Jury decision making:

A systematic review and exploration of stigma towards offenders with mental health conditions and the impact of diagnostic labels.

Sophie Shapter

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University of East Anglia

Faculty of Medicine and Health Sciences

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Primary Supervisor: Dr Peter Beazley

Thesis Portfolio Abstract

Aims: This thesis portfolio focuses on public stigma towards offenders with mental health conditions within legal settings.

Method: A systematic review was conducted focusing on the factors that influence stigma towards offenders with mental health conditions and what the consequences of this can be. The empirical paper focuses how different diagnostic labels may influence mental health stigma and juror decision making within a mock homicide trial. By conducting a replication of Baker et al., (2022), the paper compares public stigma towards two different diagnostic labels (psychopathy and personality disorder) and a control label (complex mental health condition) to further build this area of limited literature.

Findings: Seventeen studies were included within the systematic review. Factors found to influence stigma included diagnostic labels, traits, political orientation and religious beliefs. The consequences of this stigma were harsher punishment recommendations and higher likelihood of rejecting the insanity pleas of defendants. The empirical paper found no evidence that diagnostic labels influence stigmatic attitudes, causal attributes or Diminished Responsibility decision making. Perceived personal controllability of the situation was found to be a significant predictor of participants' decisions regarding Diminished Responsibility.

Conclusions: Public stigma towards offenders with mental health conditions can be influenced by a variety of factors, with significant life changing consequences within legal settings. Both clinical and legal professionals must consider the way in which information about a mental health condition is presented within a court as this may impact decision making. The limitations, implications and recommendations for future research are discussed further.

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Chapter One: General Introduction

On 23rd June 2011, Georgia Sarah Challen was convicted of murdering her husband (*R v. Challen*, 2019; Hill & Weaver, 2019). Her plea of guilty to manslaughter on the grounds of Diminished Responsibility was not accepted. During the trial, the defence's case for the plea was based on evidence from a psychiatric expert witness who argued Mrs Challen was suffering from a depressive disorder of moderate severity. The prosecution argued against this, basing their case on the opinion of another psychiatric expert witness, who reported Mrs Challen had not been suffering from any mental illness or abnormality of the mind. Mrs Challen was sentenced to life imprisonment with a minimum term of 22 years.

Eight years later, Mrs Challen successfully appealed her conviction due to new evidence of a mental health condition undiagnosed at the time of the crime and trial (*R v. Challen*, 2019). Mrs Challen was diagnosed with borderline personality disorder of moderate clinical severity and described as having symptoms of a severe clinical mood disorder, most likely bipolar affective disorder. Additionally, during her time in prison, she had experienced psychiatric episodes lasting several weeks. Furthermore, fresh psychiatric evidence suggested her mental health difficulties were exacerbated by the coercive control Mrs Challen had been experiencing from her husband. It is important to note that 'coercive control' was not a crime in England and Wales at the time of her initial trial, and only becoming recognised in law as a form of domestic abuse in 2015 (Crown Prosecution Service, 2017). Coercive control is defined as "an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim" (Crown Prosecution Service, 2017). It was deemed that the diagnostic information and new evidence and understanding of the coercive control would have provided an alternative narrative within the original trial (Davies, 2019). Her conviction was quashed, and a retrial was ordered. Before the retrial, the

crown ultimately accepted her plea to the lesser charge of Manslaughter (by reason of Diminished Responsibility), and she was released in consideration of time already served.

In the context of this thesis, it is perhaps apposite to invite the reader to consider the situation from Mrs Challen's perspective. Being diagnosed and labelled as having a personality disorder does, in general, negatively influence the way in which you are perceived by the public (Furnham et al., 2015; Sheehan et al., 2016). Even psychiatrists and healthcare workers hold stigmatising attitudes and beliefs about people with personality disorders, often perceiving them as "difficult" and "the patients psychiatrists dislike" (Koekkoek, et al., 2006; Sulzer, 2015; Lewis & Appleby, 1988; Sansone & Sansone, 2013; Ociskova et al, 2017). Yet in Mrs Challen's case, it was the elucidation of this diagnosis that ultimately led to her freedom. This raises a range of questions about the process by which such diagnoses are made (and by whom), the understanding and meaning attached to such diagnoses in the courtroom, and more generally the interface between clinical judgements and legal decisions. One might also reasonably ask why the relevance of her mental health condition was not accepted in her original trial; was this perhaps because of the impact of stigma influencing members of the jury, expert, or even judge?

Mrs Challen's case provides only a single example of the importance of proper consideration being given to mental health issues. Beyond this case, and indeed beyond the spectrum of personality disorder, it cannot be ignored that within the criminal justice system there is a disproportionately high prevalence of serious mental health conditions compared to the general population (Brandt, 2012; Brink, 2005; Fazel & Danesh, 2002; Lamb & Weinberger, 1998; McManus et al., 2016; Steadman et al., 2009). Although the statistics vary, the literature consistently shows that in multiple countries, at least 50% of all incarcerated offenders have mental health difficulties, with some research even stating that 70% of prisoners meet the criteria for two or more diagnoses (Bebbington et al., 2017; Pope

et al., 2013; Sarteschi, 2013; Singleton et al., 1998). Whilst people who have mental health difficulties are roughly no more likely, as a group, to be involved in acts of violence (Rueve & Welton, 2008), there can be no argument that in individual cases, mental health conditions and other associated conditions (including personality disorders and neurodevelopmental disorders) can have a direct functional link to offending and/or violence. There are also a number of ways, in English and Welsh law, through which a mental health condition can influence decision making in the court process, in both the stages of conviction (a task in the Crown Courts carried out by a jury) and sentencing.

This thesis portfolio consists of a systematic review and empirical paper exploring stigma towards offenders with mental health conditions. The systematic review section focuses on research regarding the causes and consequences of stigma towards offenders with mental health conditions within legal settings. The empirical paper section builds upon previous research by Baker et al., (2022) by investigating the effect of three different diagnostic labels (personality disorder, psychopathy and complex mental health condition) on mock-juror decision making and their perceptions of a defendant in relation to the legal question of Diminished Responsibility for murder (Coroners and Justice Act, 2009).

Chapter Two: Systematic Review

Stigma towards Offenders with Mental Health Conditions: A Systematic Review of the Causes and Consequences.

Sophie Shapter[a]* and P. Beazley[a]

[a] *Department of Clinical Psychology and Psychological Therapies (CPPT), Norwich Medical School, University of East Anglia, Norwich, United Kingdom.*

*corresponding author: s.shapter@uea.ac.uk

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Abstract

This systematic review aimed to explore the factors which influence stigma towards offenders with mental health conditions, and the consequences of this stigma within legal settings. A systematic search was carried out using MEDLINE, PsycINFO, PsyArticles and CINAHL Complete. Study quality was rated using the Appraisal Tool for Cross-sectional studies. Seventeen high quality studies were included within the review. All studies were conducted within North America, with the exception of one conducted in Germany. Six studies found that diagnostic labels influenced stigmatising attitudes, with offenders diagnosed with psychopathy and substance abuse disorder being consistently stigmatised more than those with other diagnoses, such as schizophrenia. Limited evidence suggested that specific traits may be particularly highly stigmatised. The consequences of stigma included harsher punishment recommendations and higher likelihood of rejecting the insanity pleas of defendants. The results are discussed in more detail along with strengths, limitations, and recommendations for future research.

Key words: Stigma, Mental Health, Offenders, Negative attitudes, Stereotypes, Criminal Justice System.

Introduction

Stigma

Stigma can be defined as a set of negative and often unfair or unjustified beliefs that a person or group of people hold about something. Goffman (1963), known as the pioneer of stigma research, classically defined stigma as an "attribute that is deeply discrediting" such as one's appearance, behaviours or abilities. More recently, Link and Phelan (2001) described stigma as including labelling, stereotyping, social separation, discrimination, and status loss for individuals being stigmatised. Stigmatising beliefs may lead to negative emotions and evaluations that in turn lead to prejudices (Crocker al., 1998), and ultimately behavioural changes, specifically discrimination. Discrimination typically takes a punitive behavioural form such as social rejection and social distancing (Corrigan & Bink, 2016; LeBel, 2008).

Public stigma comprises reactions of the general public towards a group based on stigma about that group (Rüsch et al,. 2005). Social psychology has long since observed societal tendencies to hold favourable bias towards their 'in-group' and discriminatory behaviours towards the 'out-group' (Brewer, 1979). This idea of separating 'us' from 'them' implies a separation, often leading to beliefs that 'they' i.e., the 'out-group', are fundamentally different from 'us', i.e., the 'in-group' (Link & Phelan, 2001; Rüsch et al.). To further understand this, Corrigan (2000) conceptualised a social cognitive model of public stigma, identifying three key aspects: stereotypes (negative beliefs about a group), prejudice (agreement with beliefs and/or negative emotional reactions), and discrimination (behaviour responses to prejudice). This model has particularly enhanced the understanding of public stigma towards individuals with mental health conditions (Rüsch et al.).

Mental Health Stigma

People living with mental health conditions are a group of individuals who may often be on the receiving end of public stigma (Angermeyer & Dietrich, 2006; Chang et al., 2016;

Pescosolido, 2013; Robinson et al., 2019; Sharac et al., 2010; Sickel et al., 2014). In fact, a mental health charity in the United Kingdom (UK) state that nine out of 10 people with a mental health condition report stigma and discrimination negatively impact their lives (Mental Health Foundation, 2021). One example of these harmful stigmatic beliefs is the stereotype that people with a mental health condition are dangerous and unpredictable (Corrigan & Bink, 2016; Levey et al., 1995; Marie & Miles, 2008; Silton et al., 2011). This leads to problematic discriminatory behaviours by the public and society, for example, avoidance by employers, landlords and healthcare professionals, and the public opting to keep socially distanced and segregated from people with mental health conditions (Corrigan & Bink; Feldman & Crandall 2007; Link et al. 1999). Specific negative impacts can unfortunately contribute to maintenance of the distress associated with a mental health condition. For instance, if stigma leads to segregation from the community, this may reduce self-esteem, access to healthcare, help-seeking behaviours and increase the prevalence of suicide (Angermeyer & Dietrich; Clement et al., 2015; Corbière et al., 2011; Corrigan et al., 2006; Corrigan & Bink; Lasalvia et al., 2021; Overton & Medina, 2008; Schomerus et al., 2022)

The factors that cause public stigma about mental health conditions are complex and are not well understood (Mannarini & Rossi, 2019). One example known to influence stigma is the causality attributed to an individual's mental health condition and their responsibility for the onset of the condition. Biogenetic causal beliefs increase prejudice, hostility, fear, and the desire for social distance (Feldman & Crandall 2007; Read et al., 2006). Individual differences within the public have too been found to influence stigma towards people with mental health conditions. People who have had more personal contact (i.e., familiarity) with someone with a mental health condition perceive them as less dangerous and tend not to

avoid them as much as others who have had little contact (Angermeyer et al., 2004; Corrigan et al., 2001; Corrigan et al., 2002).

Stigma Towards Offenders

Criminal offenders and ex-offenders are another group of individuals who experience stigma and prejudice (Brooks et al., 2006; Grace, 2022; Rade et al., 2016; Wakefield & Uggen, 2010). Research has shown that, similarly to individuals with mental health conditions, offenders are often stereotyped as dangerous, and are consequently marginalised from society by active avoidance, and facing restrictions or inequality in employment, housing and voting rights (Hirschfield & Piquero, 2010; Leverentz, 2011; Pogorzelski et al., 2005). As with mental health, this discrimination may somewhat perpetuate the likelihood of offending by preventing rehabilitation and reintegration into society, not to mention the impact that these factors would presumably have on an individual's mental health and wellbeing (Inzlicht et al., 2011).

It is important to note a distinction between individuals with mental health conditions and offenders, as the latter group's behaviours may more obviously validate certain stereotyped attributions. For example, an individual who has committed a violent crime could be described as a danger to the community. However, these beliefs are often heightened and exaggerated, causing the public, and professionals, to overestimate the actual threats or risks associated with offenders (Grace, 2022; Kane et al., 2018). Factors that have been found to influence stigmatising opinions towards offenders include one's political orientation, religious beliefs, gender, and amount of personal contact with offenders (Hirschfield & Piquero, 2010; Leverentz, 2011; Weekes et al., 1995), although there continues to be a lack of research into stigma towards individuals within the criminal justice system (Rade et al., 2016; West et al., 2014).

Double Stigma

Of course, it is possible for an individual to fall within multiple stigmatised groups. In this example, a criminal offender with a mental health condition. Indeed, 70% of prisoners meet the criteria for two or more mental health diagnoses (Bebbington et al., 2017; Singleton et al., 1998) and a history of trauma and adverse childhood experiences are also very common amongst prisoners (Armour, 2012; Facer-Irwin et al., 2019). It could be argued that an individual labelled with a mental health condition and as a criminal offender receives double the burden of stigmatisation. Research suggests that offenders with mental health conditions elicit more negative attitudes within the general public than offenders without (LeBel, 2008; Rade et al., 2016). This stigmatisation is also present within the UK police system, as individuals arrested with known mental health conditions are significantly more likely to be charged with a criminal offence, less likely to receive a caution and spend longer periods in police custody than people under similar accusations but without mental health conditions (Kane et al., 2018).

A review by Tremlin and Beazley (2022) found evidence within the literature of a double stigma effect towards offenders with mental health conditions, with the amount of stigma towards offenders with mental health difficulties appearing notably higher than stigma towards people without mental health difficulties or a history of offending. The consequences of stigma towards offenders with mental health can be lifechanging, particularly within a legal context, and with such a large proportion of offenders living with mental health difficulties, it is necessary that this double stigma is understood further.

Aims

The current systematic review aimed to understand the factors which influence stigma towards offenders with mental health conditions in legal settings (research question one) and the consequences of stigma towards offenders with mental health conditions in legal settings (research question two). This review will therefore build upon the findings of Tremlin and

Beazley (2022) by focusing on predictors and consequences of stigma towards offenders with mental health conditions.

Methods

This systematic review is reported with reference to the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) statement (Moher et al., 2015).

Eligibility criteria

The search aimed to find studies which focused on stigma towards offenders with mental health conditions in legal settings. 'Stigma' is measured in a wide breadth of different ways (Tremlin & Beazley, 2022) and thus studies focusing on attitudes, reactions, discrimination and decision making were included. Studies where mental health stigma towards offenders was not the focus (e.g. self-stigma, stigma towards offenders without mental health difficulties) and studies focusing on stigma towards offenders mental health difficulties outside of a legal context were excluded.

Mental health conditions included diagnostic terms from past and present editions of the Diagnostic and Statistical Manual of Mental Disorders. Primarily, this included psychotic disorders, mood/anxiety disorders, and personality disorders. Studies focusing on other aspects of psychological difficulties (e.g. learning disabilities, neurodevelopmental conditions, cognitive impairments, brain injuries, dementia) were excluded.

The term 'legal settings' was considered broadly and included samples from mock or actual jurors, as well as legal professionals such as police officers, judges and prosecutors. Studies included in this systematic review had to meet all criteria and align with the research questions.

The search included primary quantitative studies written in English only. Qualitative design studies and secondary data studies (e.g., literature reviews, meta-analyses) were excluded.

Search strategy

The following databases were searched; MEDLINE, PsycINFO, PsyArticles and CINAHL Complete.

The search terms used were (stigma* or attitude or prejud* or "negative attitude" or stereotype or discrim* or view* or perception*) AND (“mental health” or "mental illness" or “Mentally ill persons” "mental disorder" or "psychiatric illness" or "psychopath* or "psychotic") AND (offender* or criminal or convict or prisoner or defendant*) AND (police or "police officer" or officer or probation or judge or jury or juror or "prison officer*").

The abstract and title searches were carried out with a date limitation of January 2007 to August 2022. A 15-year time frame was chosen to take into consideration certain shifts in social attitudes and stigma towards mental health conditions and offenders over time, including increases in positive attitudes towards mental health conditions within the UK, but also an increase in stigma towards schizophrenia in Germany over the last 30 years (Evans-Lacko et al., 2014; Schomerus et al., 2022). Searches were conducted on 21st September 2022.

Identification and selection of studies

The search strategy outlined above was used to find and select suitable studies for the systematic review questions. The primary author screened the titles and abstracts of the search results were against the inclusion and exclusion criteria previously described. Any duplicate studies found across journals were also removed, see Figure 1 for further detail. The

final studies were checked against eligibility criteria by a fellow named author to reduce any bias. Both authors agreed that all selected studies met the eligibility criteria.

Studies Included in the Review

Figure 1 shows a PRISMA flow chart depicting the overall process of study selection. The initial search identified 1084 studies. Following the removal of duplicates and studies marked ineligible by automated tools (qualitative methods, non-English language, books), 549 studies remained. The titles and abstracts of these studies were screened, resulting in 497 being excluded due to being irrelevant. This left 52 studies that were further screened and assessed for eligibility. Following this, 17 studies were found to be eligible for this systematic review.

Methodological Quality Assessment

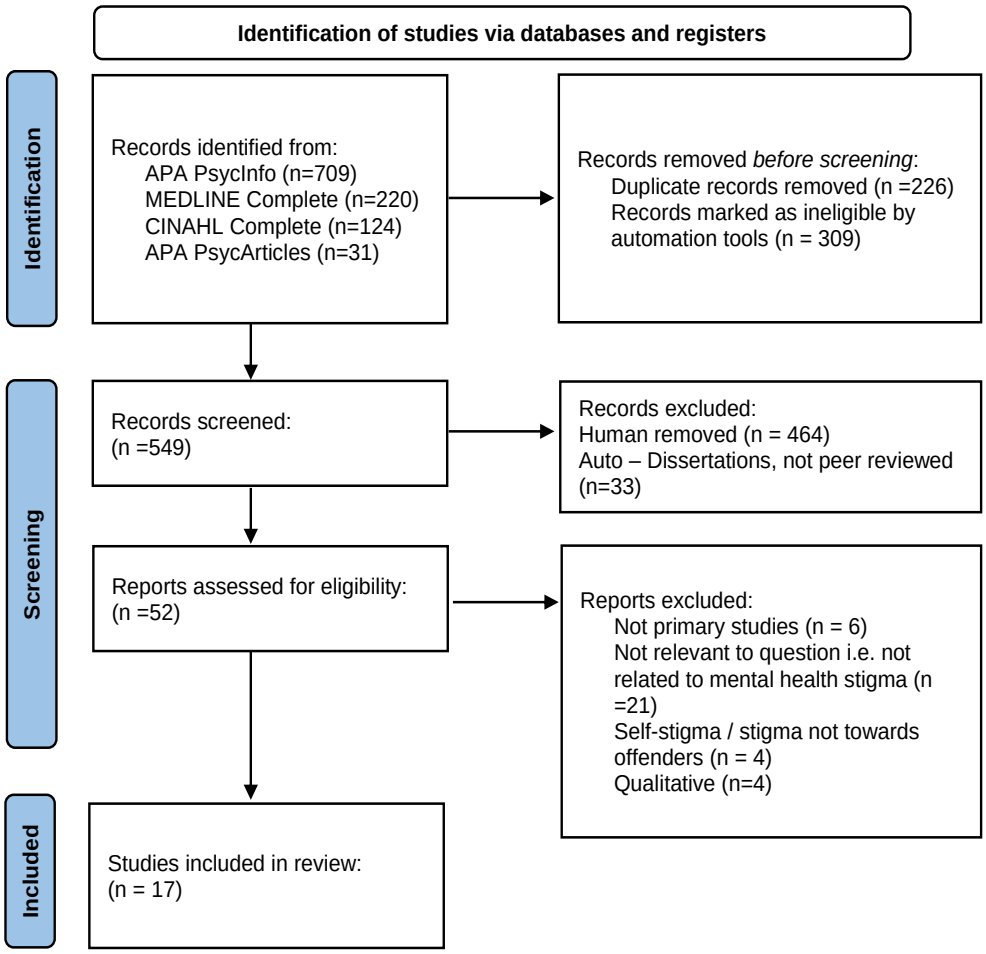
This systematic review used the Quality Assessment Tool for Observational Cohort and Cross-Sectional Studies (NIH, 2014) to assess the quality of the final 17 studies. This is used to help assess the risk of potential bias within the studies by answering 14 yes or no questions regarding methodological rigour.

Although the Quality Assessment Tool for Observational Cohort and Cross-Sectional Studies does not have a numeric scale or a final score, guidance is given under the tool on determining whether the overall quality rating of a study is good, fair or poor.

Analysis

A narrative synthesis methodology (Popay et al., 2006) was used to analyse the data and summarise the results of the final 17 papers. Key elements related to the headings within table Data was extracted headings table key elements related to diagnostic labels, offender traits/ demographics, participant traits/ demographics, mental health knowledge/education, and decisions relating to sentencing and verdicts were extracted from the final 17 studies.

Figure 1. PRISMA Study Selection Flowchart



Results

Seventeen studies were identified as eligible for this systematic review and were therefore included in the final dataset.

Study characteristics

The participant populations of the 17 studies included the general public (n=7), university students (n=6), police/prison officers (n=2) and legal professionals (n=2). Most of the studies were conducted in the United States of America (US; n=12) or Canada (n=4), with only one study being conducted outside of North America, in Germany.

Participant Characteristics

The studies' sample sizes ranged from 144 to 1,017 (total being 7,381). Where reported (*n*=15), the mean age of participants ranged from 18.99 years (*SD*=1.18) to 55 years (*SD*=7.5). Females were overrepresented in the review (see Table 1), with 11 of the 17 studies recruiting more than 50% female participants. Three of the four studies which focused on legal professionals recruited samples where males were overrepresented (over 70% participants were male).

