is central: if a person was psychotic at the time of the crime, the defendant will be considered legally insane—but if the defendant was not psychotic, the defendant will be considered sane (Melle, 2013). This is why in the Breivik case the central question was whether he suffered from a psychotic disorder. The first pair of psychiatrists who had evaluated Breivik concluded that he suffered from a psychotic illness, more specifically schizophrenia, paranoid type. Meanwhile, the second pair of psychiatrists concluded that even though there was some psychopathology, the defendant was not psychotic, and therefore, not legally insane. The court followed the second pair, providing a detailed argument explaining this decision (Syse, 2014).[8]

Yet another legal approach to defining insanity is found in The Netherlands. The criterion for legal insanity reads: "A person who commits an offence for which he cannot be held responsible by reason of the mental disorder, psychogeriatric illness and/or intellectual disability is not criminally liable."[9] This standard leaves both the nature and impact of the mental disorder open. This was, at the time, done deliberately: to leave as much room for both the expert and the court in deciding about a person's legal insanity. Research shows that judges apply a wide variety of criteria to decide on the insanity of the defendant (Bijlsma, 2016).

As said, ultimately, the judge or jury will decide whether the insanity criteria have been fulfilled. But in some jurisdictions, behavioral experts are allowed not

[8] See the English translation of the Breivik verdict Lovdata TOSLO-2011-188627-24E.

[9] Netherlands (1997). *The Dutch penal code*. Littleton, CO: F.B. Rothman. The American Series of Foreign Penal Codes. With adaptation because of a recent modification.

only to make statements about the presence of a mental disorder and its impact, but also regarding the ultimate question of the defendant's insanity, while in other legal systems, such statements are not allowed. Some scholars argue that as legal insanity is a legal matter it would be wise for behavioral experts not to make statements about it, and to restrict themselves to psychiatric and psychological concepts (Appelbaum, 2008).

In this section we have discussed four criteria for legal insanity, illustrating the variety of standards: the M'Naghten rule, the Model Penal Code test, psychosis as a criterion, and the 'open' criterion used in the Netherlands. Even though there is much variation, elements of the standards tend to be: a mental disorder resulting in problems with knowledge/appreciation and/or behavioral control.

Reliability of Insanity Assessments

Several concerns have been raised regarding the reliability of psychiatric and psychological insanity assessments, in this section we discuss two important topics. First, the evaluation of insanity concerns a moment in the *past*, and the past is gone. Typically, the crime has been committed weeks or months before the psychiatric evaluations take place. This entails that the mental state of the defendant may have changed considerably compared to the moment of the crime. For instance, the crime may have been committed under the influence of a psychotic state, induced by taking Mefloquine (Lariam), which is a medication against malaria which may sometimes induce a psychotic state. The defendant may have fully recovered by the time the evaluation is performed, so the psychosis will no longer manifest itself in the person's behavior. This means that, to a great extent, the psychiatrist will have to rely on the information the defendant can provide—as far as he remembers—about the events at the time of the crime. In addition, a relevant issue here may also be that our memory is not always reliable. If psychiatric diagnosis may be challenging in everyday clinical work, it will be extra challenging in retrospect.

Still, we should realize that both in psychiatry and in criminal law, retrospective assessments are not exceptional (Meynen, 2016). In fact, judgments about a defendant's intent, *mens rea*, or recklessness are also in retrospect; a criminal case always starts *after* the act, never during the act. In defense of retrospective assessments of mental illness in defendants, Morse and Bonnie write that the "severe mental disorder that is necessary for practical support of an insanity defense is in most cases easier to prove than ordinary mens rea" (2013, p. 493). In other words, the psychiatrist's task to retrospectively assess an illness may,

in this respect, be easier than making a judgment about the crucial legal issue of mens rea. In addition, we should acknowledge that psychiatrists more often retrospectively diagnose a disorder, for instance in civil cases, in cases of people who have been traumatized, or in everyday clinical practice. For instance, if a patient is seen by a psychiatrist because of a depressive episode, the psychiatrist will try to determine whether there have been depressive episodes in the past.

