

**Examining guilt and blame attribution for offence: Comparing a  
public and forensic psychiatric sample**

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Mentally ill individuals who have committed an offence arguably comprise one of the most stigmatized groups within our society. Study 1 examined the Canadian public's perception of the degree to which individuals suffering from a mental illness experienced guilt, and felt blameworthy for their actions. Results suggested that the public underestimates the guilt felt by these individuals, which may contribute to the negative feelings some of the public has toward mentally disordered offenders. A second study explored forensic psychiatric patients' feelings of guilt and blame surrounding their own offences. For patients without a comorbid personality disorder, a moderate negative correlation was found between mental blame and time elapsed since offence, implying that psychiatric hospital stay helps them gain a sense of personal responsibility for their offences. Further, patients with a comorbid personality disorder reported less guilt feelings for their offences than patients without a comorbid personality disorder, and were less likely to blame them on mental factors (i.e., mental illness or a lack of self-control), supporting the idea that there are additional therapeutic challenges and considerations for individuals that are suffering from more than one mental health diagnosis. Implications for both treatment and community policy will be considered in detail.

**Keywords:** guilt; blame attribution; public perceptions; forensic psychiatric patients, comorbid personality disorders

## **Introduction**

Attributions are explanations that people construct likely to facilitate their understanding of the previous behaviour of either themselves or others (Shine, 1997). *Attribution Theory* suggests that people's attributions impact their actions and emotions (Fox & Leicht, 2005) and contribute to the formation of attitudes (Kemdal & Montgomery, 2001). The application of Attribution Theory towards mentally ill offenders can help with the development of two important forensic research areas: understanding public perceptions of mentally ill offenders and conceptualizing how forensic psychiatric patients view and feel about their offences.

### ***Attitudinal research towards mentally ill offenders***

It has been well documented that mental illness is associated with stigma due to the potential misconceptions and negative attitude of the general public (Corrigan, Markowitz, Watson, Rowan, & Kubiak, 2003; Rusch, Angermeyer, & Corrigan, 2005; Martin, Pescosolido, & Tuch, 2000). Indeed, a recent review of the population-based research on attitudes towards the mentally ill indicates that much of the public fears mentally ill people because they are perceived as unpredictable and dangerous (Angermeyer & Dietrich, 2006). However, public perceptions of mentally ill persons as criminally dangerous are greatly exaggerated (Stuart & Arboleda-Florez, 2001). Partly to blame is the informal norm of the news industry to report somewhat sensationalistic news stories (Corrigan et al., 2005), as well as the public's exposure to media sources--including magazines, newspapers, and television--that portray mental illness using a negative frame that focuses on violence (Sieff, 2003). For example, Corrigan et al. (2005) reported that the majority of news stories about people afflicted by mental illness focus on negative aspects like dangerousness, unpredictability, and unsociability and

that the single largest focus of newspaper stories about mentally ill people is on their dangerousness and crime. Meanwhile, media sources like newspapers often fail to cover positive aspects of mental illness such as recovery (Wahl & Richards, 2002). The dominant negative messages of the mass media have arguably resulted in a misrepresentation of the frequency of indictable offences committed by mentally ill persons (Philo, Platt, Henderson, McLaughlin, & Burnside, 1994).

The exaggeration of dangerousness in mentally ill persons is unfortunate as the proportion of violent offences committed by individuals with severe mental illnesses is small (Matthias & Angermeyer, 2000). While some studies have suggested that there is a relationship between psychotic disorders and violence, the associated risk is minute, and moreover, is limited to specific groups of symptoms (Matthias & Angermeyer). For example, psychotic patients are more likely to be violent if they specifically have persecutory delusional beliefs (Nester, Haycock, Doiron, Kelly, & Kelly, 1995). Substance abuse and a diagnosis of antisocial personality disorder are also important risk factors for violence in mentally ill patients (Soyka, 2000). Section 301.7 of the DSM-IV-TR classifies antisocial personality disorder by a “pattern of disregard for and the rights of others” and often a “lack of remorse, as indicated by being indifferent to or rationalizing having hurt, mistreated, or stolen from another” (American Psychiatric Association [APA], 2000), suggesting that antisocial traits may lead to offending behaviour because of a lack of associated guilt feelings. The same may be true for people with narcissistic personality disorder, described in section 301.81 by “a lack of empathy” (APA [DSM-IV-TR], 2000). Typically, however, mentally ill persons are harmless to others and are actually 2.5 times more likely to be a victim of violent crime

than are members of the general population (Hiday, Swartz, Swanson, Borum, & Wagner, 1999).

