Factors Affecting Juror Decision-Making in Infanticide and Insanity Cases

Heidi Gordon

BA (Hons)

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I declare that this thesis is my own work and that, to the best of my knowledge and belief, it does not contain material from published sources without proper acknowledgement, nor does it contain material which has been accepted for the award of any other higher degree or graduate diploma in any university.

Heidi Gordon

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Literature Review

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Abstract

Infanticide, the murder of a child aged between 24 hours and 12 months, dates back to Ancient Greece, where it was primarily used for population control. It still occurs in modern society, although illegally, and is often associated with the mother experiencing a postpartum illness (Laporte et al., 2003). In Tasmania, if a woman murders her child under the age of 12 months, she may plead guilty to the legislated crime of Infanticide. This offers her a lesser charge of manslaughter, resulting in a variety of sentencing options including psychiatric treatment. In contrast, as American law does not incorporate the Infanticide provision, the defendant must prove that she is Not Guilty by Reason of Insanity. This incorporates a legal, rather than psychiatric, conception of insanity, or mental illness (Yannoulidis, 2003). This has led to critics arguing that the Infanticide provision is redundant and stereotypes women as being susceptible to mental disorders. Further, it is argued that the insanity defence needs to be updated to incorporate a psychological definition of insanity as generally understood by the public (Osborne, 1997). Whilst it is accepted that juror characteristics interplay to affect their decision-making and verdicts rendered, there are areas where little information exists as to the effects of specific attributes (for example, gender of the juror). Skeem, Louden and Evans (2004) argued that the Insanity Defence Attitudes Scale-Revised (IDA-R) can help researchers predict jurors' verdicts regarding insanity cases depending on how negatively they score on the scale. However, in order to develop a greater understanding of what attributes affect juror's verdicts, more fine-grained research is required, including exploring infanticide cases and leading to an updated insanity defence.

For the vast majority of the world's population, an idealised, stereotypical icon includes a mother holding her newborn baby – an occasion that is to be celebrated and enjoyed by the child's family. Entering motherhood can be viewed as a rite of passage and achievement. Psychologically 'healthy' women often find pregnancy a means of self-realisation or a creative act that gratifies both hers, and her partners, needs (Sadock & Sadock, 2007). The stereotypical new mother is expected to possess the intrinsic ability to love, nurture and raise her own child into adulthood (Dobson & Sales, 2000). However, due to the high rate of postpartum illnesses, one in seven mothers will struggle to meet the demands this stereotype encompasses (Beyond Blue, 2009).

The period following childbirth imposes a range of psychological, social and physical adjustments on the mother's behalf (Stanton, Lobel, Sears, & DeLuca, 2002). Despite the widespread belief that new mothers are joyous, psychologically healthy and easily adapt to the parenting role, postpartum mood disorders are a fairly common form of maternal morbidity following the delivery of a child. Postpartum affective disorders range in both severity and duration, whilst also having a detrimental effect on the woman's life and bonding with her newborn child (Dennis & Hodnett, 2007). Spinelli (n.d.) stated that mental illness during the postpartum period, primarily affective disorders, falls into one of three categories: postpartum blues (also commonly referred to as the 'baby blues'), postpartum depression and postpartum psychosis.

Postpartum illnesses

Postpartum blues is not considered to be a depression (Spinelli, n.d.). Rather, it is described as period of sometimes extreme mood fluctuations, where

the mother experiences feelings of elation, followed by depression. Findings from Spinelli's research suggest that almost every mother experiences postpartum blues. The Diagnostic and Statistical Manual (*DSM-IV-TR*) of the American Psychiatric Association (2000) reported a 70% incidence rate of postpartum blues in new mothers and that this affective turmoil usually lasts for 10-14 days. While worsening signs should be monitored for indications of depression, even severe symptoms usually dissipate without requiring treatment or intervention. A mother experiencing postpartum blues will report symptoms including feeling overwhelmed, anxious, having difficulty sleeping, as well as feelings of elation at one instant and then crying or feeling hopeless the next. Whilst postpartum blues might be considered a minimal, or even trivial, affective disorder because of its short duration, it can impose significant stresses upon the mother, her newborn and other family members due to the emotional rollercoaster the mother is experiencing.

It has been established that pregnancy and early parenthood are times of increased risk for developing an emotional disorder (Buist et al., 2006). Postpartum depression is a major health problem that affects approximately 10-20% of all childbearing women (Spinelli, n.d.). In Tasmania it is estimated that one in five mothers are believed to suffer from postpartum depression (Duncan, 2010). Further, an Australian study conducted by Buist et al. (2005), suggested that up to 50% of postpartum depression cases are overlooked primarily due to inadequate screening procedures, leaving many new mothers at risk of harm and not receiving adequate treatment. Postpartum depression can occur in the first four weeks to three months following childbirth. Al-Issa (1980) cited research

which indicated that postpartum depression usually peaks in the first few months following delivery, rather than later on.

Reported symptoms of postpartum depression include the mother experiencing conflict regarding her maternal role and/or abilities. The mother might experience persistent sadness and crying, an inability to sleep even when the baby sleeps, over-concern about the baby (including health problems, perceived deformities and perceived imminent death of the infant), anxiety and an inability to bond with the baby. In rare and more severe cases the mother may attempt, and succeed in, suicide or infanticide. The mother can be plagued by obsessions and thoughts about hurting the child, but not actually want to cause or bring about any harm.

Postpartum psychosis (sometimes referred to as puerperal psychosis) is described as a loss of contact with reality as demonstrated by hallucinations (including tactile, visual and olfactory hallucinations) and delusions (false beliefs, for example, believing one is God, or is directed by God, or some other unseen force) (Spinelli, n.d.). It is usually considered to be affective or schizoaffective in nature and is rare, although often highly predictable, occurring at a frequency of two-to-four per 1000 deliveries in Australia and New Zealand (Barnet & Morgan, 1996). Sadock and Sadock (2007) assert that symptoms of postpartum psychosis can begin within days following delivery. However, the average time of onset is within two to three weeks, and almost always within eight weeks, of childbirth.

Characteristic symptoms include the mother complaining of fatigue, insomnia, restlessness and emotional lability. This is followed by suspiciousness, confusion, irrational statements and obsessive concerns regarding the child's

health and welfare. Delusions may include that the baby is dead or defective. Once psychosis occurs, and it is usually florid in nature, the mother may be a danger to herself or her newborn, depending on the content of her delusional structure and her degree of agitation (Sadock & Sadock, 2007). Postpartum depression may or may not be associated with psychosis. Further, nonpsychotic depressed mothers are less likely to be a danger to themselves or their infant (Spinelli, 2004).

Reports of postpartum psychosis and other postpartum illnesses date back for more than 2000 years. Hippocrates described it as a madness experienced by women after giving birth due to an excessive blood flow to the brain (Spinelli, 2004). However, despite its long-observed history there is yet no formal diagnostic status of postpartum illness in the *DSM-IV-TR* (American Psychiatric Association, 2000). Rather, the *DSM-IV-TR* provides the specifier 'with postpartum onset' which can be applied to the current, or most recent, Major Depressive, Manic or Mixed episode of Major Depressive Disorder, Bipolar I Disorder, Bipolar II Disorder or to Brief Psychotic Disorder. This specifier is only to be used if the onset of the above disorders occurs within four weeks after childbirth.

Whilst the *DSM-V* is currently still under review, it adopts the position that the time-frame in which the specifier, 'with postpartum onset,' may be used has been extended to the onset of an episode occurring within six months postpartum (American Psychiatric Association, 2010). Jones (American Psychiatric Association, 2010) provided a memo outlining research to guide the proposed changes to the *DSM-V*. Mainly, that in everyday use postpartum depression is used to refer to episodes with onset up to six months following delivery. From

this, Jones argued that for unipolar depression, the previous four week time frame is too restrictive, but that the previous time frame may be acceptable for bipolar episodes. Consequently, the ultimate solution may be too complex (providing different specifiers for each disorder), therefore suggesting the criteria be extended to episodes with onsets within two to six months of delivery. It appears that, at this stage, the American Psychiatric Association is adopting the latter timeframe in the *DSM-V*.

According to the *DSM-IV-TR* it is important to distinguish mood disorders from postpartum blues. This is due to postpartum blues having transient symptoms and not significantly impairing an individual's functioning, compared to Mood Disorders. However, it is suggested that postpartum blues increases the risk for a Major Depressive Episode with postpartum onset. Due to this, further research should be undertaken to aid the development of effective screening measures to detect symptoms of mental illness during and after pregnancy before symptom severity increases (Buist et al., 2005; Buist et al., 2006).

The experience of childbirth results in many chemical changes that occur in a woman's body. This includes rapid fluctuations in levels of oestrogen, progesterone and other gonadal hormones that are produced during parturition, but which drop dramatically following birth. These changes trigger central nervous system neurotransmitter alterations to aid in the birthing process (Spinelli, 2004). Spinelli stated that the results of various research studies demonstrate that gonadal steroids impact upon a person's ability to have control over their moods. Due to this, researchers have focused on exploring the cause of postpartum illnesses by examining the withdrawal effect of the gonadal pregnancy hormones. The physiological changes of childbirth begin as some

hormone levels, which have increased vastly – sometimes up to 200-fold over the course of gestation, decline promptly within 24 hours, which coincides with the delivery of the placenta. The placenta has been linked to the source of many hormones during pregnancy. The results of Bloch et al.'s (2000) research suggested a direct link to support the involvement of the reproductive hormones oestrogen and progesterone in the development of postpartum depression. This offers a biological explanation as to why childbirth is viewed as a time of increased mental disturbance.

Infanticide

> *Force every way will have it they must die, and since this must be so, then I, their mother, shall kill them*
>
> (Euripides; quoted by Grene & Lattimore, 1955)

The murder of one's child, also referred to as filicide, is one of the oldest and most widely used means of population control. In Ancient Greece it was an accepted practice for eugenic reasons in order to maintain a stronger Grecian society by eradicating an ill, deformed or otherwise imperfect baby or child. The main accepted practice of committing filicide included exposure whereby the newborn was abandoned by roadsides or in fields, and left to die through starvation and exposure to the elements (Riechers, 2003).

The acceptance and number of women engaging in legal infanticide (the murder of a child older than 24 hours, but less than 12 months old) persisted as late as seventeenth century France. Backhouse (1984) speculates that this practice and tolerance of infanticide could be attributed to the ineffectiveness and

unavailability of birth control. Instances of infanticide continued to spread rapidly. It was most often engaged in by single women who were unable, mainly due to economic reasons and societal status repercussions, to look after and raise a child on their own.

During 1680-1800 in England, it is estimated that as many as 25% of killings were infanticide. In colonial America by comparison, the estimated prevalence was slightly higher at 33% during the same time period (Perlin, 2003). 'Overlaying' was a common method, involving the mother lying on the infant in order to smother the child to death (Hansen, 2004). However, in strong reaction to the widespread practice of infanticide, the Catholic Church declared that such an act was a mortal sin, and laws and severe secular penalties were introduced for its prevention (Spinelli, 2005).

The first of such laws stated that concealment of a murdered newborn was considered a capital offence. One of many available punishments included the sentence of 'sacking'. This consisted of the perpetrator being placed in a sack with a dog, a rooster and a snake, and then thrown in the river to drown (Spinelli, 2004). During the eighteenth century there was a high degree of accused women being convicted in the English courts. Francus (1997) cites that for 28 infanticide cases studied, 20 women were convicted, five were acquitted, one deferred judgment and two had unknown verdicts.

Nineteenth century England saw a change in the approach towards the crime of infanticide. The law stated that any mother suspected of killing her infant should be tried for murder and, if convicted, should receive the same sentence as any other murderer, namely the death penalty. However, in practice juries rarely convicted the mother of murder. Furthermore, judges were reluctant

to impose the death penalty. It was common practice for the Home Secretary to advise substitution with a less severe penalty in many maternal infanticide cases (Dobson & Sales, 2000). Rowe (1991) commented that the reluctance to enforce the death penalty also persisted in early America. Many women received a lesser penalty or were acquitted of all charges. Although infanticide was regarded as a serious crime and prosecutors aggressively sought the death penalty, infanticide proved difficult to prosecute successfully.

The reluctance to convict the mother of murder may have been due to the view that for the crime of infanticide there is rarely one victim, but rather two – the child and the perpetrator. Milner (1998) stated that there is ample evidence to support the position that parents under severe and continuing stress can act impulsively and without effective cognitive thought, to either hurt or murder their children. Perlin's (2003) research suggests that the majority of women who killed their infant child were suffering from a postpartum illness.

In 1922, the English Parliament enacted legal change by introducing the Infanticide Act. This stated that any mother who killed her child and who showed evidence of mental disturbance or illness at the time of the incident should be tried and sentenced as if she had committed manslaughter and not murder. The Infanticide Act was revised in 1938 to include that lactation, as well as childbirth, can be the mitigating factor of the mother's mental disturbance, providing that the victim is less than 12 months of age (Dobson, & Sales, 2000). The *Infanticide Act 1938* in a sense inadvertently legalised the widely held view that any woman who has given birth may have an altered and disturbed mental status. This belief tended to be adopted in the British courts at the time the Act

was enacted, with judges often drawing parallels to the erratic behaviours of female dogs after giving birth (Bartholomew & Bonnici, 1965).

As to the current legal standing of mothers in Australia, and specifically Tasmania, the *Criminal Code Act 1924* (referred hereafter as The Criminal Code) provides an alternative to a murder charge. The infanticide provision states that:

> 'A woman who by any wilful act or omission, causes the death of her child (being a child under the age of 12 months), and who was at the time not fully recovered from the effect of giving birth to the child, and the balance of her mind being; by reason thereof, disturbed, is guilty of a crime, which is called infanticide, although the offence would, but for this section, have amounted to murder' (s165A).

The Criminal Code was amended to incorporate the *Infanticide Act 1938*, which gave formal recognition to the commonly held belief that a woman may have an altered and disturbed mental status for up to a year following childbirth.

Neonaticide is a term to describe the killing of a child less than 24 hours old. Lee, Li, Kwong and So (2006) state that neonaticide can be distinguished from other filicide incidences (including infanticide) by the circumstances of the killing, motive and psychosocial background of the mother-infant relationship. Further, the denial or deception of pregnancy is a common occurrence that may result in an undetected birth. The legal consequences of both neonaticide and infanticide are similar; however Lee et al. suggest that it is often difficult to conduct systematic clinical and psychosocial research on neonaticide due to the secrecy and psychological mindset of the mother.

Being tried under s165A (and other similar provisions across Australian states) offers a lesser charge in contrast to a homicide charge. It also allows for a

variety of sentencing options including hospitalisation to receive treatment (Wilczynski, 1997). It is also important to note that the mother does not need to show that she was legally insane under s165A. Rather, the law assumes that the mothers' actions are an acute expression of a mental or emotional problem directly associated with childbirth or lactation (Vatz, 2002).

The *Infanticide Act 1938*, and other legal statutes incorporating this act across various countries including Australia, has evoked controversy particularly regarding the 'disturbed' balance of the mother's mind. It is well known that the period following childbirth imposes a range of psychological, social and physical adjustments. Among the three types of postpartum illnesses, it is said that postpartum depression has received the greatest research attention (Stanton et al., 2002). Postpartum blues, discussed previously, is considered not to constitute a depression. The period of mood fluctuations lasts for a relatively short period of time and symptoms are usually mild in severity. Due to these factors, it is said that postpartum blues is unlikely to play a causative role in infanticide incidents (Chandra, Bhargavaraman, Raghunandan, & Shaligram, 2006).

On the other hand, postpartum depression is regarded as a clinical depression that occurs during the weeks and months following childbirth. The majority of the postpartum illness and infanticide controversy is said to revolve around postpartum depression. Whilst the findings from earlier studies claim to have demonstrated that postpartum depression was common among childbearing women, more recent research suggests postpartum depression is not qualitatively different from depression experienced during other stages of one's life. In a study conducted by Kumar and Robson (1984), they reported that there were no significant differences in either the symptoms or prevalence when they compared

matched samples of childbearing versus non-childbearing women experiencing depression. Due to research such as that conducted by Kumar and Robson, Dobson and Sales (2000) suggest that there is little convincing evidence that postpartum depression is unique and different from other forms of depression. Whilst depression can be classified as a mental illness by the *DSM-IV-TR* and has been shown to be present in some women who commit infanticide, d'Orban (1979) argued that depression, on its own, is not sufficient to support the *Infanticide Act 1938* position on the postpartum defence. That is; whilst 'postpartum depression' can be used to describe a type of depression a woman experiences after giving birth, it is not adequate to state that due to this the postpartum period is a time of increased mental disturbance and therefore the infanticide provision should be available as an alternative to a homicide charge.

Another reason for questioning the supposed distinctiveness of postpartum depression from other types of depression is that the risk factors for postpartum and non-postpartum depression are similar. Stanton et al. (2002) assert that the risk factors for developing postpartum depression include a history of mood disturbance (either before or during pregnancy), a poor marital relationship, low social support and stressful life events. These predictors are similar to those common in most individuals who have developed depression. While a long-held view is that hormonal changes that occur during childbirth precipitate postpartum depression (Al-Issa, 1980), there is no strong evidence for this. However, Stanton et al. acknowledge that the findings from some research do indicate that postpartum onset leads to a different course of depression from that with a non-postpartum onset. Specifically, mothers with a previous history of mood disorders were at an increased risk of non-postpartum depression but not

postpartum depression. Likewise, women with postpartum depression with no previous history of a mood disorder were at an elevated risk for developing future postpartum depression, but not for non-postpartum depression.

Postpartum psychosis, on the other hand, is rare and usually results in hospitalisation due to the severity of symptoms experienced, including loss of contact with reality (Barnett & Morgan, 1996). Prabhu, Asokan and Rajeswari's (2005) findings from their research regarding prevalence and risk factors associated with postpartum psychiatric morbidity, suggest that postpartum psychosis is a very severe form of psychiatric illness that is seen two to four weeks post-delivery. The onset is accompanied by a wide range of psychopathological symptoms. As a result of this, the disturbances are easier to detect through investigation and anecdotes from both the mother and other family members, compared to postpartum depressive symptoms which tend to develop more insidiously in comparison (Rohde, Raic, Varchmin-Schultheib, & Marneros, 1998).

The results from reported research have provided clear scientific evidence supporting the link between childbirth and postpartum psychosis, thus supporting the *Infanticide Act 1938* stance that the postpartum period is a time of increased mental disturbance. Kendell, Chalmers and Platz (1987) conducted epidemiological research on postpartum psychosis and childbirth. This consisted of a population-based study located in Edinburgh, Scotland. The researchers cross-linked health service records on all women who had given birth to a child during a 12-year period (n= 54 087) to records in the Edinburgh Psychiatric Case Register. They found that the average number of admissions that included a diagnosis of psychosis decreased slightly during pregnancy. This then spiked in

the first three months after childbirth. After these three months, admissions for psychosis declined, but remained at an elevated rate for two years following childbirth. This finding offers support for the position that the first postpartum year is a time of high risk for mental disturbance. However, it only appears to be applicable to psychosis or severe mental illnesses that require hospitalisation, and not for affective disorders that can usually be treated on an outpatient basis, such as depression. Further, it can be argued that the 12 month period outlined by the infanticide provision, may need to be extended in cases of postpartum psychosis or severe mental illness due to its long duration and slow response to treatment.

Laporte, Poulin, Marleau, Roy and Webanck's (2003) research findings suggest that the infanticide defence tends to be associated more often with cases involving postpartum depression rather than postpartum psychosis. This may be due to individuals arguing the insanity defence in cases of psychosis. Dobson and Sales (2000) suggest that this psychotic state can provide justification for both diminished capacity under the Infanticide provision as well as the insanity defence, noting that only one defence needs to be available to the defendant.

In comparison to Australian law, the United States has no such legal Infanticide provision. A mother who contributes to the death of her child who is less than 12 months of age is prosecuted in the same way as any other perpetrator of homicide, and in some American states, faces the death penalty as a result of this. The insanity defence is available to the defendant to establish that the mother was acting under a diminished capacity at the time of the offence, arguing that postpartum illness due to childbirth may have interacted with her mental state at the time of the offence. In the majority of cases, women have been

successful in doing this, suggesting that the Infanticide provision adopted in countries like Australia is redundant.

Eradicating the infanticide provision also removes the stigma that following childbirth all women are susceptible to mental disorders, as well as allowing jurors to decide whether the defendant was suffering from a mental illness. As it stands, the infanticide provision has been criticized because of its preferential treatment of women and because it does not encourage jurors to engage in a case by case analysis (Osborne, 1987). That is; if a mother kills her infant who is under 12 months of age, the infanticide provision is automatically available to the defendant and jurors are not able to ascertain what other factors may have contributed to the mother's actions, including her mental state.

Insanity Defence

The insanity defence was established in the nineteenth century, following the decision of *B.R v M'Naghten* (1843). To establish a defence on the grounds of insanity, it must be clearly demonstrated that at the time of committing the act 'the party accused was labouring under such a defect of reason from disease of mind, as to not know the nature and quality of the act he was doing, or if he did know it, that he did not know what he was doing was wrong'. This is incorporated in s16 of The Criminal Code. Insanity, (also known as the absence of criminal responsibility), refers to the defendant's mental state at the time the offence was committed. There may be different standards according to jurisdictions. In Tasmania, to be criminally responsible the person needs to be able (at the time of the offence) to understand that what he or she was doing was wrong or against the law. This does not include understanding what is 'morally'

wrong, only wrong according to the law. The layperson may assume that a severe mental illness automatically makes one insane, but this is not the case. Whilst a severe mental illness or mental defect can be a prerequisite, the disorder must then lead to an inability to meet the legal criteria for either competence to stand trial or criminal responsibility (Turvey, 2008).

Yannoulidis (2003) argues that the insanity defence does not have the same scope as the psychiatric conception of mental disorder. Specifically, legal insanity may be considered an excuse for one's wrong actions and not a diagnosis of the individual's mental status. Further, Morris (1953) argues that the defence is 'woolly, semantically confused' and 'psychologically immature nonsense' (p. 437). This suggests that the insanity defence is not fulfilling its original intended purpose.

There has been a continual debate about the perceived need to review and update the M'Naghten standard of insanity. Attempts to alter the insanity defence have been met with little success (Becker, 2003). Despite this, one can argue that an update is critical when in 2003, Deanna Laney was found not guilty by reason of insanity as she did not know that her act was wrong because 'God' directed her actions. In contrast, Andrea Yates (2005) was found to be guilty of the murder of her children. This verdict rested on the argument that Andrea Yates knew her actions were wrong, as required by the law, as she was being directed to act by 'Satan'. This suggests that legal insanity was based upon the content of the psychotic hallucinations rather than an objective application of the law and what a 'reasonable' person would do under similar circumstances (Spinelli, 2005). Alternatively, the law may be perceived as confusing to the

common lay person, resulting in ludicrous verdicts as jurors struggle to understand complicated information.

