Perceptions of Mental Illness in the Legal System

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ABSTRACT

Previous research suggests that there are stereotypes and misperceptions about the mentally ill population which affect juror’s decision making in cases where the insanity defense is raised. Many individuals believe it to be a “loophole” in the criminal justice system for offenders to escape punishment (Skeem and Golding, 2002). This study explores community perceptions of schizophrenia and personality disorders in a legal context. Results support that individuals are significantly less confident of their verdict decisions when the offender has a mental illness than when the offender has no mental illness. In addition, the presence of a mental illness significantly affects punishment choice.
ACKNOWLEDGMENTS

Thank you to Dr. Redlich for all her support throughout this project and for being a mentor to me for the past year. I would also like to thank Reveka Shteynberg for all her support and advice about moving on with school. Last of all, I would like to thank Dr. Haugaard for the opportunity to be a member of the Honors College, which was such a valuable part of my undergraduate education.
INTRODUCTION

The legal system assumes that jurors are “blank slates” who objectively decide on the facts presented at trial to reach a legally appropriate verdict. However, research suggests that jurors have stereotypes about offenders and preconceptions which cause bias in their decision making (Skeem and Golding, 2002). These attitudes and preconceptions are especially detrimental in cases where defendants raise the controversial defense of insanity. Individuals with a serious mental illness (SMI) are at an increased risk for entering the criminal justice system, both as victims and offenders. There are many misconceptions about this population and it is widely perceived that they are dangerous and unpredictable (Bonta et al., 1998). This study will explore how community perceptions of mental illness affect their perceptions of culpability and how people perceive offenders with personality disorders in comparison to offenders with schizophrenia and those with no mental illness.

Perceptions of Mental Illness

Research suggests that negative attitudes toward the insanity defense are prevalent, highly influential on juror’s decision making, and change resistant. In fact, laypeople often express that the insanity defense is a “loophole” in the criminal justice system which allows guilty criminals to escape punishment (Skeem and Golding, 2002). Pasewark and Seidenzahl (1979), as cited by Skeem and Golding, found that laypeople believed insanity was raised in 37% of criminal cases, when the actual rate is less than 1%. This is a gross exaggeration by 41 times. In addition, even after being provided with the correct statistics, half the people maintained their misconceptions. A study by Minster and Knowles (2006) found that 95% of Americans believe mentally ill people are potentially violent. Although knowledge about mental illness in the general population has increased since the 1950s, so too has the perception that the mentally ill
are violent. The MacArthur Mental Health Module (1996), as cited by Minster and Knowles, revealed that in 1950, 4% of individuals believed the mentally ill had the potential to be violent, in contrast to 44% of people believing the mentally ill were violent in 1996. These misconceptions are extremely influential on juror’s decision making and consequently on the fate of individuals with mental illness who enter the criminal justice system as offenders. As we will see, much research has focused on individuals with serious mental illness—mainly psychotic disorders—but there is a lack of research on many other mental illnesses such as personality disorders which are common to offenders.

Legal Insanity

The definition of legal insanity has been changing for centuries and continues to change today. The term “mental illness” has different connotations in a legal and psychological sense. In a psychological sense, a person must meet the criteria of a disorder listed in the American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders-IV (2000) to be diagnosed with a mental illness. However, in a legal context, a person must be found insane by the courts according to four pre-determined tests of insanity. According to the courts, volition and responsibility determine whether and how much punishment an offender should receive (Monahan and Hood, 1976).

In contrast to the DSM-IV and the psychological definition of a mental impairment, the legal definition of insanity is the basis for determining if someone is responsible for a crime. A crime requires two elements. The first element is proof of an act that is specifically prohibited by law or actus reus. The second element is sufficient intention to commit the act or mens rea
Three ways a person can be excused from or justified for committing a crime is if he acted in self-defense, if he was forced to commit the crime by another individual, or if he is legally insane (Slovenko, 1969).

The first guidelines for a test of insanity in American and English courts were based on the 1843 trial of Daniel M’Naghten in England. The M’Nagthen rules created during this trial establish that every person is presumed to be of “sound” mind unless they can prove otherwise (Slovenko, 1969). As stated by Robinson and Dubber (2007), to prove an insanity defense “At the time of committing of the act, the party accused was laboring under such a defect of reason, from disease of the mind, as not to know the nature and quality of the act he was doing; or, if he did know it, that he did not know he was doing what was wrong” (page 338).

