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THE EFFECT OF MENTAL ILLNESS CHARACTERISTICS AND DIAGNOSES ON

JUROR SENTENCING DECISIONS

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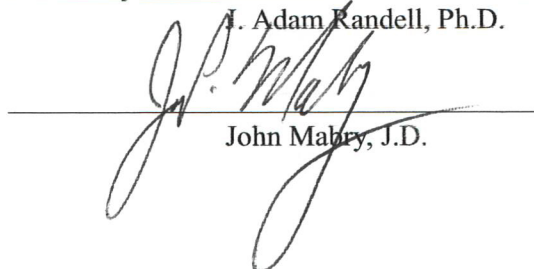
A Thesis APPROVED FOR THE

DEPARTMENT OF PSYCHOLOGY

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Abstract

Stigmas surrounding mental illness in the criminal justice system often influence jurors' decisions, sometimes aggravating (increasing) and sometimes mitigating (decreasing) sentencing decisions. Jurors' own personal experiences with mental illness could be an underlying factor in sentencing a defendant. However, personal experiences of jurors still require much research to understand individual characteristics and environmental influences in their decision making. Thus, the purpose of the present study was to investigate how mental illness symptomology may influence perceived responsibility proposed sentencing of a criminal defendant. 214 participants read a fact pattern from a Supreme Court opinion involving homicide and rated the guilt and proposed sentencing of the defendant (who either received a diagnosis of bipolar disorder, whose symptoms were described, or no mental illness was involved). Participants also completed the Brief Symptom Inventory. Results indicated that there was no interaction between mental illness of the defendant and juror sentencing decisions; however, there was an interaction between juror symptomology and recommended sentence length of the defendant in years. Personal symptomology of jurors' is a predictor of recommended sentence length of a defendant, in years (p < .05). Implications for future research and for practical applications are discussed.

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Decisions

Mental illness is becoming more of a recognized issue, leading to more discussions on issues within society, the government, and legal system that need to be remedied to better accommodate how mental illness is treated moving forward. Historically, people with a mental illness are more likely to end up in the justice system and will spend longer periods of time incarcerated than people without a mental illness. Serious mental illnesses like schizophrenia and bipolar disorder have been shown to be more mitigating in sentencing than no mental illness at all. However, there is little to no research on how less serious mental illnesses or how characterizing a mental illness without stating a diagnosis may contribute to sentencing decisions. Characterizing mental illnesses by explaining symptoms of the illnesses both serious and less serious may aid jurors in understanding how impactful mental illness is on a defendants' lives and thus affect sentencing decisions to reflect that understanding.

Background

Mental Illness and the Justice System

Mental illness is more prevalent in the court system than it is in the public. About 45% of federal prisoners report mental health concerns, with higher percentages for state prisoners and local jail inmates (Collier, 2014). This percentage is much higher than the statistic for U.S. citizens living with a mental illness on average. That is, only about one in five Americans (20%) lives with a mental illness, leaving the potentially hidden impact on the justice system as something that needs to be evaluated (National Institute of Mental Health, 2021). Contrary to stereotypes regarding mental health in the legal

system, less than 1% of defendants will claim an insanity defense, even less will have a successful "Not Guilty by Reason of Insanity" result- around .26% (Chiacchia, 2021). There are statutes in place that make an insanity defense difficult to use successfully, which helps prevent improper or illegitimate use.

This stemmed from the M'Naughten rule, which originated in the mid-1800s. Daniel M'Naughten was a man who murdered the secretary to the Prime Minister, believing that he was being conspired against and that he himself was going to be murdered; his attorneys used an insanity defense leading to a not guilty by reason of insanity verdict (Busby, 2023). M'Naughten then spent the rest of his life in a mental institution. The public was not pleased with this verdict by the jury, and the M'Naughten rule is the result. According to this rule an individual is presumed sane, unless it can be determined that they did not understand that their actions were wrong, or that they did not understand what they were doing at the time of the crime (Busby 2023). These rules were created to ensure that defendants must be insane at the time of the crime, they are liable for punishment if they were aware of their actions, and/or knew they were wrong when the crime was committed (Asokan, 2007). Defendants with a mental illness, severe or not, will go through the justice system in some form; because the insanity defense is difficult to assert with success, defendants will most likely experience a lengthy prison sentence.

Most cases, whether criminal or civil, will end with a pretrial resolution. However, there are still cases that will proceed to trial. Out of all criminal cases, about 2% will go through to the trial phase instead of being settled through plea agreement (Smith & MacQueen, 2022). Of the 2% of defendants who go to trial, defendants can

either be convicted of the charges brought against them by the jury or found not guilty. If they are convicted, they may be guilty but mentally ill, or in some states (like Oklahoma), guilty with a mental defect if they can prove they meet the requirement (Oklahoma Court of Criminal Appeals, 2019). A person may be found guilty with mental defect if they did commit the crime, but were incapable of understanding right from wrong, as well as incapable of understanding the consequences of the actions they carried out. They also must be diagnosed with antisocial personality disorder.

