

MEDICATION STATE AT THE TIME OF THE OFFENSE:
MEDICATION NONCOMPLIANCE AND CRIMINAL RESPONSIBILITY

by

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A DISSERTATION

Submitted in partial fulfillment of the requirements
for the degree of Doctor of Philosophy
in the Department of Psychology
in the Graduate School of
The University of Alabama

TUSCALOOSA, ALABAMA

2013

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ABSTRACT

Ethical and due process concerns arise when insanity standards lack a nuanced picture of how society views mental illness and its effects on the volitional nature of a defendant's actions. This project examined whether mock jurors consider meta-responsibility (MR) of mentally ill defendants, how they think about MR in relation to criminal responsibility, and if various degrees of MR differentially influence defendant responsibility and guilt. The MR benchmark manipulation was medication compliance (or noncompliance; MNC) for a NGRI defendant at three levels: medication compliant (MC/control), purposive MNC, and inadvertent MNC. The type of MNC was manipulated by establishing the defendant's insight into his illness as either High or Low. A second variable – the extent to which a forensic mental health expert explains issues relevant to the defendant's MR (i.e., MNC and insight into one's mental illness) – was also manipulated. Using a between-subjects jury deliberation paradigm and a mixed quantitative-qualitative methodology, results did not yield the hypothesized interactions between a NGRI defendant's MNC, insight, and testimony elaboration on MR and verdict. Results suggest that as ecological validity of the study parameters increased, effects found in prior research with more experimental control were unsupported. Findings were consistent with research suggesting jurors are unlikely to recognize the complexity of the relationship between a defendant's MNC and volitional, informed decision-making; thus, readily attributing MR to NGRI defendants at the cost of overlooking individual differences in case facts related to some of the key determinants of their verdicts such as MNC and insight into one's illness. Implications for future research, NGRI proceedings, and forensic mental health expert testimony are discussed.

DEDICATION

This dissertation is dedicated to my family and close friends who not only stood by me throughout the time taken to complete this manuscript, but whose encouragement and unwavering confidence in me helped to keep my passion for my work ever-present during this process.

LIST OF ABBREVIATIONS AND SYMBOLS

α	Chronbach's alpha coefficient
ANOVA	Analysis of variance
d	Cohen's d (effect size estimate)
EFA	Exploratory factor analysis
F	Fisher's F ration
FMHP	Forensic mental health professional
LMM	Linear mixed modeling
M	Mean (arithmetic average)
MANOVA	Multivariate analysis of variance
MC	Medication compliance
MC/C	Medication compliant/ Control condition
MC-Competency	Medication compliance competency
MC-Responsibility	Medication compliance responsibility
MI-Product	Product of one's mental illness
MNC	Medication noncompliance
MNC/LeLi	MNC/ Low Elaboration – Low Insight condition
MNC/HeLi	MNC/ High Elaboration – Low Insight condition
MNC/LeHi	MNC/ Low Elaboration – High Insight condition
MNC/HeHi	MNC/ High Elaboration – High Insight condition
MR	Meta-Responsibility

N	Number of participants
<i>n</i>	Number of participants per subsample (condition)
NGRI	Not guilty by reason of insanity
η_p^2	Partial Eta Squared (effect size)
<i>p</i>	Probability
<i>r</i>	Pearson correlation
SMI	Severe mental illness
<i>SD</i>	Standard deviation
<i>t</i>	Test statistic
X^2	Chi Square
=	Equal to (symbol)

ACKNOWLEDGMENTS

The enclosed dissertation would not have been possible without the guidance and support of my family, friends, colleagues, and mentors. I would like to extend a heartfelt thank you to Stan, my academic mentor and thesis committee chairperson whose wisdom and steadfast encouragement have helped me to emerge from this process even more enthusiastic about research and making a difference in the work that I do. I would also like to thank Clay Shealy and Martin Sellbom for their guidance both in and out of the classroom, and for their unwavering support of me over the years. Thank you to all of my committee members, including David Pollio, Joseph Colquitt, and Natalie Dautovich, for their expertise and assistance in ushering me through some of the most challenging aspects of this project.

I am grateful to Clay Shealy, Jennifer and Jason Wilson, and David Sams for so generously agreeing to film the stimulus for this project. Thank you to Michelle Jones, Kara Dickson, Chelsea Henderson, Sarah Greene, and Abby Clark for their tireless efforts in assisting with data collection, entry and coding. Furthermore, thank you to all of my Witness Research Lab peers and Debra Chen for their friendship and suggestions throughout this process. Finally, thank you to Scott Parrott, Nicole Psomas, and of course, my parents and siblings for their loving support and for always reminding me of the important things in life.

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INTRODUCTION

In certain cases you have to take into account negligence... and like if [the defendant] wasn't taking his medication, then his actions would be negligent...and that [would have] made him responsible for anything he's done while he was not on his medication. (*Mock juror during a focus group session; present study*).

The above statement is taken from a mock juror who was tasked as the trier of fact for a defendant who entered a Not Guilty by Reason of Insanity (NGRI) defense to second-degree murder. Guided by legal standards, mock jurors were instructed to decide two separate but related questions: (1) Was the defendant's guilt for the crime proven beyond a reasonable doubt, and (2) did the defendant show with a preponderance of the evidence that he was not criminally responsible for the crime (Packer, 2009). Never were the mock jurors instructed to deliberate on the defendant's culpability – or blameworthiness – for his behavior. They were also not asked to evaluate if the defendant was responsible for his mental state at the time of the offense (MSO). While defendant blameworthiness is an issue reserved for sentencing, scholars suggest that jurors evaluate a defendant's responsibility *for* criminal responsibility in NGRI defense cases (e.g., Finkel & Slobogin, 1995; Mitchell, 1986, 1999, 2003; Slodov, 1989). Despite its potential for very real consequences, the jury decision-making framework is ignored by the courts, overlooked by current legal standards, and rarely addressed in the psycho-legal literature.

“Meta-Responsibility”

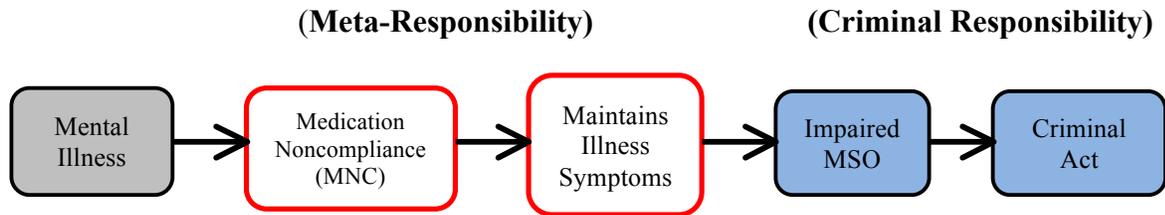
The “self-causation” or worsening of one's severe mental illness has long been debated in philosophical, medical, psychological, and even legal arenas (Mitchell, 2003). When these

forums convene, an understudied and complex psycho-legal issue emerges: “The self-causation of mental disorder and its concomitant effect on criminal responsibility” (Mitchell, 2003, p. 34). Scholars have termed the mentally ill offender as *both* “mad” (reflected by his or her mental illness) and “bad (reflected by his or her criminal behavior) (Radden, 1985, as quoted by Mitchell, 2003, p. 35). An alternative conceptualization has been offered by Mitchell (2003) that “abandons the traditional mad/bad dichotomy and acknowledges that whilst defendants may be both mad and bad, madness may be an offspring of badness” (p. 35).

It is important to note that it is neither Mitchell’s (2003) nor the present author’s position that this should be the case – that criminal responsibility should be expanded to a broader context to evaluate a person’s *responsibility* for their criminal responsibility. Instead, the present research seeks to understand how the parameters for evaluating legal conceptualizations of criminal responsibility align with how the trier of fact naturally considers the issue. Should there be disparity in these two conceptualizations, there would also be a great potential for a miscarriage of justice in the legal system – a system designed to provide a just alternative for mentally ill offenders.

Assisted by forensic mental health professionals (FMHPs) who serve as experts, the triers of fact are charged with deciding the offender’s mental state at the time of the offense (Mitchell, 2003). It is not known to what extent forensic clinicians also evaluate the offender’s ability to avoid contributing to his or her mental illness (and subsequent mentally disordered state). Even less is known about how the triers of fact – judges and jurors – consider such facts in their decision-making. Scant research does suggest that jurors go beyond the moment of the criminal act and evaluate a defendant’s responsibility for causing his or her MSO (Finkel & Slobogin, 1995). When jurors consider this type of evidence, including medication noncompliance (MNC)

of mentally disordered defendants, they are essentially evaluating a defendant's "meta-responsibility" (Finkel & Slobogin, 1995; Mitchell, 1999, p. 585). See below:



The term meta-responsibility can be understood in relation to "meta-cognition," which is defined as how persons think about thinking (Jost, Kruglanski, & Nelson, 1998). Following this definitional structure, meta-responsibility is how one assigns responsibility for responsibility (Mitchell, 2003). Although considerations of *meta-responsibility* align well with commonsense notions of blameworthiness and guilt (Mitchell, 2003), the law only permits consideration of *criminal responsibility* in NGRI cases. Unlike cases where volitional actions prior to the offense are considered, in the typical NGRI standard, the trier of fact is not instructed to consider or to not consider a defendant's actions that may have contributed to his or her MSO.

The Legal Foundations for Insanity

The trier of fact in NGRI cases is tasked with considering only the evidence pertinent to the defendant's mental state at the time of the offence (MSO). In other words, the *mens rea* (criminal intent) is to be considered proximally to the *actus rea* (the criminal act). The law has long established provisions for considering a person's inability to form *mens rea*. These provisions include modern day *diminished capacity* statutes and specifically question the defendant's ability to form the specific, requisite intent for the criminal act. As explained by Packer (2009), "the distortions in perception, or impairments in volitional control, that form the basis of an insanity defense are likely to be irrelevant to whether a defendant was able to form the intent to commit the act." Packer (2009) goes on to explain that "very few circumstances

would result in an inability or incapacity to form an intent... [except for] very rare examples, including a defendant suffering from a seizure or a profoundly retarded individual who could not comprehend the concept of stealing” (Clark, 1999). In some cases (e.g., *Clark v. Arizona*, 548 U.S. 735, 2006), the defendant, because of his psychotic state, may have failed to form the intent to commit the specific act charged (e.g., shooting a police officer but believing the officer was an alien). However, expert psychological testimony as to the delusional nature of this cognitive framework is most often not permitted, as was the case with *Clark v. Arizona* (548 U.S. 735, 2006), because *intent* for a legal question is for the trier of fact to decide (Packer, 2009).

Specific provisions for impaired volitional and cognitive control due to mental illness have been established by the courts. The result is the present-day NGRI defense (Borum, 2003). NGRI is relatively synonymous with a Not Guilty by Reason of Mental Disease or Defect plea (Packer, 2009); the former terminology will be used here for simplicity. When the affirmative NGRI defense is raised, the defendant’s MSO can be evaluated against three abilities constituting legal sanity: (1) the ability to understand the nature, character, and/or consequences of the act, (2) the ability to distinguish right from wrong, and (3) the ability to resist the impulse of the act (Rogers & Shuman, 2005). The first two prongs comprise the “cognitive” test of insanity (a.k.a., the “knowing” test, which is an offspring of the “*M’Naghten*” standard; *M’Naghten’s Case*, 10 Cl. & F. 200, 8 ER 718, 1843), whereas the latter prong is termed the “volitional” test of insanity (the “ALI” or American Law Institute Standard test) (Rogers & Shuman, 2005). While it varies by state and jurisdiction (*Clark v. Arizona*, 548 U.S. 735, 2006; Rogers & Shuman, 2005), the majority of present-day insanity tests involve only the cognitive test of insanity as outlined by the Insanity Defense Reform Act of 1984, 18 U.S.C. § 17 (Slovenko, 1995) - “It is an affirmative defense to a prosecution under any Federal statute that, at the time of the commission of the acts

constituting the offense, the defendant, as a result of a severe mental disease or defect, was unable to appreciate the nature and quality or the wrongfulness of his acts.” Where the volitional prong can be considered (in 16 states), it is not commonly done so in isolation of the cognitive prongs (Packer, 2009; Warren et al., 2004).

Thus, a legal test of insanity evaluates the defendant’s appreciation for the wrongfulness of his acts, and/or his ability to understand the nature of his actions (Insanity Defense Reform Act of 1984, 18 U.S.C. § 17; *M’Naghten’s Case*, 10 Cl. & F. 200, 8 ER 718,1843). Should the facts of the crime be proven, the defendant may be found either Guilty or NGRI. Each of these verdicts would be subsumed under an “all-or-none” judgment of the defendant’s responsibility for the act – either the person is criminally responsible (Guilty) or is not criminally responsible (NGRI) (Finkel & Slobogin, 1995, p. 441). There is no option for “not criminally responsible, but *guilty* of being not criminally responsible” (Mitchell, 2003, p. 103). Diminished capacity and partial insanity are not alternative dispositions offered to the fact-finder (Finkel & Slobogin, 1995; see case law examples in Appendix A). In this manner, the legal system does not explicitly permit consideration of the defendant’s blameworthiness for *causing* the conditions of his or her mental disease or defect (e.g., *State v. Maik*, 287 A.2d 715, N.J. 1972). Some states have expanded the typical criminal responsibility standard to a Guilty But Mentally Ill verdict. However, this alternative has been criticized for failing to add clarity to the criminal responsibility issue and instead, has been espoused as merely providing the illusion of a middle-ground verdict (Slobogin, 2006).

Legally Incapacitating Conditions and Meta-Responsibility Issues

Involuntary acts. Case law and forensic mental health practice generally cite two exceptions to meta-responsibility being a non-issue: involuntary autonomic impairment and

voluntary intoxication. The former, a non-volitional autonomic state, often clearly equates with a lack of criminal responsibility (Packer, 2009). The basic premise is that the act itself (*actus reas*) was completely out of the defendant's control. Case law heavily cites such defenses raised due to a defendant's MSO as impaired due to diabetic coma, epileptic seizure, sleep disorder; etc. (see review by Mitchell, 2003). For example, epilepsy has historically been considered viable for insanity defenses and autonomic (involuntary act) defenses (Slodov, 1989; Mitchell, 2003). There are noteworthy exceptions to this general principle, as discussed further in the *Medication Noncompliance* section below.

Voluntary intoxication. Conversely, the influence of voluntary intoxication on insanity defense viability is generally agreed on by case law (e.g., *Griggs v. Commonwealth*, 255 S.E.2d 475, Va. 1979), legal statutes, and forensic practice (Warren et al., 2004). Intoxication or substance use fails to lessen a person's criminal responsibility due to its volitional nature (*Kane v. United States*, 399 F.2d 730, 9th Cir. 1968). Despite the lack of *mens rea* formed for the specific charged offense, such volitional intent is subsumed under the choice to become intoxicated. In fact, empirical studies have found that forensic mental health practitioners often cite the presence of substance use as negating any potential use of an insanity defense (Warren et al., 2004). Carefully construed, however, best practice notes exceptions to this rule, including the cumulative effects of intoxication (e.g., dementia), and substance-induced psychotic disorders that continue past the period of intoxication but not yield permanent psychosis (Packer, 2009). When experts testify to these impairments, jurors have historically rejected such insanity claims (e.g., *Allen v. State*, 502 So. 2d 389, Ala. Crim. App. 1986); an expert testified to a robbery defendant's psychosis at the time of the offense due to volitional LSD use.

In addition, some researchers (Warren et al., 2004) have noted the likelihood of these exceptions to be overlooked by FMHPs due to their volitional face-value. Warren and colleagues (2004) postulated that the semblance of wrong-doing associated with the defendant's substance use transfers perceptions of his or her alleged criminal act (e.g., the defendant knew smoking crack was wrong and did it anyway, so his criminal behavior after that fact is grandfathered into that decision). Although not directly assessed in their research, Warren et al. (2004) speculated that a "moral bias against substance abusers, and/or the biasing effect of anticipating that juries are unlikely to negate culpability in instances in which substance abuse is involved" subverts FMHP's ability to properly assess the influence of substance use in a particular MSO evaluation.

Medication noncompliance. Despite their inconsistencies, the law and forensic mental health practice have begun to set precedents for factors that may influence criminal responsibility, such as intoxication, epilepsy, and battered woman's syndrome (Rogers & Shuman, 2005). Yet there is no clear guidance for the fact-finder as it relates to a defendant's medication noncompliance (MNC). *Medication noncompliance*, for the purposes of this paper, is operationally defined as a person's failure to comply with a prescribed order to take medication and/or a gross inaccuracy (error) in taking that medication. Some scholars have called for a clear statute that would guide the courts on this issue. Slodov (1989) stated that when a defendant consciously elects to be MNC despite knowing the risks, "he should be held responsible for risking madness under the reckless endangerment approach of the Model Penal Code" (p. 279).

Slodov (1989) cites case law referencing the precedent that the insanity defense only be raised if the "mental condition... [was] brought about by circumstances beyond the control of the defendant" (*United States v. Shuckahosee*, 609 F.2d 1351, 10th Cir. 1979). On the surface, this seems to clear up the issue of how MNC should influence the viability of an insanity defense.

This assumption is flawed, however, for several reasons. First, there is no statute explicitly stating the reverse of this case law. In other words, *if* the mental condition is brought on by the defendant's MNC, an insanity defense is negated. Second, the issue of MNC for *psychotic illnesses* cannot often be clearly defined as a "choice." There are case law precedents set by rulings where defendants' were unable to enter an autonomic defense because of medication noncompliance (*People v. Decina*, 1 A.D.2d 592, 1956; *People v. Grant*, 692 N.E.2d 1295, Ill. Ct. App. 1998); in both of these cases the defendant failed to take his prescribed medication to prevent epileptic seizures). Slodov (1989) states that "an actor who chooses to deprive himself of the influences of reason so that basal impulses direct his behavior breaches a duty owed by him to society that warrant condemnation" (p. 281). While this aspect of the argument appears defensible, the fact that mentally ill psychotic persons *as a direct function of their illness* may not have the insight to make a reasoned choice to comply or not comply with medication is neglected in Slodov's (1989) discussion.

Medication Noncompliance: An Exculpatory Position?

Slodov (1989) postulates that in circumstances where MNC will clearly increase the likelihood of harm to others, MNC would in and of itself warrant *criminal* sanctions. Our current legal system handles such issues in civil adjudications and conditional release rulings (Packer, 2009). Though echoing an extreme point of view in some respects, Slodov (1989) primarily called for uniformity across statutes. If voluntary use of LSD and mindful neglect of one's epileptic medications are not exculpatory conditions for criminal responsibility, then medication "noncompliance-induced relapse" of severe mental illness should too not be considered appropriate for an insanity defense (Slodov, 1989, p. 302). It is true that MNC for antipsychotic

medications can be a result of strictly voluntary conditions. However, noncompliance with medication by mentally ill people is not always that straightforward.

In his legal review of the issue (see Appendix B), Slodov (1989) concluded that when NGRI pleas have raised the issue of the defendant's MNC, the courts' decisions have "reflected the view that as long as a 'true' mental illness resulting in a substantial impairment of the actor's cognitive and volitional capacities exists at the time of the offense, his conduct will not be punished" (p. 307). Slodov cites eight reasons why this should not be the case (p. 307-8):

1. The high degree of control exercised by the defendant over his illness
2. The high probability that noncompliance will result in relapse
3. A direct causal link between noncompliance and relapse is established
4. There is a high recidivism rate of insanity acquitees/mentally ill offenders
5. The assumptions inherent in our criminal justice system relating to criminal responsibility do not serve to justify exculpating noncompliant offenders
6. Self-inducing an incapacity serves as a justifiable limitation to the insanity defense
7. Theoretical justifications typically used for not inquiring into the cause of mental illness do not apply to a noncompliant offender
8. The potential for abuse of using one's frailty as an excuse is high.

In line with Slodov's (1989) view, "assessing when patients should be held accountable for illness related behavior is an inherent part of medical practice" (Halleck, 1988, p. 338, 1992). The underlying reasoning is that choice is *innately linked* to responsibility for one's medical condition. Thus, ignoring the influence of free will on behavior is detrimental to the treatment of disease (Halleck, 1988, 1992). The field of psychology and behavioral science, however, would likely not propose ignoring the influence of free will, but would also not neglect the influence of deterministic diseases and their influences on choice. For example, a person's behaviors may be clouded by psychosis or a pervasive lack of insight into one's illness. There are varying degrees of a mental illness' influence on the afflicted person's cognitive and volitional abilities.

Provisions for MNC fit in current insanity test standards. On the surface, provisions for considering MNC as a meta-responsibility factor in MSO determinations are not explicitly

stated in legal standards. However, a more detailed examination would conclude that MNC could be subsumed under either the cognitive or volitional insanity test prong. Currently, no legal parameters actually do so (Packer, 2009).

Cognitive prong and MNC. The defining feature of the cognitive prong is the defendant's inability to understand that the action was legally or morally wrong (Packer, 2009). Under best practice guidelines, the FMHP would evaluate the cognitive prong by assessing the content and *quality* of the defendant's thinking at the time of the offense (Packer, 2009). A distinction must be made between delusional and otherwise extreme - yet not psychotic - dysfunctional thinking. The FMHP should use "collateral sources of information about the defendant's statements and behaviors around the time of the alleged offense" (Packer, 2009) to reach these conclusions. Evidence of irrational or rational thinking likely includes a defendant's MNC. For instance, one should take into account whether the defendant was not taking his/her medication for a delusional reason (such as doctors trying to poison him) or a rational reason (such as the avoidance of medication side effects). Inferred (although not explicitly instructed) from recent best practice guidelines (Packer, 2009), the FMHP should detail the medication non-compliance information for the courts in MSO evaluations.

Volitional prong and MNC. Rogers (1984) established five ways to assess the volitional prong of insanity. First, one should take into account whether the defendant's actions were foreseeable and therefore avoidable (Rogers, 1984). Packer (2009) illustrated the construct with the following questions:

1. Did the defendant choose to enter a high-risk situation in which he had prior difficulties with volitional control?
2. Did the defendant anticipate that a loss of control was likely to occur based either on self-appraisal or on circumstances? If yes, what impact did this awareness have on subsequent behavior?

Under standards of practice, the FMHP should gather information relevant to the questions when the volitional test is applicable. The FMHP should report findings that are *legally relevant* to the court (Packer, 2009). However, the ultimate determination of whether these conditions constitute criminally responsible or irresponsible behavior falls to the trier of fact (Packer, 2009). As mentioned previously, the court offers guidance on the legal relevance of certain conditions such as volitional substance use and non-volitional autonomic conditions. In other circumstances, such as with MNC, the parameters are less clear. Packer (2009) illustrated the point:

For example, consider the hypothetical Mr. Doe, who has a long-standing diagnosis of schizophrenia, paranoid type. He functions well when engaged in treatment taking his prescribed antipsychotic medications. However, when he discontinues his medication, his symptoms reemerge, and these have been associated in the past with assaultive behaviors. Mr. Doe does not like some of the side effects of his medications, so he discontinues them, experiences auditory hallucinations and paranoid delusions, and commits an assault and battery in reaction to these symptoms. *A thorough forensic evaluation provides clear data that his relevant legal capacities were impaired.* However, the prosecution argues that Mr. Doe *discontinued his medication*, knowing that this could lead to increased symptoms and an elevated risk for violence. This argument would be consistent with Rogers' [foreseeability/avoidability] criteria. However, *it would be inappropriate for an evaluator to opine that this meant that Mr. Doe did not qualify for the volitional prong of the insanity defense because no specific legal criterion has been established to address this issue.* Rather, the evaluator could provide information about the defendant's mental state at the time he discontinued his medications (i.e., was he psychiatrically stable at the time or had he already begun to experience symptoms that impacted his judgment), which the trier of fact could then decide how to apply.

No legal standard exists concerning MNC and criminal responsibility. Little guidance remains available to the courts on the issue because of the complexity of the science (Neumann, Walker, Weinstein, & Cutshaw, 1997). Furthermore, no single explanation covers medication and treatment adherence across individuals and illnesses (Neumann, Walker, Weinstein, & Cutshaw, 1997). However, there is a clearly established lack of judicial guidance regarding the

factors that should be presented by FMHPs in MSO evaluations and be considered when the trier of fact weighs one's contributions to the defendant's mentally disordered state.

The Role of the Forensic Mental Health Professional: MNC and MSO

The need for specificity in MSO practice guidelines. There are no regulations for what self-causation or self-contributing factors should (or should not) be considered when evaluating a defendant's criminal responsibility/MSO. The one exception, noted above, is the use of substances contributing to an impaired MSO (American Bar Association, 1989; Borum, 2003; Rogers & Shuman, 2005). Even this exception is not uniformly applied (Borum, 2003). This is not to say that the field of forensic psychology is completely void of specialized practice guidelines. Specific to MSO evaluations, leading psycho-legal scholars and practitioners have developed guidelines for information gathering (e.g., Borum, 2003; Rogers & Shuman, 2000), the use of psychological tests (e.g., Borum & Grisso, 1996; Heilbrun, 1992), the use of third party information (e.g., Heilbrun, Rosenfeld, Warren, & Collins, 1994; Heilbrun, Warren, & Picarello 2003), and specified "best practice" standards (Giorgi-Guarnieri et al., 2002; Packer, 2009). What stands out as lacking in the literatures, however, is guidance on how this information can or should be used in forming MSO opinions for the courts (Borum, 2003).

Current MSO practice parameters. Guidelines for forensic mental health professionals (FMHP) clearly emphasize the causal inferences and "theoretical speculation" necessitated by MSO evaluations (Borum, 2003, p. 207). Such inferences are no doubt a function of the uniqueness of a MSO evaluation. First, the evaluation is inherently retrospective. Second, while a diagnosable mental illness may be established in the record, "evidence for impairment in cognitive or volitional capacity can be inferred only from history and behavior around the time of the offense" (Borum, 2003, p. 206). The proximal nature of the defendant's mental state

immediately associated with (i.e., “at the time of”) the criminal act is unique because it is not an ability that can be tested in the present (Borum, 2003; Rogers & Shuman, 2005). Thus, data must be collected from time points prior to, during, and after the criminal act in order to inform this assessment (Borum, 2003). For instance, in summarizing the salient issues relevant to a defendant’s cognitive issues, Rogers and Shuman (2005) recommend the following (non-exhaustive) list of questions to query the defendant’s nature and quality of his actions (p. 198):

1. Did the defendant appear to understand the *immediate* consequences of his or her noncriminal (e.g., food preparation for breakfast) actions?
2. Did the defendant appear to understand the *immediate* consequences of his or her criminal (e.g., firing a weapon) actions?
3. In general, was the defendant engaged in *purposeful* behavior prior to the criminal actions?

In short, the insanity test’s causal component (mental disease or defect) is “almost always *inferred* from behavior” (Borum, 2003, p. 207). For example, in reference to the cognitive prong, an expert may focus on the defendant’s ability to reality test and its relation to his capacity to understand right from wrong (Packer, 2009). The mental status factors and behavioral manifestations referenced by FMHPs are matters of jurisdiction and discretion (Packer, 2009). This variability impedes establishment of uniformly objective and specialized standardized practice guidelines (Packer, 2009). Best practice calls for the FMHP to “relate the defendant’s symptoms to the specific cognitive and/or volitional prongs in the particular jurisdiction” (Packer, 2009). However, the nature of the theoretically-based, retrospective evaluation often comes up as “inadequate to explain *how* the disorder caused the impaired ability” (Packer, 2009).

MNC-relevant information gathering by the FMHP. According to best practice, the main function of FMHP as experts in MSO evaluations is to collect clinically relevant information for the trier of fact. This information should include, but is not limited to: The presence of a diagnosis of a psychotic disorder that is responsive to treatment, but which recurs *if*

the defendant discontinues treatment? If so, was the defendant actively involved in treatment (including taking prescribed medications) around the time of the alleged offense? (Packer, 2009). Medical history and response to treatment are clearly emphasized as essential components to information gathering in criminal responsibility evaluations (Packer, 2009).

The FMHP uncovers relevant symptoms and behaviors *and* links those behaviors to legally relevant standards (Packer, 2009). It is not the job of the expert to opine as to whether those behaviors were or were not reasonable (Packer, 2009). However, FMHP should go beyond providing one representation of the data relevant to MSO opinions (Packer, 2009). Due to the ambiguity inherent in these retrospective determinations, experts are urged to consider multiple explanations for behaviors and present those alternatives to the fact-finder (Packer, 2009). This form of elaboration allows the FMHP to educate the trier of fact with all viable data and serves to buttress their opinion as to the most clinically viable option. This practice guideline is a prime example of the educational role of the FMHP in court. Experts are encouraged to educate the fact-finder not only on the facts, but on how those facts fit together, alternatives to that explanation, and why their explanation best matches the available information (Packer, 2009).

From the witness stand to the jury box. Without structured parameters for how this behavioral data and inferential assessments should be conceptualized for the courts, a degree of subjectivity – clinically and expertly opined or not – is entered into the MSO evaluation. As the saying goes, you are likely to get out what you put in. With subjectivity frontloaded in FMHPs’ clinical opinions of MSO, it is plausible that the trier of fact will echo this subjectivity when assessing the credibility and value of their findings. Indeed, this writer is not aware of any empirical studies that have tested the accuracy of FMHPs to reliably assess MSO for the courts (Borum, 2003). As explained by Warren et al. (2004): “To the extent that subjective clinical

impressions guide the inquiry and determine the progression from clinical observation to psycho-legal opinion formation, the process may be too covert to permit direct observation of the sanity evaluation and its conclusions” (p. 172).

One way to inform the forensic practice of criminal responsibility evaluations is to investigate the components of MSO deemed critical by the decision-makers and fact-finders (Borum, 2003). The task involves essentially asking whether FMHPs are assisting the courts by answering the right questions. What do jurors expect to hear from the expert? What kind of explanations should experts provide, especially given the complicated nature of these causal inferences? These questions are rarely asked by the courts or psycho-legal scholars (Borum, 2003). Moreover, little is known about how these factors may or may not align with how fact-finders think through the information (Borum, 2003). If the latter is true, providing the courts with forensic mental health expertise on MSO is likely to be an even steeper uphill battle than originally thought.

Clinically relevant behavior: MNC. Practice guidelines (e.g., Rogers & Shuman, 2000) and survey research (Borum & Grisso, 1996) offer some semblance of what is considered essential to report in a MSO evaluation. Out of these elements, psychotropic medication made the list (Borum & Grisso, 1996). However, the “essential” aspect of this information is considered only as follows: “a statement identifying the defendant’s *current* use, or absence, of psychotropic medication *since the time of* the arrest and *at the time of* the evaluation” (Borum, 2003, p. 202; Borum & Grisso, 1996).

The *Rogers Criminal Responsibility Assessment Scale* (R-CRAS) is perhaps the most objective tool to assist in evaluating MSO (Rogers, 1984). The R-CRAS does not mention medication compliance (or noncompliance), but it does prompt the evaluation of the defendant’s

“*responsible* social behavior during the week prior to the alleged crime” (Borum, 2003). This query is intended to gauge loss of and consistency in behavioral control, versus a tool for collecting evidence against the defendant’s meta-responsibility for his MSO (i.e., medication noncompliance that may have exacerbated his or her mental illness) (Rogers, 1984).

Complicating this issue is the lack of empirical investigation into how forensic clinicians actually form their opinions when evaluating MSO issues in practice (Warren, Murrie, Chauhan, Dietz, & Morris, 2004). Researchers have found that on average, 26 to 33% of forensic evaluators review prior mental health records (Heilbrun & Collins, 1995; Petrella & Poythress, 1983). A select few researchers have attempted to uncover the most salient factors in FMHPs’ MSO determinations. Warren and colleagues (2004) examined 5,175 pre-trial MSO evaluations over a ten year period. Results found a best fitting model for the prediction of FMHPs’ sanity opinions with the following descriptive characteristics: non-minority status; no drug offense charges; having a prior conviction; diagnosis of psychotic, organic, or affective disorder without a personality disorder diagnosis; previous psychiatric hospitalization; and not being under the influence of substances at the time of the offense (Warren et al., 2004).

Although not included in the final model, Warren et al. (2004) found significant differences in psychotropic medication characteristics at the time of the offense for defendants labeled sane versus insane by FMHPs. Medications included anti-psychotics, lithium, anti-depressants, anti-convulsants, anti-anxiety and a combination of others (Warren et al., 2004). Out of the 1,594 defendants *prescribed* medication at the time of the offense, 17% (n = 270) were labeled insane. Out of the 2, 843 defendants *not prescribed* medication at the time, only 8% (n = 226) were deemed insane ($X^2 = 83.12, p < .0001, CC = .14$). Conversely, out of the 720 defendants who *were taking* medication at the time of the offense, 12% (n = 85) were considered

insane. Meanwhile, out of the 1,339 defendants *not taking* medication at the time, 16% (n = 215) were deemed insane ($X^2 = 6.80, p < .05, CC = .06$).

The role of the FMHP. To be clear, a defendant's "insanity" and MSO are legal questions to be answered by the trier of fact (the judge or the jury) (Packer, 2009; Rogers & Shuman, 2005; *Schuessler v. State*, 719 S.W.2d 320, Tex. Crim. App. 1986). Even the presence of a "mental disease or defect" is not a matter for the forensic clinician to decide (*McDonald v. United States*, 312 F.2d 847, D.C. Cir. 1962). Still, the FMHP is often a critical component, if not the sole contributor, to informing the decision from a scientific and medical perspective (Rogers & Shuman, 2005). Judges and jurors recognize the importance of the FMHP's testimony in NGRI defense cases and typically rely on the information for guidance (e.g., Melton, Weithorn, & Slobogin, 1987; Petrella & Poythress, 1983). However, clear limitations govern a FMHP's role in forming MSO opinions for the courts. In order to help the trier of fact focus on the important clinical factors associated with the court's legal questions, forensic psychology must generate more precise guidelines for practitioners on how to address issues such as meta-responsibility (Packer, 2009).

An Empirical Perspective: MNC and MSO

Little empirical or legal scholarship has examined the relationship among MNC, MSO evaluations, and legal standards of criminal responsibility. Sherlock (1984) introduced the issue by calling attention to the presumed link between MNC and behavior. He specifically questioned the influence of prior non-medicated high-risk or violent behavior in defendants on judicial-decision making (Sherlock, 1984). The questions remain unanswered, explored in only a handful of studies (i.e., Alicke, 1992; Finkel & Slobogin, 1995; Mitchell, 1999, 2003). Research suggests that verdicts heavily rely on perceptions of the defendant's responsibility for his or her mental

condition either before or during the index offense. Medication noncompliance may be viewed as particularly blameworthy (Finkel & Slobogin, 1995).

Finkel and Slobogin (1995) examined the predictive utility of various insanity tests, each of which differed in its level of defendant culpability afforded for consideration in NGRI determinations. The authors included an additional “relative culpability” insanity test that added shades of gray to the verdict options. Mock jurors rated the defendant’s culpability from “totally culpable” (intentional) to “partially culpable” (diminished capacity) The researchers also used different manipulations to vary defendant’s culpability for bringing about his/her MSO (Finkel & Slobogin, 1995, p. 448). In one of the case vignettes, the authors varied whether the defendant was taking prescribed medication. The manipulation included the following statement: “Months before the shooting he stopped taking his medication, without consulting his doctor” (Finkel & Slobogin, 1995, p. 454).

Out of Finkel and Slobogin’s (1995) seven culpability manipulations (e.g., drinking alcohol; missing therapy appointments), MNC was the 6th most likely to lead to a NGRI acquittal. The least likely to be acquitted was a defendant who had refused to seek treatment. Ratings on the “relative culpability” scale mirrored these findings, with MNC equated to the 2nd most blameworthy characteristic, behind treatment refusal (Finkel & Slobogin, 1995). When given the opportunity to account for culpability during the guilt phase of a NGRI case, mock jurors hold defendants accountable for their meta-responsibility, especially if it includes treatment or medication refusal (Finkel & Slobogin, 1995). Moreover, the culpability test generated statistically similar outcomes to the “no instruction” condition, providing support that mock jurors intuitively consider self-causation issues in their decision-making (Finkel & Slobogin, 1995). Coupled with other findings, the results strongly suggest that current

prototypical instructions in NGRI cases are insufficient to jurors' multi-dimensional view of criminal responsibility (Finkel, 1989, 1995; Ogloff, 1991).

Mitchell (2003) assessed mock jurors' reactions to meta-responsibility information by manipulating a defendant's MNC into one of three conditions. These conditions included the presence of MNC (similar to Finkel & Slobogin, 1995), but also introduced variability in the defendant's insight into his illness and need for treatment:

1. **Medication Compliant:** *Tom accepted that he should take the advice of the psychiatrist and was careful to take his medication.*
2. **Medication Noncompliant (Purposive = High insight):** *Tom seemed to realize he was ill but did not want to take the advice of the psychiatrist. He seemed to use his illness as an excuse to 'opt out' of normal responsibilities and stopped taking his medication.*
3. **Medication Noncompliant (Consensual = Low insight):** *Tom did not really seem to realize he was ill (probably due to the effects of his illness itself) but accepted that he should take the advices of the psychiatrist and was careful to take his medication. Soon, however, his medication caused unpleasant side effects and because of this he stopped taking it.*

Mock jurors were either provided the *M'Naghten* standard or a novel, meta-responsibility test to guide their decision-making after reading various case-vignettes (Mitchell, 2003). Results supported mock jurors' consideration of meta-responsibility in their mental illness (Mitchell, 2003). Mitchell (2003) found that the *consensual* MNC defendant was more likely to be acquitted based on NGRI rather than found guilty. NGRI verdicts were also more common for the *consensual* MNC defendant than in the other two conditions: *purposefully* MNC defendant and medication compliant (Mitchell, 2003). No differences were found in blameworthiness between the *purposefully* MNC and the compliant defendant.

The finding is perplexing. Why would a defendant who intentionally increased his likelihood of being dangerous (*purposefully* MNC) be seen as *equally culpable* to a defendant who was following the doctor's instructions to maintain his well-being and safety risks

(medication compliant)? The former would surely seem to increase meta-responsibility. However, the latter may actively work against support of an insanity defense (e.g., he took his medication, so he cannot be mentally ill at the time). Medication compliance fails to substantiate the mental illness and risk for MSO. Thus, both – purposeful MNC and medication compliance – could be seen as working against an insanity plea, but in different ways. When he is medication compliant, the defendant is not blamed for the conditions leading up to his impaired MSO because his entire defense is negated. In contrast with vignettes in which medication was not mentioned (Finkel & Slogogin, 1995), Finkel and Slogogin (1995), NGRI acquittals were more likely to occur. The findings suggest variations in the circumstances characterizing one’s meta-responsibility for his/her mental illness and MSO will influence verdict and possible cognitive processing in such cases. In sum, it appears insight into one’s illness and need for medication adds another layer of responsibility determinations to the fact-finder’s decision-making. It further complicates the issue and introduces another layer of potential bias in NGRI decision-making.

The literature indicates that jurors deciding NGRI pleas actively search for a reason the defendant may or may not have been medication compliant (Mitchell, 1999, 2003; Finkel & Slobogin, 1995). Questions remain as to which medications would constitute consideration and for what mental illnesses (i.e., severe mental illness versus brain injuries). Previous research suggests that meta-responsibility is considered more strongly in cases involving Schizophrenia versus depression or a personality disorder (Mitchell, 2004). Despite the limited findings in this area, a path for research has been established. Results suggest that individual mock jurors are more likely to deem a NGRI verdict appropriate if the defendant was MNC due to low insight and side effects (termed “consensual meta-responsibility”) rather than a defendant who “purposively” chose to stop medication to maintain symptoms despite having insight into their

illness (Mitchell, 2003, p. 51). This finding suggests more leniency of MNC when the noncompliance is congruent with jurors' already established schemas of why a person would be MNC (e.g., side effects versus purposely choosing to be disordered) (Mitchell, 2003).

Unexplored empirical issues relevant to MNC and MSO: While an informative beginning, this research needs to be further developed in a number of ways: use of an American sample; providing mock jurors with testimony to view instead of a short, written case vignette; and more stringent adherence to the ecological validity of the trial process (e.g., only allowing mock jurors to focus on guilt and not sentencing during their decision-making). Moreover, deliberation has been noticeably absent in this limited literature. There are also a number of additional empirical questions relevant to how fact-finders think about MNC and MSO that have yet to be explored, some of which are discussed below in more detail:

The equivocal MSO context. The window of time relevant to a particular defendant's MSO is determined on a case-by-case basis. No widely accepted legal standard details this time period (Slovenko, 1995). A question emerges: If medication non-compliance is deemed relevant, how far back in a person's history should jurors examine for the purposes of determining MSO? This question has been raised previously with regard to meta-responsibility. However, no standard time frame has been offered by the courts or mental health professionals (Mitchell, 2003). This standard, as outlined in *M'Naghten's Case*, 10 Cl. & F. 200, 8 ER 718 (1843), fails to clarify if medication compliance prior to the index offense is grandfathered into the MSO issue. Jurors are left to their own judgment when deciding if medication non-compliance should be a bargaining chip brought with them to the table during deliberations (Sherlock, 1985).

Past behavior while non-compliant with medication. Jurors may very well attend to a defendant's prior history of non-compliance with treatment. In fact, expert testimony to this

effect is likely to be presented during an NGRI case. A likely moderator in this relationship would be the degree to which the defendant has evidenced violence or behavior similar to the index offense when previously non-compliant with medication. However, it is unclear how this information would be or should be considered. Jurors are not given specific judicial instructions that address this issue, and most would consider it outside an expert's purpose to provide such guidance. Thus, whether prior medication non-compliance magnifies a defendant's culpability, or a history of medication compliance lessens a defendant's criminal responsibility, becomes an idiosyncratic assessment.

The influence (or lack thereof) of judicial instructions. Judicial instructions are meant to exert standards and guidance for legal decision-making. However, research has shown that varying insanity test instructions across the different legal standards, including a "no instructions" condition, has failed to yield significant differences in verdicts across groups (Finkel, 1989; see also Ogloff, 1991). Research has yielded generally adequate performance from real and mock-jurors asked to adhere to judge's instructions (Smith, 1993). However, jurors are particularly challenged with regard to discrepancies between lay and legal views of particular crimes (Smith, 1993). Additionally, research has shown that nearly half of assessed jurors have difficulty understanding standards in NGRI cases (Ogloff, 1991). Two issues result: (1) Jurors' view of the crime and associated legal standards may very well be different than the courts, and (2) jurors are unable to comprehend instructions specific to NGRI cases. As a result, jurors are often left to their own devices in determining a defendant's criminal responsibility and what standards to apply to judgments regarding the defendant's actions (Vidmar & Hans, 2007).

In such instances, jurors are likely to rely on each other to discern their task using a "commonsense justice" approach (Finkel, 1995; Perlin, 1990; Vidmar & Hans, 2007). Under the

semblance of a “common sensical” approach, a *Not Guilty* by Reason of Insanity verdict is incongruent with assigning guilt with decreased culpability (Perlin, 1990, p. 28). Jurors likely think of a defendant as not guilty for their mental illness, but guilty for medication non-compliance, which in turn, translates to guilty for the index offense *because of* their medication non-compliance. Coupled with discrepancies in how lay and legal entities view criminal acts in NGRI cases (Smith, 1993), group effects would likely exert themselves heavily in deliberations of meta-responsibility and MNC in NGRI cases. In short, mounting theoretical and empirical evidence indicates that current prototypical instructions in NGRI cases are not sufficient to jurors’ multi-dimensional view of criminal responsibility (Finkel, 1989, 1995).

Where does meta-responsibility enter the equation? Whether a defendant’s meta-responsibility is (and should) be considered in the guilt or penalty phase of a trial has previously been posed in the literature, but has yet to be resolved (Mitchell, 2004). It is likely that jurors view the guilt phase of a trial as the appropriate time to discuss a defendant’s culpability for his or her antecedent to their MSO. The degree to which this is true remains unknown. Also unclear is whether the focus may detract from more relevant evidence or legally sanctioned insanity tests. It seems that a consideration of meta-responsibility for MSO would serve as a proxy for the juror who feels compelled to focus on moral culpability, blameworthiness, and punishment in the event the law does not permit such considerations during the guilt phase a NGRI trial.

Meta-responsibility in litigation strategy. Like so many considerations of the MSO evaluation, meta-responsibility factors can serve to buttress either side (prosecution or defense) depending on the case. As Rogers and Shuman (2000) point out, it may serve the prosecution well to emphasize any responsible decisions the defendant made around the time of the offense (i.e., medication compliance). The defense may be better served by emphasizing unreasonably

irresponsible choices made by the defendant at the time of the offense (such as MNC). Likewise, either side may wish to emphasize how the defendant contributed to his mental condition depending on the nature of such evidence (Rogers & Shuman, 2000). As issues related to a defendant's meta-responsibility for his MSO find their way into trial strategy recommendations, the potential for miscarriages of justice increase. The primary threat to injustice is the subjective, idiosyncratic manner in which these evidences – responsible choices and responsibility for one's mental condition – can be applied to NGRI cases. The ultimate aim should be to inform an empirically-based framework for considering such facts in MSO evaluations. The individualized nature of MSO evaluations will not be compromised by providing a more stringent and ecologically valid decision-framework. Research has yet to assess the most effective ways to communicate MSO data relevant to meta-responsibility issues and opinions to the fact-finder.

Exploring the Fact-finders' Frame of Reference

The notion of free will that sustains the traditional punishment-oriented justice system fails to align with our current understanding of mental illness (Slobogin, 2006). As a result, alternatives to the traditional retributive model have been suggested by those who recognize the stark ideological contrast. The result has been an influx in mental health courts, restorative justice programs, and diversion programs backed by principles of therapeutic jurisprudence (Fingarette and Hasse, 1979; Mitchell, 2004; Perlin, 1990; Slobogin, 2006). The NGRI defense may have laid the groundwork for these movements, but it is surely being left behind in modern-day practice. The defense remains a part of the retributive justice model – imposing a restorative justice alternative from within this traditional system causes clashes in legal statutes, moral determinations, and decision-making. Due to this incongruence, jurors are unlikely to resolve this debate and are more likely to interpret their role incorrectly.

Societal conventions and legal statutes. A cornerstone of effective legal directives is their alignment with societal conventions (Cotterrell, 1992; Radden, 1985). The position that insanity standards should, in effect, mirror and simultaneously set the stage for how society views and treats individuals with mental illness cannot be undervalued (Mitchell, 2003). For example, societal debates related to a person's right to refuse medication and treatment have played out in the context of legislative reform. The courts are responsible for establishing directives for considering a defendant's MNC and criminal responsibility – parameters that will likely model how society understands and treats larger populations of people living with mental illness (Perlin, 1994).

Autonomy and meta-responsibility. Public sentiment concerning people with mental illness seems to be conflicted. Jurors are likely to mirror these views in varying degrees. On one hand, the public perceives people with mental illness as deserving help due to the non-volitional nature of their circumstance. At the same time, a greater respect for the autonomy of individuals living with mental illness has also been revived (Markowitz, 2005). A push to separate the individual from his or her mental illness or diagnostic label has revitalized the issue of personal responsibility for one's mental stability and treatment progress (Markowitz, 2005). In the advocacy and treatment literatures, individuals living with mental illness are being viewed as capable, cognitively aware, and autonomous (Markowitz, 2005).

An outgrowth of this discussion is the disparate views of self-causation of one's mental illness. Some view mental illness as maintained by a lack of personal responsibility and/or a willful desire to develop or maintain a mental illness (Radden, 1985; Szasz, 1961, 1997). Others view mental illness as completely determined by external forces (e.g., genetic predisposition, psychological and environmental stress) (Slovenko, 1995). For example, both substance use and

mental illnesses (e.g., depression, schizophrenia) are diagnosable mental conditions (APA, 2000). Despite this similarity, the public views substance use as a choice and typically views mental illness as non-volitional. Substance use does not lessen criminal responsibility, but mental disease or defect that impairs one's MSO *might*. As seen in this example, different assumptions regarding the volitional nature of the behavior prior to the index offense posits different standards for judging criminal responsibility (Perlin & Dorfman, 1993).

From negative stereotypes to flawed assumptions. The sentiments mentioned above, combined with other stereotypes, halt discussion about how mentally ill offenders should be treated by the community and the law (Mitchell, 2003). Jurors evaluate evidence and its credibility based on these societal and behavioral norms (Vidmar & Hans, 2007). Whether explicitly asserted or implicitly activated, “sanist” attitudes also influence NGRI adjudication procedures and outcomes (Perlin & Dorfman, 1993, p. 47). For example, people often perceive the insanity defense as an easy way to get away with crime. The fact that successful NGRI pleas are a “rarity” is accepted in the psycho-legal literature, but not by laypersons who estimate that approximately 40% of criminal trials involve a NGRI defense (Vidmar & Hans, 2007, p. 215; Skeem & Golding, 2001). Laypersons also commonly view the “mentally ill offender” as “more offender than mentally disordered” (Colombo, 1997; Mitchell, 2003, p. 92; Perlin, 1996). In general, the public would prefer that people with mental illness remain socially distant from the rest of us ‘normal’ people (Perlin, 1994).

As Perlin and Dorfman (1993) posit: “The entire legal system makes assumptions about mentally disabled people – who they are, how they got that way... what there is about them that lets us treat them differently, and whether their conditions are immutable” (p., 47). Such assumptions are readily asserted in legal decision-making, but only rarely are they backed by

empirical support or factual consideration (Perlin & Dorfman, 1993). Despite this truth, legal statutes and judicial-decision making reflect the agreed upon moral fiber of that social system (Koski, 2003). As a result, society's negative perceptions may impede the NGRI defense from serving its intended purpose – to preserve due process. Prosecutors are likely to exacerbate this bias by taking advantage of the jurors' baseline skepticism and the myriads of myths perpetuated about the NGRI defense (Perlin, 2000). This biased cognitive framework likely acts as a barrier to properly evaluating and considering evidence, especially when the NGRI defense is raised (Skeem & Golding, 2001). Examples of erroneous assumptions based on societal misperceptions of mentally ill offenders are highlighted below:

NGRI equates to a “get out of jail free” card. The assumption that the insanity defense is easy to “fake” and that NGRI acquitted defendants are “set free” may also have biasing influences on decision-making. Jurors who believe these myths may be more likely to consider a defendant's sentencing during the guilt phase of a NGRI defense. Jurors who perceive increased meta-responsibility for a defendant's MSO, may seek punishment for the defendant despite agreeing they are NGRI. Jurors are not instructed on the outcomes of NGRI acquittals, however, and in fact the court has set a precedent for this information to be withheld from the jurors (e.g., *People v. Jurczak*, 497 N.E.2d 1332, Ill. Ct. App. 1986; *State v. Robinson*, 399 N.W.2d 324, S.D. 1987). Misconceptions that such defendants are released back into the community may actually impede due process for NGRI defendants.

Mentally ill people are violent. The majority of persons living with mental illness are not at an increased risk of violence in comparison to the general population (see Corrigan, 2005). Summarizing decades of research on this topic, Silver (2006) cited the following conclusions: (1) although most people with major mental disorder do not engage in violence, the likelihood of

committing violence is greater for people with a major mental disorder than for those without; (2) substance misuse raises the risk of violence by people with mental disorder substantially; and (3) no clear understanding of the causal mechanisms that produce the association between mental disorder and violence currently exists (p. 686).

Still, past instances of violence and MNC have been found to increase *the risk* of violent behavior in a subset of persons with severe mental illness experiencing psychosis (e.g., Steadman et al., 1998). More recent research has linked antipsychotic treatment of Schizophrenia with lower violence among outpatient community members (Swanson, Swartz, & Elbogen, 2004). A juror following this logic would propose that if a MNC defendant had *only been compliant with his medication*, then their mental state would not have been so impaired as to commit the criminal act. This logic faults the defendant for his choice to be MNC; thus, failing to lessen criminal responsibility. However, there is no one-to-one relationship between MNC and violent or criminal behavior (Steadman et al., 1998). MNC is likely not the *sole* causal influence of any behavior. The ambiguity, to which risk of dangerousness of mentally ill defendants is assessed, is likely lost by most fact-finders.

Cognitive short-cuts. Decades of social psychological literature (see review by Kerr, MacCoun, & Kramer, 1996) highlight a plethora of cognitive short-cuts and information processing biases susceptible to decision-makers, often accentuated and at times attenuated by group dynamics. Applied to the present discussion, these poorly reasoned inferences may include, but are by no means limited to, the following:

1. Veiled by hindsight bias and self-referential hypothesized behavior into the defendant's situation, jurors may assume that the defendant knew or should have anticipated that MNC would lead to the index behavior (Guthrie, Rachlinski, & Wistrich, 2001).

2. Jurors may assume a 1:1 relationship between MNC and violent offending. The effects of antipsychotic medications, however, are not stable between or *within* individuals (Slobogin, 2006).
3. The ability to choose not to comply with medication may become synonymous with mental stability; resulting in juries rejecting NGRI pleas (Finkel, 1989, 1990; Roberts & Golding, 1991; Vidmar-Perrins, 1999). However, jurors may fail to consider that such decisions can be inextricably linked to a lack of mental illness insight.
4. Jurors may consider MNC as an eligibility benchmark for the NGRI defense (e.g., medication compliance may be equated with sanity, automatically excluding compliant defendants from NGRI defenses; or MNC may be viewed similar to substance use, and be viewed as exculpatory for an NGRI defense because of its proposed volitional nature). Such questions become tautological and lose sight of the proximal nature of MSO.
5. If MNC is deemed relevant, jurors are likely to debate the window of time relevant to the defendant's MSO and MNC history (Slovenko, 1995), as well as the nature of the defendant's behavior during prior periods of MNC. Expert testimony to this effect is likely to be presented during an NGRI case, but jurors are not given instructions that address this issue, and some would consider it outside an expert's purpose to provide such guidance.
6. Broader questions of meta-responsibility would likely follow. For instance, why stop at medication non-compliance when society can hold a defendant responsible for any condition that may have perpetuated the development of his or her mental disability? The answer is simple, because the *causes* of mental illness and the reasons behind treatment adherence are not that clear or even known.
7. Discussions of a defendant's MNC may arise during the guilt phase of a trial and result in consideration of case disposition before jurors are legally permitted to do so, possibly detracting from evaluations of relevant evidence.
8. Jurors may transfer the legal question of MSO to asking "Was the defendant so impaired by mental disease or defect that he did not know *that MNC* was wrong, or if he did, he was not *able to control or gain awareness of his MNC*?" In short, jurors would be tasked with equating knowing the need for medication compliance with the knowing right from wrong MSO standard. Thus, the court would have to accept that jurors are rendering a punitive verdict for a behavior that in and of itself is not illegal, that is, MNC.

9. Conversely, some jurors may take the “everybody knows” people with mental illness are MNC cognitive route (Petrlia, 2009, p. 395). Reliance on this schema would likely attenuate any real influence MNC may have had in increasing one’s risk for violence and/or impairing his MSO.
10. The fact-finder may deem certain reasons for MNC more acceptable than others (e.g., pregnancy or life-threatening physical health risks versus mild, functionally disabling side effects) (Slovenko, 1995). The new question becomes: How good is the defendant’s reason for his MNC? Such a query would no doubt necessitate both a medical and moral judgment. With the state of the science unable to provide clear guidance on the former, researching the latter may prove informative.
11. Research suggests that evidence of a defendant’s planning behavior and responsible decision-making may serve as an informational cue in mock-juries rejecting NGRI pleas (Finkel, 1989, 1990; Roberts & Golding, 1991; Vidmar-Perrins, 1999). Thus, a defendant who is medication compliant would exhibit responsible behavior and be found legally sane. Under this same reasoning, a defendant who is MNC *by choice* would also exhibit purposeful decision-making and be found legally sane. This relationship is not this simple, however. For example, planning an act that is based in disturbed thinking could actually support a case for insanity. This “choice” can be a function of the disorder itself (e.g., low insight, delusional thinking), supporting an insanity claim.
12. Reliance on simple “if, then” logic does not work. For example, *if* medication compliance, *then* you are sane, or *if* you are MNC, *then* you are insane. The issue is actually, *if the defendant chose to be medication compliant*, then he is sane, or *if he chose to not be MNC*, then he is insane.
13. Jurors will likely seek resolution by bifurcating the legal issue. Two questions may emerge from the single criminal responsibility query: (1) If the defendant is MNC, is he responsible [or not responsible] for making that choice?; and (2) If the defendant is MNC, is he responsible [or not responsible] for his MSO, which equates to a corollary: If the defendant is MNC, is he sane [or insane] for making that choice? The reasoning quickly becomes tautological.
14. The analysis could also take the shape of assessing meta-responsibility against the insanity tests: (1) Did the defendant voluntarily choose to stop complying with medication? and (2)

Did the defendant knowingly and intelligently decide to stop complying with medication? In short, the trier of fact would be tasked with equating knowing the need for medication compliance with the knowing right from wrong MSO standard. The defendant's severity of symptoms and insight into his mental illness are inextricably linked with these questions. Any resolution is nearly irresolvable and undoubtedly case-specific (Slovenko, 1995).

The search for an elusive causal link. Any person hoping to find a consensus regarding the specifics of a particular mental disorder's etiology will quickly become disillusioned. Assessing a defendant's culpability or meta-responsibility with regard to MNC may be equally impossible, especially for the lay juror. At the risk of stripping the issue of its complexity, the basic question appears similar to the "chicken or the egg" debate. In short, which came first – the psychosis or the decision to not comply with treatment? These constructs are likely inextricably linked and thus, send FMHPs and fact-finders on a search for answers that may not be available given our current understanding of psychiatric conditions and treatment adherence. The current insanity standards reflect this ambiguity, lacking a nuanced picture of mental illness and its effects on the informed or volitional nature of one's actions. Consequently, they also lack the ability to properly serve how jurors may contemplate a mentally ill defendant's responsibility for his or her actions. Nonetheless, the expert is obligated to educate the jury on these issues in a logical, well-reasoned, and informed manner.

The FMHP as the Expert Witness

Previous research has shown that content elaboration presented during expert testimony can influence decision-making (Titcomb & Brodsky, 2010). In one study, "fuller" testimonies yield more lenient verdicts post-deliberation for NGRI adjudications (Titcomb & Brodsky, 2010). It is important to note that in this study all of the mock jurors were given the same facts in the case; in the "fuller" condition, the expert simply *elaborated* on those facts during his testimony (Titcomb & Brodsky, 2010). Coupled with deliberation, the influence of expert

testimony was most impactful in the fullest condition. Research suggests that jurors consider intentionality and insight in meta-responsibility (Mitchell, 2003). Thus, elaboration by the expert on MNC, insight, and mental illness may be beneficial. It remains to be known how jurors think about these related issues and if education from an expert can appropriately inform such considerations.

The causal relationship between medication non-compliance and criminal behavior is not straightforward. Much room is left for inferences of correlational associations instead of empirical facts and causal conclusions (Rogers & Shuman, 2000). Experts testifying to meta-responsibility issues will be met by challenges from much of their testimony being clinically opined and inferentially formulated. Moreover, there have been some substantial developments in understanding the contributing factors to medication noncompliance (MNC). These reasons have been characterized as both medically (e.g., side effects) or socially (e.g., stigma) derived (Corrigan, 2005). Research has found that being prescribed atypical antipsychotics (rather than traditional antipsychotics) and having a guardian were jointly strong correlates of medication compliance for parolees mandated to outpatient treatment (Farabee, Shen, & Sanchez, 2004). However, overall, efforts to understand MNC within criminally adjudicated populations are ongoing and currently offer little guidance on the issue (e.g., Farabee, et al., 2004). The lack of substantiated empirical data will not stop jurors from actively searching for answers to questions surrounding a defendant's MNC (Mitchell, 1999, 2003; Finkel & Slobogin, 1995).

The Context for Jury Decision-Making: Influences on Evidence Interpretation

Individual Differences: The story model of jury decision-making provides a framework for how evidence interpretation affects trial outcomes (Koski, 2003). Jurors actively frame the evidence within a story to better analyze, organize, and understand the vast amount of

information presented to them (Pennington & Hastie, 2003). As Bennett and Feldman (2003) explain, “Stories are systematic means of storing, bringing up to date, rearranging, comparing, testing, and interpreting available information about social behavior,” (p. 284). The context for this story construction is inherently tied to jurors’ previously established traits, attitudes, and worldviews (Ellsworth, 2003; Koski, 2003).

Because mock jurors may interpret the evidence differently from one another, the importance of examining the variance among jurors’ potentially modifying roles in decision-making should not be overlooked. Much of the jury decision-making research focuses on how individual differences within the juror predict verdict decisions. These characteristics are important to examine empirically because of their applicability to the practice of trial consulting, developing effective litigation strategy, and informing the voir dire process (Brodsky, 2009). The particular individual difference variables of interest in the proposed study include personality, need for cognition, authoritarianism, and bias against the insanity defense.

Personality. Personality has emerged in jury decision-making as influential with regard to its influence on group dynamics. For example, juror extraversion has been linked to criminal case verdicts favoring the defendant, as well as to an increased likelihood that the juror will have a more influential role during the deliberation (Clark, Boccaccini, Callouet, & Chaplin, 2007). Research has also begun to suggest that a mock juror’s personality traits may influence his or her perceptions of expert witness’ personality and related credibility (Stroud, Cramer, Fletcher, Titcomb, & Boccaccini, 2012).

Need for cognition. Need for cognition (NFC) equates with a person’s enjoyment of and tendency towards effortful cognitive processing of information (Shestowsky and Horowitz, 2004). A jurors’ NFC is significantly related to his or her tendency to evaluate the quality of

evidence in a thoughtful, well-reasoned manner – it is considered a motivation and propensity variable (see review by Salerno & McCauley, 2009). Compared to individuals low in NFC, high NFC individuals are more resistant to persuasion against their pre-established attitudes. High NFC jurors are more active participants in decision-making processes (Haugtvedt & Petty, 1992; Shestowsky & Horowitz, 2004). High NFC individuals are also more favorable and evaluative of expert witness evidence when the internal validity is high. Thus, high need for cognition jurors are persuaded by the quality of the evidence more than tangential factors (Caccioppo, Petty, Feinstein, & Jarvis, 1996; Clark et al., 2007; McAuliff & Kovera, 2008).

Need for authoritarianism. Accepted as one of the most effective predictors of mock jurors' criminal case judgments, legal authoritarianism has been used to assess biased attitudes toward the legal system and the defendant (Devine et al., 2001; Kravitz, Cutler, Brock, 1993; Narby, et al., 1993). Authoritarianism has been positively related to beliefs that due process is secondary to crime control and misperceptions of the insanity defense (Skeem, Loudon, & Evans, 2004). Legal authoritarianism has also been found to influence quality of deliberations and positively correlate with conviction proneness, bias against the insanity defense, and lower credibility ratings of expert witnesses in NGRI cases (Clark et al., 2007; Cutler, Moran, & Narby, 1992; Narby, Cutler, & Moran, 1993). Furthermore, authoritarianism has also been found to moderate the relationship between need for cognition and punitive decisions. High authoritarianism increases the likelihood of punitive decision-making in individuals with a high need for cognition (Tam, Leung, & Chiu, 2008).

Bias against the insanity defense. In recent years, bias against the insanity defense has been operationally defined as encompassing two constructs: (1) Strict Liability, or the extent to which a juror believes mental illness is germane to criminal responsibility and 2) Perceived

Injustice and Danger, or the extent of jurors' perceptions of the misuse of the insanity defense and subsequent threats to public safety (Skeem, Loudon, & Evans, 2004). Substantial research indicates that jurors' negative attitudes towards the insanity defense strongly and obstinately bias criminal case judgments over that of the legal definitions or case evidence, particularly in mock jury research (Louden & Skeem, 2007; see also Skeem & Golding, 2001; Skeem et al., 2004).

Accounting for deliberation. As Ellsworth (2003) emphasizes, relying solely on research typified by individual differences commits the fundamental attribution error (i.e., attributing behavior to person-specific causes only, while neglecting the impact of the situation). Thus, it is imperative to include deliberation characteristics (e.g., jury size, decision rule, verdict/sentencing options, trial structure, group discussion) in a study of juror decision-making. Indeed, there has been a recent resurgence in the social psychological, psycho-legal, and methodological literatures calling for deliberation in jury decision-making research as a matter of ecological and construct validity (Diamond, 1997; Nunez, McCrea, & Culhane, 2011; see review by Salerno & Diamond, 2010).

Moreover, scholars have been encouraged to examine just *how* deliberation affects decision-making in jury research (Salerno & Diamond, 2010). Simple pre/post deliberation methodology is welcomed to explicate how individual juror preferences translate into jury decision-making (Salerno & Diamond, 2010). However, a pre/post between subjects' design would necessitate polling jurors' verdicts and evaluations of the evidence prior to their deliberations. This method instills a "verdict-driven" approach to deliberation, as opposed to an "evidence-driven" approach (Devine et al., 2001; Green et al., 2002, p. 239; Hastie, Penrod, & Pennington, 1983). The latter has been established in research using real and mock jurors as the more valid approach; allowing jurors to consider the evidence and their story of the trial as the

deliberation process *evolves* rather than arbitrarily priming the content of the deliberations (Salerno & Diamond, 2010).

Information processing. In addition to individual difference and situational factors, a juror's information processing style can also heavily influence their decision-making. The Cognitive-Experiential Self-Theory (CEST) suggests that mock jurors process information in two ways: (1) experientially (reliant of experience gleaned from affect-oriented or intuition processing); and (2) rationally (logical, analytic, and deliberate processing) (Epstein, 1994; 2003; Epstein & Pacini, 1999). The CEST aligns well with models of how mock jurors may be persuaded by the evidence and expert testimony. Most notably, the Elaboration Likelihood Model (ELM) of persuasion posits two routes to persuasion: (1) peripheral route (reliant on tangential, simple cues that demand low cognitive effort); and (2) central route (involving effortful, substantive evaluation of the message) (Chaiken, 1980; Heesacker, Petty, & Cacioppo, 1983; Petty, Cacioppo, & Schumann, 1983; Petty, Kasmer, Haugtvedt, & Cacioppo, 1987).

Jurors are active interpreters of evidence (Diamond & Casper, 1992; see review by Nietzel, McCarthy, & Kerr, 1999; Pennington & Hastie, 2003). Expert witness credibility has been found to impact mock jurors' evidence evaluations and the overall persuasiveness of expert's testimony (Brodsky et al., 2010). The influence of the content or message quality (strong versus weak) of an expert's testimony has received less empirical attention (McAuliff & Kovera, 2008; Salerno & McCauley, 2009). Together, the CEST and ELM provide a strong social psychological framework for exploring the relationship between message content, persuasion, and individual differences in jury decision-making.

It is plausible that varying the content and message elaboration of the expert's testimony (attention to central, case-specific information) will influence how mock jurors perceive and

apply an expert's testimony. Individual differences in mock jurors NFC are reflected in differential CEST information processing modes (Krauss, Lieberman, & Olson, 2004; Lieberman, Krauss, Kyger, & Lehoux, 2007). These differences can then influence the degree to which messages are centrally versus peripherally processed (McCabe, Krauss, & Lieberman, 2010). For example, Lieberman et al. (2007) found that the content of an expert's testimony exerted a differential influence on mock jurors' evidence evaluations depending on their processing style. For highly rational processors, actuarial testimony was more influential than clinical opinion testimony (Lieberman et al., 2007).

There is an additional value to assessing individual differences in CEST and ELM processing in the current study. These processing styles could help explain why some jurors rely more heavily on heuristics about the insanity defense and reasons for the defendant's MNC. Little is known about the effects of group discussion on informational processing biases that plague decision-makers (Kerr, MacCoun, & Kramer, 1996; Salerno & Diamond, 2010). Including measures of cognitive processing may help to explain why some jurors overlook additional elaboration by the expert when others increase reliance on content-rich

Problem Overview

As underscored by pioneers in mental health law jurisprudence, "the attempt to discover what the insanity defense should be, is no different from the attempt to discover what insanity is to the average person" (Finkel & Slobogin, 1995; Perlin, 1990, p. 463). It is clear MNC may factor into guilt and criminal responsibility determinations. Exploring this understudied area has the potential to inform the fact-finding process in NGRI adjudications. It is also important to uncover and guard against a "trial by heuristics," which may be rooted in over sixty years of criminalizing mental illness (Saks & Kidd, 1980; Slate & Johnson, 2008). Jurors are charged

with making a legal determination – criminal responsibility. However, it is not known how focused in on criminal responsibility, as defined by the law, jurors actually narrow their attention. Legal standards necessitate a responsibility determination focused on the mental state at the time of the act. This narrow time-frame may not align well with how jurors think through and weigh a defendant’s responsibility for his or her mental state, let alone any concomitant actions. Although the NGRI disposition has been in existence for nearly 170 years, the courts and psycho-legal experts in these cases provide little guidance for the trier of fact in such cases (Parker, 2009).

On a basic level, it is unknown if jurors are willing and/or able to follow the law in considering MSO issues. Social psychology would stack the deck against jurors’ ability to (at least naturally) follow the letter of the law in NGRI determinations. The disparity in how the law and psychology view the related issues of behavioral autonomy and choice compounds the problem. Perhaps by bringing these issues to light through expert education, jurors will at least be armed with all of the facts – from a lay, legal, and psychological perspective – that are permitted for consideration in such cases. The resultant line of inquiry is as follows: Do jurors consider meta-responsibility for a defendant’s MSO (criminal responsibility)? If so, does education from the court regarding meta-responsibility issues (e.g., insight into one’s medication and need for treatment) accentuate, attenuate, or merely inform this line of thinking?

Study Overview

This project’s overall purpose is to examine whether mock jurors consider meta-responsibility of mentally ill defendants, how they think about this construct in relation to criminal responsibility, and if various degrees of meta-responsibility differentially influence responsibility and guilt determinations. The proposed meta-responsibility benchmark

manipulation is medication compliance at three levels: medication compliant (control condition), purposive medication noncompliance, and inadvertent medication noncompliance. The type of medication noncompliance will be manipulated by varying the defendant's insight into his mental illness, either high or low insight, respectively.

A second variable – the extent to which a forensic mental health expert explains issues relevant to the defendant's meta-responsibility (i.e., medication compliance and insight into one's mental illness) – will also be manipulated. This aspect of the study has three purposes. First, manipulating the expert's testimony to these meta-responsibility factors explores, for the first time, the relative impact of experts educating the jury on meta-responsibility issues on decision-making. Second, it manipulates the expert's, and presumably, the jurors' attention to MNC when determining MSO in their evaluations (i.e., the testimony acting as a proxy for their forensic reports). Third, the low elaboration condition will allow the researcher to uncover how jurors naturally think through these issues when they are not given much guidance from the court. This research question has previously been studied by an arguably less ecologically valid manipulation that tested the influence of a “no [insanity test] instructions” condition (e.g., Finkel & Slobogin, 1995).

The key difference between the low insight-high elaboration and the low insight-low elaboration is that the former will explain: (1) how severe mental illness symptoms can contribute to low insight; and (2) that low insight can contribute to the cycle of MNC and relapse. The “causal” association between mental illness, low insight, and MNC is explicitly stated in the high elaboration condition, whereas it is not in the low elaboration testimony.

Research Questions

Medication Compliance:

- Does “meta-responsibility” for one's illness come into play in these decisions?

- Previous research suggests meta-responsibility can be captured by medication noncompliance issues. Is this how jurors naturally think about this issue?
- Do jurors consider medication (non)compliance in their MSO and verdict determinations?
- Does MNC increase defendant blame and MR determinations?
- Does MNC lessen the likelihood of a NGRI verdict?

Testimony Elaboration:

- What influence does the quality (strength) of expert witness testimony have on verdict and MR determinations?
- Do jurors pay attention to MNC and related MR issues if they are not pointed out (elaborated on) by the expert?

Interaction Effects:

- Is there a difference in the effect of MNC and MR issues when the expert does (or does not) elaborate on this information for the jurors?
- Does educating jurors about low insight attenuate or perpetuate defendant blameworthiness for MNC and MR?
- Does educating jurors about low insight attenuate or perpetuate defendant guilt?

Study Aims

The purpose of this paper is not to argue the issue of whether mentally ill persons should be held accountable for their MNC. **The first study aim is to bring to light the fact that lay jurors are unlikely to recognize the complexity of the relationship between MNC and volitional, informed decision-making** (Slovenko, 1995). Current insanity tests, and the legal system's adherence to a free-will depiction of human behavior, fail to align with jurors' more complex mental stereotypes of insanity and the insanity defense (Finkel, 1991; Skeem & Golding, 2001). They avoid consideration of society's possible stigmatizing associations of moral wrongness and blameworthiness with mental illness. Some have argued that this lack of attention in legal and forensic mental health evaluation guidelines actually perpetuates surreptitious, "covert punishment" of this population (e.g., Mitchell, 2003, p. 80; Perlin & Dorfman, 1993). The result becomes more punitive decisions with less rehabilitative and fewer just outcomes for defendant: lengthy civil commitments, guilty verdicts simply because there is

no more accurate verdict available, etc. The key supposition is that without a viable, permissible alternative, stigma and flawed reasoning seep into decision-making processes (Mitchell, 2003).

The second study aim is to explore influences of varying degrees of mental health expert testimony to this fact. Given the level of difficulty and clinical expertise necessary to conduct criminal responsibility evaluations, FMHP's tasked with this objective would benefit from guidance in how to communicate their work to the courts. These evaluations are specialized, and the manner in which they are explained to the courts should be as well. Scholars and clinicians have called for research in this area to "increase the expert's ability not only to engage in the process more reliably, but also to describe to courts more clearly how the inferential conclusions are reached" (Borum, 2003, p. 224). The expert's clinical decision-making should not be dependent on how the fact-finder thinks about the data. However, in the absence of structured guidelines for drawing causal inferences in MSO clinical judgments, experts' should come prepared to defend their findings both on the stand and in their reports to their best of their ability (Borum, 2003; Rogers & Shuman, 2000). This study aims to inform these practices.