Research on public perceptions of mentally ill offenders has potential pertinence to important forensic matters (e.g., jury deliberation), yet few empirical quantitative studies specifically examine the public's attitude toward these individuals' offence-related guilt and blame. Consider the *actor-observer effect* (Jones & Nisbett, 1971) whereby people attribute their own negative behaviour to other external sources and others' negative behaviour to internal sources (Kemdal & Montgomery, 2001). This phenomenon has not been considered for the public's understanding of offences committed by mentally ill individuals to test whether the effect may differ with this distinct population. A study by Monahan and Hood (1976) assessed the public's perception of the responsibility of mentally ill offenders and found that compared to mentally healthy offenders the public viewed the mentally ill as less morally responsible or blameworthy for their offences due to a lack of free will. The study used a between-subjects design whereby participants from a jury roll were presented with a vignette of a homicide and were subsequently assigned to a "mentally disordered history" or "control" condition. Subsequently, participants completed a seven question questionnaire about the offender's level of responsibility based on the provided background information. Unfortunately, the measure of responsibility with its lack of items had questionable construct validity and the study provided no information about empirical validation of the scale.

Nonetheless, the above study suggests that the actor-observer effect is lessened when the public (as *observers*) make attributions for the negative behaviour (the offences) of mentally ill persons (the *actors*). That is, the public likely attributes blame

to external sources more so when offences are committed by mentally ill persons rather than by mentally healthy persons. However due to the negative attitudes that the public is believed to hold towards mentally ill offenders, it appears that the actor-observer effect still occurs to some extent. Further, it is reasonable to expect that mentally ill persons blame their own offences on external sources more than the public and that the public's perception of guilt in these individuals is inconsistent with forensic psychiatric patients' own self-reports.

#### ***Attribution research involving a forensic population***

It is also important to understand how forensic psychiatric patients conceptualize their role in the commission of their offence, as the extent to which they blame different sources for their offences helps denote their sense of personal responsibility. For example, blaming external sources (i.e., environmental factors including the victim, peer pressure, and society) indicates that the responsibility of an offence is not being attributed to oneself (Dolan, 1995). Mental factors, including distorted perception, impaired judgment, and sudden loss of control, are also thought to impair perceived responsibility for an offence (Gudjonsson, 1999). A patient with schizophrenia, for example, may not feel personally accountable for a homicide "committed" out of fear and in response to command hallucinations. When mentally ill individuals highly attribute the blame of their offence to external sources or mental factors, they are arguably not holding themselves personally accountable to the same degree as other individuals

These attributions may even influence the likelihood that a mentally ill individual will reoffend. In individuals with mental illnesses, external blame attribution consistently relates to personality characteristics associated with offending and mental

element blame attribution is associated with personality characteristics related to criminality (Shine, 1997). Many criminal justice professionals also believe that a lack of guilt attribution in individuals indicates that they remain dangerous to society because they have not taken responsibility for their offence (Fox, Koning, & Leicht, 2003). Since all of these offence attributions appear to be related to reoffending behaviour, modifying them in psychiatric patients could potentially be an effective rehabilitation method. This view is supported by McGuire (1995), who summarized the research literature evaluating the effectiveness of various types of treatment in reducing reoffending and consequently suggested that successful intervention programs must consider how forensic psychiatric patients understand and explain their offending behaviour.

Unfortunately, much conflicting evidence currently exists in research examining relationships between mental illness, personality disorder, and blame attribution within the psychiatric population (Fox & Leicht, 2005). For example, it is unclear if individuals with personality disorders (i.e., axis II mental disorders) have more of an externalizing blame attribution bias when compared to individuals with mental illnesses (i.e., axis I mental disorders). Considering that externalization of blame is a central feature of many personality disorders (Cloninger, 2002) it is surprising that Moore and Gudjonsson (2002) found that psychiatric patients with personality disorders have lower external blame attribution than patients with mental illness. This counterintuitive finding may have been the result of identifying groups based solely upon patients' primary diagnoses rather than creating separate categories for patients with comorbid disorders. With this study in mind, Fox, Koning, and Leicht (2003) suggested that diagnosis alone is unreliable in assessing individuals' personal sense of responsibility

for their offences. However, perhaps a more refined way to evaluate offence attributions would be to compare comorbid patients (combination of a personality disorder and some type of Axis I mental illness) to patients with only a mental illness.