Mental Illness Stigma

In public. Stigmatization around mental illness is not a novel concept. There are several factors that go into how and why people feel any type of way towards other people who live with a mental illness. Fox and colleagues (2018) used the Mental Illness Stigma Framework to identify at least 400 mechanisms that feed into the creation of stigmas towards mental illness. Stereotyping and discrimination have garnered the most research out of these 400 mechanisms for creating stigma, both of which focus on the perceptions of others with mental illness. Stereotyping and discrimination place people living with a mental illness into an out group by the people who do not have a mental illness-a form of social rejection. Stigmatization leads to social rejection in terms of mental illness from the perceived responsibility for the mental illness, dangerousness of the mental illness, and rarity of the mental illness (Feldman & Crandall, 2007). The stigma and rejection placed on people living with a mental illness also places a higher economic burden on them. Those living with a mental illness are more likely than those without mental illness to drop out of school early, have more difficulty finding full-time employment, and have an overall lower quality of life (Doran & Kinchin, 2019).

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A considerable influence in creating these stigmas is the media. People are primed to believe mental illness is a relevant factor when exposed to media about a violent incident (Chan & Yanos, 2018). Media coverage of violence is likely a factor in why the public has the false perception that mentally ill people are violent because the public is already primed to believe mental illness had a role in the violent incident. If people are already primed to believe mental illness is a factor in a violent crime, this priming effect may be reinforcing the stigma against people with mental illness.

People with mental illness can stigmatize themselves through symbolic interaction apart from the stigma they face from public perception. Symbolic interaction adds to stigmatization of mental illness by the anticipation of rejection, stigma consciousness, self-esteem, social withdrawal, and concern with staying in the perceived boundaries placed on behavior associated with mental illness (Link et al., 2015). Symbolic interaction stigma is both a predictor in stigma related events, and an influence on the internalized stigma for those living with mental illness. People who live with a mental illness are more likely to be influenced by symbolic interaction stigmas than people without mental illness, which has potential to influence how heavily people with a mental illness stigmatize themselves alongside the stigma placed on them by the public.

A progressive model for how people with mental illness stigmatize themselves begins with being aware of the stereotypes, moving to agreeing with those assumptions, and applying them to oneself and thus hurting self-esteem and hope for the future (Corrigan et al., 2011,) see Figure 1. People with a mental illness first become aware of the negative connotations and assumptions that the public has about them. Then those with mental illness start to believe those assumptions are true and agree with the

stereotypes about themselves. Lastly, people with a mental illness start to apply the

stereotypes and assumptions to themselves, like a self-fulfilling prophecy. Once this

progressive model begins, those with mental illness will move towards acting within

those stereotypes because they agree with the labels and stereotypes that are first placed

on them by society.

Figure 1
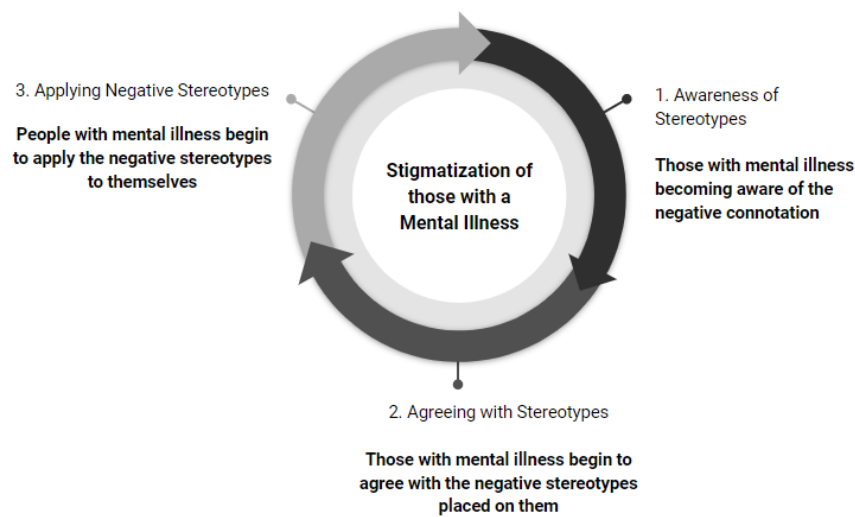
The "normal" population of society is first places the negative stigma on those

with mental illness, and then the progressive model begins. Higher subjective perceptions

of socioeconomic status, lower ability to empathize, and less knowledge about mental

illness are all factors that people without mental illness may possess that increase the

negative stigma, especially towards people with clinical depression and less remarkable

mental illnesses, but not as much towards those with schizophrenia (Foster et al., 2018).

Knowledge and empathy towards mental illness are moderators for the link between

socioeconomic status and the prejudice towards people with a mental illness; that is,

those with a higher education level and live with a mental illness will have more

difficulty in treatment if they internalize the stigma the public places on them than others

will (Hack et al., 2020).