Quality Assessment

The selected 17 studies scored highly against the Quality Assessment Tool for Observational Cohort and Cross-Sectional Studies criteria, with 13 papers rated good quality, and four papers rated fair quality. Kivisto & Swan (2011), Taylor et al., (2019), Wittmann et al. (2021) and Yelderman and Miller (2017) were the four rated fair due to certain limitations with the potential to cause biases, such as small sample sizes, lack of attention/manipulation checks and potential confounding variables not considered. Table 1 gives an overview of all the studies included in this review and their quality ratings.

It must be noted that although many of the studies were rated good quality using the quality assessment tool, there are broader flaws regarding the methodologies used within the

17 studies. A common weakness amongst all these studies is reliance on participant self-report and the potential of socially desirable responding. Additionally, experimental research often attempts to investigate something by reconstruct real-life situations. However, these reconstructions can differ significantly to reality, causing doubts to arise over the ecological validity of the research. Furthermore, experimental research is an opportunity for researchers to answer a yes or no question, rather than an explanation as to how or why they got to that answer, leaving researchers and readers to speculate about the underlying causality of the effects found.

Table 1. Overview and Characteristics of the Final studies Selected for the Current Review

Study ID	Authors of study	Sample size, gender split and mean age (SD)	Participant type/job role	Study location	Research aims/questions	Summarised main findings	Quality of study
1	Mowle et al. (2016)	419 (total) 57.8% female 42.2% male 46.52 years (SD = 13.01)	General public	USA	"This study investigated the effects of mental health and neuroscientific evidence on verdicts and sentencing recommendations in a mock criminal case."	"Main effects were detected for mental health testimony and political orientation, although interactions were noted as well. More negative reactions to defendants labeled as psychopaths were relatively consistent, whereas participants who identified as liberal generally were less punitive towards a defendant identified as schizophrenic than were more conservative jurors."	Good
2	Taylor et al. (2019)	252 (total) 48% female 52% male 37.5 years	General public	USA	"The current study explored how psychiatric conditions (CD, ADHD, MDD, schizophrenia, antisocial traits/behaviors) among waived juveniles with varying demographic factors (i.e., race-ethnicity, gender) shape jurors' perceptions of blame, punishment, dangerousness, and ability to regulate behavior."	"A schizophrenia diagnosis was associated with less blame, punishment, and capacity for behavior regulation. A description of antisocial traits/behaviors was associated with more blame, punishment, capacity for behavior regulation, and dangerousness. White juveniles described with antisocial traits were considered more blameworthy and deserving of punishment than Latinos."	Fair
3	Mossière & Maeder (2016)	242 (total) 75.6% female 24.4% male 21.75 years (SD = 6.01)	Students	Canada	"This study sought to examine the potential impact of defendant gender and mental illness type on Canadian juror decision making by manipulating the gender (man, woman) and mental illness (substance abuse disorder, schizophrenia, bipolar, depression) of the defendant in a second-degree murder case involving an insanity plea. Three variables of interest were manipulated: rebuttal illness (no mental illness, personality disorder, or psychopathy), evidentiary basis (biological or psychological), and evidentiary strength (moderately strong or moderately weak)."	"Contrary to expectations, NCRMD was chosen over a guilty verdict in the majority of cases. Findings also indicated that participant decisions and perceptions regarding defendants diagnosed with substance abuse disorder differed from the other mental illness groups. The gender of the defendant had an influence on participants' perceptions of internal attributions, and the perceived stability of criminal behaviors. Results suggest that perceptions of mental illness influence verdicts in NCRMD cases, and that defendant gender plays a role in participants' perceptions of defendants."	Good
4	Yamamoto et al. (2017)	370 (total) 68.4% female 31.6% male	General public	Canada	"The purpose of this study was to explore juror stigma toward defendants with different mental disorders (schizophrenia, substance use disorder, and depression) and	Mental disorder education, which was intended to target stigma regardless of mental disorder type, actually made participant attitudes more favorable	Good

Study ID	Authors of study	Sample size, gender split and mean age (SD)	Participant type/job role	Study location	Research aims/questions	Summarised main findings	Quality of study
		50.8 years (SD =14.7)			examine the impact of focused legal and mental disorder education on juror decision-making in NCRMD cases."	toward NCRMD in terms of both the dangers surrounding insanity pleas (i.e., "injustice and danger" attitudes) and the belief that one is responsible regardless of mental disorder (i.e., "strict liability" attitudes). The schizophrenia trial was related to the most positive insanity defense attitudes (i.e., lowest endorsement of concerns about the defense). The substance use disorder trial was associated with the highest mental disorder stigma. Finally, it appears that the NCRMD education that we provided to participants served to decrease mental disorder stigma compared with a control condition, but only for schizophrenia and substance use disorder."	
		407 (total) 63.6% female 36.4% male 46.3 years (SD = 15.8)	General public	Canada	"We selected a different vignette for Study 2 to test whether there would again be an overall preference for NCRMD and a backfire effect of the NCRMD and mental disorder education combination. It is possible that providing participants with an example of an NCRMD case could affect their NCRMD attitudes, and likewise asking participants to reflect on their own beliefs about insanity could change their response to the vignette."	"Study 2 replicated some of the effects from Study 1, but produced some unique results. Foremost, participants again generally favored NCRMD. This time the substance use condition had a greater proportion of NCRMD verdicts (as opposed to guilty verdicts in Study 1)."	
5	Maeder et al. (2020)	216 (total) 51.9% female, 46.8% male 1.4% transgender individuals 36.7 years (SD = 12.6)	General public	Canada	The purpose of this study was to examine the potential effects of racial bias (comparing Black and White defendants) in cases involving two different mental disorders (schizophrenia and depression)."	"Participants were significantly more likely to vote guilty for a Black defendant with schizophrenia as compared to depression, but there were no significant differences for the White defendant."	Good
6	Prasad & Kimonis (2018)	294 (total) 49.3% female 50.7% male 35.67 years (SD = 10.27)	General public	USA	"The aim was to investigate whether general, specific, and criterion labelling effects could be observed in participant ratings of offender dangerousness and amenability, and in sentencing decisions. It was hypothesized that formally diagnosed offenders (CD+LPE or CD), relative to control offenders (no diagnosis), would be viewed by mock jurors as more dangerous	"Relative to undiagnosed offenders, those with a CD or CD+LPE diagnosis were perceived as less amenable to treatment and more dangerous, and received a more restrictive sentence. A CD+LPE diagnosis did not incrementally increase negative perceptions relative to a CD diagnosis. Interestingly, participants recommended less restrictive sentences for youth with a	Good

Study ID	Authors of study	Sample size, gender split and mean age (SD)	Participant type/job role	Study location	Research aims/questions	Summarised main findings	Quality of study
					and less amenable to treatment, and recommended for more restrictive sentences (i.e., psychiatric hospitalization, detention-based; general labelling effect)."	CD + LPE diagnosis relative to those showing symptoms of CD + LPE without a diagnostic label. Controlling for diagnostic status, higher levels of perceived callous-unemotional traits in youth predicted negative perceptions and recommendations for more restrictive sentences."	
7	Cox et al. (2010)	144 (total) 60.4% female 39.6% male 20.31 years (SD = 4.35)	Psychology students	USA	"The purpose of the current study was to examine if introducing the PCL-R during the sentencing phase of a capital murder trial produces an undue prejudice against the defendant among mock jurors. More specifically, this study attempted to understand if mock jury members were more likely to rely on the label of ''psychopath,'' as produced by the PCL-R, when determining a defendant's sentence, thereby leading to a harsher sentence."	"Results indicated that participants were more likely to sentence the defendant to death when the defendant exhibited a high likelihood to commit future violence, whether or not the diagnostic label 'psychopath' was present. Interestingly, when asked to rate the defendant's likelihood for future violence and murder, the defendant who was a high risk for future violence and not labelled a psychopath received the highest rating. "	Good
8	Cox et al. (2013)	304 (total) 57.2% female 41.4% male 47.75 years (SD=13.30)	General public	USA	"The purpose of the present study was to examine the relationship between perceived psychopathic traits and support for capital punishment in a community sample attending jury duty, using a case vignette design adapted from earlier research in this area (Edens et al., 2005)."	"Consistent with prior findings, remorselessness predicted death verdicts, as did the affective and interpersonal features of psychopathy—though the latter effect was more pronounced among jurors who were Caucasian and/or who described their political beliefs as moderate rather than conservative or liberal."	Good
9	Rulseh et al. (2016)	346 (total) 330 final 43.3% female 56.7% male 35.03 years (SD= 12.60)	General public	USA	"The triarchic model of psychopathy proposes that this personality disorder is composed of 3 relatively distinct constructs: meanness, disinhibition, and boldness. But is being bold actually perceived by others as an intrinsically adaptive, socially desirable personality trait? We investigated this question using a novel approach—a jury simulation study that manipulated the level of triarchic traits exhibited by a white-collar criminal."	"Manipulating boldness and disinhibition resulted in more negative views of the defendant, with the boldness manipulation more consistently predicting higher global psychopathy, 'meanness,' and 'evil' ratings. Surprisingly, neither manipulation predicted sentence recommendations, although higher global psychopathy ratings did correlate with more punitive sentence recommendations."	Good
10	Murrie et al. (2007)	273 26% female 73% male	Judges (88%), referee (4%), court	USA	"We investigated potential labeling effects among a national sample of juvenile and family court judges by presenting judges	"Results revealed substantial effects (Cohen's d = .33-1.27 on 6 of 9 variables) for a history of antisocial behavior.	Good

Study ID	Authors of study	Sample size, gender split and mean age (SD)	Participant type/job role	Study location	Research aims/questions	Summarised main findings	Quality of study
		1% not reported 55 years (SD =7.5)	administrator (3%), commissioner (2%) magistrate (2%), master of juvenile court (1%)		with a series of vignettes that systematically varied the diagnosis and clinical history of an adolescent defendant. Vignettes varied history of antisocial behavior (minimal vs. substantial), presence of psychopathic personality characteristics (present vs. absent), and two diagnostic labels (conduct disorder and psychopathy)."	Psychopathic personality features also appeared influential, albeit on fewer variables. There were no negative effects associated with conduct disorder or psychopathy labels. Results suggest that the criteria underlying labels, more than labels themselves, exert influence in juvenile justice contexts."	
11	Batastini et al. (2018)	138 (total) 29.7% female 70.3% male 49.43 years (SD=12.84)	Judges (23.1%), Prosecutors (24.3%), Public Defendants (52.7%)	USA	"The primary purpose of the current study was to identify the prevalence of stigmatizing beliefs among judges, prosecutors, and public defenders."	"While controlling for age, results of a factorial MANCOVA revealed that public defenders, relative to both judges and prosecutors, endorsed more compassionate attitudes about defendants with mental illnesses. Furthermore, political ideology did not significantly influence attitudes toward mentally ill offenders. While judges and prosecutors endorsed more negative stereotypes about mental illness and perceived mentally ill defendants as a greater risk to the community, mean scores across groups suggested moderately positive attitudes overall. "	Good
12	Wittmann et al. (2021)	958 (total) 32.3% female 67.7% male 17.25 years (SD = 12.01)	Police officers	Germany	"Little is known about how German police officers perceive encounters with people with mental illness and at which rate these occur. This study examines German police officers' experiences in regard to how frequently they respond to calls involving a person with a psychiatric disorder, the reason for the dispatch, and reported subjective challenges."	"Findings suggest that the majority of officers experienced interactions with persons with mental illness as conflictual due to behaviors they perceived as unpredictable and irrational including verbal and physical aggressions. The data also showed significant differences between female and male officers in regard to what they perceived as challenging. A total of 27.9% of officers felt anxious during the interactions. Less knowledge about mental health problems was associated with greater anxiety."	Fair
13	Rendell et al. (2010)	428 (total) 62.4% female 37.6% male 18.99 years (SD=1.18)	Students	USA	"The present study examined the effect of several factors that appear to be increasingly relevant to insanity cases as certain legal and psychological trends develop. In this particular study, the defense's expert testified that the defendant had schizophrenia. The defense expert	"Consistent with the hypotheses, biological evidence was more persuasive than psychological evidence, and the rebuttal was slightly more successful when the prosecution labeled the defendant as a 'psychopath' than when they described him simply as 'not mentally ill.'"	Good

Study ID	Authors of study	Sample size, gender split and mean age (SD)	Participant type/job role	Study location	Research aims/questions	Summarised main findings	Quality of study
					supported his diagnosis with either biological or psychological evidence. In contrast, an expert testified for the prosecution that the defendant either (1) was a ‘‘psychopath,’’ (2) had a ‘‘personality disorder,’’ or (3) was ‘‘not mentally ill.’’”		
14	Kivisto & Swan (2011)	312 (total) 61.5% female 38.5% male 20.56 years (SD = 3.35)	Students	USA	“The goal of the present study was to examine how jurors’ attitudes toward the death penalty affect capital trials involving the insanity defense. Specifically, the present study examined the effects of death qualification under the *Witherspoon* and *Witt* standards on potential jurors’ attitudes toward the insanity defense. Death-qualified jurors under each standard were compared to their excludable counterparts on a variety of demographic and attitudinal measures”.	“When demographics were considered together, only religion predicted bias against the insanity defense, which was higher in those who identified with some form of Christianity. Further, religious fundamentalism, Christian orthodoxy, sociopolitical conservatism, and pro-prosecution bias were associated with stronger negative attitudes against the insanity defense. Results also support the contention that seating a death-qualified jury under either the Witherspoon or Witt standards increases bias against the insanity defense, although the consideration of automatic–death penalty jurors eliminates this effect.”	Fair
15	Yelderman & Miller (2017)	540 (total) 61.5% female 38.3% male 21 years (SD = 4.3) 298 (total) 52.1% female 46.2% male 29 years (SD = 11.3)	Students Students (49%) and general public (51%)	USA USA	“The purpose of Study 1 is to determine whether individuals’ religious characteristics were related to perceptions of mental illness defenses and the GBMI verdict.” “The first purpose of Study 2 was to replicate the findings from Study 1 in a mock juror paradigm and test the relationships between religious characteristics and legal decisions while accounting for variance explained by legal characteristics. The second purpose of Study 2 was to include both a student sample and a community member sample to increase generalizability”	“In Study 1 (attitudes survey) and Study 2 (mock juror decision-making paradigm), religious fundamentalist beliefs consistently predicted punitive attitudes and decisions related to mental health defenses and verdicts, and this was moderated by intrinsic religiosity, such that religious fundamentalist beliefs only predicted punitiveness for individuals low in intrinsic religiosity... Combined, these results suggest that religious beliefs play a role in jurors’ verdict decisions in an insanity case, and that priming fundamentalist beliefs increases jurors’ punitiveness.”	Fair
16	Jung (2015)	302 (total) 72.2% female 27.8% male 20.6 years (SD = 4.36)	Undergraduate students	USA	“We will investigate the influence of insight on juror decision-making by requiring participants to read and respond to trial scenarios describing a defendant who has been accused of assault and has a current diagnosis of schizophrenia.”	“Assigning a verdict of not criminally responsible to the defendant was not influenced by insight, but instead, by supportive attitudes of the insanity defense and higher attributions of blame to external factors and to psychological	Good

Study ID	Authors of study	Sample size, gender split and mean age (SD)	Participant type/job role	Study location	Research aims/questions	Summarised main findings	Quality of study
						factors …indicating that more stigmatizing attitudes were associated with greater guilty verdicts than NCR (i.e., insanity) verdicts."	
17	Ricciardelli et al. (2021)	1,017 (total) 44.3% female 38.6% male	Prison staff	Canada	"We examined how diverse Canadian prison staff interpret mental health and treatment seeking. This study focuses specifically on institutional correctional staff to explore how staff understand mental health, the stigma surrounding mental disorders, and care-seeking behaviours."	"Male participants were significantly more likely ($p<0.001$) to display stigma towards individuals with mental disorders and significantly less likely ($p<0.001$) to be willing to get treatment if they developed a mental health problem. We also found significant differences between prison staff based on occupation."	Good

Research Question 1. What factors influence stigma towards offenders with mental health problems in legal settings?

This review intended to explore what factors influenced public stigma towards offenders with mental health difficulties. Table 2 depicts a visual display of non-standardised effects across these studies. Stigma was measured in a variety of ways, including pre-existing measures (e.g., Community Attitudes Toward Mental Illness Scale (CATMI; Taylor & Dear, 1981), Mental Illness Stigma Scale (MISS; Day et al., 2007), Attitudes Toward Mentally Ill Offenders (ATMIO; Church et al., 2009)) and bipolar/Likert-type scales measuring trait perception (e.g., blameworthiness, dangerousness). Due to the wide variety of stigma measures it was not possible to fully compare results across the selected studies.

Diagnostic Labels

Six studies found discrepancies in stigma and attitudes between different diagnostic labels (Maeder et al., 2020; Mossière & Maeder, 2016; Mowle et al., 2016; Prasad & Kimonis, 2018; Taylor et al., 2019; Yamamoto et al., 2017). Due to the lack of consistent use of stigma measures (a theme found within past reviews; Fox et al., 2018; Tremlin & Beazley, 2022), comparing results across studies with different diagnostic terms was not possible for the selected studies, but their results will be considered in more detail within this section.

Three studies found that schizophrenia was associated with lower stigma compared to other mental health diagnoses (Mowle et al., 2016; Taylor et al., 2019; Yamamoto et al., 2017). Mowle et al. found that using the term ‘psychopath’ received more negative responses from participants compared to those diagnosed with schizophrenia. Similarly, Taylor et al. found schizophrenia was associated with the least stigma in a comparison between a range of other diagnoses including conduct disorder (CD), attention deficit and hyperactivity disorder (ADHD), major depressive disorder (MDD) and antisocial traits/behaviours. Antisocial traits were associated with the most stigma. Yamamoto et al. also found schizophrenia to be the

least stigmatised diagnostic label compared to substance use disorder and depression. Substance abuse disorder was found to be the most stigmatising diagnostic label by two studies; Yamamoto et al. and Mossière & Maeder (2016).

Maeder et al., (2020) found that diagnostic labels (schizophrenia and depression) only influenced jurors' stigmatising attitudes when the offender was Black. For White offenders, no significant differences were found between the diagnostic labels. When the offender was Black, more stigma was directed towards the offender with schizophrenia compared to depression. No other studies considered a potential interaction between mental health information and defendant ethnicity.

One study (Prasad & Kimonis, 2018) compared offenders with no mental health diagnosis to offenders with two diagnostic labels (conduct disorder (CD) and CD paired with 'Limited Prosocial Emotions' (LPE)) and offenders with no formal diagnosis but described as having 'symptoms of CD and LPE'. The offenders with formal diagnoses were perceived as less amenable to treatment and more dangerous compared to those without a diagnostic label. However, once controlling for diagnosis, negative perceptions were predicted by the socially undesirable characteristics they were described as having. These results suggest that the diagnostic labels of these conditions may not be the source of prejudicial attitudes, but rather the traits that underly these labels are of greater importance.

Offender Traits

Four other studies also found evidence of specific traits potentially holding more influence on stigma than diagnostic labels (Cox et al., 2010, 2013; Murrie et al., 2007; Rulseh et al., 2017). Cox et al. (2010) showed that a psychopath label did not influence stigmatising attitudes of the public, but the perceived risk of future violence did. Murrie et al. observed a similar effect in a professional population. This study showed that legal professionals' opinions did not differ significantly between the diagnostic labels (conduct disorder and

psychopathy) and found no negative attitudes associated with using these labels. Indeed, the results suggested that the criteria and traits underlying these labels, i.e., having a history of antisocial behaviour, influenced perceptions more than the labels themselves. Similar conclusions were drawn by Cox et al., (2013) and Rulseh et al.. Certain interpersonal and affective traits (e.g. remorselessness) increased sigma towards offenders (Cox et al., 2013) as did boldness and disinhibition (Rulseh et al.).

Stigmatiser Traits

Other studies found that individual characteristics of the participant can have an impact on their level of stigmatising attitudes towards offenders with mental health conditions. The research seems most developed in regard to the relevance of religious and political beliefs (Batastini et al., 2018; Kivisto & Swan, 2011; Mowle et al., 2016; Yelderman & Miller, 2017) with Christian religious beliefs (e.g. religious fundamentalist beliefs, Christian orthodoxy) found to be associated with higher stigma towards offenders with mental health by Yelderman and Miller, and Kivisto and Swan. Generally, conservative political beliefs were also associated with more negative attitudes and legal decisions, Kivisto and Swan found that socio-political conservatism was related to stronger negative attitudes, particularly against the insanity defence. Mowle et al. observed participants identifying as liberal being less in favour of harsher punishment for offenders diagnosed with schizophrenia. However, these results were not replicated within a sample of legal professionals (judges, public defenders, and prosecutors). Batastini et al. found that political ideology did not significantly influence attitudes towards offenders with mental health difficulties.

Surprisingly only a single study considered the impact of gender. Ricciardelli et al., (2021) also found that male prison staff were significantly more likely to display stigma towards individuals with mental health difficulties compared to female staff.

Evidence Type

Evidence type was explored by two studies (Mowle et al., 2016; Rendell et al., 2010). Rendell et al. highlighted biological causal mechanisms of mental health (e.g. neurochemical imbalances) increased participants' beliefs that the defendant's schizophrenia was more severe, that they would benefit more from treatment, and were more responsible for their behaviour. Ultimately, such evidence was associated with more support for the defence's not guilty by reason of insanity plea. Conversely, Mowle et al. found no indication that neuroscience and brain injury evidence influenced jury perceptions or decision making.

Three studies found that providing mental health education (Yamamoto et al., 2017) and having an increase of mental health knowledge (Ricciardelli et al., 2021; Wittmann et al., 2021) reduces stigma towards offenders with mental health difficulties.