Juries

> *No freeman shall be seized, or imprisoned, or dispossessed, or outlawed, or in any way destroyed; nor will we condemn him, nor will we commit him to prison, excepting by lawful judgment of his peers, or by the law of the land*
>
> (Clause 39, Magna Carta 1215; Clause 29, Magna Carta 1225)

The employment of juries during trials is based on the notion that everyone has the right to be judged by their peers. This has its origins from the Magna Carta which, among other aspects, was created to guarantee justice for all (Aldous, 2001). A person who has been accused of an indictable offence (criminal offences heard before a judge and jury in the Supreme Court) is entitled to have their innocence or guilt determined by a jury of 12 people. In trials by jury, lay persons from the community are required to render a verdict by applying correct and intricate legal standards. These standards consist of complex information which often becomes difficult for the juror to understand, let alone apply to the particular circumstances of the case, and jointly with 11 other jury members. Due to this, jurors may instead and often do, revert and rely on their own sense of what is fair in order to reach a decision and render a verdict inconsistent with the law (Lieberman & Sales, 1997). Not only are these individuals not following the given legal instructions, but the jurors' lack of

understanding impacts upon the defendant's sentence, potential freedom and, especially in countries with the death penalty, could end a defendant's life.

Judges deliver instructions to jurors in an attempt to create a legal structure to help guide jurors in their decision-making process. The specific duties of the juror and the elements of the charges against a defendant must be conveyed with instructions to individuals who tend to have limited, or no, legal background. According to Lieberman and Sales (2000), earlier research predominantly focused on juror comprehension. Findings from reported research tended to indicate that jurors have great difficulty understanding legal instructions, with some comprehension rates falling below 65%. This suggests that jurors are 'making up' their own guidelines to aid their decision making.

Wheatman and Shaffer (2001) suggest that individuals do not attend to and are less inclined to abide by legal instructions, compared to individuals who are in a group environment and are asked to reach a group consensus on a verdict. To counteract this effect, it is suggested that the comprehensibility of jury instructions can be improved by rewording them for clarity and brevity (Halverson, Hallahan, Hart, & Rosenthal, 1997). In contrast, Finkel and Handel (1989) conducted research in which they asked mock jurors to decide insanity cases without any instructions. The researchers determined that these jurors made discriminations among cases, and their constructs of insanity were relevant, flexible and more complex than the legal constructs of insanity. This suggests that a purely legal test is inadequate to capture the essence of insanity as understood by the lay person. Such divergent research indicates that the insanity defence, as understood by jurors, is lacking in depth and even incorporating commonly misunderstood psychological aspects, leading to inconsistent and

troubling verdicts. Further, juror instructions add to the complexity of the judicial arena, suggesting that simplicity may result in more consistent and reliable verdicts.

A vital aspect of the juror, as well as the judge, is to remain impartial throughout the trial in order to give a fair and unbiased verdict (Heilbronn, Latimer, Nielsen, Pagone, & Kovacs, 2002). However, personal beliefs can creep into the judicial process, affecting the decisions made. These beliefs can include attitudes towards the insanity defence and those who are mentally ill. General beliefs that the individual holds and may not even be aware of may also have an influence. Honess and Charman (2002) argue that juries are more likely to acquit if their sympathies with the defendant are easily aroused, or individual jurors may put forward strong arguments for acquittal if they hold anti-police views.

Research demonstrates that people perceive the insanity defence as a regular occurrence in the legal system, and that it is abused by defendants in order to escape criminal responsibility. In practice, the insanity defence is rarely successful with unsuccessful attempts most often receiving a longer incarceration (Ellsworth, Bukaty, Cowan, & Thompson, 1984). When the defendant successfully pleads insanity, the individual is usually committed to a secure mental health facility. According to Turvey (2008), a successful insanity plea most often results in a much longer hospitalisation than they would have received had they pleaded guilty or been convicted at trial and been incarcerated.

Attitudes are a key element in understanding, predicting and promoting a variety of behaviours. According to Ajzen and Fishbein (1973), an attitude refers to a persons' nature to respond either favourably or unfavourably to an object, person or event. Skeem, Louden and Evans (2004) developed, refined and cross-

validated the Insanity Defence Attitude Revised (IDA-R) scale to aid in detection of juror biases in the jury selection process. This instrument arose from their findings across studies that indicate a public view that the insanity defence is an abused legal loophole that frequently allows guilty criminals to escape responsibility and punishment. Further, ordinary people overestimate the number of perpetrators who enter insanity pleas and are acquitted by reason of insanity. These negative attitudes are not only prevalent, but also tend to be inflexible. Due to this, if jurors are not adequately screened in the selection process, such attitudes and biases can creep into and affect the decision-making process resulting in unfair, including lenient or harsher, verdicts.

Gender of the juror

In regard to the insanity defence, there has been little research investigating the effect of the gender of the juror. A large proportion of available research examines and focuses on the effect of the gender of the juror in the context of rape cases. To date, a clear pattern of gender differences has not yet been identified (Badzinski & Pettus, 1994). Villemur and Hyde's (1983) research determined that there was no significant main effect for the gender of the juror in a simulated rape trial. However, they discovered that the juror's gender had more complex effects in combination with other factors, including the age of the victim: female jurors attributed more blame to the defendant when the victim was older.

Wuensch, Chia, Castellow, Chuang and Cheng (1993) investigated, amongst other attributes, the gender of the juror and the effect that this had on their verdicts for burglary or swindle cases. Their results indicated that female

mock-jurors rendered more lenient sentences for female defendants compared to male defendants. Further, the attractiveness of male defendants was associated with more lenient sentencing in burglary cases. This suggests that many aspects of the judicial arena, including the gender of the juror, can sway and influence the juror's decision rather than relying solely on the facts presented to them. However, the case of a mother killing her child may provoke a more emotional response in jurors in contrast to burglary or swindle cases. Due to the societal expectation of mothers being caring, nurturing and protective of their children, Dunn, Cowan and Downs (2006) suggested that female jurors may react more negatively in maternal infanticide cases than male jurors. This may be due to factors such as disbelief in the female juror that another woman could take such actions to end her child's life. In contrast, Hoiberg and Stires' (1973) research determined that, compared to males, female jurors are more derogatory towards rape victims. This indicates that further investigation is required before definitive conclusions can be drawn.

When a mother commits infanticide, the jury tends to be predominantly female. For example, in *Yates v Texas* (2005), the jury consisted of eight women and four men. Fischer (1997) investigated effect of juror's gender, specifically whether mock juror's guilty verdicts increased as a function of the number of women on the jury in a simulated rape trial. The data indicated that guilty verdicts did not increase significantly until either females represented the majority (that is; 7:5 female to male ratio) or the jury consisted only of females. However, male jurors tend to provide more severe punishments in comparison (Kaplan &Miller, 1978).

The above literature indicates that the gender of the juror is a somewhat 'unknown' contributor to the judicial process and the verdicts and sentences rendered in a court of law. Kaplan and Miller (1978) assert that the relationship between juror gender and proneness to convict is not simple, but can be moderated by many other factors. Future research should focus on teasing out the effects of juror's gender further in order to aid the understanding of what factors contribute to and affect juror's decisions. Such research may also help lawyers to be of a benefit to their clients in the jury selection process.

Single episode versus recurring episodes of mental illness

As with gender of juror, there has been limited research on the effect in the court of law of single episode versus recurring episodes of symptoms of mental illness. The term 'transient mental illness' (which also refers to a single episode) has been coined to refer to mental illnesses whose symptoms seem to be confined to a particular place and time due to an ecological niche that permits this (O'Neill, 1999). For example, there has been an increase of identified cases of Dissociative Identity Disorder (American Psychiatric Association, 2000), which may be due to a number of factors including general awareness in society due the spread of media attention, including dramatised portrayals in film adaptations such as *The Three Faces of Eve* (Johnson, 1957). Further, modern Western society creates and fosters conditions that increase stress related illnesses, including burnout, depression and anxiety (Rubino, Luksyte, Perry, & Volpone, 2009).

Research has demonstrated that people's verdicts are influenced by the attributions they make based on the defendant's mental health. In general,

mental illness comes with stigma attached, with people making more negative attributions and assigning greater blameworthiness, responsibility and controllability where those suffering mental illness are accused of crimes (Corrigan, Markowitz, Watson, Rowan, & Kubiak, 2003). Henkel's (2008) research also demonstrates the presence of mental illness stigma. In that study, participants perceived a defendant as less culpable when they had a medical disorder. However, if the defendant was experiencing anxiety problems, he or she was not excused in the same way. Jurors may also feel pressured to convict a person suffering from a mental illness due to the misconception that these individuals are 'ticking time bombs' (Appelbaum, 2004, p. 1105), so that their incarceration is seen as necessary for public safety. This may contribute to the over-representation of people with mental illness in the criminal justice system (Henderson, 2003).

In regard to the court of law, there may be little reporting of single episodes of mental illness symptoms due to verdicts being rendered on a case-by-case basis. Further, prior diagnosis of mental illness is not a prerequisite for use of the insanity defence, as jurors are directed to focus on the act in question. This may explain the limited attention single episodes of mental illness symptoms have received within the courts and their minimal effect on juror decision-making, which points to a gap or unexplored area, in the research.

Current state of research and future directions

Currently a firm understanding exists that juror characteristics impact upon the decision-making process and verdict rendered (Lieberman & Sales, 1997). Substantially less knowledge exists regarding an in-depth understanding

of inherent beliefs and values, and the influence of juror attributes specifically regarding infanticide and insanity cases. Surprisingly, this lack of research still remains despite the occurrence of infanticide and filicide as reported by the media (for example: Leanne Azzopardi and Tanya Soutter (Australian Broadcasting Corporation News, 2004; 2008)). This highlights that further attention is needed to explore the possibility of juror characteristics when deliberating on infanticide cases incorporating a defendant who was suffering from a postpartum illness leading up to, and at the time of the crime.

There is a high prevalence of diagnosed postpartum illnesses in new mothers. It is estimated that many more mothers are undiagnosed and thus go untreated leaving both the mother and her child at risk of harm (Buist et al., 2006). Due to this high prevalence, it is more likely that the courts will be hearing more filicide and infanticide cases now and in the future.

However, controversy exists as to how infanticide should be treated and sentenced in a court of law. The *Infanticide Act 1938* was enacted to address the reluctance of eighteenth century courts to prosecute and sentence new mothers who, due to mental illness, had killed their child less than 12 months of age. Tasmania, specifically, has adopted the position that the postpartum period is a time of increased mental disturbance for up to a year following childbirth by incorporating the *Infanticide Act 1938* in section 165A of The Criminal Code.

In contrast to Australian law, American law does not adopt the infanticide provision; rather mothers who commit infanticide while suffering from a postpartum illness are required to argue that they are not guilty by reason of insanity. The insanity defence requires defendants to prove that they were acting under such a diminished capacity that they were not able to understand the nature

and quality of their act, or that what they were doing was wrong. Morris (1953) and many other critics argue that it is time for the insanity defence to be updated and adopt a more psychiatric conception of mental illness, which is generally understood by the lay person. Yannoulidis (2003) has attempted to meet this challenge and redefined the insanity defence. As yet, this updated defence has not been tested to determine whether a psychological insanity defence is more adaptable and understandable than the existing traditional defence.

It has been argued that the infanticide provision is not required due to the existing insanity defence. Further, d'Orban (1979) assumes the position that postpartum depression is not sufficient to support the existence of the infanticide provision as it does not qualitatively differ from depression experienced at other times during one's life. Further, Kendell et al. (1987) argue that support for the view that the 12 month period following childbirth is a time of increased mental disturbance in the mother is applicable only to psychosis or severe mental illness that results in hospitalisation and not for affective disorders that can be treated on an outpatient basis, such as depression. Such a serious mental illness can provide justification for diminished capacity under the infanticide provision and the insanity defence, suggesting that the infanticide provision is redundant.

Due to the sensitive nature of infanticide cases, and at times it can be considered that there are two victims (the mother and the child) it is imperative to conduct further research to ensure the law is adaptable and provides appropriate sentencing options to such cases. It is also vital to research juror verdicts and compare the two defences to determine if the infanticide defence is actually redundant, whether the insanity defence can be used for postpartum illness and

providing an insanity defence that incorporates the layperson's understanding and the current clinical conception of mental illness.

There are many aspects of the judicial arena that require further investigation in order to gain a greater understanding of juror decision-making. Factors of interest include attitudes towards the insanity defence and whether these are predictive of the verdict reached, jurors' understanding of the complex legal definitions and laws used in the judicial process, the influence of the jurors' gender on verdicts and recommended sentences, and whether single episodes of symptoms of mental illness affect juror's decisions. Findings from various researchers (for example, Corrigan et al., 2003; Villemur, & Hyde, 1983) suggest that there are complex interactions involving these factors. Fuller understanding of the influence of these factors could have practical application in courts of law, including improving the juror deliberating process and aiding them through the complex legal tests provided to them.

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Empirical Study

Mock juror's assessment of infanticide and insanity

Abstract

This study examined the effect of juror characteristics when rendering verdicts on an infanticide case, as well as investigating the efficaciousness of the infanticide provision and insanity defence. 437 participants aged between 17 to 62 years were asked to complete two questionnaires (Insanity Defence Attitudes-Revised scale and the Marlowe-Crowne Social Desirability Scale), read a case vignette and render individual verdicts regarding the criminal responsibility of the defendant in question. The results of this study indicated that a defendant's psychological history (either a single episode or recurring) had little influence over a mock jurors' decision, however a woman experiencing postpartum depression (in contrast to postpartum psychosis) was more likely to be convicted of murder. Further, the study attempted to examine whether a revised insanity defence proposed by Yannoulidis (2003) would be more effective and easier to understand than the traditional insanity defence. The study offers support for the revised insanity defence, with this verdict being rendered more often than a guilty of murder verdict, compared to the traditional insanity defence. Whilst female mock jurors' reported higher levels of sympathy towards the victim and defendant compared to males, this did not make a significant impact on their decision making. The current study offers preliminary findings as to juror characteristics that interplay on the juror decision making process in infanticide cases.

The period following childbirth imposes a range of psychological, social and physical adjustments on the mother's part (Stanton, Lobel, Sears, & DeLuca, 2002). Spinelli (n.d.) stated that mental illness during the postpartum period, primarily affective disorders, falls into three categories: postpartum blues (commonly referred to as the 'baby blues'), postpartum depression and postpartum psychosis. These postpartum illnesses can negatively influence the woman's experience of motherhood and cause her to act in unconceivable ways than she normally would. These actions may include child abuse, neglect or even causing the child's death.

The results from Perlin's (2003) research suggest that the majority of women who kill their infant child are suffering from a postpartum illness. For women who murder their child under 12 months of age, Australian law provides an alternative to the murder charge through the Infanticide provision. Whilst this provision offers a variety of sentencing options, controversy has arisen regarding whether this provision is really needed, or whether women can successfully argue a postpartum illness using the insanity defence.

In addition to the infanticide provision debate, the insanity defence has attracted controversy. For the insanity defence specifically, it is argued that the current legal precedent does not encapsulate the current understanding of mental illness as defined by the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed., Text Revision: *DSM-IV-TR*; American Psychiatric Association, 2000), or the proposed revised version (*DSM-V*; American Psychiatric Association, 2010). However attempts to reformulate a revised defence have met with little success (Becker, 2003).

Substantial research has been conducted on examining juror biases and attitudes when deliberating and rendering verdicts, including jurors' comprehension of complex legal instructions. Research has provided mixed results as to the juror's ability to deliver a reasonable verdict in line with these instructions. It has been suggested that jurors may, and often do, rely upon their own sense and intuition as to what they believe is fair in order to reach a decision and render a verdict that is often inconsistent with the law (Lieberman & Sales, 1997).

Filicide is often used as an overarching term to describe the killing of a child by its parents. It is one of the oldest, widely used means of population control and still occurred regularly as late as the seventeenth century in France (Backhouse, 1984). Although illegal, it still persists in some modern Asian communities, to maintain a balance between population growth rates and economic resources (Cornell, 1996).

Infanticide refers specifically to the murder of a child between 24 hours and 12 months of age (Friedman & Resnick, 2007). In regard to the legal standing of mothers who commit infanticide, the Tasmanian *Criminal Code Act 1924* (referred to hereafter as The Criminal Code) provides an alternative to a murder, or manslaughter, charge. This provision states that:

> *'A woman who by any willful act or omission, causes the death of her child (being a child under the age of 12 months), and who was at the time not fully recovered from the effect of giving birth to the child, and the balance of her mind being, by reason thereof, disturbed, is guilty of a crime, which is called infanticide, although the offence would, but for this section, have amounted to murder'* (Section 165A).

This provision was amended to incorporate the *Infanticide Act 1938* (Dobson & Sales, 2000), which is considered to have given formal, legal recognition to the commonly held belief that a woman may have an altered and disturbed mental status for up to a year following childbirth (Bartholomew & Bonnici, 1965). However, being tried under s165A offers a lesser charge compared to homicide. It also allows for a variety of sentencing options, including hospitalization to receive adequate treatment and continuous follow-ups by mental health workers to ensure the mother's mental state is either improving or stabilized (Wilczynski, 1997).

Neonaticide is a term to describe the killing of a child less than 24 hours old. Lee, Li, Kwong and So (2006) state that neonaticide can be distinguished from other filicide incidences (including infanticide) by the circumstances of the killing, motive and the psychosocial background of the mother-infant relationship. Further, the denial or deception of pregnancy is a common occurrence that may result in an undetected birth. The legal consequences of both neonaticide and infanticide are similar; however Lee et al. suggest that it is often difficult to conduct systematic clinical and psychosocial research on neonaticide due to the secrecy and psychological mindset of the mother.

Whilst the Infanticide provision offers a lesser charge due to the mediating effects of a postpartum illness, whether this provision is still required has attracted controversy. It is argued that it provides an 'escape' clause due to reinforcing the view that women can become mentally unstable during childbirth (Vatz, 2002). The infanticide provision has been criticized due to the preferential treatment of women, and that it does not allow a case by case analysis for jurors

to determine whether the woman in question is or is not fully recovered from the effects of childbirth (Osborne, 1987).

Mental illness during the postpartum period falls into three categories (Spinelli, n.d). Postpartum blues is not considered a depression, but rather a period of mood fluctuations that occur in up to 70% of new mothers (American Psychiatric Association, 2000). It usually lasts for a period of 10-14 days and is unlikely to play a major causative role in infanticide. Postpartum depression affects 10-20% of all childbearing women and is a clinical depression occurring during the weeks and months following childbirth. There is little evidence that postpartum depression differs qualitatively from depression that occurs at other times during one's lifespan (Kumar & Robson, 1984). While, postpartum depression is certainly a form of mental illness that has been shown to be present in a portion of women who commit infanticide, research on postpartum depression does not appear to support the English legal position that the postpartum period is a time of increased mental disturbance as stated by the infanticide provision (Dobson & Sales, 2000). In contrast, postpartum psychosis is relatively rare, but debilitating, usually requiring hospitalization for treatment. It is characterized by a loss of contact with reality as demonstrated by hallucinations and delusions. Dobson and Sales (2000) assert that this psychotic state can both provide justification for diminished capacity under the infanticide provision and for the insanity defence.

In the United States, unlike Australia, there is no legal infanticide provision. A mother who commits the act of infanticide is prosecuted in the same manner as any other homicide. The insanity defence is available for the perpetrator to argue that she was acting under a diminished capacity as a result of

the changes (hormonal and other) that occur due to childbirth. Women have been successful in using the insanity defence to escape criminal responsibility and imprisonment, suggesting that the infanticide provision may be redundant. By eradicating the infanticide provision, it removes the stigma that following childbirth all women are susceptible to mental disorders and allows jurors the opportunity to deliberate as to whether the defendant in question was suffering from a mental illness at the time the act was committed.

The insanity defence was established in the nineteenth century, following the landmark decision of *B.R v M'Naghten* (1843). To ascertain a defence on the grounds of insanity, the perpetrator must clearly establish that at the time of committing the act (appearing in s16 of The Criminal Code):

> *'The party accused was laboring under such a defect of reason from disease of the mind, as to not know the nature and quality of the act he was doing; or if he did know it, that he did not know what he was doing was wrong'*

Yannoulidis (2003) argues that the insanity defence does not encapsulate the same scope as the psychiatric conception of mental disorder. Specifically, legal insanity can be considered an excuse for one's wrong actions and not a diagnosis of the individuals' mental status. Further, Morris (1953) asserts that the insanity defence is 'woolly, semantically confused' and 'psychologically immature nonsense' (p. 437). This defence becomes confusing, especially for jurors, and fails to incorporate the current psychological understanding of 'insanity' or rather, mental illness.

In the legal realm there has been a continual debate about the perceived need to review and update the M'Naghten standard of insanity. However,

attempts to update and alter the insanity defence have met with little success. Despite this, one can still argue that a newer, revised defence is critical in view of the following two infanticide cases from America. In 2004, Deanna Laney was found Not Guilty by Reason of Insanity for the murder of her two children. The jurors based their decision on the premise that she did not know that her act was wrong because 'God' directed her actions. In contrast, in 2005 Andrea Yates was found guilty of the murder of her five children. This verdict was reached on the basis that she knew that her actions were wrong because she was directed by 'Satan' to instigate the murder of her children. This suggests that legal insanity was based upon the content of the psychotic hallucinations, rather than an understanding of whether the defendants considered their actions were wrong at the time offences (Spinelli, 2005). Alternatively, the law may be perceived as confusing to the common lay person, resulting in ludicrous verdicts as they struggle to understand complicated information.

Research demonstrates that people incorrectly perceive the insanity defence as occurring frequently in the legal system, and are of the belief that the insanity defence is abused by defendants as a means to escape criminal responsibility. Skeem, Louden and Evans (2004), argue that since these perceptions are prevalent and predominantly negative in society, it is an important consideration for jury selection. Data obtained using the revised Insanity Defence Attitudes scale (IDA-R) suggests that an individual's attitude towards insanity consists of their orientation towards strict liability and concern regarding perceived injustice and danger. The IDA-R also has predictive value, in that scores obtained on the scale are reflective of the participants' ratings of insanity. That is, individuals who demonstrated strong negative attitudes towards

the insanity defence, as measured by the IDA-R, were less likely to agree that the perpetrator was legally insane at the time the offence was committed compared to individuals who did not have a negative attitude.

In trials by jury, lay persons from the community are required to reach a verdict by applying correct and complex legal standards. Due to this complex information, jurors may often rely on their own sense of what is fair to reach their decision. This often results in the jurors rendering a verdict that is inconsistent with the law (Lieberman & Sales, 1997). Wheatman and Shaffer (2001) suggest that, compared to a group situation, individuals do not attend to and are less inclined to abide by legal instructions. To counteract this, it is suggested that the comprehensibility of jury instructions can be improved by rewording them for clarity and brevity (Halverson, Hallahan, Hart, & Rosenthal, 1997). Finkel and Handel (1989) asked mock jurors to decide insanity cases without providing any instructions. They determined that these jurors made discriminations among cases, and their constructs of insanity were relevant, flexible and more complex than the legal constructs of insanity. This research suggested that the legal test does not adequately capture the essence of insanity as understood by the lay person. The study reported here attempts to reformulate the existing insanity defence, incorporating a psychological approach to mental illness, based on a revised defence put forward previously by Yannoulidis (2003). It also attempted to compare the effects of providing the legal insanity test, either without further instruction or with a step-by-step process to determine insanity.

