Triple Stigma in Forensic Psychiatric Patients: Mental Illness, Race, and Criminality

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A dissertation submitted to the Graduate Faculty in Psychology in partial fulfillment of the requirements for the degree of Doctor of Philosophy, The City University of New York

2015
This manuscript has been read and accepted for the
Graduate Faculty in Psychology in satisfaction of the
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Abstract

TRIPLE STIGMA IN FORENSIC PSYCHIATRIC PATIENTS: MENTAL ILLNESS, RACE, AND CRIMINALITY

by

Michelle West

Advisor: Philip T. Yanos, Ph.D.

Stigma involves negative beliefs and devaluations of people in socially identified groups (e.g. race, mental illness). Although people have many reactions to social stigma, some labeled people internalize these attitudes. Research has increasingly explored mental illness self-stigma, when people with mental illness begin to believe that society’s negative beliefs are true of them (e.g., that they are hopeless due to mental illness). Self-stigma predicts poorer functional and treatment outcomes. Stigma research has typically investigated stigmatized labels individually. Forensic psychiatric patients, people with mental illness with history of criminal conviction, by definition experience multiple stigmas, yet no research has explored how stigmas due to mental illness, race, and criminal history influence each other. Forensic psychiatric stigma is particularly relevant given increasing social attention on violence, incarceration, mental illness, and race. This dissertation sought to integrate research and theory on these stigmatized identities, to extend previous research on mental illness self-stigma to a forensic psychiatric sample, and to investigate the impact of multiple stigmatized identities on self-esteem, depression, treatment adherence, and therapeutic alliance. Results indicated that mental illness self-stigma, expectations of discrimination due to criminal history, and less positive racial self-concept, all exhibited some predicted relationships with outcome variables. There was also
evidence of a combinatory effect of these types of stigma. Conclusions discuss clinical implications and targets for future research.

Keywords: stigma, self-stigma, forensic psychiatric patients, mental illness, race, offenders
Acknowledgements

I would like to thank my advisor and dissertation chair, Dr. Philip T. Yanos, for his incredible support and guidance during the process of completing this dissertation. I feel grateful to have been part of his lab during my graduate studies. He has shaped me into the clinician and researcher that I am today, and I will always value what I learned from him and his substantial contribution to my career path. I would also like to thank Dr. Daryl Wout and Dr. Diana Falkenbach for their support as members of my committee and for their feedback during the dissertation process. I would like to thank Dr. Bruce Link and Dr. Merrill Rotter for agreeing to be on my dissertation committee. I would like to thank the faculty and students of the John Jay College Doctoral Program in Clinical Psychology and how they have shaped my life and my career path; it has been an incredible journey. Finally, I would like to thank my family and friends for their consistent caring and support; I am lucky to be surrounded by amazing people.
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Chapter 1: Introduction

Stigma involves stereotyping and devaluing individuals based on their membership in particular social groups (e.g., Goffman, 1963; Link & Phelan, 2001). It has been investigated in the context of multiple socially-identified individual differences, including race, gender, physical disability, age, sexual orientation, mental illness, and criminal history. Stigma research has explored mechanisms of discrimination and the impact of stigmatization on labeled individuals. In particular, stigmatization can impact the self-concept of labeled individuals. Self-concept is multi-dimensional and substantially influenced by social roles and others’ perceptions. Thus, membership in social groups, including stigmatized ones, must typically be integrated into one’s self-concept. One possible consequence of stigmatization is the internalization of stigma (believing that stereotypes are true of oneself), also termed self-stigma.

Although self-stigma has received increasing research attention in the context of mental illness, minimal research has explored how membership in multiple stigmatized groups impacts outcomes including self-concept, self-esteem, and functioning. People with mental illness who have been arrested or convicted of criminal charges, often termed “forensic psychiatric patients,” often belong to multiple stigmatized social groups, including people with mental illness, racial minorities, and criminal offenders. The recent social attention and debate concerning the role of mental illness in violent behavior, including the Aurora theater shooting and multiple school shootings, makes the topic of stigma more relevant yet infrequently discussed in popular media. Since forensic psychiatric patients often experience multiple sources of stigmatization, expanding self-stigma research to this population provides an opportunity to examine how different types of stigma influence each other and the relative impact of these types of stigma on self-concept and other outcomes. This review overviews theory and research of stigma, self-
concept, and how stigma impacts self-concept, and then discusses specific stigmas that are particularly relevant to forensic psychiatric patients (mental illness, race, and criminal history).
Chapter 2: Literature Review

Stigma

Link and Phelan (2001) defined stigma as developing when “elements of labeling, stereotyping, separation, status loss, and discrimination co-occur in a power situation that allows the components of stigma to unfold” (p. 367). Labeling is the social selection of human differences considered important within a society, and the assignment of labels based on these differences. Stereotyping involves linking the label with negative traits generally ascribed to the group. The linking of undesirable traits provides a rationale for using the label to separate “us versus them”; conversely, separation facilitates stereotyping. As a result of the stigmatization process, the labeled group experiences discrimination and status loss. Finally, the influence of stigma on power is a commonly overlooked component because power differentials are often taken for granted. However, labels and stereotypes applied by the powerless to the powerful clearly do not result in stigma. Link and Phelan argue that each component yields an overly inclusive definition of stigma if applied individually.

There are multiple theories for why stigmatization exists. Phelan, Link, and Dovidio (2008) distinguish three purposes for stigma. The first purpose, to keep people down, reflects the motivation to exploit and dominate certain groups and maintain existing power structures. The second function, to keep people in, reflects the enforcement of norms, encouraging people to conform to expected patterns of behavior. The last purpose, to keep people away, reflects the motivation to keep at a distance people who are perceived as diseased (Phelan et al.).

Watson and River (2005) describe a social-cognitive model of public stigma, reflecting the increasing influence of attitudes. The first level, stereotype, is a negative trait generally associated with a group of people, which may or may not be accepted as true. The second level,
prejudice, is agreement with these negative beliefs about the group, often combined with an emotion (e.g., anger at or fear of the labeled group). Thus, the model distinguishes stereotypes from internal endorsement, since individuals may be aware of a stereotype but put cognitive effort into discrediting it. The third level is discrimination, or the external consequence of prejudice that occurs when negative beliefs and/or emotions influence external behavior.

Consistent with this model, Wilson, Lindsey, and Schooler (2000) distinguish implicit and explicit attitudes towards groups of people, and discuss how these attitudes may contrast (e.g., positive explicit attitudes, negative implicit attitudes) and activate in different types of situations.

Research has explored the process through which members of society learn stereotypes. *Stereotype consciousness* is a term used to capture awareness of the stereotypes generally held by society. There is evidence that most members of society learn stereotypes. In fact, research suggests that the majority (63-80%) of ten-year-olds and even some (7-15%) six-year-olds are aware of cultural stereotypes (McKown & Weinstein, 2003). Once learned, these stereotypes can impact attribution of other negative traits to stigmatized group members. *Master status theory* suggests that people perceive stigmatized or “socially deviant” group members as possessing unrelated, additional negative traits. For example, college students judged stigmatized group members (homosexuals and atheists) as more likely to be less educated, to belong to a lower social class, to do drugs, and to need psychotherapy, than non-stigmatized group members (Republicans and Catholics; Jenks, 1986). Consequently, awareness that a person belongs to a stigmatized group can lead others to develop globally negative attitudes about the person.

Discrimination is a common experience for many labeled groups, with one study finding that the most frequently reported sources of discrimination were mental illness, race, sexual orientation, and physical disability (Corrigan et al., 2003). Research has examined types of
mechanisms through which stereotyping results in discrimination against labeled individuals. In one such categorization, Link and Phelan (2001) described three general mechanisms of exclusion. At the broadest level, structural/institutional mechanisms disfavor labeled groups, for example, through loss of job and educational opportunities. Mechanisms at the level of interpersonal interactions include explicit discrimination (obvious discriminatory behaviors that derogate and exclude due to race, gender, or other group memberships), as well as implicit discrimination (more subtle, unintentional discriminatory behaviors). Implicit discrimination includes behaviors like microaggressions, the everyday unconscious, subtle, and covert verbal and nonverbal slights directed at minority group members (Sue, Capodilupo, & Holder, 2008). It is likely that both attitudes (explicit and implicit) and context influence discriminatory behavior.

The final mechanism through which stigma operates is through its impact on labeled individuals’ own beliefs and behaviors (Link & Phelan, 2001). Stigma may impact labeled people in many ways, and may explicitly or implicitly influence their beliefs and behaviors. The following section will provide context for considering the influence of stigma on self-beliefs, by briefly outlining general theories of self-concept and then discussing research on reactions to stigma.

**Self-Concept, Reactions to Stigma, and Self-Stigma**

**Self-concept.** Self-concept, which includes social identities and other aspects of the self, (e.g., self-evaluations), has been investigated within a wide range of psychological domains, including leadership (e.g., MacDonald, Sulsky, & Brown, 2008), substance addiction (e.g., Shinebourne & Smith, 2009), ethnic identity development (e.g., Cross, 1971), homelessness (Vandemark, 2007), and schizophrenia (Hemsley, 1998). Not surprisingly, multiple conceptualizations of self-concept have been described. Cheung and Lau (2001) distinguish three
branches of self-concept research: the structure of self-concept and its relations to other constructs, the sources of self-concept and their relative importance, and the processes involved in forming self-concept.

Research has defined the structure of self-concept by attempting to identify key domains and how they relate to each other. Although specific domains differ, there is agreement that self-concept is multidimensional. For example, Guardo and Bohan (1971) described four domains (humanity, gender, distinctiveness from other people, and feeling like the same person over time), while Pederson’s (1999) domains included spiritual, social, and family dimensions. Some authors argue that a multidimensional self-concept is beneficial, for example, by decreasing psychological distress and negative affect (Kiang, Yip, & Fuglini, 2008; Thoits, 1983) and increasing life satisfaction (Parker, Martin & Marsh, 2008); however, contrasting evidence suggests that simple role accumulation is not necessarily beneficial (e.g., Reitzes & Mutran, 1994). Multiple identifications may relate to each other in many ways, and in some cases may be difficult to negotiate (e.g., Settles, 2004). Some authors conceptualize self-concept as hierarchical, with some identifications being consistently more important in terms of self-concept than others (e.g., Sellers, Smith, Shelton, Rowley, & Chavous, 1998). Identity centrality research has explored how identifications vary in importance across individuals and situations (e.g., Pedersen, 1999), and suggests that more central identities are more influential than less central identities as people navigate contrasting identities across contexts (Settles, 2004). Turner and Brown (2007) found that identity centrality varied among children and age groups, and that less centralized identities related to increased identity flexibility in different contexts.

The second branch of self-concept research has investigated where identifications come from and the relative contribution of these sources. Social comparison theory suggests that an
important source of self-knowledge is comparisons with other people (Festinger, 1954), including upward comparison (e.g., to motivate improved performance) and or downward comparison (e.g., for self-enhancement). The social comparison process is extremely complex and may involve multiple simultaneous comparisons, incorporation of past experiences, and comparisons across time (Wood, 1989). Wood describes social comparison as bidirectional: individuals are actively involved in identifying social comparisons (often to support their views of themselves), at the same time as the immediate social context primes goals and provides obvious comparisons. Another relevant social theory is *symbolic interaction theory*, which focuses on the importance of perceived appraisals of important others’ influence one’s self-concept (e.g., Shrauger & Schoeneman, 1979). This theory supports common experience that other people play an important role in many aspects of how one thinks and feels about oneself.

Research has also explored processes involved in forming self-concept. Waterbor (1972) conceptualized self-identity as resulting from continuity of experience, including continuity of bodily experience, social experience, and values. Personality theories of self-concept include self-schema theory (e.g., Markus, 1977), which describes self-concept as a relatively stable knowledge structure that captures a person’s central attributes, and self-categorization theory, which describes self-concept as including personal and social identities in more flexible and context-dependent way (Turner, Oakes, Haslam, & McGarty, 1994). There is some evidence supporting self-categorization theory’s description of identity as more fluid and context-dependent (Oronato & Turner, 2004). Additionally, the *theory of planned behavior* is more behaviorally-focused and conceptualizes self-concept as stemming from past behaviors and predicting both intentions and future behaviors (e.g., Fekadu & Kraft, 2001). Some researchers have begun to develop integrative theories of self-concept. Markus and Nurius (1986) describe
“possible selves,” which include representations of the self in the past, as well as idealized and feared future selves. Possible selves are influenced by past experiences, collective social messages, comparisons with meaningful others, and immediate context. The “working self-concept” includes both stable and malleable components and uses possible selves to guide and motivate behavior and self-evaluations. Given this theory, it is not surprising that self-concept influences values and life direction (Berzonsky, Cieciuch, Duriez, & Soenens, 2011), as well as emotions, self-esteem (Phillips & Pittman, 2007; Vleioras, & Bosman, 2004), and behavior. In a consistent but somewhat different fashion, self-concept intersectionality theory focuses upon the complexities of constantly managing multiple, interacting identities (e.g., gender, race, sexuality). Individuals experience social life through their internalization (and society’s perceptions) of their multiple identities (e.g., Crenshaw, 2005). Through this complex process, one’s identities are not defined as individual formations, but rather interacting and reinforcing entities. Several studies highlight the intersecting social identities of individuals with mental illness (e.g., mental illness interacting with homelessness, gender, socioeconomic status, race and ethnicity, sexuality), and the impact this can have on systematic forces of discrimination and oppression (e.g., Benbow, Forchuk, & Ray, 2011; Collins, von Unger, & Armbrister, 2008; Nelson, 2006). These theories suggest that self-concept formation is complex, interactive, and evolving, and complicates attempts to investigate individual identities in isolation.

To summarize, the literature indicates that self-concept is multidimensional and strongly influenced by perceptions of and comparisons with other people. As a result, people typically incorporate their membership in socially-identified groups, including stigmatized ones, into their self-concept. Self-concept connects closely with emotion, motivation, behavior, and life direction, and is a complex, evolving process. This review will next discuss broadly how stigma
may impact the beliefs and behaviors of members of stigmatized groups, particularly how internalization of stigma may impact self-concept.

**Reactions to stigma.** As indicated previously, stigma can impact the beliefs and behaviors of stigmatized people (Link & Phelan, 2001). Research has investigated the stigma awareness and expectations of labeled individuals. Not surprisingly, stigmatized individuals are more likely to become aware of stereotypes, or exhibit stereotype consciousness, at a younger age (McKown & Weinstein, 2003). There also appear to be differences in expectations of being stigmatized across labeled individuals, termed *stigma consciousness* (Pinel 1999) or stigma beliefs (Link, 1987). In research with women and sexual and racial minorities, Pinel (1999, 2002) found that individual differences in stigma consciousness affected consequent behavior; participants high in stigma consciousness were more likely to attribute others’ negative feedback to their label and avoid stereotype-relevant situations.

Awareness and expectations about stigma can further impact the self-concept of labeled individuals. *Labeling theory* argued that members of stigmatized groups who are aware of the stigma automatically internalize the negative identity into their self-concept (e.g., Davis, 1972). Labeling theory was critiqued for being overly deterministic and for its failure to incorporate the range of responses to stigma (e.g., Scimecca, 1977). Subsequent theories have developed more sophisticated models to more comprehensively integrate variations in how stigma may impact self-concept. *Modified labeling theory* focuses on how stigma influences the expectations and resulting behavior of stigmatized group members. It posits that socialization teaches people to expect society to devalue and to discriminate against stigmatized groups, and these expectations become personally relevant for labeled individuals and impact both their expectations of how others will treat them and their social behaviors (Link, Cullen, Struening, Shrout, Dohrenwend,
1989). Crocker’s (1999) *situational constructionist theory* describes the impact of stigma on stigmatized individuals’ self-concepts, and also rejects the idea that stigma automatically has a negative impact on self-concept because the same context might have different meanings.

Although stigma consciousness likely impacts the self-concept of labeled individuals in some way and some individuals may internalize stigma, most authors reject the idea that internalizing stigma is an automatic reaction. Researchers (Corrigan & Watson, 2002; Watson & River, 2005) described a continuum of responses, with shame and secrecy reflecting self-stigma, affirmation capturing righteous anger, and indifference occurring between these poles. Predictors of these responses to stigma include unawareness or denial of group membership (predicting indifference about the stigma), strength of group identity, and perceived legitimacy of discrimination (Corrigan & Watson; Watson & River). The literature also distinguishes between explicit and implicit reactions to stigma, including explicit and implicit self-stigma. Paralleling concepts in the stigma literature, explicit self-stigma is conscious negative beliefs about oneself and is arguably captured by typical self-report measures. Implicit self-stigma would be captured by measures of automatic associations, even if individuals do not explicitly endorse negative beliefs about themselves.

A more subtle reaction to stigma is *stereotype threat*. Steele and Aronson (1995) defined stereotype threat as occurring when a known stereotype becomes salient and “anything one does or any of one's features that conform to it make the stereotype more plausible as a self-characterization in the eyes of others, and perhaps even in one's own eyes” (p. 797). When a stigma-relevant situation occurs, factors including specific situational cues and individual characteristics (e.g., stigma consciousness and strength of group identification) influence one’s appraisal of the situation as a threat, and resulting volitional and non-volitional behavior (Major
Examples of stereotype threat including performance detriment (e.g., poorer performance on academic tests) that may unintentionally be consistent with stereotypes about one’s group. However, there is mixed evidence for potential mechanisms of performance impairment including anxiety and decreased working memory (Wheeler & Petty, 2001). Additionally, stereotype threat may actually be divided into multiple types of treat, including group-threat, which stems from concerns about unintentionally supporting a stereotype about one’s group, and self-threat, or concerns about demonstrating that the stereotype is true of oneself (Wout, Danso, Jackson, & Spencer, 2008). Stereotype threat can occur whether or not the individual internalizes the stereotype, but some contexts may increase the believability of the stereotype, potentially increasing threat to self-evaluation (Steele & Aronson). Therefore, in some cases, stereotype threat may represent a type of implicit self-stigma.

In summary, multiple research areas have addressed how stigmatization can impact the expectations, self-beliefs, and behaviors of stigmatized individuals. Some research has suggested that even these more subtle reactions to stigma can be related to negative outcomes (Rüsch, Corrigan, Todd, & Bodenhausen, 2010). Stigma can also have a more overtly negative impact on the self-concept of labeled individuals, which will be discussed in the following section.

**Self-stigma.** Although multiple responses to stigma exist, self-stigma, also termed internalized stigma, occurs when a member of a stigmatized group internalizes stigmatizing social attitudes. There are two basic prerequisites necessary for self-stigma to occur (Corrigan & Wassel, 2008; Watson, Corrigan, Larson, & Sells, 2007): stereotype consciousness (awareness of stereotypes) and awareness of group membership. Awareness of group membership can develop before or after stereotype consciousness. Some people may not experience self-stigma because
they are unaware of or reject group membership, but self-stigma means that one has incorporated group membership, particularly the negative stereotypes, into one’s self-concept.