To support an insanity defense, the individual must prove that he was functionally impaired at the time of the offense as a direct result of a mental disease. The burden of proof is on the defendant, meaning that he must prove beyond a reasonable doubt that he is in fact insane and not responsible for the act. If a defendant is found not guilty by reason of insanity, he is acquitted of the crime and committed to a psychiatric institution for an indeterminate period of time until deemed safe to return to the community. The person is not regarded as insane solely because of a diagnosis of a mental disorder, but must prove that it was the specific disorder that led to commission of the crime (Kinscherff, 2010). Perspective jurors may be reluctant to deliver a not guilty by reason of insanity verdict because it could be seen as an escape of punishment. However, an individual found insane by the courts may spend more time in a psychiatric institution than he would have spent in prison had he been found guilty of the crime. Where case verdicts should be black and white- guilty or not guilty- jurors perceive the verdict of not guilty by reason of insanity as a shade of grey (Skeem and Golding, 2002).
The definition of legal insanity leaves room for interpretation although it is meant to be as objective as possible. Even with the varying definitions of insanity in the past century, insanity convictions remain stable. This suggests jurors are more subjective than objective in their decisions. Mock jurors who received no insanity test instructions or who are told to use their own “best lights” to decide a verdict on a case produced patterns similar to those of mock jurors who receive explicit insanity test instructions, adding more support to this suggestion (Skeem and Golding, 2002). Roberts and Golding (1991), cited by Skeem and Golding, suggest that the way jurors reach their verdict is associated with their attitudes toward the insanity defense. When defendants are perceived as being more disordered, subjects are more likely to favor an insanity verdict.

**Juror’s Perceptions of Insanity**

According to Vicki Smith’s prototype theory, as cited by Skeem and Golding (2002), a juror may make attributions about a defendant’s cognitive and volitional impairment by comparing the defendant’s characteristics to those of his or her prototype of a criminally insane defendant. Many things can contribute to an individual’s prototype of an insane defendant. News, media, and individual histories and interactions with the mentally ill population could play a role in creating these prototypes. According to prototype theory, the more closely a defendant’s attributes match those of the juror’s prototype, the more likely he or she is to judge the defendant criminally insane.

A study by Finkel and Groscup (1997), which examined student’s perceptions of insanity as related to the media, asked undergraduate students to create typical and atypical narratives about defendants who successfully or unsuccessfully plead insanity at trial. Students asked to create a typical narrative were given the instructions "I want you to construct a *typical* insanity
case, where a defendant has been charged with a crime, and where he or she pleads not guilty by reason of insanity. I want you to make this case end successfully \textit{(or unsuccessfully)} for the defendant, as the Jury will find the defendant not guilty by reason of insanity," (page 215). Two hundred ninety two narratives were collected for this study, ranging in length from half a page to five pages. Stories were categorized by two raters into over 30 specific dimensions. There were no significant differences found between the typical and atypical narratives in any of the 30 dimensions. Finkel and Groscup suggested that all narratives leaned more toward extraordinary Hollywood stories than toward typical crimes. For the successful plea, students often described a young male defendant with a documented psychiatric history who committed a crime against another male on the basis of grandiose delusions. For the unsuccessful insanity plea, students described a young male defendant who committed a crime against another young male on the basis of revenge. Therefore, students did not deem emotional reactions (which are not mental illnesses), such as revenge-seeking, to merit a valid insanity defense.

A study by Minster and Knowles (2006) compared the perceptions of the need for legal coercion for treatment of mental illness in lawyers and in a community sample. The aims of the study were to assess if the lawyer’s perceptions of need for legal coercion to treat people with schizophrenia or depression differ from those of a community sample and to assess if perceptions of dangerousness differ between legal professionals and the general community. Forty six lawyers and a matched community sample of 44 individuals were polled. The study used three vignettes about one of three characters followed by a survey. The depression vignette described a man who had been depressed for two weeks. The schizophrenia vignette described a person with paranoia who heard voices and had trouble sleeping and a ‘troubled vignette’ described someone
who occasionally felt worried and sad. Overall, 39% of individuals identified depression in the vignette and 27% correctly identified schizophrenia.

The survey questions were designed to assess if individuals believed people with mental illness should face forced treatments. Individuals were asked if the individual in the vignette should be forced by law to obtain treatment from a clinic or a doctor, take prescription medication, or be admitted to the hospital. A majority of both legal professionals and community members believed there should be forced legal coercion and medical treatment for the character with schizophrenia, but not the character with depression (Minster and Knowles, 2006). This is an important finding and suggests that a majority of individuals in the study would support commitment to a psychiatric institution as treatment for an individual with schizophrenia. However, this study did not examine forced legal coercion as punishment for a crime and as an alternative to prison.