Another potentially important aspect that has not been sufficiently examined in the literature is the influence that time elapsed since offence may have on mentally ill individuals' guilt and blame attribution. Carlin et al. (2005) hypothesized that treatment may affect psychiatric patients' offence attributions (more specifically, that external blame will decrease and shift towards self-blame or mental blame). This hypothesis was not explicitly examined but suggests that the time patients have spent in psychiatric hospitals should be considered when evaluating offence attributions. A study of prison suicides in England and in Wales between 1972 and 1987 analysed suicide notes and revealed that 12.5 % of the suicides were directly a result of guilt feelings for offence (Dooley, 1990). Most of those suicides occurred early in custody, suggesting that guilt feelings are higher when little time has elapsed since the offence. As a third of the sample had a history of psychiatric contact, it would be interesting to explore whether guilt feelings vary as a function of time elapsed since offence in forensic psychiatric patients. In the general population, guilt-proneness is linked to better perspective taking, or, understanding the point of view of someone with whom a person is in conflict (Leith & Baumeister, 1998). Therefore, it would also be interesting to explore if patients with a Comorbid Personality Disorder (CPD) who may have a limited capacity to take the perspectives of their victims feel less guilt for their offences and moreover if time affects their guilt and blame attribution differently than patients without a CPD.

### ***Overview***

The current paper reports the results of two inter-related studies conducted to assess



guilt and blame attribution of offences committed by mentally ill individuals, both within a public sample and forensic psychiatric patient sample. The goal of the first study was to further the limited body of offence-related guilt and blame attribution research by examining the public's perceptions of mentally ill offenders and exploring potential differences with forensic psychiatric patients' own perceptions of their offences. More specifically, it considered the public's beliefs about the moral responsibility and feelings surrounding offences committed by mentally ill persons. The second study<sup>2</sup> explored guilt and blame attribution for offences committed by forensic psychiatric patients considering both their psychiatric diagnosis, and time that had elapsed since their offences. The intent is to investigate how patients' understanding of their personal responsibility for their offences (in terms of blame towards external sources and mental factors) may be affected by time elapsing since their offences and further explore if there are any variations across psychiatric diagnostic categories.

## **Study 1**

### ***Exploratory hypotheses***

- (1) The public will have a tendency to underestimate feelings of offence-related guilt in mentally ill individuals.
- (2) The public's external blame attribution of offences committed by mentally ill persons will be lower than forensic psychiatric patients' external blame attributions for their own offences.

### ***Participants***

#### ***Canadian public sample***

Participants were 244 male ( $N = 69$ ) and female ( $N = 174$ ) adults<sup>1</sup> (mean age = 31 years; age range = 19 to 63 years). Participants were recruited from a suburban city through various advertising means (newspapers, community internet websites, a radio announcement, and flyers posted in public areas like recreation centres and libraries). As incentive for participation, participants were entered into a \$200 draw.

### ***Materials/apparatus***

For data collection from the public sample, the Gudjonsson Blame Attribution Inventory-Revised (BAI-R) (Gudjonsson & Singh, 1989)--which is intended to measure guilt and blame attributions surrounding specific criminal acts in mentally ill populations--was adapted. The 42-question BAI-R contains 3 distinct subscales: *Guilt Attribution*, which measures feelings of remorse or regret about committing an offence, *External Blame Attribution*, which measures how much blame of an offence is attributed to external sources like the victim or society as opposed to personal characteristics, and *Mental Element Blame Attribution*, which measures how much blame of an offence is attributed to mental factors including mental illness or a lack of self-control.

Questions were reworded from first-person narrative to third-person narrative so that questions were directed towards an individual and the homicide he is described as committing in an online vignette. For example, "Society is to blame for the crime I committed," was changed to "Society is to blame for the crime [the described offender] committed." The adapted BAI-R is intended to measure how much guilt the public perceives a described individual to have as well as how much they attribute his offence to external sources and mental factors. After evaluating the internal validity of the

adapted scale using Chronbach's alpha, a few items were dropped as they lowered the alpha values and did not theoretically endorse the intended constructs.

