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Acquitted or Confined: The impact of jury instruction, biological sex of mock-juror, and defendant mental illness on insanity defense attitudes and verdict outcomes

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ACQUITTED OR CONFINED: THE IMPACT OF JURY INSTRUCTION, BIOLOGICAL

SEX OF MOCK-JUROR, AND DEFENDANT MENTAL ILLNESS ON INSANITY

DEFENSE ATTITUDES AND VERDICT OUTCOMES

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ABSTRACT

Approximately 20% of incarcerated individuals in jails and 15% of those in state prisons have been diagnosed with a serious mental illness, meaning that there are approximately 356,000 incarcerated persons with serious mental illness in jails and prisons alone (Torrey et al., 2014). Today, mental health stigma is widely prevalent amongst society and particularly there is a strong stigma associated with mental illness and criminality (Maeder & Mossière, 2015). Thus, when mental illness is present in criminal court cases, there is the potentiality of those stigmatic views impacting verdict outcomes accommodating for mental illness (e.g., Not Guilty by Reason of Insanity and Guilty but Mentally Ill). Moreover, society typically perceives verdicts associated with insanity/mental illness as an alternative for not wanting to take responsibility for one's actions and as a "loop-hole" to get out of serving time (Hans & Slater, 1983). These misconceptions can generate biases and stereotypes in regard to the insanity defense and accused individuals diagnosed with mental illness. The present study aimed to address these biases and stereotypes by examining what factors impact mock-jurors' attitudes toward the insanity defense and potentially elicit verdict outcomes.

Participants were recruited via the internet using Amazon Mechanical Turk (MTurk). A variety of scales assessing mental health stigma, insanity defense attitudes, and several self-constructed questionnaires/ vignettes designed by the researchers were employed in the survey. Participants were also asked to complete a demographic questionnaire assessing basic demographic information as well as previous juror and criminal history, and exposure to mental health. The findings from this study imply that several juror demographics, as well as other factors, do impact verdict outcomes, however, there was a lack of significance when assessing insanity defense attitudes. Future directions, implications, and limitations are discussed.

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Introduction

Mental illness affects millions of people in today's society. The National Alliance on Mental Illness (NAMI) reports 19.1% of United States adults experience mental illness (NAMI, 2018). This percentage indicates that every one in five adults is diagnosed with a mental illness. Unfortunately, the commonality of mental illness does not mitigate the stigmatic views and negative attitudes that are still upheld when it comes to those experiencing mental health issues (Angermeyer & Dietrich, 2006; Ross & Goldner, 2009). Research suggests that this negative perception of mental illness often carries into the courtroom when a defendant is identified as having a mental diagnosis. Although precautionary measures like the development of Not Guilty by Reason of Insanity (NGRI), Guilty but Mentally Ill (GBMI), and diminished capacity have been implemented to ensure defendants diagnosed with a mental illness are treated fairly, it seems as though prejudiced attitudes and biases towards these insanity defenses still exist. Typically, these perceived negative attitudes are not of much precedence because participants in research studies often have a minute amount of knowledge pertaining to the logistics of the insanity defense. This lack of knowledge pertaining to insanity defenses is one of many factors that could potentially impact verdict outcomes in a case in which the defendant is suffering from mental illness. Thus, *the purpose of this study is to examine mental health stigma in the case of an insanity defense while also exploring other potential factors that may influence verdict outcomes.*

Mental Health Stigma

Defining Stigma

Stigma operates heavily in society and as a result, becomes internalized by those who experience it. Goffman (1963) states stigma is "an attribute that is deeply discrediting" that

reduces someone "from a whole and usual person to a tainted, discounted one (p. 3)." As research has progressed, other professionals in the field have adapted Goffman's definition to include more specific characteristics. Dudley (2000) defines stigma as stereotypes and/or negative views bestowed on a person or group of people when their characteristics or behaviors are viewed as abnormal from societal norms. These abnormal behaviors and inconsistent societal norm characteristics influence society's perception of these individuals collectively, thus creating a stereotype toward all individuals diagnosed with a mental illness (Ben-Zeev, Young, & Corrigan, 2010). Even when there are no abnormal behaviors present in an individual labeled with mental illness, the public is still likely to hold these stigmatizing views (Link, Cullen, Frank, & Wozniak, 1987).

Mental Illness and Violence

Society tends to create a strong stigmatic association between violence and those experiencing mental health issues. Angermeyer and Dietrich (2006) aimed to determine the extent to which members of society can recognize mental illness and what attitudes towards individuals with mental illness are most prevalent. Researchers concluded that society, in general, cannot accurately recognize specific mental disorders. More specifically, participants frequently categorize symptoms of schizophrenia as a mental illness more often than symptoms of depression or substance abuse. Additionally, a majority of the public indicated that those suffering from mental illness need help. However, an abundance of these participants perceived those with mental illness as unpredictable and dangerous, resulting in an immediate reaction of fear and distancing oneself from these individuals. Specifically, people with schizophrenia or alcoholism were more frequently considered as unpredictable and violent than those diagnosed with depression or anxiety disorders. This finding is interesting considering the public, in

general, inaccurately identifies those with a mental illness in the first place (Angermeyer & Dietrich, 2006).

Pescosolido and colleagues (1999) surveyed the American public to assess their views of mental illness and if a particular diagnosis made any one individual more likely to commit a violent offense. Analysis of participants' responses indicated that those with a drug (87.3%) or alcohol (70.9%) dependency or diagnosed with schizophrenia (60.9%) were more likely to commit a violent crime than those experiencing depression (33.3%) or labeled as *troubled* (16.8%). When comparing these results to that of accurate violent crimes committed by those with a mental illness, the general public overestimated the risk of violence among schizophrenia and depression, but correctly identified these among the lower-ranked groups (Pescosolido et al., 1999).

Stuart and Arboleda-Flórez (2001) also found that the general public greatly exaggerates how often those with a mental illness commit violent offenses. Using a public health approach researchers calculated the proportion of violent offenses that were committed by a person with mental illness. Less than three percent of violent crimes could be linked to persons with a diagnosis reflecting a non-substance-use disorder (e.g., mood, psychotic, anxiety, adjustment, or personality disorder). Additionally, seven percent could be connected to those with a psychoactive substance use disorder. Since the sample was representative of all offenders arrested and detained by police for violent crimes in a geographically defined area, these findings support the hypothesis established by Stuart and Arboleda-Flórez (2001) that the public risk of criminal violence perpetrated by an individual with a mental/substance is low. Furthermore, when based on the perspective of public health interventions, only one in ten violent crimes in

this sample could have been prevented if these disorders were not present (Stuart & Arboleda-Flórez, 2001).

Although several studies have examined how those with mental illness are stigmatically viewed as dangerous and as likely to commit a violent crime when compared to the general population, there are a handful of studies that have focused on the rise of violent offenses in those with mental illness. Teplin (1990) obtained a random sample of 627 male arrestees and found the prevalence of mental illness to be nearly three times that of the general population. Among the sample of arrestees, the most common diagnosis was that of substance abuse and personality disorders. In a longitudinal study of more than two million people between the years of 1965 and 1998, researchers identified an elevation of crime across multiple diagnostic categories when compared to individuals without mental illness, in the same population (Dean et al., 2018). Both men and women diagnosed with a mental disorder showed higher rates of committing a crime than those without, with the strongest associations seen for substance use and personality disorders.

Factors that elicit violence. Based on the literature, mental illness may increase the likelihood of committing violence, however, several other factors and circumstances have been shown to prompt violent behavior. Cullen and Wilcox (2013) constructed a meta-analysis examining a variety of risk factors for violent behavior; specifically, in individuals under the age of 18. Based on the analysis of these longitudinal studies, the most common individual risk factor predicting crime was previous offenses/delinquencies. Furthermore, there were a variety of family risk factors that could potentially predict violent behaviors. The two most common predictors were family cohesion and parenting style. Other risk factors that seemed to contribute

to an increase in criminal behaviors were peer structure, school environment, self-esteem, impulsivity, and socioeconomic status (Cullen & Wilcox, 2013).

   Untreated mental illness. Although most individuals with stable mental illness do not pose any risk of violence, Monahan's research (1981, 1984) acknowledges the link between violence and untreated mental illness. Monahan had concluded that the best predictors of violence among those with mental illness are the same demographic factors that are predictors of violence among non-disordered offender populations (e.g., family/peer group environment, stressful events, behavioral coping responses, affective responses, cognitive responses). Furthermore, the diagnosis or severity of the disorder, as well as personality traits, are the least likely predictors of violence among those with a mental illness. (Monahan, 1984, 1988). An additional factor that seems to be common among violent offenders with mental illness is untreated mental illness.

   In 2018 alone, less than half (43.6%) of those diagnosed with a mental illness received treatment (NAMI, 2018). It is likely, based on clinical analysis, that patients with mental illness frequently encounter barriers to treatment (e.g., stigma), and that this absence of treatment results in patients being arrested for both violent and nonviolent crimes (Rueve & Welton, 2008). Charges that are filed after an offense are often based on behaviors that are direct displays of the patients' untreated symptoms, such as paranoia leading to physical attacks or grandiosity resulting in burglary - two examples of crimes that may or may not be violent in nature. Research also suggests that victims of crimes by mentally ill individuals are often close to the patient, whereas those who are non-psychiatrically ill criminals may violate strangers more often (Rueve & Welton, 2008). When reflecting back on previous literature, more specifically the study conducted by Angermeyer and Dietrich (2006), participants indicated that they intentionally

would try to distance themselves from a stranger if they were aware, they were diagnosed, or displayed signs of mental illness. If, in fact, the majority of those who are diagnosed with a mental illness primarily commit a crime, whether it be violent or non-violent, against someone they know, why is it that the general public feels threatened by a stranger? Research shows that the media may play a large role in this stigmatic behavior.

Stigma and The Media

Mental health issues are frequently chosen as themes for both movies and television (Kimmerle & Cress, 2013). Stuart (2006) identified the media as portraying "...negative imagery with some of the most malignant and horrifying illustrations of psychiatric treatments." For example, the movie Split, which hit theaters in 2016, depicts a man with 23 distinct personalities who is perceived as a "beast" and engages in several violent behaviors (IMDb). Although not every depiction is sensationalized, extreme media portrayals inevitably sway public perceptions of the assumed Dissociative Identity Disorder, resulting in the stigmatization of mental illness (Stuart, 2006). In several Disney movies, individuals with mental illness are ridiculed by other characters, and their behaviors that represent characteristics of mental illness are used for amusement (ie., hyenas in the Lion King, Maurice in Beauty and the Beast). Additionally, stigmatizing language like "nuts", "crazy", and "lunatic" are used throughout the films to describe the characters' behaviors (Lawson & Fouts, 2004). When examining prime time TV, one in four mental illness characters kill someone and half illicit harm upon someone else. Thus, portraying that people with mental illnesses are more violent and more likely to engage in violent behaviors (Stuart, 2006).

In addition to televised film, other media outlets like news stations and journalists often contribute to this continuous cycle of negatively portraying mental illness. Journalists must sell

their stories to engage readers therefore, news that involves mental illness allows them to dispel inaccurate and stigmatizing stereotypes and amplify them. Reporters often emphasize the violent, delusional, and irrational behavior of those with mental illness, and often dramatize headlines and story content to attract attention (Stuart, 2006). By endorsing these negative stereotypes and promoting stigmatizing language, the media is establishing biases in their audience and creating a false perception of what an individual diagnosed with mental illness may look like.

The Insanity Defense

The insanity defense is commonly defined as "...a legal construct that, under some circumstances, excuses defendants with mental illness from legal responsibility for criminal behavior (Giorgi-Guarnieri et. al., 2014)." For centuries, lawmakers have established that one can be considered not responsible for an offense if, at the time of the offense, that individual was considered not "sane" (Bonnie, 1983). In more recent years with the abolishment of capital punishment in several countries and states, the insanity defense has adjusted with the times at the hands of presidents, kings, and federal governments (Giorgi-Guarnieri et al., 2014). One of the most prominent cases that induced controversy over the insanity defense was the aftermath of the attempted assassination of the President of the United States, Ronald Regan by John W. Hinckley in 1982. However, the trial of M'Naghten came many years prior to that of Hinckley v. United States, setting in motion the evolution of the insanity defense.

