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Chapter

4

Responsibility

Dr. Tianyi Zhang and Dr. Vivek Datta

The general concept of criminal responsibility is probably one of the most misunderstood concepts in the criminal justice system. Contrary to popular belief, an insanity defense is only mounted in a small number of cases, and, of them, only a small number are successful. Part of the reason that the insanity defense is seldom successful may be that the legal definition of insanity does not have a precise medical counterpart. Indeed, the legal definitions are narrow and vary from jurisdiction to jurisdiction. At the same time, the term "insanity" was devised to accommodate criminal defendants who manifest various forms of psychosis and, thus, seems inappropriate for someone with dementia.

This chapter by Dr. Tianyi Zhang and Dr. Vivek Datta explores the intersection between criminal responsibility and dementia. They review the major standards of insanity—McNaughten, Irresistible Impulse, and Model Penal Code—plus Diminished Capacity and Partial Responsibility and analyze how each may or may not accommodate someone with dementia. They conclude that the "Model Penal Code test provides the broadest formulation of legal insanity, and individuals with dementia can more reasonably attempt to claim insanity under this test."

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The concept of criminal responsibility was primarily devised with criminal defendants with psychosis in mind. While psychosis often occurs in the setting of dementia, defendants with dementia are different from those with primary psychiatric disorders such as schizophrenia and bipolar

disorder. By definition, dementia is associated with impairment in at least one domain of cognition (e.g., memory, language, executive function, etc.) severe enough to lead to functional impairment. As such, many defendants with dementia who might otherwise be found not criminally responsible, would be adjudicated incompetent to stand trial. Additionally, dementia is frequently, but not always, associated with continued deterioration in functioning. Legal tests of insanity have not kept up with our neuroscientific understanding of dementia as it relates to criminal responsibility. Dementia can impair one's ability to form a culpable mental state and impair a defendant's ability to conform their behavior to the requirements of the law, both of which are relevant to criminal responsibility. However, it is only when the cognitive deficits in dementia are not severe enough to impair competency to stand trial, that criminal responsibility would be relevant. Typically, this would include cases of what is called *mild cognitive impairment, mild behavioral impairment, and mild neurocognitive disorder.*

In mild cognitive impairment (MCI), there is a decline in cognitive function that is not severe enough to impact daily functioning. Mild behavioral impairment is a novel construct that refers to new onset neuropsychiatric symptoms of late life that are suspected to be the harbinger of dementia that occurs in advance or in concert with MCI. Mild neurocognitive disorder is similar to MCI, but is a DSM-5 diagnosis that refers to modest decline in one or more domains in cognitive functioning that could be due to any cause (e.g., vascular, brain injury, Alzheimer's) except for delirium or a primary psychiatric disorder (e.g., schizophrenia, depression). In general, if a defendant is adjudicated not criminally responsible rather than incompetent to stand trial, they will meet criteria for one of these three constructs rather than major neurocognitive disorder (i.e., cognitive decline that substantially impairs functioning).

When to Consider a Neurocognitive Disorder as Impacting Criminal Responsibility:

- New onset psychiatric symptoms first beginning after 50 should raise the suspicion of an underlying neurocognitive disorder or other medical condition as the cause.

- Certain delusional syndromes are more commonly associated with dementia. In Capgras syndrome, the person believes that one or more people have been replaced by an imposter, which can lead to violent behavior toward the imagined imposter. In De Clerambault syndrome, the individual person believes they are romantically involved with someone of higher status such as a celebrity or physician. This leads to stalking behaviors and sometimes violence. In Othello syndrome (morbid jealousy), which occurs in vascular dementia and Alzheimer's disease, the person believes their partner is having an affair, which can lead to violence against the spouse or imagined lover. In delusional parasitosis, the person believes they are infested with bugs or parasites, which may lead to property damage or harm to those believed to have caused the outbreak. Those with dementia are more likely to misplace things and develop delusions that others are stealing from them, which can lead to harm against the perceived abusers.
- Disinhibition, apparent callousness, and loss of sympathy and empathy to others are hallmarks of behavioral variant frontotemporal dementia. This can lead those afflicted to transgress social norms, including indecent exposure, shoplifting, downloading child pornography, or engaging in white collar crime such as fraud or embezzlement.
- Abnormal movements of a writhing, twisting or squirming nature (choreoathetosis) may indicate Huntington's disease, a rare inherited dementia that can begin early in life and is often associated with violence and aggression and in some cases fire-setting.
- Mania can occur in dementia, particularly in those with cerebrovascular disease, behavioral variant frontotemporal dementia, and the behavioral/dysexecutive variant of Alzheimer's disease. Characterized by elation, irritability, disinhibition, risk-taking, and grandiosity, mania can be associated with violence, sexual offending, and white-collar crime.

