Madness as the Foundation of Non-Culpability

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This dissertation is not dedicated to anyone, since it must be considered rude to pass over a former mistress.

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My third special thanks goes to my family – always there to support me for 15 YEARS!

Six years ago.

ME: - But God!

SHE: - Yes, may I help you?

Lisa, to me you are God.

Content

Madness as the Foundation of Non-Culpability

1 Introduction

One sparkling summer morning in June 1978, I witnessed how my grandmother tried to stab my grandfather with a scythe. In April that year she had scared my brother to tears, in May she had accused her best friend of stealing from her, and now this. As a child it was impossible to grasp her transformation.

To watch someone you love vanish into the hazes of dementia and realise that there is nothing you can do about it, is nothing but petrifying. My grandmother changed from being a caring, sparkling and amusing person into her own opposite. Our family doctor tried to explain to us children that a severe illness had struck our Ingeborg and that all her actions were to be blamed on the illness. It is hard for a child to understand that he never again will meet the original version of his grandmother.

But, one late afternoon when we had tea in the kitchen, she came back. Suddenly her face had a different colour and she looked shocked at us and said: *Why have I become this way, I do not want to be like this, please help me out of here*. A tentative thought, suggesting that she was hostage in her own mind, a place she no longer wanted to stay within, initially made us even more devastated – an emotional state soon replaced by joy when the possibility to communicate with that undamaged part was allowed our minds.

My grandmother was not sentenced for the scythe attack, neither was she accused nor arrested. The major reason to that was most likely that no one even considered such reactions. Was this lack of consideration and reaction an expression of humanistic values or was a decision made, but not communicated to us, based on some prerequisite for criminal responsibility?

In Sweden, the first societal assignment when a crime seems to have been committed is to hunt down evidence, i.e., fill the first vessel of criminal responsibility labelled *objective requisites*. If the court assesses the first vessel to be full, the vessel labelled *subjective requisites* is given consideration. This concerns the issue

of criminal intent, or in many cases just negligence. A third question is whether the offender had the ability to understand the nature of his/her action and to act in accordance with such ability. This third question is usually much harder to answer and therefore the court in most cases asks a physician to examine the offender.

In Sweden the offender first goes to see a psychiatrist for a short conversation. If the psychiatrist finds reasons to believe that the offender may be *sufficiently* mentally ill, i.e., may reach or pass the imaginary line were psychiatric diagnostics transforms into the legal concept *severe mental disorder*, a major forensic psychiatric examination will be recommended. This evaluation will result in a report, which explicitly comments on whether or not the offender suffered from a severe mental disorder at the time of the offence and/or during the evaluation. If he/she is assessed to fulfil the criteria for a severe mental disorder at both occasions, the court will normally choose to sentence the defendant to forensic psychiatric care, instead of prison.

However, if the crime is committed in for example Norway, Denmark or Finland, the key concept in the second part of the process is not severe mental disorder; it is instead accountability. The procedure would be similar though – a psychiatric team is (usually) consulted in order to assist the court in finding and its main task is to find out whether the offender is accountable or not. If the offender is found unaccountable, the offender will not be held responsible for the crime, and therefore not sentenced at all.

Let us sum up. A person who has committed a crime is not considered criminally responsible just because there is perfect objective evidence (the action is a crime, he/she has left fingerprints or DNA, etcetera). An offender must also fulfil the subjective demands; i.e., the criminal act must have been performed with intent, or, in many cases, negligence. However, that the offender knew the nature of his/her action and that he/she was in control of the action is, in Sweden, *not* among the prerequisites for committing a crime. In Sweden, quite contrary to most countries in the rest of the world, no one is acquitted due to unaccountability. However, whether or not the offender had the ability to understand the nature of his/her action or act in accordance with that ability matters for what penal law sanction can be imposed.

This dissertation is a minor contribution to the study of the enormous field of criminal responsibility. Its main purpose is to dig deeper into the one assumption that seems to be just as old as the first written signs of non-culpability: the connection between madness and impunity. It is based on four papers. The first of these (Anckarsäter et al., 2009) is a philosophical investigation of the concepts of mental disorder, cause and crime as used in forensic psychiatric contexts, as well as a brief review of some pertinent empirical research on mental disorder and crime. The remaining papers are all based on interviews made in 2001–2009 with 150

forensic psychiatric professionals and 46 forensic psychiatric patients. The second paper (Höglund et al., 2009) deals with what the staffs think about the relation between accountability and mental disorder. The third paper (Radovic & Höglund, 2014) investigates to what extent the patients believe that their mental disorder was a cause of their crime. The fourth paper (Höglund et al., manuscript) reports, in a quantitative way, the patients' own perceptions of their accountability at the time of the index crime.

The staff and patient studies were approved by the Ethics Committee at Lund University, Dnr. 54-01.

2 Background

2.1 Personal notes

> "This crime was not a consequence of my mental illness, although many odd actions of mine are. For instance, I have placed thousands of personal notes with passwords and lifesaving reminders to myself all over my hometown – ha-ha!"
>
> (Quotation from the patient study)

Imagine yourself stranded, Robinson Crouse style, alone on an island: would you notice if you become mad? Do you believe that your chances of detection would increase, say you were a doctor in the Origins of Madness?

In December 2013, I suddenly realised that I had lived on that island for quite some time, blind to the fact that I was suffering from a severe depression. It took me over a year to recover and even though it would be weird to recommend that experience to anyone, it doubtlessly gave me invaluable insights.

As a consequence of that, I have left notes to myself in different forms all over my house, in books, drawers and so on. This in order to remind me of the micro steps that form great changes and of the enormous power with which mental illness is quite able to hit you.

2.2 The origins of free human beings and mad ones

Regardless of the absence of clear-cut proof of a more precise where and when, one day it seemed obvious to humans that they were free, that their actions made by choice and thus entailed responsibility. Some though seemed not to be free since they acted out of madness, and for that reason should not be held responsible for their actions.

2.3 Legal mirroring and present law[1]

The Old Testament of *The Bible* contains passages that might be interpreted as saying something about accountability (*Exodus* 21:12–13; *Deuteronomy* 4:41–43). However, it is not obvious that they do. It seems more reasonable to interpret them

[1] Much of the information in this section is also to be found in Höglund et al., manuscript. Other important sources have been Svennerlind (2009, 2015).

as dealing with the distinction between, on the one hand, intentional action and, on the other, unintentional action (cf. Svennerlind, 2009:51f.).

Also the Roman law can be interpreted in various ways. From Roman law we have several words that, in slightly changed forms, are used in the traditional vocabulary. Among these is "furiosus",[2] as in "furious". It seems to have been used both as a general term for mentally ill persons and as a more specific term for a subset of mentally ill persons (cf. Sondén, 1930:12ff.). The term "furiosi" is used already in the fifth century BC, and then probably has the former meaning (cf. Svennerlind, 2009:54).

The medieval law-rolls of the Swedish provinces as well as the succeeding general city and country laws contain regulations seemingly concerned with unaccountable offenders. It also seems likely that they concern what we would classify as mentally disordered offenders. The reasons for their being exempted from punishment are still uncertain though. Is it that it would be pointless to punish them, since punishment does not deter them? Or, is it that being insane itself is a punishment, and a sufficient one as well? A third alternative might be the retributive one, that to punish them would be unjust? Unfortunately, the historical sources are somewhat indistinct (cf. Sondén, 1930:41).

For a long time a key term of Swedish penal law was "avvita". Until 1946 it was part of the main law section regulating what to do with mentally disordered offenders. I would say that it evolved to have a meaning similar to that of "insane". Its original meaning may have been more similar to that of "mad", or, even better, that of "crazy". The medical connotations of "insane" are more evident than those of "avvita". Anyhow, "avvita" should be seen as a legal term, not a medical one. The same holds for "insane" as used in the law (cf. Reznek, 1997).

From 1865 to 1965, the Swedish penal law contained a prerequisite of accountability; i.e., it allowed for what in the common law tradition is referred to as the insanity defence. The prerequisite came in two different versions. One of these, in legal force until 1946, is found in a section that can be translated:

> "A deed, committed by someone who is insane, or deprived of the use of his intellect, owing to disease or weakness due to age, shall be exempted from punishment.
>
> Has someone, through no fault of his own, got into such a state of mental aberration that he was beside himself; the deed, which he commits in this unconscious state, shall be exempted from punishment."

[2] In the Greco-Roman mythology, the *furies* are the goddesses of the underworld in charge of vengeance. It might be the case that Roman penal law originally was essentially sacred. The Swedish philosopher Axel Hägerström has argued that it indeed was so (Hägerström, 1927).

This was Ch. 5 § 5 of the Penal Code. The first paragraph of the quoted section has some similarity with the M'Naghten rules. One version of the latter is:

> "[F]irst, the accused, at the time of his act, must have suffered from a defect of reason; secondly, this must have arisen from disease of the mind;[3] thirdly, the result of it must have been that the accused did not know the nature of his act or that it was illegal." (Hart, 1968:189)

The second version of the prerequisite of accountability is found in the same section, Ch. 5 § 5 of the Penal Code, changed in 1946 and in legal force from 1965. It can be translated:

> "No one shall be held responsible for an act he commits under the influence of mental disease, mental deficiency or other mental abnormality of such a deep-going nature that it must be considered to be equivalent to mental disease.
>
> He who, through no fault of his own, temporarily has got into such a state that he was not in the possession of his senses shall not be punished."

In this version, the first paragraph is more similar to the Durham rule than to the M'Naghten rules. The Durham rule, as stated by the Court of Appeals for the District of Columbia in the case *Durham v. United States*, 2014 F.2d 862, is the following:

> "An accused is not criminally responsible if his unlawful act was the product of mental disease."

The Durham rule gives expression to a version of the so-called *medical model*, according to which the concept of legal insanity is a medical one (cf. Moore, 2015). If the first paragraph of the second version of the Swedish section of the Penal Code does not give expression to the medical model, it comes pretty close to do so (cf. Svennerlind, 2015). The revision of the prerequisite, in the direction of the medical model, can be seen as a precursor to the ideology of the Criminal Code, gaining legal force in 1965, which comprises the rejection of the prerequisite of accountability.

The main section of the regulation of the Criminal Code, concerning mentally disordered offenders, was Ch. 33 § 2. Its first paragraph is very similar to what it

[3] Concerning the applicability of the M'Naghten rules, confer Lord Devlin's reasoning in a case where arteriosclerosis affected the mind of a man attacking his wife with a hammer: "The distinction between the two categories [somatic and mental] is quite irrelevant for the purposes of the law, which is not concerned with the origin of the disease, or the cause of it, but simply with the mental condition which has brought about the act. […] Hardening of the arteries is a disease which is shown on the evidence to be capable of affecting the mind in such a way as to cause a defect, temporarily or permanently, of its reasoning, understanding and so on, and so is in my judgment a disease of the mind which comes within the meaning of the Rules." (Fenwick, 1990:274)

replaced – i.e., Ch. 5 § 5, first paragraph, of the Penal Code. The new text can be translated:

> "For a crime that someone has committed under the influence of mental disease, mental deficiency or other mental abnormality of such a deep-going nature that it must be considered to be equivalent to mental disease, no other sanction should be applied than being turned over to special care or, in cases specified in the second paragraph, fine or probation."

We see here that in the Criminal Code, the accountability prerequisite of the Penal Code's Ch. 5 § 5 has become a prerequisite for being sentenced to prison.

An interesting thing to notice is that the second paragraph of Ch. 5 § 5 of the Penal Code has no counterpart in the Criminal Code. This is the case with regard to the first version of the Criminal Code, and it is so still to this day. The second paragraph of § 5 regulated what to do with temporarily disorded offenders. Does that mean that temporarily mentally disorded offenders are punishable from 1965 and onwards? Well, the matter has not been completely settled. It can be argued that the second paragraph of Ch. 5 § 5 of the Penal Code is still in force. Strange as it may seem, this paragraph, which stipulates that temporarily unaccountable offenders are not to be held criminally responsible, may thus be part of the Criminal Code, which is considered *not* to recognize accountability as a prerequisite of being criminally responsible. If this is indeed so, it is due to a statement made by the Minister for Justice in 1964. According to him, the content of the last version of the second paragraph of Ch. 5 § 5 is to remain part of Swedish penal law (Prop. 1964:10, p. 107). It would then be as an unwritten rule that it is part of the law in force (cf. Asp et al., 2010:400ff.). Evidently, if it still were part of the Swedish penal law, it would imply that the Criminal Code gives expression to a mixed ideology.

The penal law regulation concerning mentally disorded offenders has been changed twice since the introduction of the Criminal Code: in 1992 and in 2008 respectively. Both times, one of the declared motives has been to reduce the number of offenders who may not be sentenced to prison. In other words, the so-called *imprisonment prohibition* has over time been tightened.

Among the changes of the Criminal Code, gaining legal force 1992, the most important was the one replacing the stipulations made in Ch. 33 § 2. In the revised Criminal Code, it became Ch. 30 § 6. Translated into English:

> "A person who has committed a crime caused by a severe mental disorder may not be sentenced to imprisonment. If the court in such a case finds that no other sanction should be imposed, the accused shall be free from sanction."

So, the somewhat unwieldy phrase "committed under the influence of mental disease, mental deficiency or other mental abnormality of such a deep-going nature that it must be considered to be equivalent to mental disease" was replaced by the much simpler "caused by a severe mental disorder". Among other things, the changes meant that the mental state must exert a more decisive influence on the offender when acting than had been required before the reform was made (Prop. 1990/91:58, p. 458).

The second change of the regulation gained legal force mid-year 2008. It meant a further tightening of the imprisonment prohibition. It also made the regulation of Ch. 30 § 6 a more complex one. Translated into English:

> "A person who has committed a crime caused by a severe mental disorder shall primarily be sentenced to another sanction than imprisonment. The court may sentence to imprisonment only if there are special reasons. When judging whether there are such reasons the court shall pay regard to
> 1. whether the crime is highly culpable,
> 2. whether the defendant lacks or has a limited need for psychiatric care,
> 3. whether the defendant has in connection with the crime himself caused his condition by intoxication or by any other similar means, and
> 4. the other prevailing circumstances.
>
> The court may not sentence to imprisonment, if the defendant as a consequence of the severe mental disorder has had no ability to understand the meaning of the act or to adjust his acting in accordance with such an understanding. This does not apply though if the defendant has himself caused his inability in the way described in the first paragraph.
>
> If the court in cases referred to in the first of second paragraph finds that no other sanction ought to be imposed, the defendant shall be free from sanction."

In the second paragraph a prerequisite is stipulated that is similar to that of the so-called ALI test. The latter is found in the Model Penal Code (American Law Institute, Model Penal Code Proposed Official Draft, 1962) and says: "A person is not responsible for criminal conduct if at the time of such conduct as the result of mental disease of defect he lacks substantial capacity either to appreciate the criminality of his conduct or to conform his conduct to the requirements of law" (Model Panel Code §4.01). The essential difference between the prerequisite of the Criminal Code and that expressed in the ALI test is of course that while the latter is an accountability prerequisite, the former is not. After being slightly changed, it might become one though.

In the two latest government official reports, SOU 2002:3 and SOU 2012:17, proposing changes in the Criminal Code with regard to the regulation concerning mentally disordered offenders, accountability is indeed reintroduced as a prerequisite for criminal responsibility. Thus, intent/negligence (subjective requisite)

covering a criminal action or omission (objective requisite) performed by an agent should not any longer be sufficient for criminal responsibility. The agent who is performing/omitting an action should also manifest accountability; in other words, he/she should be capable of responsibility as well. None of these suggestions have become law, though.

2.4 Scientific mirroring and the present study

The theory and practice of forensic psychiatry are based on the assumption that mental disorders in many cases lead to a propensity to commit crimes. Unless this is the case, psychiatry has no explanatory value in the forensic context; crime preventive effects cannot be expected from psychiatric treatment, and predictors of crime must be sought outside psychiatry. Therefore, it is necessary to examine this assumption in detail both conceptually and empirically. It is also important to try to find new ways of assessing the connection(s) between mental disorder and crime.

Many statistically based scientific studies have been performed on the connection between mental illness and criminal behaviour (cf. Sections 4.1.1 and 5.1.4 below). However, this kind of survey does not touch upon the nature of the individual link from one's mental state (diseased or not) to one's behaviour (criminal or not). A substantial amount of scientific papers has, on the other hand, been published on how mentally ill individuals experience and value the care they have been offered, or how their quality of life has been affected by their mental illness, but none of these studies has to my knowledge comprised specific questions on whether one's ability to make decisions, often referred to as decision-making capacity, has been injured in any way.

Thus a knowledge gap seems to exist in the field of madness and decision-making in general as well as in the specific one that concerns mental disorder and criminal responsibility. This gap will form the starting point of my dissertation. The methods I have chosen are part philosophical, part empirical but qualitative: I interview patient and staff within Swedish forensic psychiatric care on their perceptions whether, how and to what degree mental illness diminishes one's accountability, as well as whether and to what extent mental illness leads to crime.

For more about the methods used in past studies and in the present one, see Section 4.

3 Aims of the thesis

3.1 The overall aim

The overall aim of this thesis is to elucidate the relation between mental illness and accountability and to scrutinize which variables may be considered to be of importance and significance when deliberating on someone's criminal responsibility. This is done in two ways: through a conceptual analysis, and (mainly) through a series of investigations of how patients and professionals within Swedish forensic psychiatry describe if and how mental illness is connected to crime, accountability and legal responsibility.

3.2 Aims of the conceptual study (Paper 1)

- To analyse to what extent Swedish forensic professionals believe that different mental disorders influence a person's accountability, and whether they think that other factors than mental disorder should be considered when deciding whom to hold accountable.

3.3 Aims of the staff study (Paper 2)

- To analyse to what extent Swedish forensic professionals believe that different mental disorders influence a person's accountability, and whether they think that other factors than mental disorder should be considered when deciding whom to hold accountable.

3.4 Aims of the patient studies (Paper 3 and 4)

- To analyse to what degree Swedish forensic patients believe their mental disorder and/or other specific factors were connected to their criminal action(s).

- To analyse how the same patients describe themselves in terms of accountability and its components at the time of their criminal action(s).

4 Method

4.1 General methodological considerations

The first, philosophical study uses standard methods for conceptual analysis to elucidate the three central concepts: mental disorder, cause and crime. It also briefly reviews some important empirical studies by other authors on the connection between mental disorder and crime.

In the main part of this study, I wanted to collect information about first person experiences, from Swedish forensic psychiatric patients, of committing crime under the influence of a mental disorder AND second person experiences, of professionals in Swedish forensic psychiatric care, of the connection between mental disorder, other variables and accountability.

Four things are central to the leitmotif studied in this dissertation and must therefore be considered in the choice of method.

(i) Acting in general as well as acting in a criminal way is a complex phenomenon.

(ii) From a criminological point of view, our society consists of perpetrators, victims, next of kin of the members of those two groups, the public and the state itself, which shall ensure and allocate justice.

(iii) In the societies of today, criminal responsibility is relative to the circumstances and variables that are considered to have caused the crime(s).

(iv) Mental disorder has formed a cornerstone of non-culpability and still does. In Sweden the medical concept mental disorder transforms into a legal concept, that of severe mental disorder. This, the latter concept, formed until 2008 a sufficient condition for sentencing to forensic psychiatric care, instead of prison. In mid-year 2008, this was degraded to an option.

4.1.1 On the choice of methods

After noticing the knowledge gap described above, the author continued by examining which kinds of method had been used on topics close to his own. It soon became clear that register and questionnaire studies were the methods used most frequently.

Register studies

Sweden is one of the best-equipped countries in the world in which to execute register studies. It has the registers needed and researchers can get access to them after applications to Ethics Committees at universities around the country. For that reason, many such studies have been and will be carried out here. They render quantitative results at a group level and give vital information about the potential nexus between a wide range of variables and criminal actions. These studies form an essential basis for risk assessments, but since criminal responsibility is all about the single case, where a diversity of individual variables and their causing impact on one's actions are at stake, group level statistics are of low interest in that context. This kind of studies was therefore not chosen because they were already done, and moreover by most competent researchers, and because they did not fit the purpose of my work.

Questionnaire studies

Another standard scientific methodology is to start the study of a certain field or issue with a prefatory questionnaire study and then extend and/or deepen the results with a series of interviews. Searching for questionnaires that covered scientific fields near to the topic of the present study rendered a few interesting hits. One is the Social-Problem-Solving Inventory-Revised (SPSI-R), a 52-item self-report where respondents rate each item on 5-point Likert scale (D´Zurilla et al., 2002). This instrument is used to measure people´s ability to solve everyday problems. Other questionnaires that are close of certain areas of the present topic are the Self-esteem questionnaire (Thornton et al., 2004), and the Impulsivity Scale (Eysenck & Eysenck, 1978).

One of the most attention-grabbing and frequently used scales is developed by Gudjónsson and Singh (1989) and called Gudjónsson Blame Attribution Inventory (GBAI). This questionnaire has an outspoken aim though to measure blame attribution. The present aim was not to measure this but the experienced weight of variables possibly causing crime(s).

In our case, the themes that we wanted to study were found to be too complex to fit the questionnaire formula. This was made very clear in our pilot studies and provided us with a sufficient reason for using only the interview situation.

In the patient studies we wanted to come as close as possible to Swedish forensic patients' experiences. The purpose was not to get "the truth" from the patients about their accountability or the causes of their crime, but giving them an opportunity to speak freely on how they understood and experienced these things. The studies were conducted in the form of semi-structured interviews with the aim to capture the participants' beliefs. We examined to what extent the subjects believed that the mental disorder was the cause of their criminal acts and/or what other fac-

tors they thought might have contributed, and to what extent they believed themselves to have been accountable at the time of the crime.

4.1.2 Interview studies

An individual's or a group's experiences can be studied with interviews (Kvale, 2007). The study group consists of individuals who have first or second person experiences of the phenomenon that you want to study.[4] The following guidelines were used in the three interview studies: When conducting the interview it is important to have enough time and to make it explicit that the informant can stop the interview or take a break whenever he/she wants. It is preferable to use a tape-recorder if the informant accepts that. If not, one can take notes during the interview and if the situation allows it, the interviewer can repeat the answers written down to the informant in order to make sure that he/she has got it right. When the interviews have been conducted, the notes can be typed down on a computer and printed out. Then a first and naïve reading is carried out, with the purpose of getting a first impression or sense of what the answers seem to communicate. The reading continues until meaningful categories or themes appear and are identified. To prevent subjective interpretation as much as possible, it is important that more than one person read the interview results independently of each other.

The most important part of the analysis of data from an interview study consists in categorization. Since the area for the present study was new, few preformed categories were available. We therefore had to create several of the categories (themes) anew, as the need for them became evident from the data. It is inevitable that a subjective moment comes into play here. We tried to control this as much a possible by using the above guidelines.

A phenomenon may be brought under several categories, but it is also important to understand what it is that brings them together. For example "it was not me" may form a first recognised common response, followed by the identifications of themes like, "it was the illness" and "it was the drugs" and potentially also subthemes like "voices made me do it" or "alcohol makes me angry".

[4] In this case the phenomenon consisted in the first and second person's experiences of the degree of influence from mental illness and/or other variables on one´s accountability.

4.2 Detailed methodological considerations – Conceptual study

This study is reported in Paper 1.

The conceptual study does not use any empirical material of its own. However, it is not detached from forensic psychiatric reality since it uses several concrete examples to elucidate the concepts under discussion. For each of the concepts mental disorder, cause and crime, several alternative definitions in the literature are presented and discussed, and their relevance to forensic psychiatry is assessed. Also, some main alternative, empirical approaches to the connection between mental disorder are presented and evaluated from an epistemological point of view, i.e., what kind of knowledge do they contribute and how successful have they been.

4.3 Detailed methodological considerations – Staff study

This study is reported in Paper 2.

4.3.1 Setting and subjects

Four Swedish forensic psychiatric clinics were chosen to represent both court-ordered investigative work and high-security, long-term treatment with court supervision. All were highly specialized treatment/investigation facilities with regional catchment areas and licensed to accept national referrals. The study was carried out from late 2001 to early 2008.[5] This stretched period enabled a quite large sample of psychiatrists and psychologists since some persons quitted and others were hired. All psychiatrist (n=30) and psychologists (n=30), asked to participate accepted, as did nurses (n=45) and ward staff (n=45) that were randomly chosen from staff lists.

4.3.2 Data collection

We chose to make this a structured interview study (and not a questionnaire one, which was our intention originally). One reason for this decision was that a questionnaire pilot study showed that the questions asked needed personal guidance/ meeting. For example, the concept of accountability was not known to many, even when divided into three sub conceptions (reality testing, moral competence and action control).

All respondents were given a brief verbal background introduction to the study. They were also informed about the confidentiality of their answers and of the

[5] This period of time was not chosen when designing the study. A break in the thesis work made it this way.

possibility to quit during the interview if they wanted to. Interviews took from 45 minutes up to two hours to complete. The interviewer (PH) made notes and ended each interview by going through all answers with the informant to make sure that the notes were correct.

Before the interview started, accountability was defined as a person's ability to make free and responsible decisions in terms of (i) reality testing, (ii) legal/moral competence, and (iii) action control.

The two introducing questions concerned the possibility of making assessments of the impact of mental disorder on one's accountability. All informants thought that it was possible.

Respondents were then asked to rate the degree to which they thought that 12 specific psychiatric diagnoses would influence accountability (cf. Table 1 in Paper 2). In a second step, the procedure was repeated for five case vignettes. Three cases were randomly chosen from forensic psychiatric screening reports (FPSR), which had been performed on one of the Swedish examination units during the late 1990s and had been presented to the respondents by the summary made to the court (Table 2, Paper 2). Two cases were randomly chosen from the nursing investigation done by department nurses and warden staff at the same Swedish unit. The idea was to make the respondents assess the degree of accountability from (i) solely psychiatric diagnoses, (ii) psychiatric diagnoses *and* other descriptions of the patient (presented in the summaries of FPSR), and (iii) solely from other descriptions of the patient examined.

Respondents were then asked to describe their lines of reasoning behind the assessments made (Table 3, Paper 2), and then to make the same judgement of five case vignettes.

Finally, the respondents were asked to describe if any factors other than psychiatric disorders could be relevant for assessments of accountability, and in such case which factors (Table 4, Paper 2).

4.3.3 Data analysis

The assessments of psychiatric diagnoses and cases were analysed statistically. Occupation, sex and years in work were compared to answers/assessments given, with results presented in tables (Appendix 3, Paper 2). The informants' reasoning when making assessments were presented in frequency of words/phrases used. To give a more colourful description of how informants reasoned, quotations were presented and discussed (Appendix 4, Paper 2). Factors other than psychiatric diagnoses that are believed to have impact on one´s accountability were analysed and listed from frequency and presented for each occupation included in the study (Appendix 5, Paper 2).

4.4 Detailed considerations – Patient study 1 and 2

The patient studies that are reported in Papers 3 and 4, respectively, use material from the same interviews made in 2008–2009.

4.4.1 Setting

Six of Sweden's largest forensic psychiatric clinics were asked to participate in these studies, and they all agreed to do so. All six clinics were visited on one occasion each, consisting of one or two days. With the help of healthcare developers, or other appropriate contact persons with good insight into the patient clientele, patients were selected with the goal to include eight to ten patients at each clinic.

The following inclusion criteria were used:

(i) The patient should have been handed over to forensic psychiatric care due to a court order, and not just being treated there for other reasons (risk behaviour, towards others/themselves, etcetera).

(ii) The patient acknowledged that he/she suffered from a mental disorder.

(iii) The patient acknowledged that he/she had committed the crime for which he/she was sentenced; i.e., not only acknowledged performing the act in question, but also that it was unlawful.

(iv) The interview was not judged to interfere with the patient's treatment or general welfare.

A total cohort of fifty patients was selected for the study. Two of these declined to participate and in two cases it became clear during the interview that the subject did not acknowledge that he/she had performed the act for which he/she was sentenced. This means that forty-six patients were included.

These studies had primarily a qualitative approach, and therefore we had no ambition to have a selection of patients that would be representative. However, the patients who participated in this study fairly well represent the Swedish forensic psychiatric patient population. This can be seen from statistics made available by a national register called RättspsyK.[6] Cf. also below, Section 4.2.2.

Ethical considerations

All informants were given a verbal introduction to the study, including information about the confidentiality of the study and the possibility to stop/quit the interview whenever they wanted to. We also pointed out the importance of them being

[6] RättspsyK, Annual Review, 2013.

as honest as possible in their answers. Finally we asked them whether they wanted a copy of the article when being published.

4.4.2 Basic data of the study cohort

Distribution of psychiatric main diagnoses

Psychotic illness

Psychotic illness (including schizophrenia and single psychotic episode) formed the largest group of respondents in our study, namely 19 (41.3%). One respondent was diagnosed with bipolar disorder, a disorder that traditionally is categorized as a psychotic one, and was therefore included in the psychotic group in the statistical presentation, making the total cohort 20 (43.5%). The total percentage of Swedish forensic psychiatric patients diagnosed with psychotic illness is 60.9% among men and 52.6% for women; when bipolar disorder is added, the figures are 66.0% and 59.9%. That makes the percentages of these diagnoses in our cohort somewhat smaller than the national one. This is probably explained by the category of hospitals that was included in the study since these so called Region clinics customarily comprise a larger population of personality disorders and a smaller ditto with psychotic illness.