History of the Insanity Defense

The *M'Naghten* Rule. The insanity defense has taken many forms throughout history dating back to the time of the Norman conquest of England in the 11th century (Walker, 1968). The first legal test for insanity came in 1843, in the trial of M'Naghten (Giorgi-Guarnieri et al., 2014). Daniel M'Naghten was a Scottish man who believed that the Tory Party of England was

targeting him. More specifically, he believed that the leader of the Tory Party, Sir Robert Peel, was heading the torment. M'Naghten was thought to have had Peel in his crosshairs, but accidentally assassinated his secretary, Edward Drummond. Media outlets followed the case persistently due to the controversial nature of the defense being raised - not guilty by reason of insanity and acquitted of his charges. As per the rules of the verdict, M'Naghten was involuntarily committed to a mental institution for the rest of his life. Despite the testimonies of the psychiatric experts concluding M'Naghten appeared not to be of "sound mind" during the time of the shooting and Justice Tyndall supporting the assessments, the public was outraged that the jury's verdict went in favor of the insanity defense. Queen Victoria also had her own reservations about the verdict and assembled the 15 Law Lords in the House of Lords and requested they establish a stricter ruling in regard to the insanity defense ("Insanity Defense", n.d.; Giorgi-Guarnieri et al., 2014; "M'Naghten Rule", 2020; Queen v. M'Naghten, 1843).

The House of the Lords determined that every defendant is to be presumed sane and it was the duty of the defense to establish grounds of insanity and it must be proved that at the time of the crime in question the defendant was "laboring under such a defect of reason, from a disease of the mind, as not to know the nature and quality of the act he was doing; or if he did know it, that he did not know he was doing what was wrong (Queen v. M'Naghten, 1843)." Based on this ruling it is clear that there are essentially two components of the test that can be used to justify the insanity defense. First, a defendant is deemed insane if they were incapable of knowing what they were doing at the time of the offense due to psychological infirmity. The second component being, the defendant knew what he or she was doing, but they were incapable of recognizing the wrongfulness of the action committed. The test, now commonly known as the *M'Naghten* test or *M'Naghten* rule became the common law of the land in England and shortly

after was adopted by several American States. Although the same basic cognitive framework of the M'Naghten rule remained steady, many jurisdictions made their own modifications to the wording of the rule established by the House of the Lords ("M'Naghten Rule", 2020). One instance of this modification can be displayed in the case of Hinckley v. United States over a century and a half later.

Hinckley v. United States. On June 21, 1982, a Washington, D.C. jury found defendant John W. Hinckley, Jr. Not Guilty by Reason of Insanity (NGRI) on all charges related to the assassination attempt on President Reagan (Hans & Slater, 1983). After the reading of the verdict, the already publicized case resulted in a multitude of negative reactions from both the public and state lawmakers. In an ABC News poll conducted the day after the reading of the verdict, three-quarters of the Americans that participated felt "justice had not been done" (ABC News, 1982). Not only did the public speak out on the matter, but the day the verdict was reached Delaware legislators passed a new law providing a "Guilty but Mentally Ill" verdict as an alternative to insanity cases (Hans & Slater, 1983). Following in the footsteps of Delaware, many other states began proposing the abolishment or revisions of the insanity defense. As of 2019, four states (Kansas, Montana, Idaho, and Utah) have abolished the insanity defense entirely, while all other states have at least made one revision to the insanity defense since Hinckley v. United States in 1982 ("Jury Instruction", 2019).

Several public opinion polls have discovered similar findings to that of the ABC News poll and have shown that a majority of Americans believe the insanity defense is a loophole that acquits individuals of their crimes and allows too many guilty people to go free back into society, without consequences (Fitzgerald & Ellsworth, 1984; Ellsworth, Bukaty, Cowan, & Thompson, 1984). One week following the verdict of Hinckley, Hans, and Slater (1983)

conducted several phone interviews asking participants about their perceptions of the insanity

defense, specifically with the Hinckley case. The 434 respondents displayed very negative views

towards the NGRI verdict. About half of the participants felt as if the fairness of the verdict was

"not at all fair" and when asked what verdict they would have given, 73.3% of respondents

indicated they would present a "guilty" verdict. Additionally, a substantial amount of the

participants (65.7%) believed Hinkley was not insane at the time of the shooting, while 87.1%

believed the defense itself was used as a "loophole" (Hans and Slater, 1983). Based on a more

recent study, it is clear that these negative perceptions have not diminished over time. Bloechl

and colleagues (2007), found that their sample was highly consistent with this prior research and

substantially overestimated the use (29.95%) and success (30.15%) of the insanity defense.

Despite the widely shared belief that the insanity defense is used much too often and out of

context, the prevalence rate in which the insanity defense is presented in court alleviates these

numbers significantly.

Insanity Defense in the Legal System

The majority of the public believes that the insanity defense is quite common and that a

majority of defendants who claim insanity are acquitted of all charges and released back into the

public (Wheatman & Shaffer, 2001). Factually, the publics' perception of the actual prevalence

rate of those who claim insanity is astonishingly inaccurate. A large-scale study that included

states from several different regions across the United States (i.e., California, Georgia, New

Jersey, New York, Ohio, Washington, Wisconsin) reported an aggregated plea rate of only .85

per 100 felony indictments, though the rate varied across states going as low as .29 and the

highest rate being at 1.59 (Cirincione, Steadman, & McGreevy, 1995).

In a similar study spread across eight different states, Silver, Cirincione, and Steadman (1994) found that less than one percent of criminal jury trials involved the insanity defense with only 26 percent of those cases ending in a Not Guilty by Reason of Insanity (NGRI). Furthermore, in approximately 70% of cases in which the insanity defense has been successful, the prosecution and defense have agreed on the appropriateness of the insanity defense before the case even goes to trial (Costanzo & Krauss, 2010). When examining insanity defense rates in seven states, Cirincione, Steadman, and McGreevy (1995) also examined acquittal rates - the aggregated total per 100 felony indictments was .26 with the lowest rate coming in at .12 and the highest being .47. These realities of the ubiquity of the insanity defense refute the public opinion that the defense creates a loophole to avoid criminal liability and unjust freedom.

As for the perceived "freedom" that is granted once someone is acquitted of their charges, the insanity defense typically does not release the offender back into society if they have been acquitted of charges due to mental illness/impairment (Wheatman & Shaffer, 2001). Typically, acquitted defendants who use insanity as an appendage are committed to a state mental institution and remain under treatment until they show, under professional assessment, they have no serious mental illness that makes them dangerous to themselves or others (Foucha v. Louisiana, 1992).

It appears that when an offender receives a verdict of NGRI, more times than not it resembles a conviction rather than an acquittal (McClelland, 2017). NGRI patients often end up with longer, not shorter, periods of involuntary incarceration in an inpatient facility. In the case of Jones v. United States (1983), the supreme court ruled that it wasn't a violation of due process to commit NGRI defendants automatically and indefinitely, for the safety of the public, whether or not their sentence for the crime would have been lesser than their time spent in a psychiatric

facility. According to a 2017 survey conducted by the New York Times, NGRI acquittees are held for on average "...73 times as long as a person subject to civil commitment for the same mental illness (McClelland, 2017)." Contradictorily, some states have decided not to automatically commit insanity acquittees entirely, allowing researchers to evaluate the outcomes of this newly formed sentence. The Times (2017) reported that some states, like Tennessee for example, require a post-acquittal evaluation of dangerousness on an outpatient basis. Following this revision, only 55 percent of Tennessee's NGRI defendants are committed after acquittal, without any difference in recidivism.

Lack of Education

Lack of education could be a significant predictor as to why the general public fabricates this arbitrary idea that the insanity defense is used much too often and for an "easy way out". Hans and Slater (1983) conducted several phone interviews the week preceding the announcement of the NGRI verdict in the Hinckley v. United States case. Researchers asked participants if they could describe, in a few words, the *legal* definition of insanity. Over 70 percent of the sampled population gave an incorrect definition or did not know the *legal* definition of insanity. A minute percentage of those who participated could give a complete definition (.2%) and 29 percent were able to give a partial definition. Furthermore, not only were the numbers astonishingly high in terms of not knowing the actual definition of insanity, but they also did not have much confidence in the expert's testimonies either. Nearly half of the participants reported they either had no confidence at all (39.9%) or only slight confidence (19.6%) in the psychiatrist testimonies.

It appears that lack of education could be a potential factor as to why the public may hold these misconceptions about the insanity defense, but not all blame can be protruded to the lack of

purposeful research. Partial fault could be imparted to the lack of information that is shared with jurors in the courtroom in reference to the insanity defense. In Brown v. United States (2012), Korrigan Brown appealed his convictions arguing that the court did not allow him to share with the jury the consequences of an NGRI verdict. The court determined that the jury should not be instructed on the consequences of the verdict, as that is only allowed in certain circumstances. Brown argued that he fell within this category of "certain circumstances". An example of "certain circumstances" could be if during a trial there was a false misrepresentation of sentencing and in result, the jurors would then need to be informed of the error in which the judge would then clarify the proper sentencing (Gandhi & Prabhu, 2017). The appeals court determined that there was no significant error or statement that would have suggested that Brown would be released back into the public as a free man if found NGRI (Brown v. United States, 2012). Thus, there was no need to instruct the jury of the potential outcomes of the verdict. There were also several other previous cases the courts referred to similar to that of Brown v. United States to justify their ruling (Shannon v. United States, 1994; United States v. Thigpen, 1993).

Although no errors were made that required the jurors to be instructed of the consequences to an NGRI plea in the Brown v. United States (2012), it is likely, based on previous research, that the jurors did not understand the potential outcomes of the verdict due to underlying stigmatic perceptions of the insanity defense. Educating jurors could be of the utmost importance when a state has both the guilty but mentally ill (GBMI) and the NGRI verdict as potential defenses. Both verdicts include the diagnosis of mental illness, but the GBMI defendant is not acquitted of their crimes and is held with the same accountability as one who is considered sane. Additionally, their access to mental health services is minimal when compared to that of an NGRI defendant (Gandhi & Prabhu, 2017). A defendant who pleads NGRI is usually

institutionalized and receives treatment until a team of professionals finds them to no longer be of severe mental illness or harm to themselves or others. Instructing the jurors of these dissimilar outcomes may be reasonable in these circumstances to avoid jury biases.

Impact of jury instruction. In recent years, researchers have studied the impact of jury instruction and whether or not providing the outcomes of the potential verdict affects juror decision making. In a Canadian study, Maeder and Fenwick (2011) attempted to correct for jury bias by educating the participants (mock-jurors) on the NGRI plea to see if this would improve juror attitudes. When compared to the control group that received no education on NGRI, those who did receive instruction were significantly more positive. However, educating the participants did not affect the verdict outcome. Therefore, despite having a more positive outlook on the defense, they were still unlikely to find them NGRI (Maeder & Fenwick, 2011).

In a more recent study, Cotrone (2016) found similar results to that of Maeder and Fenwick (2011) - those who were educated on the consequences of the NGRI plea did have a more positive outlook in general. However, Cotrone (2016) explored both the NGRI and Guilty but Mentally Ill (GBMI) plea and found a main effect on verdict outcomes when jurors were informed of dispositional consequences. The main effect represented participants having more favorable attitudes towards the insanity defense, therefore increasing selection of an NGRI over a GBMI verdict while decreasing selection of a guilty verdict over a GBMI for those in the control group who did not receive any instruction. Cotrone (2016) explained why positive attitudes toward the insanity defense could make jurors more influenced by dispositional consequence information - "participants who were informed about the GBMI and NGRI verdict consequences became more aware of the stark differences between the two verdicts (p. 69)." Therefore, when participants were more accurately informed, they were able to recognize that the consequences of

the NGRI verdict are more aligned with their positive attitudes toward the insanity defense than

the consequences of the GBMI defense (Cotrone, 2016).

Jury Decision Making

A defendant is "innocent until proven guilty" and typically it is a jury of their peers who

is responsible for determining, beyond a reasonable doubt, their imminent fate. A jury is

typically a body of 12 people who are legally sworn to give a verdict in a legal case, based on

evidence provided in court and without any sympathy, prejudice, or fear (Maeder & Mossière,

2015). Before deliberation, jury members are given specific instructions by the judge to remain

impartial and to apply the law to the facts as he/she gives it to them; they are not to substitute

their judgment as to whether a different law should be applied and to keep their biases at bay

("Jury Instruction", 2019). However, it is unrealistic to assume that jurors can put to rest their

own previous life experiences, heuristics, biases, and stereotypes to reach an impartial verdict

since research has demonstrated that jury decision-making is much more complex.

