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Prevalence and severity of trauma- and stressor-related symptoms among jurors: A review

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ABSTRACT

Background: Jury duty is a compulsory, yet stressful, experience. Experts have argued that some jurors may experience trauma-related symptoms (e.g., intrusive thoughts, avoidance, hyperarousal, anhedonia, depression). Understanding how jury duty affects mental health has significant socio-legal implications. This manuscript presents a review of the literature examining the prevalence and severity of trauma-related symptoms stemming from jury duty.
Method: A systematic search for articles was carried out using PsychInfo, ProQuest Dissertations, PubMed, Web of Science, Google Scholar, and HeinOnline. Inclusion criteria were: 1) reported original research; 2) reported a mental health outcome in former jurors. Data were extracted and summarized using a standard form.
Results: Eighteen studies were reviewed. Trauma-related symptoms were found in as many as 50% of jurors, which persisted for months in a minority of individuals. Factors related to deliberations, trial complexity, and graphic evidence were identified as consistent sources of stress. Female gender and history of prior trauma was associated with post-trial pathology.
Conclusion: A minority of jurors may be at increased risk for psychopathology as a result of their service, especially in cases involving violent crime. However, methodological limitations found across studies highlight the need for caution in this interpretation and for further empirical research.

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1. Introduction

In Canada, as in most commonwealth countries, it is considered a civic duty to sit on a jury if selected; failing to respond to a jury summons is an offence punishable by fines and/or prison time in most provinces.[1] While many perceive jury duty as a positive, honorable, and fulfilling experience (National Center for State Courts [NCSC], 1998), is it possible that it may be hazardous to your health? Legal and academic scholars have cautioned that in a minority of cases, the stress associated with jury duty can have serious negative effects on physical and psychological health (Dabbs, 1992; Miller, 2008; Miller & Bornstein, 2004). Some literature identifies factors associated with juror stress, such as gruesome evidence, emotionally disturbing testimony, being sequestered, lengthy or interrupted trials, and limited compensation (Hafemeister & Ventis, 1994; Miller, 2008). Others have postulated that due to prolonged exposure to graphic evidence and profound empathy that may develop for the victim in certain trials, jurors are at risk for vicarious traumatization and secondary traumatic stress symptoms (Robertson, Davies, & Nettleingham, 2009). However, there has been limited systematic research examining the prevalence and severity of trauma- and stressor-related symptoms resulting from jury service. Considering that anyone at least 18 years old can be plucked out of their daily routine to serve as a juror, understanding the impact that jury duty has on mental health is of utmost importance from socio-legal and public health perspectives, and from the standpoint of service delivery.

1.1. The effects of psychological trauma and stress on mental health

The new trauma- and stressor-related disorders category in the 5th edition of the *Diagnostic and Statistical Manual for Mental Disorders* (*DSM*-5; American Psychiatric Association [APA], 2013) recognizes that stressful and/or traumatic life events can lead to pathology ranging in severity from adjustment disorders, to acute stress disorder (ASD) and posttraumatic stress disorder (PTSD; Friedman et al., 2011). Emotionally stressful and negative life events are also often associated with other psychiatric disorders, such as depression and substance misuse (Sinha, 2008; Spinhoven et al., 2010). However, specific to all trauma and stressor-related disorders listed in the *DSM*-5 is the traumatic event or stressor criterion, which in the cases of PTSD and ASD involves directly experiencing or witnessing actual or threatened death, serious injury, or sexual violence (i.e., Criterion A). Learning that a close friend or family member suffered a traumatic event also qualifies for diagnosis if the event was accidental and/or included violence. Adjustment disorder can be diagnosed in individuals who display the full clinical profile of PTSD following a stressor of lesser magnitude than that required for PTSD or ASD diagnoses, such as divorce or job loss (APA, 2013).

Symptoms of PTSD cause significant psychosocial and occupational impairment. They include intrusive memories, distressing dreams/nightmares, insomnia/difficulty sleeping, flashbacks, psychological distress and physiological reactions when exposed to memory cues, behavioral avoidance of memory cues, negative cognitions and mood (i.e., "No one can be trusted", "The world is a dangerous place"), feelings of detachment from others (i.e., dissociation), diminished interest in activities, irritability and anger, hypervigilance, and difficulty with concentration, among others. If symptoms cease prior to 1 month after the traumatic event, a diagnosis of ASD is appropriate, while symptoms persisting at least 1 month qualifies for a PTSD diagnosis. An adjustment disorder can also be diagnosed in individuals who fulfill some but not all diagnostic criteria for ASD or PTSD (or another psychiatric disorder) following a Criterion A. event (APA, 2013).

Epidemiological surveys have found that 80% to 90% of individuals are exposed to a traumatic event in their lifetime (Kessler et al., 2005; Mills et al., 2011; Monson, Lonergan, Caron, & Brunet, 2015). Trauma exposure is therefore not uncommon. PTSD has a lifetime prevalence of approximately 6–8% in the general population, and 80% of affected individuals have one or more co-occurring psychiatric disorder, most notably depression and substance abuse (Foa, Keane, Friedman, & Cohen, 2009; Kessler et al., 2005). PTSD is among the top 5 or 6 most common mental disorders according to epidemiological surveys of the general population in the US. PTSD is also substantially comorbid with other anxiety disorders, such as generalized anxiety disorder, panic disorder, social phobia, specific phobia, and agoraphobia (Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995). The prevalence of adjustment disorder – a milder form of stress-related disorder- has been found to range anywhere from 5%–20%, depending on the population under study (i.e., outpatients vs. inpatients), whereas ASD occurs in 6%–50% of trauma exposed individuals depending on the type of traumatic experience (i.e., accidents vs. interpersonal assault). While ASD is by definition short-lived, adjustment disorders can persist up to 6 months and often co-occur with other psychiatric or medical disorders (APA, 2013). Thus, the psychological consequences of stressful and traumatic events are pervasive. If all trauma-related disorders were lumped together as a single diagnostic entity, it would form the most prevalent form of disorder in our society.

1.2. Vicarious trauma and secondary traumatic stress

Some authors have suggested that jurors on criminal trials, who are exposed to disturbing evidence and emotional testimony for weeks, and sometimes months, may become vicariously traumatized (Robertson et al., 2009). Psychological trauma can be broadly defined as an event(s) that shatters one's sense of safety and trust, and ultimately destroys once held positive assumptions about the self, others, and the world (Janoff-Bulman, 1989). Vicarious trauma is a construct that describes this change in cognitive schema among professionals indirectly exposed to trauma through the events of those they are helping, while secondary traumatic stress refers to a syndrome that mimics PTSD and may occur in those that are vicariously traumatized (Baird & Kracen, 2006). Vicarious trauma and secondary traumatic stress have been most often studied in individuals who work closely and at length with trauma survivors, such as mental health professionals, nurses and doctors, and law enforcement officials among others (Baird & Kracen, 2006; Beck, 2011; Huggard & Unit, 2013; Perez, Jones, Englert, & Sachau, 2010).

Since court staff are often confronted with violent cases involving traumatic material and traumatized victims, recent investigations have sought to identify the prevalence and severity of secondary traumatic stress in these populations (Flores, Miller, Chamberlain, Richardson, & Bornstein, 2008; Levin & Greisberg, 2003; Mattison, 2012; Vrklevski & Franklin, 2008). For instance, in Levin and Greisberg's (2003) study, lawyers demonstrated more intrusion,