For the forensic psychiatric sample, the original BAI-R was used and all questions were retained. However, for the External Blame Attribution and Mental Element Blame Attribution subscales, a 6-point Likert-type scale (ranging from "strongly agree," to "strongly disagree,") was used for the responses<sup>2</sup> and scored from 0 to 5. This change was made to allow for greater discrimination between participants' responses and was also used in the version of the BAI-R that was adapted for the public.

### ***Procedure***

#### *Canadian public data collection*

The study used a between-subjects design wherein the public anonymously completed an online survey. After providing basic demographic information, all participants were presented with a vignette describing a man who commits a homicide (see Roberts, Golding, & Fincham, 1987). Subsequently, participants were told that the man was mentally healthy ( $N = 116$ ) or that he had a psychotic disorder ( $N = 128$ ). Participants in the mentally healthy condition were given a brief and vague description of his ordinary social and vocational background. Participants in the psychotic disorder condition were given a description of his psychiatric symptoms, which were designed by Roberts et al. to meet DSM III-TR diagnosis criteria for schizophrenia and also involve delusions that are tied to the offence. Based upon the described homicide and respective offender, participants were then instructed to complete the adapted BAI-R. Only submitted surveys with at least 31 of the 36 questions completed were used<sup>3</sup>. All data were collected over a period of 3 months.

### ***Results***

*Canadian public's guilt and blame attribution of mentally ill persons and their offences*

Subscale scores on the adapted BAI-R were compared across the two conditions (psychotic versus mentally healthy) using independent *t*-tests. Table 1 shows the mean and standard deviation attribution scores. There were significant differences for external blame, mental blame, and guilt attribution, with the public blaming external sources and mental factors more so for the psychotic offender than for the mentally healthy offender, yet perceiving the psychotic offender to feel less guilt for his offence than the mentally healthy offender.

Table 1. The public's mean (*M*) and Standard Deviation (*SD*) for all attribution scores.

<i>Offender group</i>	<i>Guilt</i>		<i>External Blame</i>		<i>Mental Blame</i>	
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>
Psychotic Disorder	4.46	3.37	16.25	9.75	25.05	8.73
Mentally Healthy	5.78	3.23	11.84	9.91	17.85	7.02
<i>t</i> value	-3.13		3.50		7.38	
<i>p</i> value	0.00**		0.00**		0.00***	

\*\**p* < 0.01, \*\*\* *p* < 0.001

*Comparing the public's guilt and blame attribution to forensic psychiatric patients'*

BAI-R data collected from the public sample were compared to BAI-R data collected from the forensic psychiatric patient sample through a series of independent *t*-tests. Data from the public (psychotic condition only) were compared directly to data from psychotic patients (*N* = 32) at the psychiatric hospital. Table 2 shows the mean and standard deviation scores for the two samples. There were significant differences for guilt and external blame attribution, with patients reporting more guilt and more external blame for their offences than the public. There was no difference in mental blame between the two samples.

Table 2. The public versus patient's *M* and *SD* for all attribution scores<sup>4</sup>.

<i>Sample</i>	<i>Guilt</i>		<i>External Blame</i>		<i>Mental Blame</i>	
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>
Public	6.17	4.66	17.41	10.45	25.05	8.23
Psychiatric patients	8.53	3.68	34.18	13.08	25.28	8.97
<i>t</i> value	0.01**		0.00***		0.89	
<i>p</i> value	-2.65		-7.71		-0.14	

\*\* $p < 0.01$ , \*\*\*  $p < 0.001$

### ***Discussion of Study 1***

#### *Public perceptions of the offending mentally ill and stigma*

A major aim of this study was to examine how the general public views mentally ill individuals understanding of their own offences. Tangermeyer et al. (2006) stressed the need for research on public attitudes towards mental illness to use more sophisticated quantitative approaches as most of the research is purely descriptive, offering some insight into public biases but being difficult to draw any concrete conclusions from. Our research was an attempt to address this concern and benefitted from a more quantitative approach than the majority of extant literature on the topic. Results indicated that the public views mentally ill persons with a psychotic disorder as less morally responsible for their offences compared to mentally healthy offenders, blaming external sources like the environment and mental factors such as a lack of self-control. These results are consistent with previous limited research and suggest that the public is, to some extent, receptive to the idea that mentally persons should be held less accountable for their offences. We also determined that the public perceives psychotic persons to feel less guilt for their offences than mentally healthy persons. This perception may initially seem justified by previous research. Psychiatric patients with psychotic symptoms have

been found to lack in guilt feelings as compared to psychiatric patients without psychotic symptoms (Carlin, Gudjonsson, & Rutter 2005). Nonetheless, without a direct comparison of guilt scores, it could not be inferred that the public's estimation of guilt in psychotic individuals was in accordance with the level reported by psychiatric patients. Using data from a forensic psychiatric population, we were able to better contextualize this result by exploring potential differences in attributions between the public and forensic psychiatric patients themselves.