Table 2. Effect Direction Plot Summarising the Influence of Different Factors Upon Stigma Levels

Study	Sample Size	Population	Study Method	Diagnostic Labels included		Offender Traits/ Demographics	Participant Traits/ Demographics	Evidence Type	Mental Health Knowledge/ Education
Mowle et al. (2016)	419	General Public	Mock Trial	Psychopathy and schizophrenia	▲ Psychopathy ▼ Schizophrenia		▲ Political stance - More conservative	◀▶ Neuroscience	▼
Taylor et al. (2019)	252	General Public	Mock Trial	CD, ADHD, MDD, schizophrenia, and antisocial traits/behaviours	▲ Antisocial Traits ▼ Schizophrenia	▲ Race White compared to Latino ◀▶ Gender			
Mossière & Maeder (2016)	348	Students	Mock Trial	Substance abuse disorder, schizophrenia, bipolar, and depression	▲ Substance Abuse				
Yamamoto et al. (2017)	370	General Public	Mock Trial	schizophrenia, substance use disorder, and depression	▲ Substance Abuse ▼ Depression				▼
	407	General Public	Mock Trial	schizophrenia, depression, and substance use disorder	▲ Substance Abuse ▼ Depression				▼
Maeder et al. (2020)	216	General Public	Mock Trial	schizophrenia and depression		▲ Label and race interacted. Schizophrenia highly stigmatised only for Black defendant			

Study	Sample Size	Population	Study Method	Diagnostic Labels included		Offender Traits/ Demographics	Participant Traits/ Demographics	Evidence Type	Mental Health Knowledge/ Education
Prasad & Kimonis (2018)	294	General Public	Mock Trial	'Limited Prosocial Emotions' (LPE) & Conduct Disorder (CD) symptoms, and LPE+CD diagnosis, CD diagnosis, and no label.	◀▶				
Cox et al. (2010)	144	Students	Vignettes	Psychopath and no diagnosis	◀▶	▲ Risk of future violence			
Murrie et al. (2007)	273	Legal professionals	Vignettes	Psychopathy, conduct disorder and no diagnosis	◀▶	▲ A history of antisocial behaviour, psychopathic personality traits			
Batastini et al. (2018)	169	Legal professionals	Distributed surveys				◀▶ Political orientation ▲ Legal professionals: defence prosecutors		
Cox et al. 2013	304	General Public	Rate vignette on PCL-R			▲ Remorselessness attribute core interpersonal and affective traits	▲ "Moderate" political beliefs & Caucasian		
Rulseh et al. (2016)	330	General Public	Mock Trial			▲ Boldness and disinhibition traits			
Yelderman & Miller (2017)	Study 1: 540	Students	Mock Trial				▲ Religious fundamentalist beliefs		

Study	Sample Size	Population	Study Method	Diagnostic Labels included		Offender Traits/ Demographics	Participant Traits/ Demographics	Evidence Type	Mental Health Knowledge/ Education
	Study 2: 298	Students: 146 General public: 152	Mock Trial				▲ Religious fundamentalist beliefs		
Kivisto & Swan (2011)	312	Students	Questionnaires				▲ Religious fundamentalism, Christian orthodoxy, socio-political conservatism, and pro-prosecution bias		
Rendell et al. (2010)	428	Students	Mock Trial	No diagnosis, personality disorder, and psychopathy	◀▶			◀▶ Biological	
Ricciardelli et al. (2021)		Prison Staff	Surveys/questionnaires				▲ Male		
Jung (2015)	302	Students	Mock Trial			◀▶ Defendant insight of schizophrenia	▲ Attitudes on insanity defence and blame attribution		
Wittmann et al. (2021)		Police	Questionnaires						▼

Note: ▲ = increased stigma/ most stigma, ▼ = decreased stigma/least stigma, ◀▶ = no differences/mixed findings

Research Question 2. What are the consequences of stigma towards offenders with mental health problems in legal settings?

The majority of the studies included within this review used a mock trial vignette or trial simulation methodology to explore perceptions and stigmatising attitudes towards defendants with mental health difficulties. The consequences of this stigma were captured mostly by participants' decision making regarding simulated trial verdict (i.e., guilty or not guilty by reason of insanity) and sentencing or punishment outcomes (see Table 3).

Verdicts

Verdict decision making was significantly influenced by stigmatising attitudes in eight of the studies, with all studies finding that the higher the stigma, the more likely the insanity plea would be rejected (Jung, 2015; Kivisto & Swan 201; Maeder et al., 2020; Mossière & Maeder, 2016; Mowle et al., 2016; Rendell et al., 2010; Yamamoto et al., 2017; Yelderman & Miller, 2017).

Sentencing Recommendations

Sentencing and punishment decision making was significantly influenced by stigmatising attitudes in nine of the studies (Cox et al., 2010; Cox et al., 2013; Mowle et al., 2016; Murrie et al., 2007; Prasad & Kimonis, 2018; Rendell et al., 2010; Rulseh et al., 2016; Taylor et al., 2019; Yelderman & Miller, 2017). All except two studies found that higher stigmatising attitudes correlated with harsher sentencing and punishment decisions. Rulseh et al. found mixed results, which suggested that for some traits, stigma did not predict sentencing recommendations by participants, but higher global psychopathy ratings of offenders did predict more punitive sentencing recommendations. Results from Rendell et al. showed no differences in sentencing decision making. This result may be due to Rendell et al. having the youngest sample, or perhaps the scale which was used to measure sentencing recommendations being wide, i.e., from 0 (no prison time) to 50 (life) years in federal prison.

Ricciardelli et al., (2021) captured an alternative consequence of stigma towards offenders with mental health conditions. Prison staff with higher stigma were significantly less likely to be willing to get treatment if they themselves developed mental health difficulties.

Table 3. The Consequences of Stigmatising Attitudes in Mock Legal Settings

Study	Sample Size	Population	Study Method	Verdict decision making	Sentencing/punishment decision making
Mowle et al. (2016)	419	General Public	Mock Trial	✓	✓
Taylor et al. (2019)	252	General Public	Mock Trial	n/a	✓
Mossière & Maeder, (2016)	348	Students	Mock Trial	✓	n/a
Yamamoto et al. (2017)	370	General Public	Mock Trial	✓	n/a
Maeder et al. (2020)	216	General Public	Mock Trial	✓	n/a
Prasad & Kimonis (2018)	294	General Public	Mock Trial	n/a	✓
Cox et al. (2010)	144	Students	Vignettes	n/a	✓
Murrie et al. (2007)	273	Legal professionals	Vignettes	n/a	✓
Cox et al. (2013)	304	General Public	Vignettes	n/a	✓
Rulseh et al. (2016)	330	General Public	Mock Trial	n/a	-
Yelderman & Miller (2017)	Study 1: 540	Students	Mock Trial	✓	n/a
	Study 2: 298	Students: 146 General public: 152	Mock Trial	✓	✓
Kivisto & Swan (2011)	312	Students	Questionnaires	✓	n/a

Study	Sample Size	Population	Study Method	Verdict decision making	Sentencing/punishment decision making
Rendell et al. (2010)	428	Students	Mock Trial	✓	✗
Jung (2015)	302	Students	Mock Trial	✓	n/a

Note: ✓ = Clearly reported finding that stigma was significantly associated with more punitive verdict or sentencing decision making, ✗ = non-significant, ━ = mixed, n/a= is not measured

Discussion

This systematic review explored the literature regarding stigmatising attitudes towards offenders, with the aim of summarising the findings associated with influential factors and consequences of stigma. Seventeen studies were included within the review. The eligible studies highlighted individual traits of the stigmatiser and traits of the individual receiving the stigma can affect perceptions and the consequential decision making within legal settings. In particular, the mental health language used to describe an offender, whether this be a diagnostic label or traits of a diagnosis, certainly appeared to be influential in legal settings. Furthermore, mental health knowledge, political orientation and religious beliefs influence stigmatic attitudes of individuals. Overall, the consequences of high stigma were found to be rejection of the insanity plea, and harsher sentencing recommendations by the public. Fortunately, studies focusing on legal professionals suggested these factors influenced their perceptions of offenders with mental health conditions and measured lower stigma levels overall compared to that of the general public. These findings will be considered in more detail within this discussion.

Multiple studies observed how different mental health diagnostic labels influenced stigmatising attitudes towards offenders. Individuals labelled with psychopathy and substance abuse disorder attracted more stigma than those with other diagnoses. The least stigma was commonly associated towards those diagnosed with schizophrenia. This is not to say that schizophrenia is not a stigmatised label. Within the community, discrimination and stigmatising beliefs exist, as individuals endorse a greater desire for social distance from individuals with schizophrenia than from a person with 'normal' troubles (Link et al. 1999; Martin et al., 2000), and often reported unwilling to have an individual with schizophrenia as a neighbour (Pescosolido et al., 2010). However, as a diagnostic term, schizophrenia may be perceived as less stigmatised within legal settings compared to within the community setting

due to the public being more likely to hold beliefs that individuals with schizophrenia should not be blame or punished for violent behaviours (Anglin et al., 2006) and being more supportive of hospitalisation and treatment for individuals with schizophrenia (Pescosolido et al.).

Other studies found that the trait descriptions used to depict an offender affected stigma. In fact, two studies found that the described risk of future violence influenced stigma levels regardless of the diagnostic label used. Regardless of whether it was the diagnoses or traits being manipulated, this review found that highly stigmatising attitudes were consistently related to the decision to reject the insanity plea and choose harsher sentencing/punishment outcomes (including the death penalty) for offenders. From these findings, the question of what is affecting stigmatic attitudes more, the descriptive traits or the diagnostic label, must be considered.

There is a breadth of stigma research showing perceived dangerousness of an individual is a predictor of desired social distance and avoidance of said individual (Corrigan et al. 2001; Corrigan & Bink, 2016; Feldman & Crandall 2007; Horch & Hodgins, 2008; Link et al. 1999; Rasinski et al. 2005), thus these traits could be the driving factor for stigma. On the contrary, it could be that the diagnostic labels represent such traits, thus the label is the influential information. For some members of the public, diagnostic labels may be associated with negative stereotyped traits and behaviours due to the media's portrayal of individuals with these labels (Hyler et al., 1991; Keesler, 2014; Keesler & DeMatteo, 2017; Owen, 2012; Stuart, 2006). In the mid-20th Century psychopaths were consistently depicted as villains in movies (e.g. Hannibal Lecter, Nurse Ratched from One Flew Over the Cuckoo's Nest; Keesler). Even in more contemporary movies, violence towards others and dangerousness are commonly portrayed in characters with mental health conditions (Owen; Skryabin, 2021).

Media portrayal of stories in the news have also been shown to influence inaccurate attitudes about the relationship between violence and mental health conditions (McGinty et al., 2013).

Ultimately, more research is needed to tease apart the effects of descriptive traits compared to diagnostic labels. What is important, is that the evidence suggests the labelling and language used within legal settings does have an effect on how people perceive others and should be used with caution. The wider implications of using certain labels or descriptive terms must be considered by expert witnesses giving evidence in court. At present, there is limited guidance on the content of an expert witnesses' testimony, other than ensuring integrity, reliability, clarity, impartiality, and no conflict of interests exist (Crown Prosecution Service, 2022; Tully, 2021). Experts conducting evaluations of individuals within the legal system should recognise that their clinical descriptions may have equal, if not more influence on judicial decision making than any diagnoses assigned and should therefore take heed and be cautious of the language used within their reports.

Of course, the offence itself and stigma associated with this offence cannot be ignored. It is possible that the studies included in this review are measuring a double stigma effect due to both offending behaviours and mental health conditions being present within vignettes.

Types of criminal behaviour and the information presented to a jury may elicit different stigmatising attitudes. For instance, one may assume details regarding a violent murder are likely to increase in stereotypical perceptions of the defendant being dangerous and unpredictable compared to non-violent, 'white-collar' crimes (e.g. fraud or money laundering). Conversely, Filone et al. (2014) presented mock jurors with a case vignette depicting either a white-collar or violent crime and found that the white-collar defendant elicited significantly lengthier sentencing recommendations, regardless of any diagnostic labels (psychopathy, antisocial personality disorder, and dyssocial personality disorder). However, participants within the violent crime groups reported taking more consideration of

the defendant's mental health diagnosis when making decisions regarding sentencing. Furthermore, white-collar defendants were perceived as less amenable to treatment and somewhat more likely to reoffend than violent defendants, stigmatising opinions which influenced participants' decision making.

It could be argued that when a mental health diagnosis is portrayed as a highly influential factor for the crime committed (i.e., within violent criminal cases), defendants are perceived by the jury more favourably than when mental health diagnosis is considered to be a less important factor (e.g., white collar offenders; Filone et al., 2014). Within this literature review, multiple studies highlighted that schizophrenia was less stigmatised than other mental health diagnoses within mock homicide trials. Perhaps this is due to a perceived 'better explanation' for otherwise incomprehensible behaviour. If the crime was a non-violent 'white-collar' crime, stigma levels may have been quite different. The interaction between crime type and diagnostic labels, particularly 'white-collar' crimes, has received little attention in forensic psychiatric literature (Clarkson & Darjee, 2022). Unfortunately, there is currently not enough evidence to conclude whether it is a combined effect, or one of the two overpowering the other that is influencing stigmatic attitudes. To echo Tremlin and Beazley (2022), more research is necessary to explore simultaneous stigma, and the combination of offending behaviour and mental health stigma, and how it affects public attitudes. However, we live in a complex society where multiple sources of stigma are present. There are far more factors to take into consideration within the wider world that influence our perceptions and prejudice, and although this review did not focus upon additional stigmatising factors, one included study observed a triple stigma effect when manipulating offender ethnicity within the vignettes (Fader et al., 2022; Taylor et al., 2019).

This review also found individuals identifying as politically conservative and holding religious fundamentalist beliefs endorsed more negative attitudes towards offenders with

mental health conditions and were more likely to reject the insanity plea and endorse harsher sentencing compared to those who identified as more liberal or less religious (Kivisto & Swan, 2011; Mowle et al., 2016; Yelderman & Miller, 2017). It is important to note these findings were from studies based in the US with student and public samples, and thus the generalisability of these results to the wider world is unknown.

Many papers have shown a relationship between deeply held religious beliefs and stigmatising opinions about mental health conditions including increased dangerousness, anger, responsibility, and sinful behaviours in need of punishment or that cannot be medically or psychologically treated (Stanford, 2007; Wesselmann et al., 2015; Wesselmann & Graziano, 2010). Religious fundamentalist beliefs have also been shown to be associated with negative attitudes towards offenders and ex-offenders (Miller & Hayward, 2008; Yelderman et al, 2018; Young, 1992). This range of research suggests that offenders with mental health conditions will be at further risk of experiencing double stigma from individuals holding strong religious beliefs as opposed to atheists.

Reassuringly, more positive outcomes were found in legal professional samples, as political views did not influence stigmatising levels, and mean stigma scores across the different professions (judges, prosecutors, and public defenders) suggested moderately positive attitudes overall towards offenders with mental health conditions (Batastini et al., 2018). Furthermore, the other study focusing on legal professionals included in this review found that judges held no negative attitudes towards those with a conduct disorder or psychopathy diagnosis, and were more likely to support supervision or probation, rather than any other harsher sanctions.

Perhaps lower levels of stigma within legal professionals relates to their level of knowledge or education on mental health conditions. This review found three studies suggesting that higher levels of mental health knowledge and educating laypersons about

mental health reduced stigma towards offenders with mental health conditions) and having an increase of mental health knowledge (Ricciardelli et al., 2021; Wittmann et al., 2021; Yamamoto et al., 2017). Alternatively, it could be that the higher contact rate with offenders with mental health conditions within the professional samples is what helps to reduce negative attitudes and stereotyping (Couture & Penn, 2003; Maunder & White, 2019).

Strengths and limitations

This systematic review has contributed to a limited area of literature focusing on stigma towards offenders with mental health conditions and the consequences of this stigma. However, it is clear more research is necessary, particularly across the globe as a clear limitation of this review was the lack of diversity in the studies, as all studies were from western countries, with just one study not being from North America. This may have been due in part to the review including only studies written in the English language. Due to the lack of cultural diversity, it is important to note that the findings cannot be generalised to other cultures around the world.

Further concerns arise regarding the generalisability of this reviews results. Real legal proceedings involve a group discussion to enable the jury to reach a verdict, however none of the mock jury studies within this review did not include group deliberations. Group deliberations have been shown to alter the outcome of individual verdict decisions (Devine et al., 2001), but other research suggests verdict decisions made by individual jurors prior to group deliberations tend to be the same post-deliberation (Bornstein & Greene, 2011; Sandys & Dillehay, 1995). The results of this review may not be generalisable to real-life court settings due to the lack of group deliberations present in study methodology.

The recruited samples within the studies also raise concerns around ecological validity.11 of the studies recruited disproportionately female samples, three of which had over 65% females in their sample. This is certainly something that must be taken into consideration

when interpreting these studies results as literature suggests that women show fewer stigmatising attitudes compared to men (Kaitz et al., 2022; Pascucci et al., 2017; Ruiz et al., 2022). It could be argued that the results of this review are underestimating stigma levels within the general population due to the overrepresentation of females.

Furthermore, many of the studies recruiting undergraduates had a significantly low mean age compared to the general population. Six studies reported their sample having a mean age of under 22 years old, one of which had an average age of just under 19. Considering 18 is the minimum legal age for jury duty, these samples are not an accurate representation of a jury and therefore elicits the question of whether these studies results can be generalised or would even be replicated within a court of law.

Another limitation to this review is the lack of a second rater for the quality assessment. Using a second rater would have enabled the researchers to compare and discuss differing opinions regarding the quality of the 17 studies within the review, thus increasing the inter-rater reliability. Furthermore, there is reason to be sceptical of quality assessment tools altogether. Over 300 tools have been identified in the literature (Wells et al., 2009) and perhaps unsurprisingly, it has been empirically demonstrated that the use of different quality tools for the assessment of the same studies results in different estimates of quality, which can potentially reverse the conclusions of a systematic review and therefore potentially lead to misinformation (Colle et al., 2002; Herbison et al., 2006; Moher et al, 1998). It may be that the Quality Assessment Tool for Observational Cohort and Cross-Sectional Studies used for this review was not the most appropriate tool, as many studies would be considered experimental designs, rather than observational or cross-sectional. Additionally, the Quality Assessment Tool for Observational Cohort and Cross-Sectional Studies is formed of generic tick box questions regarding broad methodological issues, perhaps missing the fundamental limitations specifically related to the literature, such as social desirability responding,

ecological validity or analysis methods. The consequences of this are concerning, as future research may be based upon inaccurate results.

Due to the wide range of stigma measures and outcomes, it was not possible to fully compare studies results, however the non-standardised summaries of effect directions were presented within a table to aid interpretation of the findings. This systematic review also excluded qualitative research, which may have provided further insight into individuals' attitudes towards offenders with mental health conditions.

Conclusions/recommendations

Stigmatising attitudes and beliefs towards offenders with mental health conditions are influenced by diagnostic labels and descriptive traits, as well as stigmatisers' attributes. Caution regarding linguistics must be taken by expert witnesses and legal professionals within the legal system to ensure prejudices do not obstruct justice. There remain important questions about whether the combination of offender and mental health labels exacerbate prejudice or if one influentially dominates attitudes more than the other. It is recommended that future research is conducted on the complexities of multi-level stigma within the criminal justice systems across different cultures and justice systems.

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Chapter Three: Bridging Chapter

Chapter two highlighted how different diagnostic terms and traits can influence public stigma associated with offenders. Furthermore, the potential consequences of this stigma were shown through opinions and decisions regarding verdicts and punishment. Multiple studies focused on psychopathy, schizophrenia or substance abuse disorder. However, there appears to be a lack of literature focusing on how a diagnosis of personality disorder influences decision making in legal settings.

Returning to the case of Mrs Challen cited in the introductory chapter (page 8). Her retrial occurred on the 7th of June 2019. In Mrs Challen's case, after the new evidence was presented regarding her experience of coercion and diagnosis of borderline personality disorder, the prosecution accepted a guilty plea to manslaughter, and she was released after being sentenced to time already served. However, there are other cases where the presence of a personality disorder diagnosis has led to quite a different outcome. Take, for example, the case of '*R v. Squelch'* (2017). In 2015, Mr Squelch killed his colleague. He pled guilty to manslaughter on the grounds of Diminished Responsibility due to his diagnosis of paranoid personality disorder (PPD). During the trial, all three of the psychiatric expert witnesses agreed that Mr Squelch met criteria for PPD, however, they held opposed opinions regarding whether PPD substantially impaired him. Although two agreed, one expert witness was of the opinion that the impairment was not substantial, and that it might only be a partial cause for the killing. The jury rejected Mr Squelch's Diminished Responsibility plea. He was convicted of murder in March 2016 and given a life sentence with a minimum term of 22 years. In 2017, Mr Squelch appealed his conviction, but the appeal was rejected (McConnell, 2017). Of course, no two cases are the same, and the details and circumstances of Mrs Challen's and Mr Squelch's cases differ. Nevertheless, whilst a diagnosis of personality disorder was involved in both trials, these cases highlight that a

diagnosis that may be seen as an ‘explanation’ for behaviour in one circumstance may not in another. What makes the difference?

Considering the evidence of stigmatising attitudes towards individuals with personality disorders in other settings (Koekkoek et al., 2006; Lewis & Appleby, 1988; Ociskova et al, 2017; Sansone & Sansone, 2013), the impact of a personality disorder diagnosis within the legal system must be understood further. The empirical study in the following chapter aimed to explore this gap in the literature by replicating and building upon the study by Baker et al., (2022). Using a mock homicide trial, Baker et al., investigated the impacts of the label “severe personality disorder” compared to “complex mental health problem” on jury decision making, causal attributions for behaviour and endorsement of stigmatising stereotypes.

Chapter Four: Empirical Paper

Mental Health Stigma: Jury Decision Making Regarding Psychopathy and Personality Disorder.

