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Does Mental Illness Affect Societal Perception of Sex Offenders?

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Does Mental Illness Affect Societal Perception of Sex Offenders?

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Abstract

Although mental illness is common in the sex offender population, it has never been examined how evidence of such may influence societal perception. In comparison to the non-sex offender population, it was hypothesized that participants would consider mental illness less mitigating for sex offenders, would be less likely to support the mental health treatment of sex offenders while incarcerated, and would consider certain mental illnesses (schizophrenia and substance abuse disorders) as particularly aggravating for this group of offenders. Respondents were asked to read a short vignette and then respond to a series of questions about culpability, sentencing decisions, and mental health treatment. Results from this study suggest that the public is less likely to consider mental illness as a mitigating factor in the sex offender population, in turn believing they should receive harsher prison sentences and are less deserving of alternatives to incarceration in comparison to non-sex offenders with identical symptomatology. However, mental illnesses considered especially dangerous were not particularly aggravating in the sex offender population. Future directions may examine how these findings differ based on various sex offenses.

Does Mental Illness Affect Societal Perception of Sex Offenders?

Over the past few decades, sex offenders have become increasingly stigmatized in the public eye, especially through strict legislation (Megan's Law, 1996; Violent Crime Control and Law Enforcement Act of 1994), and extensive media coverage of particularly shocking sexual crimes (Ducat, Thomas, & Blood, 2009). Indeed, members of society tend to believe that the sex offender population is a homogeneous group (Sample & Bray, 2006), such that all sex offenders are dangerous and likely to recidivate (Campregher & Jeglic, 2016). However, individuals in this population may differ in a multitude of ways, particularly in their presentations of mental illness, including psychotic disorders, affective disorders, and substance abuse problems (Chen, Chen, & Hung, 2016; Cochrane, Grisso & Frederick, 2001; Raymond, Coleman, Ohlerking, Christenson & Miner, 1999).

Whereas research suggests that serious mental illnesses—such as psychotic disorders—often mitigates an offender's culpability in public opinion (Barnett, Brodsky & Price, 2007), there is reason to believe this may not extend to the sex offender population (Rogers & Ferguson, 2010). Coupled with the existing perception that these offenders are especially dangerous, society may instead find evidence of a mental illness particularly aggravating in this population (Berkman, 1989). To date, however, there has been no research measuring the ways in which societal opinion toward sex offenders may be influenced by evidence of mental illness.

First, the factors that influence the public's perception of sex offenders will be examined, along with some of the effects that these produce in the public. Next, common mental health presentations of sex offenders will be discussed. Then, the potential impact that mental illness has on public perception will be reviewed. Next, stigma and the perception of mental illness in sex offenders will be examined. Lastly, the current study aims will be presented.

Literature Review

Stigmatization of Sex Offenders

Enacting stricter laws for sex offenders has become a trend across the United States in the recent past. In 1994, the Violent Crime Control and Law Enforcement Act mandated that those who commit sex crimes are required to register as a “sex offender,” which may follow them for the rest of their lives. Megan’s Law, enacted in 1996, federally allows sex offenders’ residential details to be publically disseminated, and requires law enforcement to release the necessary information to the public, in order to protect the community. More recently, the Adam Walsh Act (2006) legally mandated civil commitment procedures for repeat offenders that are considered “sexually dangerous persons.”

Other restrictions, mandated by state law, even dictate where a sex offender can reside, ranging anywhere from 500 feet from a school or school property for child sexual offenders in Illinois (720 ILCS § 5/11-9.3 b-5) to 2,000 feet from a school or any childcare facility in Iowa (Iowa Code Supp. § 692A.114). For comparison, someone convicted of murder or manslaughter and released from prison does not have broad restrictions on where one can live, nor is law enforcement required to notify one’s new neighbors that the person next door is a “murderer.” Research has demonstrated how some of the increasingly strict legislation affects this population post-release (Russell, Seymour & Lambie, 2013). Russell and colleagues (2013) found that sex offenders nearing release expressed concerns regarding their re-entrance to society, both due to difficulties finding housing and employment in accommodation with parole conditions, and because of fears about negative reactions from the community. Indeed, recently released sex offenders reported experiencing ostracization and receiving physical threats from those in society.

Other research has suggested that legislation may have a direct effect on the societal views of sex offenders (Harris & Socia, 2014). For example, Harris and Socia (2014) examined specifically how the “sex offender” label may influence the way that people conceptualize this type of offender. They found that using the term “sex offender,” rather than a more neutral alternative, “person who has committed a sex crime,” made respondents more likely to agree that an individual who committed a sex crime should not live near schools or playgrounds, should be banned from using social networking sites, and should have his identity made public to the community. This suggests that the stigma surrounding the registry and labeling of “sex offenders” may actually be more powerful in forming opinions about an individual than the actual crime committed. Importantly, these strict legislations are unique to those who have committed sex-related crimes.