Behavioral Decision Theory

Since the 1950s, the behavioral decision theory has been adopted by several disciplines

such as medicine, economics, political science, engineering, marketing, and mathematics, as well

as psychology (Payne, Bettman, & Johnson, 1992). The behavioral decision theory is a

descriptive psychological theory that offers insight into how an individual incorporates their own

beliefs and values into their decision-making process (Takemura, 2020). The decision-making

process is an important aspect of the behavioral decision theory and can be categorized into three

groups: under certainty, under risk, and under uncertainty which includes ambiguity and

ignorance (Takemura, 2014). The first category, under certainty, is a type of decision making

when the decision-maker knows with certainty all possible alternatives as well as the outcomes

associated with the alternative. Under risk is when the decision-maker is aware of the

probabilities of the various outcomes; and under uncertainty is when the outcome of the result of

selecting an alternative is not known by the decision-maker (Takemura, 2014).

When examining decision making in the context of a jury specifically, it appears that the

most appropriate category is under uncertainty. This grouping can be best supported by again

reviewing the absence of jury instruction. Currently, it is not required by law to instruct jurors of

the consequences/outcomes associated with insanity defense pleas (e.g, NGRI and GBMI). Thus,

in the context of the under uncertainty subgroup of decision making, the outcome (i.e.,

consequences for verdict outcome) of selecting an alternative (i.e., NGRI or GBMI) is unknown

by the decision-maker (i.e., juror). Jurors are expected to make a choice even though they lack

the information about the relevant probabilities and outcomes, which in turn, requires the

decision-maker to generate rationales and/or arguments that would then allow them to resolve

the conflict and decide between the alternatives (Hogarth & Kunreuther, 1995). This choice can

be defined as decision making under ignorance; one of the two sublevels associated with the

under uncertainty decision making phenomena category.

Defendant Demographics

Research has found that jurors can be influenced by several factors in a criminal court

case (Finkel & Sales, 1997; ForsterLee, Horowitz & King, 2006; Kutys, 2012). Influential

characteristics of the defendant that potentially could impact jury decision making include

gender (Davidson & Rosky, 2015), race (Poulson, 1990), attractiveness, and socioeconomic

status (Feingold & Mazzella, 1994). Correspondingly, mental illness could be another influential

defendant characteristic, based on societal stigma. Society's stigma towards mental illness,

particularly associating mental illness and dangerousness, creates a connection between mental

illness and criminality (Maeder & Mossière, 2015). Thus, generating a stereotype that will likely lead to a juror giving a guilty verdict to a defendant who has a mental illness more often than one who does not.

      Mental Illness. Reflecting back to the previous section on the insanity defense, it is clear there is an abundance of literature that explores society's perceptions and attitudes towards the insanity defense, but there is a gap in the research when it comes to addressing jurors' attitudes towards those diagnosed with a mental illness. Research has shown that labels and diagnostic classifications intensify stigma and creates this "differentness" between society and individuals diagnosed with mental illness (Corrigan, 2007). More specifically, there has been a strong stigma associated with individuals that are not only labeled as suffering from a mental illness but also labeled as an offender (Lamb & Weinberger, 1998). Furthermore, people with severe mental illness are commonly charged with more serious crimes than other non-mentally ill individuals who commit similar offenses (Tellier & Felizardo, 2011). As times have progressed, several lawmakers and legislators have acknowledged mental illness in the legal system and since have made attempts to better suit these individuals with mental illness with the development of Mental Health Courts, NGRI, and GBMI defenses (Mossière & Maeder, 2015). However, there is literature that suggests that negative attitudes towards the insanity defense are widespread amongst society and are strongly predictive of juror decision making in the case of an insanity claim (Hans and Slater, 1983; ABC News, 1982; Sabbagh, 2011).

      Several empirical studies have shown that labeling individuals diagnosed with a mental illness aids in promoting a more stigmatic perception towards that diagnosis. Specifically, there seems to be a strong stigma toward individuals diagnosed with schizophrenia. In a longitudinal study, Silton, Flannelly, Milstein, and Vaaler (2011) examined stigma in the United States,

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exploring the association between dangerousness and individuals diagnosed with mental illness. Four vignettes were used in the study, each displaying the different behaviors that are associated with a mental health "problem" (i.e., alcohol dependence, depression, schizophrenia, or minor problems). Findings from this study indicate participants perceived an individual presenting schizophrenic behavior as the most likely character to have a mental illness. Additionally, participants indicated they had a greater desire to distance themselves from the characters that were diagnosed with schizophrenia and substance abuse (alcoholism) (Silton et al., 2011). Angermeyer and Dietrich (2006), used a similar methodology and found that, in general, individuals experiencing behavior(s) associated with schizophrenia were labeled as having a mental illness (69-88%) more often than individuals displaying symptoms of depression (26-69%) or substance (alcohol) abuse disorder (16-49%).

The perceived link between dangerousness and mental illness is often most present with schizophrenia, but there is also a strong association with labeling individuals diagnosed with substance abuse disorder as dangerous and violent. Mossière and Maeder (2016) examined the association between jury decision making and mental illness type to see if mental health diagnosis had any effect on verdict outcome. Participants in this study were much harsher towards a defendant diagnosed with substance abuse disorder and overall were more likely to give a verdict of guilty rather than Not Criminally Responsible on Account of Mental Disorder (NCRMD) when compared to the other mental illness types (i.e., schizophrenia, bipolar disorder, and depression). Furthermore, the participants not only perceived the individual diagnosed with substance abuse disorder as guilty and dangerous, but they also perceived them as more in control, and capable of rational or logical behaviors, as well as more responsible for their actions (Mossière & Maeder, 2016).

A trend that appears fairly steady in this field of research is that individuals diagnosed with a substance abuse disorder are typically not recognized as having a mental illness, therefore the defendant is held fully accountable for their actions. Fenwick (2011), found that participants consistently viewed defendants with substance use disorder more negatively in comparison to defendants with schizophrenia, bipolar disorder, and depression. Jurors in this study also accredited a high degree of blame to defendants with substance use disorder. Furthermore, defendants with substance use disorder were less likely to be found NCRMD in comparison to defendants with schizophrenia, bipolar, and depression (Fenwick, 2011).

Gender. Criminal law research has typically found consistent results when it comes to gender influencing jury decision-making (McCoy & Gray, 2007; Pozzulo, et al., 2010; Maeder & Dempsey, 2013). Men are also considered to be strong and aggressive, whereas women are often perceived as more warm, nurturing, and kind (Prentice & Carraanza, 2002; Gupta, Turban, Wasti, & Sikdar, 2009). These perceptions of gender differences can often result in male defendants typically receiving harsher verdicts/sentencing when compared to women who commit similar crimes (Davidson & Rosky, 2014). However, when mental illness is brought into the equation, specifically gender-stereotypical mental illnesses, there appears to be a fluctuation of trends when it comes to the impact it has on jury decision making.

Wirth and Bodenhausen (2009) examined the role played by gender in moderating mental health stigma while specifically targeting gender-stereotypical mental disorders. The case vignettes used in the study were manipulated to reflect either a male defendant diagnosed with substance abuse disorder (alcoholism) or a female defendant diagnosed with depression. Additionally, the case included the defendants using insanity as a defense. Results were not as researchers expected; interestingly they found that when the characters were gender stereotype

consistent (e.g., male-alcoholism, female-depression) participants felt more negative, less sympathy, and less inclination to help when compared to non-gender-conforming diagnosis (e.g., male-depression, female-alcoholism). Researchers hypothesized that this inconsistent pattern could be due to the normality of these gender-stereotypical diagnoses, thus they are not perceived as a "true" mental disturbance and are considered a more "typical" behavior (Wirth & Bodenhausen, 2009). Wirth and Bodenhausen (2009) results also displayed other contradictory beliefs - female defendants were found guilty more often than men and considered to be more "responsible" for their actions, to have consciously known what they were doing at the time of the crime, and to have engaged in pre-mediation more so than men.

When studying the influence of mental illness on jury decision making, Mossière and Maeder (2016) also examined the role of gender and the impact it could potentially have on verdict/sentencing outcomes. Findings indicated that the gender of the defendant influenced participants' perceptions of internal attributions, and the perceived stability of criminal behaviors. More specifically, participants associated the female defendant's actions with her personality, and less due to societal or environmental factors. As for the male defendants, participants associated more stable attributions to his criminal behavior; he was more likely to commit a crime in the future and not likely to reform. However, despite these internal attributional differences, male defendants were not treated more harshly than female defendants which is contradictory to previous research (Mossière & Maeder, 2016).

Juror Demographics

Gender. Not only do defendants' demographics impact jury decision making, but research indicates juror demographics may also play an important role in determining a defendant's outcome. FosterLee and colleagues (2006), examined the effects of juror gender on

sentencing and information processing in the context of a murder trial and found profound differences amongst female and male mock jurors. Female jurors were more likely to elicit harsher punishment than male participants towards the Indigenous (Black) defendants. Specifically, when the trial transcripts indicated a mixed-race crime (i.e., white offender, black victim), female jurors displayed significantly more emotive responses than males, especially when the victim was black (FosterLee et al., 2006). Pozzulo and colleagues (2010) found similar results when comparing female and male jurors. Females, in particular, indicated higher responsibility to the defendant when compared to the male mock jurors who perceived the victim in the vignette to desire and cause the crime. Furthermore, female jurors identified victims as being higher on accuracy, truthfulness, and believability, while male jurors perceived the defendant higher on reliability, credibility, truthfulness, and believability (Pozzulo, et al., 2010).

Race. There is a breadth of literature surrounding the race of defendants as a factor contributing to jury decision making, however, there is a nominal amount of research recognizing the jurors' race as a potential factor that could influence verdict/sentencing outcomes. Some research focuses on the defendant's race and the impact it may have on jury decision making (Pozzulo, et al., 2010; Hunt, 2015); however, Bornstein and Rajki (1994) examined the jurors' race and how it may contribute to the decision-making process in a legal court case. Participants in this study who were identified as being a part of the "minority" group, were more likely to find the defendant liable for their crime than white participants. Furthermore, socioeconomic status (SES) was also a contributing factor to the extent that those who were

considered of the "minority" and low SES, considered the defendant responsible for their crimes more often than those of high SES and white (Bornstein & Rajki, 1994).

Age. In addition to gender and race, another common demographic, such as juror age, may also influence the jury decision-making process. In an attempt to identify juror bias in the case of psychopathy in a manslaughter case, Mossière and Dalby (2008) examined both defendant and juror demographics. Researchers wanted to examine whether or not the mock-jurors age played a role in verdict outcome. Particularly, researchers wanted to create a "young", "middle", and "old" age group and compare these specific groups to verdict/sentencing outcomes. The youngest age group proposed a guilty verdict and a sentence of probation more often than the older age group. Inversely, the middle and older age group was more likely than the youngest age group to give a verdict of not guilty, and the older age group was three times as likely than the younger age group to give a sentence of incarceration (Mossière & Dalby, 2008).

Current Study

When compared to the abundance of research that is published about stigmatic attitudes towards the insanity defense, there is a minimal amount of research that examines what could potentially reduce insanity stigma. Furthermore, little is known about what external factors, outside of the defendant's demographics, could impact the defendant's verdict/sentencing. *The purpose of this study was to examine mental health stigma in the case of an insanity defense while also exploring other factors, besides defendant demographics, that could induce negative perceptions and biases towards defendants displaying behaviors associated with mental illness.*

One factor in particular that appears to affect jury decision-making is juror gender, however, there is a minuscule amount of literature that is specific to biological sex. Therefore, for this study, researchers assessed mock juror's biological sex rather than gender in an attempt

to fill gaps in the literature, although, it is assumed, based on the time frame of previous studies, that previous researchers considered "gender" to be interchangeable with "biological sex". Additionally, little is known about how various mental illnesses in the courtroom directly affect verdict and sentencing length. Not only did this study make efforts to identify these negative attributes associated with a defendant claiming insanity, but it also explored possible effective methods to reduce such stigma within a courtroom setting. Specifically, educational instruction was examined to determine if instructing jury members of the consequences associated with NGRI and GBMI affected their stigmatic attitudes and verdict/sentencing outcomes. By examining juror attitudes towards the insanity defense and verdict/sentencing outcomes in conjunction with plea education, researchers were able to identify whether or not mental health stigma is of concern in the judicial system while bringing to light other areas of concern pertaining to the jury selection process.

<div align="center">

Hypotheses

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Hypothesis One

There will be a main effect of plea education (not guilty/guilty, NGRI, and GBMI) on insanity defense attitudes. Specifically, mock jurors who receive educational consequence instruction in reference to the guilty, NGRI, and GBMI plea will report more positive attitudes towards the insanity defense when compared to the group that receives no educational consequence instruction.

There will be a main effect of mock-juror biological sex on insanity defense attitudes. Research has shown that males more often than females place blame on the victim and are more favorable towards the defendant, whereas females commonly place the blame on the defendant and find the victim more credible and accurate (Pozzulo et al., 2010). Therefore, it is expected

male participants will be more favorable of the defendant and in result, comply with the defendant's insanity defense, ergo their attitudes towards the insanity defense will be more positive when compared to female participants.