In the justice system. There is a heavy stigma attached to mental illness,

regardless of severity. Over time, this stigma has been referred to as the criminalization

of the mentally ill. The varying outcomes for different mental illnesses in the courtroom

still raise questions. Jurors may not understand the significance or effects of a guilty but

mentally ill verdict (Sloat & Frierson, 2005). In some cases, mental illnesses have the

opposite of the predicted effect and jurors will sentence a defendant with a harsher

sentence compared to a defendant without a mental illness. Jurors considering the death

penalty may be more likely to view mental illness as an aggravating factor than

anticipated, compared to jurors viewing a case without mental illness if jurors claimed it

was a factor in the decision (Sandys et al., 2018). However, these conflicting results do

not mean mental illness must influence sentencing in a negative manner. Sometimes the

details of a crime shroud any mitigating evidence like diminished capacity, past good

behavior, or promising chance of reformed behavior in the future. Potential jurors may

also view mental illness as linked to violence, even if that assumption is false apart from

antisocial personality disorder. The nature of a crime cannot be undone or changed, but

the view of people living with mental illness as a violent population can be remedied.

Overall, very few violent crimes are linked to criminals with diagnosed mental

health disorders. Only 15% of convicted homicide offenders have been diagnosed with

major mental disorders like schizophrenia or paranoia; the prevalence of schizophrenia

alone in convicted homicide offenders is 6%, for offenders with substance abuse

disorders is about 38%, offenders with personality disorders are around 10%, and 30-70%

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of convicted homicide offenders have a grade I mental disorder or grade II personality disorder (Richard-Devantoy et al., 2009). These personality disorders include obsessive-compulsive, avoidant, paranoid, and borderline personality disorders.

Jurors believe that defendants who are found guilty but mentally ill should eventually be sent to prison (Sloat & Frierson, 2005). Judges also tend to view mentally ill defendants negatively and worthy of prison sentences. Genetic bias, which is an assumption of determinism and believing in an inability to change, is something that may cause some judges may stereotype mentally ill defendants more negatively, as well as sentence them harshly, than their non-mentally ill counterparts. This is done by judges as a means of deterrence and incapacitation. However, some genetic bias can be removed by highlighting judges' personal experiences with the genetic essentialist bias of personal experience with genetics; that is, having judges' scientific determination rather than free will in the onset and diagnosis of mental illness, especially for those who have no experience with any facet of mental illness (Berryessa, 2019).

Evidence shows potential jurors have indirect negative attitudes towards defendants with mental illness, even if they also choose more lenient sentences (Sabbagh, 2011). There are five subgroups of defendants suffering from mental illness who are more likely to be involved with the justice system. These groups are (a) defendants with misdemeanors, (b) defendants who commit crimes for survival, (c) defendants with alcohol or drug struggles, (d) defendants with character disorders, and (e) defendants with severe disorders who are suffering from delusions (Hiday & Burns, 2010). Not surprisingly, the more serious the mental illness, the higher the risk for interactions with the criminal justice system.

Defendants with severe mental illnesses are likely to be sentenced less harshly by juries than people without any mental illness, but this is not applicable to every case. People with persistent mental illness are ten times more likely to reside in state prisons after committing a crime than a mental institution (Jones & Ford, 2019). There have been multiple cases that claim defendants were sentenced by a jury based on their mental illness alone, which violates Title II of the Americans with Disabilities Act (Cohen, 2005).

Some jurisdictions will engage in discriminatory incarceration, which occurs by indefinitely adding years, one at a time, onto a sentence after the maximum to prevent a mentally ill defendant from re-entering society based on the illness alone (Cohen, 2005). This occurs because defendants with mental illness are often unable to participate in programs that may give them credit for an early release and because defendants with mental illness often have a higher likelihood of rule violations and subsequent added time-because they have greater difficulty living in prison-than non-mentally ill defendants. There has since been legislation passed that requires dangerousness assessments to try and battle these issues and remedy the Title II violation in the early 2000s.

Mental health courts have become an option, but as a result could also be furthering the stigma in the criminal justice system by utilizing them. Mental health courts may just be a way of accepting the rates with which mentally ill people are entering the justice system, rather than finding a way to address potential failures of both public health and criminal justice systems (Seltzer, 2005). One of the issues within the justice system is the increased opportunity for people with a metal illness to be arrested

compared to people without a mental illness. Those with mental illness that are arrested

by authorities spend more time in jail and are also at an increased risk for falsely

confessing to crimes as opposed to someone without mental illness. About one in ten

defendants with a mental illness will confess to a crime they did not commit (Redlich et

al., 2010). Going to trial creates additional difficulties for defendants with mental

illnesses. Jurors tend to rely on their own preexisting beliefs about people with a mental

illness, even when presented with expert testimony (Hudachek & Quigley-McBride,

2022).

Mental Illness and Juror Sentencing

The frequency of court cases involving seriously mentally ill defendants is low.

Only about 18% of crimes are linked to people with a serious mental illness (Peterson,

2014). Some jurisdictions have an overrepresentation of people diagnosed with a mental

illness in jails or prisons despite the low frequency, however. Defendants living with a

mental illness are arrested often for misdemeanors but do not go to trial or are not

prosecuted to the full extent, which can add to the inflation of numbers (Hall et al., 2019).