Expert Qualifications

A forensic neuropsychiatrist or forensic neuropsychologist would be most qualified to assess criminal responsibility in a defendant with suspected dementia. There are very few forensic neuropsychiatrists (i.e., those trained

and certified in both forensic psychiatry and neuropsychiatry) and thus several evaluators of different backgrounds may be necessary, such as a behavioral neurologist and neuropsychologist, to confirm the specific type of dementia, and a forensic psychiatrist or psychologist to evaluate whether the defendant meets criteria for legal insanity in the jurisdiction in question. Geriatric psychiatrists and geriatric medicine physicians may also be appropriate to make a diagnosis of dementia in older defendants. In some cases, a neuroradiologist may also be required to opine on brain imaging findings. Brain imaging can be used to support a specific dementia diagnosis (e.g., Alzheimer's disease, vascular dementia, frontotemporal dementia) but cannot itself assess mental state at the time of the offense. (*See* Chapter 6, Neuroimaging, and Chapter 12, Working with the Expert.)

Legal Standards for Insanity

The ongoing availability of an insanity defense in most jurisdictions in the United States reflects enduring concepts around fairness and punishment. At the present moment, the federal system and all but four states (Utah, Montana, Idaho, Kansas) allow criminal defendants to invoke an insanity defense.

The *M'Naghten* rule, established in England in reaction to the acquittal of Daniel M'Naghten of murder charges in 1843, or versions of the rule, form the foundation of the insanity defense standards in around half of the states and the federal government. The standard for insanity formulated by the *M'Naghten* rule requires "that at the time of the committing of the act, the party accused 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." This standard's sole focus on "knowing" emphasizes the individual's cognitive functioning.

Four states use the irresistible impulse test in addition to the *M'Naghten* rule. Under this test, the defendant may meet the standard for insanity if they acted from an irresistible and uncontrollable impulse due to a mental disorder at the time of the offense (Packer, 2009). The irresistible impulse test takes the individual's ability to maintain volitional control into account, although the concept of an impulse that cannot be resisted has been controversial and difficult to define.

Currently, another 21 states use versions of the standard of insanity formulated by the American Law Institute in 1962 in its Model Penal Code. The Model Penal Code test contains both cognitive and volitional prongs to establish insanity. By this standard, a defendant raising a claim of insanity must show that "as a result of mental disease or mental 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).

Dementia and Cognitive Tests for Insanity

The intersection of criminal responsibility and dementia is not well studied. Most policies, research, and case law around criminal responsibility and mental illness focus on psychotic disorders, while overlooking the complex questions around culpability that may arise for individuals with dementia. Historically, dementia has been infrequently represented as a threshold condition for the insanity defense. Psychotic disorders are the most common threshold condition among persons found not guilty by reason of insanity (Callahan et al., 1991; Warren et al., 2004). Also, individuals who had been diagnosed with a psychotic disorder were the most likely to be found not guilty by reason of insanity (Cochrane, Grisso, & Frederick, 2001).

Many cognitive and neuropsychiatric manifestations of dementia could potentially impair a person's ability to know or appreciate the nature and wrongfulness of their actions. Of the various symptoms of dementia, psychotic symptoms such as delusions and hallucinations would likely have the most straightforward application to cognitive tests for insanity. Extensive prior research and case law have explored the relationship between a person's psychotic symptoms, albeit in the context of a psychotic or affective disorder rather than dementia, and their ability to meet the standard for insanity set forth in the cognitive prong (Heck & Vaulter, 2018).