Results of the study by Minster and Knowles (2006) do not directly assess community perceptions on the culpability of offenders with mental illnesses but are relevant to the topic. Results showed the community to greatly exaggerate the likelihood of violence in individuals with mental illness. It also showed that a majority of the community supported legal coercion for these individuals and an inability to identify depression and schizophrenia given examples.

A multilevel study by Skeem and Golding (2002) attempted to determine how individuals construe to what degree of control an individual has over his criminal actions and how this affects their verdict choice. Part I of their study asked 80 individuals to candidly describe the characteristics common to their conception of the typical insane person who is not responsible for their actions because of mental illness. Results were multifaceted and could not be reduced to legal formulations or even to single, abstract themes. They were, however, found to be
thoughtful responses generally free from bizarre, dramatic features. Each juror listed an average of 7 characteristics. Typical responses consisted of two to three mental state themes (e.g. illogical, incomprehensible, delusion-based crime) and a description of the person’s human characteristics. As stated, the results were multifaceted and only 2 features were listed by 15 or more jurors. The features that jurors used most frequently were unable to discern right from wrong (n=25); unable to function in society (n=15); mentally retarded (n=14); irrational (n=14); and cannot control his thoughts, emotions, or actions (n=12). Part II of the study attempted to categorize and combine features into prototype characteristics. Researchers extracted 498 main ideas from the responses in Part I of the study which were coded into 10 categories. Five jurors were asked to sort the characteristics into as many categories as necessary of features that meant “essentially the same thing.” Results showed significant differences in juror’s conceptions of insanity. Jurors did not agree on even a subset of features that characterize insanity.

Part III of the study by Skeem and Golding (2002) used responses from Part I of the study to create a Conception Checklist, which was used to create prototypes of offenders used in the vignette study. Participants were given vignettes, placing themselves in the role of a juror in the case. They were asked to render a verdict, indicate on a scale of 0 to 100 the likelihood that they would find the defendant not guilty by reason of insanity, and describe their perception of the individual on several Likert Scales. Three prototypes were derived from the Conception Checklist: severely mentally disabled (SMD), morally insane (MI), and mental state-centered (MSC). All three groups accentuate features of psychosis and emphasize characteristics related to impaired mental state at the time of the offense, such as inability to discern right from wrong and a lack of awareness about what one is doing. Therefore, despite the specific prototype an individual may have, several key characteristics are likely to be incorporated, especially
characteristics related to psychosis. Since the prototypes have indefinite boundaries, several factors are likely to overlap. Two interesting findings of the study are that jurors are more likely to deem defendants with physical impairments such as mental retardation insane than those with “strictly psychiatric impairments” and if a defendant has tried to control the disease, such as with medication or therapy, jurors are more likely to find them not guilty. Results of this part of the study further emphasize that the perceptions of individuals and the research on insanity is highly focused on schizophrenia and psychosis.

The prototype represented by 47% of jurors was an individual with a SMD prototype. This prototype emphasizes severe functional impairment, intellectual disability, and characteristics that are long-standing and resistant to treatment. This prototype is consistent with the “wild beast standard” in tests of insanity dating to 1724. The SMD individual is animalistic, deprived of the ability to reason, and morality is out of his control. Additionally, the SMD prototype has done everything in his control to control the impairment, including medication and therapy. Interestingly, results from this study suggest that almost half of the subjects melded together characteristics of psychosis and mental retardation in a way to create the prototype of an insane person, though this is generally inaccurate.

The mental state-centered characteristics (MSC) prototype, represented by 21% of jurors, focuses solely on issues relevant to the nature and extent of the defendant’s impaired mental state at the time of the offense. Incapable of discerning right from wrong and more than “temporarily” insane are the most commonly reported characteristics of this prototype. This prototype shares most of its characteristics with the other two prototypes.

The morally insane prototype (MI), which represented 33% of jurors in the study, most closely resembles the modern conception of psychosis. The most common reported
characteristics of MI were no conscience; grossly distorted vision of reality; violent, angry, and hostile to others; extreme, unpredictable behavior; and acts without reason or provocation. This prototype reflects a “selectively diseased individual who is otherwise intact” (Skeem and Golding, 2002). In the 20th century, the term moral insanity was gradually replaced by the terms psychopathy and antisocial personality disorder. Skeem and Golding point out the resemblance of this prototype to the stereotypical criminally insane individual presented by the media which is characterized as manipulative, antisocial, and clear-thinking. Psychotic individuals have impairments in both will and reason that render them less culpable and therefore not criminally responsible, however jurors in Skeem and Golding’s (2002) study explained that it was difficult where to draw the line between psychopathy and insanity.