Self-stigma can be conceptualized as having three components paralleling the social-cognitive model of public stigma discussed previously (Watson & River, 2005): stereotype, prejudice, and discrimination. Stereotyping involves negative thoughts about the self, resulting from society’s negative beliefs about the group (called *stereotype concurrence* in some models). Prejudice reflects acceptance of these negative self-beliefs, typically accompanied by negative emotions about oneself (e.g., Werner, Aviv, & Barak, 2008). Finally, discrimination involves a behavioral response to the self-prejudice (Corrigan & Kleinlein; Watson & River, 2005), including not pursuing treatment due to beliefs that one is incapable of success.

Although many social groups are targets of stigma, this review will next focus on three groups that are particularly relevant to stigma against forensic psychiatric populations: people with mental illness, racial/ethnic minorities, and criminal offenders. For each group, this review will overview research on stigma and group members’ responses to stigma, particularly self-stigma. Finally, the minimal research investigating multiple stigmatized identities will be reviewed, with an emphasis on research relevant to forensic psychiatric populations.

**Mental Illness Stigma, Reactions to Stigma, and Self-Stigma**

**Mental illness stigma.** Although the pervasiveness and impact of mental illness stigma was at one point contested, Link et al. (1989) concluded that these attitudes exist and impact people with mental illness. Some prevalent stereotypes about people with mental illness include inferiority, violence, vulnerability, and inability to have romantic relationships or contribute to society (e.g., Ritsher, Otilingama, & Grajales, 2003). Large surveys have found that adults, including those in the US (Link, Phelan, Bresnahan, Stueve, & Pescosolido, 1999) and in
Australia (Reavley & Jorm, 2011), associated mental illness with dangerousness and preferred minimizing interactions with people with mental illness, particularly schizophrenia. Research suggests that these attitudes exist but are less pervasive in youths (Wahl, Susin, Lax, Kaplan, & Zatina, 2012). Western cultures’ attempts to decrease stigma have involved emphasizing biological causes of mental illness. However, emphasizing biological etiology may not decrease stigma (Pescosolido et al., 2010; Schomerus et al., 2012), and may actually increase social distancing and harsh treatment (Angermeyer & Matschinger, 2005; Mehta & Farina, 1997; Read & Law, 1999). Attitudes about dangerousness and avoidance of contact did not decrease significantly in the US between 1996 and 2006, despite increasing public endorsement of biological etiology (Pescosolido et al., 2010). Despite these prevailing beliefs about the dangerousness of people with mental illness, research indicates that the great majority of people (90% or more) with severe mental illness do not engage in any violent behavior (Corrigan & Watson, 2005; Swanson et al., 2006). Furthermore, the relationship between severe mental illness and violence can partly be attributed to increased rates of substance use (Elbogen & Johnson, 2009) and the remaining violence risk attributable to mental illness is small in contrast with more common characteristics such as age and gender (Corrigan & Watson, 2005).

As with any type of stigma, mental illness stigma leads to discrimination at multiple levels. At a structural level, discrimination in employment persists despite rehabilitation models of mental health treatment and changes in legislative philosophies (Stuart, 2006). Additional issues include limited adequate shelter and barriers to obtaining treatment (Overton & Medina, 2008). Media representations often misrepresent mental illness (Duckworth, Halpern, Schutt, & Gillespie, 2003), as research indicates that the media largely represents people with mental illness negatively, as violent, childlike, uncontrollable, incompetent, and social outcasts.
(Corrigan et al., 2005). Research directly examining the connection between exposure to these media portrayals and mental illness stigma is needed (Stout, Villegas, & Jennings, 2004).

At an interpersonal level, evidence consistent with master status theory suggests that people are more likely to ascribe general negative traits to a person believed to have mental illness. For example, after watching a videotaped interaction, participants gave an interviewee lower social skills ratings when they were told the person had schizophrenia (O’Connor & Smith, 1987). Similarly, a mental illness label decreased ascriptions of humanity and influenced perceptions of traits like dangerousness (Martinez, Piff, Mendoza-Denton, & Hinshaw, 2011). In addition, a mental illness diagnosis can lead to discrimination during interpersonal interactions, resulting in loss of personal relationships (Baker, Procter, & Gibbons, 2009). Stigmatization also impacts treatment relationships, with research in Australia (Hugo, 2001; Jorm, Korten, Jacomb, Christensen, & Henderson, 1999), Greece (Arvaniti et al., 2009), and the US (Van Dorn, Swanson, Elbogen, & Swartz, 2005) providing evidence that mental health and medical professionals commonly exhibit negative attitudes towards people with mental illness. Stigmatization is likely particularly harmful coming from such caregivers, and the literature describes hopelessness, negative life expectations, and “spirit breaking” as common reactions to experiencing discrimination from treatment providers (Deegan 1992 & 2000; Frese & Davis, 1997).

**Reactions to Mental Illness Stigma.** Stigma also impacts the beliefs and behaviors of people with mental illness. Research indicates that about 90 percent of people with mental illness are aware of stigmatizing views about mental illness (Wahl, 1999). Stereotype consciousness by itself is generally unrelated to self-esteem and depression (e.g., Rüsch et al., 2006). Explicit cognitive reactions to stigma include expectations of being discriminated against after previously
learned societal stigma becomes personally relevant, as described by modified labeling theory (Link, 1987; Link et al., 1989). Individuals with some diagnoses may be more likely to expect discrimination than others (e.g., Kroska & Harkness, 2008). A more implicit reaction to stigma is the automatic association between mental illness and shame, which predicts perceptions that discriminating against people with mental illness is legitimate (Rüschi, Todd, Bodenhausen, Olschewski, & Corrigan, 2010). The belief that discrimination is deserved or legitimate likely reflects some agreement with negative stereotypes, which elevates risk for self-stigma. Research suggests that even implicit self-stigma is related to negative outcomes, including lower quality of life (Rüschi, Corrigan, Todd, & Bodenhausen, 2010). Researchers have also considered whether stigma and stereotype threat may contribute to social and cognitive deficits observed in severe mental illness (Corrigan & Holtzman, 2001), and behaviorally, fear of stigmatization can prevent people with mental illness from seeking treatment (Clement et al., in press; Overton & Medina, 2008).

Awareness of stigma may contribute to some individuals’ inability to acknowledge their diagnosis, but people must typically integrate the meaning of their diagnosis into their self-concepts. As described by high-functioning adults with mental illness, reactions to diagnosis may range from adopting an “illness identity,” to integrating the diagnosis into a positive social identity (Michalak et al., 2011). The meaning of the diagnosis to self-concept has a considerable personal impact, as self-concept influences emotions, motivation, and ability to implement behavioral changes, including those that are the goals of psychotherapy (Leite & Kuiper, 2008). Therefore, the meaning of one’s diagnosis affects the complex, non-linear process of recovery from mental illness (Resnick, Fontana, & Lehman, 2005). In contrast to developing self-stigma, some people with mental illness respond to public stigma with righteous anger and
empowerment (Corrigan, Faber, Rashid, & Leary, 1999). One’s beliefs about mental illness also influence recovery. One model of recovery described in the literature involves redefining self-concept, developing hope and belief in a meaningful life, and actively working towards recovery (Andresen, Oades, & Caputi, 2003), which arguably involves rejecting social stigma. Perceiving one’s “current self” as being close to one’s “ideal self” was found to increase hope for recovery from mental illness (Buckley-Walker, Crowe, & Caputi, 2010). Additionally, there is an increasing literature describing the phenomenon of “coming out” as having a mental illness (based on sexual identity literature), with some evidence suggests may decrease self-stigma, shame, and the negative impact of stigma on quality of life (Corrigan, Morris, et al., 2010; Corrigan & Rao, 2012).

**Self-Stigma of Mental Illness.** One consequence of stigma is that people with mental illness may internalize stigmatizing beliefs. The terms “self-stigma” (e.g., Corrigan & Calabrese, 2005), “internalized stigma” (e.g., Ritsher, Otilingam, & Grajales, 2003), and “role engulfment” (e.g., McCay, & Seeman, 1998) reflect this concept in the mental illness literature. Although not everyone with mental illness will internalize stigma, recent longitudinal research suggests that awareness of public stigma predicts internalization of mental illness stigma at a later time (Vogel, Bitman, Hammer, & Wade, 2013). Increasing research has investigated how diagnosis and internalization of society’s negative attitudes towards people with mental illness leads to a damaging change in self-concept for some individuals (Livingston & Boyd, 2010).

Self-stigma appears to comprise multiple related constructs, as captured by assessment instruments. The Internalized Stigma of Mental Illness scale (ISMI; Ritsher, Otilingam, & Grajales, 2003) includes Stereotype Endorsement, Discrimination Experience, Alienation, and Social Withdrawal subscales. The stigma endorsement scale evaluates agreement with common
negative attitudes towards mental illness, and the discrimination experience scale focuses on experiences with discrimination due to mental illness. At a deeper level, the alienation subscale captures feeling like an inferior member of society due to having a mental illness, and the social withdrawal scale reflects the individual’s tendency to withdraw from others due to having a mental illness. The Self-Stigma of Mental Illness Scale (SSMIS; Corrigan, Watson, & Barr, 2006) also captures stereotype consciousness, endorsement, and internalization. The Depression Self-Stigma Scale (DSSS; Kanter, Rusch, & Brondino, 2008) and the Self-Stigma in Alcohol Dependence Scale (Schomerus, Corrigan, Klauer, Kuwert, Freyberger, & Lucht, 2011) also capture similar domains, so stereotype awareness, endorsement, and application of negative beliefs to oneself appear to be accepted components of mental illness self-stigma.

Research suggests that self-stigma is prevalent among people with mental illness. Elevated levels of self-stigma have been found in one third of consumers in outpatient psychiatric samples (Drapalski et al., 2013; Ritsher & Phelan, 2004; West, Yanos, Smith, Roe, & Lysaker, 2011), 20-33% of a psychiatric inpatient sample (Werner, Aviv, & Barak, 2008), and 41 percent of the 1229 people with schizophrenia surveyed across 14 European countries (Brohan, Elgie, Sartorius, & Thornicroft, 2010). Therefore, evidence consistently suggests that self-stigma is commonly faced by people with mental illness at many levels of care, in multiple countries, with estimates ranging from 20 to 41 percent of individuals.

Given its prevalence, research has investigated the detrimental consequences of self-stigma. Research suggests that self-stigma relates to decreased self-esteem (Corrigan, Watson, & Barr, 2006; Lysaker, Tsai, Yanos, & Roe, 2008; Werner, Aviv, & Barak, 2008) and negatively impacts social relationships (Link, Cullen, Struening, Shrout, & Dohrenwend, 1989). A meta-analysis provided further evidence of a consistent relationship (r = .28 to .58) between mental
illness self-stigma and psychosocial variables including self-esteem, hope, self-efficacy, quality of life, and social support (Livingston & Boyd, 2010). Research also suggests that higher levels of self-stigma relate to psychiatric hospitalization (Rüscher et al., 2009). Some longitudinal research has investigated the negative impact of self-stigma over time. Controlling for baseline scores, alienation predicted increased depression and decreased self-esteem four months later (Ritsher & Phelan, 2004), and self-stigma correlated with emotional distress at baseline and follow-up (Lysaker, Davis, Warman, Beattie, & Strasburger, 2007). Existing research clearly provides evidence that self-stigma is related to current and lasting negative effects on social functioning, self-esteem, emotions, and life satisfaction. Consistent with theories that self-concept is influenced by social comparisons, past behavior, and possible selves (Fekadu & Kraft, 2001; Markus & Nurius, 1986; Shrauger & Schoeneman, 1979), self-esteem detriment due to mental illness stigma likely involves a self-perpetuating cycle. Negative social experiences and awareness of negative stereotypes reinforce expectations of mistreatment by others and negative expectations of one’s chances of success, which can increase tendencies towards social and experiential avoidance. Avoidance can lead to restriction of available identities and identity flexibility, and can increasingly contribute to role engulfment and damage to self-concept.

Not surprisingly, self-stigma also affects recovery. It appears to negatively impact how people cope with mental illness and their treatment engagement, which can lengthen the course of the illness. For example, self-stigma increased the likelihood that people with depression used avoidant coping strategies (Manos, Rusch, Kanter, & Clifford, 2009), and avoidant coping (social withdrawal) predicted worsened depressive symptoms four months later (Ritsher & Phelan, 2004). Self-stigma, particularly beliefs that people with mental illness are deserving of blame or unpredictable, also appears to negatively impact attitudes towards seeking help (Brown
et al., 2010; Mojtabai, 2010; Vogel, Wade, & Hackler, 2007). Once in treatment, self-stigma appears to be detrimental to treatment outcomes by impacting hopelessness, avoidant coping, and treatment non-adherence (Drapalski et al., 2013; Yanos, Lysaker, & Roe, 2010; Yanos, Roe, Markus, & Lysaker, 2008). Additionally, there is evidence that self-stigma negatively impacts therapeutic alliance (Kvrgic, Cavelti, Beck, Rüsch, & Vauth, 2013), which is also detrimental to treatment engagement and outcomes. Research indicates that self-stigma predicts both medication and psychosocial treatment non-adherence (Fung, Tsang, & Corrigan, 2008; Tsang, Fung, & Corrigan, 2009). Both self-stigma (Livingston, Rossiter, & Verduin-Jones, 2011) and treatment non-adherence (Copeland et al., 2009) increase risk for negative quality of life outcomes, including incarceration and homelessness.

Some research has explored risk and protective factors for developing mental illness self-stigma, although more is needed. Self-stigma may differ between mental illness diagnoses. For example, women with borderline personality disorder had greater self-stigma than women with social phobia (Rüsch et al., 2006), and an international European study found that people with bipolar disorder had lower rates of self-stigma (21.7 percent; Brohan, Gauci, Sartorius, & Thornicroft, 2011) than people with schizophrenia (41 percent; Brohan, Elgie, Sartorius, & Thornicroft, 2010). Although a meta-analysis failed to find consistent relationships between self-stigma and demographic variables, including race and gender (Livingston & Boyd, 2010), self-stigma may differentially affect racial minorities, particularly African Americans (i.e., Matthews, Corrigan, Smith, & Aranda, 2006; Rao, Feinglass, & Corrigan, 2007). In one study, African Americans had higher levels of self-stigma and more negative attitudes towards seeking mental health treatment than Whites (Conner, Koeske, & Brown, 2009). Personality characteristics may also play a role, with traits like harm avoidance increasing risk and self-directedness decreasing
risk for self-stigma (Margetic, Jakovljevic, Ivanec, Margetic, & Tosic, 2010). Some evidence suggests that increased group identification and lower perceived legitimacy of discrimination protects against self-stigma and predicts increased empowerment (e.g., Corrigan & Watson, 2002; Rüscher, Lieb, Bohus, & Corrigan, 2006; Watson, Corrigan, Larson, & Sells, 2007).

In summary, mental illness self-stigma substantially impacts the lives of people with mental illness. Internalizing these negative beliefs negatively impacts emotions, self-esteem, adaptive coping, help-seeking, treatment compliance, and functional outcomes. Given self-stigma’s negative impact on treatment adherence and functioning, it likely contributes to the prolongation of symptoms, which increases individual suffering and, on a societal level, contributes to lost wages and increased treatment and entitlement costs.

**Racial Stigma, Reactions to Stigma, and Self-Stigma**

**Racial stigma.** Race is typically a more easily observed individual difference, contributing to the ease of labeling people according to racial groups. There is evidence that widely-known, often negative, stereotypes are associated with racial minority groups. Research across several decades indicates that stereotypes about Blacks have remained consistent and largely negative, with commonly identified traits including superstitious, ignorant, athletic, rhythmic, unintelligent, poor, lazy, loud, criminal, and hostile (Devine & Elliot, 1995; Katz & Braly, 1933). Negative stereotypes also exist for other racial groups. Stereotypes about Latinos include that they are lazy, unintelligent, poor, resistant to learning English, and indifferent towards education (Gonzalez & Ayala-Alcantar, 2008). Arabs are negatively stereotyped as being bloodthirsty, terrorists, oppressive, religious fanatics, and rich oil sheiks (Erikson & Al-Timimi, 2001). Consistent with master status theory, these racial stereotypes may also affect ascriptions of other traits. For example, in one study race, not gang status, predicted arrest
(Brownfield, Sorenson, & Thompson, 2001), suggesting that racial stereotypes had a greater influence on perceptions of criminality than gang membership did.

Racial stereotypes may be explicit or implicit. Devine and Elliot (1995) emphasized that awareness of commonly-known stereotypes differed from personal beliefs about racial minority groups, which have generally become more positive. Increasing research attention has focused on implicit racial biases. The implicit association test (IAT; Greenwald, McGhee, & Schwartz, 1998) is described as a measure of automatic associations between bipolar groups (e.g., black and white) and bipolar attributes (e.g., positive and negative traits). The speed at which participants pair categories with attributes is considered to be an indicator of the strength of the association between them. IAT research focused on racial groups has been interpreted as indicating implicit preferences for Whites over Blacks (e.g., Dasgupta, McGhee, Greenwald, & Banaji, 2000). Although a connection between the IAT and behavior is less commonly demonstrated, in some studies these implicit attitudes have predicted differences in behavior towards Blacks (e.g., McConnell & Leibold, 2004). Additionally, another example of subtle bias is the tendency for racial preferences to influence decisions involving ambiguous information, such as hiring decisions with equally weighted candidates (Dovidio & Gaertner, 2000). This research indicates that ambiguous contexts are more likely to permit even implicit racial biases to influence decisions and behavior.

There is substantial evidence of racial inequality at a broader, institutional level, including inequality in employment rates, wages, and incarceration (e.g., Western & Pettit, 2005), although other factors (e.g., cultural adaptation) may also contribute to these racial inequalities. Seaton (2009) describes three broader mechanisms of discrimination, including cultural racism, institutionalized racism, and collective racism. Cultural racism describes the
tendency to present the beliefs and practices of the dominant group as being superior or assumed; the term *ethnocentrism* captures a similar concept. Institutionalized racism refers to differential access to goods, services, and opportunities, with racial minorities generally awarded diminished access. Collective racism is defined as occurring when the dominant group denies the minority group their basic rights (Seaton).