Rehabilitation instructions are given to potential jurors who may have admitted bias but

are rehabilitated to remove that bias during the trial for the sake of integrity. Giving

rehabilitation instructions during the *voir dire* process (the process by which attorneys

pick a jury) may influence perceptions and sentencing; instructions may be informational

and remove some bias and preexisting negative attitude towards those with mental illness

(Crocker & Kovera, 2010). More research is needed to determine why the instructions

may have that ability.

There are times jurors or participants in a study understand to an extent the implications that mental illness has on a defendant. For example, "Not Guilty by Reason of Insanity" was chosen over a guilty verdict in three of four kinds of mental illnesses: schizophrenia, depression, bipolar, and substance abuse disorder (Mossière & Maeder, 2016). Substance abuse disorder may be an exception to the sympathies shown to defendants with other mental illnesses. Jurors or participants in a study usually view defendants with a substance abuse disorder as more in control, as well as more logical and responsible for their actions. Substance abuse is a disorder in the Diagnostic and Statistical Manual of Mental Disorders, fifth edition (DSM-5), however the public does not view it the same as other types of mental disorders. In cases involving schizophrenia, defendants were shown more leniency as compared to defendants without present mental illnesses (Sabbagh 2011). Jurors are more likely to give more lenient sentences or choose "Not Guilty by Reason of Insanity" on account of those with mental illnesses, except in instances of substance abuse (Mowle et al., 2016). Because some studies suggest that jurors view defendants with schizophrenia, bipolar disorder, and depression more leniently in sentencing studies, this finding could indicate that mental illness is a mitigating factor in the courtroom, especially if jurors understand the implications of the diagnosed illnesses.

However, assuming jurors understand the implications of a mental illness is faulty. Age of the defendant at the time they committed a crime, and the juror's perception of the defendant's ability to understand their behavior was criminal, are the two biggest mitigating factors when considering the death penalty for someone with a mental illness. Rejecting the idea of a mental illness being present, or that mental illness

could diminish a defendant's capacity to understand their behavior, increases the chances of a death penalty (Gillespie et al., 2014).

Labeling Theory

Labeling theory encompasses symbolic interaction stigma in that symbolic interaction is both a predictor of and an influence on stigmatization (Link et al., 2015). Essentially, people who have labels placed on them are more likely to fulfill the associations given with that label than people who do not receive those labels. In some cases, jurors sentence defendants differently when knowing they suffer with Schizophrenia, but not with Substance Abuse Disorder. However, jurors also tend to have preexisting negative biases toward mental illness. This comes from labels and stigma. People who are in a stigmatized or disadvantaged group are more likely to be on the receiving end of deviant labels than those who are not (Bernburg, 2009). Mentioning a mental illness by name primes recollection of those negative beliefs and perceptions about mental illness; thus, people with mental illness are labeled in a more negative light than people who do not have a mental illness.

Current Study

Harsh sentencing can impact individuals with some mental illnesses differently than it impacts individuals without them; thus, an altered sentence can still have an equal impact as a regular sentence for a defendant living without mental illness (Johnston, 2013). However, research has not investigated the difference in sentencing based on whether defendants have a named diagnosis, characterization of mental health symptoms, or no mental illness at all. Therefore, the current study examined the difference in sentencing by mental health information (diagnosis, symptoms, or none). Potentially,

defendants with the symptomology of a mental illness could aid jurors' understanding of their mentality. Removing the label of a mental illness diagnosis by name could reduce the negative implications attributed by labeling theory, thus also reducing perceived guilt and sentencing decisions made by jurors. Therefore, I expected that participants who received the symptoms only condition would recommend the least severe sentences.

It is possible that participants' own experience with mental health will affect their sentencing recommendations as jury members. Specifically, participants with higher scores on the Brief Symptom Inventory may recommend lower sentencing lengths and perceptions of guilt due to the ability to identify with the labels within mental illness stigma. The equal impact principle could be a vital factor in sentencing in the future if potential jurors can understand it and the impacts mental illness has on a person. If potential jurors perceive the characterization of a mental illness as a mitigating factor, then this thought process may be reflected in sentence severity or duration.

Method

Participants

All students, faculty, and staff at the University of Central Oklahoma who were eligible to vote were invited via e-mail blast to participate in this study. This limited participants to people at least eighteen years of age and citizens of the United States. Following the link to a survey hosted by www.qualtrics.com, participants completed a questionnaire assessing their own psychological distress, read a vignette portraying a homicide, and provided demographic information. The order of the questionnaire and vignette was counterbalanced to eliminate order effects. Participants were randomly

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assigned to one of three versions of the vignette providing them with the defendant's diagnosis, symptoms, or no mental health information.

Most of the 214 participants identified themselves as female (64.95%) and the remainder identified themselves as male (29.44%) and gender non-conforming (5.61%). Most participants identified themselves as White/Non-Hispanic (84.11%), followed by Black or African American (4.67%), Latino/a (3.27%), Asian (1.4%), Native American/American Indian or Alaska Native (1.40%), Native Hawaiian or Pacific Islander (0.47%), Multiracial (3.74%), and Other (0.93%). Their average age was 34.65 ($SD = 15.21$).