Perhaps the most substantial finding--consistent with hypothesis 1--was that the public seemed to underestimate the amount of guilt that forensic patients feel for their offences. In terms of negative attitude formation, this suggests that the public believes mentally ill individuals feel little remorse for their offences, or at least less remorse than was evident from our psychiatric sample. This result should be taken with caution as the forensic data were from patient self-reports and some patients may have been deceptive in their reporting. However, the extent of deception in the responses was likely minimal as patients were ensured that their responses on the BAI-R were not linked to their identity; therefore, patients had no reasonable incentive to respond in a socially desirable manner. Assuming the public does underestimate guilt in forensic patients, the effect could arguably contribute to a general tendency toward dehumanizing mentally ill individuals. Human characteristics are understood as "emotional, desirable, prevalent, and universal" (Haslam, Bain, Douge, Lee, & Bastian, 2005, p. 941). Guilt feelings are arguably a human characteristic as they imply social sensitivity and are predominantly linked to positive cognitive components of empathy including an increased ability to appreciate the perspectives of others (Leith & Baumesiter). The public's belief that this population lacks in guilt feelings demonstrates a belief that these

mentally ill individuals are lacking in one of the basic human emotions. This finding also depicts a stigma, an “invalidating and poorly justified knowledge structure that [leads] to discrimination” (Corrigan & Penn, 1999, p. 766). While the confirmation that stigma exists towards a population with both a mental illness and an offending history is not necessarily unexpected, the forensic patients’ self-reports which suggest that this perception of low guilt is unwarranted is much more essential to the dispersal of negative attitudes towards this population. This evidence of what is arguably a stigma, gives the potential for the development of more effective public education programs which aim to decrease the stigma surrounding mental illness.

Supporting hypothesis 2, was the tendency for forensic patients to externalize the blame of their offences more so than the public. This result is consistent with the previously described ‘actor-observer effect.’ Patients (as actors) highly attributed their own offences to external sources whereas the public (as observers) attributed those offences internally towards the mentally ill individuals. However, it is notable that the public still externalized the blame for offences committed by mentally ill persons more so than for offences committed by mentally healthy persons. While the data suggests that the actor-observer effect is applicable to both mentally ill and mentally healthy populations, it appears that the effect is lessened when mentally ill persons pose as actors. This implies that the public, to some extent, acknowledges that offences committed by mentally ill persons are not fully attributable to internal or personal characteristics. //

#### *Limitations and benefits to public-patient data comparison*

While the man with psychotic symptoms described in the vignette was generally representative of the forensic psychiatric patient sample as a whole, obviously not each

individual patient and his respective index offence matched the details provided in the vignette. For example, the described offender was male, with a psychotic disorder (as were all patients used in the comparison), but variations existed in type of offence and relationship to the victim. The vignette specifically described a homicide (i.e., a stabbing) whereas the only 6 of the 32 patients had a homicide for their index offence. Most of the patients' offences were less severe in nature (including assault, uttering threats, robbery, break-and-enter, and arson). The victim in the vignette was also a stranger, whereas patients' victims were a mixture of strangers, acquaintances, and people well known to the patients or else did not involve a direct victim. Additionally, while many of the patients had CPD diagnoses and histories of substance abuse, this information was not part of the offender's description in the vignette.

Interestingly some of the disparities between the described offender and the patient sample suggest that the difference between the public and patients' reported levels of guilt should have been even larger than was obtained by the results. For example, Fox and Leicht (2005) found that guilt feelings in psychiatric patients are highest for more severe offences. Since the patient sample had less severe offences and was compared to public data based upon a homicide, patients' guilt scores should potentially be lower simply based on the discrepancy in offence severity between the vignette and most of the patients' offences. It should also be noted that Fox et al. also found no significant relationship between guilt and offender-victim relationship so it is unlikely that this disparity in relationships across the vignettes affected the results. Further, since personality disorders are in part characterized by a lack of remorse it would be expected that the presence of CPDs in many of the patients should result in lower guilt scores as compared to the public data. Finally, the presence of substance abuse problems within



the patient sample should not have affected patients' guilt scores since substance abuse problems are typically believed to be unrelated to feelings of guilt (Dearing, Stuewig, & Tangney, 2005). In summary, if the guilt data collected from the public were compromised by a lack of representativeness of the patient sample, it appears that it would be in the direction of overestimating guilt scores in the public sample. However, our current findings indicated that the public underestimated the level of guilt within the offending mentally ill population.