In summary, jurors represented in the study had three prototypes of insanity, which are important to the way they construe individual responsibility and reach a legal decision. The three prototypes differed significantly on the construal and insanity likelihood ratings in the vignette portion of the study by Skeem and Golding (2002). These items included variables such as defendant suffers from a mental disorder, defendant appreciated what he was doing was wrong before he acted, defendant was capable of perceiving reasonable alternatives to what he did, defendant should be punished, and rating of likelihood of personal finding that defendant is not guilty by reason of insanity.

**Personality Disorders**

Although the term moral insanity encompasses antisocial personality disorder, it is necessary to examine other personality disorders as well. Personality disorders have one of the highest comorbidity rates with other mental illnesses. A study by Joyal (2011) found that 68.5%
of the population of a psychiatric hospital had comorbid personality disorders in addition to their main diagnosis. A study by Blackburn and Coid (1999), as cited by Gilbert and Daffern (2011), determined that 47% to 69% of offenders convicted of serious violent crimes met the criteria for at least one personality disorder. Antisocial personality disorder was the most common. However, because such high proportions of offenders can be classified as having antisocial personality disorder, there cannot be a categorical inclusion in the definition of criminally insane. Therefore, this and other personality disorders need to be further examined.

Personality disorders are noted for their long-standing, maladaptive patterns of experience and conduct that impacts a person’s interactions with the world across time and environment. The three most common personality diagnoses are Paranoid Personality Disorder, Antisocial Personality Disorder, and Borderline Personality Disorder. Although there are slight variations between the three, they share the same main characteristics (Kinscherff, 2010). According to DSM-IV criteria, an individual with a personality disorder has an enduring pattern of inner experience that deviates from the expectations of the individual’s culture. The pattern is manifested in two or more of the following areas: cognition, affectivity, interpersonal functioning, or impulse control. The pattern is long in duration and present across a range of social situations and leads to distress in important areas of functioning (DSM-IV, 2000).

Personality disorders are of interest to criminal justice researchers because they correlate highly with recidivism rates. It is estimated by Hiscoe et. al (2003) that reconviction rates for manslaughter, attempted or completed murder, rape, assault, or robbery were 3.7 times higher for individuals with personality disorders than reconviction rates in those without a personality disorder (Gilbert and Daffern, 2011).
Stupperich et. al (2009) proposes that offenders with personality disorders are more fearful of being left and more physically violent than the general population. Men with personality disorders are six times more likely to batter their wives than men without personality disorders. Antisocial and Borderline Personality Disorders are among the most commonly referenced subtypes in literature on intimate partner violence (Babcock and Ross, 2009). Individuals with personality disorders have higher rates of suicide, substance abuse disorders, intense emotional dysregulation, and distortions of perceived threat than the general population. They also experience despair and desperation contributing to poorly planned actions. The emotional dysregulation in combination with distortions in perceived threat is one of the most important characteristics contributing to participation in violent crime. Persons with personality disorders commonly have acute episodes of psychotic experiences, which is a risk factor for violent crime as well (Kinscherff, 2010).

Johnson et.al (2000) conducted a longitudinal study of 717 youths from upstate New York between 1983 and 1993 which assessed personality disorder symptoms and violent behaviors. He concluded that youths with personality disorders were significantly more likely than the sample of individuals with no personality disorder to commit violent crimes such as arson, vandalism, threats to injure others, mugging, and physical fights after controlling for all other covariates such as socioeconomic status and parental psychopathy. Although the sample contained individuals under the age of 18 with no diagnosis of a personality disorder (which cannot be diagnosed until age 18), they showed high levels of personality disorder symptoms and many were diagnosed with a personality disorder after the age of 18. Johnson et. al proposes that higher levels of psychological factors such as frustration, anger, emotional dysregulation, and
social cognition deficiencies may be responsible for the commission of crimes (Johnson et al., 2000).

Gilbert and Daffern (2011) propose the General Aggression Model (GAM) to explain that offenders with personality disorders, especially those with Antisocial Personality Disorder, have more constructs such as aggression-related knowledge structures, maladaptive cognitions, and anger than those of the general population. The GAM assumes that all aggressive behaviors are a result of the combination of the individual and the environment, but proposes that the cognitions of those with personality disorders cause them to act aggressively given the same situational factors as someone without a personality disorder (Gilbert and Daffern, 2011).

Young et al. (2003), as cited by Gilbert and Daffern, examines the importance of EMS or early maladaptive schema in people with personality disorders. These EMS are developed early in life in response to negative events as a way to avoid extreme emotional discomfort. The EMS are somewhat distorted representations of and adaptations to the environment. Young and colleagues contend that dysfunctional behaviors develop in response to these EMS, therefore leading to an increased propensity for aggressive behaviors (Gilbert and Daffern, 2011).