Participants identified their current legal marital status as single/never been married (51.87%), married (37.38%), legally separated (0.93%), divorced (6.54%), widowed (1.87%), or other (1.40%). They reported their sexual orientation as straight/heterosexual (64.32%), bisexual/pansexual (25.35%), gay/lesbian (3.29%), asexual (3.76%), or other (3.29%). For religious affiliation, the greatest number of participants identified as Christian (43.92%), followed by atheist (20.09%), agnostic (21.50%), pagan (0.93%), Wiccan (0.47%), Universal (0.47%), Unitarian/Universalist (1.40%), Buddhist (0.47%), and Other (10.75%). Participants reported attending religious services an average of 1.52 times per month ($SD = 3.50$).

Finally, participants chose the political affiliation with which they most identify agree as Republican (17.29%), Democrat (50.47%), Independent (17.76%), Libertarian (6.07%), or Other (8.41%). In the 2020 Presidential election, they reported voting for Donald Trump/Mike Pence (14.29%), Joe Biden/Kamala Harris (52.86%), Jo Jorgensen/Spike Cohen (0.95%), or someone else (0.48%), although many were

registered at that time but did not vote (7.62%) or were not registered to vote at that time (23.81%).

Materials

A vignette was created from an available court case heard by the Supreme Court, *Kahler v. Kansas*, 140 S. Ct. 1021, 1026-1027 (2020). The vignette is viewed by participants as follows:

In early 2009, Karen Kahler filed for divorce from James Kahler and moved out of their home with their two teenage daughters and 9-year-old son. Over the following months, James Kahler became more and more distraught. On Thanksgiving weekend, he drove to the home of Karen's grandmother, where he knew his family was staying. Kahler entered through the back door and saw Karen and his son. He shot Karen twice, while allowing his son to flee the house. He then moved through the residence, shooting Karen's grandmother and each of his daughters in turn. All four of his victims died. Kahler surrendered to the police the next day and was charged with capital murder.

This vignette shows the control condition of no mental illness diagnosis or characteristics. In the two experimental conditions (see Appendix A), details are added to this vignette to provide information about the defendant having characteristics of a mental illness, or a mental illness diagnosis. The mental illness used in this study was bipolar disorder. Questions about if participants would or would not also convict the defendant on the four counts of murder, and how long they would sentence the defendant (anywhere from 10-45 years), or life in prison will be given immediately after the vignette. Participants will not be able to go back and change their answers.

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Psychological symptoms. The Brief Symptom Inventory (BSI) is a self-report tool that measures psychological distress symptoms. The BSI consists of 53 items gauging how distressed participants have been in the last seven days on a Likert scale ranging from "0= not at all" to "4= extremely," or an "R= refuse to answer." The BSI covers nine psychological symptom areas including depression, anxiety, obsessive compulsion, somatization, hostility, interpersonal sensitivity, phobic anxiety, paranoia, and psychoticism. There are three indices used to measure distress, Global Severity, Positive Symptom Distress, and Positive Symptom Total indices. See Appendix B for a complete list of questions in the Brief Symptom Inventory (Derogatis, 1975). This tool is used to measure participants' own familiarity or experience with mental illness. All nine psychological symptom areas had an internal reliability of $\alpha = .8$ or above.

Procedure

Participants were given electronic informed consent forms at the very beginning of the survey. They were then instructed by a prompt to read a vignette involving a criminal defendant in a court case who has no mental illness characteristics or diagnosis presented, the same case including information describing either mental illness characteristics of bipolar disorder, or mental illness diagnoses of bipolar disorder, depending on the random group assignment. After viewing the vignette condition, participants received an attention check. They selected if the defense presented no mental illness information, the defense provided a diagnosis, or the defense presented symptoms experienced by the defendant. All participants who did not meet the attention check requirement were cut from data interpretation and analysis.

Participants then rated how guilty they perceive the defendant to be on a Likert Scale ranging from 1 (not guilty at all) to 10 (completely guilty) and selected the charges most appropriate for the defendant based on Kansas Law. Brief descriptions were provided so participants could make an informed decision when selecting charges- First degree murder (planned and intentional,) Second degree murder (not planned, but intentional,) Third degree murder (not planned and not intentional,) or Not Guilty by Reason of Insanity. Participants also selected a recommended sentence length on a sliding scale ranging from 0 to 50 years. Participants then completed the 53-item Brief Symptom Inventory to measure self-reported psychological symptoms, with the option to refuse to answer any of the items. Participants were debriefed on the purpose of the study and given contact information for questions, if necessary, at the end of the survey. Demographic information was gathered at the end of this survey, including age, gender, sexual orientation, familial relationships, political and religious information, if there was any previous jury experience. Participants were then debriefed of the purpose of this study and given contact information and appropriate resources for questions.