This research also has several broader impact aims. The insanity defense has a remarkably small prevalence rate in the United States judicial system – one in every four felony cases raises the issue, with roughly one in four of those cases yielding a successful NGRI acquittal (e.g., Perlin, 1994; Melton et al., 1997). In such cases, estimates suggest that FMHPs offer an opinion to the court in support of an insanity claim in less than 10% of cases (Warren et al., 1991, 2004). In the early 2000s, four states even repealed insanity tests from their criminal courts (Rogers & Shuman, 2005). Despite its infrequency, "the amount of controversy generated by this defense is enormous" (Butler & Wasserman, 2006, p. 1747). As Packer (2009) explains,

“public opinion and legislative action are influenced to a great degree by the infrequent, but highly publicized case” (the representativeness heuristic; Kahneman, Slovic, & Tversky, 1982). This sensationalism threatens due process when deciding if the defense should be raised and how it is treated once raised. Lawyers likely shy away from investing time and funds into a defense that is not justly reasoned by the fact-finder. Additional ethical and due process concerns arise when the insanity standards lack a nuanced picture of mental illness and its effects on the volitional or informed nature of one’s actions.

Thus, the overarching goal of this research is to examine attitudes towards meta-responsibility information – designated by specific variables selected in the experiment (medication noncompliance). Understanding the influence of attitudes toward the insanity defense may assist trial consultants and lawyers seeking guidance for voir dire and litigation strategy when representing NGRI defendants. Learning how to effectively communicate complex clinical issues, such as MNC and a mentally ill defendant’s insight to the court may improve the expert’s effectiveness in assisting the trier of fact. Recognizing how insanity standards are uniformly underappreciated by jurors and how jurors actually think about criminal responsibility issues from a commonsensical approach – in terms of constructs like meta-responsibility – may assist in the development of more applicable judicial instructions.

Moreover, the low base rate of NGRI cases should not marginalize a defendant’s rights to a fair trial, nor excuse a flawed system. This is particularly relevant to NGRI defendants in capital cases, where not only one’s liberty, but his/her life is in the hands of that system. The goal is not to sway the trier of fact towards leniency for the defendant. The aim is to balance the system (Brodsky, 2009). As Rogers and Shuman (2005) implore, “defendants are seriously

disadvantaged by [societal] misperceptions of the insanity defense... the defense attorneys must seek ways to educate juries and neutralize entrenched biases” (p. 181).

Although rarely raised as a criminal responsibility issue, evidence of mental illness, impaired MSO, and possibly MNC (if present) are likely to be raised during sentencing post-conviction. This is particularly true in capital cases where the defense is permitted to present any evidence mitigating the defendant’s intentionality or volition in committing the crime (*Lockett v. Ohio*, 438 U.S. 586, 1978; *Penry v. Johnson*, 532 U.S. 782, 2001). Findings relevant to meta-responsibility determinations during the guilt phase of a NGRI case may translate into how similar information is perceived during mitigation in sentencing. Indeed, recent research has focused on this marginalized population – mentally ill capital defendants – and the interaction of death qualification and punitive decisions specific to these cases (Butler & Wasserman, 2006).

In summary, societal views set the standards for the law and the treatment/due process for its citizens. In situations where society misunderstands a large portion of its citizens and those influential factors on their circumstances, it becomes a case of the blind (or the biased) leading the blind (in effect, perpetuating a biased system). Research has illuminated one such instance where forensic mental health, the law, and fact-finders have yet to understand the relationship between MNC and offending behaviors by mentally ill persons. The present research seeks to expand this work by elucidating the process by which fact-finders make decisions when presented with this psycho-legal dilemma.

METHOD

Quantitative Methodology

Design. The present study was an unbalanced between-subjects design. The first independent variable (IV) – *Medication State* – was manipulated by establishing the defendant as either Medication Noncompliant (MNC, $n = 139$) or Medication Compliant (MC, $n = 34$); the latter of which constituted the Control condition. The remaining four conditions included MNC and were defined by either High or Low testimony *Elaboration*, as well as either High or Low defendant *Insight* into his illness and need for medication. The Control condition constituted the baseline level of both elaboration and insight on the defendant’s MC. The study design is depicted below in Figure 1:

		Insight into MNC		+ MC
		High (Purposive) $n = 69$	Low (Inadvertent) $n = 70$	
Elaboration of MNC	High (Strong Explanation) $n = 70$	<i>HeHi</i>	<i>HeLi</i>	<i>C</i>
	Low (Weak Explanation) $n = 69$	<i>LeHi</i>	<i>LeLi</i>	<i>C</i>

For ease of communication, each condition is assigned a label with two identifying letters (e.g., “LeLi” or “HeLi”). The first set of letters refers to the testimony elaboration, low or high. The second set of letter refers to the level of insight, either low or high. So, a participant in the “HeLi” condition would be exposed to a High degree of elaboration regarding a defendant with Low insight into his need for medication. The qualifier “MNC” was used to denote “medication non-compliance” across each of the HeHi, HeLi, LeLi, LeHi conditions. The identifier for

membership in the control condition was MC/C for “medication compliant/control.” The dependent variables of primary interest were verdict and meta-responsibility determinations.

Hypotheses: Based on this study design, the following hypotheses were formulated:

H1: Medication Compliance:

H1a: Medication state will significantly predict of defendant blameworthiness; compared to MC/C testimony, MNC testimony will predict significantly higher meta-responsibility.

H1b: Medication state will significantly predict verdict; compared to MC/C testimony, MNC testimony will predict a significantly lower NGRI determination likelihood (verdict will be more in line with guilt than with NGRI when the defendant is MNC).

H2: Testimony Elaboration

H2a: Compared to Low Elaboration, High Elaboration (explanation) will significantly predict agreement with the expert (verdict), and **(H2b)** attention to MNC/MR issues.

H3: Interaction Effects

H3a: Results from H2 will be explained by significant interactions between elaboration and insight on MR and verdict.

Meta-Responsibility:

H3b: In the **High insight** condition, High Elaboration (**HeHi**) will predict significantly greater MR than in the Low Elaboration (**LeHi**) condition.

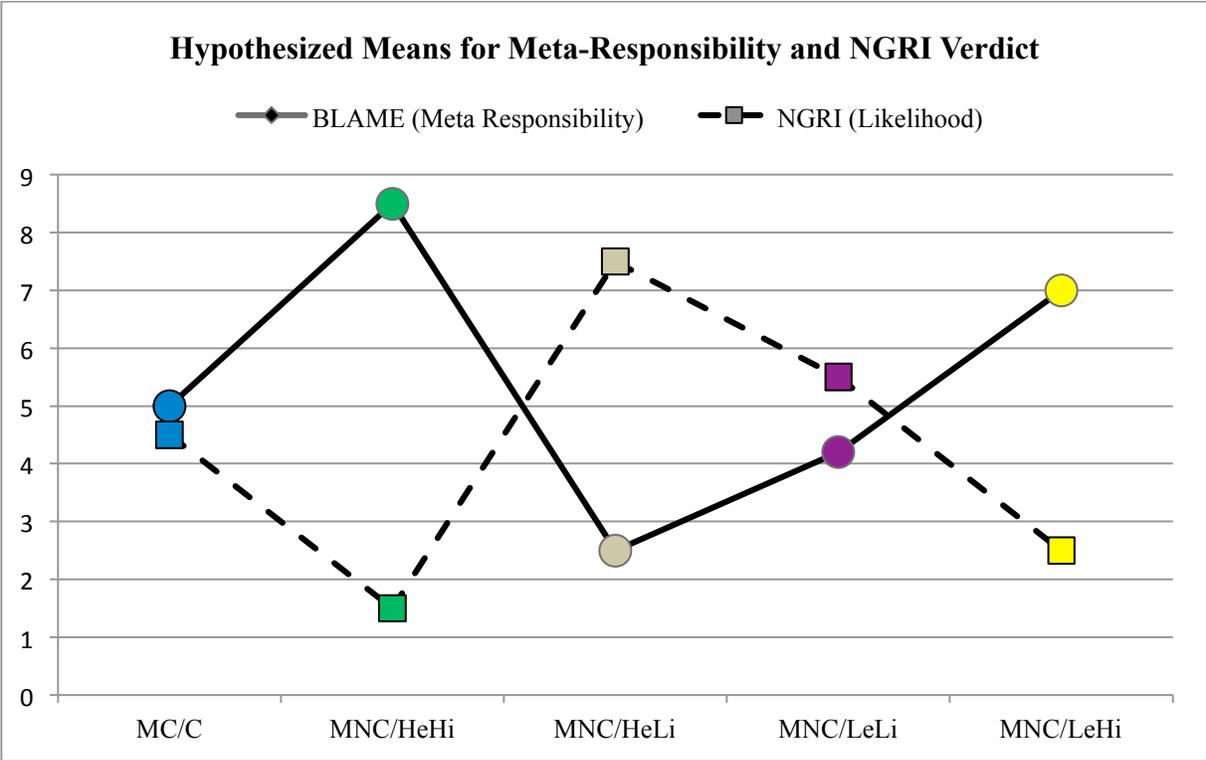
H3c: In the **Low insight** condition, Low Elaboration (**LeLi**) will predict significantly greater MR than in the High Elaboration (**HeLi**) condition.

Verdict:

H3d: In the **High insight** condition, Low Elaboration (**LeHi**) will predict significantly higher NGRI verdicts than the High Elaboration (**HeHi**).

H3e: In the **Low insight** condition, High Elaboration (**HeLi**) will predict significantly higher NGRI verdict than the Low Elaboration (**LeLi**).

H4: Overall Condition Effects: The below Figure 2 depicts the hypothesized 3-way interactions among all three IVs and compared across conditions (see next page):



Participants. Mock jurors consisted of 173 undergraduate students recruited from the

University of Alabama Introductory Psychology Research Subject Pool. Participants were recruited through a research website and received credit in partial completion of a course requirement. The research website summarized the study and allowed participants to select times for data collection sections (Appendix C).

All participants were at least 18 years of age ($M = 18.84$, $SD = 1.47$). The sample was 24% male and 76% female, 80% of whom were Caucasian, 16% of whom were African American, and 4% of whom self-identified as Hispanic. The majority of the sample reported being raised in a middle to upper-middle class socioeconomic bracket, and the sample was slightly more politically conservative and religious than not. Distributions of the above demographics were relatively even across conditions with a few notable exceptions. First, five of the mock juries were all female (one HeLi, one LeHi, and three LeHi). Second, nine of the mock juries were all Caucasian (one LeHi and two from each of the remaining conditions). In addition,

two participants reported prior juror experience (from the LeLi and HeLi conditions), with no participant having endorsed prior juror experience with a Not Guilty by Reason of Insanity plea.

According to responses generated by the “Experience with Mental Illness Questionnaire,” 20% of the sample either had indirect or direct experience working in a mental health profession. Furthermore, 51% had either personally participated in counseling or known someone who had done so. Approximately 47% of the participants had been prescribed medication or known someone who had been prescribed medication for an emotional problem, 40% of those respondents described the medication as helpful and 20% endorsed noticeable side effects of the medication. Overall, approximately 50% of the sample endorsed the belief that “someone can overcome their mental illness if they try hard enough.” These percentages regarding experience with mental illness were randomly represented across groups.

Sample size. The overall sample size was determined based on jury size ($N = 6$) and statistical power estimates for Linear Mixed Modeling (LMM) analysis appropriate for the study design. The ideal mock jury size was deemed to be six, with a minimum of five members, appropriate for an equitable analysis across group size (e.g., McLafferty, 2004). A minimum of 20 to 30 groups was recommended for LMM analysis, preferably with at least five groups per cell (Maas & Hox, 2005). The current study design equated to five cells and 25 groups total. In order to account for spoiled data from any given session (for unforeseeable reasons) and to increase the group sample size to the high-end of the minimum range, a total of six mock juries (as opposed to the minimum of five) were run for each cell. This calculation yielded a desired sample size of 180 across 30 groups. A traditional power analysis using GPower 3.1 (Faul, Erdfelder, Lang, & Buchner, 2007) was also calculated for comparison purposes to non-mixed models analysis. Using a power of .80 and an alpha of .05 for a comparable ANCOVA (main

effects and interactions) analysis, a sample size of 196 would be necessary to detect medium effects. This sample size would increase substantially to 536 in order to detect small effects. While LMM likely provides more power than this estimate, it is unlikely that small effects would be detectable with a sample size of 180. Thus, only medium sized effects are likely to emerge in the present analysis.

Recruitment of mock juries inherently varied depending on mock juror participation and no-show rate. Each session allowed enrollment of up to eight participants, but was canceled if less than five presented for the session. If more than six participants arrived at the study session, participants were randomly selected by the moderator to leave the session due to “over-enrollment” in the session. This procedure kept the mock jury size as close to six as possible and was approved by the UA IRB research compliance officer (Jeanelle Graham, M.P.H., personal communication April 16, 2012). Each of the five conditions consisted of six mock juries with the following breakdown of jury size by condition: HeLi was all six-member mock juries, HeHi and LeLi each had one of their six mock juries as a five-member jury, and Control and LeHi each had two five-member juries and the rest were six-member juries.

Procedure. The study’s procedures were informed by previous research using a similar sample and study design (Titcomb & Brodsky, 2010). Each session was conducted individually, with participants seated in a mock jury box configuration in a classroom equipped with multi-media capabilities. The researcher followed the same session script (Appendix D) at each session. Participants received a de-identifiable mock juror number that tracked participant responses and contributions to deliberations (recorded on all questionnaires and on number tags that were displayed for each participant). All participants first received the participation information sheet, which reviewed the voluntary nature of their participation and rights as a

participant (Appendix E). Next, mock jurors received the Judge's preliminary instructions (Appendix F) and opening statements from the Prosecution and Defense (Appendix G).

The researcher then informed mock jurors that they would be viewing expert witness testimony for the defense (on direct and cross-examination) and encouraged to treat the material as they would if they were actual jurors in this case. Cross examination was included to allow the prosecution an opportunity to question the expert about the specifics of the case and the expert's opinion (Rogers & Shuman, 2005). Research shows that the presence of cross examination can significantly influence a jury's evaluation of expert testimony, as well as its impact on verdict post-deliberation (see review by Salerno & McCauley, 2009).

Testimony. The testimony was extracted from the transcript of expert witness testimony called on by the defense in the New York Supreme Court case *People v. Goldstein*, 843 N.E.2d 727 (N.Y. 2005). This case was in the public domain and has been used in prior mock jury research in the field (Crocker & Kovera, 2010; Titcomb & Brodsky, 2010). The case was also chosen because of the real-life ambiguity in outcome across a deadlocked jury, guilty verdict, appeal, and eventual plea bargain. The location of the crime was moved from a New York City rail station to a rail station in Atlanta, Georgia in an effort to enhance the applicability to southern participants. All conditions included a concluding affirmation of the defendant's MSO as congruent with an NGRI defense. The inclusion of case-specific mental state at the time of the offense opinions in all conditions allows for the optimal influence of testimony on verdict decision-making (Greene et al., 2002; Nietzel et al., 1999). An *unequivocal* assertion from the expert regarding MSO was not stated given this determination is to be made by the trier of fact (Melton, Poythress, & Slobogin, 2007). Instead, an opinion was given to a "reasonable degree of

scientific certainty,” which is consistent with wording established for FMHP’s clinical opinions on MSO issues (Rogers & Shuman, 2000).

Insanity test. The study employed the same insanity test used in the original case (*People v. Goldstein*, 843 N.E.2d 727, N.Y. 2005) and in the state of Alabama (Ala. Code § 13A-3-1, 2013). The test includes the cognitive/knowning prong described above and depicted in the stimuli materials (Appendix H). This insanity test (with variations in wording) is also the most commonly used in the United States based on available data (Gee, 2003; Packer, 2009).

Defendant and charge characteristics. In this case, the defendant had a long-standing schizophrenia diagnosis and pled NGRI to the charge of Second Degree Murder for pushing a stranger onto a subway track. The murder charge was deemed acceptable for use to remain as close to the real case as possible. Murder charges have been estimated to make up one-third of the charges associated with NGRI defenses (Rodriquez, LeWinn, & Perlin, 1983). Early estimates found no differences regarding the rate of success of NGRI defenses for murder charges versus other charges (Steadman, Keitner, Braff, & Aravanites, 1983). Other research has purported that murder (along with sex crimes and robbery) were less likely to reach NGRI acquittal than lesser crimes like property damage (Bailis, Darley, Waxman, & Robinson, 1995; Warren et al., 1991). More recent research has indicated that once psychiatric diagnosis is controlled for, no significant differences emerge between various criminal charges and their predictive utility in estimating NGRI dispositions (Cochrane et al., 2001).

The defendant’s Schizophrenia (paranoid type, chronic) diagnosis was retained for use in the stimuli for several reasons. First, Schizophrenia has defining psychotic features, which align well with NGRI acquittal prevalence rates and with the insanity test’s “severe mental disease or defect” conceptualization (Callahan, Steadman, McGreevy, & Clark-Robins, 1991; Cochrane,

Grisso, & Frederick, 2001; see review by Melton et al., 1997; Warren et al., 2004; Packer, 2009).

The definition of schizophrenia provided by the DSM-IV-TR is as follows (APA, 2000):

- *A. Characteristic symptoms:* Two (or more) of the following, each present for a significant portion of time during a 1-month period (or less if successfully treated): (1) delusions (2) hallucinations (3) disorganized speech (e.g., frequent derailment or incoherence (4) grossly disorganized or catatonic behavior (5) negative symptoms, i.e., affective flattening, alogia (poverty of speech), or avolition (lack of motivation)
- *B. Social/occupational dysfunction:* For a significant portion of the time since the onset of the disturbance, one or more major areas of functioning such as work, interpersonal relations, or self-care are markedly below the level achieved prior to the onset (or when the onset is in childhood or adolescence, failure to achieve expected level of interpersonal, academic, or occupational achievement).
- *C. Duration:* Continuous signs of the disturbance persist for at least 6 months. This 6-month period must include at least 1 month of symptoms (or less if successfully treated) that meet Criterion A (i.e., active-phase symptoms) and may include periods of prodromal (symptomatic of the onset) or residual symptoms. During these prodromal or residual periods, the signs of the disturbance may be manifested by only negative symptoms or two or more symptoms listed in Criterion A present in an attenuated form (e.g., odd beliefs, unusual perceptual experiences).

In addition, Schizophrenia and other psychotic disorders have been found to be a positive predictor of successful NGRI acquittals (Warren et al., 1991; Warren et al., 2004). Finally, prior research has established a diagnosis of Schizophrenia as predictive of meta-responsibility determinations in criminal responsibility determinations (Mitchell, 2003). Because this diagnosis was held constant across conditions, it was anticipated to “level the playing field” for the feasibility of the NGRI defense as opposed to tipping the scale in that direction. This diagnosis was included in the testimony per best practice guidelines (Giorgi-Guarnieri et al., 2002; Melton et al., 1997; Packer, 2009). The defendant’s pattern of prior verbal and physically aggressive behavior coinciding with periods of MNC is also considered generally consistent with NGRI defendant histories (Warren et al., 2004). While this history may very well influence decision-making in NGRI cases, this history was held constant across randomly assigned testimonies to control for variability in influence between conditions.

Video Stimuli. Each of the five testimony conditions was pre-recorded in the University of Alabama (UA) Witness Research Lab. All stimuli materials were audio-recorded only, except for the testimony stimuli also recorded a visual of the testifying expert. The judge's part was read by an advanced member of the UA Witness Research Lab, Jennifer Wilson, M.A. The prosecutor's role was read by an Assistant District Attorney in Tuscaloosa, Jason Wilson, J.D. The defense attorney's role was read by a practicing civil litigation attorney, David Sams, J. D. The actors who portrayed the prosecutor and defense attorney are roughly the same age and similar in voice tone, clarity, and accent. The expert witness' role was portrayed by a Clinical Psychologist who is a certified forensic examiner with experience testifying in criminal responsibility proceedings, Clayton Shealy, Ph.D.

Participants were randomly assigned to view one of five testimony conditions as outlined in the study design. After viewing the testimony, participants were immediately given three minutes to complete a thought-listing task (Thought Listing Measure, TLM, see Appendix I).

Thought listing measure (TLM). Participants were asked to retrospectively list a maximum of eight thoughts that came to mind *while viewing the testimony* from the expert witness. The thought listings measured mock jurors' attitudes toward the expert witness stimulus, their attention and seriousness with regard to the task, and their quality of thoughts while viewing the testimony (Cacioppo & Petty, 1981; Wegener, Downing, Krosnick, & Petty, 1995). Thoughts were coded by two trained raters and 30% of the data was assessed for inter-rater agreement on degree of thought elaboration ($K = .98$), degree of stimulus derived thoughts ($K = .92$), and thought valence ($K = .94$) (Appendix J). In addition, thoughts were coded for references to the defendant's insight as High ($K = .89$) and Low ($K = .91$), as well as to medication ($K = .96$). For thoughts that referenced medication, each thought was also coded for references to

noncompliance as the defendant's responsibility and/or fault ($K = .92$) and to noncompliance another sources' fault (e.g., doctors, mental health system, society) ($K = .94$).

After having completed the TLM, each mock jury heard closing statements from the prosecution and the defense (Appendix K). All participants then heard final instructions from the judge (Appendix L) before being oriented to the deliberation phase of the trial.

Deliberation procedures. All mock juries deliberated before completing any remaining questionnaires or outcome measures. Deliberating mock jurors were informed that they had up to 45 minutes to deliberate regarding evidence and verdict (and permitted a minimum deliberation time of 30 minutes), at the end of which they were to vote on these judgments in hopes of reaching a unanimous outcome. This time limit has been used in previous research (Salerno & McCauley, 2009) and was selected to increase study feasibility. First-ballot voting was discouraged in an effort to avoid verdict-driven discussion (Devine et al., 2001). Mock juries unable to reach a unanimous decision heard hung jury instructions via pre-recorded audio (Appendix M) and were instructed to return to deliberations for 15 minutes and vote again (i.e., "Allen Charge," *Allen v. United States*, 1896). Mock jurors used the voting ballot recommended by the Alabama Pattern Jury Instructions (Colquitt, 1994; Appendix N). As outlined in the experimenter script (Appendix D), the researcher oversaw the deliberations, acted as the stand-in judge to provide clarity for questions asked of the law, and ensured that mock jurors followed session instructions (i.e., no use of personally identifiable information).

Measures. Prior to debriefing participants (Appendix P), all mock jurors completed the remaining questionnaires, which included the following: Verdict ratings; Meta-responsibility Questionnaire (MRQ); the Witness Credibility Scale (WCS); Revised legal attitudes questionnaire-23 (RLAQ-23); Insanity defense attitudes-revised (IDA-R); Need for Cognition

Scale (Short Form) (NCS); Big Five Mini-Marker (BFMM) personality measure; Participant reaction form (PRF); Knowledge of Mental Illness Questionnaire (KMQ); Experience with Mental Illness Questionnaire (EMQ); and Demographics Questionnaire (DEM). Each participant then received a packet containing the measures in the above listed order. A portion of these measures was counterbalanced such that 51% of the participants received the IDA-R, RLAQ, BFMM, and NCS prior to viewing the expert testimony. Due to the fact that the PRF was in part, a procedural manipulation check and because the KMQ, EMQ, and DEM questionnaires' personal nature may hinder openness on further assessments, mock jurors completed these assessments last.

Verdict ratings. Verdict was collected on a dichotomous and continuous measure (Appendix Q), adapted from previous mock juror research (e.g., Brodsky et al., 2010). In the dichotomous rating, participants voted for guilty, not guilty, or NGRI. Mock jurors also rated the probability of the defendant's guilt, as well as level of punishment, on a 7-point Likert-type scale, with 7 as the maximum confidence of guilt and most punitive punishment, respectfully. The questions queried (1) the defendant's guilt, from NGRI to Guilty (reverse coded so that the higher scores on this item were associated with agreement with the expert witness and an NGRI verdict); (2) juror confidence in their verdict; (3) level of punishment assigned; and (4) juror commitment to their punishment.

Meta-responsibility questionnaire (MRQ). Modeled from prior research as discussed in the Introduction of this document (Mitchell, 2003), a 15-item Likert-type outcome measure was used to assess evaluations of the defendant's meta-responsibility (Appendix R). Items were rated on a 7-point scale about beliefs regarding the defendant's behavior (e.g., he should have resisted his illness; he should have been more careful taking his medication; he made his illness worse

through his own fault; etc.). In prior research, these items had been found to load on two factors: *General Meta-Responsibility* and *Product of Mental Illness* (Mitchell, 2003). Three items were also included to assess the defendant's perceived ability (or competency) to function *knowingly*, *willingly*, and *intelligently* with regard to his MNC (Melton et al., 2007). An additional two items were added to test Goffman's (1963) classic sociological definition of stigma: *Damage to social reputation* and attributions of *moral weakness*. This measure will be further discussed in the preliminary results section of this document.

Witness credibility scale (WCS). The WCS was used to assess expert witness believability and perceived effectiveness for the purposes of a manipulation check. As summarized by previous research (e.g., Rogers & Shuman, 2005), the importance and potential influence of expert witness testimony in insanity defense cases cannot be underestimated. The WCS was used to ensure at least a baseline of credibility was established with the witness, as well as to screen for potentially biasing influences of the expert's testimony (e.g., overly confident, dismissive, one-sided, or defensive testimony) (Rogers & Shuman, 2005).

The WCS is composed of four subscales (i.e., knowledge, likeability, trustworthiness, and confidence) (Brodsky, Griffin, & Cramer, 2010) (Appendix S). Participants rated the expert witness on 20 items that each present a ten-point sliding Likert-type scale with an adjective and its antonym (e.g., *uninformed* to *informed*, *unfriendly* to *friendly*, *untrustworthy* to *trustworthy*, and *not confident* to *confident*). In the current study, the WCS exhibited good reliability overall ($\alpha = .88$), and within each subscale (Confidence, $\alpha = .89$; Likeability, $\alpha = .89$; Trustworthiness, $\alpha = .96$; Knowledge, $\alpha = .92$).

Revised legal attitudes questionnaire-23 (RLAQ-23). The RLAQ-23 assessed biased attitudes toward the legal system and the defendant, defined by mock jurors' authoritarianism

(Kravitz, Cutler, Brock, 1993; Narby, Cutler, & Moran, 1993) (Appendix T). Authoritarianism is accepted as a strong predictor of mock jurors' criminal case judgments and has been found to influence mock jurors' considerations of NGRI defendants' meta-responsibility (e.g., Mitchell, 2003). The scale is a 23 item, 6-point Likert-type scale in which participants indicate their level of agreement with each item that is mapped onto one of three subscales: authoritarianism (A), anti-authoritarianism (AA), and equalitarianism (E) that combine to form one score. RLAQ-23 scores were normally distributed ($M = 29.47$, $SD = 5.14$) and indicated fair reliability ($\alpha = .68$).

Insanity defense attitudes-revised (IDA-R). Potential for bias against the insanity defense was assessed using the IDA-R (Skeem, Loudon, & Evans, 2004) (Appendix U). Mock jurors rated 22 statements on a 7-point likert-type scale to assess potential beliefs that mental illness is germane to criminal responsibility, as well as perceptions of misuse of the insanity defense and subsequent threats to public safety. The IDA-R yielded a relatively normal distribution of scores ($M = 82.82$, $SD = 18.77$) and demonstrated good reliability ($\alpha = .92$).

Need for cognition scale (NCS) short form. Participants were administered the 18-item NCS as a self-reported, 5-point Likert-type measure of each participant's need for cognition (i.e., their enjoyment of and tendency towards effortful cognitive processing of information) (Cacioppo, Petty, & Kao, 1984; Shestowsky & Horowitz, 2004) (Appendix V). Cacioppo and colleagues (1984) reported that the short-form was comparable to the original 34-item NCS ($r = .95$, $p < .001$). The NCS short form yielded good reliability ($\alpha = .90$) and relatively normally distributed scores ($M = 57.69$, $SD = 13.00$).

Big five mini-marker personality measure (BFMM). Saucier's (1994) Big Five Mini-Marker scale was administered as a brief measure of the Big Five personality factors with fair to good reliability: Extraversion ($\alpha = .80$), Agreeableness ($\alpha = .83$), Conscientiousness ($\alpha = .71$),

Neuroticism ($\alpha = .71$), and Openness to experience ($\alpha = .81$). The current study assessed all five markers, with a particular interest in extraversion, which denotes sociability and propensity towards action in individuals (Clark et al., 2007). The mini-marker measure allowed for self-reporting on 40 trait-descriptive adjectives on a nine-point Likert-type scale ranging from *extremely inaccurate* (1) to *extremely accurate* (9) (Appendix W), which generated overall scores for Extraversion ($M = 6.00, SD = 1.25$), Agreeableness ($M = 7.12, SD = 1.19$), Conscientiousness ($M = 6.60, SD = 0.98$), Neuroticism ($M = 5.73, SD = 1.15$), and Openness to experience ($M = 6.43, SD = 1.13$); all of which were relatively evenly distributed with Conscientiousness exhibited moderate kurtosis and Agreeableness moderately skewed towards endorsing the trait. Scores for Conscientiousness exhibited significant positive kurtosis, while scores for Agreeableness were moderately positively skewed.

Participant reaction form (PRF). The PRF consisted of forced-choice and open-ended questions regarding mock-juror participation and self-reported experience (Appendix X).

Experience with mental illness questionnaire (EMQ). Mock jurors' general knowledge and degree of indirect and direct exposure to mental illness was assessed due to its potential influence on jury decision-making and its potentially predictive value in jury selection for these types of cases (Wiley, 2011) (Appendix Y). In short, EMQ served to control for personal relevance of the testimony biasing or otherwise inducing peripheral information processing on the part of the juror. The researcher extracted six items from Wiley's (2011) template for a supplemental juror questionnaire on this topic to serve as a manipulation check.

Demographics questionnaire (DEM). Demographic information was also collected for descriptive purposes, including the following: participant age, gender, education level of parents, political affiliation, ethnicity, and previous jury participation (Appendix Z).

Qualitative Data Collection and Analysis

It is not important whether or not the interpretation is correct – if men define situations as real, they are real in their consequences (Thomas & Thomas, 1928, p. 572 – as quoted in Berg & Lune, 2012, p. 10).

Later termed the “Thomas theorem” (Merton, 1995, p. 380), the above quote has since become a tenant of social science research. As Merton (1995) explains, “it is one thing to establish a phenomenon (i.e., show that something is empirically the case) and quite another to explain it” (p. 380). A mixed methods approach offers promise to address both these ends. In the proposed project, a mixed methods approach (Hesse-Biber, 2010) was used because there are essential aspects of the research questions that cannot be adequately assessed or explained using quantitative measures. For instance, survey methodology, informed by theory and previous research, can arm the researcher with a starting frame-work for hypothesizing about mock jurors’ experiences (Morgan, 1996). Should support for hypothesized explanations behind quantitative findings emerge, then we have triangulated, or verified (Campbell & Fiske, 1959). Triangulation confirms findings with an additional method – a qualitative method (Berg & Lune, 2012; Campbell & Fiske, 1959). This result blossoms from an approach that uses multiple lines of inquiry to investigate a phenomenon (Berg & Lune, 2012; Denzin, 1978). This study proposes the use of two method-data collection pairings: (1) Experimental design paired with quantitatively analyzed outcomes; and (2) Phenomenologically-based focus group research assessed through a qualitative exploration (as opposed to a formal analysis).

This approach is “not additive in nature” (Fielding & Fielding, 1986; Pollio, personal communication). It is essential to approach mixed methods research “by improving and extending our theories and not by recording an endless list of aimless observations” (Chalmers, 1978, p. 31). There is a purpose behind the “mixing” of methods (Pollio, personal

communication) in that one informs the other to “counteract threats to validity identified in each” (Fielding & Fielding, 1986, p. 31). Decades of focus group research has shown the incremental validity in conceptualizing phenomena that can be gleaned from the interactive and open-ended focus group approach (see review by Morgan, 1996).

Qualitative approach: Phenomenological perspective. An investigative phenomenological exploration (Smith & Osborn, 2008), narrowed to the mock jurors’ participation in this study *and* focused on their responses to the study’s specific research questions, is proposed. This latter aspect of the method – guiding the qualitative exploration with specific research questions – is the benefit of focus groups over analyzing deliberations from a bottom-up perspective. The general aim is for mock jurors to re-construct their own narrative of influences on their decision-making while being prompted on the key elements of the experimental study design. “Understanding the essence of an experience” is the primary focus of the phenomenological approach (Creswell, 2007, p. 78).

Qualitative method: Focus groups. While the traditional phenomenological approach is to conduct individual interviews (Creswell, 2007), the interactive nature of mock jury decision-making (i.e., deliberations) is mirrored much more so in focus groups than individual narratives. This speaks to the validity of using focus groups insofar as the approach matches external criterion and the “social context” (group pressure, cohesion, and polarization included) of interest (Morgan, 1996). Though it is important to “not to confuse the standard *decision-making paradigm* in small groups research with the data gathering goals of focus groups” (Morgan, 1996, p. 148; Morgan & Krueger, 1993). A focus group’s purpose is much more specific.

A focus group is defined as “a research technique that *collects data* through *group interaction* on a topic determined by the *researcher*” (Morgan, 1996). Inherent in this definition

are three strengths of this approach. First, focus groups set out to answer specified research questions, but do so without overly restricting the line of inquiry. Second, focus groups have the advantage of creating an empirically substantiated “group effect” where participants query, challenge, and explain perspectives to each other (Carey 1994, Carey & Smith 1994)). Finally, the moderator, as an essential feature of the focus group, can query unanswered questions or differences between members (Morgan, 1996). The paradox is that the moderator can also become a primary weakness to the quality and meaning of focus group data if he or she is overly directive, unskilled, or ill-prepared (Agar & MacDonald, 1995; Morgan, 1996; Saferstein, 1995).

Focus group design. A concatenated method (quantitative and qualitative data collection at the same time) was implemented in the current study (Hesse-Biber, 2010). For a select number of mock juries, post-research session focus groups were conducted. This design permitted both quantitative and qualitative data collection from the *same* sample. Mock jurors relayed their experiences from the experimental session and deliberations, providing a one-to-one correspondence of quantitative outcomes and qualitative explanations. The aim was that through this process, some potential causal conditions for various outcomes (i.e., verdict, decision-making strategy, topics of focus during deliberation) would emerge.

Note that the purpose was not to account for *all* of the variance in why deliberations led down certain decision-making paths or to certain verdicts (Glaser & Strauss, 1967; Popper, 1980). Such a Grounded Theory approach (Glaser & Strauss, 1967) was beyond the scope of this project and would almost necessitate two separate studies – one quantitative and qualitative. Instead, the mixed-method approach used qualitative data to confirm and inform quantitative findings (Berg & Lune, 2012; Dabbs, 1982; Glaser & Strauss, 1967). The qualitative findings were used for explanatory utility and to compliment the quantitative aspect of the study, which

served as the crux of the analysis. This design – qualitative focus groups as the follow-up to the quantitative analysis – is one of four common combinations of focus group and survey data (Morgan, 1993, 1996).

Focus group sampling. The optimal sample size for the qualitative explanation was dependent on the function of the exploration. On a small scale, the goal was to randomly sample the context within which each experimental condition experienced deliberation. This sampling procedure is termed “segmentation” as it segments the focus groups’ compositions based on a particular research questions (Morgan, 1996). Thus, one research session per experimental condition was randomly selected to participate in a follow-up focus group session, for a total of five focus groups (i.e., one focus group for MC/C, HeHi, HeLi, LeHi, LeLi). Segmented sampling is commonly used in focus group research because of its advantages in homogeneity among group members (shared experience) and comparative analysis capabilities (Morgan, 1996). When using a factorial design with multiple independent variables (as in the current study), it is acceptable to examine one focus group “per cell” in the overall design (Knodel, 1993). A total of four to six focus groups is an appropriate overall sample size to reach saturation for any given research topic (Morgan, 1996). However, because the current study used a semi-segmented approach to sampling, it is critical that the focus groups had a more structured than unstructured approach to questions (Morgan, 1996). This format was intended to generate enough discussion on each topic from the single focus group representative of each experimental condition (Morgan, 1996).

Focus group size. From a phenomenological perspective, it is appropriate to collect qualitative data from several persons who have shared the same experience (Creswell, 2007). It is the description of the findings that should be exhaustive, not necessarily the data collection

(Creswell, 2007). In the current study, five focus groups interviewed 29 participants (in a group format), which surpassed the 10-interview minimal criteria for phenomenological data collection (Onwuegbuzie & Collins, 2007). The focus group size was also guided by external criterion – with the optimal participant size mirroring that of the phenomena being studied (Morgan, 1996). Thus, focus groups in the current study were primarily six-member groups, with one condition (LeHi) being a five-member group. In focus group research, six-members are considered the “rule of thumb” anchor of appropriate focus group size standards (i.e., 6 to 10 homogeneous strangers) (Greenbaum 1988, 1993, McQuarrie 1996). Furthermore, a focus group of this size allowed for ease in moderating the group, and for time for each member to participate adequately given the time constraints of the study and the potential for participant fatigue (Morgan, 1996).

Focus group procedure. Focus groups took place directly after all questionnaires were completed, prior to debriefing. The focus group was part of the research recruitment description for these sessions (see Appendix AA) and was not a surprise to the participants. The typical focus group length runs one to three hours (Wilkinson, 2008), with 90 minutes being a commonly reported average length of discussion (Morgan, 1996). The sessions were permitted to up to 60 minutes, with the mean focus group time being approximately 29 minutes of discussion given the structured nature of the focus group and the length of participation by participants up to that point. Participants remained seated in their same places, wearing their same mock juror numbers.

Focus group format. Although there is no meta-analysis on the topic to date, some form of standardized parameters in focus group discussion stands out as the norm (Morgan, 1996). The level of standardization should be tailored to the particular project’s goals (Morgan, 1996). In the current study, the moderator followed a semi-structured experimenter script and

standardized set of open-ended questions (termed the focus group schedule), which was asked of all focus groups (Wilkinson, 2008; see Appendix BB). The series of open-ended questions were based on each quantitatively tested research question (see Appendix CC). The standardized questions to be asked of all focus groups are as follows:

1. How did the **defendant's medication compliance** influence your decision-making in this case? Did it make him more or less blameworthy?
2. How did hearing about the defendant's **insight** – or understanding - into his mental illness affect your decision?
3. What's **something new that you learned** (if anything) from the expert about the mental illness or medication compliance?
- 4 What **stood out to you most** – had the most impact - about the defendant's mental illness and treatment in this case?

Note that the adaptive nature of the focus group structure permitted the researcher to more-or-less allow the participants to guide the flow of discussion and responses to the standardized questions. Additional questions and topics were discussed as time permitted, although the researcher allowed for (and prompted) at least five minutes of discussion per standardized question. These standardized questions were required of each to enhance analysis across groups (Knodel, 1993). To this aim, a “funnel” format was implemented to organize the questions and flow of the focus group dynamic in a way that addressed a “fixed set of core questions and then proceeded to a variable set of specific issues” (Morgan, 1993, 1996, p. 143; Smith & Osborn, 2008). The moderator completed the funneling and prompt check-list outlined on the focus group schedule (derived from Smith & Osborn, 2008; Wilkinson, 2008) during each session to increase adherence to a uniform framework across groups (Appendix BB).

The focus group, as most commonly done, was moderated by the principle researcher (Wilkinson, 2008). This moderator met the following set of requirements, all met by the researcher in this study: “basic interviewing skills, some knowledge of group dynamics, and some experience running group discussions” (Wilkinson, 2008, p. 190). The moderator's role

was to facilitate topic-focused discussion *between* participants (i.e., avoiding a situation where the moderator is simply interviewing each participant in a group setting) (Wilkinson, 2008). Having an intimate knowledge and understanding of the study's specific research questions was not a biasing factor, but in contrast, was an asset to the facilitation of the focus group's narrow purpose.

Like most aspects of the focus group design, level of moderator involvement was in direct relation to the research goals (Morgan, 1996). Two aspects of moderator involvement were required to be established (McDonald, 1992; Morgan, 1996). First, the moderator used questions to focus the discussion of issues relevant to the phenomena of interest (and away from topics obviously irrelevant to the research questions). This element of the design would typically be considered a more structured approach (Morgan, 1992). Second, the moderator exerted some control over the group dynamics (ensuring every participant provides at least one response to each issue), but did not attempt to equally divide the overall time among group members. This element of the design would commonly be considered a less structured approach to group dynamic moderation (Morgan, 1992). The less directive, more naturalistic group dynamic is often preferred by focus groups in the social sciences (Krueger 1994, Merton, Fiske, & Kendall, 1990; Wilkinson, 2008).

Qualitative data collection. Follow-up focus group sessions and mock jury deliberations were videotaped using a Sony (DCR PC101) MiniDV Compact Camcorder. The experimenter set up the camcorder on a tripod prior to the study session to ensure that each participant's mock juror number (displayed on a name-tag on their shirt) was visible to the camera. Each session was saved on a separate MiniDV and labeled with the session number, condition, and date. To improve accuracy in the audio quality of the recordings, each session was also audio-recorded

using a Crown Sound Grabber II pressure-zone microphone. This battery-operated device was equipped with omni-directional sound detection, which allowed it to remain stationary on a flat surface (desk) in the center of the participants' semi-circle desk arrangement. The device's voice detection optimizes at between 6 and 12 voices. Three transcriptionists from the UA Witness Research Lab transcribed the video-recordings into a Microsoft word document file. Video recordings were used to clarify transcription questions (e.g., matching voices to participants).

Post-Focus Group Questionnaire. Borrowed from small groups research design and increasingly used more in focus group data collection (e.g., Sussman, Burton, Dent, Stacy, & Flay, 1991), a post-focus group questionnaire was also used to record participant's self-reported reflections on participation in the focus group. This brief questionnaire attempted to capture any influence the focus group may have had on changes in their verdict, their feelings about their discussion, and the extent to which they believed they shared their open and honest opinions during the group (Morgan, 1996; see Appendix DD).

Focus group data exploration. The purpose of the focus group data was defined by the research questions and specified hypotheses that formed the basis for the quantitative analysis. This approach allowed for the mock jurors to inform the researcher about three main aspects of the phenomena being studied: (1) Confirmation of any results that did or did not emerge through the quantitative analysis; (2) First-hand descriptions of the contributing mechanisms (self-identified by the mock jurors) that led to these quantitative findings; and (3) Insight into the process behind their decision-making based on experimental condition. To identify statements in meaningful units, a key-word search will be conducted for terms identified *a priori* as relevant to the relevant research questions.

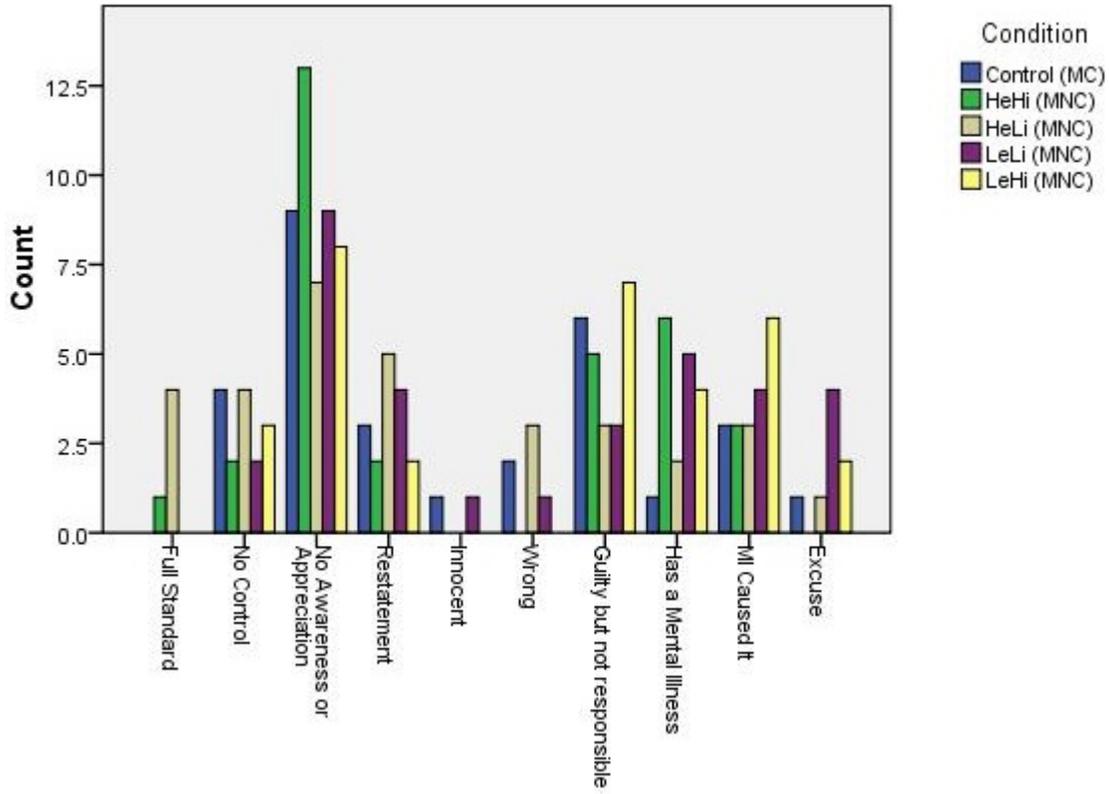
RESULTS: PRELIMINARY ANALYSIS

Manipulation Checks: Participant Reaction Form (PRF)

Pleas and Standards. A mix of closed- and open-ended questions was included in the PRF to assess participants' general understanding of the legal standards and burden of proof presented in this case. Approximately 93% of participants reported that the prosecution was trying to prove the defendant "guilty" as opposed to NGRI or not guilty. Nearly half of the errors in reporting the prosecution's aim was evidenced by participants in the LeHi condition reporting the prosecution was seeking a NGRI verdict (the remaining incorrect responses were evenly distributed across the other three MNC conditions). In addition, approximately 95% reported that the defendant had entered a plea of NGRI (78%) or not guilty (17%) – with both verdicts relatively evenly distributed across conditions. Again, the majority of errors in reporting the defense's plea as "guilty" were evidenced in the LeHi condition.

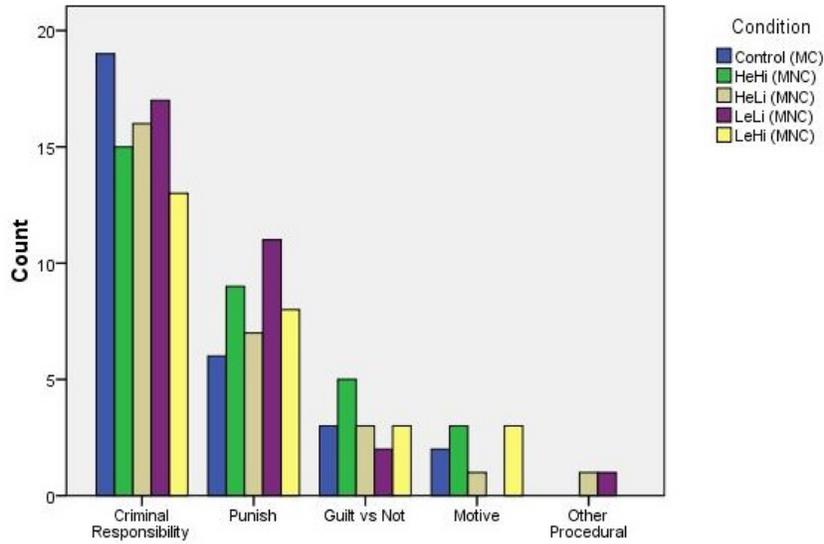
When asked to describe the NGRI defense, less than 5% of the 159 responding participants provided a response that was more wrong than right. The remaining responses that were more right than wrong were categorized as follows: approximately 29% noted a lack of appreciation or awareness of a defendant's actions, 15% described *how* a defendant was guilty but not responsible, 12% stated that a defendant's mental illness "caused" his or her actions, 11% stated that a defendant has a mental illness, 10% literally restated "not guilty by reason of insanity," 9% referenced a defendant having "no control" over his or her actions, 5% accurately stated parts of the defense while referring to it as an "excuse," and 3% cited the *full* NGRI defense accurately. The pattern of responses by condition is provided in Figure 3 below:

PRF: Mock Jurors' Descriptions of "NGRI Defense" by Condition and Descriptor



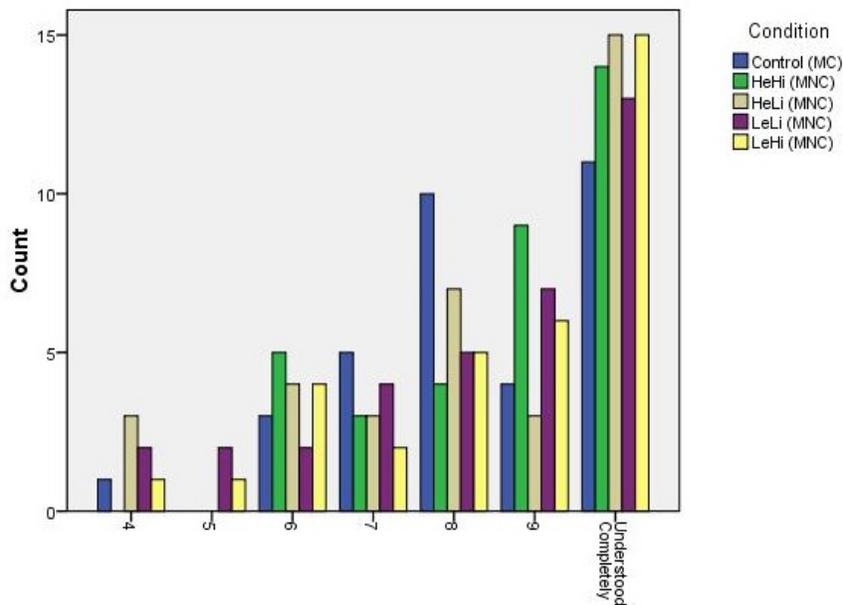
When asked *If you found that the defendant DID do the crime, what decision did you have to make next?*, the majority (approximately 54%) of participants described deciding on an aspect of criminal responsibility as the next task at hand. Despite specific and repeated judicial instructions to not consider sentencing or punishment in their verdict determinations, over 27% of respondents cited “sentencing” or some aspect of “punishment” as the next task at hand. The remaining responses included deciding between “guilt and not guilty” (11%), motive (6%), and other procedural issues such as voting or discussing the evidence (2%). The pattern of responses by condition is provided in Figure 4 below (see next page):

PRF: Mock Jurors Procedural Understandings for “Next Step” by Condition



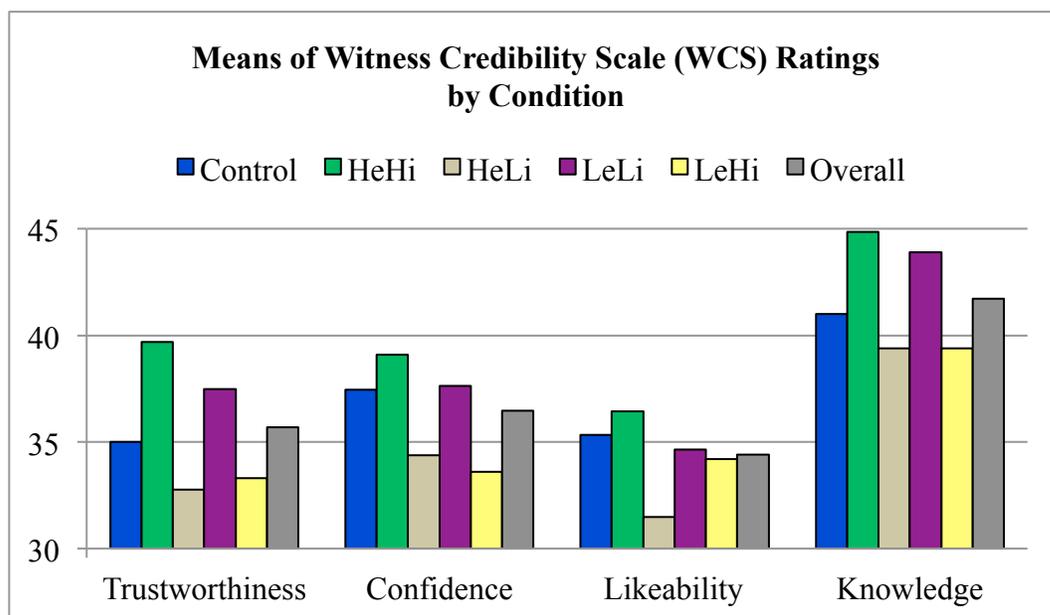
Comprehension of Judicial Instructions. Participants were also asked to provide a self-report of their comprehension of the judge’s instructions in this case. They responded to a Likert-type item on a scale from 1 (*Did Not Understand*) to 10 (*Completely Understood*) as part of the PRF. Responses ranged from 4 to 10 ($M = 8.43, SD = 1.70$). The pattern of responses by condition is provided in Figure 5 below (see next page):

PRF: Self-Reported Comprehension of Judicial Instructions by Condition



Participation. Over 98% of participants affirmed that they had no prior knowledge of the study and over 99% of participants affirmed that they indeed took the study seriously.

Expert Witness Credibility. A baseline of witness credibility was established across conditions for overall witness credibility ($M = 148.15, SD = 32.60$) and each of the credibility factors ($M_{\text{Confid}} = 36.48, SD = 9.11$; $M_{\text{Like}} = 34.42, SD = 8.92$; $M_{\text{Trust}} = 35.70, SD = 11.44$; $M_{\text{Know}} = 41.72, SD = 8.50$). Distributions were checked for normality and deemed within acceptable limits, which suggested that the testimony was not overly confident, dismissive, one-sided, or defensive (Rogers & Shuman, 2005). One exception was that knowledge scores across the sample were significantly skewed in the direction of the expert as knowledgeable. This skewed distribution is expected given that Knowledge is a prerequisite to status as an expert witness (FRE 702, 2011) and implicitly inferred in the eyes of mock jurors (Krauss & Sales, 2001; Neal, Guadagno, Eno, & Brodsky, in press; Titcomb, Neal, Wilson, & Brodsky, under review). Although no statistically significant differences emerged, descriptive information regarding jurors viewed the expert’s credibility may help to extrapolate results from the primary analysis. WCS ratings by condition are depicted in Figure 6:

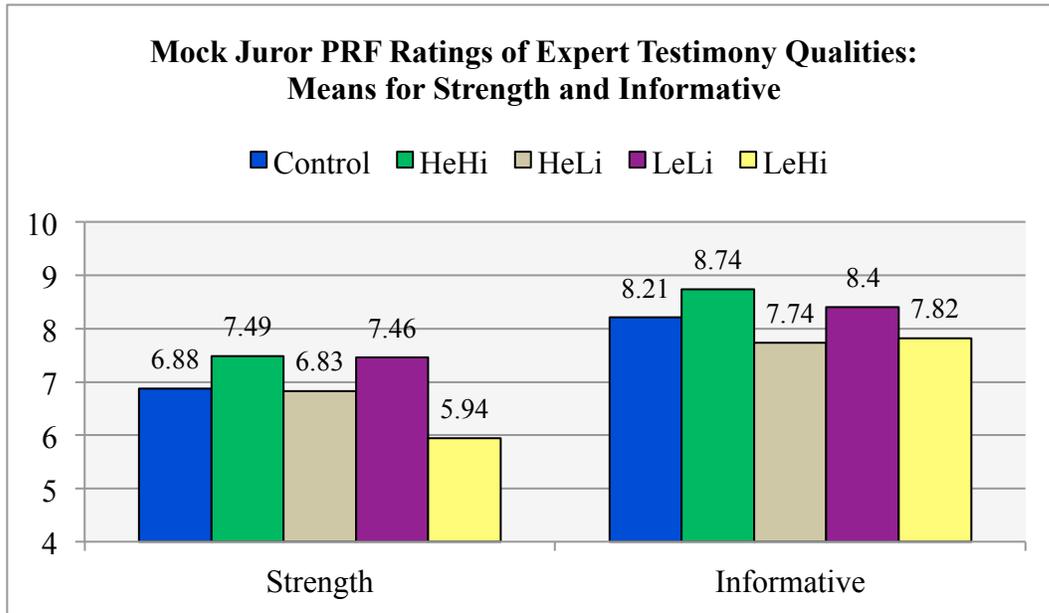


Across conditions, the Control condition yielded the most consistently similar ratings to the overall means for each of the WCS facets, suggesting the Control condition is an appropriate comparison condition. A guiding principle in the expert witness credibility research is that expert credibility positively correlates with mock juror decision-making processes (Brodsky et al., 2010) and its statistically significant predictive utility in ultimate decisions is variable (e.g., Brodsky et al., 2009; Neal, Nagle, Cramer, & Brodsky, in press). Thus, should variation in credibility emerge in this study, it was anticipated that the pattern of credibility ratings would mirror each experimental condition's hypothesized agreement with expert on verdict. In other words, the WCS ratings were anticipated to rank lowest for the conditions that were hypothesized to disagree most with the expert's opinion of the defendant as NGRI (i.e., the HeHi and LeHi conditions). As seen in Figure 6, this pattern held true for the LeHi condition, yet was reversed for the HeHi condition. In fact, HeHi yielded the highest credibility ratings.

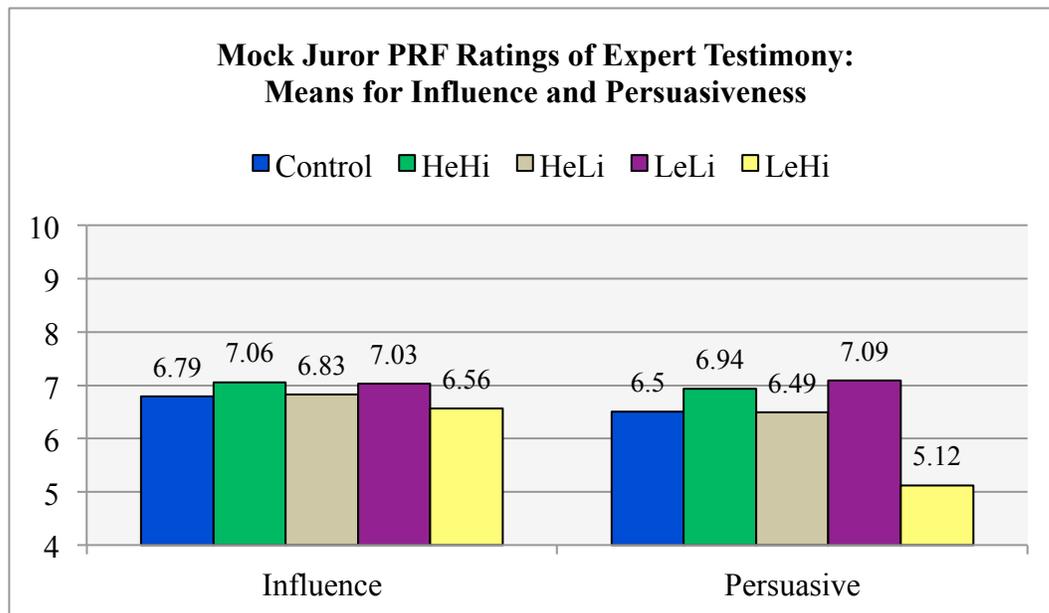
Medication Compliance. The conditions were developed so that the Control condition was the only of the five in which the defendant was compliant with his prescribed medication. The PRF checked this manipulation by querying mock jurors understanding of whether the defendant was compliant with his medication. Results indicated that medication compliance/noncompliance was successfully manipulated between conditions with two exceptions: One participant in the Control condition reported that the defendant was *not* on medication, while one participant in the LeHi condition reported that the defendant was on medication.

Elaboration. On the PRF, elaboration was assessed directly through a question asking *How informative was the expert testimony?*, as well as querying the *strength* of the expert testimony. Means for the testimony's *informative* nature were relatively similar across Low

Elaboration ($M = 8.12$, $SD = 1.81$) and High Elaboration groups ($M = 8.24$, $SD = 1.52$), as were those for testimony *strength* ($M = 6.71$, $SD = 2.17$ and $M = 7.16$, $SD = 2.00$). Results by condition are displayed below in Figure 7:

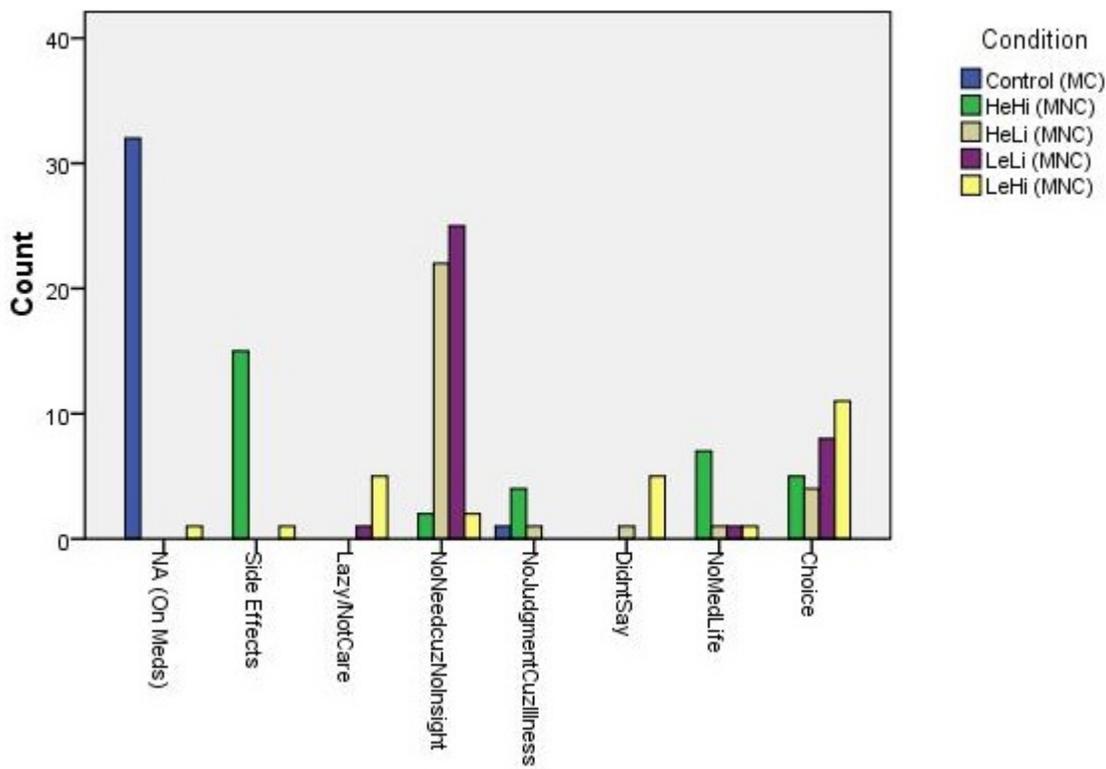


Mock juror ratings of the testimony's *influence* and *persuasiveness*, which could also speak to testimony elaboration, are depicted in Figure 8 below:



Insight. The PRF also queried whether the defendant “knew he had a mental illness” in order to assess participants’ views of the defendant’s lack of insight into his illness. As anticipated, for the Control and High Insight conditions, 100% of participants answered “yes – he knew he had a mental illness” to this question. However, only 9% of participants within the LeLi condition reported that the defendant completely lacked insight into his illness; whereas, 20% in the HeLi condition stated the defendant lacked all insight into his illness. A follow up question on the PRF queried whether the defendant was to blame for not taking his medication. Responses were coded into face-valid categories and displayed in Figure 9 below:

PRF: Count Data by Condition of Descriptions of Who/What was to blame for MNC?



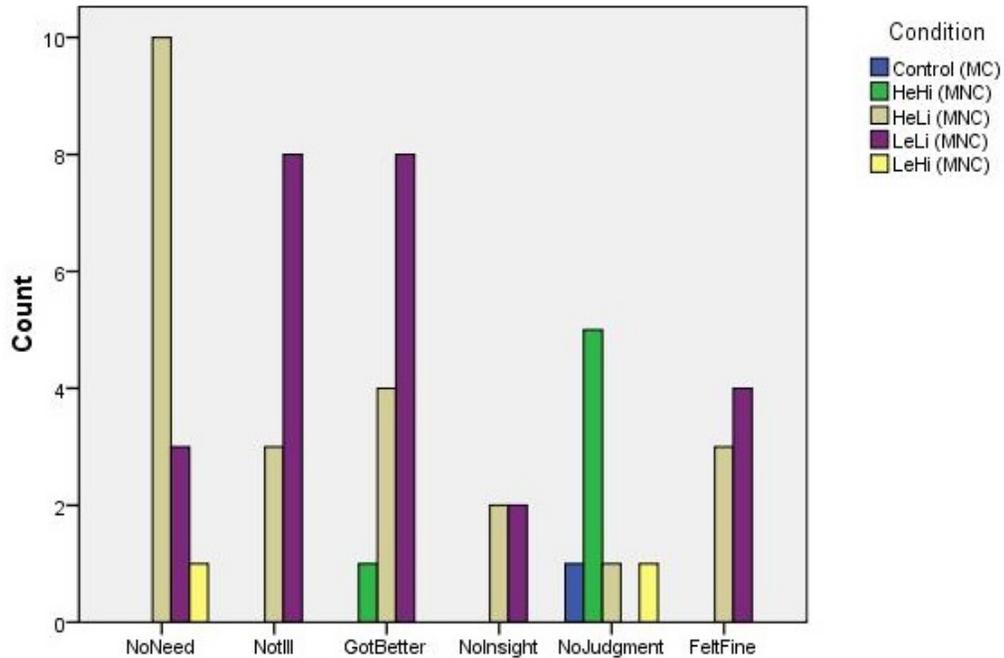
To understand the differences, it is informative to look *within* independent variable manipulations (e.g., Insight). For instance, by examining the two High Insight conditions, we see that when the expert elaborated on the High Insight (**HeHi**), side effects were cited as the

primary reason (46% of the time) for the medication noncompliance, followed by a desire to live a medication-free life, his choice, and lacking judgment. In contrast, when High Insight was not explained (LeHi), the defendant's choice was cited as the primary reason (43% of the time) for not taking his medication, followed by equal reports of the defendant not caring or being lazy and statements that the expert did not say why he was noncompliant.

When examining the two Low Insight conditions, it is evident that across both elaboration conditions (HeLi and LeLi), the majority of mock jurors (70 to 75% within these conditions) stated that the defendant believed he did not need his medication. However, if examined closer, distinctions between the two Low Insight groups are revealed particularly with regard to the "[MNC] by choice" variable. When more detail was provided in the HeHi condition, mock jurors were the most likely out of all the conditions to cite the specific reasons why he chose not to take the medication (i.e., HeHi accounted for 94% of the "side effects" references and 70% of the reports of the defendant not wanting to live a life on medication) as opposed to a generalized choice.

As intended, the majority of mock jurors across the Low Insight manipulations alluded to their beliefs that the defendant was medication noncompliant due to some degree of a lack of insight. These statements (i.e., those alluding to a lack of insight) were explored to examine potential differences among these responses. All conditions were explored, with the specific aim of anecdotally comparing the HeLi and LeLi conditions to see if there were differences within the Low Insight condition between the two Elaboration conditions. Responses were categorized into the results pictured in the below Figure 10 (see next page):

Further descriptive data for mock jurors who reported
PRF: Descriptors by Condition of Reasons for Reporting “The defendant did not believe he needed medication.”



As seen in Figure 10, six categories emerged: the defendant felt he had *no need* for the medication; the defendant did *not realize he was ill*; the defendant *felt better* and thus, did not believe he needed the medication; the defendant lacked understanding or “insight” into his need for the medication because of his illness; the defendant lacked “judgment” due to his illness; and more or less because he “felt fine.” For the Low Insight conditions, the Figure 10 shows that the references to a specific lack of “insight” were evenly distributed across the two conditions – regardless of elaboration. Within the HeLi condition, 43% of the responses endorsed a general statement that the defendant did not believe he *needed* the medication. In the LeLi condition, mock jurors stated in equal percentages (32% each) that the defendant did not believe he had an illness or that he believed he had improved on the medication, thus, eliminating the need for the medication.

Outcome Measures: Meta-Responsibility Questionnaire

The 14-items of the MRQ were subjected to an Exploratory Factor Analysis (EFA) using SPSS 17.0. EFA was used in order to examine the interrelationships among the MRQ items, while simultaneously reducing the MRQ item pool into potentially meaningful factors within this sample. The 173 sample size was deemed “close to small,” yet sufficient for EFA when in the presence of multiple correlations over .80 (which the current data generated), especially given that the sample size exceeded the 10 participants per item (14 MRQ items) requirement. Table 1 displays the corresponding correlation matrix.

Table 1

Bivariate Correlations of Meta-Responsibility Questionnaire Items

Item	<i>M</i>	<i>SD</i>	1	2	3	4	5	6	7	8	9	10	11	12	13	14
1. Has a duty to take responsibility for his own illness.	5.89	1.26	-													
2. Understood that he was ill.	6.30	1.12	.29**	-												
3. Caused his own illness.	1.90	1.41	.10	<-.01	-											
4. Killed the victim because of his illness.	4.04	1.69	-.24**	-.24**	-.09	-										
5. [His] illness affected his ability to look after himself (e.g., take his medication) and resist getting more ill.	4.11	1.96	-.23**	-.29**	-.17	.50**	-									
6. Liked being ill.	3.57	1.76	.16*	.26**	.30**	-.37**	-.33**	-								
7. Should have resisted his illness more.	4.22	1.67	.21**	.14	.14	-.13	-.18*	.38**	-							
8. Should have been more careful in taking his medication.	6.30	1.13	.28**	.03	.03	-.05	-.10	.23**	.15	-						
9. Made his illness worse through his own fault.	5.17	1.86	.38**	.09	.22**	-.28**	-.25**	.37**	.30**	.55**	-					
10. Knowingly did or did not comply with his medication.	6.05	1.23	.35**	.30**	<.01	-.15	-.20**	.23**	.14	.26**	.44**	-				
11. Willingly did or did not comply with his medication.	5.92	1.34	.41**	.33**	.02	-.21**	-.23**	.22**	.14	.22*	.44**	.83**	-			
12. Intelligently did or did not comply with his medication.	5.26	1.78	.29**	.26**	.07	-.31**	-.24**	.25**	.11	.13	.36**	.58**	.62**	-		
13. Has a weak character.	4.16	1.49	.15*	.11	.22**	-.19*	-.20**	.35**	.24**	.17*	.40**	.19*	.17*	.21**	-	
14. [His] mental illness damage' s his social reputation.	5.24	1.59	-.18*	.14	.09	.15	.04	-.03	<-.01	-.12	-.04	-.08	-.08	-.07	.12	-

Note. *n* = 174. **p* < .05, ***p* < .01 (2-tailed). Higher scores indicate higher agreement with item.

To determine the number of factors to retain from the EFA, a parallel analysis (i.e., an eigenvalue Monte Carlo simulation) was implemented using the rawdata.sps macro (O’Connor, 2000). Specifications for the parallel analysis included 5,000 parallel datasets set at the 95th percentile for Common Factor/Principal Axis Analysis with permutations (randomization) of the

raw data set. Results yielded four factors to extract as their eigenvalues exceeded the corresponding criterion values from the randomly generated data matrix. Using Maximum Likelihood estimation and Direct Oblimin oblique rotation, the EFA revealed that the additional assumptions of performing the EFA were met (i.e., Bartlett’s test of Sphericity was in fact significant at the $p < .001$ level and that the KMO value was indeed over .6 at .78).

The four-factor solution explained a total of approximately 45% of the variance, with Factors 1 through 4 contributing 24.08%, 10.17%, 6.60%, and 4.18% of the variance, respectively. As seen in Table 2 below, the rotated solution revealed that the majority of correlations between the Factors were weak ($r < .3$).

Table 2
Bivariate Correlations of Between Factors using Direct Oblimin Rotation

Factor	1	2	3	4
1. Medication Compliance Competency	-			
2. Meta-Responsibility	.191	-		
3. Medication Compliance Responsibility	.327	.155	-	
4. Mental Illness Product	.377	-.175	-.247	-

Two correlations between Factors were slightly more substantial (i.e., positive correlation between Factors 1 and 3, and negative correlation between Factors 1 and 4). Overall, these results provide support for a four factor solution, as displayed in the Pattern Correlation Matrix provided in Table 3 (continued on next page).

Table 3
Factor Loadings for Exploratory Factor Analysis with Direct Oblimin oblique Rotation of MRQ Items

Item* (The defendant...)	MC- Competency	Meta- Responsibility	MC- Responsibility	MI-Product
11. Willingly did or did not comply with his medication.	.967	-.048	.017	.066
10. Knowingly did or did not comply with his medication.	.907	-.011	.077	.138
12. Intelligently did or did not comply with his medication.	.621	.072	-.033	-.122
1. Has a duty to take responsibility for his own illness.	.282	-.021	.266	-.190

13. Has a weak character.	.079	.540	.103	-.020
6. Liked being ill.	.051	.486	.088	-.296
3. Caused his own illness.	-.054	.450	-.006	-.040
7. Should have resisted his illness more.	.027	.362	.118	-.097
14. [His] mental illness damages his social reputation.	.007	.305	-.180	.273
8. Should have been more careful in taking his medication.	-.001	.054	.793	.102
9. Made his illness worse through his own fault.	.228	.357	.575	.004
4. Killed the victim because of his illness.	.016	-.132	.019	.719
5. [His] illness affected his ability to look after himself (e.g., take his medication) and resist getting more ill.	-.049	-.192	.020	.559
2. Understood that he was ill.	.291	-.024	-.110	-.339

Note. *All items began with the phrase “The defendant...” which was left off for ease of presentation. Factor loadings considered appropriate for each factor are **boldface**. MC-Competency = Medication Compliance Competency; MC-Responsibility = Medication Compliance Responsibility; MI-Product = Mental Illness Product.