Legislation is not the only factor that serves to stigmatize this population in public perception. Research has shown how the public is influenced by media portrayals of crime (Malinen, Willis & Johnson, 2014), and coverage of sex crimes most commonly incorporates “highly sensational wording and content” to illicit fear and anger from the audience (Ducat, et al., 2009, p.160). Only focusing on the most severe crimes in the media helps create a false perception that all sex offenders are dangerous “superpredators” who will reoffend (Campregher & Jeglic, 2016). By placing inflexible restrictions on the entire population, legislation works in tandem with the media to create the belief that sex offenders are a homogeneous group, as if no specific characteristics differentiate individual offenders and their propensity for violence (Sample & Bray, 2006).

Mental Illness Presentations in Sex Offenders

In reality, sex offenders may differ in a variety of ways, particularly in whether they suffer from mental illness (Ahlmeyer, Kleinsasser, Stoner & Retzlaff, 2003). This factor is especially relevant for the sex offender population, as these individuals exhibit a wide range of symptomatology (Ahlmeyer et al., 2003), and may be up to seven times more likely to suffer from a mental illness than the general public (Chen et al., 2016). However, while instances of severe mental illness such as bipolar disorder, schizophrenia, and other psychotic disorders are evident in this population (Fazel, Sjöstedt, Långström & Grann, 2007), overall frequencies of SMI are relatively low for sex offenders (Ahlmeyer et al., 2003).

The available literature supports Ahlmeyer and colleagues' (2003) assertion that sex offenders present with a wide variety of mental illnesses. While there is not one, large comprehensive study examining the most common mental illness presentations in this population, a few smaller studies do find substance abuse, psychotic disorders and mood disorders to be prevalent. In their recent study, Chen and colleagues (2016) found that 69% of their sample of 68 Taiwanese sex offenders met criteria for an Axis I disorder—the majority being substance-related disorders, as well as mood disorders, “impulse-control” disorders, ADHD, and anxiety disorders. Similarly, in a sample of 55 sex offenders, Cochrane and colleagues (2001) found that 42 of the 55 were diagnosed with a substance-related disorder, and 16 presented with a psychotic disorder, while only 5 presented with a mood disorder. Alternatively, Raymond et al. (1999) found a predominance of mood disorders in their sample of pedophilic sex offenders ($N = 42$). In this study, 67% of the sample met criteria for a mood disorder, with major depressive disorder being common.

In addition to psychotic, substance, and mood disorders, sex offenders also present with the more expected personality and paraphilic disorder diagnoses. In their 2001 study, Cochrane

et al. also found that 42 of their 55-participant sample had a personality disorder diagnosis, the most prominent being Antisocial Personality Disorder; still, the majority of personality disorders were represented, even in this small sample. In addition to a wide range of possible personality disorders, Abel, Becker, Cunningham, Mittelman and Roulea (1988) found that sex offenders often suffer from multiple paraphilic diagnoses, rather than just one. Pedophilia was the most common paraphilia in the sample, with frotteurism and exhibitionism also being common, often presenting with multiple other paraphilias.

The Influence of Mental Illness on Public Perception

Despite the vast range of mental illnesses from which sex offenders may suffer (Ahlmeyer et al., 2003), it is unclear whether the presence of mental illness may influence the way the public perceives these offenders. Indeed, research suggests that certain mental illnesses possess their own stigma (Crisp, Gelder, Rix, Meltzer & Rowlands, 2000). Although research supports the notion that those suffering from mental illness are more likely to be victims, rather than perpetrators of violent crime (Stuart, 2003), the public may hold alternate beliefs. For example, Crisp and colleagues (2000) surveyed 1,737 adults regarding seven different types of mental illnesses. They found that 70% of respondents believed that those with schizophrenia or alcohol/drug abuse problems were dangerous, and 80% of respondents believed they were unpredictable.

Although public opinion suggests a belief that those with SMI, like schizophrenia, are particularly dangerous (Crisp et al., 2000), there are complex findings about the actual relationship between SMI and violence. Generally, research suggests that SMI does contribute to a higher risk of violence, but this finding is only significant when those individuals are suffering from a co-morbid substance abuse disorder (Elbogen & Johnson, 2008). More

specifically, results from a recent meta-analysis suggest that those with psychotic disorders are more prone to commit violent acts; however, these findings also suggest that it may be comorbid substance abuse that is responsible for the increased risk of violence (Fazel, Gulati, Linsell, Geddes, & Grann, 2009). While there is a high comorbidity between substance use and SMI (Blanchard, Brown, Horan & Sherwood, 2000), researchers found that those individuals who only demonstrated substance abuse had a similar risk of violence as compared to those with a psychotic disorder and a comorbid substance abuse disorder. Indeed, substance use alone is associated with the perpetration of violence (Boles & Miotto, 2003).