Results

A multivariate analysis of covariance (MANCOVA) was used to examine differences in sentencing recommendations and ratings of guilt by mental health information condition, while controlling for own overall psychological symptomatology. There was no significance found between groups of no mental illness ($M_{adj} = 40.19$, $SD = 2.21$), symptomology of a mental illness ($M_{adj} = 36.94$, $SD = 1.33$), or a diagnosis of a mental illness ($M_{adj} = 38.97$, $SD = 1.74$) for sentencing recommendations $F(2, 184.97) = 0.96$, $p = .39$. There was also no significance found in perceived guilt in the no mental

illness (M_{adj} = 9.26, SD = .24), symptomology (M_{adj} = 9.04, SD = .14), or diagnosis (M_{adj} = 8.98, SD = .19) conditions $F(2, 1.02) = 0.47$, $p = .63$. See Figure 2.

Figure 2
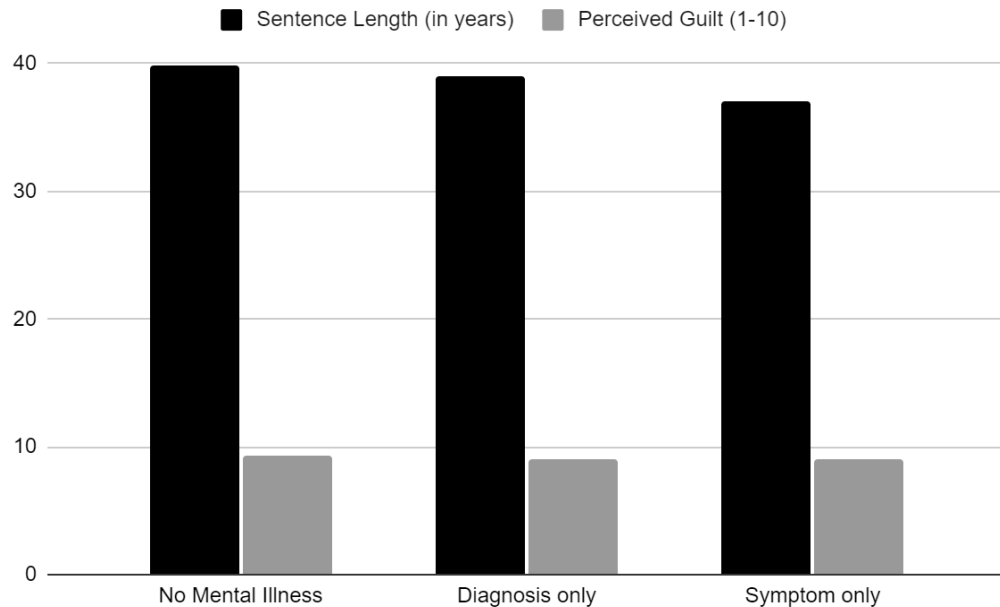
However, the analysis did reveal that the covariate of personal psychological symptomatology (BSI Global) does predict their recommended sentence length in years (p < .05). Specifically, as personal psychological symptoms increased in participants, the recommended sentence length (in years) decreased, which was determined by a regression analysis β = -.14, $t(214) = -2.18$, $p < .05$.

Discussion

It can be concluded that personal symptomology is a predictor in the recommended sentence length for a defendant, regardless of the defendant's mental health condition. This demonstrates that mental illness plays a factor in the courtroom and needs further evaluation to discover under what other circumstances it may affect juror sentencing. Theories have shown that potential jurors may not understand the

impact of mental illness in cases like the death penalty, still leaving cases with heavy prison sentences up for debate. This study confirms that lenient sentencing is a potential outcome for defendants when jurors themselves have experience with mental illness. This could also be due to an in-group bias more than empathy, which are moderators worthy of testing in the future. The results of this study revealed one of the hidden impacts of mental illness in the courtroom, and this could change the way courts manage these kinds of cases. This is important because there has been a rise in people with severe mental illness committing homicide and being imprisoned as normal rather than being also referred to some kind of treatment; there are other calls from research emphasizing the need to make treatment or transfers of these individuals to a safer environment for their mental illness (Flynn et al., 2021).

Finding that personal symptomology is a mitigating factor in juror sentencing decisions emphasizes the importance of educating the public as potential jurors that mental health is something to be taken seriously, and potentially encourage reform in requirements to be eligible for the specialty mental health court. Requirements for entry to the mental health court system could be changed to create more equal opportunity for defendants with a mental illness to enter their system and prompt more research into the selection biases involved. If more research can be done to explore the effects of mental illness on sentencing decisions, defendants may choose to go through with the jury process instead of taking a plea deal. Defendants with mental illness may be able to receive more reflective sentences of equal impact if jurors can view mental illnesses as mitigating factors by understanding the characteristics of those mental illnesses and labels that are associated with them if they also experience mental illness symptomology.

This could in turn reduce extra risk of harm for a mentally ill defendant while in the general population of prison, and hopefully make the mental health courts more accessible.