Delusions and other psychotic symptoms commonly appear in various neurocognitive disorders including Alzheimer's disease, Parkinson's disease dementia, dementia with Lewy bodies, and vascular dementia (Cipriani et al., 2014). The delusional beliefs most commonly described in people with dementia have a paranoid or persecutory nature, such as believing that other people are trying to steal their property or mean to

cause them bodily harm; these types of delusions have been associated with episodes of physical aggression (Cipirani et al., 2014; Deutsch et al., 1991). Co-occurring symptoms of dementia may contribute to the persistence and intensity of delusional beliefs. For example, increased cognitive rigidity, loss of abstract reasoning, and impairments in working memory may make it more difficult for an individual with delusions to hold and manipulate information that supplies evidence to the contrary.

Many adult defendants, as the result of their significant cognitive impairments in the later stages of dementia, would be considered insane by the *M'Naghten* rule. Individuals with late-stage symptoms of dementia can experience confusion and decreased attentional capacity that can lead to aggression and other behavioral disturbances while rendering them unable to notice and remain aware of their behavior. Individuals with impaired autobiographical memory may forget social norms and laws and engage in behaviors they did not recognize were socially inappropriate or criminal. The preceding examples describe adults with severe, global impairments to the extent that they would also likely be found incompetent to stand trial.

Challenges with Insanity Standards that Only Provide a Cognitive Test

Defendants with dementia in jurisdictions that only provide a cognitive test for establishing insanity face a number of challenges. Some individuals with dementia begin exhibiting socially inappropriate and criminal behaviors while they are in the early stages of their illness and therefore may not appear impaired enough to meet the standard for insanity. A study of patients with dementia who demonstrated physical aggression found that around one-third of patients with vascular or mixed dementia, one-half of the patients with frontotemporal dementia, and one-fifth of the patients with Alzheimer's disease exhibited aggression during the first half of their disease duration (Liljegren, Waldo, & Englund, 2018).

Criminal or socially inappropriate behaviors can be the first manifestation of dementia for many people. One study of individuals with frontotemporal dementia found that 46.2 percent demonstrated behavioral disinhibition and 21.1 percent demonstrated social awkwardness as their

first symptom (Lindau et al., 2000). Another study found that 17 percent of patients with Huntington's disease and 14 percent of patients with behavioral variant frontotemporal dementia initially presented with behaviors that could be interpreted as criminal, such as sexual advances, theft, and public urination (Liljegren et al., 2015). Many individuals have relatively preserved cognitive functioning in the prodromal and early stages of dementia and likely would not be considered insane under the *M'Naghten* test.

Defendants with behavioral variant frontotemporal dementia are particularly vulnerable in jurisdictions allowing only for a cognitive prong in their insanity standard. Some people with early-stage behavioral variant frontotemporal dementia can demonstrate severe impairments in their decision-making and judgment, while performing normally on the classical battery of neuropsychological testing (Manes et al., 2011). One study found that patients with frontotemporal dementia were more likely than patients with Alzheimer's disease and normal controls to approve emotional moral violations when presented with moral dilemmas, yet they appeared to have a relatively preserved knowledge of moral values and ability to distinguish right from wrong (Mendez & Shapira, 2009).

Individuals with behavioral variant frontotemporal dementia, who demonstrated nonviolent criminal behaviors, have verbalized an understanding of the criminal nature of their behavior and continued to engage in the behavior (Liljegren et al., 2019). Other adults with frontotemporal dementia, who committed crimes of physical assault, sexual assault, stalking, and child molestation, expressed awareness that their behaviors were wrong and proceeded to act in an unempathetic and disinhibited manner (Mendez et al., 2005; Mendez, 2010). If they were to face criminal charges, they would not be able to use the insanity defense in many jurisdictions.