Factor 1 (*Medication Compliance Competency*, or *MC-Competency*) is a 4-item factor that denotes the defendant’s competency to fulfill his duty to take his medication ($M = 23.09$, $SD = 4.48$; range = 8 to 28 out of a possible range of 4 to 28). Factor 2 (*Meta-Responsibility*) is a 5-item factor that combines Goffman’s (1963) classic sociological stigma identifiers with a general responsibility for his illness, which paints the defendant as weak or apathetic about his illness ($M = 19.07$, $SD = 4.68$; range = 7 to 35 out of a possible range of 5 to 35). Factor 3 (*Medication Compliance Responsibility*, or *MC-Responsibility*) is a 2-item factor that appears to denote the defendant’s fault in not adhering to his medication ($M = 11.46$, $SD = 2.66$; range = 2 to 14 out of a possible range of 2 to 14). Factor 4 (*Mental Illness Product*, or *MI-Product*) is a 3-item factor that captures beliefs that the defendant’s actions were a product of his mental illness, including his illness being responsible for his low insight, MNC, worsening of symptoms, and his violent acts ($M = 9.84$, $SD = 3.68$; range = 3 to 18 out of a possible range of 3 to 21).

RESULTS: PRIMARY ANALYSIS

Linear Mixed Models

Data from mock jurors who function as a group during deliberations are inherently “dependent” on the functioning of the group. In other words, there may be reason to believe that data generated from mock jurors in mock jury A, for example, would be more similar to *each other* than they would be to data from jurors in mock jury B. Thus, the nature of the data from deliberating mock jurors would constitute a violation of the assumptions of independence and a likely increase in the probability in Type I errors (Tabachnick & Fidell, 2007).

To account for this potential violation, Linear Mixed Modeling (LMM) analysis was used in SPSS 17.0 to examine if data among mock jurors were indeed statistically dependent on group membership (Field, 2009; Tabachnick & Fidell, 2007). The bottom level (Level 1) is constituted by the individual mock juror ratings on the outcome measures. However, these mock jurors were organized into groups and thus, their data are said to be *nested* within mock juries. It would erroneous to consider the “jury” variable (i.e., jury group one through thirty) as a Level 2 variable. The specific parameters of the *random effect* of group on the model is not theoretically meaningful; the random effect’s purpose in this analysis was to test for dependency due to group. “Level 2” data would be generated if a measured outcome that defined the group at the jury level was being assessed for its potential influence on juror level data. For example, if overall SES of a jury was being examined for its potential influence on mock juror verdicts, then mock *jury* SES would be the Level 2 outcome and mock *juror* verdict would be the Level 1 outcome. Such hierarchical-level modeling is beyond the scope of the present hypothesis testing and analysis.

However, LMM was implemented to account for the possible random effect of *nesting* individual Level 1 data within groups. Thus, jury group is considered a contextual factor that should be examined for dependency within the model.

Examining Dependency. The first step in the analysis is to test whether “group” does indeed introduce *statistical dependency* in the data by generating correlated residuals. To test the random effect of the grouping variable on the model, five models were analyzed, each with one of the continuous dependent variables specified. Jury group was entered as a *random effect*, while the three independent variables (i.e., medication compliance, elaboration, and insight) were entered as *fixed effects* in each model. The five analyses described below are essentially testing whether mock jurors' ratings for each DV were more similar to each other than to other groups. Group did exert a statistically significant effect on verdict, $F(1, 29) = 387.24, p < .001$. Intraclass Correlation Coefficients (ICCs) were calculated to evaluate the percentage of variance explained by the significant effect of group on verdict, which accounted for approximately 53% of the variance in verdict. Remaining analyses also yielded significant effects of group on all MRQ factors including on MCCompetency, $F(1, 29) = 2191.21, p < .001$, Meta-Responsibility, $F(1, 29) = 2043.97, p < .001$, MCResponsibility, $F(1, 29) = 1204.66, p < .001$, and MIProduct, $F(1, 29) = 442.13, p < .001$; with approximately 23%, 9%, 35%, and 37% of variance explained by group, respectively. Overall, analyses clearly justified the use of LMM to account for the correlations between mock juror data caused by the grouping variable.

Primary Analysis Plan

This study was designed to examine main effects of each IV (i.e., medication state, elaboration, and insight), as well as hypothesized interaction effects. The planned analysis would have examined each IV and hypothesized interaction terms as fixed effects in the linear mixed

model. Elaboration and Insight were to be considered dichotomous predictor variables with three levels (control, low, and high) and Medication State was considered a dichotomous predictor with an asymmetric covariance matrix at two levels (compliant and noncompliant).

Each independent variable was to be designated as a *fixed factor* in the model. The hypothesized two-way interaction of Elaboration*Insight and the three-way interaction of Elaboration*Insight*Medication Compliance were also intended to be entered in the model. Based on the statistically dependency analyses, the subsequent series of LMM analyses would also be designed to account for the covariation within groups (as explicitly modeled by including the grouping variable as a *random effect* in the model to permit the intercepts to vary across groups). The subsequent analysis would have permitted testing the hypothesized main effects of Medication State on outcome (H1 series), Elaboration on outcome (H2 series), the interaction of Insight and Elaboration on outcome (H3 series), and 3-way interactions including Medication State (H4 series).

Assumptions Testing. The LMM parametric assumptions, including equal variance and normal distributions, were not violated. The additional LMM assumption that the intercepts in groups (juries) were normally distributed around the overall model was also verified. However, the parameter estimates for each IV and interaction terms could not be populated due to significant collinearity between the IVs. In other words, some categories of the IVs are linear combinations of other IV categories. The manipulated conditions essentially controlled for isolated, independent effects of elaboration and insight; thus, individualized parameter estimates by IVs and interaction terms were statistically redundant.

This finding is conceptually consistent with the experimental design as well. For example, in the HeHi condition, the expert highly elaborated (IV₁) on the fact that the defendant

had high insight (IV₂) and was medication noncompliant (IV₃). In other words, the nature of High Elaboration, for example, was different in High vs. Low insight conditions and Medication Compliant vs. Noncompliant conditions. It is also conceptually more appropriate to compare between overall conditions to test the hypothesized relationships in **H4** (as opposed to, for example, comparing High vs. Low Elaboration controlling for Insight, as stated originally in **H2**). Descriptive data for each IV are depicted in Table 4 below (continued on next page):

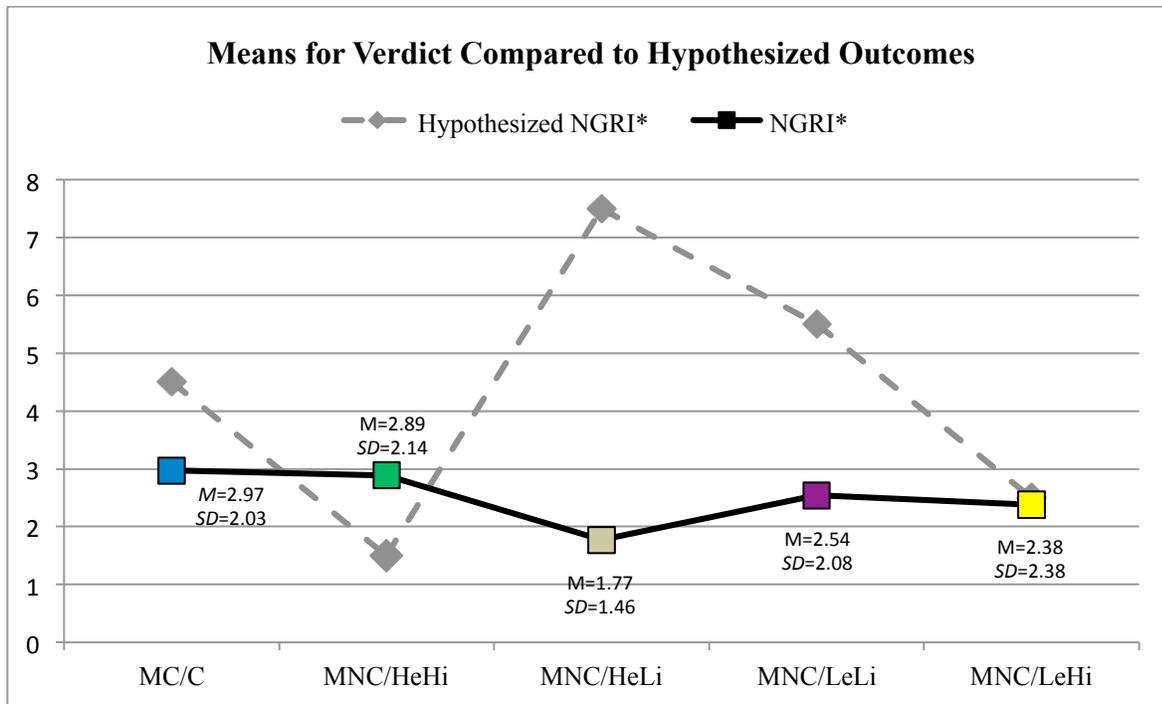
Table 4
*Descriptive Data for Independent Variables on Verdict and MRQ Factors**

Variable	n	Verdict***		MC-Competency		MC-Responsibility		Meta-Responsibility		MI-Product	
		M	SD	M	SD	M	SD	M	SD	M	SD
Elaboration											
Low	69	2.46	2.17	23.97	4.03	12.58	1.70	19.55	4.92	10.09	3.68
High	70	2.33	1.90	23.09	4.68	11.73	2.50	18.98	4.87	9.94	3.80
Control**	34	-	-	-	-	-	-	-	-	-	-
Insight											
Low	70	2.16	1.82	23.07	4.65	12.10	1.98	18.77	4.57	10.79	3.62
High	69	2.64	2.21	23.99	4.06	12.20	2.36	19.74	5.17	9.12	3.70
Control**	34	-	-	-	-	-	-	-	-	-	-
Medication											
Compliant	34	2.97	2.04	21.35	4.54	8.62	2.62	18.32	3.67	9.15	3.42
Noncompliant	139	2.40	2.01	23.52	4.38	12.15	2.17	19.25	4.89	10.01	3.73

Note. *MRQ factors are rated on a likert-type scale from 1 (strongly disagree) to 7 (strongly agree).
 Control condition data is generated across the “medication compliant” row. *Higher verdict scores relate to higher likelihood of finding the defendant NGRI (as opposed to guilty), on a 7-point reverse coded likert-type scale.

Primary Analysis. Preliminary analysis provided support for analyzing the IVs as combined conditions (i.e., MNC/C, MNC/HeHi, MNC/HeLi, MNC/LeLi, and MNC/LeHi). Therefore, each condition was designated as a *fixed factor* in the model and jury group was designated as a *random contextual effect*. The primary dependent variables tested were verdict (higher scores indicating greater likelihood of agreement with the expert for a NGRI verdict) and the MRQ factors (MC-Competency, MC-Responsibility, Meta-Responsibility, and MI-Product).

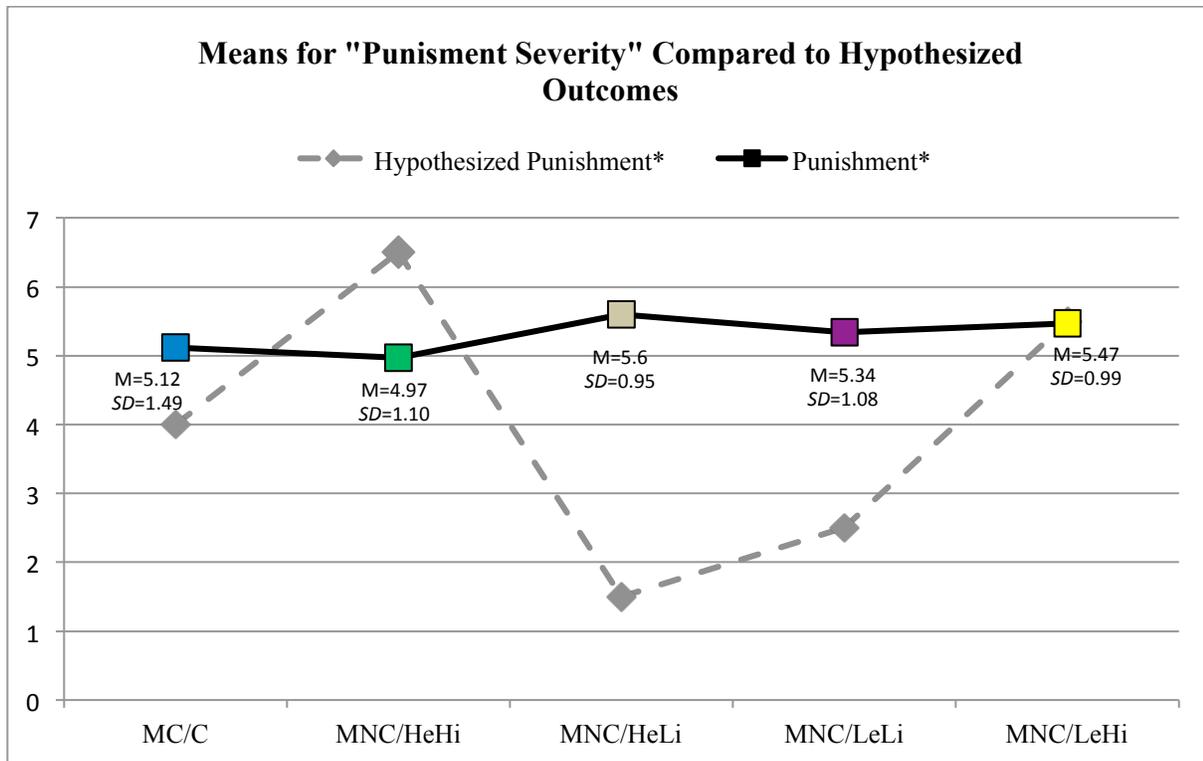
Verdict Outcomes. Testimony condition did not exert a significant effect on *NGRI* verdict ratings, $F(4, 25.19) = .53, p = .713$, with effect sizes between conditions ranging from very small to medium (Cohen’s *d* equivalents) as show below in Figures 11-12 (see next page):



Note. *Higher numbers indicate more agreement with the expert (i.e., increased likelihood of NGRI verdict).

As shown in Figures 11-12, the between-conditions analysis did not generate any support for the relationships postulated in **H3d**, **H3e**, and more clearly in **H4**. In fact, although statistically insignificant, the reverse of the relationships postulated in **H3d** and **H3e** appeared. The HeHi condition yielded higher NGRI determinations than the LeHi counterpart, as did the LeLi condition over the HeLi condition.

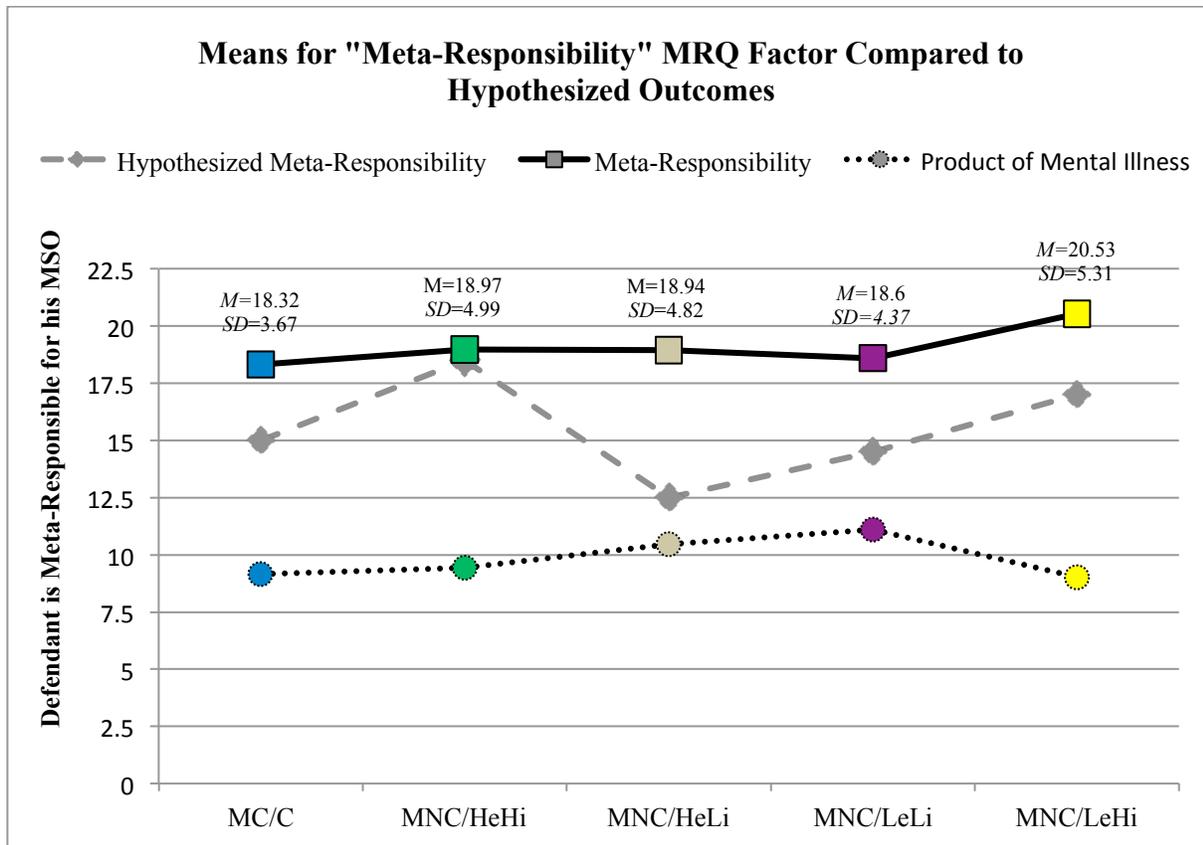
Testimony condition also failed to exert a significant effect on the remaining three verdict-related outcomes: Mock juror *confidence* in their verdict determination, $F(4, 25.31) = 1.13, p = .365$; *punishment* assigned, $F(4, 25.18) = 1.33, p = .287$; *commitment* in sentencing determination, $F(4, 25.22) = .81, p = .530$, with effect with effect sizes between conditions ranging from very small to medium (Cohen's *d* equivalents). Results for *punishment* are displayed in Figure 12 and compared to expected outcomes extrapolated from **H4**:



Note. * Higher numbers indicate greater punishment severity.

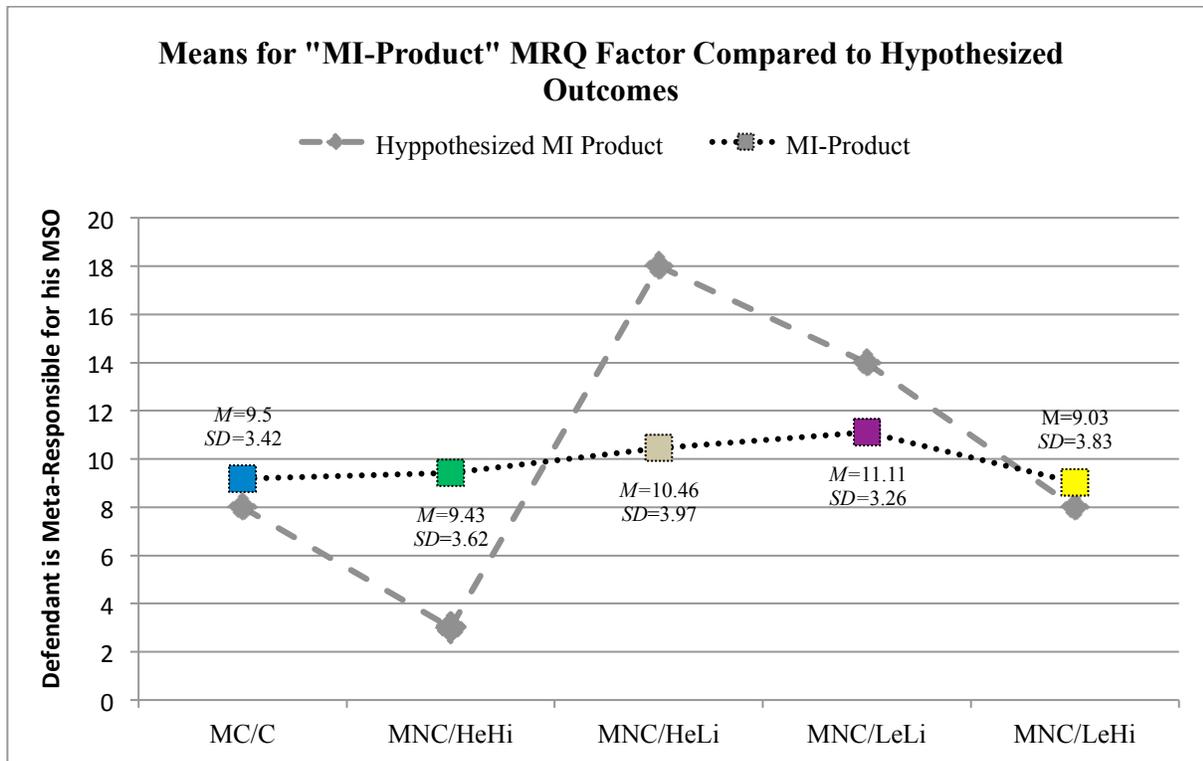
Contrary to anticipated findings in **H3d**, **H3e**, and **H4**, results again revealed reversals in hypothesized outcomes. Although statistically insignificant across the High Elaboration conditions, HeLi generated greater severity of punishment than did the HeHi condition, and the mean differences between the Low Elaboration conditions are barely present on severity for punishment.

Meta-Responsibility Outcomes. Testimony condition failed to exert a significant effect on Meta-Responsibility, $F(4, 24.60) = .79, p = .544$, or on Mental Illness Product (MI-Product), $F(4, 25.15) = .76, p = .560$, with effect sizes for both outcomes between conditions ranging from very small to medium (Cohen's d equivalents) as shown in the below Figures 13-15 (next page):

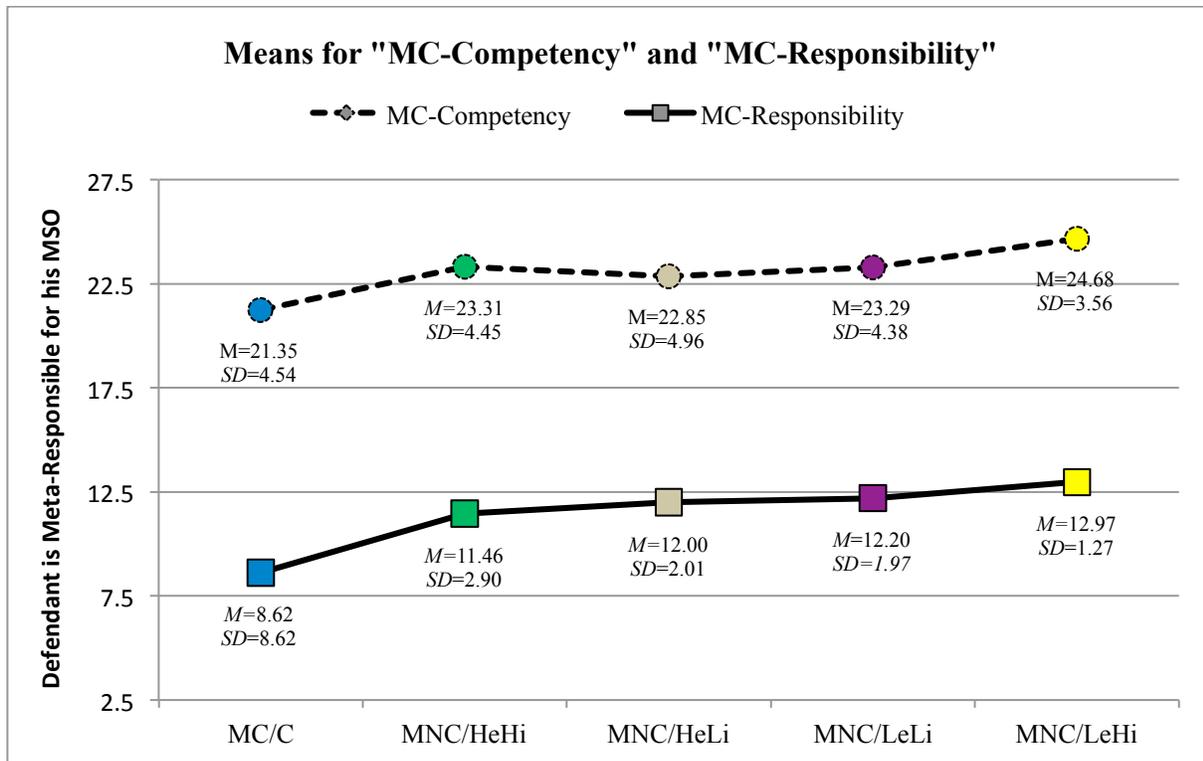


As seen above in Figure 13, the only slight variation in Meta-Responsibility scores was a slightly higher rating from mock jurors in the LeHi condition. The elevation of LeHi scores on Meta-Responsibility is inconsistent with the **H3b** and **H4**, which postulated that HeHi would generate the highest Meta-Responsibility ratings. Moreover, the Meta-Responsibility ratings yielded no statistically significant results between conditions.

As depicted below in Figure 14, **H3b** and **H4** expected the HeHi condition to generate the lowest degree of attributing the defendant's actions to his mental illness, because of the elaboration provided regarding the defendant's High Insight and purposive MNC. In addition, **H3c** and **H4** stated that LeLi would generate significantly higher meta-responsibility ratings (and concomitantly lower attributions of responsibility to the defendant's illness) than the HeLi condition. However, these differences were not supported either, as seen below (next page):



Condition also failed to exert a statistically significant effect on ratings of the defendant's Medication Compliance Competency (MC-Competency), $F(4, 25.09) = 1.78, p = .344$, with effect sizes between conditions ranging from very small to medium (Cohen's d equivalents). However, a significant effect for condition on ratings of the defendant's responsibility to take his medication (Medication Compliance Responsibility, or MC-Responsibility), did emerge, $F(4, 24.63) = 13.79, p < .001$, with no significant covariates. The difference between the LeLi and MC/C condition on MC-Responsibility yielded a medium effect ($d = 0.57$), and the difference between the LeHi and MC/C condition yielded a medium to large effect ($d = 0.71$), with the remaining differences between conditions being relatively small effects, as seen in Figure 15 (next page):



Note. **MC-Competency** is a 4-item factor that can range from 4 to 28. **MC-Responsibility** is a 5-item factor that can range from 5 to 35.

Although the Medication Compliance/MNC variable was not isolated in the analysis (as was originally intended with regard to **H1a**), it is clear that differences between the MC/C group and the respective four MNC conditions did not differ significantly in ratings of Meta-Responsibility, MI-Product, or MC-Competency. The one exception is the significant effect ($p < .001$) of condition on MC-Responsibility. Dummy coded post-hoc analysis indicated that both LeLi ($p = .027$) and LeHi ($p < .001$) conditions yielded significantly higher MC-Responsibility ratings over those generated by mock jurors in the Control condition.

Subject Variables. Table 5 (see next page) provides correlational data between each of the subject variables assessed and the primary dependent variables.

Table 5

Correlation matrix of mock juror subject variables on primary dependent variables.

Subject Variable	<i>n</i>	NGRI Likelihood	MC- Competency	MC- Responsibility	Meta- Responsibility	MI- Product
Insanity Defense Attitudes	171	-.48**	.44**	.41**	.27**	-.34**
Need for Cognition	173	.23**	-.12	-.21**	< -.01	.04
Legal Attitudes - Authoritarianism BFMM	167	-.14	.24**	.26**	< -.01	-.14
Openness to experience	172	.01	-.01	-.06	-.02	.02
Conscientiousness	172	.04	.06	.05	.03	< .01
Extraversion	172	-.19*	.10	.19*	.21**	-.12
Agreeableness	171	< .01	-.02	.08	-.03	.12
Neuroticism	170	-.04	.02	.05	.03	-.12

Note. *Correlation is significant at the 0.05 level (2-tailed). **Correlation is significant at the 0.01 level (2-tailed).

All continuous potential covariates were centered and examined for main effects and interactions within the above described models. Entering the covariates into the respective models did not change the pattern of results with regard to hypothesis testing of the overall condition on outcome. Out of the pool of subject variables measured via the IDA-R, NFS, RLAQ-23, and the BFMM, insanity defense attitudes was the only significant effect found on the primary outcome variables. Higher scores on the IDA-R reflect bias against the insanity defense. In the current study, IDA-R scores ($M = 82.82$, $SD = 18.77$) exerted a significant main effect on likelihood of a NGRI verdict, $F(68, 77) = 1.84$, $p < .01$, as well as a marginally statistically insignificant effect on Meta-Responsibility, $F(68, 90) = 1.34$, $p = .071$.

Thought Listing Measure

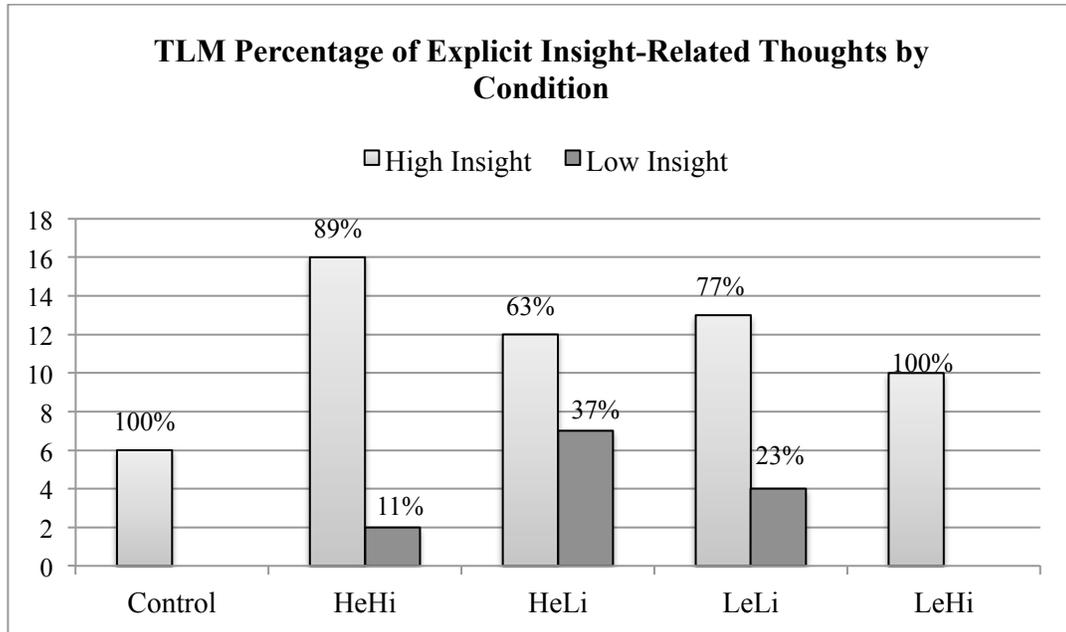
Thought Elaboration. The total number of thoughts obtained for each mock juror was summed to assess overall thought elaboration (i.e., the amount of thoughts generated by each juror). Overall, 913 thoughts were generated during the task. Total thought elaboration was relatively evenly distributed across conditions, with the High Elaboration condition ($n = 192$ for HeHi and $n = 188$ for HeLi) generating slightly more thoughts than the Low Insight ($n = 183$ for LeLi and $n = 178$ for LeHi) and the Control ($n = 172$) groups.

Central vs. Peripheral Statements. Stimulus derivation was evaluated by coding each thought as either central (i.e., message relevant), or as peripheral or unrelated (i.e., both message irrelevant) to the expert witness' message. The ratio of each participant's total message-focused thoughts to the total number of thoughts (i.e., central thoughts/ total elaboration) was calculated to assess degree of central processing of the testimony (Guadagno & Cialdini, 2002). While five of the four conditions generated approximately 70% stimulus-derived central thoughts (70% for Control, 69% for HeLi, 68% for LeHi, and 71% for LeLi), the HeHi condition generated 81% stimulus-derived central thoughts. Thus, the percentage of peripheral thoughts for the HeHi condition was approximately half (16%) that of the remaining conditions, which generated approximately 30% peripheral thoughts.

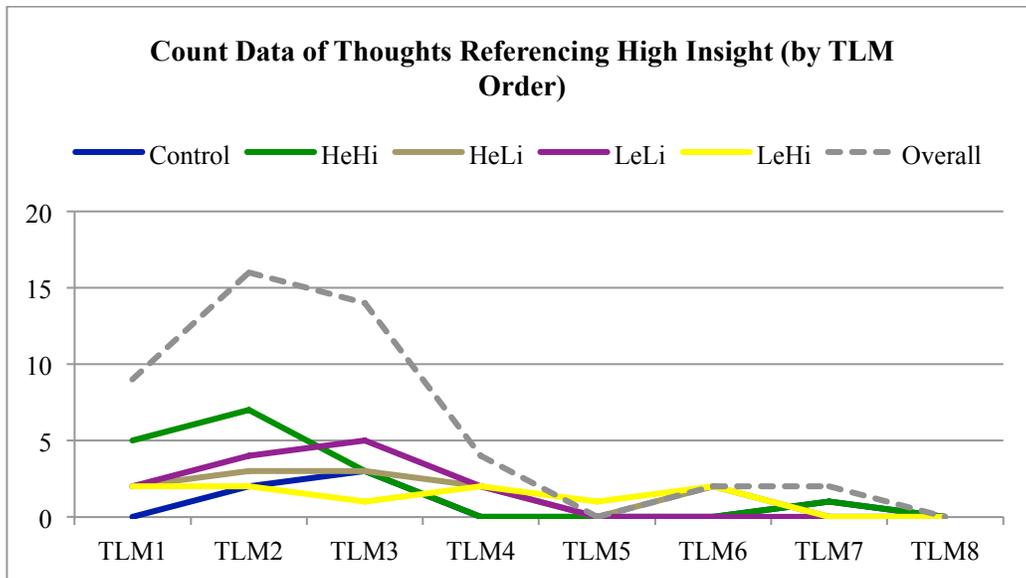
Argument Persuasiveness. The valence of the thoughts as positive, negative, or neutral/irrelevant to the witness' argument was also rated. Thought valence typically provides a measure of overall persuasiveness of the expert's testimony (i.e., positive thoughts yield more agreement with the expert's message) (Guadagno & Cialdini, 2002). The majority of thoughts were rated as neutral toward the message. Between those thoughts coded as either positive or negative, it appeared that the HeLi condition generated the most balanced valence ($n_{\text{neg}} = 26$, $n_{\text{pos}} = 24$) followed by the LeLi condition ($n_{\text{neg}} = 34$, $n_{\text{pos}} = 29$). The remaining conditions generated markedly more negatively than positively valenced thoughts, with a 13-point difference for the HeHi condition ($n_{\text{neg}} = 35$, $n_{\text{pos}} = 22$), an 18-point difference for the Control condition ($n_{\text{neg}} = 34$, $n_{\text{pos}} = 16$), and a 19-point difference for the LeHi condition ($n_{\text{neg}} = 19$, $n_{\text{pos}} = 38$).

Insight-Related Statements. Thoughts were also coded for relative reference to insight and medication noncompliance. A clear reference to the defendant's insight was present in approximately 8% of the thoughts listed overall. The Control condition generated the lowest

percentage of *insight-related thoughts* (3%), followed by the LeHi condition (6%), and a relatively even percentage across the LeLi, HeHi, and HeLi conditions (9%, 9%, and 10%, respectively). The percentages of *insight-related thoughts* broken down into “low” and “high” insight categories within conditions, as well as the count data between conditions, are detailed below in Figure 16:

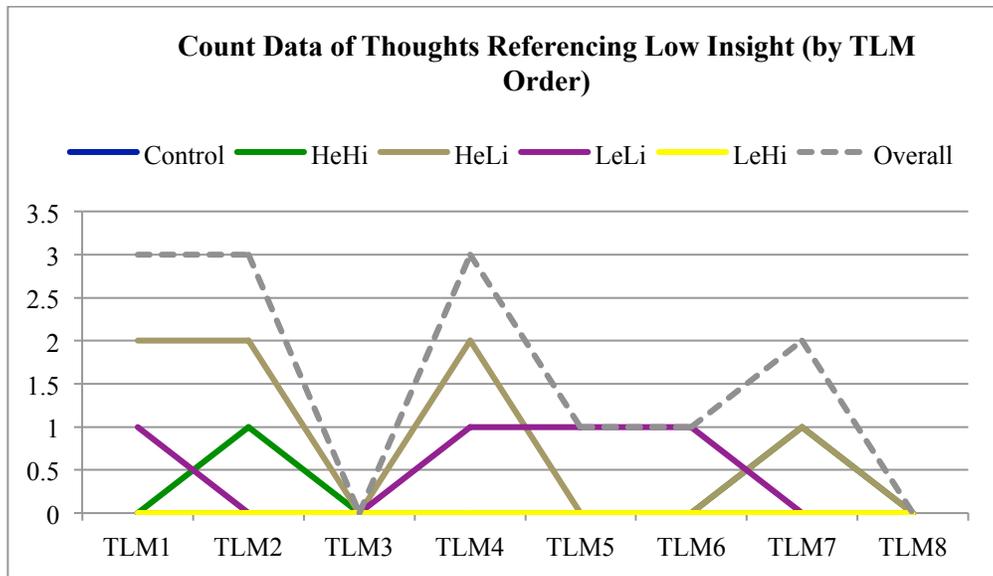


Recall that mock jurors had an opportunity to list up to eight thoughts within the three-minute time period. In an effort to elucidate which thoughts were most readily reported by mock jurors between conditions, statements were also tallied within thought number (one through eight) and presented in the order they were listed. Difference between conditions at the earlier time points labeled “TLM 1” through “TLM 4,” as well as the peaks in the frequencies at particular TLM points by condition, show what particular types of thoughts were most cognitive available (salient) and when among conditions Figures 17-18 (see next two pages):

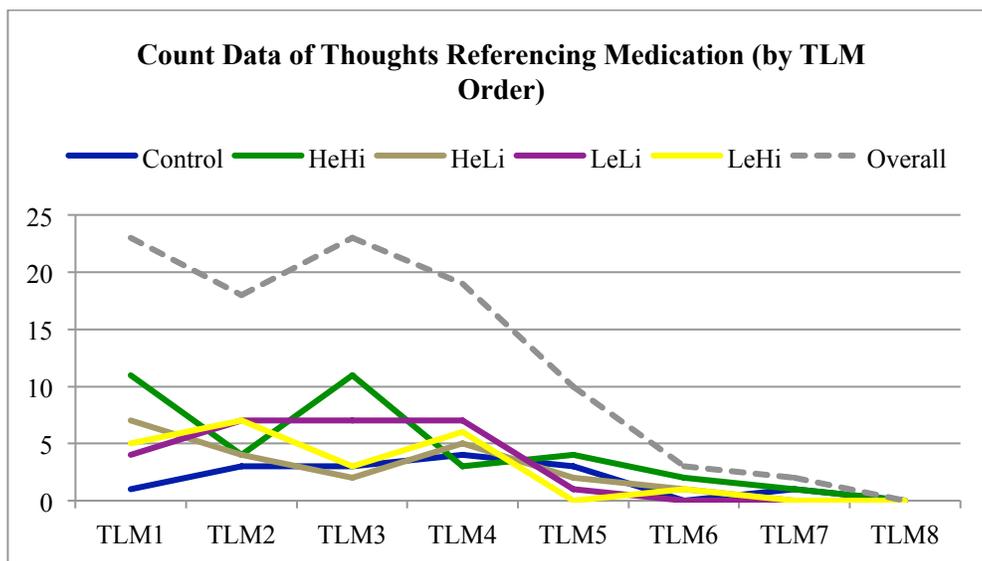


Regarding thoughts referencing the defendant’s High Insight into his mental illness, as anticipated, the HeHi condition reported the most thoughts and reported them the earliest in the TLM. A three-way tie unexpectedly emerged among the two Low Insight conditions (LeLi and HeLi) and the High Insight LeHi condition at TLM1 for number of High Insight thoughts. The LeLi condition (and to a lesser extent the HeLi condition) increased the number of High Insight comments early on in the TLM; the LeHi did not show this increase. While the LeLi and HeLi conditions’ references to High Insight peaked and then dropped off early on in the TLM, the LeHi condition maintained a low level of references to High Insight throughout the TLM. Overall, results suggest that High Insight was present in the LeHi mock jurors at varying levels of importance, yet was perhaps a more salient (and potentially influential) thought for the HeHi and even the LeLi conditions.

The additional Figure 18 (next page) shows mock jurors’ reported thoughts referencing the defendant’s Low Insight. While the overall number of thoughts is relatively small ($n = 13$), it is noteworthy that the counts appear in the anticipated conditions, with the HeLi condition reporting the most Low Insight thoughts (particularly early on), followed by the LeLi condition.

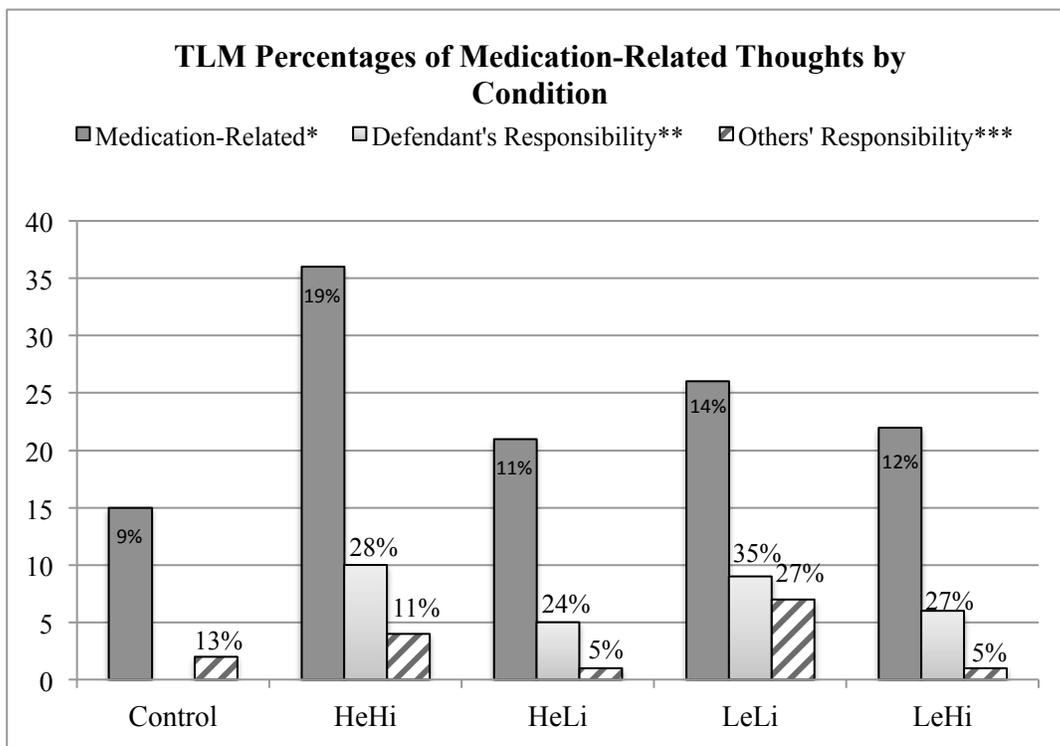


Medication-Related Statements. Approximately 13% of total thoughts across conditions explicitly referenced medication. This 13% is considered the *total of medication-related thoughts* (n = 120). Out of the *total medication-related thoughts*, most of the conditions generated similar percentages of medication references (17% from HeLi, n = 21; 18% from LeHi, n = 22; and 22% from LeLi, n = 26), the Control condition contributed a lower percentage of medication-related thoughts (13%, n = 15), and HeHi generated a higher percentage (30%, n = 36). Order effects of *medication-related thoughts* are presented in Figure 19:



Based on the frequencies displayed in Figure 19, it appears that High Elaboration conditions generated the highest percentages of *medication-related thoughts* at TLM1 and TLM3. The HeHi group peaked early in the *medication-related thoughts* listings, which suggested these thoughts were more accessible or salient to mock jurors' in this condition. However, the Low Elaboration conditions (LeHi and LeLi) also peaked early in the thought-listing exercise, at TLM2, which suggests that thoughts were raised regarding medication perhaps in part due to the lack of elaboration on the topic.

Medication-related thoughts were then assessed within each condition, as pictured in Figure 20 below:

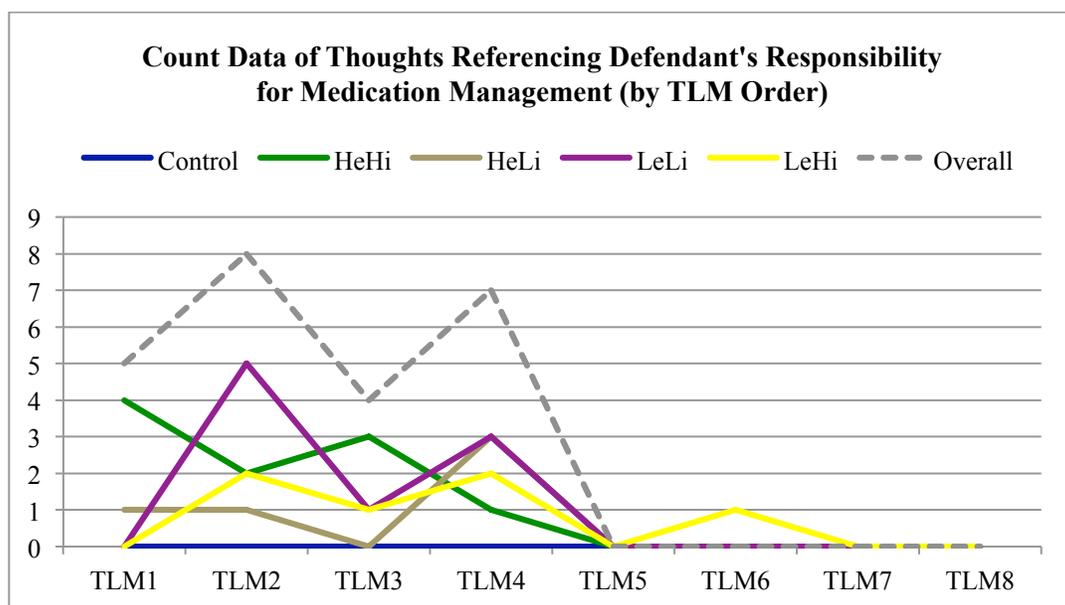


Note. *Percentages of medication-related thoughts to total thoughts within group. **Percentages of references to **defendant's responsibility** for medication monitoring to total *medication* thoughts within group. ***Percentages of references to **others' responsibility** for medication monitoring to total *medication* thoughts within group.

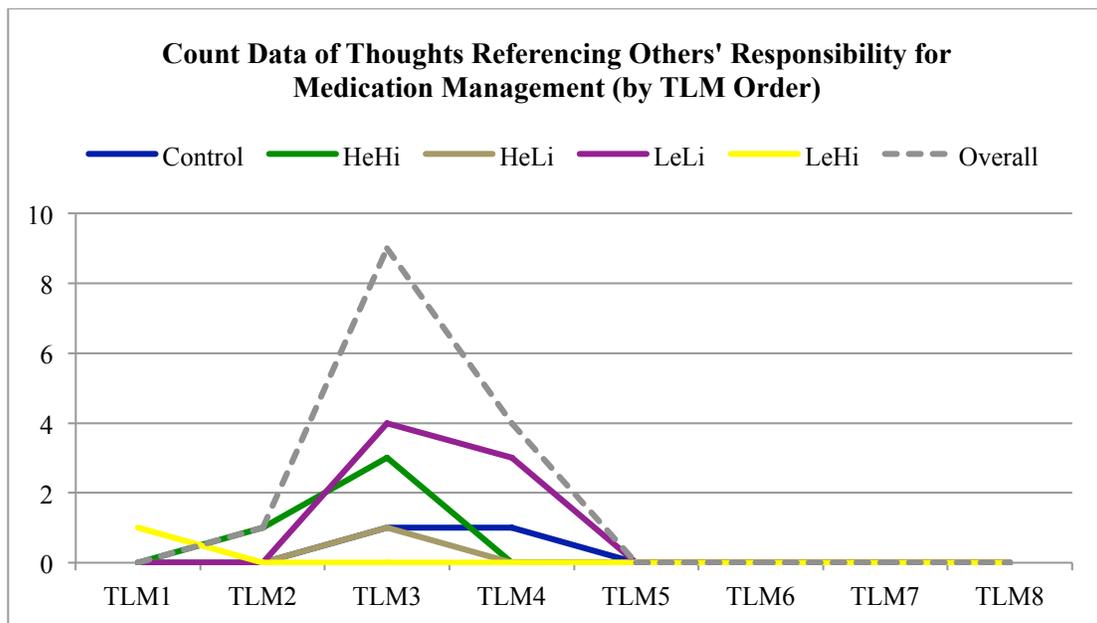
Figure 20 shows that the HeHi led conditions in relative frequencies of *medication-related thoughts* by accounting for nearly 20% of the thoughts generated by mock jurors within

this condition – the HeHi condition. Also displayed in Figure 20, thoughts were coded for explicit reference to responsibility for monitoring the defendant’s medication compliance – either as the defendant’s responsibility, or that of other parties such as doctors or society in general. For example, within the HeHi condition, 28% of medication-related thoughts attributed responsibility to the defendant for his MNC, 11% attributed responsibility to others, and the remaining 61% did not attribute blame for medication monitoring or noncompliance in their *medication-related thoughts*. When medication was mentioned in the Control condition, blame for medication management was attributed 13% of the time and always to others rather than to the defendant. The LeLi condition had the highest percentage of *medication-related thoughts* attributing blame to the defendant, but it also generated the closest tally between blaming the defendant and blaming others. On the other hand, HeHi yielded attributions to the defendant roughly two and a half more times than to others. The remaining experimental conditions of HeLi, and LeHi equitably attributed blame to the victim five times more than they did to others.

Finally, thoughts referencing responsibility for medication management were also tallied and assessed in order of reporting, as depicted in Figures 21-22.



As seen in Figure 21, thoughts referencing the defendant as blameworthy for his medication noncompliance were most salient (reported and peaked earlier) for the HeHi condition, followed by the LeLi condition. While these thoughts were reported throughout the LeHi condition, they appeared to peak for both the LeHi and the HeLi condition about mid-way through the TLM, suggesting they were less salient for these groups. Compared to thoughts that blamed the defendant for his medication noncompliance (as seen in Figure 21), thoughts that blamed others for the defendant's medication noncompliance were overall less salient as seen in Figure 22:



RESULTS: QUALITATIVE FOCUS GROUP EXPLORATION

Qualitative data were organized using Atlas.ti, Version 7, which is a software program designed specifically for qualitative data analysis and research (ATLAS.ti Scientific Software Development). The software read the uploaded focus groups transcriptions, each placed in a separate data file. While Atlas.ti can code directly from audio files, it is more straight-forward to import the transcriptions into the software in text format (Friese, 2010). The audio files were, however, synchronized with its corresponding text file to allow for user-friendly querying and time-stamping of illustrative quotes (Friese, 2010).

To assist in transforming the focus group data into meaningful information (Berg & Lune, 2012), a set of *a priori* key-words were derived from key concepts related to the research questions and literature (e.g., Mitchell, 2003; Perlin, 1994, 1996; Sherlock, 1984). For example, some of the key words selected are as follows: Medication, compliant, insight, blameworthiness, mental health, schizophrenia, guilty (Appendix EE). Because these key words are identified prior to explanation of the focus group data, no inter-reliability ratings are necessary. In contrast to *open coding*, where the researcher tags the text for codes, the proposed method will use Atlas.ti's "text search" function to identify all *a priori* selected key-words. This process automatically identified the presence of key-words in the text and flagged that text (Friese, 2010). The unit of analysis was *utterances* (defined by the key words) compared within focus group research questions and across focus *groups*, as opposed to participants (Carey & Smith, 1994; Gamson, 1992; Morgan, 1995, 1996). The key-words were flagged with semantic based codes. The presence (or absence) of key concepts was compared across files (focus groups) to isolate

comparisons across focus group responses to the same open-ended question (Appendix BB). For those groups that identify certain key concepts in their focus group narratives, descriptive information for each code was discussed both within and across focus groups.

Focus Group Participants

Demographic data within the focus group sample generally mirrored that of the overall study sample (see Table 6). The sample was 76% female and comprised of the following endorsed racial background: 86% Caucasian, 10% Hispanic, and 4% African American. The HeLi focus group endorsed slightly more religious affiliation ($M = 7.33$, $SD = .82$) than the average across focus groups ($M = 6.10$, $SD = 2.96$). The LeLi and HeHi were skewed as the most politically conservative focus groups ($M = 7.83$, $SD = 3.06$ and $M = 7.00$, $SD = 2.97$, respectively), across the focus group conditions ($M = 6.60$, $SD = 2.58$). Table 6 presents the means for the each of the primary attitudinal subject variables between focus groups:

Table 6
Descriptive data for attitudinal subject variables by focus group.

Sample	n	NFS		IDA-R		RLAQ-23	
		M	SD	M	SD	M	SD
Focus Group							
MC/Control	6	63.83	14.50	67.83*	18.26	29.60	8.68
HeHi	6	60.00	14.01	68.00*	21.78	27.33	6.02
HeLi	6	56.50	15.57	83.67	9.85	29.50	0.58
LeLi	6	56.17	11.30	90.50	26.55	29.00	4.65
LeHi	5	51.60	17.36	69.60*	21.58	27.40	6.07
Overall	29	57.83	14.10	76.14	21.14	28.50	5.53
Total Sample							
MC/Control	34	60.14	13.32	81.15	17.59	29.72	6.17
HeHi	35	56.37	12.23	79.91	18.75	29.11	5.07
HeLi	35	56.65	13.14	87.62	16.65	29.31	5.29
LeLi	35	55.17	12.40	84.60	19.08	29.85	19.08
LeHi	34	60.26	13.77	80.82	21.37	29.35	5.21
Overall	173	57.69	12.99	82.82	18.76	29.46	5.13

Note. *Represents more than a 10-point mean difference between focus group results and the overall sample.

Focus Group Follow-Up Questionnaire

Based on the follow-up questionnaire, 100% of focus group participants believed they were given the chance to share their opinions during the focus group. On a scale from 1 to 10

(completely honest), participants reported high level of honesty during the focus group ($M = 9.72$, $SD = .53$), as well as a low tendency to hold back what they wanted to say ($M = 2.31$, $SD = 1.95$; on a scale from 1 to 10 with 10 being holding back completely).

Focus group participants had previously voted as a jury on verdict. Both the Control and HeHi groups had found the defendant NGRI, while the HeLi, LeLi, and LeHi groups found the defendant guilty. The LeLi group generated some inconsistencies, however, because one participant had agreed unanimously on a jury verdict of guilty, yet reported her individual verdict as NGRI. Regarding post-focus group dissonance, three of the mock jurors in the HeLi condition stated that the focus group had altered their verdicts (from guilty to closer to NGRI) and that they were more open to the idea that the defendant may have had low insight. These mock jurors reported bias in their understanding of the testimony. They provided the following reasons for altering their opinions post-focus group: “The fact that I had it completely wrong that he said he had a mental illness;” “Most of us had memory bias and selective auditory so once those were corrected that changed it;” “I am very skeptical about everything but I am more open to him not knowing that he is mentally ill...made me consider ALL aspects of the defendant.

Focus Group Outcomes Compared to Overall Sample

Quantitatively-derived results were complimented with a qualitative exploration of focus group data collected from each study condition. The aim was not to conduct a separate qualitative analysis. Instead, the focus group data were examined specifically to clarify features of the study design and manipulation, or conceptual elements of the study, which may have contributed most to the pattern of results denoted above. Thus, the overall purpose of the qualitative component of the study was to draw a one-to-one correspondence of quantitative outcomes with qualitative explanations. Focus group data from each of the experimental and

control conditions were explored on the basis that they were randomly selected mock juries that were representative of jurors’ experiences in each of the respective conditions. To increase confidence in this assumption, means for the primary outcome variables were compared between focus group data and the overall sample by condition. Table 7 and Figures 23-27 below (see next page) provide descriptive data for these comparisons.

Table 7
Descriptive Data for Focus Groups on Primary Outcome Variables*

Sample	n	Verdict***		MC-Competency 4-item		MC-Responsibility 2-item		Meta-Responsibility 5-item		MI-Product 2-item	
		M	SD	M	SD	M	SD	M	SD	M	SD
Focus Group											
MC/Control**	6	3.50	2.07	21.33	4.80	8.33	1.37	17.50	2.51	11.17	1.17
HeHi**	6	6.00	1.55	19.83	5.34	9.83	2.56	15.17	2.86	14.00	1.79
HeLi	6	1.83	0.98	23.33	2.58	11.33	2.34	18.33	4.80	9.83	1.72
LeLi	6	2.00	2.00	23.33	5.61	12.83	2.04	18.33	1.21	11.83	3.19
LeHi	5	1.20	0.45	23.20	4.21	12.00	1.58	18.40	5.55	8.00	2.35
Overall	29	2.97	2.28	22.17	4.54	10.83	2.51	17.52	3.60	11.07	2.81
Total Sample											
MC/Control	34	2.97	2.03	21.35	4.53	8.62	2.62	18.32	3.67	9.14	3.42
HeHi	35	2.89	2.14	23.31	4.45	11.45	2.90	18.97	4.99	9.43	3.61
HeLi	35	1.77	1.46	22.86	4.96	12.00	2.01	18.94	4.82	10.45	3.96
LeLi	35	2.54	2.08	23.29	4.37	12.20	1.97	18.60	4.37	11.11	3.26
LeHi	34	2.38	2.28	24.67	3.55	12.97	1.27	20.53	5.31	9.02	3.83
Overall	173	2.51	2.04	23.09	4.48	11.46	2.67	19.07	4.67	9.84	3.67

Note. *MRQ factors are rated on a likert-type scale from 1 (strongly disagree) to 7 (strongly agree). **Jury verdict was “NGRI” (as opposed to “Guilty” for the remaining focus groups). ***Higher verdict scores relate to higher likelihood NGRI verdict (as opposed to guilty), on a 7-point reverse coded likert-type scale.

Figure 23

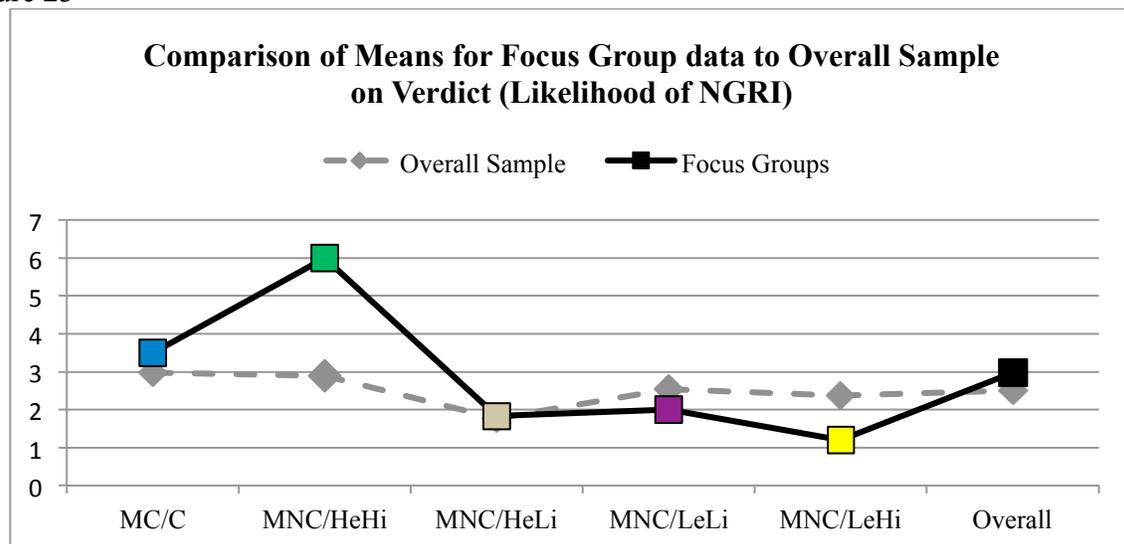


Figure 24

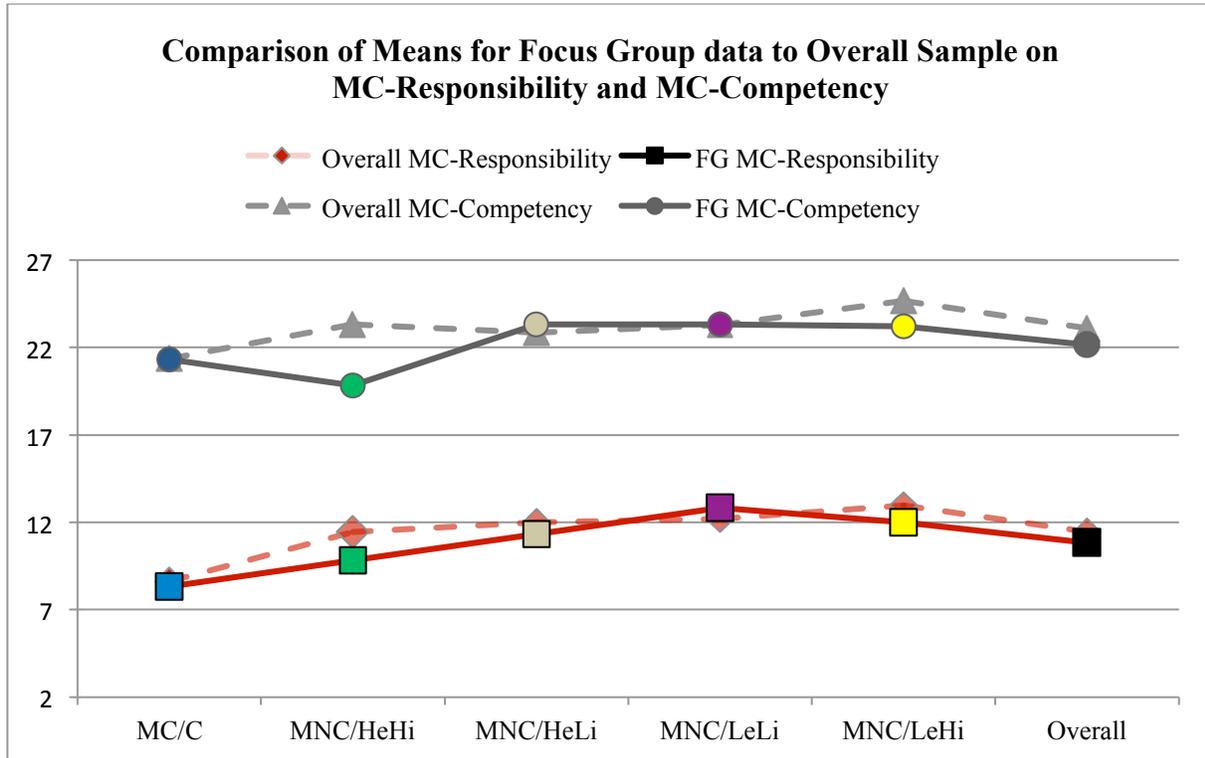


Figure 25

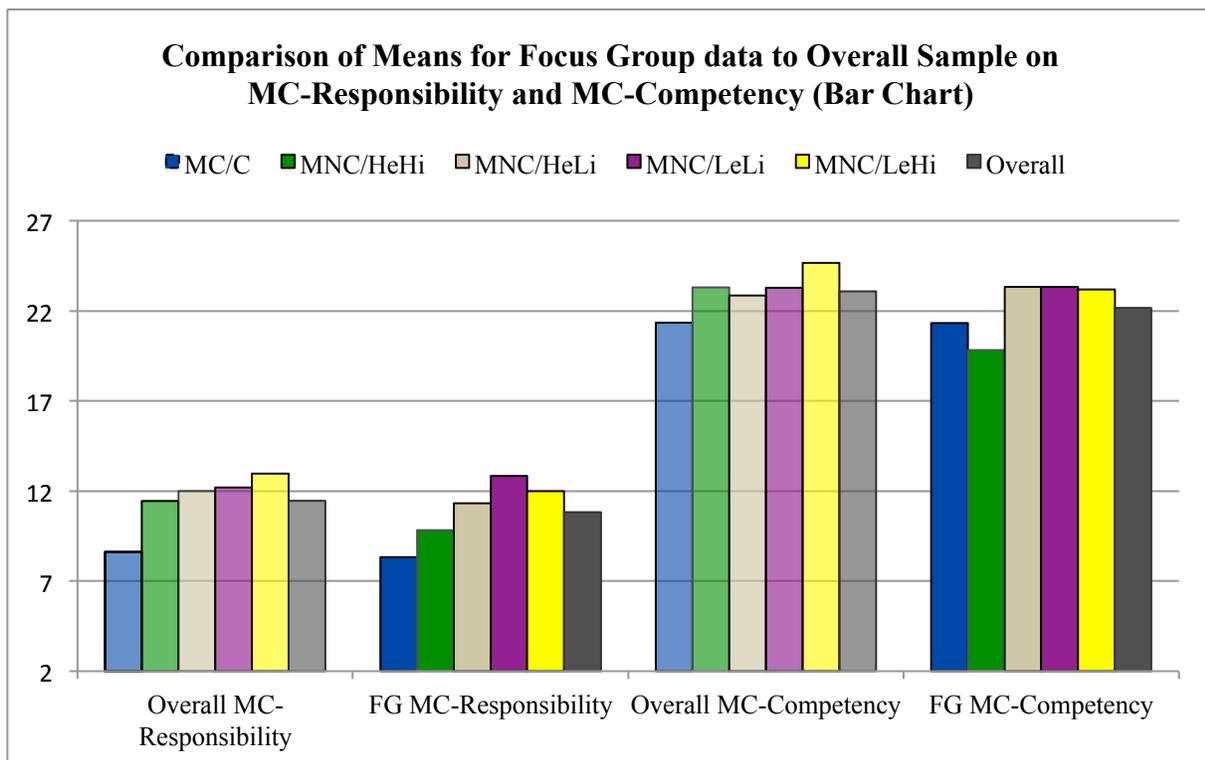


Figure 26

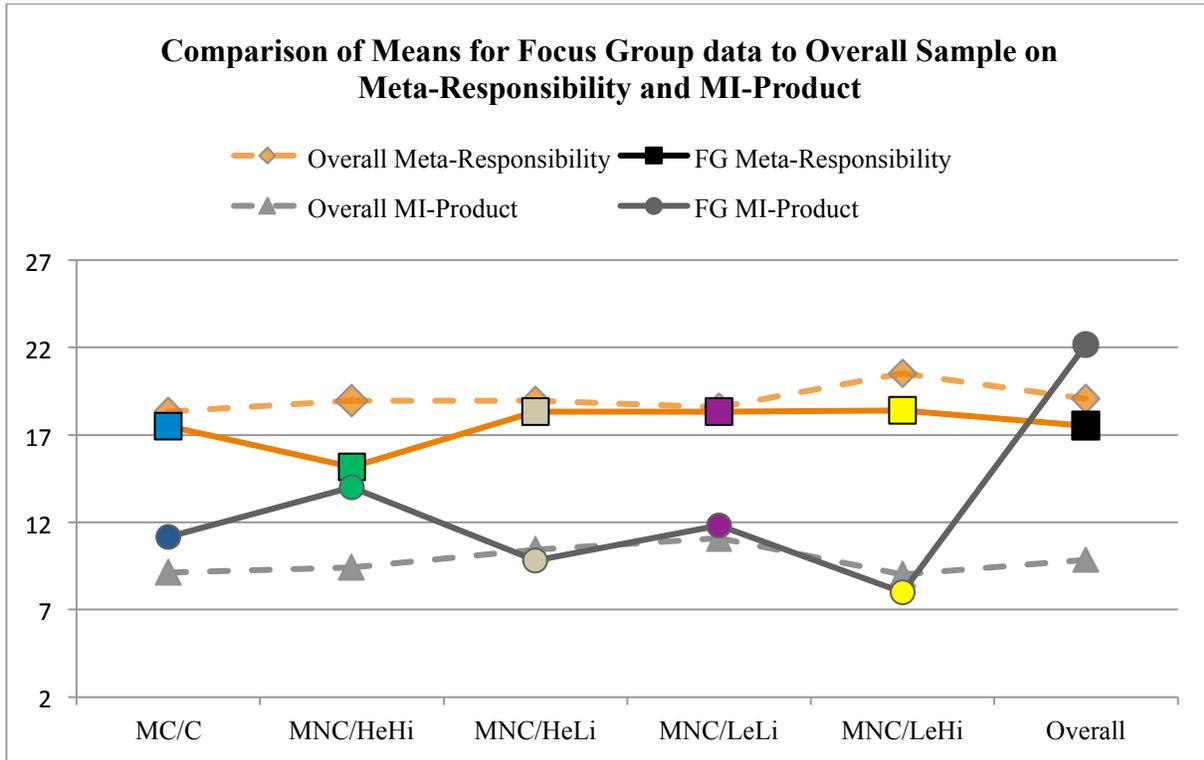
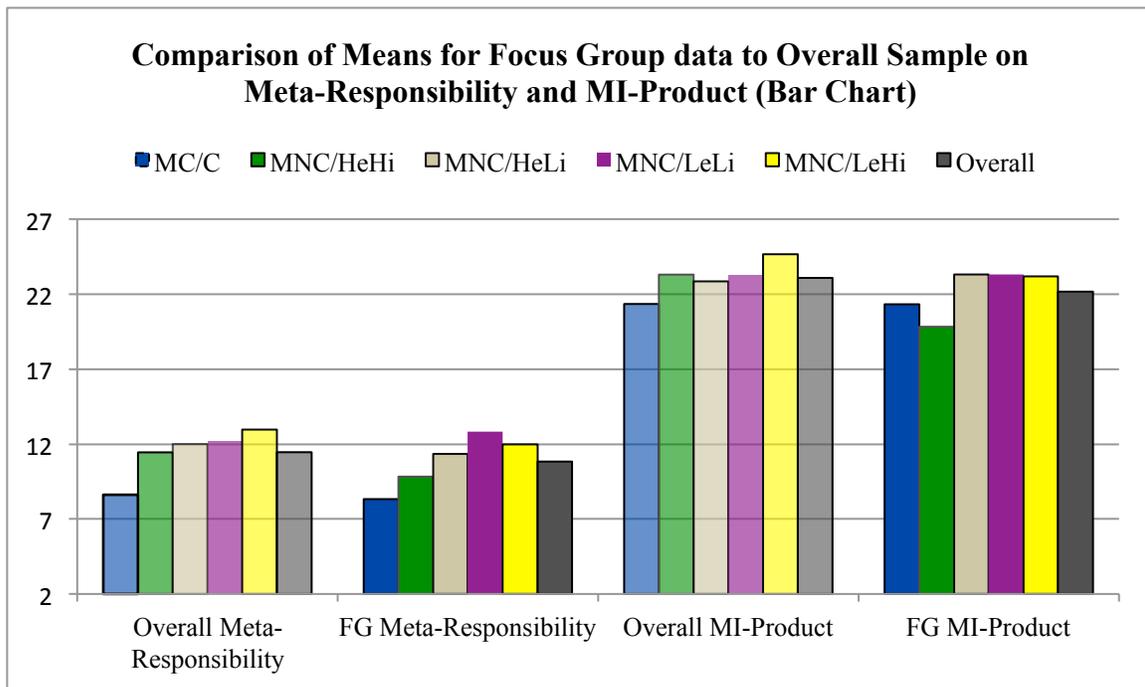


Figure 27



As illustrative above, the overall sample the MC/Control and HeHi conditions yielded the highest likelihood of NGRI verdicts, followed by LeLi, LeHi, and HeLi. While these means were ordered this way relative to each other, the differences between verdict ratings were not statistically significant. The pattern of verdicts across the focus group conditions tell a slightly different story. First, the HeHi focus group appeared to be markedly more in favor of a NGRI verdict than the other focus group conditions and the overall sample conditions. Second, in the LeHi focus group participants found the defendant slightly less MR (because they believed the defendant's MSO was not impaired) and were markedly more punitive in their verdict. However, in both the focus group and the overall sample, the LeHi verdict was more punitive than the HeHi verdict. Taken together, differences in verdict means between the samples, along with the pattern of results illustrated above for the MRQ factors, suggest caution should be used when interpreting focus group data as having one-to-one correspondence with conditions representative of the overall sample, particularly regarding the HeHi and LeHi conditions.

However, the primary objective of the focus groups was to ensure the manipulations of the independent variables (i.e., medication compliance, insight, and elaboration) were successful. In other words, the main goal was to rule out internal validity problems that could explain the lack of statistically significant quantitative findings. For instance, when hypothesized findings are supported, the explanations for those findings are often inherent in the theoretical framework for those hypotheses. However, when hypotheses are unsupported, as was primarily the case in this study, qualitative exploration can examine a multitude of potential explanatory factors. This approach also helps to prevent erroneously or prematurely concluding that hypothesized findings are simply not supported phenomena (Popper, 1980). A final benefit to a selective qualitative exploration is to inform future experimental designs equipped to enhance internal validity of

manipulations. Coupled with the fact that the overall direction of each condition’s verdict and meta-responsibility outcomes between focus groups and the overall sample were relatively similar, the use of focus groups as a comparative sample for these aims appears appropriate.