Psychiatry, Psychology and Law

Sophie Shapter[a]*, I. Edwards[b] and P. Beazley[a]

[a] *Department of Clinical Psychology and Psychological Therapies (CPPT), Norwich Medical School, University of East Anglia, Norwich, United Kingdom;* [b] *Law School, University of East Anglia, Norwich, United Kingdom*

s.shapter@uea.ac.uk *corresponding author

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See Appendix A for author guidelines. The word limit for this journal is 12,000.

Abstract

Stigma towards mental health conditions can have resounding consequences for individuals within the criminal justice system. Furthermore, certain diagnostic labels used may influence this stigma. This study aimed to replicate and build upon previous literature exploring public stigma towards offenders diagnosed with personality disorder. Using a mock homicide trial, participants played the part of a juror. Stigmatising beliefs, causal attributions and opinions regarding Diminished Responsibility were compared between three groups, each of which heard the defendant labelled with a different diagnosis: Psychopathy, personality disorder or complex mental health condition. No differences were found between the diagnostic labels for stigmatising beliefs, causal attributions, or Diminished Responsibility opinions. However, additional analysis suggested that regardless of baseline stigma towards offenders with mental health conditions, participants who believed the defendant was unable to manage the situation, unable to regulate, and lacked power within their situation were more likely to give the Diminished Responsibility defence. The results contribute to our understanding of the factors which may influence juror decision making in regard to defendants with mental health conditions.

Keywords: personality disorder, psychopathy, stigma, Diminished Responsibility, juries, jury, jury decision making, mental health, mock jury, causal attributions.

Introduction

Research has consistently found evidence that public mental health stigma (differentiated from 'self-stigma') is common and experienced internationally across a wide range of conditions (Angermeyer & Dietrich, 2006; Chang et al., 2016; Pescosolido, 2013; Robinson et al., 2019; Sharac et al., 2010; Sickel et al., 2014). These stigmatic attitudes can have significant negative impacts on the lives of those with mental health conditions (Angermeyer & Dietrich, 2006; Lasalvia et al., 2021), affecting employment possibilities (Corbiere et al., 2011), reducing likeliness of getting support (Clement et al., 2015) and negatively impacting self-esteem (Corrigan et al., 2006). Ultimately, the consequences of this stigma exacerbate an individual's mental health difficulties (Sickel et al., 2014, Thornicroft, 2008). Public beliefs around the cause of mental health conditions can influence stigmatising attitudes, a striking example being biogenetic causal beliefs of mental health conditions and using labelling such as 'illness' increase public perceptions of dangerousness, unpredictability, fear, and desire for social distance (Read et al., 2006). Additionally, researchers suggest stigma results from insufficient or inadequate knowledge about mental illness, i.e., higher mental health literacy reduces stigmatising attitudes (Reavley & Jorm 2011; Simões de Almeida et al., 2023). One of the most critical times when public stigmatic attitudes might substantially intersect with and impact on a person with a mental health condition is during jury duty.

When a member of public is on the jury of a criminal trial, they carry a considerable burden of responsibility. As a randomly selected group of the public (Juries Act 1974 and Criminal Procedure Rules 2020 (SI 2020/759)) – a 'jury of peers' - the jury in a Crown Court determines whether the defendant is to be convicted of the alleged offence, i.e., guilty, or not guilty. However, the decision made by the jury is not always correct. Spencer (2007) conducted a study estimating the accuracy of jury verdicts using data from criminal cases in the United States (US). The results suggest the conditional probability that juries incorrectly convict given that the

defendant truly was not guilty (i.e., Type I error) was estimated at 25%, and the probability a jury incorrectly acquits given the defendant truly was guilty (i.e., Type II error) was 14%.

Fundamentally, the judicial system does not come without the inherent bias and heuristics of human decision making (Tversky & Kahneman, 1974). Decision making within a legal context primarily involves closed, forced questions – i.e., did the defendant commit the crime? There is no grey area, with 'guilty' and 'not guilty' being the only two possible verdicts (other than in a small number of cases in which 'not guilty by reason of insanity' is a possible verdict; Trial of Lunatics Act 1883, s. 2), and a decision must be made. In a court of law, there are rules and regulations in place to ensure a fair trial. However, this cannot resolve the fact that the members of the jury are only human, and thus may make biased or misguided decisions.

When considering factors that may affect jurors' judgments, there is a body of research which has identified various personal characteristics known as 'extra-legal factors' (e.g., gender, ethnicity, and attractiveness) as being relevant to the jury decision making process (Bagby et al., 1994; Guy & Edens, 2003). Research published on the role of mental health conditions or stigma as an extra-legal factor is very limited despite the presence and awareness of stigmatised attitudes within the general public (Mossière & Maeder, 2016). Moreover, the few studies that have been conducted are specific to countries and their different legal systems such as the US, (Greene & Cahill, 2012), Canada (Mossière & Maeder, 2015), and Australia (Jorm, 2012).

As a defendant's future lies in the hands of the jury, stigmatising attitudes of the jurors are particularly relevant, especially since conceptualisations of mental health stigma often include attributions of personal responsibility and blame for illness and dangerousness (Corrigan & Watson, 2002; Corrigan et al., 2002), which are particularly relevant stigmatic beliefs when it comes to criminal behaviour. Studies have shown harsher judgments are made about punitive outcomes, recidivism ratings and perceived characteristics (e.g., dangerousness, perceived control over their actions) for defendants with mental health conditions compared to defendants

without mental health conditions (Blais & Forth, 2014; Edens et al., 2006). These stigmatising beliefs become more relevant and concerning when the defence of Diminished Responsibility is considered by a jury.

Diminished Responsibility

In England and Wales, Diminished Responsibility (s. 2, Homicide Act 1957, as amended by s.52 Coroners and Justice Act, 2009) is a partial legal defence that can be used when the defendant is charged with murder and is diagnosed with a mental health condition. If the jury decide the Diminished Responsibility criteria are met, a defendant is convicted of voluntary manslaughter rather than murder. This in turn allows the judge discretion in sentencing, rather than having to impose a mandatory life sentence which follows a conviction for murder. The judge can impose a hospital order under section 37 of the Mental Health Act 1983 to ensure treatment (in a mental health hospital) is received rather than punishment (by a custodial sentence) in appropriate cases. This discretion is not available to a judge where a defendant is found guilty of murder due to the mandatory life sentence which would include a minimum custodial term.

The Diminished Responsibility defence requires the presence of an "abnormality in mental functioning" which:

(1) arose from a recognised medical condition
(2) substantially impaired the defendant's ability to do one or more of:
    a) understand the nature of their conduct
    b) to form a rational judgement
    c) exercise self-control
(3) provides an explanation for the defendant's acts and omissions in doing or being a party to the killing.

(s. 2, Homicide Act 1957; as amended by s.52 Coroners and Justice Act, 2009)

A defendant charged with murder bears the burden of proving that, on the balance of probabilities, the above criteria for Diminished Responsibility are met (s 2(2), Homicide Act 1957). Expert psychologists or psychiatrists are required to testify their understanding of the defendant's mental state and their clinical opinion as to whether the defendant's "abnormality of mental functioning", arising from a recognised medical condition, substantially impaired the defendant's ability to understand their conduct, to form a rational judgement, and/or to exercise self-control during their actions, i.e., the requirements for Diminished Responsibility as laid out in s.2 of the Homicide Act 1957.

It is important to note how the decision of Diminished Responsibility is unique from other criminal decisions made within court. Whilst the decision about guilt must be determined to the criminal standard, i.e., beyond reasonable doubt, Diminished Responsibility is one of the few areas in criminal law where the civil standard, i.e., on a balance of probabilities, applies. The balance of probability standard means that the court must be satisfied that Diminished Responsibility is more likely than not (Judicial College, 2022). If the jurors and judge do not conclude that it is more likely than not that the defendant meets the criteria, the defendant should be found guilty of murder. Therefore, it could be argued that decision making regarding Diminished Responsibility is more vulnerable and susceptible to bias and stigma compared to the decision regarding a defendant being guilty or not guilty. Only small impressions may be necessary to change a juror's judgment from less likely than not to more likely than not, whereas far greater impressions must be made to sway as juror from guilty to not guilty, given that the standard of proof is 'beyond reasonable doubt', i.e., the prosecution has to make the jury 'sure' in order to prove guilt (Judicial College, 2022).

Diminished Responsibility and Psychopathy

'Psychopathy' is a term which has been shown to be particularly stigmatising in the court of law (Cox et al., 2010, 2013; Mowle et al., 2016). This term is well established in the forensic

clinical literature (Hare et al., 2013) and represents an aspect of the so-called 'Dark Triad' personality traits (Book et al., 2015). It can be understood both in terms of diagnostic level concepts (e.g., an extreme variant antisocial and narcissistic personality diagnosis) and 'normative' overarching personality domains (Miller et al., 2001). Therefore, it is perhaps unsurprising that psychopathy is often linked to individuals being perceived to be dangerous, evil, violent, and unpredictable (Berg et al., 2013; Gao et al., 2009; Kelley et al., 2019; Kiehl & Hoffman, 2011; Smith et al., 2014).

Whilst there is broader research considering negative associations of other personality presentations, much of this is outside the sphere of criminal decision making. It is thus unknown whether the negative attitudes associated with psychopathy arise because of its unique profile in being associated with social harm, or because of stigma shared with other personality disorders more generally. This presents the question of whether stigma towards psychopathy arises from underlying stigma towards personality disorders, or if psychopathy is seen as entirely separate, with the stigma arising from the psychopathy label itself. Of course, it may not be within a layperson's ordinary knowledge that psychopathy is a type of personality disorder, hence an assumption could be made that the label of psychopathy itself is influencing stigmatic attitudes. This may be particularly influenced by the media's portrayal of characters such as Hannibal Lecter (Keesler & DeMatteo, 2017).

As psychopathy is predominantly characterised by interpersonal, moral, and emotional deficits (Camp et al., 2013; Kiehl & Hoffman, 2011), this stigma can promote the beliefs that psychopathy is less of a mental health disorder, and more of a "moral illness" in which individuals choose to commit horrific, immoral actions (Thi, 2016). Indeed, some authors have considered psychopathy, or the wider 'Dark Triad' traits, as the closest psychological representation of the moral concept of 'evil' (Book et al., 2015). However, there has been research that suggests psychopathy is not always strongly linked to increased violence and

criminal behaviour (Berg et al., 2013; Camp et al., 2013; Hall & Benning, 2006). It is important to note that a longstanding debate within the literature is whether criminal behaviour is a central component of psychopathy or perhaps just a downstream correlate of the core emotional disturbance of psychopathy (Hare & Neumann, 2010; Skeem & Cooke, 2010). There are of course individuals who may meet the criteria for psychopathy but do not get involved with criminal or violent behaviours, so-called "successful psychopaths", such as psychopathic lawyers, professors, businessmen, and politicians (Cleckley, 1951; Hare, 2003; Mullins-Sweatt et al., 2010). Violence and criminal behaviours are not a direct part of the psychopathy diagnostic criteria, yet public fear of psychopaths is still shown to be high (Edens et al., 2005, 2006).

Research has shown through mock trial simulations that these stigmatising beliefs impact mock jury decision making. One study found that participants reported individuals with psychopathy as responsible for their actions, capable of determining right and wrong, and not generally in need of hospitalisation (Smith et al., 2014). These stigmatised opinions undermine the criteria of Diminished Responsibility, suggesting that an individual with psychopathy would be more likely to be denied Diminished Responsibility by the jury and given a life sentence for murder. Another study observed concerning levels of stigma towards psychopathy compared to other labels, as when a defendant was described as psychopathic, 60% of participants supported a death sentence compared to just 30% when the testimony indicated that he was "psychotic" and 38% when described as "not mentally disordered" (Edens et al., 2005). This stigma appears to have influenced the real-world as certain state laws in the US such as in Oklahoma and Oregon specifically exclude psychopathy from the insanity defence, the equivalent of Diminished Responsibility (Morse, 2018; Jacewicz, 2016).

Although there is a scope of literature focusing the impacts of a psychopathy label in courtrooms, there has been limited research with inconsistent results exploring stigma related to

other diagnostic labels such as schizophrenia or borderline personality disorder within mock trials (Berryessa & Wohlstetter, 2019; Filone et al., 2014; Truong et al., 2021).

Diminished Responsibility and other personality disorders

At present, there is little research regarding public stigmatic attitudes towards borderline personality disorder within legal settings. Mackay and Mitchell (2017) and Mackay (2018) reviewed 90 Diminished Responsibility pleas to explore jury verdicts for differing mental health conditions. Of the 90, 15 of the defendants had personality disorder diagnoses. Eleven were convicted of murder and received mandatory life sentences, and just three received discretionary sentences. For context, of 34 cases citing schizophrenia in relation to the Diminished Responsibility defence, seven were given mandatory or discretionary life sentences, and 24 were granted Diminished Responsibility. The difference in these numbers suggests personality disorder is treated or seen differently by the courts than other mental health problems. More research is needed to explore how different diagnoses are portrayed and how this impacts jury decision making.

To address the gap within the literature regarding personality disorders, Baker et al., (2022) looked at how the term ‘severe personality disorder’, impacted mock jurors’ stigmatic attitudes and causal beliefs around the defendant in a fictional homicide trial, finding this term to be associated with higher levels of stigma than a more neutral term ‘complex mental health condition’. However, no differences were observed in opinions about Diminished Responsibility as all participants chose to accept the plea. The researchers acknowledged this may have been due to limitations of the study, including the trial vignette appearing overly compassionate and sympathetic towards the defendant, a small, well-educated, and disproportionately female sample, and potential confounding variables emerging from the group discussion (e.g., social desirability).

The current study

To further explore how mental health diagnoses impact jury decisions and following wider writing about a 'replication crisis' in clinical psychology (Wiggins & Christopherson, 2019), this study replicated Baker et al., (2022). The limitations above will be addressed by altering the vignette to reduce sympathetic responses, increasing the size and diversity of the sample using online recruitment, and focusing on the decisions made by individual jurors (as opposed to aiming to replicate a full jury simulation study) to avoid any additional variables that come with group social interaction. Additionally, the study by Baker et al. was limited to one mental health diagnosis, thus it seems important to expand and include additional mental health terms. Due to the high level of research around stigma regarding psychopathy within a legal setting, including this term will give further context to how stigmatised the term 'personality disorder' is by the public relative to the term 'psychopathy'.

This study will use the terms 'personality disorder', 'psychopathy' and 'complex mental health condition'. Baker et al., (2022) used the term 'severe personality disorder' to be consistent with new ICD-11 categories, however, Baker et al., hypothesised the word 'severe' may itself have enhanced the stigmatising process separately to the personality disorder label. To reduce this potential variable the word 'severe' will not be used in the present study.

Hypotheses

First hypothesis: It is hypothesised that there will be more stigmatising attitudes in the personality disorder and psychopathy compared to the control group 'complex mental health condition'. It is unknown whether a difference between the terms 'personality disorder' and 'psychopathy' will be found.

Second hypothesis: It is predicted that there will be more stigmatising causal attributions made in the 'personality disorder' and 'psychopathy' conditions compared to the control condition.

Third hypothesis: It is hypothesised that the Diminished Responsibility decisions will be less favorable in the 'personality disorder' and 'psychopathy conditions' compared to the control group 'complex mental health condition'.

Fourth hypothesis: It is hypothesised that higher stigmatising beliefs towards offenders with mental health difficulties will increase the likeliness of the Diminished Responsibility defence being rejected.

Methods

Design

This study aimed to assess stigma-related beliefs, causal attributions, and individual opinions regarding Diminished Responsibility in a mock homicide trial. The mock trial involved a fictional defendant with mental health problems being tried for homicide and was presented online via videos to participants. Participants were asked to imagine taking the role of a juror within the mock trial.

The study used a between-subjects design, with quantitative data collected to explore potential differences between three differing mental health terms; 'personality disorder', 'psychopathy', and 'complex mental health condition'. This latter term was intended to act as a control condition that would have activated the bias arising from *having* a mental health diagnosis/condition but without invoking the specific bias attributable to the two specific diagnostic terms. All participants were presented with the same information about the case and defendant except for the mental health term which was manipulated.

Materials

Mock Trial

This study is based on the mock homicide trial from Baker et al., (2022). As with Baker et al, the methodology aimed to present a mock homicide trial as realistically as possible by

producing a filmed trial reconstruction using actors. Two separate videos were created for this study; the first showed the expert witness testimony presented by a fictional clinical psychologist and the second video contained the prosecution and defence arguments and the judge's instructions to the jury (i.e., the participants of the study). These videos presented a condensed version of a mock homicide trial, running to a total of just under 18 minutes viewing time. Unlike Baker et al., this study ensured all volunteered actors within the videos were all similar age, ethnicity, and gender. This was to control for and remove any additional bias or variables within this study. Additionally, this study did not reveal the defendant's and victim's names and gender throughout the trial, again with the aim of not invoking any other biases, particularly regarding gender or ethnicity.

The recruitment process of this study also differed from Baker et al., (2022). Participants in this study were conducted online via the online platform Amazon Mechanical Turk (MTurk). MTurk and other online platforms are commonly used to recruit for psychological research and are becoming more popular due to convenience and reduced costs of recruitment, increased sample diversity and similar quality and reliability to more traditional methods (Buhrmester et al., 2011; Irvine et al., 2018; Pauszek et al., 2017; Strickland & Stoops, 2019). This method of recruiting allowed this study to address the sample size and diversity limitations mentioned by Baker et al. due to the adoption of a face-to-face campus recruitment methodology.

Due to additional limitations mentioned by Baker et al., (2022) regarding the group discussions and potential biases at play such as socially desirable responding, this study removed the group discussion and collective verdict step.

Expert witness testimony

The expert witness testimony (see Appendix C) was presented by a fictional clinical psychologist describing the defendant's mental health history and explaining their mental health

condition. It is important to note that this script was altered slightly from Baker et al., (2022), as one limitation in their study was the vignette being overly sympathetic and compassionate towards the defendant, which may have accounted for all participants accepting the Diminished Responsibility plea. To address this, the balance between mitigating factors and personal issues and the crime committed was shifted by including more details on the ferocity of the attack or injuries sustained and removing some of the details around the defendant's past. Examples of alterations include the number of times the defendant had been to hospital due to self-harm being reduced from six to four, and the age that they experienced childhood abuse being removed. No information was disclosed regarding the crime during this video, and it was shown prior to a written case scenario being shared with the participants. This allowed the measurement of participant stigmatic beliefs to be based only on the defendant's diagnosis and the description of the condition, not the crime.

Case Scenario

The written case scenario is based on the same vignette used by Baker et al., (2022) and describes how the killing occurred and the events which led up to the killing (see Appendix D). The alterations that were made to the case scenario in this study included the removal of the defendant and victim names and all pronouns were changed to they/them. Information regarding Diminished Responsibility was also provided at this stage of the study (see Appendix E),

Trial reconstruction

The second video presents the prosecution and defence arguments focusing on the defence of Diminished Responsibility. This is then followed by the judge's summary of the trial and instructions to the jury to decide whether the defence of Diminished Responsibility applies. All scripts are the same as those used in Baker et al., (2022) with the exception of the names being removed and all pronouns have been changed to they/them (see Appendix F).

Experimental Manipulation

For each condition, the scripts were identical, except for the mental health diagnosis used which was manipulated depending on the condition (personality disorder, psychopathy, complex mental health condition). The same actors, background, day of filming and camera angle were used for each condition.

Measures

Four measures were used in this study: The Public Attitudes Towards Offenders with Mental Illness Scale (PATOMI), the Attribution Questionnaire-27 (AQ-27), the Revised Causal Dimension Scale (CDS-II) and the Diminished Responsibility Questionnaire (DRQ).

Two of the four measures (AQ-27 and DRQ) were used in the original Baker et al., (2022) study and two additional measures (PATOMI and CDS-II) were included due to these having a specific focus relevant to the present research question and to address a limitation acknowledged by Baker et al.

The Public Attitudes Towards Offenders with Mental Illness Scale

The PATOMI (Walkden et al., 2021; Appendix G) is a tool that measures stigma towards mental illness in offenders. It is a 28-item questionnaire that uses a 5-point scale (from strongly agree to strongly disagree). A higher overall PATOMI score indicates less stigma. The PATOMI has high internal reliability (α= .90; Walkden et al., 2021). The PATOMI was not used by Baker et al., (2022) and is included in the present study to measure participants' baseline attitudes and biases towards offenders with general mental health difficulties.

The Attribution Questionnaire-27

The AQ-27 (Corrigan et al., 2003; Appendix H) measures participants' stigma-related beliefs about the defendant. Typically, the AQ-27 begins with a short written vignette about a man named Harry with a diagnosis of Schizophrenia. Baker et al., (2022) adapted the AQ-27 by

changing the vignette to reflect their defendant “Sarah” and her mental health problems. The present study uses the adapted AQ-27 from Baker et al., but with names removed and pronouns altered. The questionnaire consists of 27 Likert-scaled items ranging from one (not at all) to nine (very much). These 27 items are categorised into nine subscales (blame, anger, pity, dangerousness, help, fear, avoidance, segregation and coercion). Avoidance was reverse scored as per the AQ-27 scoring instructions. A total AQ-27 score can be calculated by summing up the individual subscales (note pity and help were reversed scored for the total AQ-27 score). The higher the score, the more that factor is endorsed by the subject. Baker et al., found the AQ-27 to have an acceptable level of internal consistency ($\alpha = .67$). It was presented to participants after they have learned about the defendant’s mental health problems, but before they had learned the details of the case, thus gaining a measurement of stigmatising attitudes prior to knowing what the criminal behaviour entails (see Figure 1 for details of procedure order)

The Revised Causal Dimension Scale

The CDS-II (McAuley et al., 1992; Appendix I) measures participants’ attributions regarding the cause of the behaviour exhibited by the defendant. In other words, it captures whether the participant believes the cause for the defendant’s behaviour was due to internal factors (i.e., the person was in control) or external factors (i.e., the person was not in control). The questionnaire consists of 12 questions, each scored on a 9-point bipolar scale and measures participant perceptions in four subscales (personal controllability, external controllability, stability, and locus of causality). A high score indicates the cause is believed to be within the person and a low score indicating the cause is believed to be outside the person. The average internal consistencies across studies using the CDS-II have been reported as follows; personal controllability= .79, external controllability= .82, locus of causality= .67 and stability= .67 (McAuley et al.). Baker et al., (2022) used an alternative measure known as the Causal Attribution Questionnaire (CAQ: Dagnan et al., 1998; Markham & Trower, 2003) to measure

causal attributions. This adapted the CAQ to reflect aspects of the case scenario. Due to the adaptations, the CAQ had not received psychometric validation in the form it was used. However, the CAQ internal consistency was assessed for the dimensions of locus, stability and controllability and found to be adequate (Russell et al., 1987). McAuley et al., (1992) and Boisvert and Faust, (1999) reported that the CDS-II is an equally reliable and valid measure of causal dimensions. Additionally, the CDS-II is significantly shorter in comparison to the CAQ, thus capturing responders' causal attributions and reducing participant questionnaire fatigue. Due to the points states above, the present study adopted the CDS-II rather than the CAQ.