In regard to the gender of the juror, a clear pattern has not yet been identified. When a mother commits infanticide and is charged with homicide,

juries tend to be predominately female, for example in *Yates v Texas*, the jury consisted of 8 women and 4 men. Due to the perceived loving and nurturing mother stereotypes, Dunn, Cowan and Downs, (2006) propose that female jurors may react more negatively towards a mother killing her child, compared to male jurors. The findings reported in published literature tend to indicate that the gender of the juror is a somewhat 'unknown' contributor to the judicial process. Kaplan and Miller (1978) assert that the relationship between juror gender and proneness to convict is not simple, but can be moderated by many other factors. Future research should focus on teasing out the effects of jurors' gender in order to aid the understanding of what affects juror's decision making.

As with gender of juror, there has been limited research on the effect of a single episode versus recurring episodes involving symptoms of mental illness. The term 'transient mental illness'(also referring to a single episode) has been coined to refer to mental illnesses whose symptoms seem to be confined to a particular place and time due to an ecological niche that permits this (O'Neill, 1999). For example, there has been an increase of identified cases of Dissociative Identity Disorder (American Psychiatric Association, 2000), which may be due to a number of factors including general awareness in society from media attention, including dramatised film portrayals such as *The Three Faces of Eve* (Johnson, 1957). Further, modern Western society creates and fosters conditions that increase stress related illnesses, including burnout, depression and anxiety (Rubino, Luksyte, Perry, & Volpone, 2009).

Research has demonstrated that people's verdicts are influenced by the attributions they make based on the defendant's mental health. In general, mental illness comes with stigma attached, with people making more negative

attributions and assigning greater blameworthiness, responsibility and controllability where those suffering from a mental illness are accused of crimes (Corrigan, Markowitz, Watson, Rowan, & Kubiak, 2003). Jurors may also feel pressured to convict a person suffering from a mental illness due to the misconception that these individuals are 'ticking time bombs' (Appelbaum, 2004, p. 1105), so that their incarceration is seen as necessary for public safety. This in turn, may contribute to the over-representation of people with mental illness in the criminal justice system (Henderson, 2003). This line of argument may suggest that individuals with a history of mental illness are more likely to be successfully prosecuted, compared to individuals experiencing their first symptoms of a mental illness (Corrigan et al., 2003). In regard to the court of law, there may be little reporting of single episodes of mental illness symptoms due to verdicts being rendered on a case-by-case basis. Further, prior diagnosis of mental illness is not a prerequisite for use of the insanity defence, as jurors are directed to focus on the act in question. This may explain the limited research attention that transient mental illness symptoms have received within the courts and their effect on juror decision-making.

The aim of the present study was to build upon the emerging literature investigating the insanity defence and the infanticide provision, including the effects of individual juror attributes. Specifically, this study used vignettes to examine mock jurors' judgments of responsibility in regard to mothers who commit infanticide. In addition, the study investigated the impact of providing a brief summary of judges' instructions of the legal precedents that took the mock juror through a step-by-step process (brief legal instructions) in order to reach a verdict on the mock jurors' decision-making process, as well as various other

attributes: gender of the juror, jurors' attitudes regarding the insanity defence, social desirability and jurors' confidence in their verdict.

In relation to the insanity defence, two types of insanity defences were utilized. These included the traditional M'Naghten rules as incorporated in s16 of The Criminal Code, and the restructured, psychologically-based definition of insanity developed by Yannoulidis (2003). This reconstructed insanity defence was under empirical investigation for the first time, and it was not known if the reformulated defence would be preferred to the traditional insanity defence. As a result, it would have been possible to hypothesise that the frequencies of participants rendering verdicts that accepted a reformulated insanity defence would be similar to those rendering verdicts that accepted a traditional insanity defence. On the other hand, it could be argued that participants would report higher confidence when using the psychology-related insanity defence in conjunction with legal instructions in the form of a step-by-step analysis of the provided law. In regard to the infanticide provision, mock jurors may indicate greater confidence in their verdict when using this provision on the basis that it adequately encapsulates the current position of the mother in terms of not recovering from the full effects of birth.

Prior research (e.g. Stanton et al., 2002) has indicated that postpartum depression does not meet the criteria for the Infanticide provision, mainly because it can be characterized as a depression similar to what can occur at any stage in one's life. Despite this, it is argued that the hormonal changes that coincide with pregnancy are influential in the development of postpartum depression. If the former view is held by the general population, it can be hypothesized that mothers diagnosed with, or experiencing symptoms of,

postpartum psychosis will be perceived more as meeting the criteria for the infanticide provision and insanity defence, compared to mothers experiencing postpartum depression. Further, mothers with a history of either depression or psychosis, as opposed to a single episode or occurrence of a postpartum mood disorder, will be more likely to receive an insanity or infanticide verdict (as opposed to a Murder verdict), due to their past mental health history.

In regard to juror attributes, it was hypothesized that mock-jurors' attitudes towards the insanity defence would predict their verdict (Skeem et al., 2005). That is, jurors demonstrating strong attitudes against the insanity defence would be more likely to render a Murder verdict than jurors who do not hold this opposing attitude. It was hypothesized that the gender of the juror would influence verdicts, but two alternate lines of prediction could apply, namely that female mock jurors would react more negatively towards the vignettes compared to male mock jurors, or conversely that female jurors would sympathise more than males with the defendant, understanding better the turmoil associated with childbirth.

Method

Participants

A total of 437 participants took part in the study. The data from four participants were excluded from subsequent analysis due to substantial missing information. This resulted in data from 434 participants being used (333 females and 101 males). Participants were recruited through undergraduate psychology classes in conjunction with advertisements posted on campus at the University of Tasmania (UTAS) and on the UTAS School of Psychology website.

Participants ranged in age from 17 to 62 years (Mean Age = 23.65 years, *SD* = 8.29). The mean age of female participants was 23.53 years (*SD* = 8.17), while the mean age for the male participants was 24.02years (*SD* = 8.71). There was no significant difference between the mean ages of male and female participants $F(1, 432) = .265$, $p = .61$. There were no exclusion criteria to participate in the study.

Materials

Two self-report questionnaires were used, the Insanity Defence Attitudes-Revised Scale (IDA-R; Skeem, Louden, & Evans, 2004) and the Social Desirability Scale (M-C SDS; Crowne & Marlowe, 1960). In addition to these scales, systematically varied vignettes were used, coupled with the presence or absence of judicial instructions. A post-questionnaire scale was administered to assess the participants' belief as to whether postpartum illnesses (depression and psychosis) are legitimate illnesses.

The IDA-R is a self-report 19-item questionnaire used to assess an individual's attitude toward the insanity defence. The IDA-R incorporates two dimensions. The first dimension, consisting of 9 items, is Strict Liability. This refers to the extent to which prospective jurors believe that mental illness reduces an individual's capacity for rational decision-making and control, and that reduced capacity is relevant to the issue of criminal responsibility. The second dimension is Injustice and Danger, consisting of 10 items. This reflects the extent to which prospective jurors believe the insanity defence is misused, perhaps with the effect of jeopardising public safety.

By constructing the IDA-R, Skeem et al.'s (2004) aim was to design and develop an understanding of core dimensions of contemporary attitudes towards the insanity defence, and to validate a measure of these dimensions. This was to improve the precision of future research on jurors' decisional processes in insanity cases and to aid legal professionals in identifying impartial jurors at voir dire. The development and validation process included choosing items that were representative of pre-existing insanity attitude measures (Hans, 1986; Roberts, Golding, & Fincham, 1987). Their results indicate adequate psychometric properties (Strict Liability, $\alpha = .68$; Injustice and Danger, $\alpha = .88$), particularly given that these were short (9-10 item) scales. In regard to convergent and divergent validity, Skeem et al. compared the IDA-R to other legal attitudes scales and found moderate to strong correlations with similar scales

The IDA-R was also deemed to be strongly predictive of mock juror s' insanity case judgments (Skeem & Golding, 2001). Predictive utility generalises across geographic jurisdictions and manipulation of case facts. However, the IDA-R has not been used in any published research since it was developed, and as a result has not been used as a research instrument in a non-American population.

The M-C SDS is a 33-item, true-false, self-report questionnaire that measures an individual's need to 'obtain approval by responding in a culturally appropriate and acceptable manner' (Crowne & Marlowe, 1960, p. 353). The M-C SDS items are targeted for behaviours that are socially desirable but unlikely to occur. The scale is internally consistent and predicts individuals' tendency to describe unpleasant tasks in favourable terms (Crowne & Marlowe, 1960; Marlowe & Crowne, 1961).

Crowne and Marlowe (1960) found the internal consistency of the 33 items to be .88, and the test-retest correlation was .89. Other researchers have also examined the psychometric properties of the M-C SDS, with results indicating that the internal consistency of this scale is adequate. Nordholm (1974) generated a coefficient of .73, Crino, Svoboda, Rubenfeld, and White (1983) generated coefficients that ranged from .70 - .77, Tanaka-Matsumi and Kameoka (1986) generated a coefficient of .79, and Holden and Fekken (1989) generated a coefficient of .78.

Vignettes were developed and provided as 'cases' for mock jurors to make a verdict judgment and record their responses to the case provided. These vignettes contained the same core information, namely a mother smothering her infant, but differed in regard to mental status (postpartum depression or postpartum psychosis) and mental health history (either no history (single episode) or a previous history (recurring)). The cases were largely adapted from *Yates v Texas* (2005) and through reports in published research. All participants were provided with the same vignettes, however half of the participants received step-by-step instructions that were aimed to take them through the law provided. Each vignette contained a different legal test (infanticide, legal insanity, or the reformulated psychological insanity defence).

Participants were asked to render a verdict (Guilty of Murder, Not Guilty or a verdict relevant to the legal test provided). Participants were then able to rate their level of confidence in their verdict using a 10-point Likert scale, with a rating of 1 = not confident, 5 = Neutral and 10 = extremely confident. A post-experimental questionnaire was also administered. This consisted of five questions asking the participant to rate their level of sympathy for the defendant

and the victim, as well as their level of knowledge about postpartum illness and whether they considered postpartum depression and postpartum psychosis to be a legitimate illness. Each question was rated on a 10-point Likert-format scale. The vignettes and scales can be viewed in Appendix A.

Procedure

Participants responded to research advertisements by email. Upon registering their interest participants were provided with a questionnaire package, either by email or provided with directions to a place in the UTAS School of Psychology department, where questionnaire packages could be collected. The questionnaire package included an information sheet (see Appendix B), and completion of the questionnaires was taken as consent to participate.

Participants were asked to complete the questionnaires independently and were not required to record any identifying information other than age, gender and how many children they had in their household (see Appendix A). They were asked to return the completed questionnaires either by email or by leaving them in a secure box located in the School of Psychology office to maintain confidentiality. A total of three questionnaires were returned by email (and upon receipt the questionnaire was printed and the original email deleted to maintain confidentiality). The remaining questionnaires were returned by posting them in the above secured box.

Design

The present study aimed to investigate the efficacy of the insanity and infanticide defence, including a revised psychology-related insanity defence, and

to examine what juror characteristics influence decision-making and verdicts when presented with an infanticide case. The design of the experiment incorporated a 2 [mental status: postpartum psychosis, postpartum depression] x 3 [legal defence: Infanticide, Insanity, Revised Insanity] x 2 [instructions: legal test alone, legal test with step-by-step instructions] x 2 [mental illness history: transient, recurring] x 2 [juror gender: male, female] between subjects factorial design. The dependent variables were participants' scores on the IDA-R, verdicts rendered, confidence ratings and their perceived level of knowledge regarding postpartum illnesses and whether postpartum illnesses constitute a 'legitimate' mental illness.

Results

The data obtained from the questionnaire packages were scored according to the instructions provided by the instruments and analysed. All relevant output for the following analyses can be located in Appendix C.

The mean number of participants in each condition is 18, with a range of 16 to 23. There was a fairly even spread (3.7% - 5.3%) of participants within each of the 24 conditions. A more detailed graph can be located in Appendix D. From the demographic information collected from the questionnaire packages, 45.5% of participants reported living with at least one child (M = 1, SD= 1.15) and 99.53% reported spending at least one hour per week with children (M = 3.48 hours, SD= 2.01). Of those who participated, 1.15% had served on a jury before, whilst 18.89% had experienced the death of their own child under the age of 7 in the past five years, or the child of a close friend or relative. A more

detailed representation of the sample can be viewed in the Tables located in Appendix D.

Scoring Procedure: IDA-R

Completed IDA-R questionnaires were entered into a data file. Scores were derived for the Total scale, as well as the Strict Liability, and Injustice and Danger dimensions. Raw scores ranged from 37 -78 (M = 58.32, SD= 7.52) for the total score, 12-44 (M = 28.00, SD= 5.77) for the Injustice and Danger dimension and 20-41 (M = 30.32, SD =3.30) for the Strict Liability dimension. For all of the above scales, higher scores indicate more negative attitudes to the insanity defence.

Scoring Procedure: M-C SDS

Completed M-C SDS questionnaires were scored according to the procedure developed by Crowne and Marlowe (1960). Using the scoring template, participants' scores were calculated by summing the scores for the relevant items. Raw scores ranged from 3 to 32 (M = 15.51, SD = 5.40). Higher scores reveal a greater level of social desirability, indicating that higher scorers tended more to deny that they would engage in activities generally deemed socially unacceptable, and would be more likely to portray their own behaviour in an unrealistically favourable light.

Factor Analysis: IDA-R

To investigate the underlying structure of the IDA-R and compare it with the factor structure obtained by Skeem et al (2004), data collected from 434

participants were subjected to principal axis factoring with varimax rotation. Whilst Skeem et al.'s original research employed a principal components analysis, Field (2005) asserts that both methods yield similar results.

Two factors (with Eigenvalues exceeding 1) were identified as underlying the 19 questionnaire items. In total, these factors account for 40.79% of the variance in the questionnaire data. The rotated component solution appears in Table 1, alongside the results of Skeem et al for comparison. As shown, the present results are comparable to those in the American sample, and support the assertion that the *IDA-R* possesses a two factor structure: Strict Liability, and Injustice and Danger.

Gender Differences

A one-way between groups analysis of variance (ANOVA) was used to investigate the impact that gender had on the scores obtained on the M-C SDS and the IDA-R including the total score and scores on the Injustice and Danger, and Strict Liability dimensions. There was a significant effect for the M-C SDS, indicating that females scored significantly higher ($M = 15.91$, $SD = 5.45$) on social desirability than males ($M = 14.20$, $SD = 5.00$): $F(1, 432) = 7.95$, $p < .01$. No significant effects for gender were obtained for the IDA-R Total: $F(1, 432) = .16$, $p = .69$, Injustice and Danger: $F(1, 432) = .02$, $p = .88$, or Strict Liability: $F(1,432) = .41$, $p = .52$ scores.

Table 1
Internal Structure of the IDA-R: Skeem et al (2005) and Current Study

		Skeem et al (2005)		*Present Study*	
		Component		Component	
Item		Injustice & Danger	Strict Liability	Injustice & Danger	Strict Liability
19	With slick attorneys and a sad story, any criminal can use the insanity defence to finagle his way to freedom	.82	.19	.75	.11
12	Perfectly sane killers can get away with their crimes by hiring high-priced lawyers and experts who misuse the insanity defence	.82	.17	.75	-.05
10	As a last resort, defence attorneys will encourage their clients to act strangely and lie through their teeth to appear 'insane'	.80	0	.72	.00
13	The insanity defence plea is a loophole in the law that allows too many guilty people to escape punishment	.79	.35	.70	.27
2	For the right price, psychiatrists will probably manufacture a 'mental illness' for any criminal to convince the jury that he is insane	.72	0	.53	.16
6	The insanity defence threatens public safety by telling criminals that they can get away with a crime if they come up with a good story about why they did it	.71	.39	.60	.29
8	The insanity defence returns disturbed, dangerous people to the streets	.64	.44	.62	.32
18	Many of the crazy criminals that psychiatrists see fit to return to the streets go on to kill again	.52	.26	.47	.22
16	Most defendants who use the insanity defence are truly mentally ill, *not* fakers	-.49	-.25	-.37	-.15
17	Some people with severe mental illness are out of touch with reality and do not understand that their acts are wrong. These people cannot be blamed and do not deserve to be punished	0	-.79	-.09	-.63
14	We should punish people who commit criminal acts, regardless of their degree of mental disturbance	.42	.77	.18	.75
1	I believe that people should be held responsible for their actions no matter what their mental condition	.29	.74	.18	.66
11	A defendant's degree of insanity is irrelevant: if he commits the crime, then he should do the time	.43	.71	.38	.72
3	I believe that we should punish a person for a criminal act *only* if he understood the act as evil and then freely chose to do it	0	-.69	-.06	-.38
15	It is wrong to punish people who commit crime for crazy reasons while gripped by uncontrollable hallucinations or delusions	0	-.69	-.13	-.56
9	Mentally ill defendants who plead insanity have failed to exert enough willpower to behave properly like the rest of us. So, they should be punished for their crimes like everyone else	.36	.69	.35	.66
5	It is wrong to punish someone for an act they commit because of *any* uncontrollable illness, whether it be epilepsy or mental illness	-.11	-.62	-.09	-.50
4	I believe that *all* human beings know what they are doing and have the power to control themselves	.30	.59	.15	.52
7	I believe that mental illness can impair people's ability to make logical choices and control themselves	-.19	-.40	-.03	-.40
	Variance accounted for	27%	27%	33%	13%

Factors Associated with Verdict Judgment

Verdict data was analysed using a loglinear analysis to study the relationships between multifactorial categorical variables and to assess how effectively the total data could be mapped onto a particular subset of all the possible main and interaction effects in the overall design, thus revealing the simplest subset of factors which could adequately account for the data. To explore the associations between variables, a saturated loglinear model was first entered (postpartum illness, psychological history, instructions, law and IDA-R scores, together with the dependent variable of verdict rendered). Interactions were then eliminated in downward hierarchical fashion, if their contribution to accounting for the data proved non-significant. Participant gender was not included in this analysis because male participants were far fewer than females.

For IDA-R scores, a median split on the total score was used to divide participants into high and low groups. In regard to verdict, Guilty of Infanticide, Not Guilty by Reason of Insanity and Not Guilty by Reason of Insanity (psychological insanity) were coded as Other, so that there were three alternatives: Murder, Not Guilty and Other. This was because, although participants received different judicial instructions, the three Other verdicts were functionally equivalent within the overall log-linear design and differences could be followed up after significant effects were obtained.

The log-linear analysis indicated that all higher order effects, other than two-way effects (χ^2 (135) = 207.49, p<.001), were eliminated as the results indicated that they did not contribute to significantly fit with the data. Further, as this specific analysis was conducted to assess contributors to verdict, any significant effects that did not involve verdict are not discussed here.

Law and IDA-R model

The loglinear model tested for participant's verdicts in relation to the legal test they were provided with and their IDA-R scores (high or low) was significant, χ^2 (4) = 14.78, p<.01. Chi-square tests on the IDA-R and verdict were performed separately for each level of legal instructions. This revealed a significant association between IDA-R scores and verdict for the reformed Psychological Insanity alternative, χ^2 (1) = 12.19, p <.001. This association was not evident for Infanticide or the traditional Insanity Defence. The participants who were high scorers on the IDA-R were significantly more likely to render a Murder verdict, than an NGRI, where this was the opposite for low IDA-R scorers, who chose to render a NGRI verdict rather than Murder. Not Guilty verdicts were not rendered by either high or low scorers. This interaction is depicted in Figure 1.

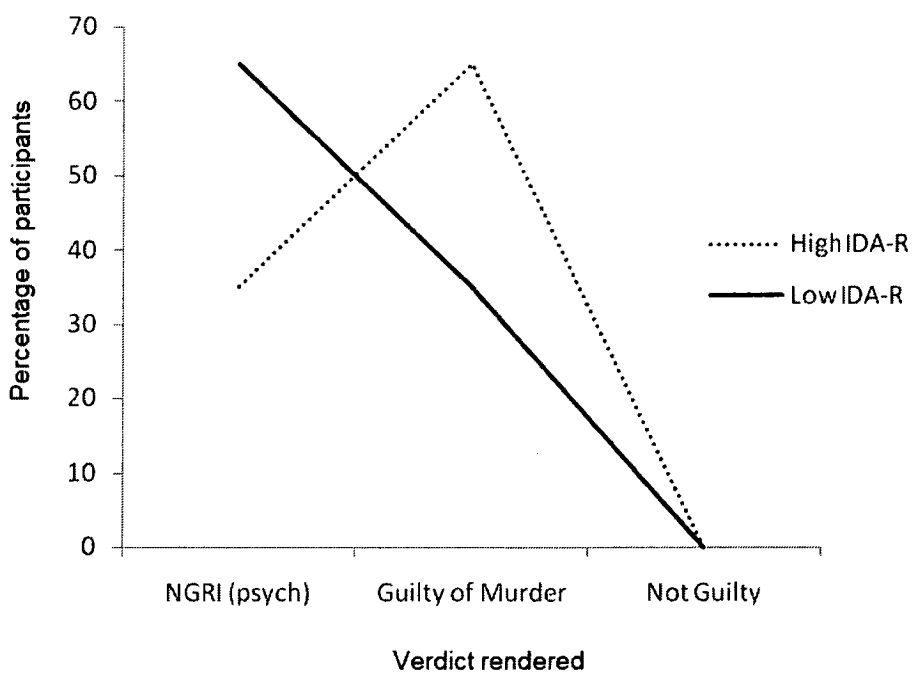

Figure 1. Percentage of high and low IDA-R scorers rendering verdicts in the reformulated insanity condition.

Illness and verdict model

The loglinear model tested for verdicts in relation to the defendant's diagnosis (postpartum depression or psychosis) was significant, χ^2 (2) = 20.89, p<.001. For both of the postpartum illnesses, the frequency of Not Guilty verdicts was found to be similar. A defendant experiencing post-partum depression was more likely to receive a Guilty of Murder verdict. In comparison, there was little difference in the verdicts rendered when participants received a post-partum psychosis scenario. Rather, there was a higher usage of the Infanticide and NGRI (both traditional and psychological) compared to post-partum depression. This interaction is depicted in Figure 2.