Focus Group Exploration

The key-word based concepts identified in each of the focus group’s narratives was organized by the primary questions regarding the influence of medication compliance and insight, as well as what the mock jurors learned from the testimony and what stood out most to them from the testimony. The below Tables 8-11 provides all key concepts extracted from each of the focus group transcripts with illustrative quotes where appropriate. The complete transcripts for each focus group are provided in Appendices FF-JJ.

Table 8 Focus group results by condition for: “How did the defendant’s medication compliance influence your decision-making?”				
MC/C	MNC/HeHi	MNC/HeLi	MNC/LeLi	MNC/LeHi
Wanted to know if he was medication compliant before the expert even brought it up	Recognized he was MNC because of (1) poor judgment; (2) side effects; (3) wanted a life without medicine	Recognized the defendant was MNC and “insane”	Recognized the defendant was MNC	Recognized the defendant was MNC
MC at first because he was told to, but then became compliant because he had insight	Understood when the patient was stable, he was still MNC because he did not want to be on medication	Believed that (to some extent) the defendant understood that he needed medication because: (1) previous compliance, (2) prescription, and (3) past violence	Mock jurors did not relate insight to compliance (believed he should take the medication regardless of insight)	Believed the defendant should have “hired someone... written notes everywhere” (etc.) to make him MC (was not “proactive”)
Wanted a “blood test” to verify he was taking MNC (“If he wasn’t [taking it] then he would be accountable for his crime.”)	MNC was a sign that the defendant lacked rational, good judgment (e.g., not taking it just because “he doesn’t like the way it makes him feel”)	Due to jurors inferring insight, they believed “he should have been able to know that...it was wrong that he wasn’t taking medication”		Defendant’s MNC/MC did not influence his behavior at the time (did not believe he was psychotic)

	<p>It was hard to decide on the initial reason for being MNC (side effects vs. “not want to”)</p> <p>MNC should have never have been his choice</p>	<p>It was “interesting” that the defendant was paranoid about his medication (believing it was cyanide)</p>		
Overall Reported Influence on Decision-Making				
<p>“...then he was doing all that he could to control his illness...and if it didn’t work then it wasn’t his fault”</p>	<p>Very important to their decision-making</p>	<p>MNC increased his MR and his guilt because he cannot use insanity as an “excuse” if he did not “take precautions”</p>	<p>MNC led to increased MR, yet not “guilt”</p>	<p>MNC made the defendant “more guilty” regardless of whether he was psychotic or not at the time of the offense</p>
<p>The hospital was at fault for not making sure his medication was working</p>	<p>Mental health system was responsible for MNC (not the defendant)</p>	<p>Perceived the defendant as lazy and purposely defiant (“it’s not hard to get up and take a pill everyday”)</p>	<p>His “choice” to not defer to the doctors was blameworthy</p>	<p>Believed the defendant thought his MNC would make him less blameworthy because it would diminish his control over his illness (used MNC as a “scapegoat” to be violent</p>
<p>Lessened his guilt</p>	<p>All but one juror thought about MNC beforehand (after it was raised in deliberations, the MNC lessened culpability)</p>	<p>Reasoned that he was capable of MC because if he was not capable of being compliant (could not “remember to take a pill”) then the doctors should have <i>or would have</i> been monitoring it closer</p>	<p>Drinking and driving analogy**</p>	<p>Some jurors did not use the MNC in their decision-making because they believed his MSO was not impaired (thus, making MNC/MC irrelevant) – believed that MC would have made him more guilty</p>
<p>Epilepsy and driving analogy*</p>	<p>Debated the “consciousness” of his decision to be MNC (<i>if</i> conscious decision, then hold responsible; but <i>if</i> not conscious because he has Schizophrenia, then not meta-responsible)</p>		<p>“I think it’s impossible to ignore [his MNC and meta-responsibility]. That’s the biggest causation of his actions.”</p>	

Note. Two of the focus groups brought up examples of laws or situations that they viewed as comparable to the defendant’s meta-responsibility for his MSO.

*The MC/Control group raised this issue of epilepsy and the legal requirement that people with epilepsy take medication in order to drive. In this example, mock jurors viewed the epileptic as having high insight and being MC. If the epileptic was MNC, then they would hold he or she responsible for any subsequent crimes (i.e., having a seizure while driving and killing someone) because of “negligence.” The epileptic was viewed as being MC *because* of his or her insight that if they do not take medication, they will have a seizure. Some of the mock jurors believed that there should be a 1:1 relationship between this example and that of a schizophrenic. Others stated that the disorders are not the same because the symptoms differ. These jurors explained that seizures are 100% automatic and cannot be controlled by choice (behaviors/thinking), but that a psychotic episode is *not* 100% void of personal control. If psychotic behavior can be controlled by either medication *and/or by* choice, then medication compliance would not have a 1:1 relationship with meta-responsibility. Moreover, medicine for Epilepsy is practically 100% effective at preventing seizures, but that medication for Schizophrenia is not.

**The LeLi focus group introduced the analogy of alcohol use and driving. They established that a person has three opportunities to engender meta-responsibility for their driving behavior: (1) the choice to start to drink, (2) the choice to keep drinking, and (3) the choice to drive home (and in this example, resulting in killing another driver). As you progress through the choices, it appears the level of *unimpaired* insight diminishes. Following this reasoning, the drunk driver would be held accountable for the decisions made when insight was the highest (i.e., stage one or possibly two) and potentially then be meta-responsible for resultant choices and behavior (in stage three and so forth). However, the LeLi mock jurors held the drunk driver equally accountable across all three time points regardless of diminishing insight. They held the drunk driver accountable for his choices while insight was intact, and for ignoring what they believed “most people who drink know” even while intoxicated – that alcohol impairs self-control. They stated the drunk driver have some awareness that what he or she is experiencing (the belief that they are “okay” to drive), is false and impaired. The mock juror was basically holding the hypothetical drunk driver accountable in the face of his or her low insight because despite not having rational thinking abilities at the time, they “*knew* they had been drinking.” The analogy served to explain how the LeLi condition believed that regardless of insight, the defendant in this case should have either been MC or *known* that he needed to be institutionalized for medication management simply because he had been diagnosed with Schizophrenia in the past.

MC/C	MNC/HeHi	MNC/HeLi	MNC/LeLi	MNC/LeHi
Defendant had insight into his illness (that it was affecting his life)	The defendant had high insight, yet could not “control” his illness at times	Thought his low insight and his paranoia while psychotic was “interesting”	Unsure at first of what moderator meant by “insight” (equated it with MSO)	Defendant knew the consequences of MNC and “what he was capable of doing”
Proof of insight: (1) medication compliance (but skeptical); (2) checked self into hospital; (3) diagnosed later in life so knew life before to compare; (4) hospital had released him; (5) length of disease	Distinguished between “understanding of his illness” and “rational thinking” (believed he had understanding, but not rational thinking)	“[The expert] said he was unable to completely understand it...”/ “The doctor made it seem like he didn’t understand” (noted these comments were inconsistent with some of his history)	Some jurors inferred high insight: (1) prior incidents of violence; (2) history of treatment and prescription; (3) knew it was wrong after the incident when interviewed by police	Due to his insight, the defendant knew the “steps” to better control his illness and behavior

Believed the defendant primarily thought like a “normal” person		Inferred some level of insight from history: (1) going to hospital at 1 st episode; (2) claiming mental illness during interrogation; (3) being free in the community	Other jurors viewed insight as more variable; less insight in times of psychosis	
Defendant stayed and talked to the police		“Even if he didn’t necessarily know that he was Schizophrenic, he knew that he was insane... <i>something</i> was wrong”	Believed the defendant’s reasoning was impaired due to Schizophrenia, <i>so</i> he should defer to the doctors (referred to <i>A Beautiful Mind</i> example)	Believed the defendant was “fine...running the risk” of his MNC (alluding to insight of the risk)
		Debated among the jurors regarding his level of insight reported to the police/ etc.		
		Did not understand how low insight could exist (sleepwalking analogy debated) or be proven		
Overall Reported Influence on Decision-Making				
Showed the defendant had insight and “it probably was the illness that caused [his violence]”	The defendant was less culpable	Believed he used his illness as an “excuse”	Less decisiveness and cohesion among the mock jurors’ opinions	
Did not view the insanity defense as a viable “excuse;” thought it would be more likely for someone without genuine impaired MSO to just “run” instead	Mental health system was more culpable	Agreed that insight or understanding is “different with a mental illness,” but unable to reach a conclusion about how exactly and to what extent it influences rational thinking and judgment	Perceived level of insight made the defendant more culpable	The defendant’s insight and lack of effort to “make it better,” increased the defendant’s culpability
		Insight made him more culpable	Blamed the defendant for not “trusting” the doctors	

Table 10

Focus group results by condition for:

“What is something new that you learned through the testimony?”

MC/C	MNC/HeHi	MNC/HeLi	MNC/LeLi	MNC/LeHi
Schizophrenia has an onset in early adulthood (previously believed that it was diagnosed in childhood)	The “chemical basis” of the disorder; thought it was more environmental	Factual information about schizophrenia (e.g., it is not multiple personalities)	Medication helps treat schizophrenia	It is possible to have insight into your mental illness
The defendant would have known a “life with and without” schizophrenia	The “extreme” nature of schizophrenia as a mental illness	People with schizophrenia may not realize what they are doing or that it is wrong (low insight; impaired MSO is possible)	“Doctor knows best” and the defendant should listen to him	
The sometimes episodic nature of schizophrenia		Schizophrenia can be a “get out of jail free card”		
		Mentally ill people are very dangerous		
Overall Reported Influence on Decision-Making				
Suggested that the defendant had some insight into his mental illness	Biological basis of the disorder lessened responsibility of the defendant	Help to shape their impressions of what punishment the defendant should receive (punitive/secure)	Influenced their impressions of the defendant’s MNC	Influenced their impressions of the defendant’s MNC
Suggested that the defendant could not control some aspects of his illness	Gave jurors the impression that the illness’s severity could “lead to somebody’s death”	Induced sympathy for the defendant Made them want to hear from the defendant (and see the defendant)		

Table 11

Focus group results by condition for:

“What stood out to you most about the testimony?”

MC/C	MNC/HeHi	MNC/HeLi	MNC/LeLi	MNC/LeHi
Held defendant accountable for not resisting the “urge” to push the woman	Blamed the institutions and mental health system for letting the defendant out in public	“[Defendant’s MNC]...pretty much what I based my opinion on”	The defendant knew <i>something</i> was wrong and that 12 hours later, he knew he had done something	Expert focused on his history of Schizophrenia and not enough on the time of the offense
Defendant’s MC (medication compliance)	Defendant had no motive; “I just don’t believe a sane person would have done that to a random person”	Hospital’s inability to “keep count of” their mentally ill patients who are released to the community	“On-and-off” nature of the offense was not consistent with a psychotic break	“On-and-off” nature of the offense was not consistent with a psychotic break
Believed the prosecution was prepared for the witness and the witness did a good job supporting his history of mental illness; found the expert neutral	Expert was viewed as credible and logical	Defendant’s history of violent offenses	The neutrality of the expert witness	Perceived the expert witness as potentially a hired gun for the defense (but credible)
	Deliberations	Believed the defendant had blamed his illness as the cause of his behavior at each assault by claiming his illness at the scene	Defendant’s history of violent offenses and awareness of him “getting more aggressive every time”	Defendant’s history of violent offenses
	Defendant’s choice to not take his medication		Defendant’s long-time diagnosis	
Overall Reported Influence on Decision-Making				
Trusted the expert’s opinion	Believed that if it was anyone’s fault, it was the mental health system’s fault	Held defendant responsible for not taking his medication due to the belief that he had <i>some</i> insight	Believed the defendant had insight into his mental illness and should have been taking his medication	Believed the defense was intentionally trying to claim impaired MSO when they knew it was not (e.g., “he didn’t have Larry telling him to do it”)

Thought the defendant's MC showed he was trying to be responsible (which outweighed his irresponsibility of not resisting the urge to push her)	Moved jurors' thinking away from the emotionality of the victim/murder and toward trying to understand the defendant's state of mind	Focused on needing to control the defendant and keep him out of the community	Focused heavily on punishment; believed defendant needed to be "locked up" and that he would receive mental health treatment in jail if Guilty	Did not believe that the defense had proven their case by the facts
	"He shouldn't be responsible for taking his medicine, so he shouldn't be a part of society if he can't even <i>make the decision</i> if he's going to take his medicine."		Viewed insanity defense as an "excuse"	Viewed insanity defense as an "excuse"
			Tired of the defendant receiving "just a slap on the wrist" and believed the doctors could not treat him	<i>Did not mention punishment as a factor, yet focused on the illegitimacy of the defense</i>

DISCUSSION

This study implemented a mock jury paradigm to investigate one of the most stigmatized and misunderstood defenses in criminal proceedings – the insanity defense (Perlin, 1994, 1996, 2000; Perlin & Dorfman, 1993; Skeem & Golding, 2001; Vidmar & Hans, 2007). Previous research has uncovered that while insanity defense bias heavily influences decision-making in these cases (Eno Louden and Skeem, 2007; Skeem, Eno Louden, & Evans, 2004; Skeem & Golding, 2001), jurisdictional variations in definitions of insanity and the legal standards regarding the NGRI defense carry little predictive influence on outcomes (Finkel & Slobogin, 1995; Ogloff, 1991). The law and psycho-legal scholars are then left with the question of “What else explains [NGRI] decisions?” (Devin, 2012, pg. 85). This study hypothesized that the trier of fact may heavily weigh a defendant’s meta-responsibility for his or her impaired MSO when evaluating evidence in NGRI defenses based on prior research (Finkel & Slobogin, 1995; Mitchell, 2003). Meta-responsibility was experimentally manipulated using varying degrees of defendant medication compliance and insight. It also tested various degrees of explanation to these factors in expert testimony in hopes of learning more about how mock jurors consider these factors and ways in which FMHPs can best communicate this information on the stand.

The various experimentally constructed interactions of medication state, insight, and testimony elaboration in the present study failed to yield statistically significant predictions regarding verdict and meta-responsibility, with one exception. Compared to when a defendant was MC, when the defendant was MNC, mock jurors were significantly more likely to view the defendant as having an increased responsibility or duty for his or her medication compliance.

Combined with qualitative data explorations, findings clearly suggest that mock jurors do in fact consider MR in their decision-making when the NGRI defense is raised. Not only do they consider MR and medication compliance, but they also consider other legally extraneous variables such as a defendant's level of insight into his need for medication and the appropriate level of punishment for such a defendant. This phenomena is illustrated by a mock juror in the LeLi focus group who explained that *not* considering MR would be impossible in a NGRI defense, stating "I would say the Judge is wrong on that...that's just a law loop hole" [to permit people with mental illness to not take responsibility for their actions].

However, the question remains as to whether there was a meaningful difference in how the experimental groups considered MR (i.e., MNC and insight). Although there is little guidance on the issue of effect sizes and LMM analysis, recall that it was extrapolated from non-mixed model power estimates that small effects were unlikely to be uncovered by the present study due to constraints of the sample size. Moreover, there appeared to be a ceiling effect for mock jurors' perceptions of a defendant's insight in the current study. Mock jurors may operate under the assumption that people with SMI have high insight and thus, be reluctant or cognitively less able to consider low levels of insight in a NGRI defendant. The study was also similar to other mock juror decision-making studies in that a floor effect for guilt (as opposed to NGRI) was also evidenced. Taken together, these findings are consistent with prior research that found mock jurors were unable to appreciate the complexity of the relationship between MNC and volitional, informed decision-making (Slovenko, 1995) and made it more likely that if differences were to emerge, they would have been small effects and less readily detectable in the present study. They also suggest that the experimental manipulations of Low Insight and Elaboration may have been too weak to engender effects of these MR variables that may have

otherwise more directly influenced outcomes in this case scenario. Thus, there may be aspects of the study design and the nature of the phenomena being studied (e.g., small effect sizes that necessitate more investigative power), that increased the likelihood of Type II error (i.e., concluding that the groups do not differ, when in fact they do differ) (Cohen, 1992).

Validity of Experimental Conditions

Medication state. Both quantitative analysis and qualitative exploration indicated that medication state was successfully manipulated in the present study. Responses from the PRF and focus group data indicated that the MC/Control condition perceived the defendant as MC, whereas the remaining MNC conditions all concluded the defendant to be MNC.

Testimony elaboration. Results of the TLM supported successful elaboration manipulations. Compared to the Control and Low Elaboration conditions, the High Elaboration condition generated the highest thought elaboration on the TLM, as well as the highest percentage of stimulus-derived thoughts and the lowest percentage of peripheral or irrelevant thoughts. While these results were the most pronounced for the HeHi condition, they were not as pronounced for the HeLi as was anticipated. Together, these findings suggest that Elaboration was better differentiated within the High Insight condition than the Low Insight condition.

For both testimony *strength* and the *informative* queried via the PRF, the HeHi and LeLi conditions are rated relatively similar and above the Control condition. Although no statistically significant differences emerged in corresponding analysis, the mean differences are worth reviewing to extrapolate explanations for results of the primary analysis. It was anticipated that both High Elaboration conditions (HeHi and HeLi) would be the highest rated on testimony strength and informative nature. Instead, HeLi was rated lower than the LeLi condition on both testimony strength and informative nature. Although anecdotally derived, it is possible that the

HeLi condition introduced a highly elaborated description of Low Insight that was inconsistent with how mock jurors typically think of levels of awareness and insight in the typical human condition, thus, weakening the testimony's intended elaborative aims and leaving mock jurors with more questions than answers. These suppositions were further supported by mock jurors' ratings of the expert's *knowledge* as captured by the WCS, as well as the testimony's *influence* and *persuasiveness*.

Elaboration was manipulated by providing increased explanation for the defendant's MNC and either his High or Low Insight (depending on condition). PRF results suggest that within the High Insight condition, mock jurors did in fact cite the specific reasons the defendant had been purposively MNC; whereas, in the Low Elaboration condition, the reasons were vague despite them having been mentioned by the expert in the Low Elaboration condition. Moreover, TLM results suggest that High Insight thoughts were more salient for the HeHi mock jurors than for the LeHi jurors. These findings indicate that differences between Elaboration levels of at least the High Insight condition were successfully manipulated.

Regarding the Low Insight condition, the reader is reminded that due to results from Pilot Study I (Appendix OO), emphasis regarding the defendant's Low Insight had been added to the LeLi condition because participants were missing the references to Low Insight altogether in some cases. Despite increasing elaboration slightly in the LeLi condition post-pilot, there was still a noticeable difference in ratings of insight between the Low and High Elaboration "Low Insight" conditions on both the PRF and the TLM, providing at least partial support for differences emerging between the elaboration manipulations for the Low Insight group as well. Still, For the Low Insight conditions, references to a *specific* reason for lack of "insight" were evenly distributed across the two conditions – regardless of elaboration. In fact, the lack of

elaboration on the defendant's Low Insight (LeLi) counter intuitively appeared to generate a larger representation of specific reasons for the minimal insight, yet did not generate substantively different reasons from those mock jurors exposed to the HeLi condition. Thus, there is reason to believe that the Elaboration manipulation for the Low Insight conditions was at least partially successful; yet, future research is necessary to uncover whether the lack of differences between the Low Insight conditions was due to a weak manipulation of Elaboration, or better explained by mock jurors' perceptions of Low Insight and their need for greater elaboration of Low (versus High) Insight in order to centrally process and evaluate the differences.

Defendant's insight. On the PRF, all respondents in the MC/Control and both High Insight conditions reported "yes" the defendant had insight into his condition, supporting a successful manipulation of Insight for the High Insight condition. MC/Control focus group participants admitted that High Insight was not explicitly stated in the testimony, but they believed that the defendant's High Insight was "implied" by other case facts and medication compliance because the defendant was a "grown man" and "wouldn't take medicine just because he's told to [do so]." The mock jurors in the MC/Control condition also believed that insight would be readily maintained by people living with severe mental illness. While the HeHi focus group determined that the defendant's insight was "higher than other mentally ill patients," they also reported that his insight was not high enough to "fully take control of his actions" and decisions to be MNC. So although the HeHi focus group endorsed High Insight, they were in fact conceptualizing High Insight coupled with poor judgment and volition.

For the Low Insight conditions, the testimony was manipulated so that a higher proportion of respondents would understand the defendant lacked insight into his illness, with the

percentages anticipated to be higher for the HeLi (High Elaboration) than the LeLi (Low Elaboration) conditions. PRF and TLM results provided mixed support for the manipulation of Insight for the Low Insight group. Both results supported the expected pattern (although not the strength) of the intended manipulation for the Low Insight conditions. Mock jurors more readily generated thoughts regarding High (versus Low) Insight on the TLM, even for the Low Insight conditions. On the PRF, for the roughly 30% of mock jurors who reported the defendant has having “Low Insight,” a higher percentage of them were from the HeLi condition than from the LeLi condition. Although only 30% of the Low Insight mock jurors endorsed “yes” when queried if the defendant lacked insight, approximately 75% of the Low Insight mock jurors attributed the defendant’s MNC to his low insight. It appears that when faced with an absolute response option on the PRF (i.e., “yes” or “no”), Low Insight mock jurors were hesitant to endorse a complete “lack of insight;” whereas High Insight mock jurors readily reported the presence of insight. Investigation into the reasons Low Insight mock jurors believed the defendant was MNC were surprising, however. Logic would lead one to believe that believing the defendant was “[MNC] by choice” would equate with having High Insight (and thus, not be endorsed by Low Insight mock jurors). However, the LeLi condition generated the second highest percentage of “by choice” endorsements overall (which was almost double the number of “by choice” endorsements reported in the HeLi condition). Within the “by choice” category, the HeLi condition generated the least number of endorsements. So compared to High Insight groups, the HeLi condition generated fewer “by choice” thoughts (as would be anticipated). However, the LeLi condition yielded a higher percentage of “by choice” thoughts than anticipated. One can extrapolate anecdotally that the lack of elaboration in the low insight condition (LeLi) negated the attention to the *low insight* nature of the testimony. Instead, the

defendant was seen as making *more* of a presumably informed “choice” in the low versus high insight condition when more detail was provided in the latter.

Low Insight manipulation: A closer look. The focus group exploration provided further clarity into whether the insight ratings for the Low Insight group were better explained by a manipulation failure or by unexpected interaction effects of the MNC/Elaboration/Insight manipulation. The fact that the LeLi group believed the defendant had insight into his mental illness ran contrary to the study design and manipulations. At first, this seems like a straightforward manipulation flaw. It is likely that the ambiguous references to the defendant having vague and little insight into his mental illness were overshadowed by the more salient aspects of the testimony that may infer insight (e.g., the defendant’s long history of mental illness; the prosecution’s repeated statements that the defendant “used his illness as an excuse every time he got into trouble;” and the fact that the defendant asked for a doctor after the incident). However, the LeLi group repeatedly referenced the defendant informing the police and others that he “has schizophrenia,” which was never testified to in the case. It is possible that the LeLi group inserted the defendant’s High Insight into the testimony as a direct result of the Low Elaboration. In other words, there was Low Elaboration explaining what “Low Insight” meant and why he had it. Because they could not fully grasp “Low Insight,” they changed their beliefs – by assigning the defendant more insight than was actually discussed (Festinger, 1957; Jones & Kohler, 1959). This reasoning by itself could lend support for a successful manipulation of LeLi.

However, there is also evidence that the HeLi condition perceived the defendant as having insight. Because both of the Low Insight groups perceived the defendant as having insight, it would be logical to assume that the Low Insight manipulation was unsuccessful. A closer examination of the focus group data indicates that the HeLi group did in fact learn that

low insight is possible for people with Schizophrenia. They also reported the belief that the defendant had factual, albeit not well-developed, insight into his condition (e.g., “I don’t think he understands, like he actually has a mental illness, I just think he understand the problem and he does have enough mental capacity to recognize he has to do something about it;” “Well, I don’t know if ...he necessarily knew that the medicine would help, but he knew that...the medicine was for insanity). In this focus group illustration, HeLi mock found it more appropriate to air on the side of “vaguely insightful” as opposed to lacking insight, thus, suggesting a potential ceiling effect of insight on mock juror decision-making.

Mock jurors in the HeLi focus group also tended to interpret testimony manipulated to signify Low Insight (e.g., becoming MNC after feeling relief from symptoms on medication; not taking medication when becoming symptomatic, not filling his prescription) as signs of purposive (High Insight) MNC. This finding indicated that a conceptual flaw may have been introduced into the HeLi manipulation because of the mock jurors baseline understandings and interpretations of “Low Insight” may have required more education than conceived by the researcher. Thus, the HeLi condition may have exhibited High Elaboration yet also High (versus the intended Low) Insight. The HeLi focus group participants also had a tendency to interpret factual evidence that was presented across all conditions as support for insight (e.g., asking to be taken to the hospital when he gets in trouble with the police). In fact, toward the end of the focus group (after being prompted by the moderator’s questions), one HeLi mock juror even stated that she “had thought the expert had said [he had Schizophrenia and needed medication] after every single incident...and I don’t know where I got that from... I must have made it up, and that was my main thing that I considered.” Thus, there is some evidence to suggest that mock jurors in the HeLi group may have been primed to search for evidence that was contrary to the claim of Low

Insight. This evidentiary search may be a function of the affirmative NGRI defense. It may also reflect the tendency to search for evidence that confirms stereotypes or disconfirms evidence contrary to our stereotypes (Pettigrew, 1979; Snyder & Swann, 1978) – the stereotype being that people with mental illness are aware of their illness.

Both Low Elaboration groups also had the most skepticism and questions regarding the defendant's MSO. They both believed that the defendant was trying to claim that his psychosis went "on and off like a light switch." The mock jurors in both Low Elaboration groups caught the fact that the expert said that Schizophrenia does not work like this. However, they did not appear to understand the nuances of how the defendant's thinking and behavior the day of the incident reflected impairment or a building up to the incident. They also had less understanding of how the defendant could have any clue that something was wrong (after the incident when the defendant to ask to be taken to the doctor) *if* he had an impaired MSO. It seems that the extraneous factors of the case could have been perceived as high insight on the part of the defendant, and/or as faking his illness – but primarily for the Low Elaboration groups that did not receive psycho-education regarding insight.

Potential Low Insight manipulation confounds. There were clearly aspects of the testimony and case presentation that both the Low Insight groups readily perceived as evidence of insight (e.g., defendant's violent and psychiatric history, asking to be taken to a hospital after the incident). In addition, the testimony regarding Low Insight was not absolute. In other words, the expert did not testify that the defendant lacked "all" insight into his illness. However, varying levels of insight into his illness and more explicitly, the defendant's *lack of insight into his need for medication*, were targeted aims of the manipulation. Without further analysis or follow-up studies, theoretical accounts for why this may be (e.g., confirmatory bias; cognitive dissonance)

are just that – theories ripe for falsification and exploration. It may very well be that the manipulations were just too ambiguous for the lay mock juror and that they did not convey a strong enough or internally consistent enough manipulation of the primary independent variables of interest. Still, experts, lawyers, and FMHPs can glean valuable information about the difficulties of conveying a mentally ill defendant’s Low Insight to mock jurors, particularly in the face of a long history of illness and violence. Final key aspects of the study design that may have hampered the salience of Low Insight manipulations is the presence of a fervent cross-examination that the defendant did in fact have purposive knowledge into his illness and actions, as well as the emotionally charged opening and closing statements presented to all mock jurors.

Implications of Failing to Reject the Null Findings

Of course, it is also plausible that there is verisimilitude to the lack of statistically significant findings in the present study. Caution should be taken to not overly interpret a failure to reject null findings, as it is not known if in fact the null (no difference between groups) is “true,” or if the null is indeed false, but the present study design and analysis failed to reject the null (Type II error) (Cohen, 1992; 1994). Future analyses should aim to examine statistical approaches that would allow for testing claims that the differences between the groups are likely to be negligible – essentially supporting that no meaningful differences exist between groups (e.g., Murphy & Myers, 1999).

However, even if small effects were to emerge between how the various conditions considered MR, MNC, and insight factors, perhaps they would have little predictive utility in influencing verdict. Indeed, empirical aims of mock jury research are often to inform scientific jury selection (Lieberman, 2011). This practice is based on the principle that through social science research it is possible to “identify desirable and undesirable jurors...to maximize the

likelihood of a favorable jury decision” (Devine, 2012, p. 51). However, the purpose and implications of the present study extended beyond the aims of SJS. Instead of seeking a *favorable* verdict in NGRI cases, this study examined mock juror decision-making to increase the likelihood of a *fair* verdict. The case was purposefully selected to be ambiguous without heavily weighted evidence in one direction or the other. The focus shifted from individual juror characteristics that may predict verdict to that of the expert mental health testimony presented to the decision-makers. It is this testimony – and the forensic mental health evaluations and legal standards on which the testimony is based – that can be standardized to provide critical information decision-makers seek in NGRI cases.

It is possible that in the present study, the differences in testimony were not strong enough to differentially influence decision-making. At the same time, there is data to support how the mock jurors heavily weighed consideration of MR, MNC, and insight factors in this study, and that some differences within these factors between conditions were perceived. Taken together, these findings suggest that mock jurors relied on assumptions of mental illness, insight, MNC, and MR when evaluating the evidence presented by the expert. If there truly are no differences in how mock jurors use this information to make judgments – even when the information (case facts) themselves vary significantly – then there appears to be room for a miscarriage of justice. It is possible, that in such instances, mock jurors more heavily weighed their assumptions and biased interpretations of MR factors over the evidence itself. For instance, MR may be so deeply or implicitly interwoven with lay jurors understanding of criminal responsibility, that there is little an expert, lawyer, or legal instruction can do to draw their attention away from MR, or toward differences in MR that make the defendant more or less culpable. However, given that mock jurors in the present study considered these factors, and did

so in a way that was inconsistent with the nuanced manner in which the expert was attempting to convey the information, there is reason to suspect that communication of FMH testimony to the trier of fact can be improved. At the very least, knowing that mock jurors may be unable or unwilling to appreciate critical differences in a NGRI defendant's case facts should incite psycho-legal scholars to better understand the cognitive and decision-making processes contributing to outcomes in NGRI cases.

Preliminary Implications

Given the lack of statistically significant findings in the present study's quantitative analysis, caution should be exercised when extrapolating implications of the research. The lack of significant findings can certainly generate areas for future research. Even so, the fact that the hypothesized results in this study were not supported raises more questions than it does answers. However, it is also possible to unearth a host of avenues for future research and consideration for lawyers, trial consultants, FMHPs, experts, and psycho-legal researchers based on the findings from the TLM, PRF, and focus group exploration. Still, the findings from the qualitative exploration should not be overgeneralized, especially given their informal nature and the fact that small-scale segmented sampling may confound findings for any one particular experimental condition sampled (Morgan, 1996). Future research using a formal qualitative analysis of both the TLM results and the deliberations will provide a more appropriate basis for generating implications of this study. For example, additional analysis could derive key concepts based on the quantitative analysis of the TLM data (from more formal coding of the "topic/content" of each mock juror's thoughts). In addition, the transcribed deliberations can be matched to mock juror numbers and subjected to qualitative analysis on the participant level with open-coding procedures that will allow for tracking of participant responses and contributions to

deliberations. Proposed uses for these data include coding deliberations to uncover themes of major topics/evidence discussed, sequencing of the deliberation process, and group-effect cognitive processes in decision-making (Hinz, Tindale, Vollrath, 1997) – in essence supplying data for a Study II and establishing a line of future research. Preliminary topics for research and practice are discussed below.

Potential Implications for Lawyers and Trial Consultants

The Insanity Defense as an “excuse.” Data from the focus groups provides potentially fruitful information regarding when and why the insanity defense may be most likely to be conceived as an “excuse” or scapegoat for the defendant. Both the Low Elaboration groups believe that the defendant was using his mental illness as an excuse (LeLi: “...because he knows he has a problem and he can’t use it as an excuse any longer;” LeHi: “he...just tried blaming it away and automatically just shifted back to acting”). The difference between the LeLi and LeHi conditions was that the Low Insight condition focused on the defendant’s awareness of his genuine *problem*; whereas, the High Insight condition described the defendant’s insight as allowing him to lie or *act* impaired. It appears that the insight (low vs. high) defined the bias against the insanity defense by those mock jurors. When insight is low, the defense is viewed as legitimate but not sufficient. When insight is high, the defense is viewed as illegitimate and dishonest. Future research is needed to examine if these findings hold true with larger samples.

Potential interactions of the seriousness of the charge. The MC/C condition reported learning new information that appeared balanced for and against the defendant that simultaneously informed them that some insight is possible, but that the illness is hard to control and unpredictable. The neutral information base likely contributed to the mock jurors’ conclusions that they should reach a NGRI verdict, given research has shown that with

ambiguous evidence and serious crimes/charges, mock jurors tend to air on the less punitive side (Kerr, 1978). The phenomenon is known as the *severity-leniency hypothesis* (Kerr, 1978) and states that jurors will require more evidence to convict as a function of the severity of the charge (and thus, the consequences for the defendant). However, more recent data suggest that a more serious charge signifies a more dangerous criminal and a higher responsibility of the juror to “keep the defendant off the streets,” which results in *more punitive* verdicts (Devine et al., 2004; Devine, Buddenbaum, Houpp, & Studebaker, 2009). This latter finding may help to explain why the HeLi condition yielded more punitive decision-making and higher meta-responsibility ratings despite the defendant’s low insight. In essence, the High Elaboration of the defendant’s Low Insight may have triggered a back-fire effect that increased the defendant’s perceived dangerousness more so than it lessened his culpability. Given the rarity of leniency shifts in verdict, and the well-documented bias against the insanity defense (e.g. Skeem & Golding, 2001) and perceived dangerousness of people living with severe mental illness (Corrigan, 2005; Silver, 2006), the relative influence toward or away from unfairly punitive effects in NGRI proceedings is worth further exploration.

High Insight may not be overly biasing toward guilt... if you embrace it. On the TLM, the HeHi condition generated the largest proportion of “lack of judgment” attributions to the defendant across the conditions, which was also consistent with the HeHi focus group findings. Overall, focus group and TLM data suggest that High Elaboration of High Insight may in some cases, bias the trier of fact toward leniency toward the defendant. It is noted though, that thoughts regarding the defendant as responsible for his MNC were also most salient for the HeHi mock jurors in the overall sample, and that the HeHi focus group was markedly more lenient than the HeHi condition in the overall sample. It is possible that the “lack of judgment” assigned

to the defendant in the HeHi focus group was at least, partially responsible for some of the variance in their decision-making. If supported by future research, this line of testimony could be particularly informative and influential in NGRI defense cases. That said, a defendant's de facto inability for sound judgment due to living with a severe mental illness (even at times of "high insight") is quite a complex issue to raise, with significant human rights and legal implications. Researchers should work with legal experts in the areas of mental health disability law to examine these issues and their influence on NGRI decision-making further.

Dispersion of blame for a defendant's MNC and MSO. Although mock jurors across conditions were more likely to hold the defendant accountable for his MC/MNC than others, each condition did generate thoughts about blaming others for the defendant's MNC. These thoughts were generally most salient as mock jurors were approaching the half-way point of the TLM, which suggested that questions others' responsibility in the defendant's MSO and MNC was part of their case conceptualization, yet not the most salient factor to come to mind. In particular, the LeLi condition generated two to four times the number of thoughts regarding others' responsibility than did the other conditions. In the focus group, however, one key difference between the LeLi and the HeLi groups was that the HeLi group cited the mental health system's failure to safely manage the defendant. The explanation for this seemingly contradictory finding is that the LeLi condition generally yielded thoughts on the TLM that were *asking questions* regarding others' responsibility in the defendant's MNC/MSO. Whereas, the HeLi focus group was a clear example of *attributing a significant portion of the blame* for the defendant's MNC to others. For this mock jury at least, the added High Elaboration of Low Insight did not appear to displace the defendant's MR for his MSO and MNC, but it did appear to prompt more blame attributions to parties other than just the defendant.

Another example extracted from the focus group exploration was the fact that the most prominent factor that played into the HeHi group's decision-making was the blameworthiness they attributed to the mental health system for "failing" the defendant and society. Part of the motivation for this reasoning appeared to be that mock jurors in this group could not seem to understand how a defendant would have such High Insight into his illness, yet still behave in such a psychotic manner at times. To justify this dissonance (Festinger, 1957; Jones & Kohler, 1959), they focused even more on trying to empathize with the defendant's mental state and used the High Elaboration of his High Insight as evidence that the defendant did in fact lack judgment and reasoning abilities. Because the High Insight was used as a sign of the defendant's lessened culpability, the HeHi group displaced some of that blameworthiness onto the mental health system. Based on these illustrative findings and the little research available on the subject in psych-law research fields, there is much still unknown about the circumstances under which MR is shared among NGRI defendant and other societal and mental health parties.

Potential Implications for FMHPs and Experts

The importance of testifying to medication state. Despite the medication issue being discussed much less in the Low Elaboration (compared to the High Elaboration) condition, both the LeLi and LeHi conditions generated *medication-related thoughts* to a roughly equivocal degree as the High Elaboration conditions. These thoughts were generated early, suggesting their high salience. A logical supposition is that *medication-related thoughts* raised by the Low Elaboration condition were questions regarding the medication because it was only briefly mentioned without explanation. However, a large portion of these thoughts were definitive statements about the defendant's need for medication or peripherally-based attitudes regarding his noncompliance. Across the Low Insight conditions, *medication-related thoughts* peaked

much earlier when there was Low Elaboration (LeLi) versus High Elaboration (HeLi), again suggesting that the lack of elaboration generated more salient questions or thoughts about the medication than when more elaboration was provided. Even in the LeHi focus group when most participants believed the defendant's MSO was unimpaired and that he was in fact, faking his defense, some of the mock jurors still considered MNC. For these mock jurors, the defendant's MNC was support for his "scapegoat" defense to help prove his psychosis at the time of incident. Overall, this pattern of results reflects mock jurors' attention to MNC issues, particularly when they are briefly mentioned and not provided further elaboration.

Explanations of mental illness and influences on MR. Despite being presented with High Elaboration of the defendant's High Insight, the HeHi group heavily based their decision-making on the uncontrollable and biological nature of the illness, which removed responsibility from the defendant even though he had insight. The High Elaboration however, was not focused on the biological or extreme nature of the illness. Instead, this information was held constant across groups. The HeHi group was the only group to generate discussion of the disease aspect of Schizophrenia during the focus group. The HeLi group was the only group to relate feelings of induced sympathy toward the defendant from the testimony, which appeared to be related to the Low Insight that is possible. In other words, mock jurors felt bad for the defendant because he was not only losing touch with reality, but he did not understand that he was losing touch with reality at times. Additional research could vary the manner and extent to which Schizophrenia is defined for the trier of fact. Preliminary qualitative explorations suggest that the relative emphasis placed on nature versus nurture in the development of the disease may influence decision-making in NGRI cases. Moreover, the LeLi condition appeared to generate a blanket acceptance of the doctor's knowledge of schizophrenia; yet, the Low Elaboration of why the

defendant had Low Insight perhaps contributed to why they penalized the defendant for either (a) not having insight, or (b) not following the doctor's orders especially because he had low insight. When High Elaboration of the defendant's Low Insight was provided, the HeLi group appeared to use the further High Elaboration of the defendant's Low Insight as evidence of the defendant's dangerousness and need for a punitive or restrictive response to his actions.

Educating the trier of fact on "Low Insight." Both the HeLi and LeHi groups reported learning something new about the defendant's level of insight, in the expected directions. While this finding supports the intended experimental manipulations, it also raises some questions. The statement that one "learned something" typically refers to the fact that the newly learned information was previously unknown or not understood. How then is it possible for participants who were randomly assigned to conditions to "learn" in one condition that low insight is possible, and in another condition, "learn" that high insight was possible? It begs questions as to what exactly is the typical baseline understanding of insight and severe mental illness. It also suggests that there is no real baseline for understanding insight because it is not a salient consideration for people who do not have a mental illness themselves. Once presented with information on insight, however, it may take less elaboration to convince the message receiver that High Insight exists than it does Low Insight. Therefore, understanding or accepting the phenomenon of Li may be harder than the Hi counterpart for mock jurors to believe, empathize, or incorporate into their decision-making. For instance, the LeLi focus group unwaveringly denied that individuals with severe mental illness could maintain Li, especially after a doctor has diagnosed and attempted to treat them. For some of the focus group LeLi participants, they were even unable to discuss a hypothetical of a defendant lacking insight because they did not think it was possible to "prove" that he would have "absolutely zero proof that he was mentally ill." This

potential ceiling effect of mock jurors' assumption of insight in people with severe mental illness may speak to their expectations of experts and their testimony regarding Low Insight.

Potential Implications for Future Research

Why so punitive? Reflections on the LeHi focus group. The LeHi testimony may have presented the weakest defense due to the anticipated punitive effect of High Insight combined with a lack of explanation by the expert. Although it was initially postulated that the High Elaboration would make High Insight more pejorative, results of the TLM and focus groups suggest that introducing High Insight without a thorough explanation may essentially introduce a strong, negative impression of the defendant, thus, weakening the argument and the informative nature of the testimony. Moreover, when it came to depictions of High Insight (purposive) MNC in the LeHi condition, TLM data suggest that a *lack of elaboration* was essentially more damaging – painting the defendant as more purposive and blameworthy in his medication noncompliance – than was the additional elaboration to those facts (in the HeHi condition).

Insight versus Judgment in the HeHi focus group. The HeHi focus group uncovered a clinical distinction – that of insight versus judgment – that may provide footing for future research on perceived “insight” of NGRI defendants. HeHi participants reported the defendant as having “as much insight as you can expect a mentally ill person to have.” They also believed that the defendant’s MNC was a sign of poor judgment *inherent in* Schizophrenia. They viewed the defendant’s decision to be MNC as affording the defendant too much autonomy (i.e., “...he shouldn’t be responsible for taking his medicine, so he shouldn’t be a part of society if he can’t even *make the decision* if he’s going to take his medicine”). The implication is that the defendant should not be in society if he refuses his medication, because if he was capable of good judgment, then he would be medication compliant. While it certainly is preferable for persons

with mental illness to take medication as prescribed, it is not necessarily *irrational* for them to choose not to do so in some cases (although it may be poor judgment). The question that is raised is one of a more foundational nature: Should persons with mental illness be permitted to make decisions about their care and treatment, or does their illness impair them so much that they cannot do so in a knowing, intelligent, and voluntary manner? Mock jurors seemed to answer this question for themselves in the HeHi focus group in this study; thus, aligning with prior research that suggests that different assumptions regarding the volitional nature of the behavior prior to the index offense posits different standards for judging criminal responsibility (Perlin & Dorfman, 1993). It may behoove the rights of people with mental illness (Markowitz, 2005), as well as the fairness of the NGRI adjudication process if FMHPs and the law could provide appropriate guidance on such issues for the trier of fact. Future research should focus on the potential implications of testimony that aims to more explicitly outline these complicated and idiosyncratic clinical/legal issues for the decision-maker.

Meta-responsibility may dampen culpability in some cases. The MC/C group considered the defendant's medication compliance as a major factor in their decision-making. They reportedly viewed the defendant's medication compliance as evidence that the defendant was attempting to take responsible steps to prevent violent acts in conjunction with his illness. This may be an example of how meta-responsibility could *lessen* culpability and did so in this group. The cognitive association between medication compliance and lessened culpability is still primarily unknown. For instance, is compliance deemed a generally "acceptable" response to having a mental illness, or is there a more specific association (e.g., safe, cautious, socially aware, trustworthy)? It may also be that compliance signaled to the mock juror that the defendant could get better and in fact, wants to get better, which would lessen his risk for future violence

and danger to society in the future. Future research is necessary to determine which, if any, of these possible explanations holds predictive utility in jury decision-making and NGRI contexts.

Mixed-method mock jury studies. This study also underscores the value in integrated, mixed methods analysis in mock jury research. With an annual approximation of 155,000 jury trials and 1.5 million empaneled jurors in the United States in recent years (Mize, Hannaford-Agor, & Waters, 2007), advances in the study of judicial decision-making is warranted. The present state of mock jury research is often limited by an overreliance on quantitative design and analysis (Devine, 2012). A mixed approach, however, assists in interpreting results, provides illustrative examples of the findings, informs unexpected results, and provides insight into the sources of various attitudinal and behavioral outcomes (Morgan, 1996; Morgan & Krueger 1993). Whereas surveys may be more effective at capturing the prevalence of an experience (Ward, Bertrand, Brown, 1991), qualitative methods can buttress this experience with insight (Morgan, 1996; Morgan & Krueger, 1993). In the current study, for instance, the additive qualitative aspect was helpful in protecting against erroneous assumptions about why and how the hypothesized findings were not confirmed (Chalmers, 1978). Moreover, future research on the current study's data modeling Level 2 factors (e.g., "jury" factors such as overall SES, IDA-R ratings, deliberation style and focus) derived from both quantitative and qualitative aspects of the design may prove beneficial in extracting meaning from the data. Mixed-methods and multi-level modeling align well with modern, "integrative multi-level" theories of jury decision-making (Devine, 2012, p. 181).

Potential Implications for the Law

Verdict versus sentencing in NGRI decision-making. It is clear from the TLM, PRF, and focus group data that mock jurors across conditions struggled to adhere to the bifurcated nature

of the criminal proceedings (i.e., to determine verdict irrespective of sentencing possibilities). Despite being instructed by the Judge to not discuss punishment or consider sentencing in their decisions, every focus group reported these factors as guiding their decision-making. The HeHi group blamed the mental health system for not removing the defendant's opportunity for poor judgment (i.e., not allowing him to decide not to take his medication). They believed the defendant should be hospitalized to prevent his bad judgment from causing problems in the future. The LeLi group debating their beliefs about what would happen to the defendant if he was found Guilty vs. NGRI; their primary focus was to control his dangerousness (e.g., "...it's about time we lock him up or something"). The other Low Insight group (HeLi), also discussed the punishments they believed would correspond to the verdict options. When paired with High Elaboration, however, the HeLi group appeared to be more focused than the LeLi group on making sure the defendant received help in a secure environment (whereas the LeLi group wanted to make sure the defendant received punishment in a secure environment). Both LeHi and LeLi groups considered punishment and were more *incorrect* than they were correct when hypothesizing about possible sentences relative to the verdict options.

Both the MC/Control group and the HeHi group held the mental health system more culpable for monitoring the defendant's illness than they did the defendant. This similarity is not as transparent as it seems. The MC/Control group viewed the defendant's MNC as a sign that the mental health system should have stepped in and monitored his MC. The MC/Control group also believed the defendant was doing everything in his power to be well and that it just was not enough. The HeHi group believed that the defendant was *unable* to do everything in his power to be well on his own. Had the defendant still had High Insight and been medication *compliant*,

then the HeHi group claimed they would have used it as evidence of the defendant's rational decision-making abilities and thus, they would have been more likely to find him guilty.

The MC/Control group also considered sentencing to hold the defendant accountable while still allowing him to receive treatment. When asked if the purpose of deciding a verdict was to hold the guilty party accountable, one mock juror in the MC/Control condition asked if that was a "trick question." When asked if they believed they could make a verdict determination irrespective of the sentencing possibility, most mock jurors in all groups stated that they could not. One juror in the HeLi condition explained that "I think everyone would consider it in their minds, whether they say it out loud or not." Thus, punishment and prospective sentencing likely significantly influenced mock jurors' decision-making in the case. It is unknown to what degree hypothesized punishment potentially influenced, interacted with, or overrode other case facts such as the defendant's insight and MNC. The inability and/or unwillingness for mock jurors to strictly adhere to their duty as outlined by the law in NGRI proceedings warrant future attention by researchers and judicial authorities.

Judicial instructions. Another key area for future research relates to judicial instructions in NGRI cases. Despite rating their comprehension of judicial instructions relatively high, a large portion of mock jurors in this study provided inaccurate or incomplete descriptions of their duty, the NGRI defense, and the burden of proof in the case. This finding is consistent with reviews that uniformly report poor comprehension and use of instructions by mock and real jurors (e.g., Lieberman, 2009). Future studies could more closely examine the degree of influence judicial instructions have on juror/jury behavior and if improving standard instructions may better align decision-making with their task. Prior research, for example, has shown that varying the definition of insanity does little to influence decisions in NGRI cases (e.g., Finkel & Slobogin,

1995; Ogloff, 1991). Follow-up studies could test standardized instructions against those modified to incorporate explicit instruction on NGRI-defense related psycho-legal factors. While there is some support that such modifications would increase attention to the central issues (e.g., MSO) and decrease focus on issues that are not a matter of law (e.g., MR for MSO), there is also data that suggest such specific instructions could hinder comprehension and introduce additional bias (Lieberman, 2009). Given the potential influence of opening and closing statements in these cases, it may be fruitful to test how various instructions espoused by either side in a NGRI case's closing arguments may guide mock jurors' consideration of MR, MNC, MSO, and punishment and/or sentencing factors.

Comparison research with Judges. Additional research may be warranted with decision-makers who have an expertise in the law, namely Judges who are often charged with deciding outcomes of a NGRI defense. Given the mock jurors' attention to legally extraneous variables in the present study, a comparison between Judges who are intimately knowledgeable of the law with lay jurors may very likely unearth different findings. For instance, at times mock jurors' reasoning of case facts was proposed as analogist to voluntary intoxication or failure to take epileptic medication despite a lack of legal precedent linking MNC and these types of cases. Given the lack of legal precedent for how the trier of fact should consider MNC, if at all, or if they should weigh level on insight when and if considering this evidence, it is worth exploring whether Judges and decision-makers do in fact consider such factors.

Empirical Strengths

A primary strength of this study is its formidable theoretical foundation from the social psychological, mental health, and psycho-legal literatures (Wiener, Krauss, & Lieberman, 2011). This study was also informed by several prior studies that had explicitly made known the

differences in Medication Compliance and Insight (Mitchell, 1999; Sherlock, 1984). In other words, previous studies had very clearly – often in a few sentences of a case scenario – established a defendant as either high or low on insight/medication compliant or MNC, and then queried individual mock jurors on meta-responsibility and verdict. There is an inherent push-pull between ecological, external, and internal validity in jury research. It is therefore desirable that researchers conduct multiple studies of the same research question where degrees of constraints to these validities are proportionally varied (Devine, 2012). The current study served as the first study to examine views of a NGRI defendant’s meta-responsibility in a mock jury decision-making paradigm with enhanced ecological validity.

According to a recent review of mock jury studies over the past six decades, a continuum of jury research quality has emerged in the field (Devine, 2012). Based on these parameters, the current study’s methodology would fall between “very good” and “high quality,” in part due to the following: the use of standardized researcher scripts, random assignment, experimental control, use of a real trial transcript that has been used in prior research (Crocker & Kovera, 2010), jury instructions adapted from real procedures, standards used most often in U.S. criminal court systems (Gee, 2003; Packer, 2009), inclusion of direct and cross-examination, realistic trial depictions with actors depicting their real-life professions, and a deliberation component (Devine, 2012). Moreover, the assessment of mock juror experiences and instruction comprehension, as well as the counter-balancing of questionnaires strengthened the study’s internal reliability. Key components of group decision-making that are often overlooked (Davis et al., 1993), but which were included in the present study, are measuring outcomes such as verdict on a continuum and assessing subject variables such as bias against the insanity defense.

Aspects of the design and analysis (i.e., LMM procedures) used nested mock juries, which allowed for the inclusion of deliberation. Indeed, the inclusion of deliberation is perhaps the study's most noteworthy strength. Nevertheless, juror and jury-decision making research is often stripped of the fact finders' "lived experience" (Creswell, 2007, p. 78), even when deliberations are included in the study design. Thus, this study's final major strength was the mixed-methods approach. This approach helped fill gaps in investigating the research aims and understanding the findings.

Limitations and Empirical Considerations

Several limitations were present in this study's design and others were imposed by logistical constraints. First, to maximize control across conditions, one expert was chosen for all conditions, which limits generalization to male, middle-aged, Caucasian experts. Second, mock jurors only viewed testimony from the defense. To lessen the effect of this limitation (e.g., Salerno & McCauley, 2009; *Daubert v. Merrell Dow Pharmaceuticals, Inc.*, 113 S. Ct. 2786, 1993), mock jurors were provided an equivalent degree of case facts presented by both the defense and the prosecution, as well as explicit instructions on the burden of proof in the case.

Third, there are questions about the use of a college sample in mock jury research, although prior research has traditionally permitted use of such samples (i.e., Bornstein, 1999). However, recent research suggests that some differences in outcome exist when using student as opposed to community samples (Hosch, Culhane, Tubb, & Granillo, 2011; Keller & Wiener, 2011). This limitation is perhaps best conceptualized as a methodological tradeoff in early phase research. In determining acceptable logistical constraints of a study, the use of undergraduate college participant pools for mock jury research has recently been described as an acceptable tradeoff for the inclusion of other advances to construct and ecological validity such as

deliberations (Devine, 2012; Wiener, Krauss, & Lieberman, 2011). Overall, the use of a college sample has been deemed no more problematic to generalizability than are other variables that hinder generalizability of any mock jury study (e.g., jurisdiction, region, type of trial) (Devine, 2012). Still, the restricted participant range in age and demographics (i.e., primarily Caucasian females) is noted and a broader range would be worthwhile in the future (McCabe & Krauss, 2011). Moreover, it would assist external validity of the present findings to examine how the Experience with Mental Illness Questionnaire (EMQ) responses compare to the general population. It is possible that these experiences (either directly or indirectly) on the part of the participants in this study influenced not only their self-selection to participate in this study, but their responses and decision-making regarding the key variables of interest in this study. There may have also been cultural and/or regional factors (e.g., Southern culture) that define this population and their responses (e.g., the overall punitive nature of the verdict determinations). It may also be fruitful to compare the present sample to areas that may have strongly engendered stereotypes and possible stigma of “mentally ill criminals” (i.e., towns and cities that have fallen victim to highly publicized cases involving such defendants – for example, Newtown CT and the Sandy Hook Elementary School shooting).

Another limitation of the present study lies in the use of a 6-member mock jury when a 12-member jury is the National standard. While the use of a 6-member jury has been accepted by the courts (*Williams v. Florida*, 90 S. Ct. 1893, 1970), this decision has been scrutinized by psycho-legal researchers as ill-informed (Saks & Marti, 2001). While, some studies have shown differences in outcome if deliberation time and format is open-ended (Devine, Clayton, Dunford, Seying, & Pryce, 2001; Saks & Marti, 1997), these differences have been small in effect (see review by Devine et al., 2001) and are unlikely to bias juries toward a particular verdict outcome

(Devine, 2012). Moreover, the courts continue to show an increasing preference for smaller juries (Melton et al., 2007) and smaller juries allow for more efficient deliberations and data collection.

Finally, the lack of a live trial simulation and the limited time allotment for deliberation are noted. However, special attention was paid to ensure an evidence-driven approach to deliberations, which has been shown to maximize deliberative impact on initial verdicts and may have served to use well the limited deliberation time (Davis et al., 1989; Devine et al., 2001; Greene et al., 2002). Even so, this study shares in the common criticism that post-deliberation outcomes yielded from brief deliberations may be more reflective of a first ballot vote than an outcome evinced by a full deliberation (Salerno & Diamond, 2010). Scholars have noted that initial ballot votes based on even minimal deliberations should not necessarily be interpreted as indicative of the individual juror's pre-deliberation preference (Davis et al., 1989; Greene et al., 2002; Sandys & Dillehay, 1995). Thus, the brief deliberations provided a compromise that increased ecological validity in the design over not including deliberations.

Conclusion

The current study experimentally manipulated hypothesized key areas of import in decision-making in a NGRI defense. Future research should continue to explore the pieces of information that are most influential and malleable in their presentation in these cases. This line of research ultimately seeks to extend the jurisprudence of the insanity defense and the intention behind it – to consider a defendant's criminal responsibility in his or her acts. The extent to which mock jurors misconstrue this aim, or are unable/unwilling to restrict their decision-making to this aim, speaks to the need for psycho-legal scholars to consider these potential influences on decision-making in NGRI defense contexts, as well as other court proceedings involving mental

health testimony (e.g., mitigation). This research would also extend to the practice of FMHPs who are tasked with evaluating these psycho-legal constructs and conveying them to the court.

As was the case in this study, the value of a finding in mock jury research is seldom found in its ability to predict outcome. It is much more useful to find tangible ways in which testimony or evidence presentations can be modified to protect against baseline biases and misinterpretations of the evidence. Balanced jury research should aim to “understand the conditions when juries will best *perform* their focal task – thoroughly reviewing the evidence and making reasoned decisions with an appropriate understanding of their instructions” (Devine, 2012, pg. 225). Studies like the present project simultaneously aim to uncover decision-making in court proceedings while varying the manner in which potentially biasing evidence is presented. Future studies that further these aims have the potential to not only understand why jurors make the decisions they do, but how we as psycho-legal professionals can ensure that we arm the trier of fact with information presented in the most fair manner possible.

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APPENDIX

Appendix A

Case law examples of medication noncompliance and intoxication failing to meet diminished capacity standards (2004).

Effects of Delusions and Medications

The Pennsylvania Supreme Court ruled that testimony concerning a murder defendant's delusions about painful treatments of his injured legs and speculation on the effects of prescribed medications did not require a reduced capacity defense or preclude a death penalty. *Pennsylvania v. Terry*, 521 A.2d 398 (Pa. Sup. Ct. 1987).

The defense failed to present sufficient evidence to warrant a jury instruction on diminished capacity. Expert testimony regarding Terry's delusions about prison guards injecting poison into his ankles to cripple him and their abstract speculations over the potential effects of numerous drugs was found to be irrelevant evidence. This testimony was couched in terms of possibilities and did not relate either these or other psychological and physiological conditions discussed to the allegation that he had planned and fatally beaten a prison guard with a baseball bat.

The expert witnesses had failed to relate any of the defendant's claimed mental conditions to the brutal beating death and their general abstract testimony on the effects of medication was of no help in the jury's deliberations.

The sentencing jury heard all the evidence offered to reduce the degree of the homicide through a diminished capacity defense and was properly instructed on how punishment could be mitigated if the evidence was ac-

cepted. As a result, the imposition of the death sentence was approved.

Jury Instructions and Lay Testimony

The New York Court of Appeals approved jury instructions on a burglary defendant's intoxication and its possible effects on his ability to form the required intent, but ruled that an additional jury charge on diminished capacity had not been warranted. The court properly restricted testimony that the defendant's alleged chronic alcoholism did not amount to insanity. *New York v. Westergard*, 511 N.Y.S.2d 587 (N.Y. Ct. App. 1986).

The jury was correctly instructed that while intoxication is not a defense to a criminal charge, evidence of intoxication could be considered in determining whether the defendant's mind was so obscured by alcohol or drugs that he was incapable of forming a conscious objective to commit burglary. Although proof of a mental defect other than insanity may in some cases negate a specific criminal intent, the New York legislature enacted a specific provision on intoxication.

Evidence of intoxication may be offered by the defense whenever it is relevant to negate an element of the crime charged. Expert testimony indicated that Westergard was a functioning alcoholic who became intoxicated and incapable of acting purposefully regarding a conscious objective. No error was found in the trial court's refusal to instruct the jury that diminished capacity had a bearing on the issue of intent since the instruction given adequately covered the possible effect of the defendant's alcoholism and intoxicated condition.

The panel was convinced that the trial court had acted within its discretion in limiting the testimony of the defendant's parents, who claimed that their son's chronic alcoholism and drug abuse amounted to a disease or serious mental disorder short of insanity that nevertheless relieved him of criminal liability. The parents were only permitted to address the events of the night of the burglaries; their testimony concerning past events had been correctly excluded.

D. Cases

The legal significance of noncompliance was broached in *State v. McCleary*.¹⁸⁴ The defendant had a history of chronic paranoid schizophrenia that predated the criminal conduct by eleven years. He had been taking antipsychotic medication continuously since his first episode of illness,¹⁸⁵ until three or four days prior to going to a city park, disrobing, and wrestling a handgun away from a park ranger.¹⁸⁶ He was arrested and charged with robbery and pleaded not guilty by reason of insanity.¹⁸⁷ The court reviewed the psychiatric status of the defendant at the time of the act which supported his contention that he was insane at the time of the crime.¹⁸⁸ The trial court convicted the defendant, stating unequivocally that:

[T]here is a distinction between insanity and insanity that can be controlled. This may simply be the reverse of the law that applies where one induces his own "insanity," by becoming intoxicated and thereby engaging in wrongful behavior. Here this Defendant had the training, the experience, the opportunity and the medication with which to control his behavior He chose not to do that and, thereby, placed himself in the position where he was able to engage in anti-social and, indeed, criminal behavior.¹⁸⁹

On appeal,¹⁹⁰ the appellate court reversed on the grounds that the defendant had established his insanity defense by a pre-

ponderance of the evidence. As to the trial court's conclusion that noncompliance with medication should give rise to responsibility, the appellate court concluded that in spite of demonstrating a cause for the defendant's illness, it did not rebut the existence of his mental disorder at the time of the offense.¹⁹¹

In *State v. Johnson*,¹⁹² the consequences of noncompliance were graphically laid out:

[The defendant] is a long-time victim of severe mental illness and has repeatedly been diagnosed as schizophrenic. Since the onset of his disease in approximately 1974, he has led a nomadic life, wandering from place to place, frequently being hospitalized after episodes of bizarre behavior. Prior to his arrival in Arizona, he had been hospitalized at least five times in Canada, Michigan, Washington and Utah. After being medicated and stabilized in the structured setting of a hospital, [the defendant] has suffered relapses upon his release. As he testified, "I get to feeling better and almost on top of the world so to speak, and I don't feel I need any help, so I quit taking my medicine."

After arriving in Arizona, [the defendant] was twice hospitalized at the Arizona State Hospital. He was released from his second hospitalization there on April 18, 1984 He again failed to follow through on his out-patient treatment or to take his medication On June 16, 1984, less than two months after his release, [the defendant] beat his arthritic, wheelchair-bound neighbor to death with a tire iron.¹⁹³

The defendant was acquitted as not guilty by reason of insanity.¹⁹⁴

In *United States v. Samuels*,¹⁹⁵ the defendant had been convicted for mailing letters threatening to take the life of the President of the United States.¹⁹⁶ He challenged the jury's finding that he was sane on the grounds that there was insufficient evidence of his sanity at the time of the offense. He had been previously diag-

nosed as schizophrenic and had been responsible for administering his own medication.¹⁹⁷ At the time of the offense, the defendant was in the midst of a noncompliance-induced psychosis. The court stated that the defendant had:

[p]resented evidence . . . that when he was taking his medication his assaultive and threatening behavior would become stabilized. [He also offered evidence] that in the months preceding his arrest . . . he had not been taking his medication. Furthermore, [his] witnesses testified as to his long history of prior hospitalizations and treatment for his mental problems. [He] had a history of episodic illness which followed the pattern of events which occurred in the months prior to his arrest. Typically, after he had been hospitalized and had taken medication long enough to stabilize his behavior and thought processes, he would become happier and hopeful of finding a steady job. However, when he was unable to find work he would begin to withdraw and stop taking his medication. At this point, [he] would become hostile and exhibit paranoid schizophrenic behavior.¹⁹⁸

The court reversed the jury, finding that "the prosecution's evidence was so weak that a reasonable juror would necessarily possess a reasonable doubt as to [the] defendant's sanity."¹⁹⁹

In *Naidu v. Laird*,²⁰⁰ a wrongful death action was brought against a psychiatrist at the state hospital where one Hilton W. Putney had been in treatment.²⁰¹ Putney was involved in an auto

accident while in a psychotic state resulting from his noncompliance with medication and deliberately drove his car into that of the decedent.²⁰² He was charged with manslaughter but was found not guilty by reason of insanity.²⁰³ Putney's eighteen-year psychiatric history was extensively documented by the court.²⁰⁴ Between

1965 and 1977, Putney was hospitalized twenty-one times. The court noted that nine of these times were the direct result of Putney's refusing to take his antipsychotic medicine, and the court implied that noncompliance was often the precipitating factor in the twelve remaining hospitalizations.²⁰⁵ Also, the court noted six instances involving the police or criminal justice system, nine separate instances where civil commitment procedures were invoked, four attempts at suicide, and two previous deliberate auto accidents.²⁰⁶

Appendix C

*Research recruitment description for sessions **without** focus group participation.*

The following information will be provided on the psychology research pool website to describe the study (along with the IRB approval code for the study):

.....

Study Name – “Criminal trial: You be the juror!”

Description - Participants will be asked to read a short fact sheet about an actual criminal case where the defendant is charged with 2nd degree murder. The participants will then view a videotaped excerpt of testimony from the trial, participate in a mock-jury deliberation, and complete a written questionnaire about the case and about oneself. Participation generally should not take the full 2.5 hours.

Eligibility Requirements – Participants must be 18 years of age or older.

Duration – 150 minutes (2.5 hours)

Credits – 4 Credits

Researchers – Caroline Titcomb, MA

Email: ctitcomb@crimson.ua.edu

Office: 359C Gordon Palmer

Appendix D

Experimenter Script

Session Coordinator – Caroline Titcomb, MA (Read to participants)

Script Derived from:

- **Black** – Titcomb & Brodsky, under review (Titcomb’s MA Thesis)
- **Red** – Contingent on session/ optional script

Participant Information & Study Introduction

Is everyone here to participate in the study “Criminal Trial: You be the Juror”? Before we get started I’m going to go over some important information with you regarding your participation in this study – so you know why we are asking you to participate and so hopefully you’ll get more out of participating. I’m going to read the instructions, but let me know if you have questions at any time.

Participant Information Sheet will be handed out, while the researcher reads the following: You can keep this sheet for your records; it has contact information on it if you need to get in touch with anyone after the study is over. Let me explain a little about your rights as participants. Your names will be recorded to ensure that you receive credit for your participation. The sheet with your names on it will be kept separate from all other study materials. Your responses to questionnaires will be kept confidential. After credit has been granted for your participation, the sheet containing your names will be destroyed. Your participation in this study is completely voluntary. You may choose not to participate at all or you can decide to withdraw from the study at any time if you do decide to participate. There are no foreseeable risks to you for participating in this study; however, you will receive research credit for your participation and you could gain a greater insight into the process of criminal trials.

If you have concerns about this study you can speak to me after we are through today, or you may contact me, my adviser Dr. Brodsky, or the research compliance officer at any point in the future. Our contact information is on your information sheet. Does anyone have any questions about any of this? ***Researcher will address any questions.***

Research on the trial process helps lawyers, courts, and scholars make the justice system run efficiently and effectively. These studies often use participants like you as mock-jurors. Since these studies are used to learn more about how trials operate in real life, it is important that they are as similar to real criminal trials as possible. So, this study will use excerpts from a real criminal case and for the remainder of the experiment, you are to assume the role of a juror in this criminal trial. Your juror number is the number on your desk in front of you. Please take that number now and attach it to the upper center of your shirt.

Researcher will assist with making sure all juror IDs are attached properly. These IDs will be used to track your decisions in the following proceedings. In a few moments you will view a videotaped excerpt of important testimony from the trial. After you have viewed the testimony, you will take part in a short deliberation and complete questionnaires concerning the testimony, the verdict, and some information about yourselves. Any questions? ***Researcher will address any questions.***

Packet One Completion (Counterbalanced Measures)

The following instructions in bold will only apply to participants who complete Packet A prior to viewing the testimony. I am now going to pass out the first set of questionnaires. Please write your juror ID on the first page in the space provided. If you have any questions as you fill them out, raise your hand and I will come and address the issue. When you are done with the questionnaires, please turn them face down to

signal that you are finished. I will collect them when everyone is done. ***Researcher will pass out Packet A and collect them when everyone is finished.***

Juror Role Orientation and Judge's Preliminary Instructions

We will now listen to an excerpt of the Judge's preliminary instructions to the jury in this case. Please remember to assume the role of a juror in this case from here on out. Had you been a real juror in this case, some of this information would have been presented to you during the jury selection process. The Judge would have also instructed you on your role – things like, a juror must give his or her undivided attention to the trial; a juror's verdict can only be based upon the evidence presented; and jurors must not come to any decisions until they hear all the evidence and law applicable to the case.

******Play Preliminary Instructions Audio Clip******

Introducing Opening Statements Instructions

You will now hear audio of the opening statements from both sides in this trial. It is important to note that due to the limited time today, you can treat these opening statements as representing the case facts and evidence presented by both sides during the trial. So, although opening and closing statements are usually only previews or summaries of evidence, here we will consider them accurate representations of what was presented during this trial. ******Play Opening Statements Audio Clip******

Testimony Video Introduction

Ok, now you will view an excerpt from an expert witness called by the defense attorney in the case. The expert is a psychiatrist who was retained to conduct an unbiased evaluation of Mr. Duncan's mental state at the time of the offense. The mental state at the time of the offense is the single most important factor in this case. You will watch and hear the defense attorney ask questions and the expert witness respond – this is called direct examination of the expert. You will then see the prosecuting attorney ask questions and the expert, again, will respond – this is called cross examination. It is essential that you treat this important material as you would if you were an actual juror in this case. ***Video will play.***

******Play Testimony Video Clip – One of Five Randomized Conditions******

Thought Listing Measure

Now I am going to pass out a form. You will have exactly 3 minutes to complete this task. On this page, please write as many thoughts – any thoughts – that you can remember coming to mind *while* you were watching the expert testimony video. Please write one thought per box. Don't worry about grammar or writing complete sentences – just write the basic meaning of each thought you recall. When you are done with the task, please turn them over to signal that you are finished. ***Researcher will pass out the TLM and then conclude the task after exactly three minutes and take up the forms.***

Introducing Deliberations

Now that we have learned the facts of the case and have had a chance to view some testimony regarding the defendant's mental state at the time of the offense, I am going to ask you to make some decisions regarding the case. However, before juries determine a verdict in a criminal trial, they deliberate. Thus, I am going to ask you all to convene as a jury for 30 minutes. We are going to videotape this portion of the study so we can remember what was said, but the videos not contain any identifying information. Spend the next 30 minutes engaged in group discussion about the case. After 30 minutes, each of you will cast your vote regarding verdict. As in real-life, the jury's decision must be unanimous. That means that all jurors must cast the same vote in order for the verdict to be upheld by the court. I will be available to act as the judge to clarify any of the legal instructions provided to you.

Introducing Judge’s Instruction Audio

To help you understand your role as jurors, you will now listen to an excerpt of the Judge’s instructions to the jurors in this case:

*****Play Judge’s Instructions Sound Clip*****

A few notes about the deliberations: First, there are other pieces of information that must be considered when deciding on a verdict, but think back to the evidence presented to you here today to base your evaluations of the evidence and your decisions. Second, in an effort to protect the confidentiality of each participant, please do not use names (yours, or anyone else’s) during the discussions. Feel free to use Juror ID numbers if you so desire. Any questions before you begin selecting your foreperson? **Researcher will address questions.** Okay, now you may begin your deliberations, starting with your foreperson selection. **Participants will take part in a 30 minute group discussion, under the supervision of the researcher. The researcher will accept the final “jury vote” reached unanimously as the jury verdict. If this occurs prior to the 30 minute period, mock jurors will be encouraged to continue deliberations for the purposes of collecting qualitative data.**

Researcher Prompts During Deliberations

If the mock-jury stops deliberations prior to the full 30 minutes or asks a question of the experimenter unrelated to instructions of the law, the following prompts may be used, as appropriate:.

OPTION 1 - You still have [time] minutes left; please continue your discussions until closer to when the full 30 minute time period is up.

OPTION 2 - Think back to what was important to you in reaching your decision or evaluating the evidence. You may want to discuss these aspects of the case or your opinion.

ONLY If jurors ask about sentencing - Your only task is to determine verdict during this phase of the trial.

Ending Deliberations

Okay, times up. I am now going to hand out voting ballots. Please complete the information on the ballot and turn it over when you are done. **Participants will complete the ballots with the dichotomous and continuous verdict ratings.** I will now collect the ballots. **The researcher will collect the ballot, determine if a unanimous verdict has been reached, and announce whether or not the jury reached a unanimous outcome.**

If the decision is not unanimous, the researcher will provide the jury with an additional 15 minutes of deliberations with the following instructions: Since you did not reach a unanimous decision, you will be given an additional 15 minutes to continue deliberations. This will be the last deliberation for the purposes of this study. The same jury instructions and goal of a unanimous decision apply. I will now read judge’s instructions when situations like this arise.

*****Session Coordinator will read Hung Jury Instructions to Jury*****

Participants will deliberate for an additional 15 minutes. Okay, times up. I am now going to hand out voting ballots. Please complete the information on the ballot and turn it over when you are done. **Participants will complete the ballots with the dichotomous and continuous verdict ratings.** I will now collect the ballots as deliberations must conclude at this point due to time constraints. **The researcher will collect the ballots, record the verdict, determine if a unanimous verdict has been reached, and announce whether or not the jury reached a unanimous outcome. After the second vote, due to logistics of the study, if a unanimous decision is not reached, the jury will be considered deadlocked. Deliberations will conclude.**

Packet Two: Questionnaire Distribution

Now I am going to ask that you complete the final set of questionnaires. Once I pass out the questionnaires, please take your time and fill them out carefully. Please write in your juror number on the top of the first page in the designated area. ***Researcher will ensure all participants complete this step (and will provide reminder prompts for this instruction as needed).*** On the questionnaires regarding the expert witness, please make sure that you're thinking about the witness you saw in the video excerpt. If you have any questions as you fill them out, raise your hand and I will come and address the issue. When you are done with the questionnaires, please turn them over to signal that you are finished. I will collect them when everyone is done. ***Researcher will pass out Packet 1 and 2 if the participants have not completed Packet 1 yet, and just Packet 2 if the participants completed Packet 1 prior to viewing the testimony. The researcher will then collect them when everyone is finished. Then, the experimenter will proceed with the debriefing.***

Debriefing

I'd like to start off by handing out a brief description of the study you just participated in – I will then tell you about the study, the importance of your participation, and answer any questions you may have. ***Debriefing form will be handed out.*** While one of the aims of this study was to examine deliberations in mock-jury research, the primary goal of the study is more specific.