Indeed, mental illness may negatively influence a defendant's actions in such a way that contributes, partially or entirely, to the crime committed (Roseman, 1997), and research has suggested that serious mental illness may contribute to 1 in 20 sex crimes (Fazel & Grann, 2006). However, it is unknown whether evidence of mental illness may affect public perception in a manner that promotes leniency for such offenders, or in a way that warrants a desire for harsher treatment. Some research has suggested that mental illness is considered mitigating by the general public (Barnett et al., 2007). Barnett and colleagues (2007) asked participants to rate leniency in sentencing decisions when presented with ten possible mitigating factors, including: sexual abuse as a child, being under the influence when the crime occurred, being hospitalized for a mental illness, attending church regularly, major head injury, etc. The researchers found hospitalization due to a mental illness and presence of schizophrenia to be two of the top mitigating factors in the study. This suggests that, at the least, serious mental illness is regarded as mitigating when considering a general offender's culpability.

Alternatively, it is possible that mental illness is considered an aggravating factor, influencing public opinion in the opposite manner (Berkman, 1989). While little research has

been conducted examining this possibility, Berkman (1989) argues that, in the case of one defendant, the evidence of his mental illness directly contributed to his being sentenced to the death penalty, rather than saving him from it. The man's defense introduced evidence of schizophrenia and hallucinations during the sentencing phase of the trial to show that he was mentally ill; however, the jury chose to sentence the man to death because they believed his mental illness rendered him particularly dangerous. While Barnett and colleagues (2007) found that SMI warranted leniency in public opinion, in specific instances it may result in a desire for harsher treatment due to a perception of increased dangerousness.

Sex Offenders, Mental Illness, and Stigmatization

Because of the high prevalence of mental illness in the sex offender population (Chen et al., 2016), it is particularly relevant to consider how symptom presentations may influence public perception of these offenders. Generally, research suggests that the public prefers harsh punishment when it comes to this population. For example, Mears, Mancini, Gertz and Bratton (2008) found overwhelming support for sex offender registries (92%) and residency restrictions (76%). Some (46%) participants agreed that incarceration is the best response for even non-contact crimes, such as indecent exposure.

The preference for harsh punishment remains true even when presented with the alternative option of rehabilitation. Rogers and Ferguson (2010) asked participants to respond to statements either advocating for punishment or rehabilitation based on a vignette detailing a non-sexual crime or a sexual crime. Respondents were more likely to believe that sex offenders should be punished, even when presented with the option of rehabilitation. However, no research has examined whether findings such as these may be mediated by factors such as the presence of mental illness. It is important to consider the ways that mental health presentations

may influence public perception of sex offenders, especially amidst suggestions that treating underlying mental illness may effectively reduce recidivism in this population (Gordon & Grubin, 2004).

While some research has suggested that mental illness is thought of as a mitigating factor in general offenders' culpability (Barnett et al., 2007), there is no current research that extends this to the sex offender population specifically. Because of the way this population is portrayed in the legislation and the media, it is imaginable that mental illnesses that are considered mitigating in general offenders may not be perceived in the same way for sex offenders. Paired with the beliefs about dangerousness associated with specific mental illnesses, it is possible that certain symptoms will be considered more aggravating for sex offenders than they would in the general offender population. Considering the current trend in the literature indicating a preference for punishment of sex offenders, offenders with such symptoms may actually provoke societal desires for harsher treatment.

Current Study

The current study intended to examine whether mental illness is thought of as a mitigating factor for sex offenders in public perception. Because of the wide range of symptomatology with which a sex offender may present (Ahlmeyer et al., 2003), coupled with the stigma concerning certain mental illnesses (Crisp et al., 2000), this study also intended to investigate whether these opinions are differentially affected by specific mental illnesses; namely, psychotic, substance use, mood, paraphilic, and personality disorders. The results of this study could have implications for the way legislation and the media treat this population as a whole in modern society. Considering the prevailing theme in research suggesting sex offenders

should receive harsh punishments (Rogers & Ferguson, 2010; Mears et al., 2008), this study predicts the following hypotheses:

Hypothesis 1: Participants will view mental illness as significantly less mitigating in sexual offenders than they do for general offenders.

Hypothesis 2: Participants will view sex offenders as less deserving of mental health treatment while incarcerated than they would view non-sexual offenders.

Hypothesis 3: Participants will believe that sex offenders displaying psychotic symptoms or symptoms of substance abuse should receive the most severe sentences and/or be civilly committed post-release.