## **Study 2**

### ***Exploratory hypothesis***

- (1) Psychiatric patients with a CPD, regardless of other existing mental illness, will differ in their guilt and blame attribution as compared to patients without a CPD.

### ***Participants***

#### *Forensic psychiatric patient sample*

Participants were 34 male patients (mean age = 41; age range = 19 to 65 years), who were contained at the Forensic Psychiatric Hospital (a medium and maximum security institution) in British Columbia, Canada. All participants had been found *not criminally responsible by reason of mental disorder* for their index offence(s).

### ***Procedure***

#### *Forensic Psychiatric Hospital data collection*

Data were collected directly at the hospital premises over a period of 3 weeks.

Researchers administered the original BAI-R to all eligible, consenting patients.

Patients completed the R-BAI in a group setting within their secure units and were

seated well apart from one another. It was clearly outlined to the patients that all data collected would be kept completely confidential and would have no effect upon their release outcomes. Each participant was assigned a number so that his data would not be directly linkable to his name or identity. Afterwards, all relevant information on patients, including psychiatric background and offence history, was collected from patients' hospital files.

### **Results**

#### *Forensic psychiatric patients' guilt and blame attribution of their offences*

*Demographic Information.* Mean time spent in hospital since index offence was 75 months (ranging from 1 to 325 months) and mean time elapsed since index offence was 97 months (ranging from 2 to 336 months). Table 3 shows patients' diagnostic information.

Table 3. Diagnostic description of patients.

		<i>Comorbid Cluster B Personality Disorder<sup>5</sup></i>	<i>Substance Abuse</i>
<i>Primary Diagnosis</i>	<i>N</i>	<i>N</i>	<i>N</i>
Schizophrenia	17	7	13
Schizoaffective disorder	8	8	7
Psychotic disorder NOS	3	1	1
Bipolar disorder	2	0	2
Other* <sup>6</sup>	4	2	2
<b>Total</b>	<b>34</b>	<b>18</b>	<b>25</b>

Within the patient sample, analyses of guilt and blame attribution scores were conducted using a series of independent *t*-tests. The sample was separated into two

comparison groups: patients with a CPD ( $N = 18$ ) and patients without a CPD ( $N = 16$ ). There was a significant difference in mental blame and guilt, with patients without a CPD blaming their offences more on mental factors and feeling more guilt than patients with a CPD. There was no significant difference in external blame between the two groups. Table 4 shows the results using CPD presence as a grouping factor. Although not the focus of this study, similar analyses were also conducted with the presence of a substance abuse problem, intellectual impairment, and affective disorder as the grouping factor, but no significant results were found.

Table 4. *M* and *SD* attribution scores for patients with and without a CPD

<i>Sample</i>	<i>Guilt</i>		<i>External Blame</i>		<i>Mental Blame</i>	
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>
Patients with CPD	7.39	3.28	36.01	13.03	21.72	9.09
Patients without CPD	9.49	3.83	33.36	13.19	28.00	8.64
<i>t</i> value	-1.73		0.59		-2.06	
<i>p</i> value	0.05* (1-tailed)		0.56		0.05*	

\* $p < 0.05$

Additionally, bivariate correlations were used to examine if a relationship existed between guilt and blame attributions and age, time elapsed since the index offence, and time spent in hospital. No significant correlation was found between either guilt or external blame attribution and age, time elapsed since offence, or time spent in hospital. An overall negative significant correlation was found between mental blame and time elapsed since offence. However, when considering patients with and without a CPD separately, this correlation was only significant for patients without a CPD. Also interesting, is that the overall positive correlation between mental blame and guilt, which has been found consistently in previous studies (e.g., Crisford, Dare, & Evangelini,

2008; Fox, Koning, & Leicht, 2003), when broken down further, was only significant for patients without a CPD. Table 5 shows the correlation breakdown.