Personality disorder

In our study 36.9% of the participants had some kind of personality disorder as the main psychiatric diagnosis. The percentage is high in comparison with the total Swedish cohort of forensic psychiatric patients: women 11.7% and men 5.6%. This is in line with the assumption made above that the number of individuals with personality disorder form a larger group than average at those clinics included in the study.

Neurodevelopmental disorders

The percentage of Swedish forensic psychiatric patients with neuropsychiatric syndromes (men 12.7% and women 15.7%) is about the same as in our cohort (10.9%). Two (4.3%) of our respondents were diagnosed with mental retardation, which is in line with the national distribution (men 4.0% and women 2.9%).

Distribution of index crime

Violent crime

Nearly half (46.7%) of the study cohort had committed violent crimes (other than murder), which is more than in the total cohort of Swedish forensic psychiatric patients (31.7%). Violent crime constitutes the most common index crime in both groups.

Arson

In our study, the number of individuals convicted for arson was just as many as the ones found guilty of sexual offences (10.9%). Arson is the second most common index crime (19.6%) amongst those being sentenced to forensic psychiatric care in Sweden.

Murder

Murder is the third most common index crime in Sweden among Swedish forensic psychiatric patients (16.5%), but was the second most common in this study sample (28.2%). This is probably explained by the assignment which larger forensic psychiatric clinics have in Sweden, which is to offer care for patients that are assessed as dangerous.

Sexual offense

Five of the respondents (10.9%) had committed a sexual offense, which is in line with the total cohort in Sweden (8.1%).

Distribution of sex and years in treatment

Sex

The distribution of sex among Swedish forensic psychiatric patients has over time been 9 to 1 in favour of men (recent statistics showing 4 to 1). Three (6.5%) respondents in our study were of female sex and 43 (93.5%) of male ditto.

Years in treatment

In order to make our results available to a simple analysis in terms of the length of years in care, we divided our respondents into two groups: those given care in more than one year but less than five, 23 (50%), and those given care more than five years, also 23 (50%). The median length of care of all Swedish forensic psychiatric patients that were discharged in the years of 2009–2014 was 46 months (almost 4 years).

4.4.3 Data collection

The interviews were carried out by PH and notes were taken by Susanna Radovic.[7] Notes were typed down directly in connection to the interviews. In addition to the transferred records of what had been said and seen, other factors of possible interest, such as body language, specific expressions and emotional responses to the questions, were documented. The interviews lasted between thirty minutes to

[7] Not all patients (n=8) who participated in the pilot study wanted to participate in the interview if it would be recorded.

two hours. The sessions began with the interviewers asking some preliminary questions about the crime and the diagnoses. This to make sure that the subjects' judgments about what had happened and about their mental status were in accordance with the judicial decisions and the journals. After this introduction the main interview started.

4.4.3.1 Part 1 (reported in Paper 3)

The part of the interviews that is reported on in Paper 3 focused on two questions. The first question addressed the possible causes for the violent act. The subjects were asked whether they thought that the mental disorder was the sole causal factor, a contributing factor or not at all a factor behind the criminal act. We also asked the participants whether they thought that, given the same circumstances, they would do the same thing again. The second question was an attempt to encourage the subjects to look at the original situation, but from a different perspective. The idea was that the answers to this question also indicate which factors the subjects believed had led up to the crimes.

4.4.3.2 Part 2 (reported in Paper 4)

The second part of the interviews concerned how the patients wanted to describe their state of mind at the time of the crime in terms of accountability and its components. Five specific questions were asked:

1) In your opinion, did you know what you were doing when you committed the act for which you later were sentenced (for instance: did you think you were doing something else than you actually did)?

2) In your opinion, did you understand what consequences this might bring on you and on others involved?

3) In your opinion, did you know what is generally considered right and wrong in society?

4) In your opinion, could you (at the time of the crime) have refrained from committing the act?

5) In your opinion, could you possibly have found some other solution to your problems?

4.4.4 Data analysis

In Part 1 (Paper 3), a qualitative method for data analysis was used. It was carried out in three stages, inspired by Ricoeur (1976). First, we read the whole material with an open mind/naive reading, to capture the specific cross-cutting themes. After that, we compiled these themes. In step three, we identified subgroups within each theme.

Results were primarily reported in the form of representative examples of the found themes. But they were also analysed statistically for possible links between answers given and psychiatric diagnosis, index crimes and/or length of forensic psychiatric care.

The analysis of Part 2 proceeded in a somewhat different manner, with the main results given as descriptive statistics of answer categories related to diagnosis groups. However, the first stage of the analysis was qualitative in the sense that it involved the creation of several new categories under which to sort the answers.

5 Results

5.1 Conceptual study

5.1.1 The concepts of mental and mental disorder

The Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) describes mental as: a) inner experiences, relating to mood, thought content, or sensory experiences, b) behavioural patterns, and c) cognitive functions, such as learning, social understanding and reality assessment (APA, 2000).

Generally, these descriptions of mental aspects complement each other, and together they form an ideal for clinical work. In the forensic context, however, test–retest reliability, transparency and objectivity become more important than comprehensiveness. Therefore, the role of clinical judgments based on hermeneutic assessments of inner experiences should be and has been questioned.

None of the commonly used mental disorder categories has yet been identified as a taxon that is clearly delineated from the normal variation or from other disorders (Cloninger, 1999). Mental disorders have generally not been found to have a specific aetiology in a substantial proportion of cases or to be diagnosable by methods other than clinical interviews and assessment of behaviours and/or self-reported symptoms over the lifetime. Exceptions are rare neurological disorders with prominent mental symptoms. Indeed, definitions of dimensions of inter-individual mental differences, defined as specifically as possible and including behaviour patterns, seem a better fit to the scientific literature.

Psychiatric research has sometimes attempted a shortcut to explain crimes by diagnosing patterns of crimes as mental disorders. Here, the lack of definitional clarity has become abysmal. Diagnoses such as kleptomania, intermittent explosive disorder, paedophilia, or psychopathy, have been defined on the basis of criminal behaviour patterns and mainly researched among convicted offenders. It came as no surprise when a large-scale meta-analysis of the predictive value of the different "facets" of psychopathy for crimes showed that the strongest predictor was – criminal behaviours (Walters, 2008).

A more constructive approach is to talk of behaviour patterns as what they are. The DSM-IV criteria for conduct disorder, or most criteria for antisocial personality disorder, describe aggressive antisocial behaviours and are thereby useful as dependent variables in research on causative factors behind an increased propensity to commit crimes. See 5.4 below.

5.1.2 The concept of cause

Probability theory defines the relation between "risk" factors and effects as an increased probability of the effect in the presence of the risk factor (cf. Cartwright, 1979; Reichenbach, 1956). In our context, probabilism would mean that particular forms of mental disorders are likely to be associated with particular forms of criminal acts. The risk factor may be assumed to be a full or partial cause of the event if there is a temporal relation so that the risk factor can be shown to generally precede the effect, if covariation with other factors (referred to as "confounders") can be accounted for by logistic or other multivariate statistical models, and if reasonable models are at hand for understanding how the causation operates. In other cases, risk factors can be judged to be merely coincidental to or reflections of common causes. By using probabilism in this way, scientific exploration has been made possible beyond experimental models testing causation.

As mental disorders in the vast majority of those afflicted do not lead to crime, a possible definition of causation in this context may be that a mental factor is a cause of a crime if the mental factor is an insufficient but necessary part of a set of conditions that together are unnecessary but sufficient for the crime (a so-called INUS condition, Mackie, 1965, 1974).

5.1.3 The concept of crime

The focus on mental disorder may direct the searchlight of forensic psychiatry towards individual criminal acts or towards patterns of criminal behaviours occurring in individuals rather than to crime as a societal or group phenomenon. This may be too narrow a perspective. A crime takes place in a situation, and the vast majority of crimes are clearly influenced by the situations in which they arise. Only rarely is a crime planned and determined by a single mind. A major shortcoming of the standard psychiatric approach is the emphasis on the individual and the relative down-tuning of the role of the interaction between people, including co-perpetrators and victims.

5.1.4 The empirical evidence for a connection between mental disorder and crime

Patterns of aggressive antisocial behaviours are described in the major psychiatric diagnostic schemes (as "conduct disorder" in the DSM-IV, showing a high overlap with attention-deficit/ hyperactivity disorder (AD/HD), or as "hyperkinetic conduct disorder" in the ICD-10, WHO, 1990). A number of longitudinal studies have shown that hyperactive children are at increased risk of developing oppositional attitudes, norm-breaking conduct, and out-right criminality – and that children with such aggressive antisocial behaviour patterns are at increased risk of developing just about any type of mental disorders in adulthood (Kim-Cohen et al., 2003).

As suggested, aggressive behaviour patterns could thus be studied as dependent variables in studies using other inter-individual mental differences, such as general learning, special cognitive dysfunctions (both verbal learning deficits and specific spatial or integrative problems), and inattention together with other possible explanatory factors, such as socio-economic disadvantages, in common empirical models. Aggressive antisocial behaviour patterns may express reduced ability to conform behaviour to societal norms, to long-term constructive goals, and to an empathic understanding of others, meaning that the behaviours per se reflect the complicated psychiatric concept of personality disorder.

The lifetime progression of stable patterns of aggressive behaviours preceding mental disorders has not been adequately taken into account in studies of unique criminal events in the mentally ill. Several much-cited register-based studies have shown that a history of inpatient treatment for psychosis and mental retardation carries an increased risk of violent offending, of the magnitude of five times the risk in the general male population (Fazel et al., 2009; Hodgins, 1992). The total number of crimes ascribable to persons with these disorders is in the order of a few percents (Wessley, 1997), and rarely are individuals with psychotic disorders ever sentenced for violent crimes. There was one violent crime – simple assault – in 450 patient years for schizophrenia in one of the studies showing the highest relative risks (Lindqvist & Allebeck, 1990). In contrast, the overlap between schizophrenia and other adult mental disorders with childhood-onset aggressive antisocial behaviour disorders is in the range of 25–60% (Hodgins et al., 2007; Kim-Cohen et al, 2003). As various forms of substance abuse complicate this picture of "comorbidity" even further, it may be asked whether mental disorders cause the criminal acts noted among sufferers or if the causation is reversed, so that crime is the cause of mental disorder, or whether mental disorders, substance abuse, and criminal behaviour patterns are caused by other genetic or developmental factors.

It is also instructive to look at the types of crimes encountered among persons with psychotic disorders. There are crimes for which a manifest psychosis is an uncontroversial INUS condition. There are also violent behaviours (both against oneself and others) that precede the clinical onset of schizophrenia or come very unexpectedly during maintenance phases (Saarinen et al., 1999). Other studies indicate that patients often had discontinued their treatment before committing an act of violence (Arango et al., 2006), but we still do not know whether there is a causative link between the two or whether they are both related to something else. It also remains a fact that treatment for schizophrenia has not been shown to affect the risk of violent crimes in randomized controlled trials. Even a controlled study of intensive case management could not document any positive effects on violent crime (Walsh et al., 2001). This does not have to mean that treatment is of no use, but the scientific question remains open and needs investigation.

5.2 Staff study

5.2.1 General descriptions and statistical comparisons between professional groups

From the detailed account of answer patterns provided in Table 1 of Paper 2, it may be deduced that assessments were quite consistent, especially for the cases with psychosis. It also emerges from the data that forensic psychiatric professionals generally held the opinion that accountability is diminished to a very considerable degree (ratings of 4 or 5 on the dimensional scale were used, where 5 stands for "not at all accountable") by a wide range of psychiatric disorders. Diagnostic denominations such as psychosis, dementia, and mental retardation thus seem to indicate to professionals that people assigned these diagnoses generally have severely diminished accountability.

Grades 4 or 5 were invariably rated for the diagnosis of schizophrenia and paranoid psychosis, for dementia by 90% of the informants, and for mental retardation by 70%. Interestingly, both mania (by definition comprising psychotic features) and Tourette's syndrome were assessed as compromising accountability to a lesser degree. Significant differences between staff categories were only found concerning personality disorders and psychopathy. These differences were consistent, as informants with short or medium long professional training rated the reduction of accountability caused by personality disorders much lower than informants with long professional training, such as medical doctors and psychologists.

5.2.2 Other factors listed as relevant for assessments of accountability

When asked about other factors that might influence a person's degree of accountability, most informants indicated several such factors. The frequencies of specific words and expressions used by the informants in each professional group are given in Table 2, Paper 2.

Substance abuse

A total of 131 informants (87%) mentioned substance abuse (alcohol-, drug- or other kinds of self-medication) as an important factor with a negative impact on accountability. Several subjects pointed out that substance abuse might reduce the ability to form judgments, but also argued that the diminished accountability caused by substance abuse should not entail that the person should be exempt from criminal responsibility.

Personality traits

Seventy-two informants (48%) indicated that general personality has an impact on how psychiatric disorders/problems affect accountability. They mentioned, for example, traits such as "kind", "patient", and "caretaking" as ameliorating factors

and “aggressive” and “bitter” as personality traits that would influence accountability in a negative direction.

Social factors

Eighty-eight informants (59%) said that social context is important for a person’s accountability. To have someone “to love, to talk to, and to trust” was believed to have an impact on how a psychiatric disorder affects accountability. Loneliness (n=31, 21%) and socio-cultural acceptance of violence (n=37, 25%) were other factors mentioned in this context.

Situational factors

Respondents also mentioned situational factors as relevant. Specific circumstances at the time of the criminal act may influence the person in the direction of diminished accountability. Economic pressure and emotional stress were regarded as relevant (n=59, 39%), as were situational panic (n=29, 19%) and circumstances involving one’s own children (n=6, 4%).

5.2.3 Qualitative thematic analyses of answers to the open questions

Four main themes emerged when the notes made during interviews were analysed. In Paper 2, several quotations illustrating each theme are given; here they are represented by only one or two for each. Each subject has a unique number, i.e., different quotes from the same subject have identical numbers.

Theme A. Unawareness

The most common answer of all (n=57, 38%) was that the informant had not previously thought about mental disorders as connected to accountability. However, all informants stated that the interview initiated new ways of thinking about mental illness and legal/moral responsibility and they did not hesitate to answer the questions posed. Several subjects reported that they were thinking of specific patients they had met during their careers in order to get a picture of the extent to which one’s accountability is affected by certain diagnoses.

Quotation 1: “I haven’t realised until now, when you ask me these questions, that mental illness is so strongly connected to moral and legal issues.” (Female ward staff)

Quotation 2: “I have never connected mental illness to legal issues. When I think about patient x, y, and z, it is impossible to hold any of them responsible for their actions while they were suffering from untreated mental illness.” (Male nurse)

Theme B. Complexity

Respondents identified factors other than psychiatric diagnoses/problems as relevant for the assessments of accountability. The second most common observation (n=55, 37%) was a remark to the effect that psychiatric diagnoses tell us something, but not everything, about a person's accountability. A number of these informants claimed that they found it peculiar that the current Swedish system for sending patients to forensic psychiatric treatment is based on psychiatric diagnosis and its severity rather than on considerations of accountability.

Quotation 4: "I more and more realise how little diagnoses tells us about a person. Women with schizophrenia, for example, are acting out all the time, while men hide in their rooms but are more violent when being violent, so to speak." (Female psychiatrist)

Quotation 5: "It is, of course, a strange judicial system Sweden has — we look simply for certain diagnoses, serious mental illnesses, when deciding to hold somebody legally responsible. Of course it is of great interest whom the illness has struck." (Male ward staff)

Theme C. Funnelication[8]

One out of six respondents reflected upon freedom, moral competence, and autonomy.

Twenty-one respondents (14%) mentioned "free will" or other terms conceptually close to this when they were asked how they had reasoned. Respondents indicated, for example, that psychiatric disorders/problems diminish autonomy (capacity to make informed and deliberate decisions), individual freedom, moral competence, and impulse control.

[8] This concept is, to the best of my knowledge, introduced in the psychiatric literature for the first time by the publication of this dissertation. The concept is made from that of funnel, a most valuable tool when pouring for example water into a bottle because of its tapering shape. Funnelication denotes the shrinking amount of options, and is for example a most relevant way to describe what happens during an escalating substance abuse. In the initial phase you experience say five equally attractive possibilities of how to spend your Friday evening: going to the movies, visit a concert, read a novel, go the pub or for a long walk. As the abuse escalates, the amount of options shrink since many of them no longer attract you and the ones left become more and more identical. In the final stage there are no other options than those including alcohol and the funnelication is completed. This picture may also be used as one way to describe bipolar disorder and its parts, depression and mania. I believe that the concept of funnelication may be of use in understanding and describing a wider scenario. In this scenario there are (at least) three funnels: (i) life-span or major funnelication, (ii) situational or minor funnelication and (iii) imploding or micro funnelication. The first (i) touches upon all events over a life-span that may affect both the amount of and the quality of our available tools, (ii) comprises all the current data that may or may not be compatible with your tools, while (iii) is an effort to put into words what many patient has described to me as a feeling of imploding before exploding.

Quotation 6: “Yes, of course mental illness kills freedom and therefore it is not right to even consider moral judgement.” (Female psychiatrist)

Quotation 7: “Suffering from serious mental illness is pain, free will is not there, and therefore there is no crime committed, in the common way of using that concept.” (Male psychologist)

Theme D. Symptomentalism[9]

The informants described that they had considered the descriptions of symptoms provided by the Diagnostic and Statistical Manual of Mental Disorders (DSM) to guide their assessments. The fourth most common theme among the respondents (8.5%) was the mentioning of the DSM system and the symptoms described there for the diagnostic categories.

Quotation 9: “I tried to remember what is said in the DSM-IV.

When suffering from certain symptoms – to what degree do these symptoms affect your accountability? That is how I was thinking while assessing.” (Male psychiatrist)

Theme E. Miscellaneous

Some respondents (n=9, 6%) described other ways of reasoning that could not be thematically classified. One such notion was a simple statement that if a person suffers from a mental disorder he or she should never even be included in a legal process.

Quotation 10: “I believe that when a person is mentally ill, the question of legal responsibility should be put aside.” (Female psychologist)

5.3 Patient study – Part 1 (Paper 3)

5.3.1 General descriptions of themes found

On the first interview question, four of our subjects replied that a severe mental disorder was the sole cause of the crime. Thirteen of the forty-six subjects answered that a severe mental disorder was a contributing factor to what had happened. Fifteen subjects claimed that the mental disorder did not play any role when they committed the criminal act. Five subjects replied that they did not remember or did not know, while the remaining nine answers were difficult to classify according to these themes. To the second question, sixteen subjects said they would do it again, sixteen that they definitely would not. Ten subjects said

[9] Another concept invented by the author.

that it depended on the circumstances, and the remaining four subjects claimed that the question could not be answered. The contributing causes that came up as themes were drug abuse and aggression. Yet another theme found in the material was blame.

5.3.2 Themes and subthemes

Below, the results from the interviews are described in groups according to these themes. Under each theme, two quotes from the interviews are listed as examples. More examples can be found in Paper 3. Each subject has a unique number, i.e., different quotes from the same subject have identical numbers.

Theme A. Single cause

Four subjects answered that a severe mental disorder was the only cause of the crime.

Quotation 1. “I would think so, yes. I love my father but cannabis abuse gave me a psychosis and inside the psychosis I believed my father was the devil.”

Quotation 2. “I am convinced that the disorder caused the crime. I would not have become a criminal if it wasn't for the mental illness.”

Theme B. Contributing factor

Thirteen subjects answered that a severe mental disorder was a contributing factor to what happened.

Quotation 5. “Yes or no, I heard voices, but kind of knew they were voices and not real, but I felt calmer when I obeyed them. Then I smoked hashish and that made me calm but often also worse. I am not sure how it’s all connected. But sure, the voices wanted it more than I did most of the times.”

Quotation 6. “I have a personality disorder and I guess it makes me do different things than the so-called normal population would. I have no patience and get real easily pissed off and stuff. But what I did, well I don’t know, maybe it’s the disturbance in my brain that speaks to a part.”

Theme C. The mental disorder had nothing to do with the crime

Fifteen subjects answered that the mental disorder did not play any part in the circumstances that led up to the crime.

Quotation 10. “No, it had nothing to do with that. My wife was going to take off with my kid. I went out of my mind and I threatened her with a knife and then I put it in her. You don't have to be sick to do that.”

Quotation 12. “I did of course set the fire and I wanted to set fire, they had mistreated her, I did it for her sake. I would have had done it again. And then maybe I am weird to think it was the best solution, but I thought it all through.”

Subthemes to B and C. Substance abuse and aggression

Among the subjects who replied that the mental disorder had nothing to do with the crime or that it was merely a contributing factor we found two major themes in their explanations for their actions, namely, (i) drugs and (ii) aggression.

Substance abuse

Thirteen subjects brought up drugs in their explanations for why they committed the crime.

Quotation 14. “No, it twisted it all some more, but I have never behaved well and taking amphetamine and stuff, it destroys your head.”

Quotation 15. “The main cause was probably that I drank so much, it messed up my brain.”

Aggression

Six subjects referred to anger when they explained why they had committed the crime.

Quotation 8. “No, not at all. I had hated my father for a long time. He had to die. That I had been drinking that day and drove around in the car so that I could decide exactly how to do it had as much impact. That no one bothered me. Had my sister called, I would perhaps not have done it, at least not that day. But then he came against me in his usual manner and I floored him with the first punch.”

Quotation 17. “No, I raped her because I was angry.”

Theme D. Blame

Yet another theme that we found concerned blame. Five respondents addressed the question of blame, all of them in terms of pointing out that they did not want to blame the disorder (or anything else) for what happened.

Quotation 6. Perhaps the disorder in my brain speaks to some part, but I cannot put the blame on that. I have my responsibility, naturally.

Quotation 18. “I’m aware of what I have done, I cannot blame anyone else.”

Theme E. Repeating the offence

The answers to the second interview question were gathered under four different themes; (i) I would do the same thing again, (ii) I would not do it again, (iii) it depends on the circumstances and the question is impossible to answer (iv).

Reoffending

Sixteen subjects answered that they would do the same thing again. Several of them just gave a simple "yes", or "yes of course" to this question, but some elaborated on the answer.

Quotation 4. "Yes, I don't like it when people boss me around."

Quotation 9. "I chose the best alternative. Would have done it again. It's about either me or them and I won't let myself down."

Not reoffending

The same number of participants (16) said that they would not do the same thing again.

Quotation 16. "I know how to wind down now; I get calmer faster and have time to understand what's best for me in the so-called long run."

Quotation 24. "No, now I would talk to the staff. Maybe I would walk away. I do that when I'm pissed off. So does my dad."

5.4 Patient study – Part 2 (Paper 4)

5.4.1 Initial notes

During the dialogues with the patients it soon became clear that seven categories or question themes, rather than five, were "the real thing". The qualitative data analysis (based on the notes taken during the interview together with additional notes directly after the interview) ended up in the following categories/question themes: ACT KNOW (was aware of the nature of one's action), ACT CONS (considered the consequences of one's actions), MORAL KNOW (was aware of society's view of whether the act was right or wrong), MORAL ACT (acted in accordance with that awareness), IMPULSE (was in control of one's impulses), ALTER (considered alternative action options) and FUTURE (estimated the propensity for committing a similar crime again). These categories/question themes were then analysed in a quantitative manner in relation to main psychiatric diagnosis, index crime, length of care and sex. The 46 psychiatric main diagnoses were clustered into three groups, that is: PSYCHOSIS (19 psychosis/schizophrenia

and 1 bipolar), PERS. DISORDER (19 personality disorders) and ORGANIC (7 autism spectrum disorders and 2 mental retardation).

An introductory and general overall presentation of the results will be followed by seven sections; one for each question theme and with focus on the result as related to the respondents' psychiatric main diagnoses group-affiliation. All data that are described in the text can be found in Table 1 below and Tables 2-8 of Paper 4.

5.4.2 Overall study results

Initially, all the answers were sorted into four categories: NO, PARTLY, YES and NOT SURE, and were distributed as follows: NO, 197 (61.1%), PARTLY, 26 (8.1%), YES, 90 (28.0%) and NOT SURE, 9 (2.8%). This suggests an overall and most general first conclusion: the cohort expressed an experience of quite damaged vital capacities at the time of the index crime.

Table 1

CATEGORY	TOTAL	ACT KNOW	ACT CONS	MORAL KNOW	MORAL ACT	IMPULSE	ALTER	FUTURE	
ANSWER	(%)	(%)	(%)	(%)	(%)	(%)	(%)	(%)	%
NO	**61.1**	**26.1**	**80.4**	**41.3**	**91.3**	**80.4**	**76.1**	**32.6**	**63.9**
NOT SURE	**2.8**	**0**	**0**	**2.2**	**2.2**	**8.7**	**4.4**	**2.2**	
PARTLY	**8.1**	**8.7**	**2.2**	**8.7**	**6.5**	**2.2**	**6.5**	**21,7**	**36.1**
YES	**28.0**	**65.2**	**17.4**	**47.8**	**0**	**8.7**	**13.0**	**43.5**	
Sum	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

When instead dividing the overall result by lumping NO and NOT SURE together, as well as PARTLY and YES, we get two basic answer categories or groups; the first forming 63.9% of the total result and the latter 36.1%.

Noteworthy is that the positive score-results in both ACT KNOW (65%) and MORAL KNOW (56.5%) suggest that these abilities are the ones most intact (together with the self-assessment of one being able to refrain from committing the same crime as the index crime in the FUTURE). Far more severely damaged are

the ability to consider consequences (ACT CONS) and alternatives (ALTER) of one's acts, which a vast majority of 8 out of 10 denied having done. 9 out of 10 respondents declared not to have acted according to their knowledge of what is seen to be morally right and wrong in society, while the same number of participants (92.1%) believed themselves not to have been in control of their impulses when committing their index crime.

5.4.3 ACT KNOW

Total cohort results

The proportion of informants answering YES and NO respectively is the opposite in this theme question compared to the overall percentage distribution. Thirty respondents (65%) answered YES, which indicates that when it comes to being aware of the nature of one's actions, Swedish forensic psychiatric patients to a large extent seem to recall that they did know what they did.

Psychotic illnesses and ACT KNOW

When asked whether they knew or were aware of the nature of the action they were sentenced for, the psychotic cohort splits in two: 10 persons say they knew/were aware and 10 answer that they did not know/were unaware or that they just partly knew/were partly aware.

Personality disorders and ACT KNOW

The PD answering results, i.e. NO (29.4%), PARTLY (5.9%) and YES (64.7%), are almost identical to the overall percentage distribution (see above).

Neurodevelopmental disorders and ACT KNOW

Persons with a neuropsychiatric diagnosis (mainly Asperger's syndrome) or mental retardation had a quite different response pattern (in comparison with PS and PD) when asked whether or not they knew what they did when committing the crime. Without exception, the immediate response to the ACT KNOW-theme question was YES (of course I knew what I did).

5.4.4 ACT CONS

Total cohort results

When asked to recall whether or not they had considered the consequences of their action(s) at the time of the crime, 37 (80.4%) of the respondents answered that they had not.

Psychotic illnesses and ACT CONS

None of the respondents that suffered from psychosis at the time of index crime were able to recall having spared a single thought to consequences.

Personality disorders and ACT CONS

Four respondents (23.5%) answered that they had or partly had done some consequential thinking at the time of the offence. Three out of four (76.5%) declared that they had not reflected on which effects their actions might generate.[10]

Neurodevelopmental disorders and ACT CONS

The members of the neurodevelopmental disorders group answered either yes (44.4%) or no (55.5%). Although the answers were uttered in the same natural way as to the previous question, almost as if the answer was self-evident, the reply content diverged (from one extreme to the other).

5.4.5 MORAL KNOW

Total cohort results

The overall result in this category is quite equally distributed between the two basic response categories.

Psychotic illnesses and MORAL KNOW

When asked whether or not they were aware of society's opinion on wright and wrong, 13 (65%) of the respondents in this diagnostic group declared that they were not.

Personality disorder and MORAL KNOW

The answering results in this category is pretty much the opposite of those in the psychotic cohort: 11 (64.8%) declared to have been aware, 3 (17.6%) stated that they were partly aware and 3 (17.6%) answered NO (I was not aware).

Neurodevelopmental disorders and MORAL KNOW

5 (64.8%) claimed that they were aware, 1 (11.1%) partly aware and 3 (33.3%) did not believe that they were aware of the societal values at the time of the crime.

[10] This result, it may be suggested, add up with the perfunctory description of this diagnostic group as irresponsible and self-absorbed. This lead will be followed up in Discussion.

5.4.6 MORAL ACT

Total cohort results

The experienced propensity/ability to act in accordance with one's moral knowledge was overall very low. None of the respondents answered YES and 6 (6.5%) answered PARTLY. As many as 42 (91.3%) rejected the thought of having acted in line with what they knew was moral common sense and one of the respondents was not sure.

Psychotic illnesses and MORAL ACT

None of the respondents in this group claimed to have acted in accordance with their moral knowledge. In fact 19 (95%) declared not having acted in such a way.

Personality disorders and MORAL ACT

As many as 15 (88.2%) respondents answered NO, and two answered PARTLY (11.8%).

Neurodevelopmental disorders and MORAL ACT

Also this group reported a lack of acting in accordance with their moral knowledge.