The overall purpose of the present study is to examine how mock jurors processed evidence in a Not Guilty by Reason of Insanity case where the defendant was not compliant with his medication. We wanted to learn about how jurors considered this evidence. For example, did they consider evidence of medication noncompliance a great deal in their decisions? Did they blame the defendant for not taking his medication? Therefore, we manipulated whether the defendant in the trial was on or off his medication at the time of the offense. We also adjusted things like whether the defendant had high or low insight or awareness into his need for medication. Finally, we manipulated how the expert presented this evidence to see what impact a strong versus weak explanation of medication noncompliance and insight into one's mental illness would have on mock jurors' understanding of the evidence. So, while this research is based on a real case, the videos were created here in our research lab to create these specific scenarios. Your condition had the defendant [on/off] his medication, having [high/low] insight into his mental illness and need for treatment, and had the expert present a [strong, weak, general] explanation of these facts.

Participants were not told the full purpose of the study during the research session, so that the study's aims would not bias how you interpreted the evidence. This withholding was used because research shows that participants would have a hard time evaluating the evidence as a real juror might if they were told to attend to medication noncompliance evidence.

Does anyone have any questions about the experiment or what we expect to find in our research? ***Researcher will address any questions.*** Okay. You should have your research credit granted by this point. Please contact me if you do not using the email address listed on the debriefing form. I have one final request before you go that is crucial to this study. I need to ask all of you to make sure that you do not talk about the true nature of this study with any friends, roommates, colleagues, etc. If future participants know what this study is actually about it will invalidate the entire study. If you have any questions in the future feel free to contact anyone on the information sheets that you have. Thank you very much for your time and your cooperation in not revealing the true goals of this study.

Appendix E

Participant Information Sheet

Title of Research Project: *Criminal Trial: You be the Juror*

Investigators: Caroline Titcomb, M.A. & Stanley Brodsky, Ph.D.

It is important that you read the following explanation of this research study. This document describes the purpose, procedures, possible benefits and risks, and confidentiality of this study.

Purpose and Procedures: The current study is examining the role of deliberation in criminal case outcomes. If you decide to take part in this study, you will be asked to participate as a mock-juror in the trial phase of a criminal trial. You will be asked to view a videotaped excerpt of testimony from a trial, participate in a shortened mock-jury deliberation, and complete a written questionnaire. The questionnaire asks that you: 1) make a rating of the expert testimony seen in the video; 2) state a verdict for the case; 3) give your opinion on such issues as the legal system and the insanity defense; 4) provide information regarding how you think and your personality; 5) describe your experience as a participant and thoughts regarding the case; and 6) give a short demographic description of yourself (e.g., age, gender, prior jury experience, etc.). The deliberations will be videotaped and de-identified. Participating in this study will take up to 2.5 hours.

Benefits and Risks: There are no direct benefits to you for participating in the study, but you will receive 4 research credits. Potential benefits include learning more about the trial process and gaining insight into personal beliefs regarding the legal system. This study will help psychologists and lawyers better understand how jurors make decisions and how deliberations impact verdicts. There are no expected risks or discomforts involved with participating in this study. If at any point you feel uncomfortable, you may stop participating without any penalty.

Confidentiality: Your name will only be recorded to ensure you receive credit for your participation and will be kept separate from the other study materials. The documents containing participant names will be destroyed once all credit has been awarded. There will be no identifying information on the demographic sheet, questionnaires, or video recordings that would allow the researcher, or anyone else, to determine which person completed the materials. The deliberation videos and questionnaires with no identifying information will be stored in a locked file cabinet in Gordon Palmer Hall. Data will be entered into a password-protected, confidential database on a university computer. The questionnaires will be stored for seven years to comply with the American Psychological Association's research standards. Once the study is completed, the videos will be stored in a locked cabinet for up to two years, with coded identities removed, for further analysis of the data and then destroyed.

Withdrawal without Prejudice: Your participation is voluntary. You may choose not to take part at all. If you decide to participate, you are free to withdraw at any time. Leaving the study will not result in any penalty, and you will still receive the 4 research credits.

Cost of Participation: There will be no cost to you for participating in the current research study. All materials needed for the study will be provided for you.

Alternative Procedures: Please see your class professor for any alternative procedures or assignments you can complete if you choose not to participate in this study.

Questions: If you have any questions regarding the research study or any possible research related injuries right now, please ask them. If you have questions about the study later on, please contact Caroline Titcomb, MA at ctitcomb@crimson.ua.edu or Dr. Stanley Brodsky (faculty advisor for the current study and licensed psychologist) at sbrodsky@bama.ua.edu. Dr. Brodsky is a licensed psychologist and is available if any aspect of participation is upsetting. If you have any questions about your rights as a research participant, you may contact the University of Alabama Research Compliance Officer at (205)348-5152.

Script Derived from:

- **Black** - *People v. Goldstein*, 2005 (Case transcript)
- **Blue** – Adjusted or added for the purposes of this study

Prosecutor – Jason Wilson, JD (Audio Only)

Word Count - 834

Good morning, ladies and gentlemen. It is my purpose to give you a guideline of where I believe the People’s evidence will take you, the significance of certain things, and what we will be trying to prove by way of this evidence.

The defendant, Andrew Duncan is on trial for the crime of Murder in the Second Degree for the death of Ms. Katelyn Webber on January 3, 2006. What we intend to show in this case is that the defendant, who is a diagnosed schizophrenic – there is no argument about that – but he uses his illness to get what he wants out of situations. That’s his objective. He uses it to avoid obligations, escape from punishment, and in this case, exact a form of revenge for what he sees as unpleasant treatment by others, most notably (to use a street term) when he feels dissed by women.

The People will have to prove that the following happened on January 3, 2006: Katelyn Ann Webber, a resident of Atlanta, was waiting for the northbound Gold-rail subway train at the Midtown stop. You will learn that while Ms. Webber was waiting for the delayed train, she was reading something and she was leaning against a pillar. The defendant was also present in the rail station that day, and was seen walking in an odd way and behaving strangely – taking **childlike** little baby steps.

I expect that you will learn through evidence that another woman was also in the vicinity waiting for the train – standing at a different pillar, about 10 to 12 feet from Ms. Webber. This woman, Dawn Lawrence, observed the defendant pacing back and forth and watching her and Ms. Webber. The defendant approached her, Ms. Lawrence, and she told the defendant to “get away.” After this encounter, Ms. Lawrence observed the defendant’s demeanor change. She watched him walk away normally to the other end of the platform – then look as if to see if a train was coming – and then return to where Katelyn Webber stood reading a magazine.

I expect you will hear evidence that the defendant then asked Ms. Webber the time. Ms. Webber replied that it is about five o’clock, and those are the last words I anticipate will be proven that she ever spoke. You will hear evidence that as the train then entered the station, the defendant set himself up directly behind Katelyn Webber, and as the train came barreling in at about 35 miles per hour, he pushed off the wall, grabbed Ms. Webber from behind, and pushed her in front of the oncoming train – immediately obscuring Ms. Webber’s body under the train. The defendant was, however, able to stop himself.

When the train came to a stop and the motorman came out, he tearfully addressed the defendant and asked him how he could do such a thing. You will hear evidence that the defendant said, “I’m psychotic, I need a doctor, take me to the hospital.” The defendant used his insanity as a tool to insulate him from the consequences of his acts right away.

The defendant was calm, cooperative, and followed directions from civilians and police after the incident. The defendant was taken to the police station and read his rights. Twelve hours after the incident - he minimized his behavior to the police, talking about how he pushed her

lightly and that he didn't intend to do so, "some force was within him" – that he would never do this "because it was wrong." As you will hear by way of the evidence, the defendant consistently when he has a situation when there may be some problem for him, immediately he invokes his mental illness.

Even though the defendant is mentally ill and even though he is a diagnosed schizophrenic, you will hear evidence in this case that a schizophrenic is like any other group of individuals- there is a full range of how this illness affects them. The actions of this man can be attributed entirely to the decisions that he willfully decided to make. This defendant was not homeless or penniless. He was functioning at a high level and his mental illness, ladies and gentlemen, did not impair his ability at the time that he murdered Katelyn Webber. That was a decision that he made, fully conscious of what was happening. He believed he could talk his way out of it. I need a hospital. This time he went too far.

At the conclusion of all of the evidence, I will ask you to hold the defendant accountable for his actions; he is not an individual who is representative of mental illness in this country, he is an individual who makes personal choices and did this because he wanted to do it. So at the conclusion of the evidence, ladies and gentlemen, I will ask you to return a verdict of guilty for murder in the second degree. Thank you.

COURT - Jennifer Wilson, MA (Audio Only)

Thank you Mr. Green. Defense, your opening statement?

Defense Attorney – David Sams, JD (Audio Only)

Word Count - 820

Good morning, ladies and gentleman. Mr. Green has told you a tragic story about a young woman who lost her life well before her time. I'd like to tell you a story now, about a young man who lost his mind. This case is about ten years of deterioration of a young man's mind to the point of insanity, schizophrenia. You will hear about Andrew Duncan's ten year odyssey through a mental health system and revolving door therapy. Ladies and gentlemen, the mental health system failed Andrew Duncan; they abandoned him when he truly needed help. The evidence in this case will show that my client believed that his own mother was poisoning his food. You will hear how he saw people shrinking, people growing. You will hear how he heard voices talking to him, voices of people who were not there. You will hear how Andrew believed that he was being controlled by outside forces, how people were manipulating his thoughts. His own family abandoned him, and that's just the beginning of Mr. Duncan's slide into this hell on earth that ended with that psychotic attack, not an intentional, cold-blooded act as Mr. Green described to you.

You will hear the evidence that Andrew Duncan in her early years was a very gifted student. He did well in school, but in late high school, he realized things were not quite right with his brain. Then he attended university, where the real symptoms started to appear – as they often do in a case of schizophrenia – inability to concentrate, hearing voices, acting strange. His family provided him with private doctors and you will hear how he was first institutionalized in 1995 – how his mother called the police because she couldn't handle her own son's bizarre and paranoid behavior. Andrew Duncan was institutionalized many times over the course of his illness. This is all documented – we're not making this stuff up.

Due to the severe symptoms he experienced over the course of his illness, Andrew committed acts of violence against others- doctors, therapy leaders, nurses. He believed that the doctors were poisoning him with cyanide, and that someone was after him with a gun. Andrew was told by several clinics that he could no longer attend because of his assaultive behavior. Back on the street, he would commit assaults against strangers, often pushing or shoving them. Once arrested, he would be hospitalized again. Once, in a therapy session, Andrew Duncan refused to sign a contract promising to seek help if he felt the urge to push and shove. Why did he refuse? Because he didn't know why he was doing it; he felt he couldn't enter into a contract that he couldn't keep because he couldn't control his symptoms.

The central issue in this case is Mr. Duncan's state of mind at the moment that he pushed the woman off the platform. The evidence will again show no motive, no intent, no awareness of risk. It is an act against a total stranger. The day on the platform, January 3, 2007, expert testimony will show the deterioration of Andrew's mental state had gone from bad to worse. Witnesses who have regular contact with Andrew will testify to how he was different that day, worse than before. I expect you will hear how he was dazed, standing in the pouring rain, and didn't even know what day it was and how after saying he was going home, he wandered off in the wrong direction.

Yes, the evidence will show that at times, Andrew is highly functional, but at other times, he's very bad. And this particular day, he was very bad. On the platform, witnesses reported that he was pacing back and forth. He was talking to himself and stomping his feet. I expect you will hear witnesses from the platform that day explain how they noticed Mr. Duncan's behavior and told him to stop it because his strange walking was making people nervous. Then the psychotic attack came over him and he lost complete control. It happened, and he stood there as if in a trance, waiting for the police. He did not try to run away – more bizarre behavior. On the surface, the evidence will show Andrew appears to be in control. However, if you scratch the surface, you will see the depth of the psychosis.

This was not the act of a cold-blooded killer. He didn't know what he was doing. He surely didn't know that it was wrong if he didn't know what he was doing. The evidence and the expert, scientific testimony you will hear will prove to you that Mr. Green has not met his burden of proof beyond a reasonable doubt and that Andrew is not guilty of intentional murder. I plan to prove that Andrew Duncan is not responsible, not because it's an easy burden to reach, but because it's the right burden. Thank you.

Appendix G

Judge's Preliminary Instructions to the Jury

Script Derived from:

- **Purple** - Colquitt, 1994 (AL Pattern Judge's Instructions)
- **Black** - *People v. Goldstein*, 2005 (Case transcript)
- **Blue** - Titcomb's thesis
- **Brown** – Wording from AL Patter Instructions adjusted slightly for logistics/truncating instructions

Read by: Jennifer Wilson, MA (audio only) *Words Count – 455*

Good morning, folks. We are ready to begin the next stage of the trial. I want to give you some brief instructions after which Mr. Green, - **who is prosecuting** this case, will make an opening statement. **This statement will** outline what he says the witnesses will testify to and what he expects to prove in the course of the trial. Then, Mr. Canfield – **who is the defense attorney**, may **also make an** opening statement.

When the openings conclude, witnesses will be called to the stand. **Here** a witness will take the stand and be sworn and be questioned on direct-examination by Mr. Canfield (**the defense attorney**). **Then, the prosecution** may choose to ask some other questions and that's called cross examination. After the People and the defense both rest, each side may make a closing argument. We usually call that a summation or summary of what each side hoped to prove.

After the arguments by counsel, I will instruct you on the law and at that point, the case will be yours for deliberation. **For now, just know that** under our legal system, the prosecution (**Mr. Green**) has the burden of proving the crime, **but the defense (Mr. Canfield) must show that if a crime did take place, that the defendant was not criminally responsible for such actions.**

My function as the Judge here is to instruct you on the law. Your function is **to judge the facts based on the evidence and their credibility (or lack thereof)**. **We** simply ask you to use your common sense and your life experience.

The Court would appreciate your compliance with some **rules of conduct**. **First**, do not discuss anything about the case among yourselves until after you heard all the evidence and I have instructed you **on the law**. **Second, the law permits you to take notes, but please let me know if you have any issues or concerns with this, and I will instruct you properly on the use of notes.** **However, when you decide what notes to take down**, you are making decisions about the case and my own feeling is **that it's a little early for you to do that in this case.** **Also, note-taking** distracts you from watching and listening to the witnesses and that's part of the credibility evaluation. So at this point, my suggestion to you is that you not take notes.

Finally, keep an open mind, don't form any opinions or conclusions with respect to the guilt or non-guilt or responsibility of the defendant except to continue to presume his innocence. Okay, you're about to hear the prosecution – otherwise known as the People – make an opening statement and the defense may open as well. **Mr. Green, you may begin.**

Appendix H

Testimony Conditions

Foundational Testimony

All mention of medication removed
All direct mention of insight removed

Script Derived from:

- *People v. Goldstein*, 2005 (Case transcript) – **PRIMARY SOURCE**
- Crocker & Bull Kovera (2010, Truncated from transcript)
- Titcomb's Thesis

DIRECT

Word Count - 132

THE COURT: Mr. Canfield, your witness.

DEFENSE ATTORNEY: Yes, your Honor. At this time, the defense would like to call Dr. Mark Harper to the stand.

THE COURT: Dr. Harper, please.

DEFENSE ATTORNEY: Good morning, Dr. Harper.

EXPERT WITNESS: Good morning.

DEFENSE ATTORNEY: Could you please tell the court your current title and position, Doctor?

EXPERT WITNESS: I am a Professor of Psychiatry at Emory University and I'm also the Clinical Director of the Department of Psychiatry at Emory University Hospital.

DEFENSE ATTORNEY: Dr. Harper, could you please give us the background of your education?

EXPERT WITNESS: Yes. I attended Tulane University, graduating with a Bachelor's Degree in Biology. I then attended Vanderbilt School of Medicine. My psychiatric training was at Emory University Hospital where I completed a residency in general psychiatry.

Word Count: 1575

DEFENSE ATTORNEY: Now, Doctor, in very general terms, please tell us what is Schizophrenia?

EXPERT WITNESS: Schizophrenia is a brain disease that has mental symptoms. It causes severe disruption of almost all mental functioning and is considered perhaps the most serious of all mental illnesses. The primary cause of Schizophrenia is still unknown, but we know that it is a disruption in the neurotransmitters (or electrical signals) and chemicals in the brain.

DEFENSE ATTORNEY: Doctor, what are the core symptoms of Schizophrenia?

EXPERT WITNESS: The core symptoms used to diagnose Schizophrenia are hallucinations, which are perceptions that have no basis in reality, such as hearing voices when no one is there or seeing things that are not really there. Another core symptom is experiencing delusions. Delusions are false beliefs held with conviction, even though they have no real basis in reality. An example of a delusion is a paranoid belief that someone is trying to kill you. Another major Schizophrenia symptom is thought disorder. Patients who suffer from Schizophrenia say they can't get their thoughts straight. They can't think properly or reach logical conclusions; their brains just don't process information the same as people without the illness.

DEFENSE ATTORNEY: Thank you, Dr. Harper. How might a person with Schizophrenia act?

EXPERT WITNESS: Well, if a person with Schizophrenia is fairly psychotic, they are likely get confused easily and their speech is often hard to understand or illogical. Their behavior will often not make sense to others. They may be erratic or the opposite of that – they may act very slowed in their responses to situations. Then there is a disturbance in emotional expression; called “constricted emotions” where they don't show the full range of emotions. They appear flat, dull, spacey, or other times, they may show inappropriate emotions that do not match expected reactions given the situation, like laughing at sad situation.

DEFENSE ATTORNEY: When does this disease usually start?

EXPERT WITNESS: It starts in late adolescence. There are usually times in which the patient's symptoms become more intense than usual. So, it's typical for persons with Schizophrenia to have a level of baseline functioning, and then from time to time, more severe symptoms of hearing voices or becoming agitated can flare up.

DEFENSE ATTORNEY: That is an interesting point, doctor. Are schizophrenic patients usually violent?

EXPERT WITNESS: Patients who have Schizophrenia are most likely to be aggressive when their symptoms are most intense. When their delusions and hallucinations are under control, they don't tend to be any more aggressive than anyone else.

[Insert 1]

DEFENSE ATTORNEY: Doctor, did you make a diagnosis of Andrew Duncan in this case?

EXPERT WITNESS: Yes. Schizophrenia – a particular form of Schizophrenia called Paranoid Schizophrenia. This diagnosis is also present in Mr. Duncan’s some 3500 pages of medical records.

[Insert 2]

[Insert 3]

[Insert 5]

[Insert 6]

DEFENSE ATTORNEY: In your expert opinion, doctor, did Mr. Duncan’s mental illness contribute to violent or aggressive acts?

EXPERT WITNESS: Mr. Duncan often battled with the severe symptoms of Schizophrenia and he had violent outbursts. Over the course of ten years, these outbursts included, uh, **[reads from list]** pushing and threatening his mother; assaulting a staff member of a hospital *after* hearing voices telling him to do so; assaulting a stranger at a supermarket; attacking a psychiatrist at one of the hospitals; assaulting a child at a Barnes and Noble; attacking a resident doctor; punching two patrons at a Burger King; suddenly punching a female patient at a psychiatric facility in the face. **[flips through notes]** After several of these incidents, Mr. Duncan’s chart has quotes from the defendant saying that he did not know why he did these things. His medical records described Mr. Duncan as becoming increasingly and unexpectedly agitated and paranoid. In records, the patient has stated that quote - "I sometimes can’t control my arms and that’s when I get into trouble and I end up hurting people” - end quote.

DEFENSE ATTORNEY: Now, Doctor, can you tell us please a little bit about Andrew Duncan’s medical and psychiatric history?

EXPERT WITNESS: Okay. Mr. Duncan’s symptoms began in high school - they became severe during his freshman year in college. He was first hospitalized in 1995. He was treated by a psychiatrist who prescribed antipsychotic medication. Over a ten year period, psychiatric facilities continuously treated him, prescribed medication, and then discharged him to the community. He was hospitalized for **[look at notes]** 7 months in 2000 and an entire year in 2002. In 2004, he spent two weeks in a psychiatric facility. He spent 196 days in the hospital in 2005 and 2006; in 2006 alone he spent 130 days in the psychiatric hospital, indicating an extremely severe course of illness at that point.

DEFENSE ATTORNEY: Dr. Harper, can you share with the Court, Mr. Duncan’s history of symptoms related to his Schizophrenia?

EXPERT WITNESS: Yes. **[while glancing at notes]** Over the course of his illness, he experienced the following symptoms, among others: delusions that his mother and his doctors

were trying to poison him; hearing voices telling him to kill himself; delusions that someone was after him with a gun; illogical speech; disorganized thoughts; hallucinations that people were shrinking and growing; delusions that the earth is running out of oxygen; hallucinations that people were turning purple; auditory hallucinations telling him to hurt someone; delusions that a person named Larry was trying to manipulate his thoughts and was trying to steal his excrement; false beliefs that he was a ghost and had never been born.

[Insert 7]

DEFENSE ATTORNEY: Thank you Doctor. On Christmas day in 2003 when Mr. Duncan was hospitalized, what incident occurred?

EXPERT WITNESS: According to records, Mr. Duncan told staff that his friend was a master psychic who was telling him strange things – that he had never been born and that he was a ghost. He said that people were coming to get him and that something or someone had entered his body, causing him to push people against his will.

DEFENSE ATTORNEY: Thank you Dr. Harper. So in your expert clinical opinion, how would you summarize Mr. Duncan’s treatment history?

EXPERT WITNESS: The psychiatric facilities continuously treated him, prescribed medication, and subsequently discharged him to the community. He’s been schizophrenic now for 10 years. Despite medications and treatment, his illness has yet to stabilize and in fact, has become worse over the years.

DEFENSE ATTORNEY: Dr. Harper, what is your clinical opinion of the origins of Mr. Duncan’s history of assaultive and aggressive behavior?

EXPERT WITNESS: This is not somebody that gets angry and assaults a person. He is a person who strikes out for no reason and can’t understand why. He says that he can’t control it because he doesn’t want to do it. It’s not an intended act; it is a symptom of his illness – he feels like his cannot control his actions and is **[using quotation mark hand gestures]** “a puppet on a string.”

DEFENSE ATTORNEY: Doctor, do you have any opinion as to Mr. Duncan’s course of Schizophrenia up to this point in time?

EXPERT WITNESS: Yes. In 2005 and 2006, his illness became much more severe. His baseline illness had gotten worse. We know that because he was having more frequent symptoms. He was not able to function out of the hospital very well and kept going back to the hospital when his symptoms flare out of control.

DEFENSE ATTORNEY: Dr. Harper, when you interviewed Andrew Duncan, did he know the date and day of the week this tragic incident had occurred?

EXPERT WITNESS: No. In fact Mr. Duncan had taken a train that day as he reportedly had done hundreds of times before, to see his brother at work, but January 3, 2007 was a Sunday and he knows his brother never works on Sundays.

DEFENSE ATTORNEY: When you interviewed Andrew Duncan, how did he describe the incident on January 3, 2007?

EXPERT WITNESS: That he knows he pushed Katelyn Webber to her death.

[Insert 4]

DEFENSE ATTORNEY: In your expert psychiatric opinion, what have you concluded about that incident?

EXPERT WITNESS: The defendant pushed Ms. Webber to her death at a time when his psychotic symptoms were at their worst. He was suffering from an acute exacerbation of his psychotic symptoms, which means his brain was interfering with his ability to function and think. He couldn't think or plan. He had no reason. It was a sudden psychotic act.

DEFENSE ATTORNEY: One final question, Doctor. Can you render an opinion to a reasonable degree of scientific certainty whether Andrew Duncan because of his mental disease or defect, lacked substantial ability to know or understand the quality and consequences of his actions during the incident that lead to Katelyn Webber's death on January 3, 2007?

EXPERT WITNESS: I *can* render an opinion. At that time, Mr. Duncan's understanding and awareness of his behavior and the consequences of his actions were extremely impaired due to his severe mental illness and psychosis.

DEFENSE ATTORNEY: Doctor, can you render an opinion to a reasonable degree of scientific certainty whether Andrew Duncan because of his mental illness, lacked substantial ability to understand that his actions were wrong?

EXPERT WITNESS: I *can* render an opinion. At the time of the act leading to Katelyn Webber's death, Mr. Duncan's mental illness and severe psychosis significantly impaired his ability to discern right from wrong.

DEFENSE ATTORNEY: Thank you Doctor, I have no further questions.

CROSS
Words - 1534

THE COURT: Mr. Green?

PROSECUTION: Thank you, your Honor. I do have cross for this witness. Dr. Harper, you were asked to prepare for the defense a rationale connecting the defendant's diagnosis with your opinion of his actions on the platform, correct?

EXPERT WITNESS: Yes.

PROSECUTION: Now, in this rationale, did you explore the defendant's activities the day before the incident and the day after the incident?

EXPERT WITNESS: Yes.

PROSECUTION: So, wouldn't it be relevant to your consideration to examine the defendant's conduct during the 36 hours to 48 hours leading up to the killing of Katelyn Webber?

EXPERT WITNESS: Yes. However, it is my understanding that the critical issue was that day and most particularly, the time on the platform – not the day before, not two days before, not three days before...

PROSECUTION: ...So are you saying that the events leading up to and shortly after this incident are not something you would consider in formulating your opinion?

EXPERT WITNESS: No. I am saying that it's my understanding that the time of the offense or alleged act is the *most* important time period to consider.

PROSECUTION: So you would dismiss any of his conduct moments prior to the incident and moments after the incident; is that right?

EXPERT WITNESS: I would not dismiss it, no.

PROSECUTION: Well what weight would you give it?

EXPERT WITNESS: It depends on what the information is. The nature of psychiatric symptoms in a schizophrenic patient is that they can intensify quite suddenly.

PROSECUTION: So is it true you would describe this incident as a sudden psychotic moment in the defendant's life, of which he had no warning?

EXPERT WITNESS: No. He is schizophrenic. He has been severely schizophrenic for ten years at the time of the tragedy and at the moment of the tragedy his symptoms welled up with great intensity.

PROSECUTION: So, what is the exact moment you are describing – when you say Andrew Duncan went into this psychotic attack?

EXPERT WITNESS: He was psychotic that day. He was functioning on a very low level that day and his symptoms intensified. He had an acute exacerbation of his symptoms leading to a psychotic episode while on the station platform similar to episodes he's had before.

PROSECUTION: So you cannot tell us exactly what he was thinking at the moment that he killed Katelyn Webber.

EXPERT WITNESS: No, I cannot. As a psychiatrist, I can never be 100% sure what another person is thinking. However, I can use my expertise and years of experience and training to form a clinical opinion of what Mr. Duncan was thinking at that time.

PROSECUTION: So, you can tell us what he was thinking at that moment?

EXPERT WITNESS: No, because he wasn't consciously thinking – he was psychotic.

PROSECUTION: After the incident, when the defendant asked for a doctor, can you explain why his symptoms seemed to have gone on and off like a light switch?

EXPERT WITNESS: Symptoms of Schizophrenia do not work like that. They can have sudden onsets, but there is usually some noticeable build-up of symptoms, like described in the witness reports I reviewed. He would not suddenly be no longer psychotic. He may have needed a doctor, but this does not necessarily equate with no longer being psychotic, especially after the stress and tragedy of the incident.

PROSECUTION: You interviewed the defendant. In your report to the Court, doctor, you wrote that the defendant had quote - overwhelming sensations - end quote, and that he quote - felt that something bad was going to happen - end quote. Why didn't he go to the doctor then?

EXPERT WITNESS: He was not thinking normally. He said that he went to the station, felt these sensations coming on that were overwhelming. He walked around and they went away. He again started feeling that something bad was going to happen and then it went away, and then the train was coming and he felt the sensation again. Eh, at the *time* of Ms. Webber's death, he may very well have been feeling intense paranoia that built up to a sorta bodily reaction to this symptom.

PROSECUTION: Did you read the police report detailing the interview with the defendant just hours after Ms. Webber's death?

EXPERT WITNESS: Yes.

PROSECUTION: If the defendant can't turn his symptoms on and off, then how do you explain the statement he made to the police stating that he would have never intentionally pushed Ms. Webber because quote – it would be wrong to do it – end quote?

EXPERT WITNESS: A hallmark symptom of Schizophrenia is confusion and disorganized thoughts. It is very possible that Mr. Duncan's thinking 12 hours after the incident was different than it was earlier that day on the platform.

PROSECUTION: Doctor, just because someone has Schizophrenia doesn't mean they can't tell right from wrong does it?

EXPERT WITNESS: It depends, but people with Schizophrenia are just like any other people in terms of varying degrees of awareness and cognitive abilities.

PROSECUTION: Did you use a test to test Mr. Duncan's his mental state at the time of offense?

EXPERT WITNESS: No. Due to the retrospective nature of the evaluation, no such test exists.

PROSECUTION: On the day of Ms. Webber's death, Mr. Duncan went to a fast food restaurant and purchased food, then sat and ate it with a former patient he ran into at that fast food restaurant, is that correct?

EXPERT WITNESS: Yes. That is what was reported.

PROSECUTION: In *your* report, you say that the defendant spoke to this acquaintance for about 20 minutes, then he loaned her a small amount of money, and then he went to the music store and listened to some records, is that correct?

EXPERT WITNES: Yes.

PROSECUTION: Do those acts sound like the acts of a severely psychotic person, Doctor?

EXPERT WITNESS: In the context as you described them, no.

PROSECUTION: Can I ask you to think back to the incident when the defendant assaulted a woman in a supermarket several years ago? After the guard detained him, do you recall that the defendant immediately announced that he was sorry, he was sick, that he was a psychiatric patient and when the guard said he was going to call the police, the defendant begged him not to, providing all of the explanations that I have just described?

EXPERT WITNESS: I believe so, yes, that he wanted to go to the hospital.

PROSECUTION: And the day before Ms. Webber's tragic death, on January 2nd, the defendant indeed went to the hospital, but did he complain of psychotic symptoms that day or ask to be hospitalized?

EXPERT WITNESS: No, the day before the incident on the platform he was complaining of a sprained ankle. He later reported to me that that same day on January 2nd, that **[look at notes]** quote - people looked like they were undead – end quote.

[Insert 8]

[Insert 9]

[Insert 10]

PROSECUTION: Now let's talk about the incident in which the defendant assaulted a child at the Barnes and Nobles. Are you aware that at the scene, one of the first things that he informed the police was that he should be taken to the hospital?

EXPERT WITNESS: Yes.

PROSECUTION: Then a few months later, something else happened. He kicked in the door of a neighbor's house and asked to be taken to the hospital. What is the significance of that scenario doctor? On that specific day?

EXPERT WITNESS: It was the day before he was supposed to appear in court for the Barnes and Noble incident.

PROSECUTION: And you don't infer from this that it was a mechanism for him to avoid having to go back to court?

EXPERT WITNESS: No, because a couple of weeks later he did go to court.

PROSECUTION: So, you don't think there's any relation between the defendant kicking in his neighbor's door and asking to be brought to the hospital and the defendant's scheduled court date the next day?

EXPERT WITNESS: There very well might be a connection - the upcoming court date could have been a stressful trigger that intensified Mr. Duncan's symptoms and his need to be hospitalized.

PROSECUTION: No further questions, Your Honor.

THE COURT: Dr. Harper, you may step down.

Testimony Manipulation Inserts

CONTROL CONDITION

Script Derived from:

- **Green** – Added by Titcomb (Modified for the purposes of the dissertation conditions)
- **Blue** – Mitchell (1999, 2003)
- **Black** – *People v. Goldstein*, 2004 (Case transcript)
- **Red** – Adjusted or added post-pilot testing.

Medication Compliant – Control (MC/Control)

Direct

[Insert 1 - C]

DEFENSE: **How do you, Doctor**, treat people with Schizophrenia?

EXPERT WITNESS: Schizophrenia is primarily treated with antipsychotic medications that may also have some side effects.

[Insert 2 - C]

DEFENSE: Was Andrew Duncan treated with medications?

EXPERT WITNESS: Yes. Mr. Duncan was primarily prescribed Haldol over his years of treatment.

[Insert 3 - C]

DEFENSE: In your clinical opinion Doctor, how did Mr. Duncan react to needing medication?

EXPERT WITNESS: Mr. Duncan accepted that he should take the advice of the psychiatrist. He seemed to realize he was mentally ill and he was careful to take his medication.

[Insert 4 - C]

DEFENSE: Was Andrew Duncan taking his medication during the time of the incident on January 3rd, 2007?

EXPERT WITNESS: Yes. Pharmacy records and Mr. Duncan himself reported that he was compliant with his medication during the time period leading up to and during the offense.

[Insert 5 - C]

DEFENSE: Did you have opportunities to interview Andrew Duncan when he was both on and off his medication?

EXPERT WITNESS: No.

[Insert 6 - C]

DEFENSE: Can you tell us any differences that you might have expected to observe in his medicated and un-medicated state?

EXPERT WITNESS: Mr. Duncan has traditionally been and is currently compliant with his medications, so it was not possible to interview him off his medication. However, if untreated, persons with Schizophrenia will become more psychotic and their thinking will become markedly impaired.

[Insert 7 - C]

DEFENSE: From the defendant's medical records, is there any evidence that he was seeking help for his condition?

EXPERT WITNESS: Yes. In 1999, he checked himself into a psychiatric facility. Another time that year, he called 911 asking to be brought to the ER. A few years later, he signed into yet another hospital.

Cross

[Insert 8 - C]

PROSECUTION: Isn't it true, that the defendant routinely blamed his illness when confronted with problem situations, saying quote – Well, I'm not feeling well – or I need to have my medication adjusted?

EXPERT WITNESS: Those statements were in Mr. Duncan's record from times when he was admitted to the hospital. However, medication adjustments are common to the treatment of Schizophrenia.

[Insert 9 - C]

PROSECUTION: So, just to reiterate, Andrew Duncan was on his medication during the offense?

EXPERT WITNESS: Yes, that is correct.

[Insert 10 - C]

PROSECUTION: Isn't it true that in the defendant's hospital records from 2001, he had refused to sign a patient contract agreeing to not hit or act aggressively towards patients and staff.

EXPERT WITNESS: Yes. He refused because he felt he couldn't enter into a contract that he couldn't keep.

Medication Noncompliant (MNC) **Low Elaboration and High Insight (LeHi)**

- **Medication Noncompliant**
- **Low Elaboration**
- **High Insight**

Direct

[Insert 1 – LeHi]

DEFENSE: How do you, doctor, treat people with Schizophrenia?

EXPERT WITNESS: Schizophrenia is primarily treated with antipsychotic medications that may also have some side effects.

[Insert 2 – LeHi]

DEFENSE: Was Andrew Duncan treated with medications?

EXPERT WITNESS: Yes. Mr. Duncan was primarily prescribed Haldol over his years of treatment. Medical records typically describe Mr. Duncan as responding well to the medication when he was in a supervised setting that required him to take his medication.

[Insert 3 – LeHi]

DEFENSE: In your clinical opinion doctor, how did Mr. Duncan react to needing medication?

EXPERT WITNESS: Mr. Duncan seemed to realize he was mentally ill, but he did not want to take the advice of the psychiatrist or be dependent on medication. He took medication when in the hospital because he had to, but he stopped taking his medication when he was not in a supervised setting, when he was in the community.

[Insert 4 – LeHi]

DEFENSE: Was Andrew Duncan taking his medication during the time of the incident on January 3rd, 2007?

EXPERT WITNESS: No. His medical records note that he was not taking his medication, and we know that his prescription had not been filled for several weeks.

[Insert 5 – LeHi]

DEFENSE: Did you have opportunities to interview Andrew Duncan when he was both on and off his medication?

EXPERT WITNESS: Yes.

[Insert 6 – LeHi]

DEFENSE: Can you tell us any differences that you might have **observed** in his medicated and un-medicated state?

EXPERT WITNESS: **Yes.** He was more psychotic off his medication; his thinking was markedly impaired.

[Insert 7 – LeHi]

DEFENSE: From the defendant’s medical records, is there any evidence that he was seeking help for his condition?

EXPERT WITNESS: Yes. In 1999, he checked himself into a psychiatric facility after becoming nervous and scared. Another time that year, he called 911 asking to be brought to the ER stating that he was confused and could not function and needed some help. A few years later, he signed into yet another hospital after hearing voices and complaining that someone was trying to evaporate his brain. On his application for admission, he writes that his reasons for applying for admission are “severe Schizophrenia.”

Cross

[Insert 8 – LeHi]

PROSECUTION: **Isn’t it true, that the defendant routinely blamed his illness when confronted with problem situations, saying quote – Well, I’m not feeling well – or I need to have my medication adjusted?**

EXPERT WITNESS: Yes. He did.

[Insert 9 – LeHi]

PROSECUTION: **So, just to reiterate, even though the defendant knew he was supposed to be on medication, Andrew Duncan was not on his medication during the offense?**

EXPERT WITNESS: **Yes, that is correct.**

[Insert 10 – LeHi]

PROSECUTION: **Isn’t it true that in the defendant’s hospital records from 2001, he had refused to sign a patient contract agreeing to not hit or act aggressively towards patients and staff.**

EXPERT WITNESS: Yes. He refused because **he believed his mental illness was causing these behaviors.**

Medication Noncompliant (MNC)
Low Elaboration and Low Insight (LeLi)

- **Medication Noncompliant**
- **Low Elaboration**
- **Low Insight**

Direct

[Insert 1 – LeLi]

DEFENSE: How do you, Doctor, treat people with Schizophrenia?

EXPERT WITNESS: Schizophrenia is primarily treated with antipsychotic medications that may also have some side effects.

[Insert 2 – LeLi]

DEFENSE: Was Andrew Duncan treated with medications?

EXPERT WITNESS: Yes. Mr. Duncan was primarily prescribed Haldol over his years of treatment. Medical records typically describe Mr. Duncan as responding well to the medication when he was in a supervised setting that required him to take his medication.

[Insert 3 – LeLi]

DEFENSE: In your clinical opinion doctor, how did Mr. Duncan react to needing medication?

EXPERT WITNESS: Mr. Duncan did not really seem to realize or even understand that he was ill. At first, he took the advice of the psychiatrist and took his medication. Very soon, however, he stopped taking his medication altogether when he was in the community. He did not understand that he was sick and needed to continue to take the medication.

[Inset 4 – LeLi]

DEFENSE: Was Andrew Duncan taking his medication during the time of the incident on January 3rd, 2007?

EXPERT WITNESS: No. His medical records note that he was not taking his medication, and we know that his prescription had not been filled for several weeks.

[Insert 5 – LeLi]

DEFENSE: Did you have opportunities to interview Andrew Duncan when he was both on and off his medication?

EXPERT WITNESS: Yes.

[Insert 6 – LeLi]

DEFENSE: Can you tell us any differences that you might have observed in his medicated and un-medicated state?

EXPERT WITNESS: Yes. He was more psychotic off his medication; his thinking was markedly impaired.

[Insert 7 – LeLi]

DEFENSE: From the defendant's medical records, is there any evidence that he was seeking help for his condition?

EXPERT WITNESS: Yes. In 1999, he checked himself into a psychiatric facility after becoming nervous and scared. Another time that year, he called 911 asking to be brought to the ER stating that he was confused and could not function. A few years later, he signed into yet another hospital after hearing voices and complaining that someone was trying to evaporate his brain.

Cross

[Insert 8 – LeLi]

PROSECUTION: Isn't it true, that the defendant routinely blamed his illness when confronted with problem situations, saying quote – Well, I'm not feeling well – or I need to have my medication adjusted?

EXPERT WITNESS: Yes. He did.

[Insert 9 – LeLi]

PROSECUTION: So, just to reiterate, even though the doctors had prescribed medication, Andrew Duncan was not on his medication during the offense?

EXPERT WITNESS: Yes, that is correct, he did not understand that he was sick and needed to stay on the medication. When he began to feel better, he stopped taking the medication.

[Insert 10 – LeLi]

PROSECUTION: Isn't it true that in the defendant's hospital records from 2001, he had refused to sign a patient contract agreeing to not hit or act aggressively towards patients and staff.

EXPERT WITNESS: Yes. He refused because he did not know why he was doing these behaviors.

Medication Noncompliant (MNC) **High Elaboration and High Insight (HeHi)**

- **Medication Noncompliant**
- **High Elaboration**
- **High Insight**

Direct

[Insert 1 – HeHi]

DEFENSE: How do you, Doctor, treat people with Schizophrenia?

EXPERT WITNESS: Schizophrenia is primarily treated with antipsychotic medications that may also have some side effects. There are two forms, what are called traditional antipsychotics and newer antipsychotics. These medications are generally good at treating classic symptoms of Schizophrenia - what you would think of as psychotic symptoms – like hallucinations and delusions – but they are less effective at clearing up the thought dysfunction.

[Insert 2 – HeHi]

DEFENSE: Was Andrew Duncan treated with medications?

EXPERT WITNESS: Yes. Mr. Duncan was primarily prescribed Haldol over his years of treatment.

DEFENSE: Can you tell us a bit about Haldol and these other medications?

EXPERT WITNESS: Yes. Haldol is a traditional antipsychotic. What we call “traditional” antipsychotics are usually reserved for use when psychotic symptoms are extreme or hard to treat with the newer medications. Both forms of medication can be effective treatments, but traditional antipsychotics are sometimes preferred for treating severe psychotic symptoms.

DEFENSE: Are there side effects to these medications?

EXPERT WITNESS: Yes, there can be. Everyone's response to medication is different. Some medications work better for some people and some side effects are more present in some patients. Traditional antipsychotics, like the ones prescribed to Mr. Duncan, they have been found to bring with them some moderate to serious side effects. For this reason, the newer medications are often preferable if possible.

DEFENSE: What are some of these side effects?

EXPERT WITNESS: In clinical studies, the *most* serious side effects found have been fatigue and dull energy, foggy thinking, significant weight gain, sexual dysfunction, and uncontrollable Parkinson's like tremors and slowed movements. Treating physicians are trained to be on the look out for these side effects and monitor them; adjusting medications when they become significant problems., so such serious side effects are pretty rare these days.

[Insert 3- HeHi]

DEFENSE: Did Mr. Duncan experience any of these side effects, Doctor?

EXPERT WITNESS: Medical records typically describe Mr. Duncan as responding well to the medication when he was in a supervised setting – a setting that mandated that he take his medication. His records do note some *mild to moderate* side effects of his medication regimen. The most common side effects noted in Mr. Duncan's charts were **[looks at notes]** grogginess during the day, sleep difficulties, and some weight gain.

DEFENSE: In your clinical opinion Doctor, how did Mr. Duncan react to needing medication?

EXPERT WITNESS: Both in records and when I interviewed him, Mr. Duncan seemed to accept that he was mentally ill. This is what physicians call having insight into your mental illness. Not all Schizophrenics have this insight, but Mr. Duncan did. Mr. Duncan also recognized his need for medication. Although Mr. Duncan knew he had a mental illness and understood that he would always need medication, he did not want to live with the side effects of the medication. His record also noted that he did not want to live his life dependent on medication. He did what the doctors said while he was in the hospital, but he stopped taking his medication when he was not in a supervised setting, when he was out in the community.

[Insert 4 – HeHi]

DEFENSE: Was Andrew Duncan taking his medication during the time of the incident on January 3rd, 2007?

EXPERT WITNESS: No. His medical records note that he was not taking his medication, and we know that his prescription had not been filled for several weeks. A major consequence of Schizophrenia is often poor judgment, when not supervised, poor judgment associated with psychosis and confused thinking. We know that when Mr. Duncan is off his medication, it's like a downward slide from bad to worse.

[Insert 5 – HeHi]

DEFENSE: Did you have opportunities to interview Andrew Duncan when he was both on and off his medication?

EXPERT WITNESS: Yes.

[Insert 6 – HeHi]

DEFENSE: Can you tell us any differences that you might have **observed** in his medicated and un-medicated state?

EXPERT WITNESS: **Yes**. He was more psychotic off his medication; his thinking was markedly impaired.

[Insert 7 – HeHi]

DEFENSE: From the defendant’s medical records, is there any evidence that he was seeking help for his condition?

EXPERT WITNESS: Yes. In 1997, he checked himself into a psychiatric facility after becoming nervous and scared. Another time that year, he called 911 asking to be brought to the ER stating that he was confused and could not function and needed some help. In the records for a subsequent hospitalization, the patient stated [look at notes] that he wanted to study his illness and he wanted to get a degree in psychology. A few years later, he signed into yet another hospital after hearing voices and complaining that someone was trying to evaporate his brain. On his application for admission, he writes that his reasons for applying for admission are “severe Schizophrenia, hopefully will cure.”

Cross

[Insert 8 – HeHi]

PROSECUTION: **Isn’t it true, that the defendant routinely blamed his illness when confronted with problem situations, saying quote – Well, I’m not feeling well – or I need to have my medication adjusted?**

EXPERT WITNESS: Those statements were in Mr. Duncan’s record from times when he was admitted to the hospital. However, medication adjustments are common to the treatment of Schizophrenia because as the symptoms change and progress, the medications need to be monitored and adjusted.

[Insert 9 – HeHi]

PROSECUTION: **So, just to reiterate, even though the defendant knew he had a mental illness and he knew he was supposed to be on medication, Andrew Duncan was not on his medication during the offense?**

EXPERT WITNESS: **Yes, that is correct**. This is called medication noncompliance and is very common in persons with Schizophrenia for a variety of reasons. **For Mr. Duncan, it appeared to be because of his mild to moderate side effects that I mentioned earlier and his desire to live his life free of medication.**

[Insert 10 – HeHi]

PROSECUTION: **Isn’t it true that in the defendant’s hospital records from 2001, he had refused to sign a patient contract agreeing to not hit or act aggressively towards patients and staff.**

EXPERT WITNESS: **Yes. He refused because he believed his mental illness was causing these behaviors**, so he couldn’t enter into a contract that he couldn’t keep.

Medication Noncompliant (MNC)

High Elaboration and High Insight (HeLi)

- Medication Noncompliant
- **High Elaboration**
- Low Insight

Direct

[Insert 1 – HeLi]

DEFENSE: How do you, Doctor, treat people with Schizophrenia?

EXPERT WITNESS: Schizophrenia is primarily treated with antipsychotic medications that may also have some side effects. There are two forms, what are called traditional antipsychotics and newer antipsychotics. These medications are generally good at treating classic symptoms of Schizophrenia - what you would think of as psychotic symptoms – like hallucinations and delusions – but they are less effective at clearing up the thought dysfunction.

[Insert 2 – HeLi]

DEFENSE: Was Andrew Duncan treated with medications?

EXPERT WITNESS: Yes. Mr. Duncan was prescribed primarily Haldol over his years of treatment.

DEFENSE: Can you tell us a bit about Haldol and these other medications?

EXPERT WITNESS: Yes. Haldol is a traditional antipsychotic. What we call “traditional” antipsychotics are usually reserved for use when psychotic symptoms are extreme or hard to treat with the newer medications. Both forms of medication can be effective treatments, but traditional antipsychotics are sometimes preferred for treating severe psychotic symptoms.

DEFENSE: Are there side effects to these medications?

EXPERT WITNESS: Yes, there can be. Everyone’s response to medication is different. Some medications work better for some people and some side effects are more present in some patients. Traditional antipsychotics, like the ones prescribed to Mr. Duncan, they have been found to bring with them some moderate to serious side effects. For this reason, the newer medications are often preferable if possible.

DEFENSE: What are some of these side effects?

EXPERT WITNESS: In clinical studies, the *most* serious side effects found have been fatigue and dull energy, foggy thinking, significant weight gain, sexual dysfunction, and uncontrollable Parkinson’s like tremors and slowed movements. Treating physicians are trained to be on the look out for these side effects and monitor them; adjusting medications when they become significant problems, so such serious side effects are pretty rare these days.

[Insert 3 – HeLi]

DEFENSE: Did Mr. Duncan experience any of these side effects, Doctor?

EXPERT WITNESS: Medical records typically describe Mr. Duncan as responding well to the medication when he was in a supervised setting – a setting that mandated that he take his medication. His records do note some *mild to moderate* side effects of his medication regimen.

The most common side effects noted in Mr. Duncan's charts were **[looks at notes]** grogginess during the day, sleep difficulties, and some weight gain.

DEFENSE: In your clinical opinion doctor, how did Mr. Duncan react to needing medication?

EXPERT WITNESS: Both in records and when I interviewed him, Mr. Duncan did not seem to realize or understand that he was mentally ill. This is what physicians call a lack of insight into your mental illness. This lack of insight into knowing and believing you are schizophrenic is a very common.

DEFENSE: Doctor, can you explain how a person can have a mental illness and not realize it?

EXPERT WITNESS: Schizophrenics may realize something is wrong, in fact, they will often be in distress because their confusion or severe symptoms – they just are not able to understand that they have a mental illness causing these problems. Schizophrenia causes breaks from reality, mistrust of others, and disrupted thinking – all these makes it difficult for patients to understand that they are mentally ill. When hospitalized, Mr. Duncan took the advice of the psychiatrist and took his medication. Soon, however, because of his lack of insight into his mental illness, Mr. Duncan stopped taking the medication when he was in the community. He had also been dealing with some of the mild to moderate side effects of the medication. His thought disorganization and lack of understanding of his mental illness, led him to believe that he no longer needed the medication once he was feeling better.

[Insert 4 – HeLi]

DEFENSE: Was Andrew Duncan taking his medication during the time of the incident on January 3rd, 2007?

EXPERT WITNESS: No. His medical records note that he was not taking his medication, and we know that his prescription had not been filled for several weeks. Without insight - or in other words, without understanding and accepting that he was mentally ill – we can see how Mr. Duncan would not understand or believe he needed medication. This is why medication noncompliance is so commonly linked to Schizophrenia. The illness can cause the inability to understand your need for medication. Also, a major consequence of Schizophrenia is often poor judgment when not supervised, poor judgment associated with psychosis and confused thinking. We know that when Mr. Duncan is off his medication, it's like a downward slide from bad to worse.

[Insert 5 – HeLi]

DEFENSE: Did you have opportunities to interview Andrew Duncan when he was both on and off his medication?

EXPERT WITNESS: Yes.

[Insert 6 – HeLi]

DEFENSE: Can you tell us any differences that you might have observed in his medicated and un-medicated state?

EXPERT WITNESS: Yes. He was more psychotic off his medication; his thinking was markedly impaired.

[Insert 7 – HeLi]

DEFENSE: From the defendant's medical records, is there any evidence that he was seeking help for his condition?

EXPERT WITNESS: Yes. In 1997, he checked himself into a psychiatric facility after becoming nervous and scared. Another time that year, he called 911 asking to be brought to the ER stating that he was confused and could not function. A few years later, he signed into yet another hospital after hearing voices and complaining that someone was trying to evaporate his brain. Mr. Duncan was clearly in distress during these time periods, but he did not seem to realize his problems were due to a mental illness and he did not believe that taking medication would help.

Cross

[Insert 8 – HeLi]

PROSECUTION: Isn't it true, that the defendant routinely blamed his illness when confronted with problem situations, saying quote – Well, I'm not feeling well – or I need to have my medication adjusted?

EXPERT WITNESS: Those statements were in Mr. Duncan's record from times when he was admitted to the hospital. However, medication adjustments are common to the treatment of Schizophrenia because as the symptoms change and progress, the medications need to be monitored and adjusted.

[Insert 9 – HeLi]

PROSECUTION: So, just to reiterate, even though the doctors had prescribed medication, Andrew Duncan was not on his medication during the offense?

EXPERT WITNESS: Yes, that is correct. This is called medication noncompliance and is very common in persons with Schizophrenia for a variety of reasons. For Mr. Duncan, it appeared to be because of his lack of insight into his mental illness and the side effects that I mentioned earlier. Why would he take medication for an illness he does not understand he has? This is a common problem for people with Schizophrenia and can lead to medication noncompliance. It becomes a cycle of low insight – medication noncompliance – and worsening of symptoms. When they feel better, they don't understand they need to stay on the medication.

PROSECUTION: So, even though he has been treated for Schizophrenia for a decade and he is always prescribed medication in the hospital, we are supposed to believe that the defendant did not know he was sick?

EXPERT WITNESS: No. It is clear that Mr. Duncan realized something was wrong with him, (as I stated before), but because of his mental illness, he was unable to understand and accept on his own that he had a diagnosable disease called Schizophrenia and that he needed to be treated with medication.

[Insert 10 – HeLi]

PROSECUTION: Isn't it true that in the defendant's hospital records from 2001, he had refused to sign a patient contract agreeing to not hit or act aggressively towards patients and staff.

EXPERT WITNESS: Yes. He refused because he did not know why he was doing these behaviors; so he felt he couldn't enter into a contract.

Appendix I

Thought Listing Measure

The investigators are interested in what thoughts came into your mind as you were hearing the case of *State v. Duncan*. That is, you might have had thoughts that had little to do with the topic or what it had to say. Regardless, we are interested in any and all thoughts that you remember coming to mind. Please write your thoughts in the space provided on the paper. PLEASE WRITE ONLY ONE (1) "THOUGHT" PER BOX.

Don't worry about grammar or writing complete sentences, just write the basic meaning of each thought you can recall coming to mind.

1.)
2.)
3.)
4.)
5.)
6.)
7.)
8.)

Appendix J

Thought Listing Measure Coding Scheme

Adapted from Guadagno & Cialdini, 2003; Titcomb & Brodsky, under review

Total Elaboration = Sum the total number of thoughts for each juror.

Stimulus Derivation

1 = **Central** (Restatements, agreements, elaboration, disagreements, counterarguments, questions, or reactions to the argument/testimony; anything *within* the testimony that may affect decision-making)

2 = **Peripheral** (Vague reference to case argument; anything that may affect decision-making; i.e., - You can not necessarily tell why the juror is coming to his/her conclusion)

3 = **Unrelated** (Completely unrelated to the juror's decision-making process)

Thought Valence (towards the defense or expert testimony; *NOT necessarily just towards witness or defendant*)

1 = **Positive** (i.e., thought can never be considered negative)

2 = **Negative** (i.e., thought can never be considered positive)

3 = **Neutral/Irrelevant** (i.e., thought can be considered negative or positive)

Appendix K

Closing Statements

Script Derived from:

- **Black** - *People v. Goldstein*, 2005 (Case transcript)
- **Red** – Adjusted or added for the purposes of this study

COURT - Jennifer Wilson, MA (Audio Only)

Mr. Canfield, your closing statement, please.

Closing Statements: MC/C

Defense Attorney – David Sams, JD (Audio Only)

DEFENSE: Ladies and Gentlemen. Andrew Duncan lives with Schizophrenia. He has received this diagnosis **and medication** from dozens of doctors; he has the classic symptoms of this disease. His illness has become progressively worse **and the medication did not seem to be helping**. The mental health system failed Mr. Duncan by only providing a revolving door of services. **Due to the severe symptoms of his illness, Andrew committed acts of violence against others**. Andrew Duncan did not have control over himself. It wasn't a loss of control, as the State would have you believe. There was no debate in his mind of right and wrong. The experts told you this, from the moment he pushed a woman in front of the train. He wasn't there, his mind wasn't there, he wasn't debating the issue. Of course after it happened, afterwards when people tell him what happened, then he knows it's wrong. Of course, anyone knows it's wrong, but the issue is the moment he did it was his mind there? The timing of the act makes no difference if the act was not decided on with a right mind. The law states that a person is not responsible for their actions if they do not comprehend the nature and the consequences of their action or if they do not know that action is wrong. At the time of the event on the subway platform, Andrew Duncan did not know the nature of his actions. It would be unlawful to find Mr. Duncan responsible according to the law. Thank you.

COURT - Jennifer Wilson, MA (Audio Only)

Mr. Green, you may give your closing statement.

Prosecutor – Jason Wilson, JD (Audio Only)

PROSECUTION: Thank you. Ladies and Gentlemen, Andrew Duncan is mentally ill **and he takes medication for that**. As you saw earlier, Andrew Duncan was reporting symptoms that are not characteristic of Schizophrenia or any other known mental illness. He has a motive to exaggerate his symptoms here, as he has had a motive to in the past. And with past violent episodes, he has always tried to avoid punishment. If Andrew Duncan was exaggerating his Schizophrenia symptoms, and there is evidence that he was, then he did know what he was doing on that awful day and he did know what he was doing was wrong. Andrew Duncan had a pretty good day that fateful day for Katelyn Webber. That day, he visited places he wanted to visit and enjoyed things he wanted to enjoy. He is claiming he couldn't control himself because he knows he can get away with it. He knows that the law does make this exception for truly mentally ill people. With people like Andrew Duncan abusing the system in this way, how can we protect our citizens? He needs to be found responsible for this crime. He understood the nature of his behavior at the time, its consequences, and that it was wrong. Thank you.

Closing Statements: MNC/LeHi

DEFENSE: Ladies and Gentlemen. Andrew Duncan lives with Schizophrenia. He has received this diagnosis **and medication** from dozens of doctors; he has the classic symptoms of this disease. His illness has become progressively worse **and the medication did not seem to be helping, he stopped taking it.** The mental health system failed Mr. Duncan by only providing a revolving door of services. **Andrew Duncan refused to take his medication. Due to the severe symptoms of his illness, Andrew committed acts of violence against others.** Andrew Duncan did not have control over himself. It wasn't a loss of control, as the State would have you believe. There was no debate in his mind of right and wrong. The experts told you this, from the moment he pushed a woman in front of the train. He wasn't there, his mind wasn't there, he wasn't debating the issue. Of course after it happened, afterwards when people tell him what happened, then he knows it's wrong. Of course, anyone knows it's wrong, but the issue is the moment he did it was his mind there? The timing of the act makes no difference if the act was not decided on with a right mind. The law states that a person is not responsible for their actions if they do not comprehend the nature and the consequences of their action or if they do not know that action is wrong. At the time of the event on the subway platform, Andrew Duncan did not know the nature of his actions. It would be unlawful to find Mr. Duncan responsible according to the law. Thank you.

PROSECUTION: Thank you. Ladies and Gentlemen, Andrew Duncan is mentally ill **and although he was prescribed medication, he did not take it.** As you saw earlier, Andrew Duncan was reporting symptoms that are not characteristic of Schizophrenia or any other known mental illness. He has a motive to exaggerate his symptoms here, as he has had a motive to in the past. And with past violent episodes, he has always tried to avoid punishment. If Andrew Duncan was exaggerating his Schizophrenia symptoms, and there is evidence that he was, then he did know what he was doing on that awful day and he did know what he was doing was wrong. Andrew Duncan had a pretty good day that fateful day for Katelyn Webber. That day, he visited places he wanted to visit and enjoyed things he wanted to enjoy. He is claiming he couldn't control himself because he knows he can get away with it. He knows that the law does make this exception for truly mentally ill people. With people like Andrew Duncan abusing the system in this way, how can we protect our citizens? He needs to be found responsible for this crime. He understood the nature of his behavior at the time, its consequences, and that it was wrong. Thank you.

Closing Statements: MNC/LeLi

DEFENSE: Ladies and Gentlemen. Andrew Duncan lives with Schizophrenia. He has received this diagnosis **and medication** from dozens of doctors; he has the classic symptoms of this disease. His illness has become progressively worse **and the medication did not seem to be helping, he stopped taking it.** The mental health system failed Mr. Duncan by only providing a revolving door of services. **Andrew Duncan failed to take his medication. Due to the severe symptoms of his illness, Andrew committed acts of violence against others.** Andrew Duncan did not have control over himself. It wasn't a loss of control, as the State would have you believe. There was no debate in his mind of right and wrong. The experts told you this, from the moment he pushed a woman in front of the train. He wasn't there, his mind wasn't there, he wasn't debating the issue. Of course after it happened, afterwards when people tell him what happened, then he knows it's wrong. Of course, anyone knows it's wrong, but the issue is the moment he did it was his mind there? The timing of the act makes no difference if the act was not decided on with a right mind. The law states that a person is not responsible for their actions if they do not comprehend the nature and the consequences of their action or if they do not know that action is wrong. At the time of the event on the subway platform, Andrew Duncan did not know the nature of his actions. It would be unlawful to find Mr. Duncan responsible according to the law. Thank you.

PROSECUTION: Thank you. Ladies and Gentlemen, Andrew Duncan is mentally ill **and although he was prescribed medication, he did not take it.** As you saw earlier, Andrew Duncan was reporting symptoms that are not characteristic of Schizophrenia or any other known mental illness. He has a motive to exaggerate his symptoms here, as he has had a motive to in the past. And with past violent episodes, he has always tried to avoid punishment. If Andrew Duncan was exaggerating his Schizophrenia symptoms, and there is evidence that he was, then he did know what he was doing on that awful day and he did know what he was doing was wrong. Andrew Duncan had a pretty good day that fateful day for Katelyn Webber. That day, he visited places he wanted to visit and enjoyed things he wanted to enjoy. He is claiming he couldn't control himself because he knows he can get away with it. He knows that the law does make this exception for truly mentally ill people. With people like Andrew Duncan abusing the system in this way, how can we protect our citizens? He needs to be found responsible for this crime. He understood the nature of his behavior at the time, its consequences, and that it was wrong. Thank you.

Closing Statements: MNC/HeHi

DEFENSE: Ladies and Gentlemen. Andrew Duncan lives with Schizophrenia. He has received this diagnosis **and medication** from dozens of doctors; he has the classic symptoms of this disease. His illness has become progressively worse **and the medication did not seem to be helping, he stopped taking it. Many schizophrenics refuse to comply with taking medication or need supervision to ensure compliance.** The mental health system failed Mr. Duncan by only providing a revolving door of services. **Due to the severe symptoms of his illness, Andrew committed acts of violence against others. That day on the platform, we know he was off his medication and the expert showed how this coincides with a deterioration of Andrew's illness.** Andrew Duncan did not have control over himself. It wasn't a loss of control, as the State would have you believe. There was no debate in his mind of right and wrong. The experts told you this, from the moment he pushed a woman in front of the train. He wasn't there, his mind wasn't there, he wasn't debating the issue. Of course after it happened, afterwards when people tell him what happened, then he knows it's wrong. Of course, anyone knows it's wrong, but the issue is the moment he did it was his mind there? The timing of the act makes no difference if the act was not decided on with a right mind. The law states that a person is not responsible for their actions if they do not comprehend the nature and the consequences of their action or if they do not know that action is wrong. At the time of the event on the subway platform, Andrew Duncan did not know the nature of his actions. It would be unlawful to find Mr. Duncan responsible according to the law. Thank you.

PROSECUTION: Thank you. Ladies and Gentlemen, Andrew Duncan is mentally ill **and although he was prescribed medication, he chose not take it.** As you saw earlier, Andrew Duncan was reporting symptoms that are not characteristic of Schizophrenia or any other known mental illness. He has a motive to exaggerate his symptoms here, as he has had a motive to in the past. And with past violent episodes, he has always tried to avoid punishment **and he has not been on his medication. That day on the platform, he was not on his medication – [with emphasis] he chose not to take his medication.** If Andrew Duncan was exaggerating his Schizophrenia symptoms, and there is evidence that he was, then he did know what he was doing on that awful day and he did know what he was doing was wrong. Andrew Duncan had a pretty good day that fateful day for Katelyn Webber. That day, he visited places he wanted to visit and enjoyed things he wanted to enjoy. He is claiming he couldn't control himself because he knows he can get away with it. He knows that the law does make this exception for truly mentally ill people. With people like Andrew Duncan abusing the system in this way, how can we protect our citizens? He needs to be found responsible for this crime. He understood the nature of his behavior at the time, its consequences, and that it was wrong. Thank you.

Closing Statements: MNC/HeLi

DEFENSE: Ladies and Gentlemen. Andrew Duncan lives with Schizophrenia. He has received this diagnosis **and medication** from dozens of doctors; he has the classic symptoms of this disease. His illness has become progressively worse **and the medication did not seem to be helping, he stopped taking it. Many schizophrenics, because of thought disorganization and confusion, fail to comply with taking medication. He believed that the doctors were poisoning him with cyanide. Other times, when he was feeling better, he no longer understood that he needed to stay on the medication.** The mental health system failed Mr. Duncan by only providing a revolving door of services. **Due to the severe symptoms of his illness, Andrew committed acts of violence against others. That day on the platform, we know he was off his medication and the expert showed how this coincides with a deterioration of Andrew's illness.** Andrew Duncan did not have control over himself. It wasn't a loss of control, as the State would have you believe. There was no debate in his mind of right and wrong. The experts told you this, from the moment he pushed a woman in front of the train. He wasn't there, his mind wasn't there, he wasn't debating the issue. Of course after it happened, afterwards when people tell him what happened, then he knows it's wrong. Of course, anyone knows it's wrong, but the issue is the moment he did it was his mind there? The timing of the act makes no difference if the act was not decided on with a right mind. The law states that a person is not responsible for their actions if they do not comprehend the nature and the consequences of their action or if they do not know that action is wrong. At the time of the event on the subway platform, Andrew Duncan did not know the nature of his actions. It would be unlawful to find Mr. Duncan responsible according to the law. Thank you.

PROSECUTION: Thank you. Ladies and Gentlemen, Andrew Duncan is mentally ill **and although he was prescribed medication, he did not take it.** As you saw earlier, Andrew Duncan was reporting symptoms that are not characteristic of Schizophrenia or any other known mental illness. He has a motive to exaggerate his symptoms here, as he has had a motive to in the past. And with past violent episodes, he has always tried to avoid punishment **and he has not been on his medication. That day on the platform, he was not on his medication – regardless of the reason, he wasn't taking it.** If Andrew Duncan was exaggerating his Schizophrenia symptoms, and there is evidence that he was, then he did know what he was doing on that awful day and he did know what he was doing was wrong. Andrew Duncan had a pretty good day that fateful day for Katelyn Webber. That day, he visited places he wanted to visit and enjoyed things he wanted to enjoy. He is claiming he couldn't control himself because he knows he can get away with it. He knows that the law does make this exception for truly mentally ill people. With people like Andrew Duncan abusing the system in this way, how can we protect our citizens? He needs to be found responsible for this crime. He understood the nature of his behavior at the time, its consequences, and that it was wrong. Thank you.

Appendix L

Judge's Charge (Instructions) to the Jury

Script Derived from:

- **Purple** - Colquitt, 1994 (AL Pattern Judge's Instructions)
- **Black** - *People v. Goldstein*, 2005 (Case transcript)
- **Blue** - Titcomb & Brodsky, under review (Titcomb's thesis – piloted and finalized script)
- **Brown** – Wording adjusted slightly for logistics/truncating instructions
- **Red** – Adjusted based on Pilot results

Read by: Jennifer Wilson, MA (audio only) (*Word Count – 954*)

Jurors, before you deliberate I have to explain the rules of law which you must follow in order to be fair to both sides. **Remember to begin your deliberations by presuming the defendant innocent of the charge.** Follow the law and not just what you might personally think is just.

You have three verdict options. Your duty as a juror is determine if the defendant is guilty, not guilty by reason of insanity, or not guilty. **Recall that the Prosecution is trying to prove the defendant to be guilty. The Defense is trying to show that the defendant is Not Guilty by Reason of Insanity.**

This is the guilt phase of the trial. Thus, sentencing comes later and should not be considered now **or in your deliberations.** You are not to consider the punishment if the defendant is found guilty or not guilty by reason of insanity when you are determining your verdict.

Essentially we have two trials here. **In your first decision, you must determine if the state has proved the elements of the crimes. The question to ask yourself is “Is the defendant’s guilt established?” If so, then your second decision is to determine if the defendant is criminally responsible for that crime or if he is “Not Guilty by Reason of Insanity.”**

To make this first decision, start your deliberations by presuming the defendant’s innocence. Before a conviction can be had in this case, **you must** all agree **unanimously** that the State’s credible evidence shows the defendant’s guilt beyond a reasonable doubt.

The phrase “reasonable doubt” is self-explanatory. It is a doubt based upon reason and common sense. The law does not require proof beyond *all* doubt – **a reasonable or very little amount of doubt can remain.** So, **first you go over in your minds the entire case and give consideration to all the testimony. Then you consider the amount of doubt you have remaining.** If you have **no** doubt or **very little** (less than a reasonable amount) of doubt left, then the State has proved the defendant did the crime. If a small amount of personal doubt remains – as long as it’s not too unreasonable or too much, then the State has proven that the crime happened the way they said it did. However, if you are left with a reasonable doubt or more **that it happened the way the State says,** then the defendant is entitled to the benefit of that doubt, and you should find him NOT GUILTY [**Instruction I.4**].

The charge you need to consider is Murder in the Second Degree. To convict, the State must prove each of the following: 1) That Katelyn Webber is dead; 2) That the defendant Mr. Duncan caused her death; and 3) That in doing so, the defendant either intended to cause or death OR that he was aware of the grave risk to Ms. Webber's life, but consciously disregarded this foreseeable risk [**Instruction 6.3, Ala. Code 13A-6-2a(2)**].

The defendant has pled not guilty by reason of insanity. So if you decide that the defendant committed the crime, you must then make a second decision. This is where you consider the defendant's **defense** that he nevertheless is *not* criminally responsible *because* of a severe mental disease or defect. **The defense must show this. They must show that first that** the defendant was suffering from a severe mental disease; **and second** that as a result of this mental disease, he was **either** (a) was unable to appreciate the nature and quality, *or consequences* of his acts or (b) he was unable to appreciate the wrongfulness of his acts.

So, you **are not** just determining if the defendant has a mental illness because some mentally ill people can be responsible for their criminal conduct. To be found **not** responsible, the defense must also show **one of three things happened because** of his mental disease or defect. **These three things are either** the defendant did *not know what he was doing, or that he did not know the consequences of his actions, or that he was unable to know that his actions were wrong.* **Wrong** is used in its broadest sense, including what was legally wrong, **as well as** what ordinary people commonly understand to be morally wrong, bad or evil.

The defense must prove this with a preponderance of the evidence. **This is just a legal term for proving something with a majority of the evidence (as opposed to requiring something be proven with all of the evidence).** A **preponderance of the evidence** means that the degree of certainty should be **more certain** than it is *uncertain* that the defendant was **not** criminally responsible. If the defendant was *not* criminally responsible for the act *due to his state of mind at the time of the offense*, then you must find him Not Guilty By Reason of Insanity because his mind essentially was incapable of committing a crime.

Your first task at the start of the deliberation is to select a jury foreperson, for example, by majority vote. Deliberations should not begin until the foreperson is selected. The **foreperson's role** is to preside over the discussion of the case and to act as chairperson for the jury when communicating with the Judge. **When you have reached a verdict in this case, then you will complete the verdict form and the foreperson will submit the verdict.**

Any verdict returned must be the verdict of all six of you; that is, it must be a unanimous verdict. It is your duty as jurors to be open-minded, to consult with one another to deliberate with the goal of reaching agreement. Each of you must decide the case for yourself, but only after impartial consideration of the evidence.

Appendix M

Hung Jury Instructions to the Jury

Script Derived from:

- **Purple** - Colquitt, 1994 (AL Pattern Judge's Instructions)

Read by: Jennifer K. Wilson, MA (audio only) (*Word Count - 299*)

Members of the jury, I am sorry to hear that you are unable to reach a verdict. The Court cannot release you at this time. You should make further efforts to arrive at a verdict. Each juror is entitled to his or her opinion of the evidence, but if you cannot agree, a mistrial would be declared and this case would have to be tried again. There is no reason to believe that another jury would have better or clearer evidence than has been presented to you.

This does not mean that you should surrender an honest conviction as to the weight or the effect of any evidence solely because of the opinion of other jurors or because of the importance of arriving at a decision. But you should give respectful consideration to each other's views and talk over any differences of opinion in a spirit of fairness and candor. If possible, you should resolve any differences and come to a common conclusion so that the case may be completed. I would be happy to give you any explanatory charge of the law.

It is natural that differences of opinion will arise. When they do, each juror should not only express his opinion, but the facts and reasons upon which he bases that opinion. By reasoning the matter out, it may be possible for all jurors to agree. What I have said to you must not be taken as an attempt on the part of the Court to require or force you to surrender your honest and reasonable convictions founded upon the law and the evidence in this case. My sole purpose is to impress upon you your duty and the desirability and importance of reaching a verdict if you can conscientiously do so. You may continue your deliberations.

Appendix N

Pattern jury instruction's recommended voting ballot.

Session ID: _____

Foreperson ID: _____

Jury Verdict Form

State vs. Andrew Duncan

GUILTY VERDICT

We, the jury, find the defendant Andrew Duncan guilty of the offense of Second Degree Murder as charged in the indictment.

Foreperson

NOT GUILTY VERDICT

We, the jury, find the defendant Andrew Duncan not guilty of the offense of Second Degree Murder as charged in the indictment.

Foreperson

NOT GUILTY BY REASON OF SEVERE MENTAL DISEASE OR DEFECT VERDICT

We, the jury, find the defendant Andrew Duncan not guilty by reason of severe mental disease or defect of the offense of Second Degree Murder as charged in the indictment.