Table 5. Correlation matrixes for age, time elapsed since offence, and time spent in hospital with attribution scores as dependent variables and with consideration of CPD.

<i>All patients</i>						
<i>Variable</i>	1.	2.	3.	4.	5.	6.
1. Age	-					
2. Time since offence (months)	0.39*	-				
3. Time spent in hospital (months)	0.35*	0.87***	-			
4. BAI-R guilt score	-0.21	-0.05	-0.06	-		
5. BAI-R external blame score	0.113	-0.05	-0.10	-0.51*	-	
6. BAI-R mental blame score	-0.40*	-0.40*	-0.34	0.52**	-0.57***	-
<i>Patients with CPD</i>						
<i>Variable</i>	1.	2.	3.	4.	5.	6.
1. Age	-					
2. Time since offence (months)	0.25	-				
3. Time spent in hospital (months)	0.26	0.87***	-			
4. BAI-R guilt score	-0.11	0.27	0.14	-		
5. BAI-R external blame score	0.211	-0.19	-0.14	-0.58*	-	
6. BAI-R mental blame score	-0.40	-0.28	-0.25	0.39	-0.521*	-
<i>Patients without CPD</i>						
<i>Variable</i>	1.	2.	3.	4.	5.	6.
1. Age	-					
2. Time since offence (months)	0.51*	-				

3. Time spent in hospital (months)	0.40	0.82***	-			
4. BAI-R guilt score	-0.12	-0.38	-0.23	-		
5. BAI-R external blame score	-0.05	0.14	-0.16	-0.43	-	
6. BAI-R mental blame score	-0.22	-0.53*	-0.37	0.57*	-0.64**	-

\* $p < 0.05$ , \*\* $p < 0.01$ , \*\*\* $p < 0.001$

## ***Discussion of Study 2***

### *Relationships between CPDs and guilt and blame attribution in patients*

The aim of this study was to investigate if certain diagnostic categories affected guilt and blame attribution in forensic psychiatric patients. There were several interesting findings regarding patients with a Comorbid Personality Disorder (CPD). It was expected that patients with a CPD would have less guilt for their offences because of the defining characteristics of the type of personality disorders that were present in the patient sample. Specifically, only comorbid antisocial personality disorder, narcissistic personality disorder, or traits of either were coded in the current sample. Interestingly, no significant differences in external blame were found when comparing patients with a CPD to those without. As discussed earlier, previous research has produced mixed results, possibly because of comorbidity issues and the associated classification problems.

To avoid this problem and better deal with comorbidity, we compared patients with only an Axis I mental disorder to patients with an Axis I mental disorder and CPD (or traits of one) but found no difference in external blame. This may in part be due to our more exclusive personality disorder classification scheme. We only included cluster B personality disorders and restricted them to antisocial or narcissistic personality

disorders. One problem with this method of analysis was the potential impact of the accompanying mental health issues. Fortunately, the distribution of the different primary psychiatric disorders across groups with and without a CPD (Table 3) was relatively even aside from patients with schizoaffective disorder who all had a CPD. Therefore, any possible impact that the Axis I disorders may have had on guilt and blame attribution scores was reasonably balanced across groups.

A novel finding in this study was that differences in mental blame attribution existed between patients with and without a CPD. It is interesting that patients with a CPD were less likely to blame their offence on mental factors than patients without a CPD. On the surface, it may appear that the presence of a CPD helps patients to take responsibility for their offence (i.e., they are not subscribing their mental illness and its associated lack of self-control as an explanation for their offences). However, while mental blame is conceptually associated with a denial of personal responsibility, it is also related to acceptance of mental illness and with realization that help is required (Gudjonsson, 1983). Patients with a CPD may have been hesitant to acknowledge their mental illnesses and therefore did not want to explain their offences in terms of mental factors. For example, one patient (who was not included in the study as his measure was not properly completed) wrote comments such as “I’m not mentally ill,” “I am absolutely and always in full control over my actions,” and “What I did was not beyond my control - God controls.” In a sense, the lack of mental blame may be indicative of a defence mechanism, or an “innate involuntary regulatory [process] that [allows] individuals to reduce cognitive dissonance . . . by altering how events are perceived” (Vaillant, 1994) to protect their grandiose sense of self-importance and ego associated with their CPD. If these patients consider a mental illness as a flaw, but view

themselves as important, their schema of themselves would be disturbed by acknowledging that their offence resulted from their mental illness. There is always the small chance that the patients simply responded in a manner which they considered to be desirable to the researchers (i.e., not showing their mental weakness). However, as mentioned above, the current study was set up to eliminate this possibility as much as possible. Overall, the relationship between CPD and mental blame attribution appears complex and requires further examination.