In addition to EMS, people with personality disorders have a higher availability of aggressive scripts, measured by the Schedule of Imagined Violence (Grisso et al., 2000). This scale determines whether or not a person has mental imagery of physically harming others, and the frequency and chronicity of these thoughts. For people with more aggressive scripts, an aggressive response will be triggered in more situations than a person with normal levels of aggressive scripts. Frequent rehearsal of the scripts makes the script more accessible, creating a feedback mechanism which increases the likelihood of violent responses. Offenders with personality disorders frequently believe that violence is the only way to respond to a situation
when an individual without a personality disorder would not consider aggression as a response. The GAM proposes that the combination of accessible aggressive cognitions and aggressive scripts and experience of internal states that activate the aggressive cognitions are responsible for the aggressive behavior (Gilbert and Daffern, 2011).

Another possible explanation for increased aggression in people with personality disorders is maladaptive defense mechanisms that promote a tendency to direct aggression toward others, especially in persons with Antisocial Personality Disorder. Defense mechanisms are defined as unconscious mental operations that protect against extreme negative emotions and excessive anxiety (Presniak, Olson, and MacGreggor, 2010). Results of studies regarding defense mechanisms may be inaccurate because it is difficult to have patients consciously describe their unconscious mental operations. Presniak et al. attempt to address this problem by using multiple questionnaires and methods of measurement. Presniak’s study supported devaluation of others and grandiosity as two defenses that were significantly higher in the group with APD as compared to the control group with no personality disorder. These defenses cause a person with a personality disorder, when faced with challenge by another, to devalue the other’s opinion and have an unrealistic sense of superiority, in turn causing conflict.

As described, personality disorders have been linked to violence and high recidivism rates. It has also been suggested that the early maladaptive schema and high level of aggressive scripts in individuals with personality disorders are linked to an increase in violence (Gilbert and Daffern, 2011; Presniak et al., 2010). Although there is abundant research on perceptions of culpability of individuals with schizophrenia and mental disability, there is a lack of research concerning perceptions of culpability of individuals with personality disorders.
A study by Fraser and Gallop (1993) examined how the label of borderline personality disorder affects staff’s perceptions and causal attributions about patient’s behavior. The sample consisted of 164 patients and 17 registered nurses in four psychiatric units. The patient sample consisted of individuals with schizophrenia (12.8%), affective disorder (55.4%), borderline personality disorder (20.7%), and “other” which consisted of any diagnosis other than the three previously mentioned. There were two components to the study. First, Fraser and Gallop observed group “discussions” in the psychiatric units and recorded patient behaviors and staff responses. He was unaware of the diagnoses of the individuals. Heineken’s Confirmation/Disconfirmation Rating Instrument was used to rate and code nurse’s responses to patients. The classification system had seven response categories: confirming, disparagement, inadequate, ambiguous, impervious, indifferent, and tangential. Differences between confirming and disconfirming responses were calculated for each patient by subtracting the total confirming score from the total disconfirming score. Results of this component of the study showed significant differences in confirming/disconfirming responses between diagnostic groups. Significant differences were found between the affective disorders and borderline personality disorder (BPD) groups and between the BPD and “other” groups. No difference was found between the BPD and schizophrenia groups.

The second component of the study by Fraser and Gallop (1993) used the Staff Response subscale of Colson’s Hospital Treatment Rating Scale (1986) to investigate nurses’ self-reported responses to specific diagnostic categories. This scale used 16 emotional response items and the same staff was used for both components of the study. Participants were given a description of a patient exhibiting challenging behavior in which he or she was diagnosed with affective disorder, schizophrenia, or BPD. Patients with borderline personality disorder attracted more negative
responses from staff than those with the label of schizophrenia or affective disorder. The causes of the negative behavior were rated as more stable in patients with BPD, and the patient was thought to be more in control of his behaviors. Additionally, staff reported less sympathy and less optimism for patients with BPD.

Results of this study by Fraser and Gallop (1993) should be interpreted with caution as there was only a single rater of confirming and disconfirming responses in the first component of the study. However, the rater’s notes from the discussions did not show extreme differences in behaviors between groups that would elicit different staff responses. This study supports that BPD generates negative and stereotypical responses regarding behavior. This study is of value to my research because these stereotypical responses to individuals with personality disorders are important in a legal context. Individuals may unconsciously react more negatively to offenders with personality disorders than those with other mental illnesses or with no mental illness, leading to unfavorable judgments and verdict choices.