The Diminished Responsibility Questionnaire

The DRQ was created by Baker et al., (2022; see Appendix J) to capture each participant's judgements relating to the legal question of Diminished Responsibility. The circumstances of the crime are broken down into four scenarios, with each part rated against each aspect of the main legal criteria of Diminished Responsibility using five questions; Was this related to a recognised medical condition? Could they understand their conduct, form a rational judgement, or exercise self-control? Do any of these factors explain how they acted? Participants rate their opinions on each question via a 7-point bipolar scale. Scores were calculated for the five subscales (recognised medical condition, understanding of conduct, rational judgment, self-control and explanation of actions) and a total DRQ score. The understanding of conduct, rational judgment and self-control subscales are reverse scored. Higher scores show more likeliness to accept the Diminished Responsibility plea. Baker et al., found the DRQ to have excellent internal consistency ($\alpha = .94$).

Participants

Power analyses undertaken during the planning stage of the study indicated that the minimum number of participants required for the study was 132. This was undertaken using G*Power software (see Appendix K). This number would enable the use of MANOVA analyses

with a medium effect size of 0.07 and power of 0.8. A total of 142 participants completed the study. Thirteen participants were excluded from the sample due to completing the study in under 13 minutes, leaving a total of 129 participants for analysis. Thirteen minutes was the minimum time calculated that would allow for watching the videos using the double speed playback option and at least minimal engagement with the other study materials.

The aim of using an online recruitment procedure was to capture a sample which was more of a representation of the UK population compared to the sample recruited by Baker et al (2022). The ethnicities of participants were varied and similar to that of the UK population (The Office for National Statistics, 2020). Table 4 shows the breakdown of gender and ethnicity across the three conditions.

Table 4. Participant Demographics

Demographics	Complex Mental Health Condition	Personality Disorder	Psychopathy	Total
Gender				
Male	22	24	28	74
Female	19	15	16	50
Other	2	-	3	5
Ethnicity				
White (British/Irish/Other)	32	37	27	96
Asian/Asian British	-	-	7	7
Black/African/Caribbean/Black British)	6	1	4	11
Other ethnic group	3	1	8	12
Prefer not to say	2	-	1	3

Sample procedure

Participants were recruited via MTurk. The study was made available to potential participants on the MTurk website. Recruitment and data collection took place between 16th

March 2022 and 29th March 2022. Participants were told that the study will last approximately 30 minutes and to ensure they have enough time to complete the study in one sitting before they begin. Once participants completed the study, they were given a unique completion receipt containing a code to enter into MTurk which allowed them to collect their payment of $3. This is in line with other research using MTurk as a recruitment platform (Irvine et al., 2018; Maeder et al., 2020; Pauszek et al., 2017; Prasad & Kimonis, 2018).

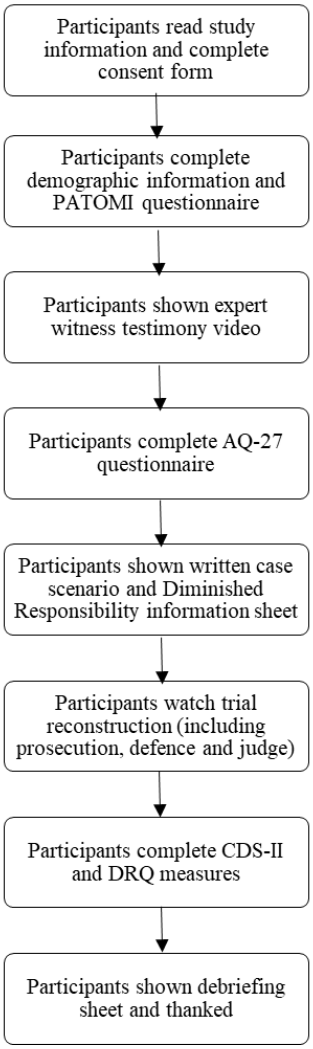
Inclusion/exclusion criteria

The participants inclusion/exclusion criteria for this study were based on the UK jury duty criteria according to the Juries Act 1974. To ensure participants were eligible for jury duty, and thus this study, participants were questioned on the criteria prior to completing the study (see Appendix L).

Study Procedure

Participants were first presented with the participant information which explained the aims of the study briefly and a consent form (see Appendix M and Appendix N respectively). Participants were not aware that the study had differing conditions, and so were naïve to the manipulation. Participants were randomly allocated equally by the survey link into one of the three conditions: Complex mental health condition (n=43), personality disorder (n=39) and psychopathy (n=47). Figure 2 illustrates the study procedure and order in which participants were presented with questionnaires and videos.

Figure 2. A Flowchart Documenting the Study Procedure



Analysis

This study design used one independent variable with three levels ('personality disorder', 'psychopathy' and 'complex mental health condition'). Any potential differences between these conditions were assessed using the dependant variables.

To test the first three hypotheses and explore differences between the conditions, a series of ANOVAs and MANOVAs were used. To test the fourth hypothesis, a hierarchical regression was used to investigate the relationship between stigma towards offenders with mental health conditions and Diminished Responsibility decisions made.

Ethical Approval

Ethical approval was received from the University of East Anglia Faculty of Medicine and Health Sciences ethics panel (see Appendix O). Due to the nature of the case and some of the details included within the case scenario, information was provided regarding how participants could seek additional support after the study if they were distressed by the material (see Appendix P).

Results

To test the hypotheses of this study, a series of ANOVAs and MANOVAs were used to explore any potential differences between the three conditions. Further analysis included a linear regression to investigate the relationship between stigma towards mental illness and offenders and likeliness of granting the defendant Diminished Responsibility.

Stigma-related beliefs

To test the first hypothesis regarding differences between conditions in stigmatising beliefs, a one-way ANOVA was performed to compare the effect of three different mental health terms on stigma-related beliefs about the defendant. The AQ-27 total score was used as the dependent variable. Levene's test for homogeneity of variance ($F(2, 126) = .499$, $p = .608$) was conducted the assumptions were met. Normality checks using histograms and Q-Q plots showed data was normally distributed and thus the assumptions were met for normality. There were no statistically significant differences between groups in Diminished Responsibility opinions ($F(2,126) = 0.90$, $p = .41$). The first null hypothesis cannot be rejected as the results suggest there is no difference between the three different mental health terms for stigma-related beliefs. The descriptive statistics of AQ-27 scores can be seen in in table 5.

Table 5. Total and Subscale Scores Mean Scores of the AQ-27 in Each Condition

Group		Total	Blame	Anger	Pity	Help	Dangerousness	Fear	Segregation	Coercion	Avoidance
Complex Mental Health Condition (n=43)	Mean	109.37	13.16	9.40	18.42	17.19	12.67	11.14	11.30	15.77	17.53
	SD	23.71	4.22	5.32	5.61	5.29	5.69	5.80	3.81	5.37	4.16
Personality Disorder (n=39)	Mean	101.67	11.46	8.08	19.05	17.51	11.15	8.87	10.92	15.41	18.33
	SD	32.19	5.31	5.58	5.66	6.54	6.32	6.17	3.59	5.42	4.39
Psychopathy (n=47)	Mean	101.79	12.60	8.38	20.45	18.51	11.19	9.49	11.36	16.09	17.64
	SD	28.62	5.01	5.48	5.17	5.81	6.01	5.69	4.21	4.19	4.15

Note: The AQ-27 has a maximum total score of 243 and a minimum score of 27. The subscales maximum scores are 27 and minimum three. Higher scores are associated with higher rates of stigmatic judgement.

Causal Attributions

A one-way MANOVA was conducted to explore the second hypothesis and determine whether there is a difference between the three mental health terms in beliefs about the cause for the defendant's behaviour measured by the four subscales of the CDS-II (locus of causality, personal controllability, external controllability, and stability). Levene's test for homogeneity of variance was conducted for each of the subscales: Locus of causality ($F(2, 126) = 3.50$, $p = .033$), personal controllability ($F(2, 126) = .311$, $p = .733$), external controllability ($F(2, 126) = 2.91$, $p = .058$), and stability ($F(2, 126) = .4.31$, $p = .015$). Assumptions were met for personal controllability and external controllability but violated for Locus of causality and stability. Due to these violations, the data should be viewed with caution. Normality checks using histograms and Q-Q plots showed data was normally distributed and thus the assumptions were met for normality. Table 6 provides details on descriptive statistics for each subscale in each condition. There were no statistically significant differences in causal attributions based on the different mental health terms used ($F(8, 246) = 1.01$, $p = .43$; Wilk's lambda = .94, partial eta squared = .03). Therefore, the second null hypothesis cannot be rejected as the results show there is no difference between the three different mental health terms for causal attributions of the defendant's behaviour.

Table 6. CDS-II Subscale Mean Scores in Each Condition

Group		Locus of causality	External control	Stability	Personal control
Complex mental health condition (n=43)	Mean	18.32	11.70	13.70	14.77
	SD	3.38	3.75	2.72	4.79
Personality disorder (n=39)	Mean	18.34	13.46	14.08	14.56
	SD	4.03	5.11	3.83	5.10
Psychopathy (n=47)	Mean	17.45	14.13	14.12	15.20
	SD	4.65	5.00	4.39	4.69

Note: Subscale scores have a minimum of three and maximum of 27 with a high score indicating the cause is believed to be within the person and a low score indicating the cause is believed to be outside the person.

Diminished Responsibility

A one-way ANOVA was performed to compare the effect of three different mental health terms on opinions of Diminished Responsibility and test the third hypothesis. Levene's test for homogeneity of variance ($F(2, 126) = 1.07$, $p = .346$) was conducted and the assumptions were met. Normality checks using histograms and Q-Q plots suggested data was normally distributed; thus the assumptions were met for normality. Table 7 shows the descriptive statistics for the DRQ scores in each condition. There were no statistically significant differences between groups in Diminished Responsibility opinions ($F(2,126) = 0.23$, $p = .80$), thus the third null hypothesis cannot be rejected.

Table 7. Mean of the DRQ Total Scores in Each Condition

Condition	Mean	Standard Deviation
Complex mental health condition (n=43)	80.07	24.82
Personality disorder (n=39)	83.56	24.69
Psychopathy (n=47)	81.81	20.72

Note: The DRQ has a total maximum score of 140 and a minimum score of 20. Higher scores show more likeliness to accept the Diminished Responsibility plea.

Hierarchical Regression

To test the fourth hypothesis, a three-stage hierarchical multiple regression was conducted with the Diminished Responsibility decisions (DRQ total score) as the dependent variable. The Enter method was used for this regression to control which variables enter at each stage. Tests to see if the data met the assumption of collinearity indicated that multicollinearity was not a concern (PATOMI, Tolerance = .50, VIF = 1.98; AQ-27, Tolerance = .53, VIF = 2.21; Causality, Tolerance = .88, VIF =1.13; External controllability, Tolerance = .85, VIF =1.17; Stability, Tolerance = .91, VIF =1.10; Personal controllability, Tolerance = .71, VIF =1.41; Complex mental health condition, Tolerance = .73, VIF = 1.38;

Personality disorder, Tolerance = .77, VIF = 1.30). Residual and scatter plots indicated the assumptions of normality, linearity and homoscedasticity were met.

The stigma variables (PATOMI and AQ-27) were entered at stage one of the regression. The CDS-II subscale variables (causality, external controllability, stability, and personal controllability) were entered at stage two, and the three mental health conditions at stage four. The final stage included the three group conditions to confirm no differences would be found between the groups. Dummy variables were created to allow the groups to be represented as numerical variables within in regression analysis. The two stigma variables were entered first due to their potential for a broader impact on decision making.

An examination of correlations revealed that no independent variables were highly correlated, with the exception of the PATOMI and AQ-27 total scores, and the DRQ total scores and CDS-II Personal controllability (see Appendix Q). However, as the Tolerance and VIF collinearity statistics were all within accepted limits, the assumption of multicollinearity was deemed to have been met.

The hierarchical multiple regression revealed that stage one was significant ($F(2,126) = 19.62$, $p < .001$). Both baseline stigma (i.e., the PATOMI scores) and stigma towards the defendant (AQ-27) contributed significantly to the regression model and accounted for 23.7% of the variation in Diminished Responsibility deliberations ($\beta = .22$, $t = 2.07$, $p = .041$ and $\beta = -.31$, $t = -2.87$, $p = .005$, respectively).

Stage two was also significant ($F(6,122) = 20.33$, $p < .001$). Introducing the CDS-II subscale variables increased the explained variation to 50% (an additional 26.2% of variance explained) in Diminished Responsibility opinions, and this change in R^2 was significant ($F(4, 122) = 16.01$, $p < .001$). The PATOMI and AQ-27 were no longer significant predictors of Diminished Responsibility. The personal control subscale was the only significant predictor

within this model (β = -.54, t = -7.18, p < .001); the other subscales of the CDS-II did not make a significant contribution to the model.

Finally, the addition of the three groups to the regression model explained an additional 1% of the variation in Diminished Responsibility. This change in R^2 square was not significant, (F(2, 120) = 0.16, p = .86).

When all independent variables were included in stage three of the regression model, the overall model remained significant (F(8, 120) = 15.01, p < .001) and accounted for 50.1% of the variance in Diminished Responsibility opinions. The only individual variable which significantly contributed to the model when controlling for other variables was the CDS-II personal control subscale, which uniquely explained 26.2% of the variation in Diminished Responsibility opinions. Whilst the two variables relating to stigma did significantly contribute to the model in the first step, they were no longer individual significant predictors in the third step, suggesting that their impact was no longer significant once the personal control variable was controlled for.

Discussion

This study aimed to explore how different mental health diagnoses impact decision making and perceptions of mock-jury participants within a homicide trial scenario. The study replicated and expanded on previous research by Baker et al., (2022). The three groups within the study each heard a different diagnostic term ('complex mental health condition', 'personality disorder' or 'psychopathy') in an otherwise identical mock trial. It was hypothesised that participants within the 'personality disorder' and 'psychopathy' conditions would present more stigmatising beliefs, make more stigmatising causal attributions and be less favourable regarding the defendant's Diminished Responsibility plea.

The results showed the diagnostic term used did not significantly impact stigmatising beliefs, causal attributions, or decision making regarding Diminished Responsibility. The lack of differences between the conditions suggests either that negative attitudes (stigma) towards the diagnoses was not formed (perhaps because the stigma formed as a consequence of the offence was itself so high), or if it was, it represented a general labelling effect towards mental health terms as a whole, rather than a specific labelling effect for either personality disorder or psychopathy.

Given the literature highlighting stigma for personality disorder and the portrayal of psychopathy in the media (Hyler et al., 1991; Keesler, 2014; Owen, 2012; Skryabin, 2021; Stuart, 2006), this is perhaps at first glance a surprising finding. Nonetheless, it is consistent with the findings of the meta-analysis by Berryessa and Wohlstetter (2019) who found no significant punishment outcome differences in studies using vignettes of defendants with a psychopathic label compared to defendants with a different mental health diagnosis. Analysis of studies comparing an offender with a psychopathic label vs. an offender with no label found that two of the punishment outcomes studied (legal sentence/sanction and dangerousness) differed significantly. Taken together, these results suggest more stigmatic opinions are present towards offenders with mental health labels, regardless of diagnosis.

One possible explanation of not observing significant differences in stigma between the diagnostic groups may be a lack of knowledge about psychopathy and personality disorders. Research has shown lay public participants are significantly less likely to correctly identify a case of psychopathy than they are of either depression or schizophrenia (Furnham et al., 2009). Keesler and DeMatteo (2017) found laypersons to have a mixed understanding of psychopathy and that exposure to film and television protagonists with psychopathic traits positively correlated with endorsing positive distractor traits (e.g., secretive, intelligent, good people-reader, dark/mysterious) suggesting that individuals familiar with protagonist psychopaths may tend to romanticise psychopathy. However, other studies suggest the media often depict psychopathic characters as violent towards others and dangerous villains, consequently negatively influencing the way the public conceptualise the term 'psychopath' and other mental health conditions (Hyler et al., 1991; Keesler, 2014; Owen, 2012; Skryabin, 2021; Stuart, 2006). Furthermore, laypersons' knowledge of personality disorders has been shown to be low, perhaps less than that of psychopathy, with one study finding participants significantly more likely to identify psychopathy compared to borderline personality disorder in vignettes (Furnham et al., 2015; Furnham & Winceslaus, 2012; Wright & Furnham, 2014).

Research has shown that better educated people (in general) and those having personal experience of specific mental health conditions have greater mental health literacy (Carr & Furnham, 2021). Higher mental health literacy has been associated with lower levels of stigmatising attitudes towards mental health (Reavley & Jorm 2011; Simões de Almeida et al., 2023). In relation to this study, it could be that the different labels did not significantly influence participants' decision making due to low levels of knowledge or understanding about personality disorders and psychopathy, or mental health generally. Alternatively, similar mental health literacy levels could have been present in each group, thus no differences were observed between stigmatising attitudes. Future research should consider measuring participants' literacy on diagnostic terms used within vignettes.

An alternative explanation could be the language used. Using the term ‘is a psychopath’ to describe a juvenile led a mock jury to believe they posed greater risk of future criminal behaviour and deserved greater punishment compared with juvenile defendants described as ‘meeting diagnostic criteria for psychopathy’ or labelled with ‘conduct disorder’ (Boccaccini et al., 2008). Perhaps if the present study had used ‘psychopath’ rather than ‘psychopathy’ to describe the defendant, a difference would have been found between the conditions.

One of the more intriguing findings within this study was how the ‘personal control’ subscale significantly predicted participants’ Diminished Responsibility decision making. This subscale measured the extent to which participants believed the crime was out of the defendant’s personal control. The more individuals believed the defendant was unable to manage the situation, unable to regulate, and lacked power within the situation, the more likely they were to accept the Diminished Responsibility plea. This was found to be the case regardless of participants’ baseline stigma towards offenders with mental health conditions, and stigmatising attitudes held towards the defendant within the vignette.

It may seem unintuitive that stigma isn’t influential in opinions regarding Diminished Responsibility, however, it could be argued that the three questions that make up the personal control subscale are similar to the Diminished Responsibility criteria. The three personal control questions asked participants to consider whether the defendants’ situation is manageable by the defendant or not, if the defendant can regulate or not, and whether the defendant has power or not within the situation. These questions seem comparable to one section of the Diminished Responsibility criteria which states there must be an abnormality of mental functioning which substantially impaired the defendant’s ability to understand the nature of their conduct during the situation, to form a rational judgement about the situation and their actions, or to exercise self-control during the situation. Perhaps these similarities can

explain the importance of the personal control subscale as a predictor of Diminished Responsibility decision making.

This result is important to highlight for legal professionals, as the way in which the defendant is portrayed within the court may have a profound impact on jury decision making. A defendant described as powerless, having difficulties regulating themselves and unable to manage in certain circumstances may sway the jurors, despite their personal opinions of offenders with mental health conditions. Professionals might be advised to take particular caution when describing and explaining traits relating to personal control. It could be argued that within this study, the language used to describe the defendant was more influential than the diagnostic labels themselves. This is a particularly significant finding in regard to the Diminished Responsibility plea which, as previously discussed, is a decision made to civil standards, on a balance of probabilities.

This thesis adds further insight into an under-researched area through the replication of Baker et al., (2022). It seems important to consider the present study's results in relation to the findings of Baker et al. The present study found more differentiation in responses regarding Diminished Responsibility compared to Baker et al., who found universal endorsement of Diminished Responsibility, as opposed to murder both in group discussion verdicts and individual ratings across both diagnostic labels. Although it is unclear as to why this may have been the case, potential explanations may include the alterations made to the study materials, or larger the sample size with wider demographics. This study sought to address limitations acknowledged by Baker et al., such as a disproportionately female and well-educated sample, the potentially over sympathetic vignette and revealing victim and defendant genders. It may be that the successful adjustments made within this study reduced additional biases and gathered more ecologically valid data, thus explaining a wider range of opinions.

However, Baker et al., (2022) found a significant difference in stigmatising attitudes between the two terms ‘Severe Personality Disorder’ and ‘Complex Mental Health Problems’. Labelling the defendant with a ‘Severe Personality Disorder’ resulted in them being perceived as more dangerous, as more in need of coercive psychiatric treatment, and more in need of segregation from the public. As previously discussed, the present study found no significant differences between the diagnostic labels used. One potential explanation for this may be the removal of the word ‘severe’ within this study may have reduced participants’ stigmatising attitudes within the personality disorder group, and perhaps the word ‘complex’ may have simultaneously negatively influenced stigma within the complex mental health condition group.

Strengths and Limitations

The limitations acknowledged by Baker et al., (2022) regarding sample size and demographics, the invalid measure of causal attributions, gender biases and group power dynamics were addressed in the present study which is considered a strength by the authors. However, this study is not without its limitations, and these should be taken into consideration when interpreting the results.