Stigmatization during interpersonal interactions also appears to be a common experience for racial minorities. For example, 91.4 percent of a sample of Black, Latino, Asian American, American Indian, and Biracial community members reported discrimination experiences (Carter & Forsyth, 2010). Not surprisingly, racial minority groups generally report more discrimination experiences than Whites (e.g., Harvey, 2001). Just as racial biases may be either explicit or implicit, it is possible to distinguish both overt and subtle racial discrimination. A meta-analysis concluded that negative racial attitudes related to intent to discriminate, but did not strongly predict discriminatory behavior (Schutz & Six, 1996). However, negative emotions towards a group were more predictive of discriminatory behavior than attitudes alone (Talaska, Fiske, & Chaiken, 2008), indicating that the affective component of prejudice was more likely to motivate discriminatory behavior. Explicit prejudiced attitudes and emotions increase likelihood for discrimination, but more subtle discriminatory behavior may be connected with more implicit attitudes. *Racial microaggressions* are considered to be more implicit behaviors which include everyday subtle and covert verbal, nonverbal, and environmental slights (Sue, Capodilupo, & Holder, 2008). Several subtypes of microaggressions have been described, including *microinsults*, expressions of rudeness or insensitivity for an individual’s racial identity, and *microinvalidations*, dismissing or diminishing others’ racial experience.
Reactions to Racial Stigma. The final mechanism of racial stigmatization is through its impact on the emotions, beliefs, and behaviors of racial minorities. The impact of racism and discrimination is variable across individuals and situations (Harvey, 2001; Major & O’Brien, 2005). Reactions are influenced by differences in perception of events (e.g., is it discrimination or not), the meanings attributed to discriminatory experiences (e.g., relevance to self-concept), emotional reactions (e.g., anger, depression), and resulting behaviors (coping strategies, including avoidance and activism). Interpretations of discrimination can be influenced by past experiences and personal characteristics of the person experiencing discrimination (Major & O’Brien).

Experiences with both explicit and implicit racism impact individuals’ expectations of others’ negative attitudes towards them and their group, whether or not they internalize these attitudes. Brown and Lee (2005) investigated stigma consciousness across racial groups, finding that Black and Hispanic undergraduates exhibited higher stigma consciousness than Asians and Whites, while Asians had higher levels than Whites. Another cognitive reaction to awareness of structural racism is system blame, including expecting the US government to harm Blacks, a belief which is more common among Black Americans than Whites (Crocker, Luhtanen, Broadnax, & Blaine, 1999). In addition, research indicates that discrimination experiences predict decreasing expectations of positive public regard towards one’s group over time (Seaton, Yip, & Sellers, 2009). Implicit discrimination also impacts perceptions of how society perceives racial minorities; for example, common meanings ascribed to experiences with microaggressions include: you do not belong, you are abnormal, you are intellectually inferior, you are not trustworthy, and you are all the same (Sue, Capodilupo, & Holder, 2008).
In addition to impacting expectations and other cognitive reactions, racial discrimination can result in emotional consequences. Carter and Forsyth (2010) reported that the most common emotional responses to implicit racism were anger and feeling disrespected, with sadness being less common. Discrimination can have an emotional impact enduring months or years after the incident, and has been linked to negative consequences including mental and physical health problems, which in turn can negatively impact functioning. Higher reported discrimination experiences have been related to consequences including psychological distress, state and trait anxiety, depression, powerlessness, and goal disruption, in studies that have included Black, Latino/a, and Asian college students and community members (Harvey, 2001; Hwang & Goto, 2008; Moradi & Risco, 2006; Seaton, 2009).

Stigmatization can also influence the behavior of racial minorities, including behaviors that unintentionally confirm stereotypes. For example, perceived racial discrimination predicted increased traumatic stress symptoms among Mexican American adolescents, which in turn predicted increased high risk behaviors (e.g., drugs, fights), supporting the idea that high risk behaviors may be used as a coping strategy (Flores, Tschann, Dimas, Pasch, & de Groat, 2010). In addition, initial research on stereotype threat found that Black participants who were told that a test was diagnostic of abilities had more race-related word completions, endorsed fewer traits consistent with Black stereotypes, got fewer questions correct, and took longer to answer (Steele & Aronson, 1995), indicating both stereotype activation and impaired performance. Another behavioral response is disengagement from domains in which negative racial stereotypes exist. Black students appear to be more likely to disengage academically than White students, especially if racial bias is primed or if disengagement is chronic due to chronic discrimination. Evidence consistent with this pattern includes findings that discrimination in school was related
to decreased school bonding among Black youths (Dotterer, McHale, & Crouter, 2009), the self-esteem of White students was more affected than that of Black students by feedback about performance on an intelligence test (Major, Spencer, Schmader, Wolfe, & Crocker, 1998), and increased stigma consciousness was related to decreased grade point average (GPA Brown & Lee, 2005). Disengagement from academic domains may help one cope with stereotypes about Blacks being unintelligent, but it also provides apparent confirmation of the stereotype by contributing to the academic achievement gap between Blacks and Whites.

Racial stigmatization may impact the expectations, emotions, and behaviors of racial minorities in many ways, even when individuals reject negative societal attitudes. Racism can also impact the self-concept of racial minorities. Research indicates that internalization of stigmatizing attitudes is far from the only reaction to stigma consciousness; in fact, at times stigma may help protect self-concept. Attributing negative feedback to social stigma rather than to the self and choosing in-group members rather than advantaged out-group members as social comparisons can protect self-esteem, particularly in the context of negative feedback (Crocker & Major, 1989; Crocker, Voelkl, Testa, & Major, 1991).

**Racial Self-Stigma.** Mental illness self-stigma may be more common than self-stigma related to race, although no research directly compares them. In fact, while developing a measure of racial/ethnic identity, Phinney (1992) found that so few participants endorsed items reflecting negative racial self-concept that the final measure excludes them. Possible reasons for lower prevalence of explicit racial self-stigma include the current societal rejection, at least explicitly, of the legitimacy of racial discrimination, the relatively more positive role models who belong to racial minority groups, the relatively younger age at which race becomes integrated into self-concept, and increased likelihood that children will learn coping skills for racial discrimination.
from family members (e.g., parents). However, racial minorities may also internalize stigmatizing attitudes towards their racial group, perhaps especially more implicit self-stigma.

Some evidence of racial self-stigma may be reflected in research on collective self-esteem (CSE) and racial identity development. CSE represents one’s beliefs and feelings about the groups to which one belongs. Beliefs about how the community views the group are public CSE, whereas private CSE reflect personal beliefs about the group. Private CSE was found to predict well-being for Black students (Crocker, Luhtanen, Blaine, & Broadnax, 1994), and personal and ethnic self-esteem partially mediated the relationship between discrimination and distress for male ethnic minority adolescents (Cassidy, O’Connor, Howe, & Warden, 2004).

Models of racial and ethnic identity development may also reflect internalization of racial stigma. Cross’s (1971) Nigrescence model describes five stages of Black identity development, and similar racial identity models have been developed for several other racial groups (see Sue & Sue, 2008) including Asian American identity (Sue, 1989), and Latino/Hispanic identity (Ruiz, 1990). Most such models include an initial stage involving either unawareness of racial identity and/or acceptance of the dominant culture, including its stigmatization of racial minorities, and later stages reflecting increased awareness and integration of race into self-concept. Research suggests that the initial phase of racial identity development may relate to relatively lower psychological health, including decreased self-actualization and self-acceptance, increased feelings of inferiority, inadequacy, hypersensitivity, and anxiety (Parham & Helms, 1985), and increased risk for health and other problems (Seaton, 2009).

Evidence of subtle racial self-stigma may also be found in the internalization of “colorism,” in which gradations of skin tone are valued or devalued by society within and/or between racial/ethnic groups (e.g., Buchanan, Fischer, Tokar, & Yoder, 2008; Harrison &
Devaluing darker skin tones appears to contribute to decreased body satisfaction and perceptions of attractiveness (Hill, 2002) and attempts to change skin tone through skin-lightening products (Glenn, 2008). Similarly, internalization of Western or White ideals of hair (e.g., “good hair”) may also reflect subtle internalization of racial stigma (Robinson, 2011).

**Criminality Stigma, Reactions to Stigma, and Self-Stigma**

*Criminality stigma.* There is less research on stigmatization of people due to having a criminal offense history, despite evidence of stigma against this group. In a national survey study, although a substantial minority of respondents explicitly rejected stereotypes about ex-offenders, the majority endorsed common stereotypes of ex-offenders as dangerous and dishonest (Hirschfield & Piquero, 2010). There is unmistakable overlap between stigmas related to mental illness, race, and criminality, particularly stereotypes of dangerousness and aggression.

It may be easier to hide one’s ex-offender status than other stigmatized identities (e.g. race); therefore, at times, it may be easier to avoid criminality stigma. However, in some contexts such secrecy may be impossible. Many employers require applicants to report their criminal background, conduct a background check, and require individuals with a criminal record to explain the context of their conviction. Increased difficulty of finding employment is an institutional mechanism of stigmatization. Only 12 percent of employers were supportive of hiring ex-offenders, which increased to 30 to 50 percent if ex-offenders had higher education, if government support was offered, or if the crime was unrelated to the job (Albright & Denq, 1996). In a competitive job market, it may often be easier to avoid hiring ex-offenders.

Research on criminality stigma during interpersonal interactions is more limited. No identified research has distinguished explicit from implicit forms of discrimination, including microaggressions, but there is evidence that stigma against offenders can limit social networks.
and supports. For instance, a longitudinal study of adolescents concluded that being labeled a criminal and the resulting stigma impacts peer networks, which in turn impacts future criminal involvement (Bernburg, Krohn, & Rivera, 2006).

**Reactions to Criminality Stigma.** Some research has examined stigma consciousness among offenders. A large study of inmates near release found a general consensus of anticipated rejection by others in multiple social contexts (Winnick & Bodkin, 2008), and participants in a qualitative study of stigma experiences of ex-offenders in higher education described fears about social and employment discrimination, and exhibited secrecy through attempts to hide their offense history and selectively choosing who to tell (Copenhaven, Edwards-Willey, & Byers, 2007). Some evidence suggests that stigma consciousness can vary based on demographic variables. For example, White participants and those with no post-release experience had elevated anticipated rejection due to their ex-offender status (Winnick & Bodkin).

Stigma may also impact other outcomes for offenders, including increased risk for severe health problems found among people with incarceration histories, potentially through the negative impact of incarceration and stigma on stress, coping, and social supports (Schnittker & John, 2007). Stigma, coping, stress, and poor social supports likely also contribute to elevated suicide rates found among recently released prisoners (Pratt, Piper, Appleby, Webb, & Shaw, 2006). There is less research on more implicit self-stigma reactions of people with criminal histories, including stereotype threat. There is also minimal research systematically exploring the impact of criminality stigma on the self-concept of stigmatized individuals.

**Self-stigma of criminality.** Although the impact of stigma on offenders has been explored somewhat, research has largely not addressed the role of self-stigma in these outcomes. However, change in self-concept as a result of offender status has received some research
attention. *Labeling theory* proposes that being labeled and stigmatized as a “criminal” causes changes in self-concept and increases risk for re-offense (e.g., Thomas & Bishop, 1984; Wellford, 1975). There is minimal support for the concerns represented in labeling theory. Although recidivism rates were higher among juvenile offenders who were randomly assigned to dispositions with more prominent offender labels, there was no evidence of differences in self-concept across dispositions (Klein, 1986), nor was there evidence that punishment contributed to a delinquent self-concept in a study comparing labeling theory with other theories of punishment (Thomas & Bishop, 1984). Accordingly, Wellford (1975) argued that labeling theory is largely unsupported by available criminology research, with particularly limited support for its claims about identity change due to being labeled an offender. No known research has directly explored how internalization of criminality stigma may predict negative outcomes.

**Multiple Stigmatized Identities: Forensic Psychiatric Patients**

Despite the multidimensionality of self-concept, less research has investigated the experiences of individuals with multiple stigmatized identities, including how they may affect each other, become internalized, and affect outcomes. One area of research relevant to the experience of several marginalized identities uses an intersectionality framework, defined as the way social categories mutually construct each other (Cole, 2009). A recent qualitative study found that lesbian, gay, and transgender participants with mental illness reported stigma in multiple contexts, feeling alienated, limited social acceptance, and struggles to find a valued self-concept (Kidd, Veltman, Gately, Chan, & Cohen, 2011). Another study of multiple stigmatized identities found that mental illness discrimination was more closely related to psychiatric symptoms and social rejection, whereas discrimination due to other group memberships was related to broader quality of life variables (Sanders Thomson, Noel, & Campbell, 2004). This
preliminary research suggests that people who belong to multiple stigmatized groups may face unique struggles in self-concept and be particularly at risk for compromised outcomes.

People with both mental illness and criminal history, labeled ‘forensic psychiatric patients,’ are particularly relevant to the experience of multiple stigmas and represent an important research population for social and theoretical reasons. The stereotype that people with mental illness are dangerous is widely held and common in media portrayals, and clearly overlaps with stereotypes about offenders. These attitudes are common among police officers, correctional officers, and mental health workers (Margetic, Aukst-Margetic, Ivanec, & Filipic, 2008; Watson, Corrigan, & Ottati, 2004). Furthermore, there is considerable overlap between mental illness and the correctional system (Lurigio, 2011), with rates of severe mental illness higher in prisons and jails compared to the community (Diamond, Wang, Holzer, Thomas, & Cruser, 2001). Rates of seeking psychiatric treatment appear to be higher among offenders compared to the general population (Rodriguez, Keene, & Li, 2006), but there remains a discrepancy between mental health needs of offenders and services received (Lurigio, 2011; Steffan & Morgan, 2005). Both stigma against forensic psychiatric patients and attitudes towards available mental health services within this population may contribute to this discrepancy.

Forensic psychiatric patients necessarily have two highly stigmatized labels; additionally, racial stigma is highly relevant in the correctional system. Negative portrayals of forensic psychiatric patients as dangerous, aggressive, and unpredictable overlap with attitudes about racial minorities. Moreover, multiple policies contribute to the demonstrated racial disparities in incarceration, with particularly elevated incarceration rates for Black males (Miller, 2010; Pettit & Western, 2004; Schlesinger, 2011). Racial inequality in incarceration has been described as a predominant mechanism for marginalization of racial minorities and for perpetuating societal
power hierarchies (e.g., Alexander, 2010; Loury, 2008). Due to these incarceration patterns, many forensic psychiatric patients also belong to racial minority groups. No known studies have investigated the racial/ethnic composition of forensic psychiatric populations broadly (i.e., across geographic regions), but some studies have reported the racial composition of their samples. For instance, studies have reported on forensic psychiatric samples being composed of 51% racial minorities in Florida (Roman & Gerbing, 1979), 59% in California (Vess, Murphy, & Arkowitz, 2004), 79% in New York City (Casper & Clark, 2004), and 25% in the United Kingdom (Dickens, Lange, & Picchioni, 2011).

Some preliminary research has begun to investigate outcomes for people in forensic contexts who are multiply stigmatized. Offenders with dual diagnoses of mental illness and substance abuse appear to have high recidivism rates (90%; Hartwell, 2004), higher than offenders with substance use disorders alone (Messina, Burdon, Hagopian, & Prendergast, 2004). Although not investigated in these studies, this group may have particular difficulty reintegrating into society due to discrimination or to increased risk for developing a negative self-concept. One recent study of self-stigma in a forensic psychiatric sample found no self-stigma differences between people assigned to mandated treatment in forensic versus civil mental health systems (Livingston, Rossiter, & Verdun-Jones, 2011). However, qualitative evidence suggested that forensic labeling may increase exposure to stigma for some individuals. Additionally, self-stigma among forensic psychiatric patients predicted outcomes including more severe psychiatric symptoms and history of incarceration and homelessness (Livingston et al.). However, no research has investigated how self-concept related to mental illness, race, and offender status may influence each other and outcomes for forensic psychiatric patients.

Chapter 3: Research Conducted
Purpose of Study and Hypotheses

Broadly, this study contributes to the stigma, self-stigma, and self-concept literatures by investigating reactions to stigma among forensic psychiatric patients. It investigated discrimination experiences based on membership in several stigmatized groups; the relative relationship between self-concept related to mental illness, race, and criminality, and outcome variables; and the potential mediating role of stigmatized identity centrality and coping skills on the relationship between self-stigma and these outcomes. More specifically, the study investigated the following specific hypotheses and exploratory areas of interest.

1) Analyses first investigated basic scale characteristics. Several scales, although relatively well-researched, have limited psychometric data in forensic psychiatric populations, so information relevant to scale properties and consistency with previous research was necessary. Similarly, some questionnaires are fairly new and have limited validation research (e.g., Beliefs about Criminals Scale).

2) Analyses investigated frequency of discrimination experiences reported by participants. It was unclear what source of discrimination (due to mental illness, race, offense history, or others) would be most commonly reported, because no research had directly compared them in this population.
   a. Based on relevant previous research, it was hypothesized that discrimination due to mental illness and race will be commonly reported in this sample.
   b. Due to the predominance of the criminal offense histories in the lives of these participants, it was also predicted that discrimination experiences due to being a criminal offender would be prevalent in this sample.
c. It was predicted that discrimination experiences would be related to increased perceptions of negative public attitudes towards relevant groups.

d. The relationship between reported discrimination experiences and self-stigma were exploratory. Given how prevalent stigmatizing attitudes are in society, it was unclear whether directly experiencing discrimination would be a necessary prerequisite to experiencing negative consequences of stigma, particularly self-stigma.

3) Exploratory correlational and ANOVA analyses investigated the possible impact of demographic variables on self-stigma, mediator, and outcome variables included in this study.

a. There are inconsistent findings in the literature about possible racial differences in mental illness stigma and self-stigma. Analyses investigated for possible differences between racial groups in included measures, particularly for the possibility that mental illness stereotype agreement and self-stigma are higher among Black participants.

b. Analyses investigated for differences in stigma measures between diagnoses, based on research showing that some diagnoses (e.g., schizophrenia) are related to increased perceptions, agreement, and self-stigma of mental illness.

4) Correlational analyses investigated the relationship between the three stigmatized identities, and the relationship between stigma scales and outcome variables (depression, self-esteem, participant- and clinician-rated treatment adherence, and treatment alliance).

a. It was hypothesized that there would be relationships between outcomes measures. It was expected that there would be a negative correlation between self-esteem (RSES) and depression (CES-D). It was expected that there would be a positive correlation
between self-esteem and treatment adherence, and a negative correlation between depression and treatment adherence.

b. It was hypothesized that scales reflecting awareness of stigma (SSMIS-Stereotype Awareness, BACS-A, and CSES-Public) would be unrelated to self-esteem (RSES) and depression (CES-D).

c. It was hypothesized that self-stigma of mental illness would predict increased depression, decreased self-esteem, decreased treatment alliance, decreased participant-reported and clinician-reported treatment adherence, and decreased working alliance.

d. It was hypothesized that criminality self-stigma would predict increased depression, decreased self-esteem, decreased treatment alliance, and decreased participant-reported and clinician-reported treatment adherence. Correlations between working alliance and criminality identity were exploratory.

e. It was hypothesized that less positive racial self-concept would predict increased depression, decreased self-esteem, decreased treatment alliance, and decreased participant-reported and clinician-reported treatment adherence. Correlations between working alliance and racial self-concept were exploratory.