Potential Limitations

It is possible that the sample demographics-being part of a university community-and size affected the results of this study. The sample limits the generalizability of the findings. This sample is drawn from the university, whereas juries are created from an entire community. Jurors are typically less educated, and the university population is composed of people in higher education. If there were more participants in this study, and the demographics were more diverse, there may be more interpretable results. A larger sample size with mare varied demographics would more greatly reflect the general population and give more data to accurately determine how mental illness effects juror sentencing decisions whether that be personal symptomology of the juror, or symptomology of the defendant.

Another potential limitation to this study is the kind of crime used, and the way it is presented. Using a violent crime involving murder and quoting the case verbatim from the Supreme Court record may have removed the ambiguity in perception of guilt of the defendant. Also, the severity of the crime alone might make people less likely to use mitigating information, even if homicide may be a more realistic crime. A less violent crime, or a description of the crime that is more ambiguous may be more sufficient in future research to delve into perceptions of guilt of the defendant by potential jurors. A future direction for research could be to see how many jurors with mental health experiences are enough to make a difference in deliberations.

The Equal Impact Principle

Mentally ill persons may feel an equal impact of a sentence by view of the public, even if it reflects a different amount of severity to the average person due to safety risks, when they are not placed in a mental health facility or receive treatment through a mental health court. People living with a mental illness are more likely to be sexually, physically, and psychologically harmed when in prison than people without mental illness, immediately placing them at a higher risk of danger. Therefore, a prison sentence for a person with a mental illness of the same length as a non-mentally ill person may not be equal in severity. A method to reduce the effects of not understanding the impact of mental illness on a person is to educate potential jurors about the consequences their verdicts place on defendants. Jurors may focus on just deserts, where the defendant is considered to receive the punishment, they deserve for the crime committed. The justice system and potential jury may also use retributive justice which focuses more on the retribution or punishment, rather than focusing on rehabilitation of the defendant. Another option is restorative justice as a method for handling consequences of illegal action, which focuses on taking responsibility for criminal actions as well as eventual societal reintegration.

Sentencing those with mental disorders the same as those without a mental illness may be detrimental in the long run. The equal impact principle may help aid in mental illness being a mitigating factor in sentence severity if jurors understood the impact mental illness and the risks it places on defendants in prison. There are other factors that go into considering the equal impact principle for punishment of mentally ill offenders. It must be considered if a mentally ill defendant can appreciate a sentence imposed upon

them, the increased risk of victimization while serving their sentence, and if sending a mentally ill defendant to a secured place where they are highly likely to suffer physical and psychological harm could be considered inhumane (Johnston, 2017).

However, the likelihood of being accepted into a mental health court for serious offenses is low, but statistics are unclear due to selection biases in the selection process. However, there are factors of the defendant that seem to make serious violent crimes less acceptable to mental health court like motivation, treatability, support from victims and likelihood of conviction (Wolff et al., 2011). To have a case moved to mental health court, a defendant must be diagnosed with a mental illness that may or may not be severe or chronic, and the charges typically are limited to those with non-violent offenses and misdemeanors. A mentally ill defendant who commits a violent crime is not barred from the opportunity to enter the mental health court system, but it is more likely to enter the regular justice system to receive consequences. When considering the factors for determining consequences for criminal conduct, both the crime and the mental illness the individual is diagnosed with are involved. Treatment is most effective when focused on both the mental illness symptoms and the criminogenic thinking of the defendant because mental illness symptoms and criminal thoughts are not entirely independent of each other (Scanlon & Morgan, 2021). Sentencing may be capable of fulfilling an equal impact when it considers both factors, instead of a lengthy prison sentence focusing only on criminal factors or psychiatric treatment that only considers the mental illness symptoms.

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Appendix A

Vignettes are randomly ordered, with all participants viewing one of three conditions: the control condition with no mental illness, or one of two experimental conditions where characteristics of bipolar disorder are given without a diagnosis, or a diagnosis of Bipolar is given.

1. In early 2009, Karen Kahler filed for divorce from James Kahler and moved out of their home with their two teenage daughters and 9-year-old son. Over the following months, James Kahler became more and more distraught. On Thanksgiving weekend, he drove to the home of Karen's grandmother, where he knew his family was staying. Kahler entered through the back door and saw Karen and his son. He shot Karen twice, while allowing his son to flee the house. He then moved through the residence, shooting Karen's grandmother and each of his daughters in turn. All four of his victims died. Kahler surrendered to the police the next day and was charged with capital murder.

2. In early 2009, Karen Kahler filed for divorce from James Kahler and moved out of their home with their two teenage daughters and 9-year-old son. Over the following months, James Kahler became more and more distraught. On Thanksgiving weekend, he drove to the home of Karen's grandmother, where he knew his family was staying. Kahler entered through the back door and saw Karen and his son. He shot Karen twice, while allowing his son to flee the house. He then moved through the residence, shooting Karen's grandmother and each of his daughters in turn. All four of his victims died. Kahler surrendered to the police the next day and was charged with capital murder.

At trial, a forensic psychologist testifies that Mr. Kahler has been diagnosed with bipolar disorder.