Foreperson

Appendix P

Debriefing Form

To the participant:

If you have any questions or concerns following this session, you may contact the primary investigator, Caroline Titcomb, at ctitcomb@crimson.ua.edu. Further, you may contact the faculty supervisor, Stanley Brodsky, Ph.D., at sbrodsky@bama.ua.edu. Dr. Brodsky is a licensed clinical psychologist and is available if any aspect of participation is upsetting. If you have questions about your rights as a person taking part in a research study, you may call the Research Compliance Officer at UA at (205) 348-8461.

The overall purpose of the present study is to examine how mock jurors processed evidence in a Not Guilty by Reason of Insanity case where the defendant was not compliant with his medication. We wanted to learn about how jurors considered this evidence. For example, did they consider evidence of medication noncompliance a great deal in their decisions? Did they blame the defendant for not taking his medication? Therefore, we manipulated whether the defendant in the trial was on or off his medication at the time of the offense. We also adjusted things like whether the defendant had high or low insight or awareness into his need for medication. Finally, we manipulated how the expert presented this evidence to see what impact a strong versus weak explanation of medication noncompliance and insight into one's mental illness would have on mock jurors' understanding of the evidence. So, while this research is based on a real case, the videos were created here in our research lab to create these specific scenarios. Your condition had the defendant [on/off] his medication, having [high/low] insight into his mental illness and need for treatment, and had the expert present a [strong, weak, general] explanation of these facts.

Participants were not told the full purpose of the study during the research session, so that the study's aims would not bias how you interpreted the evidence. This withholding was used because research shows that participants would have a hard time evaluating the evidence as a real juror might if they were told to attend to medication noncompliance evidence. If you have any concerns about this withholding feel free to contact any of the above listed individuals.

Also, this study is concerned with how personality variables, as well as attitudes toward the legal system and insanity defense, may affect impressions of the defendant or verdict, which is why you answered questionnaires concerning some of your characteristics and thoughts about these constructs.

Please refrain from discussing this study with any friend, roommates, colleagues, etc. It is absolutely critical that other participants do not know the true nature of the study before they participate in it.

If you want to obtain the results of the study once it is complete, you may email the primary investigator. She will then keep your contact information on file and send the results once the data has been analyzed. Thank you for taking the time to participate in this study. Your cooperation is appreciated.

Sincerely,

Caroline Titcomb, MA
Department of Psychology
The University of Alabama
359C Gordon Palmer Hall
ctitcomb@crimson.ua.edu

Appendix Q

Verdict Form

Instructions: Please answer the following questions by placing a  mark on the one answer that best represents your opinion for each question.

1. What is your verdict?

1	2	3
Guilty	Not Guilty by Reason of Insanity (NGRI)	Not Guilty

**IF YOU ANSWERED (1, Guilty) OR (2, NGRI) FOR ITEM #1,
PLEASE ANSWER THE FOLLOWING QUESTIONS #2 THROUGH #5:**

2. Is the defendant guilty?

1	2	3	4	5	6	7
Definitely NGRI			Neutral			Definitely Guilty

3. How confident are you about that verdict?

1	2	3	4	5	6	7
Not at all Confident			Neutral			Very Confident

4. What should the level of punishment be?

1	2	3	4	5	6	7
As lenient as possible			Neutral			As harsh as possible

5. How committed to your sentencing decision are you?

1	2	3	4	5	6	7
Not at all Confident			Neutral			Very Confident

Appendix R

Meta-Responsibility Questionnaire (MRQ)

Please rate your level of **agreement** with the following statements using the below scale:

1	2	3	4	5	6	7
Strongly disagree		Somewhat disagree		Somewhat agree		Strongly agree

1. _____ The defendant has a duty to take responsibility for his own illness.
2. _____ The defendant understood that he was ill.
3. _____ The defendant caused his own illness.
4. _____ The defendant killed the victim because of his illness.
5. _____ The defendant's illness affected his ability to look after himself (e.g., take his medication) and resist getting more ill.
6. _____ The defendant liked being ill.
7. _____ The defendant should have resisted his illness more.
8. _____ The defendant should have been more careful in taking his medication.
9. _____ The defendant made his illness worse through his own fault.
10. _____ The defendant knowingly did or did not comply with his medication.
11. _____ The defendant willingly did or did not comply with his medication.
12. _____ The defendant intelligently did or did not comply with his medication.
13. _____ The defendant has a weak character.
14. _____ The defendant's mental illness damage's his social reputation.

Appendix S

Witness Credibility Scale (WCS)

Instructions: Please rate the *defense expert witness* for the following items on the scale provided. If you are unsure, please take your BEST GUESS.

Example:

1	2	3	4	5	6	7	8	9	10
<i>Dressed Formally</i>					<i>Dressed Informally</i>				

1	2	3	4	5	6	7	8	9	10
Unfriendly					Friendly				

1	2	3	4	5	6	7	8	9	10
Disrespectful					Respectful				

1	2	3	4	5	6	7	8	9	10
Unkind					Kind				

1	2	3	4	5	6	7	8	9	10
Ill-mannered					Well-mannered				

1	2	3	4	5	6	7	8	9	10
Unpleasant					Pleasant				

1	2	3	4	5	6	7	8	9	10
Untrustworthy					Trustworthy				

1	2	3	4	5	6	7	8	9	10
Untruthful					Truthful				

1	2	3	4	5	6	7	8	9	10
Undependable					Dependable				

1	2	3	4	5	6	7	8	9	10
Dishonest					Honest				

1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	----

Unreliable

Reliable

1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	----

Not confident

Confident

1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	----

Inarticulate

Well-spoken

1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	----

Tense

Relaxed

1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	----

Shaken

Poised

1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	----

Not Self-Assured

Self-Assured

1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	----

Uninformed

Informed

1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	----

Illogical

Logical

1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	----

Uneducated

Educated

1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	----

Unwise

Wise

1	2	3	4	5	6	7	8	9	10
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Unscientific

Scientific

Appendix T

Revised Legal Attitudes Questionnaire (RLAQ-23)

Instructions: *Indicate your level of agreement with each of the following items by pairing each item with a number based on this scale:*

1	2	3	4	5	6
Strongly Disagree	Disagree	Slightly Disagree	Slightly Agree	Agree	Strongly Agree

- ___ Unfair treatment of underprivileged groups and classes is the chief cause of crime.
- ___ Too many obviously guilty persons escape punishment because of legal technicalities.
- ___ Evidence illegally obtained should be admissible in court if such evidence is the only way of obtaining a conviction.
- ___ Search warrants should clearly specify the person or things to be seized.
- ___ No one should be convicted of a crime on the basis of circumstantial evidence, no matter how strong such evidence is.
- ___ There is no need in a criminal case for the accused to prove his innocence beyond a reasonable doubt.
- ___ Any person who resists arrest commits a crime.
- ___ When determining a person's guilt or innocence, the existence of a prior arrest record should not be considered.
- ___ Wiretapping by anyone and for any reason should be completely illegal.
- ___ Defendants in a criminal case should be required to take the witness stand.
- ___ All too often, minority group members do not get fair trials.
- ___ Because of the oppression and persecution minority group members suffer, they deserve leniency and special treatment in the courts.
- ___ Citizens need to be protected against excess police power as well as against criminals.
- ___ It is better for society that several guilty men be freed than one innocent one wrongfully imprisoned.
- ___ Accused persons should be required to take lie-detector tests.
- ___ When there is a "hung" jury in a criminal case, the defendant should always be freed and the indictment dismissed.
- ___ A society with true freedom and equality for all would have very little crime.
- ___ It is moral and ethical for a lawyer to represent a defendant in a criminal case even when he believes his client is guilty.
- ___ Police should be allowed to arrest and question suspicious looking persons to determine whether they have been up to something illegal.
- ___ The law coddles criminals to the detriment of society.
- ___ The freedom of society is endangered as much by overzealous law enforcement as by the acts of individual criminals.
- ___ In the long run, liberty is more important than order.
- ___ Upstanding citizens have nothing to fear from the police.

Appendix U

Insanity Defense Attitudes Scale – Revised (IDAR)

Instructions: *On the following pages, you will find statements that express commonly held opinions about the insanity defense. We would like to know how much you agree or disagree with each of these statements. Indicate your level of agreement with each of the following items by pairing each item with a number based on this scale:*

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Instructions: Please place a ✓ mark over the corresponding number.

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

Not at all	1	2	3	4	5	6	7	Very Strongly
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21. How personally important is your opinion on the insanity defense?

Not at all	1	2	3	4	5	6	7	Very Important
------------	---	---	---	---	---	---	---	----------------

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

Not at all	1	2	3	4	5	6	7	Very Much
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Appendix V

Need for Cognition Scale, Short Form

Instructions: *For each of the statements below, please indicate to what extent the statement is characteristic of you. Please use the following scale:*

1	2	3	4	5
Extremely Uncharacteristic of Me <i>(Not at all like me)</i>	Somewhat Uncharacteristic of Me	Uncertain	Somewhat Characteristic of Me	Extremely Characteristic of Me <i>(Very much like me)</i>

- ___ I would prefer complex to simple problems.
- ___ I like to have the responsibility of handling a situation that requires a lot of thinking.
- ___ Thinking is not my idea of fun.
- ___ I would rather do something that requires little thought than something that is sure to challenge my thinking abilities.
- ___ I try to anticipate and avoid situations where there is likely chance I will have to think in depth about something.
- ___ I find satisfaction in deliberating hard and for long hours.
- ___ I only think as hard as I have to.
- ___ I prefer to think about small, daily projects to long-term ones.
- ___ I like tasks that require little thought once I've learned them.
- ___ The idea of relying on thought to make my way to the top appeals to me.
- ___ I really enjoy a task that involves coming up with new solutions to problems.
- ___ Learning new ways to think doesn't excite me very much.
- ___ I prefer my life to be filled with puzzles that I must solve.
- ___ The notion of thinking abstractly is appealing to me.
- ___ I would prefer a task that is intellectual, difficult, and important to one that is somewhat important but does not require much thought.
- ___ I feel relief rather than satisfaction after completing a task that required a lot of mental effort.
- ___ It's enough for me that something gets the job done; I don't care how or why it works.
- ___ I usually end up deliberating about issues even when they do not affect me personally.

Appendix W

Big Five Mini-Marker (BFMM)

How accurately can you describe yourself?

Instructions: Please use this list of common human traits to describe yourself as accurately as possible. Describe yourself as you see yourself **at the present time**, not as you wish to be in the future. Describe yourself as you **are generally or typically**, as compared with other persons you know of the same sex and of roughly your same age.

Before each trait, please **write a number** indicating how accurately that trait describes you, using the following rating scale:

1	2	3	4	5	6	7	8	9
Extremely Inaccurate	Very Inaccurate	Moderately Inaccurate	Slightly Inaccurate	Neither Inaccurate nor Accurate	Slightly Accurate	Moderately Accurate	Very Accurate	Extremely Accurate

- | | | | |
|------------------|------------------|-------------------|--------------------|
| ___ Bashful | ___ Energetic | ___ Moody | ___ Systematic |
| ___ Bold | ___ Envious | ___ Organized | ___ Talkative |
| ___ Careless | ___ Extraverted | ___ Philosophical | ___ Temperamental |
| ___ Cold | ___ Fretful | ___ Practical | ___ Touchy |
| ___ Complex | ___ Harsh | ___ Quiet | ___ Uncreative |
| ___ Cooperative | ___ Imaginative | ___ Relaxed | ___ Unenvious |
| ___ Creative | ___ Inefficient | ___ Rude | ___ Unintellectual |
| ___ Deep | ___ Intellectual | ___ Shy | ___ Unsympathetic |
| ___ Disorganized | ___ Jealous | ___ Sloppy | ___ Warm |
| ___ Efficient | ___ Kind | ___ Sympathetic | ___ Withdrawn |

Appendix X

Participant Reaction Form (PRF)

INSTRUCTIONS

1. The **Prosecution** is trying to show that the defendant is _____. The **Defendant** entered a plea of _____ in this case. What does this plea try to show? _____

2. If you found that the defendant **DID** do the crime, what **decision** did you have to make **next**?

3. How would you rate your comprehension of the judge's instructions?

1	2	3	4	5	6	7	8	9	10
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Did Not Understand

Completely Understood

EXPERT TESTIMONY

4. How much did the expert witness' testimony **INFLUENCE** your verdict?

1	2	3	4	5	6	7	8	9	10
----------	----------	----------	----------	----------	----------	----------	----------	----------	-----------

Not at all

Very much

5. Rate the **OVERALL STRENGTH** of the expert's testimony?

1	2	3	4	5	6	7	8	9	10
----------	----------	----------	----------	----------	----------	----------	----------	----------	-----------

Very WEAK

Very STRONG

6. How **PERSUASIVE/CONVINCING** was the expert's testimony?

1	2	3	4	5	6	7	8	9	10
----------	----------	----------	----------	----------	----------	----------	----------	----------	-----------

Not at all Persuasive

VERY persuasive

7. How **INFORMATIVE** was the expert's testimony?

1	2	3	4	5	6	7	8	9	10
----------	----------	----------	----------	----------	----------	----------	----------	----------	-----------

Not at all Informative

VERY informative

KNOWLEDGE CHECK

8. Was the defendant taking his medication at the time of the crime? ____ **YES** ____ **NO**

IF NOT, why was he NOT taking his medication? _____

9. Did the defendant understand he had a mental illness? ____ YES ____ NO

If NOT, why did he NOT understand he had a mental illness? _____

If NOT, What or Who is to blame for the defendant not taking his medication? _____

DECISION-MAKING

10. How much did the DELIBERATION change your original opinion about the defendant's blameworthiness?

1	2	3	4	5	6	7	8	9	10
----------	----------	----------	----------	----------	----------	----------	----------	----------	-----------

Not at all

*Completely
Reversed it*

11. If DELIBERATION did change your opinion, how so? ____ Defendant MORE to blame; ____ Defendant LESS to blame. Please explain: _____

12. How much is the defendant AT BLAME for HIS MENTAL STATE at the time of the crime?

1	2	3	4	5	6	7	8	9	10
----------	----------	----------	----------	----------	----------	----------	----------	----------	-----------

Not at all

100%

13. How much did the defendant's medication compliance (or noncompliance) impact your verdict?

1	2	3	4	5	6	7	8	9	10
----------	----------	----------	----------	----------	----------	----------	----------	----------	-----------

Not at all

*Minor
Influence*

*Moderate
influence*

*Major
Factor*

14. If MEDICATION compliance (noncompliance) did impact your opinion, how so?

____ Defendant MORE to blame; ____ Defendant LESS to blame. Please explain: _____

PARTICIPATION CHECK

15. Did you take this study seriously? Please be honest. ____ NO ____ YES

16. Had you heard anything about this study prior to participating? ____ NO ____ YES

Appendix Y

Experience with Mental Illness Questionnaire (EMQ)

1. Have you or anyone close to you ever taken any courses or training in or worked in the field of mental health or with people who have mental health issues? ___NO ___YES, IF YES, is this:
 you spouse/partner child relative friend

Please explain: _____

2. Have you or anyone close to you ever suffered from an emotional problem or mental illness of any kind? ___No ___YES, IF YES, is this: you spouse/partner child relative friend

Please explain: _____

3. Have you, anyone in your family, or anyone close to you ever received counseling for any kind of emotional, family or psychological problem or for a mental illness of some kind? ___NO ___YES, IF YES, is this: you spouse/partner child relative friend

Please explain: _____

4. Have you, anyone in your family, or anyone close to you used medications for emotional or psychological problems? ___NO ___YES, IF YES, is this: you spouse/partner child relative friend

4a. Please explain: _____

4b. Was this medication helpful? ___NO ___YES

4c. Did you, or your family member, or person close to you have any side effects from using this medication? ___NO ___YES, IF YES, what side effects: _____

5. Do you think that anyone can overcome any kind of mental health problem if they try hard enough? ___NO ___YES, IF YES, Please explain your thoughts on this: _____

6. Are any of your answers to the questions in this questionnaire so personal that you would not want them to be discussed in front of other jurors? ___NO ___YES, if YES, what item #? _____

Appendix Z

Demographic Questionnaire
(DEM)

1. My gender is:

Male Female Other

2. I consider myself to be:

African American Native American Asian
 Pacific Islander Biracial Caucasian
 Hispanic Other (Specify _____)

5. Total household income per year - your best estimate

\$10,000 or less \$100,000 or higher
 \$10,001 - 50,000 Don't have any idea
 \$50,001 - 100,000 Prefer not to report

6. On a scale of 10 to 1, with 10 being "extremely religious" and 1 being "Not at all religious", I consider myself to be: (PLEASE CIRCLE ONE NUMBER)

Not at all Religious	1	2	3	4	5	6	7	8	9	10	Extremely Religious
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7. I am _____ years old.

8. Freshman _____ Sophomore _____ Junior _____ Senior _____ Other _____

9. Major: _____

10. What part of the country are you from? South__ North__ Midwest__ West__ NA__

10. Have you ever been a juror for either a civil or criminal trial? YES__ or NO__

9a. If yes, what was your verdict? _____

11. Have you ever been a juror for a not guilty by reason of insanity case? YES__ or NO__

10a. If yes, what was your verdict? _____

12. What is your political orientation? PLEASE CIRCLE ONE NUMBER:

Very Liberal	1	2	3	4	5 Moderate	6	7	8	9	10	Very Conservative
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Appendix AA

*Research recruitment description for sessions **with** focus group participation.*

The following information will be provided on the psychology research pool website to describe the study (along with the IRB approval code for the study):

.....

Study Name – “Criminal trial: You be the juror!”

Description - Participants will be asked to read a short fact sheet about an actual criminal case where the defendant is charged with 2nd degree murder. The participants will then view a videotaped excerpt of testimony from the trial, participate in a mock-jury deliberation, and complete a written questionnaire about the case and about oneself. Participants will then participate in a group discussion about their thoughts on the case and how they reached their decisions.

Participation generally should not take the full 3.5 hours.

Eligibility Requirements – Participants must be 18 years of age or older.

Duration – 210 minutes (3.5 hours)

Credits – 5.5 Credits

Researchers – Caroline Titcomb, MA

Email: ctitcomb@crimson.ua.edu

Office: 359C Gordon Palmer

Appendix BB

Focus group schedule.

Focus Group Schedule

Date: _____ Session ID: _____ Start Time: _____ End Time: _____

Introduction

- Thank participants
- Orient them to the purpose of the focus group
- Ground rules (confidentiality, video-camera, audio-recording, talking time)

Answer Questions

Standardized Questions (Ask to all focus groups – *Optional prompts*)

- 1. How did the **defendant's medication compliance** influence your decision-making in this case? Did it make him more or less blameworthy?
 - Did it make him more or less responsible for his behavior*
 - Did the defendant's medication non/compliance play into your verdict vote?*
- 2. How did hearing about the defendant's **insight** – or understanding - into his mental illness affect your decision?
 - Did it make him more or less responsible for his behavior*
 - Did the defendant's insight play into your verdict vote?*
- 3. What's **something new that you learned** (if anything) from the expert about the mental illness or medication compliance?
 - Was this information helpful in making your decision?
 - Did you learn something new about medication compliance and schizophrenia?*
 - Did you learn something new about insight and mental illness?*
- 4 What **stood out to you most** – had the most impact - about the defendant's mental illness and treatment in this case?

Additional Questions (if necessary, time permitting)

- What else did you want to hear from the expert about the defendant's mental illness or medication compliance?*
- How did the **expert's testimony** influence your decisions about the defendant's blameworthiness in this case?*

Close of Session

- Reiterate thank you and answer questions
- Introduce follow-up questionnaire

Appendix CC

Match between research questions and focus group schedule questions.

Research Questions	<i>Quantitative Hypotheses</i>	<i>Qualitative Questions</i>
<p>Do jurors consider medication (non)compliance in their MSO and verdict determinations?</p> <p>Does “meta-responsibility” for one’s illness come into play in these decisions? If so, what is the role of medication (non)compliance in this meta-responsibility issue?</p> <p>Does MNC increase defendant blame and MR determinations?</p> <p>Does MNC lessen the likelihood of a NGRI verdict?</p>	<p><u>H1: Medication Compliance</u></p> <p>H1a: MNC will predict meta-responsibility determinations (positive relationship).</p> <p>H1b: MNC will predict NGRI determinations (negative relationship).</p> <p>H1c: Medication compliance will exert no overall effect on meta-responsibility or verdict.</p>	<p>What did you think about the defendant in this case?</p> <p>What stood out to you most about the defendant’s mental illness and treatment in this case?</p> <p>What did you think about the defendant’s medication compliance?</p> <p>How did the defendant’s medication compliance influence your decision-making in this case?</p> <p>Did the defendant’s medication (non)compliance play into your verdict in this case?</p>
<p>What influence does the quality (strength) of expert witness testimony have on verdict and MR determinations?</p> <p>Do jurors pay attention to MNC and related MR issues if they are not pointed out (elaborated on) by the expert?</p>	<p><u>H2: Testimony Elaboration:</u></p> <p>H2a: Testimony elaboration will be significantly positively associated with verdict.</p> <p>H2b: Testimony elaboration will be significantly positively associated with attention to MNC and MR issues.</p>	<p>Were there particular aspects of the testimony that stood out to you as particularly helpful or influential?</p> <p>What did you learn from the expert about the defendant’s mental illness or medication compliance that was particularly informative or helpful?</p> <p>What else did you want to hear from the expert about the defendant’s mental illness or medication compliance?</p>
<p>Is there a difference in the effect of MNC and MR issues when the expert does (or does not) elaborate on this information for the jurors?</p>	<p><u>H3: Interaction Effects:</u></p> <p>H3a: The defendant’s insight will interact with testimony elaboration on blameworthiness, meta-responsibility, and verdict.</p>	<p>How did the expert’s testimony influence your decisions about the defendant’s medication compliance in this case?</p>

<p>Does educating jurors about low insight attenuate or perpetuate defendant blameworthiness for MNC and MR?</p> <p>Does educating jurors about low insight attenuate or perpetuate defendant guilt?</p>	<p>H3b: In the High insight condition, blameworthiness and MR ratings will be higher for the defendant for jurors in the High testimony elaboration (HH) condition (versus the low elaboration, HL, condition).</p> <p>H3c: In the Low insight condition, blameworthiness and MR ratings will be higher for the defendant for jurors in the Low testimony elaboration (LL) condition (versus the high elaboration, LH, condition).</p> <p>H3d: In the High insight condition, likelihood of NGRI verdicts will be lessened for jurors in the High testimony elaboration (HH) condition (versus the low elaboration, HL, condition).</p> <p>H3e: In the Low insight condition, likelihood of NGRI verdicts will be lessened for jurors in the Low testimony elaboration (LL) condition (versus the high elaboration, LH, condition).</p>	<p>How did the expert's testimony influence your decisions about the defendant's blameworthiness in this case?</p> <p>How did hearing about the defendant's insight into his mental illness affect your decision?</p> <p>How did hearing about the defendant's mental illness and about medication compliance influence your decision?</p> <p>Do you think your verdict would have been different if you had heard more(less) about the defendant's mental illness and medication compliance?</p>
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Appendix DD

Post-focus group questionnaire.

Focus-Group Follow Up Questionnaire
(FGFQ)

1. Did participation in the focus group change your verdict vote?

____ NO ____ YES – If so, what is your NEW verdict vote? _____

If so, what was said in the focus group that changed your vote the most?

2. Did participation in the focus group change your opinion of the defendant?

____ NO ____ YES – If so, what about your opinion of the defendant changed?

3. Rate how honest you were about your responses during the focus group?

1	2	3	4	5	6	7	8	9	10
<i>Completely Dishonest</i>					<i>Completely Honest</i>				

4. Rate how much of your opinion you held back during the focus group?

1	2	3	4	5	6	7	8	9	10
<i>None of it (I shared all of my opinions)</i>					<i>All of it (I completely held back my opinions)</i>				

5. Were you *more* comfortable sharing your opinions in the ____ deliberation or the ____ focus group?

6. Do you believe you were given a chance to share your opinion in the focus group?

____ NO ____ YES

7. What surprised you most about the focus group? _____

Appendix EE

List of key words.

- Medication
 - Haldol
 - Meds
 - Prescription
- Compliance
 - Noncompliance
 - Taking
 - Not taking
- Insight
 - Aware(ness)
 - Understand(ing)
 - Low
 - High
 - Symptom
 - Side effects
- Blameworthiness
 - Fault
 - Responsible (responsibility)
 - Insanity
 - Duty
 - Obligation
 - Intentional
- Mental Health
 - Doctors
 - Hospital
- Schizophrenia
 - Illness
 - Mental Illness
 - Disease
 - Disorder
 - Sick
- Guilty
 - Not Guilty
 - Insanity
 - Reason of Insanity
 - Reasonable Doubt
 - Innocence
 - Jail
 - Lock up

Appendix FF

Focus Group Transcription: Control

Moderator: So really my first question is, I want to understand a little bit more about how the defendant's medication compliance came into play in your decision making. So, how did that affect or influence your decision making in the case?

83: Assuming that he actually followed it; then he was doing all that he could to control his illness.

Moderator: To control his illness?

84: That's the only way he knew how to. If we have to take his testimony as truth then...he was physically doing everything he could to contribute.

Moderator: Okay.

79: With [inaudible] I mean, it was, you know...It was very, uh, I thought he was very compliant with everything. Uh, as far as, you know, his illness goes. He...the hospital trips, uh, you know, medication, all that. Uh, and that made him look probably less guilty. Because even though he's taking the medication, he was still having those, uh, symptoms, and, uh, erratic behavior. So...I thought it played a pretty big role/

80: Yeah.

84: I think, like, the medication...He was showing that he did understand that he had this mental illness and that it was affecting his life. And, if he was using this as a plead to get out of something, your first instinct wouldn't put your [inaudible, 2 seconds] it's probably not going to be oh you know what, I'll argue insanity so I can get out of it. It's probably going to be, I'm going to run and get out of here. So, the fact that he stayed and was willing to talk to the police showed that he was...he did understand that this illness affected him and that it probably was the illness to cause...it.

80: And this is all assuming that he did actually take his medicine.

79: Yeah.

80: Like we were all saying, we all know with fact/

81: With fact.

80: That he was taking...his drugs.

Moderator: Um hum.

81: You know that he, like, got it, but now that he's actually taking it.

Moderator: Um hum.

81: It was like in his body.

82: That's why we were hoping he had taken a blood test...

81: Yeah.

Moderator: One, one more time.

82: That's why we were hoping that they had like a blood test of him. Like, at the time of the crime, so that we would know that, like, he had been taking his medicine. So, he would be; if he wasn't, then he would be accountable for his crime.

Moderator: So if he, you wanted a blood test/

82: Yeah.

Moderator: To make sure that he was...to prove that he was taking the medication/

Group: Yes.

Moderator: Because if not, then he should be held accountable for crime. Were those the words you used?

82: Right.

Moderator: Okay.

82: Yeah.

Moderator: So ya'll said a few things, so let me make sure I got it right. So ya'll said that you did pay attention to the fact that he was medication compliant. Yes?

82: Yes.

Moderator: Was there anybody who didn't pay attention to that until you started to deliberate? Like, let me ask in a less confusing way. Who did not pay attention to the fact that he was taking his medication while you were listening to the testimony?

79: I think, I think. I mean I, uh, it struck me as, you know, I mean it made a lot go up in my head.

Moderator: Um hum.

79: He's doing what he needs to.

Moderator: Right.

79: It would be one thing if he wasn't, but...that might change the verdict a little bit.

Moderator: Okay, and so and that's one of the things that ya'll have kind of all alluded to that is then is that if he wasn't medication compliant, he would be/

80: Guilty.

Moderator: Guilty? And need to be held accountable. Okay.

79: And I think/

Moderator: Can you tell me more about that?

79: Well, I think we had seen more, uh, you know we just didn't, we didn't have a lot of information to go on, based on if he really didn't take his medication. But, I mean he, uh, he, he didn't, if he wasn't taking his medicine, uh, you know, he know, he, he knew he had the schizophrenic, schizophrenia, for, what? 1995.

80: Ten years.

79: Yeah, when he was diagnosed. Uh, and, you know...he had been in and out of the hospital and he, he knew that he had numerous, uh, assault cases.

Moderator: Um hum.

79: He knew the, uh, risks. So, since...if, if he knew the risks that would mean he was pretty much in control, or more in control of his actions. Even though he may not have been at the time. He, uh...

84: And, like, what I would think of is like...certain cases you have to take into account negligence. And like if he wasn't taking his medication, then his actions would be negligent. And that made his responsibility for anything he's done while he not on his medication.

Moderator: Um hum.

84: So by saying that he was taking his medication, he was doing what he was told to do. What he was planned to do, and what society said he needed to do in order to control his illness. And, if it didn't work, that wasn't his fault. That was the hospital's fault for giving him the wrong medication, not realizing the affects of the medication, or whatever it may be.

Moderator: Um hum. And was negligence something that the judge, or I, informed you to pay attention to? Or is it just something that you naturally gravitated towards?

83: I think it's natural/

81: Natural. Yeah.

Moderator: Four naturals? So ya'll were thinking that before it was brought up in deliberations?

81: That was the main thing I was looking for /

Group: Yeah. Um hum.

81: Really.../

84: When they brought it up with the doctor/

82: If he was taking his medication/

81: Yeah, if he was taking his medicine.

84: Yeah.

Moderator: Okay. So 81 and 82 said it was the main thing you were looking for? If he was taking his medication? Before the doctor even brought up medication?

Group: Um hum.

Moderator: Okay so it sounds like his medication compliance made him less blameworthy.

83: Yes.

Moderator: Because he was doing everything he could?

Group: Right.

Moderator: Okay. So, how did hearing about the defendant's insight influence your decision? Do you know what I mean by insight?

82: The way he was feeling like during the beginning?

Moderator: Well, let's do it this way. So let's go around and just say, yes, no, whether you know whether what I mean when I say the defendant's insight.

79: Uh, how the defendant's thinking...

Moderator: How he's thinking? You said no (80). You said no (81).

81: I'm not sure.

Moderator: Okay. No (82). No (83).

84: Like, makes sense, because he was having it before he actually committed the crime.

Moderator: The symptoms before he's had, before he committed the crime. Okay. So let me ask it a different way. So, how did the defendant's understanding of his illness, his knowledge and awareness that he has a mental illness...did ya'll even think about that?

82: Um hum.

Moderator: Yes for 82 and 83 and 84, and 81 and 79, and 80. So you all thought about it. So, did you conclude personally that he does have an understanding that he has a mental illness or that he does not?

Group: Yes. He does. He does.

Moderator: That he does.

79: And that, we talked about, uh, when he was there, he should have done more. Whne he was at the train station, or whatever, he should have done more to, uh, to take himself out of that, uh, situation like that. But...

Moderator: Um hum.

79: At the same time, that wasn't the, uh, crime, you know.

Moderator: Um hum.

79: It was more, it was...the verdict that we had to come to was about the murder.

Moderator: Um hum.

79: And if he was in the right state of mind. Uh, but...

Moderator: So did ya'll think about those things separately, like his medication compliance and his insight, or his understanding into his illness, like.../

82: Well, I think they go hand in hand.

83: Yeah.

81: Yeah.

80: They go hand in...

81: Because if you understand that you have an illness then you'll try to take your medicine and stabilize yourself.

82: You'll take your/

80: And help...

79: If he has insight.../

Moderator: And stabilize yourself.

81: Um hum.

79: If he has insight, uh, about his illness he's probably going to take, be more likely to take his medicine.

84: if he didn't know he had a mental illness, he wouldn't be taking the medication.

79: Yeah.

82: And on top of that, he had been hospitalizing himself.

Moderator: He was hospitalizing himself?

82: Um hum. And going to, and like whenever he did get convicted, or, like, had his assaults, he always said, like, I have Schizophrenia. So like, he knew that he had Schizophrenia.

Moderator: Um hum. Okay, so, can somebody, like Mr. Duncan, could he have been taking his medication because he was told to? And not really understand the true nature and seriousness of his illness?

83: Most people wouldn't just take something when their told to, they actually want to understand what's going on with themselves.

Moderator: Um hum.

80: I think in the beginning he could have.

Moderator: He could have what?

84: that was kind of the time that he thought he was poisoned.

80: Yeah I think in the beginning he would have taken his medicine just because he was told to. But I think as time goes by, he finally realizes he's taking the medicine for his own good.

81: Yeah.

82: Yeah, I mean, he's a grown man. He wouldn't do something...he didn't want to do.

Moderator: he's a grown man. He wouldn't do something he didn't want to do.

82: So he had to understand that, you know that I have an illness. I need to take my medicine.

79: And, you know/

81: And like/

79: And, and if, if he's not in a schizophrenic out, in, in one of those crazy/

Moderator: Episodes?

79: So it's, you know he's going to be thinking...like a normal...for the most part like a normal person.

84: At baseline...

Moderator: Um hum.

79: Uh, which means he would probably, he would do what a normal adult would do.

Moderator: Um hum.

79: If they knew, uh, I, I have epilepsy and I take medication, because I know if I don't I will have seizure.

Moderator: Um hum.

79: You know? And, it's like that. So...

Moderator: So, what if somebody with epilepsy had a seizure while they were driving and hit somebody and killed them?

80: By law, your, it's okay if you're on your medicine, but if you're not on your medicine/

Moderator: Um hum.

79: If you're on it/

80: You're held responsible, because/

Moderator: Yeah. So if you're not taking your medicine though, if you don't take your medicine...

80: You have to be...you have to be seizure free without your medicine for six months/

79: Well, I depends/

80: Based on the state. Tennessee, it's six months.

Moderator: But what if it's not six months?

80: Like if it's less than six months?

Moderator: Uh huh.

80: Then you're held responsible. By law, you are held responsible.

Moderator: Yeah. So is that the same in this situation or different?

80: Different.

79: Well, I mean/

82: Those are two different illnesses.

81: Two different, yeah...

Moderator: Those are two different illnesses?

81: It affects you in two different ways/

80: Yeah a seizure, you go, you just...

81: It's your body.

82: You can't control your seizure.

80: You, you, you, you go out.../

82: It just comes on.

79: Yeah.

80: Where, with/

84: It's hard to control an episode.

81: Well yeah.

80: Well with a seizure/

84: That's like totally contradicting our entire conversation/

80: With a seizure, you're going out. You're blacking out, but with schizophrenia, you're still, you're body is still in motion.

84: Um hum.

80: Where, in a seizure, what he (79) has, what I have/

84: Well our person's still out of control of what he's doing/

82: It's true.

80: We, we go down, but he's still up. He still has the ability to affect somebody/

84: I'm not saying that.

Moderator: Yeah. I/

84: I, I, I think he/

Moderator: Well because some people have personal experiences with it, we'll, we'll, we'll need to move on to a different subject. But no, no, no, no, so that makes sense. I was just wondering if the same logic would work.

79: I didn't, I have...I get that, well, I...

80: It, it, it [inaudible].

79: I was driving, uh, before six months, and, uh, I didn't kill somebody, but I ran...I was, I felt like I was going to go into a seizure, and I ran in through a convenience store.

Moderator: Mmm...

79: It was bad.

Moderator: Well, I'm sorry to hear that. Let's not talk, I won't ask any more personal [inaudible]. But okay, so, you said well that contradicts what you were saying/

84: Right.

Moderator: But, but, that's because you see mental illness as, as, the same losing of your faculties. Like it's still not, if it's not, even though you're not flailing out of control, it's still not conscious decision making, which is what you don't have when you have a seizure...

84: Right.

79: And which I think, if you're, if a person like us, and is on seizure medication, isn't taking their medication and drives under the time, you know, then I think they should be held accountable. Uh, if, but, you know, just like this guy, if he had not been taking his medication

and then we probably would have, you know, we probably would have changed our time a little bit.

84: Right.

Moderator: And so, if he wasn't taking his medication, but he didn't understand that he was supposed to be taking his medication, would that make a difference? Like right now, ya'll have it that he understands he's supposed to take his medication, and he's taking it. So then you have the option of understanding he took his medication, and understanding that he's supposed to take his medication, and then not taking it.

84: So, that, that's his fault. Because he knows that he's supposed to take his medicine and he doesn't do it. But then it's his fault that these occurrences are happening.

Moderator: Right. And the third thing, what if he doesn't understand really that he has a mental illness?

84: I think that's probably on the hospital for letting him out and letting him go back into society knowing that he doesn't have control over what's happening/

80: And he doesn't understand what's happening.

84: Yeah.

79: Well and here's the thing, from what we saw he took his medicine.

Moderator: Yeah.

84: Yeah.

79: So, I mean, I mean, that's all we can go by/

Moderator: Yeah.

79: Even though we may think otherwise, we can only go on what we saw.

Moderator: Okay, alright, good point. Alright, so what's something new that you learned, if anything, from the expert?

79: Uh/

Moderator: Nothing for 83. Nothing for 82. 84. Nothing?

81: Like about, that's what he talked about, like just everything he talked about?

Moderator: Yeah like factual wise/

81: Yeah, just like/

Moderator: Because you, like basically, he wouldn't know anything about Mr. Duncan. Yeah, just like factual/

81: Yeah like factual, about like Schizophrenia.

Moderator: Sure.

81: Yeah. I mean just, yeah factual stuff.

Moderator: You did learn something?

81: I did learn stuff. Yeah.

Moderator: Is there anything in particular that you remember learning?

81: Um...

Moderator: That you didn't know?

81: Just that they can be like, people who have Schizophrenia can be, like, seemingly, like totally stable at one point and then something triggers it.

Moderator: Um hum

81: Like I thought that it was for the most part, like, the person was always kind of out of sorts, like, constantly.

Moderator: Um hum.

81: But they said that like his medication wasn't really working, but he was still like, he would go in and out. Of like being stable and like having an episode.

Moderator: Um hum.

81: That's about it.

Moderator: Okay. Thanks for sharing. Anybody else? Learn anything new...or surprising. Hmm. So what stood out to you most in the testimony?

79: I think, I think the, uh, prosecution was very prepared for that witness.

84: I think they were very good.

79: I mean, yeah, I mean, I, I mean, I think he probably could have...hit on some subjects a little harder than he did. And/

Moderator: Yeah. I heard ya'll talking about the prosecution a lot.

84: Yeah, there were parts with the doctor that, like, the doctor kind of like didn't answer his question directly but he kind of just like looped, like when they were talking about the time frame.

Moderator: Um hum.

84: They kind of looped around to say, well I consider this the most important, and the other guys were like what about the other part.

Moderator: Um hum.

84: Like they just kind of skittered on it. Where if the prosecution had kind of gone further into detail with that, the doctor probably would have gone, more on his side, and less, you know what I'm saying.

Moderator: Um hum.

84: He probably would have said something the prosecution could use later on, because he didn't know how to directly answer his question.

Moderator: So ya'll didn't think the cross was that effective?

84: No.

Moderator: No. I have the head shaking from 82, and I'm a bit curious.

79: And, and/

82: Because what, I mean, because something that stood out to me was when the doctor was talking about how he was going in and out, like when he was at the bus stop, and he said that, like, that he knew that he had an urge coming on. That always stood out to me because, I mean, if he knew that he should have walked away.

Moderator: Okay, so when he was standing at the bus stop and the doctor says he has an urge coming on, he knew he should have walked away, so you were going to hold him responsible for that?

82: Yes. That was the main part of what I was holding him responsible for until we deliberated.

Moderator: And what changed during the deliberation to make you go the other way?

82: Um, well the fact that we were talking about, like, his compliance to his medicine.

Moderator: His compliance with the medicine...

82: And, um, that, I think 80 was saying that at the time, when he was like, you know how we said he was going in and out/

Moderator: Um hum.

82: Well, 80 said at that time, that he wasn't himself, because he went into his Schizophrenia state. So that kind of, you know, persuaded me as well.

Moderator: That he was no longer himself/

82: Right.

Moderator: Because he was in his Schizophrenia state.

82: Right.

Moderator: Which is what 80 had said. I'm just repeating you.

82: Okay.

Moderator: Because you have a soft voice. I don't want to lose the information. Probably sounds funny. You don't have to transcribe that part. Um, okay, anything else stand out to anybody? No? I mean how did the expert's testimony influence your decision in general? I mean, did it influence it, was it a big part, was there other things that you were thinking about it?

79: Well that's all we really had/

80: That's all we had.

81: That's all.

79: So I mean, it was, because all, because the, uh, defense, ya know, laid it, I mean they laid it out pretty well that he had been in and out of hospitals, he had, he he'd been diagnosed for ten years.

Moderator: um hum.

79: With Schizophrenia.

80: He was the only real neutral person, where, because he had the two attorneys arguing for their sides.

79: Yeah so/

Moderator: Um hum. SO everybody thought he was pretty neutral then? Head shakes all around...Okay. SO let me go back to one, one area. So I understand ya'll's take on whether was taking his medication or not, and how that would affect it, but let me be real clear in my inquiry as to whether, if he didn't understand that he had a mental illness, what could lead to him after ten years of not really getting the, not really understanding that he had a mental illness at that point...cool? Is that possible?

82: Maybe after having it so long, it just seemed normal to him.

Moderator: After having it so long, it seemed normal to him. And/

84: How would they [inaudible] when he was diagnosed? Do we know?

82: They said it starts at a young age. Doesn't it?

83: Freshman in college.

82: And then, like, the symptoms came on.

79: But, well they said, they said, uh, it comes late adolescence.

83: Right.

84: Because like I mean, if you were like six or seven years old and that's all you knew.../

82: Right.

84: It would be a totally different story, but if you grew up, like, it'd be like one of us right now, just seconds from schizophrenic, being diagnosed schizophrenic.

Moderator: Um hum.

84: We know life before Schizophrenia.

81: I thought it was diagnosed before you were like 18, 19, I thought it was like/

80: I thought it was middle school.

81: I thought it was like middle school, elementary...

82: Yeah, like young.

Moderator: Okay.

82: Cause there's like/

81: Like I really/

Moderator: So let's/

81: I don't know. I just like, that was weird to me.

Moderator: Mmmm... That it started later?

81: That it was later.

80: Something we learned from the doctor.

Moderator: Okay. So is there something though, so what I hear is that you're comparing someone with clear thinking like you have now to then, once you have Schizophrenia, and your confused thinking... in that confused thinking state you're going to be able to compare that it's different now than it was then. While you're confused and psychotic, you are going to rationally be able to compare from before?

83: I mean before he did see purple people, so...

Moderator: Yeah, but they weren't real yet. Now they're real, because he's psychotic.

84: But if you, if you/

Moderator: Does that make sense?

84: It makes sense, but if you're sitting there and like all the sudden, a year later, I start seeing purple people/

Moderator: Um hum.

84: And I go to that guy and I say listen something is up, I'm seeing purple people. And the doctor says, well chances are you're schizophrenic, I'm going to be like okay that makes sense. And then I know that I'm schizophrenic and these things are going to be happening to me, and I'm going to think they're real in those time periods.

Moderator: Oh.

84: But, in the baseline/

Moderator: Um hum.

84: When he's stable for those time periods you, you're going to realize that something's wrong/

Moderator: So do you, I understand, I understand, what all of you are saying. So my question is, in general, the understanding then, or the agreement is people with Schizophrenia are able to recognize that their symptoms are not real?

79: Not, when they're, when they're in their normal...I think when they're in their normal state they'll...but they are not/

84: I don't think [inaudible] It would be like saying that every single schizophrenic person/

Moderator: Right.

81: Yeah.

84: When they're not in an episode, when they're not in an episode they know that they're schizophrenic. That would be hard/

81: Right. You can't just classify, yeah...

79: In this case.

84: in this case.

Moderator: In this case, he understood that he had an illness. And did the doctor ever say that he knew he had the illness?

84: No but if he's/

81: I don't remember.

83: It checked himself into a hospital.

84: yeah, he checked himself into a hospital.

Moderator: Um hum. He checked himself into a hospital, because he said he needed to.

79: For a, a couple of times.

80: A couple of times, yeah.

81: And he/

Moderator: Did he ever check himself into a hospital saying he was schizophrenic? Or did he just check himself into a hospital because?

81: They never said/

80: We never knew/

84: The only time that they said otherwise was like the day before when he had like a sprained ankle or something.

82: Yeah.

Moderator: Um hum.

84: Because like the prosecution was like well he was in the hospital, but the doctor was like oh it was for a sprained ankle.

Moderator: Yeah.

84: it wasn't for Schizophrenia, so...

Moderator: But so ya'll assume when he checked himself into the hospital, when the doctor said he checked himself into the hospital, that that meant he knew something was wrong and the thing that was wrong was Schizophrenia?

82: Um hum.

84: I hoped that the doctor wouldn't be/

Moderator: No that the/

84: Be unclear about that, like/

Moderator: Yeah.

84: He would realize that he was speaking psychiatrically, but...

82: yeah.

Moderator: And that the defendant understood, at those times, that it was mental illness causing the problem?

82: Yeah.

Moderator: And that he wasn't just in distress and freaking out so he went to go get help?

82: I guess.

Moderator: Do you understand the difference?

84: Yeah.

82: Yes.

81: um hum.

80: Um hum.

84: I, I figured something out to/

81: Yeah we really didn't.

84: Make him fit in on it.

Moderator: But, in general what you took away from it was that he understood, so he went to get help?

Group: Yeah, Yes.

Moderator: That wasn't argued. Okay so that's the [inaudible] part/

81: I feel like it was implied.

Moderator: It was implied. Yeah.

Group: Um hum.

Moderator: Okay. Well ya'll gave me everything I wanted to know. Anything else? No? Ya'll were too easy. I feel like I missed something. SO what do ya'll think is going to happen to him if he follows his verdict? The verdict that you gave...

82: [Inaudible]

81: [Inaudible]

79: It is [inaudible].

80: Criminally insane hospital.

81: Yeah.

82: He needs to stay there.

Moderator: He really needs to stay at the hospital?

82: Yes.

81: Yeah. Yeah, he's not going to go back out and just live a normal life.

83: Because his medication's not helping him.

84: Once you [inaudible]

Moderator: And ya'll asked me during; the medicine's not helping him, okay, so ya'll asked me during the deliberation about whether you could, about what the punishment would be. Right?

Group: Um hum

Moderator: Were ya'll supposed to be considering punishment in your decision?

Group: No. Nah. Not so much.

Moderator: No? So what led ya'll to that?

84: Because it's hard to say not guilty if he's just going to walk on the street/

83: If he's just going to go right back into/

82: Right. And the fact that somebody is dead and somebody needs to be held accountable for it. He needs to be punished in some kind of way.

80: Like, somebody needs to be punished.

82: But we don't want to put him in jail. Like, because of his/

84: That wouldn't help.

80: That would just make it worse.

83: yeah.

82: Yeah.

80: We feel, we felt that putting him in a jail setting would just make it worse. Where putting him in a criminally insane, psychiatric hospital would help.

81: Right.

Moderator: Would help him, but would still be holding him accountable for it?

80: Exactly.

Group: Right.

79: And. And, keeping him safe from society and/

84: And keeping society away from him.

Moderator: And keeping him away from society and society away from him. Alright. And so you're thinking about the consequences and whether he's going to be punished, right?

Group: Um hum.

84: Well, I mean/

Moderator: As opposed to/

84: He clearly/

Moderator: Do ya'll see that as, so ya'll see that in its strict, like tied to the verdict. And it...yeah...

84: It's like, society has to take action. When, when a life is taken someone has to be held accountable, something has to be done to make sure that doesn't happen again. Now that/

Moderator: Is that the point of getting a verdict? To hold the person accountable if they did it? I mean there's no, I'm not, it's just a question.../

84: Is that a trick question?

Moderator: Sorry. No. I'm just asking. I'm trying to understand. What I do is take what you say and try to reflect it back to make sure I'm getting it correctly.

80: I think so.

Group: Yes.

Moderator: Okay, so the whole point of the verdict is to find what's accountable and who's accountable. And to/

84: Can't we just [inaudible], I'm so confused.

Moderator: Right. We voted not guilty by reason of insanity, so you're still holding him accountable/

82: Yes.

Group: Um hum.

Moderator: Like we said, just in the most appropriate way.

Group: Yes. Yeah.

Moderator: yeah.

79: For his safety, and the others/

80: Everybody's safety, his safety.

81: Yeah.

82: Yes.

79: Is, if I was the judge that I would say that he needs to go to a mental facility/

Moderator: Right.

81: yeah.

Moderator: So if you were a real juror in this case, and the judge told you not to consider punishment, and only to consider verdict and the facts, would you be able to do it, you think?

82: I don't think so.

81: No.

84: It would probably come to my mind/

82: Right.

84: But, you, you can go around it.

82: You can, but it would be really hard.

Moderator: You can try.

82: Because you don't want to just let him go. You don't want to be just like no he's not guilty, so we're just going to let him go.

Moderator: Um hum.

82: Because, he obviously did it. Like he said that he did it. It never was/

83: There's no debate about whether he pushed he in front of the train.

82: Right.

Moderator: Right.

81: Yeah.

82: And so, something needs to be done about it, but we want to go about it the right way.

Moderator: Yeah, and 81 and 80 said ya'll, you two wouldn't be able to not think about it either?

81: Yeah.

Moderator: Alright. Anything else? That you felt like was important leading to your decision? Okay... Well let me end this focus group.

Appendix GG

Focus Group Transcription: HeHi

Moderator: Alright, so basically like what I was saying, the goal of this part is just to learn a little bit more about why you came to the decisions that you came to and I know that you just filled out a questionnaire about it, but the point now is for me to just ask you some more direct questions. Okay, so I can't really answer any questions about the case or anything until afterwards, so that's one hiccup in this process. But, um. The first question is how did the defendant's medication compliance, so the fact that he was either taking his medication or didn't take his medication, how did that impact your decision-making.

1: We felt like, um, while it did play a roll in his mental illness, ah so I guess it manifested itself because he wasn't taking his medicine, um he himself should not be held directly responsible for that because he wasn't inside of a mental health facility where compliance is forced/

Moderator: Ahuh.

1: and that uh, since he was abusive in the mental health facilities, he beat up on doctors and other health care workers, we were kinda confused as to why he did get let out. He should have been kept in and kept on medication. So, he kinda fell through the cracks and it wasn't necessarily all his fault that he wasn't taking meds.

Moderator: Okay.

3: That was a good point and played a big role in my decision because if he was taking medicine, then my whole entire look on the situation would have probably been different.

2: It worked in favor of the defence because it showed that um he was not like it gave them more to prove that he wasn't able to make judgment calls and it helped them prove that he was unstable.

Moderator. Okay, so you said that it worked in favor of the defense and that it showed that he was not able to make judgment calls.

3, 4, and 6: Ahuh

Moderator: Okay. I don't know how good that camera works. Um okay, so how about your three, was it something that you thought about or was it something more like an afterthought?

6: I agree with like what she said and also it proved like that/

Moderator: Like what, like number 2 or 3?

6: Um 2 because like he can't be held responsible because he should've been in a place where they were like giving it to him and it worked in favor of the defense to like prove that.

4: I agree with that also because he should be somewhere to where they like make him take it and also he's already in a state where he is, you know, not all the way there mentally, and so that kinda is an excuse for him why he didn't take his medicine because he's technically not all the way there but someone should have made sure that he took his medicine.

Moderator: Okay. So somebody should have made sure that he took his medicine because he's in a state that's not all the way there so he should he needed to be in a hospital where they would like make him take his medicine. Okay. How about you number five?

5: Um, I completely agree. I think that he shouldn't, that he shouldn't be responsible for taking his medicine, so he shouldn't be a part of society if he can't even make the decision if he's going to take his medicine.

Moderator: So he shouldn't be responsible for taking his medicine and he shouldn't be a part of society if he can't make that decision to take his medicine.

5: Yea.

Moderator: So if ya'll were going to rate it, which I guess you did already on your questionnaires, but like how important was the medication noncompliance to you in your decision, like juror number three said that if he was compliant it would have been completely different.

2: Very important.

3: Yea, it was/

5 and 6: Yea.

6: Very.

Moderator: So everybody's shaking their heads. All the jurors are. Okay, so was it something you thought about while you were listening to the testimony or did you have to have somebody bring it up.

1, 2, 6: I thought.../

4: I thought about it.

Moderator: Okay, so everybody thought about it/

5: I didn't. No, I didn't.

Moderator: Okay.

5: I didn't really take it into consideration until we started talking about it and I was like oh that's right, he wasn't.

Moderator: Ahuh. And so when you heard like when it came up in the discussion that he wasn't taking it, did that make him more or less blameworthy?

5: Less.

3: Just because medication can have such an effect on someone. It can change the way they act.

Moderator: So all of ya'll are saying that it made him less blameworthy because he wasn't on his medicine?

Group: Yes

Moderator: So, how did hearing about the defendant's insight affect your decision? Do you know what I mean by insight?

2: No.

1: Knowing that he was ill, you mean, or...

2: His insight into his crime or his illness?

Moderator: Okay. Alright. Well, I'll just get information on what ya'll think that means first. So, number one you said something and number two you said something, what do ya'll think I mean by when I say that the defendant's insight.

5: That he knew he was mentally ill.

6: Yea.

4: That he knew he was mentally ill.

3: Yea.

Moderator: Okay. Yea, so basically insight is his understanding of his mental illness, so his understanding that he was mentally ill.

6: I think that while he understands it, it doesn't mean that he can control it. Like he can understand that he is mentally ill but he can't put away the thoughts in his head.

3: Or in a split second it can change/

6: Yeah.

3: He could understand it and then completely go a different way.

6: Ahuh.

3: And not understand why he did it. Not understand his actions.

4: I think that because he understands he has a mental illness that he needs to, you know, take the incentive to go get help, you know even though they like let him out because he was showing like behavioral problems, I think that because he knows he's mentally ill and he has past incidents that have happened I think that he should also take incentive to, because you know he has moments when he is okay. I think like he is in one of those right states of mind, he should take those moments and incentive to go get help.

Moderator: So when he's in the right state of mind because he knows he has a mental illness, he should take the incentive to go get help.

1: Yes.

5: Yes.

6: Ahuh.

2: Right.

3: For the safety of everybody else too not just for like himself.

6: I think that/

3: I think/

1: And he has been before like he did check himself into a mental hospital/

2: But his insight is impaired by his mental illness even though he understands that he has a mental illness.

6: I think the fact that he didn't put himself in a, well he had before, but the fact that he didn't continue it shows the fact that he really isn't in the state of mind to completely understand his condition/

2: Ahuh

3: Because if he really did then he probably would've checked himself into...

1: Or that he knows that something is wrong with him but when it manifests he can't think rationally, so he doesn't think I need to take myself to the mental hospital and check myself in.

5: Yea.

6: He uh every time it seems like he calls out for help. He kicks in his neighbor's door and says I need you to take me to the hospital.

2: And he has an understanding of his illness however, he doesn't like to take his medicine. He doesn't like the way his medicine makes him feel. Therefore when he gets in his states he's not going to want to go because he knows it means he'll have to go back on the medicine that he doesn't like.

6: Yea.

2: And he's impaired.

6: Ahuh.

2: So he can't make the proper judgment choice to know that just because life on the medicine ideal for him, for everyone else and probably for his own safety he probably should be on medicine.

6: Yea.

4: And he knows that he should be because when after he did the crime he was like take me to the hospital. It's like he has a pattern. He does know that he needs to be there.

Moderator: So he knows that he needs to be there, but just knowing that he needs to be there and knowing that he needs to take his medicine doesn't make him more blameworthy to ya'll?

2: No.

5: No.

1: No because he doesn't behave rationally/

4: Because he has been to like a mental institution before and it said that they released after like they said he showed signs of abuse to other people, they should've made it more strict...

Moderator: So it seems like ya'll are telling that there are two reasons it didn't make him more blameworthy. So even though he knew he should've taken his medicine and even though he knows that like something's wrong and that he should go to the hospital, it didn't make him more blameworthy because first, he still can't think rationally all the time so that knowing isn't... so okay one and two and five and six and I guess three and four, all agree with that. Okay, and then also that because it's like not just his responsibility is what I'm hearing.

2: Yea.

Moderator: It's like the hospital's responsibility like they shouldn't have let him go.

2: Yes.

5: Right.

3: They need to have like in the consent like a pattern to like take his medicine and maybe something will change.

Moderator: So what... So would you say that the defendant had high or low insight, did he know he had mental illness, like if you have to pick high or low?

2: He had high insight. As much insight as you can expect a mentally ill person to have.

Moderator: Okay, that's number two's description.

3: He knew, but I guess in that split instance, whenever he pushed her he didn't well right after he knew, so I guess his mind is jumbled back and forth.

6: I don't think it's as high as it should be for him to be out in public. It may be higher than other mentally ill patients but it wasn't high enough for him to like fully take control of his actions.

Moderator: Okay, what do ya'll think four, five, and one. Did he know he had an insight. Was his insight high or low?

4: I think he knows he has a problem but I think he can also use it as an excuse for the things that he does.

5: Considering he, they had it on record that for 10 years he had abusive behavior and had been in institutions and stuff. That he had very high insight that he was mentally ill.

Moderator: Okay. So four and five think he has high insight and that he might even use that to his advantage?

5: I wouldn't say that he uses it to his advantage. He just knew.

3: He just knew.

Moderator: But four thinks he used it to his advantage? If not, tell me.

4: Not necessarily use it to his advantage but like he knows what he's doing is wrong after he did it, he was like take me to the hospital, I would never do that, it's wrong to push someone.

Moderator: But the knowing and the ability to... his knowing is not the same as somebody's whose not sick. Is that what/

2 and 6: Ahuh.

5: Yea, yes.

1: Right, yea, I don't know. By high insight do you mean like if you ask him at any point in time do you have a mental illness, he would say yes something is wrong with me and if low insight he would sometimes say something is wrong with him or say nothing's wrong with me?

Moderator: Pretty much say nothing's wrong.

1: I mean I don't know. He would fall into the middle. I don't think he falls into either one of those.

Moderator: So let's talk about what the doctor said about his insight. Do you remember specifically how the doctor kinda described it? Not word for word, but I mean his understanding of his mental illness. Do you think the doctor/

2: He had a high understanding of his mental illness. I just remember the doctor saying that he had expressed a desire to get a degree in psychology and help other people like him.

5: Yea.

3: He wanted to like/

2: Understand.

3: To heal himself and understand why he was the way he was.

6: Right.

Moderator: Okay, so does everyone... Four you're a little late on that one. Did you really agree with that or are you just joining in? It's okay.

4: I mean, I see what they're saying, but I didn't really think about it before.

Moderator: So, just to make sure we're on the same page. For ya'll, even though he understood that he needed to take his medication, and he understands that he's sick, it didn't make him more blameworthy for ya'll/

6: Yea

Moderator: Because his thinking is different.

2: Right.

Moderator: Got it. Thanks. So, what were his reasons for not taking his medication?

5: He didn't like the side effects.

Moderator: Okay. Anybody remember anything else?

2: I think for him the root of it was that he didn't like the side effects but the mental illness caused his judgment to be poor therefore he chose not to take it.

Moderator: Okay.

2: He thought he didn't. He either thought he didn't have to or had something told him that because he didn't like it he didn't have to be on it.

3: Maybe he just didn't realize the importance of taking the medication. Didn't realize what would happen if he didn't.

2: When he... I feel like when you don't take it then he would get lower and lower into his illness which would make him decide he didn't need to take it more because he wasn't taking it.

Moderator: Like a cycle?

5: Ahuh.

2: Yea.

Moderator: So, were there any other reasons other than the side effects?

5: They said he didn't want to spend his life on the medication or something to that nature.

Moderator: So he didn't want to spend his life on his medication, so he just didn't want to be on it?

5: Yea.

2: Ahuh.

3: Didn't want to be dependent on it.

Moderator: So what do ya'll think about that reason as opposed to literally not understanding that he needed it?

6: Well that would make me lean toward more blameworthy because I mean he's just deciding I don't want to be on medication for the rest of my life and he doesn't care about it effects other people.

5: Yea.

2: Yea.

4: He obviously needs it.

Moderator: Right. So everyone's saying that that would make him more blameworthy because he's choosing not to be on it?

2, 4, 5, and 6: Right.

Moderator: But ya'll didn't see it that way... because you don't think he could make that choice...

6: Plus you got other factors. Like I agree with two that the more he's not on his medication the more it's like the voices telling him not to too and his judgment's impaired. And it's just hard to decide what the initial reason was, was it the side effects or was it he just didn't want to take it/

3: Or he didn't understand the importance of taking it...

5: Ahuh.

3: I think it could go either way.

Moderator: What got him on medication noncompliant trained to begin with. Is that what you're saying?

6: Yea.

5: Yea.

Moderator: Okay. But it would make a difference then if/

2: It makes him more blameworthy but you have to consider the other factors.

6: Yea.

Moderator: And for ya'll as a jury, you've all pretty much decided that the other factors are even if he's just choosing even if he just straight up doesn't want to be on it and there's no like, huge real reason, that he can't really be held responsible for that decision as much as somebody who doesn't have a mental illness?

6: Yes.

5: Right.

2: I think that he can be held responsible for not taking the medicine, but I don't think that we can hold him responsible for the actions at the time of the incident because he wasn't on his medicine.

Moderator: Why not?

2: Because his medicine keeps him at a more higher level of like sanity and being able to control himself.

1: But if he consciously made the decision to get to that point by not taking his medicine and then he killed somebody in that state because of a result of his conscious decision/

2: Yea, that's what I'm saying/

1: But should we hold him responsible for that?

2: I don't think so because he wasn't on his medicine/

3: I don't think that it should've ever been his choice to take the medicine/

6: Yea/

5: I think that he should be made to take the medicine.

4: I think that he should be in a place like in an institution/

1: So do ya'll disagree with me?

6: No, I don't disagree with you/

Moderator: Let's all answer that question that number one asked. Just real briefly. So number two said?

2: I don't disagree that he should not be held responsible for not taking his medicine. But I don't think he should be held responsible for what he did as a result of not taking his medicine.

Moderator: Right. So the question is should his conscious choice to not take the medicine make him responsible for his state at the time of the offense and you said...

2: No.

Moderator: Number three?

3: No.

4: No.

5: No.

6: I would've said no at the beginning but it's just difficult because he did consciously choose and then he did something bad. He made that choice and then... but/

1: Let me raise a... are we assuming that the conscious decision to not take the medicine is the only reason he's not on the medicine because if so/

6: Yea, I just don't know/

1: Because if so then I think, I mean/

5: Yea.

3: It should've never been his choice to begin with.

6: That's my main thing.

3: It should never have been his choice. He should never have a choice to take his medicine or not.

Moderator: Three, four, five and six seem to keep coming back to the idea that it doesn't matter whether he chose not to or not because it shouldn't have been his choice.

1: He should've been/

6: He should've been not in public to begin/

2: He should be/

[Inaudible group comments]

Moderator: So even if the medication noncompliance makes him more blameworthy for the mental state at the time of the offense, it doesn't actually make him more blameworthy, it just makes society more blameworthy?

3: Right.

6: He shouldn't have been in public at that state.

5: Ahuh.

6: He was clearly not ready to be in public.

Moderator: So when we say the conscious decision, ya'll's framework is that he can't really make a conscious decision because of his schizophrenia. Conscious meaning good judgment.

2, 3, 4, 5, 6: Yes.

Moderator: Okay. Anything you learned new during the testimony, about anything? Mental Illness? Schizophrenia? Anything?

1: I didn't know that it like involved like neurotransmitters and stuff, I just thought like it was kind of like, I don't know.

3: I didn't know it was that extreme.

6: I didn't either.

3: Like it could lead to somebody's death because of it.

5: I didn't know it went to that extreme.

1: I didn't know... I didn't really... I was really uneducated about it beforehand.

5: Yea.

1: I didn't realize it had a strong chemical basis. I thought it was more environmental.

5: And I didn't realize that... I remember the doctor saying that it was one of the more extreme mental illnesses. I didn't/

2: Yea, I didn't know that either.

[Inaudible mumbles]

Moderator: Did any of that play into your decision at all?

6: Not really.

5: No.

Moderator: Do you think if it had been a less extreme disorder or something that wasn't necessarily brain related that it would've made a difference.

5: I do.

6: Yea.

4: Yea.

Moderator: So it did play into your decision?

2: Oh, I thought you meant the new part.

Moderator: Oh.

6: Yea, the knowing of how severe any disease is is important because if it's not as severe then obviously/

2: I think that that could, because I knew that it was a chemical type illness and um, for me, that's what makes like it a big factor.

Moderator: So what stood out to you most? What had the most impact on your decision?

4: The fact that he had been institutionalized before and they let him out.

6: And for me it was like he had no motive and I need to like believe that he is crazy and I just don't think that a sane person would have done that to a random person and I don't think that he had control over his actions and no motive and like she's just a random person and he pushed her in front of a train so he must have clearly had some form of mental illness.

1: I think that well of course doctors are all very educated, but not only did he have a high level of education he's also the department head at the psychiatry department at Emory so I think that would add to his credibility and also everything was very clinical, and also he was very logical, so the mix of credibility and logic.

3: I guess I'll go with him. Like all the proof and everything leading up to how he did it.

5: I think what was most important was the deliberation because my judgment was clouded by emotion towards the victim and so thinking that she died and she was an innocent victim and for no reason he pushed her with no motive. So in my mind, I was like, oh he's guilty, so guilty. And then once we talked about it, I kinda changed my mind.

Moderator: Okay we're done with the focus group...

Appendix HH

Focus Group Transcription: HeLi

Moderator: So, just to start off, how did the defendant's medication compliance, or lack thereof, so his medication non-compliance, influence your decision?

24: He didn't take it, and he knew that he didn't take it. And, he knew he was insane, so...he was responsible for the actions.

Moderator: Um hum.

24: Uh, despite the fact that he was insane.

23: The doctor said that he was, uh, acted way more well mannered when he was on the medication then when he wasn't. So whether it was his choice to take it or not, somebody should have had him taking it.

Moderator: Um hum.

24: So he acts...like a normal person instead of insane.

Moderator: Who's responsible, who's, who's responsibility is it for him to take the medicine?

23: His ultimately, but if he can't make the decision himself then his family or somebody should take after him/

19: [Inaudible]

Moderator: And if somebody else doesn't do that, does that make him more responsible?

19: I think because he was aware that he needed to take his medication, and just didn't because he felt better, then it was probably his fault.

24: The fact that he told, on multiple occasions he told the police that he was insane and that was an excuse for his actions, he, he knew that he was insane, and he knew the medicine would help him. Well, I don't know if I would necessarily knew that the medicine would help, but he knew that he, the medicine was for his insanity. So, the fact that he used that as an excuse, and yet did not take precautions to prevent that, um...made him responsible for his actions.

Moderator: So what do you ladies in the middle think?

21: I/

Moderator: How did his medication-noncompliance go into your decision?

22: Um, I think... Well I think since he wasn't taking his medication, but, like what he (24) said, but he knew that he was, like, psychotic, that shows that he should have known that he should be taking his medication. If that makes sense what so ever...Like/

Moderator: It does, yeah. That makes sense. Um, ok, sorry go ahead. I was thinking. I shouldn't have stepped in there; I didn't mean to interrupt you.

22: And, I guess...now I've lost my train of thought. Um, so, medication, okay. So the fact that he wasn't taking his medication, wait, I'm going to try, I don't even know what I'm trying to say right now.

Moderator: You said it. You did a good job explaining it.

22: Um, the fact that he didn't take his medication, however, he knew that he was psychotic, that he had a mental illness, he should have been able to know that he, like he, he knew it was wrong that he wasn't taking his medication. So, I feel like because of that, he is guilty.

Moderator: What about you two (20 and 21)?

20: I think if he can get up and get dressed every day, he should take a pill every day. I feel like it's not that hard to be like, oh. The fact that he didn't [inaudible] and hadn't for weeks, I just feel like he knew something was wrong and he didn't do anything about it.

21: And he like, what he said (23), if he couldn't do it then someone should have been there to help him take it. Like a doctor or something, because clearly he was really insane from all the past things that he had done.

Moderator: Okay.

24: But the thing that you/

Moderator: This will have a really hard time hearing you, so you said, so juror number 21 said that you agree with number 23 about if he didn't take his medication, then somebody needs, somebody should have made him. Because clearly...something about past incidents?

21: He had many past incidents.

Moderator: Um hum.

21: That he, that showed he needed to be on medication.

Moderator: That showed, many past incidents that showed he needed to be on medication. Sorry.

24: I do think it's interesting to note that he thought that there was cyanide in the medicine.

Moderator: Um hum.

24: Um, which could have played a part in why he didn't take it, or yeah didn't take it. That was annoying me so much the entire time.

Moderator: Sorry.

24: That's okay.

19: [Inaudible, 1 second]

Moderator: Okay, so let's talk a little bit more...well wait a second, so if you had to like...so medication, um...okay, so who thought about his medication-noncompliance before you even started deliberating? Like while you were paying attention to the testimony?

19: [Raises hand]

Moderator: So it came into your, your thinking. Everybody, ya'll are shaking your heads. So, ya'll thought about it/

24: Yes.

21: Uh huh.

Moderator: As a factor while it was happening?

24: Right.

Moderator: 23 did you think about it before?

23: Yes.

Moderator: You did? Okay. How about you (20)?

20: Oh yeah.

Moderator: Yeah. Okay. And so you all agree that he was not taking his medication....and how did you learn that?

19: The, um/

24: Doctor said it.

19: Doctor. Thank you. The doctor said it.

Moderator: Okay, so the doctor said that he wasn't on his medication. Ya'll also mentioned his understanding of his illness. What's that called?

24: Insight.

Moderator: Um hum. Yeah the doctor said it in the testimony. It's okay. I just wanted to know if ya'll picked up on that.

19: Um, I...I remember hearing about t, but I don't...

Moderator: Okay. And so when you remembering hearing about it, the doctor talking about his, Mr. Duncan's understanding of his illness, what did the doctor say?

19: He said he was unable to act, to completely understand it, that he was mentally ill. He just knew that something was wrong, because of his Schizophrenia.

Moderator: Um hum.

19: So he's not...

Moderator: Right.

24: But I think it's interesting though that he did didn't really know that he was necessarily psychotic...schizophrenic.

Moderator: Right.

24: But, he, uh, just knew something was wrong, because he admitted himself/

Moderator: Um hum.

24: On multiple occasions. However, regardless of whether that, whether he, he, was diagnosed with that, he used the excuse that he was mentally insane. And so, even if he didn't necessarily know that he was schizophrenic, he knew that he was insane. He used that as an excuse. And so...

Moderator: And when did he do that?

22: In the/

24: Right during the interview, or the, uh, uh, interrogation by the police. However, we noted, or at least, or yeah we noticed, we noted that he did not have a lawyer present at the time. And so the lawyer might have said, you have Schizophrenia, claim it.

Moderator: Okay.

24: I mean that can get you out of, that's a get out of jail free card.

22: But didn't he say that on the scene? Or am I getting mixed up?

19: Yes. He/

23: I thought he said that as soon as the train driver came over to him.

22: Yeah.

Moderator: So 21, 22, and 23 thought that as soon as the train left, or as soon as the woman died that he said that he has, what do you think that he said?

21: He, I thought that the driver, the train driver, came out and was like, why would you do that or something/

22: And he's/

21: And he was like I'm insane.

24: It's fuzzy on the details.

Moderator: And he said, I'm insane?

21: He said some, yeah, something.

22: And that's why I thought he was guilty, because if he was aware of the fact/

23: Maybe he didn't say he was insane. Maybe it was mentally ill.

21: But still/

Moderator: Would it surprise you know that he didn't say either of those things?

22: Wait really?

24: I was fuzzy about that. I feel like...I feel like he, he might have/

Moderator: You didn't hear that 20?

20: No.

24: I thought he said something big. There was, they kind of talked about that a little bit.

Moderator: Yeah.

24: I thought he claimed something along those lines. Or, I mean, he stuck around.

Moderator: So what did you think that he said? Do you remember what he said?

20: I remember him staying there.

Moderator: He did stay.

20: He didn't run away, which I thought was kind of weird.

Moderator: Right. So he did ask to be taken to a hospital. So he did ask to be, immediately. So when they, so when they asked him how you are doing, he asked to be taken to a hospital. So that's what happened. Does that mean that he thinks he's insane? If he asks to be taken to a hospital...when somebody just died right in front of him and he's obviously upset? Do ya'll go there with it, in your mind?

19: I thought about that, because he, he stopped himself too. So it could be, I said this, it could be like voices in his head that told him to kill himself, and told him to hurt other people that he claimed...and, so, the voices could have come back since he was talking, facing and talking to himself. And he was trying to kill himself along with her, and stopped himself and realized what he was doing.

Moderator: Um hum. So let's, let's back up just a little bit and remember I'm not trying to attack your or anything, I'm trying to understand what it is, but I just, I have to basically just ask questions. That's the nature of this ghost. So, let's back up a little bit to his understanding of his mental illness, which is called his insight into his mental illness, so who here thought that he did understand that he has a mental illness?

24: Not necessarily that he has a mental illness, but that something was wrong.

Moderator: So 24 thought he knew something was wrong. 22 thought that he had a mental, knew that he had a mental illness.

22: Yes.

23: I did.

Moderator: You thought that too 23?

19: I think, with the Schizophrenia he has, he's incapable of actually knowing that he has that illness, but he's aware that there is a problem.

Moderator: He's aware there's a problem.

21: Didn't he call the police one time on himself? Or like...

Moderator: So he called the police one time on himself.

21: Right?

24: Yeah he said he needed to be taken to a hospital.

22: Yeah.

Moderator: Yeah. Yup.

21: Yeah.

Moderator: Um hum. So do you think he knows that he has a mental illness?

21: I don't know if it's like a mental illness, but I know he, I mean I don't know, but I think he knows that something is wrong, because if nothing is wrong, he wouldn't call into the police.