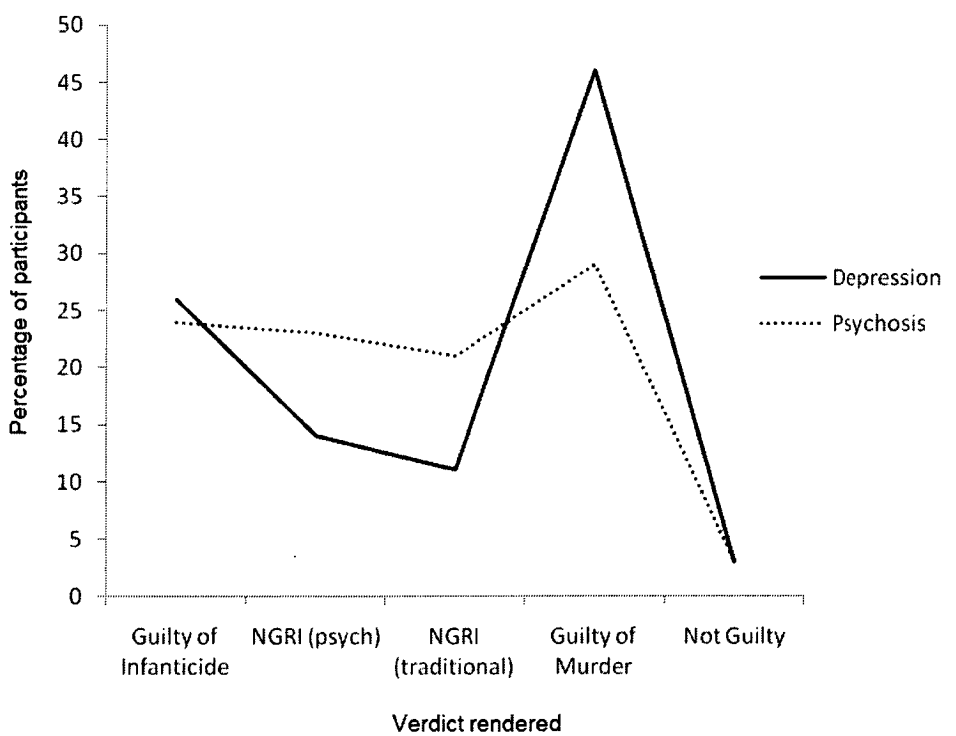

Figure 2. Percentage of participants' verdicts rendered across the postpartum illness conditions.

Instructions and verdict model

The loglinear model tested for verdicts in relation to whether or not participants received step-by-step instructions was significant, χ^2 (2) = 7.06, p<.05. Participants who did not receive step-by-step instructions were more inclined to render a Guilty of Murder verdict, followed by a Guilty of Infanticide verdict compared to those who did receive instructions. This interaction can be viewed in Figure 3.

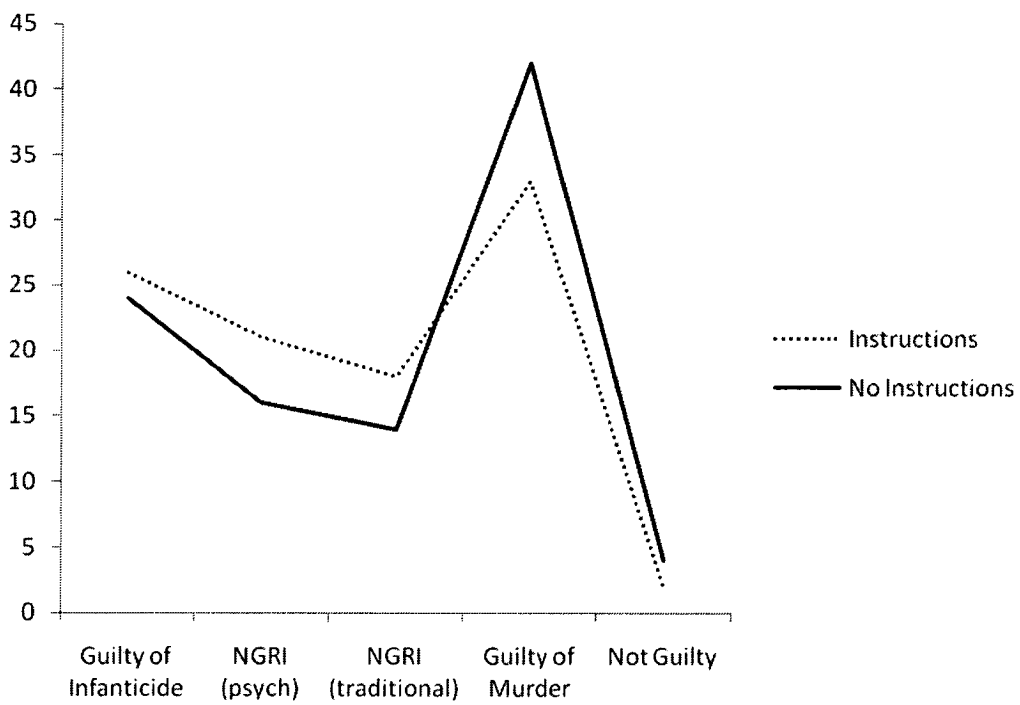

Figure 3. Percentage of participants' verdicts rendered when provided, or not provided, with instructions.

Psychological History, Legal Test and Verdict

Chi-square tests were conducted to assess the relationship between the defendant's psychological history (transient or recurring) and the legal test

participant's were provided with (Infanticide, Insanity or Psychological Insanity). The chi-square tests revealed that for a transient history of mental illness, there was a significant association between the legal test and the verdict rendered, χ^2 (8) = 261.09, p<.001; this was also true for a recurring history, χ^2 (8) = 310.83, p<.001.

The frequencies indicate that participants who received the Infanticide alternative were more likely to render a Guilty of Infanticide verdict than a Guilty of Murder or Not Guilty verdict, regardless of the defendant's psychological history. For the psychological Insanity defence, participants rendered a Not Guilty by reason of Insanity verdict more often in the transient condition compared to the recurring, preferring a Guilty of Murder verdict in the latter. In regard to the traditional legal Insanity defence, participants were more likely to render a murder verdict in the transient condition, but a Not Guilty by Reason of Insanity in the recurring condition. Cell percentages of this three-way model are shown in Table 2.

Table 2

Percentage of Participants' Verdicts for the Transient or Recurring Psychological History Condition

History	Law	Verdict					Total
		Infanticide	Insanity	Insanity (psych)	Murder	Not Guilty	
Transient	Infanticide	70	-	-	23	7	100
	Insanity		42	-	55	3	100
	Insanity (psych)			60	40	0	100
Recurring	Infanticide	88	--	-	5	7	100
	Insanity		48	-	52	0	100
	Insanity (psych)			51	48	1	100

Psychological History, IDA-R scores and Verdict

Chi-square analyses were performed to examine verdicts in relation to the defendant's psychological history and IDA-R scores. This analysis demonstrated a significant interactive association with participants' verdicts in the transient condition, χ^2 (4) = 11.34, $p<.05$, but not for the recurring condition.

In the Transient condition, it can be seen from Figure 4 that High IDA-R scorers were more likely to render a verdict of either Infanticide or Murder (both guilty verdicts). In contrast, whilst Low scorers were more likely to render these guilty verdicts, there was a higher usage of both of the insanity defences compared to High scorers.

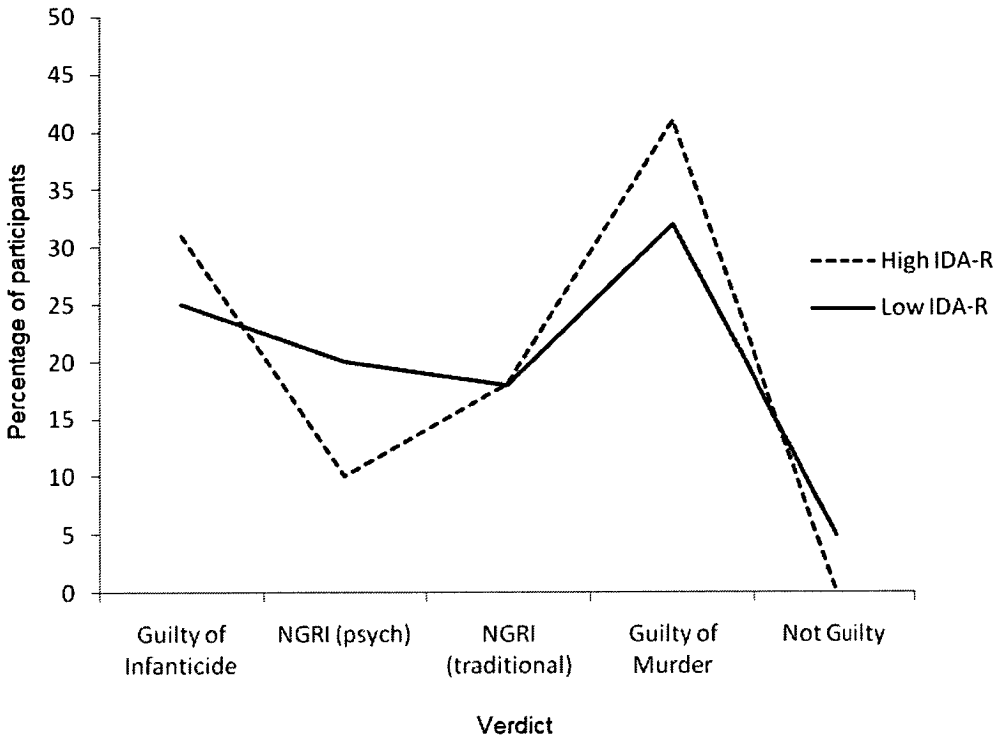

Figure 4. Percentage of participants classified as high or low scorers on the IDA-R and their verdicts rendered.

Legal Test and Verdict

As the above analyses combined a Guilty of Infanticide and NGRI (traditional and reformulated) into the one variable (named Other), a chi-square analysis was conducted that separated these verdicts, as well as combining the Not Guilty and Guilty of Murder verdict. This analysis was highly significant, χ^2 (8) = 565.26, p<.001. The data can be viewed in Table 3, and demonstrates that in the Infanticide condition, participants rendered a Guilty of Infanticide verdict 80% of the time compared to a Guilty of Murder or Not Guilty Verdict. When presented with the traditional Insanity test, participants were more likely to render a Guilty of Murder verdict than a NGRI verdict. When providing participants with the reformulated, psychological Insanity defence, participants

chose a NGRI verdict slightly more (54%) than a Guilty of Murder verdict (46%). A Not Guilty verdict was not chosen in this condition.

Table 3

Number and Percentage of Verdicts Rendered by Participants across the Legal Test Conditions

Condition	Verdict *N* (%)					Total
	Infanticide	Insanity	Insanity (Psych)	Murder	Not Guilty	
Infanticide	109 (80)	-	-	19 (13)	10 (7)	138 (100)
Insanity (Traditional)	-	69 (47)	-	75 (51)	3 (2)	147 (100)
Insanity (Psychological)	-	-	80 (54)	68 (46)	0	148 (100)
Total	109	69	80	162	13	433

No other significant interactions or effects were determined in the loglinear analysis.

The Effect of Gender on Verdict

Data pertaining to gender was analysed separately, using chi-square analyses, due to the high proportion of female participants.

IDA-R Scores x Verdict

Breaking the data down by gender, there was a significant association between scores on the IDA-R and verdicts rendered for females, χ^2 (4) = 11.06, p<.05. A non-significant trend occurred in males, χ^2 (4) = 8.19, p=.08. Due to the higher number of participants in the low IDA-R group, group percentages have been used to discuss the interaction. The association for females can be viewed in Figure 5. This depicts that, while high and low IDA-R scorers rendered a high frequency of Guilty of Murder verdicts; low IDA-R scorers had a higher frequency of NGRI (both defences) than high IDA-R scorers. A similar, but non-significant, trend was also found in males.

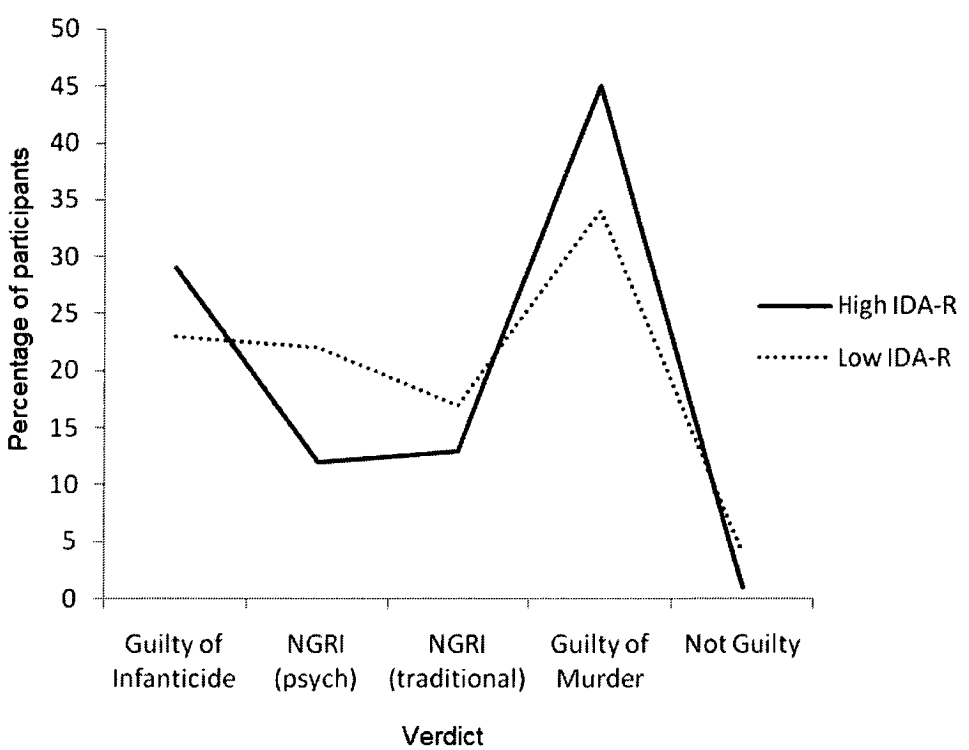

Figure 5. Percentage of female participants classified as high or low scorers on the IDA-R and their verdicts rendered.

Illness x Verdict

There was determined to be a significant association between the post-partum illness experienced by the defendant and the verdict rendered for females, χ^2 (4) = 23.84, p<.001, but not for males, χ^2 (4) = .85, p=.93. The association for females can be viewed in Figure 6. This demonstrates that women were significantly more likely to render a Guilty of Murder verdict if the defendant was experiencing post-partum depression more often compared to the other verdicts and when the defendant was experience postpartum psychosis. In contrast, when the defendant was experiencing postpartum psychosis, there was no discernible difference between the frequencies of all the verdicts rendered, excluding the Not Guilty verdict.

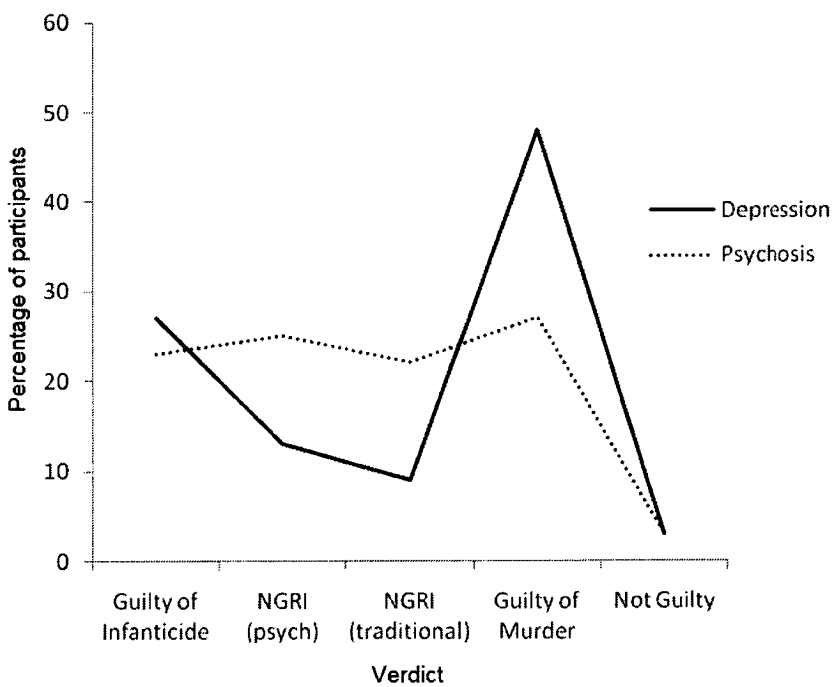

Figure 6. Percentage of female participants' verdicts rendered across the postpartum illness conditions

No other significant effects were determined for the effect of the participant's gender on their verdict.

Confidence x verdict

A one-way between subjects ANOVA demonstrated that there was no significant difference between the mean confidence ratings in relation to the verdict rendered, F (4, 428) = 1.48, p = .208. The mean confidence ratings for each verdict can be viewed in Table 4.

Table 4

Number of Participants, Means and Standard Deviations of Confidence Ratings for Each of the Five Verdicts Rendered

	N	*M*	*SD*
Infanticide	109	6.83	1.87
Reformulated Insanity	80	6.44	2.07
Insanity	69	6.35	1.83
Murder	162	6.83	2.01
Not Guilty	13	6.08	2.18
Total	433	6.66	1.97

Juror instruction and confidence ratings

A two-way mixed subjects ANOVA demonstrated that there were no significant differences between confidence ratings for participations who received step-by-step judicial instructions (M = 6.71, SD = 2.00) and those who did not (M = 6.60, SD = 1.93): F (1, 431) = .35, p = .557.

Post-Experimental Questionnaire

In summary, this data from the post-experimental questionnaire indicates (using sample means) that participants held a neutral level of sympathy towards the defendant ($M = 5.73$, $SD = 2.34$), but were extremely sympathetic towards the victim ($M = 9.01$, $SD = 1.61$). Participants knew some information regarding postpartum illnesses ($M = 4.86$, $SD = 2.44$) and generally thought that postpartum depression ($M = 7.07$, $SD = 2.21$) and postpartum psychosis ($M = 6.57$, $SD = 2.00$) were legitimate illnesses.

To assess the size and direction of the linear relationship between sympathy towards the defendant and victim, jurors' self-reported level of knowledge regarding postpartum illnesses, and whether jurors consider postpartum depression and psychosis to be legitimate illnesses, bivariate Pearson's product-movement correlations coefficient (r) were calculated. The results can be viewed in Table 5.

Table 5

Correlations between Items on the Post-experimental Questionnaire

	Sympathy Towards Victim	Knowledge	Depression Legitimate Illness	Psychosis Legitimate Illness
Sympathy towards Defendant	.075	.143*	.489*	.490*
Sympathy towards Victim		-.041	.031	.067
Knowledge			.462*	.361*
Depression Legitimate Illness				.707*

*significant at the $p < .01$ level

This demonstrates that greater sympathy towards the defendant was influenced by a greater level of knowledge the juror reported regarding postpartum illnesses and the more likely they considered postpartum depression and psychosis to be legitimate illness.

Gender and Sympathy

A one-way between subjects ANOVA demonstrated that there was a significant effect of jurors' gender on the level of sympathy for both the defendant (F (1, 431) = 5.57, p<.05) and the victim (F (1, 431) = 12.43, p<.001). In both instances, females' ratings of sympathy were significantly higher than those of males for the defendant (M = 5.88, SD = 2.33) and the victim (M = 9.16, SD = 1.5) males (defendant: M = 5.25, SD = 2.32, victim: M = 8.52, SD = 1.86).

Children and Sympathy

A one-way between subjects ANOVA demonstrated that, participants who currently reside with children did not show significant differences in their reported level of sympathy for both the defendant (F (4, 424) = .95, p =.435) and the victim (F (4, 424) = 1.51, p = .20), compared to participants who did not reside with children.

Discussion

The aim of this study included examining mock juror attributes, incorporating the gender of the juror, jurors' attitudes regarding the insanity defence and jurors' confidence in their verdict, when rendering judgments of criminal responsibility in infanticide cases. It further aimed to examine a revised

version of the insanity defence, put forward by Yannoulidis (2003). This revised insanity defence attempts to incorporate what is now understood about mental illnesses with the traditional legal test.

Yannoulidis (2003) provided a reformulated insanity defence which adopted a psychological approach in contrast to the traditional legal approach. As this reformulated psychological insanity defence was under investigation for the first time, it was not known whether it would be preferred to the traditional insanity defence. As a result it was hypothesised that the frequencies of participants rendering verdicts that accepted a reformulated insanity defence would be similar to those rendering verdicts that accepted a traditional insanity defence. However, it was argued that participants would report higher confidence levels when using the psychological insanity defence in conjunction with legal instructions in the form of a step-by-step analysis of the provided law. The results from the present study indicated that there was not a significant main effect for verdict nor was there a significant association between a juror's rated level of confidence and their verdict rendered.

In relation to the Infanticide provision, it was hypothesised that mock jurors may indicate greater confidence in their verdict when using this provision on the basis that it adequately encapsulates the current position of the mother in terms of not being fully recovered from the effects of birth. This was supported in the current study with participants choosing a Guilty of Infanticide verdict 80% of the time in comparison to a Guilty of Murder or Not Guilty verdict.

In regard to postpartum illness, it was argued that mothers in the vignettes who had been diagnosed with postpartum psychosis would be perceived more as meeting the criteria for the Infanticide provision and Insanity Defence, compared

to mothers experiencing postpartum depression. Further, it was hypothesised that mothers with a history of mental illness following the postpartum period would be more likely to receive an Insanity or Infanticide verdict (as opposed to a Murder verdict), compared to mothers who had only experienced a single episode of mental illness symptoms. The results indicated that participants who received the Infanticide provision were more likely to render a Guilty of Infanticide verdict regardless of the defendant's psychological history. In comparison, a Not Guilty by Reason of Insanity (NGRI) verdict was more often rendered for mothers who experienced a single episode, rather than recurring mental illness when jurors were provided with the psychological Insanity Defence, but not the traditional insanity defence. In the traditional legal insanity condition, participants rendered more Guilty of Murder verdicts for the recurring mental illness condition.

It was hypothesised that by utilising the IDA-R, it would be possible to determine whether mock-juror's attitudes would predict their verdict rendered. The results from this study determined that the IDA-R was predictive for the revised psychological insanity defence only, and not the traditional legal insanity test. This was further affected by the gender of the juror, with females who scored low on the IDA-R rendering more NGRI (for both defences) than high IDA-R scorers. This was not significant for male jurors.

In relation to the gender of the juror, it was hypothesised two alternative lines of prediction could apply. This included that female mock jurors would react more negatively towards the mother in the vignettes compared to males, or conversely that female jurors would sympathise more than males with the defendant. The results indicated that females rated higher levels of sympathy for

both the defendant and victim, in comparison to males. However, there was a not a significant interaction between the gender of the juror and the verdict rendered. Further, whether the defendant lived with children or not, did not have an effect on their level of sympathy towards the defendant or victim.

In relation to the participant sample who took part in this research, 45.5% reported living with one or more children and nearly all participants (99.53%) reported having at least one hour of contact with children per week. However, a relatively high proportion of participants (18.89%) had experienced the death of their own child, or the child of a close friend or relative, under the age of 7 years and within the past five years. The high percentage of participants experiencing the death of a child may be a true representation of the general public, demonstrating the wide effect a child's death has upon other people.