Because this is the first study of this kind, there were no more specific hypotheses based on the type of mental illness being presented; however, considering the “dangerous” stigma associated with specific disorders (Crisp et al., 2000), it is possible that various mental illnesses will influence sentencing decisions in differing ways. This aspect of the study was exploratory to examine whether different mental illnesses (psychotic, substance use, mood, paraphilia, and personality) influenced participants’ ratings concerning sentence severity, culpability, and treatment availability.

Method

Research Design

The present study employed an experimental design, through random administration of an online survey. Each participant received one of twelve possible conditions, as determined by a combination of the two independent variables: the Type of Offender (sexual vs. non-sexual) and the Type of Mental Illness with which the offender presented (psychotic disorder; mood disorder; paraphilic disorder; substance abuse disorder; personality disorder; no mental health

symptoms). The dependent variables were the participants' responses to a number of questions related to sentencing, culpability, and mitigating factors.

Participants

An advertisement briefly describing the study was posted on Amazon Mechanical Turk to recruit participants. Participants were informed that their opinions were desired concerning the sentencing decisions of criminal offenders. A total of 606 individuals responded to the survey; 72 participants were excluded due to short response times (<40s), resulting in a total number of participants, $N = 534$. The majority of participants identified as male (55.8% $n = 298$), 43.1% as female ($n = 230$), and 0.4% as Other ($n = 2$); 4 participants did not report gender information. Over half (55.8%) of participants identified as White ($n = 298$) and 30.5% as Asian ($n = 163$). The remaining participants identified as Hispanic or Latin American (4.9%, $n = 26$), Black or African American (5.1%, $n = 27$), American Indian or Alaska Native (2.2%, $n = 12$), or Other (0.9%, $n = 5$). The majority of participants identified as being between 25-34 (42.1%, $n = 225$) or between 35-44 (20.2%, $n = 108$). The remaining participants were between ages 18-24 (16.3%, $n = 87$), ages 45-54 (10.3%, $n = 42$), ages 55-64 (7.9%, $n = 42$), or identified as 65+ (2.5%, $n = 14$). Three participants declined to answer age and race/ethnicity information. Inclusion criteria required the respondent to have access to the Internet and be 18 years of age or older.

Participants were randomly assigned to one of twelve conditions. Because of the exclusion of some participants, group sizes were not equal. Information regarding group sizes is presented in Table 1. There were no significant differences among demographic characteristics across groups.

Table 1

Condition	Frequency of participants (N)	Percent of Participants (%)
Non-Sexual/Psychotic	45	8.4
Non-Sexual/Depressive	48	9.0
Non-Sexual/Paraphilic	29	5.4
Non-Sexual/Substance	45	8.4
Non-Sexual/Personality	51	9.6
Non-Sexual/None	45	8.4
Sexual/Psychotic	42	7.9
Sexual/Depressive	32	6.0
Sexual/Paraphilic	57	10.7
Sexual/Substance	44	8.2
Sexual/Personality	42	7.9
Sexual/None	54	10.1

Procedure

Participants accessed the survey through Amazon Mechanical Turk. They were first asked to read and agree to a consent form. The consent form described their role in the study and provided them with information about the research in general. Each respondent was then randomly assigned one of twelve possible vignettes. After reading the vignette, they were asked to respond to a number of questions. Lastly, respondents filled out a short demographic section. All responses were entered and recorded using Qualtrics. On average, participants took about 2.3 minutes, but there was a wide variability in response time. Participants who responded in less than 40 seconds were excluded, but a number of respondents completed the survey in 40

seconds; the longest response time was 31.2 minutes. Once the survey was finished, participants were paid \$0.20 for their participation.

Materials

While the vignette was loosely based upon one used in prior research (Rogers & Ferguson, 2010), more comparable offenses were chosen and mental health information was included. Jack, 23-years-old, was convicted of either *physically assaulting* an acquaintance of his, Anne, or of *possessing child pornography*. Specific offenses were used rather than describing Jack as a “sex offender” or a “general offender,” because the description of a specific offense is likely less detrimental than the stigma connected with the *sex offender* label (Harris & Socia, 2014). Because there was no recent research assessing comparative crime severity at the time the study was conducted, the researchers chose *physical assault* and *possession of child pornography*, believing they would be considered of equal severity. To remain sensitive to the stigma against sexual offenses, a non-contact sexual offense was chosen in an effort to ensure that the sexual offense would be considered equally, or even less, severe as compared to physical assault.