5.4.7 IMPULSE

Total cohort results

No less than 41 (89.1%) responded negatively when asked if they were in control of their impulses at the time of the crime. However, the ORGANIC-group seemed different in comparison with the other two diagnostic groups since five (55.5%) answered NO or NOT SURE while four (44.5%) declared that they were in control or at least partly in control.

Psychotic illnesses and IMPULSE

When asked whether or not they experienced being in control of their impulses at the time of the index crime, 13 (65%) responded NO and 1 (5%) NOT SURE

Personality disorders and IMPULSE

Not less than 17 (88.2%) of the respondents answered NO and 2 (11.8%) declared being PARTLY in control of their impulses

Neurodevelopmental disorders and IMPULSE

While 5 (55.5%) answered NO or NOT SURE, 4 (44.5%) declared that they were in control or at least partly in control

5.4.8 ALTER

Total cohort results

The overall result in this theme (cf. Section 5.4.2) indicates a general lack of considering alternative action possibilities

Psychotic illnesses and ALTER

Among the respondents diagnosed with psychotic illness no one declared to have considered alternative actions, with one claiming to partly have done so, one not being sure while 18 (90%) answered that they had NOT been considering alternative actions.

Personality disorders and ALTER

On this question theme the personality disorders cohort are almost equal to the psychotic ditto, shown by the 14 (82.3%) respondents who answered NO.

Neurodevelopmental disorders and ALTER

This group shows a different pattern: 6 (66.7%) answering NO or YES, 2 (22.2%) NOT SURE and one (11.1%) PARTLY.

5.4.9 FUTURE

Total cohort results

The total result – positive (65.2%) and negative (34.8%) – suggests that 2 of 3 forensic psychiatric patients are more or less certain that they will manage to refrain from future criminality. No specific results of interest emerged from splitting the data into diagnostic groups.

5.4.10 Bonus results

During the interviewer's (PH) halts at six Swedish forensic psychiatric clinics, in order to interview patients (not staff) on quite difficult, and, as described by a clinical executive head of one of the forensic psychiatric clinics, *almost philosophical*, matters, rendered not only 46 pleasant conversations but also three striking and most noteworthy observations.

Patients' interest in question themes

From day one of the interview series, it was evident that the theme questions included in the study were of great interest and importance to the patients. This was not an expected response (at least not to the interviewer PH), since the purpose of the question asked was

(i) to bring them back to the very moment when they committed the crime,

(ii) to make them face the fact (according to the forensic psychiatric evaluation, at least) that a severe mental disorder influenced them in executing the crime, in order to make them evaluate their own state of mind at the time of the crime,

(iii) to make a scientific attempt to discover answers to questions that most people probably would find more or less impossible to unravel in a defendable manner.

Patients' reasoning skills

It was a most vitalizing and strengthening experience to discover the patients as being skilful reasoners in matters of causation and accountability. It became evident that they had contemplated these issues long before this interview study took place.

Staff's interest in question themes

The third bonus result could be summarized in one sentence: "standoffish attitude to us patients' reasoning skills." This is a comment made by one of the patients that took part in etcetera.

6 Discussion

6.1 Conceptual study

Most of this paper has a discussing character. To the arguments in the Results section above (Section 5.1), I only want to add that the determination of INUS causes of a criminal act must as a rule involve first-person experiences of the act and its circumstances. This stands in sharp contrast to the determination of risk factors.

6.2 Staff study

6.2.1 Unconscious consensus

This study examined the potential existence of a common understanding of the relationship between psychiatric diagnostic labels and accountability. All participants found it acceptable to assess accountability from just psychiatric diagnostic labels. This does not necessarily mean that the subjects think that such assessments can be made quite as easily in actual practice. Some respondents found the task hard to understand; one psychiatrist, for instance, accepted to participate after a more than two hour long discussion of the assessment. Other respondents found the job hard but interesting. Some thought it was like a picnic. Some did the assessment quickly and other reasoned with themselves back and forth.

The final question of the interview comprised an opportunity for the respondent to comment on the study in general and to describe how they had approached the questions. Almost two thirds answered that they felt unaccustomed to the thought of a connection between psychiatric diagnoses and accountability. This is a quite remarkable finding, regardless the fact that accountability is not in use in Sweden, since they all work with persons that were sentenced to forensic psychiatric care instead of prison – a sentence based on a most similar linking.

Nevertheless, the result of the assessments shows only minor differences between the four professional groups, indicating consensus within the forensic psychiatric community about how psychiatric disorders affect accountability. The "agreement" is (i) that schizophrenia, paranoid psychosis, dementia and mental retardation denote mental states that are to be considered as *severe enemies to one's accountability*, (ii) that personality disorders and psychopathy *are not* to be considered in this way and (iii) that depression, mania, Asperger's and Tourette's syndrome belong somewhere in between these two groups. It may also be added that

during my fifteen years as lecturer and supervisor, I have asked approximately 2 700 individuals to conduct the same assessment and this result repeats itself over and over again.[11]

Madness has long formed the natural basis for questioning one's criminal responsibility. In my opinion for so long that they almost can be considered as twins or at least as the medico-legical version of the chicken and the egg. This study was not just an effort to see whether this understanding still exists, it was also the gentle start of a longer excursion into the details of current assumptions.

6.3 Patient study – Part 1

6.3.1 Initial summary

The fact that a vast majority of the study respondents pointed to other factors than mental illness as most influential to their crime, squares surprisingly well with population based register studies showing that the correlation between major mental disorder and violent crime is possibly mediated by other factors, such as substance abuse and socio-economic deficiencies. Maybe we are witnessing the first signs of a paradigm shift where mental illness is forced to abdicate as the single most important factor behind all kind of unaccountable actions.

6.3.1 Substance abuse

We can discern some differences in how the relation between substance abuse and the criminal act are described by the subjects. In some cases the subjects seem to mean that using drugs were an influential factor in so far as the drugs had inflicted permanent damage to their cognitive capacities, e.g., one respondent notes that using drugs had destroyed her head. In other cases the subjects might just as well be referring to how being intoxicated affects your control of actions. Subject 5 says that smoking hashish often makes you worse.

6.3.2 Aggression

A few respondents brought up anger as a contributing factor. This is hardly surprising either, the subjects have committed violent (on some occasions sexual) acts and aggression is of course linked to violence.

The subjects 16, 17 and 10 clearly state that the anger in their case was in their view not connected to the disorder. Subject 30 answers "no" to the question and discusses his sadness and anger, and adds that he somehow lost contact with reality. He does however not think that the disorder played any part in what took

[11] Since I have documented all these sessions including the assessment results, an analysed version of them all will be published soon.

place, but seems to mean that the strong emotions and the stressful situation by themselves triggered a state of lost reality contact.

6.3.3 Social circumstances

Another subject explains his actions with the combined facts that he was broke, on drugs and felt stalked and harassed by the police: you don't have to be mentally ill to be broke, homeless and on drugs. A third one who claimed that his criminal actions had nothing to do with a mental disorder said: you don't have to be sick to stab your wife if she threatens to take off with your child.

6.3.4 Moral insanity?

One respondents claimed that the persons he had killed was a menace to society in general, and to him in specific since they constantly bugged him asking for money, cigarettes, alcohol or drugs. In addition, he believed that he did the victims a favour by killing them since their lives weren't worth anything anyway.

6.3.5 Controlling ones actions

Yet another way to look at this comes up in the quote from subject 6, where the subject says that the disorder was a contributing factor to the violent behaviour in so far as his impatience and short fuse are symptoms of the disorder. Here, the subject seems to primarily think about how the disorder has affected his ability to control his impulses and emotions. The standard definition of action responsibility first formulated by Aristotle says that in order to be responsible for what you have done you must both know what you do and be able to control your actions.

6.3.6 Concluding remarks

The development of a person's criminal responsibility reminds one of a Swiss cheese: there are more black holes than visible material. Imagine the new-born child, then add for instance 45 years and a murder charge: which events over the years are of relevance for the subjective pre-requisite and for accountability? What is the definition of a mitigating event? Is there a definition? Additionally one must not forget that any suggestions regarding such a definition, or where the borders of criminal responsibility are to be drawn, are answers to a moral question (ultimately). These things, and more, has convinced me that the question of criminal responsibility is secondary to preventive answers.

6.4 Patient study – Part 2

6.4.1 Initial notes

Is there a link between certain psychiatric diagnoses and certain "parts" of accountability? One might hypothesise that different diagnoses affect different abilities relevant for accountability. Schizophrenia may, e.g., be regarded as primarily affecting a person's ability to assess reality and appreciate what he or she is doing, while Tourette's syndrome instead reduces a person's action control, but not his/her knowledge of the nature of the actions performed. Is it possible to identify the exact moment when a decision is made and is that knowledge necessary in order to rate the relative importance of the abilities involved in the making of a legally responsible action? The following discussion may shed some light on these, to say the least, hard questions.

6.4.2 ACT KNOW

Two thirds of the respondents answered that they were aware of the nature of their actions when they committed the index crime. One explanation of this phenomenon might be that it is a quite frightening or at least an outlandish thought to consider that *something else* than one's own conscious self was the origin of one's deeds. It would at the same time be unfair to presume that the respondents' experiences were consciously fabricated. Given the accuracy of the testimonies, these persons either lack some other vital faculty or they should have been sentenced to prison.

Only 7 (35.0%) of the persons diagnosed with psychotic disorders declared not to have been aware of the nature of their actions. This suggests that almost two thirds of the respondents in this group knew what they did – despite the severe character of the mental disorder they suffered from. This finding suggests that suffering from a psychotic disorder does not *necessarily* result in extinction of one's reality testing.

Worth noting is that the result in the PERSONALITY DISORDERS group on this matter is more or less identical to that of the PSYCHOSIS-group: five out of seventeen respondents (29.4%) diagnosed with a personality disorder state that they did not know what they did/were not aware of the nature of their actions. This might be explained by the fact that a personality disorder must be considered as *severe* in order to render forensic psychiatric care instead of prison. This severity can consist in for instance OCD, but also in an inclination to go into psychotic episodes.

All respondents diagnosed with neurodevelopmental disorders claimed (with emphasis) to have known what they did. Given that this really was the case, one can wonder why they were recommended care instead of prison; especially when

they also report that, despite their decent moral knowledge, they acted in the opposite direction. One possibility, which occurred to me, may be to claim that they are morally insane. That, on the other hand, is light-years away from my experiences of persons with for instance Asperger's syndrome.

6.4.3 ACT CONS

It is noteworthy that no less than 37 (80.4%) of the respondents declare that they did not consider the consequences of their actions. Split into diagnosis groups we find that the neurodevelopmental group (again) has a different pattern compared with the two others. Consequences were not considered by four of the respondents and the silent message I picked up was that these (the consequences) were obvious, considering the action they had chosen to perform. The other respondents, who answered that they *did* think of consequences, found no reason to do anything else than what was planned from the very beginning.

6.4.4 MORAL KNOW and MORAL ACT

The discussions of the question themes of MORAL KNOW and MORAL ACT are preferably performed together. The reason for that is that the practical value of MORAL KNOW is intimately connected with the quality of MORAL ACT.

Our study showed that 43.5% declared having had adequate knowledge of what is considered right and wrong generally in society, while 56.5% responded that they had not. This result, how encouraging or depressing it may be, loses in relevance when considering the fact that just 6.5% acted in accordance with that insight, and a vast majority of 93.5% acted without any guidance of the acknowledged moral knowledge.

The members of the personality disorder group gave the impression of tending to overstep moral lines deliberately. But to decide in which cases this is true one needs further studies. The same goes for the patients in the neurodevelopmental group, who seemed to have a morality of their own and show no explicit willingness to reconsider it.

6.4.5 IMPULSE and ALTER

Being in control of one's impulses, at least in a pausing-ability kind of sense (see below), might be considered a prerequisite for being able to contemplate alternative actions; a skill absolutely essential in decision-making

Only 10.1% of the respondents declared to have been in control of their impulses at the time of the index crime. It might therefore seem a bit strange that 19.6% claimed to have contemplated alternatives. The explanation of that might be that the "extra" 10% in the ALTER-group could be described as having control over the first impulse (giving them the opportunity to identify alternative actions) but

lacking control over the second impulse (rendering them doing what they craved the most in the end).

This result is in line with a *psychosis diagnosis,* since damaged reality testing potentially diminishes one's ability to contemplate, and even more, reconsider the first impulse. Also, suffering from demanding voices can potentially eliminate the ability to pause before acting. Since the respondents within this psychiatric diagnosis group scored much higher both in ACT KNOW and MORAL KNOW than expected, it can be suggested that one of the main problems within the forensic psychiatric patient cohort is rather connected to impulse control than to the two other factors.

The members of the neurodevelopmental group tended to declare a higher level of awareness than the other two. Perhaps this is not at all surprising, considering that NP-individuals at a group-level are most eager to be thorough when making decisions.

The declared absence of consequential thinking could also be an expression for a lack of interest in what effect one's actions will have on other people's and/or one's own well-being. If this result has any bearing on the general forensic psychiatric cohort, it is to be considered as an aspect not to oversee.

In sum, Swedish forensic psychiatric patients suffer primarily from a low degree of impulse control and inability to identify attractive alternatives, and not from any deficient knowledge about what they did. This is very far from the common view(s) about these patients.

7 Conclusions

I. The Square Comic Strip Approach

One's understanding of other's doings will fail if not based on complex interactions between inner processes and outer circumstances. The development of the understanding can be modelled as a structured mapping using Comic Strip Squares, starting with (i) a thorough identification of the content of the other's basic toolbox, (b) a description of each relevant scenario this toolbox is confronted with and (c) the toolbox owner´s personal testimony and suggestions on which impulses and alternatives will influence the whole picture in the following Square. This model may be used in psychiatric evaluations, criminal responsibility assessments and expert examinations of decision-making competence and as the very hub of risk management.

II. Unconscious Consensus

No less than 150 Swedish forensic psychiatric professionals were asked to rate 12 psychiatric diagnostic labels from an accountability perspective. The results reveal that education, occupation, working experience, sex, age and the geographical location of the respondent's home clinic made few significant differences. This points to a strong consensus in this matter, which is an interesting finding that calls for further research. It is also a remarkable one, considering that 2/3 of the respondents said that they never before had acknowledged this way of thinking.

III. Funnelication

Swedish forensic psychiatric patients point to another set of factors as being the most behaviour influential than Clinical Lexicons and Educational textbooks do. The defected impulse control and inability to identify attractive alternatives seem to originate from three types of Funnelication: (i) life-span or major, (ii) situational or (iii) minor and imploding or micro.

IV. Worst Case Scenario

Criteria used as prerequisites for criminal responsibility may not denote anything in reality. Psychiatric diagnoses may falsely have been linked to certain disabilities and, in the following Comic Strip Square, these disabilities will be ascribed to the one suffering from the psychiatric diagnosis.

Will it then be (a) an offender's psychiatric diagnosis or (b) the disabilities associated with it that will make the main criteria when deciding on his/her criminal responsibility?

V. Upgraded Value of 1st Person Experiences

The line is thin between good and bad (i) understanding, (ii) diagnostics and (iii) treatment of persons with dysfunctional behaviour patterns. The origins of one's problems vary as well as the methods used. What doesn't vary is the value of a good treatment relationship; and, I believe, what should not vary is one's right to speak and be listened to. Thus, let us upgrade the value of 1st person experiences.

8 Future studies

More scientific studies making use of first person experiences are obviously needed in order to help determine the INUS causes of crime, both in general and in connection with mental disorders. It is also urgent that proper methods making optimal use of such experiences are developed for the forensic psychiatric examination of the single case. Finally, the potential consequences for legislation of the results and viewpoints presented here should be investigated.

References

American Law Institute (1962). Model Penal Code, Proposed Official Draft.

American Psychiatric Association (2000). The Diagnostic and Statistical Manual of Mental Disorders (DSM-IV).

Anckarsäter, H., Radovic, S., Svennerlind, C., Höglund, P., & Radovic, F. (2009). Mental disorder is a cause of crime: The cornerstone of forensic psychiatry. *International Journal of Law and Psychiatry, 32*, 342–347.

Arango, C., Bombin, I., Gonzalez-Salvador, T., Garcia-Cabeza, I., & Bobes, J. (2006). Randomised clinical trial comparing oral versus depot formulations of zuclopenthixol in patients with schizophrenia and previous violence. *European Psychiatry, 21*(1), 34–40.

Asp, P., Ulväng, M., & Jareborg, N. (2010). *Krminalrättens grunder* [The foundations of criminal law]. Stockholm: Iustus.

Cartwright, N. (1979). Causal laws and effective strategies. *Noûs, 13*(4), 419–437.

Cloninger, C. R. (1999). *The temperament and character inventory – Revised.* St. Louis, MO: Center for Psychology and Personality, Washington University.

D'Zurilla, T. J., Nezu, A. M., & Maydeu-Olivares, A. (2002). *The social problem-solving inventory-revised (SPSI-R): technical manual*. North Tonawanda, NY: Multi-Health Systems, Inc.

Eysenck, S. B. G., & Eysenck, H. J. (1978). Impulsiveness and venturesomeness: Their position in a dimensional system of personality description. *Psychological Reports, 43*(3), 1247–1255.

Fazel, S., Gulati, G., Linsell, L., Geddes, J. R., & Grann, M. (2009). Schizophrenia and violence: systematic review and meta-analysis. *PLOS Medicine, 6*(8), 1–15.

Fenwick, P. (1990). Automatism. In R. Bluglass & P. Bowden (eds.), *Principles and practice of forensic psychiatry*, London: Churchill Livingstone, 271–286.

Gudjónsson, G, & Singh, K (1989). The revised Gudjónsson Blame Attribution Inventory. *Personality and Individual Differences, 10*, 67–70.

Hart, H. L. A. (1968). *Punishment and responsibility. Essays in the philosophy of law.* Oxford: Oxford University Press.

Hodgins, S. (1992). Mental disorder, intellectual deficiency, and crime: evidence from a birth cohort. Archives of General Psychiatry, 49, 476–483.

Hodgins, S., Cree, A., Alderton, J., & Mak, T. (2007). From conduct disorder to severe mental illness: associations with aggressive behaviour, crime and victimiz ation.

Hägerström, A. (1927). *Der römische Obligationsbegriff im Lichte der allgemeinen römischen Rechtsanschaung. I.* Uppsala: Almqvist & Wiksell.

Höglund, P., Svennerlind, C., & Malmgren, H. (manuscript). When licensed to speak: Swedish forensic psychiatric patients reveal a parallel universe. (Submitted)

Höglund, P., Levander, S., Anckarsäter, H., & Radovic, S. (2009). Accountability and psychiatric disorders: How do forensic psychiatric professionals think? *International Journal of Law and Psychiatry, 32*, 355–361.

Kim-Cohen, J., Caspi, A., Moffitt, T. E., Harrington, H., Milne, B. J., & Poulton, R. (2003). Prior juvenile diagnoses in adults with mental disorder: developmental follow-back of a prospective-longitudinal cohort. *Archives of General Psychiatry, 60*(7), 709–717.

Kvale, S. (2007). *Doing interviews.* Thousand Oaks, Cal.: Sage Publications.

Lindqvist, P., & Allebeck, P. (1990). Schizophrenia and crime: a longitudinal follow-up of 644 schizophrenics in Stockholm. *The British Journal of Psychiatry, 157*(3), 345–350.

Mackie, J. (1974). *The cement of the universe*. Oxford: Clarendon Press.

Mackie, J. (1965). Causes and conditions. *American Philosophical Quarterly, 2*(4), 245–264.

Moore, M. S. (2015). The quest for a responsible responsibility test: Norwegian insanity law after Breivik. *Criminal Law and Philosophy, 9*(4), 645–693.

Radovic, S., & Höglund, P. (2014). Explanations for violent behaviour—An interview study among forensic in-patients. *International Journal of Law and Psychiatry, 37*, 142–148.

Prop. [Government bill] 1990/91:58, Ompsykiatrisk tvångsvård, m.m. [On compulsory psychiatric care, etc.].

Prop. 1964:10, Kunglig Maj:ts. Proposition till riksdagen med förslag till lag om införande av brottsbalken m.m. [The Swedish Government's proposed bill to the Parliament concerning introduction of Criminal Code etc.].

Reichenbach, H. (1956). *The direction of time*. Berkeley & Los Angeles: University of California Press.

Reznek, L. (1997). *Evil or ill? Justifying the insanity defence.* London & New York: Routledge.

Ricoeur, P. (1976). *Interpretation theory: Discourse and the surplus of meaning*. Fort Worth: Texas Christian University Press.

RättspsyK, Annual Review (2013).

Saarinen, P. I., Lehtonen, J., & Lönnqvist, J. (1999). Suicide risk in schizophrenia: an analysis of 17 consecutive suicides. *Schizophrenia Bulletin, 25*(3), 533–542.

Sondén, T. (1930). *De sinnessjukas straffrättsliga ställning i Sverige. En översikt* [The penal law status of the insane in Sweden. An overview]. Stockholm: Nordisk bokhandel.

SOU 2012:17 [Government official report], Psykiatrin och lagen – tvångsvård, straffansvar och samhällsskydd [Psychiatry and the law – compulsory care, criminal responsibility and social protection].

SOU 2002:3, Psykisk störning, brott och ansvar [Mental disorder, crime and responsibility].

Svennerlind, C. (2015). From being unaccountable to suffering from severe mental disorder and (possibly) back once again to being unaccountable. *Dialogues in Philosophy, Mental and Neuro Sciences, 8*(2).

Svennerlind, C. (2009). Tillräknelighet i svensk rätt [Accountability in Swedish law]. In Radovic, S., & Anckarsäter, H. (eds.), *Tillräknelighet* [Accountability] (pp. 51–106). Lund: Studentlitteratur.

Thornton, D., Beech, A., & Marshall, W. L. (2004). Pretreatment self-esteem and post treatment secual recidivism. *International Journal of Offender Therapy and Comparative Criminology, 48*, 587–599.

Walsh, E., Gilvarry, C., Samele, C., Harvey, K., Manley, C., Tyrer, P., Creed, F., Murray, R., & Fahy, T. (2001). Reducing violence in severe mental illness: randomised controlled trial of intensive case management compared with standard care. *British Medicine Journal, 323*, 1093–1095.

Walters, G. F. (2008). Effects of a larger versus shorter test-release interval on recidivism prediction with the psychological inventory of criminal thinking styles (PICTS). *International Journal of Offender Therapy and Comparative Criminology,*

Wessley, S. (1997). The epidemiology of crime, violence and schizophrenia. *British Journal of Psychiatry, 32*, 8–11.

World Health Organisation (1990). International classification of disease: WHO ICD-10.

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Paper /

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Mental disorder is a cause of crime: The cornerstone of forensic psychiatry

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ABSTRACT

The assumption that mental disorder is a cause of crime is the foundation of forensic psychiatry, but conceptual, epistemological, and empirical analyses show that neither *mental* nor *crime*, or the *causation* implied, are clear-cut concepts. "Mental" denotes heterogeneous aspects of a person such as inner experiences, cognitive abilities, and behaviour patterns described in a non-physical vocabulary. In psychology and psychiatry, *mental* describes law-bound, caused aspects of human functioning that are predictable and generalizable. Problems defined as mental disorders are end-points of dimensional inter-individual differences rather than natural categories. Deficits in cognitive faculties, such as attention, verbal understanding, impulse control, and reality assessment, may be susceptibility factors that relate to behaviours (such as crimes) by increasing the probability (risk) for a negative behaviour or constitute causes in the sense of INUS conditions (Insufficient but Non-redundant parts of Unnecessary but Sufficient conditions). Attributing causes to complex behaviours such as crimes is not an unbiased process, and mental disorders will attract disproportionate attention when it comes to explanations of behaviours that we wish to distance ourselves from. Only by rigorous interpretation of what psychiatry actually can inform us about, using empirical analyses of quantified aggressive antisocial behaviours and their possible explanatory factors, can we gain a clearer notion of the relationship between mental disorder and crime.

1. Introduction

Forensic psychiatry and psychology (here jointly referred to as forensic psychiatry) form a clinical and theoretical speciality probing into the areas of criminality, penal justice, and treatment of criminal offenders. This application is based on the assumption that mental factors, at least in some sufferers, lead to a propensity to commit crimes. Unless this is the case, psychiatry has no explanatory value to criminal courts, crime preventive effects cannot be expected from psychiatric treatment, and predictors of crime must be sought outside psychiatry. This also means that it is crucial to examine this assumption in detail in order to specify its conceptual preconditions and to evaluate the information actually provided by the empirical literature.

Psychiatry was developed with the core ambition to describe, explain, and treat states of insanity by applying the modern medical model. Inherent in its praxis is a medical terminology, naming conditions and syndromes and postulating aetiological mechanisms (which have varied from brain pathology to infectious agents, from childhood sexual fantasies and instincts to genes and "chemical imbalances" but always conformed to the models of causation and predictability essential to the modern medical paradigm). From the beginning, psychiatry did not restrict itself to insanity but strived to explain human behaviour more generally, extrapolating knowledge from the "mad" persons confined to asylums into everyday life phenomena, such as anxiety or shyness, sexuality, and schooling, norm transgressions in general, and criminal law in particular. Thus, psychiatry was a central player in the expansion of the "triumphalistic" medical paradigm (Le Fanu, 1999), which saw modern medicine as the royal road to the understanding and alleviation of man's ailments and sufferings.

The area of crime and punishment has always attracted human curiosity and imagination. Psychiatrists, being no exception, have contributed their expertise, often with a humanistic stance against harsh punishments and penal law retributivism. The psychiatric approach was long opposed by hard-line moralists and conservatives (Qvarsell, 1993, p. 162). Eventually, as the task of exerting societal control over undesired behaviours to an increasing extent was assigned to psychiatry, confrontations flared up on a new frontier, namely with radicals opposed to control structures (Szasz, 1961).

Psychiatrists' perspective on mental disorder as the cause of crime has thus been one of a "scientific" approach to crime and punishment as opposed to the legalistic or retributionistic models that were characterized as "moralistic" or even "transcendental" by early psychiatrists (Kinberg, 1935, chap. III). However, as experimental settings for testing a causal connection between mental disorder and crime are virtually impossible to design, there has never been much of an empirical basis to back the stance of psychiatry. A long time was to elapse before the question of causation was actually examined beyond the mere identification of mental problem constellations among subjects who had committed criminal acts. Today, the notion of a causative role for

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mental disorders behind crimes rests mainly on probabilistic inferences from epidemiological studies.

From the *legislator's point of view*, the assumption of a causal connection between mental disorder and crime has major consequences. Most countries consider accountability a requisite for punishment, and mental disorders are generally the only legally acceptable factors giving reduced accountability. In Sweden, there is a presumption for sanctions other than imprisonment for crimes committed "under the influence of a severe mental disorder". The role attributed to mental disorders ultimately depends on the guiding *aims* of penal law. *Justice* may be understood as the establishment of guilt or as some form of equalling out wrongs, whereas modern penal systems have to serve several, partly conflicting, goals. If *retribution* is the goal, reduced accountability due to mental disorder must be considered as humans have unequal chances of refraining from crime (Rhee & Waldman, 2002). If the goal instead is *crime prevention* (through treatment, incapacitation, deterrence, or combinations thereof), sanctions have to be devised in relation to the risk of criminal recidivism and their scientifically documented preventive effect. Factors that would be considered mitigating in the context of retribution (such as youth, poor social integration, impulsivity, and deficits in other mental faculties) may instead call for harsher preventive measures, such as long-term incarceration or intensive societal surveillance. Every attempt at implementing a purposeful societal approach to criminal offenders would thus require a clear definition of the *aim* of the penal law. If the legislator wants the system to fulfil several aims, it should be clearly stated what these aims are and what their relative priorities should be when conflicts ensue. No system could fully serve each and every aim.

The lawyer's perspective is focused on the procedures of the judicial process. In the individual case, the causal role of a mental disorder behind a crime has to be determined, and the normal requirements of justice, such as equality, predictability, and transparency, have to be upheld. Lawyers must know what expertise to ask for and exactly what type of knowledge the different experts can provide. They must also be familiar with the grounds for questioning expert opinions and seek a second view, or with how to challenge a testimony presented in the courtroom. At the end of the day, it is also the lawyers who will have to evaluate the causal relation between the psychiatric problems diagnosed and the crime committed. "Beyond any reasonable doubt", the normal standard of certainty in law, has to be accommodated to the lesser precision of the clinical judgment of psychiatrists.

The *offender* and *victim perspectives* on the assumed connection should also be considered. By assuming that mental disorders lead to crime, the role of the acting subject and his individual responsibility is left suspended. Though this may come as a relief to some perpetrators or those affected by the crime, it may also be seen as a betrayal. Ascribing a crime to the influence of a mental disorder is intrinsically linked to a reduction of responsibility. Furthermore, as forensic psychiatric care is often of unlimited duration and renders the patient dependent on professional expertise, it reduces autonomy to a far greater extent than the praxis in conventional corrective institutions. Also *everyman's perspective* on crime and criminals is belittled and silenced in the presence of expert opinion. Public opinion is often mocked as uninformed and revengeful but may contain a commonsensical understanding that is not always apparent in subcultures of experts.