There will be a main effect of the defendants' symptomatic mental health behaviors on insanity defense attitudes. Individuals with schizophrenia and substance abuse disorder are often perceived as dangerous, unpredictable, and violent when compared to individuals diagnosed with depression (Angermeyer & Dietrich, 2006). Furthermore, individuals experiencing symptoms associated with schizophrenia are labeled with having a mental illness more often than individuals displaying behaviors associated with substance abuse (Angermeyer & Dietrich, 2006). Therefore, it is expected that defendants displaying symptoms associated with schizophrenia will generate more negative attitudes towards the insanity defense in comparison to substance abuse disorder.

These previous main effects will qualify for a significant interaction between educational consequence instruction, mock-jurors biological sex, and defendant mental illness on insanity defense attitudes. It is expected that mock-jurors who identify as female, receive no educational consequence instruction, and are randomly assigned to trial transcript B in which the defendant is displaying symptoms of substance abuse disorder, will perceive the insanity defense in a more negative light. These findings are suspected due to the empirical research indicating female jurors tend to place more blame onto the defendant when compared to men who typically associate blame with the victim (Pozzulo, et al., 2010). Furthermore, individuals displaying symptoms of substance abuse disorder are generally perceived as being dangerous and in control of their behaviors, therefore, they are held more accountable for their actions (Mossière & Maeder, 2016; Silton et al., 2011).

Hypothesis Two

There will be a relationship between plea education (not guilty/guilty, NGRI, and GBMI) and verdict outcomes. Participants who receive the educational instruction will be more likely to find the defendant Not Guilty by Reason of Insanity (NGRI), whereas participants who receive no educational consequence instruction and are only given basic jury instruction before deliberation will be more likely to find the defendant guilty or Guilty but Mentally Ill (GBMI).

Hypothesis Three

There will be a relationship between mock-juror biological sex and verdict outcomes. Research often highlights defendant demographics and the impact these characteristics may have on defendant verdict outcomes, however, there is minimal evidence that supports the idea that the juror's sex may also play a significant role in the decision-making process. When examining juror sex, researchers have found that females are typically harsher than men when determining a verdict (FosterLee et al., 2006). Therefore, female participants are expected to give harsher verdict outcomes (e.g., guilty) when compared to male participants.

Hypothesis Four

There will be a relationship between the defendants' symptomatic mental health behaviors and verdict outcomes. Literature has shown that mock-jurors are more likely to give a verdict of guilty than Not Criminally Responsible on Account of Mental Disorder (NCRMD) when a defendant is diagnosed with a substance abuse disorder (Mossière & Maeder, 2016). Given the similarities between NGRI, GBMI, and NCRMD, researchers anticipate that mock-jurors will be more likely to hand down an NGRI or GBMI verdict when the defendant displays schizophrenic behaviors when compared to defendants who are experiencing symptoms of substance abuse disorder.

Hypothesis Five

Ho and Jaconelli (2019) found that participants in their study who had the most associations with mental illness (e.g., diagnosed with a mental illness and/or had a family member/friend who was diagnosed) held the fewest stigmatic cognitions towards mental health when compared to the other groups. Therefore, researchers expect that *participants who report that they themselves have been diagnosed with a mental illness will indicate more positive attitudes towards mental illness, in general when compared to individuals who have not been diagnosed with a mental illness.*

Hypothesis Six

There is an abundance of evidence-based literature that indicates individuals diagnosed with a mental illness are perceived as more dangerous and violent (Mossière & Maeder, 2016; Angermeyer & Dietrich, 2006; Stuart and Arboleda-Flórez (2001). However, that is not the case as the annual incidences of violent crime on those diagnosed with severe mental illness (168.2 incidents per 1000 persons) is more than four times higher when compared to the general population rates (Teplin et al., 2005). Therefore, it is expected that *participants who report that they themselves have been diagnosed with a mental illness will associate less dangerousness and fear towards others with mental illness when compared to individuals who have not been diagnosed with a mental illness.*

Methods

Recruitment

This study was implemented via Amazon Mechanical Turk (MTurk) - a virtual labor market that is utilized by social science researchers to recruit large pools of participants. "Workers" on MTurk complete online Human Intelligence Tasks (HITs) and receive some type

of monetary compensation for their participation. This study in particular would be considered an "external" HIT, meaning a link will be embedded into MTurk that will redirect the "Worker" to an online survey on an external site (e.g., Survey Monkey). More times than not, survey questions may elicit sensitive or personal information, or they may pose a greater than minimal risk to participants in the study. Therefore, MTurk is commonly utilized in the field since no identifiers can be linked to the data, either directly or through a coding system as long as a specific criterion is met (i.e., does not ask for ID number; no identifying indicators included on the survey; IP address is not collected by external site).

Participants

Participants in this study included 323 individuals, all of which were recruited via MTurk. Of these participants, there were 119 females, 201 males, and three that preferred not to say. To avoid sampling from protected populations, individuals under the age of 18 and above the age of 65 were excluded from the study. Participants' reported ages ranged from 22 to 65 with the mean age of the sample being 33.20 years. The sample was primarily Caucasian (N = 134), with 26 African American, 94 Asian/Pacific Islander, 45 Hispanic, and 17 Native American/Alaskan Native.

Procedures

When accessing MTurk, participants were able to see the available survey amongst other surveys. Participants selected the embedded link and were then taken to the recruiting script for the survey. At this time participants were given informed consent. They were instructed to print the informed consent for their records. The informed consent further stressed the voluntary nature of the project and the anonymity of responses. That is, individuals may choose not to participate or may leave the study at any time without penalty (other than that of not receiving

the small monetary compensation) by exiting the window. Furthermore, participants were provided with the contact information of all researchers involved and instructed to take this opportunity to reach out to researchers if they had any questions about the study or their rights as a participant. By continuing the survey past the consent form, participants indicated their voluntary willingness to participate in the study. At the end of the survey, participants were debriefed and thanked for their participation. Contact information for the faculty sponsor and principal investigator, as well as the Fort Hays State University ethics committee, and the National Alliance of Mental Illness (NAMI) hotline, were provided once again on the debriefing form.

To ensure participants' amenity is upheld, no names or identifying information were included in the survey. The survey questionnaire included demographic information about the participant, including their biological sex, age, race, ethnicity, whether or not they have ever been diagnosed with a mental illness, and if they know someone who has been diagnosed with a mental illness. A variety of scales assessing mental health stigma were utilized and adapted from while including self-constructed questions designed by the researchers. Stigma questions included information assessing attitudes toward community members with mental illness including, positive and negative attitudes towards those diagnosed with a mental illness, their treatment, perceived dangerousness, fearfulness, and community segregation. Participants were instructed on their role as a participant, meaning they are to perceive themselves as a "juror" for the remainder of the current study.

Participants were randomly assigned to one of two manipulated trial transcripts in which they were asked to examine it carefully. Defendant and victim demographics, details of the crime, setting, and a proposed plea remained consistent through both trial transcript A and B.

However, the abnormal behaviors displayed by the defendant were manipulated. In trial transcript A, the defendant was experiencing symptoms of schizophrenia, whereas, in trial transcript B, the defendant was presenting symptoms of substance abuse disorder. Participants were then randomly assigned to one of three educational consequence instruction groups - guilty/not guilty, NGRI, or GBMI. Participants were also given manipulation checks following the trial transcript and the education consequence instruction to ensure the vignette was read carefully and with intent. Furthermore, a scale measuring attitudes towards the insanity defense was utilized to examine participants' perceptions of the defense being highlighted in the study. One open-ended question was also included at the conclusion of the survey asking participants "Are there any outside factors that would have made you change your verdict outcome?" Survey participation took approximately 25 minutes to complete.

Materials

Demographic Questionnaire. Participants were asked to complete a demographic questionnaire assessing basic demographic information (e.g., biological sex, age, race, ethnicity, and education; Appendix A). Additionally, participants were asked to indicate whether or not they know someone that has been diagnosed with a mental illness and if they themselves have ever been diagnosed with a mental illness. Researchers also asked participants if they have ever served as a jury member in a criminal court case and if they themselves have ever been charged with a felony crime. Participants were given a "prefer not to say" option in case they felt uncomfortable disclosing this type of information.

Mental Illness Attitudes Measure. The Mental Illness Stigma Scale (MISS) was developed to address the limitations of previous mental illness attitudes measures (Day, Edgren, & Eshleman, 2007; Appendix B). Commonly, the scale is used to measure general mental health

attitudes as well as a few specific attitudes. The scale is compiled of 28 specific mental illness statements measured on a 7-point Likert-scale where 1 indicates the highest level of disagreement (completely disagree) and 7 indicates the highest level of agreement (completely agree). Furthermore, the scale includes seven subscales measuring attitudes and beliefs about mental illness including anxiety, relationship disruption, hygiene, visibility, treatability, professional efficacy, and recovery. High scores on anxiety, relationship distribution, hygiene, and visibility indicate more stigmatized attitudes, whereas high scores on the other three subscales indicate positive attitudes towards mental illness. The internal consistency of these subscales measured by Cronbach's alpha is relatively high ranging from .71 to .90.

Attribution Questionnaire (AQ-27). Participants completed one of three Attribution Questionnaires; the 27-times version (AQ-27) created by Corrigan (2003; Appendix C). The AQ-27 was developed based on attribution theory (Weiner, 1995) and is used to measure the nine stereotypes associated with individuals diagnosed with a mental illness: blame, anger, pity, help, dangerousness, fear, avoidance, segregation, and coercion. However, for the purpose of this study, only the scale items measuring dangerousness, fear, and segregation will be utilized. In terms of psychometric properties, Corrigan and colleagues (2004) administered the AQ-27 to 54 community college samples and found the test-retest reliability for the nine subscales to range from .55 (blame) to .87 (dangerousness), indicating the scale as a whole ranges from poor reliability to good reliability. Subscales indicative of poor reliability were not utilized in this study.

The AQ-27 provides a short vignette about an individual named "Harry"; a 30-year-old man diagnosed with schizophrenia. Following the vignette is when participants were instructed to read various stigmatizing statements indicating their level of agreement on the nine items

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(three per subscale) attributable to the three subscales derived from the AQ-27. Items were measured on a 9-point Likert type scale with 1 indicating "not at all" and 9 indicating "very much". An example of an item on the dangerousness subscale includes, "I would feel unsafe around Harry." and on the fearful subscale, "Harry would terrify me."

Trial Transcript. Participants were randomly assigned to read one of two trial transcripts in which the defendant is being charged with second-degree murder (Appendix D). One transcript exhibited the defendant as presenting with symptoms of schizophrenia, while the other presented the defendant as displaying symptoms of substance abuse. This particular vignette was chosen from a study conducted by Schlumper (2011) examining juror's pre-existing biases in cases utilizing the insanity defense. All aspects of the trial remained consistent with that of Schlumper (2011), other than the behaviors the defendant displayed throughout the transcript.

The trial transcript describes the case of a 28-year-old male, Jim Green, who is charged with the second-degree murder of Robert Wilson, a 30-year-old town local. Green and his lawyers entered a plea of NGRI. The details of the case include that Robert Wilson, the victim, was having a party at his apartment when he stepped out to run to the grocery store. When several hours passed, Robert's friends notified the police who eventually found Robert's body behind the grocery store. Police picked up the defendant, Jim Green blocks away from the crime. Several eyewitnesses reported seeing Green loitering the store around the time of the crime and several days before that. Additionally, Green was found with blood all over his hands and his prints were found on the murder weapon. At the trial, a court-appointed psychologist and psychiatrist testified in agreement that the defendant was seriously mentally ill and not likely to improve with treatment.

Juror Knowledge Measure. All participants were assessed for their knowledge of consequence outcomes for all verdict options in the study (Appendix E). These particular questions regarding NGRI and GBMI were chosen from a study conducted by Sloat and Frierson (2005) that examined juror knowledge and attitudes towards verdicts that accommodate for mental illness. One multiple-choice question for each verdict outcome was used to assess the participant's knowledge of immediate outcomes associated with these verdicts. Specifically, for NGRI, the correct verdict outcome is "the defendant goes to a psychiatric hospital and is then released to go home when he or she is no longer a danger to him or herself or others." Furthermore, the correct option for GBMI is "the defendant goes to a psychiatric hospital for treatment and is transferred to prison when stable enough to complete the sentence." Finally, participants were asked whether or not they believe jurors should be informed of these outcomes before deliberation.