Dementia and Volitional Tests for Insanity

Structural abnormalities of the brain, particularly those in the frontal and temporal lobes, give rise to a number of symptoms that compromise a person's ability to control impulses or to act freely as a moral agent. Features of frontotemporal dementia and other neurodegenerative disorders

involving these brain regions include loss of empathy and remorse, decreased inhibitory control, new compulsive behaviors, impairments in moral and social decision-making, and reward and punishment processing.

The following is an example of impulsive behavior in a person with frontotemporal dementia. A 60-year-old male with two years of personality changes demonstrates an increased appetite and a preference for breads, pastas, desserts, and candy. He starts eating the food off of his children's plates when they sit down for family meals. He develops a pattern of entering the grocery store, walking over to the candy aisle, reaching into the bins of sweets to grab and eat them, and then leaving without paying. When he walks by restaurants with outdoor dining, he grabs leftover food off of the tables and stuffs it into his mouth.

This man with pathological stealing of food would be unlikely to meet the standards for insanity in states that use the irresistible impulse test. The precise nature of the processes in frontotemporal dementia that lead to repeated, impulsive, and often socially inappropriate or criminal behaviors is not fully understood. However, recent literature has compared this feature of frontotemporal dementia to kleptomania and other impulse control disorders, substance use disorders, and obsessive-compulsive disorder (Mendez, 2011), which are generally not accepted as threshold conditions by the irresistible impulse test.

Although impulsivity is a common feature among individuals with dementia, it is unlikely that they would experience an impulse so strong that it could not be resisted. In fact, most manifestations of dementia would not produce an internal coercion strong enough to satisfy the irresistible impulse test. For example, delusions of jealously commonly occur among people with dementia with Lewy bodies, Alzheimer's disease, and vascular dementia and can increase their violence risk (Tsai et al., 1997; Hashimoto, Sakamoto, & Ikeda, 2015), but delusional jealousy would not qualify as an impulse that could not be resisted or controlled.

Many defendants with dementia may find that the Model Penal Code test has better application to their circumstances than the *M'Naghten* rule or the irresistible impulse test. For individuals with early-stage frontotemporal dementia, the volitional prong of the Model Penal Code, which focuses on the lack of substantial capacity to conform behavior to the requirements of the law, may be the only standard under which they could reasonably attempt to establish insanity. The Model Penal Code test does include language that specifically excludes the use of psychopathy

(American Law Institute, 1962), which shares many structural, functiona and behavioral similarities with behavioral variant frontotemporal deme tia. However, there currently is no specific language that would exclu people with behavioral variant frontotemporal dementia from using t insanity defense.

The following is an example of a man with frontal lobe dysfunctio who raised the insanity defense in a jurisdiction that uses the Model Pen Code test. Andrew Steele was a 39-year-old man living in Wisconsin, wh had recently retired as the result of his amyotrophic lateral sclerosis. H was charged with two counts of first-degree intentional homicide after h killed his wife and sister-in-law and then attempted to kill himself. He pl not guilty by reason of mental disease. Prior to killing his wife and siste in-law, he wrote a semi-incoherent suicide letter, describing a suicide pa between the three of them among other content. The forensic psychiatri for the defense described the contents of his letter as delusional and co sistent with deterioration in his brain. The defense argued that as a resu of his amyotrophic lateral sclerosis, Mr. Steele experienced abnormaliti in his hippocampus, causing poor impulse control, and in his frontal lob causing decreased inhibitory control and changes to his personality, whi rendered him unable to conform his conduct to the requirements of t law (Hoag, 2015; Trevelen, 2015).

Mr. Steele was found not guilty by reason of mental disease. He pass away from breathing complications of his amyotrophic lateral scleros two years later (Trevelen, 2017). His verdict was controversial within h own community as well as in the legal and medical communities (Lou 2015). The controversy is unsurprising, as Mr. Steele's verdict occurs the intersection a number of current trends and challenges in criminal la including general hostility toward the insanity defense, criticism of t volitional prong of the insanity defense, and ongoing efforts to understa and delineate the legal implications of dementia.