The other independent variable was the offender’s mental illness. Symptom description was used rather than diagnostic labels both to avoid stigma and to provide the respondent with an accurate portrayal of mental illnesses. Descriptions were based off of the literature suggesting the most prevalent mental disorders in the sex offender population (Fazel et al., 2007; Raymond et al., 1999; Abel et al., 1988; Chen et al., 2016; Cochrane et al., 2001). For the purposes of the vignette, symptoms were arbitrarily chosen from the diagnostic criteria provided for these mental illnesses in the Diagnostic and Statistical Manual of Mental Disorders 5 (American Psychological Association, 2013). For the substance abuse category of mental illness, a broader

symptomatology was used to more fully represent the whole category. The six possible mental health presentations follow:

1. *Psychotic, Schizophrenia:* In the month leading up to the crime, Jack was suffering from delusional thoughts. When speaking with people, his speech often seemed derailed and confused. He also was displaying a marked decrease in emotional expression. Because of Jack's symptoms, he had been missing a substantial amount of work.
2. *Mood, Major Depressive Disorder:* In the two weeks leading up to the crime, Jack had reported feeling depressed for most of the day, every day. He was having trouble sleeping, and felt fatigued and lacking in energy most days.
3. *Paraphilic, Pedophilia:* In the 6 months prior to the crime, Jack had been experiencing recurrent and intense sexually arousing fantasies involving prepubescent children. Jack admits having acted on these urges with someone 5 years his junior.
4. *Substance use:* In the year prior to the crime, Jack has had a problematic pattern of substance use leading to distress. Jack often uses the substance in a large amount and while he has tried to stop using it, he has been unsuccessful in his attempts.
5. *Personality, Antisocial Personality Disorder:* Since the age of 15 years, Jack has displayed a pervasive pattern of disregard for the rights of others. Jack is often impulsive, irritable and aggressive, and demonstrates a lack of remorse for his actions.
6. *None:* In the time prior to his arrest, Jack did not display any mental health symptoms related to any diagnosis.

In total, there were 12 different vignettes, with two possibilities for the type of offender variable [sex offender vs. non-sexual offender] and six possibilities of the presenting symptomatology, representing a category of mental disorders [psychotic; substance abuse; depressive; paraphilic; personality; none]. Examples of the full vignette follow: one of the sex offender condition, and one of the non-sexual offender condition. The parts that vary based on the symptomatology condition are in italics.

Jack is a 23-year-old male. Jack was accused and convicted of possession of child pornography, and is now in a correctional facility for his crime awaiting sentencing. *In the month leading up to his crime, Jack was suffering from delusional thoughts. When speaking with people, his speech often seemed derailed and confused. He also was displaying a marked decrease in emotional expression. Because of Jack's symptoms, he had been missing a substantial amount of work.*

Jack is a 23-year-old acquaintance to Anne. Jack was accused and convicted of physically assaulting Anne, and is now in a correctional facility for his crimes awaiting sentencing. *In the year prior to his crime, Jack has had a problematic pattern of*

substance use leading to distress. Jack often uses the substance in a large amount and while he has tried to stop using it, he has been unsuccessful in his attempts.

After reading the vignette, the respondents were asked to consider questions related to Jack's criminal sentencing. Participants were first asked to rate the severity of Jack's crime, his culpability, the appropriate severity of his prison sentence, and the importance of his mental health symptoms when considering his sentence severity on a 4-point Likert scale (i.e., (1) *How would you rate the severity of Jack's crime?*, (2) *How culpable do you find Jack?*, (3) *How severe do you think Jack's prison sentence should be?*, (4) *If you were a member of the jury hearing Jack's case, how important would his mental health symptoms be when considering the severity of his prison sentence?*). A response of "1" indicated a rating of "Not at all" and "4" indicated "Extremely." Participants were further asked to rate their agreement with a series of questions concerning mental health. The statements were as follows: (5) *Do you agree or disagree with the statement, "Mental health treatment should be made available to Jack while he is incarcerated"?*, (6) *Do you agree or disagree with the statement, "A mental health alternative should have been used instead of incarceration, such as hospitalization"?*, and (7) *Do you agree or disagree with the statement, "Jack should not be in prison, because he is mentally ill"?*. An eighth question was asked of only those participants in the sexual offender conditions, concerning civil commitment procedures (i.e., (8) *How much do you agree or disagree with the statement, "After his prison sentence, Jack should be indefinitely committed to a forensic hospital for treatment"?*). These responses were recorded on a 5-point Likert scale, with 1 indicating "Fully disagree," 3 indicating "Neutral," and 5 indicating "Fully agree."

Data Collection and Analysis

Data were collected from the online survey site for the 534 participants and transferred to SPSS Version 21. For each question, an ANOVA was conducted comparing the results across

all conditions to determine whether there were any main effects of offender condition or symptom presentation, as well as any interaction effects. Bonferroni post-hoc tests were run where statistically significant differences were found. Descriptive statistics were also calculated for each condition, per question.

Question 1 was designed as a control question. No differences across responses to Question 1 would indicate that the severity of crime is controlled for within the study; in other words, “possession of child pornography” and “physical assault” are comparable in their perceived severity.