Verdict Outcome. Based on the trial transcript, participants were instructed to choose one of the four verdict options: guilty, not guilty, NGRI, or GBMI (Appendix F). Additionally, participants were asked to rate how confident they are in their verdict decision on a scale of 1 to 10; 1=lowest level of confidence, 10=highest level of confidence. Furthermore, participants indicated whether or not they believed the defendant would re-offend if they were to be released back into the community.

Educational Consequence Instruction. Participants were randomly assigned to one of three groups for educational consequence instruction (Appendix G). Participants in the educated condition read an explanation of the consequences associated with NGRI and GBMI verdicts. Whereas participants randomly assigned to the third group (i.e., not guilty/guilty) received no

instruction besides that of what the judge in a regular court case would deliver prior to deliberation.

Insanity Defense Attitudes-Revised (IDA-R). Participants' attitudes towards the insanity defense were measured using an Insanity Defense Attitudes - Revised scale (IDA-R) (Skeem, Louden, & Evans, 2004; Appendix H). In their attempt to create a more valid and reliable measure, a series of three different studies were conducted with over 400 mock-jurors. Researchers were able to organize the findings from these studies into three different parts to aid in refining their modified version of the IDA scale. First, two key elements may underlie mock-jurors' attitudes toward the insanity defense: the extent to which mental illness correlates with criminal responsibility and punishment (strict liability) and the degree of perceived injustice and dangerousness associated with the case. Secondly, the IDA-R assesses these two elements with good internal consistency (Strict Liability, $\alpha = .80$; Perceived Injustice and Dangerousness, $\alpha = .90$) and is moderately a strong predictor of mock jurors' insanity case judgments. Finally, the utility of the IDA-R in capturing participants' attitudes toward the insanity defense may not be confined to one geographical jurisdiction and remains consistent even when facts of the case are manipulated (Skeem, Louden, & Evans, 2004).

The IDA-R scale assesses participants' beliefs about mental illness and criminal responsibility, in addition to perceptions of misuse in the case of an insanity defense. The revised version of the IDA consists of 19 core items and three general opinion items, all of which are measured on a 7-point Likert-scale with 1 indicating the highest level of disagreement (strongly disagree) and 7 indicating the highest level of agreement (strongly agree). As previously stated, the IDA-R is compiled of two key dimensions - Strict Liability and Perceived Injustice and Danger. The strict liability element relates to participants' perceptions of mental illness and the

impact it may have on criminal responsibility. The second dimension of Perceived Injustice and Danger examines the participant's perceptions of the use or misuse of the insanity defense and the potentiality of injustice occurring. For the purpose of this study, the IDA-R was utilized as a dependent variable to see whether participants' attitudes towards the insanity defense differed depending on the manipulation of three other variables (e.g., educational consequence instruction, juror biological sex, and defendant mental health behaviors).

Manipulation Check. Following the educational consequence instruction and the trial transcript, participants were asked to complete a manipulation check to ensure the consequence instruction and trial transcript were read thoroughly and with intent (Appendix I). Participants were asked a series of questions on the main points relating to verdict options: NGRI and GBMI. Furthermore, participants were asked to identify significant events that took place in the trial transcript like behaviors (indicative of mental illness) the defendant may have been engaging in, what crime had been committed, what happened to the victim, and so forth. When examining participants' responses to the manipulation checks, a majority (over half) of those who participated selected the correct response.

Results

Standard data cleaning procedures were utilized. The data were screened for missing data; for missing raw scores the average score was inserted in the place of the missing data. Participants who did not complete at least 10% of the survey were not used in the analyses. Examination of the histograms indicated that the distribution shapes for each of the variables were normally distributed; skewness and kurtosis were used as an additional measure of distribution. For several variables in the Insanity Defense Attitudes - Revised (IDA-R) and Mental Illness Stigma Scale (MISS), the skewness and kurtosis were slightly out of the

acceptable range of -1 to 1. To further examine this distribution, researchers multiplied the standard error for kurtosis/skewness by three and compared this standard error value to the original kurtosis/skewness score. The standard error score when multiplying by three was larger than the original kurtosis/skewness score, thus it was concluded that the scores for all variables were normally distributed. Furthermore, reliability for the IDA-R and MISS scales was assessed using Cronbach's alpha. It was determined that the items used to assess insanity defense attitudes possess acceptable reliability ($\alpha = .71$). Additionally, the items for the MISS scale were deemed as possessing strong reliability ($\alpha = .86$).

Factorial ANOVA

A between subjects 2x2x3 factorial ANOVA was conducted to test for Hypothesis seven. Three independent variables (A, mock-juror biological sex; B, defendants' symptomatic mental health behaviors; C, plea education) with two levels for variables A (male and female) and B (schizophrenia and substance abuse), and three levels for variable C (not guilty/guilty, GBMI, and NGRI) were tested to assess for differences in insanity defense attitudes. Results indicate a significant main effect of mock-juror biological sex [$F(1, 320) = 4.18$, $p = .04$, partial $\eta2 = .01$]. Participants who reported that their biological sex was female (N=119) scored higher on the insanity defense attitudes measure ($M = 4.55$) than males (N=201; $M = 4.42$), indicating females were more stigmatic towards the insanity defense than males. Moreover, there was no significant main effect found for plea education [$F(2, 320) = 1.87$, $p = .16$, partial $\eta2 = .01$] and defendants' symptomatic mental health behaviors [$F(1, 320) = .12$, $p = .73$, partial $\eta2 = .00$]. These main effects were not qualified by a significant interaction effect [$F(2, 320) = 2.19$, $p = .11$, partial $\eta2 = .01$].

Chi-Square

A 3x4 contingency chi-square was used to examine the relation between plea education (i.e., not guilty/guilty, NGRI, and GBMI) and verdict outcome. The relation between these variables was not significant [X^2 (6, 322) = 9.28, p = .16; see Figure 1]. Furthermore, two additional 2x4 contingency chi-squares were employed to examine biological sex (i.e., male and female) and verdict outcome, as well as defendant mental illness (i.e., schizophrenia and substance abuse disorder) and verdict outcome. The relation between mock-juror biological sex and verdict outcome was significant [X^2 (3, 319) = 12.82, p = .01; see Figure 2], indicating males were more likely than females to select a verdict of guilty. Moreover, when examining the relation between defendant mental illness and verdict outcome, there was no significance [X^2 (3, 322) = 1.67, p = .64; see Figure 3].

Independent Samples *t*-test

An independent samples *t*-test was performed to assess whether participants' mental health attitudes differed significantly for participants who reported being diagnosed with a mental illness (group 1) compared to those who are not diagnosed with a mental illness (group 2). It was hypothesized that group 1 would report less stigmatic attitudes towards mental health when compared to group 2. The assumption of homogeneity of variance was assessed by Levene's test, F = .94, p = .33. This indicated no significant violation of the equal variance assumption; therefore, the equal variances assumed version of the *t*-test was used. Participants' mental health attitudes differed significantly between the groups, t(305) = 2.56, p = .01. Mean mental health attitudes for the diagnosed group (M = 4.94, SD = .66) were higher than mean mental health attitudes for those who were not diagnosed with a mental illness (M = 4.75, SD =

.62). These results were contrary to that of our hypothesis, indicating those diagnosed with a mental illness were more stigmatic than those who were not diagnosed with a mental illness.

An independent samples *t*-test was performed to assess whether participants' perceptions of those being diagnosed with a mental illness are dangerous differed significantly for participants who reported being diagnosed with a mental illness (group 1) compared to those who are not diagnosed with a mental illness (group 2). It was hypothesized that group 1 would associate less dangerousness with those diagnosed with a mental illness when compared to group 2. The assumption of homogeneity of variance was assessed by Levene's test, $F = .58$, $p = .45$. This indicated no significant violation of the equal variance assumption; therefore, the equal variances assumed version of the *t*-test was used. Participants' mental health attitudes differed significantly between the groups, $t(305) = 3.26$, $p < .001$. Mean dangerousness for the diagnosed group ($M = 6.91$, $SD = 1.58$) was higher than mean dangerousness for those who were not diagnosed with a mental illness ($M = 6.28$, $SD = 1.73$). These results were contrary to that of our hypothesis, indicating those diagnosed with a mental illness associated more dangerousness with those diagnosed with a mental illness than those who were not diagnosed with a mental illness.

An independent samples *t*-test was also performed to assess whether participants' fearfulness of those diagnosed with a mental illness differed significantly for those who reported being diagnosed with a mental illness (group 1) compared to those who are not diagnosed with a mental illness (group 2). It was hypothesized that group 1 would be less fearful of those diagnosed with a mental illness when compared to group 2. The assumption of homogeneity of variance was assessed by Levene's test, $F = .04$, $p = .85$. This indicated no significant violation of the equal variance assumption; therefore, the equal variances assumed version of the *t*-test was used. Participants' mental health attitudes differed significantly between the groups, $t(305) =$

3.68, $p < .001$. Mean fearfulness for the diagnosed group ($M = 7.00$, $SD = 1.71$) was higher than mean fearfulness for those who were not diagnosed with a mental illness ($M = 6.28$, $SD = 1.68$). These results were contrary to that of our hypothesis, indicating those diagnosed with a mental illness were more fearful of those also diagnosed with a mental illness than those who were not diagnosed.

Exploratory Analysis

Since a majority of significant relationships occurred with mock-juror biological sex, researchers believed it would be of importance to further investigate other participant demographics and the impact they may have in the court of law due to the lack of research on juror characteristics. A chi-square test of independence was performed to examine the relation between mock-juror ethnicity and verdict outcome. The relation between these variables was significant [X^2 (15, 320) = 38.57, $p < .001$; see Figure 4], indicating those who reported they were Caucasian were more likely to select a verdict of guilty than all other ethnic groups. Furthermore, a chi-square analysis was used to examine participants' age, which was grouped into "young" (N=137), "middle" (N=110), and "older" (N=68) groups, in relation to verdict outcomes. Researchers found no statistically significant results amongst the age groups and participants selected verdict outcome [X^2 (6, 315) = 10.70, $p = .10$; see Figure 5].

An independent samples t-test was performed to assess whether participants' insanity defense attitudes differed significantly between those diagnosed with a mental illness (group 1) and those who are not diagnosed with a mental illness (group 2). The assumption of homogeneity of variance was assessed by Levene's test, $F = 1.58$, $p = .21$. This indicated no significant violation of the equal variance assumption; therefore, the equal variances assumed version of the t-test was used. Participants' insanity defense attitudes differed significantly between the groups,

$t(305) = 2.47$, $p = .01$. Mean for insanity defense attitudes for the diagnosed group ($M = 4.57$, $SD = .44$) was higher than mean insanity defense attitudes for those who were not diagnosed with a mental illness ($M = 4.42$, $SD = .59$), indicating those diagnosed with a mental illness were more stigmatic towards the insanity defense than those not diagnosed with a mental illness.

An additional chi-square test of independence was performed to examine the relationship between participants' perception of the defendant reoffending and verdict outcome. The relation between these variables was significant [X^2 (3, 317) = 8.11, $p = .04$; see Figure 6], indicating those who believed the defendant would re-offend (N = 274) were more likely to find the defendant guilty when compared to those who believed the defendant would not re-offend (N = 43).

Finally, researchers examined mock-jurors current knowledge of dispositional outcomes relating to NGRI and GBMI. When reviewing the participant's knowledge relating to the consequences associated with NGRI only 16.4% of participants (N=53) selected the correct response (i.e., the defendant goes to a psychiatric hospital and is then released to go home when he or she is no longer a danger to him or herself or others). However, when participants were asked their knowledge pertaining to the consequences of GBMI nearly half of the participants (47.4%; N=153) selected the correct response (i.e., the defendant goes to a psychiatric hospital for treatment and is transferred to prison when stable enough to complete the sentence). The correct dispositional outcome for GBMI was also the most frequent choice selected by participants when they were asked about the consequences for NGRI (N=124). To examine these findings further, researchers performed a chi-square test of independence to assess whether or not prior juror knowledge impacted the verdict outcome. The relation between these variables was significant [X^2 (9, 316) = 29.36, $p < .001$; see Figure 7], indicating participants who selected

the correct dispositional outcome for GBMI were more likely to select that verdict outcome over all other verdict outcome options.

Discussion

The findings from this study indicate that several juror demographics, as well as personal beliefs, do impact verdict outcomes. Contrary to that of previous research, males in this study were more likely than females to elicit harsher punishment upon the defendant (see FosterLee et al., 2006; Pozzulo, et al., 2010). These findings could be explained by the type of crime presented to participants. Participants in this study were exposed to a random, male-on-male crime that included a fatal stabbing and a defendant suffering from mental illness, whereas a majority of research regarding gender/sex influencing verdict outcomes focuses on sexual assault crimes (FosterLee et al., 2006; Villemur & Hyde, 1983). By utilizing a trial transcript in which the crime was not sexually driven, researchers were able to fill a gap in the literature while illuminating how the act of the crime also influences verdict outcome, when incorporating gender/sex.