Diminished Capacity: *Mens Rea* Variant

Many jurisdictions permit a diminished capacity defense, or *mens r* defense, for crimes that require specific intent. Defendants may use diminished capacity defense to defend against the requisite mental el ment of the crime charged, which the prosecution must prove in ord to convict; this may potentially result in the defendant's conviction

a lesser offense (Packer, 2009). Some defendants, who do not meet their jurisdiction's standards for insanity as a defense, may have experienced a mental impairment at the time of the offense that could arguably have prevented them from forming the required *mens rea* for an offense.

The following are representative examples of individuals with Alzheimer's disease, exhibiting behavior that could be considered criminal, who likely were not capable of forming the specific intent to commit the crimes.

- A 79-year-old woman was diagnosed with Alzheimer's disease two years ago. She recently has become more forgetful and left her house keys in the front door and left the stove on by accident a few times. She and her family felt that it would probably be fine for her to continue shopping on her own in the familiar environment of a nearby grocery store, where she has been a patron for over 30 years. One day, she went to the grocery store, filled her cart with over $300 worth of items, and calmly walked out the store door without paying.
- A 72-year-old woman was recently diagnosed with Alzheimer's disease. She decided to sell her house, where she had been living alone for the two decades, and move in with her daughter, who lives in a different neighborhood. During her first month of living with her daughter, she went on a walk to explore the neighborhood and became disoriented with her new surroundings. Several hours later, her daughter received a call from a disgruntled neighbor, who complained that her mother had just wandered into his backyard and then yelled at him when he asked her to leave.

Criminal behaviors demonstrated by persons with Alzheimer's disease typically involve nonviolent offenses such as shoplifting and trespassing, often inadvertently as the result of the forgetfulness and confusion that develop over the course of the dementia. Most of these incidents likely never come to legal attention. The families, communities, and health care providers supporting an individual with dementia will often problem solve to find a solution without involving the legal system.

However, there are instances in which neighbors and other affected individuals are not tolerant of these nonviolent criminal behaviors. For example, Nancy Daoust, a 58-year-old woman with frontotemporal dementia and a tendency to wander around her neighborhood, was

cited for trespassing after her neighbor called law enforcement because she wandered onto his property, rang his doorbell, and then walked away (Low, 2019). More cases similar to Ms. Daoust's may be brought to legal attention in the future, as communities struggle to adjust to certain challenges of living alongside older adults with dementia and as the population of the United States continues to age.

Diminished Capacity: Partial Responsibility Variant

Partial responsibility is the more controversial variant of the diminished capacity defense. Certain forms of a partial responsibility excuse are allowed in a few jurisdictions where it is used as an affirmative defense in criminal homicide prosecutions. Defendants may claim that they were experiencing mental impairments, falling short of the standard for insanity, at the time of the offense and that they are therefore less culpable than someone who killed while in a normal state of mind. Partial responsibility defenses may be used to mitigate the offense from first-degree murder to second-degree murder or from murder to manslaughter (Dressler, 2005).

The doctrine of partial responsibility can be relevant to certain individuals with dementia, who may demonstrate physical aggression and, much more rarely, lethal violence. In adults with dementia, the onset of physical aggression may occur with the emergence of severe behavioral changes, as in the case of frontotemporal dementia. It may also occur as the result of cognitive impairments that make it difficult for people with dementia to accurately interpret their environments, as in the case of vascular dementia or Alzheimer's disease; among this population, the most common triggers for physical aggression are situations such as receiving intimate care that provoke feelings of being intruded upon, threatened, or frightened (Liljegren, Waldo, & Englund, 2018; Keene et al., 1999).

The following is an example of how reactive lethal violence might occur in someone living with dementia. Howard Darst, an 89-year-old man with Alzheimer's disease, was charged with beating his wife to death in August 1996. On the night of the incident, he and his wife slept in their living room to watch the closing ceremony of the summer Olympics rather than keep to their usual routine of sleeping in their bedroom. At some point during the night, Mr. Darst woke up in these unexpected

surroundings and then beat his wife to death with a cane (Statement of Donna Cohen, PhD, 2004). The charges against Mr. Darst were ultimately dropped, as he likely was not competent to stand trial. However, his case illustrates how a partial responsibility defense might be relevant to a different individual with milder cognitive impairments, who remains competent to stand trial and had committed reactive lethal violence.