One of the main limitations within this study was the length of the mock trial and online questionnaires. Due to the online nature of the data collection, it was not possible to know how much of the videos were watched by whom, whether the information provided was read thoroughly, or how much of the case was followed or understood. Some participants may have watched the videos in double speed to reduce the total length of time spend participating. This was taken into consideration when choosing a cut off time of 13 minutes, as anything faster than this indicates a lack of true engagement. However, it was not possible to identify which participants did watch videos using the double speed option and which did not, thus there may have been participants who skipped sections of the video or answered questionnaires without thought. Future research should seek to address this, perhaps by

including manipulation or knowledge checks at certain points within the study to assess engagement, consider reducing the length of time the study takes to reduce fatigue, or even returning to an in-person format to address this limitation.

The ecological validity of this study may be questioned due to the mock trial being conducted online via videos. Future research should consider returning to a face-to-face design within a mock court room to enhance the immersive experience for participants and thus increase ecological validity. Additionally, this study measured individual opinions regarding Diminished Responsibility and lacked a group deliberation stage to decide on a jury verdict. This is of course not a parallel of what a jury actually does, where the task is to make decisions collectively and reach a unanimous verdict. Nonetheless, the jury is itself a collection of individual jurors, and demonstrating the relevance of attitudinal factors such as stigma in decision making in an individual is presumably the first step in understanding how that individual might behave within a group. Indeed, previous literature suggests that recording verdict decisions made by individual jurors prior to group deliberations tends to be the most accurate prediction of their verdict post-deliberation (Sandys & Dillehay, 1995). Furthermore, the opinions held by the majority of jurors at the beginning of a deliberation ends up being the final decision in about 90% of trials (Bornstein & Greene, 2011).

Furthermore, the online study meant that group verdict stage was unfeasible and thus was eradicated from the methodology. Again, future research should consider a face-to-face group discussion to address this limitation as this studies mock trial was significantly difference compared to legal procedures within England, where a collective group of eligible jurors would discuss the case together and make individual decisions in a group format before reaching a verdict. Ideally, participants would have met face to face or the mock trial and replicated this group stage, preferably recruiting prospective jurors who were selected for jury duty but were no longer required, however very few studies have been able to do this (Sloat & Frierson, 2005; Thomas, 2020). This may reflect wider difficulties in ecologically valid research in jury decision making, particularly in jurisdictions

such as England and Wales, where significant legal limitations are placed on the conduct of actual research with real juries (with the University College London Jury Project, led by Cheryl Thomas, perhaps being the only example of research that comes closest to this ideal; Thomas, 2020). However, a group decision may not influence overall outcomes, as previous literature suggests that although some individuals may be swayed by the group discussions, verdict decisions made by individual jurors prior to group deliberations tends to be the same decision post-deliberation (Bornstein & Greene, 2011; Sandys & Dillehay, 1995).

It is important to highlight a significant strength of this paper was the wide diversity in ethnicity and gender of participants, particularly compared to the limited sample recruited by Baker et al., (2022). However, due to the online nature of this study, there is no way of confirming the captured participant demographics are true. Furthermore, the sample only included individuals with access to the internet. It is important to consider that adults in the UK who use the internet regularly tend to be younger, higher earners and have a higher education (Local Government Association, 2021; The Office for National Statistics, 2020), thus the sample may not be representative of the general adult population regarding these demographics. It is important to make the link here between education levels, mental health knowledge and stigma. Higher educated (in general) individuals have been shown to have greater mental health literacy than those less educated (Carr & Furnham, 2021) and higher levels of mental health literacy is related to less stigmatising attitudes towards offenders with mental health conditions (Ricciardelli et al., 2021; Wittmann et al., 2021; Yamamoto et al., 2017). Future research should consider measuring participant mental health literacy to capture individual and group knowledge, and the impacts this may have on stigma outcomes.

Further Research

This study found evidence of a generalised mental health labelling effect as the specific diagnostic terms used did not impact stigmatising beliefs towards the defendant, causal attributions, or opinions on Diminished Responsibility. To further explore this effect,

future research could be conducted using alternative labels to those used within this study, such as ‘psychopath’, to see if similar conclusions are able to be made. Adding a control condition with no mental health labels may also be considered to assess stigmatising opinions. Furthermore, murder may have interacted with stigma levels and opinions on Diminished Responsibility in this study, thus the crime committed by the defendant may also be something to consider manipulating in future research.

Additionally, no group discussions took place in this study. Future research may need to consider whether this is a necessary stage for ecological validity, and an important area to investigate in relation to individual jurors’ stigma and biases.

Conclusions

This study built upon limited research regarding the diagnosis of personality disorder in a legal context. Replicating Baker et al., (2022) and using case simulation methodology, this paper sought to explore how stigmatising beliefs, causal attributions and decisions regarding the Diminished Responsibility plea may be impacted by differing mental health diagnoses heard by the jury. The results presented a concerning positive relationship between levels of stigma towards offenders with mental health conditions and Diminished Responsibility decisions, as mock jurors with higher stigma were more likely to reject the Diminished Responsibility plea. However, the extent to which individuals believe the defendant is unable to control or regulate was shown to be a key factor in decision making, more so than any stigmatising attitudes held. Although the similarities between the three conditions suggests that the mental health information presented to a jury may not be important, legal professionals and expert witnesses must be mindful about how they are portraying the defendant in regards to the personal controllability of their behaviour. Though there are still many unanswered questions, it is clear that mental health diagnoses and information regarding these should be used with caution within a court of law, as it can have

significant implications for defendants. Future guidance for expert witness testimonies and defence/prosecution lawyers should consider these results to ensure a fair and just trial.

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Chapter Five: Discussion and Critical Evaluation

This thesis intended to explore the influential factors and consequences of stigma towards offenders with mental health conditions within legal settings. This chapter will summarise the findings of the two papers, discuss the strengths and limitations, and consider the implications of the results upon the legal system, clinical professionals, and future research.

Findings

Taken together, the findings of both papers reveal the importance of jurors' perception of a defendant and the causes of the crime. The systematic review revealed that certain diagnostic labels were associated with negative attitudes towards offenders, as did certain traits. Substance abuse, psychopathy and antisocial traits (including risk of future violence, remorselessness, and disinhibition) were related to high levels of stigma from the public, whereas schizophrenia and depression were associated with lower levels of stigma. Moreover, this stigma did not come without consequences. Higher levels of stigma were found to influence decision making within legal settings such that more stigma increased the likelihood that a defendant was found guilty of murder and given harsher sentencing outcomes.

In comparison to the systematic review, the results of the empirical paper were that diagnosis did not appear to affect stigma, causal attributions or decision making regarding Diminished Responsibility. However, the results suggested that beliefs about the cause of the crime were most influential when it came to Diminished Responsibility outcomes. Perceiving the defendant as having high personal control predicted a greater likelihood of rejecting the Diminished Responsibility plea. In other words, participants who believed the defendant held power within the situation, and was able to manage and regulate their behaviour were more likely to consider the defendant guilty of murder. Reassuringly, the three questions within the personal control measure are similar to the Diminished Responsibility criteria, thus the results suggest that the main

influential factors in Diminished Responsibility decision making is perception of personal control, i.e., perceptions that are aligned to the criteria.

At this point, it is apposite to return to the two cases of '*R v. Challen'* (2019) and '*R v. Squelch*' (2017) introduced previously within this thesis (page 8). The findings of this thesis could be related to these cases to hypothesise some of the factors which may have influenced the outcomes of the trials. Take Mrs Challen's retrial for example. During the retrial, the court heard new evidence about her diagnosis of borderline personality disorder and the coercive control Mrs Challen had experienced from her husband (*R v. Challen*, 2019). It could be argued that the new evidence of coercive behaviours from her husband portrayed Mrs Challen as having little personal control, thus the jury were more likely to accept the Diminished Responsibility plea. Furthermore, the way in which Mrs Challen was described within the trial may have influenced the jury's decisions.

When thinking about the case of Mr Squelch, details of the situation may have influenced the jury's perception of his personal control. For example, Mr Squelch drove his colleague to work, attacked him from behind, and stabbed him multiple times (*R v. Squelch*, 2017; McConnell, 2017). It could be hypothesised that the jury believed he was in a position of power, managing the situation and able to regulate at the time of the crime. However, it is important to note that the attack was caught on CCTV and played at the trial, which may have been a powerful and influential piece of evidence within the case (Hopper, 2016). It is conceivable that observing the crime exacerbates negative opinions and makes it harder for the jury to speculate the defendant lacked personal control.

Strengths and Limitations

The two papers within this thesis give further insight into stigma towards offenders with mental health conditions within legal settings, a limited area of research. The empirical paper is a replication of Baker et al., (2022), which in itself can be acknowledged as a strength due to the noted 'replication crisis' in clinical psychology (Wiggins & Christopherson, 2019; Woodell, 2020).

Conducting the replication allowed the limitations acknowledged by Baker et al., to be addressed, an additional strength of the empirical paper to note. However, the adaptations made did not come without their own limitations. Using online recruitment and participation methods allowed a larger and more diverse sample to participate compared to Baker et al., but this caused concerns regarding participant engagement levels and the ecological validity of the study.

Due to the online nature of the study, measuring the level of participant engagement and attention was unattainable. It is not possible to know how much of the videos were watched by whom, whether the information provided was read thoroughly, and how much of the case was followed or understood. Future research should seek to address this, perhaps by including manipulation or knowledge checks at certain points within the study to assess engagement, consider reducing the length of time the study takes to reduce fatigue, or even returning to an in-person format to address this limitation.

Additionally, the online study meant that group verdict stage was unfeasible and thus was eradicated from the methodology. This is a significant difference compared to legal procedures within England, where a collective group of eligible jurors would discuss the case together and make individual decisions in a group format before reaching a verdict. Ideally, participants would have met face to face at the mock trial and replicated this group stage, preferably recruiting prospective jurors who were selected for jury duty but were no longer required, however very few studies have been able to do this (Sloat & Frierson, 2005; Thomas, 2020). This may reflect wider difficulties in ecologically valid research in jury decision making, particularly in jurisdictions such as England and Wales, where significant legal limitations are placed on the conduct of actual research with real juries (with the University College London Jury Project, led by Cheryl Thomas, perhaps being the only example of research that comes closest to this ideal; Thomas, 2020). However, a group decision may not influence overall outcomes, as previous literature suggests that although some individuals may be swayed by the group discussions, verdict decisions made by

individual jurors prior to group deliberations tends to be the same decision post-deliberation (Bornstein & Greene, 2011; Sandys & Dillehay, 1995).

The systematic review included 17 studies of high quality, an important strength to highlight. Notable limitations of the systematic review acknowledged by the authors include the limited locality of the studies included. All but one of the studies were conducted in North America, the majority being from the US where the legal system is heavily intertwined with politics (Hamilton, 2012). Due to the vast differences within criminal justice systems around the world, the extent to which the review results can be generalised to other countries and cultures is unknown. Juries have differing roles and tasks in different jurisdictions, not to mention the variations in jury selection (e.g., in the US, lawyers have the ability to exclude some jurors without giving reason, whereas in the UK, the jury is selected as random, i.e., a "jury of peers"). Significant differences exist in many aspects of legal systems across the world (Hans, 2008), thus more thought must be given to what decision is being made and to what standard, how jurors are selected (both in research and reality), and what information these jurors are presented with. The systematic review particularly highlights how little research has been conducted in England and Wales. More research is therefore necessary to understand how mental health conditions influence jury decision making within the legal system of England and Wales.

Implications

Although further research is required to make firm conclusions, the evidence suggests the labelling and language used within legal settings does influence jury decision making. The wider implications of using certain diagnostic labels or descriptive terms must be considered by expert witnesses giving evidence in court and there is an obvious necessity for caution. Experts assessing defendants and providing evidence within the legal system should recognise that their clinical descriptions may have a significant impact on the jury's perceptions and decision making, perhaps more so than any diagnoses present. Experts should therefore carefully consider the language used

within their reports and be aware of the influential power this may hold, particularly when themes of control are mentioned.

More broadly, these considerations must also be taken outside of the legal system. The way in which clinicians label and describe individuals with mental health conditions will no doubt influence public stigma and perceptions, thus caution must be taken when discussing individuals with other professionals and laypersons.

Future Research

The findings of the empirical paper indicate that specific diagnostic terms do not impact stigmatising beliefs, causal attributions, or opinions on Diminished Responsibility. However, the systematic review found evidence that diagnostic labels do influence stigma. More research is necessary to explore the potential impact diagnostic labels can have within a legal context. There is also the possibility that stigma arises from mental health diagnoses in general. Alternatively, this could be due to the crime of murder itself being highly stigmatised. To explore these hypotheses, future research should consider using a vignette without a mental health condition present, and perhaps consider manipulating the crime type.

Furthermore, there is a clear lack of research involving certain diagnoses such as personality disorders within legal settings. Personality disorders are highly prevalent in the prison population as statistics suggest prisoners are six times more likely to have a diagnosis of personality disorder compared to an individual within the general community (Fazel & Danesh, 2002; National Guideline Alliance (UK), 2017). Future research is therefore necessary to continue to investigate stigma and attitudes towards offenders with personality disorders and understand the causes and consequences of this within legal settings.

Several limitations of the empirical paper derived from conducting the study online. Future researchers should consider alternative methods to address these limitations, such as including

knowledge/manipulation checks online, or conducting the study in-person. Returning to an in-person design would allow the option for a group discussion to be included. Future research should consider exploring group jury and individual juror decision making in relation to stigmatising beliefs, perhaps considering if stigmatic attitudes are related to individuals' traits or characteristics, and whether this might influence how an individual engages within a jury, for example, dominance or authoritarian attitudes (McGowen & King, 1982)

Future researchers must also consider the methods in which they chose to measure stigma. This study used the PATOMI and AQ27, both of which were highly correlated with one another, but measuring two separate aspects of stigma. There are many more measures that exist, and caution should be taken when designing future studies (Tremlin & Beazley, 2022), particularly when considering adapting an already exist measure. For example, although many studies using the AQ-27 have adapted the vignette originally designed for it (including this thesis), it is unclear whether this is measuring exactly what the AQ-27 initially intended (Baker et al., 2022; Batastini et al., 2014; Lloyd et al., 2018). Furthermore, future research may want to want to be include additional measures, for example, measuring mental health literacy, as in the empirical paper, there was no way of knowing whether the sample had more or less knowledge or awareness of mental health, specifically personality disorder or psychopathy compared to the rest of the general public, and how this may have influenced the results.

Overall Conclusions

This thesis has shown that public stigma towards offenders with mental health conditions matters within legal settings. Many factors influence this stigma, most notably defendant traits, diagnoses and stigmatiser traits. This stigma appears to influence juror decision making regarding verdicts and sentencing recommendations. Most intriguingly, this study found evidence to suggest that jurors' perception of the defendants personal control predicts their opinions regarding the Diminished Responsibility plea. However, this area of literature is still limited, and more research is

necessary to make concrete conclusions on the extent to which these factors influence jury decision making.

What can be concluded is the necessity for clinicians and legal professionals to take heed and practice with caution, particularly when describing defendants within a court of law. The careless use of language and labels may have significant adverse implications for individuals on trial, possibly influencing life-changing decisions about an individual's freedom and liberty.

References for Additional Chapters

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Appendices

Appendix A: Psychiatry, Psychology and Law Author Guidelines

Journal Author Guidelines for 'Psychiatry, Psychology and Law'

About the Journal

Psychiatry, Psychology and Law is an international, peer-reviewed journal publishing high-quality, original research. Please see the journal's Aims & Scope for information about its focus and peer-review policy.

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Updated 22-08-2022

Appendix B: Appraisal tool for Cross-Sectional Studies (AXIS)

Question		Yes	No	Don't know/ Comment
Introduction				
1	Were the aims/objectives of the study clear?			
Methods				
2	Was the study design appropriate for the stated aim(s)?			
3	Was the sample size justified?			
4	Was the target/reference population clearly defined? (Is it clear who the research was about?)			
5	Was the sample frame taken from an appropriate population base so that it closely represented the target/reference population under investigation?			
6	Was the selection process likely to select subjects/participants that were representative of the target/reference population under investigation?			
7	Were measures undertaken to address and categorise non-responders?			
8	Were the risk factor and outcome variables measured appropriate to the aims of the study?			
9	Were the risk factor and outcome variables measured correctly using instruments/measurements that had been trialled, piloted or published previously?			
10	Is it clear what was used to determined statistical significance and/or precision estimates? (e.g. p-values, confidence intervals)			
11	Were the methods (including statistical methods) sufficiently described to enable them to be repeated?			
Results				
12	Were the basic data adequately described?			
13	Does the response rate raise concerns about non-response bias?			
14	If appropriate, was information about non-responders described?			
15	Were the results internally consistent?			
16	Were the results presented for all the analyses described in the methods?			
Discussion				

17	Were the authors' discussions and conclusions justified by the results?			
18	Were the limitations of the study discussed?			
Other				
19	Were there any funding sources or conflicts of interest that may affect the authors' interpretation of the results?			
20	Was ethical approval or consent of participants attained?			

Appendix C: Script for the Expert witness testimony

Experimental "personality disorder" condition (for the other two conditions, al details will be the same, except for swapping the term "personality disorder" for either "psychopathy" or "complex mental health condition")

This case concerns a 29-year-old, who has mental health problems consistent with a presentation of personality disorder. They experience a high degree of anxiety with panic attacks, which they find very difficult to cope with. Due to their personality disorder, they experience rapid and extreme variations in their mood which can be difficult for them to understand and to regulate, particularly when they are under stress. They find their anxiety and their moods difficult to predict, which have meant that they have been unable to work for the past several months, after being asked to leave their last job after an argument with a member of staff. As part of their severe personality disorder, they can find it difficult to maintain stable relationships with other people, as they can feel a range of intense emotions and go from feeling adoration to jealousy, anger and betrayal. They can also misperceive situations as more threatening than they are, which can make them feel very unsafe and angry. This has often led to them having a panic attack or becoming impulsively aggressive toward themself or others, which has led to contact with the police on several occasions. Part of this tendency to read situations as threatening, as part of their personality disorder presentation, is their difficulty in making sense of the thoughts, intentions and perspectives of other people.

They struggle with coping with their unstable moods and anxiety, and this as well as being unable to work has meant that They has often felt depressed and hopeless, and had suicidal thoughts. They sometimes thinks about ending their life, but hasn't made any plans to do this recently. However, they have made attempts on their life in the past, which had led to them being diagnosed with personality disorder at age 20 after taking an overdose. The most recent attempt on their life was a year ago, when they severely cut their wrists. In the past year, they have gone to A+E four times, having cut themself.

They suffered sexual abuse from their stepfather during childhood. They told their mother about the abuse, although their mother did not believe them and thought they were trying to break up their relationship. Due to this, they felt rejected by their mother and could not turn to anyone else for help. They often have anxieties and fears around being rejected by others, which can underlie their difficult feelings and changing moods. They have wondered whether their younger sister might have also been abused although the sister does not want to discuss this. Between the ages of 18 and 20, they had a series of difficult relationships with abusive partners and reported physical and sexual assaults, which led to them overdose and their diagnosis of personality disorder. Since then, they have engaged with mental health services on a few occasions and currently sees a nurse from their personality disorder team.

Appendix D: Circumstances of the case.

Case details summary

The defendant, a 29-year-old, is accused of the murder of the victim, 37. They were known to each other before the event, as they lived nearby on the same suburban estate and shared mutual friends. Although they did not know each other well, the victim would walk past the defendant's house and wave to them occasionally on their walk to work.

They met each other fully on the 13th August, 2020, when they both attended a barbeque held by one of the defendant's friends on the estate. The defendant had gone to the barbeque with their younger sister, who on later questioning said that she had persuaded the defendant to go, as they had been feeling particularly low and short-tempered recently and that the barbeque might cheer them up. In the course of the party the victim, having had several alcoholic drinks, struck up a conversation with the defendant's sister and over the course of the evening, they became increasingly close and flirtatious as they joked together. At one point in the evening, the defendant became angry at the victim and they began to have a heated argument. The defendant had not been drinking alcohol. From questioning a witnesses of the argument, the defendant accused the victim of "crowding" her sister, and called them a "creep". After a couple of minutes of arguing, the defendant threw a drink in the victim's face, after which her sister told them to go home, and that she would see them later at their house.

The defendant returned home. On later questioning they reported being "fucking fuming" and that they tried to calm down at home. Back at the barbeque, in the aftermath of the argument the defendant's sister apologised to the victim, and said that the defendant had "anger management issues" and "issues with men because of their past". The victim had then said that they felt bad about arguing with the defendant and that they wanted to apologise and bring them back to the party. While the sister asked them not to, later on unknown to her they left the barbeque and went to the defendant's house.

The victim arrived at the defendant's home and knocked first on the door, and then on an adjacent open window in the kitchen of her house, while calling for them. The defendant entered the kitchen area and on seeing the victim, was verbally abusive to them. From a neighbour's report, they heard the defendant shouting at them and calling them "a fucking creep, first coming for my little sister and now me in my house". It is not known what the victim said in response, but it appears that while the victim was apologetic at first, they began to argue back. The neighbour's report described both shouting for around half a minute. The defendant became increasingly aggressive and distressed in their tone, screaming at the victim and throwing small items out of the kitchen window at them.

The defendant then took a kitchen knife from the side, opened the front door and stabbed the victim in the neck, causing major injuries. A neighbour who had heard the commotion called the police, who found the victim in a critical condition. The defendant had fled the scene, but was later found by police, distressed on a nearby housing estate. The victim was declared deceased shortly after being found by police at the scene.

When questioned by police, the defendant said that they felt frightened when they saw the victim come to their house. They said that the victim reminded them of their stepfather as he wore a similar football shirt, and they felt "creeped out" by the victim. The defendant said that they "lost it" when they stabbed the victim in the neck. The defendant expressed that they regretted what happened.