Similar to that of gender/sex there appears to be a breadth of literature examining the impact of ethnicity/race on verdict outcomes. Researchers in this study found that participants who identified as Caucasian were more likely to select a guilty verdict than all other ethnic groups. Moreover, those who reported they were Hispanic were more likely to choose Guilty but Mentally Ill (GBMI) over all other verdict outcomes. Research shows that the Hispanic population is typically stigmatic towards those diagnosed with a mental illness (Collado et al., 2019), however, based on the results from this study, our Hispanic sample overwhelmingly chose a verdict outcome accommodating for mental illness in which the dispositional outcome would be the defendant receiving mental health treatment. These findings show promising potential in

destigmatizing mental illness in the Hispanic community and pave the road for future research.

This study demonstrates it would be beneficial to have a set of jury members from diverse backgrounds, however, when looking at states/communities that are predominantly Caucasian, like that of many midwestern states, there is a strong likelihood of a dominantly white jury in the court of law. Thus, there should be a greater effort made to create diverse juries in terms of ethnicity and sex based on the variability in verdict outcome choices in this study. Furthermore, this selectiveness in the jury selection process also benefits both the prosecution and defense based not only on the diversity in verdict outcomes by ethnicity and sex, but insanity defense attitudes as well since females were more stigmatic towards the insanity defense when compared to males.

Although no significance was found pertaining to jury instruction and verdict outcomes, it appears that the more knowledge one has on a particular defense the more likely one is to select it. Specifically, participants who selected the correct dispositional outcome for GBMI were more likely to select that verdict outcome over all other options, thus supporting the idea that an overall understanding of the consequences associated with the verdict may be a predictor of the juror's verdict outcome choice. However, these results were not reciprocated when examining NGRI as only 53 participants selected the correct dispositional outcome for the insanity defense and 124 incorrectly chose the other verdict option, GBMI. This uncertainty between verdict outcomes could be due to several factors such as the prevalence of each verdict outcome in participant's own state/community, personal exposure to one plea over the other, and whether or not they received the educational jury instruction to GBMI, NGRI, or no insanity defense plea instruction at all. Additionally, although GBMI and NGRI are different when evaluating dispositional outcomes, some similarities between the two could have confused participants. If

convicted of GBMI or NGRI the defendant will go to a psychiatric hospital to receive treatment

for their illness, however, the dissimilarity between the two lies in the area of post-treatment. If

found GBMI, the defendant will be sent back to prison to finish their sentence following

treatment, whereas, if the defendant is found to be NGRI, they are released back into the

community when he or she is no longer a danger to him or herself or others.

Atypical to that of previous research (Ho & Jaconelli, 2019), researchers in this study

found that those who were diagnosed with a mental illness were more stigmatic towards those

with mental illness and endorsed stigmatic traits associated with mental health such as

dangerousness and fearfulness when compared to those not diagnosed. Although this contradicts

literature in the field of mental health stigma, this finding can be explained best by the self-

stigma phenomena. Self-stigma occurs when individuals diagnosed with a mental illness

internalizes the public's negative attitudes towards mental health and in result, suffer numerous

negative consequences (Corrigan & Rao, 2012). It is possible the participants in this study were

internalizing those typical negative features like dangerousness and fearfulness, thus resulting in

themselves being stigmatic towards others suffering from mental illness. However, when

examining the means in both groups one and two, the values were in close proximity of one

another and the effect sizes were minute, suggesting the true difference between the two is

minimal, thus, these findings should be interpreted with caution due to practicality. To provide

support regarding the inference self-stigma influenced these results, future research should

include a scale measuring self-stigma to account for this potentially confounding variable.

Limitations

When examining the influence of mock-juror biological sex, plea education, and

defendant mental illness (i.e., trial transcript A and B) on insanity defense attitudes researchers

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were not able to support their hypothesis with a significant interaction effect. This could be due to several factors surrounding the sample of this study and methodology. Manipulation checks were utilized in this study and although over half of the participants responded correctly to the checks, there were still a significant number of participants that responded incorrectly that were not excluded from the study. Due to the sample size, these participants were not excluded to ensure there was an appropriate number of participants per each condition. Thus, a finding of no significance could be attributed to participants not fully reading the trial transcripts and jury instruction in which they were assigned.

Several elements relative to the methodology of this study could be considered as limitations while also providing insight into areas of improvement for further research. The trial transcript utilized in this study was derived from a previous study (Schlumper, 2011), however, researchers adapted the transcript to suit the objectives of this study, thus the validity and reliability of both transcript A and B are unknown. However, researchers were able to fill a gap in the literature by utilizing a male-on-male crime that included a close contact murder, whereas research typically narrows in on sexually based crimes involving a male defendant and female victim. The crime in the trial transcript was also random, thus if the crime was more targeted or discriminatory based, results could vary and provide further important implications in the field of jury decision making. Moreover, participants completed the survey via the internet, however, it may be more beneficial to implement the survey face-to-face and provide oral readings of the transcripts and plea education to ensure participants absorbed the information. Due to the 2020/21 pandemic, this survey procedure was not feasible. By conducting the survey face-to-face with participants, researchers would be able to control for the participants potentially skipping over reading material as they easily could in an internet setting.

This study was targeted more towards juror demographics rather than defendant demographics, however, if researchers were to include more defendant demographics it is likely the outcome would be different. Previous research has shown that defendant demographics such as race, gender, and labeled mental health diagnosis influence verdict choice (Finkel & Sales, 1997; ForsterLee, Horowitz & King, 2006; Mossière & Maeder, 2016; Silton et al., 2011). Although researchers in this study implicitly included the diagnosis of schizophrenia and substance abuse disorder, labeling the defendant's diagnosis explicitly may yield different results. Therefore, it may be beneficial for future researchers to include not only mock-juror demographics but also the defendants.

This study was also limited in terms of the insanity defense pleas used - Guilty but Mentally Ill (GBMI) and Not Guilty by Reason of Insanity (NGRI). Other appendages to the insanity defense include Not Criminally Responsible by Reason of Mental Disorder, diminished capacity, and *Mens Rea* which is typically utilized in states where the insanity defense has been abolished. Researchers chose to utilize GBMI and NGRI due to the stigma typically associated with these pleas and their prevalence. However, future research may benefit from including these other pleas in conjunction with plea education of such appendages.

Despite these limitations, these results still provide important implications for the judicial system as well as mental health stigma. When jurors are selected, the judge as well as the prosecutor and defense attorney go about a process known as voir dire where potential jurors are questioned to determine their suitability to serve on the jury. Typically, questions are targeted towards ensuring the juror will remain objective throughout the trial. Based on results from this study, we can see factors like juror demographics and personal beliefs regarding recidivism, as well as insanity defense attitudes, impact verdict outcome choices and should not be ignored by

judges and attorneys. Moreover, results from this study shed insight on understanding the role of self-stigma and how that may impact someone's perception of mental health as well as their judgment when they themselves are diagnosed with a mental illness. Future research should strive to build a more defined connection between self-stigma and the impact it may have in the judicial court system or more specifically, those who serve on a jury.

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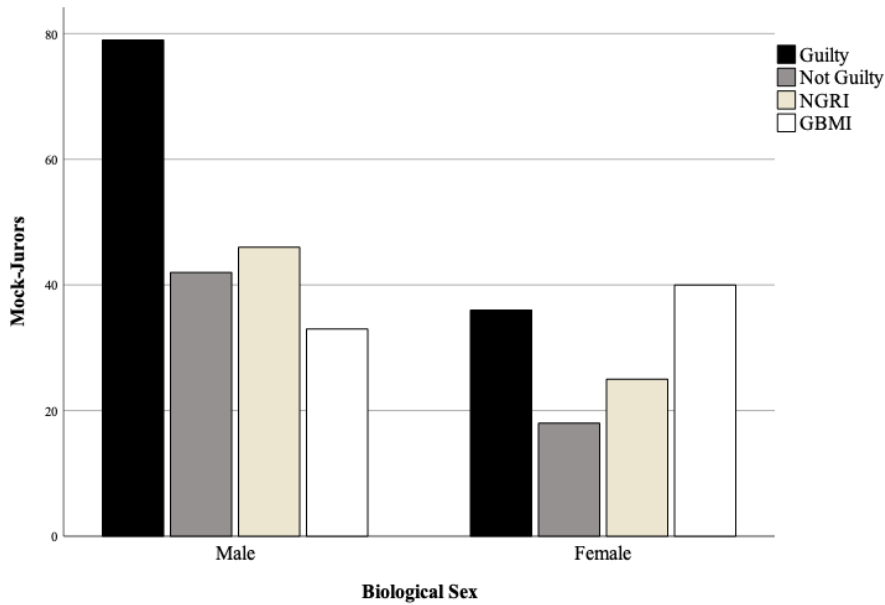University Press, 1*.

Figure 1

1 The relation between plea education (i.e., not guilty/guilty, NGRI, and GBMI) and mock-jurors verdict outcome choice.
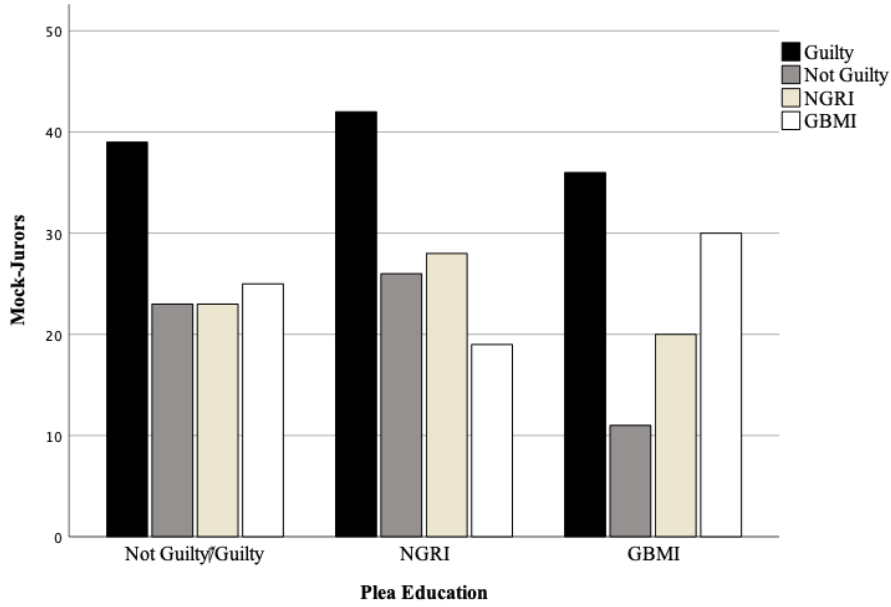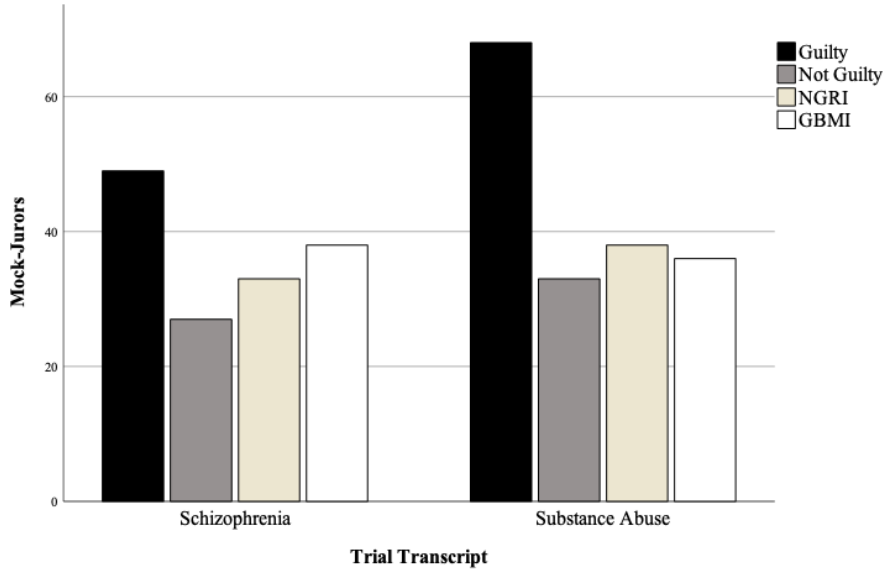