With these different perspectives in mind, we will analyze the assumption that mental disorders lead to crime, aiming to establish useful definitions, identify knowledge standing on firm scientific ground, and be frank about what we don't know, which may be the "not-yet-known" or aspects that are theoretically inconsistent with a psychiatric or psychological approach.

2. *Mental* disorder is a cause of crime

Numerous definitions of *mental* have been attempted over the years, but consensus remains to be established (for a comprehensive overview, see Brülde & Radovic, 2006). Let us be content with some examples of what mental can, and cannot, be. The *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV, American Psychiatric Association (APA) describes *mental* as: a) inner experiences, relating to mood, thought content, or sensory experiences, b) behavioural patterns, and c) cognitive functions such as learning, social understanding and reality assessment (APA, 2000).

As these descriptions refer to different ways of conceiving the human, let us refer to them as *aspects* of the mental. The first aspect, *inner* (subjective) *experiences*, denotes the inner life that a subject can be aware of. Mental representations are not limited to sequences of language but may be "iconic" or non-symbolic, merging sensory input with memories and emotions. Subjective experiences are made the object of science by methods that are basically hermeneutic in a wide sense and dependent on the clinical encounter. The requirement that scientific knowledge should be generalizable to persons other than those under direct observation is as important for assessments of inner experiences as behaviour observations or tests of abilities. As a somewhat different aspect, *cognitive processes* represent knowledge of the world and the self and are thus intrinsically linked to learning and structured by language. Learning, and the ability to learn, are more accessible for quantification than inner experiences, and may, in part, be evaluated by tests. The *behavioural* manifestations of the mental were once proclaimed by behaviourist philosophers and psychologists to be the only aspect accessible for scientific exploration. Behaviours do indeed lend themselves to quantification by various forms of assessments based on their observability (self-rate, collateral, or clinician-rated), but it may seem misleading to refer to mental aspects if behavioural manifestations are all that have been studied.

Generally, these descriptions of mental aspects complement each other, and together they form an ideal for clinical work. In the forensic context, however, test–retest reliability, transparency, and objectivity become more important than comprehensiveness. Behaviour assessments and cognitive tests may therefore be more acceptable and useful than hermeneutic assessments of inner experiences. In forensic psychiatry, the concept of *mental* may thus be limited to include only such law-bound patterns of behaviours and faculties that are possible to describe by replicable methods.

Let us now turn to what is *not* mental in this respect. Throughout the history of human thought, few other distinctions have evoked so much controversy as the one between the mind and the body. In the DSM-IV-TR, it is regretted that the term "mental disorder" emphasizes mental as something distinct from physical, which is regarded as an "anachronism of mind/body dualism" (APA, 2000, p. xxx). This conflict partly stems from epistemological problems. The mental (or the mind) is considered in terms of "experience", "knowledge", and "being" that are distinct from how the brain and its physiological processes are conceived of. This does not *per se* exclude that different descriptions refer to the same underlying phenomenon. Just as a notion of *beauty* may be applied to the same body that is scientifically examined as an organism, and perhaps to some extent even be causally determined by it (correlations between notions of beauty and physiological processes may be assumed), it is obvious that notions of beauty and of physiology operate according to different epistemological premises. The means by which we decide upon aesthetical matters are not the same as those we use in the natural sciences, nor are the concepts used in the different contexts inter-translatable in a straight-forward sense. The use of a plurality of concepts and methods does not in itself imply a plurality of real world items.

Being aware of the preconditions and rules governing scientific approaches to problems and what these can actually inform us about is part of the acquisition of knowledge. Sets of corresponding methods form a perspective that will eventually illuminate a specific aspect of the phenomenon under study. Such a "cut" towards knowledge may be referred to as an *epistemological framework*. In order for us to

interpret and communicate knowledge, the epistemological framework has to be understood and shared. Sloppy extrapolation of knowledge from one illuminated aspect to others is as much an error of reason as are breaches of methods within one approach. This point is not intended to open up for a relativistic approach to knowledge — it is, on the contrary, a call for rigour in the search and interpretation of knowledge about the human being (for a commentary on this approach see, for instance, Flanagan, 1992).

Distinctions about what is *not mental* are especially important in the forensic applications of psychiatry and psychology. Here, physical processes are not measured in order to form an opinion on mental issues (as in the notorious attempt by Lombroso (1896) to explain criminal behaviours with physical properties). Nor do they in any respect clarify or address moral aspects of mental phenomena. The epistemological framework of psychology and psychiatry does not produce the concepts or the methods that can give an answer to what is morally good and bad or about human intentions that can be so classified. As psychiatry and psychology study regularities, and acts of free will are unpredictable, notions that presuppose freedom (such as *evil*) escape scientific explanations. Needless to say, this does not prevent the consequences of mental processes, e.g. behaviours, to be good or bad.

3. Mental *disorder* is a cause of crime

The DSM-IV-TR states that "each of the mental disorders is conceptualized as a clinically significant behavioural or psychological syndrome or pattern that occurs in an individual" (APA, 2000, p. xxxi). Numerous other terms, more or less synonymous with "mental disorder", have been suggested, e.g. "illness" or "condition". Mainstream psychiatric texts use the term "mental disorder" as a compromise. The stated advantages are that the term is unspecific about non-physical entities, such as the soul, and about the aetiology of problems, such as in illness. "Disorder" is a broadly defined term. It indicates a lack of some sort of order but does not specify what that order is. Is a mentally disordered person someone who in some mental aspect lies outside the variation contained in the central standard deviations of the normal curve? Or does he fail to live up to an ideal, ordered, state of mind? Or does he present symptoms that are qualitatively different from what is experienced by healthy persons (such as hallucinations, delusions, tics, or compulsions)?

All three definitions are open to justified criticism. Symptoms such as hallucinations are not limited to persons exhibiting other features of mental disorder (van Os, Hansson, Bijl, & Ravelli, 2000). Dysfunction and suffering depend to a considerable degree on the environmental demands made on an individual, and deviance from the average may be both advantageous and disadvantageous (Baron-Cohen, 2000). The statistical approaches invariably include measurement problems.

None of the commonly used mental disorder categories has yet been identified as a taxon that is clearly delineated from the normal variation or from other disorders (Cloninger, 1999). Mental disorders have generally not been found to have a specific aetiology in a substantial proportion of cases or to be diagnosable by methods other than clinical interviews and assessment of behaviours and/or self-reported symptoms over the lifetime. Exceptions are rare neurological disorders with prominent mental symptoms, such as bilateral limbic brain damage giving rise to various forms of amnestic syndromes, or Huntington's disease and other dementias. "Markers" for validity of diagnostic categories have been sought in a host of laboratory methods, from psychometric testing to brain imaging and molecular genetics, without any findings that are either clearly delineated from the normal variation or specific for a diagnostic category. Correlations between neuroscientific findings and psychiatric features have sometimes been stronger for specific behaviour patterns than for diagnostic denominations (e.g. Soderstrom, Blennow, Sjodin, & Forsman, 2003). The effects of psychotropic drugs are not confined to diagnostic categories; their targets are symptoms or behaviours that cut across today's definitions. Psychiatric diagnoses have been critically described as "reifications" of inter-individual differences. This argument has often been swept away by references to "anti-psychiatry". Instead, it should be carefully considered, not least because the notion of categories of disordered subjects is in conflict with empirical research from mainstream psychiatry (Anckarsäter, in press).

Indeed, definitions of dimensions of inter-individual mental differences, defined as specifically as possible and including behaviour patterns, seem a better fit to the scientific literature. When associated with shortcomings in intra- and interpersonal functioning, it may even be justified to talk of "deficits" or "problems" among those less advantaged. The decision whether to define such terms so narrowly that they just capture one aspect of mental phenomena at the time, or to lump them into domains of covarying dimensions, has to depend on the purpose of diagnostics and be guided by statistical analyses of empirical data. Given the preliminary status of today's scientific knowledge and the great heterogeneity and non-specificity of, for example, molecular genetic findings, the first step to take is to be clear about what is meant by the diagnostic definitions and what remains to be clarified about them. Separating behaviour patterns from interpretations of inner experiences or assessments of cognitive faculties would permit the scientific study of correlations between definitional levels (e.g. which cognitive deficits accompany which behaviour patterns), something that is now hampered by the heterogeneous and ambiguous definitions applied in psychiatric research. Finally, it has to be emphasized that interpersonal differences in no way may be assumed to be interval data associated with other dimensions and with causes in linear ways. Instead, non-linear methods treating a multitude of ordered rather than measured data are required to account for complexity.

4. Mental disorder is a *cause* of crime

What then does the assumption that mental disorder is a *cause* of crime actually mean? As we have seen, psychiatry considers behaviour as a part of the mental. The easiest way to deal with the relationship between mental disorder and crime would therefore be just to consider criminal acts to be a form of mental disorder. This stance has never been met with much enthusiasm, however. Thought of as two distinct phenomena, the connection has been postulated as leading from mental disorder to crime and to be, at least in some respect, causal. At the same time, it is evident that causation in this context cannot mean that mental disorder is a necessary or sufficient cause of crimes.

Modern medicine has increasingly come to work with *probabilistic* models. Probabilistic theory defines the relation between "risk" factors and effects as an increased probability of the effect in the presence of the risk factor (cf. Cartwright, 1979; Reichenbach, 1956). In our context, probabilism would mean that particular forms of mental disorders are likely to be associated with particular forms of criminal acts. The risk factor may be assumed to be a (full or partial, see below) cause of the event (meaning that causation is "attributed" to the factor) if there is a temporal relation so that the risk factor can be shown to generally precede the effect, if covariation with other factors (referred to as "confounders") can be accounted for by logistic or other multivariate statistical models, and if reasonable models are at hand for understanding how the causation operates. In other cases, risk factors can be judged to be coincidental to or reflections of common causes. By using probabilism in this way, scientific exploration has been made possible beyond experimental models testing causation. The terms "risk" and "risk factors", assigned to the cardiologist Dawber (Kannel, Dawber, Kagan, Revotskie, & Stokes, 1961) as models to identify background factors, such as elevated blood pressure, cholesterol, and smoking, behind coronary heart disease. They have become central to medical research and have even come to represent a paradigmatic feature of society today (Beck, 1992). The concept of *risk* is therefore a means of

avoiding statements of causation, and "explanatory value" in this context will mean "proportion of the variation statistically related to the variation in the risk factor", which does not necessarily "explain" it in the common, causal meaning of the word.

Statistical covariation does not, however, provide grounds for exemptions in the penal law in connection with mental disorders. According to the Swedish penal law, an unaccountable person who has committed a crime under the influence of a severe mental disorder cannot be sentenced to prison (but to other forms of sanctions), and it is stated in the preliminary works to the legislation that this link should be "unproblematic" if the defendant suffered from a severe mental disorder at the time of the crime (The Parliamentary Standing Committee on the Administration of Justice, 1990/91). However, as mental disorders in the vast majority of those afflicted do not lead to crime, a possible definition of causation in this context may be that a mental factor is a cause of a crime if the mental factor is an insufficient but necessary part of a set of conditions that together are unnecessary but sufficient for the crime (a so-called INUS condition, Mackie, 1965, 1974). Suppose, for example, that a lit match causes a forest fire. The lighting of the match is not by itself sufficient; many matches are lit without bringing about forest fires. But the lit match is in this case a part of a constellation of conditions that together are sufficient for the fire. The match was dropped on a pile of dry leaves, and a gust of wind contributed to the lighting of the fire. Each of the components, the match, the pile of leaves, and the wind, is an INUS condition, each was insufficient, each was necessary, and all together were sufficient for the forest fire, even if other sets of conditions also could have led up to the same effect.

Counter-factuality is thus a prerequisite for a factor to be an INUS condition under the given set of conditions (it should be possible to conclude that "if the mental factor had not occurred or been present, then the crime would not have occurred", cf. Lewis, 1973; Mackie, 1965, 1974). From this follows manipulability, that it is possible to change the effect or the probability of the effect by changing the cause.

Mackie's model provides a useful framework to deal with causation behind complex human behaviours such as violent crime. The way we attribute causation even in the sense of INUS conditions in complex chains of events has to be considered. Singling out one of the INUS conditions as the cause of a certain event is often a matter of choice and not based on rigorous scientific investigations. Since each factor, by definition, forms a necessary part of the overall condition, we do not really have any grounds for pinpointing one of them as contributing to the effect to a higher degree than the others.[1] Human minds, however, strive to attribute causes in order to be able to predict what will happen in the future. Only in very rare instances are such attributions of causation based on experiments or strict, logical deductions. As the factors that may be shown to cause human actions in the INUS sense are invariably numerous and interact in complex constellations, the way we identify causes and assign importance to them is in itself the object of psychological research (Cheng, 1997).

As for crime and punishment, there is every reason to believe that mental disorders attract undue attention among possible explanatory factors. Generally, we have a strong tendency to assign causation of undesired events to factors that are strange or exotic in relation to ourselves, classically to other ethnic groups or to people with features that in one way or the other make them different from us. This powerful force directs our attention towards mental disorders among all the possible INUS conditions that may be discerned in the background to a crime. In forensic psychiatric research and expert opinion, the attribution of causation has no doubt been influenced by ideas developed within the professional psychiatric paradigm. And for the causation that is to be judged by the lawyer, counter-faction will be non-informative. How could any mental condition, taken as inner experiences, cognitions, and/or behaviour patterns, be ruled out as a contributing factor in the very complex sets of factors influencing human action?

[1] There may be other reasons though. If we want to attribute blame, we must pick out a factor that can fulfil this role. A person may be blameworthy, not a pile of leaves, in any proper sense of the word.

5. Mental disorder is a cause of *crime*

The term "crime" is no less in need of a precise definition than "mental", "disorder", or "cause". Leaving aside the legal definition, we may consider how crimes, generally in the form of violent, sexual or aggressive behaviours against others, are approached from the perspective of being caused by mental disorders. The focus on mental disorder will also direct the searchlight of forensic psychiatry towards individual criminal acts or towards patterns of criminal behaviours occurring in individuals rather than to crime as a societal or group phenomenon. This may be too narrow a perspective.

A crime takes place in a situation, between people, and the vast majority of crimes are clearly influenced by the situations in which they arise. Only rarely is a crime planned and determined by a single mind. A major shortcoming of the psychiatric approach is the emphasis on the individual and the relative down-tuning of the role of the interaction between people, including co-perpetrators and victims. The capacity to empathize and act compassionately shows not only a constitutional inter-individual variation but also an intra-individual variation in state-dependent actual functioning (cf. Constantino & Todd, 2003; Gabbard, 2004). Each and every one of us may stop forming meta-representations of the other's mind, the ordinary household quarrel being just as good an example as more dramatic scenes of conflict. A person who commits a heinous crime on his own is more likely to differ from the normal variation on at least some mental features than someone taking part in a similar crime as part of a group of offenders. Even small groups may release dynamics that deprive their members of inhibitory forces. A mathematical hypothesis to predict an individual's actual capacity for empathy (E) would assume that his or her natural capacity for empathy (e) should be divided by the square root of the number of people (n) involved and interacting in the actual act.

Another situational factor that plays a major role in the background to many violent crimes is the influence of drugs. These effects are not easily defined in relation to other mental factors or to situations. Alcohol, for example, may trigger aggression and reduce inhibitory faculties but can also diminish reactivity and reduce anxiety, thus acting as a susceptibility factor or as a protective factor depending on the situation, the degree of influence, and the subject's other psychological and psychiatric problems. When faced with the task of explaining the background to a particular criminal act, aspects of reduced or changed mental abilities have to be considered in the context of situational, social factors, each of which may constitute an INUS condition.

Perhaps due to this empirical dilemma, psychiatric research has instead attempted a shortcut to explain crimes by diagnosing *patterns of crimes* as mental disorders. Here, the lack of definitional clarity has become abysmal. Diagnoses such as kleptomania, intermittent explosive disorder, paedophilia, or psychopathy, have been defined on the basis of criminal behaviour patterns and mainly researched among convicted offenders. In order to have them constitute mental disorders, heterogeneous aspects of inner phenomena or cognitions have been assembled into diagnostic designations. By their circular reasoning and limited empirical support from studies in the general population, these diagnoses have continued to fuel heated controversies about which aspects should be counted as "belonging" to the respective syndromes. It came as no surprise when a recent large-scale meta-analysis of the predictive value of the different "facets" of psychopathy for crimes showed that the strongest predictor was — criminal behaviours (Walters, 2008).

A more constructive approach is to talk of behaviour patterns as what they are. The DSM-IV criteria for conduct disorder, or most criteria for antisocial personality disorder, describe aggressive antisocial behaviours and are thereby useful as dependent variables in research

on causative factors behind an increased propensity to commit crimes (even if specificity for subtypes of behaviours, such as the proposed "overt" vs. "covert", "predatory" vs. "reactive" criminality, has to be examined). The majority of violent crimes are committed by a comparatively small number of subjects, and consistencies in behaviours are more easily identified when behaviours are regarded as such, without the admixture of other aspects of the mental.

Patterns of aggressive antisocial behaviours are described in the major psychiatric diagnostic schemes (as "conduct disorder" in the DSM-IV, showing a high overlap with attention-deficit/ hyperactivity disorder (AD/HD), or as "hyperkinetic conduct disorder" in the ICD-10, WHO, 1990). Hyperactivity in AD/HD or hyperkinetic disorder is in itself defined as a difficulty in adjusting behaviours to specific requirements and borderline aggressive behaviours, such as interrupting others in conversations or inability to wait for one's turn in queues. A number of longitudinal studies have shown that hyperactive children are at increased risk of developing oppositional attitudes, norm-breaking conduct, and out-right criminality — and that children with such aggressive antisocial behaviour patterns are at increased risk of developing just about any type of mental disorders in adulthood (Kim-Cohen et al., 2003). From what we know about the stability of behaviour patterns, it may thus be assumed that aggressive children are at increased risk of growing into adults with criminal records and a mental health dossier. We also know that both aggression and mental disorders are over-represented among the socio-economically disadvantaged, that they aggregate in families, and that the causes behind these misfortunes are complex, involving both genetic and environmental factors that play different roles across individuals and social contexts.

As suggested, aggressive behaviour patterns could thus be studied as dependent variables in studies using other inter-individual mental differences, such as general learning, special cognitive dysfunctions (both verbal learning deficits and specific spatial or integrative problems), and inattention together with other possible explanatory factors, such as socio-economic disadvantages, in common empirical models. To the extent that aggressive antisocial behaviour patterns may be ascribed to causes other than a free choice, they may be presumed to express reduced ability to conform behaviour to societal norms, to long-term constructive goals, and to an empathic understanding of others, meaning that the behaviours *per se* reflect the complicated psychiatric concept of personality disorder.

Neither has the lifetime progression of stable patterns of aggressive behaviours preceding mental disorders been adequately taken into account in studies of unique criminal events in the mentally ill. Several much-cited register-based studies have shown that a history of inpatient treatment for psychosis and mental retardation carries an increased risk of violent offending, of the magnitude of five times the risk in the general male population (Fazel, Gulati, Linsell, Geddes & Grann, submitted for publication; Hodgins, 1992). The total number of crimes ascribable to persons with these disorders is in the order of a few percents (Wessley, 1997), and rarely are individuals with psychotic disorders ever sentenced for violent crimes. There was one violent crime – simple assault – in 450 patient years for schizophrenia in one of the studies showing the highest relative risks (Lindqvist & Allebeck, 1990). In contrast, the overlap between schizophrenia and other adult mental disorders with childhood-onset aggressive antisocial behaviour disorders is in the range of 25–60% (Hodgins, Cree, Alderton, & Mak, 2007; Kim-Cohen et al, 2003). As various forms of substance abuse complicate this picture of "comorbidity" even further, it may be asked whether mental disorders cause the criminal acts noted among sufferers or if the causation is reversed, so that crime is the cause of mental disorder, or whether mental disorders, substance abuse, and criminal behaviour patterns are caused by other genetic or developmental factors.

It is also instructive to look at the types of crimes encountered among persons with psychotic disorders. There are crimes for which a manifest psychosis is an uncontroversial INUS condition. There are also violent behaviours (both against oneself and others) that precede the clinical onset of schizophrenia or come very unexpectedly during maintenance phases (Saarinen, Lehtonen, & Lönnqvist, 1999). Other studies indicate that patients often had discontinued their treatment before committing an act of violence (Arango, Bombin, Gonzalez-Salvador, Garcia-Cabeza & Bobes, 2006), but we still do not know whether there is a causative link between the two or whether they are both related to something else. It also remains a fact that treatment for schizophrenia has not been shown to affect the risk of violent crimes in randomized controlled trials. Even a controlled study of intensive case management could not document any positive effects on violent crime (Walsh et al., 2001). This does not have to mean that treatment is of no use, but the scientific question remains open and needs investigation.

6. Summary and proposition

Having critically examined the assumption that mental disorder is a cause of crime, we have arrived at the point where conclusions and propositions for future research may be attempted. It appears that the conjunction of mental disorder and crime should not be taken as self-evident. We may have to be satisfied with stating that quantifiable consistencies in aggressive antisocial behaviours may be discerned over the lifetime, and that cognitive deficits and other mental problems are found in the background as probabilistic covariates that may be interpreted as INUS conditions alongside numerous other factors, such as genes, neurobiological aberrations or social, cultural, and economic situations. The empirical research identifying factors that explain parts of the variation in human behaviour actually maps factors that reduce our freedom of choice, but as long as the whole variation has not been explained, or sufficient causes of behaviours have not been identified, science has not disproved that free will influences human behaviour.

Empirical research on probabilistic covariation and general principles for assigning causation in the INUS sense, such as time-sequence, mechanistic explanations, experiments and counter-faction, applies first to inter-individual variation in patterns of aggressive behaviours and has to be further interpreted in relation to unique criminal events. It should also be kept in mind that the attribution of causation may itself be influenced by less than rational thought patterns. But by being clear about the specificity of behaviour patterns, several considerable societal advantages are achieved. We avoid implicating the vast majority of those who suffer from mental health problems and never display aggressive behaviours in the context of crime, and the legislators and lawyers, just as everyman in society, will be empowered to understand the results of psychiatric assessments and research. Laws concern behaviours and may therefore directly relate to definitions of behaviour patterns without depending on hermeneutic expert evidence.

In addition, science concerned with the causes of crime may be advanced beyond theoretical rivalry. Cognitive science, neuroscience, and the social sciences may all serve to identify explanatory factors to the inter-individual variation in aggressive antisocial behaviours. Possible treatment strategies (pharmacological, educative, behavioural, or others) may be identified on the basis of such covariation, and their efficacy may be tested against the defined behaviour. Assessments of behavioural patterns may also be used to assess the risk for future aggressive acts alongside all other possible predictors.

By insisting on involving mental phenomena in the explanation of crime above and beyond the empirical support for doing so, psychiatry has held back research on the interplay between, on the one hand, contexts and other environmental susceptibility factors, and, on the other, individual mental phenomena, as a background to criminal behaviours. Our understanding of mental processes has to be based on the individual in interaction with a context. Unfortunately, psychiatry's narrow focus on individuals and disorders has been paralleled by sociology's macro-social perspective, in which individual vulnerabilities have been largely disregarded. Instead of separating the scientific

approach to background factors to crime into two or several conflicting traditions, where one is focused on the context only and the other on the individual only, new mathematical models treating complex interactions should be developed.

By attempting to propose a sufficient model for the causation of crimes, psychiatry has also obscured its true task. The role of psychiatry is clearly to treat and alleviate mental health problems. As a group, persons with aggressive antisocial behaviours have complex psychological, social, cultural, and mental problems in addition to their behavioural aberrations. Diagnosing and treating mental health problems in the forensic setting is therefore important regardless of the assumption of a causal relationship between mental disorder and crime. Treating health problems is the goal of medicine, and it seems a reasonable idea that general efforts to change the life premises and health of offenders might reduce their propensity to commit new crimes. The option to study treatments in relation to aggressive antisocial behaviours is open and calls for scientific efforts. Honesty demands, however, that we declare that we do not yet have empirical support for the notion that treating psychiatric disorders prevents crime, and that involuntary treatment with this goal is not evidence-based.

While general psychiatry has been circumscribed from the vast influence it once had, forensic psychiatry has instead been entrusted with more and more authority during latter decades. In several countries, e.g. the U.K. and Sweden, new or revised laws are opening up for psychiatry to use more coercive measures and to play a prominent role in crime prevention on the assumption of a causal relationship between mental disorder and crime. Hopefully, the analyses presented here have served to reveal the lack of scientific and philosophical support for such legislative changes.

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References

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders*, 4th ed Washington DC: American Psychiatric Association.
Anckarsäter H. (in press). Empirical data calls for a postpsychiatric conceptualization of mental health problems. *International Journal of Law and Psychiatry*.
Arango, C., Bombin, I., Gonzalez-Salvador, T., Garcia-Cabeza, I., & Bobes, J. (2006). Randomized clinical trial comparing oral versus depot formulations of zuclopenthixol in patients with schizophrenia and previous violence. *European Psychiatry*, *21*, 34—40.
Baron-Cohen, S. (2000). Is Asperger syndrome/high-functioning autism necessarily a disability? *Development and Psychopathology*, *12*, 489—500.
Beck, U. (1992). Risk society — Towards a new modernity London: Sage Publications Ltd.
Brülde, B., & Radovic, F. (2006). What is mental about mental disorder? *Philosophy, Psychiatry, and Psychology*, *13*, 99—116.
Cartwright, N. (1979). Causal laws and effective strategies. *Noûs*, *13*, 419—437.
Cheng, P. W. (1997). From covariation to causation: A causal power theory. *Psychological Review*, *104*, 367—405.
Cloninger, R. (1999). A new conceptual paradigm from genetics and psychobiology for the science of mental health. *Australian and New Zealand Journal of Psychiatry*, *33*, 174—186.
Constantino, J. N., & Todd, R. D. (2003). Autistic traits in the general population: A twin study. *Archives of General Psychiatry*, *60*, 524—530.
Fazel, S., Gulati, G., Linsell, L., Geddes, J.R., & Grann, M. (2009). Schizoprenia and violence: A systematic review and metaanalysis. *PloS* (*Public Library of Science*) Electronic publication ahead of print (August 11).
Flanagan, O. (1992). Consciousness reconsidered Cambridge, Mass: MIT Press.
Gabbard, G. O. (2004). The illusion of safety. *American Journal of Psychiatry*, *161*, 427—428.
Hodgins, S. (1992). Mental disorder, intellectual deficiency, and crime. Evidence from a birth cohort. *Archives of General Psychiatry*, *49*, 476—483.
Hodgins, S., Cree, A., Alderton, J., & Mak, T. (2007). From conduct disorder to severe mental illness; associations with aggressive behaviour, crime and victimization. *Psychological Medicine*, *8*, 1—13.
Kannel, W. B., Dawber, T. R., Kagan, A., Revotskie, N., & Stokes, J., III (1961). Factors of risk in the development of coronary heart disease — Six-year follow-up experience. The Framingham Study. *Annals of Internal Medicine*, *55*, 33—50.
Kim-Cohen, J., Caspi, A., Moffitt, T. E., Harrington, H., Milne, B. J., & Poulton, R. (2003). Prior juvenile diagnoses in adults with mental disorder: Developmental follow-back of a prospective-longitudinal cohort. *Archives of General Psychiatry*, *60*, 709—717.
Kinberg, O. (1935). Basic problems of criminology Copenhagen: Levin & Munksgaard.
Le Fanu, J. (1999). The rise and fall of modern medicine. *Lancet*, *354*, 2092.
Lewis, D. (1973). Causation. *Journal of Philosophy*, *70*, 556—567.
Lindqvist, P., & Allebeck, P. (1990). Schizophrenia and assaultive behaviour: The role of alcohol and drug abuse. *Acta Psychiatrica Scandinavica*, *82*, 191—195.
Lombroso, C. (1896). L'uomo delinquente in rapporto all' antropologia, alla giurisprudenza ed alle discipline carcerarie Milano: Hoepli.
Mackie, J.L. (1965). Causes and conditions. *American Philosophical Quarterly*, 2, 245–255 & 261–264.
Mackie, J. L. (1974). The cement of the universe. A study of causation, 2nd ed Oxford: Clarendon Press 1980.
Qvarsell, R. (1993). Utan vett och vilja. Om synen på brott och sinnessjukdom Stockholm: Carlssons.
Reichenbach, H. (1956). The direction of time Berkeley: University of California Press Los Angeles.
Rhee, S. H., & Waldman, I. D. (2002). Genetic and environmental influences on antisocial behavior: A meta-analysis of twin and adoption studies. *Psychological Bulletin*, *128*, 490—529.
Saarinen, P. I., Lehtonen, J., & Lönnqvist, J. (1999). Suicide risk in schizophrenia, an analysis of 17 consecutive suicides. *Schizophrenia Bulletin*, *25*, 533—542.
Soderstrom, H., Blennow, K., Sjodin, A. -K., & Forsman, A. (2003). New evidence for an association between the CSF HVS/5-HIAA ratio and psychopathic traits. *Journal of Neurology, Neurosurgery and Psychiatry*, *74*, 918—921.
Szasz, T. S. (1961). The myth of mental illness: Foundations of a theory of personal conduct New York: Harper & Row.
The Parliamentary Standing Committee on the Administration of Justice. (1990/91). Report JuU34. Mentally disordered offenders Stockholm: Ministry of Justice.
van Os, J., Hansson, S. L., Bijl, R. V., & Ravelli, A. (2000). Strauss (1969) revisited: A psychosis continuum in the general population? *Schizophrenia Research*, *45*, 11—20.
Walsh, E., Gilvarry, C., Samele, C., Harvey, K., Manley, C., Tyrer, P., et al. (2001). Reducing violence in severe mental illness: Randomised controlled trial of intensive case management compared with standard care. *British Medical Journal*, *323*, 1093—1096.
Walters, G. F. (2008). Effects of a longer versus shorter test-release interval on recidivism prediction with the psychological inventory of criminal thinking styles (PICTS). *International Journal of Offender Therapy and Comparative Criminology* Electronic publication ahead of print (July 25).
Wessley, S. (1997). The epidemiology of crime, violence and schizophrenia. *British Journal of Psychiatry*, *32*, 8—11.
World Health Organization. (1990). International classification of diseases : WHO ICD-10.

