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# Mental disorder and legal responsibility: The relevance of stages of decision making

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ABSTRACT

The paper discusses the relevance of decision-making models for evaluating the impact of mental disorder on legal responsibility. A three-stage model is presented that analyzes decision making in terms of behavioral control. We argue that understanding dysfunctions in each of the three stages of decision making could provide important insights in the relation between mental disorder and legal responsibility. In particular, it is argued that generating options for action constitutes an important but largely ignored stage of the decision-making process, and that dysfunctions in this early stage might undermine the whole process of making decisions (and thus behavioral control) more strongly than dysfunctions in later stages. Lastly, we show how the presented framework could be relevant to the actual psychiatric assessment of a defendant's decision making within the context of an insanity defense.



## 1. Introduction

In court, forensic psychiatrists and psychologists[1] are regularly asked to assess a defendant's mental condition within the context of an insanity defense (Rogers & Shuman, 2005). If they decide that psychiatric illness played a substantial role[2] in the commitment of the crime, the court may rule that the defendant does not bear legal responsibility for their action. There is ample literature on considerations that could inform a psychiatric assessment within the context of an insanity defense, which partly depend on the various legal rules that guide such a defense, such as the M'Naghten Rule, Durham Rule, and Model Penal Code (Borum & Fulero, 1999; Buchanan, 2000; Elliott, 1996; Morse, 2011; Rogers & Shuman, 2005). In general, criteria that often feature in legal insanity standards are:

A) that defendants did not know their behavior was morally wrong
B) that defendants did not know what they were doing
C) that defendants had no control over what they were doing.[3]

Although differences between legal insanity standards might partially reflect different views on the general conditions for responsibility, they could also be seen as different ways of expressing the same underlying idea: a mental disorder may exculpate defendants if the disorder compromised their ability to make decisions for action.[4] After all, the different components mentioned appear to be relevant as far as they have influenced a defendant's decision making about the course of action (Meynen, 2013). The idea that mental disorders may undermine a person's responsibility for actions by undermining decision-making processes is not only reflected in legal regulations, but also in moral philosophy (Kalis, 2011; Meynen, 2010; Wallace, 1994). In fact, the elements of a 'healthy' decision-making process could be seen as elements of normal behavioral control by an agent. In standard situations, we hold each other morally responsible for those actions that are self-initiated and the result of a decision-making process in which the subject could, if necessary, consciously intervene. We therefore do not hold people morally responsible for behaviors like sneezing or reflex movements, or behaviors brought about by coercion (Kalis, 2011; Wallace, 1994). However, in the context of this paper we are primarily concerned with legal responsibility, and it must be noted that moral and legal responsibility do not always go together. We take moral responsibility to be a prerequisite for legal responsibility (for an overview of different responsibility concepts see Vincent, 2011). In the present paper, we will consider legal insanity as a condition in which the defendant's decision-making process was dysfunctional to such an extent that the defendant no longer bears legal responsibility for the behavior resulting from it.

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[1] In this paper we focus on psychiatrists, but much of what we state about psychiatrists is also relevant for psychologists.

[2] The question what constitutes a 'substantial role' is answered differently in different legal frameworks, more details on this below.

[3] See, e.g., Elliott (1996), Robinson (1998), and Simon and Ahn-Redding (2006). A and B are, for instance, reflected in the M'Naghten Rule, C is reflected in the Irresistible Impulse Test/Rule, while A and C are reflected in the Model Penal Code.

[4] As Alec Buchanan writes: "If psychiatric conditions are to be grounds for exculpation, they must impair the sufferer's ability to choose. There are many ways in which they may do this" (Buchanan, 2000, p.80). In discussing decision making in this paper, we only focus on making decisions *for action*, and thus leave aside other types of decision making.

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Although much has been written about issues related to legal insanity, central questions in the field of criminal law and forensic psychiatry and psychology remain: how to optimally assess a defendant's decision-making capacities at the time of the crime, and how to standardize judgment procedures to such an extent that equality before the law is guaranteed, while also leaving room for those aspects of clinical judgment and experience that may resist rigid standardization? In this paper we aim to contribute to these debates, proposing an underlying theoretical framework derived from (neuro)psychological and philosophical research on decision making, that could contribute to the specification and conceptual justification of criteria for criminal responsibility as they are used in different legal systems. We will not focus on specific criteria employed in individual jurisdictions (Meynen, 2012, 2013). More precisely, we aim to transcend the boundaries of particular jurisdictions in order to develop a general and conceptual perspective on mental disorder and legal responsibility. For instance, when we use the phrase 'a disorder compromised one's ability to make decisions for action' (see above), this is a conceptual statement rather than the wording of a particular legal insanity standard. In fact, even if a legal insanity standard does not explicitly mention 'compromised decision making', this does not rule out the relevance of decision making to the phenomena mentioned in these standards (see also above). For instance, a capacity for decision making appears to be *implied* in the Model Penal Code when it states that "…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 of his conduct or to conform his conduct to the requirements of the law" (American Law Institute, 1962). This statement implicitly refers to decision making, as we typically conform our conduct to the requirements of the law by *making decisions* about our conduct (see also Meynen, 2013).