5) The study also investigated the potentially combinatory or additive impact that these stigmatized identities may have on outcomes.

a. It was hypothesized that there would be a positive correlation between the measures of self-concept related to mental illness (SSMIS-Stereotype Self-Concept), race (CSES-Private), and criminality (BACS-C).
b. It was hypothesized that the combination of these stigmatized identities would influence each other to have an independent relationship with outcomes, particularly self-esteem detriment.

6) Analyses investigated for possible mediators (stigmatized identity centrality and coping skills used for discrimination) of the relationship between self-stigma and outcome measures.

a. It was predicted that increased centrality of mental illness identity would be related to increased mental illness self-stigma, decreased self-esteem, and increased depression.

b. It was predicted that increased centrality of criminality identity would be related to increased criminality self-stigma, decreased self-esteem, and increased depression.

c. Analyses of the relationship between racial identity centrality and racial self-concept was exploratory.

d. It was predicted that more positive, active coping skills would be correlated with decreased self-stigma scores and with improved outcomes (increased self-esteem and treatment adherence scores, and decreased depression).

e. Because more central identities are likely to have a larger impact on self-concept and outcomes, it was predicted that increased centrality of mental illness and criminality identities would predict increased self-stigma and poorer outcomes, and would mediate these relationships.

f. Based on the emphasis on the importance of coping skills in clinical practice, it is expected that coping likely influences the relationship between stigmatization and self-concept. It was predicted that higher levels of problem-centered coping would correlate with decreased self-stigma and better outcomes, and would mediate these relationships.
Several less structured, qualitative measures were also included in this study, to further investigate how experiences with these three stigmatized identities influence this unique sample. These preliminary, qualitative analyses were largely exploratory.

a. It was predicted that having more, positive sources of self-concept (using responses on the TST) would be related to decreased self-stigma scores.

b. Analyses explored how mental illness, racial, and criminal offense-related identities may combine and influence each other.

c. Analyses explored how potential coping strategies, protective factors, and targets for intervention that may address forensic stigma.

Methods

Participants

A total of 82 participants were recruited from two sites, in the interests of representing a wider range of symptom presentations and involvement with the legal system. One group of participants (N = 31) was drawn from Bronx Psychiatric Center, a long-term psychiatric inpatient hospital that has a large number of people with both chronic mental illness and arrest histories. The other group of participants (N = 51) was drawn from the Bronx TASC Mental Health Court Program. Bronx TASC is a diversion program designed to identify individuals with criminal charges who have mental illness and would benefit from treatment services, and connects eligible individuals with services as an alternative to incarceration. The inclusion criteria for participation in the study was having mental illness diagnosis and a history of criminal justice involvement, and being able to communicate in English. Participants were permitted to participate in the study regardless of diagnosis, race/ethnicity, gender, or age.
A subset of participants were selected to participate in a second, less structured interview. These participants were selected based on their representativeness of different diagnoses, offense histories, and racial/ethnic group membership, in addition to their ability and willingness to express their experiences with stigma in a more detailed, personal format.

Participants were majority male, racially diverse, middle-aged, and single, with varying educational backgrounds. The majority of participants had psychotic spectrum or mood disorders, and about half of participants had dual diagnoses of a substance use disorder. The most common criminal charges were drug-related charges, attempted murder, and assault. Some previous research with samples of forensic psychiatric patients in New York City (Casper & Clark, 2004; Price, David, & Ortiz, 2004) have reported a limited number of these demographic variables, which were largely consistent with this study in terms of age, race, and gender. Tables 1 and 2 include more detailed demographic information describing participants in this study.

Measures

Demographics Questionnaire. A demographics questionnaire was completed based on information from participants and their charts. Information included on the demographics form includes participants’ age, race, birth country, gender, marital status, years of education, age of first hospitalization, number of hospitalizations, psychiatric diagnoses, psychiatric medications, total length of time incarcerated, most recent offense, and time since adjudication. With participant consent, this information, particularly information related to psychiatric and offense history, was confirmed with a chart review.

Experience of Discrimination Scale (EDS; Sanders Thompson, Noel, & Campbell, 2004). The Experience of Discrimination Scale is an adaptation of previous questionnaires assessing experiences with racial discrimination, which was designed to investigate
discrimination due to membership in a variety of groups. It asks participants to answer yes or no to whether or not they have ever experienced discrimination. Participants who respond ‘yes’ then indicate whether they have experienced discrimination due to multiple types of group membership (e.g., religion, mental illness, race, age, gender, and physical disability). Finally, they are asked to indicate in what context this discrimination had occurred (employment, housing, treatment, education, etc.). This questionnaire has been found to be helpful in two large studies (Corrigan, Thompson, Lambert, Sangster, Noel, & Campbell, 2003; Sanders Thompson, et al.). This questionnaire was modified slightly in this study to include status as a criminal offender as a possible stigmatized group, and asked participants to indicate frequency of discrimination experiences rather than simply presence or absence of discrimination.

**Twenty Statements Test (TST; Kuhn & McPartland, 1954).** The TST is a self-report, open form measure that requires respondent to answer the statement “I am ___” twenty times. It was developed to explore self-concept and allows researchers to explore participants’ perceptions of themselves and their relationships with others. This more free-form instrument allows for an initial, rough investigation of multiple types of identifications, thus various methods have been used to analyze responses. One coding scheme (Watkins, Yau, Dahlin, & Wondimu, 1997) involves calculating the percentage of responses given that fall in each of four categories: idiosyncratic responses (personal qualities, beliefs, emotions), large group responses (membership in groups with many members), small group responses (membership in groups with few members), and allocentric responses (about interdependence with others, sociability, friendship, concern about views of others). There is support for the interrater reliability of this method (.91; Grace & Cramer, 2003). It is also possible to categorize responses as positive or negative. Although validation evidence for this measure varies and is hard to interpret given the
qualitative nature of the measure, it has been suggested in the literature that this more open-ended format provides helpful additional information when exploring a complex construct like self-identity, particularly if combined with other, more structured measurement techniques (Grace & Cramer).

**Self-Stigma of Mental Illness Scale (SSMIS; Corrigan, Watson, & Barr, 2006).** The SSMIS is a 40-item self-report scale designed to measure increasing levels of influence of stigma, including stigma internalization. Each item is rated on a 9-point agreement scale (1 = strongly disagree, 9 = strongly agree). It can be divided into four subscales (ten items each): stereotype awareness (e.g., “I think the public believes most persons with mental illness are dangerous”), stereotype agreement (e.g., “I think most persons with mental illness are dangerous”), and stereotype self-concurrence (e.g., “Because I have a mental illness, I am dangerous”). The fourth scale, self-esteem decrement, was not included in this study. Initial validation studies indicated that the different scales had good internal consistency in a sample of adults with psychiatric diagnoses, with alphas ranging from .72 to .89, as well as demonstrating validity through predicted relationships with self-esteem and depression symptoms (Corrigan et al.). In a meta-analysis, Livingston and Boyd (2010) report that the average internal consistency of this measure is good (α = .84).

**Collective Self-Esteem Scale-Race/Ethnicity Version (CSES-R; Luhtanen & Crocker, 1992).** The Collective Self-Esteem Scale is a 16-item self-report scale, responded according to a 7-point Likert scale ranging from 1 (strongly disagree) to 7 (strongly agree) that was designed to measure individuals’ evaluations of their membership in a social group. It has four subscales, each with four items: Private (extent to which individuals feel positively about their racial/ethnic group; e.g., “I feel good about the race/ethnicity I belong to”), Public
which individuals believe others have positive feelings towards their group; e.g., “Overall, my racial/ethnic group is considered good by others”), Membership (individuals’ beliefs that they are a good member of the group; e.g., “I am a worthy member of my race/ethnic group”), and Importance to Identity (centrality of racial/ethnic identity; e.g., “The racial/ethnic group I belong to is an important reflection of who I am”). In a preliminary validation study, the four scales were found to have adequate internal consistency reliability, ranging from $\alpha = .73$ to .80 in various samples of undergraduates (Luhtanen & Crocker). Utsey, S.O., & Constantine, M.G. (2006). The race/ethnicity version of this scale requests the respondent to answer questions according to their membership in their racial/ethnic group, without specifying a particular race or ethnicity. In this study, the Private Collective Self-Esteem subscale was used to indicate racial self-stigma, and the Importance to Identity subscale was used to indicate centrality of racial identity.

**Beliefs about Criminals Scale (BACS; Mashek, Meyer, McGrath, Stuewig, & Tangney, 2002).** The BACS is a 12-item self-report measure, answered on a 7–point Likert scale (1 = totally disagree to 7 = totally agree), designed to be answered by individuals with criminal offense histories to measure stigma against criminals. It is divided into two scales. BACS-A reflects participants’ beliefs about how community members feel and what they think about “criminals” in general (e.g., “People in the community believe criminals are bad people”), and BACS-B reflects participants’ expectations about how people in the community would treat them if they were aware of the participant’s criminal record (e.g., “People in the community will treat me fairly”). In previous research in a sample of incarcerated individuals, the BACS subscales had good internal consistency reliability ($\alpha = .81$ to .83; Mashek et al.). This measure was altered for this study by adding a third scale, BACS-C, designed to capture negative self-
concept stemming due to having a criminal background (e.g., “Because I am an offender, I am a bad person”), as well as slightly altering some wording to make the measure appropriate for participants who are not currently incarcerated.

**Importance to Identity Index (III).** The Importance to Identity Index used in this study is based on the 4 self-report items, rated on a 7-point Likert scale, comprising the Importance to Identity subscale of the Collective Self-Esteem Scale (CSES; Luhtanen & Crocker, 1992). The original Importance to Identity subscale, which focused on racial/ethnic identity, was found to have good internal consistency reliabilities (α = .73 to .86) in an initial validation study (Luhtanen & Crocker). In this study, participants were asked to answer these 4 questions with respect to the centrality of their identity as a person diagnosed with a mental illness (e.g., “My mental illness is an important reflection of who I am”) and as a person with a criminal history (e.g., “Being a criminal offender is an important reflection of who I am”), in addition to completing it for their racial identity as part of the CSES-R as described above. This procedure, in which this subscale is used in isolation to indicate centrality of stigmatized identities, is similar to that used by Quinn and Chaudoir (2009) in a study of thirteen types of concealed identities. The total scores will be used to reflect the centrality of both mental illness and offender group membership to the participant’s sense of self.

**Coping with Discrimination Scale (CDS; Wei, Alvarez, Ku, Russell, & Bonett, 2010).** The CDS is a 25-item self-report measure designed to measure the coping skills people may use to cope with discrimination. It has five scales, each with five items: Education/Advocacy (e.g., “I try to educate people so that they are aware of discrimination”), Internalization (e.g., “I wonder if I did something wrong”), Drug/Alcohol Abuse (e.g., “I use drugs or alcohol to numb my feelings”), Resistance (e.g., “I get into an argument with the person”), and Detachment (e.g.,
“I’ve stopped trying to do anything”). The items are non-specific with regards to type of discrimination, although it was originally developed with racial discrimination in mind. A initial validation studies indicated that the CDS scales had adequate reliability coefficients (α = .67 to .90 for studies 1 and 2) in a sample of university students, as well as exhibiting predicted relationships with measures of depression, anxiety, and ethnic identity (Wei et al.).

**Rosenberg Self-Esteem Scale (RSES; Rosenberg, 1989).** The RSES is a widely-used 10-item self-report scale developed to measure global self-esteem. Participants to rate items (e.g., “I feel that I am a person of worth, at least on an equal basis with others”) on a 4-point Likert scale (0=Strongly disagree, 3=Strongly agree), after which items scores are summed to create a total score ranging from 0 to 30, with higher scores representing higher global self-esteem (e.g., Sinclair et al., 2010). There is evidence supporting its internal consistency, with Cronbach’s alphas ranging from .84 to .91 when examined across different age, racial, and gender groups (Sinclair et al.). Substantial validation of the RSES has been conducted. For example, the measure has been found to exhibit a predicted pattern of relationships with a measure of perceptions of stigma in a sample of participants diagnosed with schizophrenia (Razali, Hussein, Tg, & Tg, 2010).

**Center for Epidemiological Studies Depression Scale (CES-D; Radloff, 1977).** The CES-D is a widely used and validated self-report measure designed to capture number and frequency of depression symptoms. Its 20 items (e.g., “I did not feel like eating; my appetite was poor” and “I felt depressed”) are answered on a 4-point Likert scale (0 = rarely/none of the time, 3 = most/all of the time). Higher scores indicate more depression, and research has suggested a cutoff of 16 as indicative of clinical depression (Boyd, Weissman, Thompson, & Myers 1982).
It has demonstrated good reliability and validity in many samples (e.g., Foley, Reed, Mutran, & DeVellis, 2002; Orme, Reis, & Herz, 1986).

**Medication Adherence Rating Scale (MARS; Thompson, Kulkarni, & Sergejew, 2000).** The MARS is a 10-item self-report scale designed to measure patients’ self-reported psychiatric medication-related behaviors and beliefs. Its items are selected from the Drug Attitudes Inventory (DAI; Hogan, Awad, & Eastwood, 1983), a 30-item scale of clients’ beliefs about medications, and the Medication Adherence Questionnaire (MAQ; Morisky, Green, & Levine, 1986), a 4-item scale designed to measure clients’ medication-taking behaviors. Each item (e.g., “When you feel better, do you sometimes stop taking your medicine?”) of the MARS is answered yes or no, and final scores range from 0 (low likelihood of adherence) to 10 (high likelihood of adherence). In an initial validation study, the MARS was found to have good internal reliability (α = .75) and test-retest reliability after a two-week interval (χ^2 = .72) in a sample of adults with mental illness (Thompson et al.). Evidence supporting its validity included a positive relationship with other measures of medication adherence and with blood levels (Thompson et al.). In order to permit comparisons between participant and treating clinician-rated medication compliance, both the original patient (or participant)-rated version (MARS-PV) of this scale and a version slightly revised to permit rating by the participant’s treating clinician (MARS-Clinician Version, or MARS-CV) were employed in this study.

**Psychosocial Treatment Compliance Scale (PTCS; Tsang, Fung, & Corrigan, 2006).** The PTCS is a 17-item scale measuring a patient’s adherence to psychosocial treatment that is rated by clinicians or other observers on a 5-point Likert scale. It yields a total score and two subscales, Participation (12 items; e.g., “Actively participated in prescribed psychosocial treatment”) and Attendance (5 items; e.g., “Attended prescribed psychosocial treatment”). In an
initial validation study, internal consistency reliability (Participation: $\alpha = .96$, Attendance: $\alpha = .87$) and test-retest reliability (Participation: $r = .90$, Attendance: $r = .06$) were high for both scales in a sample of adults with psychotic diagnoses. There was evidence of convergent validity through the relationship between PTCS scores and measures of self-esteem, attitudes towards medication, and medication compliance (Tsang et al.). In order to permit comparisons between participant and treating clinician-rated psychosocial treatment compliance, both the original clinician-rated version of this scale (identified as PTCS-CV) and a version slightly revised to permit rating by the participant (PTCS-Participant Version, or PTCS-PV) will be employed in this study.

**Working Alliance Inventory-Short Form (WAI-SR; Hatcher, & Gillaspy, 2006; Horvath & Greenberg, 1989; Tracey & Kokotowicz, 1989).** The WAI-S is a 12-item self-report measure, answered according to a 7-point Likert scale (1 = Never to 7 = Always), designed to measure therapy clients’ ratings of treatment alliance. It yields both a total score and three subscales: Task Scale (agreement on therapy tasks between client and therapist; e.g., “We agree on what is important for me to work on”), Goal Scale (agreement on treatment goals; e.g., “___ and I are working towards mutually agreed upon goals.”) and Bond Scale (strong relational bond between client and therapist; e.g, “___ and I trust one another”). The WAI-S subscale and total scores have exhibited good reliability ($\alpha = .73$ to $.92$) and acceptable relationships with the full version of the WAI and with treatment outcomes (Busseri & Tyler, 2003; Munder, Wilmers, Leonhart, Linster, & Barth, 2010).

**Forensic psychiatric stigma experiences interview.** This interview is a series of open-ended questions developed for this study to organize the collection of qualitative data. These questions asked participants to describe their experiences with discrimination related to mental
illness, race, and criminality, explain how their reactions to and thoughts about these experiences have changed over time, and explore how these different stigmatized identities may influence each other.

**Procedures**

Participants were recruited at the two treatment sites by the primary investigator and trained research assistants. Participants were considered eligible to participate if they had a psychiatric diagnosis, a history of criminal charges, and the ability to communicate in English. At Bronx TASC, all service recipients who were able to communicate in English were eligible to be approached for the study. At Bronx Psychiatric Center, all inpatients met the psychiatric history requirement, but did not necessarily have the required legal history. Therefore, a brief chart review was conducted to identify which individuals had a history of criminal charges. Individuals with the required legal history were approached for participation in the study. All potential participants were informed of the purpose of the study, its potential risks and benefits, and other information that had a foreseeable impact on their decision to participate, in accordance with informed consent procedures. Researchers assessed for ability to consent and participate based on participants’ demonstrated comprehension of the consent process, and ongoing during the research protocol. Participants signed a consent form indicating their willingness to participate in the study, and provided a second signature to indicate willingness to allow the researcher to view their chart and ask their treating psychologist to provide additional information.

If they consented, participants were provided with a series of questionnaires in a packet, including the demographics questionnaire, EDS, SSMIS, CSES-R, BACS, III-Mental Illness and III-Offender, CDS, RSES, CES-D, PTCS-PV, and MARS-PV. Participants were given the option
of completing the questionnaires independently, with a researcher present to answer their questions, or to have the researcher verbally administer the questionnaires and record their responses. This procedure was designed to permit participation regardless of reading ability and increase participant attention to and engagement with the questionnaires. Descriptive analyses indicate that the majority (67 out of 82) of participants elected to have the researcher read the questionnaires and record their responses.

With participant consent, research assistants confirmed demographic information by reviewing information from the participant’s chart, particularly psychiatric diagnosis, psychiatric medications, most recent legal charge(s), total time incarcerated, and time since adjudication. In addition, clinicians who had knowledge of participants’ engagement in psychiatric treatment were asked to complete two questionnaires (PTCS-CV, MARS-CV) addressing participants’ medication and psychosocial treatment adherence. Clinicians completed these questionnaires based on their general knowledge of the participant’s engagement in treatment. At Bronx Psychiatric Center, these questionnaires were completed by either the psychiatrist or treatment team leader. At Bronx TASC these forms were completed by the participant’s case manager.