Criminal Responsibility and Parallels in Civil Law

The complex problems around criminal responsibility in adults with dementia have some parallels in the civil law system. One such example is the financial exploitation of older adults, which has important implications to both civil and criminal law. Between 3.5 percent and 20 percent of adults over the age of 65 have experienced some form of financial exploitation such as theft, scams, unauthorized use of their accounts, or coercion or deception into signing documents or engaging in transactions that are misrepresented as legitimate (Wood & Lichtenberg, 2017).

Older adults with dementia experience various impairments that can result in a loss of financial skills, weakening of financial judgment, vulnerability to undue influence, and inability to detect and protect themselves from financial exploitation. Declines in cognitive abilities including memory, arithmetic skills, language, and executive function have been associated with financial incapacity (Wood & Lichtenberg, 2017). Behavioral changes such as apathy, paranoia and suspiciousness toward formerly trusted loved ones, loss of judgment, and impulsivity can make people with dementia more susceptible to undue influence. As adults with dementia experience functional decline and lose their ability to perform the necessary activities of daily living, they may become increasingly dependent on family or caregivers, which further increases their vulnerability to undue influence.

Some older adults may be misled into becoming involved with the fraudulent scheme themselves. The following vignette describes one such example. A 69-year-old male with several years of memory loss, speech difficulties, errors in managing his personal finances, and new beliefs in conspiracy theories, who has never formally received a diagnosis of dementia, was charged with attempting to defraud a government official.

He had been a retired widower, who was living alone, when an acquaintance invited him to join a new business venture. He was excited to participate in this opportunity and eagerly invested a significant portion of his own savings into the new business. He attempted to recruit several of his neighbors and members of his church congregation into the business venture. When his friends and neighbors expressed their misgivings to him, he angrily defended his business partner, who he claimed was a completely trustworthy and reliable man.

Within the civil law system, increased awareness of financial exploitation of adults with dementia has resulted in problem-solving efforts to address this emerging problem. Civil court systems have trialed enhanced service provision, increased referrals for assessments of testamentary capacity and financial capacity, and guardianship as a last resort (Gassoumis, Navarro, & Wilber, 2015; Voskou et al., 2018). Just as the financial and testamentary capacity of older adults is questioned in the civil law system, similar questions around criminal responsibility should be raised for older adults who come into contact with the criminal justice system because of apparent participation in fraud. When working with older clients or clients with dementia facing fraud charges, attorneys should consider whether their client was aware of the fraud or if the client had been misled into participating or had only participated in the fraudulent scheme under undue influence.

Conclusion

Some defendants with dementia, particularly those experiencing psychosis or mania, could be found legally insane under the standards established by the *M'Naghten* rule and the ALI standard. Many more offenders would not be considered legally insane by any cognitive test of insanity. Individuals with frontotemporal dementia and early-stage dementias often have relatively preserved cognitive functions and understanding of social mores and laws yet engage in criminal behaviors after experiencing changes in personality, judgment, decision-making capabilities, and impulsivity. As the impulses featured in dementia typically fall short of being unable to control or resist, most offenders with dementia would not be considered legally insane under the irresistible impulse test. The Model Penal Code test provides the broadest formulation of legal insanity, and individuals

with dementia can more reasonably attempt to claim insanity under this test. Other defenses such as diminished capacity can be used by defendants who may have inadvertently engaged in criminal behavior as the result of symptoms of their dementia, but fall short of meeting the legal standard for insanity.

At the time of writing, there are ongoing ambitious endeavors to characterize the precise relationship between dementia and criminal behaviors, expansions in the use of neuroscience in the courtroom, and challenges to the insanity defense, including the recent *Kahler v. Kansas*, 589 U.S. (2020). This chapter offers a preliminary review of the intersection between criminal responsibility and dementia and eagerly anticipates future literature and discussion on this topic.

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