Figure 2

2 The relation between mock-juror biological sex and verdict outcome choice.
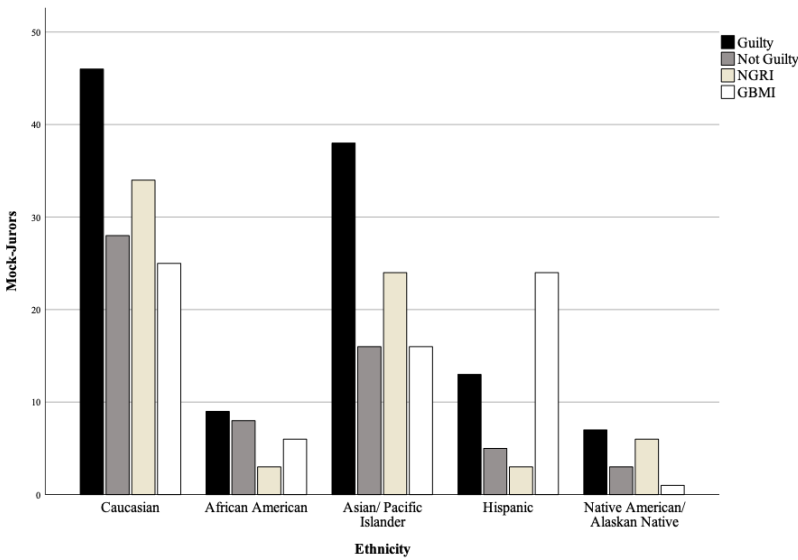
Figure 3

3 The relation between trial transcript and mock-jurors verdict outcome choice.

Figure 4

4 The relation between mock-juror ethnicity and verdict outcome choice.

Figure 5

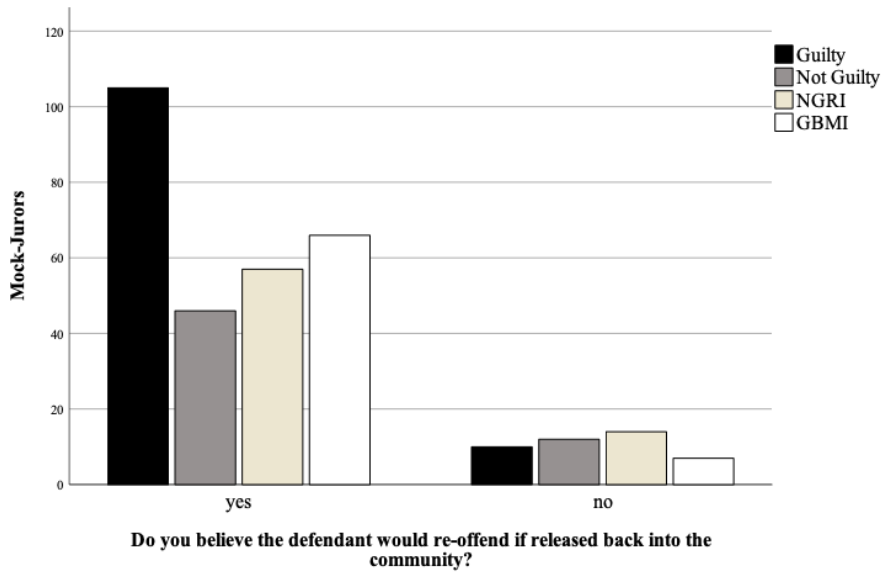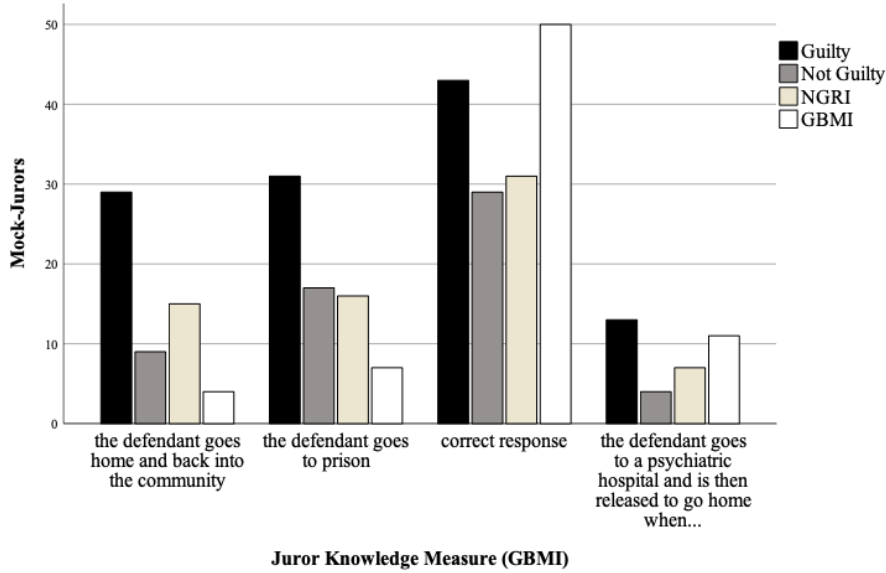*5 The relation between participants age group and verdict outcome choice.*
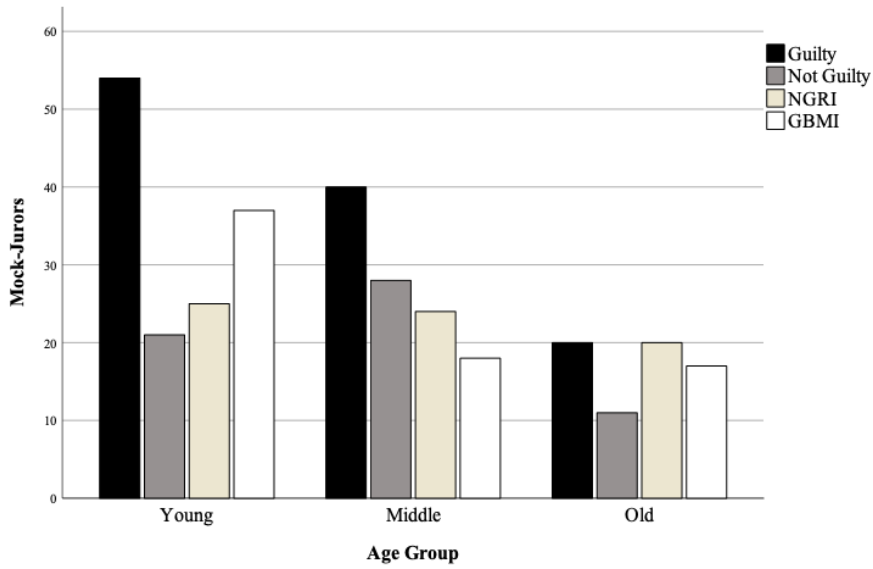
Figure 6

6 The relation between mock-jurors perception of defendant recidivism and verdict outcome choice.

Figure 7

7 The relation between participants perceived knowledge of dispositional outcome of verdict outcome choices and chosen verdict outcome for defendant.

Appendix A - Demographic Questionnaire

1. Biological Sex
1 - Male
2 - Female
3 - Prefer not to say

2. Age _____

3. Ethnicity
1 - Caucasian
2 - African American
3 - Asian/Pacific Islander
4 - Hispanic
5 - Native American/Alaskan Native
6 - Other _____

4. What is your highest level of education?
1 - No schooling completed
2 - Some high school, no diploma
3 - High school graduate, diploma or the equivalent (e.g., GED)
4 - Some college credit, no degree
5 - Trade/technical/vocational training
6 - Associate degree
7 - Bachelor's degree
8 - Graduate Degree (e.g., Masters, Ph.D., PsyD)

5. Have you ever been charged with a felony?
1 - Yes
2 - No
3 - Prefer not to say

6. Have you ever served as a jury member in a criminal case?
1 - Yes
2 - No
3 - Prefer not to say

7. Have you ever been diagnosed with a mental illness?
1 - Yes

2 - No

3 - Prefer not to say

8. Has someone close to you ever been diagnosed with a mental illness?

1 - Yes

2 - No

3 - Prefer not to say

Appendix B - Mental Illness Attitudes Measure

Please indicate the extent to which you agree or disagree with the statements listed below using the following scale:

1	2	3	4	5	6	7

Completely   Neutral   Completely
Disagree   Agree

1. There are effective medications for mental illnesses that allow people to return to normal and productive lives.

2. I don't think that it is possible to have a normal relationship with someone with a mental illness.

3. I would find it difficult to trust someone with a mental illness.

4. People with mental illnesses tend to neglect their appearance.

5. It would be difficult to have a close meaningful relationship with someone with a mental illness.

6. I feel anxious and uncomfortable when I'm around someone with a mental illness.

7. It is easy for me to recognize the symptoms of mental illnesses.

8. There are no effective treatments for mental illnesses.

9. I probably wouldn't know that someone has a mental illness unless I was told.

10. A close relationship with someone with a mental illness would be like living on an emotional roller coaster.

11. There is little that can be done to control the symptoms of mental illness.

12. I think that a personal relationship with someone with a mental illness would be too demanding.

13. Once someone develops a mental illness, he or she will never be able to fully recover from it.

14. People with mental illnesses ignore their hygiene such as bathing and using deodorant.

15. Mental illnesses prevent people from having normal relationships with others.

16. I tend to feel anxious and nervous when I am around someone with a mental illness.

17. When talking with someone with a mental illness, I worry that I might say something that will upset him or her.

18. I can tell that someone has a mental illness by the way he or she acts.

19. People with mental illnesses do not groom themselves properly.

20. People with mental illnesses will remain ill for the rest of their lives.

21. I don't think that I can really relax and be myself when I'm around someone with a mental illness.

22. When I am around someone with a mental illness I worry that he or she might harm me physically.

23. Psychiatrists and psychologists have the knowledge and skills needed to effectively treat mental illnesses.

24. I would feel unsure about what to say or do if I were around someone with a mental illness.

25. I feel nervous and uneasy when I'm near someone with a mental illness.

26. I can tell that someone has a mental illness by the way he or she talks.

27. People with mental illnesses need to take better care of their grooming (bathe, clean teeth, use deodorant).

28. Mental health professionals, such as psychiatrists and psychologists, can provide effective treatments for mental illnesses.

Appendix C - Attribution Questionnaire (AQ-27)

PLEASE READ THE FOLLOWING STATEMENT ABOUT HARRY:

"Harry is a 30 year-old single man with schizophrenia. Sometimes he hears voices and becomes upset. He lives alone in an apartment and works as a clerk at a large law firm. He has been hospitalized six times because of his illness."

NOW ANSWER EACH OF THE FOLLOWING QUESTIONS ABOUT HARRY.

CIRCLE THE NUMBER OF THE BEST ANSWER TO EACH QUESTION.

1	2	3	4	5	6	7	8	9

Not at   Very

all   much

DANGEROUSNESS:

2. I would feel unsafe around Harry.

13. How dangerous would you feel Harry is?

18. I would feel threatened by Harry.

FEAR:

3. Harry would terrify me.

19. How scared of Harry would you feel?

24. How frightened of Harry would you feel?

SEGREGATION:

6. I think Harry poses a risk to his neighbors unless he is hospitalized.

15. I think it would be best for Harry's community if he were put away in a psychiatric hospital.

17. How much do you think an asylum, where Harry can be kept away from his neighbors, is the best place for him.

Appendix D - Trial Transcripts

<u>Trial Transcript A:</u>
The defendant, Jim Green, has been charged with second-degree murder and has entered a plea of NOT GUILTY BY REASON OF INSANITY.

Robert Wilson, age 30, often walked to Stevenson's Grocery Store, which was across the street from his apartment building. One evening, he had a few of his friends over to watch a football game on TV. He offered to go to the store to get some snacks and beverages but had not returned after several hours. One of his friends, Andrew, decided to go to the store himself to check if Robert was still there. Not finding him, he returned to Robert's apartment and called the police, who found Robert's body behind the store. The medical examiner confirmed that the victim had died as a result of being stabbed twice in the back. A knife found at the scene was confirmed to be the murder weapon. On the knife, the police found fingerprints, which matched those of Jim Green, who was picked up a block away from the store.

28-year-old Jim Green was identified by the store clerk as having loitered around the store's parking lot for the past few days. The store clerk indicated that Green had been pacing back and forth in the parking lot and had appeared to be "arguing with himself" and "yelling at someone that wasn't there" about two hours before the crime. Furthermore, Green had come into the store that morning and when checking out seemed to have disorganized and incoherent speech patterns. The police had initially only wanted to question him but decided to fingerprint him after the store clerk stated that Jim had left the area shortly after the victim did. Upon further inspection, the police noticed that he had blood on his hands. Additionally, two eyewitnesses stated that they saw Green wandering in the store's parking lot and then leave abruptly just after the victim left the store.