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Accountability and psychiatric disorders: How do forensic psychiatric professionals think?

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ABSTRACT

Swedish penal law does not exculpate on the grounds of diminished accountability; persons judged to suffer from severe mental disorder are sentenced to forensic psychiatric care instead of prison. Re-introduction of accountability as a condition for legal responsibility has been advocated, not least by forensic psychiatric professionals. To investigate how professionals in forensic psychiatry would assess degree of accountability based on psychiatric diagnoses and case vignettes, 30 psychiatrists, 30 psychologists, 45 nurses, and 45 ward attendants from five forensic psychiatric clinics were interviewed. They were asked (i) to judge to which degree (on a dimensional scale from 1 to 5) each of 12 psychiatric diagnoses might affect accountability, (ii) to assess accountability from five case vignettes, and (iii) to list further factors they regarded as relevant for their assessment of accountability. All informants accepted to provide a dimensional assessment of accountability on this basis and consistently found most types of mental disorders to reduce accountability, especially psychotic disorders and dementia. Other factors thought to be relevant were substance abuse, social network, personality traits, social stress, and level of education.

1. Introduction

Most penal codes include a requisite of accountability for a person to be considered legally responsible for his or her deeds. Accountability is usually defined in terms of the M'Naghten rules that state that in order to be legally responsible for a criminal act, the perpetrator must have (i) known what he was doing, and (ii) known that what he did was wrong (see e.g., Hart, 1992). The Criminal Code of Canada states that: "No person is criminally responsible for an act committed or an omission made while suffering from a mental disorder that rendered the person incapable of appreciating the nature and quality of the act or omission or of knowing that it was wrong" (Section 16 of the Criminal Code of Canada). In some countries, a volitional criterion is added stipulating that in order to be accountable, a person must also be able to control his or her actions. The Penal Code of Finland includes such a volitional criterion: "The offender is not criminally responsible if at the time of the act, due to mental illness, severe mental deficiency or a serious mental disturbance or a serious disturbance of consciousness, he/she is not able to understand the factual nature or unlawfulness of his/her act, or his/her ability to control his/her behaviour is decisively weakened (criminal irresponsibility)". (Section 4 of the Criminal Code of Finland) (authors' translation).

Sweden and a few other regions in the world (Greenland, Idaho, Montana, and Utah) have a system that does not allow acquittal on the grounds of reduced accountability (SOU, 2002:3). The very term "unaccountability" ("otillräknelighet") was long ago omitted from the Swedish legislation. Instead, when an offender is found to suffer from a severe mental disorder (medico-legally defined by the nature and degree of the disorder), involuntary psychiatric treatment replaces prison as sanction.

Numerous arguments speak against the current Swedish system, and the search for an alternative has long been in process. The re-introduction of accountability as a requisite for criminal convictions has been called for by most participants in the debate, including several parliamentary committees. A recent addendum to the current legislation (voted by the Swedish Parliament in May 2008) allows prison sentences regardless of mental disorder if the crime is severe, if the need for treatment is limited, or if the offender himself has brought about the disorder by, for instance, intoxication. Offenders who "lacked the capacity to realise the nature of the deed or adjust their actions according to such knowledge" due to a severe mental disorder will, however, still be sentenced to treatment.

If the concept of accountability were to be reintroduced in the Swedish juridical system, who would be given the task of assessing accountability? In the current Swedish system, forensic psychiatric

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assessment teams authorized by the National Board of Forensic Medicine provide the courts with written expert opinions on whether the defendant suffers from a severe mental disorder and whether the crime was committed under the influence of such a disorder. Expert opinions are rarely questioned. Forensic psychiatrists have played a prominent role in the preparatory work for a new legislation. Considering their historical role in Swedish legislative and tribunal processes, it is highly likely that their advice will also be sought on accountability in individual cases. Since the way psychiatric experts and other forensic professionals use concepts and ideas will be a decisive factor in the implementation of any suggested legal reforms, their discernment of the issues involved should be considered in detail both before such reforms are introduced and in the process of implementing new laws.

To explore such aspects, we have interviewed representatives of four categories of forensic psychiatric staff (psychiatrists, psychologists, nurses, and ward attendants) to collect data on:

1. how these professionals would assess a person's accountability on the basis of psychiatric diagnoses and case vignettes depicting mental health problem constellations,
2. whether the assessments differ across the professional groups,
3. which other variables, besides mental health problems, the respondents would consider to be relevant for the assessments of accountability, and
4. how the respondents describe the reasoning behind their considerations when assessing accountability.

2. Methods

The study includes five Swedish forensic psychiatric clinics chosen to represent both court-ordered investigative work and high-security long-term treatment. All psychiatrists ($n=30$) and psychologists ($n=30$) on duty on the day the institutions were visited were asked to participate, while nurses ($n=45$) and ward staff ($n=45$) were randomly chosen from staff lists. All gave informed consent to participate in the study. The current Swedish legislation requires these professional categories to be represented in forensic psychiatric assessment teams for court-ordered investigations. Another professional category participating in such teams, the forensic social workers, were not included in the present study as they perform social rather than psychiatric assessments. The study was approved by the Ethics Committee at Lund University (Dnr. 54-01).

All informants were given a brief, verbal background introduction to the study. They were also informed about the confidentiality of their answers. In order to ease understanding of the questions, every informant was given a written copy of the questions during the interview.[1] Interviews took from 45 min to 2 h to complete. The interviewer (PH) took notes and ended each interview by going through all answers, including specific words and exact quotes, with the informant to make sure that the notes were correct.

Before the interview, accountability was defined as comprising (i) knowledge of the nature of one's actions, (ii) knowledge of the moral value of one's actions, and (iii) the ability to control one's actions. This definition was chosen from classical theories of retribution and the extended M'Naghten rules, as presented above (Nordenfelt, 1992; Moore, 1980). All interviews started with an introductory question (omitted from the written questionnaires) about whether the respondent thought that it was possible to assess how specific psychiatric diagnoses influence accountability. All informants agreed that it could be done.

[1] One of the authors (PH) tested the questionnaire on subjects working in different areas in forensic psychiatry prior to the study and did not encounter any specific problem concerning the comprehensibility of the questions involved.

Respondents were first asked to rate the degree to which they thought that 12 specific psychiatric diagnoses, and the psychiatric disorders described in five case vignettes would influence accountability on a scale ranging from 1 to 5, where 1 was defined as "not at all impaired" or "fully accountable" and 5 as "maximally impaired" or "not at all accountable". The vignettes were extracted from true cases, three randomly chosen from preliminary forensic psychiatric investigations by psychiatrists and two from nursing evaluations. The purpose was to use real cases as described in the written psychiatric evaluations/investigations. The vignettes differ both in length and content and are included in Appendix A.

We chose to let the respondents assess accountability as a dimensional phenomenon. The meaningfulness of a graded concept has been questioned, and it is problematic for lawyers to accommodate notions of being "almost accountable" or "nearly accountable" (Wennberg, 2002). In psychology and psychiatry, however, it is reasonable to think that a person can have a more or less accurate view of the nature of her actions or a diminished, but not totally absent, action control. The term "diminished accountability" has been proposed to be in the Swedish code (SOU, 2002:3. Official Government Reports Series, 2002:3), and internationally there are a number of current legislations that make use of this notion. Given these considerations, we set out to test the hypothesis that psychiatric staff would consider it possible to assess accountability dimensionally.

In a second step, respondents were asked to describe which other factors, beside psychiatric variables, they would consider relevant for assessments of accountability.

Finally, the respondents answered an open question about how they had formed their opinions about accountability.

2.1. Analyses of results

The graded assessments of accountability in psychiatric diagnoses and cases were treated as ordinal data and analyzed statistically by the Statistical Package for the Social Sciences (SPSS) version 15.0 (Pallant, 2006). Beside descriptive statistics, the ratings across the different professional groups of each diagnosis and each case vignette were compared by non-parametric Kruskal–Wallis analysis of variance in order to detect systematic differences across the professional groups. The questions about which factors the informants considered to be relevant for the assessments are presented by quantitative renderings of the frequencies of different words and expressions. Finally, in a semi-qualitative step, quotes on how the assessments were made were analyzed for possible themes by a close re-reading of the raw data. By nature, a thematic analysis such as this depends on the interpreters and will never be free from a considerable element of subjectivity. To provide as objective data as possible, we have included both quotations and prevalences of individual words or short expressions in the material.

3. Results

3.1. General descriptions of answers and statistical comparisons between professional groups

From the detailed account of answer patterns provided in Table 1, it may be deduced that assessments were quite consistent, especially when psychosis was at hand, and that forensic psychiatric professionals generally held the opinion that accountability is diminished to a very considerable degree (ratings of 4 or 5 on the dimensional scale were used, where 5 stands for "not at all accountable") by a wide range of psychiatric disorders.

Diagnostic denominations such as psychosis, dementia, and mental retardation thus seem to indicate to professionals that people assigned these diagnoses generally have severely diminished accountability. Grades 4 or 5 were invariably rated for the diagnosis of schizophrenia

Table 1
Psychiatric diagnoses, cases vignettes, and their assessed influence on accountability.

	Psychiatrists ($n=30$)*						Nurses ($n=45$)						Ward staff ($n=45$)						Psychologists ($n=30$)**						Group comparison
Scale steps	1	2	3	4	5	md	1	2	3	4	5	md	1	2	3	4	5	md	1	2	3	4	5	md	p-value
Schizophrenia	–	–	–	15	15	4.5	–	–	–	12	33	4.5	–	–	–	17	28	4.5	–	–	–	14	16	4.5	0.161
Paranoid psychosis	–	–	–	10	20	4.5	–	–	–	12	33	4.5	–	–	–	13	32	4.5	–	–	–	7	23	4.5	0.850 0.093
Dementia	–	–	6	8	16	4	–	–	3	12	30	4	–	–	2	8	35	4	–	–	4	8	18	4	0.111
Mental retardation	–	1	7	13	9	3.5	–	–	7	15	23	4	–	–	5	15	25	4	–	1	4	10	15	3.5	0.128
Depression	–	4	14	9	3	3.5	–	7	15	14	9	3.5	1	4	14	9	3	3	–	5	18	7	–	3	0.619
Mania	–	5	10	12	3	3.5	–	3	23	16	3	3.5	–	7	19	16	3	3.5	–	2	12	12	4	3.5	0.956
Asperger	2	4	11	7	6	3	–	6	16	19	4	3.5	–	7	18	16	4	3.5	1	2	15	8	4	3	1.167
Tourette	3	6	8	12	1	3	–	15	17	11	2	3.5	–	9	21	12	3	3.5	1	8	11	8	2	3	<0.001
Borderline PD	2	14	10	3	1	3	10	28	7	–	–	2	12	27	6	–	–	2	5	11	12	1	–	2.5	<0.001
Antisocial PD	16	13	1	–	–	2	8	20	13	4	–	2.5	9	24	8	4	–	2.5	12	12	3	2	1	3	<0.001
Psychopathy	–	6	15	8	1	3.5	5	18	15	7	–	2.5	1	27	14	3	–	2.5	1	6	13	9	1	3	0.892
Narcissistic PD	9	16	5	–	–	2	15	27	3	–	–	2	13	29	3	–	–	2	13	9	8	–	–	2	
Case vignettes																									
Case 1	–	–	–	5	20	4.5	–	–	–	12	33	4.5	–	–	2	13	30	4	–	–	–	8	17	4.5	0.606
Case 2	–	–	–	6	19	4.5	–	–	1	10	34	4	–	–	1	14	30	4	–	–	–	9	16	4.5	0.646
Case 3	–	4	3	9	9	3.5	1	8	4	12	20	3	1	10	5	14	15	3	–	3	1	8	13	3.5	0.329
Case 4	–	1	4	9	11	3.5	–	–	5	18	22	4	–	–	5	19	21	4	–	–	2	11	12	4	0.889
Case 5	–	–	–	12	13	4.5	–	–	1	20	24	4	–	–	–	21	24	4.5	–	–	–	7	18	4.5	0.383

* Five Psychiatrists did not assess the case vignettes (see Method).
** Five Psychologists did not assess the case vignettes (see Method).
Md = median, PD = personality disorder.

and paranoid psychosis, for dementia by 90% of the informants, and for mental retardation by 70%. Interestingly, both mania (by definition comprising psychotic features) and the extremely compulsive Tourette's syndrome were assessed as compromising accountability to a lesser degree. Significant differences between staff categories were only found concerning personality disorders and psychopathy. These differences were consistent, as informants with short or medium long professional training rated the reduction of accountability caused by personality disorders much lower than informants with long professional training, such as medical doctors and psychologists.

All vignette cases were consistently assessed as having diminished accountability by all four professional categories. All but two informants assigned scores 4 or 5 to the first two vignettes (median 4.5). Vignette number three seemed to be the most difficult to assess, with answers ranging between 1 and 5 (median 3). The overall median for vignette number four was 4. For vignette number five, all but eight informants (95%) gave scores of 4 or 5 on the accountability scale.

3.2. Other factors listed as relevant for assessments of accountability

When asked about other factors that might influence a person's degree of accountability, most informants indicated several such factors. The frequencies of specific words and expressions used by the informants in each professional group are given in Table 2. Needless to say, the meaning attributed to these words and expressions may differ between individuals, and the frequencies therefore provide only an overview of factors that considerable subgroups of forensic psychiatric staff regarded as relevant.

3.2.1. Substance abuse

A total of 131 informants (87%) mentioned substance abuse (alcohol-, drug- or other kinds of self-medication) as an important factor with a negative impact on accountability. Several subjects pointed out that substance abuse might reduce the ability to form judgments, but that the diminished accountability caused by substance abuse should not entail that the person should be exempt from criminal responsibility.

3.2.2. Personality traits

Seventy-two informants (48%) indicated that general personality has an impact on how psychiatric disorders/problems affect accountability. They mentioned, for example, traits such as "kind", "patient", and "caretaking" as ameliorating factors and "aggressive" and "bitter" as personality traits that would influence accountability in a negative direction.

Table 2
Factors other than psychiatric diagnoses thought to influence accountability.

	Psychiatrists ($n=30$)	Nurses ($n=45$)	Ward staff ($n=45$)	Psychologists ($n=30$)	Total ($n=150$)
Alcohol abuse	27	38	40	26	131
Drug abuse	25	39	39	27	130
Social network	16	33	30	9	88
Personality traits	14	16	23	19	72
Social stress/pressure	14	16	23	19	72
Education	18	19	12	14	51
Employment	14	12	9	11	46
Sex/gender	6	15	12	7	40
Moral competence	12	9	5	12	38
Socio-cultural acceptance of violent behaviour	14	9	5	9	37
Loneliness	5	3	12	11	31
Situational panic/fear	2	6	10	11	29
Social investments	3	12	8	2	23
Own children involved	4	0	0	2	6

3.2.3. Social factors

Eighty-eight informants (59%) said that social context is important for a person's accountability. To have someone "to love, to talk to, and to trust" is believed to have an impact on how a psychiatric disorder affects accountability. Loneliness ($n = 31$, 21%) and socio-cultural acceptance of violence ($n = 37$, 25%) were other factors mentioned in this context.

3.2.4. Situational factors

Respondents also mentioned situational factors as relevant. Specific circumstances at the time of the criminal act may influence the person in the direction of diminished accountability. Economic pressure and emotional stress were regarded as relevant ($n = 59$, 39%), as were situational panic ($n = 29$, 19%) and circumstances involving one's own children ($n = 6$, 4%).

3.3. Qualitative thematic analyses of answers to the open questions

Four main themes emerged when the notes made during interviews were analyzed.

Theme A. The informant felt unaccustomed to the thought of a connection between psychiatric diagnoses/problems and accountability.

The most common reaction ($n = 57$, 38%) was that the informant had not previously thought about mental disorders as connected to accountability, but all informants stated that the interview initiated new ways of thinking about mental illness and legal/moral responsibility and they did not hesitate to answer the questions posed. Several subjects reported that they were thinking of specific patients they had met during their careers in order to get a picture of the extent to which one's accountability is affected by certain diagnoses.

Quotation 1: "I haven't realised until now, when you ask me these questions, that mental illness is so strongly connected to moral and legal issues." (Female ward staff)

Quotation 2: "I have never connected mental illness to legal issues. When I think about patient x, y, and z, it is impossible to hold any of them responsible for their actions while they were suffering from untreated mental illness." (Male nurse)

Quotation 3: "Trying to come to grips with this question I imagine a scenery where a number of patients with different diagnoses pinch me hard in the arm. How much would I blame them? You see this is quite a new way of thinking for me." (Female psychologist)

Theme B. The respondents identified factors other than psychiatric diagnoses/problems as relevant for the assessments of accountability.

The second most common observation ($n = 55$, 37%) was a remark to the effect that psychiatric diagnoses tell us something, but not everything, about a person's accountability. A number of these informants claimed that they found it peculiar that the current Swedish system for sending patients to forensic psychiatric treatment is based on psychiatric diagnosis and its severity rather than on considerations of accountability.

Quotation 4: "I more and more realise how little diagnoses tells us about a person. Women with schizophrenia, for example, are acting out all the time, while men hide in their rooms but are more violent when being violent, so to speak." (Female psychiatrist)

Quotation 5: "It is, of course, a strange judicial system Sweden has — we look simply for certain diagnoses, serious mental illnesses, when deciding to hold somebody legally responsible. Of course it is of great interest whom the illness has struck." (Male ward staff)

Theme C. The informants reflected upon freedom, moral competence, and autonomy.

Twenty-one respondents (14%) mentioned "free will" or other terms conceptually close to this when they were asked how they had reasoned. Respondents indicated, for example, that psychiatric disorders/problems diminish autonomy (capacity to make informed and deliberate decisions), individual freedom, moral competence, and impulse control.

Quotation 6: "Yes, of course mental illness kills freedom and therefore it is not right to even consider moral judgement." (Female psychiatrist)

Quotation 7: "Suffering from serious mental illness is pain, free will is not there, and therefore there is no crime committed, in the common way of using that concept." (Male psychologist)

Quotation 8: "Take, for example, a full-blown psychosis — no correct evaluation of reality, therefore no moral competence, and therefore no incitement to act differently than your first impulse tells you." (Male psychiatrist)

Theme D. The informants described that they had considered the descriptions of symptoms provided by the Diagnostic and Statistical Manual of Mental Disorders (DSM) to guide their assessments.

The fourth most common theme among the respondents (8.5%) was the mentioning of the DSM system and the symptoms described there for the diagnostic categories.

Quotation 9: "I tried to remember what is said in the DSM-IV. When suffering from certain symptoms — to what degree do these symptoms affect your accountability? That is how I was thinking while assessing." (Male psychiatrist)

Theme E. Miscellaneous

Some respondents ($n = 9$, 6%) described other ways of reasoning that could not be thematically classified. One such notion was a simple statement that if a person suffers from a mental disorder he or she should never even be included in a legal process.

Quotation 10: "I believe that when a person is mentally ill, the question of legal responsibility should be put aside." (Female psychologist)

4. Discussion

4.1. Psychiatric diagnoses, case vignettes, and accountability

One interesting finding was that all participants agreed to assess accountability from mere information about psychiatric diagnosis. This does not, however, necessarily mean that the subjects think that such assessments can be made quite as easily in actual practice. It is one thing to answer these questions in the context of a scientific study, another to actually make decisions that affect people's lives. Hence, the informants would probably be more hesitant to judge patients' accountability in real situations. It also needs to be added that in a real forensic situation the team often meets people with dual (or more) diagnoses and very complicated life situations, which will make the assessment task much more complex than indicated in this study. It is also essential to remember that the informants were not explicitly asked to judge whether a typical patient suffering from one of the disorders should be held legally responsible for his actions. It is thus likely that the informants were not primarily thinking about accountability in connection to exemption from punishment, but in terms of mental competence and general decision-making capacity. Still, several informants touched upon the legal issue in the discussion.

Since we used a graded scale for accountability, it is also possible that the informants were thinking about comparisons between the different diagnostic labels. Nevertheless, the general agreement that the mere diagnosis of schizophrenia and several other disorders indicates a total or almost total lack of accountability remains an intriguing phenomenon. The finding was further supported by the ratings of case vignette number three, which actually contained no information with a bearing on accountability, and of the personality disorders, where a fair number of informants across professional categories seemed to assume reduced accountability.

There were only minor differences between the four professional groups, indicating consensus within the forensic psychiatric community about how psychiatric disorders affect accountability. A frequent

remark was that psychiatric disorders interfere with a person's ability to make free and autonomous choices and decrease his freedom. To the concluding questions, however, more than a third of the informants pointed out that they thought that even if psychiatric diagnoses might indicate something about a person's accountability, they do not give the whole picture.

4.2. General discussion of concepts used and some limitations of our study

Since the definition of accountability used here involved three different parameters it is not clear how the subjects in detail conceived of the different stages of diminished accountability. The primary aim of the study was to investigate whether professionals in forensic psychiatry thought it at all possible to assess accountability according to classic legal criteria on the basis of mere information about psychiatric diagnoses. It may thus be the case that the offender assessed was assumed to fulfil one, two, or all three of the criteria for diminished accountability. He might, for instance, be able to control his actions, but fail to appreciate their nature, or be aware of the nature of his actions, know what is morally acceptable, but have a severely diminished wilful control of his actions. One might also hypothesise that different diagnoses are believed to affect different abilities relevant to accountability. Schizophrenia may e.g., be regarded as primarily affecting the patient's ability to assess reality and appreciate what he or she is doing, while Tourette's syndrome instead reduces the patient's volitional control, but not his knowledge of the nature of the actions he performs.

The first part of the definition of accountability entails that in order to be fully accountable, a person needs to appreciate the true nature of his actions. What does it mean to appreciate the nature of one's actions? A person may perform a certain action unconsciously, as in automatisms, which means that he has no awareness at all of what he is doing. Another possible case is that while performing an action of a certain kind, the subject believes that he is doing something else, and yet another one that he does not fully realise the possible consequences of his actions. These are all possible examples of not realizing the nature of one's own actions.

The second part of the definition, knowing what is right or wrong, may be referred to as moral competence. "Right" and "wrong" normally refers to values in the society one lives in. But what about the person who has theoretical knowledge about these matters but is not motivated by it? Several informants assessed moral competence as a factor that increases accountability. This might be interpreted as referring to the theoretical aspect of moral competence: if you know what is right and wrong you are more accountable than if you do not. It is also possible that the informants mean that a strong moral sense strengthens the ability to control actions. In that case, one regards moral competence not merely as knowledge of right and wrong, but also as knowledge that motivates moral actions and prevents norm-breaking behaviour.

Finally, in order to be judged as accountable, a subject has to be able to control his actions. What does it take to be able to control one's actions? A minimal definition of action control entails that the agent must to be able to (i) decide how to act in order to achieve what he wants, (ii) perform the action he chooses. However, in forensic psychiatric circumstances, a negative formulation may be more relevant: The accountable agent must be able to refrain from performing the actions he does not really want to perform. In order to perform the action that one chooses and refrain from doing what one does not want to do, one also needs to be free from compelling circumstances, external as well as internal.

Evidently it is a difficult theoretical problem to define what it means to really want to do something, as opposed to not really want to. Impulses are often regarded as not being the result of the agent's true desires, but to act out of impulse may sometimes be what the subject really wants but does not dare. Maybe it would be more to the point to distinguish between short-term and long-term desires. Someone might perhaps really want to have a cigarette, but at the same time he wishes to quit smoking. The first desire would be a short-term and the latter a long-term desire. "Short" and "long" do not necessarily denote how long the desires survive in the subject. An impulse may last for several hours or come back on a regular basis during a long period of time.

The volitional criterion has been regarded as problematic in the juridical debate, and in many countries it is not possible to be exempted from punishment due to lack of wilful control of one's actions. It is e.g., argued that it is difficult to assess whether a person could not refrain from performing a certain action or whether he chose not to (Becker, 2003). Giving in to an obsession or an impulse could thus be regarded as a voluntary decision on behalf of the agent. It is, however, proposed that the volitional criterion should be used in Sweden (SOU, 2002:3), but the committee adds that accountability should primarily be interpreted in terms of insight. Given that the respondents rated schizophrenia and paranoid psychosis highest on the scale, it may be assumed that they judged that reduced reality testing reduces accountability more than diminished action control does.

Several of the informants discussed moral and legal responsibility. One informant said: "I have never connected mental illness to moral issues. I believe I should have done that — who can hold someone responsible for their actions while they were suffering from mental illness?" To be morally responsible for an action is to be worthy of a particular kind of reaction–praise, blame, or something akin to these–for having performed it. Only moral agents can be morally responsible. The standard definition of moral agent requires that such an agent must exercise a special kind of control over his actions. Aristotle maintained (1) that moral agents must possess a capacity for decision and (2) that their actions must be voluntary. A voluntary action must in turn fulfil two conditions. First (2a), the action must have its origin in the agent, i.e. it must be up to the agent whether to perform that action or not, it cannot be compelled externally. Second (2b), the agent must be aware of what it is he is doing or bringing about.

The first parameter in Aristotle's definition of a moral agent refers to what we referred to as "autonomy" above, while the latter denotes accountability. Given that a person is not autonomous in this sense, or not accountable, he cannot be held responsible for his actions. This standpoint, which can be found in the classical theories of retribution as well as in most criminal codes, is the same as that which several of the informants reached by their own line of reasoning.

Another, but related, understanding of being unaccountable is that being unaccountable is close to, or even the same as, being unreliable — not to be counted with. In everyday language, the Swedish term for unaccountability sometimes carries such a connotation. It seems possible that some of the informants had this meaning in mind when assessing accountability. One of the informants gave the following description of typical cases of schizophrenia: "Women with schizophrenia, for example, are acting out all the time, while men hide in their rooms but are more violent when being violent, so to speak." The reference to violence and "acting out" suggests that the informant thinks that the task of judging whether a person is accountable or not is the same as, or is intimately connected to, predictions of risk behaviour. The remark is thus of epistemic nature; a person is unaccountable if it is difficult to know what he will do next.

5. Conclusions

According to Swedish psychiatric staff, something about a person's accountability may be assessed solely from psychiatric diagnoses, generally to the point of assuming that people with certain diagnoses or problems have severely diminished accountability. Informants further judged that specific diagnoses differ in their impact on accountability depending on to whom the diagnoses have been applied: sex/gender, education, drug and/or alcohol abuse, personality, life experience, and social network/investments are qualified variables thought to influence accountability and decision-making capacity.

Interpretations of what accountability is may have varied, although there was a fair consensus among forensic psychiatric professionals on how to make the assessments for each specific diagnosis. Their answers, indicating that all persons with a quite wide range of mental disorders are to be regarded as "unaccountable" or close to it, most probably differ sharply from views held among legislators, lawyers, and users of mental health services. Further studies with the same scope as this one but comparing representatives of different professional and cultural backgrounds seem crucial in order to arrive at definitions that may be used and understood across societal sub-cultures.

If Sweden would introduce the international concept of accountability as suggested, it will be essential to decide who should perform these assessments — and how. We can be far from certain that the change would automatically improve the legal rights of the individual. To assess accountability may be just as difficult as to assess severe mental disorder in the relevant medico-legal sense.

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Appendix A

Case 1

A is a 35-year-old man who grew up under difficult circumstances. His mother was an alcoholic and A often witnessed how she was physically abused by different men. When A was 14 years old his mother killed a man, and he was sent to a foster home. At an early age he showed conduct disorders such as aggression, irritability, impulse and concentration difficulties, restlessness, etc. He had trouble making friends, and some of his primary school time was spent at special units for children with conduct disorders. A has not worked for 10 years (since 1989). During the last 2 years he has been granted sickness benefits on the grounds of personality disorder and intermittent explositivity.

As an adult, A is still showing signs of serious psychiatric difficulties; in addition to those already mentioned: anxiety, depression, paranoid delusions, compulsive and aggressive behaviour. He denies experiencing these problems. He has since an early age had contact with psychiatric care and has for six periods been admitted to psychiatric coercive care.

A started to drink beer when he was 10–11 years old. He has also abused drugs and reports that he has taken up to 100 Rohypnol tablets in one day. Today he is still using alcohol and drugs and suffers from severe personality disorder and dysthymia. His intermittent explosive disorder is in itself a serious mental disorder. He has shown obvious signs of characteristic brain damage, probably as a result of his mothers' alcohol abuse. A has neither his own living quarters, nor family or children.