Australian Bureau of Statistics (ABS; 2008) released a media release pertaining to the health of children in Australia. In this release, it was stated that the death rates for children aged 1-14 years of age had decreased from 30 to 15 deaths per 100, 000 children. During a two year period (2002-2004) an average of 1 200 infant deaths occurred in Australia each year. In 2005, the death rate for neonatal deaths (deaths within the first four weeks of life) was 3.6 per 1,000 live births, and 1.4 per 1,000 live births for post-neonatal infant deaths (deaths after 28 days and before one year of life). It was also reported that the death rate for children aged 1-14 years has decreased, but remains stable for children under 12 months of age. However, whilst the ABS (2008) data statistics might represent a small proportion of recorded child deaths, the current study may suggest that there is a wide emotional ramification that a child death has many individuals, including parents, extended family and friends.

A limitation includes that the question enquired about whether the participant had experienced the death of their own child, or that of a close friend or relative. This can encompass a wide proportion of the population due to friendship networks, especially given the small population of Tasmania in comparison to other Australian states. Further, the question enquires only for children aged under the age of 7 years. In responding, participants may have included incidences of miscarriages experienced by themselves, relatives or friends. Robotham and Somerville (2009) report that one in three women aged less than 30 years has experienced a miscarriage. This figure could therefore inflate the data from the current study, resulting in the high proportion of participants who have reported experiencing a child death.

Alternatively, this research was advertised with the explicit requirements that participation would involve, namely, that the individual would be required to complete questionnaires and deliberate, as an individual, on the guilt of a defendant who is charged with the murder of her own child and wishes to argue a defence to the charge. As a result of this, participants who had experienced either the death of their own, or someone-else's, child may have been selectively drawn to the experiment due to the emotional salience of the advertised research (Williams, Mathews & MacLeod, 1996). If this was indeed the case for the current study, it can be argued that the results cannot be generalised to the wider community. Further research would be required to separate those who had experienced their own child's death and those who had answered the question referring to a friend or relatives child. In terms of jury selection and cases of infanticide, it would be highly likely that a parent who has experienced the death of a child would be excluded from jury duty.

In relation to social desirability, females scored higher (M = 15.91) than males (M = 14.20) on the M-C SDS instrument. Whilst this difference was slight, it was deemed to be statistically significant. Despite this, it is not uncommon for these gender differences to exist when measuring socially desirable behaviours. Katkin (1996) evaluated whether gender differences existed on two measures of social desirability, including the M-C SDS. That research determined that females' scores correlated more highly than males' on both of the administered social desirability instruments. Katkin suggested that it may be assumed that females' socially desirable responses are more strongly reinforced than for males, which is indicated by higher scores. Therefore, it can be argued that this difference in social desirability most likely is not unrepresentative sampling in regard to this variable and that the results obtained are reliable, which would not have been so if the males had scored higher on this instrument.

The factor analysis conducted in the present study on the IDA-R yielded similar, but slightly lower, loadings than those obtained by the creators, Skeem et al. (2004). Skeem et al. tested the IDA-R on a sample of 426 Americans drawn from a wider population. In contrast, this study obtained 437 participants drawn predominantly from a university population. This limited sample may have contributed to the lower loadings. However, the instrument was developed in an American sample, and American law and sentences differ from Australian law, including a death penalty in some states of America. A recent study, also conducted in America, by Vitacco et al. (2009), demonstrated that higher scores on the IDA-R (reflecting a negative attitude towards the insanity defence) were also related to higher perception of insanity defence use and greater support for the death penalty. As a result of this finding, it is suggested that the IDA-R

requires further validation within an Australian sample before more definitive conclusions can be made.

In relation to psychological history, the current study hypothesized that mock-jurors would be more likely to render a verdict of Guilty of Infanticide or Not Guilty by Reason of Insanity (either traditional or reformulation-psychological defence) when the mother had a previous established history of postpartum depression or psychosis, compared to mother who did not have a documented history (considered a transient, or single episode, illness). This hypothesis was not supported in the present study. Rather, jurors were significantly more likely to render a verdict of Guilty of Infanticide more often than Guilty of Murder or Not Guilty, regardless of the defendant's psychological history. This was also true for the reformulated psychology insanity defence.

Previous research suggests that juror's verdicts are influenced by attributions they make based on the defendant's mental health. When the perpetrator is diagnosed with a mental illness, jurors make more negative attributions and assign greater blameworthiness, responsibility and controllability (Corrigan, Markowitz, Watson, Rowan, & Kubiak, 2003). In contrast, Henkel's (2008) research also supports this finding, with jurors more likely to find a defendant guilty if he/she is experiencing a mental illness, compared to a medical disorder. This may be due to jurors feeling pressured to convict a person suffering from a mental illness due to the misconception that these individuals are 'ticking time bombs' (Appelbaum, 2004, p. 1105), so that their incarceration is seen as necessary for public safety.

In the case of infanticide, it may be perceived that there are two victims in this emotive crime – the child as well as the mother. As a result of this,

participants may have felt that rendering a Guilty of Infanticide or NGRI was acceptable, regardless of the defendant's psychological history, due to the variety of sentencing options that were available when rendering a verdict, including receiving treatment or being hospitalized. Alternatively, all legal tests for infanticide and insanity asked the juror to make a judgment based on the current incident. As, at the time of the child's death, all scenarios depicted the mother laboring under a postpartum illness, the juror may not have factored the defendant's psychological history into their decision-making process as stated by the legal tests.

When incorporating mock-jurors' IDA-R scores, there was a significant effect for a defendant acting under a transient postpartum illness (both depression and psychosis) upon the jurors' verdict. This demonstrated that high IDA-R scorers were more inclined to render a guilty verdict (either Murder or Infanticide) than a not guilty verdict (including NGRI) compared to low IDA-R scorers. This supports Skeem et al.'s (2004) assertion that the IDA-R has predictive utility, and this is also true for across legal jurisdictions. Skeem et al.'s original study was focused upon an American sample, whereas the current study incorporated an Australian sample. However, it was not generalised across case manipulations, as this effect was not significant for recurring psychological history condition.

It can be argued that this finding was due to the sensitive nature of the scenarios presented in the current study. Skeem et al. (2004) employed vignettes that were previously used in a study conducted by Roberts, Golding, and Fincham (1987). The vignettes depicted mentally ill individuals who were diagnosed with either schizophrenia or a personality disorder. These vignettes

included a man murdering a mailman either by stabbing and removing the mailman's heart (bizarre condition) or stabbing (non-bizarre condition), whilst also considering the effect of planfulness (either the act was planned or it was spontaneous). The differs greatly from the current study, where there was no planned act, the act of smothering may be regarded as less violent than stabbing (Dunn et al., 2006) and further, the mental illnesses used in the current study were specifically for the postpartum period and involved the death of a child. These factors may have provoked more sympathy in the juror's for both the defendant and victims (as indicated by the results of the post-experimental questionnaire) thus affecting the predictive utility of the IDA-R in infanticide cases.

Interestingly, when accounting for the legal test provided to mock jurors and their IDA-R scores, there was a significant effect for the reformulated insanity defence but not for the traditional insanity defence or the infanticide provision. This effect, again, supports Skeem et al.'s (2004) assertion that the IDA-R has predictive utility. However, the same was not true for the traditional legal insanity defence. It may be speculated that the reformulated insanity defence taps into the laypersons' understanding of insanity as suggested by the literature (Turvey, 2008). The reformulated insanity defence was proposed by Yannoulidis (2003) as the current legal insanity defence does not encompass the psychiatric conception of mental disorder and may be considered to be an excuse for an individual's actions, rather than pertaining to their mental status and psychological history which impacted upon their actions at the time of the crime.

In research that examines mock jurors' verdicts in insanity cases, without providing them with legal tests or instructions, these jurors rendered verdicts that

would be considered to be more accurate than those rendered when the insanity defence is employed. Finkel and Handel (1989) determined that in these instances, mock jurors made discriminations among cases, and that their concepts of insanity were relevant, flexible and were more complex than that encapsulated by the legal insanity defence. The finding that the reformulated insanity defence had a significant association with participant's IDA-R scores may reflect this literature. That is; due to the complex information that is incorporated in the legal insanity defence and the instructions provided to jurors in order to guide them in their decision-making, participants may be more inclined to render verdicts that are inconsistent with the law. In contrast, the reformulated insanity defence is closely associated to the internal schemas of what they understand as insanity and mental illness that the IDA-R was able to 'tap into' these internal beliefs, and thus provide a true reflection of their attitude and higher predictive utility.

It was hypothesized that mothers diagnosed with, or experiencing symptoms of, postpartum psychosis would be perceived more as meeting the criteria for the infanticide provision and insanity defence, compared to mothers experiencing postpartum depression. This was supported by the findings in the current study. Mock jurors were more likely to render a Guilty of Murder verdict if the defendant was suffering from postpartum depression. For postpartum psychosis, there was a higher usage of the Guilty of Infanticide or NGRI (traditional and reformulated), compared to those rendered n the postpartum depression scenarios. These three options allow the defendant to receive treatment and /or hospitalization rather than a jail-term sentence. This suggests that mock jurors perceived postpartum psychosis as being more likely to meet the

criteria set out by these legal tests, whereas a defendant experiencing postpartum depression was not excused from the murder verdict more readily.

This finding regarding postpartum illnesses strengthens the argument put forward by d'Orban (1977) that suggests that postpartum depression, in isolation to other mental illnesses, is not sufficient to support the criteria set out by the infanticide provision or insanity defence. Further, postpartum depression is not viewed as acute enough to affect the defendant's reasoning to know the nature and quality of the act committed was wrong, or that due to postpartum depression she did not know what she was doing was wrong, as stipulated by the insanity legal test. The impediment with this finding is that the infanticide provision tends to be more associated with cases involving postpartum depression (Laporte et al., 2003). This may be due to women arguing the insanity defence in the instance of postpartum psychosis. Therefore, due to the high incidence rate of postpartum depression and the significant impact on the mother and her child, not only including murdering her child, but also neglect and child abuse that can arise due to this postpartum illness, greater research attention should be paid to this area. That is to say, that due to the high incidence rate of depression in new mothers, the detrimental effect on the mother and the relationship with her child, and the demonstration that a woman suffering from postpartum depression is more likely to be found guilty of the crime, more needs to be done in the court of law to allow for and to consider the findings from the current research.

In regard to legal instructions and juror confidence, it was hypothesized that participants would report higher confidence when choosing to render the reformulated insanity defence and when they are provided with step-by-step instructions. The results from this study showed that in fact there was no

significant effect for confidence in relation to verdict. However, it was demonstrated that when mock-jurors did not receive step-by-step instructions, they were more inclined to render a Guilty of Murder verdict compared to participants who did receive such instructions. This may suggest that the step-by-step instructions allowed participants the opportunity to more fully comprehend and work through the legal tests and thus render alternative verdicts than those who were provided with the legal test only. It can be argued that this contradicts Wheatman and Shaffer's (2001) results, where they determined that individuals do not attend to and are less inclined to abide by legal instructions. In the current study, it appeared that mock jurors did follow the legal instructions, when they are provided in an understandable, simplified form and in a way that broke down the legal test into a series of steps.

For the insanity defences, as the reformulated insanity defence was under investigation for the first time, it was unknown if it would be rendered as a verdict more frequently in comparison to the traditional insanity defence. This study demonstrated that when participants received the traditional insanity defence, participants were more likely to render a Guilty of Murder than a NGRI verdict (51% compared to 47%). In contrast, when participants were presented with the reformulated insanity defence, a NGRI was the more likely verdict than one of murder (54% compared to 46%). It has been continually argued that an update of the insanity defence is imperative to incorporate what is now understood about mental illnesses (Morris, 1953; Becker, 2003). This study offers preliminary evidence that a reformulated insanity defence that is either the same, or similar, to that proposed by Yannoulidis (2003) offers the promise of

being an acceptable, easier to understand and a preferred insanity defence compared to the M'Naghten rule.

Previous literature (for example, Kaplan & Miller, 1978) indicates that the gender of the juror is an unknown contributor to the judicial process. Further, the relationship between the jurors' gender and the proneness to convict is not simple, but can be moderated by many other factors. The current study hypothesized that the gender of the juror would influence the verdicts rendered, but two lines of argument could apply. This includes that female mock jurors could react more negatively towards the defendant compared to male mock jurors (resulting in a higher frequency of Guilty of Murder verdicts), or female mock jurors may sympathise more than males and render more NGRI (traditional and reformulated) or Guilty of Infanticide verdicts.

There was a significant difference in levels of rated sympathy for the defendant and victim between males and females, with females rating significantly higher levels of sympathy in both instances. The results from the current study also indicated a significant association between IDA-R scores for females, but not for males. This demonstrated that the IDA-R had high predictive utility, with high scoring females rendering a higher frequency of Guilty of Murder verdicts and low IDA-R scorers rendering a higher frequency of NGRI (both the traditional and reformulated defence) verdicts. A similar significant association between illness and verdict was also determined with female jurors rendering a higher frequency of Guilty of Murder verdicts when the defendant was experiencing postpartum depression. This was not apparent for the postpartum psychosis condition, or for male jurors. There is no concrete evidence from these findings to reinforce the claim that the infanticide provision should be

abolished, leaving women who have committed a crime, and suffering from a postpartum illness to argue their diminished criminal responsibility using the insanity defence (Osborne, 1987).

Whilst females rated higher levels of sympathy towards the defendant and the victim, this did not affect the frequency of Guilty of Murder or NGRI verdicts. It may be suggested that, due to the high level of emotion that the death of a child provokes, this has overridden any sympathy towards the defendant affecting the verdict rendered. Participants may have actually perceived that there were two victims in the scenario, the mother and the child (Laporte et al., 2003) and thus hindered their emotion and sympathy from interplaying in their decision as they attempted to deliver a fair and just verdict.

Lastly, the post-experimental questionnaire indicated that whilst the population held some knowledge regarding postpartum illnesses, on the whole information is lacking. This is concerning due to the high incidence rates of postpartum illnesses, specifically postpartum depression. This lack of information may also demonstrate why participants felt that postpartum illness, particularly postpartum depression, are not legitimate illnesses. It can be suggested that health organizations need to address this area and provide information campaigns to the wider community. This in turn, may lower the amount of postpartum illnesses developing into more serious cases, as new mothers (and their families) become more aware of the signs and symptoms and seeking treatment at an earlier, rather than later, stage of the illness (Buist et al., 2005; Buist et al., 2006). Currently, the Australian Health Ministers' Advisory Council and the Australian Government have collaborated to develop the National Perinatal Depression Initiative (Australian Government Department of

Health and Aging, 2010). This initiative aims to improve prevention and early detection of antenatal (during pregnancy) and postnatal depression, as well as providing better support and treatment for expectant and new mothers who are experiencing depression. This initiative offers promising results in terms of detecting depression, providing treatment, as well as ensuring follow-up support and engagement with other health services are maintained for optimal benefits.

There are some limitations to the current study that could be addressed if this research were to be replicated to help maximize the quality of the information obtained. An area of further enhancement is to include a screening item on the demographic questionnaire to ascertain whether participants were experiencing, or had previously experienced, a mental illness. This could incorporate adding a measure of current depression symptoms, for example the Depression, Anxiety and Stress Scale (DASS; Lovibond & Lovibond, 1995), or explicitly asking whether the participant (and/or any of the participant's family) have experienced a postpartum illness.

The participant sample for the current study was primarily recruited from a university, specifically students studying psychology. In regard to the insanity defence it is argued that, in general, university students hold mixed opinions about the defence, compared to the general public. Large-scale attitude surveys demonstrate that the wider community holds an overwhelming negative opinion of the mentally ill and even more negative opinions of the criminally insane (Steadman & Cocozza, 1978). Furthermore, these attitudes are entrenched in the belief that the insanity defence is a loophole in the criminal law where its use is often highly exaggerated and the public are often misinformed about the common dispositional effects of an insanity acquittal (Roberts et al., 1987). Due

to the population from which this participant sample was derived, the results may have been affected and biased towards the attitudes and opinions of psychology university students. It is also assumed that the mean age of a jury panel would be slightly older than that obtained in the current sample. As such, it is recommended that future research into infanticide draws from the general population to gain more insight into the attitudes and juror characteristics that interplay in the juror decision making process in infanticide and insanity cases. Further, the current questionnaire only obtained data as to whether the participant was living with any children in the household. If this study were to be replicated, this question could be broken down to enquire specifically whether the children are the participants' step-children or siblings (given the young age of the participant sample).

The current study has provided some important initial insights into understanding what juror factors can impact upon their decision making process when rendering verdicts regarding the guilt of the defendant in infanticide cases. While this line of research has tended to be overlooked in the past, receiving little investigative attention, this study has highlighted the importance of awareness of postpartum illnesses and the impact a mental illness has in the court of law. In regard to the reformulated insanity defence, this study demonstrated that it was an effective attempt at updating the traditional insanity defence, as this verdict was rendered more frequently. This suggests that the reformulated definition may encapsulate what jurors now understand of insanity and is more comprehensible. In the current study, women suffering from postpartum depression were more likely to be found Guilty of Murder, than women suffering from postpartum psychosis. This suggests that participants distinguished that

postpartum depression does not meet the legal criteria for insanity and the infanticide provision as proposed by Stanton et al. (2002). It was determined that the IDA-R had predictive utility in regard to verdicts rendered, however it requires further research and refinement before it can be regarded as a psychometrically sound measure in an Australian population.

In conclusion, the current study investigated the effect of various mock-juror attributes when rendering verdicts on infanticide and insanity cases, including trialling a revised insanity defence that incorporates a psychological definition of mental illness. The current study demonstrated that the revised insanity defence devised by Yannoulidis (2003) shows promise of leading the way in successfully constructing a preferred and updated insanity defence. The current study also indicated that there is a pervasive negative attitude within the community towards postnatal depression. That is; many individuals regard postnatal depression as not constituting a 'legitimate' mental illness. This finding suggests that community-based interventions need to be conducted to increase the population's understanding and knowledge regarding postnatal illnesses. This, in turn, will also increase awareness and detection of postnatal illnesses resulting in more women who are affected seeking treatment. The current National Perinatal Depression Initiative (Australian Government Department of Health and Aging, 2010) is designed to meet this need. Lastly, the study indicated that female participants' sympathy towards the defendant and victim did not appear to alter their verdict compared to males. This demonstrates that loading the jury with females for infanticide cases will not result in biased verdicts. However further research; including investigating the effect of gender

in group deliberations will need to be conducted before a definitive conclusion can be reached.

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Appendix A: Questionnaire and Vignettes

Demographic Questionnaire:

Please answer the following questions:

What is your current age (in years)? _____

Sex (please circle): MALE FEMALE

How many children live in your household? 0 1 2 3 4+

On average, how many hours do you have in contact with children per week?

0 1-2 3-4 5-6 7-8 9+

Have you ever served on a jury before? YES NO

In the last ten years have you, or a close friend or relative, experienced the death of a child under the age of 7 years?

YES NO

Insanity Defence Attitudes Scale - Revised

Please rate the extent to which you agree or disagree with the following statements by circling the appropriate number. A rating of 1 = you strongly disagree, 3-neutral and 5= strongly agree.

		Strongly disagree Strongly agree				
1	I believe that people should be held responsible for their actions no matter what their mental condition	1	2	3	4	5
2	For the right price, psychiatrists will probably manufacture a "mental illness" for any criminal to convince the jury that he is insane	1	2	3	4	5
3	I believe that we should punish a person for a criminal act *only* if he understood the act as evil and then freely chose to do it	1	2	3	4	5
4	I believe that all human beings know what they are doing and have the power to control themselves	1	2	3	4	5
5	It is wrong to punish someone for an act they commit because of *any* uncontrollable illness, whether it be epilepsy or mental illness	1	2	3	4	5
6	The insanity defence threatens public safety by telling criminals that they can get away with a crime if they come up with a good story about why they did it	1	2	3	4	5
7	I believe that mental illness can impair people's ability to make logical choices and control themselves	1	2	3	4	5
8	The insanity defence returns disturbed,					

	dangerous people to the streets	1	2	3	4	5
9	Mentally ill defendants who plead insanity have failed to exert enough willpower to behave properly like the rest of us. So, they should be punished for their crime like everyone else	1	2	3	4	5
10	As a last resort, defence lawyers will encourage their clients to act strangely and lie through their teeth to appear "insane"	1	2	3	4	5
11	A defendant's degree of insanity is irrelevant: if he commits the crime, then he should do the time	1	2	3	4	5
12	Perfectly sane killers can get away with their crimes by hiring high-priced lawyers and experts who misuse the insanity defence	1	2	3	4	5
13	The insanity plea is a loophole in the law that allows too many guilty people to escape punishment	1	2	3	4	5
14	We should punish people who commit criminal acts, regardless of their degree of mental disturbance	1	2	3	4	5
15	It is wrong to punish people who commit crime for crazy reasons while gripped by uncontrollable hallucinations or delusions	1	2	3	4	5
16	Most defendants who use the insanity defence are truly mentally ill, *not* fakers	1	2	3	4	5
17	Some people with severe mental illness are out of touch with reality and do not understand that their acts are wrong. These people cannot be blamed and do not deserve to be punished	1	2	3	4	5
18	Many of the crazy criminals that psychiatrists see fit to return to the streets go on to kill again	1	2	3	4	5
19	With slick lawyers and a sad story, any criminal can use the insanity defence to cheat his way to freedom	1	2	3	4	5

Marlowe-Crowne Social Desirability Scale

Please read the following statements, and circle whether the statements are true (they apply to you) or false (they don't apply to you), for most of the time.