It was also interesting to see a negative relationship between time elapsed since offence and mental blame for patients without a CPD. The finding that mental blame decreases in patients without a CPD as time elapses since their offence is a positive one, indicating that the psychiatric treatment these patients received appears to have contributed to their sense of personal responsibility for their offences. To our knowledge, this is the first time this result has been identified, as previous studies have not specifically considered time as a factor which affects guilt and blame attributions. Contrary to Carlin et al.'s (2005) reasoning that externalization of blame would shift towards increased self-blame or mental blame as a result of treatment<sup>7</sup> (i.e., external blame would decrease while mental blame would increase), the opposite was found. There was no significant correlation between external blame and time spent in hospital, and mental blame actually decreased as time elapsed. One possible explanation is that our sample was biased due to attrition bias. The sample may have been unrepresentative and biased the data as only patients who were then presently contained in the psychiatric hospital were included in the sample. Previous patients, who we did not have access to, may have been released back into the community as a result of taking personal responsibility (denoted by a decrease in external blame) and expressing guilt for their

offences. Therefore, our sample may have included only patients who across time were resistant to changes in their guilt and blame attribution.

### **General Discussion**

These studies pose important direction for future research. In regards to public perceptions of mentally ill offenders, there is a need for similar studies to be conducted. Study 1 was the first of its kind, so for complete validation, the results should be replicated. As with any psychology study, based largely upon comparing group means, caution must be taken in applying the results to all members of the population. Much variability existed in both the public's and patients' attributions which suggests that not all members of society view the mentally ill in a negative and biased way. However, our data strongly suggest that a substantial amount of people hold a measurable amount stigma towards the mentally ill, at least in terms of perceiving them to have little guilt for their offences.

Based upon study 2, we also propose that rehabilitation programs for forensic psychiatric patients aiming to prevent recidivism should be designed and evaluated with consideration of differences between patients with and without a cluster B CPD. Future research may want to further investigate how the presence of a CPD affects how patients understand their existing mental illness in relation to their offences. While previous research has suggested that diagnosis is not an effective way to evaluate offence attributions, we propose that with proper categorization (i.e., grouping together more specific disorders that are similar to one other), diagnosis is valuable way of understanding how psychiatric patients conceptualize their offences. We also suggest that future studies considering the effect of time or treatment on offence attributions



develop and use a scale which specifically measures internal attributions as there appears to be complications in assuming that changes in external blame, mental blame, or guilt are directly associated with an increased sense of personal responsibility.

Finally, it would be beneficial for future research to consider how the time that patients spend in psychiatric hospitals and the type of treatment they receive may affect their guilt and blame attribution. While our data only show a significant relationship between patients' levels of mental blame and time elapsed since their offence (rather than time spent in the hospital which only approached the significance levels), the correlation between time elapsed since offence, and time spent in hospital is high. It is possible that the effect that time elapsed since offence appears to have in decreasing patients' mental blame is mediated by the amount of time spent in the hospital and the type of treatment that they receive. Future studies should examine this further to help better illuminate how psychiatric hospitals might facilitate patients in taking personal responsibility for their offences.

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**Notes**

1. One participant did not report gender.
2. The original BAI-R gave participants the choice of responding “True” or “False” and was scored 0 or 1.
3. Only 2 items could be unanswered from the Guilt or External Blame subscale, and only 1 item from the Mental Blame subscale.
4. As a few questions were dropped on the BAI-R that was administered to the public, the public’s total subscale scores were compensated for (i.e., increased proportionately to become directly comparable to the BAI-R subscale scores of the patients). As a methodological check, the public’s adapted BAI-R subscale scores were also compared to the patients’ BAI-R subscale scores with the same questions dropped. With either method of comparison, the *p*-values were at the same significance level for all subscales.
5. All but 2 participants (who had Cluster B traits) had antisocial personality disorder, narcissistic personality disorder, or both.
6. Includes autism, substance induced psychosis, atypical psychosis with depression, and hepatic encephalopathy.
7. “Treatment” is considered synonymous with time elapsed since offence as most patients spent the vast majority of their time in a psychiatric hospital following their index offence (Table 5).

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