Two experienced mental health professionals (a psychologist and a psychiatrist) were appointed by the court to examine the defendant. These professionals' reports and testimony were in agreement and indicated that the defendant was seriously mentally ill and not likely to improve with treatment. They testified that the defendant showed that he didn't know right from wrong and was not capable of understanding the harmful consequences of his actions. They also stated that the defendant did not know what he was doing at the time he committed the crime, and still wasn't sure that he had committed it at all and believed that the victim was "the man from the closet" and that the killing was in self-defense. The convenience store clerk testified that he had actually hired the defendant to clean the store's parking lot, which was part of the clerk's duties but had changed his mind when the defendant had started harassing customers. The defendant's uncle testified that Green had been staying with him for the past two weeks since moving to town. The defendant's uncle also stated that Green had confided in him that he thought people were out to get him and that he often felt the need to protect himself. The uncle testified that he attributed the defendant's frequent episodes of bizarre behavior to hallucinations and delusions as he would often find Green "talking to his closet" and "laughing at nothing while moving his eyes around the room as if he was being told to look at something by someone." The

uncle was not aware that for the past several years, Green had been in and out of mental hospitals where he was treated for mental illness. His medical records indicated several hospital admissions where Green was given medication, which improved his condition only briefly. Once he was released, his problems seemed too much for him to control, even while he was medicated. At times during the trial, the defendant showed strange mood swings and appeared to argue with his lawyers. Green and his lawyers entered a plea of Not Guilty by Reason of Insanity.

<u>Trial Transcript B:</u>
The defendant, Jim Green, has been charged with second-degree murder and has entered a plea of NOT GUILTY BY REASON OF INSANITY.

Robert Wilson, age 30, often walked to Stevenson's Grocery Store, which was across the street from his apartment building. One evening, he had a few of his friends over to watch a football game on TV. He offered to go to the store to get some snacks and beverages but had not returned after several hours. One of his friends, Andrew, decided to go to the store himself to check if Robert was still there. Not finding him, he returned to Robert's apartment and called the police, who found Robert's body behind the store. The medical examiner confirmed that the victim had died as a result of being stabbed twice in the back. A knife found at the scene was confirmed to be the murder weapon. On the knife, the police found fingerprints, which matched those of Jim Green, who was picked up a block away from the store.

Jim Green was identified by the store clerk as having loitered around the store's parking lot for the past few days. The store clerk indicated that Green had appeared "drunk" every evening "stumbling around the parking lot" acting "disoriented". Furthermore, the store clerk said Green was a frequent customer and would come in daily to purchase hard liquor. Police also have had several instances in which they have had to remove Green from local bars due to situations in which he was being physically hazardous. The police had initially only wanted to question him but decided to fingerprint him after the store clerk stated that Green had left the area shortly after the victim did. Upon further inspection, the police noticed that he had blood on his hands. Additionally, two eyewitnesses stated that they saw Green wandering in the store's parking lot and then leave abruptly just after the victim left the store.

Two experienced mental health professionals (a psychologist and a psychiatrist) were appointed by the court to examine the defendant. These professionals' reports and testimony were in agreement and indicated that the defendant was seriously mentally ill and not likely to improve with treatment. They testified that the defendant showed that he was impaired and didn't know right from wrong and at the time was not capable of understanding the harmful consequences of his actions. They also stated that the defendant did not know what he was doing at the time he committed the crime, and still wasn't sure that he had committed it at all and believed that the victim was probably threatening him in some way and that the killing was in self-defense, or that the police were just making up the crime to put him away since they have dealt with him multiple times prior to this event. The convenience store clerk testified that he had

actually hired the defendant to clean the store's parking lot, which was part of the clerk's duties but had changed his mind when the defendant had started harassing customers and drinking on the job. The defendant's uncle testified that Green had been staying with him for the past two weeks since moving to town. The defendant's uncle also stated that Green had confided in him that he had lost his last couple of jobs because of his drinking and seemed to be very upset about the situation, especially when he was drinking. The uncle testified that he attributed the defendant's frequent episodes of bizarre behavior to alcohol use. The uncle was not aware that for the past several years, Green had been in and out of rehabilitation centers where he was treated for substance abuse. His medical records indicated several hospital/rehabilitation admissions where Green participated in several interventions, which improved his condition only briefly. Once he was released, his problems seemed too much for him to control. At times during the trial, the defendant showed strange mood swings and appeared to argue with his lawyers.

Appendix E - Juror Knowledge Measure

What do you think the dispositional outcome of NGRI is?
(1) the defendant goes home and back into the community
(2) the defendant goes to prison
(3) the defendant goes to a psychiatric hospital for treatment and is transferred to prison when stable enough to complete the sentence
(4) the defendant goes to a psychiatric hospital and is then released to go home when he or she is no longer a danger to him or herself or others (correct response for NGRI).

What do you think is the dispositional outcome of GBMI?
(1) the defendant goes home
(2) the defendant goes to prison
(3) the defendant goes to a psychiatric hospital for treatment and is transferred to prison when stable enough to complete the sentence (correct response for GBMI)
(4) the defendant goes to a psychiatric hospital and is then released to go home when he or she is no longer a danger to him or herself or others.

Do you believe that jurors should be informed of the outcome of these verdicts prior to deliberation?
1 - Yes
2 - No

Appendix F - Verdict Outcome

Based on the information given, what verdict would you choose in the case of the defendant who is being charged with second-degree murder?
1 - Guilty
2 - Not Guilty
3 - Not Guilty by Reason of Insanity (NGRI)
4 - Guilty but Mentally Ill (GBMI)

On a scale of 1 (not at all) to 10 (very), how confident are you in your verdict decision?

1	2	3	4	5	6	7	8	9	10
Not at all confident				Neutral					Very Confident

Do you believe the defendant would re-offend if released back into the community?
1 - Yes
2 - No

Are there any outside factors that would have made you change your verdict outcome?
_____

Appendix G - Educational Consequence Instruction

Not Guilty/Guilty Instruction:
"In your deliberations, your duty is to apply (the Court's) (my) instructions of law to the evidence that you have seen and heard in the courtroom. You are not allowed to look at, read, consult, or use any material of any kind, including any newspapers, magazines, television and radio broadcasts, dictionaries, medical, scientific, technical, religious, or law books or materials, or the Internet in connection with your jury service. I want to emphasize that you must not seek or receive any information about this case from the Internet, which includes all social networking, Google, Wikipedia, blogs, and any other website. You are not allowed to do any research of any kind about this case. Do not use any information from any other source concerning the facts or the law applicable to this case other than the evidence presented and the instructions that I give you. Do not do your own investigation about this case."

NGRI Instruction:
**Insert "not guilty/guilty" instruction

"Not Guilty by Reason of Insanity indicates that the defendant had a mental illness that prevented him or her from understanding that what he or she did was wrong. Should you find the defendant not guilty by reason of insanity at the time of the crime, the defendant will be committed to a state mental health facility until such time, if ever, that the court is satisfied that he should be released pursuant to law."

GBMI Instruction:
**Insert "not guilty/guilty" instruction

"Guilty but Mentally Ill indicates that the defendant had a mental illness that prevented him or her from controlling his or her actions according to the law. Should you find the defendant guilty but mentally ill at the time of the crime, the defendant will be confined to prison to serve their sentence. The court will then determine whether and to what extent the defendant requires treatment for mental illness, if at all. When, and if, the defendant's mental illness is deemed to have been stabilized, the offender is required to serve out the rest of his/her sentence."

Appendix H - Insanity Defense Attitudes - Revised

Please indicate the extent to which you agree or disagree with the statements listed below using the following scale:

1	2	3	4	5	6	7
Strongly Disagree			Neutral			Strongly Agree

1. I believe that people should be held responsible for their actions no matter what their mental condition.

2. I believe that all human beings know what they are doing and have the power to control themselves.

3. The insanity defense threatens public safety by telling criminals that they can get away with a crime if they come up with a good story about why they did it.

4. I believe that mental illness can impair people's ability to make logical choices and control themselves.

5. A defendant's degree of insanity is irrelevant: if he commits the crime, then he should do the time.

6. The insanity defense returns disturbed, dangerous people to the streets.

7. Mentally ill defendants who plead insanity have failed to exert enough willpower to behave properly like the rest of us. So, they should be punished for their crimes like everyone else.

8. As a last resort, defense attorneys will encourage their clients to act strangely and lie through their teeth in order to appear "insane."

9. Perfectly sane killers can get away with their crimes by hiring high-priced lawyers and experts who misuse the insanity defense.

10. The insanity plea is a loophole in the law that allows too many guilty people to escape punishment.

11. We should punish people who commit criminal acts, regardless of their degree of mental disturbance.

12. It is wrong to punish people who commit crime for crazy reasons while gripped by uncontrollable hallucinations or delusions.

13. Most defendants who use the insanity defense are truly mentally ill, not fakers.

14. Some people with severe mental illness are out of touch with reality and do not understand that their acts are wrong. These people cannot be blamed and do not deserve to be punished.

15. Many of the crazy criminals that psychiatrists see fit to return to the streets go on to kill again.

16. With slick attorneys and a sad story, any criminal can use the insanity defense to finagle his way to freedom.

17. It is wrong to punish someone for an act they commit because of any uncontrollable illness, whether it be epilepsy or mental illness.

18. I believe that we should punish a person for a criminal act only if he understood the act as evil and then freely chose to do it.

19. For the right price, psychiatrists will probably manufacture a "mental illness" for any criminal to convince the jury that he is insane.

1	2	3	4	5	6	7
Not at All			Neutral			Very Much

20. How strongly do you feel about the insanity defense?

21. How personally important is your opinion on the insanity defense?

22. How much do you care about the insanity defense?

Appendix I - Manipulation Check

Insert following "Educational Consequence Instruction" for NGRI/GBMI:

What will happen if the defendant is found to be *(NGRI/GBMI)*?
1 - the defendant will be acquitted of all charges and released back into the community
2 - the defendant will be committed to a state mental health facility until such time, if ever, that the court is satisfied that he should be released pursuant to law. *(the correct answer for NGRI)*
3 - the defendant will be confined to solitary confinement
4 - the defendant will then be sent to a psychiatric hospital for treatment and transferred to prison when deemed stable enough to complete the sentence. *(the correct answer for GBMI)*

Insert following "Trial Transcript":

What is one of the behaviors/symptoms the defendant was displaying in the trial transcript?
1 - Rapid Speech
2 - Hallucinations *(the correct answer for transcript A)*
3 - Excessive Drinking *(the correct answer for Transcript B)*
4 - Profusely Sweating

What crime was being committed in the trial transcript?
1 - Robbery
2 - Hit and Run
3 - Murder *(correct)*
4 - Trespassing

What happened to the victim in the trial transcript?
1 - Stabbed with a knife *(correct)*
2 - Shot with a gun
3 - Hit with a car
4 - Beaten with a bat

Appendix J - Letter of approval from the Institutional Review Board (IRB)

FORT HAYS STATE UNIVERSITY
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OFFICE OF SCHOLARSHIP AND SPONSORED PROJECTS

DATE: December 2, 2020

TO: Haley Moon
FROM: Fort Hays State University IRB

STUDY TITLE: [1684004-1] Exploration of Factors Impacting Mock-Juror Decision Making
IRB REFERENCE #:   21-0044
SUBMISSION TYPE: New Project

ACTION: DETERMINATION OF EXEMPT STATUS
DECISION DATE: December 2, 2020

Thank you for your submission of New Project materials for this research study. The Fort Hays State University IRB Administrator has determined that this project is EXEMPT FROM IRB REVIEW according to federal regulations.

Please note that any changes to this study may result in a change in exempt status. Any changes must be submitted to the IRB for review prior to implementation. In the event of a change, please follow the Instructions for Revisions at http://www.fhsu.edu/academic/gradschi/irb/.

The IRB administrator should be notified of adverse events or circumstances that meet the definition of unanticipated problems involving risks to subjects. See http://www.hhs.gov/ohrp/policy/AdvEvntGuid.htm.

We will put a copy of this correspondence on file in our office. Exempt studies are not subject to continuing review.

If you have any questions, please contact Leslie Paige at IRB@fhsu.edu. Please include your project title and reference number in all correspondence with this committee.

- 1 -

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Thesis: ACQUITTED OR CONFINED: THE IMPACT OF JURY INSTRUCTION, BIOLOGICAL SEX OF MOCK-JUROR, AND DEFENDANT MENTAL ILLNESS ON INSANITY DEFENSE ATTITUDES AND VERDICT OUTCOMES

Author: Haley Moon

Signature: *Haley Moon*

Date: 03/26/2021