Questions 2, 3 and 4 assess **Hypothesis 1**, that participants will view mental illness as significantly less mitigating in sexual offenders as they do in general offenders.

Questions 5, 6, and 7 assess **Hypothesis 2**, that participants will view sex offenders as less deserving of mental health treatment than non-sexual offenders.

Questions 3 and 8 assesses **Hypothesis 3**, that participants will believe that sex offenders displaying psychotic symptoms or symptoms of substance abuse should receive the most severe sentences and/or should be indefinitely civilly committed.

Results

A 2 (Type of Offender: Sexual or Non-Sexual) x 6 (Type of Mental Illness: Psychotic, Mood, Paraphilic, Substance Use, Personality, None) ANOVA was conducted for each question to determine whether there were significant differences across conditions. Additionally, descriptive statistics were run to examine how the type of mental illness influenced responses for specific questions. ANOVA results can be found in **Tables 2-9**.

Descriptive Statistics

Averages were calculated for each condition per question. Values for each mean can be found in **Tables 10-17** (*Appendix B*).

ANOVAs

Crime Severity. A main effect was found for Type of Offender in ratings of crime severity, $F(1, 520) = 4.497, p = 0.034, \omega^2 = 0.007$. Participants rated the sexual crime ($M = 3.14, SD = 0.82$) as significantly more severe than the non-sexual crime ($M = 2.98, SD = 0.72$). A main effect of Type of Mental Illness was not significant, $F(5, 520) = 1.904, p = 0.092, \omega^2 = 0.009$. An interaction effect of Type of Offender by Type of Mental Illness was also not significant, $F(5, 520) = 1.410, p = 0.219, \omega^2 = 0.004$.

Culpability. An interaction effect in how respondents rated culpability was found for Type of Offender by Type of Mental Illness, $F(5, 520) = 2.292, p = 0.045, \omega^2 = 0.012$. A simple main effects analysis revealed that the type of offender significantly affected culpability ratings when offenders presented with psychotic symptoms, $p = 0.005$, but not for depressive ($p = 0.210$), paraphilic ($p = 0.538$), substance ($p = 0.917$), personality ($p = 0.133$), or no mental health symptoms ($p = 0.549$). Sex offenders with psychotic symptoms ($M = 3.190$) were rated as significantly more culpable than the non-sexual offenders with psychotic symptoms ($M = 2.711$). A main effect was also found for the Type of Mental Illness in how culpable participants rated the offender, $F(5, 520) = 3.225, p = 0.007, \omega^2 = 0.021$. A post-hoc Bonferroni test revealed that participants rated the offenders presenting with psychotic symptoms as significantly less culpable ($M = 2.94, SD = 0.78$) than those presenting with no mental health symptoms ($M = 3.41, SD = 0.72$), $p = 0.0013$. A main effect was not demonstrated for Type of Offender, $F(1, 520) = 1.009, p = 0.316, \omega^2 < 0.001$.

Sentence Severity. Main effects were found for both Type of Offender and Type of Mental Illness in participants' ratings of sentence severity. Participants gave responses indicating that they would give a significantly more severe sentence to the Sexual Offender ($M = 2.92$, $SD = 0.86$) as compared to the Non-Sexual Offender ($M = 2.71$, $SD = 0.78$), $F(1, 518) = 6.360$, $p = 0.012$, $\omega^2 = 0.010$. Responses also significantly differed based on the Type of Mental Illness presented, $F(5, 518) = 4.177$, $p = 0.001$, $\omega^2 = 0.029$. A post-hoc Bonferroni test revealed that participants responded that they believe those with psychotic symptoms ($M = 2.47$) should receive significantly less severe sentences than those with paraphilic symptoms ($M = 2.99$), $p < 0.001$, those displaying symptoms of substance abuse ($M = 2.88$), $p = 0.015$, and those displaying no mental health symptoms ($M = 2.91$), $p = 0.004$, but not those with depressive symptoms ($M = 2.83$), $p = 0.077$ or those with symptoms of a personality disorder ($M = 2.82$), $p = 0.069$. No other significant differences were found among ratings based on the type of mental illness. An interaction effect of Crime Type by Mental Health Presentation was not significant for ratings of sentence severity, $F(5, 518) = 1.810$, $p = 0.109$, $\omega^2 = 0.008$.