1.	Before voting I thoroughly investigate the qualifications of all the candidates	TRUE	FALSE
2.	I never hesitate to go out of my way to help someone in trouble	TRUE	FALSE
3.	It is sometimes hard for me to go on with my work if I am not encouraged	TRUE	FALSE
4.	I have never intensely disliked someone	TRUE	FALSE
5.	On occasion I have had doubts about my ability to succeed in life	TRUE	FALSE
6.	I sometimes feel resentful when I don't get my way	TRUE	FALSE
7.	I am always careful about my manner of dress	TRUE	FALSE
8.	My table manners at home are as good as when I eat out at a restaurant	TRUE	FALSE
9.	If I could get into a movie without paying and be sure I was not seen, I would probably do it	TRUE	FALSE
10.	On a few occasions, I have given up doing something because I thought too little of my ability	TRUE	FALSE
11.	I like to gossip at times	TRUE	FALSE
12.	There have been times when I felt like rebelling against people in authority even though I knew they were right	TRUE	FALSE
13.	No matter who I'm talking to, I'm always a good listener	TRUE	FALSE
14.	I can remember 'playing sick' to get out of something	TRUE	FALSE
15.	There have been occasions when I took advantage of someone	TRUE	FALSE
16.	I'm always willing to admit it when I make a mistake	TRUE	FALSE
17.	I always try to practice what I preach	TRUE	FALSE
18.	I don't find it particularly difficult to get along with loud mouthed, obnoxious people	TRUE	FALSE
19.	I sometimes try to get even rather than forgive and forget	TRUE	FALSE
20.	When I don't know something I don't mind at all admitting it	TRUE	FALSE
21.	I am always courteous, even to people who are disagreeable	TRUE	FALSE
22.	At times I have really insisted on having things my own way	TRUE	FALSE
23.	There have been occasions when I felt like smashing things	TRUE	FALSE
24.	I would never think of letting someone else be punished for my wrong-doings	TRUE	FALSE
25.	I never resent being asked to return a favour	TRUE	FALSE
26.	I have never been irked when people expressed ideas very different from my own	TRUE	FALSE
27.	I never make a long trip without checking the safety of my car	TRUE	FALSE
28.	There have been times when I was quite jealous of the good fortune of others	TRUE	FALSE
29.	I have almost never felt the urge to tell someone off	TRUE	FALSE

30.	I am sometimes irritated by people who ask favours of me	TRUE	FALSE
31.	I have never felt that I was punished without cause	TRUE	FALSE
32.	I sometimes think when people have a misfortune they only got what they deserved	TRUE	FALSE
33.	I have never deliberately said something that hurt someone's feelings	TRUE	FALSE

Case Vignettes

Postpartum depression, smothering, re-occurring

Katie is a 30 year old woman who is a high school teacher, although has taken the last two years off work. She is married and has a child, Sam, who is 18 months old and recently gave birth to her second child, Lauren, 8 weeks previously. Katie has a history of depression, beginning in adolescence. She was also diagnosed with post-partum depression, following the birth of Sam. However, the symptoms were noticed early and treated immediately.

Following the birth of her second child, Katie became sad with frequent periods of tearfulness. She also lost weight, felt lethargic, guilty over trivial problems, experienced little pleasure in life and showed little interest in looking after the children. Her partner, John, had noticed small changes in Katie's mood, but had been working overtime, and so was too busy to address any problems.

In the eighth week following the birth of Lauren, Katie had received a phone call from John late in the afternoon, stating that he probably would not be home as he had been asked to work back and had to attend a conference early in the morning. She put the children to bed early and went to bed for an early night herself. However, at 2am in the morning Lauren began screaming. Katie was worried that she would awaken her Sam and quickly ran to attend to her. She tried to settle Lauren down, but she continued to cry for an hour. Katie then placed her back in the crib and placed the pillow over Lauren's face and proceeded to smother her. Afterwards, she rang John and told him he could come home and hung up. John was worried about the phone call and returned home immediately. Katie was sitting silently in the lounge room, refusing to say anything. He called the police upon discovery of Lauren's body.

Katie has been charged (under Infanticide provision OR charged with Murder and wishes to argue the Insanity defence). You, as a jury member, have been asked to provide a verdict.

Postpartum depression, smothering, transient

Katie is a 30 year old woman who is a high school teacher, although has taken the last two years off work. She is married and has a child, Sam, who is 18 months old and recently gave birth to her second child, Lauren, 8 weeks previously. It is stated that Katie has never been diagnosed, or experienced any symptoms of depression previously.

Following the birth of her second child, Katie became sad with frequent periods of tearfulness. She also lost weight, felt lethargic, guilty over trivial

problems, experienced little pleasure in life and showed little interest in looking after the children. Her partner, John, had noticed small changes in Katie's mood, but had been working overtime, and so was too busy to address any problems.

In the eighth week following the birth of Lauren, Katie had received a phone call from John late in the afternoon, stating that he probably would not be home as he had been asked to work back and had to attend a conference early in the morning. She put the children to bed early and went to bed for an early night herself. However, at 2am in the morning Lauren began screaming. Katie was worried that she would awaken her Sam and quickly ran to attend to her. She tried to settle Lauren down, but she continued to cry for an hour. Katie then placed her back in the crib and placed the pillow over Lauren's face and proceeded to smother her. Afterwards, she rang John and told him he could come home and hung up. John was worried about the phone call and returned home immediately. Katie was sitting silently in the lounge room, refusing to say anything. He called the police upon discovery of Lauren's body.

Katie has been charged (under Infanticide provision OR charged with Murder and wishes to argue the Insanity defence). You, as a jury member, have been asked to provide a verdict.

Postpartum psychosis, smothering, re-occurring

Katie is a 30 year old woman who is a high school teacher, although has taken the last two years off work. She is married and has a child, Sam, who is 18 months old and recently gave birth to her second child, Lauren, 8 weeks previously. Katie has a history of psychosis, and experienced some symptoms following the birth of Sam. However, these were noticed early and treated immediately.

Following the birth of her second child, Katie stated repeatedly that she 'just didn't feel right' and that her family would be 'better off without her' to family and friends. It was also noticed that she repeatedly checked on the children and was constantly worried about their health and safety for no apparent reason and always appeared agitated. Katie complained of hearing voices and noises that constantly interrupted her thoughts. This was disregarded as Katie lives in a busy district near a train station. Burns and sores were also noticed on her arms, but as she cooked often, these were disregarded. Her partner, John, had noticed small changes in Katie's mood and behaviour, but had been working overtime, and so was too busy to address any problems.

In the eighth week following the birth of Lauren, Katie had received a phone call from John late in the afternoon, stating that he probably would not be home as he had been asked to work back and had to attend a conference early in the morning. She put the children to bed early and went to bed for an early night herself. However, at 2am in the morning Lauren began screaming. Katie was worried that she would awaken her Sam and quickly ran to attend to her. She tried to settle Lauren down, but she continued to cry for an hour. Katie then placed her back in the crib and placed the pillow over Lauren's face and proceeded to smother her. Afterwards, she rang John and told him he could come home and hung up. John was worried about the phone call and returned home immediately. Katie was sitting silently in the lounge room, refusing to say anything. He called the police upon discovery of Lauren's body.

Katie states that following the birth of her child, Satan repeatedly came to her, telling her that he was going to take her baby and that her child would grow up and destroy the world. In crisis, she turned to God, who ordered her to send Lauren to him, so that he could protect her. Although she was reluctant to do so, she soon believed that this was the only way to save her child and the world.

Katie has been charged (under Infanticide provision OR charged with Murder and wishes to argue the Insanity defence). You, as a jury member, have been asked to provide a verdict.

Postpartum psychosis, smothering, transient

Katie is a 30 year old woman who is a high school teacher, although has taken the last two years off work. She is married and has a child, Sam, who is 18 months old and recently gave birth to her second child, Lauren, 8 weeks previously. It is stated that Katie has never been diagnosed, or experienced any symptoms of psychosis previously.

Following the birth of her second child, Katie stated repeatedly that she 'just didn't feel right' and that her family would be 'better off without her' to family and friends. It was also noticed that she repeatedly checked on the children and was constantly worried about their health and safety for no apparent reason and always appeared agitated. Katie complained of hearing voices and noises that constantly interrupted her thoughts. This was disregarded as Katie lives in a busy district near a train station. Burns and sores were also noticed on her arms, but as she cooked often, these were disregarded. Her partner, John, had noticed small changes in Katie's mood and behaviour, but had been working overtime, and so was too busy to address any problems.

In the eighth week following the birth of Lauren, Katie had received a phone call from John late in the afternoon, stating that he probably would not be home as he had been asked to work back and had to attend a conference early in the morning. She put the children to bed early and went to bed for an early night herself. However, at 2am in the morning Lauren began screaming. Katie was worried that she would awaken her Sam and quickly ran to attend to her. She tried to settle Lauren down, but she continued to cry for an hour. Katie then placed her back in the crib and placed the pillow over Lauren's face and proceeded to smother her. Afterwards, she rang John and told him he could come home and hung up. John was worried about the phone call and returned home immediately. Katie was sitting silently in the lounge room, refusing to say anything. He called the police upon discovery of Lauren's body.

Katie states that following the birth of her child, Satan repeatedly came to her, telling her that he was going to take her baby and that her child would grow up and destroy the world. In crisis, she turned to God, who ordered her to send Lauren to him, so that he could protect her. Although she was reluctant to do so, she soon believed that this was the only way to save her child and the world.

Katie has been charged (under Infanticide provision OR charged with Murder and wishes to argue the Insanity defence). You, as a jury member, have been asked to provide a verdict.

Legal test and Juror Instructions

Infanticide provision – no instructions

In order to decide whether the defendant (Katie) is guilty of Infanticide under section of s165A of the Tasmanian Criminal Code (1924), it must be demonstrated that

> A woman who by any willful act or omission, causes death of her child (being a child under the age of 12 months), and who was at the time not fully recovered from the effect of giving birth to the child, and the balance of her mind being, by reason thereof, disturbed, is guilty of a crime, which is called infanticide, although the offence would, but for this section, have amounted to murder.

Using the above legal principle please reach a verdict as to whether the Katie is guilty or not guilty under the section.

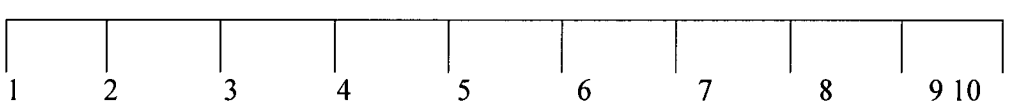
I find the defendant to be (please circle one):

GUILTY (of Infanticide)

GUILTY (of Murder)

NOT-GUILTY

Please rate your confidence in your verdict:



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

Infanticide provision – instructions

In order to decide whether the defendant (Katie) is guilty of Infanticide under section of s165A of the Tasmanian Criminal Code (1924), it must be demonstrated that

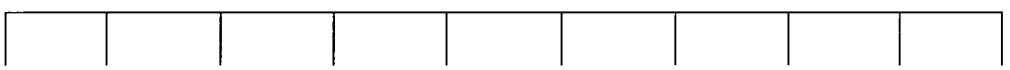
> A woman who by any willful act or omission, causes death of her child (being a child under the age of 12 months), and who was at the time not fully recovered from the effect of giving birth to the child, and the balance of her mind being, by reason thereof, disturbed, is guilty of a crime, which is called

infanticide, although the offence would, but for this section, have amounted to murder.

Using the above legal principle please reach a verdict as to whether the Katie is guilty or not guilty under the section.

In order to do this, please consider the following:

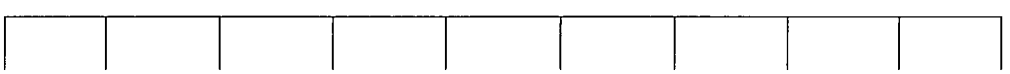
1. Did Katie cause the death of her 8 week old infant, Lauren, by either acting or failing to act?



1 2 3 4 5 6 7 8 9 10

Definitely NO — Don't Know — Definitely YES

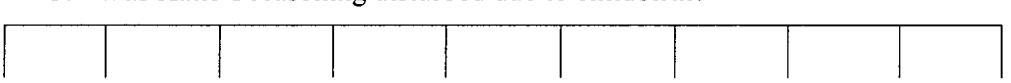
2. Was Katie fully recovered from the effects of giving birth?



1 2 3 4 5 6 7 8 9 10

Definitely NO — Don't Know — Definitely YES

3. Was Katie's reasoning disturbed due to childbirth?



1 2 3 4 5 6 7 8 9 10

Definitely NO — Don't Know — Definitely YES

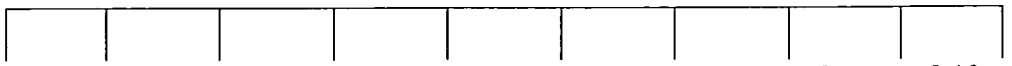
I find the defendant to be (please circle one):

GUILTY (of Infanticide)

GUILTY (of Murder)

NOT-GUILTY

Please rate your confidence in your verdict:



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

Insanity – no instruction

In order to decide whether the defendant (Katie) is not guilty by reason of insanity (NGRI) in regard to the charge of homicide under section of s157 of the Tasmanian Criminal Code (1924), it must be demonstrated that

(1) A person is not criminally responsible for an act done or an omission made by him

(a) when afflicted with mental disease to such an extent as to render him incapable of –

(i) understanding the physical character of such act or omission;

or

(ii) knowing that such act or omission was one which he ought not to do or make;

Using the above legal principle please reach a verdict as to whether the Katie is guilty or not guilty under the section.

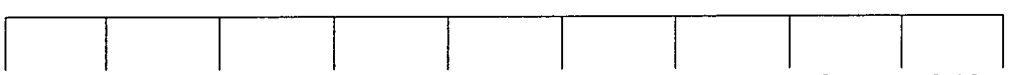
I find the defendant to be (please circle one):

GUILTY

NOT GUILTY

NOT-GUILTY (by reason of insanity)

Please rate your confidence in your verdict:



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

Insanity – instructions

In order to decide whether the defendant (Katie) is not guilty by reason of insanity (NGRI) in regard to the charge of homicide under section of s157 of the Tasmanian Criminal Code (1924), it must be demonstrated that

(1) A person is not criminally responsible for an act done or an omission made by him

(a) when afflicted with mental disease to such an extent as to render him incapable of –

(i) understanding the physical character of such act or omission;

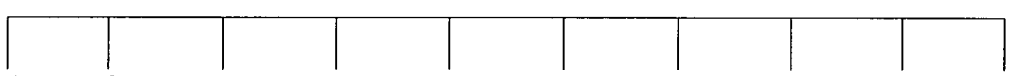
or

(ii) knowing that such act or omission was one which he ought not to do or make;

Using the above legal principle please reach a verdict as to whether the Katie is guilty or not guilty under the section.

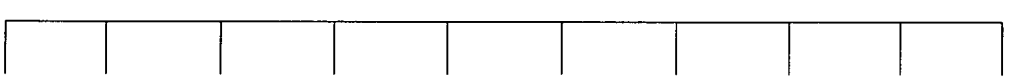
In order to do this, please consider the following:

1. When Katie committed the act (or failed to act) was she suffering from a mental illness?



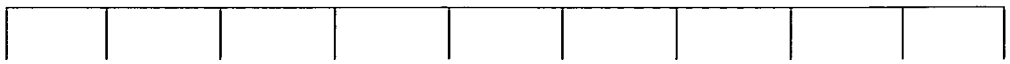
1	2	3	4	5	6	7	8	9 10
Definitely NO				Don't Know				Definitely YES

2. Did Katie understand the physical character of the act, or her failure to act? That is; did she know that her actions would lead to the infants death?



1	2	3	4	5	6	7	8	9 10
Definitely NO				Don't Know				Definitely YES

3. Did she know that her actions (or failure to act) was wrong>



1	2	3	4	5	6	7	8	9 10
Definitely NO				Don't Know				Definitely YES

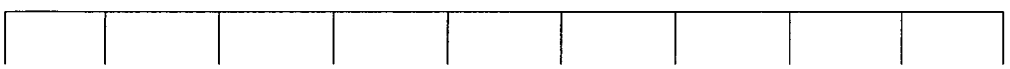
I find the defendant to be (please circle one):

GUILTY

NOT GUILTY

NOT-GUILTY (by reason of insanity)

Please rate your confidence in your verdict:



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

Reformulated insanity – no instructions

In order to decide whether the defendant (Katie) is not guilty by reason of insanity (NGRI) in regard to the charge of homicide under section of s157 of the Tasmanian Criminal Code (1924), it must be demonstrated that

A person is not criminally responsible if at the time of the commission of the offence he or she had a mental impairment which included in its symptoms or consequences a loss of cognitive competency to think of the reasons which people are expected to regard as sufficient grounds for refraining from commission of the offence.

Using the above legal principle please reach a verdict as to whether the Katie is guilty or not guilty under the section.

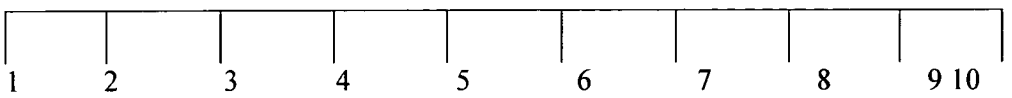
I find the defendant to be (please circle one):

GUILTY

NOT GUILTY

NOT-GUILTY (by reason of insanity)

Please rate your confidence in your verdict:



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

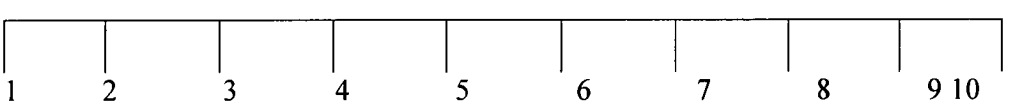
Reformulated insanity – instructions

In order to decide whether the defendant (Katie) is not guilty by reason of insanity (NGRI) in regard to the charge of homicide under section of s157 of the Tasmanian Criminal Code (1924), it must be demonstrated that

> A person is not criminally responsible if at the time of the commission of the offence he or she had a mental impairment which included in its symptoms or consequences a loss of cognitive competency to think of the reasons which people are expected to regard as sufficient grounds for refraining from commission of the offence.

Using the above legal principle please reach a verdict as to whether the Katie is guilty or not guilty under the section. In order to do this, please consider the following:

1. Was Katie suffering from a mental impairment at the time of the homicide?



1	2	3	4	5	6	7	8	9 10
Definitely NO				Don't Know				Definitely YES

2. Did a mental impairment (including its symptoms, or consequences of its symptoms) affect her ability to make decisions?

1	2	3	4	5	6	7	8	9 10
Definitely NO				Don't Know				Definitely YES

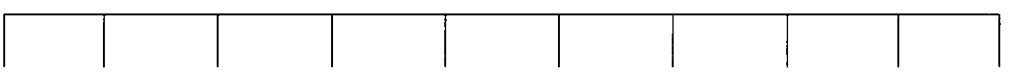
I find the defendant to be (please circle one):

GUILTY

NOT GUILTY

NOT-GUILTY (by reason of insanity)

Please rate your confidence in your verdict:

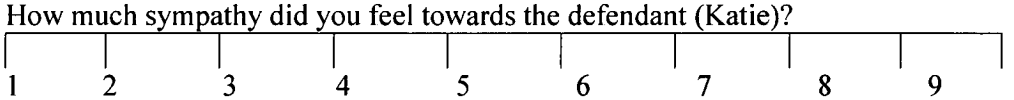


1	2	3	4	5	6	7	8	9 10
Not at all Confident				Neutral			Extremely Confident	

Post-Experimental Questionnaire

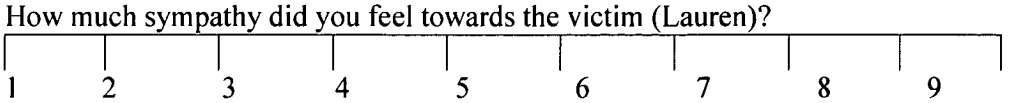
Please answer the following questions:

How much sympathy did you feel towards the defendant (Katie)?



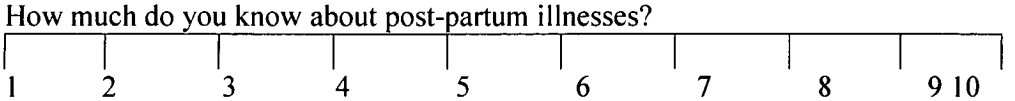
1	2	3	4	5	6	7	8	9	10
None				Neutral				Extremely Sympathetic	

How much sympathy did you feel towards the victim (Lauren)?



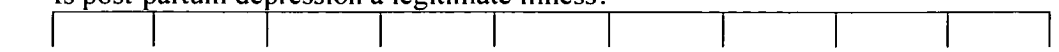
1	2	3	4	5	6	7	8	9	10
None				Neutral				Extremely Sympathetic	

How much do you know about post-partum illnesses?



1	2	3	4	5	6	7	8	9 10
Very little or none				Some Information				A lot

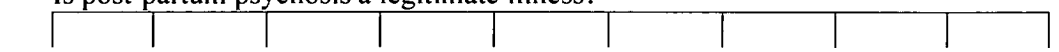
Is post-partum depression a legitimate illness?



1 2 3 4 5 6 7 8 9 10

Definitely No — Neutral — Definitely Yes

Is post-partum psychosis a legitimate illness?



1 2 3 4 5 6 7 8 9 10

Definitely No — Neutral — Definitely Yes

Appendix B: Participation Advertisement and Information Sheet

WOULD YOU LIKE TO BE A JUROR?

I am looking for participants who would be willing to give up ½ an hour of their time for a Psychology Masters study.

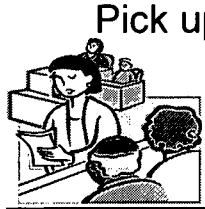
Participation involves filling out questionnaires and deliberating, as an individual, on the guilt of a defendant who is charged with the murder of her child and wishes to argue a defence to the charge.

Participants will receive ½ hour research credit for their participation

Might be interested? Please contact me for more information: Heidi (hdgordon@utas.edu.au)

OR

Pick up and return a questionnaire package located outside Sue's office (Rm 110) in the School of Psychology.



Ethics approval number: H10193

Heidi:
hdgordon@utas.edu.au
Heidi:
hdgordon@utas.edu.au
Heidi:
hdgordon@utas.edu.au
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hdgordon@utas.edu.au
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hdgordon@utas.edu.au
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hdgordon@utas.edu.au
Heidi:
hdgordon@utas.edu.au
Heidi:
hdgordon@utas.edu.au
Heidi:
hdgordon@utas.edu.au

22nd June, 2008

Private Bag 30 Hobart
Tasmania Australia 7001
Phone (03) 6226 2237
Fax (03) 6226 2883

SCHOOL OF PSYCHOLOGY

Mock juror's assessment of infanticide and insanity
Peter Ball (Chief Investigator, School of Psychology)
Heidi Gordon (Student Investigator)

We would like to invite your participation to investigate people's thinking about women who are charged with the murder of their child. This research project is being undertaken as part of Heidi Gordon's Masters Degree in Clinical Psychology.

The purpose of this research is to investigate the decision-making process when jurors deliberate about a mothers' innocence/guilt, when charged with the murder of her child. Participation involves completing a questionnaire package. You will also be asked to read a short account of a fictional case (based on a number of actual cases) concerning a mother and the death of her child. You will be asked to record a verdict regarding the defendant's innocence/guilt and perceptions of postpartum illnesses following childbirth. It is estimated that all this should take approximately 30 minutes.

It is important to understand that your involvement in this study is voluntary. While we would be pleased to have you participate, we respect your right to decline. There will be no adverse consequences to you if you decide not to participate. If you decide to discontinue participation at any time, you may do so without providing an explanation. All information will be treated in a confidential manner and as the questionnaires are completed anonymously, it will not be possible to use your name in any publication arising out of the research. All of the research will be kept in lockable storage in the School of Psychology at the University of Tasmania, for a period of at least five years, as required by the National Health and Medical Research Council.

There are no foreseeable risks anticipated with participation in this study. Should you have any concerns or questions you are able to contact the researchers. If you would like to discuss any aspect of this study, please feel free to contact the researchers. We will be happy to discuss any aspect of the research with you. Once we have analysed the information obtained, a summary of our findings will be made available on request, after the 30th November, 2009. You are welcome to contact us at that time to discuss any issue relating to the research study.