Appendix E: Juror Diminished Responsibility Information Sheet

Juror Information Sheet: Diminished Responsibility

You have now heard information about the defendant and their mental health problems, as well as the events of the crime committed.

The video clips you are about to see explain that while there is no doubt that the defendant committed the act of killing the victim, their plea is that they are guilty to manslaughter, not murder, on the grounds of **Diminished Responsibility** due to their mental health problems.

The Prosecution and Defence arguments will debate whether **Diminished Responsibility** applies when considering the defendant's actions.

Diminished Responsibility is a legal defence in cases of homicide. It means that a defendant is judged as less responsible for their actions because of their mental health problem. It affects the sentence handed to the defendant by the judge. It could mean that a person is treated for their mental health problems in a secure psychiatric hospital rather than a prison, or there can be time in hospital before going to prison once these mental health problems are treated. It can also mean that a person's sentence (their punishment for the crime) is reduced by years.

As a jury, you are asked to consider whether you think the defendant had **Diminished Responsibility** for the crime.

For Diminished Responsibility to apply, the following criteria must be met. Please consider these criteria carefully, and whether you think these apply to the defendant in this case.

There must be an abnormality of mental functioning which:

A) arose from a recognised medical condition

B) substantially impaired the defendant's ability to do one or more of:

1. **understand the nature of their conduct** during the situation
2. **to form a rational judgement** about the situation and their actions
3. **to exercise self-control** during the situation

C) provides an explanation for the defendant's actions.

If you think that the defendant's mental functioning was affected by a medical condition, and that this affected their ability to understand their conduct, make a rational judgement, or exercise self-control over their actions during the crime, and this explains their actions, then **Diminished Responsibility** would apply.

Appendix F: Scripts for the trial reconstruction

Note: These scripts are provided for the "Personality Disorder" condition. For the other conditions, all references to this are replaced with "psychopathy" and "complex mental health condition" and are otherwise unchanged.

Initial Prosecution statement

Your honour, members of the jury, I represent the Prosecution in this case. The defendant is charged with the common law offence of murder, in that they have been found to have attacked and stabbed the victim, Paul Simons, causing serious bodily harm resulting in his death. The Defence's plea on this matter, however, is guilty to manslaughter on the grounds of Diminished Responsibility, one that the Prosecution rejects. Let us consider the question of what murder itself entails, and contemplate whether this applies in this case to a point of being beyond reasonable doubt. Murder, in English law, means the unlawful killing of another human being with malice aforethought, meaning that the defendant intended to kill or at the least intended to cause serious harm to the victim. Now, let us consider the facts of the case, and in particular the question of the intention to cause serious harm. On the 13th August 2020, following an earlier unprovoked and aggressive altercation with the victim at a communal barbeque, of which they was the driver, the victim presented at the defendant's home intending to make some form of restitution. The victim did not enter the home unduly, but knocked at the door and attempted to speak with them. It appears that on encountering the victim outside of their home, the defendant continued to behave in a hostile and overly aggressive manner, to which the victim began to respond, though not in a manner which could have reasonably provoked what was to occur. The defendant then took a knife from the side of the kitchen in their home, opened their front door, approached the victim and stabbed them. Consider the nature of intention. To have intention, there must be knowledge of a virtually certain consequence following an action – namely, that serious harm is a virtually certain result of assault with a knife- and it is argued that the defendant knew this well. In addition, in considering the point of malice in their intentions, it is argued that they foresaw the risk that serious harm or killing would occur as the result of their actions, and that they deliberately took this risk. The defendant and victim were heard by neighbours to be shouting for a period of at least 30 seconds, and this was not the product of a sudden, startling or threatening provocation on the part of the victim. The defendant was able to consider their actions as they carried them out, knew the consequences and risks, and chose these as part of malicious intention to cause the victim serious harm, or death.

To the jury, as you make your deliberations, should you agree that the defendant killed the victim unlawfully with malice aforethought, you must find the defendant guilty of murder.

Defence case

Your honour, members of the jury, I represent the Defence in this case. As we have heard, the defendant's plea in this case guilty to manslaughter, not to murder, on the grounds of Diminished Responsibility. We have heard the Prosecution's argument that the defendant acted purposefully and with intent to cause at least serious harm during the events that led up to the death of the victim. I will present the facts of this case with respect to further consideration of the nature of the defendant's mental health difficulties, and argue that, contrary to the Prosecution's claims, the criteria of Diminished Responsibility do in fact apply in this case. I will suggest that you should find them not guilty of murder, but instead guilty of manslaughter on the grounds of Diminished Responsibility. Given the nature of their *Personality Disorder*, they were not able to understand the nature of their conduct, to form a rational judgement, nor to exercise self-control over their actions. I will suggest to you, members of the jury, that their *Personality Disorder* substantially impaired their ability to do those things. When you have heard our evidence, if you believe that it is more

likely than not that the criteria of Diminished Responsibility does apply in this case, your verdict should be one of manslaughter and not murder. Should doubt exist in your mind, you should find a verdict of manslaughter and not murder.

In support of the view of the Defence, I present as evidence the report of Dr Jane Bellbottom, a psychiatrist instructed to interview the defendant and determine whether the defendant's mental health condition meant that the Diminished Responsibility criteria do in fact apply.

As this report confirms, Dr Bellbottom agrees that the defendant suffers from *Personality Disorder (Borderline Pattern)*, which is a recognised medical condition. When Dr Bellbottom assessed them, they showed pronounced anxiety and a fluctuating emotional state, consistent with earlier observations from the personality disorder community mental health team. Dr Bellbottom notes that stressful events can trigger extreme emotional variations and impulsive behaviours which are difficult to control. They describe a pronounced fear of abandonment and rejection from others, which leads them to behave in potentially manipulative ways to avoid this. These, together with the defendant's history of sexual and physical abuse, are significant explanatory factors in the defendant's actions during the crime, which means you can properly find them not guilty of murder and guilty of manslaughter on the grounds of Diminished Responsibility.

We now consider Dr Bellbottom's views regarding the Diminished Responsibility impairment criteria, one or more of which must apply.

First, the defendant's ability to understand their conduct. Dr Bellbottom expresses the view that the defendant understood their conduct during the evening, and during the incident itself, but that their conduct itself was affected by the other two factors.

Second, the defendant's ability to form a rational judgement, which it is argued was substantially impaired at the time of the crime. Dr Bellbottom argues that, as part of their *Personality Disorder*, They were less able to make a rational judgement about the situation compared to a person without this condition. They saw the situation as more dangerous and threatening than it actually was, and this was affected by their history of abuse and the victim's appearance, which in resembling their historical abuser, triggered memories and emotions associated with this abuse and substantial fear. This informed a belief that they would be attacked by the victim, and that they needed to defend themself.

Third, the defendant's ability to exercise self-control in this situation. Dr Bellbottom argues that given that the defendant could not rationally judge the danger of the situation, the ensuing extreme fear and stress meant that they could not control their impulsive and aggressive behaviours and could not exercise self-control as they stabbed the victim.

In summary of Dr Bellbottom's report, the impairments relate to the factors of the ability to form a rational judgement, and to exercise self-control during the incident. Both are judged by Dr Bellbottom to be substantially impaired, due to the defendant's *Personality Disorder,* and so the level of responsibility and culpability in this case is lowered. Dr Bellbottom recommends that the defence of Diminished Responsibility does apply in this case. May I remind you that this need only exist on the balance of probabilities – if you feel that these criteria have been made out and apply to the defendant, the defence applies, and the charge is one of manslaughter.

Members of the jury, I would invite you to consider everything that has been presented here as you make your deliberations, and find the defendant not guilty of murder, but guilty of manslaughter on the grounds of Diminished Responsibility. Thank you.

Having heard the defence case for Diminished Responsibility, the prosecution will present its evidence on the issue.

Prosecution vignette script

Your honour, members of the jury, the Prosecution rejects the Defence's case and we present our own evidence on the issue. Now, there is no dispute as to whether the incident of the killing of the victim by the defendant has occurred. However, the Defence suggests that the legal defence of Diminished Responsibility applies in this case. The argument behind this is that their mental health state at the time meant they was less responsible for their actions, by reason that their *Personality Disorder* meant that they were unable to form a rational judgement of the situation and exercise self-control during the incident. Today, I urge you to reject that view; I put it to you that the defendant was in fact able to form a rational judgement, and exercise self-control over their actions. It is the Crown's view that the criteria of Diminished Responsibility do not apply in this case. If you believe that the defendant did not have Diminished Responsibility in this case the verdict must be guilty to the charge of murder. I suggest to you that this was a straightforward case of the defendant acting deliberately, in a calm and considered manner; the defendant stabbed the victim intending to cause serious harm.

In support of the view of the Crown, I present as evidence the report of Dr Michael Albert, a psychiatrist commissioned to interview the defendant and provide a clinical opinion on whether the defendant's mental health problems at the time of the crime qualify for the criteria of Diminished Responsibility.

As the summary report explains, Dr Albert's view is that the defendant's mental health problems are consistent with *Personality Disorder* a recognised condition. As part of this condition, unstable emotions, interpersonal difficulties and impulsive behaviours are present, and these fluctuate markedly over time in a way which can be difficult to predict. He notes that the defendant has manipulative traits as well, in that they could appear helpless or feign other symptoms of mental illness to affect the behaviour of others. While these may be contributing factors in this situation, it is Dr Albert's view that the defendant bears a high degree of responsibility for the crime, and that their mental health problems do not explain their actions. They did not impair their ability to understand what they were doing, to form a rational judgment about how to behave, or to exercise self-control.

It is Dr Albert's view that the defendant was jealous of the victim at the party, as they took attention away from their sister, who had taken them there. The defendant became angry towards the victim. As such, the defendant orchestrated many of the earlier events of the evening, such as getting into an argument, throwing a drink in the victim's face and leaving. When the victim arrived at the defendant's home, the defendant, still angry and jealous toward the victim, became aggressive and stabbed them without restraint.

Summarising this report, we consider Dr Albert's views of the potential impairments under the Diminished Responsibility criteria:

First, the defendant's ability to understand their conduct at the time of the crime. On this matter I put it you that the defendant fully understood what they were doing during the events of the day, including at the time of the fatal stabbing. They were jealous and angry towards the victim, acted in a way to manipulate the situation at the party, and then acted out their anger and jealousy towards the victim purposefully. Their *Personality Disorder* did not by itself account for their actions.

Second, the defendant's ability to form a rational judgement. While it can be said that the defendant's judgements and thought processes might differ from that of a person without these problems, I suggest to you that their *Personality Disorder* does not rule out a capacity to form a rational judgement about their actions.

Third, the ability of the defendant to exercise self-control over their actions during the incident. Dr Albert notes that while impulsive behaviours can be in part due to *Personality Disorder*, he believes that the extreme actions taken by the defendant were a reflection of something more sinister- an intention to cause severe harm to the victim, due to their anger and jealousy. The defendant did not lose self-control, rather that they acted deliberately, with purpose, and intentionally killed the victim.

In summary, Dr Albert's report states that in considering the defendant's *Personality Disorder* and its weight upon the defendant's responsibility over their actions, the mental health problems in this case do not explain the defendant's actions to any substantial degree. The defendant was fully responsible for their actions in this case. Dr Albert has stated clearly that the Diminished Responsibility criteria do not apply.

Members of the jury, it is your duty to consider the facts of this case. Recognise this brutal killing for what it was: a deliberate, considered series of actions by someone fully in control of their actions and wholly responsible for them. The proper verdict in this case must be that they are guilty of murder. Thank you.

Trial Judge's directions to the Jury:

Members of the jury, my role is to explain to you what the law is and then your task is to apply the law to the facts of the case before you.

You, in the course of your duty, have a collective responsibility for the verdict in this case. You have taken an oath to try the case based upon the evidence given in this court, and you must base your verdict upon this alone. It is very important that you do not undertake any research of your own on the internet; you must judge the case solely on the evidence you have seen and heard here in court.

The defendant is charged with murder. In English law, murder is the unlawful killing of another person with malice aforethought. You may ask, what does that mean? In English law today, malice aforethought means either that the defendant intended to kill another person or intended to cause another person serious harm. It does not mean that they planned the killing ahead of time, not that they acted with malice in a loose moral sense. The question for you to decide is whether, at the moment they stabbed the victim, they intended to cause at least serious harm to the victim.

The prosecution's case is that they did intend to cause at least serious harm. Whether they did is for you to decide.

If you are not sure that they did intend to cause serious harm to him, then your verdict must be one of not guilty on the charge of murder, but guilty instead of manslaughter.

The defence case is that they were suffering from Diminished Responsibility at the time of the killing.

Appendix G: The Public Attitudes Towards Offenders with Mental Illness Scale (PATOMI)

Please read each of the following statements about defendants and circle the answer that represents how you might feel towards them, if you met them or were put in charge of what could happen to them.

1. As soon as an offender shows signs of mental disturbance, he should be hospitalised

1	2	3	4	5
Strongly agree	Somewhat agree	Neither agree nor disagree	Somewhat disagree	Strongly disagree

2. More tax money should be spent on the care and treatment of offenders with mental illness

1	2	3	4	5
Strongly agree	Somewhat agree	Neither agree nor disagree	Somewhat disagree	Strongly disagree

3. An offender with mental illness should be isolated from the rest of the community

1	2	3	4	5
Strongly agree	Somewhat agree	Neither agree nor disagree	Somewhat disagree	Strongly disagree

4. The best therapy for many offenders with mental illness is to be part of a normal community

1	2	3	4	5
Strongly agree	Somewhat agree	Neither agree nor disagree	Somewhat disagree	Strongly disagree

5. Offenders with mental illness are a burden on society

1	2	3	4	5
Strongly agree	Somewhat agree	Neither agree nor disagree	Somewhat disagree	Strongly disagree

6. Offenders with a mental illness are far less of a danger than most people suppose

1	2	3	4	5
Strongly agree	Somewhat agree	Neither agree nor disagree	Somewhat disagree	Strongly disagree

7. Locating forensic mental health facilities in a residential area downgrades the neighbourhood

1	2	3	4	5
Strongly agree	Somewhat agree	Neither agree nor disagree	Somewhat disagree	Strongly disagree

8. A woman would be foolish to marry an offender who suffered from a mental illness, even though he seems fully recovered.

1	2	3	4	5
Strongly agree	Somewhat agree	Neither agree nor disagree	Somewhat disagree	Strongly disagree

9. Less emphasis should be placed on protecting the public from offenders with mental illness

1	2	3	4	5
Strongly agree	Somewhat agree	Neither agree nor disagree	Somewhat disagree	Strongly disagree

10. Increased spending on forensic mental health services is a waste of tax money

1	2	3	4	5
Strongly agree	Somewhat agree	Neither agree nor disagree	Somewhat disagree	Strongly disagree

11. No one has the right to exclude offenders with mental illness from their neighbourhood

1	2	3	4	5
Strongly agree	Somewhat agree	Neither agree nor disagree	Somewhat disagree	Strongly disagree

12. Offenders with mental illness need the same kind of control and discipline as a young child

1	2	3	4	5
Strongly agree	Somewhat agree	Neither agree nor disagree	Somewhat disagree	Strongly disagree

13. I would not want to live next door to an offender who has been mentally ill

1	2	3	4	5
Strongly agree	Somewhat agree	Neither agree nor disagree	Somewhat disagree	Strongly disagree

14. Residents should accept the location of forensic mental health facilities in their neighbourhood to service the needs of the community

1	2	3	4	5
Strongly agree	Somewhat agree	Neither agree nor disagree	Somewhat disagree	Strongly disagree

15. There are sufficient existing services for offenders with mental illness

1	2	3	4	5
Strongly agree	Somewhat agree	Neither agree nor disagree	Somewhat disagree	Strongly disagree

16. Offenders with mental illness should be encouraged to assume the responsibilities of normal life

1	2	3	4	5
Strongly agree	Somewhat agree	Neither agree nor disagree	Somewhat disagree	Strongly disagree

17. Local residents have good reason to resist the location of forensic mental health services in their neighbourhood

1	2	3	4	5
Strongly agree	Somewhat agree	Neither agree nor disagree	Somewhat disagree	Strongly disagree

18. Our forensic mental health hospitals seem more like prisons than places where offenders can be cared for

1	2	3	4	5
Strongly agree	Somewhat agree	Neither agree nor disagree	Somewhat disagree	Strongly disagree

19. Locating forensic mental health services in residential neighbourhoods does not endanger local residents

1	2	3	4	5
Strongly agree	Somewhat agree	Neither agree nor disagree	Somewhat disagree	Strongly disagree

20. Forensic mental hospitals are an outdated means of treating offenders with mental illness

1	2	3	4	5
Strongly agree	Somewhat agree	Neither agree nor disagree	Somewhat disagree	Strongly disagree

21. Offenders with mental illness do not deserve our sympathy

1	2	3	4	5
Strongly agree	Somewhat agree	Neither agree nor disagree	Somewhat disagree	Strongly disagree

22. Forensic mental health facilities should be kept out of residential neighbourhoods

1	2	3	4	5
Strongly agree	Somewhat agree	Neither agree nor disagree	Somewhat disagree	Strongly disagree

23. One of the main causes of offender mental illness is a lack of self-discipline and will power

1	2	3	4	5

Strongly agree	Somewhat agree	Neither agree nor disagree	Somewhat disagree	Strongly disagree

24. We have the responsibility to provide the best possible care for offenders with mental illness

1	2	3	4	5
Strongly agree	Somewhat agree	Neither agree nor disagree	Somewhat disagree	Strongly disagree

25. Offenders with mental illness should not be given any responsibility

1	2	3	4	5
Strongly agree	Somewhat agree	Neither agree nor disagree	Somewhat disagree	Strongly disagree

26. Residents have nothing to fear from offenders coming into their neighbourhood to obtain forensic mental health services

1	2	3	4	5
Strongly agree	Somewhat agree	Neither agree nor disagree	Somewhat disagree	Strongly disagree

27. Most women who were once patients in a forensic mental hospital can be trusted as baby sitters

1	2	3	4	5
Strongly agree	Somewhat agree	Neither agree nor disagree	Somewhat disagree	Strongly disagree

28. It is frightening to think of offenders with mental illness living in residential neighbourhoods

1	2	3	4	5
Strongly agree	Somewhat agree	Neither agree nor disagree	Somewhat disagree	Strongly disagree

Appendix H: The Attribution Questionnaire 27 (AQ-27)

Now that you have watched the description of the defendant and their problems by the psychologist expert witness, please read each of the following statements about the defendant and chose the answer that represents how you might feel towards them, if you met them or were put in charge of what could happen to them.

1. **I would feel aggravated by the defendant.**

1	2	3	4	5	6	7	8	9

Not at all Very much

2. **I would feel unsafe around the defendant.**

1	2	3	4	5	6	7	8	9

Not at all Very much

3. **The defendant would terrify me.**

1	2	3	4	5	6	7	8	9

Not at all Very much

4. **I would feel angry at the defendant.**

1	2	3	4	5	6	7	8	9

Not at all Very much

5. **If I oversaw the defendant's mental health treatment, I would require them to take their medication and/or attend therapy.**

1	2	3	4	5	6	7	8	9

Not at all Very much

6. **If I were an employer, I would consider interviewing the defendant for a job, after they had served their sentence.**

1	2	3	4	5	6	7	8	9

Not at all Very much

7. **I think the defendant poses a risk to their neighbours unless they are put in prison.**

1	2	3	4	5	6	7	8	9

Not at all Very much

8. I would be willing to talk to the defendant about their problems.

1	2	3	4	5	6	7	8	9

Not at all Very much

9. **I feel pity for the defendant.**

1	2	3	4	5	6	7	8	9

Not at all Very much

10. I would think that it was the defendant's own fault that the crime occurred.

1	2	3	4	5	6	7	8	9

Not at all Very much

11. How controllable, do you think, is the cause of the defendant's behaviour?

1	2	3	4	5	6	7	8	9

Not controllable Totally controllable

12. I would feel irritated by the defendant

1	2	3	4	5	6	7	8	9

Not at all Very much

13. How dangerous would you feel the defendant is?

1	2	3	4	5	6	7	8	9

Not at all Very much

14. How much do you agree that the defendant should be forced into treatment for their mental health problems, even if they do not want to?

1	2	3	4	5	6	7	8	9

Not at all Very much

15. I think it would be best for the defendant's community if they were put into prison.

1	2	3	4	5	6	7	8	9

Not at all Very much

16. I would share a lift by car with the defendant every day.

1	2	3	4	5	6	7	8	9

Not likely Very likely

17. **How much do you think a prison, where the defendant can be kept away from their neighbours, is the best place for them?**

1	2	3	4	5	6	7	8	9

Not at all Very much

18. I would feel threatened by the defendant.

1	2	3	4	5	6	7	8	9

Not at all Very much

19. How scared of the defendant would you feel?

1	2	3	4	5	6	7	8	9

Not at all Very much

20. How likely is it that you would help the defendant?

1	2	3	4	5	6	7	8	9

Not likely Very likely

21. How certain would you feel that you would help the defendant?

1	2	3	4	5	6	7	8	9

Not certain Very certain

22. How much sympathy would you feel for the defendant?

1	2	3	4	5	6	7	8	9

Not at all Very much

23. How responsible, do you think, is the defendant for the crime?

1	2	3	4	5	6	7	8	9

Not at all Very much

24. How frightened of the defendant would you feel?

1	2	3	4	5	6	7	8	9

Not frightened Very frightened

25. If I were in charge of the defendant's treatment, I would force them to live in a group home or facility.

1	2	3	4	5	6	7	8	9

I would not I would

26. If I were a landlord, I probably would rent an apartment to the defendant.

1	2	3	4	5	6	7	8	9

I probably would I would not

27. How much concern would you feel for the defendant?

1	2	3	4	5	6	7	8	9

No concern a lot of concern

Appendix I: The Revised Causal Dimension Scale (CDS-II)

You are now going to presented with questions that relate to the case. You will be asked to think of a main reason for the cause of this crime, and then rate the cause.