Mental Illness Consideration. A main effect for both Type of Offender and Type of Mental Illness was found for how likely participants were to consider mental illness when making sentencing decisions. Participants' responses indicated that they would be significantly less likely to consider the Sexual Offender's mental illness ($M = 2.70$, $SD = 0.97$) than the Non-Sexual Offender's mental illness ($M = 2.85$, $SD = 0.92$) when making sentencing decisions, $F(1, 517) = 4.898$, $p = 0.027$, $\omega^2 = 0.008$. Type of mental illness significantly affected how likely participants were to consider mental illness when making sentencing decisions, $F(5, 517) = 5.033$, $p < 0.001$, $\omega^2 = 0.037$. The post-hoc test revealed that participants were significantly more likely to consider psychotic disorders ($M = 3.14$) when considering sentencing decisions as

compared to depressive symptoms ($M = 2.53$), $p < 0.001$, and no mental health symptoms ($M = 2.60$), $p = 0.001$, but not as compared to symptoms of a paraphilia ($M = 2.96$), $p = 1.00$, symptoms of substance disorder ($M = 2.73$), $p = 0.054$, or symptoms of a personality disorder ($M = 2.77$), $p = 0.110$. An interaction effect of Type of Crime by Type of Mental Illness was not significant for ratings of mental illness consideration, $F(5, 517) = 1.182$, $p = 0.317$, $\omega^2 = 0.002$.

Treatment while Incarcerated. No main effects or interaction effects were found for ratings of support for mental health treatment while incarcerated. Responses did not significantly differ between Type of Crime, $F(1, 520) = 0.327$, $p = 0.568$, $\omega^2 = -0.001$ or Type of Mental Illness, $F(5, 520) = 1.693$, $p = 0.135$, $\omega^2 = 0.007$. Furthermore, the interaction effect of Type of Crime by Type of Mental Illness was not significant, $F(5, 520) = 0.582$, $p = 0.714$, $\omega^2 = -0.004$.

Alternative to Incarceration. Main effects were found for both Type of Offender and Type of Mental Illness in how likely participants were to agree that an alternative to incarceration should have been used. Respondents were significantly less likely to agree that an alternative to incarceration should have been used for the Sexual Offender ($M = 2.79$, $SD = 1.28$) as compared to the Non-Sexual Offender ($M = 3.02$, $SD = 1.17$), $F(1, 518) = 3.876$, $p = 0.0495$, $\omega^2 = 0.006$. Responses also significantly differed per Type of Mental Illness for how likely the participant was to agree that an alternative to incarceration should have been used, $F(5, 518) = 4.642$, $p < 0.001$, $\omega^2 = 0.032$. A post-hoc Bonferroni test revealed that participants were significantly more likely to agree that an alternative should have been used for those offenders presenting with psychotic symptoms ($M = 3.43$) as compared to those with symptoms of a paraphilia ($M = 2.84$), $p = 0.029$, those with symptoms of a personality disorder ($M = 2.71$), $p = 0.001$, and those with no mental health symptoms ($M = 2.66$), $p < 0.001$, but not those with

symptoms of depression ($M = 2.92$), $p = 0.105$ or those with symptoms of a substance disorder ($M = 2.97$), $p = 0.186$. An interaction effect of Type of Offender by Type of Mental Illness was not significant, $F(5, 518) = 0.499$, $p = 0.777$, $\omega^2 = -0.005$.

Offender in Prison. A main effect was found for Type of Mental Illness for how likely the participant was to agree that the offender should not be in prison because of his mental health symptoms, $F(5, 519) = 4.247$, $p < 0.001$, $\omega^2 = 0.030$. A post-hoc Bonferroni test revealed that participants were significantly more likely to agree that the offender should not be in prison when he was suffering from a psychotic symptoms ($M = 3.07$) as compared to symptoms of depression ($M = 2.43$), $p = 0.010$, symptoms of a paraphilic disorder ($M = 2.45$), $p = 0.014$, symptoms of a personality disorder ($M = 2.52$), $p = 0.029$, and no symptoms of a mental illness ($M = 2.34$), $p < 0.001$, but not as compared to those with symptoms of a substance disorder ($M = 2.54$), $p = 0.053$. A main effect for Type of Offender was not significant, $F(1, 519) = 0.851$, $p = 0.357$, $\omega^2 = -0.0003$, nor was an interaction effect for Type of Offender by Type of Mental Illness, $F(5, 519) = 0.447$, $p = 0.815$, $\omega^2 = -0.005$.

Civil Commitment. A one-way ANOVA revealed no significant differences in ratings of civil commitment, $F(5, 263) = 0.436$, $p = 0.823$, $\omega^2 = -0.012$.

Discussion

Findings reveal that evidence of mental illness is considered significantly less mitigating for sex offenders as compared to non-sex offenders. Results suggest public belief that sex offenders should be assigned harsher prison sentences; should not have evidence of mental illness strongly considered at trial; should receive fewer recommendations for alternatives to incarceration as compared to non-sex offenders; and are more culpable than non-sex offenders

when presenting as psychotic, despite identical symptomatology. While past research suggests that, at the least, serious mental illness is thought of as a mitigating factor in public perception (Barnett et al., 2007), others have suggested that it may be aggravating if such mental health symptoms are perceived as rendering an offender particularly dangerous (Berkman, 1989). Results of this study suggest that the public considers mental illness differentially mitigating for sex offenders, but evidence of those mental illnesses considered “dangerous” and “unpredictable” (Crisp et al., 2000) were not particularly aggravating.