A second point of concern regards the risk of faking a disease (malingering) or faking good (dissimulation, behaving as if one is healthy) (Gold & Frierson, 2018). To a considerable degree, psychiatrists have to rely on a patient's or defendant's own words in order to be able to establish the presence of a disorder. Psychiatry has a profound interest in 'subjective' phenomena, such as a person's mood, fears, anger, hopes, desires, obsessions, etcetera. Usually, people have to *tell* psychiatrists and psychologists about these phenomena, otherwise they will not know about them; 'objective' tests for establishing the presence of a mental illness are—apart from some neuropsychiatric disorders (see below)—not available. More specifically, there are currently no brain scans that could detect or visualize paranoid delusions, hallucinations, sexual desires, and so on. Yet, patients and defendants need not be truthful about the signs and symptoms they are experiencing. In fact, the risk of deception is often considered increased in the context of a criminal case. Defendants may try to behave as if they have a disorder if they feel that this will help to achieve a favorable legal outcome. Being considered insane may result in involuntary admission to a mental hospital but for some defendants this may be preferable to a long prison sentence. In other cases, a defendant may feel that he should hide his symptoms and try to convince the psychiatrist and psychologist that he is sane in order to avoid an insanity verdict. The risk of both scenarios is generally recognized in forensic psychiatry and psychology—and it entails a challenge (Meynen, 2017). This makes forensic psychiatric assessment (extra) vulnerable for malingering and faking good.

Surely, forensic evaluators are aware of this risk, and they will be on the alert regarding discrepancies between the things a defendant says or between the defendant's account and information from other sources, such as police files or, if available, medical information about earlier admissions to a mental hospital. For instance, the expert may obtain parts of a person's medical record, providing evidence of (previous) psychotic and/or manic episodes. Witness accounts may provide important information about the defendants' actions and their utterances at the time of the crime. In general, obtaining and corroborating evidence from different sources is crucial in forensic psychiatric assessments.

Neuroscience and Insanity Evaluations

Can neuroimaging be used to make psychiatric assessments of legal insanity more 'objective' (Meynen, 2020)? Brain scans have already been used in assessments of a defendant's sanity (de Kogel & Westgeest, 2015). Yet, concerns have been raised that showing brain scans in the courtroom may unduly impress the jury (Shniderman, 2014). In clinical and forensic practice, neuroimaging can be helpful to diagnose a neurological or neuropsychiatric disorder, such as Alzheimer's dementia or vascular dementia. Still, in the standard diagnostic process of psychiatric disorders such as bipolar disorder, autism, depression, and psychosis, brain scans are not routinely used, in spite of decades of neurobiological research on these disorders. Incidentally, brain scans may be used in psychiatric practice, but often to exclude the presence of a neurological disorder, such as a brain tumor or epilepsy (Linden, 2012; Meynen, 2020).

In a forensic setting, if some brain abnormality has been found, the relevance of that abnormality (e.g., a brain tumor) with respect to the legally relevant act has to be established. Some brain tumors may not influence a person's mental functioning at all, while others have disastrous consequences for a person's capacities. In order to get more insight into the impact of the neurological or neuropsychiatric disorder on the person's functioning, a neuropsychological evaluation may be performed (Meynen, 2019). In such an evaluation, a neuropsychologist examines specific neurocognitive functions—such as planning and impulse-control—and, if dysfunctions are observed, she tries to relate them to behavioral problems the person may encounter. This may also shed light on how the brain abnormality may have impacted on the person's behavior at the time of the crime. It is good to keep in mind that brain abnormalities per se do not have to be relevant for the question about a defendant's sanity: it is always about the relevance of the abnormalities for the legal question at hand. In fact, given the current state of neuroscience, the role of neuroimaging and measurements of biological parameters is very limited. Still, in some criminal cases, it provides relevant information. Therefore, it is important that forensic psychiatrists and psychologists recognize signs and symptoms of neurological disease and know when and how to consult a neurologist for further examination.

Conclusion

Legal insanity is an intriguing element of criminal law and it is often considered crucial for the fairness of the justice system. We have discussed some of the

challenges it entails, both from a legal perspective and from a psychiatric and psychological perspective. Even though, eventually, the judge or jury decides about a defendant's sanity, it is of utmost importance that behavioral experts provide them with all the relevant information in order for justice to be done.

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