The M'Naghten Rule focuses on defendants' knowledge, instead of on their conduct: "…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 he was doing; or, if he did know it, that he did not know he was doing what was wrong." (M'Naghten's Case, 10 Cl. & Fin. 200, 8 Eng. Rep. 718, H.L. 1843). The link between knowledge and decision making may appear to be weaker than between conduct and decision making. Still, the idea underlying the M'Naghten standard appears to be that compromised insight in the nature, quality, or wrongfulness of the act may lead to compromised decisions about the course of action (see also Meynen, 2013, and Section 4). Clearly, it is beyond the scope of this article to discuss all legal insanity standards and to determine how each of them relates to the idea of 'compromised decision making'. It is even possible that not everybody agrees that a particular legal standard reflects compromised decision making on the part of the defendant. Still, we assume that most will agree that in general, the impact of a mental disorder on a defendant's decision making at the moment of the crime is relevant to psychiatric assessments within the context of an insanity defense (see also Meynen, 2013).

The proposal developed in this paper consists of three steps. First, we outline a stage model that distinguishes between three aspects of decision making, as suggested by Kalis, Mojzisch, Schweizer, and Kaiser (2008). Second, we discuss the impact that impairments in each of these stages could have on a person's actions. Third, we argue that impairments in different stages might have different implications for legal responsibility. Therefore, this framework could inform actual assessments of defendants as well as research on decision making in persons suffering from mental disorder.

## 2. A three-stage model of decision making

The proposal we aim to develop in this paper is that in assessing the impact of psychiatric dysfunctions on decision making, it is important to distinguish three different stages of the decision-making process, and to investigate how different dysfunctions can affect each of these stages (Kalis et al., 2008). The framework divides the decision-making process in the stages: option generation, option selection, and action initiation (Fig. 1). These stages should capture decision making in general, although we do not claim that every decision-making process proceeds in a strict linear fashion: feedback loops, for instance, are likely to occur. The main aim of the model is to distinguish different and crucial elements or aspects of the decision-making process, which are, to a large extent, dependent on one another.

This framework, introduced in Kalis et al. (2008), builds upon and expands existing sequential models of decision making and action (Ernst & Paulus, 2005; Heckhausen & Gollwitzer, 1987; Heckhausen & Heckhausen, 2008). For example, the Rubicon model developed by Heckhausen and Gollwitzer consists of four action phases. Firstly, in the predecisional phase (1) different options for action are evaluated in terms of their desirability and feasibility. When this evaluative process leads to a decision, one moves on to the postdecisional phase (2). In this phase the focus is on transforming a decision into action, thus on planning. As soon as the person takes steps toward actual execution of the action, the process moves on to the actional phase (3). After the action has been performed, the action is evaluated: this is referred to as the post-actional phase (4). According to Heckhausen (Heckhausen & Gollwitzer, 1987; Heckhausen & Heckhausen, 2008), information processing during both the predecisional phase and the postactional phase is open-minded and impartial. However, during the postdecisional phase and the actional phase, information processing is thought to be biased in favor of the chosen alternative. A similar but more concise stage-model has more recently been developed by Ernst and Paulus (2005), who distinguish three phases: (1) formation and evaluation of preferences regarding different options, (2) selection and execution of the action; and (3) action evaluation.[5]

When we compare our model to these earlier models, some differences should be noted. First, we focus on the stages up to, and including, the initiation of the action, which means that we exclude the stage of outcome evaluation. This is because the legal investigation in the context of an insanity defense mostly focuses on the defendant's decision-making process up to the unlawful act. More importantly, we include the stage of generating options for actions as a separate stage in our model. Option generation has so far been largely ignored in decision-making research; we argue that this aspect of decision-making is particularly relevant in addressing questions of legal insanity. Thirdly, contrary to most existing models our stages refer to *transition points* in the decision-making process: for example, we use the term option selection to refer to the point where an actual decision is made. For Heckhausen, this point would lie 'in between' the predecisional and the post-decisional phase. In our model, option generation refers to the transition point between a phase where no options are available and the phase that Heckhausen would describe as the predecisional phase. In the remainder of this section, we briefly discuss each of the three stages included in our model in the normal (nonpathological) condition. In the next section, we relate the three stages to psychopathology.

Stage 1 In order to decide what to do in a certain situation, one must come to see that certain options are available for action. We refer to this stage as *option generation*. One can come up with options for action via very different mental operations, for example, by memory retrieval, by creative processes, or by directly perceiving possibilities in one's environment (Kalis et al., 2008; Smaldino & Richerson, 2012). Meanwhile, what these different processes have in common is that they determine our *range* of possibilities in a certain situation: specific courses of action that are open to us. Our behavioral repertoire is broad, but always limited by the actual options we generate. 'Options' could be defined as representations of candidates for goal-

[5] An extended version of this comparative analysis of stage models can be found in Kalis et al. (2008). On option generation see also Kalis, Kaiser, and Mojzisch (2013).