My research will explore how community perceptions of mental illness affect their perceptions of culpability and how people perceive the culpability of offenders with personality disorders in comparison to offenders with schizophrenia and those with no mental illness. Participants will be given a crime vignette about an individual diagnosed as troubled (control), with schizophrenia, or with borderline personality disorder. They will then be asked about their perceptions of responsibility for the crime and recommend a punishment. I hypothesize that participants will perceive individuals with schizophrenia as less responsible for their actions than individuals with a personality disorder and will consequently judge individuals with schizophrenia as not guilty by reason of insanity more often than individuals with a personality disorder. I also hypothesize that individuals with sympathize less with individuals with a
personality disorder than individuals with schizophrenia or with no mental illness. I believe individuals will be less likely to sentence individuals to a prison term if the individual suffers from schizophrenia as compared to an individual with a personality disorder.

METHODS

Sample

The sample contained 75 participants: 50 females (66.7%) and 25 males (33.3%). The sample was recruited via Facebook and personal email. All participants are currently college students or college graduates. This study does not have IRB approval because it is for educational purposes only, although, participants were informed before beginning the survey that it was anonymous, voluntary, and for education purposes only.

Design

The design included three vignettes modeled after vignettes used by Skeem and Golding (2002) and Ghetti and Redlich (2001). The three vignettes described a crime committed by an individual labeled as troubled (control condition), having schizophrenia, or having borderline personality disorder. Besides the label, every other aspect of the vignette was held constant. Participants were given a questionnaire which assessed participant’s perceptions of responsibility of the offender, sympathy toward the offender, and how the offender should be punished. The vignettes are listed below.

- Vignette A. David is a twenty nine year old man who lives alone in an apartment in the city. David has never been able to keep a girlfriend for long but has a good relationship with his family. He has been working at a department store for the last three months. When things go wrong, he gets nervous and has trouble sleeping. Last week, David had an argument with his neighbor, Joe, who made vicious comments about David’s family. When David confronted Joe about the comments, a physical fight ensued. Immediately after the fight, David returned to the Joe’s house with a gun and shot him. Joe died as a
result of David’s actions. Police responded immediately and arrested David. He was examined by a court psychiatrist who indicated that David suffers from schizophrenia, a serious mental illness.

- **Vignette B.** David is a twenty nine year old man who lives alone in an apartment in the city. David has never been able to keep a girlfriend for long but has a good relationship with his family. He has been working at a department store for the last three months. When things go wrong, he gets nervous and has trouble sleeping. Last week, David had an argument with his neighbor, Joe, who made vicious comments about David’s family. When David confronted Joe about the comments, a physical fight ensued. Immediately after the fight, David returned to the Joe’s house with a gun and shot him. Joe died as a result of David’s actions. Police responded immediately and arrested David. He was examined by a court psychiatrist who indicated that David had no serious mental illness present, but seemed ‘troubled.’

- **Vignette C.** David is a twenty nine year old man who lives alone in an apartment in the city. David has never been able to keep a girlfriend for long but has a good relationship with his family. He has been working at a department store for the last three months. When things go wrong, he gets nervous and has trouble sleeping. Last week, David had an argument with his neighbor, Joe, who made vicious comments about David’s family. When David confronted Joe about the comments, a physical fight ensued. Immediately after the fight, David returned to the Joe’s house with a gun and shot him. Joe died as a result of David’s actions. Police responded immediately and arrested David. He was examined by a court psychiatrist who indicated that David suffers from borderline personality disorder.

**Procedure**

Participants were given links to one of three online surveys, each containing one of the vignettes. Links were randomly assigned to participants via Facebook and personal email. Participation lasted approximately five minutes, and participants were not compensated for their time. Participants were asked to indicate a verdict choice (guilty, not guilty, or not guilty by reason of insanity) and a punishment (no punishment, probation, prison term, or confinement to a psychiatric institution). Seven point Likert scales (1=very little and 7=a lot) were used to assess participants’ perceptions of culpability, responsibility, dangerousness, sympathy, and credibility of the offender (see Appendix for questionnaire). Age and gender were also recorded for each participant. Age was not significantly different across conditions.
RESULTS

Verdict decision counts by condition are shown in the table below. Because there were either 0 or 1 decisions of “not guilty” across the three conditions, “not guilty” and “not guilty by reason of insanity” were coded together into a new variable shown as “not guilty by reason of insanity” below. The Perason Chi-Square analysis is not significant, $\chi^2 (2) = 5.367$, $p = .068$, meaning condition did not have a significant effect on verdict decision.