This study has been approved by the Tasmanian Social Science Human Research Ethics Committee. If you have concerns or complaints about the conduct of this study you should contact the Executive Officer of the HREC (Tasmania) Network on (03) 6226 7479 or email human.ethics@utas.edu.au. The Executive

Officer is the person nominated to receive complaints from research participants. You will need to quote H10193.

Thank you for taking the time to consider this study. Your consent to participate will be indicated simply by returning a complete questionnaire package. This information sheet is for you to keep.

Peter Ball (Chief Investigator): P.Ball@utas.edu.au
Heidi Gordon (Student Investigator): hdgordon@utas.edu.au

Appendix C: SPSS Data Output

Factor Analysis

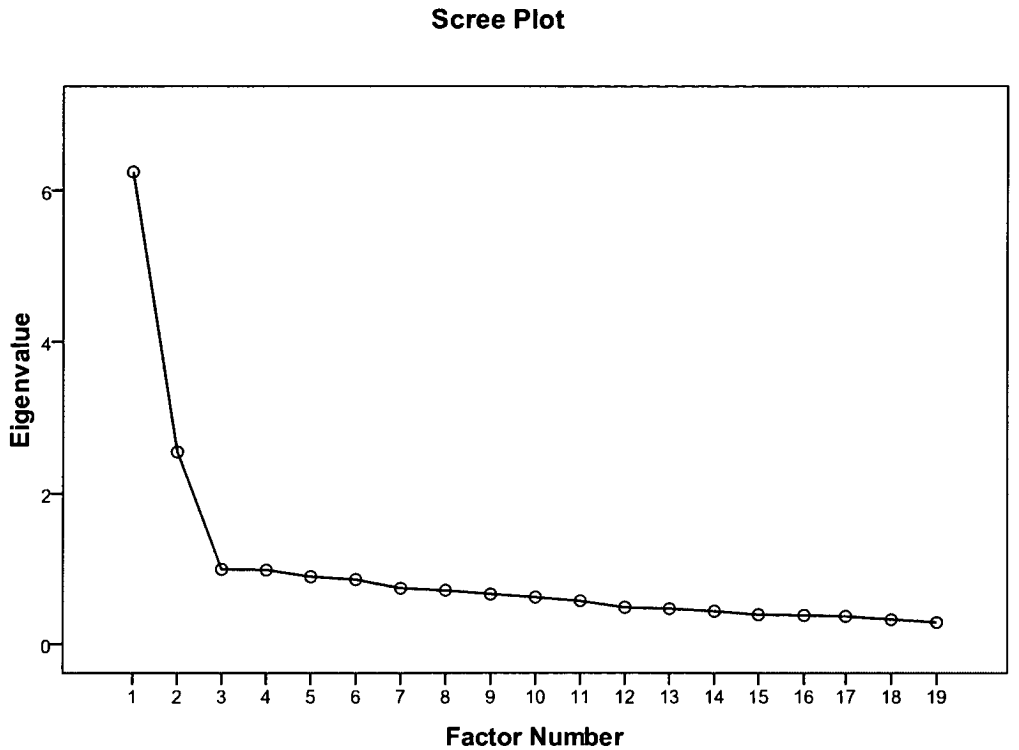
KMO and Bartlett's Test

Kaiser-Meyer-Olkin Measure of Sampling Adequacy.		.913
Bartlett's Test of Sphericity	Approx. Chi-Square	3011.325
	df	171
	Sig.	.000

Total Variance Explained

	Initial Eigenvalues			Extraction Sums of Squared Loadings			Rotation Sums of Squared Loadings		
Factor	Total	% of Variance	Cumulative %	Total	% of Variance	Cumulative %	Total	% of Variance	Cumulative %
1	6.246	32.872	32.872	5.711	30.059	30.059	3.913	20.593	20.593
2	2.550	13.422	46.294	2.002	10.537	40.596	3.801	20.003	40.596
3	.995	5.237	51.531						
4	.985	5.183	56.714						
5	.897	4.720	61.435						
6	.858	4.518	65.952						
7	.742	3.907	69.860						
8	.715	3.765	73.625						
9	.665	3.501	77.126						
10	.624	3.284	80.410						
11	.575	3.028	83.438						
12	.487	2.566	86.003						
13	.470	2.474	88.478						
14	.437	2.297	90.775						
15	.390	2.051	92.826						
16	.383	2.014	94.840						
17	.369	1.945	96.785						
18	.325	1.709	98.494						
19	.286	1.506	100.000						

Extraction Method: Principal Axis Factoring.



Factor Matrix[a]

	Factor	
	1	2
1.1	.585	-.341
1.2	.489	.258
1.3	-.296	.229
1.4	.472	-.269
1.5	-.409	.297
1.6	.627	.216
1.7	-.291	.263
1.8	.665	.209
1.9	.711	-.225
1.10	.513	.509
1.11	.771	-.251
1.12	.492	.563
1.13	.682	.297
1.14	.651	-.408
1.15	-.480	.312

1.16	-.388	-.149
1.17	-.502	.387
1.18	.489	.176
1.19	.605	.448

Extraction Method: Principal Axis Factoring.

a. 2 factors extracted. 5 iterations required.

Rotated Factor Matrix[a]

	Factor	
	1	2
1.1	.182	.652
1.2	.530	.155
1.3	-.053	-.371
1.4	.151	.522
1.5	-.087	-.498
1.6	.600	.282
1.7	-.025	-.392
1.8	.623	.313
1.9	.353	.657
1.10	.723	-.008
1.11	.378	.717
1.12	.745	-.062
1.13	.697	.262
1.14	.183	.746
1.15	-.128	-.558
1.16	-.382	-.163
1.17	-.090	-.627
1.18	.474	.214
1.19	.746	.100

Extraction Method: Principal Axis Factoring.

Rotation Method: Varimax with Kaiser Normalization.

Rotated Factor Matrix[a]

	Factor	
	1	2
1.1	.182	.652
1.2	.530	.155
1.3	-.053	-.371
1.4	.151	.522
1.5	-.087	-.498
1.6	.600	.282
1.7	-.025	-.392
1.8	.623	.313
1.9	.353	.657
1.10	.723	-.008
1.11	.378	.717
1.12	.745	-.062
1.13	.697	.262
1.14	.183	.746
1.15	-.128	-.558
1.16	-.382	-.163
1.17	-.090	-.627
1.18	.474	.214
1.19	.746	.100

Extraction Method: Principal Axis Factoring.

Rotation Method: Varimax with Kaiser Normalization.

a. Rotation converged in 3 iterations.

M-C SDS Scores

Descriptives

SocDes score

	N	Mean	Std. Deviation	Std. Error	95% Confidence Interval for Mean	Minimum	Maximum

					Lower Bound	Upper Bound		
female	333	15.91	5.454	.299	15.33	16.50	4	32
male	101	14.20	5.004	.498	13.21	15.19	3	29
Total	434	15.51	5.396	.259	15.00	16.02	3	32

ANOVA

SocDes score

	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	227.903	1	227.903	7.954	.005
Within Groups	12378.514	432	28.654		
Total	12606.417	433			

IDA-R

Descriptives

		N	Mean	Std. Deviation	Std. Error	95% Confidence Interval for Mean		Minimum	Maximum
						Lower Bound	Upper Bound		
Total	female	333	58.245	7.5943	.4162	57.426	59.063	37.0	78.0
	male	101	58.584	7.3147	.7278	57.140	60.028	40.0	76.0
	Total	434	58.324	7.5232	.3611	57.614	59.034	37.0	78.0
Inj & dan	female	333	27.980	5.7490	.3150	27.361	28.600	12.0	42.0
	male	101	28.079	5.8850	.5856	26.917	29.241	14.0	44.0
	Total	434	28.003	5.7743	.2772	27.459	28.548	12.0	44.0
Str Liability	female	333	30.264	3.2465	.1779	29.914	30.614	21.0	41.0
	male	101	30.505	3.4860	.3469	29.817	31.193	20.0	39.0
	Total	434	30.320	3.3013	.1585	30.009	30.632	20.0	41.0

ANOVA

		Sum of Squares	df	Mean Square	F	Sig.
Total	Between Groups	8.928	1	8.928	.157	.692

	Within Groups	24498.338	432	56.709		
	Total	24507.266	433			
Inj & dan	Between Groups	.755	1	.755	.023	.881
	Within Groups	14436.489	432	33.418		
	Total	14437.245	433			
Str Liability	Between Groups	4.489	1	4.489	.411	.522
	Within Groups	4714.492	432	10.913		
	Total	4718.982	433			

Log-linear

Data Information

		N
Cases	Valid	432
	Out of Range[a]	0
	Missing	1
	Weighted Valid	432
Categories	Illness	2
	Trans/reoc	2
	Law	3
	Instruc	2
	high/ low idar	2
	verdict2	3

a. Cases rejected because of out of range factor values.

Cell Counts and Residuals

Illness	Trans/reoc	Law	Instruc	high / low idar	verdict 2	Observed Count[a]	Observed %	Expected Count	Expected %	Residuals	Std. Residuals
Depression	Transient	Infanticide	yes	high >60	inf, insri	9.500	2.2%	9.500	2.2%	.000	.000
					murder	1.500	.3%	1.500	.3%	.000	.000
					not guilty	.500	.1%	.500	.1%	.000	.000

Cell Counts and Residuals

Illness	Trans/reoc	Law	Instruc	high / low idar	verdict 2	Observed Count [a]	Observed %	Expected Count	Expected %	Residuals	Std. Residuals
Depression	Transient	Infanticide	yes	high >60	inf, ins, ri	9.500	2.2%	9.500	2.2%	.000	.000
					murder	1.500	.3%	1.500	.3%	.000	.000
				low <=60	inf, ins, ri	4.500	1.0%	4.500	1.0%	.000	.000
					murder	2.500	.6%	2.500	.6%	.000	.000
					not guilty	1.500	.3%	1.500	.3%	.000	.000
			no	high >60	inf, ins, ri	2.500	.6%	2.500	.6%	.000	.000
					murder	2.500	.6%	2.500	.6%	.000	.000
					not guilty	1.500	.3%	1.500	.3%	.000	.000
				low <=60	inf, ins, ri	8.500	2.0%	8.500	2.0%	.000	.000
					murder	5.500	1.3%	5.500	1.3%	.000	.000
					not guilty	1.500	.3%	1.500	.3%	.000	.000
		Legal insanity	yes	high >60	inf, ins, ri	1.500	.3%	1.500	.3%	.000	.000
					murder	4.500	1.0%	4.500	1.0%	.000	.000
					not guilty	1.500	.3%	1.500	.3%	.000	.000
				low <=60	inf, ins, ri	6.500	1.5%	6.500	1.5%	.000	.000
					murder	6.500	1.5%	6.500	1.5%	.000	.000
					not guilty	.500	.1%	.500	.1%	.000	.000
			no	high >60	inf, ins, ri	1.500	.3%	1.500	.3%	.000	.000
					murder	3.500	.8%	3.500	.8%	.000	.000
					not guilty	.500	.1%	.500	.1%	.000	.000

Cell Counts and Residuals

Illness	Trans/reoc	Law	Instruc	high / low idar	verdict 2	Observed Count [a]	Observed %	Expected Count	Expected %	Residuals	Std. Residuals
Depression	Transient	Infanticide	yes	high >60	inf, ins, ri	9.500	2.2%	9.500	2.2%	.000	.000
					murder	1.500	.3%	1.500	.3%	.000	.000
				low <=60	inf, ins, ri	4.500	1.0%	4.500	1.0%	.000	.000
					murder	9.500	2.2%	9.500	2.2%	.000	.000
					not guilty	.500	.1%	.500	.1%	.000	.000
		reformulated insanity	yes	high >60	inf, ins, ri	.500	.1%	.500	.1%	.000	.000
					murder	6.500	1.5%	6.500	1.5%	.000	.000
					not guilty	.500	.1%	.500	.1%	.000	.000
				low <=60	inf, ins, ri	10.500	2.4%	10.500	2.4%	.000	.000
					murder	3.500	.8%	3.500	.8%	.000	.000
					not guilty	.500	.1%	.500	.1%	.000	.000
			no	high >60	inf, ins, ri	2.500	.6%	2.500	.6%	.000	.000
					murder	5.500	1.3%	5.500	1.3%	.000	.000
					not guilty	.500	.1%	.500	.1%	.000	.000
				low <=60	inf, ins, ri	6.500	1.5%	6.500	1.5%	.000	.000
					murder	4.500	1.0%	4.500	1.0%	.000	.000
					not guilty	.500	.1%	.500	.1%	.000	.000
	Reoccuring	Infanticide	yes	high >60	inf, ins, ri	9.500	2.2%	9.500	2.2%	.000	.000
					murder	.500	.1%	.500	.1%	.000	.000

Cell Counts and Residuals

Illness	Trans/reoc	Law	Instruc	high / low idar	verdict 2	Observed Count [a]	Observed %	Expected Count	Expected %	Residuals	Std. Residuals
Depression	Transient	Infanticide	yes	high >60	inf, ins, ri	9.500	2.2%	9.500	2.2%	.000	.000
					murder	1.500	.3%	1.500	.3%	.000	.000
					not guiltv	.500	.1%	.500	.1%	.000	.000
				low <=60	inf, ins, ri	9.500	2.2%	9.500	2.2%	.000	.000
					murder	.500	.1%	.500	.1%	.000	.000
					not guiltv	1.500	.3%	1.500	.3%	.000	.000
			no	high >60	inf, ins, ri	6.500	1.5%	6.500	1.5%	.000	.000
					murder	.500	.1%	.500	.1%	.000	.000
					not guiltv	.500	.1%	.500	.1%	.000	.000
				low <=60	inf, ins, ri	9.500	2.2%	9.500	2.2%	.000	.000
					murder	1.500	.3%	1.500	.3%	.000	.000
					not guiltv	2.500	.6%	2.500	.6%	.000	.000
		Legal insanity	yes	high >60	inf, ins, ri	3.500	.8%	3.500	.8%	.000	.000
					murder	2.500	.6%	2.500	.6%	.000	.000
					not guiltv	.500	.1%	.500	.1%	.000	.000
				low <=60	inf, ins, ri	6.500	1.5%	6.500	1.5%	.000	.000
					murder	6.500	1.5%	6.500	1.5%	.000	.000
					not guiltv	.500	.1%	.500	.1%	.000	.000
			no	high >60	inf, ins, ri	1.500	.3%	1.500	.3%	.000	.000
					murder	6.500	1.5%	6.500	1.5%	.000	.000

Cell Counts and Residuals

Illness	Trans/reoc	Law	Instruc	high / low idar	verdict 2	Observed Count [a]	Observed %	Expected Count	Expected %	Residuals	Std. Residuals
Depression	Transient	Infanticide	yes	high >60	inf, ins, ri	9.500	2.2%	9.500	2.2%	.000	.000
					murder	1.500	.3%	1.500	.3%	.000	.000
					not guiltv	.500	.1%	.500	.1%	.000	.000
				low <=60	inf, ins, ri	2.500	.6%	2.500	.6%	.000	.000
					murder	9.500	2.2%	9.500	2.2%	.000	.000
					not guiltv	.500	.1%	.500	.1%	.000	.000
		reformulated insanity	yes	high >60	inf, ins, ri	2.500	.6%	2.500	.6%	.000	.000
					murder	4.500	1.0%	4.500	1.0%	.000	.000
					not guiltv	.500	.1%	.500	.1%	.000	.000
				low <=60	inf, ins, ri	6.500	1.5%	6.500	1.5%	.000	.000
					murder	8.500	2.0%	8.500	2.0%	.000	.000
					not guiltv	.500	.1%	.500	.1%	.000	.000
			no	high >60	inf, ins, ri	.500	.1%	.500	.1%	.000	.000
					murder	6.500	1.5%	6.500	1.5%	.000	.000
					not guiltv	.500	.1%	.500	.1%	.000	.000
				low <=60	inf, ins, ri	5.500	1.3%	5.500	1.3%	.000	.000
					murder	8.500	2.0%	8.500	2.0%	.000	.000
					not guilty	.500	.1%	.500	.1%	.000	.000

Cell Counts and Residuals

Illness	Trans/reoc	Law	Instruc	high / low idar	verdict 2	Observed Count [a]	Observed %	Expected Count	Expected %	Residuals	Std. Residuals
Depression	Transient	Infanticide	yes	high >60	inf, insanity	9.500	2.2%	9.500	2.2%	.000	.000
					murder	1.500	.3%	1.500	.3%	.000	.000
Psychosis	Transient	Infanticide	yes	high >60	inf, insanity	7.500	1.7%	7.500	1.7%	.000	.000
					murder	3.500	.8%	3.500	.8%	.000	.000
					not guilty	.500	.1%	.500	.1%	.000	.000
				low <=60	inf, insanity	5.500	1.3%	5.500	1.3%	.000	.000
					murder	2.500	.6%	2.500	.6%	.000	.000
					not guilty	.500	.1%	.500	.1%	.000	.000
			no	high >60	inf, insanity	5.500	1.3%	5.500	1.3%	.000	.000
					murder	1.500	.3%	1.500	.3%	.000	.000
					not guilty	.500	.1%	.500	.1%	.000	.000
				low <=60	inf, insanity	9.500	2.2%	9.500	2.2%	.000	.000
					murder	.500	.1%	.500	.1%	.000	.000
					not guilty	2.500	.6%	2.500	.6%	.000	.000
		Legal insanity	yes	high >60	inf, insanity	1.500	.3%	1.500	.3%	.000	.000
					murder	2.500	.6%	2.500	.6%	.000	.000
					not guilty	.500	.1%	.500	.1%	.000	.000
				low <=60	inf, insanity	8.500	2.0%	8.500	2.0%	.000	.000
					murder	4.500	1.0%	4.500	1.0%	.000	.000
					not guilty	.500	.1%	.500	.1%	.000	.000
			no	high	inf, insanity	4.500	1.0%	4.500	1.0%	.000	.000

Cell Counts and Residuals

Illness	Trans/reoc	Law	Instruc	high / low idar	verdict 2	Observed Count [a]	Observed %	Expected Count	Expected %	Residuals	Std. Residuals
Depression	Transient	Infanticide	yes	high >60	inf, ins, ri	9.500	2.2%	9.500	2.2%	.000	.000
					murder	1.500	.3%	1.500	.3%	.000	.000
				>60	murder	7.500	1.7%	7.500	1.7%	.000	.000
					not guilty	1.500	.3%	1.500	.3%	.000	.000
				low <=60	inf, ins, ri	5.500	1.3%	5.500	1.3%	.000	.000
					murder	4.500	1.0%	4.500	1.0%	.000	.000
					not guilty	.500	.1%	.500	.1%	.000	.000
		reformulated insanity	yes	high >60	inf, ins, ri	3.500	.8%	3.500	.8%	.000	.000
					murder	4.500	1.0%	4.500	1.0%	.000	.000
					not guilty	.500	.1%	.500	.1%	.000	.000
				low <=60	inf, ins, ri	9.500	2.2%	9.500	2.2%	.000	.000
					murder	2.500	.6%	2.500	.6%	.000	.000
					not guilty	.500	.1%	.500	.1%	.000	.000
			no	high >60	inf, ins, ri	6.500	1.5%	6.500	1.5%	.000	.000
					murder	3.500	.8%	3.500	.8%	.000	.000
					not guilty	.500	.1%	.500	.1%	.000	.000
				low <=60	inf, ins, ri	8.500	2.0%	8.500	2.0%	.000	.000
					murder	2.500	.6%	2.500	.6%	.000	.000
					not guilty	.500	.1%	.500	.1%	.000	.000
	Reoccurin	Infanticide	yes	high	inf, ins, ri	6.500	1.5%	6.500	1.5%	.000	.000

Cell Counts and Residuals

Illness	Trans/reoc	Law	Instruc	high / low idar	verdict 2	Observed Count [a]	Observed %	Expected Count	Expected %	Residuals	Std. Residuals
Depression	Transient	Infanticide	yes	high >60	inf, ins, ri	9.500	2.2%	9.500	2.2%	.000	.000
					murder	1.500	.3%	1.500	.3%	.000	.000
	g			>60	murder	.500	.1%	.500	.1%	.000	.000
					not guilty	.500	.1%	.500	.1%	.000	.000
				low <=60	inf, ins, ri	7.500	1.7%	7.500	1.7%	.000	.000
					murder	1.500	.3%	1.500	.3%	.000	.000
					not guilty	1.500	.3%	1.500	.3%	.000	.000
			no	high >60	inf, ins, ri	4.500	1.0%	4.500	1.0%	.000	.000
					murder	1.500	.3%	1.500	.3%	.000	.000
					not guilty	.500	.1%	.500	.1%	.000	.000
				low <=60	inf, ins, ri	9.500	2.2%	9.500	2.2%	.000	.000
					murder	.500	.1%	.500	.1%	.000	.000
					not guilty	1.500	.3%	1.500	.3%	.000	.000
		Legal insanity	yes	high >60	inf, ins, ri	3.500	.8%	3.500	.8%	.000	.000
					murder	3.500	.8%	3.500	.8%	.000	.000
					not guilty	.500	.1%	.500	.1%	.000	.000
				low <=60	inf, ins, ri	9.500	2.2%	9.500	2.2%	.000	.000
					murder	3.500	.8%	3.500	.8%	.000	.000
					not guilty	.500	.1%	.500	.1%	.000	.000
			no	high >60	inf, ins, ri	7.500	1.7%	7.500	1.7%	.000	.000
					murder	4.500	1.0%	4.500	1.0%	.000	.000

Cell Counts and Residuals

Illness	Trans/reoc	Law	Instruc	high / low idar	verdict 2	Observed Count [a]	Observed %	Expected Count	Expected %	Residuals	Std. Residuals
Depression	Transient	Infanticide	yes	high >60	inf, ins, ri	9.500	2.2%	9.500	2.2%	.000	.000
					murder	1.500	.3%	1.500	.3%	.000	.000
					not guilty	.500	.1%	.500	.1%	.000	.000
				low <=60	inf, ins, ri	8.500	2.0%	8.500	2.0%	.000	.000
					murder	3.500	.8%	3.500	.8%	.000	.000
					not guilty	1.500	.3%	1.500	.3%	.000	.000
		reformulated insanity	yes	high >60	inf, ins, ri	3.500	.8%	3.500	.8%	.000	.000
					murder	3.500	.8%	3.500	.8%	.000	.000
					not guilty	.500	.1%	.500	.1%	.000	.000
				low <=60	inf, ins, ri	11.500	2.7%	11.500	2.7%	.000	.000
					murder	.500	.1%	.500	.1%	.000	.000
					not guilty	.500	.1%	.500	.1%	.000	.000
			no	high >60	inf, ins, ri	3.500	.8%	3.500	.8%	.000	.000
					murder	4.500	1.0%	4.500	1.0%	.000	.000
					not guilty	.500	.1%	.500	.1%	.000	.000
				low <=60	inf, ins, ri	6.500	1.5%	6.500	1.5%	.000	.000
					murder	6.500	1.5%	6.500	1.5%	.000	.000
					not guilty	.500	.1%	.500	.1%	.000	.000

a. For saturated models, .500 has been added to all observed cells.