Participants were assigned individual identification numbers. A study record log with both identification numbers and participants’ names was stored in a separate location than the completed data packets, along with signed consent forms. The database did not include participant names or other individually identifying information, and the record sheet will be destroyed by the primary investigator after completion of data collection and creation of the database.

Selected participants were interviewed to collect data for the qualitative component of the study after completion of the quantitative data collection. These participants were selected from
those who completed the qualitative component of the study. They were informed about the purpose of the interview and completed a separate consent form, including consent to have their interview audio recorded. The length of these interviews varied, but tended to be one to two hours in duration. Qualitative interviews were transcribed, and transcribed interviews were analyzed for content and themes relevant to topics of interest described previously.

Results

Data Preparation and Analysis

Data analyses were completed using IBM SPSS 21 statistical analysis package. Mean replacement was used to replace missing data points. The majority of scales required minimal replacement of data points (e.g., had less than 1 percent of the data points replaced); the exception was the treatment adherence scales (MARS-CV = 1.5%, PTCS-CV = 5.6%, PTCS-PV = 3.3%). Participants who completed less than half of the items in a measure were coded as missing the relevant measure.

There were not enough participants in some demographic groups to allow for certain comparisons. For the purposes of analyses, racial groups were coded into four groups: White, African American/Black, Latino/a/Hispanic, and Other (including Asian American, Middle Eastern, Native American, and mixed race participants). There were not enough participants in the racial groups included in “Other” to allow for reliable comparisons. Concerning marital status, there were not enough participants who indicated they were living with a partner or in a domestic partnership, so these categories were excluded from demographic analyses. All reported analyses including these demographic variables used these recoded categories. Primary psychiatric diagnosis was coded into categories: schizophrenia, schizoaffective disorder, psychotic disorder NOS/other psychotic disorder, bipolar disorder, major depressive disorder,
mood disorder NOS, and PTSD/other anxiety disorder. Substance use was coded as either present (if the person had any current diagnosis of any substance abuse or dependence) or absent. Criminal charges were categorized into the following groups based on the participants’ most serious recent charge: murder/manslaughter, attempted murder or assault, robbery/burglary, arson (including attempted arson), drug-related charges (possession, sale), and other/unknown (including threatening a police officer and possession of weapons).

The results below investigate basic scale properties; demographic differences in study variables; prevalence of reported discrimination experiences and their relationships with stigma variables; the relationship between the three stigma measures and outcome measures; the potential interaction between self-stigma measures in predicting outcome variables; potential mediators; and exploratory analyses of more qualitative measures.

Analyses of Scale Properties

Self-Stigma of Mental Illness Scale (SSMIS). On all SSMIS subscales, a score of 10 is the lowest possible score (indicating that the person strongly disagreed with all items) and a score of 90 is the highest (strongly agree to all possible items). Scores on the SSMIS Stereotype Awareness Scale ranged from 10 to 90 (M = 56.58, SD = 22.76). Scores on the SSMIS Stereotype Agreement Scale ranged from 10 to 82 (M= 31.88, SD = 16.47). Scores on the SSMIS Stereotype Self-Concurrence Scale ranged from 10 to 55 (M = 22.83, SD = 12.50), suggesting that no participants strongly agreed with all items on this scale measuring mental illness self-stigma.

Statistics for skewness and kurtosis were in acceptable range for SSMIS Awareness and Agreement scales; there was evidence that the SSMIS Stereotype Self-Concurrence scale was positively skewed. Due to skewness, the SSMIS-Self-Concurrence scale was corrected using a
natural log correction, which resulted in values with acceptable skewness statistics. All other SSMIS-Self-Concurrence analyses were conducted using this transformed variable.

Cronbach’s alpha was used to investigate the inter-item consistency of the SSMIS scales, which were in acceptable range for all scales: SSMIS-Awareness (α = .92), SSMIS-Agreement (α = .84), and SSMIS-Stereotype Concurrence (α = .78). These internal consistencies are consistent with previous SSMIS research conducted in non-forensic samples (e.g., Corrigan, Watson, & Barr, 2006). Also consistent with previous studies, SSMIS Stereotype Awareness scale was not correlated with the SSMIS Stereotype Agreement or the Stereotype Self-Concurrence scales, but the Stereotype Agreement and Stereotype Self-Concurrence scales were significantly correlated (r (79) = .59, p = .00). These similarities with previous research provide some evidence that the measure performed similarly in this forensic sample.

**Beliefs about Criminals Scale (BACS).** Scores on the BACS-A, which measures awareness of negative public attitudes towards offenders, ranged from 14 to 51 (M = 33.04, SD = 8.17). The lowest possible score on this scale is 8 and highest possible score is 56, indicating that the mean score fell in the middle of the scale. Scores on the BACS-B, which measures expectations of discrimination for offense history, ranged from 4 to 28 (M = 18.37, SD = 6.27). The lowest possible score on this scale is 4 and the highest is 28, indicating that participants tended to endorsing some expectations of discrimination. Scores on the BACS-C, a measure of internalization of stereotypes about offenders, ranged from 8 to 32 (M = 13.55, SD = 6.32). The lowest possible score on this scale is 8 and highest possible score is 56, indicating that participants did not tend to endorse most items about internalizing stereotypes about offenders.

Statistics for skewness and kurtosis were in acceptable range for BACS-A and BACS-B; BACS-C was positively skewed. Due to skewness, the BACS-C scale was corrected using a
natural log correction, which resulted in values with acceptable skewness statistics. All other
BACS-C analyses were conducted using this transformed variable. Internal consistency was
acceptable for BACS-B ($\alpha = .85$) and BACS-C ($\alpha = .75$), but were low for BACS-A ($\alpha = .62$). The
reliability for BACS-A was lower than that found in previous correctional samples (Mashek,
Meyer, McGrath, Stuewig, & Tangney, 2002), but the statistic for BACS-B was similar to
previous research. The BACS-A, reflecting awareness of stereotypes about criminals, was not
correlated with the BACS-B, reflecting expectations of stigmatization, or BACS-C, reflecting
stereotype self-concurrence. BACS-B was also not correlated with BACS-C.

**Collective Self-Esteem Scale (CSES).** The lowest possible score for CSES Total is 16
and the highest is 112, and for each of the subscales the lowest possible score is 4 and the highest
is 28. In this study, scores on the CSES-Total scale ranged from 44 to 112 ($M = 83.61$, $SD =
13.29$) and the CSES-Membership scale ranged from 10 to 28 ($M = 21.72$, $SD = 4.72$). CSES-
Private ranged from 8 to 28 ($M = 23.91$, $SD = 4.20$), which indicated that participants tended to
report positive internal attitudes about their racial/ethnic group. CSES-Public ranged from 5 to
28 ($M = 18.81$, $SD = 5.45$), CSES-Identity ranged from 6 to 28 ($M = 19.36$, $SD = 5.26$). The
CSES-Private Scale was negatively skewed and kurtotic, so the CSES-Private scale was
corrected using a square root transformation, which resulted in values with acceptable skewness
statistics. All other CSES-Private analyses were conducted using this transformed variable.

In terms of internal consistency, statistics were acceptable for CSES-Total ($\alpha = .75$), but
were low for other CSES scales: CSES-Public ($\alpha = .60$), CSES-Private ($\alpha = .65$), CSES-
Membership ($\alpha = .57$), CSES-Importance to Identity ($\alpha = .59$). These subscale score reliabilities
were lower than those found for samples of undergraduate students (Luhtanen & Crocker, 1992).
CSES Total scores were correlated with all CSES scale scores (Public: $r (81) = .62$, $p < .001$;
Private: $r (81) = -.78, p < .001$; Membership: $r (81) = .72, p < .001$; and Importance to Identity: $r (81) = .61, p < .001$. The CSES Public Scale was correlated with the CSES Private scale ($r (81) = -.30, p = .01$), but not with the Membership or Importance to Identity scales. The CSES Private Scale was correlated with the Membership ($r (81) = -.62, p < .001$) and Importance to Identity ($r (81) = .35, p = .001$) scales. The CSES Membership scale was correlated with the Importance to Identity scale ($r (81) = .26, p = .02$).

**Working Alliance Inventory (WAI).** The lowest possible WAI Total score is 12 and the highest is 84; for each of the subscales the lowest score is 4 and the highest is 28. WAI-Total scores ranged from 34 to 80 ($M = 68.97, SD = 11.67$), WAI-Bond scores ranged from 10 to 28 ($M = 23.26, SD = 4.77$), WAI-Task scores ranged from 10 to 28 ($M = 22.41, SD = 4.26$), and WAI-Goal scores ranged from 10 to 28 ($M = 23.34, SD = 4.57$). These scores suggested that participants tended to report more positive impressions of their therapy relationships than negative impressions. There was evidence that WAI-Goal was negatively skewed.

Internal consistency was acceptable for WAI-Total ($\alpha = .86$) and WAI-Bond ($\alpha = .78$), but was low for WAI-Task ($\alpha = .58$) and WAI-Goal ($\alpha = .69$). These latter internal consistencies are lower than those found in previous research (Busseri & Tyler, 2003; Munder, Wilmers, Leonhart, Linster, & Barth, 2010) WAI-Total was correlated with all WAI scales (Bond: $r(79) = .89, p < .001$; Task: $r(79) = .81, p < .001$; Goal: $r(79) = .87, p < .001$). WAI-Bond was correlated with WAI-Task ($r(79) = .59, p < .001$) and WAI-Goal ($r(79) = .71, p < .001$). WAI-Task was correlated with WAI-Goal ($r(79) = .60, p < .001$).

**Rosenberg Self-Esteem Scale (RSES).** The lowest possible score on the RSES is 0 and the highest score is 30; scores of 15 and lower have been interpreted as indicating possible low self-esteem. In this study, scores ranged from 8 to 30 ($M = 20.70, SD = 5.77$), indicating that the
mean score was higher than the typical cutoff for low self-esteem but some participants scored below this cutoff. There was no evidence of skewness or kurtosis. Internal consistency reliability was in the acceptable range ($\alpha = .85$). These findings are consistent with some previous research (Sinclair et al., 2010), suggesting that the RSES performed similarly in this forensic sample.

**Center for Epidemiological Studies-Depression Scale (CES-D).** The lowest possible score is 0 and the highest possible score is 60, and studies have suggested a cutoff of 16 or higher as being indicative of clinical depression. Scores ranged from 0 to 55 ($M = 21.92$, $SD = 13.42$), suggesting that the mean score was above typical cutoffs for depression. There was no evidence of skewness or kurtosis. Internal consistency was in an acceptable range ($\alpha = .91$), and consistent with previous research (Foley, Reed, Mutran, & DeVellis, 2002; Orme, Reis, & Herz, 1986).

**Medication Adherence Rating Scale (MARS).** The highest score on the MARS is 10 and the highest is 20, with higher scores indicating higher likelihood of medication adherence. MARS-CV scores ranged from 10 to 20 ($M = 18.07$, $SD = 2.37$), and MARS-PV scores ranged from 11 to 20 ($M = 16.79$, $SD = 2.40$), indicating that both the clinician and the participant version of the medication adherence scale tended to be higher than the absolute midpoint of the scale. MARS-PV skewness and kurtosis scores were acceptable, but MARS-CV scores were negatively skewed. Reliability was low for MARS-CV ($\alpha = .603$) and MARS-PV ($\alpha = .622$). These reliability scores are lower than found in previous research in a non-forensic sample (Thompson, Kulkarni, & Sergejew, 2000).

**Psychosocial Treatment Compliance Scale (PTCS).** The lowest PTCS score is 17 and the highest is 85. PTCS-CV scores ranged from 42 to 85 ($M = 68.58$, $SD = 7.68$), and PTCS-PV scores ranged from 33 to 85 ($M = 70.24$, $SD = 9.51$), indicating that both clinician and
participant reported psychosocial treatment compliance tended to be higher than the absolute midpoint of the scale. PTCS-CV skewness and kurtosis scores were acceptable, but PTCS-PV scores were positively kurtotic. Internal consistency reliability was acceptable for PTCS-CV (\(\alpha = .956\)) and PTCS-PV (\(\alpha = .922\)), which is consistent with previous research in a non-forensic population (Tsang, Fung, & Corrigan, 2006).

**Coping with Discrimination Scale (CDS).** The lowest possible score for the CDS Total is 25 and the highest is 150; for each of the subscales, the lowest possible score is 5 and the highest is 25. CDS-Total scores ranged from 30 to 109 (M = 61.27, SD = 14.76), CDS-EA scores ranged from 5 to 30 (M = 13.85, SD = 7.34), CDS-In scores ranged from 5 to 28 (M = 12.69, SD = 5.24), CDS-Drugs/Alcohol scores ranged from 5 to 30 (M = 11.42, SD = 6.37), CDS-Resistance ranged from 5 to 26 (M = 12.95, SD = 4.81), and CDS-Detachment scores ranged from 5 to 30 (M = 11.03, SD = 5.71).

Skewness and kurtosis statistics were acceptable for all CDS subscales. Internal consistency reliability was acceptable for most CDS scales: CDS-Total (\(\alpha = .70\)), CDS-Education/ Advocacy (\(\alpha = .86\)), CDS-Drugs/Alcohol (\(\alpha = .71\)), and CDS-Detachment (\(\alpha = .78\)). Internal consistency was low for two CDS scales: CDS-Internalization (\(\alpha = .65\)) and CDS-Resistance (\(\alpha = .44\)); these reliabilities are lower than those found in previous non-forensic, undergraduate research samples (Wei, Alvarez, Ku, Russell, & Bonett, 2010).

**Importance to Identity Index (III).** Scores for both III-Mental Illness and III-Offender measures can range from 4 to 28, with higher scores indicating greater centrality of the relevant identity. III-Mental Illness scores ranged from 4 to 26 (M = 15.57, SD = 5.57), and III-Offender scores ranged from 4 to 27 (M = 12.53, SD = 5.94). Skewness and kurtosis statistics were acceptable for both scales. The internal consistency of both scales was low: III-Mental Illness (\(\alpha = .65\)).
and III-Offender (α = .62). This reliability is lower than that found in previous research focused on racial identity centrality (Luhtanen & Crocker, 1992). The III-Mental Illness and the III-Offender were correlated (r(79) = .31, p = .01).

**Discrimination Experiences**

The frequency of different types of discrimination experiences reported by participants were analyzed using simple descriptive analyses of the types of discrimination included in the Experience with Discrimination Scale (EDS). Correlational analyses then investigation the relationship between discrimination experiences and the stigma measures used in this study.

A total of 53 out of 82 participants (64.6%) reported that they had been discriminated at some point in the past. Consistent with hypotheses 2a and 2b, discrimination experiences due to race, mental illness, and incarceration were the most commonly reported in this study. A total of 43 participants (53.7%) reported that they had been discriminated against based on their race, 38 (47.5%) reported discrimination due to mental illness, 33 (40.7%) reported discrimination due to past incarcerations, 28 (34.1%) reported discrimination due to SES, 26 (31.7%) reported discrimination due to country of origin, 21 (25.6%) reported discrimination due to gender, 16 (19.8%) reported discrimination due to religion, 16 (19.5%) reported discrimination due to physical disability, 16 (19.5%) reported discrimination due to age, 15 (18.3%) reported discrimination due to sexual orientation.

In terms of where reported discrimination occurred, 33 participants (41.2%) reported discrimination by law enforcement, 26 participants (31.7%) reported discrimination in housing, 25 participants (30.5%) reported discrimination in employment contexts, 23 participants (28%) reported discrimination in education, 17 participants (20.7%) reported discrimination in public accommodations, 14 participants (19.1%) reported discrimination in consumer-operated mental
health services, and 19 participants (23.2%) reported discrimination in traditional mental health services.

Exploratory analyses (2c) explored whether discrimination experiences related to stigma measures. Reported frequency of discrimination experiences due to mental illness positively correlated with BACS-B \( (r(77) = .26, p = .02) \) but not with SSMIS or CSES scales. Discrimination experience due to race positively correlated with BACS-B \( (r(78) = .25, p = .03) \) and negatively correlated with CSES Public \( (r (81) = -.22, p = .05) \), but was unrelated with SSMIS scales. Discrimination experiences due to past incarcerations was correlated with SSMIS-Awareness \( (r(80) = .33, p = .03) \), SSMIS-Agreement \( (r(78) = -.23, p = .05) \), and BACS-B \( (r(78) = .40, p <.001) \), but not with CSES scales.

**Analyses of Demographic Variables**

These analyses explored whether there were differences in scales used in this study based on included demographic variables (see Tables 3 and 4). Results of these analyses are highlighted below.

There were no significant differences for demographic variables on the Coping with Discrimination Scale (CDS), the Identity Centrality Index (ICI), the Center for Epidemiological Studies-Depression scale (CES-D), and the Rosenberg Self-Esteem Scale (RSES).

Contrary to Hypothesis 3a, there was not a significant difference between racial groups in mental illness stereotype awareness, agreement, or self-stigma. There was a significant difference across racial groups in reported age-related discrimination experiences on the EDS \( (F(77, 3) = 2.95, p = .05, \eta^2 = .10) \), such that White participants on average reported more discrimination experiences due to age than other racial groups. Contrary to Hypothesis 3b, there was not a significant difference in stigma scores based on psychiatric diagnosis. Number
of past hospitalizations was negatively correlated with the SSMIS-Stereotype Awareness scale ($r(81) = -.24$, $p = .03$), suggesting the participants with fewer hospitalizations reported more awareness of public stigmatization of mental illness. Years incarcerated was positively correlated with the SSMIS-Stereotype Agreement scale ($r(76) = .23$, $p = .04$), indicating that participants who had more total years incarcerated were more likely to agree that societal stereotypes about people with mental illness are true.

There was a significant difference in BACS-A scores across racial/ethnic groups ($F(3, 74) = 3.92$, $p = .01$), such that White participants exhibited higher awareness of negative attitudes about offenders in the community than Latino/a/Hispanic participants ($LSD = 8.47$, $p = .02$). There was a significant difference in BACS-C scores between genders ($F(1, 77) = 7.31$, $p = .01$), indicating that men exhibited higher internalization of negative attitudes towards offenders than women did. This finding was equivalent to the significant finding for non-transformed BACS-C. There was a significant difference in BACS-A scores based on substance use disorder ($F(1, 81) = 3.93$, $p = .05$), indicating that the group of participants without a substance use disorder reported higher awareness of negative community attitudes about offenders. BACS-A scores were significantly correlated with indicators of mental illness severity. They were positively correlated with age of first hospitalization ($r(76) = .24$, $p = .04$) and negatively correlated with number of past hospitalizations ($r(79) = -.23$, $p = .05$), suggesting that participants who were psychiatrically hospitalized later and participants who had fewer hospitalizations were more aware of negative public attitudes towards offenders.