<table>
<thead>
<tr>
<th></th>
<th>Not Guilty By Reason of Insanity</th>
<th>Guilty</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Control- Count</td>
<td>3</td>
<td>22</td>
<td>25</td>
</tr>
<tr>
<td>- % Within Condition</td>
<td>12%</td>
<td>88%</td>
<td>100%</td>
</tr>
<tr>
<td>Personality Disorder- Count</td>
<td>12</td>
<td>18</td>
<td>30</td>
</tr>
<tr>
<td>- % Within Condition</td>
<td>40%</td>
<td>60%</td>
<td>100%</td>
</tr>
<tr>
<td>Schizophrenia- Count</td>
<td>7</td>
<td>18</td>
<td>25</td>
</tr>
<tr>
<td>- % Within Condition</td>
<td>28%</td>
<td>72%</td>
<td>100%</td>
</tr>
</tbody>
</table>

No participants in any of the conditions chose probation as a punishment so it is omitted from the table below. In addition, across all conditions only one participant chose “no punishment” so it was omitted from the analysis as well. Participants were more likely to choose commitment to a psychiatric institution as punishment for the personality disorder condition (58.6%) than for the schizophrenia condition (52%) or the control condition (8%). Pearson Chi
Square analysis, \( \chi^2(2) = 15.557, p=.000 \), showed that condition had a significant effect on punishment choice (p<.05).

<table>
<thead>
<tr>
<th>Condition</th>
<th>Prison Term</th>
<th>Commitment to Psychiatric Institution</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Control- Count</td>
<td>22</td>
<td>2</td>
<td>24</td>
</tr>
<tr>
<td>% Within Condition</td>
<td>91.7%</td>
<td>8.3%</td>
<td>100%</td>
</tr>
<tr>
<td>Personality Disorder-</td>
<td>12</td>
<td>17</td>
<td>29</td>
</tr>
<tr>
<td>% Within Condition</td>
<td>41.4%</td>
<td>58.6%</td>
<td>100%</td>
</tr>
<tr>
<td>Schizophrenia</td>
<td>12</td>
<td>13</td>
<td>25</td>
</tr>
<tr>
<td>% Within Condition</td>
<td>48%</td>
<td>52%</td>
<td>100%</td>
</tr>
</tbody>
</table>

To determine if each of the five variables (culpability, responsibility, dangerousness, credibility, and sympathy) were significantly different in each of the test conditions (schizophrenia, personality disorder, or no disorder), ANOVAs were performed. Confidence was the only condition to show significance in the ANOVA (F=4.356, sig=.016) signifying an interaction between condition and confidence ratings. Post Hoc LSD tests revealed that participants were significantly more confident of their verdict decisions for the control condition than the personality disorder condition. In addition, participants were significantly more confident of their verdict decisions for the control condition than for the schizophrenia condition. Differences between schizophrenia and personality disorder were not significant.

<table>
<thead>
<tr>
<th></th>
<th>Control</th>
<th>Personality Disorder</th>
<th>Schizophrenia</th>
</tr>
</thead>
<tbody>
<tr>
<td>Confidence</td>
<td>M 5.08a</td>
<td>M 4.30b</td>
<td>M 4.38b</td>
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<tr>
<td></td>
<td>(SD .812)</td>
<td>(SD 1.208)</td>
<td>(SD 1.208)</td>
</tr>
<tr>
<td>Credibility</td>
<td>M 3.64</td>
<td>M3.53</td>
<td>M 3.52</td>
</tr>
<tr>
<td></td>
<td>(SD 1.036)</td>
<td>(SD 1.167)</td>
<td>(SD 1.388)</td>
</tr>
<tr>
<td></td>
<td>M 4.56 (SD 1.474)</td>
<td>M 4.31 (SD 1.072)</td>
<td>M 4.92 (SD 1.248)</td>
</tr>
<tr>
<td>------------------------</td>
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</tr>
<tr>
<td>Dangerousness</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Responsibility</td>
<td>M 5.76 (SD .663)</td>
<td>M 5.55 (SD .736)</td>
<td>M 5.24 (SD 1.091)</td>
</tr>
<tr>
<td>Sympathy</td>
<td>M 2.68 (SD 1.314)</td>
<td>M 2.90 (SD 1.062)</td>
<td>M 2.68 (SD 1.345)</td>
</tr>
</tbody>
</table>

Note: Means with different subscripts are significantly different at p<.05.

CONCLUSIONS

Earlier in this paper I discussed the importance of juror’s perceptions of mental illness on verdict decisions. Stereotypes and preconceptions of these individuals cause bias in their decision making (Skeem and Golding, 2002). Since individuals with a serious mental illness are at an increased risk of entering the criminal justice system, this topic merits special interest (Bonta et al., 1998).