Goodness-of-Fit Tests

	Chi-Square	df	Sig.
Likelihood Ratio	.000	0	.
Pearson	.000	0	.

K-Way and Higher-Order Effects

	K	df	Likelihood Ratio		Pearson		Number of Iterations
			Chi-Square	Sig.	Chi-Square	Sig.	
K-way and Higher Order Effects[a]	1	143	506.104	.000	449.333	.000	0
	2	135	207.490	.000	188.161	.002	2
	3	109	99.947	.721	118.115	.259	5
	4	65	43.191	.983	39.485	.995	6
	5	24	14.043	.946	11.138	.988	5
	6	4	3.463	.484	2.447	.654	5
K-way Effects[b]	1	8	298.614	.000	261.172	.000	0
	2	26	107.542	.000	70.046	.000	0
	3	44	56.756	.094	78.630	.001	0
	4	41	29.148	.917	28.347	.933	0
	5	20	10.580	.956	8.691	.986	0
	6	4	3.463	.484	2.447	.654	0

df used for these tests have NOT been adjusted for structural or sampling zeros. Tests using these df may be conservative.

a. Tests that k-way and higher order effects are zero.

b. Tests that k-way effects are zero.

Partial Associations

Effect	df	Partial Chi-Square	Sig.	Number of Iterations
Illness*Transreoc*Law*Instruc*highlow	2	2.279	.320	4
Illness*Transreoc*Law*Instruc*verdict2	4	1.962	.743	6
Illness*Transreoc*Law*highlow*verdict2	4	.551	.968	5
Illness*Transreoc*Instruc*highlow*verdict2	2	3.986	.136	3

Illness*Law*Instruc*highlow*verdict2	4	.715	.949	5
Transreoc*Law*Instruc*highlow*verdict2	4	.244	.993	6
Illness*Transreoc*Law*Instruc	2	.543	.762	5
Illness*Transreoc*Law*highlow	2	.066	.967	5
Illness*Transreoc*Instruc*highlow	1	.948	.330	6
Illness*Law*Instruc*highlow	2	2.236	.327	6
Transreoc*Law*Instruc*highlow	2	3.661	.160	5
Illness*Transreoc*Law*verdict2	4	4.671	.323	5
Illness*Transreoc*Instruc*verdict2	2	1.630	.443	5
Illness*Law*Instruc*verdict2	4	6.766	.149	4
Transreoc*Law*Instruc*verdict2	4	1.606	.808	6
Illness*Transreoc*highlow*verdict2	2	.874	.646	5
Illness*Law*highlow*verdict2	4	3.845	.427	5
Transreoc*Law*highlow*verdict2	4	.625	.960	5
Illness*Instruc*highlow*verdict2	2	.228	.892	6
Transreoc*Instruc*highlow*verdict2	2	.876	.645	5
Law*Instruc*highlow*verdict2	4	7.058	.133	4
Illness*Transreoc*Law	2	.549	.760	6
Illness*Transreoc*Instruc	1	.047	.829	6
Illness*Law*Instruc	2	2.638	.267	5
Transreoc*Law*Instruc	2	.078	.962	6
Illness*Transreoc*highlow	1	.739	.390	5
Illness*Law*highlow	2	1.176	.555	5
Transreoc*Law*highlow	2	3.124	.210	5
Illness*Instruc*highlow	1	1.739	.187	5
Transreoc*Instruc*highlow	1	.184	.668	5
Law*Instruc*highlow	2	6.249	.044	5
Illness*Transreoc*verdict2	2	.269	.874	5
Illness*Law*verdict2	4	3.328	.505	5
Transreoc*Law*verdict2	4	15.332	.004	5
Illness*Instruc*verdict2	2	4.286	.117	5

Transreoc*Instruc*verdict2	2	1.538	.463	6
Law*Instruc*verdict2	4	.634	.959	5
Illness*highlow*verdict2	2	2.653	.265	5
Transreoc*highlow*verdict2	2	6.481	.039	5
Law*highlow*verdict2	4	14.784	.005	4
Instruc*highlow*verdict2	2	.555	.758	5
Illness*Transreoc	1	.146	.703	5
Illness*Law	2	5.805	.055	4
Transreoc*Law	2	.504	.777	5
Illness*Instruc	1	1.506	.220	5
Transreoc*Instruc	1	.013	.908	5
Law*Instruc	2	.283	.868	5
Illness*highlow	1	3.685	.055	5
Transreoc*highlow	1	.226	.635	5
Law*highlow	2	5.119	.077	5
Instruc*highlow	1	.066	.798	5
Illness*verdict2	2	20.894	.000	4
Transreoc*verdict2	2	1.023	.600	5
Law*verdict2	4	72.366	.000	4
Instruc*verdict2	2	7.062	.029	5
highlow*verdict2	2	12.166	.002	5
Illness	1	.037	.847	2
Transreoc	1	.037	.847	2
Law	2	.518	.772	2
Instruc	1	.333	.564	2
highlow	1	24.312	.000	2
verdict2	2	273.376	.000	2

Sex: IDA-R x Verdict

Crosstabs

Sex = female

Case Processing Summary[a]

	Cases					
	Valid		Missing		Total	
	N	Percent	N	Percent	N	Percent
high/ low idar * Verdict	332	100.0%	0	.0%	332	100.0%

a. Sex = female

high/ low idar * Verdict Crosstabulation[a]

Count

		Verdict					
		Infanticide	Reform Insanity	Insanity	Murder	Not Guilty	Total
high/ low idar	high >60	35	15	16	54	1	121
	low <=60	49	47	35	71	9	211
Total		84	62	51	125	10	332

a. Sex = female

Chi-Square Tests[b]

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	11.055[a]	4	.026
Likelihood Ratio	11.912	4	.018
Linear-by-Linear Association	.031	1	.860
N of Valid Cases	332		

a. 1 cells (10.0%) have expected count less than 5. The minimum expected count is 3.64.

b. Sex = female

Directional Measures[d]

			Value	Asymp. Std. Error[a]	Approx. T	Approx. Sig.
Nominal by Nominal	Lambda	Symmetric	.000	.000	.[b]	.[b]
		high/ low idar Dependent	.000	.000	.[b]	.[b]
		Verdict Dependent	.000	.000	.[b]	.[b]

	Goodman and Kruskal tau	high/ low idar Dependent	.033	.017		.026[c]
		Verdict Dependent	.009	.005		.022[c]

a. Not assuming the null hypothesis.

b. Cannot be computed because the asymptotic standard error equals zero.

c. Based on chi-square approximation

d. Sex = female

Symmetric Measures[a]

		Value	Approx. Sig.
Nominal by Nominal	Phi	.182	.026
	Cramer's V	.182	.026
	Contingency Coefficient	.180	.026
N of Valid Cases		332	

a. Sex = female

Sex = male

Case Processing Summary[a]

	Cases					
	Valid		Missing		Total	
	N	Percent	N	Percent	N	Percent
high/ low idar * Verdict	101	100.0%	0	.0%	101	100.0%

a. Sex = male

high/ low idar * Verdict Crosstabulation[a]

Count

		Verdict					
		Infanticide	Reform Insanity	Insanity	Murder	Not Guilty	Total
high/ low idar	high >60	13	4	5	20	2	44
	low <=60	12	14	13	17	1	57
Total		25	18	18	37	3	101

a. Sex = male

Chi-Square Tests[b]

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	8.190[a]	4	.085
Likelihood Ratio	8.512	4	.075
Linear-by-Linear Association	.599	1	.439
N of Valid Cases	101		

a. 2 cells (20.0%) have expected count less than 5. The minimum expected count is 1.31.

b. Sex = male

Directional Measures[e]

			Value	Asymp. Std. Error[a]	Approx. T[b]	Approx. Sig.
Nominal by Nominal	Lambda	Symmetric	.046	.073	.621	.534
		high/ low idar Dependent	.114	.173	.621	.534
		Verdict Dependent	.000	.000	[c]	[c]
	Goodman and Kruskal tau	high/ low idar Dependent	.081	.052		.088[d]
		Verdict Dependent	.023	.016		.056[d]

a. Not assuming the null hypothesis.

b. Using the asymptotic standard error assuming the null hypothesis.

c. Cannot be computed because the asymptotic standard error equals zero.

d. Based on chi-square approximation

e. Sex = male

Symmetric Measures[a]

		Value	Approx. Sig.
Nominal by Nominal	Phi	.285	.085
	Cramer's V	.285	.085
	Contingency Coefficient	.274	.085
N of Valid Cases		101	

a. Sex = male

Sex: Illness x Verdict

Crosstabs

Case Processing Summary

Sex		Cases					
		Valid		Missing		Total	
		N	Percent	N	Percent	N	Percent
female	Illness * Verdict	332	100.0%	0	.0%	332	100.0%
male	Illness * Verdict	101	100.0%	0	.0%	101	100.0%

Illness * Verdict Crosstabulation

Count

Sex			Verdict					
			Infanticide	Reform Insanity	Insanity	Murder	Not Guilty	Total
female	Illness	Depression	46	22	16	81	5	170
		Psychosis	38	40	35	44	5	162
	Total		84	62	51	125	10	332
male	Illness	Depression	11	9	8	19	2	49
		Psychosis	14	9	10	18	1	52
	Total		25	18	18	37	3	101

Chi-Square Tests

Sex		Value	df	Asymp. Sig. (2-sided)
female	Pearson Chi-Square	23.839[a]	4	.000
	Likelihood Ratio	24.242	4	.000
	Linear-by-Linear Association	3.106	1	.078
	N of Valid Cases	332		
male	Pearson Chi-Square	.854[b]	4	.931
	Likelihood Ratio	.861	4	.930
	Linear-by-Linear Association	.420	1	.517
	N of Valid Cases	101		

a. 1 cells (10.0%) have expected count less than 5. The minimum expected count is 4.88.

b. 2 cells (20.0%) have expected count less than 5. The minimum expected count is 1.46.

Directional Measures

Sex				Value	Asymp. Std. Error[a]	Approx. T[b]	Approx. Sig.
female	Nominal by Nominal	Lambda	Symmetric	.100	.027	3.546	.000
			Illness Dependent	.228	.058	3.546	.000
			Verdict Dependent	.000	.000	.[c]	.[c]
		Goodman and Kruskal tau	Illness Dependent	.072	.028		.000[d]
			Verdict Dependent	.024	.010		.000[d]
male	Nominal by Nominal	Lambda	Symmetric	.018	.067	.263	.793
			Illness Dependent	.041	.152	.263	.793
			Verdict Dependent	.000	.000	.[c]	.[c]
		Goodman and Kruskal tau	Illness Dependent	.008	.018		.932[d]
			Verdict Dependent	.002	.005		.952[d]

a. Not assuming the null hypothesis.

b. Using the asymptotic standard error assuming the null hypothesis.

c. Cannot be computed because the asymptotic standard error equals zero.

d. Based on chi-square approximation

Symmetric Measures

Sex			Value	Approx. Sig.
female	Nominal by Nominal	Phi	.268	.000
		Cramer's V	.268	.000
		Contingency Coefficient	.259	.000
	N of Valid Cases		332	
male	Nominal by Nominal	Phi	.092	.931
		Cramer's V	.092	.931
		Contingency Coefficient	.092	.931
	N of Valid Cases		101	

Psychological History x Law x Verdict

Crosstabs

Case Processing Summary

Trans/reoc		Cases					
		Valid		Missing		Total	
		N	Percent	N	Percent	N	Percent
Transient	Law * Verdict	214	100.0%	0	.0%	214	100.0%
Reoccuring	Law * Verdict	219	100.0%	0	.0%	219	100.0%

Law * Verdict Crosstabulation

Count

Trans/reoc			Verdict					Total
			Infanticide	Reform Insanity	Insanity	Murder	Not Guilty	
Transient	Law	Infanticide	49	0	0	16	5	70
		Legal insanity	0	0	30	39	2	71
		reformulated insanity	0	44	0	29	0	73
	Total		49	44	30	84	7	214
Reoccuring	Law	Infanticide	60	0	0	3	5	68
		Legal insanity	0	0	39	36	1	76
		reformulated insanity	0	36	0	39	0	75
	Total		60	36	39	78	6	219

Chi-Square Tests

Trans/reoc		Value	df	Asymp. Sig. (2-sided)
Transient	Pearson Chi-Square	261.093[a]	8	.000
	Likelihood Ratio	287.172	8	.000
	Linear-by-Linear Association	14.422	1	.000
	N of Valid Cases	214		
Reoccuring	Pearson Chi-Square	310.826[b]	8	.000

Chi-Square Tests

Trans/reoc		Value	df	Asymp. Sig. (2-sided)
Transient	Pearson Chi-Square	261.093[a]	8	.000
	Likelihood Ratio	287.172	8	.000
	Linear-by-Linear Association	14.422	1	.000
	N of Valid Cases	214		
	Likelihood Ratio	345.975	8	.000
	Linear-by-Linear Association	53.588	1	.000
	N of Valid Cases	219		

a. 3 cells (20.0%) have expected count less than 5. The minimum expected count is 2.29.

b. 3 cells (20.0%) have expected count less than 5. The minimum expected count is 1.86.

Directional Measures

Trans/reoc				Value	Asymp. Std. Error[a]	Approx. T[b]	Approx. Sig.
Transient	Nominal by Nominal	Lambda	Symmetric	.524	.055	7.571	.000
			Law Dependent	.667	.050	8.934	.000
			Verdict Dependent	.369	.072	4.255	.000
		Goodman and Kruskal tau	Law Dependent	.610	.015		.000[c]
			Verdict Dependent	.338	.033		.000[c]
Reoccuring	Nominal by Nominal	Lambda	Symmetric	.574	.051	8.300	.000
			Law Dependent	.720	.049	9.084	.000
			Verdict Dependent	.426	.063	5.442	.000
		Goodman and Kruskal tau	Law Dependent	.702	.013		.000[c]
			Verdict Dependent	.438	.027		.000[c]

a. Not assuming the null hypothesis.

b. Using the asymptotic standard error assuming the null hypothesis.

c. Based on chi-square approximation

Symmetric Measures

Trans/reoc			Value	Approx. Sig.
Transient	Nominal by Nominal	Phi	1.105	.000
		Cramer's V	.781	.000
		Contingency Coefficient	.741	.000
	N of Valid Cases		214	
Reoccuring	Nominal by Nominal	Phi	1.191	.000
		Cramer's V	.842	.000
		Contingency Coefficient	.766	.000
	N of Valid Cases		219	

Psychological History x IDA-R x Verdict

Crosstabs

Case Processing Summary

		Cases					
		Valid		Missing		Total	
Trans/reoc		N	Percent	N	Percent	N	Percent
Transient	high/ low idar * Verdict	214	100.0%	0	.0%	214	100.0%
Reoccuring	high/ low idar * Verdict	219	100.0%	0	.0%	219	100.0%

high/ low idar * Verdict Crosstabulation

Count

			Verdict					
Trans/reoc			Infanticide	Reform Insanity	Insanity	Murder	Not Guilty	Total
Transient	high/ low idar	high >60	23	11	7	41	3	85
		low <=60	26	33	23	43	4	129
	Total		49	44	30	84	7	214
Reoccuring	high/ low	high >60	25	8	14	33	0	80

high/ low idar * Verdict Crosstabulation

Count

Trans/reoc			Verdict					Total
			Infanticide	Reform Insanity	Insanity	Murder	Not Guilty	
Transient	high/ low idar	high >60	23	11	7	41	3	85
		low <=60	35	28	25	45	6	139
	Total		60	36	39	78	6	219

Chi-Square Tests

Trans/reoc		Value	df	Asymp. Sig. (2-sided)
Transient	Pearson Chi-Square	11.340[a]	4	.023
	Likelihood Ratio	11.767	4	.019
	Linear-by-Linear Association	.678	1	.410
	N of Valid Cases	214		
Reoccuring	Pearson Chi-Square	8.444[b]	4	.077
	Likelihood Ratio	10.665	4	.031
	Linear-by-Linear Association	.010	1	.922
	N of Valid Cases	219		

a. 2 cells (20.0%) have expected count less than 5. The minimum expected count is 2.78.

b. 2 cells (20.0%) have expected count less than 5. The minimum expected count is 2.19.

Directional Measures

Trans/reoc				Value	Asymp. Std. Error[a]	Approx. T	Approx. Sig.
Transient	Nominal by Nominal	Lambda	Symmetric	.000	.000	.[b]	.[b]
			high/ low idar Dependent	.000	.000	.[b]	.[b]
			Verdict Dependent	.000	.000	.[b]	.[b]
		Goodman and	high/ low idar Dependent	.053	.029		.024[c]

	Kruskal tau	Verdict Dependent	.017	.010		.006[c]
Reoccuring Nominal by Nominal	Lambda	Symmetric	.000	.000	.[b]	.[b]
		high/ low idar Dependent	.000	.000	.[b]	.[b]
		Verdict Dependent	.000	.000	.[b]	.[b]
	Goodman and Kruskal tau	high/ low idar Dependent	.039	.019		.078[c]
		Verdict Dependent	.007	.006		.165[c]

a. Not assuming the null hypothesis.

b. Cannot be computed because the asymptotic standard error equals zero.

c. Based on chi-square approximation

Symmetric Measures

Trans/reoc			Value	Approx. Sig.
Transient	Nominal by Nominal	Phi	.230	.023
		Cramer's V	.230	.023
		Contingency Coefficient	.224	.023
	N of Valid Cases		214	
Reoccuring	Nominal by Nominal	Phi	.196	.077
		Cramer's V	.196	.077
		Contingency Coefficient	.193	.077
	N of Valid Cases		219	

Confidence x Instructions

Oneway

Descriptives

Confidence

	N	Mean	Std. Deviation	Std. Error	95% Confidence Interval for Mean		Minimum	Maximum
					Lower Bound	Upper Bound		

yes	210	6.714	2.0040	.1383	6.442	6.987	1.0	10.0
no	223	6.603	1.9349	.1296	6.348	6.858	1.0	10.0
Total	433	6.657	1.9672	.0945	6.471	6.843	1.0	10.0

ANOVA

Confidence

	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	1.336	1	1.336	.345	.557
Within Groups	1670.485	431	3.876		
Total	1671.821	432			

Juror x confidence

Univariate Analysis of Variance

Warnings

Post hoc tests are not performed for Instruc because there are fewer than three groups.

Between-Subjects Factors

		Value Label	N
Instruc	1	Yes	210
	2	No	223

Descriptive Statistics

Dependent Variable:Confidence

Instruc	Mean	Std. Deviation	N
yes	6.714	2.0040	210
no	6.603	1.9349	223
Total	6.657	1.9672	433

Levene's Test of Equality of Error Variances[a]

Dependent Variable:Confidence

F	df1	df2	Sig.
.112	1	431	.738

Tests the null hypothesis that the error variance of the dependent variable is equal across groups.

a. Design: Intercept + Instruc

Tests of Between-Subjects Effects

Dependent Variable:Confidence

Source	Type III Sum of Squares	df	Mean Square	F	Sig.
Corrected Model	1.336[a]	1	1.336	.345	.557
Intercept	19181.244	1	19181.244	4948.932	.000
Instruc	1.336	1	1.336	.345	.557
Error	1670.485	431	3.876		
Total	20860.750	433			
Corrected Total	1671.821	432			

a. R Squared = .001 (Adjusted R Squared = -.002)

Estimated Marginal Means

1. Grand Mean

Dependent Variable:Confidence

Mean	Std. Error	95% Confidence Interval	
		Lower Bound	Upper Bound
6.659	.095	6.473	6.845

2. Instruc

Dependent Variable:Confidence

Instruc	Mean	Std. Error	95% Confidence Interval	
			Lower Bound	Upper Bound
yes	6.714	.136	6.447	6.981
no	6.603	.132	6.344	6.862

Sex and sympathy
Oneway

Descriptives

		N	Mean	Std. Deviation	Std. Error	95% Confidence Interval for Mean		Minimum	Maximum
						Lower Bound	Upper Bound		
Symp. D	female	332	5.878	2.3335	.1281	5.626	6.130	1.0	10.0
	male	101	5.252	2.3255	.2314	4.793	5.712	1.0	10.0
	Total	433	5.732	2.3439	.1126	5.511	5.953	1.0	10.0
Symp. V	female	332	9.16	1.500	.082	9.00	9.32	1	10
	male	101	8.52	1.863	.185	8.16	8.89	4	10
	Total	433	9.01	1.613	.078	8.86	9.17	1	10

ANOVA

		Sum of Squares	df	Mean Square	F	Sig.
Symp. D	Between Groups	30.302	1	30.302	5.574	.019
	Within Groups	2343.121	431	5.436		
	Total	2373.424	432			
Symp. V	Between Groups	31.512	1	31.512	12.433	.000
	Within Groups	1092.405	431	2.535		
	Total	1123.917	432			

Appendix D: Breakdown of Participant Data

Frequency and Percentage of Participants in Each Condition

Postpartum Depression			Postpartum Psychosis		
Code	*N*	%	Code	*N*	%
HIY	18	4.1	HIY	16	3.7
HIN	20	4.6	HIN	16	3.7
HLY	18	4.1	HLY	18	4.1
HLN	17	3.9	HLN	23	5.3
HRY	20	4.6	HRY	17	3.9
HRN	19	4.4	HRN	19	4.4
TIY	17	3.9	TIY	16	3.7
TIN	19	4.4	TIN	17	3.9
TLY	18	4.1	TLY	16	3.7
TLN	17	3.9	TLN	20	4.6
TRY	19	4.4	TRY	18	4.1
TRN	17	3.9	TRN	19	4.4

Key:

H = Psychological History
T = Transient (no history)
I = Infanticide
L = Legal Insanity
R = Reformulated Insanity
Y = Legal Instructions
N = No Legal Instructions

Frequency and Percentage of Participants with Children Living in Their Household

Number of Children	Frequency	Percentage
0	234	53.9
1	68	15.7
2	77	17.7
3	40	9.2
4 +	11	2.5
Missing data	4	0.5
Total	434	100

Frequency and Percentage of Hours (On Average) Participants Reported in Contact with Children per Week

Number of hours (on average)	Frequency	Percentage
0	90	21
1-2	103	24
3-4	49	11
5-6	34	8
7-8	15	3
9+	142	33
Missing data	1	0
Total	434	100

Number and Frequency of Participants who have Served on a Jury Previously

	Served on a jury previously	
	N	%
Yes	5	1.2
No	425	97.9
Missing Data	4	0.9
Total	434	100

Number and Frequency of Participants who have Experienced the Death of a Child under 7 Years of Age

	Experienced the death of a child	
	N	%
Yes	82	18.9
No	349	80.4
Missing Data	3	0.7
Total	434	100