There was a difference between genders in CSES-Private scores ($F(1, 79) = 9.11$, $p = .00$), such that women had more positive internal attitudes about their racial/ethnic identity. There was a difference in CSES Importance to Identity scores based on presence or absence of
substance use disorder \( (F(1, 79) = 5.27, p = .02) \), such that people with a substance use disorder reported that their racial/ethnic identities were more important to them. There was a significant correlation between age and CSES Total scores \( (r(81) = -.24, p = .03) \), CSES Private scores \( (r(81) = -.27, p = .01) \), and CSES Membership scores \( (r(82) = -.24, p = .03) \), such that younger participants exhibited more positive internal attitudes about their race and believed they were a good member of their racial/ethnic group. Number of past hospitalizations was negatively correlated with CSES Membership scores \( (r(81) = -.22, p = .05) \), such that participants with more hospitalizations reported feeling that they were a less good member of their racial/ethnic group. Total years incarcerated was also correlated with CSES Total scores \( (r(78) = -.25, p = .03) \), CSES Private scores \( (r(78) = -.30, p = .01) \), and CSES Membership scores \( (r(78) = -.24, p = .04) \), suggesting that participants with more years incarcerated had less positive internal attitudes about their racial/ethnic group and felt like a less good member of their racial/ethnic group. These findings for transformed CSES-Private were also significant when investigated using non-transformed CSES-Private scores.

There was a significant difference between genders in PTCS-CV scores \( (F(1, 70) = 4.16, p = .05) \), such that women had higher clinician-reported likelihood of medication adherence. The MARS-CV was significantly different across racial/ethnic groups \( (F(5, 67) = 5.57, p = .00) \), but post hoc analyses indicated that the “other” racial group accounted for this significant difference in clinician-rated medication adherence and so is difficult to interpret. Years of education was positively correlated with the MARS-CV \( (r(64) = .27, p = .03) \) and the MARS-PV \( (r(69) = .29, p = .02) \), indicating that participants with more years of education had higher likelihood of medication adherence as reported by both clinicians and participants. Number of past hospitalizations was negatively correlated with the MARS-CV \( (r(72) = -.29, p = .02) \) and the
PTCS-CV (r(72) = -.30, p = .01), indicating that participants with more hospitalizations had lower clinician-reported medication and psychosocial adherence scores. Total years incarcerated was positively correlated with the PTCS-PV (r(74) = -.38, p = .00), indicating that participants with more years incarcerated had better participant-reported psychosocial treatment compliance. Time since adjudication was positively correlated with the MARS-PV (r(74) = .29, p = .01), indicating that participants with more time elapsed since adjudication self-reported higher likelihood medication adherence (perhaps because participants with more time since adjudication were inpatient).

There was a significant difference in WAI-Task scores based on substance use disorder (F(1, 77) = 4.72, p = .03), such that people with a substance use disorder reported higher agreement on the focus of psychiatric treatment between themselves and their clinician.

**Correlational Analyses: Stigma and Outcome Measures**

**Outcome Measures.** Analyses explored the relationship between outcome measures in this study: depression (CES-D), self-esteem (RSES), medication adherence (MARS-PV and MARS-CV), and psychosocial treatment adherence (PTCS-PV and PTCS-CV). See Table 5 for these correlations.

Consistent with hypothesis 4a, there was a significant negative correlation between CES-D and RSES, indicating that higher self-esteem related to lower depressive symptoms. Also consistent with hypothesis 4a, the participant version of both treatment adherence measures (MARS-PV and PTCS-PV) were correlated with both the CES-D and RSES, indicating that higher self-esteem and lower depression related to higher participant-reported medication and psychosocial treatment adherence. Findings were less consistent for the clinician versions of the treatment adherence scales; both clinician-reported adherences scales were positively correlated
with RSES, but not with CES-D. There was a significant correlation between treatment adherence measures completed by the same source: the two participant versions correlated ($r(75) = .40$, $p < .001$) and the two clinician versions correlated ($r(72) = .43$, $p < .001$). There was also a significant correlation between participant and clinician versions of the MARS ($r(69) = .31$, $p = .01$). There was not a significant correlation between PTCS scores completed by the two sources.

**Stigma and outcome measures.** Correlations explored the relationship between measures of stigma of mental illness (SSMIS-Stereotype Awareness), stigma of criminality (BACS), and attitudes about one’s racial group (CSES), and the outcome measures of the study. Table 6 describes SSMIS correlations, Table 7 describes BACS correlations, and Table 8 describes CSES correlations.

Consistent with hypothesis 4b, the SSMIS-Stereotype Awareness scale was not correlated with the CES-D or the RSES. The SSMIS-Stereotype Agreement scale was positively correlated with the RSES ($r (79) = -.28$, $p = .01$), but not with the CESD or any of the treatment adherence measures. Consistent with hypothesis 4c, the SSMIS-Stereotype Self-Concurrence scale was positively correlated with the CESD ($r (79) = .33$, $p = .003$) and negatively correlated with the RSES ($r (79) = -.41$, $p < .001$) and MARS-PV ($r (78) = -.34$, $p = .002$). Thus, increased in mental illness self-stigma scores related to increased depression scores and decreased self-esteem and participant-reported medication adherence. These findings for the transformed SSMIS-Self-Concurrence scale was consistent with findings for non-transformed variable. However, contrary to hypothesis 4c, there was not a significant relationship between SSMIS-Stereotype Self-concurrence and the psychosocial treatment adherence scale (PTCS-PV or PTCS-CV) or the therapy alliance (WAI) scales.
Table 7 describes correlations between BACS scores and outcome measures. The BACS-A was positively correlated with the PTCS-CV ($r(70) = .26, p = .03$), indicating that increased awareness of negative community attitudes about criminals was related to increased clinician-reported psychosocial treatment compliance. The BACS-B was significantly correlated with the CES-D ($r(79) = .24, p = .03$) and the PTCS-PV ($r(76) = -.23, p = .04$), indicating that increased expectations of being discriminated against due to criminal history related to increased depression and decreased participant-reported psychosocial treatment compliance. Contrary to hypothesis 4d, the BACS-C did not correlate with self-esteem, depression, or treatment adherence measures. However, the BACS-C negatively correlated with all WAI scores (which was consistent with findings with the non-transformed BACS-C), indicating that increased internalization of stigma about offenders was related to less positive attitudes about treatment alliance with one’s clinician.

Table 8 describes relationships between racial identity (CSES) and outcome measures. Consistent with hypothesis 4b, beliefs about public attitudes about one’s racial group (CSES-Public) were not correlated with any outcome measures. Consistent with hypothesis 4e, the CSES Private scale was correlated with the CES-D ($r(79) = .37, p = .001$) and the RSES ($r(81) = -.47, p < .001$), indicating that more positive internal attitudes about one’s race/ethnic group related to decreased depression and increased self-esteem. CSES-Private was also positively correlated with PTCS-PV ($r(76) = .28, p = .015$), indicating that more positive internal attitudes about one’s race/ethnic group related to increased psychosocial treatment compliance. The CSES-Private was also negatively correlated with the WAI Total ($r(79) = -.28, p = .01$), WAI Bond ($r(79) = -.34, p = .003$), and WAI-Goal ($r(79) = -.23, p = .01$), indicating that more positive internal attitudes about one’s race/ethnic group related to less positive attitudes about alliance
with one’s clinician. These findings for CSES-Private were consistent with findings using the non-transformed variable. The CSES Membership scale was correlated with the CESD ($r(79) = -.43$, $p < .001$), the RSES ($r(81) = .56$, $p < .001$), and the PTCS-PV ($r(76) = .33$, $p = .003$), indicating that feeling like a good member of one’s racial/ethnic group related to decreased depression, increased self-esteem, and increased psychosocial treatment compliance.

**Analyses of Combination of Self-Stigma Variables**

This study also investigated the potentially combined impact of stigma identities in this sample. Correlational analyses investigated the relationships between measures of mental illness, criminality, and racial identity measures. Then a series of Univariate General Linear Model analyses were used to investigate the relationship between the three self-stigma-related measures, the interactions between them, and the outcome measures used in this study.

**Correlations between stigma measures.** Correlational analyses explored the relationship between the measures of mental illness, racial, and criminality identities. The BACS-A was positively correlated with the SSMIS Stereotype Awareness Scale ($r(79) = .24$, $p = .03$) but not the other SSMIS scales, meaning that as awareness of negative societal attitudes about people with mental illness increased, so did awareness of societal attitudes about offenders. The BACS-B (expectations of stigmatization due to offense history) was also positively correlated with the SSMIS Stereotype Awareness Scale ($r(79) = .31$, $p = .01$). Consistent with hypothesis 5a, the BACS-C was positively correlated with both the SSMIS Stereotype Agreement scale ($r(79) = .42$, $p < .001$) and the Stereotype Self-Concurrence scale ($r(79) = .39$, $p < .001$), suggesting that increased internalization of attitudes about people with mental illness related to both increased expectations of discrimination due to being an offender and increased internalization of negative attitudes about being an offender. These findings for
the transformed SSMIS-Stereotype Concurrence and BACS-C scales were consistent with significant findings for the non-transformed variables.

The CSES Public scale was negatively correlated with the SSMIS Stereotype awareness scale ($r(81) = -.24, p = .04$) and there was a trend for a negative correlation with the BACS-A ($r(79) = -.22, p = .06$), suggesting that beliefs of more negative societal attitudes towards one’s race related to increased awareness of negative attitudes towards people with mental illness and offenders. The CSES Private scale was not correlated with any of the SSMIS scales, but consistent with hypothesis 5a, was negatively correlated with the BACS-C ($r(79) = -.322, p = .004$). This indicated that less positive attitudes towards one’s racial group related to increased internalization of negative attitudes about offenders related, but was unrelated to mental illness self-stigma. This finding for the transformed BACS-C and CSES-Private was consistent with significant findings for the non-transformed variables.

**Regression Analyses.** To further investigate hypothesis 5b, a series of regression models explored the relationship between the three self-concept variables (SSMIS-Self-Concurrence, BACS-C, and CSES-Private) and each of the dependent variables (RSES, CES-D, MARS-PV, PTCS-PV, MARS-CV, and PTCS-CV). Interaction terms were created to explore whether the combination of these variables had a more than just additive impact on the dependent variables. Significant interaction effects indicate that the effect (on the dependent variable) of one variable in the interaction term depends on the level of the other variable in the interaction term. For each outcome variable (RSES, CES-D, and all four treatment adherence measures), several regression models were investigated to investigate the main effects of the three self-concept variables, the three two-way interactions between each pair of self-concept variables, and the one three-way interaction between all three variable. Because some demographic variables were correlated
with relevant measures, they were also entered into the regression analyses to investigate if they influenced these relationships. The indicated findings were consistent comparing transformed and non-transformed variables. Partial eta squared is the effect size measure given in the SPSS output for these analyses.

Regression analyses investigating predictors of self-esteem (RSES) were consistent with Hypothesis 5b. The first regression model included just main effects of SSMIS-Self-Concurrence, BACS-C, and CSES-Private. In this model, both CSES-Private (F(1,75) = 19.34, p < .001, partial eta² = .21) and SSMIS-Self-Concurrence (F(1,75) = 11.74, p < .001, partial eta² = .14) significantly predicted RSES scores, but BACS-C did not. The second model included these main effects and three two-way interaction variables between each pair of self-stigma variables. In this model, there were no significant main effects, but there was a significant interaction effect for CSES-Private x BACS-C (F(1,72) = 5.36, p = .02, partial eta² = .07). The next model included main effects and a three-way interaction between all three predictor variables. In this model, there were significant main effects for CSES-Private (F(1,74) = 5.04, p = .03, partial eta² = .06) and SSMIS-Self-Concurrence (F(1,74) = 8.20, p = .005, partial eta² = .10). Finally, the last model included all main effects and both two- and three-way interaction effects. In this model, there were main effects of CSES-Private (F(1,71) = 4.36, p = .04, partial eta² = .06), BACS-C (F(1,71) = 5.07, p = .03, partial eta² = .07), and SSMIS-Self-Concurrence (F(1,71) = 3.93 p = .05, partial eta² = .05). There was a significant interaction effect for CSES-Private x BACS-C (F(1,71) = 4.99, p = .03, partial eta² = .07), indicating that the lower the CSES-Private scores, the greater the effect of BACS-C scores on RSES scores. There was also a significant interaction effect for SSMIS-Self-Concurrence x BACS-C (F(1,71) = 3.89, p = .05, partial eta² = .05), indicating that the higher the BACS-C scores, the greater the impact of SSMIS-Self-
Concurrence scores on RSES. When demographic variables were added to the model, the only significant demographic predictor of RSES scores was gender, such that women had higher self-esteem scores. Stigma predictors remained significant even when demographic variables were included in the model.

Regression analyses investigating predictors of the CES-D were partially consistent with Hypothesis 5b. The first model included just main effects of SSMIS-Am, BACS-C, and CSES-Private. In this model, there were significant effects on CESD scores of both CSES-Private (F(1,75) = 10.18, p = .002, partial eta² = .12) and SSMIS-Self-Concurrence (F(1,75) = 7.37, p = .01, partial eta² = .09). The second model added two-way interactions between these predictor variables, and had significant main effects for CSES-Private (F(1,72) = 4.77, p = .03, partial eta² = .06) and significant interaction effects for CSES-Private X BACS-C (F(1,72) = 5.65, p = .02, partial eta² = .07), suggesting that the lower the CSES-Private scores, the greater the effect of BACS-C scores on CES-D scores. The next model included main effects and a three-way interaction between all predictors on CES-D. In this model, there were significant main effects for CSES-Private (F(1,74) = 5.93, p = .02, partial eta² = .07) and SSMIS-Self-Concurrence (F(1,74) = 8.33, p = .005, partial eta² = .10). The last model included all main effects and both two- and three-way interaction effects. In this model, there were no significant effects. When demographic variables were added to the model, the only significant demographic predictor of CES-D scores was gender, such that women had higher depression scores. Stigma predictors remained significant even when demographic variables were included in the model.

Regression analyses investigating predictors of the MARS-Participant Version were partially consistent with Hypothesis 5b. The first model included just main effects of the predictor variables on MARS-PV scores, which found a main effect of SSMIS-Self-Concurrence
(F(1,74) = 9.99, p = .002, partial $\eta^2 = .12$). The next model included main effects and two-way interaction effects and found no significant main effects and an interaction effect for CSES-Private X BACS-C (F(1,71) = 5.3, p = .02, partial $\eta^2 = .07$), suggesting that the lower the CSES-Private scores, the greater the effect of BACS-C scores on MARS-PV. The next model included main effects and a three-way interaction effect between all predictors and found a main effect of SSMIS-Self-Concurrence (F(1,73) = 9.89, p = .002, partial $\eta^2 = .12$) but no significant interaction effects. The final model included all main effects and both two- and three-way interaction effects. In this model, there were no significant effects. When demographic variables were added to this full model, the only significant predictor of MARS-PV scores was gender, such that men had higher MARS-PV scores than women. Stigma predictors remained significant even when demographic variables were included in the model.

Regression analyses investigating predictors of the PTCS-Participant Version were largely inconsistent with Hypothesis 5b. The first model included just main effects and found a main effect for CSES-Private (F(1,72) = 7.94, p = .006, partial $\eta^2 = .10$). The second model included main effects and two-way interaction effects and did not find any main or interaction effects. The next model included main effects and a three-way interaction and did not find any significant effects. The final model included all main and interaction effects and found no significant main or interaction effects. There were no significant demographic predictors of PTCS-PV scores. Stigma predictors remained significant even when demographic variables were included in the model.

Regression analyses investigating predictors of the MARS-Clinician Version were largely partially consistent with Hypothesis 5b. The first model included just main effects and found no significant effects. The second model included main effects and two-way interaction
effects and found a main effect of BACS-C (F(1,63) = 5.20, p = .03, partial eta² = .08), and interaction effects for SSMIS-Self-Concurrence X CSES-Private (F(1,63) = 4.38, p = .04, partial eta² = .07) and CSES-Private X BACS-C (F(1,63) = 4.25, p = .03, partial eta² = .06). The next model included main effects and a three-way interaction and did not find any significant effects. The final model included all main and interaction effects and found no significant main or interaction effects. However, when demographic variables were included in this full model, number of hospitalizations (F(1,44) = 5.05, p = .03), and BACS-C (F(1,44) = 5.05, p = .03) were both statistically significant. When demographic variables were added to this full model, increased number of past hospitalizations predicted decreased MARS-CV scores. Stigma predictors remained significant even when demographic variables were included in the model.

Regression analyses investigating predictors of the PTCS-Clinician Version were inconsistent with Hypothesis 5b. None of the four investigated models found any significant main or interaction effects.

Mediation Analyses

This study also aimed to investigate two possible mediator variables for the relationship between self-stigma and outcome variables. Mediators have been minimally investigated in general, and have never been investigated in a forensic sample. Initial analyses investigated the correlation between mediator variables, stigma variables, and outcome variables. Then a series of regression analyses investigated for mediation relationships.

Correlations between Mediator Variables and Both Stigma and Outcome Measures.

Table 9 describes the pattern of correlations between the measures of the centrality of the stigmatized identities included in this study (mental illness, race, and criminality) were correlated with the stigma measures and the outcome measures.
The III—Mental Illness was significantly correlated with the SSMIS-Agreement ($r(79) = .23, p = .05$) and, consistent with hypothesis 6a, the SSMIS-Self-Concurrence scale ($r(79) = .31, p = .005$), indicating that as centrality of the mental illness identity increased, agreement with mental illness stigma and internalization of this stigma also increased. Consistent with hypothesis 6b, the III-Offender scale was correlated with the BACS-C ($r(79) = .29, p = .01$), indicating that increases in the centrality of the offender identity related to increases in internalization of stigma about offenders. The III-Offender also correlated with the SSMIS-Self-Concurrence scale ($r(79) = .24, p = .04$), indicating that increased offender identity centrality related to increased internalization of mental illness stigma. Related to 6c, the CSES-Importance to Identity scale positively correlated with the CSES-Private scale ($r(81) = .34, p = .002$) scale, indicating that more positive internal attitudes about one’s race related to increased racial identity centrality. In terms of outcome measures, consistent with 6a, the III-Mental Illness was negatively correlated with the RSES ($r(79) = -.36, p = .001$), indicating that as centrality of mental illness identity increased, self-esteem decreased. Consistent with 6b, the III-Offender was correlated with the CES-D ($r(79) = .33, p = .003$) and the RSES ($r(79) = -.39, p < .001$), indicated that more centralized offender identity related to increased depression and decreased self-esteem. No III scales were correlated with the WAI.