Skeem and Golding (2002) suggest that negative attitudes toward the insanity defense are highly influential on juror’s decision making and are change resistant. Results of this study support these conclusions. The presence of a personality disorder or schizophrenia significantly lowered participant’s confidence of their verdict decisions, however the specific disorder did not seem to matter in confidence ratings. The results support that the presence of a mental health disorder affect juror’s verdict decisions.

Minster and Knowles (2006) found that 44% of people believed that the mentally ill had the potential be to be violent. Interestingly, results of this study showed that participants did not rate the individuals with schizophrenia or a personality disorder as more dangerous than the individual with no mental illness. However, offenders with a personality disorder or schizophrenia were judged as less credible than an offender with no mental disorder, though not to a significant level.
According to Fraser and Gallop’s (1993) results, nurses’ responses were more negative toward patients with a personality disorder than patients with affective disorders or “other” mental illnesses, probably signifying that the nurses felt less sympathy for these patients. Contrary to my hypothesis, participants rated sympathy for the offender almost equally across all three conditions. They showed no more sympathy for an offender with a mental illness than one with no mental illness. The vignettes used in this study did not describe behaviors specific to individuals with personality disorders or schizophrenia, which could explain one reason for this discrepancy. Perhaps because all vignettes gave the offender the exact same characteristics besides the diagnostic label, participants did not consider other characteristics of the diagnosis that were not explicitly mentioned in the vignettes.

According to Vicki Smith’s prototype theory (cited by Skeem and Golding, 2002), a juror will make attributions about offenders by comparing the offender’s characteristics to those of his prototype of a mentally ill offender. Skeem and Golding’s study demonstrated that individuals most commonly reported a SMD prototype, which is generally inaccurate in describing offenders who plead insanity. The SMD emphasizes severe functional impairment and intellectual disability. Another prototype, reported by about one third of the participants, represented a psychotic individual. In my study, only 28% of participants in the schizophrenia condition and 40% of participants in the personality disorder condition found the offender not guilty by reason of insanity. The rate of not guilty by reason of insanity verdicts is not as high as expected. According to the prototype theory, some individuals may have judged individuals with a personality disorder and a personality disorder as guilty because they do not display characteristics that fit the SMD prototype, similar to the “wild beast standard” of the 1700’s.
Results showed that condition had a significant effect on punishment. Participants were significantly more likely to sentence offenders with a personality disorder or schizophrenia to commitment to a psychiatric institution than the control condition. Although participants were more likely to sentence individuals with a mental illness to a psychiatric institution than to a prison term, results were not as drastic as expected. Almost half of the participants for both the schizophrenia and personality disorder conditions recommended a prison term as a punishment. A large proportion of participants found the offender guilty but recommended commitment to a psychiatric institution as punishment. One explanation for this discrepancy could be a lack of knowledge about what happens to offenders who are actually found not guilty by reason of insanity. As Skeem and Golding (2002) highlight, many laypeople express that the insanity defense is a “loophole” in the criminal justice system which allows guilty criminals to escape punishment. Participants in the study may have felt that the offender had a mental illness and was not responsible for their actions but chose the guilty verdict because they believed the offender still deserved punishment. Another possible explanation is that the participants recognized the presence of a mental disorder but did not think it directly caused the offender’s actions.

Examining these results, I believe it would be interesting to examine individual’s perceptions of the functions of different punishments for offenders with mental illness. It would be interesting to see if individuals perceive the function of commitment to a psychiatric institution as punishment, as rehabilitation, or as solely a deterrent. I believe it is necessary to give jurors explicit instructions regarding exactly what will happen to offenders who are found not guilty by reason of insanity, especially in cases where the insanity defense may be raised.
Although further research into perceptions of mental illnesses is needed, this study provides evidence that the presence of a mental illness does affect juror’s decision-making.

REFERENCES


APPENDIX

1. What is your age? ____________

2. What is your gender? Male Female

3. If you were a juror at David’s trial would you find David

   Guilty Not Guilty Not Guilty by Reason of Insanity
   (A verdict of not guilty by reason of insanity requires that at the time of the act, due to a severe mental defect, the defendant is unable to appreciate the nature and quality of the wrongfulness of his acts)

4. Please rate the confidence of your verdict choice
   1 2 3 4 5 6
   very confident of innocence very confident of guilty

5. Regardless of whether you think David is guilty or not, how likely is it that David is responsible
for Joe’s death?

1 2 3 4 5 6
not likely likely

6. How credible do you find David?

1 2 3 4 5 6
not at all very much so

7. How much sympathy do you have for David?

1 2 3 4 5 6
none a lot

8. How dangerous is David to the community?

1 2 3 4 5 6
not dangerous extremely dangerous at all

9. How should David be punished?

No Punishment Probation Prison Term Commitment to Psychiatric Institution