Instructions: Think about the case that has been presented to you thus far. The items below concern your impressions or opinions of the cause or causes of the defendant's behaviour. Circle one number for each of the following questions.

Is this cause(s) something:

1. That reflects an aspect of the defendant	9	8	7	6	5	4	3	2	1	reflects an aspect of the situation
2. Manageable by the defendant	9	8	7	6	5	4	3	2	1	not manageable by the defendant
3. Permanent	9	8	7	6	5	4	3	2	1	temporary
4. The defendant can regulate	9	8	7	6	5	4	3	2	1	The defendant cannot regulate
5. Over which others have control	9	8	7	6	5	4	3	2	1	over which others have no control
6. Inside of the defendant	9	8	7	6	5	4	3	2	1	outside of the defendant
7. Stable over time	9	8	7	6	5	4	3	2	1	variable over time
8. Under the power of other people	9	8	7	6	5	4	3	2	1	not under the power of other people
9. Something about the defendant	9	8	7	6	5	4	3	2	1	something about others
10. Over which the defendant has power	9	8	7	6	5	4	3	2	1	over which the defendant has no power
11. Unchangeable	9	8	7	6	5	4	3	2	1	changeable
12. Other people can regulate	9	8	7	6	5	4	3	2	1	other people cannot regulate

Appendix J: Diminished Responsibility Questionnaire (DRQ)

You are now going to think about the facts of these case, and rate whether the Diminished Responsibility criteria apply to each part of the situation.

1. The victim arrived at the defendant's house, and the defendant was verbally abusive to the victim, calling them "a F****** creep, first coming for my little sister and now me in my house".

Was this related to a recognised medical condition?

Not related to a recognised medical condition	1	2	3	4	5	6	7	Entirely due to a recognised medical condition

Could the defendant understand their conduct, form a rational judgement, or exercise self-control?

Totally unable to understand the nature of her conduct	1	2	3	4	5	6	7	Fully able to understand the nature of her conduct
Totally unable to form a rational judgement	1	2	3	4	5	6	7	Fully able to form a rational judgement
Totally unable to exercise self-control	1	2	3	4	5	6	7	Fully able to exercise self-control

Do any of these factors explain how the defendant acted?

These do not explain their actions	1	2	3	4	5	6	7	One or more of these factors fully explains their actions

2. The defendant became increasingly aggressive and distressed in their tone, screaming at the victim and throwing small items out of their kitchen window at the victim.

Was this related to a recognised medical condition?

Not related to a recognised medical condition	1	2	3	4	5	6	7	Entirely due to a recognised medical condition

Could the defendant understand their conduct, form a rational judgement, or exercise self-control?

Totally unable to understand the nature of her conduct	1	2	3	4	5	6	7	Fully able to understand the nature of her conduct
Totally unable to form a rational judgement	1	2	3	4	5	6	7	Fully able to form a rational judgement
Totally unable to exercise self-control	1	2	3	4	5	6	7	Fully able to exercise self-control

Do any of these factors explain how the defendant acted?

These do not explain their actions	1	2	3	4	5	6	7	One or more of these factors fully explains their actions

3. The defendant then took a kitchen knife from the side, opened their front door and stabbed the victim in the neck, causing major injuries.

Was this related to a recognised medical condition?

Not related to a recognised medical condition	1	2	3	4	5	6	7	Entirely due to a recognised medical condition

Could the defendant understand their conduct, form a rational judgement, or exercise self-control?

Totally unable to understand the nature of her conduct	1	2	3	4	5	6	7	Fully able to understand the nature of her conduct
Totally unable to form a rational judgement	1	2	3	4	5	6	7	Fully able to form a rational judgement
Totally unable to exercise self-control	1	2	3	4	5	6	7	Fully able to exercise self-control

Do any of these factors explain how the defendant acted?

These do not explain their actions	1	2	3	4	5	6	7	One or more of these factors fully explains their actions

4. The defendant fled the scene but was later found by police on a nearby housing estate, in a distressed condition.

Was this related to a recognised medical condition?

Not related to a recognised medical condition	1	2	3	4	5	6	7	Entirely due to a recognised medical condition

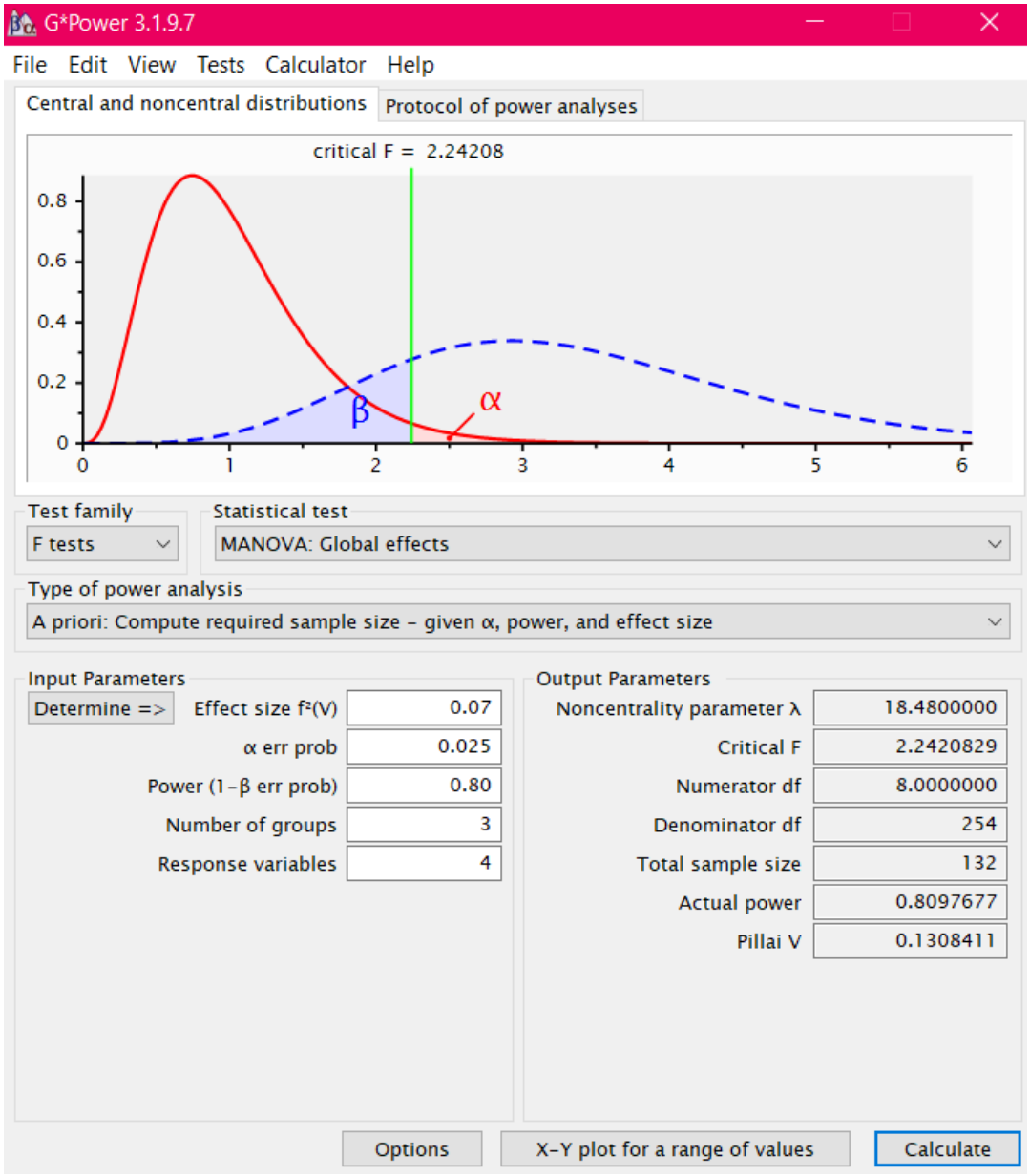
Could the defendant understand their conduct, form a rational judgement, or exercise self-control?

Totally unable to understand the nature of her conduct	1	2	3	4	5	6	7	Fully able to understand the nature of her conduct
Totally unable to form a rational judgement	1	2	3	4	5	6	7	Fully able to form a rational judgement
Totally unable to exercise self-control	1	2	3	4	5	6	7	Fully able to exercise self-control

Do any of these factors explain how the defendant acted?

These do not explain their actions	1	2	3	4	5	6	7	One or more of these factors fully explains their actions

Appendix K: G* Power Calculations



Appendix L: Demographic Information

1. Choose one option that best describes your ethnic group or background
   American Indian or Alaskan Native
   Arab
   Asian
   Black
   Black African
   Black African-American
   Black British
   Black Caribbean
   Bangladeshi
   Chinese
   Indian
   Latino
   Mexican
   Mexican-American
   Native Hawaiian or other Pacific islander
   Pakistani
   White British / Welsh / Scottish / Northern Irish
   White Gypsy or Irish Traveler
   White Irish
   White and Asian
   White and Black African
   White and Black Caribbean
   White (other)
   I'd rather not say
   Other
   If you selected Other, please specify:

2. To which gender identity do you most identify?
   Female
   Male
   Transgender Female
   Transgender Male
   Gender variant/non-conforming
   Prefer not to say
   Other
   If you selected Other, please specify:

3. Are you over 18 and under 76?
- Yes
- No

4. Have you lived in the UK for at least five years?

- Yes
- No

5. In the last 10 years, have you served any part of a sentence of imprisonment or a sentence of detention, received a suspended sentence, been subject to a community order/sentence?
- Yes
- No

6. Have you ever served a term of imprisonment or detention of five years or more?
- Yes
- No

7. Are you currently on bail in criminal proceedings?
- Yes
- No

8. Are you a resident in a hospital on account of mental disorder as defined by the Mental Health Act 1983?

- Yes
- No

Appendix M: Participant Information Sheet

Study Title: Jury perceptions of mental health disorders and decision making in a homicide case.

Thank you for your interest in this project. Before you participate, it is important to take time to look through the information on this page to help you decide whether to take part. If you have any questions or would like further information, I will be happy to answer any questions you may have before you complete the study, via email at s.shapter@uea.ac.uk.

What are the aims of the study?

The study aims to investigate how people might judge aspects of a fictional case where someone has been killed, and the person accused of murder has a complex mental health problem. This is important because different mental health problems could impact an individual's behaviour or their judgement if they commit a crime and there is little understanding of how jury members weigh up this information when they make decisions during a trial. These decisions could relate to whether someone is charged with murder, or with manslaughter, depending on how jurors think about the impact of the mental health problems could have on the person's responsibility for their actions. These could be affected by factors like mental health stigma, which has not been studied in research of this type, and this is a key aim of this study.

Choosing whether to participate

You may take part if you wish, and you do not have to take part in this research if you do not want to. This study is not expected to cause any distress; however, we appreciate that some of the information presented in the video may be sensitive and distressing for some people. Topics within this study that participants may find difficult include murder, historical abuse, mental health terms, and legal sentencing. If you would like to take part, you will be asked to complete a consent form before participating to indicate this on the next page. You may withdraw from the study at any time by closing your browser. However, once you have completed the study, data will be anonymised and thus it will not be possible for you to withdraw.

What will I be asked to do?

After reading this information page and completing the consent form on the next page, you will be shown a series of video clips and written information which outline a trial. You will also be asked to complete questionnaires at various points.

To begin with you will be asked some demographic information about yourself. This allows us to measure how diverse our participant sample is. Then you will be asked to complete a questionnaire around your thoughts on mental health offenders. Following this, you will be shown a video of a clinical psychologist who will describe the defendant's mental health problems. After this, you will be asked to fill in a questionnaire which will ask questions about your thoughts on the defendant and their mental health problem. You will then be given a passage to read with the details of the crime and some information on what Diminished Responsibility means. Next, you will be shown a series of videos of the prosecution and defence arguments about the case and the judges summary. You will then be asked as a juror, to consider whether the person had "Diminished Responsibility" for the crime, and you will be given information about how it would affect sentencing of the defendant.

Please note, in order for you to receive your payment via MTurk, you must complete the study and note down your completion receipt number. This will be the survey code you can enter into MTurk.

Altogether, the study session should take 30-35 minutes to complete.

Are there risks in taking part?

During the study there will be details of a fictional case where someone has been killed, as well as psychological information about the defendant's mental health problems including early traumatic events including sexual abuse. Only necessary information will be given, and potentially upsetting details will not be described in detail. However, it is important that you consider whether you would be affected by the content of the study before deciding whether to participate.

This study is not expected to cause any distress; however, we appreciate that some of the information presented in the video may be sensitive and distressing for some people. The defendant has been created with reference to parts of information from other cases, but the defendant and case itself are entirely fictional. The people you will see in the videos are actors reading from a script. You are advised to stop completing the survey if at any time you feel uncomfortable. Similarly, you do not need to answer any questions that may cause you any discomfort or distress and you can leave them blank if you wish to. Due to the study carried out online, we will not be able to provide individual debrief sessions. If you need further support, please contact your GP or a helpline, such as Samaritans (by calling 116 123) or Campaign Against Living Miserably (CALM; You can call the CALM on 0800 58 58 58), in the first instance.

What will happen if I want to withdraw from the study?

You may withdraw yourself and your information from the study at any time. If you do, you do not have to give any reason. To do so, simply close your browser to discontinue the study. Once you have completed the study, data will be anonymised and thus it will not be possible for you to withdraw.

Will my information be kept safe?

If you choose to participate in this study, we do not collect any identifying information such as your name and thus will be stored anonymously. However, we will ask for some demographic information such as ethnicity, age group and your occupation or subject of study if you are a student. Information about your part in the study will be held securely in accordance with the General Data Protection Regulation (GDPR), and not shared with any other agencies.

What will happen once the data is analysed?

As the study is part of my Doctorate in Clinical Psychology, it will be submitted to the University of East Anglia for marking. The results will also be submitted to a relevant journal for publication and presented at a conference at the university. If you would like to receive the results of the study, please email s.shapter@uea.ac.uk and a brief report of the results will be sent to you upon completion.

Who is overseeing and funding this research?

This research forms part of my Doctorate in Clinical Psychology with the University of East Anglia. It is organised by myself, but is overseen by my Research Supervisor and subject to internal review processes within the Doctorate in Clinical Psychology Programme department. The research is funded by the University of East Anglia.

Who has approved this study?

This research has been reviewed and approved by the Faculty Research Ethics Panel of the University of East Anglia.

For further information, please feel free to contact myself (Sophie Shapter, Trainee Clinical Psychologist): s.shapter@uea.ac.uk. You may also contact my research supervisor, Dr Peter Beazley (p.beazley@uea.ac.uk).

If you would like to make a complaint or contact someone independent to the study, you may contact Professor William Fraser, Head of the UEA Medical School, via email: W.Fraser@uea.ac.uk.

Appendix N: Participant Consent Form

Thank you for your interest in this study. Please ensure that you have read the Participant Information Sheet thoroughly and have considered whether you would like to take part in this research.

If you are unsure about taking part and have any questions prior to completing the study, you may contact the researchers via email: s.shapter@uea.ac.uk.

If you are happy to take part, please answer each item to show your understanding and consent to participate in this research.

I am over 18 years of age
Yes No
I have read the Participant Information Sheet and understand what the study involves and what I will be asked to do.
Yes No
I am aware that my information and study data will be held securely, and I understand that my answers to this study will be anonymised once I complete it, thus it will be impossible to withdraw my answers once complete.
Yes No
I am aware that I can withdraw my consent to participate, as well as my information and data gathered, at any point before it has been analysed and without giving a reason and I understand I will require my completion receipt number to do so.
Yes No
I understand that I will be paid £2.50 for the completion of this study and that I must use my receipt number generated at the end of this study to receive my payment on Mturk.
Yes No
I consent to not save, record, or share any information and video materials of the study.
Yes No
I would like to take part in this research.
Yes No

By continuing to the next page, you are confirming that you have answered the above questions truthfully and agree to take part in this research.

Appendix O: Ethical Approval

Faculty of Medicine and Health Sciences Research Ethics Committee

University of East Anglia
NORWICH MEDICAL SCHOOL
Bob Champion Research & Educational Building
Rosalind Franklin Road
University of East Anglia
Norwich Research Park

Sophie Shapter
Norwich Medical School
University of East Anglia
Norwich Research Park
Norwich
NR4 7TJ

22 November 2021

Dear Sophie

Project Title: An Examination of Stigmatising Attitudes, Causal Attributions and Jury Decision Making Regarding the diagnoses of "Personality Disorder" and "Psychopathy" compared to control term "Complex Mental Health Condition".

Reference: 2021/22-019

Thank you for your email of 14.11.21 notifying us of the amendments to your above proposal. These have been considered and I can confirm that your amended proposal has been approved.

Please can you ensure that any further amendments to either the protocol or documents submitted are notified to us in advance, and that any adverse events which occur during your project are reported to the Committee.

Approval by the FMH Research Ethics Committee should not be taken as evidence that your study is compliant with GDPR and the Data Protection Act 2018. If you need guidance on how to make your study GDPR compliant, please contact your institution's Data Protection Officer.

Please can you arrange to send us a report once your project is completed.

Yours sincerely

Dr Jackie Buck
Chair
FMH Research Ethics Committee

Appendix P: Participant Debrief Information

Thank you very much for taking part in this research study. Now that the study is complete, this form contains further information about the study.

NB**: Do not close your browser until you have received your completion receipt!** For you to receive your payment via MTurk, note down your completion receipt number. This will be the survey code you can enter into MTurk.

What is the study about?

This study is investigating attitudes towards individuals with a psychiatric diagnosis of Personality Disorder or Psychopathy, and whether the presence of these terms might have affected the judgements made about them and the decisions made about the case. All participants learned about the crime committed and the events leading up to and after this. Some participants saw a narrative about the defendant's history and emotional problems, with these referred to as "complex mental health problems". Some participants saw the same narrative, but the defendant's mental health was described due to a "Personality Disorder" or "Psychopathy" instead.

The first questionnaire was exploring your attitudes towards offenders with mental health conditions. After viewing the clinical psychologist's testimony, you were asked to complete a further two questionnaires. One of these measured your thoughts and attitudes toward the defendant. The second questionnaire aimed to measure "causal attributions"- these mean judgements about where a behaviour has come from, and whether this is due to the person (internal), or another factor separate from them (external).

After this, you shown the defence and prosecution arguments, and judges summary, and were asked to decide if the defendant had "Diminished Responsibility" over their actions. This meant you had to try and decide whether their mental health problem meant they understood the nature of their conduct, whether they could form a rational judgement, and whether they could exercise self-control. A judgement of "Diminished Responsibility" due to a mental health problem means that a person could be treated in a forensic psychiatric service for their mental health problems, instead of going directly to prison where they would not receive the same kind of treatment.

This is important research because individuals with a diagnosis of "Personality Disorder" often face stigma from various sections of society, such as professionals in mental health services but also in the general public. There is research to suggest that due to this term, they might be likely to be seen as morally responsible for their mental health problems and their behaviour, compared to people with other mental health problems.

Psychopathy is often linked to individuals perceived to be dangerous, evil, violent, and unpredictable. As psychopathy is predominantly characterised by interpersonal, moral, and emotional deficits, this stigmatisation can promote the beliefs that psychopathy is less of a mental health disorder, and more of a "moral illness" in which individuals choose to commit horrific, immoral actions. In fact, individuals attending jury duty have reported that they perceived individuals with psychopathy as responsible for their actions and capable of determining right and wrong. This stigmatised attitude undermines the criteria of Diminished Responsibility, thus an individual with psychopathy would be more likely to be denied Diminished Responsibility by the jury and given a life sentence for murder.

Therefore, it's important that we recognise how the presentation of information about mental health problems affects understanding and decision making. This could help understanding of a person, their behaviour and their mental health problems. If people with this diagnosis face stigma within parts of the criminal justice system, it could also help make sure that our juries are well-informed and fair to these people.

If you would like to know more about this study, or would like to be sent a copy of the results in the future, please contact the main researcher, Sophie Shapter, via email: s.shapter@uea.ac.uk.

What to do if you need further support following taking part in this study

If you need further support or are feeling distressed following taking part in this study, we advice that you contact a healthcare professional such as your GP or make contact with a helpline, such as Samaritans (116 123) or Campaign Against Living Miserably (CALM; You can call the CALM on 0800 58 58 58), in the first instance.

If you wish to speak to an independent contact, separate from the study, you may also contact Dr Niall Broomfield, Programme Lead for the Doctoral Programme in Clinical Psychology (n.broomfield@uea.ac.uk).

If you would like to make a complaint or contact someone independent to the study, you may contact Professor William Fraser, Head of the UEA Medical School, via email: W.Fraser@uea.ac.uk.

Thank you for your participation.

Appendix Q: Table of intercorrelations

Table 8:

Intercorrelations between the multiple variables used within the regression analysis.

					CDS-II Subscales			
		DRQ total score	PATOMI total score	AQ-27 total score	Causality	External Control	Stability	Personal Controllability
CDS-II Subscales	DRQ total score	1.00	.43*	-.46*	-.18*	.07	-.22*	-.67*
	PATOMI total score	.43*	1.00	-.69*	-.13*	-.08	-.13*	-.41*
	AQ-27 total score	-.46*	-.69*	1.00	.17*	.00	.04	.48*
	Causality	-.18*	-.13*	.17*	1.00	-.28*	-.04	.10
	External Control	.07	-.08	.00	-.28*	1.00	.14*	-.01
	Stability	-.22*	-.13*	.04	-.04	.14*	1.00	.23*
	Personal Controllability	-.67*	-.41*	.48*	.10	-.01	.23	1.00

*=significant