Contrary to hypothesis 6d, none of the CDS scales were correlated with the SSMIS scales. Consistent with hypothesis 6d, the CDS Education/Advocacy scale was negatively correlated with the BACS-C ($r(78) = -.25, p = .03$), indicating that increased internalization of stigma about offenders related to decreased use of education and advocacy to cope with discrimination. Additionally, the CDS Education/Advocacy scale correlated with the CSES-Private scale ($r(80) = .26, p = .02$) and the Importance to Identity scale ($r(80) = .40, p < .001$),
indicating that increased use of education and advocacy to cope with discrimination related to more positive feelings towards one’s racial/ethnic group. Several CDS scales were correlated with outcome measures in ways consistent with hypothesis 6d. The Drugs/Alcohol scale (r(78) = .35, p = .002) and Detachment scale (r(78) = .30, p = .01) correlated with the CES-D, suggesting that as depressive symptoms increased the use of drugs or alcohol and detachment to cope with discrimination also increased. The Education/Advocacy scale (r(81) = .28, p = .01), the Drugs/Alcohol scale (r(81) = -.23, p = .04), and the Detachment scale (r(81) = -.27, p = .02) were all correlated with the RSES, suggesting that increased self-esteem related to increased use of education or advocacy to cope with discrimination, and decreased use of drugs or alcohol and detachment to cope. The CDS Detachment scale (r(77) = -.332, p = .003) negatively correlated with the MARS-PV, indicating that as increases in detachment as a coping strategy related to decreases in participant-reported medication adherence. The CDS Internalization scale was correlated with the PTCS-PV (r(75) = .242, p = .0376), indicating that increased tendency to internalize, or blame oneself, for discrimination experiences related to increases in psychosocial treatment compliance. The indicated findings were consistent comparing transformed and non-transformed variables.

**Regression Mediation Analyses.** As a test of Hypothesis 6e, a series of regression analyses (see Baron & Kenny, 1986) investigated whether any of the Importance to Identity Index measures (III-Mental Illness, III-Offender, or III-Race/Ethnicity), or any of the Coping with Discrimination Scales served as mediators between self-stigma measures and outcome measures. III-Mental Illness did not mediate or partially mediate the relationship between SSMIS-Stereotype Self-Concurrence scores and CES-D scores, because III-Mental Illness did not predict CES-D scores. BACS-C scores did not predict CES-D or RSES scores, so mediation
was not possible. The measure of racial identity centrality (CSES-Importance to Identity scale) did not predict outcome variables either, so no mediations were possible.

As a test of Hypothesis 6f, the III-Mental Illness scale partially mediated the relationship between SSMIS-Self-Concurrence and RSES scores (see Diagram 1). The standardized regression coefficient between SSMIS-Self-Concurrence and RSES decreased when controlling for III-Mental Illness scores. The other conditions of mediation were also met: SSMIS-Self-Concurrence was a significant predictor of RSES and of III-Mental Illness, and III-Mental Illness was a significant predictor of RSES while controlling for SSMIS-Self-Concurrence. This partial mediation indicates that the relationship between mental illness self-stigma and self-esteem detriment can be partially explained by the centrality of the mental illness identity (or how important the mental illness identity is to the person).

Additionally, as presented in Diagram 2, the CSD-Education/Advocacy scale partially mediated the relationship between CSES-Private and RSES scores. The standardized regression coefficient between CSES-Private and RSES decreased when controlling for CDS-Education/Advocacy scores. The other conditions of mediation were also met: CSES-Private was a significant predictor of RSES and of CDS-Education/Advocacy, and CDS-Education/Advocacy was a significant predictor of RSES while controlling for CDS-Education/Advocacy. This partial mediation indicates that the relationship between internal attitudes about one’s race and self-esteem is partially mediated by reported use of education and/or advocacy to cope with discrimination experiences.

**Qualitative Analyses: Twenty Statements Test (TST)**

The more free-form response format of the Twenty Statements Test permitted exploratory investigation of how participants’ stigmatized identities related to their other
identities, as well as how these relationships relate to their functioning. Preliminary investigation of the TST investigated whether participants’ self-identifications were related to self-stigma measures or outcome measures.

To test Hypothesis 7a, number of TST responses, with the maximum number of responses being 20, were counted for all participants. In addition, each of participants’ responses were categorized as either “individual” (reflecting individual characteristics, such as ambitious, happy, and smart) or “relational” (reflecting relationships with others or reference to relationships, such as father, outgoing, and loved). For each participant, a percentage individual and percentage relational was calculated. Total number of responses was correlated with BACS-A (r(78) = .319, p = .004) and with CSES-Private scores (r(80) = -.240, p = .032), indicating that ability to provide more TST responses related to increased BACS-A scores and decreased CSES-Private scores. TST-Percent Relational scores were correlated with correlated with BACS-C scores (r(78) = -.260, p = .021). None of the included TST measures were correlated with outcome measures (depression or self-esteem).

Qualitative Analyses: Qualitative Interviews

Finally, analyses of the qualitative interview data were conducted to investigate exploratory topic 7b and 7c, using an inductive thematic analysis that is commonly employed in qualitative research (e.g., Fereday & Muir-Cochrane, 2001). This approach aids in identifying key themes and patterns in the participants’ responses. A total of 8 participants completed qualitative interviews, 3 from Bronx Psychiatric Center and 5 from Bronx TASC. Participants were similar in mean age to the sample overall (M = 45.1, SD = 12.1), and had an average of 12.1 years of education (SD = 2.6). Participants were racially diverse (3 Latino/a, 4 Black/African American, 1 White) and largely born in the US. There were majority male (2
female), and single (2 married). Their diagnoses included schizophrenia (N = 2), schizoaffective disorder (N = 2), bipolar disorder (N = 2), major depressive disorder (N = 1) and PTSD/other anxiety (N = 1). The majority (N = 5) had a substance use disorder diagnosis. The mean age of first hospitalization was 24.1 (SD = 11.6), the mean number of past hospitalizations was 9.9 (SD = 10.4). Their charges included assault/attempted murder (N = 4), arson/attempted arson (N = 2), and drug-related charges (N = 2). The mean years incarcerated was 2.0 (SD = 3.1).

In terms of mental illness stigma, some participants described frustration about the process involved in seeking help; one in particular expressed frustration that was necessary to receive a diagnosis in order to receive help. All participants described challenges during their first experiences with the mental health system, particularly experiencing confusion resulting from not being informed what their diagnosis was and/or what it meant. Participants described resulting difficulty accepting diagnoses; one participant explained:

"Mental health professionals just basically gave me a label and then just wanted me to accept it without really going in to some of the reasons that mental illness takes place, how do you get it...they weren’t very informative, so I just felt like I had this stigma attached to me when I was first diagnosed."

In particular, several participants described discrimination from mental health providers; for instance, one person explained:

"I was in the psychiatric ward, and there was this male nurse. He’s an RN. He was just being nasty, so he said, ‘You all are just a bunch of monkeys up in here.’"

Several participants described keeping their mental illness hidden, as well as experiencing rejection and distancing from others, including being called “damaged goods” or being treated like someone with an “airborne disease”. Despite these experiences, several of these participants
denied having been discriminated against. One reported that it took time and noticing that not all mental health providers exhibited similar attitudes, to begin identifying this negative treatment as discrimination. Few participants expressed pride or positive feelings about having a mental illness.

Participants also discussed several common themes related to racial and offender stigmas. The majority of participants described experiences with racial discrimination, which included experiences from childhood to adulthood, and overall reported mixed feelings about how others perceive their group. Despite this awareness, largely participants reported positive feelings and pride about their racial/ethnic identity. Concerning criminality-specific stigma, most participants described increased difficulty obtaining employment after receiving criminal charges, which they attributed to potential employers learning of their record. A few participants also described difficulty obtaining housing that they attributed to their offense histories.

Qualitative analyses focused on how these stigmatized identities might combine (hypothesis 7b), and participants’ descriptions suggested that mental illness and offender labels may have a particularly negative impact on racial/ethnic minorities. In particular, several participants discussed how mental illness and offender stigmas may differentially impact racial minorities. Several participants discussed how the experience of mental illness diagnosis and treatment may be different for racial minorities, particularly for Blacks. One talked about the possibility that racial minorities may be more likely to anticipate receiving poorer quality treatment or working with providers who may not care about them. Two participants discussed how Blacks may also have less information about what mental illness is, and may get help “too late”. These factors may influence people’s willingness to seek and engage in treatment. One participant shared: “when I first became ill, especially in the black community, you just didn’t
talk about mental illness and I just felt stigmatized a great deal. I didn’t accept the fact that I was mentally ill and I didn’t want to take the medication.”

Multiple participants discussed their experiences with the connections between race/ethnicity, expectations of violence, and having a criminal record. Several participants described experiences in which people directly expressed stereotypes about violence. One (Latino) participant remembered: “I had a lady once say…, ‘Hurry up get away from that man he looks like he’s got a killer face and that he killed somebody.’ I felt very bad.” Another (Black) participant described interactions at work: “One woman told me, ‘Why are your people so violent?’ Stuff like that. That’s what took place on the job.” Others described believing that race influences the process in legal proceedings, including racial minorities being less likely to have options like alternative to incarceration programs.

Participants also described several ways in which mental illness and the legal system interact. Several participants described differential treatment for people with mental illness and criminal records, including different treatment by providers and a tendency for people with mental illness to be dismissed or discredited while incarcerated. Several participants also discussed the impact that social conversations about violent behavior, particularly in the media, and one participant expressed a desire to communicate that people should not be afraid of people with mental illness.

In terms of coping with discrimination experience (Hypothesis 7c), participants described that they have learned strategies over time, and have found it particularly helpful to think of mental illness as “just another part of life” and to hear that others have had similar experiences, either by speaking with peers or by seeing relevant information in the media. One participant
described that it helped him cope with racial discrimination that others were facing similar experiences, and described learning how to cope through what his parents taught him.
Chapter 4: Discussion

Summary of Study

There is a growing body of research separately investigating stigmatizing attitudes towards people with mental illness, racial minorities, and criminal offenders, and the range of reactions to stigma which range from empowerment to self-stigma. There is also growing research on the impact of stigma on self-concept, particularly mental illness stigma. Most existing research on the impact of multiple stigmatized identities on self-concept has examined types of stigma in isolation, but some preliminary research has begun to investigate the experiences of multiply stigmatized individuals. However, this is the first known study to investigate the combination of several stigmatized identities that are particularly relevant in forensic psychiatric populations: mental illness, racial, and criminality stigmas. This study included measures of discrimination experiences, self-concept related to these three identities, and outcome measures including depression, self-esteem, treatment adherence, and working alliance. The study also included possible mediators—identity centrality and coping skills. Finally, the study included qualitative measures of self-concept in order to explore how these stigmatized identities relate to self-concept more broadly and to attempt to describe how these identities combine, and to identify protective factors and areas for further research.

Summary and Interpretation of Results

Basic scale analyses conducted to examine the scale properties within this forensic sample (Hypothesis 1) suggested that some scales performed similarly in this forensic sample as in previous, non-forensic validation studies. The reliabilities and skewness/kurtosis statistics in this sample were consistent with previous research for the measure of self-esteem (RSES; Sinclair et al., 2010), the measure of depression (CES-D; Foley, Reed, Mutran, & DeVellis,
2002; Orme, Reis, & Herz, 1986), and the measure of psychosocial treatment adherence (PTCS; Tsang, Fung, & Corrigan, 2006). For the mental illness stigma measure (SSMIS), reliabilities were similar to previous research in non-forensic samples (Corrigan, Watson, & Barr, 2006); however. The measure of criminality stigma (BACS) had low reliability for the BACS-A and adequate reliability for BACS-B, which was only partially consistent with previous research in a correctional sample (Mashek, Meyer, McGrath, Stuewig, & Tangney, 2002). The measure of criminality self-stigma, a newly developed measure, had adequate internal consistency. The reliabilities of the subscales in the measure of racial self-concept (CSES) were low in this forensic sample, and lower than previous research in samples of undergraduate participants (Luhtanen & Crocker, 1992). All scales relevant to self-concept (due to mental illness, race, and criminality) were skewed in this sample. Reliabilities were inconsistent with previous research and low for some subscales of the measure of working alliance (WAI; Busseri & Tyler, 2003; Munder, Wilmers, Leonhart, Linster, & Barth, 2010), the medication adherence measure (MARS; Thompson, Kulkarni, & Sergejew, 2000), and the coping with discrimination measure (Wei, Alvarez, Ku, Russell, & Bonett, 2010). Reliabilities were consistently low for the importance to identity reliabilities, all of which were lower than reliabilities found for racial identity centrality found in a non-forensic sample (Luhtanen & Crocker, 1992). Overall, there is some evidence that these measures performed similarly in this forensic sample than in previous non-forensic studies; however, some measures appeared to elicit inconsistent responses from participants in this sample (see “Limitations” section for further discussion).

One question in this study concerned the prevalence and types of discrimination experienced by forensic psychiatric patients (Hypothesis 2). Discrimination experiences were common; consistent with predictions (Hypotheses 2a and 2b), discrimination due to race, mental
illness, and past incarcerations were the most commonly reported by participants in this study. This finding is consistent with some previous research (Corrigan et al., 2003), with the addition of discrimination due to criminal offense history which was added in this study. The most common contexts for discrimination were law enforcement, housing, and employment, which is consistent with qualitative interview findings in which participants described discrimination experiences in the context of housing and employment (due to their offense histories) and in law enforcement (due to their race). Participants’ descriptions of their difficulty getting hired due to their criminal records is consistent with previous research (Albright & Denq, 1996). There were no significant demographic differences in discrimination experiences.

Analyses also investigated the relationship between discrimination experiences and the perception and internalization of stigma (Hypotheses 2c and d). There was some evidence, consistent with Hypothesis 2c, that discrimination experiences were related to perceptions of negative public attitudes and to expectations of discrimination. Frequency of discrimination experiences due to mental illness was related to expectations of discrimination due to being an offender. Frequency of discrimination experiences due to race was also related to expectations of discrimination due to being an offender, as well as beliefs that the public has more negative perceptions of one’s racial group. Discrimination experiences due to being an offender were related to awareness of and agreement with stereotypes about mental illness, as well as to expectations of discrimination due to being an offender. Therefore, some findings were consistent with previous research suggesting that discrimination experiences predict decreasing expectations of positive public regard towards one’s group over time (Seaton, Yip, & Sellers, 2009).
Interestingly, discrimination experiences were not correlated with mental illness self-stigma. One possible explanation for this null finding is that stigma of mental illness is so prevalent society (e.g., in media) that direct experience with mental illness discrimination is not necessary for internalization. Another possibility is that participants may tend not to identify relevant experiences as discrimination, particularly if they internalize stigmatizing ideas about mental illness. There is some support for this interpretation in the qualitative interviews; some participants described highly negative experiences of being mistreated based on their mental illness, but did not necessarily identify these experiences as discrimination. One participant specifically discussed changes in his perception that such mistreatment was discrimination as a result of his observations that some staff were stigmatizing and others were non-stigmatizing of inpatients. This interpretation may be relevant to previous research indicating that perceiving negative treatment of people with mental illness as legitimate increases risk for self-stigma (Rüsch, Todd, Bodenhausen, Olschewski, & Corrigan, 2010). People who perceive mistreatment as legitimate may be less likely to describe mistreatment due to their mental illness as discrimination. Another explanation is that more subtle discriminatory experiences (e.g., microaggressions) may also affect people’s perceptions of stigma without being identified by participants as being discrimination experiences. These findings suggest that it is not necessary for a person to experience direct, explicit discrimination experience in order to be aware of or internalize stigmatizing attitudes against mental illness.

Contrary to Hypothesis 3a, this study did not find evidence of significant differences between racial groups in the measure of mental illness stigma awareness, agreement, or internalization. Although some studies have indicated there is no consistent relationship between race and mental illness self-stigma (Livingston & Boyd, 2010), some studies have found that
mental illness stigma may differentially affect Blacks (i.e., Conner, Koeske, & Brown, 2009; Matthews, Corrigan, Smith, & Aranda, 2006; Rao, Feinglass, & Corrigan, 2007). Additionally, this study did not find a significant difference in stigma perceptions or internalization based on psychiatric diagnoses (Hypothesis 3b). Some research has found differences between diagnostic groups in mental illness self-stigma (Brohan, Elgie, Sartorius, & Thornicroft, 2010; Brohan, Gauci, Sartorius, & Thornicroft, 2011). However, these null findings may be due to insufficient power to find differences between these demographic groups.

Findings of this study supported Hypotheses 4b and 4c, extending previous mental illness self-stigma research to this forensic psychiatric sample. In support of Hypothesis 4b and consistent with previous research (Rüs et al., 2006), awareness of public stigma about mental illness was unrelated to mental illness self-stigma, but increased agreement with these stereotypes was related to increased self-stigma. Additionally, mental illness self-stigma related to increased depression and decreased self-esteem, and with decreased likelihood of medication adherence (Hypothesis 4c). However, contrary with hypotheses, there was no relationship between mental illness self-stigma and the measure of psychosocial treatment compliance. Consistent with predictions, increased centrality of the mental illness identity to one’s self-concept was related to increased mental illness self-stigma (Hypothesis 6a). In support of Hypothesis 6e, mental illness identity centrality also served as a partial mediator of the relationship between mental illness self-stigma and self-esteem, suggesting that the centrality of the mental illness identity contributes to the relationship between mental illness self-stigma and damaged self-esteem. Contrary to expectations (Hypotheses 6d and 6f), the measure of strategies people use to cope with discrimination was unrelated to mental illness self-stigma. Although previous research has found that mental illness self-stigma is detrimental to therapeutic alliance
(Kvrgic, Cavelti, Beck, Rüscher, & Vauth, 2013), this study did not find any relationship between the measures of therapeutic alliance and mental illness self-stigma.

Although descriptive statistics indicated that entirely negative internal attitudes about one’s race/ethnicity (negative racial self-concept) were uncommon, the measure of racial self-concept did exhibit expected patterns of relationships with outcome variables. In terms of demographic relationships, racial self-concept was higher for women than men, was higher for younger participants, and was lower for participants who spent more time incarcerated. One interpretation of this latter finding is that it reflects societal dynamics of race and incarceration, and increased experiences in the legal system can lead to more negative experiences related to one’s racial group. Similar to the findings for mental illness stigma, beliefs about public attitudes towards one’s race/ethnicity alone were unrelated to depression and self-esteem (Hypothesis 4b). Consistent with Hypothesis 4e, less positive racial self-concept related to increased depression, decreased self-esteem, and decreased psychosocial treatment compliance. There was no relationship between racial self-concept and medication adherence. Interestingly, more positive racial self-concept related to more negative attitudes about the working alliance with participants’ clinician. The explanation for this finding is unclear, although one possibility is that it may in some way stem from the common racial/ethnic mismatch between clinicians (who are more commonly White) and clients in forensic psychiatric contexts. In contrast with findings for mental illness self-stigma (Hypotheses 6c), increased centrality of racial identity was related to more positive racial self-concept. This finding suggests that people who see their racial identity as important to who they are may be more likely to exhibit positive self-concept. Consistent with Hypothesis 6d, more positive racial self-concept was related to increased use of education and advocacy to cope with discrimination experiences. Coping using education or
advocacy also served as a partial mediator of the relationship between racial self-concept and self-esteem (Hypothesis 6f), suggesting that the coping strategies one uses for discrimination contributes to the relationship between racial self-concept and self-esteem.