Case 2

B is a 51-year-old man with epilepsy and chronic alcohol abuse, for which he has been treated for at least 20 years. Five years ago, B was found unconscious with a skull fracture. He is disoriented regarding time, place, and persons, and he is aggressive. He has concentration- and memory difficulties and problems with interpretation of what he sees. He is not considered capable of living on his own and has been in a private nursing home for the last 6 years. Nurses there report that B "did not recognize his own room or the staff". This man suffers from serious memory disturbances and confabulates continuously. He is to be considered as suffering from Korsakow's syndrome.

Case 3

C is a 43-year-old man with an emotionally dysfunctional childhood that mostly was spent in different institutions, due to abuse and conflicts at home. He quit elementary school at 15 years of age and has since that day worked at Samhall (special employment for disabled persons). He cannot remember being sexually abused as a child. C denies having psychiatric problems before the present examination but reports overconsumption of alcohol during weekends. C denies any sexual interest in children and cannot explain his crime (sexual child abuse). He reports that alcohol consumption is what makes him lose control over his impulses. No serious mental illness can be found, but he seems to suffer from some immature/infantile personality disorder and obviously lacks empathic understanding. His crimes are, however, of a sexual nature, and they have increased in severity since the last time he was convicted. It is therefore important to give him therapeutic treatment during his prison term.

Case 4

D is a 30-year-old man who is calm when arriving to the ward for forensic psychiatric assessment. He does not express any feelings about this examination. He has on a couple of occasions shown signs of psychotic experiences. He has been observed wandering back and forth in the corridor performing physical rituals, such as boxing himself, pulling at his ear-lobes, and alternating between walking on his toes and heels. D has been lying on the TV-couch with his hands over his ears screaming that he wanted to be left alone; told the staff that he had to go to Copenhagen to save a 4-year-old child from getting killed. He has also sexually harassed female staff and patients. He has complained over headache almost every day. D has slept well at night except for once when he had nightmares. He has been playing both table tennis and chess. He has not managed to keep order in his room or maintain his personal hygiene. D has shown no inclination to take other persons' interests into account — neither staff nor other patients. He did not hesitate to put his dirty, naked feet on the table in front of the TV (communal TV room for all patients).

Case 5

E is a 51-year-old man who was agitated on admittance to the forensic psychiatric examination but claimed to be "no man of violence". He has divided the staff into two groups: the good and the bad. He has reacted and acted differently based on whom he is talking to. If E has not liked the person he is talking to, he has used plenty of dirty words. He has been walking restlessly, up and down the corridor. He has continuously showed that he is suspicious and believed everybody is talking about him all the time. He has been observed behind doors etc. trying to overhear what is said. He has been looking for wrongs in other people and with precision pointed these out but has ignored his own. He has been easily upset, irritated, and verbally threatened others. E has slowly but adequately answered all questions asked. He does, however, have problems listening to other people and speaks back to you in an agitated way. E has reported several suicide attempts in the past but has not wanted to talk about suicide during the examination period. He says that he looks upon himself as a free person today but admits that he was in poor psychological shape during his divorce. Restless, intense, with sleeping difficulties, he was observed talking to himself, saying that he cannot live without his ex-wife and has told the ward staff that he had wanted to kill himself but does not want to talk about his attitude to suicide now. He reports that he is totally non-ill today, but admits that he has been psychologically unstable when divorcing his wife. He feels lonely and unfairly treated and says that nobody can help him in this matter. E does not believe that he can have a life without his wife, and he has not committed any

criminal action. He has a long beard and does not want to shower unless explicitly asked to do so.

References

Becker, R. F. (2003). The evolution of insanity standards. *Journal of Police and Criminal Psychology*, *18*, 41—45.
Hart, H. L. A. (1992). *Punishment and responsibility: Essays in the philosophy of law.* Oxford: Clarendon Press.
Moore, M. S. (1980). Legal conceptions of mental illness. In B. A. Brody & H. T. Engelhardt (Eds.), *Mental Illness: Law and Public Policy*. Dordrecht: D. Reidel.
Nordenfelt, L. (1992). *On crime, punishment and psychiatric care.* Stockholm: Almqvist & Wiksell International.
Pallant, J. (2006). *SPSS 15.0 for Windows.* SPSS Inc.
SOU 2002:3. Official Government Reports Series. (2002). *Psykisk störning, brott och ansvar (in Swedish)*. Stockholm: Ministry of Justice.
Wennberg, S. (2002). Psykisk, störning, brott och ansvar — För och emot psykansvars-kommitténs betänkande. *Svensk Juristtidning*.

Paper 1

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Explanations for violent behaviour—An interview study among forensic in-patients

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ABSTRACT

The alleged relation between mental disorder and violent criminal behaviour has been investigated mainly from an epidemiological perspective. Population-based registry studies have shown that violence occurs more frequently among people with mental disorders, like schizophrenia and bipolar disorder, compared with control subjects, but that the increased risk is largely mediated by drug abuse and socio-economic deprivation. The aim of this study was to explore how patients who have committed violent or sexual crimes and have been sentenced to forensic psychiatric care by a Swedish court of law construed their criminal actions in terms of causes. Forty-six participants from six different Swedish forensic psychiatric clinics were included in the study. A semi-structured interview study was conducted and the data was analysed using a thematic analysis. A large group of the participants did not believe that the mental disorder played any role in the criminal events. Contributing causes that were mentioned were drug abuse and social factors.

1. Introduction

What is the relation between mental disorders and violence? Is violence more common among people with mental disorders than in the general population? The question has primarily been investigated from an epidemiological perspective. Such studies have found that violence occurs slightly more frequently among people with major mental disorders, i.e., schizophrenia and other psychotic disorders, compared with control subjects (e.g., Arseneault, Moffitt, Caspi, Taylor, & Silva, 2000; Elbogen & Johnson, 2009; Fazel & Grann, 2006; Joyal, Dubreucq, Grendon, & Millaud, 2007; Swanson, Holzer, Ganju, & Jono, 1990). The total number of crimes that can be ascribed to persons with these disorders, however, is in the order of a few percents (Wessley, 1997), and in the general population, individuals with psychotic disorders sentenced for violent crimes are a small number. There was one violent crime – simple assault – in 450 patient years for schizophrenia in one of the studies showing the highest relative risks (Lindqvist & Allebeck, 1990). Furthermore, the overlap between schizophrenia and other adult mental disorders with childhood-onset aggressive antisocial behaviour disorders is in the range of 25–60% (Hodgins, Cree, Alderton, & Mak, 2007; Kim-Cohen et al., 2003) and it has been shown that the increased risk for violent crime among patients with schizophrenia is largely mediated by drug abuse and socio-economic deprivation (Fazel, Långström, Hjern, Grann, & Lichtenstein, 2009; Fazel, Lichtenstein, Grann, Goodwin, & Långström, 2010; Steadman, Mulvey, Monahan, et al., 1998; Swanson et al., 1990). It could hence be suggested that major mental disorders do not by themselves cause crime, but that among people with a history of destructive and anti-social behaviour, past and current drug abuse and poor social and economic status, a major mental disorder slightly increases the already increased risk of violent behaviour.

Sweden and a few other jurisdictions in the world have a unique kind of penal system when it comes to the handling of mentally disordered criminal offenders, which does not entail acquitting criminal offenders on the grounds of unaccountability. If a Swedish court of law judges that a criminal offender has been acting under the influence of a severe mental disorder she cannot be sentenced to prison, nor will she be acquitted. Instead, she may be sentenced to forensic psychiatric care that is a criminal penalty among others, given that there is a need for psychiatric treatment at the time of the trial. It has been suggested from the legislators that *under the influence* should be interpreted in causal terms, which indicates that an underlying idea in the Swedish system is that mental disorders can cause someone to commit a crime. In order to specify what causation might mean in these circumstances, the Swedish legislators write: "the causality demand is not fulfilled if the mental disorder did not have a "decisive influence" on the act" (Prop., 1990/91:58, p 457ff).

This understanding of causation can be assimilated with the epidemiological data. That a severe mental disorder has a *decisive* influence on someone's behaviour does not necessarily mean that it is the only cause behind the crime. A possible interpretation of *decisive influence* can instead be spelled out in counterfactual terms: it is true that a severe mental disorder caused a criminal act if the crime *would not have taken place* if the offender *did not suffer* from the severe mental disorder. That

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does not leave out the possibility of there being other equally decisive factors at play. To take an example: A person who suffers from schizophrenia robs a store. Does the fact that he is schizophrenic automatically lead to the conclusion that he was acting under the influence of the disorder? No, it may of course be the case that he acted for reasons that were not at all related to the disorder. He could be committing the crime because he wanted money to pay off a gambling debt. In this hypothetical case the person would still have committed the crime even if he did not suffer from schizophrenia.[1] In contrast, if the person's belief that he had to pay off a debt were part of a system of delusional beliefs where he falsely conceived of himself as being followed by a loan shark, then it would perhaps be true that he would not have robbed the store if he wasn't suffering from these delusions. In the latter case, in contrast to the former, it would hence be accurate to say that a severe mental disorder had a decisive influence on the act. But again, this does not preclude the possibility that there were other causes in motion at the same time. Even if it is true that our person would not have committed the crime if he did not suffer from the severe mental disorder, it may at the same time be true that the crime would not have happened if the offender was not provoked by the victim, if he had eaten a steady breakfast, had not been drunk, and so on.

This state of affairs is captured in the philosopher J. L. Mackie's analysis of causation. He suggests that causes are at a minimum INUS conditions, that is, "insufficient but necessary parts of a condition which is itself unnecessary but sufficient for their effects" (Mackie, 1965). Given this exploration a mental disorder might be a necessary part of some overall condition including other factors such as drug abuse, socio-economic problems, situational factors and so on, that leads to a certain event. The disorder is an insufficient part, which means that by itself it would not have caused the violent behaviour, but together with other equally necessary (but by themselves insufficient) factors it can be considered as a contributory cause for someone to commit a crime.

The present study addressed the question of the relationship between mental disorders and violent crimes from a different angle, namely the first-person perspective. The study was an interview study among in-patients in forensic psychiatric care in Sweden with the aim to investigate how the offenders themselves evaluate the possible causal factors behind their violent behaviour. The subjects in the study have all committed violent or sexual crimes and were sentenced to psychiatric care by a criminal court. The aim of the study was *not* to assess whether the court verdict was correct or not, the subjective opinions have little bearing on this. The subjects may not remember what happened, they may be insincere, or they may not at all know why they did what they did, to name a few possible sources of error. The answers given by the participants may therefore primarily reflect the subjects' perceptions and reflections at the time of the interview, rather than form an accurate description of their state of mind at the time of the crime. Still, the subjective viewpoint on this question has not as far as we know been systematically investigated and the offenders' own stories present a complementary perspective to what has been found about the connection between mental disorder and violence in other types of studies.[2]

2. Methods and design of the study

The study was conducted in the form of semi-structured interviews with the aim to capture the participants' beliefs about possible causes behind their criminal acts. We examined to what extent the subjects believed that the severe mental disorder was the cause of their criminal acts and/or what other factors they thought might have contributed.

2.1. Participants

Six of Sweden's largest forensic psychiatric clinics were selected for the study. All six clinics were visited on one occasion, consisting of one or two days. With the help of the representatives of the psychiatric staff, patients sentenced to inpatient care as a sanction for a criminal offence that, according to the court, had been committed under the influence of a severe mental disorder, were selected with the aim to include eight to ten patients from each clinic. The selected patients were informed about the study and asked to participate. The interviews took place in a private room on the ward.

The following inclusion criteria were used:

(i) the subject should acknowledge that he or she suffered from a severe mental disorder,
(ii) the subject should acknowledge that he or she had committed the crime for which he or she was sentenced, that is, not only performing the act in question, but also agree that it was a criminal offence, and
(iii) the interview should not interfere with the patient's treatment or general welfare.

Fifty patients were selected for the study. Two of these declined to participate and in two cases it became clear during the interview that the subjects did not acknowledge that they had performed the criminal act for which they were sentenced, which means that forty-six patients were included in the study. Of these, thirteen subjects were convicted of murder, twenty-one subjects of other violent crimes (assault and aggravated assault), five subjects had committed arson and the remaining seven were sentenced for sexual crimes. Twenty-three of the subjects had been in forensic psychiatric care between one and five years, and the rest for more than five years. There were forty-three men and three women included in the study.[3]

2.2. Ethical considerations

All informants were given a verbal introduction to the study, including information about the confidentiality of the study and the possibility to stop the interview at any time they preferred. Patients in forensic psychiatric care present a particular concern from an ethical point of view since they are both patients and prisoners. In this study we particularly stressed that the interviews were conducted by persons who had no influence over decisions regarding the patient's prospects of probation, discharge or possible benefits within the care. Still, the subjects in this study are in a vulnerable situation, and we took caution not to pressure a subject if he showed any reluctance to answer a question or discomfort of some other kind. The study was approved by the Ethics Committee at Lund University, Dnr 54-01.

2.2.1. Data collection

Interview data were collected between 2008 and 2009. After consent had been agreed and the subjects had been informed about the study and their rights, the interviews focused on two questions. The first question addressed the possible causes for the violent act. The subjects were asked whether they thought that the severe mental disorder was the sole causal factor, a contributing factor or not at all a factor behind the criminal act. We also asked the participants whether they thought that, given the same circumstances, they would do the same thing again. The second question was an attempt to encourage the subjects to look at the original situation, but from a different perspective. The idea was that the answers to this question also indicate which factors the subjects believed had led up to the crime, e.g., if a subject answers: "no, because I am well now", it suggests that the subject viewed the

[1] It could however be a bit more complicated than that. What if it was the case that the person in this example stole money to pay for drugs, but would not have started using drugs in the first place if he wasn't schizophrenic?

[2] Qualitative studies exploring other aspects of subjective experiences in relation to violent offending have been conducted, primarily with issues of recovery and redemption in focus (e.g., Ferrito, Vetere, Adshead, & Moore, 2012; Maruna, 1997).

[3] We will use the pronominal "he" consistently even when quoting a female participant, in order both to protect the anonymity of the subjects and to avoid unnecessary repetitions of "he or she".

mental disorder as a contributing factor, even if he didn't acknowledge this in the answer to the first question. In the case where the subjects answered that the disorder was a contributing factor or no factor, most subjects named other circumstances as possible causes of the action. The interviews were carried out by PH and notes were taken by SR and lasted between 30 min to 2 h to complete.[4]

2.2.2. Data analysis

Following transcription of the interview material, the analysis focused on what causal role the participants thought that the severe mental role had played, what other contributing factors they identified and how they expressed their ideas about re-committing the crime. The analysis followed the outline of a thematic analysis, as described by Braun and Clarke (2006). The analysis starts with an active "reading through" of the material. In a subsequent step the replies to the different questions were analysed in order to find initial codes that formed the basis for the themes. For each questions, themes were searched for in the answers. A theme represents here a patterned response within the data. Prevalence was one consideration when establishing themes, but not the only one. The most important deliberation, beside prevalence, was whether the theme captured something important in relation to the research questions. Themes were thus identified from a primarily deductive perspective (Boyatzis, 1998) and via the explicit meaning of the data, which entails a minimal amount of interpretation of the statements themselves. The data have on the basis of this explicit meaning been organised to show patterns of semantic content. The selected material was translated to English by the authors.

3. Results

Four subjects replied that a severe mental disorder was the sole cause of the crime. Thirteen of the forty-six subjects answered that a severe mental disorder was a contributing factor to what had happened. Fifteen subjects claimed that the mental disorder did not play any role when they committed the criminal act. Five subjects replied that they did not remember or did not know, and the remaining nine answers were difficult to classify according to these themes. To the second question, sixteen subjects said they would do it again, sixteen that they definitely would not. Ten subjects said that it depended on the circumstances, and the remaining four subjects claimed that the question cannot be answered. The contributing causes that came up as themes are: drug abuse and aggression. Yet another theme found in the material was blame. Below, the results from the interviews are described in groups according to these themes. Under each theme, quotes from the interviews are listed as examples. Each subject has a unique number, i.e., that different quotes from the same subject has identical numbers.

3.1. Single cause

Four subjects answered that a severe mental disorder was the only cause of the crime.

1. "I would think so, yes. I love my father but cannabis abuse gave me a psychosis and inside the psychosis I believed my father was the devil."
2. "I am convinced that the disorder caused the crime. I would not have become a criminal if it wasn't for the mental illness."

3.2. Contributing factor

Thirteen subjects answered that a severe mental disorder was a contributing factor to what happened.

3. "Contributing cause. The disorder made me focus on that. Otherwise, I would have committed some other crime. Robbery would have made more sense."
4. "It was many things, Yes it was contributing, the SOB [the severe mental disorder]."
5. "Yes or no, I heard voices, but kind of knew they were voices and not real, but I felt calmer when I obeyed them. Then I smoked hashish and that made me calm but often also worse. I am not sure how it's all connected. But sure, the voices wanted it more than I did most of the times."
6. "I have a personality disorder and I guess it makes me do different things than the so-called normal population would. I have no patience and get real easily pissed off and stuff. But what I did, well I don't know, maybe it's the disturbance in my brain that speaks to a part."
7. "It played a role, I would think. I had weird thoughts then, thought that the whole world was about getting me killed. Everyone was in on the conspiracy."

3.3. The mental disorder had nothing to do with the crime

Fifteen subjects answered that the mental disorder did not play any part in the circumstances that lead up to the crime.

8. "No, not at all. I had hated my father for a long time. He had to die. That I had been drinking that day and drove around in the car so that I could decide exactly how to do it had as much impact. That no one bothered me. Had my sister called, I would perhaps not have done it, at least not that day. But then he came against me in his usual manner and I floored him with the first punch."
9. "No, I chose to kill those people. Their lives weren't worth anything anyhow. I did them a favour so to speak."
10. "No, it had nothing to do with that. My wife was going to take off with my kid. I went out of my mind and I threatened her with a knife and then I put it in her. You don't have to be sick to do that."
11. "No, it was because I was broke, took drugs and felt persecuted by the police. You don't have to be sick to feel or to be persecuted."
12. "I did of course set the fire and I wanted to set fire, they had mistreated her, I did it for her sake. I would have had done it again. And then maybe I am weird to think it was the best solution, but I thought it all through."

3.4. Other contributing factors

Among the subjects who replied that the mental disorder had nothing to do with the crime or that it was merely a contributing factor we found two major themes in their explanations for their actions and that was (i) drugs and (ii) aggression.

3.4.1. Drug abuse

Thirteen subjects brought up drugs in their explanations for why they committed the crime.

13. "I wouldn't have done it if it wasn't for the drugs, but my friend was probably the one who made me do it, she kind of pressured me."
14. "No, it twisted it all some more, but I have never behaved well and taking amphetamine and stuff, it destroys your head."
15. "The main cause was probably that I drank so much, it messed up my brain."
5. "Yes or no, I heard voices, but kind of knew they were voices and not real, but I felt calmer when I obeyed them. Then I smoked hashish and that made me calm but often also worse."

3.4.2. Aggression

Six subjects referred to anger when they explained why they had committed the crime.

[4] The results presented in this paper form one part of the overall interview material, which also included questions about the content of the psychiatric care.

16. "No, I was just real pissed off."
30. "No, I had a life that tried hard to go to hell. On top of that, my love had left me just before the crime. I loved her, she was my everything. Our children. I was so sad, and then it became anger and I threatened her a little roughly. But I didn't mean much by it and in the end she reported me to the police, that I can understand, can't I? It became too much, too heavy, and I kind of lost contact with reality. Was just thinking about one thing. To get them back."
17. "No, I raped her because I was angry."
10. "No, it had nothing to do with that. My wife was going to take off with my child. I became out of my mind and I threatened her with a knife and then I put it in her. You don't have to be sick to do that."

3.5. Blame

Yet another theme that we found concerned blame. Five respondents addressed the question of blame, all of them in terms of pointing out that they did not want to blame the disorder (or anything else) for what happened.

18. "I'm aware of what I have done, I cannot blame anyone else."
19. "A contributing cause, but I cannot put the blame on that. That's no excuse. I know how to tell right from wrong but am good at telling lies. I am a person who is responsible for his actions."
20. "The only cause. […] It's hard to blame someone else. Stab three people and then say it wasn't my fault. You have to take responsibility for your actions."
6. Perhaps the disorder in my brain speaks to some part, but I cannot put the blame on that. I have my responsibility, naturally.

3.6. Repeating the offence

The answers to the final question have been gathered under four different themes; (i) I would do the same thing again, (ii) I would not do it again, (iii) it depends on the circumstances, and (iv) the question is impossible to answer.

3.6.1. Reoffending

Sixteen subjects answered that they would do the same thing again. Several of them just gave a simple "yes", or "yes of course" to this question, but some elaborated on the answer.

9. "I chose the best alternative. Would have done it again. It's about either me or them and I won't let myself down."
4. "Yes, I don't like it when people boss me around."
21. "I couldn't resist. That's just how it is. I would have done it again."

3.6.2. Not reoffending

The same number of participants (16) said that they would not do the same thing again.

16. "I know how to wind down now; I get calmer faster and have time to understand what's best for me in the so-called long run."
14. "No, I got a girlfriend now. The treatment here has given me thoughts again."
22. "No, I would never do that again. Now, I am prepared for that kind of thoughts and have decided never to do anything like that again."
23. "No, it would not happen again, I have a social position now."
24. "No, now I would talk to the personnel. Maybe I would walk away. I do that when I'm pissed off. So does my dad."

3.6.3. Reoffending dependent on other circumstances

Ten subjects answered that it depends on to what extent the hypothetical situation would resemble the past (real) one.

25. "Yes, I would do it again, but only to her, because she is like she is. If I get angry with someone here, I can always talk to them instead."
26. "I should have left her sooner. I had nowhere to go. Couldn't move anywhere. I would not act the same way again now that I have my own place to live."
5. "Yes, if I would get myself into that stuff again. I felt so bad and didn't even think about how miserable my life was, I would probably do the same thing again, what do you think?"
27. "Pretty good chance, but with your help I will probably not end up there again."
1. "I am afraid I will. I cannot smoke again. I never want to be there again. My dad and I are friends and I never want to hurt him again. He's the only one I got."
19. "I'm scared of meeting the people I hang out with. I cannot guarantee that I won't relapse."

3.6.4. The question is impossible to answer

Four subjects expressed doubt that the question could be answered at all.

28. "Have no idea. I only had one mother."
29. "I can hardly answer that. Nothing will ever go back to exactly the same as it was."

4. Discussion

Only four subjects answered that the mental disorder was the sole cause for the crime. This squares well with population based studies that have shown that the correlation between major mental disorder and violent crime is possibly mediated by other factors, such as drug abuse and socio-economic deficiency. Not even the replies we assembled under this theme do unequivocally lend themselves to this interpretation. Subject 2 e.g., makes a conditional statement, "I would not have committed the crime if it wasn't for the disorder." He does not clearly state that the disorder was the only cause. He might hence think that there were other contributing causes as well.

The most straightforward explanation for why so few subjects answered that the severe mental disorder was the only cause might be that the respondents made an accurate observation of the circumstances around the criminal act. But what about the large group (fifteen subjects) who answered that the mental disorder played no role at all in the events? Were they wrong? Or were they right as well and in these cases the court ruling was erroneous and they had not in fact committed the criminal acts under the influence of a disorder? It's difficult to tell. If we look closely at the answers in this group it seems as if some of the participants might be wrong about whether the disorder influenced them. Subject 9 claims that he did the victims a favour by killing them since their lives weren't worth anything anyway. Another subject explains his actions with the combined facts that he was broke, on drugs and felt persecuted by the police (11). And he adds: you don't have to be sick to feel persecuted or be persecuted. Subject 10 says that his criminal actions had nothing to do with a mental disorder. He had, according to himself, good reasons to act the way he did and concludes that you don't have to be sick to stab your wife if she threatens to take off with your child. Now, if these ideas (that killing someone is doing him or her a favour, to be persecuted by the police, that it is right to stab one's partner if he threatens to take one's child) are delusional beliefs, it may be accurate to claim that these persons were in fact influenced by their disorders when they committed the violent act and given that they were delusional and lacked insight about their condition, these facts may not be accessible to the subjects themselves. It could, however, also be the case that the beliefs referred to here were not delusions in a psychiatric meaning, and that would in turn mean the subjects were right about not having acted for reasons connected to a mental disorder.

When it comes to judging whether a violent offender is "legally sane", these questions become pressing. It may seem to most of us that it is simply not true that anyone can do anyone a favour by killing

her (at least if the victim is not terminally ill) and that may lead some of us to conclude that a person who believes this to be the case must be "out of his mind". And many of us would probably want to question whether you can be sane and think that it is perfectly all right to physically assault someone if he threatens to take your child away. But from the fact that it is odd, cruel and out of the ordinary, it does not necessarily follow that it is disordered in a clinical sense. We can simply not say, given the facts we have here, whether the subjects quoted above were right or wrong about their motives being un-connected to a mental disorder.

In contrast, some respondents who answered that they were influenced by the mental disorder corroborated this by referring to their motives as affected by the mental disorder. Subject 5 says that he heard voices and that they pressured him to do things and even though he was "kind of aware" they were not real, they still played an important role since it felt easier to obey them. Subject 7 says he had "weird thoughts" of a paranoid character that probably played a part in the event. And subject 17 reports that he committed the crime because he wanted to and that was to set some score right and that he really thought it through, but adds that it was perhaps weird to think that this was the best solution.

The insight that your thoughts and ideas are tainted by a mental disorder may exist at the time of the violent act or appear afterwards (after recovering). Subject 7 says that he had weird thoughts "then", which suggests that he believed in them at that time, but have come to realise that they were symptoms of a disorder afterwards. Subject 5 on the other hand, seems to mean that he already at the time of the crime was semi-conscious that the voices he heard were hallucinations.

Yet another way to look at this comes up in the quote from subject 6, where the subject says that the disorder was a contributing factor to the violent behaviour in so far as his impatience and short fuse are symptoms of the disorder. Here, the subject seems to primarily think about how the disorder has affected his ability to control his impulses and emotions. The standard definition of action responsibility first formulated by Aristotle says that in order to be responsible for what you have done you must both know what you do and be able to control your actions. When establishing in what way a mental disorder may influence behavioural control, two factors are commonly put forward and that is lack of impulse control and the presence of compulsions.[5] Subject 5 says that the voices wanted it more than he did most of the times and although he kind of knew they were not real, he felt better to obey them.[6]

4.1. Drugs and aggression

The most common examples of other contributing factors that were mentioned in the interviews were drugs and aggression, respectively. The mentioning of drugs is consistent with what has been found in population-based registry studies.

We can discern some differences in how the relation between drug abuse and the criminal act are described by the subjects. In some cases the subjects seem to mean that using drugs were an influential factor in so far as the drugs have inflicted permanent damage to their cognitive capacities, e.g., subject 14 notes that using drugs destroys your head. In other cases the subjects might just as well be referring to how being intoxicated affects your control of actions. Subject 5 says that smoking hashish often makes you worse.

A few respondents brought up anger as a contributing factor. This is hardly surprising either, the subjects have committed violent (on some occasions sexual) acts and aggression is of course linked to violence. An interesting inquiry is the nature of the relation between aggression and the mental disorder in these cases. Subject 6 believes that his lack of patience and bad temper is attributable to the disorder. In such a case the aggression might be interpreted as a symptom of the disorder and in so far as the crime was committed because the agent was angry, one might say that the disorder caused the crime. Naturally, a person who suffers from a mental disorder undergoes emotions that are not symptoms of the disorder as such. Strong emotions may overpower a person and undermine her abilities to think and act rationally, and this is the case regardless whether she has a mental disorder or not. A person with schizophrenia may, hence, experience emotions that are not symptoms of the disorder, and they may in turn influence her to act. The subjects 16, 17 and 10 clearly state that the anger in their case was in their view not connected to the disorder. Subject 30 answers "no" to the question and discusses his sadness and anger and adds that he somehow lost contact with reality. He does however not think that the disorder played any part in what took place, but seems to mean that the strong emotions and the stressful situation by themselves triggered a state of lost reality contact.

4.2. Blame and responsibility

Four subjects raised the question of blame even if none of the questions in the interview explicitly addressed this issue. However, pointing out a causal factor as a possible explanation for one's behaviour can function as a way of avoiding responsibility for what happened, e.g., "I stole the car because he forced me," implies that the other person should at least be partly blamed for what happened.

The question of blaming something only becomes relevant when the action in question is negatively valued (in a moral sense). We do not blame anyone or ourselves for doing something that is considered morally right (or morally indifferent). Naming an external cause for a positive event indicates praising rather than blaming. "He made me save the rabbit". On the other hand, pointing out a cause for a morally valued action does not necessitate either blame or praise. "She made me do it, but I don't blame her".

In the present study all subjects who discussed blame did it in terms of not wanting to blame the disorder for what they did. Subject 19 says that although the disorder was a contributing factor to what lead up to the criminal act, he could neither blame the disorder nor did it excuse what he did. Subject 20 even claims that although the disorder was the only factor behind the criminal act, it still felt strange to blame anything but herself/himself for the crime. Since blaming often takes place on an implicit level, giving a causal explanation for some immoral behaviour may be interpreted as an attempt to blame that factor and avoid responsibility. This does not only happen when the causal factor is external. Explaining a violent act by referring to a mental disorder could also be a way to resist taking responsibility. A possible explanation for why four subjects brought this up is hence that they acknowledged the difference between merely pointing out a cause and blaming that cause and wanted to emphasise that in their case, even though the disorder influenced their actions, being mentally ill should not exempt them from moral responsibility.