3. In early 2009, Karen Kahler filed for divorce from James Kahler and moved out of their home with their two teenage daughters and 9-year-old son. Over the following months, James Kahler became more and more distraught. On Thanksgiving weekend, he drove to the home of Karen's grandmother, where he knew his family was staying. Kahler entered through the back door and saw Karen and his son. He shot Karen twice, while allowing his son to flee the house. He then moved through the residence, shooting Karen's grandmother and each of his daughters in turn. All four of his victims died. Kahler surrendered to the police the next day and was charged with capital murder.

At trial, a forensic psychologist testifies that Mr. Kahler has experienced severe mood swings both high (abnormal and persistent elevated, expansive, or irritable mood, goal-directed behavior or energy) and low (depressed mood, loss of interest/pleasure in activity, sleep disturbance, sense of worthlessness or delusional/excessive guilt, recurrent thoughts of death, impaired thinking/concentration/decisional capacity, excessive tiredness,) disorganized and impulsive behavior, and unwanted or delusional thoughts.

Appendix B

Brief Symptom Inventory. Participants are instructed to answer with 0-

Not at all, 1- A little bit, 2- Moderately, 3- Quite a bit, 4- Extremely, R- Refuse to

answer.

DURING THE PAST 7 DAYS, how much were you distressed by:

1. Nervousness or shakiness inside 0 1 2 3 4 R

2. Faintness or dizziness 0 1 2 3 4 R

3. The idea that someone else can control your thoughts 0 1 2 3 4 R

4. Feeling others are to blame for most of your troubles 0 1 2 3 4 R

5. Trouble remembering things 0 1 2 3 4 R

6. Feeling easily annoyed or irritated 0 1 2 3 4 R

7. Pains in the heart or chest 0 1 2 3 4 R

8. Feeling afraid in open spaces 0 1 2 3 4 R

9. Thoughts of ending your life 0 1 2 3 4 R

DURING THE PAST 7 DAYS, how much were you distressed by:

10. Feeling that most people cannot be trusted 0 1 2 3 4 R

11. Poor appetite 0 1 2 3 4 R

12. Suddenly scared for no reason 0 1 2 3 4 R

13. Temper outbursts that you could not control 0 1 2 3 4 R

14. Feeling lonely even when you are with people 0 1 2 3 4 R

15. Feeling blocked in getting things done 0 1 2 3 4 R

16. Feeling lonely 0 1 2 3 4 R

17. Feeling blue 0 1 2 3 4 R

18. Feeling no interest in things 0 1 2 3 4 R

DURING THE PAST 7 DAYS, how much were you distressed by:

19. Feeling fearful 0 1 2 3 4 R

20. Your feelings being easily hurt 0 1 2 3 4 R

21. Feeling that people are unfriendly or dislike you 0 1 2 3 4 R

22. Feeling inferior to others 0 1 2 3 4 R

23. Nausea or upset stomach 0 1 2 3 4 R

24. Feeling that you are watched or talked about by others 0 1 2 3 4 R

25. Trouble falling asleep 0 1 2 3 4 R

26. Having to check and double check what you do 0 1 2 3 4 R

27. Difficulty making decisions 0 1 2 3 4 R

DURING THE PAST 7 DAYS, how much were you distressed by:

28. Feeling afraid to travel on buses, subways, or trains 0 1 2 3 4 R

29. Trouble getting your breath 0 1 2 3 4 R

30. Hot or cold spells 0 1 2 3 4 R

31. Having to avoid certain things, places, or

        activities because they frighten you 0 1 2 3 4 R

32. Your mind going blank 0 1 2 3 4 R

33. Numbness or tingling in parts of your body 0 1 2 3 4 R

34. The idea that you should be punished for your sins 0 1 2 3 4 R

35. Feeling hopeless about the future 0 1 2 3 4 R

36. Trouble concentrating 0 1 2 3 4 R

DURING THE PAST 7 DAYS, how much were you distressed by:

37. Feeling weak in parts of your body 0 1 2 3 4 R

38. Feeling tense or keyed up 0 1 2 3 4 R

39. Thoughts of death or dying 0 1 2 3 4 R

40. Having urges to beat, injure, or harm someone 0 1 2 3 4 R

41. Having urges to break or smash things 0 1 2 3 4 R

42. Feeling very self-conscious with others 0 1 2 3 4 R

43. Feeling uneasy in crowds 0 1 2 3 4 R

44. Never feeling close to another person 0 1 2 3 4 R

45. Spells of terror or panic 0 1 2 3 4 R

DURING THE PAST 7 DAYS, how much were you distressed by:

46. Getting into frequent arguments 0 1 2 3 4 R

47. Feeling nervous when you are left alone 0 1 2 3 4 R

48. Others not giving you proper credit for your achievements 0 1 2 3 4 R

49. Feeling so restless you couldn't sit still 0 1 2 3 4 R

50. Feelings of worthlessness 0 1 2 3 4 R

51. Feeling that people will take advantage of you if you let them 0 1 2 3 4 R

52. Feeling of guilt 0 1 2 3 4 R

53. The idea that something is wrong with your mind 0 1 2 3 4 R