The criminality-related stigma, discrimination expectations, and self-stigma measure used in this study is new and investigates relatively uninvestigated constructs. This construct has also never been investigated in the same study as racial and mental illness stigmas. In terms of demographic relationships, White participants exhibited higher awareness of criminality stigma in the community than Latino/a/Hispanic participants, and men exhibited more internalization of criminality stigma than women. Having a less severe course of mental illness (based on past hospitalizations and age of onset) was related to increased awareness of negative community attitudes about offenders. Increased expectations of discrimination due to one’s offense history related to increased depression and decreased psychosocial treatment engagement. This finding may reflect a tendency for people who expect to be disregarded as a criminal, will tend to feel more depressed and to be less able to engage in psychosocial treatment (but not medication adherence). However, it is not possible to determine with certainty the direction of this relationship based on the design of this study. Contrary to Hypothesis 4d, the measure of internalization of criminality stigma was unrelated to measures of depression, self-esteem, or treatment adherence. However, increased criminality self-stigma was related to less positive attitudes about the treatment alliance with one’s clinician. As predicted (Hypothesis 6b), centrality of criminality identity was related to increased criminality self-stigma, suggesting that people are more likely to internalize the stigmatized identity if it is more central. The use of education or advocacy to cope with discrimination was also related to decreased criminality self-
stigma (Hypothesis 6d). None of the included mediator variables mediated between criminality self-concept and outcome variables.

In addition to investigating the individual contributions of mental illness, racial, and offender self-concepts, this study investigated how experience of these stigmatized identities may influence each other, including how these identities may combine to impact outcomes. Not surprisingly, increased awareness of each type of stigma was related to increased awareness of the other types of stigma, indicating that some people may exhibited higher awareness of social stigma of all types. This increased awareness was not by itself related to negative outcomes. It is possible that some personality variables like sensitivity (e.g., some people are more aware of and sensitive to the impressions of other people) may contribute generally to both awareness and internalization of all types of stigma. Not surprisingly, increased racial discrimination experiences were related to increased awareness of negative societal attitudes about race, as well as to higher expectations of being discriminated due to being an offender. Increased discrimination experiences due to past incarceration was related to increased awareness of mental illness stigma, increased agreement with mental illness stigma, and increased expectations of being discriminated against due to being an offender. Additionally, higher mental illness self-stigma related to higher criminality self-stigma, and less positive racial self-concept related to increased criminality self-stigma. Increased centrality of the offender identity was also related to increased mental illness self-stigma. These patterns of overlap may indicate that there is overlap between stigmatizing ideas about people with mental illness, racial/ethnic minorities, and offenders.

These relationships are consistent with the overlap between the stereotypes/stigma associated with these identities (e.g., expectations of dangerousness), as well as with predicted
overlap between how these identities impact labeled individuals. Given this overlap, analyses investigated how these identities may combine to influence outcomes (Hypothesis 5b). The most consistent significant findings were for self-esteem. Analyses indicated that increased mental illness and criminality self-stigma and less positive racial self-concept were all independently related as predicted with decreased self-esteem. Additionally, the interaction of racial self-concept and criminality self-stigma, and the interaction of mental illness and criminality self-stigmas, had an impact on self-esteem. These interactions indicated that first, the lower the racial self-concept, the greater the effect of criminality self-stigma on self-esteem, and second, the higher the criminality self-stigma, the greater the impact of mental illness self-stigma on self-esteem. These interaction effects provide some evidence for a combinatory effect of stigmatized identities on self-concept and is consistent with intersectionality theory (Cole, 2009).

Additionally, there was also evidence that the combination of racial self-concept and criminality self-stigma contributed to decreased medication adherence, which was consistent when medication adherence was rated by either participants or clinicians. This interaction indicates that at lower levels of racial self-concept, the greater the impact of criminality self-stigma on medication adherence. These significant interactions indicate that self-stigma combinations have a negative impact on self-concept that is greater than the contribution of each stigmatized identity separately, and that the combined internalization of these identities may impact medication adherence, which may have a substantial effect of the course of one’s illness (e.g., Altman et al., 2006; Jaeger et al., 2012).

The results of this study provided additional information about how these stigmatized identities can combine in a forensic psychiatric sample. Despite the absence in this study of significant differences between racial groups on quantitative measures of perceived mental
illness stigma and self-stigma (possibly due to low power), there was some evidence in participants’ interview responses that mental illness stigma might have a different impact on Blacks. Participants expressed that Blacks may be more likely to anticipate receiving inadequate treatment and may know less about or avoid discussing mental illness, and consequently seek treatment later than they would otherwise. This issue is relevant to early intervention efforts and efforts to make treatment available to all people who need it.

Investigating these identities in combination can also inform potential intervention and coping strategies. In this study it was notable that, despite mixed feelings about how others perceived their race, most participants described having positive feelings and beliefs about their racial/ethnic groups. Additionally, racial identity centrality was related to more positive racial self-concept. These patterns were reversed for mental illness and criminality self-stigmas. It is likely that a combination of factors contribute to these contrasting patterns. Rejection of racial stigma is likely more prevalent in the media and in social commentary than is rejection of stigma against mental illness and criminal offenders. Societal rejection of stigmatizing attitudes may be protective against internalization of these attitudes. Additionally, there is some evidence in this study that people may fail to label discrimination due to mental illness as discrimination. Evidence from racial stigma literature indicates that attributing feedback to social stigma rather than to the self can protect self-esteem, particularly in the context of negative feedback (Crocker & Major, 1989; Crocker, Voelkl, Testa, & Major, 1991). Therefore, working with people in forensic psychiatric contexts to identify discrimination may help protect against internalization. Finally, several participants described benefitting from learning strategies to cope with racial stigma from their families. No participants described such learning experiences for coping with mental illness stigma; therefore, learning coping strategies from peers and families is likely an
effective way to decrease susceptibility to internalization of stigma. Finally, findings that education and advocacy is an effective way to cope with discrimination due to race and criminal history. This coping strategy may contribute to participants’ ability to react to discrimination with righteous indignation, rather than internalization of stigma. Treatment could both allow individuals who have internalized stigma of mental illness to learn from peers with mental illness and teach family members how to support effective coping strategies. Treatment can also encourage people to do education and advocacy activities themselves, to build positive self-concept around mental illness identity.

In summary, these findings both extend previous findings on the detrimental impact of mental illness self-stigma on self-esteem, depression, and treatment adherence. Predicted relationships were more consistent for some outcome measures than others (e.g., more consistent for self-esteem than for treatment adherence). It also found evidence for a combinatory impact of these stigmatized identities on self-concept. Therefore, people in forensic psychiatric contexts may be particularly at risk for self-esteem detriment due to facing the combination of these sources of stigma. These findings reinforce the importance of addressing how stigma from multiple sources may impact self-concept, in treatment. Several psychotherapy group treatments are available that target mental illness self-stigma (e.g., Lucksted et al., 2011; Roe et al., 2010). However, it may be helpful to develop group therapy specific to forensic populations, which incorporate additional common sources of stigma. A treatment manual would facilitate the dissemination of such interventions in relevant forensic psychiatric contexts. Additionally, the qualitative interviews conducted in this study also highlight the importance of continuing to do outreach to educate the community about the facts, versus the myths of mental illness, and the
detrimental impact that stereotypes of dangerousness have on labeled individuals. This outreach may target mental health providers, youths, and law enforcement.

**Limitations of Current Study**

There were multiple limitations of this study. Although a larger sample size would have been helpful to increase the power of statistical analyses, it was not feasible to collect data from more participants. As a result, there was not enough power to detect differences between groups for some demographic variables. In particular, there were not enough participants in some racial/ethnic groups to permit comparisons. Therefore, null findings for demographic comparisons in this study cannot be interpreted as indicating that there are no differences based on demographic variables.

There were also limitations of the measures included in the study. Although the study protocol attempted to use multiple sources of information by including a basic chart review and clinician-reported treatment adherence measures, most included measures were based on participant self-report. Self-report measures in this study suffer from all typically acknowledged weaknesses of self-report data, including impression management, low awareness of issues addressed by the questionnaires, poor comprehension of questions, and low motivation to engage in responding to questions. The study protocol attempted to account for some of these weaknesses by administering these questionnaires individually with participants, which allowed for increased efforts at engagement and explaining confusion about the items. But it is likely that substantial unexplained variance in this study is due to these measurement issues. Additionally, the measures included in this study were included as the best found measures of the included variables. However, some of these measures may function differently in this forensic psychiatric sample than in the samples in which they were initially validated. In particular, some
measures were difficult to use in this study because of confusing wording, double negatives, and other item development issues. These issues were evident in the low internal consistency reliability statistics in this study for several measures, particularly the Collective Self-Esteem Scale and the measures of identity centrality adapted from the CSES. Low reliability for some scales is a limitation, but is not believed to have been a substantial problem for the study. Additionally, several variables were skewed, which required transformations. To account for this concern analyses were conducted with both transformed and non-transformed variables.

Additionally, it was not feasible to include some variables that are relevant to this study. The study protocol relied on a chart review to determine participants’ diagnoses and did not conduct diagnostic or symptom-related interviews, so there is no data on current symptoms (aside from self-reported depressive symptoms). Similarly, the study did not assess participants’ insight, quality of life, or social functioning, all of which have been found to have relevant relationships with self-stigma. This study also did not measure other types of reactions to stigma, including empowerment and righteous anger.

**Conclusions and Suggestions for Future Research**

Minimal research has investigated stigma and self-stigma within a forensic psychiatric sample, where people could potentially exhibit a triple self-stigma combining stigmas related to mental illness, race, and criminality. Given the overlap between the stereotypes applied to these labels (e.g., dangerousness), this study extended previous stigma and self-concept research to a forensic psychiatric sample, and to investigate the potentially unique and detrimental impact of these combined identities on self-concept and treatment variables. This study focused on outcome measures of depression, self-esteem, and treatment adherence. Findings indicated that there were relationships between self-stigma variables and self-esteem, and some relationships
with therapy alliance and treatment adherence. Treatment adherence is essential to symptom improvement and to decreasing risk factors among people with mental illness (Elbogen, Van Dorn, Swanson, Swartz, & Monahan, 2006), which is especially important for treatment with forensic populations. This preliminary research indicates that self-concept detriment due to these multiple stigmas is relevant to recovery-related variables in a forensic psychiatric population. This study provided evidence that stigma and self-stigma likely interfere with goals of treatment and recovery in a forensic psychiatric population.

The experience of forensic psychiatric patients is particularly relevant given the increasing social attention on mental illness, race, and incarceration. Mental illness stigma and self-stigma are relevant to the increasing social and political attention to mental illness, the content of which likely fuels stereotypes and interferes with goals of early detection and intervention. However, the majority of recent public discussion about mental illness in the context of the Aurora Theater shooting and multiple school shootings has centered on the connection between mental illness and violence. Such messages likely increase social distancing from people with mental illness and are unlikely to motivate the public or policy-makers to devote more resources to the treatment of mental illness. Furthermore, these media portrayals contribute to the fear and uncertainty experienced by people who struggle with their decisions to seek mental health treatment. No one who is considering seeking treatment wants to affiliate with the media and social portrayal of a “crazy person,” a consequence of mental illness stigma which interferes with goals of early detection and intervention. However, despite these issues, there has been minimal commentary in recent media discussions addressing the stigma of mental illness and its negative impact (Davidson, 2013; Watson, 2013). There was evidence that there is
an awareness of these societal conversations among the participants of this study, as explained by one participant:

“there is a stigma but it’s not being spoken on. There’s a great stigma right now because of cases that we’ve heard with the teenagers, from teenagers to adults, and the criminal activities that they’ve committed with shooting people in school to kidnapping and sodomizing and raping...because they first say, ‘Do they have a mental background?’”

Although stigma remains prevalent, there are increasing efforts to combat it. The Surgeon General’s first report on mental illness in 1999 called attention to mental illness stigma and its negative impact, particularly that stigma is a prominent barrier to effective, early treatment. Advocacy organizations, including the National Alliance of Mental Illness (NAMI), and public service campaigns, and the work of individual people with mental illness (e.g., Elyn Saks) have also increase public attention to these issues.

A review of literature relevant to stigmas relevant in forensic psychiatric populations indicates that there are gaps in existing research. For instance, no research has investigated microaggressions and stereotype threat related to mental illness and offense history, and there is extremely limited research on self-stigma related to offense history. Future research could investigate stereotype threat reactions related to the societal expectation that people with mental illness, especially those labeled “forensic psychiatric patients” will be violent. Research should also investigate the types of microaggressions experienced by people with mental illness and offenders, and investigate the prevalence of these behaviors (from the perspective of targets and perpetrators of microaggressions). Future research should expand the findings of this study by investigating additional protective factors or mediators that may impact the relationship between awareness of stigma, internalization of stigma, and negative outcomes. Future research should
also investigate current psychiatric symptoms (particularly negative symptoms of schizophrenia), social anxiety, insight, social functioning, recovery orientation, and quality of life, with a forensic psychiatric population. Future longitudinal research on the ability of self-stigma to predict outcomes in this population, as well as the relationship between stigma variables and re-arrest, or recidivism, is needed. Finally, future research should include measures of reactions including empowerment, advocacy, and righteous anger to incorporate a broader range of reactions to public stigma.

Future research should also investigate how to address stigma against forensic psychiatric patients. Reintegration after incarceration or after psychiatric hospitalization presents challenges (e.g., Hartwell, 2004; Yanos, Roe, & Lysaker, 2010), but forensic psychiatric patients may experience additional difficulties with reintegration. Two primary strategies could address this issue: decreasing stigma in the community and among outpatient mental health providers, and psychotherapy with labeled individuals to combat self-stigma. Combating social stigma requires a multifaceted, multilevel approach because multiple mechanisms contribute to their persistence and maintenance (Link & Phelan, 2001). Education and contact with stigmatized groups are two commonly discussed methods of changing stigma at the societal level. Significant research and recent meta-analysis found that both contact and education helped reduce stigma; education was more effective for adolescents and contact was more effective for adults (Alexander & Link, 2003; Corrigan, Morris, Michaels, Rafacz, & Rüsch, 2012; Corrigan & O'Shaughnessy, 2007; Penn, Kommana, Mansfield, & Link, 1999; Pescosolido et al., 2010). Researchers have discussed increasing efforts to use the media to decrease public stigma (Stuart, 2006). Education and media efforts should address mental illness stigma and normalize symptoms, rather than focusing exclusively on messages about the biological basis of mental illness (which has been
shown to be insufficient at decreasing stigma). Future research should also investigate the effectiveness of targeting stigmatizing attitudes towards mental illness earlier, during childhood. There is an increasing push for earlier treatment of mental illness, which is only possible if people are willing to seek treatment earlier in the course of the illness. Broader changes in social attitudes towards mental illness and seeking treatment would likely improve the effectiveness and impact of these early detection efforts.

Future research should also investigate psychotherapy for self-stigma among forensic psychiatric patients. Previous research of psychotherapy for self-stigma include cognitive behavioral group therapy (Lucksted et al., 2011), acceptance and commitment therapy (Luoma, Kohlenberg, Hayes, Bunting, & Rye, 2008), and narrative enhancement therapy (Kondrat & Teater, 2009; Roe et al., 2010) approaches. This research can provide a starting point for future investigation and refinement of these strategies for the combination of stigmatizing attitudes faced by individuals in forensic psychiatric populations.
Appendix A: Tables

Table 1: Participant demographic information (categorical)

<table>
<thead>
<tr>
<th>Category</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
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<td><strong>Gender</strong></td>
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<td>0%</td>
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<td>35.8%</td>
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<td>16.0%</td>
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<tr>
<td>Arab/Middle-Eastern</td>
<td>1</td>
<td>1.2%</td>
</tr>
<tr>
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Table 2: Participant demographic information (continuous variables)

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Note: table reports F values; * p < .05, ** p < .01, *** p < .005
Table 4: Correlations between continuous demographic variables and scales

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Note: table reports r values; * p < .05, ** p < .01, *** p < .005
Table 5: Correlations between outcome measures

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* p < .05, ** p < .01, *** p < .005
Table 6: Correlations between SSMIS and outcome measures

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* p <.05, ** p <.01, *** p < .005
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* p < .05, ** p < .01, *** p < .005
# Table 8: Correlations between CSES and outcome measures

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<td><strong>WAI-Total</strong></td>
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<td>.25*</td>
<td>-.28**</td>
<td>.05</td>
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<tr>
<td><strong>WAI-Bond</strong></td>
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<td>.27*</td>
<td>-.34***</td>
<td>.08</td>
<td>.27*</td>
</tr>
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<td>.13</td>
<td>-.21</td>
<td>.04</td>
<td>.11</td>
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<tr>
<td><strong>WAI-Goal</strong></td>
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<td>.29**</td>
<td>-.23*</td>
<td>.02</td>
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* p < .05, ** p < .01, *** p < .005
Table 9: Importance to Identity Indicator (III), and stigma and outcome measures

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<th>III-Mental Illness</th>
<th>III-Offender</th>
<th>III-Race/Ethnicity</th>
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<td>.24*</td>
<td>-.04</td>
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<td>-.19</td>
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<td>BACS-C</td>
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<td>.29**</td>
<td>.09</td>
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<tr>
<td>CSES-Private</td>
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<td>.30**</td>
<td>-.35***</td>
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<td>CSES-Public</td>
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<td>.06</td>
</tr>
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* p < .05, ** p < .01, *** p < .005
Appendix B: Figures

Figure 1: Partial mediation between SSMIS-Self-Concurrence and RSES

SSMIS-Self-Concurrence $\rightarrow$ III-Mental Illness: $eta = .31^{***}$

III-Mental Illness $\rightarrow$ RSES: $eta = -.36^{***}$

SSMIS-Self-Concurrence $\rightarrow$ RSES: $eta = -.41^{***}$ ($-.33^{***}$)

Note: *p<.05, ** p < .01, *** p < .005
Figure 2: Partial mediation between CSES-Private and RSES

Note: *p < .05, ** p < .01, *** p < .005
References


Jaeger, S., Pfiffner, C., Weiser, P., Kilian, R., Becker, T., Längle, G., … Steinert, T. (2012). Adherence styles of schizophrenia patients identified by a latent class analysis of the