23: He would have had to know to some extent, but when, did they just, did he blackout during all the times that he like hurt other people? Or did they not explain to him if he did black out what happened? Did he, does that just completely disappear in his mind? Does it not exist that he hit a kid and was hurting his mom or whatever he was doing to his mother for that matter/

19: Right.

Moderator: So good, good question. And so, what did the doctor say about that and his understanding of that?

23: I mean somebody along the line would have had to told him/

Moderator: Um hum. Um hum.

24: He said he didn't trust him. Or he, he didn't believe his doctors. And he thought they were out to kill him.

Moderator: Right.

24: So he might not have necessarily believed that, uh, that he, that they were telling him the truth.

23: So does that mean he was blacked out during these...I mean...I guess. I don't really know what happens, but/

Moderator: It's hard for, if, is this right, like if you're trying to say that, I think this is what I'm hearing, is that you/

(End of Video 1)

Moderator: It's hard for you to understand how he could have that, given the, the explanation repeatedly given to him and for him not to get it?

23: Yeah.

19: Isn't that part of Schizophrenia though? Not remembering when you change into the different selves I guess you would say.

Moderator: You can't answer the question/

23: Still the effect of you taking, that's like if you sleep walk/

19: Oh that's right/

23: Like people tell you, you sleep walk. You still know you sleep walk. I mean you don't actually remember doing it, but if someone says, you sleep walk, that's why you walked into the fridge and ate all the food last night, then like obviously you know you did that.

19: Yeah, but it's...it's different with a mental illness.

23: It's basically the same, I guess, because if you don't know, then you don't know. If you're asleep then you don't know. SO is being mentally ill...

24: I think it's the fact that, that um, he can't trust them. Like even if he told them, like, like, if someone told me I slept walk I could trust them, but I can see in the kitchen if the foods gone or whatever, but if I'm schizophrenia, schizophrenic, I, I don't trust them. I don't believe that he's, uh, telling the truth, or, maybe I even see the food there or something.

23: Then I would say that that is a severe enough case to where he shouldn't be out in public at all.

24: I definitely don't think he should be out in public.

19: I don't think he trusts himself.

Moderator: So let's back up just a little bit. So these are all good points. So, you ladies in the middle, what do you think about his understanding of his mental illness? How did that factor into your decision?

21: I don't think he did understand.

Moderator: You don't think he did understand?

21: And I think he did, but I don't know. I don't know, like...he understood but he doesn't know what to do about it. Like he's mentally ill. He.../

Moderator: So he understood but he doesn't know what to do about it because he's mentally ill.

21: I guess.

Moderator: I'm just repeating. Um, what about you, 20?

20: I just don't, I don't know enough about mental illnesses, especially, like, Schizophrenia, to even know if he can function well enough to realize what he's done.

Moderator: Um hum. But it seems like ya'll determined that on your own...or you determined that.

20: I feel like if doctors will let him be in public then he can remember to take the pill. And I think that's like a huge thing.

Moderator: Okay.

24: They just said it in the opening statement; the mental health care system failed him.

Moderator: Uh huh.

24: Where it should have recognized what we've just recognized here that maybe even he...I think he recognized something was wrong, I think he recognized he had Schizophrenia. And I think that is the downfall of the, uh, he should have taken the medicine but where, he wasn't. And, uh, the mental health care system should have realized that and should have kept him at a place like Bryce or something, uh, where he does not have this, I mean a psychiatrist should have realized he has the capability, and the, uh, I mean he, he's able to go kill somebody and there's a potential that he could hurt somebody seriously. You, you, look at his past and where he has...and they didn't keep him, because they just hoped that he would take his medicine.

23: But we don't know that the health care system actually failed him because the defense lawyer said that, so maybe he's just trying to help out his.../

24: But we did that we can trust what they say.

Moderator: You can trust it as facts they intended to present into evidence, yeah. You couldn't completely trust what was [inaudible]. But yeah.

24: Right.

Moderator: Okay so backing up just a little bit again, okay so now that you've had a little bit more time to reflect on the testimony, who in hear still thinks that he did not understand that he, or who in hear still think that he understood that he was supposed to take his medicine? Just say yes.

24: There's a difference.

Moderator: Just say yes, or just say you did if you did. Or I did.

23: I did.

24: I think he should have known he was supposed to take his medicine.

Moderator: Okay so 24, 23, 22, and 20.

22: I think yes.

Moderator: Yes? 21 too? And 19. Okay. Alright. Um, so what's something new that you learned from the testimony?

19: I really liked the doctor's testimony.

Moderator: Um hum. What did you learn new about?

19: I learned a lot about Schizophrenia.

Moderator: What stood out to you the most?

19: Um, basically that the, because the common, the common thoughts of Schizophrenia is that you turn into a completely different person. Like usually people think that you just had like a Dr. Jekyll and Mr. Hyde type thing. And it's apparently not like that in most cases.

Moderator: Okay so you learned that it's not really like multiple personalities?

19: Yeah.

Moderator: Okay. How about you, 20? First off, what's something new that you learned, and what stood out to you most about the testimony?

20: Um, I learned that like, people can do things and I guess it not, they don't realize why they're doing it, that it's wrong. And it stood out to me that mental illnesses are so like, people seem to look over them, or look passed them. So we need to be more sympathetic towards those, especially with all the questions that I got asked about it. I just like didn't realize that that was such a big get out of jail free card.

Moderator: Um hum. So it convinced you that it is a get out of jail free card?

20: I mean, it just seems like...I don't know. I watch a lot of Law and Order, which is probably not relevant, but when people are like oh I have this mental illness blah, blah, blah, I'm insane/

Moderator: Um hum.

20: It just seems to people that are like go get help instead of punishing them for what they've done.

Moderator: Um hum. OS what stood out to you most while you were watching the testimony, like what influenced, like when you sat down to deliberate, like what piece of evidence were you thinking about?

20: Him not taking the medicine/

22: I think/

Moderator: Him not taking the medicine?

22: I mean I thought that he had said he had, um, something wrong after every single incident. And I don't know where I got that from. But like he didn't say that.

Moderator: Um hum.

22: So I guess I just like made it up, and that was my main thing that I considered. And I don't know how I just like...completely made that up or something.

Moderator: Well. Sorry again. Okay. So number 21 what did you think about what you learned from the testimony?

21: Um, I learned about Schizophrenia too, because I knew nothing. I mean, I knew some things about it but I'm not sure.

Moderator: Okay.

21: But what stood out to me was the whole medicine thing. That he wasn't taking it, that's pretty much what I based my opinion on.

Moderator: How about you, 23? Did you learn anything new from the testimony?

23: I, I learned that mentally ill people are very dangerous.

Moderator: Okay. Is that something that the expert said? Or is it just something that you felt?

23: Um, it was something that I felt, because he's like a repeat offender. So, I mean...

Moderator: So that's based off of something you learned then? Okay. What stood out to you most when you were coming to sit down to deliberate?

23: That he kept hurting people over and over again.

Moderator: Okay, so his history right? Okay. How about you 24? What did you learn and what stood out to you most?

24: I'm not sure that, I mean, I can't really pull from any facts that I remember.

Moderator: That's okay.

24: I know I, I, did learn some stuff that I recall though. But uh, what stood out to me was the most was just that, I feel like it was mentioned with the hospital that, and it stands out that they can't really keep count of that. Uh, they can't keep count of all the people that should be in there.

Moderator: Okay.

24: And it's kind of scary.

Moderator: And for you that trumped the medication thing, but you were also thinking about medication? Okay so if I presented a whole new version of the testimony right, and said that he has absolutely no idea that he has a mental illness, like he goes to the hospital and things, but he never believes them, like doesn't believe them, like he knows something is wrong, because he goes to a hospital all the time right? And he's knows something is wrong because he gets all

upset, and frazzled and stuff. But he has no understanding that it's a mental illness that requires medication, then would that change your opinion?

23: No

24: If you had proof, but I don't think you could prove that.

Moderator: No, no, no, I'm saying I'm saying if I could give you proof/

24: I know. I'm saying if there was no, absolutely zero way, and he did not use it as an excuse, um, then yeah.

Moderator: How would it change your opinion?

24: If, if he, if he had zero, absolutely zero proof that he was mentally ill, and, as a result, didn't take his medicine, then yeah I think he, I think he did out of, uh, out of the condition he was in with Schizophrenia. And that....

20: I think a big thing is though he was taking the medicine, and the he stopped.

Moderator: Um hum. Um hum.

24: That's what I'm saying. I don't think he/

20: like if he had never taken the medicine/

Moderator: What did the expert say about that? Did you remember?

24: About him not taking the medicine?

22: Didn't he say/

Moderator: Taking it and then not taking it.

22: Didn't he say like he would take it and then he would feel better, and feel that he didn't need to take it? And, so then he would stop.

Moderator: yeah, that's one of the things that he said. SO what do ya'll thin about that?

22: That there should have been someone there/

Moderator: Does that make sense to you?

22: What, like, kind of a guardian situation to make he that he continued/

Moderator: Um hum.

20: It makes sense that he, but like, it, when he feels weird again or when he starts hearing voices I feel like he should recognize oh something's wrong, I should probably take my medicine again. Or at least refill it. I feel like the fact that he didn't refill/

Moderator: Um hum.

20: The prescription stood out to me a lot.

Moderator: Um hum. So let me, um, sorry, ya'll are doing a great job. Okay, so again. So if I was able to communicate to you that he does not understand that he needs his medication, and therefore, would you hold him more or less responsible for taking it? Let's just start there. Like if he doesn't know that he's supposed to take it/

20: Had he ever taken it before?

Moderator: Is he still...let's just start bare minimum right? So again, he doesn't understand that he needs his medication, would you hold him responsible for taking it or no?

22: Less, yeah/

21: Less responsible.

19: Cause then he should be, then he should have a care taker to help him.

Moderator: Right, so I'm getting that just the evidence that he wasn't hospitalized all the time to you is evidence that he is capable of understanding that he can take his, that he needs medication...because they let him out.

22: Yes.

21: Um hum.

Moderator: Is that what I'm understanding? So three of you, 20, 21, 22, agree that just the fact that he's not hospitalized, right, that that's, at least supports the fact that he understands at least he needs treatment. Okay, but what if he doesn't? So at this point, he doesn't understand he needs treatment, and he doesn't, um, he doesn't take his medication, and so he's psychotic and he commits the crime, is it his fault?

19: And then he can be dubbed mentally insane, which is what [inaudible].

Moderator: So then he can be mentally insane, because then he didn't realize that he/

19: I mean he could/

23: It's still his fault.

Moderator: You think it's still his fault.

19: He could still be mentally insane, but/

Moderator: So it could still be his fault because of...?

23: He killed someone.

Moderator: Because he did it. Okay. Alright. Okay.

23: Whether he did it intentionally or not...

22: But if he had no idea what he was doing was wrong, and he had no idea that something about him was wrong, that there's a way he could prevent that, I don't see how he can be proved/

19: [Inaudible]

24: I think that had already/

23: I think it would be different it were somebody that...just say that he killed someone that you knew, would your opinion change then? Because, I mean, you can't just have him out there. Even...whether he does or does not know, he still killed someone that was living on the Earth.

19: But/

Moderator: So as a juror, as, as, as s juror, your job is to follow the law, so according to the law would he still be guilty?

23: No.

Moderator: But you, you wouldn't be saying he's not guilty, if you were on that jury?

23: I wouldn't.

Moderator: That's why they have jury selection. I'm just kidding...Um, okay, so, okay. So when the expert was talking about his understanding of his mental illness, what did ya'll hear? What did you take from that? Because somehow ya'll decided that he does have understanding.

19: I only decided he does from...it helped...the whole medicine, and from his personal experience. The doctor made it seem like he didn't understand.

Moderator: Um hum.

19: Like I said before, I don't think he understands, like he actually has a mental illness, I just think he understands the problem and he does have enough mental capacity to recognize he has to do something about it. So he does take himself to the hospital.

24: I think we go back to regardless of, of what happened right after the incident, twelve hours later, the police interrogation, if there was a lawyer or not, he said he had a mental illness. Uh.../

Moderator: Did he?

24: That, they said that/

22: They, yeah/

24: They said that. I know they said that/

22: I heard something with him saying he was mentally ill.

24: He did.

22: I don't know what it was but/

24: In the interrogation.

Moderator: Um hum.

24: That he did, and I think, I think it's because the lawyer was there, but they don't say that. Uh, and so...

Moderator: You sure he didn't say that he knew it was wrong? Twelve hours later...

21: He did say that.

24: So if he didn't say at all, not one time during that, he never, he never said that he had something wrong with him?

Moderator: He said he knew it was wrong.

24: Okay.

Moderator: So, it's really interesting though, like how it's perceived, and how it comes out/

24: I also think that in high school, well high school it started, then college he started realizing something was going on, so he went to a hospital.

Moderator: Um hum.

24: I think that, that right there is proof that he knew something was up.

22: That he knew, yeah...

Moderator: Yeah. And so, okay. So ya'll don't remember the doctor saying anything like explaining any of that or how that works with people with Schizophrenia? Or explaining how people can know what's wrong, but still not have insight into their illness?

24: Then he should have been in the hospital.

Moderator: Is that his fault?

24: No, it's not his fault.

Moderator: Right.

24: It, it's the health care system's fault, but...now that I'm trapped.

Moderator: That's okay. Well I'm not trying to trap or make anybody uncomfortable. I'm literally just trying to see, like, what you took from the testimony. And it's becoming clearer to me that one thing you did not take is an explanation of how somebody can know that something's wrong, but still not have a clear insight into their mental illness and their need for medication. Did ya'll, none of ya'll felt that way right?...Ya'll are like come on I said no. Okay. Alright. Just say, just transcribe, please, that everybody agrees with my comment that I've repeated seventy-eight times. Okay. Is there anything else that you wanted to hear or learn from the expert? Or about the case? In order to make your decision., or did you have a pretty clear mind?

19: There's definitely evidence missing, but I can't figure out what I would like to hear.

24: I would have like to heard him, and, and him and the witness.

19: Yeah, the witness.

22: Um hum.

Moderator: You want to hear him and the witness?

24: I wanted to see him too, and that was probably, that, that probably had nothing to do with the evidence. I mean the evidence was...yeah/

19: Usually visuals do though.

22: But couldn't that be biased too?

24: Oh, it would have been biased

22: If you see someone, and you're like oh, he's a murderer. Like we should put him, you know? Like, it, so maybe it helps that we didn't get, maybe listening to him and hearing him talk would be helpful, but, I think, like maybe seeing him would be counter...

Moderator: Why'd you want to see him (24)?

24: I just wanted to see him. Uh, I, and I know it's bad, but I, I, would have made judgments on him. By seeing him...

Moderator: Um hum. [Inaudible]/

20: I wanted to see if he was like remorseful.

Moderator: You wanted to see his remorse?

24: Yeah, I uh/

20: Yeah like to see if he actually like registered what he did was wrong.

Moderator: Yeah. So that's one, one other, one last thing I wanted to talk to ya'll about. So one of the tings ya'll talked about a lot was punishment and whose fault it is and [inaudible] and things. And one of the things I didn't hear ya'll talk about a lot was the actual law of the case. And the actual...the fact that it's two stages, and that ya'll are in the guilt-verdict stage of the case, and were instructed to not to discuss punishment or what he deserves or what the victim deserves. So can you just tell me a little bit more about that? Like what took you there when the judge instructed you to go somewhere else?

24: We, we stopped, or we kind of talked about it, and then we were like, can we talk about this?

Moderator: Um hum.

24: But I, I mean I know we weren't supposed to, but it I mean he, he deserved one thing. I mean, I think he was guilty, but, he, it's not like he deserved the death penalty from it.

Moderator: Um hum.

24: And I know that's not our responsibility, but that's, I feel, I just feel like that's a very vital part of it. I mean he, he needed help.

19: Yeah.

24: He needed help. He didn't need to be set free, but I, and I just, I hate that it's, that's not our responsibility to decide. It's either, you know, death or life, not death, life, or life with help.

Moderator: Um hum.

24: I mean it's really just, I, I hate, I hate the fact that we couldn't, we couldn't decide that.

Moderator: Um hum. So, and ya'll didn't actually have any choices right? Because you were not informed of what the penalties would be for those three verdicts/

24: Right.

Moderator: So ya'll each determined in your own mind what those would be. Right? And so what, what would be just the, since you thought about it, what did you think would be the punishment for somebody who's found not guilty?

24: Completely not guilty, not, not the/

Moderator: Uh huh.

24: So not the third choice?

19: Set free.

Moderator: Okay. How about guilty for him, in this case? What would be his punishment?

19: Him?

Moderator: Um hum.

22: Twenty-five/

19: I would hope , I would hope that they would give him prison, but I would hope it would be like solitary confinement, imprisonment. Not with somebody, because I'm afraid that his, he would randomly out lash.

Moderator: In this case.

24: I think it would be Taylor-Hardin. I'm doing a presentation on the state of mental health care in Alabama so/

Moderator: Okay.

24: And so I know about all the facilities here in Alabama, and I really think it would be Taylor-Hardin, which is Taylor-Hardin Secure Mental Facility. It's, it's for people with mental illness, illnesses, for people with mental illness who have committed a crime. So they're/

Moderator: Right.

24: They're locked up in prison, but they're given the care they deserve. They need.

Moderator: So, right, but that's not what ya'll decided. Because ya'll decided guilty.

24: I think if guilty, that's where he would go. I'm not sure I made that clear.

Moderator: Alright. So, but ya'll were all thinking about punishment and what he deserves?

24: Yes.

Moderator: As opposed to the law and what the judge asked you, asked you to think about. Because, because it just comes out/

22: I think it's just like natural.

24: Um hum.

22: To think like, you know, he could kill someone, and think about what's gonna happen to the person.

Moderator: Do you think if you were in a real case you would be able to focus in on the law? And not focus in on sentencing and punishment and what he deserves, what she deserves?

22: I don't know.

Moderator: Just be honest. I don't care. I'm not going to tell a judge.

22: I don't know.

Moderator: 23 says no. 22 you don't look likely.

24: I don't think we knew the law.

19: I think everyone would considers it in their minds, whether they say it out loud or not.

Moderator: Okay.

23: Naturally, you can't just, like, ignore that.

Moderator: Right.

19: It's, it's human...

Moderator: Even though that's what you're instructed to do? Right? And you (24) said you didn't know the law?

24: I'm not sure I, I exactly knew what, what the law was about. How mental illness plays a part in to, to murder.

Moderator: Did ya'll listen, I don't know, so did anybody else hear the judge say the law? Like your verdict options and what they each mean? That's the law.

22: We get that.

Moderator: Oh.

22: But I understand what you mean, like, are you trying to say you don't know how him being mentally ill, ill affects where he goes?

19: His placement.

24: Right. Not, not even where he goes, but like, at what point...does depression, mild depression, which a number of people have, does that count as a mental, mental illness? Uh/

Moderator: Oh, so you just want to more about, like, what counts as an insanity plea and what doesn't?

24: I guess, I/

Moderator: What else would you like to know?

24: A lot of stuff. I mean I don't, I don't think I can name any certain one question about the like, he was, he was, he had that mental illness, does that mean any murder he committed, he could have claimed it? Or, or does/

Moderator: What does the expert say?/

24: Do you have to prove?

Moderator: About that? Like what's the most important time period?

22: In the moment, like that specific, like that/

22: When that happens, not like the day before...

24: How do you discern that?

Moderator: From a psychological evaluation.

24: Okay.

Moderator: That the expert gave.

24: Okay.

Moderator: All good questions. Like, like I would like you to write a twenty page paper and submit that to me, and I'll do research on all your questions.

24: Okay.

Moderator: Um, no I like that. That's good. That, that's what we want.

22: But then again he can't get the evaluation until a bunch of time has passed.

Moderator: Yup. Yeah. Okay. So I think at this point we, we've finished the focus group. So anything else ya'll wanna say? Before we talk...I really appreciate you all being so open and honest, and comfortable enough to talk and tell me what your opinion is. Um, so, yeah we'll stop the video and then I'll probably answer any questions you have.

Appendix II

Focus Group Transcription: LeHi

Moderator: Okay, this is the focus group for September twenty-sixth, twenty-twelve. I don't want to stand over there to talk to you. Okay, so, I appreciate everybody for participating in this part. We don't do it with every session, but it's very helpful to help us understand a little bit more about what led, um, you guys to your decisions in the case. Okay. So just to start out, maybe if you could tell me how the defendant's medication compliance influenced your decision making in the case. So either the defendant's compliance or lack, lack, thereof in the case.

56: Um, it influenced me to think he was more guilty. Because, I mean, not necessarily him being able to remember it, to take it every day, because I know he's not...schizophrenic...but like having someone there like to administer his medication and make sure he takes it and stuff, so he doesn't do anything wrong.

Moderator: Um hum. So it seems like, for you, that it made him, it made you feel like he was more guilty.

56: Yes.

Moderator: But you feel like it made him more guilty because somebody else wasn't there to give him the medication or because he didn't take it?

56: Like, because he didn't take it. But like...he could have had someone, because he could use the excuse of being Schizophrenic, and not taking it. But he could have made sure that someone...like hired someone or had someone there to like make sure he took it.

57: He wasn't proactive in making sure/

56: Yeah.

57: ...he actually was accountable.

56: Yeah.

Moderator: I understand. Do you mind putting your juror number up? (59)

59: Oh sorry.

Moderator: That's okay. So they can see it. Thanks. What else do ya'll think? Who else? Somebody who hasn't spoken...about how the defendant's medication compliance, or lack thereof, influenced your decision making...for example, do you feel like it made him less or more blameworthy?

58: I think, in his mind, he'd thought it'd make him less blameworthy. Since like, if you're not on your medication people are going to think, oh, like, you don't have control over it, but like she said, like, if he truly wanted to control his disease, like he would have, he would have found some way like...Whether it be like writing notes everywhere, like take your medicine, or hiring

someone to like come and make sure he's that taking his medicines, or whatever. Like, he could have done that, but he like just blatantly didn't care to take his medicines.

Moderator: And what do the rest of ya'll think? Do you have any thoughts on it?

55: Um, I agree with what like he said. Like, even though, like, um, like he was like forgetful and stuff, like he should have like made an effort to like make sure that he did take them.

Moderator: Did it influence your decision, do you think? Like did it influence your, your, thoughts of how blameworthy he was? Or was it just another fact?

56: I thought it made him more blameworthy.

Moderator: Um hum. Does anybody agree or did it not really affect it? We can go about it one by one if you don't care. So, for example, juror number 59, do you think that the fact that he wasn't on his medication made him more blameworthy or less blameworthy? Or you didn't factor it into his blameworthiness?

59: Um, I think that it made him more blameworthy because if he wasn't on his medication and this, like, did happen, compared to him just like doing it, like his own fault that he didn't take his medication. And even though like, it's not like he had voices telling him to do it, he still did something. Whereas if he had his medication, that might not have happened. Does that make sense?

Moderator: Yeah, so basically, you're saying that if he was on his medication it might not have even happened, even though you found that his mental state was not impaired at the time?

59: Yeah, well, yeah...that's what I said.

Moderator: And you said yes that's what you said? But it...it gets confusing.

59: yeah.

Moderator: So a lot of times I'm just repeating things back to you to make sure I heard them correctly.

56: Or even if, like, say he was on his medication, and he still murdered the person, it would make him less blameworthy because obviously he's trying to like get better, if he's taking his medication.

57: See I think that would just prove his guilt more, if he was on his medication. But like him taking it or not taking it didn't really influence me because I kind of paid attention to everything else and I kind of didn't really think so much about the use of medication or not just because they argued all the other cases where he was violent, and they didn't bring up this one. They didn't defend this one, and say oh Larry, the person that told him to be violent, told him to do this. Or there was no argument that in that moment he was psychotic and voices were talking to him and telling him to be violent. He just...was. He just did. So to me that didn't really matter because obviously it wasn't a factor in this specific incident.

Moderator: Um hum.

58: I think for me, like, the only thing that the medication came in was like him not being on it. Like, he could use that as a scapegoat for, like, why he did it. Like why he did what he did, because like, if he was on medication, then he has nothing to blame it on, but like... Like we said, I don't think... he, he was in the right state, but with having that prior, um, psychotic attacks, or whatever, that he could easily use that like as the crutch for like why he did it. But, if he would have been on his medication, people would have been like, been like no that doesn't matter, you're on your medicine so... he could almost use like not being on it to justify why he did it.

59: Um, I think going back to what she said, like, um, because he wasn't on his medicine... I don't think a normal person would just do that without being like ill in some way. Like, not a normal person would just push someone in front of a train for like no reason. That kind of thing...

Moderator: Okay. Can you tell me more about how that led to your decision?

59: Umm... I'm really nervous.

Moderator: You're doing a good job.

59: Um. I'm trying to make it like not confusing, like when I say it.

Moderator: That's okay. You can say it. I'll make sense of it later.

59: Um. Let me think for a second.

Moderator: Want us to come back to it?

59: Yeah.

Moderator: Okay. Well how about, how did hearing about the defendant's insight affect your decision making? Do you know what I mean by insight?

56: Like his knowledge of the disease and stuff?

Moderator: His knowledge of his disease, yeah so. Juror number 56 knew. Do the rest of ya'll know what I meant when I said insight?

58: Um hum.

Moderator: 57, 58. How about you 59?

59: Yeah.

Moderator: Yeah. Sort of. 55, a little less clear.

55: Um hum.

Moderator: Did the witness talk about that? The expert talk about his knowledge and his insight?

56: Yes.

57: He brought up that he knew he was sick, like all the time. That's what he always claimed whenever he did something bad. Oh I'm sick. Oh I'm sick. I'm sick. I'm sick. You can't blame me, I'm sick. So...

Moderator: So it did talk about the fact that he knew that he was sick?

Group: Um hum.

Moderator: Number 57, number 58 thought that. 56. So how did it affect your decision? Like did it make him more responsible? Or less responsible?

57: It kind of just made him look like he was using it as a reason to be violent, like it was a scapegoat for him.

Moderator: Um hum.

57: He could be violent because he could say he was sick.

Moderator: Does anybody else feel differently about that? I have two heads shaking no.

58: I agree with like what she said. Like I said earlier, I think he just used the disease, like him not being on his medicine, to do whatever he wanted because he could always blame it on his disease. If he like, he like got in trouble for it, like with any of his actions he was just like oh I'm sick so you can't blame me for it because I can't control it. But, I mean if you're always...if that's always your go to thing, it's like the boy who cried wolf. After a while we are going to stop believing you. Like every time you do something and said oh I'm sick all the time, like, it becomes less and less credible. Especially with this, where he didn't even hear the voices, like nothing is adding up. Like why did you do it this time without hearing voices? If you're trying to say it's sick...

Moderator: Um hum.

57: And like, with like, I believe some of the previous sentences, but they would like say later on he would come back and say he was sick. It wasn't like ten seconds later...I'm sick. It was like a day later when they confront him with something he did. I just couldn't control myself. And, I feel like, at the beginning, he was genuine about his illness. And now he's kind of like letting it just be like an excuse to do whatever the heck he wants to do.

Moderator: Anybody else want to add to that at all?

56: I just feel the same. Like maybe later you can realize, like, oh wait I did that because I'm schizophrenic. But like, I feel like, right after you murder someone to go and like be calm and be like I need to go to the hospital...it just doesn't really add up in my opinion.

Moderator: Um hum.

57: And the psychiatrist said that wasn't normal. After he was asked three times...because he didn't want to answer the question at first.

Moderator: So what exactly did he say wasn't normal?

57: The immediate change over into being calm. He said, like, if, you're still going to be, like, weird, and you're still going to be kind of like one a break/

56: On a psychotic break/

Moderator: Right.

57: And he said like after the, uh, prosecution kept saying well is it normal that he went like this to this...he was like no. After three times of asking him.

Moderator: Right. Yeah. Said is it normal that, would it, for your psychotic episode to turn on and off like a light switch and he said no.

56: Yeah.

Moderator: Is that what ya'll thought he was describing was that because he said he was sick, that meant he was no longer psychotic in that moment?

57: I think that's whenever he started to acknowledge what he did. Because, like, why would you just scream out, I'm sick. Because, like I said earlier, if you tell a two year old or a three year old that just kicked his brother, hey what are you doing? He's not going to be like, I'm three.

Moderator: Um hum.

57: You can't blame me. I'm three. They're just like, what? I kicked him. What do you want me to do about it?

Moderator: Um hum.

57: I mean, so, knowing that like it just doesn't add up why he would just immediately switch it, and then claim sickness. It's just kind of weird that he would do that.

56: I fell like after like he murdered the girl he would be kind of confused and like out of it as to what was going on. Instead of like right away acknowledging like oh yeah I'm schizophrenic, like take me to a hospital/

57: Yeah.

56: Like you would kind of be just like disoriented. I feel like...so...

Moderator: So if you're, if you have Schizophrenia, and you have insight into your Schizophrenia, what does that mean?

57: I think a lot of schizophrenics know like that they have it, and then they stop taking their medication and then they don't know they have it. Because that's what I've seen, like, whenever I've like looked into it and stuff/

Moderator: Um hum.

57: Is they'll be fine while they're on their medication and be like yes I'm going to be proactive about it, and I'm going to work towards being better, and every time I hear this voice, I'm going to tell it no. And then they get off their medication and they have no idea what's going on with themselves anymore. And the second they get back on it, they are back to knowing what's going on. So, I guess, my back knowledge of Schizophrenia makes me go that doesn't seem normal to me...because if you're not on your medication, you usually don't know what you're doing or that you're sick, or anything. You're just so and so told me to. That's all it is whenever someone asks you.

Moderator: So even if you have insight into your illness when you're actively psychotic you shouldn't have quite so much insight? So it made ya'll think that he was lying?

57: Um hum.

Moderator: Is that...I see four heads shaking yes so I'm thinking that's a yes. Okay.

56: Yeah.

Moderator: So did you consider his insight? Like the fact that he, he, knew he was supposed to be on medication, like he had an illness that needed medication in your decision...Or is just something we're talking about now? So you put it together...

57: I think that was definitely one of our big decision makers/

56: Yeah.

57: I think we all agreed when we were deliberating it that just was weird. That he knew what it was, and then he just claims he's sick. So then obviously he's just...it seems like he's just making it a scapegoat for himself. He's using/

Moderator: Well, what if he hadn't said anything right after the incident? So what if he hadn't said, I'm sick, and then later at the hospital, be so blunt. I'm sick, I know I'm supposed to be my medication...

58: Something else that like got to me was, like, also with him going straight to like being calm, was like/

56: Yeah.

58: How he was like so responsive to like everybody, what they were saying, like, I feel like, if you're in the middle of, like, a psychotic break, like you're still going to, like when people are approaching you, like you're still going to have that hesitancy. Like, because you think that people are coming after you, like especially with him, saying he thought of everybody being undead or whatever. Like, I'm not going to let somebody that is undead...like if part of walking dead, like the TV. show, like I'm not going to let a zombie just walk up to me and like talk to me. Like, I'm going to like fight back and he didn't do that to anybody else. Like he didn't try to like swing on anybody or push people away. Like he was just like totally responsive to everything like everybody was saying and that's when he was like, I'm sick get me to the hospital.

56: Yeah, and we talked about how it like seemed kind of planned in the moment. Like, him going up to the girl and asking her what time it was and like positioning himself, when he was like about to push her and stuff. And like, during an actual psychotic break, I feel like you wouldn't /

57: It would be more spontaneous.

56: Think that through...yeah.

57: And you would be just like, throw.

56: Freak out.

57: Because you can't really get ahead of a train, out of the train tracks that fast. They're pretty deep.

Moderator: So you would think that it would be that insanity in the moment and something like that would be automatic, as opposed to you wouldn't be able to/

56: Think it, like think out the process of/

57: It just seems...it appears too planned. It seems like he thought about it too much. And then him immediately going to being calm, makes him going, I'm sick, seem really like he's just using it to explain what he did.

Moderator: Um hum. Did you learn anything new from the testimony? Like just anything new at all? From like what the expert said? About anything?

56: I learned more about Schizophrenia, just because I didn't know that much about it.

Moderator: Um hum. Was it helpful making your decision making at all?

56: Um hum.

Moderator: What part helped?

56: I guess, just like, I don't know, learning like the symptoms and like everything. And like how, um, you can like have knowledge that you have it and stuff...because I didn't know that. I thought that if you had it, you didn't know you had it. If that make sense?

Moderator: Um hum.

56: So...

57: I feel like him explaining like his whole back story and how he normally acted when he legitimately had a schizophrenic break/

56: Yeah.

57: Also it just proved what the defense was already doing, because it was different than all the other ones. He didn't have Larry telling him to do it. He didn't claim that he had voices. It was just there. It was just kind of...it made him seem like he was lying more. And then the fact that

the expert was really, looking like he was reading it from a script made me not believe what he was trying to say.

Moderator: Um hum. And what parts did look like he was reading?

57: He never really looked at the defense. Like whenever the prosecution came up, he seemed like he was more honest and he like he would look at the prosecution, but if you watch the video, he's just like (looks away).

56: Yeah, and he lifts up the paper.

57: Yeah and he picks up the papers and he like, um, and you can see him looking down at it before he answers. And it's just kind of like, I don't think, I feel like he planned out what he was going to say more. Whereas with the prosecution, he didn't know it was coming, so it was just an honest answer.

Moderator: Right. Okay.

57: I kind of feel like he was biased towards the defense. So that makes me not want to take into account his biases towards the defense at all.

Moderator: I understand. So I think during that part is when he was, he was, reading lists, like long lists of like hospital records.

57: Um hum.

Moderator: So do you think that he should have had that part, not that I'm, I'm just wanting to know like the better, should he have had that memorized? Or, would that have sounded just as planned? I mean...

57: No. It's just...to me...he just appeared biased.

Moderator: Sorry. Okay.

57: And he looked dishonest, like the/

Moderator: Yeah.

57: His whole time up there talking to the defense, he just, he didn't seem honest.

Moderator: Okay. What are/

57: So I think that just played into me thinking he was just reading to her.

Moderator: Um hum. What else did ya'll think about the witness then? The rest of you...

56: Um, I agree with her, like, I just thought that, it seemed a little, like when he was like talking to the defense, a little too planned out and stuff like that.

Moderator: Um hum.

58: I think. I mean, I think he had a good, like when they were doing his whole background, I mean he's credible, and stuff but, I feel like it's one of those things that they knew it would be someone that would kind of side with them more.

Moderator: Um hum.

58: So that's why they picked him. Like, you can pick like any, like with research and stuff, you can always try to find a doctor or whatever that like sides with you. So like, there might have been some like prior bias that we don't know about as to why they picked him of all people, because he doesn't have like a history with him. So it's, it's not like he's his go to doctor. So it's almost like somebody that maybe, not knowing all this stuff, like he has like a bias towards helping those type of like cases or something.

Moderator: Um hum.

57: I think the fact that the defense hired him kind of backs that up.

Moderator: Okay. Would it have been less biased if he would have been his doctor?

56: I/

57: I think I would have believed it more.

56: I think it could have been more biased because he could have like an emotional connection to his patient. Like, depending on how much he's worked with his and stuff...

Moderator: Okay. So, you said you learned something new about insight? The fact that people can have insight into their illness... You didn't know that before? Was that new for anybody else? Not new for anybody else? Not to the degree that you talked about? So if you had to rate it, on a scale from one to ten, of how important his insight, or his knowing about his Schizophrenia, influenced your decision; ten being like it was a huge part of your decision, how would you rate it? From one to ten...Do you know?

55: Um, probably like an eight because he like knew the consequences of it.

Moderator: Of what?

55: Like his disease...Like if he didn't take like his medication and stuff/

Moderator: Okay.

55: He knew what could happen, and what he was like capable of doing.

Moderator: Okay.

56: And I'd say an eight or a nine, because if you like have no insight of it, like you don't know any steps to take to better control it.

Moderator: Um hum.

56: And he was like pretty aware that he had it so...

57: A seven or eight probably.

Moderator: Okay.

58: I'd say like an eight or a nine, just because with him, if he didn't know anything about it, like you couldn't blame him for like a lot of the stuff, like the different attacks. Like if he had no clue, what was causing it..but like him knowing it, like he, he ran the risk of, especially not being on his medicine, of like having those attacks and he was fine with like running the risk.

Moderator: Um hum. How about you 59?

59: Um. I like definitely considered it and I think that it was important, but for his action of pushing her I don't think that was like "an attack" of his illness. I just think that was something that he wanted to like see how far he could go with it. So...I like thought that his insight was important, but, at the same time, for that like that one incident, I kind of questioned it for a little bit...

Moderator: Okay. I think this relates to what you were talking about before. So like his insight and medication non-compliance, and all that stuff can lead up to how you're conceptualizing him as a defendant I guess, but if you don't think that the incident had anything to do with his mental illness then they...don't really relate anymore. Is that what you were referring to?

59: Kind of. Like, obviously, like a normal person wouldn't do that so like so it had something to do with his illness, but I don't think that it was like a huge factor like on the attack, because he was normal before and after. And like he didn't have anybody like telling...like "voices in his head."

Moderator: Um hum. What if he did have voices in his head telling him to do it, and it was very clear?

59: I think that, if like he did hear voices, he would have done it, and like, been okay with it because don't people with the disease or the illness, like if you hear voices, you always are not going to do it and you don't listen to them you like kind of hurt your, or want to hurt yourself afterwards or something?

56: Or you think you can do it and it will go away.

57: That's what a lot of...that's kind of like...

Moderator: Well let's think about one specific example so we'll all be on the same page. So if in this case, the defendant heard the voice and listened to the voice and did it, that would be an obvious sign of his symptoms, of his illness, right?

Group: Um hum.

Moderator: So then the behavior would relate, like the incident would relate to his illness.

56: Yeah.

Moderator: SO how would his not taking his medication come into play then?

57: I couldn't really like blame him necessarily, because he was having a psychotic break and I don't necessarily hold him personally responsible for always taking his medication because I feel like his mom, or his family that was around him, should have kept him proactive. But I know that a lot of people with mental illnesses don't like taking medication, because they feel worse about themselves. So knowing that, it makes me not take that into account and I probably would have said not guilty by reason of insanity. But, to me, the two instances aren't linked so I couldn't.

Moderator: Um hum, And they're not linked because of his insight into his mental illness? Because he knew he had a mental illness, the medication would have, whether he was on it or not, doesn't really come into play because the insight makes you feel like he was just lying...right? Am I understanding?

Group: Yeah.

Moderator: Sorry. Um. So what stood out to you most about the case? Like what had the most impact about the defendant or his mental illness? Just down the line...

59: Um, I would say before and after he was so normal and just tried blaming it away.

Moderator: Okay.

58: Yeah, I would say just like just how, um, it seemed liked it was just so thought out and he automatically just shifted back to acting, I guess, normal at the end and like just acting like...he, he needed help. Like it just didn't fit in with the rest of it. And all the prior attacks...

Moderator: Um hum. Because when you're psychotic, you wouldn't have that insight? Right?

58: Well I just think that...well, what I mean by like normal like where he just seemed like...he went from like pushing her and then like with all the other attacks like it was like, it wasn't immediately that he was back to like, I need help I need to go to the doctor, like...

Moderator: Um hum.

58: It just seemed like it was, it's so much different than all the other attacks that they had mentioned that they had. Like, it just seemed like it was almost...he was using it as like a, a crutch. Like his safety net to go to of why he did it.

57: I think, for me, it was like the fact that the prosecution made their point, and they argued it well and they presented a good case. And the defense didn't defend this incident. They defended his fact that he was actually schizophrenic, which they didn't really need to.

Moderator: Um hum.

57: Because the prosecution wasn't arguing that.

Moderator: Um hum.

57: But they didn't argue that he was psychotic in that moment. They argued that he was psychotic in general. So to me, the fact that they didn't present any evidence to defend

themselves whenever the prosecution presented evidence that condemned their case, that definitely played a huge role, in my decision.

Moderator: Um hum. I'm definitely following you there. So, what kind of things could, things that about it, him at the time that would have made it seem like he was psychotic, at the time?

56: If he had actually, like, shown any of his other symptoms. Like hearing Larry talking to him, or seeing like dead people or whatever his symptoms were.

Moderator: Um hum.

56: If they had said he had experienced that.

Moderator: Um hum.

57: Or just arguing on that incidence in general. Like for awhile they spent a lot of time on the boy. Like, that he attacked a little boy, and they didn't really ever talk about him killing the girl. So that, I don't know, they were trying to defend him using a case previous, which doesn't relate.

Moderator: Um hum. So what stood out to you most (56)?

56: Um, what she (57) saying about, like, the defendant's strategy, I guess, and not really touching on the actual murder, and um also like how it didn't seem like he was on a psychotic break because kind of how he thought through murdering the girl, and then...

Moderator: Um hum.

56: And not displaying like any symptoms of being like out of it or anything after. Being like normal. So basically...

Moderator: What about you 55?

55: For me, it was like his behavior before and after, like the incident.

Moderator: And how was his behavior before?

57: He was acting a little weird but like a couple of hours before that he was acting normal. Because he had lunch with that...other patient.

Moderator: Um hum.

57: And then he acted kind of funny, but not like violent funny. And then he went and attacked the girl, and then he was...light switch...it's off. So it's weird...It just didn't go along with what they said would be consistent with a psychotic break.

Moderator: Um hum. Alright. One second, let me check this. Alright well I think I pretty much have, I think I understand what led to ya'll's decision. Anything else you think I need to know? We understand your frame of mind? Ok. Alright, let me stop this.

Focus Group Transcription: LeLi

Moderator: Um, okay so the first thing I kind of want to talk about is, uh, I need to have a little bit of a better understanding of how the defendant's medication compliance, or his lack thereof, influenced your decision? So specifically, did you think about it on your own, or while you were watching the testimony, or was it something that you thought about once it came up in deliberation?

40: I thought about it as soon as, like, they were talking to the doctor, but...

38: Yeah.

39: Me too.

38: In the video.

Moderator: In the video? So it sounds like everybody agrees, including 37. Where the camera can't see. Um, okay, so you thought about it while you were watching the video, so it was something you were thinking about, so did his noncompliance make him more or less blameworthy?

39: More blameworthy.

Moderator: More blameworthy for you, and for 40 and 41?

38: Same.

Moderator: 37 and 38? How about for you 42?

42: Well I mean, I guess it made him look guilty but that doesn't, I mean, that doesn't mean I think he's completely guilty. But yeah that, that would kind of make him more guilty.

Moderator: Okay. So for you still though the fact that he didn't take his medication was still a negative thing?

42: Yeah, yeah, absolutely.

Moderator: It made him more guilty, or closer to that/

42: Yeah yeah.

Moderator: So instead of guilt maybe like blameworthy?

42: Like responsible more than guilty.

Moderator: Okay. Can you tell me a little more?

42: About?

Moderator: Just what, what it is that made him more responsible.

42: Well that, I mean, yes I realize he should have taken his medicine and he's responsible for not like not taking it, but at the same time, well what I had just already said, but yeah.

Moderator: Okay. So who thinks it was his responsibility to take his medication? The, that cannot hear your arms. But okay so it was 40, 38, 39, all of ya'll thought he was responsible, 37?

40: Yes.

Moderator: For taking his medication. Okay.

39: He was completely normal when he woke up, so he was completely aware that he needed to take his medication in order for those episodes to occur.

Moderator: I heard ya'll talking about that a little bit, so that he was completely normal when he woke up, so was there evidence saying that he was normal that day?

39: Yeah.

38: Wasn't/

39: Didn't the, when they went to through/

Moderator: Remember I'm just asking questions, so.

39: His activities before, the doctor had brought up, he was just going through a normal day, doing things that he enjoyed doing he said, so obviously he made those decisions under normal circumstances, to go do things that he enjoyed, that day.

Moderator: Um hum. Did they say that part? Or is that the part, that's just what, if you're doing something you enjoy doing and you're, you're able to kind of get around in the environment, to you, you assume that means you're, you're okay. Right?

39: Yes.

Moderator: Okay. So does anything that day that wasn't normal, quote un-quote, that he was doing?

40: He was at the train station on Sunday, when he knew that his brother didn't work on Sundays.

Moderator: Um hum. So is that clear thinking?

40: No.

Moderator: No?

40: I mean they said, it's was like, kind of, I don't know it's like both sides. It's like he knows that his brother doesn't work on Sundays, yet he's at the train station.

Moderator: Um hum.

39: See that's normal thinking I think.

Moderator: That's he's able to think through that his brother ...because he's going to see his brother, and he knows that he's got to get to the train station to see his brother, so it shows that he's thinking through, does that makes sense?

39: Yeah.

Moderator: Even though he got the day wrong?

39: Um hum.

Moderator: Okay. But it still shows that he knows that he has to get to his brother?

39: Um hum.

Moderator: Okay. Um, was there anything else that you learned about his behavior that day that influenced what you thought he was thinking, like how he was thinking that day?

40: I can't remember the, if the doctor ever wanted to like, because I know the prosecution wanted to know about like the days before and the day after.

Moderator: Um hum.

39: And he never went in to it.

40: Yeah. Did he? I don't remember if he did or not.

39: He didn't.

Moderator: Right, yeah so, they were talking for a little bit there about the days before and what did the expert say in response to those questions?

40: He said it matter in his opinion.

Moderator: Right.

39: But, but then again, but then they would ask the question a different way and he would be like yeah to does matter. So he kind of went back and forth. He kind of like, you know?

Moderator: Um hum.

39: Contradicted himself.

Moderator: Yeah, because I think he basically said that it matters, but not as much as something else. Right? What was the most important thing to consider?

42: His state at that time.

Moderator: His state at that moment?

42: Um hum.

Moderator: Okay well let's talk about a little bit more about his insight. So what do I mean by the defendant's insight?

40: Whether he knew it was right or wrong at that moment.

Moderator: Whether he knew it was right or wrong at that moment?

42: What was going on in his mind.

Moderator: What was going on in his mind at the time? Okay. So actually what I'm referring to specifically the expert didn't inform you of this, but is his actually understanding of whether he knows he has a mental illness or not. So kind of broader than that. So his understanding of whether he knows he's sick.

38: Like he did know.

39: He knows.

41: He told the police he was.

Moderator: And he told the police he was. I heard, we'll come back to that, because I heard that a few times. Um hum. Okay. So who thought, we'll just go around, who thought that he did know that he was sick? 37 says yes.

38: Yeah.

Moderator: 38.

39: Yes.

40: At the time of the incident I think he knew he was sick. Maybe like not in his earlier years, but he definitely knew by like 2006, that he had Schizophrenia.

Moderator: By the time it happened? Okay. And 41 says yes. Do you think that he knew he was sick, 42?

42: Well I mean, like the fact that you know that you're sick doesn't mean that you have it in mind all the time so...

Moderator: Okay.

42: And especially if you're sick like you're not going to think, oh it's because I'm sick that I'm doing these things, like maybe at that moment you think that's the most reasonable thing.

Moderator: Um hum. And I heard ya'll talking about that a lot, so, let's, let's back up a little bit more. So does knowing what's wrong with you, say, does know, does Mr. Duncan knowing that something's wrong with him and that he needs to go to the hospital, like he said when the police

came, he said I need to go to the hospital, when you say that and he knows that he's sick does that mean that he has a full understanding of his sickness?

38: Yeah.

Moderator: Yes?

39: Yes. He has a full understanding that he has to take that medication.

38: Well the fact that he, like he has medication for it/

Moderator: Um hum.

38: He's already diagnosed and that, afterwards he was like I'm, I know that was wrong.

Moderator: Um hum.

38: And I knew, I knew what I did was wrong. And he knew about, like the fact that he said that, like he was already conscious, like oh that was wrong I shouldn't have done that.

Moderator: Um hum. And when did they say that he knew it was wrong?

40: Twelve hours later.

Moderator: Twelve hours later, at the station. Okay so let's back up just a little bit more. So, the fact that five of you thought that he understood that he had an illness and was supposed to be taking his medication, how does that influence your verdict?

39: As in like group conformity? Pretty much.

Moderator: Oh. Well that's very interesting, but I was actually just thinking like before you'd sort of been talking about it, but we heard you talk about it as well. But yeah so yeah if you thought, just while you were talking, thinking about it about the evidence and you were saying well he know he has a mental illness and he knows that he supposed to take his medication and he doesn't, did that make him more or less blameworthy?

39: More.

40: Yeah, more blameworthy, but I just I don't get why he's even out of the hospitals in the first place. That's just my whole shabeel.

Moderator: You don't get why he was even out of the hospital in the first place?

38: Well I think they said, I think in the beginning they said that the reason that/

39: They couldn't control him.

38: Yeah they couldn't, they were, they weren't going to keep him in the hospital because he kept hurting people. But he was like, he shouldn't be in the hospital, he should be in like a/

40: Yeah well then he needs to go up one then he needs to go to something more secure.

38: Um hum.

Moderator: Okay.

40: So why did they did they just release him if they knew he was a fighter?

39: That's true.

38: That was the wrong decision.

Moderator: So let's back up again a little bit. Sorry I'll keep bringing ya'll back to this. So what if the doctor had made it very clear that Mr. Duncan did not understand that he was sick? And what if you were convinced that the doctor, that Mr. Duncan didn't realize that he was suppose to be sick and taking his medicine? How would that have changed?

38: I would have thought that he would be guilty with insanity, because he didn't know.

Moderator: Because he didn't know...

38: That he was sick.

Moderator: Um hum. And that he was supposed to take his medicine/

38: Right.

Moderator: How about you 37? Would that change your opinion?

37: Um hum. I think he's guilty [inaudible].

Moderator: Because he didn't know that he had to? Do you agree or disagree 39?

39: Or really, I don't know because I feel like if you're e getting help like that then you're going to know. If he didn't know all together and hadn't visited a doctor, I would think he's not guilty by insanity. But he had been to a doctor so he, there's no way he could have absolutely not known he was insane.

38: Yeah.

39: People cannot just be feeding him stuff like this for no reason.

Moderator: Okay. So you're saying maybe if it was like his first break and he had never been to a doctor and he didn't have any clue, then maybe/

39: Yes.

Moderator: But if he had been to the doctor before and still had no understanding and the doctor said he really has no understanding, you still wouldn't be able to wrap your head around how he couldn't have any understanding? Right?

39: Yes.

Moderator: 39 and 37 you seem to kind of agree.

37: Yeah I didn't think about that when she said it, but now I kind of am on the fence of both.

Moderator: Okay. How about you 40? If he, going back to calling ya'll numbers, if he hadn't known or had not known that he was sick and still not taken his medication, would that have changed anything?

40: Not for me personally. No.

Moderator: Okay. And why so?

40: I just, I don't, uh, I means it's the same old thing. Like he's been going to doctors since 1995.

Moderator: Um hum.

40: That's eleven years.

Moderator: Um hum.

40: And uh if, if he's not in some kind of like psych ward or something like that by then and like obviously, but all the doctors are saying he's getting more aggressive every time. And he's, he's fully aware of that I think. And it's about time we lock him up or something. I don't know. Just/

Moderator: So you're saying just for safety reasons?

40: Yeah.

Moderator: You wouldn't be able to finish anything else. Okay. How about 41? If you thought that, if you really believed that he didn't understand that he had a mental illness and he still chose not to take his medicine, would you be able to believe that ever?

41: I don't know.

Moderator: You don't know? Well what if the doctor said that he thought he was, that he didn't understand tha the needed his medication?

41: Then I would change it to guilty by insanity.

Moderator: But I heard that during the deliberations that was be hard for some of you to kind of think about the idea, like you were saying 42, that he might not understand that he needs to take his medication.

38: But I think he did understand.

Moderator: Um hum.

40: Yeah.

39: Even if he didn't understand, he was given medication so that's his choice not to take it so he's going to suffer the consequences/

38: But even if he didn't understand, yeah, if he didn't understand that he was sick, he still knew there was something wrong/

Moderator: Um hum.

38: With him that he had to take medicine.

Moderator: Um hum.

38: So the fact that like you have to take your medicine to feel better regardless of, you know, whatever, because he might not have thought that him hearing voices or him being paranoid was like him being sick. He could have thought it was just normal.

Moderator: Um hum.

38: And the fact that he was given medicine shows that he should know that at least something's wrong that he has to take that. Like, why would someone give you medicine unless you need it?

Moderator: Um hum. So even if you don't believe that you're sick, you should just trust the doctors because they were giving medicine to him so obviously you obviously need it.

38: Right.

40: Right. And that's, did you know about the case I was talking about? Have you ever seen A Beautiful Mind.

Moderator: I can't really answer questions during this part of it/

40: Okay, well...

Moderator: But I heard you talk about it/

40: It's about, it's about that true story about the economist, I don't know, back in the 40's or something.

Moderator: Um hum.

40: And like he had no idea that he had Schizophrenia like throughout his college career, and like but then he eventually he had doctors telling him this stuff and at first he didn't want to believe it and that kind of reminded me of Andrew Duncan. Like, they're out to get me and stuff. But I mean, it's like, but this guy, the guy that came up with all these theories was actually smart enough to realize like when he almost like drowned his child or like almost killed somebody, he realized like, okay yeah I got a problem. But like, Andrew Duncan keeps being more aggressive and like keeps believing that he doesn't have a problem.

Moderator: Yeah so you're saying at some point the, the person, that person was able to gain insight into his illness and it's unbelievable that after eleven years Mr. Duncan wouldn't have gained insight into his illness?

40: Yeah. So there, yeah so that's sounds like it's his choice by then. And it's just, he needs to, he's guilty.

Moderator: Okay. Um, and so 42 would it change your thought process at all if you had thought that he, well you thought that he didn't understand that he needed his medication, right?

42: Well he didn't, but at the same time I think, I mean we don't always know like, for example if the, the doctors are going to let him live at his own house, and like with no major security, like maybe he can think like oh maybe it's not that bad or not completely understand/

Moderator: Um hum.

42: Like he could not completely understand that he could be that dangerous.

Moderator: Right.

42: So that, that like could have made him be like, oh okay to not take his medicine or maybe he wasn't consciously not taking the medicine, maybe he was just like, or what I said like he, I mean nobody wants to be sick. But, but I mean I would still think that it's by insanity.

Moderator: Um hum. Okay. So is there anything new that you learned during the testimony or during...I guess yeah pretty much during the testimony? That you, anything new that you learned you learned about mental illness in general or insight or medication or anything like that?

40: Medication seems to help.

Moderator: Medication seems to help?

40: Yeah.

Moderator: Okay.

40: Doctor knows best. I guess.

Moderator: Doctor knows best. So what stood out to you most, just going in a circle, like what stood out to you about what you...more or less what led to you decision? 37?

37: What led to my, what led me to find him guilty?

Moderator: Yeah. What stood out the most?

37: Was that he would like admit himself saying that I know something's wrong, I can't control myself.

Moderator: Um hum.

37: So he knows something's is not right and so I know, and then he, twelve hours later he said that he knew it was wrong. So...

Moderator: Um hum.

37: That's what made me believe he was guilty.

Moderator: Okay. How about you 38? What stood out the most?

38: Um, well the fact that he was already diagnosed with Schizophrenic and he had medicine, and the fact that he had past anyway, because he, he's hurt, he had been violent before/

Moderator: Um hum.

38: And so like those were, you know it's not okay to hurt someone, be violent, but it was almost like a slap on the wrist, like you know, you've brought, you know you need to take your medicine or whatever, and then it escalated to killing someone. That's a fact like you have to draw the line when you actually take a life.

Moderator: Okay. What stood out to you the most 39?

39: Um, when he told the police officer that he was schizophrenic, because he knows he has a problem and he can't use it as an excuse any longer. For murdering someone.

Moderator: Um hum. And when did he tell the police officer that he had Schizophrenia?

39: Twelve hours later after.

Moderator: Um hum. Okay. And how about you 40? What stood out to you the most?

40: The fact that he's been free for eleven years and he had, there was 3,500 pages worth of medical records of his exponential aggravation.

Moderator: Okay.

40: And how the doctors didn't take care of that.

Moderator: Okay. And how about you 41? What stood out to you the most?

41: The exact same thing he (40) just said.

Moderator: Okay. And how about you 42? What stood out to you the most to lead you to the decision that you made?

42: Well at first like I didn't know, because I didn't know a lot, well too much about Schizophrenia/

Moderator: Um hum.

42: So I what I was thinking was like well maybe he could have made it up or something. And then like, I guess it was mainly like what the doctor said. Because even if you understand like, like what it does and like how, I mean how people with those illnesses like do things. Does that make sense?

Moderator: Um hum. And so, and you used that to, to understand from your perspective how he would have been able to make the decision or not to take his medicine, right?

42: Yeah.

Moderator: Because I think throughout the deliberation, just to infer, so we can move things along, that you were inferring pretty much that he would never be like in the right state of mind enough to decided whether he could or couldn't take his medicine.

42: Yeah, yeah. Almost. Like I said/

Moderator: Almost? Okay. Whereas others, like 41 used an example things like that about how you take medicine. So if you take medication then you know every day. Right? And so...is that the same though? As somebody with Schizophrenia?

41: I don't know.

Moderator: You don't know? Yeah.

41: I don't have Schizophrenia so I don't know.

Moderator: True. So based off what the doctor said though does it sound like you would be clear thinking enough in order to take medication?

39: I think he would.

Moderator: Yeah. Okay. I know it sounds like I'm attacking you, it's because I have to ask questions and not provide any feedback. Um, okay, well there's one last thing I wanted to ask ya'll about. Ya'll talked about how it like drew a parallel to drinking and driving. Can ya'll tell me a little bit more about that?

38: Because so much drinking, um, like they have a choice, like, like if you know that alcohol is bad for you, you know that, most people who drink know what alcohol can, like does to you. Like being drunk and you know losing self-control. Like, you know there's a choice to drive home or not and you know you shouldn't if you are drinking, and it's the fact that if someone's drinking decided to drive home because they thought they were okay, but they knew they were drinking.

Moderator: Um hum.

38: And they hit like killed someone, I think that's the same, it was around the same, you know, like/

39: Because they weren't in the right state of mind.

Moderator: Um hum.

39: Just like he wasn't when he murdered this woman, but before they were in the right state of mind to know that that was a wrong decision.

38: You, you know that you're not/

41: Or you could stop drinking.

39: Yeah.

Moderator: So before, before the incident, and what did the judge tell ya'll or what were the rules about what, what time period you were supposed to be thinking about? Were you supposed to be thinking about like before when he chose not to take his medicine or focus in on the moment?

39: The moment.

Moderator: Right. But that was obviously hard to do/

38: But he didn't take his medicine, well he didn't take his medicine/

Moderator: Without, without considering what led him to that moment? Yeah. Do you think if you were instructed specifically to just focus in on that moment and that whatever led to it, up to that point, do you think you would, like you're supposed to ignore...

39: I think it's impossible to ignore that. That is the biggest causation of his actions.

Moderator: Um hum.

39: So I would say the judge is wrong in that. That's...

Moderator: Um hum.

40: That's just a law loop hole.

39: Um hum.

Moderator: Um hum. A law loop hole. Okay, anything else? I know ya'll are antsy to go, but it's really valuable to hear ya'll talk. So is there anything else that led to your decision or that you felt that I should know from your deliberations? Ya'll talked a lot during ya'll's deliberations. So that was helpful to understand where you were coming from. Okay. So did the expert testimony make him seem more or less blameworthy?

39: More.

Moderator: Why so?

39: It, wasn't he for the defendant or are you allowed to answer that?

40: Yeah he was, he was/

39: He was the defendant's witness?

38: [Inaudible, 1 second]

Moderator: He was called on by the defense.

39: Okay.

38: Did he actually like the , all the information that he like stated and all of the facts and all the like all that was, it wasn't, I think it was just neutral. Like it was just plain information. It was like/

39: I mean he told, he told, yeah. I, I think what he was saying was neutral but/

38: It did, it didn't/

39: It still ended up making him look even more blameworthy, because...

38: He stated all the facts.

39: Yeah. He stated the facts.

Moderator: 40 doesn't look like/

40: I mean I thought the doctor was a little biased towards the defense.

Moderator: Um hum. Why?

40: In favor of the defense, because I mean it was a patient of his and he had to look over him after and before it too. And uh, he was trying to not really plead, but I felt like he was trying towards the, uh, get off easier plea. Insanity plea. But I mean he was providing the facts on both sides clearly and perfectly so. I mean, he gave both sides good advice so but I still felt like he was in favor of the defense.

Moderator: Um hum. And so, last question and then I'll, ya'll tried not to talk about punishment, but I did hear you take, speaking about punishment, so what happens if the defendant ends up guilty? What would his punishment be, do you think?

39: Jail.

Moderator: Jail?

40: It's not jail but he goes to a special prison.

39: He goes to a prison and gets help.

37: And he goes to like a psychiatric hospital/

39: And he has no choice, He's going to get the help.

Moderator: Um hum. So 37 and 39 think he goes to jail but he gets help and support/

37: Like counseling...to talk/

Moderator: Counseling. And 40 you think he goes to like a state psychiatric/

40: Yeah. State psychiatric/

38: That's what I think too.

40: Where he's kept there for/

38: But like that's like, like he's guilty, but he's not just like oh because you're insane/

37: Yeah like/

40: I don't, yeah, I don't know what the years are for murder, but he'd be at that psychiatric ward for/

38: It's like a prison for people like them.

Moderator: Um hum. So 41 you said you think he goes to jail? Anything special about him going to jail or would he just go to jail?

41: Just go to jail for however long.

Moderator: How about 42? What do you think would happen to him if he's found guilty?

42: Well I mean I would hope that he wouldn't just go to jail. I would hope that he would get like help.

Moderator: Um hum.

42: But I don't know if that's necessarily going to happen because like usually when somebody's just guilty that means you are guilty because you wanted to kill her, or, I'm not, I mean just like that, you're guilty and you go to jail and that's it.

Moderator: Uh huh.

42: So that's why, you know.

Moderator: So what happens if you're found not guilty by reason of insanity then?

39: That's when I think you go to a psychiatric ward.

42: Yeah.

Moderator: Um hum. SO what, so 40 and 38, sorry to put you on the spot/

38: I think you go to a, like, I think it would just be you would be like placed under supervision and it's almost like, like not like a probation but like, um, uh almost like a probation but like/

Moderator: But like out in the community?

38: Yeah, but I mean like in your house. Like you have to like supervised at all times, like...

Moderator: Okay.

40: Not guilty means that you'll serve no time.

Moderator: Uh huh.

40: And by insanity means you're going to have some kind of doctoral help.

38: Right and be like supervised/

40: Yeah.

Moderator: Okay. Okay. Ya'll are done. I'm going to give you a questionnaire and then you can go. I'm going to stop this.

Appendix KK

Piloted Judge's Charge (Instructions) to the Jury

Script Derived from:

- **Purple** - Colquitt, 1994 (AL Pattern Judge's Instructions)
- **Black** - *People v. Goldstein*, 2004 (Case transcript)
- **Blue** - Titcomb & Brodsky, under review (Titcomb's thesis – piloted and finalized script)
- **Brown** – Wording adjusted slightly for logistics/truncating instructions

Read by: Jennifer Wilson, MA (audio only) (*Word Count* – 828)

Jurors, before you deliberate I have to explain the rules of law which you must follow in order to be fair to both sides. **Remember to** follow the law and not just what you might personally think is just.

Your duty as a juror is determine if the defendant is guilty, not guilty by reason of insanity, or not guilty. This is the guilt phase of the trial. Thus, sentencing comes later and should not be considered now. You are not to consider the punishment if the defendant is found guilty or not guilty by reason of insanity when you are determining your verdict.

Essentially we have two trials here. **In your first decision, you must determine if the state has proved the elements of the crimes. The question to ask yourself is “Is the defendant’s guilt established?” If so, then your second decision is to determine if the defendant is criminally responsible for that crime or if he is “Not Guilty by Reason of Insanity.”**

To make this first decision, start your deliberations by presuming the defendant’s innocence. Before a conviction can be had in this case, **you must** all agree **unanimously** that the State’s credible evidence shows the defendant’s guilt beyond a reasonable doubt.

The phrase “reasonable doubt” is self-explanatory. It is a doubt based upon reason and common sense. The law does not require proof beyond *all* doubt. **So you must consider the doubt you have remaining** after going over in your minds the entire case and giving consideration to all the testimony. **If you have no doubt or if only less than a reasonable doubt remains, then the standard of proof has been met and the facts of the crime have been proven presented by the state have been proven. However, if you are left with a reasonable doubt or more, then the defendant is entitled to the benefit of it, and you should find him NOT GUILTY [Instruction I.4].**

The charge you need to consider is Murder in the Second Degree. To convict, the State must prove each of the following: 1) That Katelyn Webber is dead; 2) That the defendant Mr. Duncan caused her death; and 3) That in doing so, the defendant either intended to cause or death OR that he was aware of the grave risk to Ms. Webber’s life, but consciously disregarded this foreseeable risk **[Instruction 6.3, Ala. Code 13A-6-2a(2)].**

The defendant also has pled not guilty by reason of insanity. So if you decide that the defendant committed the crime, you must then make a second decision. This is where you consider the

defendant's **defense** that he nevertheless is *not* criminally responsible *because* of a severe mental disease or defect. The **defense** must show this. They must show that **first** that the defendant was suffering from a severe mental disease; **and second** that as a result of this mental disease, he was **either** (a) was unable to appreciate the nature and quality, or consequences of his acts or (b) he was unable to appreciate the wrongfulness of his acts.

So, you **are not** just determining if the defendant has a mental illness because some mentally ill people can be responsible for their criminal conduct. To be found **not** responsible, the defense must also show that **because** of his mental disease or defect, the defendant *did not know what he was doing, or that he did not know the consequences of his actions, or that he was unable to know that his actions were wrong.* **Wrong** is used in its broadest sense, including what was legally wrong, **as well as** what ordinary people commonly understand to be morally wrong, bad or evil.

The defense must prove this with a preponderance or majority of the evidence. A **preponderance of the evidence** means that the degree of certainty should be **more certain** than it is *uncertain* that the defendant was **not** criminally responsible. *If the defendant was not criminally responsible for the act due to his state of mind at the time of the offense,* then you must find him Not Guilty By Reason of Insanity because his mind essentially was incapable of committing a crime.

Your first task at the start of the deliberation is to select a jury foreperson, for example, by majority vote. Deliberations should not begin until the foreperson is selected. The **foreperson's role** is to preside over the discussion of the case and act as chairperson for the jury when communicating with the Judge. *When you have reached a verdict in this case, then you will complete the verdict form and the foreperson will submit the verdict.*

Any verdict returned must be the verdict of all six of you; that is, it must be a unanimous verdict. It is your duty as jurors to be open-minded, to consult with one another to deliberate with the goal of reaching agreement. Each of you must decide the case for yourself, but only after impartial consideration of the evidence.

Appendix LL

FOLLOW-UP QUESTIONS: Instructions Pilot

1. How would you rate (**CHECK MARK**) your comprehension of the judge’s instructions?

1	2	3	4	5	6	7	8	9	10
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*Did Not
Understand*

*Completely
Understood*

2. As a juror, you should start your deliberations thinking the defendant is _____.

3. The **Prosecution** is trying to show that the defendant is _____. The **Defendant** entered a plea of _____ in this case. What does this plea try to show?

4. List **ALL** the possible verdict options for this case? _____

5. If you think it was proven that the defendant **DID** do the crime, what must you do you do next?

6. Which side must prove that the defendant **is** guilty beyond a reasonable doubt?

The Prosecution _____ The Defense _____

7. Which side must prove that the defendant was **not** responsible for his actions at the time of the offense?

The Prosecution _____ The Defense _____

8. Describe in your own words, what does *proving something beyond a reasonable doubt* mean?

9. What does showing something by a *preponderance of the evidence* mean?

10. What important first thing must you do at the start of your deliberation?

11. The jury’s verdict in this case must be: _____ unanimous **OR** _____ by majority rule

12. What should **NOT** be considered in your decision-making? _____

13. Any questions about the instructions? _____

Appendix MM

Piloted testimony manipulations for each of the five conditions.

MC/C

Direct

DEFENSE: How do you, Doctor, treat people with Schizophrenia?

EXPERT WITNESS: Schizophrenia is primarily treated with antipsychotic medications that may also have some side effects.

DEFENSE: Was Andrew Duncan treated with medications?

EXPERT WITNESS: Yes. Mr. Duncan was primarily prescribed Haldol over his years of treatment.

DEFENSE: In your clinical opinion Doctor, how did Mr. Duncan react to needing medication?

EXPERT WITNESS: Mr. Duncan accepted that he should take the advice of the psychiatrist. He seemed to realize he was mentally ill and he was careful to take his medication.

DEFENSE: Was Andrew Duncan taking his medication during the time of the incident on January 3rd, 2007?

EXPERT WITNESS: Yes. Pharmacy records and Mr. Duncan himself reported that he was compliant with his medication during the time period leading up to and during the offense.

DEFENSE: Did you have opportunities to interview Andrew Duncan when he was both on and off his medication?

EXPERT WITNESS: No.

DEFENSE: Can you tell us any differences that you might have expected to observe in his medicated and un-medicated state?

EXPERT WITNESS: Mr. Duncan has traditionally been and is currently compliant with his medications, so it was not possible to interview him off his medication. However, if untreated, persons with Schizophrenia will become more psychotic and their thinking will become markedly impaired.

DEFENSE: From the defendant's medical records, is there any evidence that he was seeking help for his condition?

EXPERT WITNESS: Yes. In 1999, he checked himself into a psychiatric facility. Another time that year, he called 911 asking to be brought to the ER. A few years later, he signed into yet another hospital.

Cross

PROSECUTION: Isn't it true, that the defendant routinely blamed his illness when confronted with problem situations, saying quote – Well, I'm not feeling well – or I need to have my medication adjusted?

EXPERT WITNESS: Those statements were in Mr. Duncan's record from times when he was admitted to the hospital. However, medication adjustments are common to the treatment of Schizophrenia.

PROSECUTION: So, just to reiterate, Andrew Duncan was on his medication during the offense?

EXPERT WITNESS: Yes, that is correct.

PROSECUTION: Isn't it true that in the defendant's hospital records from 2001, he had refused to sign a patient contract agreeing to not hit or act aggressively towards patients and staff.

EXPERT WITNESS: Yes. He refused because he felt he couldn't enter into a contract that he couldn't keep.

Closing Statements:

DEFENSE: Ladies and Gentlemen. Andrew Duncan lives with Schizophrenia. He has received this diagnosis and medication from dozens of doctors; he has the classic symptoms of this disease. His illness has become progressively worse and the medication did not seem to be helping. The mental health system failed Mr. Duncan by only providing a revolving door of services. Due to the severe symptoms of his illness, Andrew committed acts of violence against others. Andrew Duncan did not have control over himself. It wasn't a loss of control, as the State would have you believe. There was no debate in his mind of right and wrong. The experts told you this, from the moment he pushed a woman in front of the train. He wasn't there, his mind wasn't there, he wasn't debating the issue. Of course after it happened, afterwards when people tell him what happened, then he knows it's wrong. Of course, anyone knows it's wrong, but the issue is the moment he did it was his mind there? The timing of the act makes no difference if the act was not decided on with a right mind. The law states that a person is not responsible for their actions if they do not comprehend the nature and the consequences of their action or if they do not know that action is wrong. At the time of the event on the subway platform, Andrew Duncan did not know the nature of his actions. It would be unlawful to find Mr. Duncan responsible according to the law. Thank you.

PROSECUTION: Thank you. Ladies and Gentlemen, Andrew Duncan is mentally ill and he takes medication for that. As you saw earlier, Andrew Duncan was reporting symptoms that are not characteristic of Schizophrenia or any other known mental illness. He has a motive to exaggerate his symptoms here, as he has had a motive to in the past. And with past violent episodes, he has always stated that he was mentally ill right from the start in order to avoid punishment. If Andrew Duncan was exaggerating his Schizophrenia symptoms, and there is evidence that he was, then he did know what he was doing on that awful day and he did know what he was doing was wrong. Andrew Duncan had a pretty good day that fateful day for Katelyn Webber. That day, he visited places he wanted to visit and enjoyed things he wanted to enjoy. He is claiming he couldn't control himself because he knows he can get away with it. He knows that the law does make this exception for truly mentally ill people. With people like Andrew Duncan abusing the system in this way, how can we protect our citizens? He needs to be found responsible for this crime. He understood the nature of his behavior at the time, its consequences, and that it was wrong. Thank you.

MNC – LeHi

Direct

DEFENSE: How do you, doctor, treat people with Schizophrenia?

EXPERT WITNESS: Schizophrenia is primarily treated with antipsychotic medications that may also have some side effects.

DEFENSE: Was Andrew Duncan treated with medications?

EXPERT WITNESS: Yes. Mr. Duncan was primarily prescribed Haldol over his years of treatment. Medical records typically describe Mr. Duncan as responding well to the medication when he was in a supervised setting that required him to take his medication.

DEFENSE: In your clinical opinion doctor, how did Mr. Duncan react to needing medication?

EXPERT WITNESS: Mr. Duncan seemed to realize he was mentally ill, but he did not want to take the advice of the psychiatrist or be dependent on medication. He took medication when in the hospital, but he stopped taking his medication when he was not in a supervised setting.

DEFENSE: Was Andrew Duncan taking his medication during the time of the incident on January 3rd, 2007?

EXPERT WITNESS: No. His medical records note that he was not taking his medication, and we know that his prescription had not been filled for several weeks.

DEFENSE: Did you have opportunities to interview Andrew Duncan when he was both on and off his medication?

EXPERT WITNESS: Yes.

DEFENSE: Can you tell us any differences that you might have observed in his medicated and un-medicated state?

EXPERT WITNESS: Yes. He was more psychotic off his medication; his thinking was markedly impaired.

DEFENSE: From the defendant's medical records, is there any evidence that he was seeking help for his condition?