Studies using the instrument: Gudjonsson Blame Attribution Inventory (GBAI) (Gudjonsson, 1984; Gudjonsson & Singh, 1989) have found that violent offenders suffering from mental disorders were not as prone as one might expect to attribute blame to the disorder. GBAI uses three factors of blame attribution: *external attribution*, *mental element attribution* and *guilt feelings*. External attribution is concerned with to what extent an individual attributes the cause of the crime to external factors such as society or other people in a way to disclaim responsibility. Mental element attribution aims to measure to what degree the subject believes that the act was an act of their own choosing

[5] The Swedish governmental inquiry (SOU, 2002:12) suggests that command hallucinations may on occasions be such a strong coercive factor that it should excuse the person who acted under such an influence.

[6] Given the epistemological and conceptual difficulties involved in assessing whether an act was performed under the influence of a mental disorder (or caused by it), the discussion about whether the subjects were correct or not in their judgments may seem inappropriate in the first place. Still, forensic psychiatrists make these kinds of assessments in the Swedish system despite these difficulties. Being influenced by delusions or command auditory voice hallucinations are examples of factors that are weighed in when establishing whether an offender acted under the influence of a severe mental disorder.

or if was rather due to mental factors such as depression or stress, which in turn might diminish control of one's actions. Guilt feelings measure to what extent the individual feels guilt or remorse for his criminal act. GBAI has been used in both prison and forensic psychiatric settings in several countries (e.g., Batson, Gudjonsson, & Gray, 2010; Dolan, 1995; Gudjonsson & Singh, 1989; Moore & Gudjonson 2002; Tolfrey, Fox, & Jeffcote, 2011).

One persistent result in these studies is that the degree of perceived control, measured by the mental element factor, correlates positively with reports of guilt and remorse. This means that the experience of lacking control over one's actions leads to a higher degree of feelings of guilt and remorse, which may seem counter-intuitive given that loss of control from a legal point of view instead often is viewed as a mitigating factor, or even a factor that may reduce legal responsibility entirely. In the present study, we did not ask about feelings of guilt, but the results nonetheless indicate that being "objectively judged" out of control because of mental illness does not necessarily reflect how the individual perceives the situation in terms of responsibility.

It should be noted that all studies using the GBAI-R instrument have been conducted among subjects from Northwestern Europe and it could be the case that the tendency to not blame psychiatric conditions and to claim to take responsibility is partly a reflection on cultural norms. Further, if taking responsibility for one's actions is perceived as the socially desirable thing to do, there could also be a reason to suspect that the subjects' answers were partly due to a willingness to accommodate these perceived cultural expectations and that they might not reflect a true willingness to assume responsibility of one's actions.

4.3. Repeating the offence

Sixteen subjects replied that given the same circumstances they would commit the crime again, while sixteen others said they would not. The diversity of answers might be due to different interpretations of the question. One possible way of understanding the question is to imagine a future situation that is exactly like the previous one. In that case, it follows that, necessarily, the effect would be the same, and hence, the answer would be: "I would do it again".[7] Another interpretation which seems to be what the subjects who answered that they would not do it again had in mind, pictures a situation that could take place in the real future. The subjects whose answers can be found under this theme, mentioned different factors that would make a future situation different from what they had been through, and, in turn, would hopefully prevent them from doing the same thing again. Two participants said that they are better now at controlling their anger, and one said that he could better handle his thoughts now. One subject said that he had a girlfriend; one claimed that the social circumstances had changed. Another subject says that he's afraid he would do it again, if he doesn't refrain from smoking and yet another that having one's own place to live is a protective factor. Two subjects emphasised the victim in their replies. Subject 28 said that he only had one mother and 25 that he would do it to the victim again.

From these results one might infer further information about the participants' views about causes for the original violent act. If e.g., better social circumstances in terms of living conditions and partners (14, 23, 26) are factors that would protect against relapsing in criminality, poor living conditions and the lack of life partner might consequently be seen as factors that increase the likelihood of committing a crime. Some of the subjects said that they would do the same thing to the same victim (25, 28) which indicates that in their view their violent behaviour would not affect any random person and that a strong factor behind the criminal act was the relation to the victim. A plausible interpretation is thus that the things mentioned by the subjects here, were regarded by the subjects as important factors behind the violent act. If the hypothetical exclusion of one factor is believed to change the turn of events, that factor is consequently believed to play a crucial role. However, in contrast to the other answers the subjects gave to the first question (about causal factors behind the crime), it is not clear whether this conclusion was reached by the subjects themselves.

[7] Not necessarily, if one believes in an absolute freedom of will, which means that if we acted freely we could have acted differently than we actually did, one might think that one could have acted differently even if the (material) circumstances were exactly the same. Perhaps subject 9 was thinking along those lines. He says he chose to do what he did and he would choose the same thing again.

5. Limitations

There are a multiple of sources of possible errors when it comes to using self-reported data in research. As a general observation, people tend to forget and accurate memories of events may be distorted due to misinformation given by others. In this context, it may be especially difficult for the respondents to correctly remember factors at the time of the crime, given that they all suffered from psychiatric problems. On the other hand, it has been argued that the fact that an offender (or a suspect of a crime) suffers from a major mental disorder such as schizophrenia does not in itself entail that she is unfit to be interviewed (Gudjonsson, 1995a,b) and that each case should be judged individually. The participants in this study were all judged by representatives of the psychiatric staff to be fit to be interviewed. Another possible source of error is the described tendency for respondents to present a favourable image of themselves. Studies have shown that participants may in order to conform to social norms either come to believe in the false (but socially desirable) information they report, or they may fake their answers accordingly (Huang, Liao, & Chang, 1998; King & Bruner, 2000). This phenomenon is most likely to occur when the questions concern socially sensitive questions such as level of physical activity (Adams et al., 2005), and domestic violence (Babcock, Costa, Green, & Eckhardt, 2004). Given that the topic of this study concerns an area of socially non-accepted behaviour (violent and sexual crimes) the tendency among the respondents to adjust their answers in order to "look better" cannot be underestimated. In order to slightly reduce the risk for this kind of reaction we took care explaining that the strict confidentiality of the study meant that the participants' answers would not have any influence on decisions concerning benefits within the care or discharge.

The choice of close-ended questions and the analytic approach to data analysis may have limited the findings. A completely open-ended interview approach with a subsequent inductive thematic analysis would probably have generated further unexpected themes. However, given the number of participants in the study this would have been very difficult to do. We chose to let the benefit of including many different perspectives on the questions outweigh the value of finding further possible themes.

6. Conclusions

The most striking result is that such a large proportion of the group answered that the disorder had nothing to do with the crime. This may of course be true, but there are other more likely interpretations. Such as: the subjects did not realise that their actions were influenced by the disorder; or they did not want to blame the disorder for something they thought they should take responsibility for.

If we look at the contributing factors mentioned by the subjects in the study, the content of the answers corresponds well with what population-based register studies have found. Drug abuse stands out as the most important factor here as well as in other studies. Another interesting finding was that several subjects claimed that they could not or did not want to blame the disorder even if it was perceived as an influential factor. These findings correspond to what has been found using GBAI.

The study adds new data to epidemiological studies, in terms of experiential details about how being mentally ill may influence someone

to commit a violent crime and in what way using drugs is perceived as influencing one's actions. Even if no conclusive conclusions can be drawn from these interviews about actual causes, it still remains an interesting observation that the answers correspond fairly well with statistic findings, indicating that the subjects in the study might be fairly accurate in their first-person observations, which in turn suggests that interview studies among mentally disordered persons can be useful in order to generate new hypotheses about the correlation between violence and mental disorder.

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References

Adams, S., Matthews, C., Ebbeling, C., Moore, C., Cunningham, J., Fulton, J., et al. (2005). The effects of social desirability and social approval on self-reports of physical activity. *American Journal of Epidemiology*, *161*(4), 389–398.

Arseneault, L., Moffitt, T., Caspi, A., Taylor, P., & Silva, P. (2000). Mental disorders and violence in a total birth cohort: Results from the Dunedin study. *Archives of General Psychiatry*, *57*(10), 979–986.

Babcock, J., Costa, D., Green, C., & Eckhardt, C. (2004). What situations induce intimate partner violence? A reliability and validity study of the Proximal Antecedents to Violent Episodes (PAVE) scale. *Journal of Family Psychology*, *18*(3), 433–442.

Batson, A., Gudjonsson, G., & Gray, J. (2010). Attribution of blame for criminal acts and its relationship with psychopathy as measured by the Hare Psychopathic Checklist (PCL-SV). *The Journal of Forensic Psychiatry and Psychology*, *21*, 91–101.

Boyatzis, R. E. (1998). *Transforming qualitative information: Thematic analysis and code development*. Sage.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*, 77–101.

Dolan, B. (1995). The attribution of blame for criminal acts: Relationship with personality disorders and mood. *Criminal Behavior and Mental Health*, *5*, 41–51.

Elbogen, E., & Johnson, S. (2009). The intricate link between violence and mental disorder: Results from the National Epidemiologic Survey on alcohol and related conditions. *Archives of General Psychiatry*, *66*, 152–161.

Fazel, S., & Grann, M. (2006). The population impact of severe mental illness on violent crime. *American Journal of Psychiatry*, *163*(8), 1397–1403.

Fazel, S., Långström, N., Hjern, A., Grann, M., & Lichtenstein, P. (2009). Schizophrenia, substance abuse, and violent crime. *JAMA*, *301*(19), 2016–2023 (20).

Fazel, S., Lichtenstein, P., Grann, M., Goodwin, G., & Långström, N. (2010). Bipolar disorder and violent crime. New evidence from population-bases longitudinal studies and systematic review. *Archives of General Psychiatry*, *67*(9), 931–938.

Ferrito, M., Vetere, A., Adshead, G., & Moore, E. (2012). Life after homicide: Accounts of recovery and redemption of offender patients in a high security hospital: A qualitative study. *Journal of Forensic Psychiatry and Psychology*, *23*(3), 327–344.

Gudjonsson, G. (1984). Attribution of blame for criminal acts and its relationship with personality. *Personality and Individual Differences*, *5*(1), 53–58.

Gudjonsson, G. (1995a). The vulnerabilities of mentally disordered witnesses. *Medicine, Science and the Law*, *35*, 101–106.

Gudjonsson, G. (1995b). "Fitness for interview" during police detention: A conceptual framework for forensic assessment. *Journal of Forensic Psychiatry*, *6*, 185–197.

Gudjonsson, G., & Singh, K. (1989). The revised Gudjonsson Blame Attribution Inventory. *Personality and Individual Differences*, *10*(1), 67–70.

Hodgins, S., Cree, A., Alderton, J., & Mak, T. (2007). From conduct disorder to severe mental illness: Associations with aggressive behaviour, crime and victimization. *Psychological Medicine*, *8*, 1–13.

Huang, C., Liao, H., & Chang, S. (1998). Social desirability and the clinical self-report inventory: Methodological considerations. *Journal of Clinical Psychology*, *54*(4), 517–528.

Joyal, C., Dubreucq, J. -L., Grendon, C., & Millaud, F. (2007). Major mental disorders and violence: A critical update. *Current Psychiatry Reviews*, *3*, 33–50.

Kim-Cohen, J., Caspi, A., Moffitt, T. E., Harrington, H., Milne, B. J., & Poulton, R. (2003). Prior juvenile diagnoses in adults with mental disorder: Developmental follow-back of a prospective-longitudinal cohort. *Archives of General Psychiatry*, *60*, 709–717.

King, M., & Bruner, G. (2000). Social desirability bias: a neglected aspect of validity testing. *Psychology and Marketing*, *17*(2), 79–103.

Lindqvist, P., & Allebeck, P. (1990). Schizophrenia and assaultive behaviour: The role of alcohol and drug abuse. *Acta Psychiatrica Scandinavica*, *82*, 191–195.

Mackie, J. L. (1965). Causes and conditions. *American Philosophical Quarterly*, *2*, 245–255 (& 261–264).

Maruna, S. (1997). Going straight: Desistance from crime and self-narratives of reform. *The Narrative Study of Lives*, *5*, 59–93.

Moore, E., & Gudjonsson, G. (2002). Blame attribution regarding index offence on admission to secure hospital services. *Psychology, Crime and Law*, *8*(2), 131–143.

Prop. (1990). *Government legislative bill. Psykiatrisk tvångsvård*, *91*. (pp. 58), 58 (Compulsory psychiatric care).

SOU (2002). *Swedish government official reports. Psykisk störning, brott och ansvar*, *3*, (Mental disorder, crime, and responsibility).

Steadman, H., Mulvey, E., Monahan, J., Robbins, P. C., Appelbaum, P. S., Grisso, T., et al. (1998). Violence by people discharged from acute psychiatric inpatient facilities and by others in the same neighborhoods. *Archives of General Psychiatry*, *55*(5), 393–401.

Swanson, J., Holzer, C., Ganju, V., & Jono, R. (1990). Violence and psychiatric disorder in the community: Evidence from the Epidemiologic Catchment Area surveys. *Hospital & Community Psychiatry*, *41*(7), 761–770.

Tolfrey, M., Fox, S., & Jeffcote, N. (2011). Beliefs about substance use and the attribution of blame for offending. *Journal of Forensic Psychiatry and Psychology*, *22*, 2.

Wessley, S. (1997). The epidemiology of crime, violence and schizophrenia. *British Journal of Psychiatry*, *32*, 8–11.

Paper 2

When licensed to speak: Swedish forensic psychiatric patients reveal a parallel universe

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Abstract

Results are reported from an interview study with 46 criminal offenders sentenced to forensic psychiatric care in Sweden. The questions asked belonged to three groups, the first concerning whether the offender knew what he/she was doing at the time of the act, the second concerning whether he/she was aware of the society's view of whether the act was right or wrong, and the third concerning his/her ability to refrain from the act. The participants showed a great ability to reason about these matters. This was quite contrary to the beliefs of almost all of the staff. The participants' testimonies reveal substantial reasons for societal rethinking when it comes to criminal responsibility, psychiatric treatment and risk management.

Keywords

Mental illness, accountability, criminal responsibility, psychiatric evaluation, psychiatric care

1 Introduction

The concept of accountability plays a central role in most penal codes, and seems to be on its way to being reintroduced in the Swedish Criminal Code. It is therefore very important to analyse the content of this concept and the meaning of the words used to express it. It is also important to anchor this analysis in the actual linguistic practice of other people than legal practitioners and, not least, in the complex psychological reality that the words reflect. In the present paper some results are reported from an interview study with 46 criminal offenders sentenced to forensic psychiatric care. The questions asked belonged to three groups: one concerning whether the offender knew what he/she was doing at the time of the act, the second whether he/she was aware of the society's view of whether the act was right or wrong, and the third concerning his/her ability to refrain from the act. Of these, only the first and third kinds of issues are used as criteria in the Swedish system. The results make it clear that especially the second but also the third question allow for a host of different interpretations. In view of our findings it is a good thing that the recent Swedish additions to the Criminal Code do not use lacking awareness of right and wrong as a criterion for exemption from imprisonment, at least not explicitly. However, the use of the ability to control behaviour as a criterion also carries many dangers, and effort should be put into the further clarification of this criterion. This and several other reasons for societal rethinking when it comes to criminal responsibility, psychiatric treatment and risk management, also came to fore in the participants' testimonies.

1.1 Legal and conceptual background

Most penal codes allow the insanity defence. For that purpose, many of them recognize various versions of the M'Naghten rules, of which one version reads: "[F]irst, the accused, at the time of his act, must have suffered from a defect of

reason; secondly, this must have arisen from disease of the mind; third, the result of it must have been that the accused did not know the nature of his act or that it was illegal" (Hart 1968:189). Quite a few penal codes also recognize, in addition to the cognitive prerequisites of the M'Naghten rules, a control prerequisite. An example is the ALI test: "A person is not responsible for criminal conduct if at the time of such conduct as the 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 law" (American Law Institute, Model Penal Code §4.01, Proposed Official Draft, 1962).

When it comes to mentally disordered criminal offenders, the Swedish Criminal Code differs from most penal codes. From mid-year 2008, the second paragraph of its Ch. 30 § 6 stipulates a disjunctive prerequisite that can be rendered as follows in English: "The court may not sentence to imprisonment, if the defendant as a consequence of […] severe mental disorder has had no ability to understand the meaning of the act or to adjust his acting in accordance with such an understanding." The disjuncts are rather similar to those expressed by the M'Naghten rules and ALI test respectively but there are also several dissimilarities. Contentwise, knowledge about the criminality of the act is not mentioned. Even more importantly, while the M'Naghten rules and the ALI test take legal sanity to be a condition for criminal responsibility, the prerequisite of the Swedish Criminal Code only takes it to be a condition for imprisonment. Somewhat paradoxically, it can therefore be said with regard to the Swedish system that since forensic psychiatric care is among the possible penal sanctions, accountability is not required for criminal responsibility. Anyone who commits a crime intentionally, or, in some cases, negligently, can be sentenced to a penal law sanction. An exception are minors, who are exempted from penal law sanctions altogether.

The first paragraph of Ch. 30 § 6 of the Criminal Code decrees: "A person who has committed a crime caused by a severe mental disorder shall primarily be sentenced to another sanction than imprisonment. The court may sentence to imprisonment only if there are special reasons." Before mid-year 2008, the same law section ruled out imprisonment for crimes caused by severe mental disorder. From 2008 this has been tightened up. What now exempts from imprisonment is inability to understand the meaning of the act or inability to adjust the acting in accordance with such an understanding, if this is due to severe mental disorder. Thus, what used to be an imprisonment prohibition has become a presumption for another sanction than imprisonment.

A key concept of the Swedish regulation is that of *severe mental disorder*. Seemingly, it has the appearance of a medical concept. However, it is a legal concept since the court is the ultimate authority when it comes to deciding whether it is applicable. This notwithstanding forensic psychiatry is influential, to say the least, in deciding whether an accused is suffering from a severe mental disorder at the time of the legal proceedings as well as at the time of the crime, and whether the criminal act was committed due to severe mental disorder. The decision it not made easier by the fact that there is no explicit definition of the concept, either in the Criminal Code, the government bill drafting the legislation, or in any other legislation or government bill. For the guidance of the courts and others, there is a collection of examples of what may be accepted as severe mental disorders. The collection is found in the government bill drafting the original version of the Criminal Code paragraph in which the concept is used. In English translation:

> "As severe mental disorders should primarily be accepted conditions of psychotic character, consequently conditions involving deranged reality evaluation and with such kinds of symptoms as delusions, hallucinations and confusion. Moreover, following a brain lesion, a mental impairment of

severe kind (dementia) with deranged reality evaluation and inability to orientate in life may result.

Severe depressions involving contemplation of suicide should also be accepted as severe mental disorders. Furthermore, grave personality disorders with impulse breakthroughs (character disorders) should also be accepted as severe mental disorders, for example certain disabling neuroses and personality disorders with impulse breakthroughs of a psychotic character.

Compulsory care should furthermore be actualized when a crisis reaction is of such a nature that the effect on the psychological functional level becomes so marked that it is of a psychotic kind.

As severe mental disorder should also be classified the alcohol psychoses, such as delirium tremens, alcoholic hallucinations and evident conditions of dementia. The same holds for the psychoses that drug addicts can contract. Also in other situations when a drug addict is in a state of severe confusion and it is evident that his physical health or his life is in danger, compulsory care should be an option. In certain cases a state of abstinence can also be so grave that it during a short time must be described as a severe mental disorder. It goes without saying that a severe addiction that only has grave physical complications should not lead to compulsory psychiatric care." (Prop. 1990/91:58, p. 86)

Besides being part of the Criminal Code, severe mental disorder is also a key concept of the Compulsory Mental Act. Being committed to compulsory mental care has as a necessary condition that of suffering from a severe mental disorder. This is hinted at in the third paragraph of the quotation. That the penal law is supposed to have the concept of severe mental disorder in common with the regulation of compulsory institutional care is problematic though. It is bound to

mix the quite different aims of two legal domains (cf. Svennerlind, 2015; Malmgren et al., 2010).

Although not seen from the quotation, the government bill distinguishes between the *kind* and *degree* respectively of a mental disorder. It is stated that when assessing whether a mental disorder is severe or not, its kind and degree need to be weighted together. Kind relates in a not quite clear way to the nosological type of mental disorder while degree relates to psychosocial level of functioning and the symptoms in the specific instance of the disorder in question (SOSFS 2000:12, p. 5). Certain mental disorders are said to be severe with regard to kind always, while instances of them need not be so with regard to degree. Schizophrenia is a case in point. Depression is mentioned as an example of a mental disorder that can be severe with regard to degree, while not being severe with regard to kind. It is unclear whether this implies that instances of depression can only be severe mental disorders due to degree rather than kind. Anyhow, depression involving the contemplation of suicide is listed as a clinical entity that should be considered a severe mental disorder.

It can be seen from the quotation that a mental disorder paradigmatically qualifies as a severe mental disorder if there are symptoms of psychosis, such as deranged reality evaluation, manifested as delusions, hallucinations or confusions. The practices of Swedish courts and forensic psychiatric examinations are in line with this (Borgeke, 2012, p. 304; RMV-Rapport 2013:1). The near relationship that supposedly holds between legal insanity and psychosis is also manifested in many, if not all, penal law systems allowing for the insanity defence. A case in point is the Norwegian Penal Code, which even uses the word “psychotic”. In translation, the first paragraph of its § 44 stipulates: “A person who at the time of the act was psychotic or unconscious shall not be liable to penalty.” The Norwegian term for “unconscious” is “bevisstløs”. In NOU 2014:10, p. 51, its meaning is commented on: “The term ‘unconscious’ is aimed at some very rare cases where the

perpetrator acted without perceiving the environment whatsoever, often with complete amnesia afterwards." Is "psychotic" here a medical or a legal term? Which alternative is chosen may have profound implications, which is shown by the Breivik case (cf. Moore, 2014). If "psychotic" has its psychiatric meaning, the sentencing of the court must be decided by how the psychiatrist classifies the perpetrator. If "psychotic" is instead a legal term, not naming a category of psychiatric disorder, the sentencing of the court is in principle independent of psychiatric classifications.

Our point here can also be expressed as follows. Ponder upon once more the prerequisite of the second paragraph of Ch. 30 § 6 of the Criminal Code: "The court may not sentence to imprisonment, if the defendant as a consequence of […] severe mental disorder has had no ability to understand the meaning of the act or to adjust his acting in accordance with such an understanding." This may, with "not sentence to imprisonment" changed to "not sentence to any penal law sanction", become a prerequisite for criminal liability. In fact, this has more or less been proposed by several Swedish government official reports (SOU 2002:3; SOU 2012:17). What would then be the function of the prefix "severe", considering that it expresses a legal rather than a psychiatric concept? If severe mental disorders are the ones that show inabilities such as the ones mentioned, the formulation seems circular. Furthermore, that severe mental disorder always result in such inabilities is inconsistent with the first paragraph of Ch. 30 § 6, quoted above, expressing a presumption for penal law sanction other than imprisonment. However, it seems evident that at least some of the intuitions that form the basis of the concept severe mental disorder concern accountability, i.e., capability of being responsible. The severe mental disorders would then be the mental disorders compromising accountability (cf. Malmgren et al., 2010).

In the search for better criteria for exemption from imprisonment – or, for that matter, for exemption from punishment – it is necessary that one does not limit

oneself to a more or less *a priori* conceptual analysis. Investigations of the psychological reality behind the crucial terms are also urgently needed. Hence, a series of interviews were conducted with Swedish forensic psychiatric patients. Both the present paper and an already published one (Radovic & Höglund, 2014) are based on material from these interviews, but they focus on different subsets of questions. The previous paper analyses the patients' answers to questions about what they thought caused them to commit their crimes, while the present paper examines how they experienced their state of mind at the time of the crime in terms of reality testing, moral competence and action control. No study similar to these two has to the best of our knowledge been done before.

2 Aim

The aim of this study was to collect and analyse data on

(i) How Swedish forensic psychiatric patients experienced their state of mind at the time of the crime in terms of reality testing, moral competence and action control.

(ii) The competence among Swedish forensic psychiatric patients to reason on their state of mind at the time of the crime.

3 Methods and design of the study

Since a pilot study showed that using a self-administered questionnaire was not satisfying, we chose to meet all respondents in an interview-like situation. The main difference between these two alternatives was that the interviewer (PH) then could clarify, in an individual-adjusted mode, the background, relevance and purpose of the study and the specific overall meaning of the questions as well as give details and examples (if needed) of the concepts used and – perhaps above all – answer any potential question-content-queries from the respondent.

Thus, semi-structured interviews were conducted in order to get a (first) qualitative sample of Swedish forensic psychiatric patients' view on their own *accountability-status* while committing their index crimes.

3.1 Participants

Six of Sweden's largest forensic psychiatric clinics were selected for the study. The clinics were visited on one occasion each, consisting of one or two days. The following inclusion criteria were used:

(i) The subject should acknowledge that he or she suffered from a severe mental disorder.

(ii) The subject should acknowledge that he or she had committed the crime for which he or she was sentenced, that is, not only acknowledge to have performed the act in question, but also agree that it was a criminal offence.

(iii) The interview should not interfere with the patient's treatment or general welfare.

With help from a representative from each clinic visited, eight to ten patients sentenced to forensic psychiatric care were selected and invited to partake as respondents. A total of 50 patients were selected for the study. Two of them declined to participate, and during the interviews it became clear that two patients did not acknowledge that they had performed the criminal act for which they were sentenced. Thus, all in all forty-six patients were included. Of these, thirteen were convicted of murder, twenty-one of other crimes of violence (assault and aggravated assault) and five of arson, while the remaining seven were convicted of sex crimes. Twenty-three of the subjects had been in forensic psychiatric care for between one and five years, and the rest for more than five years. Forty-three men and three women were included in the study.

3.2 Ethical considerations and data collection

The Ethics Committee at Lund University approved the study (Dnr 54-01). Interview data were collected between 2008 and 2009.

Patients in forensic psychiatric care present a particular concern from an ethical point of view since they are both patients and prisoners. In this study we particularly stressed that the interviews were conducted by persons who had no influence over decisions regarding the prospect of probation, discharge or possible benefits within the care. Still, the subjects in this study are in a vulnerable situation, and we therefore took caution not to put pressure on a subject if he/she showed any reluctance to answer a question, or showed discomfort of some other kind.

The initial information and invitation to participate in the study was mediated to the patients by the representative at each clinic. Each patient was given a verbal introduction to the study, including information about the confidentiality and the absolute right to stop or pause at any time. This information as well as the interview took place in a private room at the ward. Unambiguous experiences from the pilot study concerning reluctance to participate in an audio-recorded interview (i.e. none of the pilot study interviews would have been possible to follow through if recording had formed a strict demand), made us decide not to use any audio recording equipment. Instead notes were taken during the interview, and the notes were transcribed instantly after each interview. Beside the verbal response of the participants, notes were sometimes added about facial expressions, body language, mood/temperament etcetera. Each interview took between thirty minutes to two hours to complete.

A few questions formulated in advance (intended to function more like starters than as the main course of each question-theme) were handed over to the respondent before starting the interview. This was made in order to enable an

alternate way for the patient to as completely as possible embrace the nature of the enquiry. These questions were:

1) In your opinion, did you know what you were doing when you committed the act for which you later were sentenced (for instance: did you think you were doing something else than you actually did)?

2) In your opinion, did you understand which consequences this might bring on you and on others involved?

3) In your opinion, did you know what is generally considered right and wrong in society?

4) In your opinion, could you (at the time of the crime) have refrained from committing the act?

5) In your opinion, could you possibly have found some other solution to your problems?

The interview started with a brief presentation of central concepts. Then the interview continued with the interviewer asking the questions as written – but the interview become more of a conversation, going back and forward, repeating questions, modifying answers and so forth.

3.3 Data categorisation and analysis

There are innumerably many ways of categorising a given set of data. Categories were searched for, given the aims of the study, to best describe the actual content of the dialogues with the patients. The five specific questions (listed above) are based on the trinity of accountability: reality testing, moral competence and action control. However, during the interviews it gradually became clear that seven categories or question themes, rather than three or five, were "the real thing". The final data categorisation (based on the notes taken during the interview together with additional notes directly after the interview) contains the following

categories/question themes: ACT KNOW (was aware of the nature of one's action), ACT CONS (considered the consequences of one's actions), MORAL KNOW (was aware of society's view of whether the act was right or wrong), MORAL ACT (acted in accordance with that awareness), IMPULSE (was in control of one's impulses), ALTER (considered alternative action options) and FUTURE (estimated the propensity for committing a similar crime again). Examples of quotations illustrating these categories are given below.

The answers pertaining to these categories/question themes were then analysed quantitatively in relation to main psychiatric diagnosis, index crime, length of care and sex. No calculations above the level of percentages and no significance testing of group differences have been performed, since it is thought that the descriptive statistics used is sufficient to convey the essential quantitative information in the data. Another, planned paper will deal with the qualitative data; see Future studies.

4. Results

An introductory and general overall presentation of the results will be followed by seven specific sections; one for each question theme and with focus on the result as related to the respondents' main psychiatric diagnosis-group affiliation. All data are given in tables 1-8, and results that are considered enough interesting are also described in the main text.

Note that the 46 psychiatric main diagnoses have been clustered into three groups, that is: PSYCHOSIS (19 psychosis/schizophrenia and 1 bipolar), PERSONALITY DISORDER (17 subjects) and NEURODEVELOPMENTAL DISORDERS (7 autism spectrum disorders and 2 mental retardation). It might also be of interest to the reader that several additional data analyses were done, for instance in order to identify potential differences due to index crime or the number of years spent in

forensic psychiatric care. However, these attempts generated no results of substantial interest.

4.1 Basic data of the study cohort

4.1.1 Distribution of psychiatric main diagnoses

Psychotic illness

Psychotic illness (including schizophrenia and single psychotic episode) formed the largest group of respondents in our study, namely 19 (41.3%). One respondent was diagnosed with bipolar disorder, a disorder that traditionally is categorized as a psychotic one, and was therefore included in the psychotic group in the statistical presentation, making the total cohort 20 (43.5%). The total percentage of Swedish forensic psychiatric patients diagnosed with psychotic illness is 60.9% among men and 52.6% for women; when bipolar disorder is added, the figures are 66.0% and 59.9%. That makes our cohort of these diagnoses somewhat smaller than the national one. This is probably explained by the *category* of hospitals that was included in the study since these so called Region clinics customarily comprise a larger population of personality disorders and a smaller ditto with psychotic illness.

Personality disorder

In our study 36.9% of the participants had some kind of personality disorder as the main psychiatric diagnosis. This percentage is high in comparison with the total Swedish cohort of forensic psychiatric patients: women 11.7% and men 5.6%. This is in line with the assumption made above that the number of individuals with personality disorder form a larger group than average at those clinics included in the study.

Neurodevelopmental disorders

The percentage of Swedish forensic psychiatric patients with neuropsychiatric syndromes (men 12.7% and women 15.7%) is about the same as in our cohort (10.9%). Two (4.3%) of our respondents were diagnosed with mental retardation, which is in line with the national distribution (men 4.0% and women 2.9%).

4.1.2 Distribution of index crime

Violent crime

Nearly half (46.7%) of the study cohort had committed violent crimes (other than murder), which is more than in the total cohort of Swedish forensic psychiatric patients (31.7%). Violent crime constitutes the most common index crime in both groups.

Arson

In our study, the number of individuals convicted for arson was just as many as the ones found guilty of sexual offences (10.9%). This might seem a bit odd, but in fact arson is the second most common index crime (19.6%) amongst those being sentenced to forensic psychiatric care in Sweden.

Murder

Murder is the third most common index crime in Sweden (16.5%) but was the second most common in this study sample (28.2%). This may be explained by the assignment which larger forensic psychiatric clinics have in Sweden, which is to offer care for those patients assessed to be too dangerous and/or difficult to treat at smaller clinics.

Sexual offense

Five of the respondents (10.9%) had committed a sexual offense, which is pretty much in line with the total cohort in Sweden (8.1%).

4.1.3 Distribution of years in care and of sex

Years in care

In order to make our results available to a simple analysis in terms of the length of years in care, we divided our respondents into two groups: those given care in more than one year but not more than five, 23 (50%), and those given care more than five years, also 23 (50%). The median length of care of the forensic psychiatric patients that were discharged in the years of 2009-2014 was 46 months (almost 4 years).

Sex

The distribution of sex among Swedish forensic psychiatric patients has over time been 9 to 1 in favour of men (recent statistics showing 4 to 1). Three (6.5%) respondents in our study were of female sex and 43 (93.5%) of male ditto.

4.2 Overall study results

Initially, all the answers were sorted into four categories: NO, PARTLY, YES and NOT SURE. Having done this, we found that our theme questions had rendered the following answers: NO, 197 (61.1%), PARTLY, 26 (8.1%), YES, 90 (28.0%) and NOT SURE, 9 (2.8%). See Table 1. This suggests an overall and most general first conclusion: the cohort expressed an experience of quite damaged vital capacities at the time of the index crime. This result is just marginally affected by removing the FUTURE score and keeping answers concerning the experienced state of mind at the time of the offense: NO, 182 (65.9%), PARTLY, 16 (5.8%), YES, 70 (25.4%) and NOT SURE, 9 (2.9%).

Table 1 (all diagnosis groups)

CATEGORY	TOTAL	ACT KNOW	ACT CONS	MORAL KNOW	MORAL ACT	IMPULSE	ALTER	FUTURE	
ANSWER	(%)	(%)	(%)	(%)	(%)	(%)	(%)	(%)	%
NO	**61.1**	**26.1**	**80.4**	**41.3**	**91.3**	**80.4**	**76.1**	**32.6**	**63.9**
NOT SURE	**2.8**	**0**	**0**	**2.2**	**2.2**	**8.7**	**4.4**	**2.2**	
PARTLY	**8.1**	**8.7**	**2.2**	**8.7**	**6.5**	**2.2**	**6.5**	**21,7**	**36.1**
YES	**28.0**	**65.2**	**17.4**	**47.8**	**0**	**8.7**	**13.0**	**43.5**	
Sum	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

When instead dividing the overall result by lumping NO and NOT SURE together, as well as PARTLY and YES, we get two basic answer categories or groups; the first forming 63.9% of the total result and the latter 36.1%. This means that our respondents gave a negative response to our questions in two cases of three, which again indicates that their level of functioning was quite damaged – at least to their own experiences. Noteworthy is that the positive score-results in both ACT KNOW (65%) and MORAL KNOW (56.5%) suggest that these abilities are the ones most intact (together with the self-assessment of one being able to refrain from committing the same crime as the index crime in the FUTURE). Far more severely damaged are the ability to consider consequences (ACT CONS) and alternatives (ALTER) of one's acts, which a vast majority of 8 out of 10 denied having done. 9 out of 10 respondents declared not to have acted according to their knowledge of what is seen to be morally right and wrong in society, while the

same number of participants (92.1%) believed themselves to have been in control of their impulses when committing their index crime.

4.3 ACT KNOW

4.3.1 Total cohort results

The proportion of informants answering YES and NO respectively is the opposite in this theme question compared to the overall percentage distribution. 30 respondents (65%) answered YES, which indicates that when it comes to being aware of the nature of one's actions, Swedish forensic psychiatric patients to a large extent seem to recall that they did know what they did. On the other hand, 12 patients (26%) declared that they *did not know* what they did, and another 4 (9%) that they only partly or to some extent were aware of what they actually did.

4.3.2 ACT KNOW by means of diagnosis group

Table 2 (ACT KNOW)

CATEGORY	TOTAL		PSYCHOSIS		PERS. DISORDER		NEURO. DISORDER		
ANSWER	N	%	N	%	N	%	N	%	%
NO	12	26.1	7	100.0	5	76.5	0	44.4	26.1
NOT SURE	0	0	0	0	0	0	0	0	
PARTLY	4	8.7	3	0	1	5.9	0	0	73.9
YES	30	65.2	10	0	11	17.6	9	55.6	
sum	46	100.0	20	100.0	17	100.0	9	100.0	100.0

Psychotic illnesses and ACT KNOW

When asked whether they knew or were aware of the nature of the action they were sentenced for, the psychotic cohort splits in two: 10 persons say they

knew/were aware and 10 answer that they did not know/were unaware or that they just partly knew/were partly aware.

Personality disorders and ACT KNOW

The PD answering results NO (29.4%), PARTLY (5.9%) and YES (64.7%) are almost identical to the overall percentage distribution in this section.

Neurodevelopmental disorders and ACT KNOW

Persons with a neuropsychiatric diagnosis (mainly Asperger's syndrome) or mental retardation had a quite different response pattern (in comparison with PS and PD) when asked whether or not they knew what they did when committing the crime. Without exception, the immediate response to the ACT KNOW-theme question was YES (of course I knew what I did).

4.4 ACT CONS

4.4.1 Total cohort results

When asked to recall whether or not they had considered the consequences of their action(s) at the time of the crime, 37 (80.4%) of the respondents answered that they had not.

4.4.2 ACT CONS by means of diagnosis group

Table 3 (ACT CONS)

CATEGORY	TOTAL		PSYCHOSIS		PERS. DISORDER		NEURO. DISORDER		
ANSWER	N	%	N	%	N	%	N	%	%
NO	37	80.4	20	100.0	13	76.5	4	44.4	80.4
NOT SURE	0	0	0	0	0	0	0	0	
PARTLY	1	2.2	0	0	1	5.9	0	0	19.6
YES	8	17.4	0	0	3	17.6	5	55.6	
sum	46	100.0	20	100.0	17	100.0	9	100.0	100.0

Psychotic illnesses and ACT CONS

None of the respondents that suffered from psychosis at the time of index crime were able to recall having given any thought to consequences.

Personality disorders and ACT CONS

Four respondents (23.5%) answered that they had or partly had done some consequential thinking at the time of the offence. Three out of four (76.5%) declared that they had not reflected on which effects their actions might generate.

Neurodevelopmental disorders and ACT CONS

The members of the neurodevelopmental group answered either YES (44.4%) or NO (55.5%). Although the answers were uttered in the same natural way as to the previous question, almost as if the answer was self-evident, the reply contents diverged from one extreme to the other.

4.5 MORAL KNOW

4.5.1 Total cohort results

The overall result in this category is quite equally distributed between the two basic groups.

4.5.2 MORAL KNOW by means of diagnosis group

Table 4 (MORAL KNOW)

CATEGORY	TOTAL		PSYCHOSIS		PERS. DISORDER		NEURO. DISORDER		
ANSWER	N	%	N	%	N	%	N	%	%
NO	19	41.3	13	65.0	3	17.6	3	33.3	43.5
NOT SURE	1	2.2	1	5.0	0	0	0	0	
PARTLY	4	8.7	0	0	3	17.6	1	11.1	56.5
YES	22	47.8	6	30.0	11	64.8	5	55.6	
Sum	46	100.0	20	100.0	17	100.0	9	100.0	100.0

Psychotic illnesses and MORAL KNOW

When asked whether or not they were aware of society's opinion on wright and wrong, 13 (65%) of the respondents in this diagnostic group declared that they were not.

Personality disorder and MORAL KNOW

The PD answering results in this category is pretty much the opposite of those in the psychotic cohort: 11 (64.8%) declared to have been aware, 3 (17.6%) stated that they were partly aware and 3 (17.6%) answered NO (I was not aware).

Neurodevelopmental disorders and MORAL KNOW

Five (64.8%) claimed that they were aware, 1 (11.1%) partly aware and 3 (33.3%) did not believe that they were aware of the societal values at the time of the crime.

4.6 MORAL ACT

4.6.1 Total cohort results

The experienced propensity/ability to act in accordance with one's moral knowledge was overall very low. None of the respondents answered YES and 6 (6.5%) answered PARTLY. As many as 42 (91.3%) rejected the thought of having acted in line with what they knew was moral common sense and one of the respondents was not sure.

4.6.2 MORAL ACT by means of diagnosis group

Table 5 (MORAL ACT)

CATEGORY	TOTAL		PSYCHOSIS		PERS. DISORDER		NEURO. DISORDER		
ANSWER	N	%	N	%	N	%	N	%	%
NO	42	91.3	19	95.0	15	88.2	8	88.9	93.5
NOT SURE	1	2.2	1	5.0	0	0	0	0	
PARTLY	3	6.5	0	0	2	11.8	1	11.1	6.5
YES	0	0	0	0	0	0	0	0	
sum	46	100.0	20	100.0	17	100.0	9	100.0	100.0

Psychotic illnesses and MORAL ACT

None of the respondents in this group claimed to have acted in accordance with their moral knowledge. In fact 19 (95%) declared not having acted in such a way.

Personality disorders and MORAL ACT

As many as 15 (88.2%) respondents answered NO, and two answered PARTLY (11.8%).

Neurodevelopmental disorders and MORAL ACT

Also this group reported a lack of acting in accordance with their moral knowledge.

4.7 IMPULSE

4.7.1 Total cohort results

No less than 41 (89.1%) responded negatively when asked if they were in control of their impulses at the time of the crime.

4.7.2 IMPULSE by means of diagnosis group

Table 6 (IMPULSE)

CATEGORY	TOTAL		PSYCHOSIS		PERS. DISORDER		NEURO. DISORDER		
ANSWER	N	%	N	%	N	%	N	%	%
NO	37	80.4	17	85.0	15	88.2	3	33.3	89.1
NOT SURE	4	8.7	3	15.0	0	0	2	22.2	
PARTLY	1	2.2	0	0	2	11.8	1	11.1	10.9
YES	4	8.7	0	0	0	0	3	33.4	
Sum	46	100.0	20	100.0	17	100.0	9	100.0	100.0

Psychotic illnesses and IMPULSE

When asked whether or not they experienced being in control of their impulses at the time of the index crime, 13 (65%) responded NO and 1 (5%) NOT SURE

Personality disorders and IMPULSE

Being in control of one's impulses was not something the members of this group embraced, when trying to recall their state of mind at the time of the index crime. No less than 17 (88.2%) of the respondents answered NO and 2 (11.8%) declared being PARTLY in control of their impulses

Neurodevelopmental disorders and IMPULSE

This group seemed different in comparison with the other two diagnostic groups since five (55.5%) answered NO or NOT SURE while four (44.5%) declared that they were in control or at least partly in control.

4.7 ALTER

4.7.1 Total cohort results

The overall result in this theme (cf. Section 4.2) indicates a general lack of considering alternative action possibilities

4.7.2 ALTER by means of diagnosis

Table 7 (ALTER)

CATEGORY	TOTAL		PSYCHOSIS		PERS. DISORDER		NEURO. DISORDER		
ANSWER	N	%	N	%	N	%	N	%	%
NO	35	76.1	18	90.0	14	82.3	3	33.3	80.4
NOT SURE	2	4.3	1	5.0	0	0	2	22.2	
PARTLY	3	6.5	1	5.0	2	11.8	1	11.1	19.6
YES	6	13.1	0	0	1	5.9	3	33.4	
sum	46	100.0	20	100.0	17	100.0	9	100.0	100.0

Psychotic illnesses and ALTER

Among the respondents diagnosed with psychotic illness no one declared to have considered alternative actions, with one claiming to partly have done so, one not being sure while 18 (90%) answered that they had NOT been considering alternative actions.

Personality disorders and ALTER

On this question theme the personality disorders cohort are almost equal to the psychotic ditto, shown by the 14 (82.3%) respondents who answered NO.

Neurodevelopmental disorders and ALTER

This group shows a different pattern: 6 (66.7%) answering NO or YES, 2 (22.2%) NOT SURE and one (11.1%) PARTLY.

4.8 FUTURE

4.8.1 Total cohort results

The total result – positive (65.2%) and negative (34.8%) – suggests that 2 of 3 forensic psychiatric patients are more or less certain that they will manage to refrain from future criminality.

Table 8 (FUTURE)

CATEGORY	TOTAL		PSYCHOSIS		PERS. DISORDER		NEURO. DISORDER		
ANSWER	N	%	N	%	N	%	N	%	%
NO	15	32.6	8	40.0	4	23.5	3	33.3	34.8
NOT SURE	1	2.2	0	0	0	0	1	11.1	
PARTLY	10	21.7	4	20.0	4	23.5	2	22.2	65.2
YES	20	43.5	8	40.0	9	53.0	3	33.4	
sum	46	100.0	20	100.0	17	100.0	9	100.0	100.0

Psychotic illnesses and FUTURE

NO SPECIFIC results of interest to highlight.

Personality disorders and FUTURE

NO SPECIFIC results of interest to highlight.

Neurodevelopmental disorders and FUTURE

NO SPECIFIC results of interest to highlight.

4.9 Bonus results

During the interviewer's (PH) halts at six Swedish forensic psychiatric clinics, in order to interview patients (not staff) on quite difficult, and, as described by a clinical executive head of one of the forensic psychiatric clinics, *almost philosophical*, matters, rendered not only 46 pleasant conversations but also three striking and most noteworthy general observations. These "bonus results" are not based on a systematic analysis of notes but on the summed experiences of the main investigator.

4.9.1 Patients' interest in question themes

From day one of the interview series, it was evident that the theme questions included in the study were of great interest and importance to the patients. This was not an expected response (at least not to the interviewer PH), since the purpose of the questions asked was

(i) to bring them back to the very moment when they committed the crime,

(ii) to make them face the fact (according to the forensic psychiatric evaluation, at least) that a severe mental disorder influenced them in executing the crime, in order to make them evaluate their own state of mind at the time of the crime,

(iii) to make a scientific attempt to discover answers to questions that most people probably would find more or less impossible to unravel in a defendable manner.

4.9.2 Patients' reasoning skills

It might be proper to remind oneself of the state of affairs that forms the reality for most patients (including those who regardless of these conditions chose to partake in the study): **inner conditions** (*e.g. losses, sorrows, mental illness, harsh past*), **outer reality** (*e.g. locked up as a forensic psychiatric in-patient after having committed a crime caused by a severe mental disorder*) and a **most uncertain future** (a sentence to forensic psychiatric care in Sweden means potentially for life, since they all lack time limitation). Therefore it was a most vitalizing and strengthening experience to discover these persons as being skilful reasoners in these matters. It became evident to the interviewer that they had contemplated these issues long before this interview study took place.

4.9.3 Staff's interest in question themes

The third bonus result could be summarized in one phrase: "standoffish attitude to us patients' reasoning skills." This is a comment made by one of the patients that

took part in the present study. Without getting lost in details and phrases used by the staff that showed interest in the question themes, the general reaction when they laid eyes on the questionnaire used was to (i) laugh out loud, (ii) ask me if I ever had met a forensic psychiatric patient before and/or (iii) explain to me that this crap had nothing to do with either the essentials of forensic psychiatric care or the reason for which its patients end up in the same care.

5 Discussion

5.1 Overall results

One unorthodox way of presenting an overall interpretation of the study result is to upgrade the response on each question theme (ACT KNOW and so on) to a tentative trait of the general Swedish forensic psychiatric patient. We then get a person who is aware of the nature of his/her actions in 2 of 3 situations, *but* considers the consequences of his/her actions in less than 1 of 5 situations; a person who is aware of societal common sense moral in 1 of 2 scenarios, *but* (for different reasons) practically never acts in accordance with that knowledge; a person who considers alternative actions in 1 of 4 situations, *but* is in control of his/her impulses in only 1 of 10 scenarios.

Odd as it may be, this sketchy interpretation may form a potential argument for further investigations in order to pinpoint which specific vital abilities in the total Swedish forensic psychiatric patient cohort are at high risk of being damaged.

Even more important, since it probably will have impact on both care-quality and length of care, is to identify vital abilities and their current state at an individual/patient-specific level. This identification process as well as the sub-sequent structuring and planning of care should be conducted together with the patient. His/her opinions, answers and overall skills to reason on these matters will probably render essential information.

5.2 ACT KNOW

Two thirds of the respondents answered that they were aware of the nature of their action when they committed the index crime. One possible explanation of this phenomenon might be that it is quite a frightening or at least outlandish thought to consider that *something else* than my own conscious self was the origin of my deeds. It would on the other hand be unfair to the respondents to presume that they did not tell the truth. Given that they told the truth, it is noteworthy that only 7 (35.0%) of the persons diagnosed with psychotic illnesses declared not to have been aware of the nature of their actions. In other words, 13 (65%) of the respondents in the PSYCHOSIS-group declared to have been thoroughly or partly aware of the nature of their actions. Now, *that* would be a result with a potential for challenging the widespread belief of the overall-devastating nature of psychotic disorders.

Worth noting is that the result in the PD-group in this matter is more or less identical to the PSYCHOSIS-group: five out of seventeen respondents (29.4%) diagnosed with a PD state that they did not know what they did/were not aware of the nature of the action. This might be explained by the fact that a personality disorder must be considered as *severe* in order to render forensic psychiatric care instead of prison. This severity can consist of for instance OCD, but also of an inclination to go into psychotic episodes.

In the third diagnostic group, neurodevelopmental disorders, 100% of the respondents claimed (with emphasis) to have known what they did. Given that this really was the case, one can wonder why they were recommended care instead of prison; especially when they also report that despite their decent moral knowledge they acted in the opposite direction.

Given that these “testimonies” are correct, 26% of the persons taking part in this study did not know what they did when committing the act that later on was to form the foundation of their sentence to forensic psychiatric care. If the findings

are generalizable and the total present-day number of Swedish forensic psychiatric patients is in the order of 1500, almost 400 of them had no ACT KNOW at the time of the crime. From a subjective pre-requisite perspective (a demand that is supposed to be fulfilled also in Swedish Courts of Law) this is quite a remarkable finding.

5.3 ACT CONS

The ability and willingness to consider the (potential) consequences of one's actions could probably be seen as a most common human trait. Very few of us do *not* spend our days analysing the present situation in that sense. Given that assumption, it is quite remarkable that no less than 37 (80.4%) of the respondents declare that they did not consider the consequences of their actions. Split into diagnosis groups we find that the Neurodevelopmental disorders group (again) has a different pattern compared with the two others, with a slight majority answering that they did think of consequences. On the other hand, that reasoning or calculation did not make them do anything else than what they had planned from the very beginning.

5.4 MORAL KNOW and MORAL ACT

The discussions of the question themes of MORAL KNOW and MORAL ACT are preferably performed together. The reason for that is (as pointed out earlier) that the real value or practical value of MORAL KNOW is intimately connected with the quality of MORAL ACT.

In this study the overall result of MORAL KNOW was that the respondent cohort was rather equally divided: 43.5% declared having had adequate knowledge of what is considered right and wrong generally in society, while 56.5% responded that they did not. This result, how encouraging or depressing it may be, loses in relevance when considering the fact that just 6.5% acted in accordance with that

insight and a vast majority 93.5% acted without any guidance of the acknowledged moral knowledge.

A clinical effort to explain this phenomenon might be that an acute psychotic condition, for instance, often means diminished or eliminated ability to sort impressions, rendering it difficult to decide the proportional value of things. If this condition comprises demanding voices (which you feel obliged to follow), the knowledge of right and wrong is overruled by stronger incitements. A deeper analysis, based on a qualitative analysis of the answers, might reveal more and vital information in this matter.

The personality disorders group gives an impression of tending to overstep moral lines deliberately. In other words there seemed to be a tendency in this group to have *chosen* not to act in accordance with one's moral knowledge (at least this was the overall impression of the interviewer, PH). The same goes for the patients in the ORGANIC group, who seem to have a morality of their own and show no explicit willingness to reconsider it.

So far it is tentatively concluded that no matter the quality of one's KNOW-ability, a low degree of functioning of the subsequent ability to ACT in accordance with that knowledge will lower or eliminate the value of the KNOW-ability. This reasoning is plausible not only for ACT KNOW vs ACT CONS, but also for MORAL KNOW vs MORAL ACT. The propensity/ability to act in harmony with one's moral knowledge is just as important as having that knowledge. In our respondent cohort less than 1 out of 10 fulfilled the last part, leaving the relatively high average score on MORAL KNOW in splinters.

5.5 IMPULSE and ALTER

Being in control of one's impulses, at least in a pausing-ability kind of sense, might be considered almost a prerequisite for being able to contemplate alternative

actions; a skill absolutely essential in decision-making since choosing between one thing isn't much easier than to applaud with one hand

Only 10.1% of the respondents declared to have been in control of their impulses at the time of the index crime. It might therefore seem a bit strange that 19.6% claimed to have contemplated alternatives. The explanation of that might be that the "extra" 10% in the ALTER-group could be described as having control over the first impulse (giving them the opportunity to identify alternative actions) but lacking control over the second impulse (rendering them doing what they craved the most in the end).

This result is in line with a *psychosis diagnosis,* since damaged reality testing potentially diminishes one's ability to contemplate, and hence to reconsider the first impulse. Also, suffering from demanding voices can potentially eliminate the ability to pause before acting. Since the respondents within this psychiatric diagnosis group scored much higher both in ACT KNOW and MORAL KNOW than expected, it can be suggested that one of the main problem within the forensic psychiatric patient cohort is rather connected to impulse control than to the two other factors.

The neurodevelopmental diagnoses group tended to declare a higher level of awareness than the other two. Perhaps this is not at all surprising, considering that NP-individuals at group-level are most eager to be thorough when making decisions and on occasion that they (for once) are not – they become just as eager to appear as thorough decision-makers.

The declared absence of consequential thinking could also be an expression for a lack (for a shorter period of time or as an authentic personal trait) of interest in what effect one's actions will have on other people's and/or one's own well-being. If this result has any bearing on the general forensic psychiatric cohort, it is to be considered as an aspect not to oversee.

5.6 FUTURE

Even though the distribution of the answers given by the respondents points in different directions, one can conclude that a majority believe that they will not re-offend.

5.7 Bonus results

We found (without intending to) that (i) Swedish forensic psychiatric patients were most skilful in reasoning on quite delicate matters like reality testing, moral competence and action control, and (ii) that the overall attitude among staff (indifferent of profession) was that "their" patients would not stand a chance in answering questions like these.

We believe that such underestimating of those skills may have severe consequences.

6 Limitations of the study

When asking someone to share their opinions of something, there is always a potential risk of getting answers that are "improved" in order to "satisfy" the interviewer. This risk may even be higher when asking questions of the kind that were asked in this study. Hopefully that risk was diminished by the fact that the interviewer (PH) was in no way involved in the care of any of respondents. It was also explicitly made clear during the introduction of the interview that it was important that the respondent would answer as truly as possible.

The way of selecting the subjects for study, the complexity and the metaphysical nature of the matters which the respondents were asked to reason on, the qualitative way of arriving at the basic categories for the analysis plus the datum that this study is the first of its kind, all make any generalization of the results presented very tentative and in need of further studies.

On the other hand we believe that the interview method, that did not follow a strict protocol but was always adapted to the subject and the situation, constitutes a strength rather than a weakness of this study.

7 Conclusions

Most of the interviewed Swedish forensic patients thought that neither reality testing nor moral competence was a problem to them at the time of the index crime. The abilities that emerged as severely damaged or extinguished were action control, alternative-action-identification and acting in accordance with the acknowledged moral knowledge. The overall most significant reason for acting as they did seems to have been that they nurtured a quite different set of values than society at large. Given the accuracy of the findings, these testimonies may point to that (i) the criteria used as pre-requisites for criminal responsibility do not denote anything in real life, (ii) certain diagnoses may falsely have ascribed forensic-psychiatric patients disabilities they do not have, AND may therefore (iii) have lead to a misdirected treatment of generations of psychiatric patients.

The divergence between the present findings and the received view on mentally disturbed offenders, together with the respondents' skill in reasoning on quite delicate matters like reality testing, moral competence and action control, indicate that the value of first-person observations should be re-appreciated. They may in the future form one of the major sources of a deeper understanding of the precursors to crime in general and to crimes committed by mentally disturbed offenders in particular.

8 Further studies

The qualitative analysis of the present material will be an important complement to the current study.

More studies like this one, with larger number of respondents, is one way to examine the validity of what was found in this study.

Generally, although many large-scale surveys have been made of forensic psychiatric patients, we still know very little about how these patients experience their problems. This issue is best explored using first-person observations.

There is also a need for developing a systematic theory of such observations in the context of forensic psychiatry.

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References

American Law Institute. Model Penal Code, Proposed Official Draft; 1962.

Borgeke M. Att bestämma påföljd för brott [To decide sanction for crimes]. Stockholm: Nordstedts juridik; 2012.

Hart HLA. Punishment and responsibility. Essays in the philosophy of law. Oxford: Oxford University Press; 1968.

Malmgren H, Radovic S, Thorén H, Haglund B. (2010). A philosophical view on concepts of psychiatry. *International Journal of Law and Psychiatry*. 2010;33:66-72.

Moore MS. The quest for a responsible responsibility test: Norwegian insanity law after Breivik. *Criminal Law and Philosophy*; 2014. [Published online 27 March 2014].

NOU [Norwegian Government Official Report] 2014:10 Skyldevne, sakkunnighet og samfunnsvern [Accountability, expertise and social protection].

Prop. [Government Legislative Bill] 1990/91:58 Om psykiatrisk tvångsvård, m.m. [On compulsory psychiatric care, etc.].

RMV-Rapport [Report of the National Board of Forensic Medicine] 2013:1 Rättspsykiatriska bedömningar i praktiken – vinjettstudie och uppföljning av over 200 fall [Forensic psychiatric examinations in practice – vignette study and follow-up on more than 200 cases].

SOSFS [Statue Book of the National Board of Health and Welfare] 2000:12 Psykiatrisk tvångsvård och rättspsykiatrisk vård [Compulsory psychiatric care and forensic psychiatric care].

SOU [Swedish Government Official Report] 2012:17 Psykiatrin och lagen – tvångsvård, straffansvar och samhällsskydd [Psychiatry and the law – compulsory care, criminal responsibility and social protection].

SOU 2002:3 Psykisk störning, brott och ansvar [Mental disorder, crime and responsibility].

Svennerlind, C. From being unaccountable to suffering from severe mental disorder and (possibly) back once again to being unaccountable. *Dialogues in Philosophy, Mental and Neuro Sciences*. 2015;8(2).