EXPERT WITNESS: Yes. In 1999, he checked himself into a psychiatric facility after becoming nervous and scared. Another time that year, he called 911 asking to be brought to the ER stating that he was confused and could not function and needed some help. A few years later, he signed into yet another hospital after hearing voices and complaining that someone was trying to evaporate his brain. On his application for admission, he writes that his reasons for applying for admission are "severe Schizophrenia,"

Cross

PROSECUTION: Isn't it true, that the defendant routinely blamed his illness when confronted with problem situations, saying quote – Well, I'm not feeling well – or I need to have my medication adjusted?

EXPERT WITNESS: Yes. He did.

PROSECUTION: So, just to reiterate, even though the defendant knew he was supposed to be on medication, Andrew Duncan was not on his medication during the offense?

EXPERT WITNESS: Yes, that is correct.

PROSECUTION: Isn't it true that in the defendant's hospital records from 2001, he had refused to sign a patient contract agreeing to not hit or act aggressively towards patients and staff.

EXPERT WITNESS: Yes. He refused because he believed his mental illness was causing these behaviors.

Closing Statements:

DEFENSE: Ladies and Gentlemen. Andrew Duncan lives with Schizophrenia. He has received this diagnosis and medication from dozens of doctors; he has the classic symptoms of this disease. His illness has become progressively worse and the medication did not seem to be helping, he stopped taking it. The mental health system failed Mr. Duncan by only providing a revolving door of services. Andrew Duncan refused to take his medication. Due to the severe symptoms of his illness, Andrew committed acts of violence against others. Andrew Duncan did not have control over himself. It wasn't a loss of control, as the State would have you believe. There was no debate in his mind of right and wrong. The experts told you this, from the moment he pushed a woman in front of the train. He wasn't there, his mind wasn't there, he wasn't debating the issue. Of course after it happened, afterwards when people tell him what happened, then he knows it's wrong. Of course, anyone knows it's wrong, but the issue is the moment he did it was his mind there? The timing of the act makes no difference if the act was not decided on with a right mind. The law states that a person is not responsible for their actions if they do not comprehend the nature and the consequences of their action or if they do not know that action is wrong. At the time of the event on the subway platform, Andrew Duncan did not know the nature of his actions. It would be unlawful to find Mr. Duncan responsible according to the law. Thank you.

PROSECUTION: Thank you. Ladies and Gentlemen, Andrew Duncan is mentally ill and although he was prescribed medication, he did not take it. As you saw earlier, Andrew Duncan was reporting symptoms that are not characteristic of Schizophrenia or any other known mental illness. He has a motive to exaggerate his symptoms here, as he has had a motive to in the past. And with past violent episodes, he has always stated that he was mentally ill right from the start in order to avoid punishment. If Andrew Duncan was exaggerating his Schizophrenia symptoms, and there is evidence that he was, then he did know what he was doing on that awful day and he did know what he was doing was wrong. Andrew Duncan had a pretty good day that fateful day for Katelyn Webber. That day, he visited places he wanted to visit and enjoyed things he wanted to enjoy. He is claiming he couldn't control himself because he knows he can get away with it. He knows that the law does make this exception for truly mentally ill people. With people like Andrew Duncan abusing the system in this way, how can we protect our citizens? He needs to be found responsible for this crime. He understood the nature of his behavior at the time, its consequences, and that it was wrong. Thank you.

MNC – LeLi

Direct

DEFENSE: How do you, Doctor, treat people with Schizophrenia?

EXPERT WITNESS: Schizophrenia is primarily treated with antipsychotic medications that may also have some side effects.

DEFENSE: Was Andrew Duncan treated with medications?

EXPERT WITNESS: Yes. Mr. Duncan was primarily prescribed Haldol over his years of treatment. Medical records typically describe Mr. Duncan as responding well to the medication when he was in a supervised setting that required him to take his medication.

DEFENSE: In your clinical opinion doctor, how did Mr. Duncan react to needing medication?

EXPERT WITNESS: Mr. Duncan did not really seem to realize or even understand that he was ill. At first, he took the advice of the psychiatrist and took his medication. Very soon, however, he stopped taking his medication altogether.

DEFENSE: Was Andrew Duncan taking his medication during the time of the incident on January 3rd, 2007?

EXPERT WITNESS: No. His medical records note that he was not taking his medication, and we know that his prescription had not been filled for several weeks.

DEFENSE: Did you have opportunities to interview Andrew Duncan when he was both on and off his medication?

EXPERT WITNESS: Yes.

DEFENSE: Can you tell us any differences that you might have observed in his medicated and un-medicated state?

EXPERT WITNESS: Yes. He was more psychotic off his medication; his thinking was markedly impaired.

DEFENSE: From the defendant's medical records, is there any evidence that he was seeking help for his condition?

EXPERT WITNESS: Yes. In 1999, he checked himself into a psychiatric facility after becoming nervous and scared. Another time that year, he called 911 asking to be brought to the ER stating that he was confused and could not function. A few years later, he signed into yet another hospital after hearing voices and complaining that someone was trying to evaporate his brain.

Cross

PROSECUTION: Isn't it true, that the defendant routinely blamed his illness when confronted with problem situations, saying quote – Well, I'm not feeling well – or I need to have my medication adjusted?

EXPERT WITNESS: Yes. He did.

PROSECUTION: So, just to reiterate, even though the doctors had prescribed medication, Andrew Duncan was not on his medication during the offense?

EXPERT WITNESS: Yes, that is correct.

PROSECUTION: Isn't it true that in the defendant's hospital records from 2001, he had refused to sign a patient contract agreeing to not hit or act aggressively towards patients and staff.

EXPERT WITNESS: Yes. He refused because he did not know why he was doing these behaviors.

Closing Statements:

DEFENSE: Ladies and Gentlemen. Andrew Duncan lives with Schizophrenia. He has received this diagnosis and medication from dozens of doctors; he has the classic symptoms of this disease. His illness has become progressively worse and the medication did not seem to be helping, he stopped taking it. The mental health system failed Mr. Duncan by only providing a revolving door of services. Andrew Duncan failed to take his medication. Due to the severe symptoms of his illness, Andrew committed acts of violence against others. Andrew Duncan did not have control over himself. It wasn't a loss of control, as the State would have you believe. There was no debate in his mind of right and wrong. The experts

told you this, from the moment he pushed a woman in front of the train. He wasn't there, his mind wasn't there, he wasn't debating the issue. Of course after it happened, afterwards when people tell him what happened, then he knows it's wrong. Of course, anyone knows it's wrong, but the issue is the moment he did it was his mind there? The timing of the act makes no difference if the act was not decided on with a right mind. The law states that a person is not responsible for their actions if they do not comprehend the nature and the consequences of their action or if they do not know that action is wrong. At the time of the event on the subway platform, Andrew Duncan did not know the nature of his actions. It would be unlawful to find Mr. Duncan responsible according to the law. Thank you.

PROSECUTION: Thank you. Ladies and Gentlemen, Andrew Duncan is mentally ill and although he was prescribed medication, he did not take it. As you saw earlier, Andrew Duncan was reporting symptoms that are not characteristic of Schizophrenia or any other known mental illness. He has a motive to exaggerate his symptoms here, as he has had a motive to in the past. And with past violent episodes, he has always stated that he was mentally ill right from the start in order to avoid punishment. If Andrew Duncan was exaggerating his Schizophrenia symptoms, and there is evidence that he was, then he did know what he was doing on that awful day and he did know what he was doing was wrong. Andrew Duncan had a pretty good day that fateful day for Katelyn Webber. That day, he visited places he wanted to visit and enjoyed things he wanted to enjoy. He is claiming he couldn't control himself because he knows he can get away with it. He knows that the law does make this exception for truly mentally ill people. With people like Andrew Duncan abusing the system in this way, how can we protect our citizens? He needs to be found responsible for this crime. He understood the nature of his behavior at the time, its consequences, and that it was wrong. Thank you.

MNC - HeHi

Direct

DEFENSE: How do you, Doctor, treat people with Schizophrenia?

EXPERT WITNESS: Schizophrenia is primarily treated with antipsychotic medications that may also have some side effects. There are two forms, what are called traditional antipsychotics and newer antipsychotics. These medications are generally good at treating classic symptoms of Schizophrenia - what you would think of as psychotic symptoms - like hallucinations and delusions - but they are less effective at clearing up the thought dysfunction.

DEFENSE: Was Andrew Duncan treated with medications?

EXPERT WITNESS: Yes. Mr. Duncan was primarily prescribed Haldol over his years of treatment.

DEFENSE: Can you tell us a bit about Haldol and these other medications?

EXPERT WITNESS: Yes. Haldol is a traditional antipsychotic. What we call "traditional" antipsychotics are usually reserved for use when psychotic symptoms are extreme or hard to treat with the newer medications. Both forms of medication can be effective treatments, but traditional antipsychotics are sometimes preferred for treating severe psychotic symptoms.

DEFENSE: Are there side effects to these medications?

EXPERT WITNESS: Yes, there can be. Everyone's response to medication is different. Some medications work better for some people and some side effects are more present in some patients. Traditional antipsychotics, like the ones prescribed to Mr. Duncan, they have been found to bring with them some moderate to serious side effects. For this reason, the newer medications are often preferable if possible.

DEFENSE: What are some of these side effects?

EXPERT WITNESS: In clinical studies, the *most* serious side effects found have been fatigue and dull energy, foggy thinking, significant weight gain, sexual dysfunction, and uncontrollable Parkinson's like tremors and slowed movements. Treating physicians are trained to be on the look out for these side effects and monitor them; adjusting medications when they become significant problems. so such serious side effects are pretty rare these days.

DEFENSE: Did Mr. Duncan experience any of these side effects, Doctor?

EXPERT WITNESS: Medical records typically describe Mr. Duncan as responding well to the medication when he was in a supervised setting – a setting that mandated that he take his medication. His records do note some *mild to moderate* side effects of his medication regimen. The most common side effects noted in Mr. Duncan's charts were [looks at notes] grogginess during the day, sleep difficulties, and some weight gain.

DEFENSE: In your clinical opinion Doctor, how did Mr. Duncan react to needing medication?

EXPERT WITNESS: Both in records and when I interviewed him, Mr. Duncan seemed to accept that he was mentally ill. This is what physicians call having insight into your mental illness. Not all Schizophrenics have this insight, but Mr. Duncan did. Mr. Duncan also recognized his need for medication. Although Mr. Duncan knew he had a mental illness and understood that he needed medication, he did not want to live with the side effects of the medication. His record also noted that he did not want to live his life dependent on medication. He took medication when in the hospital, but he stopped taking his medication when he was not in a supervised setting.

DEFENSE: Was Andrew Duncan taking his medication during the time of the incident on January 3rd, 2007?

EXPERT WITNESS: No. His medical records note that he was not taking his medication, and we know that his prescription had not been filled for several weeks. A major consequence of Schizophrenia is often poor judgment, when not supervised, poor judgment associated with psychosis and confused thinking. We know that when Mr. Duncan is off his medication, it's like a downward slide from bad to worse.

DEFENSE: Did you have opportunities to interview Andrew Duncan when he was both on and off his medication?

EXPERT WITNESS: Yes.

DEFENSE: Can you tell us any differences that you might have observed in his medicated and un-medicated state?

EXPERT WITNESS: Yes. He was more psychotic off his medication; his thinking was markedly impaired.

DEFENSE: From the defendant's medical records, is there any evidence that he was seeking help for his condition?

EXPERT WITNESS: Yes. In 1997, he checked himself into a psychiatric facility after becoming nervous and scared. Another time that year, he called 911 asking to be brought to the ER stating that he was

confused and could not function and needed some help. In the records for a subsequent hospitalization, the patient stated **[look at notes]** that he wanted to study his illness and he wanted to get a degree in psychology. A few years later, he signed into yet another hospital after hearing voices and complaining that someone was trying to evaporate his brain. On his application for admission, he writes that his reasons for applying for admission are “severe Schizophrenia, hopefully will cure.”

Cross

PROSECUTION: Isn't it true, that the defendant routinely blamed his illness when confronted with problem situations, saying quote – Well, I'm not feeling well – or I need to have my medication adjusted?

EXPERT WITNESS: Those statements were in Mr. Duncan's record from times when he was admitted to the hospital. However, medication adjustments are common to the treatment of Schizophrenia because as the symptoms change and progress, the medications need to be monitored and adjusted.

PROSECUTION: So, just to reiterate, even though the defendant knew he had a mental illness and he knew he was supposed to be on medication, Andrew Duncan was not on his medication during the offense?

EXPERT WITNESS: Yes, that is correct. This is called medication noncompliance and is very common in persons with Schizophrenia for a variety of reasons. For Mr. Duncan, it appeared to be because of his mild to moderate side effects that I mentioned earlier and his desire to live his life free of medication.

PROSECUTION: Isn't it true that in the defendant's hospital records from 2001, he had refused to sign a patient contract agreeing to not hit or act aggressively towards patients and staff.

EXPERT WITNESS: Yes. He refused because he believed his mental illness was causing these behaviors so he couldn't enter into a contract that he couldn't keep.

Closing Statements:

DEFENSE: Ladies and Gentlemen. Andrew Duncan lives with Schizophrenia. He has received this diagnosis and medication from dozens of doctors; he has the classic symptoms of this disease. His illness has become progressively worse and the medication did not seem to be helping, he stopped taking it. *Many* schizophrenics *refuse* to comply with taking medication or need supervision to ensure compliance. The mental health system failed Mr. Duncan by only providing a revolving door of services. Due to the severe symptoms of his illness, Andrew committed acts of violence against others. That day on the platform, we know he was off his medication and the expert showed how this coincides with a deterioration of Andrew's illness. Andrew Duncan did not have control over himself. It wasn't a loss of control, as the State would have you believe. There was no debate in his mind of right and wrong. The experts told you this, from the moment he pushed a woman in front of the train. He wasn't there, his mind wasn't there, he wasn't debating the issue. Of course after it happened, afterwards when people tell him what happened, then he knows it's wrong. Of course, anyone knows it's wrong, but the issue is the moment he did it was his mind there? The timing of the act makes no difference if the act was not decided on with a right mind. The law states that a person is not responsible for their actions if they do not comprehend the nature and the consequences of their action or if they do not know that action is wrong. At the time of the event on the subway platform, Andrew Duncan did not know the nature of his actions. It would be unlawful to find Mr. Duncan responsible according to the law. Thank you.

PROSECUTION: Thank you. Ladies and Gentlemen, Andrew Duncan is mentally ill and although he was prescribed medication, he chose not take it. As you saw earlier, Andrew Duncan was reporting symptoms that are not characteristic of Schizophrenia or any other known mental illness. He has a motive to exaggerate his symptoms here, as he has had a motive to in the past. And with past violent episodes, he has always stated that he was mentally ill right from the start in order to avoid punishment and he has not been on his medication. That day on the platform, he was not on his medication – [**with emphasis**] he chose not to take his medication. If Andrew Duncan was exaggerating his Schizophrenia symptoms, and there is evidence that he was, then he did know what he was doing on that awful day and he did know what he was doing was wrong. Andrew Duncan had a pretty good day that fateful day for Katelyn Webber. That day, he visited places he wanted to visit and enjoyed things he wanted to enjoy. He is claiming he couldn't control himself because he knows he can get away with it. He knows that the law does make this exception for truly mentally ill people. With people like Andrew Duncan abusing the system in this way, how can we protect our citizens? He needs to be found responsible for this crime. He understood the nature of his behavior at the time, its consequences, and that it was wrong. Thank you.

MNC - HeLi

Direct

DEFENSE: How do you, Doctor, treat people with Schizophrenia?

EXPERT WITNESS: Schizophrenia is primarily treated with antipsychotic medications that may also have some side effects. There are two forms, what are called traditional antipsychotics and newer antipsychotics. These medications are generally good at treating classic symptoms of Schizophrenia - what you would think of as psychotic symptoms – like hallucinations and delusions – but they are less effective at clearing up the thought dysfunction.

DEFENSE: Was Andrew Duncan treated with medications?

EXPERT WITNESS: Yes. Mr. Duncan was prescribed primarily Haldol over his years of treatment.

DEFENSE: Can you tell us a bit about Haldol and these other medications?

EXPERT WITNESS: Yes. Haldol is a traditional antipsychotic. What we call “traditional” antipsychotics are usually reserved for use when psychotic symptoms are extreme or hard to treat with the newer medications. Both forms of medication can be effective treatments, but traditional antipsychotics are sometimes preferred for treating severe psychotic symptoms.

DEFENSE: Are there side effects to these medications?

EXPERT WITNESS: Yes, there can be. Everyone's response to medication is different. Some medications work better for some people and some side effects are more present in some patients. Traditional antipsychotics, like the ones prescribed to Mr. Duncan, they have been found to bring with them some moderate to serious side effects. For this reason, the newer medications are often preferable if possible.

DEFENSE: What are some of these side effects?

EXPERT WITNESS: In clinical studies, the *most* serious side effects found have been fatigue and dull energy, foggy thinking, significant weight gain, sexual dysfunction, and uncontrollable Parkinson's like tremors and slowed movements. Treating physicians are trained to be on the look out for these side effects

and monitor them; adjusting medications when they become significant problems, so such serious side effects are pretty rare these days.

DEFENSE: Did Mr. Duncan experience any of these side effects, Doctor?

EXPERT WITNESS: Medical records typically describe Mr. Duncan as responding well to the medication when he was in a supervised setting – a setting that mandated that he take his medication. His records do note some *mild to moderate* side effects of his medication regimen. The most common side effects noted in Mr. Duncan’s charts were **[looks at notes]** grogginess during the day, sleep difficulties, and some weight gain.

DEFENSE: In your clinical opinion doctor, how did Mr. Duncan react to needing medication?

EXPERT WITNESS: Both in records and when I interviewed him, Mr. Duncan did not seem to realize or understand that he was mentally ill. This is what physicians call a lack of insight into your mental illness. This lack of insight into knowing and believing you are schizophrenic is a very common. Schizophrenia causes breaks from reality, mistrust of others, and disrupted thinking that makes it difficult for patients to understand that they are mentally ill. When hospitalized, Mr. Duncan took the advice of the psychiatrist and took his medication. Soon, however, because of his thought disorganization and some of the mild to moderate side effects of the medication, Mr. Duncan stopped taking the medication.

DEFENSE: Was Andrew Duncan taking his medication during the time of the incident on January 3rd, 2007?

EXPERT WITNESS: No. His medical records note that he was not taking his medication, and we know that his prescription had not been filled for several weeks. Without insight - or in other words, without understanding and accepting that he was mentally ill – we can see how Mr. Duncan would not believe he needed medication. Also, a major consequence of Schizophrenia is often poor judgment when not supervised, poor judgment associated with psychosis and confused thinking. We know that when Mr. Duncan is off his medication, it’s like a downward slide from bad to worse.

DEFENSE: Did you have opportunities to interview Andrew Duncan when he was both on and off his medication?

EXPERT WITNESS: Yes.

DEFENSE: Can you tell us any differences that you might have observed in his medicated and un-medicated state?

EXPERT WITNESS: Yes. He was more psychotic off his medication; his thinking was markedly impaired.

DEFENSE: From the defendant’s medical records, is there any evidence that he was seeking help for his condition?

EXPERT WITNESS: Yes. In 1997, he checked himself into a psychiatric facility after becoming nervous and scared. Another time that year, he called 911 asking to be brought to the ER stating that he was confused and could not function. A few years later, he signed into yet another hospital after hearing voices and complaining that someone was trying to evaporate his brain. Mr. Duncan was clearly in distress during these time periods, but he did not seem to realize his problems were due to a mental illness and he did not believe that taking medication would help.

Cross

PROSECUTION: Isn't it true, that the defendant routinely blamed his illness when confronted with problem situations, saying quote – Well, I'm not feeling well – or I need to have my medication adjusted?
EXPERT WITNESS: Those statements were in Mr. Duncan's record from times when he was admitted to the hospital. However, medication adjustments are common to the treatment of Schizophrenia because as the symptoms change and progress, the medications need to be monitored and adjusted.

PROSECUTION: So, just to reiterate, even though the doctors had prescribed medication, Andrew Duncan was not on his medication during the offense?

EXPERT WITNESS: Yes, that is correct. This is called medication noncompliance and is very common in persons with Schizophrenia for a variety of reasons. For Mr. Duncan, it appeared to be because of his lack of insight into his mental illness and the side effects that I mentioned earlier. Why would he take medication for an illness he does not understand he has? This is a common problem for people with Schizophrenia and can lead to medication noncompliance. It becomes a cycle of low insight – medication noncompliance – and worsening of symptoms.

PROSECUTION: So, even though he has been treated for Schizophrenia for a decade and he is always prescribed medication in the hospital, we are supposed to believe that the defendant did not know he was sick?

EXPERT WITNESS: No. It is clear that Mr. Duncan realized something was wrong with him, (as I stated before), but *because* of his mental illness, he was unable to understand and accept *on his own* that he had a diagnosable disease called Schizophrenia and that he needed to be treated with medication.

PROSECUTION: Isn't it true that in the defendant's hospital records from 2001, he had refused to sign a patient contract agreeing to not hit or act aggressively towards patients and staff.

EXPERT WITNESS: Yes. He refused because he did not know why he was doing these behaviors; so he felt he couldn't enter into a contract that he couldn't keep.

Closing Statements:

DEFENSE: Ladies and Gentlemen. Andrew Duncan lives with Schizophrenia. He has received this diagnosis and medication from dozens of doctors; he has the classic symptoms of this disease. His illness has become progressively worse and the medication did not seem to be helping, he stopped taking it. *Many* schizophrenics, because of thought disorganization and confusion, *fail* to comply with taking medication. He believed that the doctors were poisoning him with cyanide. The mental health system failed Mr. Duncan by only providing a revolving door of services. Due to the severe symptoms of his illness, Andrew committed acts of violence against others. That day on the platform, we know he was off his medication and the expert showed how this coincides with a deterioration of Andrew's illness. Andrew Duncan did not have control over himself. It wasn't a loss of control, as the State would have you believe. There was no debate in his mind of right and wrong. The experts told you this, from the moment he pushed a woman in front of the train. He wasn't there, his mind wasn't there, he wasn't debating the issue. Of course after it happened, afterwards when people tell him what happened, then he knows it's wrong. Of course, anyone knows it's wrong, but the issue is the moment he did it was his mind there? The timing of the act makes no difference if the act was not decided on with a right mind. The law states that a person is not responsible for their actions if they do not comprehend the nature and the consequences of their action or if they do not know that action is wrong. At the time of the event on the subway platform, Andrew Duncan did not know the nature of his actions. It would be unlawful to find Mr. Duncan responsible according to the law. Thank you.

PROSECUTION: Thank you. Ladies and Gentlemen, Andrew Duncan is mentally ill and although he was prescribed medication, he did not take it. As you saw earlier, Andrew Duncan was reporting symptoms that are not characteristic of Schizophrenia or any other known mental illness. He has a motive to exaggerate his symptoms here, as he has had a motive to in the past. And with past violent episodes, he has always stated that he was mentally ill right from the start in order to avoid punishment and he has not been on his medication. That day on the platform, he was not on his medication – regardless of the reason, he wasn't taking it. If Andrew Duncan was exaggerating his Schizophrenia symptoms, and there is evidence that he was, then he did know what he was doing on that awful day and he did know what he was doing was wrong. Andrew Duncan had a pretty good day that fateful day for Katelyn Webber. That day, he visited places he wanted to visit and enjoyed things he wanted to enjoy. He is claiming he couldn't control himself because he knows he can get away with it. He knows that the law does make this exception for truly mentally ill people. With people like Andrew Duncan abusing the system in this way, how can we protect our citizens? He needs to be found responsible for this crime. He understood the nature of his behavior at the time, its consequences, and that it was wrong. Thank you.

Appendix NN

FOLLOW UP QUESTIONS: Testimony Pilot

1. Rate the **OVERALL STRENGTH** of the expert's testimony?

1	2	3	4	5	6	7	8	9	10
<i>Very WEAK</i>					<i>Very STRONG</i>				

2. How **PERSUASIVE/CONVINCING** was the expert's testimony?

1	2	3	4	5	6	7	8	9	10
<i>Not at all Persuasive</i>					<i>VERY persuasive</i>				

3. How **INFORMATIVE** was the expert's testimony?

1	2	3	4	5	6	7	8	9	10
<i>Not at all Informative</i>					<i>VERY informative</i>				

4. Was the defendant taking his medication? **YES** **NO**
 4a. **If NOT**, why was he NOT taking his medication?

5. Did the defendant understand he had a mental illness? **YES** **NO**
 5a. **If NOT**, why did he NOT understand he had a mental illness?

5b. **What or Who** is to **blame** for the defendant not taking his medication?

6. In your opinion (based on what you read), how much is the **defendant AT BLAME** for **HIS MENTAL STATE** at the time of the crime?

1	2	3	4	5	6	7	8	9	10
<i>Not at all at blame</i>					<i>100% at Blame</i>				

7. Anything else you (as the juror) wanted to know about the defendant's mental illness, his understanding of his mental illness, or his medication?

Appendix OO

Pilot Study: Pre-Study Check of Instructions and Manipulations

Several aspects of the proposed study design were piloted using UA undergraduate psychology students to assist in the stimuli development (i.e., the Judge's charge to the jury; the expert's testimony manipulations). This pilot data were collected exempt from the UA Institutional Review Board approval (per Policy 1.2 of the UA IRB standards, which states that "students doing pilot studies for their own thesis or dissertation" research are not required to seek IRB approval for research exercises or small studies being conducting to pilot procedures and manipulations). This pilot data are not permitted to be disseminated outside of the dissertation document (i.e., cannot be included in future publications). However, the purpose of the data collection was to serve as an initial manipulation check, which will be continued throughout the study (that can be reported in future publications).

The researcher conducted three data collection sessions using three different groups of undergraduate psychology statistic students ($N = 127$). Permission to conduct this data collection was given by the instructor Gregg Bell, PhD. Prior to any data collection, participants were informed of the nature of the pilot data collection, the voluntary nature of their participation, and that they would receive no credit from the research pool or their instructor for participation. Each pilot session lasted approximately 15 to 20 minutes in length. Due to the constraints of the session and given the narrow purpose of the data collection, no demographic or otherwise identifiable information was collected. All participants received a brief verbal introduction by the researcher, the respective stimulus material, and a one-page questionnaire. At the end of each session, participants were provided with the researcher's name and contact information, as well as her supervisor's contact information, for any concerns or questions related to their

participation. All pilot data were analyzed in SPSS 17.0 and assessed for general trends and descriptive summaries.

Judicial Instructions Pilot

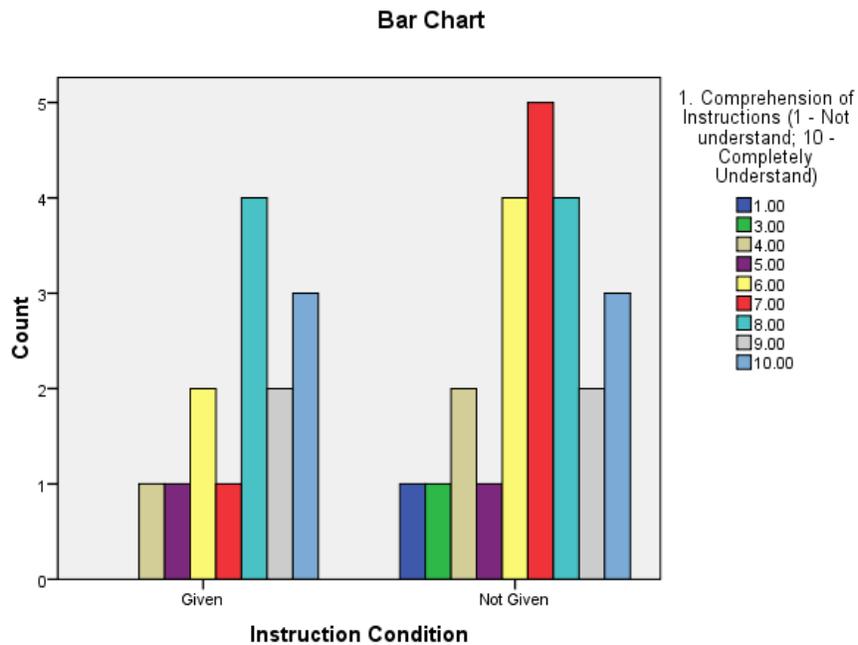
The Judge's "charge" (instructions) to the mock jury in this case was piloted for two purposes: (1) to test mock jurors' comprehension of the instructions, and (2) to explore potential differences in comprehension between participants who were read the instructions *only* (Not Given written instructions, "NG" condition) and those who were provided with a written instruction *in addition* to having them read by the researcher (Given written instructions, "G" condition). In mock jury research there is a tradeoff between optimizing the participant's comprehension of the task (to increase validity of findings) and maintaining verisimilitude with the procedures as accepted by the courts. Mock jurors have been found to demonstrate difficulty in comprehending instructions during NGRI proceedings (e.g., Crocker & Kovera, 2010; Finkel & Slobogin, 1995; Ogloff, 1991). However, jurors in similar, real-life proceedings are not given written instructions and are not typically discouraged to take notes on these instructions (Colquitt, 1994).

To examine differences in comprehension of the proposed instructions in this study, a portion of the participants ($n = 14$) were randomly assigned to the "G" condition and given the pilot instruction (Appendix KK) with which to read along. The remaining participants ($n = 23$) were randomly assigned to the "NG" condition and only received the outcome questionnaire. See Appendix LL for details of the corresponding manipulation check questionnaire. Participants rated comprehension of instructions on a likert-type scale from 1 (Did not understand) to 10 (Completely understood). Overall self-rated comprehension of the instructions was acceptable to good ($M = 7.14$, $SD = 2.18$), with the comprehension of participants in the G condition ($M =$

7.71, $SD = 1.90$) roughly one-rating point higher than the NG participants ($M = 6.78$, $SD = 2.30$). An independent samples t-test indicated no statistically significant difference between groups on self-reported comprehension, $t(35) = 1.27$, $p = .211$ (two-tailed) with the magnitude of the mean difference (.93) having a small to medium effect ($\eta^2 = .04$). The below chart provides the count data for endorsement of comprehension ratings “1” through “10,” separated by group. Note that the outcome is *count* data and thus, the relative height of the bars should not be interpreted as comparable percentages given there are different n’s between groups. As seen in the below Figure 28, although the lowest ratings for comprehension were from the NG condition, this condition also yielded some of the highest ratings (possibly indicating a greater range due to the higher n represented by this condition).

Figure 28

Self-reported comprehension of judicial instruction (Pilot Study)



In addition to self-reported comprehension, actual comprehension total scores were calculated for each participant, which was then used to compute a percent correct score for each participant. For example, if participant X correctly answered 12 of 13 items, her *percent correct score* would be $12/13 = 92\%$. Percent correct scores were compared with self-reported comprehension (e.g., a “7” would translate to an estimated level of comprehension at 70%). Finally, the actual percent correct score was subtracted from the self-reported comprehension score, to generate a *percent difference* score for each participant (i.e., for participant X this score would be 22%, meaning she actually evidenced higher comprehension than she self-reported). Percent difference scores by condition is represented below in Table 13 (*next page*):

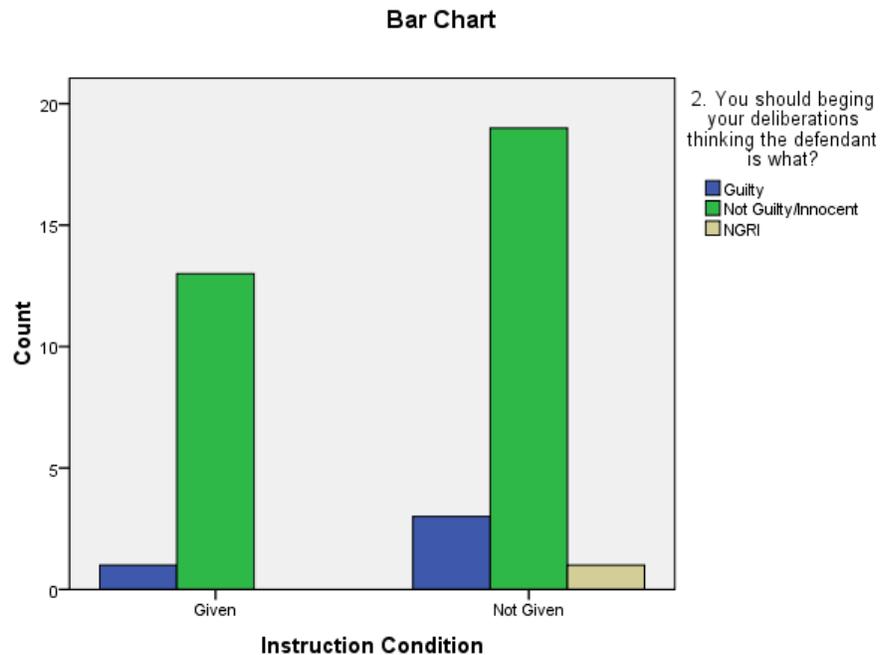
Accuracy of Self-Reported Comprehension					
Overall Sample N = 37		By Condition			
		G Condition (n = 14)	NG Condition (n = 23)		
% Difference	Cumulative Frequency	% Difference	Cumulative Frequency	% Difference	Cumulative Frequency
= 0	3	= 0	2	= 0	0
≤ 10%	15	≤ 10%	6	≤ 10%	9
≤ 25%	30	≤ 25%	12	≤ 25%	18
≤ 40%	34	≤ 40%	13	≤ 40%	21
≤ 50%	35	≤ 50%	13	≤ 50%	23
≤ 52%	37	≤ 52%	14	≤ 52%	23
<u>Range of % Difference</u> 0 – 52 <u>Mean Difference</u> 16.34% (SD = 13.70)		<u>Range of % Difference</u> 0 – 52 <u>Mean Difference</u> 14% (SD = 15) % of Participants who performed better than their estimated level of comprehension = 50% % of Participants who performed worse than their estimated level of comprehension = 50%		<u>Range of % Difference</u> 2 - 46 <u>Mean Difference</u> 18% (SD = 13) % of Participants who performed better than their estimated level of comprehension = 70% % of Participants who performed worse than their estimated level of comprehension = 30%	

As depicted above, the majority of participants overall underestimated their level of comprehension of the instructions. Of note, the participants who were not given written instructions were more likely to underestimate their comprehension. This result suggests that the lack of a written compliment to the instructions may have more of an impact of perceived comprehension than actual deficits in understanding. An independent samples t-test indicated no statistically significant difference between groups on actual comprehension of the instructions, $t(35) = 1.17, p = .250$ (two-tailed) with the magnitude of the mean difference (.84) having a small to medium effect ($\eta^2 = .04$). The remaining items are presented below:

Item 2: *You should start your deliberations thinking the defendant is what?* The majority of participants stated that deliberations should start by presuming the defendant innocent, as seen in Figure 29. However, due to the importance of this presumption in legal decision-making, and because several participants endorsed incorrect responses, an additional emphasis was placed on this instruction in the final stimuli.

Figure 29

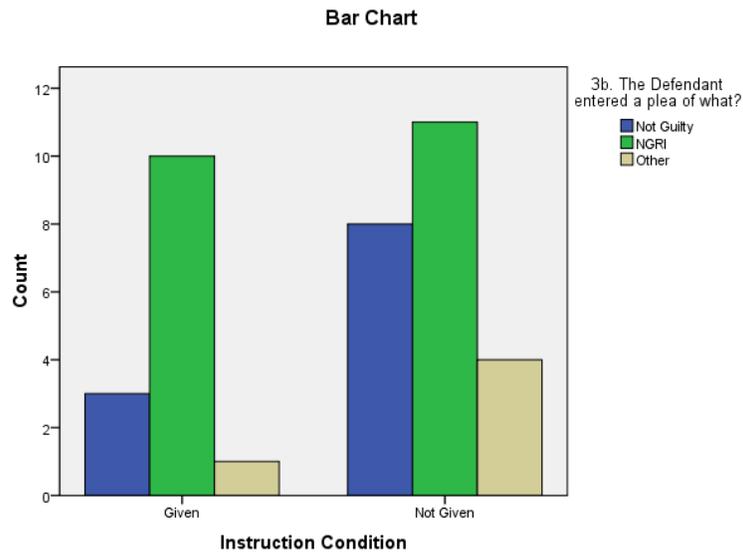
Self-reported comprehension of what verdict to use as the baseline for deliberations
(Pilot Study)



Item 3b: *The defendant entered what plea?* Most participants understood that the defendant was entering a plea of Not Guilty by Reason of Insanity (NGRI), although some endorsed a Not Guilty plea, as seen in Figure 30. These frequencies are displayed in the below table. It should be noted that the majority of responses captured by the “Other” category represented a plea generally representing a NGRI plea (i.e., “Guilty by Mental Illness;” “Insanity”). Based on these findings, an additional statement about the defendant’s plea was added to the instructions. However, it should be noted that in the full experimental session, this information would have also been presented at several other times.

Figure 30

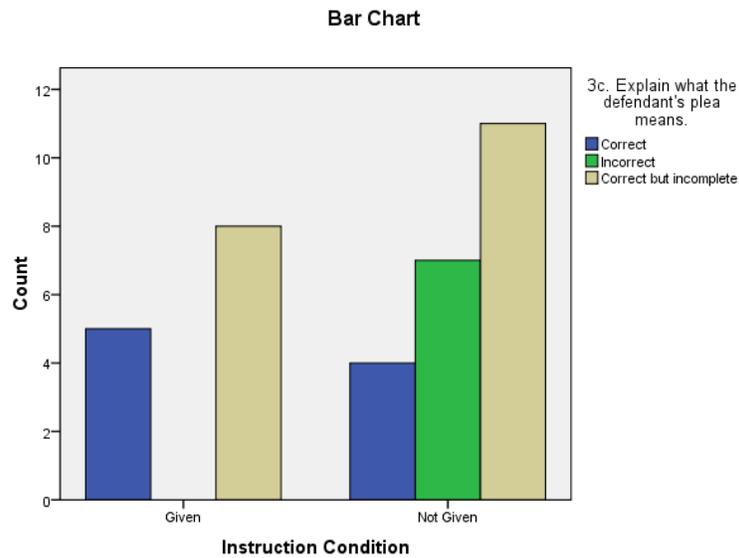
Self-reported comprehension of the defendant’s plea (Pilot Study)



Item 3c: *What does [NGRI] try to show?* Most of the participants’ definitions of a NGRI plea were accurate, but not complete (i.e., they would include only one or two of the definitional components of the plea), as seen in Figure 31. It was noted that the only incorrect responses emerged from the participants in the NG condition, which indicated the need for an additional clarification of the insanity test definition (which was included in the final stimuli). Overall, however, participants performed better on this item than prior research would have estimated (i.e., that prospective jurors rarely – less than 20% of the time – are able to identify the specific criteria associated with the respective insanity test being used) (Ogloff, 1991).

Figure 31

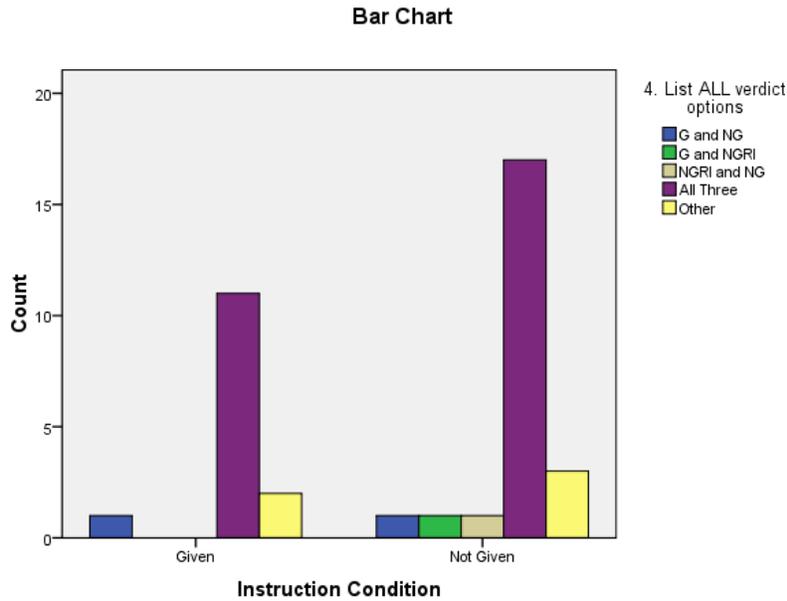
Self-reported explanation of the defendant’s plea (Pilot Study)



Item 4: *List all possible verdict options in this case.* Almost all of the participants were aware of at least two of the three verdict possibilities. As seen in Figure 32, results suggest that a group of six mock jurors would be able to generate all three possible verdict outcomes together, which are also listed on the verdict voting form.

Figure 32

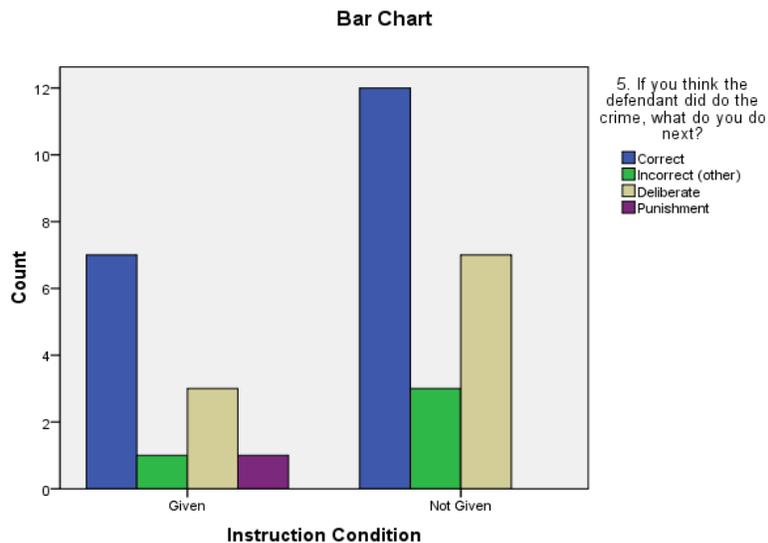
Self-reported comprehension of possible verdict options (Pilot Study)



Item 5: *If you think it was proven that the defendant DID the crime, what must you do next?* Question 5 queried if participants understood criminal responsibility was to be assessed after the facts of the crime were proven by the prosecution. As seen in Figure 33, results suggest that the question was somewhat vague in its inquiry, with a portion of respondents indicating that “deliberation” is next. However, the majority of participants correctly identified determining criminal responsibility as the next step, suggesting adequate comprehension across groups.

Figure 33

Self-reported comprehension of the need to decide criminal responsibility (Pilot Study)



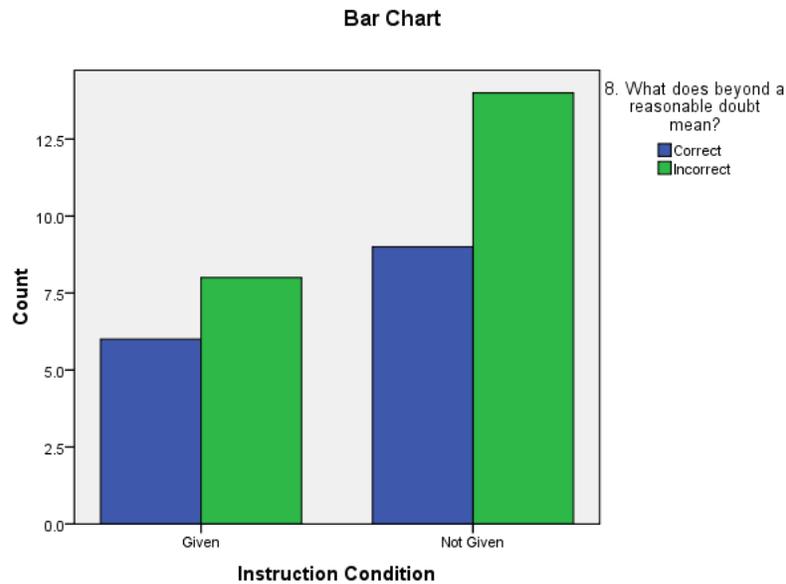
Items 6 and 7: *Which side must prove the defendant is guilty beyond a reasonable doubt? Which side must show the defendant was not responsible for his actions at the time of the offense?* Nearly all participants across groups correctly identified the prosecution as the party responsible for proving guilt beyond a reasonable doubt, and the defense as having the burden of proving the defendant was not criminally responsible.

Item 8: Responses to question 8 (*What does beyond a reasonable doubt mean?*) were coded as “correct” or “incorrect.” Within both groups, the majority of responses were deemed more incorrect than correct, as seen in Figure 34. These results fell just below estimated findings based on previous research (i.e., that roughly 49% of prospective jurors in NGRI cases are unable to demonstrate comprehension of standards of evidence) (Ogloff, 1991). After further evaluating the responses, most of the incorrect responses fell into one of two categories: (1) a definition more closely related to the preponderance of the evidence standard; or (2) definitions that included some reference to being 100% certain or having no doubt remaining. Thus, the

definition for this instruction was modified in the final instruction stimulus, informed by wording in seven clearly correct definitions provided by participants.

Figure 34

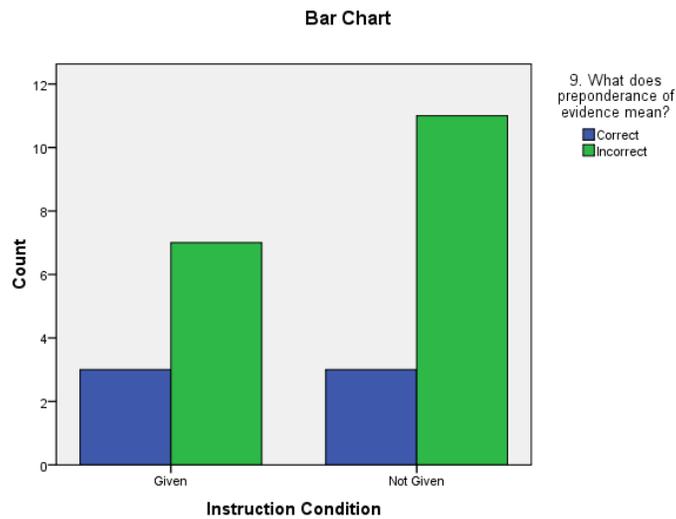
Self-reported comprehension of “beyond a reasonable doubt” (Pilot Study)



Item 9: Responses to question 9 (*What does preponderance of the evidence mean?*) were coded as “correct” or “incorrect.” Within both groups, the majority of responses were deemed more incorrect than correct, as seen in Figure 35. After further evaluating the responses, most of the incorrect responses fell into one of two categories: (1) “I don’t know/can’t remember;” or (2) definitions that included some reference to considering “all of the evidence” or 100% certainty. Thus, the definition for this instruction was modified in the final instruction stimulus.

Figure 35

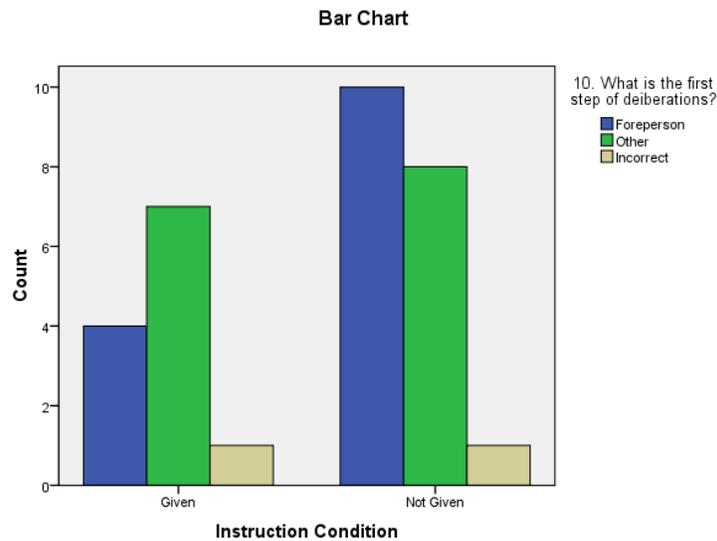
Self-reported comprehension of “preponderance of the evidence” (Pilot Study)



Item 10: *What important first thing must you do at the start of your deliberation?* Item 10 was intended to query if jurors understood the importance of selecting a foreperson at the start of deliberations. A correct answer would be mention of electing a foreperson. Although the question was vaguely worded, a good portion of participants endorsed the need to select a foreperson in response to this item. As seen in Figure 36, results also revealed that a large portion of respondents reported other important aspects of the deliberation process that were mentioned (e.g., “Have an open mind;” “Look at all of the evidence before deciding the case”). It was noted that participants in the G condition reported these “other” instructions more so than they did electing a foreperson. This finding suggests that “other” important tasks of the deliberation – remaining unbiased and open to discussion – are more readily conveyed when participants read the instructions (G condition). However, the frequency of these “other” accurate responses was still high for participants in the NG condition, as seen in the below bar chart.

Figure 36

Self-reported comprehension of how to begin deliberations (Pilot Study)



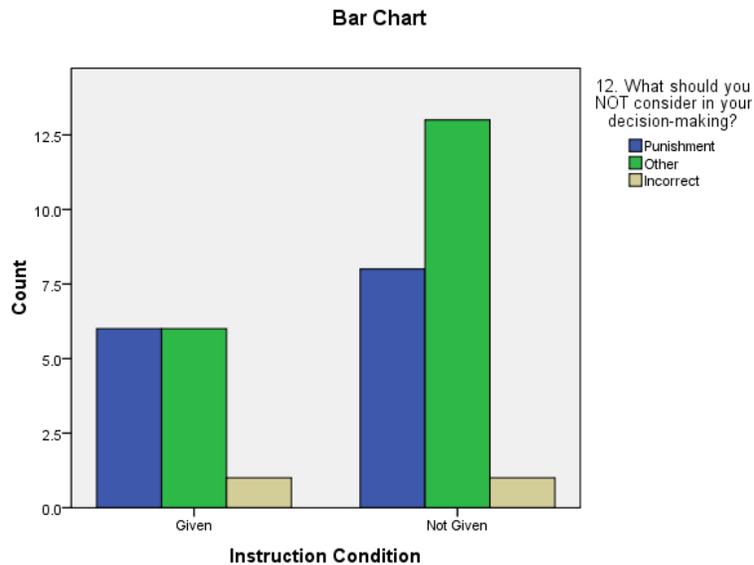
Item 11: *The jury’s verdict must be unanimous or by majority rule?* Nearly all participants across groups correctly identified the requirement for the jury’s decision to be agreed on unanimously. There were no differences across groups based on frequency counts and respective percentage of correct answers.

Item 12: *What should NOT be considered in your decision-making?* Question 12 was intended to assess participant’s understanding that they are not to consider punishment or sentencing during this phase of the study. As seen in Figure 38, results suggest that the question was somewhat vague in its inquiry, with a portion of respondents indicating other correct responses (e.g., “bias;” “what we think is just;” “personal opinion”). However, roughly half of the participants correctly identified this instruction and the majority of remaining responses were not inaccurate. There were also a few incorrect responses that stated the defendant’s insanity or his mental illness should *not* be considered in their decision-making. No modification was made to the instructions, however, given that results suggest that a group of six mock jurors would be

able to add clarity to the select few participants overall who were making this erroneous assumption.

Figure 38

Self-reported comprehension of what not to consider in decision-making (Pilot Study)



Testimony Manipulations Pilot

These five conditions were manipulated through adjustments to the expert witness' testimony. Given the centrality of the expert's testimony in the study design, manipulation checks on these five conditions were warranted. The sample consisted of 90 undergraduate participants, each randomly assigned to one condition: MC/C (n = 10), MNC/LeHi (n = 20), MNC/LeLi (n = 20), MNC/HeLi (n = 20), and MNC/HeHi (n = 20). Participants were provided with a written testimony vignette that included only the manipulated portions of the testimony for that condition, which consisted of direct and cross examination of the expert, as well as closing statements from the prosecution and defense (see Appendix MM). Participants read the vignette and answered a one-page questionnaire regarding the testimony (see Appendix NN).

Open-ended items (items 4a, 5a, and 5b) were coded into categories for ease of analysis. Results are presented below.

Testimony elaboration: The first three questions were designed to examine the relative strength (item 1), persuasiveness (item 2), and informative value (item 3) of the testimony across conditions. A multivariate analysis of variance (MANOVA) was used to explore difference between the experimental conditions on each of these outcomes. Results revealed a significant difference among conditions on the combined dependent variables, $F(12, 255) = 1.88, p = .037$; Pillai's trace = .244, $\eta_p^2 = .08$ (indicating that 8% of the variance in testimony quality ratings overall is explained by experimental condition).

The minimum sample size necessary for the quantitative analyses used (MANOVA) is recommended at 20 participants per condition (Tabachnick & Fidell, 2007). This minimum was achieved for only the four experimental conditions. In addition, the assumption of multivariate normality was violated (Mahal = 30.64, critical value = 16.27). Thus, the results should be interpreted with caution and primarily used to uncover any potential trends or glaring problems with the manipulations. Indeed, if after applying a Bonferroni adjusted alpha of .017 to the data (due to the constraints of our data from the small sample size, and due to violations of assumptions), no statistically significant difference was found. Given the purpose of our pilot data, however, the dependent variables were still considered separately for descriptive purposes. The only difference to reach statistical significance (at the .017 alpha level) was the informative nature of the testimony, $F(4, 64.32) = 4.53, p = .002; \eta_p^2 = .18$ (accounting for 18% of the variance). The high elaboration conditions endorsed the testimony as slightly more informative (HeLi: $M = 7.90, SD = .42$; and HeHi: $M = 8.70, SD = .42$) than did the other conditions (C: $M = 6.6, SD = .60$; LeLi: $M = 7.20, SD = .42$; and LeHi: $M = 6.50, SD = .42$). No condition rated

the testimony as particularly uninformative. These results suggest that the manipulation for *elaboration* of the testimony was adequately represented in the testimony conditions, as the high elaboration conditions were rated as more informative.

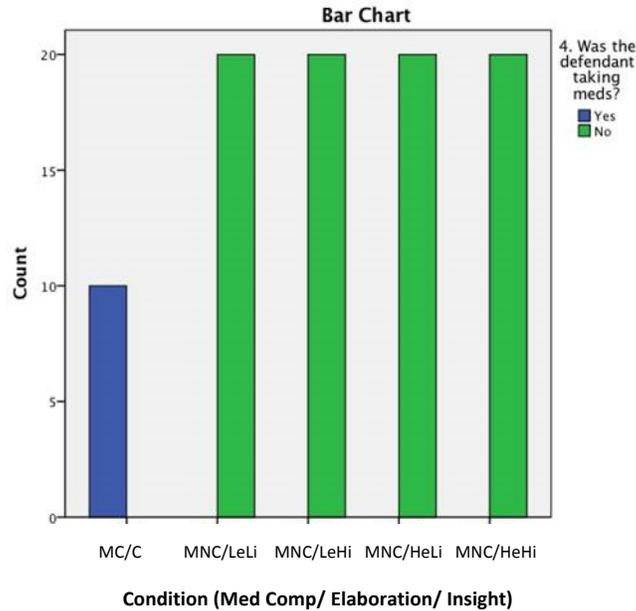
There was also a lack of differences among conditions on ratings of the testimony’s *strength* and *persuasiveness*. This finding suggests that the manipulation achieved relatively balanced testimonies across conditions, with no one testimony condition being overly influential or convincing. Cognizant of the lack of statistical differences, Table 14 indicates that this trend* was in fact present in the mean differences:

1. Rate overall strength of testimony	<i>M</i>	<i>SD</i>	2. How persuasive/convincing was testimony?	<i>M</i>	<i>SD</i>
MC/C	5.80	2.14	MC/C	5.70	2.40
MNC/LeLi	6.85	1.26	MNC/LeLi	6.65	1.49
MNC/LeHi	6.60	1.23	MNC/LeHi	5.90	1.65
MNC/HeLi*	7.25*	1.33	MNC/HeLi	6.80	1.19
MNC/HeHi*	7.35*	1.95	MNC/HeHi	7.30	2.15
Total	6.87	1.59	Total	6.55	1.80

Medication compliance. As seen in Figure 39, results of item 4 (*Was the defendant taking his medication*) confirmed that all participants correctly identified whether the defendant was or was not taking his medication in the control and experimental conditions, respectively.

Figure 39

Self-reported comprehension of the defendant’s medication compliance (Pilot Study)

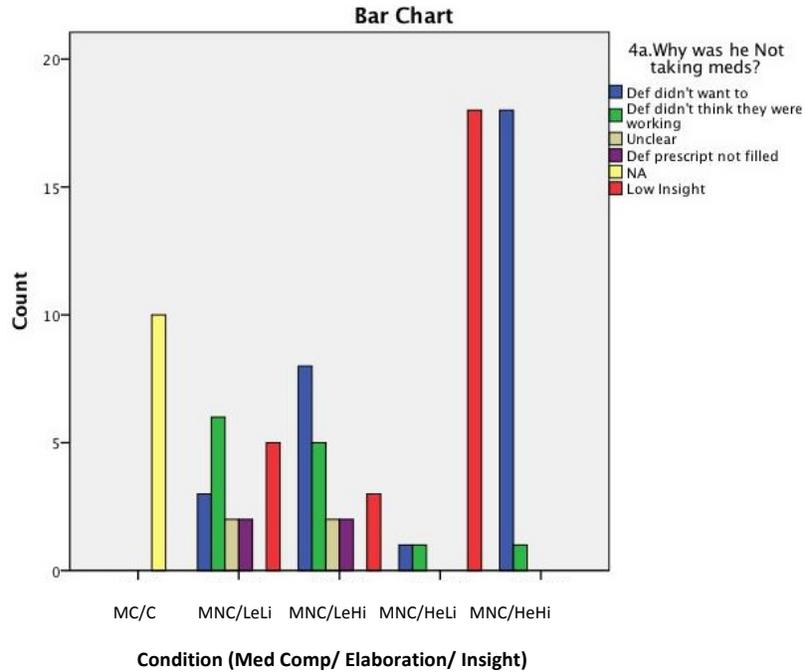


However, the follow-up question to this item (item 4a) indicated that some participants were unclear as to whether the defendant had been off his medication at the time of the offense because the testimony indicated that Mr. Duncan “had been” taking his medication, but was not at the time of the offense. As a result of this minimal confusion gleaned from a handful of questionnaires, a clarification was added to each of the four experimental conditions to affirm the defendants’ medication noncompliance at the time of the offense.

Additional descriptive information was generated from item 4a (*Why was the defendant not taking his medication*) reproduced in Figure 40 (*next page*):

Figure 40

Self-reported comprehension of reasons for the defendant’s MNC (Pilot Study)

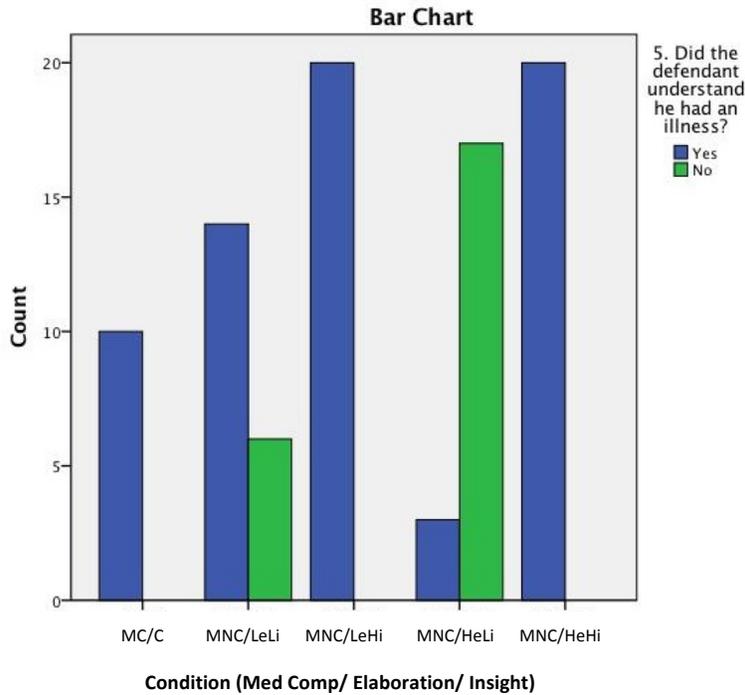


These data indicate that the reasons for the defendant’s medication noncompliance (as described by the expert) were being successfully communicated to participants. In summary, the modal reason for each condition matches what was expected in the experimental manipulation: MNC/LeLi = Defendant did not think the medication was working and Low insight; MNC/LeHi = Defendant did not want to take the medication; MNC/HeLi = Low insight; MNC/HeHi = Defendant did not want to take the medication. Moreover, the reasons were endorsed in the expected direction, with “low insight” being reported more for the respective high elaboration condition, and “defendant not want to take the medication” being reported more for the respective high elaboration condition (versus the low elaboration condition).

Insight into mental illness. Item five queried the extent of the defendant’s insight into his mental illness. Overall, results indicated that the manipulations were effective communicators with respect to the defendant’s differing levels of insight, as seen in the Figure 41:

Figure 41

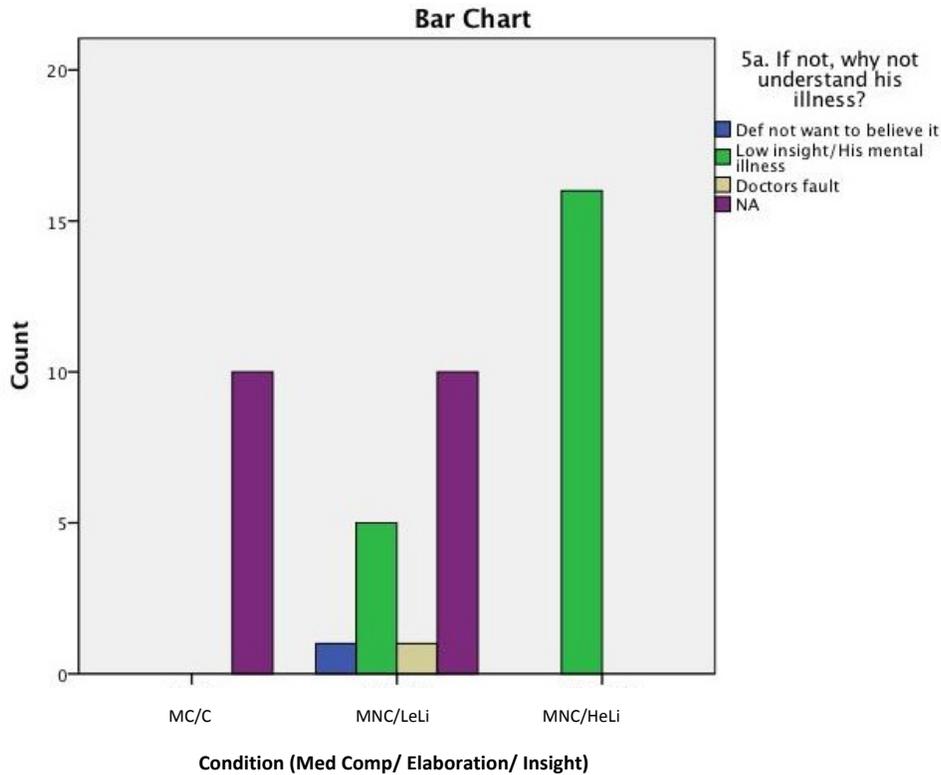
Self-reported comprehension of the defendant's insight (Pilot Study)



The unexpectedly high frequency of “yes” responses (indicating the defendant *did* have insight into his mental illness) in the MNC/LeLi condition suggests that for the low insight conditions, testimony elaboration may have increased jurors’ understanding or acceptance that the defendant’s low insight was in fact a bona fide symptom of his mental illness. Responses to item 5a indicate that participants in the MNC/LeLi condition are less consistent in their endorsements of why the defendant lacked understanding of his illness, as depicted in Figure 42 (*next page*):

Figure 42

Self-reported comprehension of reasons for impaired insight (Pilot Study)



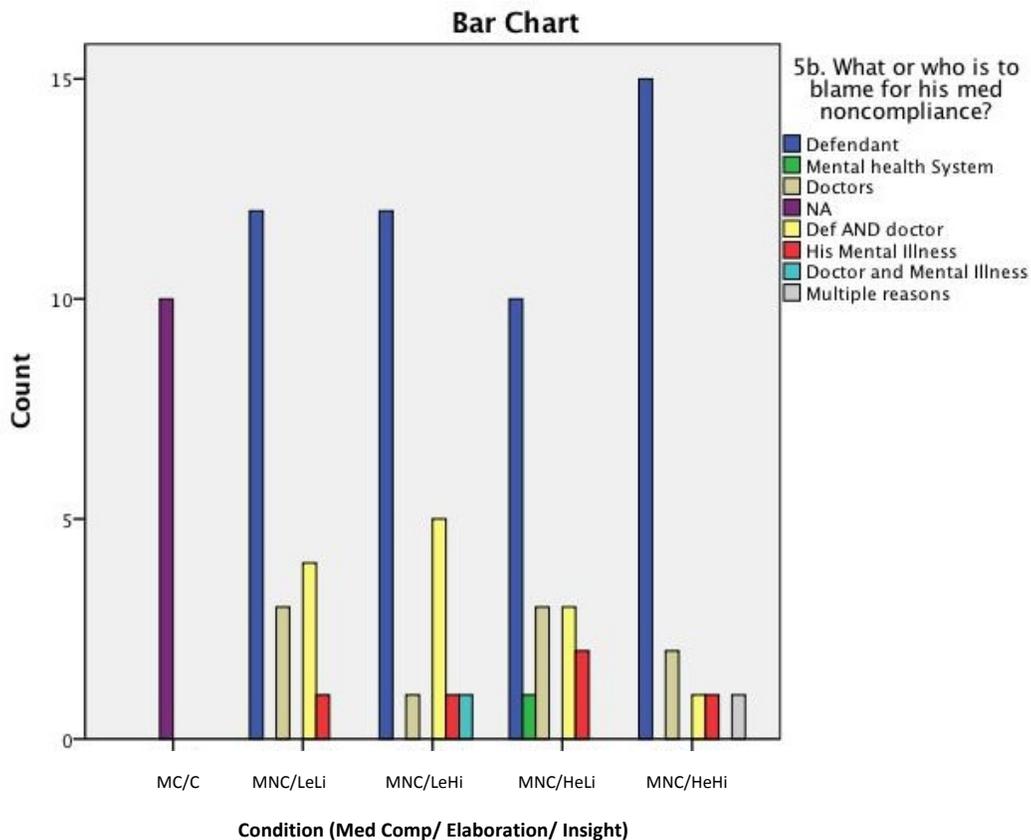
This pattern of results underscores the complex nature of mock jurors’ understanding of insight, and supports the need for additional quantitative and qualitative data to understand this aspect of decision-making. Because of this preliminary finding, however, an additional declarative, blanket statement was added to the final testimony for the MNC/LeLi condition (“He did not understand that he was sick and needed to continue taking the medication.”) This addition was intended to clarify the expert’s testimony that the defendant did in fact lack insight into his illness.

Although participants attended to the differences in the defendant’s level of insight between conditions, the connection between the defendant’s level of insight and his medication noncompliance appears to have been less clearly conveyed to the reader. As seen in Figure 43, across all four MNC conditions, the *defendant* was most likely to be blamed for not taking his medication – representing a high ceiling effect of the data. The researcher had previously

postulated that the defendant would be less likely to be blamed in the low insight conditions, especially in the MNC/HeLi condition. To ensure the expert effectively conveyed the relation between insight and medication noncompliance, additional emphasis was added to the MNC/HeLi condition.

Figure 43

Self-reported blameworthiness for defendant's MNC (Pilot Study)

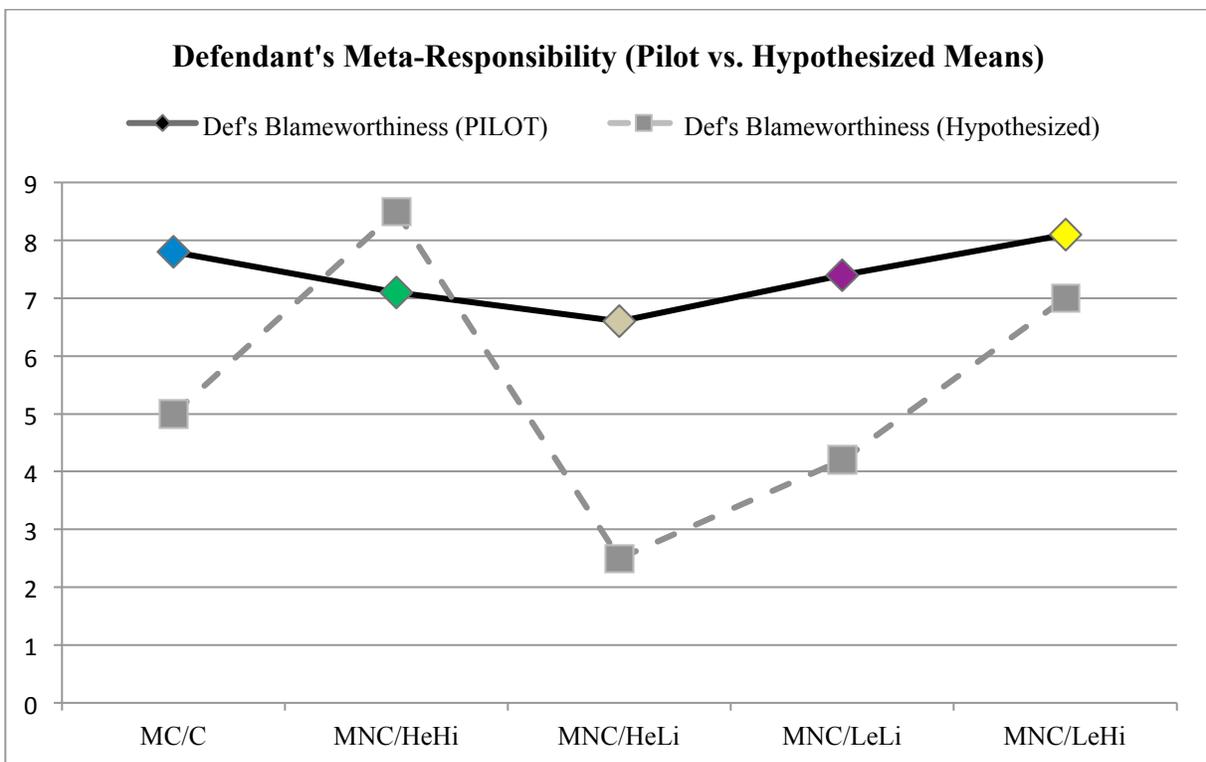


Meta-responsibility check. Finally, item 6 (*How much is the defendant at blame for his mental state at the time of the offense, MSO*) was included as a brief pilot of the hypothesized relation between defendant medication noncompliance/insight and meta-responsibility determinations. The defendant was deemed at least partially to blame for his MSO ($M = 7.33$, $SD = 2.31$). A one-way between groups analysis of variance (ANOVA) was used to explore

differences in attributions of defendant blame for his MSO. Results revealed no statistically significant differences, $F(4, 89) = 1.24, p = .301$, although the directions of the means are generally consistent with the pilot results with the exception of the HeHi condition (*next page*):

Figure 44

Self-reported means comparison between pilot data and hypothesized results for defendant's meta-responsibility (Pilot Study)



Compared to the hypothesized results, less variability was evident in the pilot sample (perhaps due to the small sample size and contrived nature of the pilot session). Results also suggest the education by the expert (i.e., high elaboration) may help to dampen blameworthiness attributions, regardless of whether the defendant exhibited purposive or inadvertent medication noncompliance. Still, these pilot findings were preliminary.

Pilot Study Conclusions

Overall, piloting the Judge's charge to the jurors indicated that the initial instructions (Appendix KK) were generally understood by mock jurors. After correcting for self-reported comprehension, jurors' understanding increased in more than half of the participants. Any differences between groups appeared minimal and likely minimized by revisions to the final stimuli (highlighted in red on Appendix L). Revisions to the initial instructions included several modifications. First, three aspects of the instructions were more heavily emphasized (i.e., the defendant's presumption of innocence; the name of the defendant's plea; and all definitional components of the NGRI plea). Instructions on the *reasonable doubt* and *preponderance of the evidence* standards were also clarified. These adjustments also included additions of phrasing used by participants who correctly defined these concepts in their own words. The final format of the Judge's charge to the jurors is provided in Appendix L. Several instruction manipulation checks were retained from the pilot questionnaire (Appendix LL) for use in the proposed Participant Reaction Form (PRF, Appendix X).

With regard to the testimony manipulations, the pilot data indicated that only minimal modifications to the original testimony conditions were warranted (highlighted in red in Appendix H). The piloted testimonies adequately manipulated the high versus low elaboration variable, with the high elaboration conditions rated as more informative. This manipulation did not unduly increase the strength or persuasiveness of the testimonies. The presence of medication noncompliance was attended to by pilot participants, and a clarification was added to each of the four experimental conditions to affirm the defendants' medication noncompliance *at the time of* the offense. Differences in the defendant's level of insight and reasons for his medication noncompliance were evidenced in the anticipated direction by condition. Participants in the

MNC/LeLi condition were the least consistent in their endorsements of why the defendant lacked understanding of his illness, suggesting the most ambiguity in decision-making for these participants. To minimize the risk that participants were *completely* missing the low elaborating expert's mention of the low insight, an additional statement to this effect was added for the MNC/LeLi testimony. Pilot results also indicated the need for the connection between the defendant's level of insight and his medication noncompliance to be more clearly conveyed in the MNC/HeHi condition.