Mental Illness as a Mitigating Factor

Findings indicate that the public would consider evidence of *any* mental illness significantly less important if making a sentencing decision for a sex offender as compared to a non-sex offender. Consequently, the public is likely to believe that sex offenders should receive harsher prison sentences as compared to non-sex offenders, despite crimes of similar severity and symptomatology. This finding is supported by previous research suggesting that the public prefers the harshest punishments available for sex offenders (Rogers & Ferguson, 2010; Mears et al., 2008). Despite the fact that serious mental illness may contribute to sex crimes (Roseman, 1997; Fazel & Grann, 2006), it appears that evidence of such symptoms or diagnoses may not mitigate a defendant’s culpability in society’s perception (Roseman, 1997). Some research suggests that individuals consider SMI mitigating for general offenders (Barnett et al., 2007), but these findings suggest that this is not true for sexual offenders.

More specifically, findings also suggest a belief that sex offenders presenting with psychotic symptoms are significantly more culpable than non-sex offenders presenting as psychotic, despite identical symptomatology. This finding adds a caveat to prior research suggesting that SMI is considered mitigating in societal perception (Barnett et al., 2007): while

the public might believe that a serious mental illness such as schizophrenia warrants leniency for non-sex offenders, it is significantly less influential when considering the culpability of sexual offenders. Although Crisp et al. (2000) found that the majority of their participants believed those with schizophrenia were dangerous and unpredictable, these results suggest that the public still considers sex offenders as more blameworthy for their actions than non-sex offenders, regardless of the supposed unpredictable nature of a psychotic disorder.

The results of this aspect of the study may be influenced by the societal stigma surrounding this population. Because the public has begun to think of sex offenders as a homogeneous group (Sample & Bray, 2006), in which the “generic sex offender” is a dangerous “superpredator” (Campregher & Jeglic, 2016), it is possible that the concept of “mental illness” is not compatible with society’s image of this offender. In turn, the possibility that mental illness may have influenced the offender’s actions may not occur to those in the general public, because they consider all sex offenders to be capable of such extremely violent crimes without the contribution of mental illness. In other words, because sex offenders are believed to be extremely dangerous, the public may assume that the offender is solely responsible for his actions. In turn, evidence of mental illness, which can potentially influence an offender’s actions (Roseman, 1997), may not decrease an offender’s culpability in the eyes of the public.

This possibility could have implications for those sex offenders with mental illness and the way in which they are treated in society, particularly post-release. For example, consider an offender whose mental illness is determined to have negatively influenced his or her actions, such that their sentence is mitigated and they are eventually released into society. Those in the community who feel that this individual is wholly responsible for their crime and should have received a longer sentence may ostracize, lash out or threaten the recently released offender

(Russell et al., 2013). Such treatment could be especially detrimental for an individual with mental illness.

Alternatively, it is possible that the stigmatization of sex offenders both in legislation and the media predisposes the public to prefer harsh punishment for these offenders, regardless of whether they consider mental illness to have influenced the offender's actions or not (Violent Crime Control and Law Enforcement Act of 1994; Megan's Law, 1996; Ducat et al., 2009; Malinen et al., 2014). Prior research has suggested that the "sex offender" label alone inclines the public to believe this population should have harsh restrictions in where they can live, and in their access to social networking sites (Harris & Socia, 2014). In other words, simply knowing that the defendant has committed a sex crime may influence public perception.

These findings may have implications for those involved in the justice system. For one, defense lawyers may have trouble creating an empathic portrayal of a mentally ill client, who has committed a sexual offense to a predisposed jury. As for the sentencing phases of a trial, judges may be pressured by public opinion and outcry to assign harsher sentences to sex offenders, regardless of the possibility of a mitigating mental illness. Not only does this finding have implications for the justice system, however—it may even suggest a larger issue within the societal context. The increase of harsh legislation specific to this population (Violent Crime Control and Law Enforcement Act of 1994; Megan's Law, 1996) and the biased portrayal against sex offenders in the media (Ducat et al., 2009; Malinen et al., 2014) may be creating a stigma with far-reaching effects on the entire population.

Opinions of Mental Health Treatment

Results also indicate that the public is significantly less likely to believe that sex offenders should receive options for an alternative to incarceration as compared to non-sex

offenders, despite similar mental health presentations. This finding is also supported in the literature, as previous research has suggested that the public prefers punishment for sex offenders even when presented with an alternative, rehabilitative option (Rogers & Ferguson, 2010). This is particularly detrimental to a population in which mental illness is common (Fazel et al., 2007) and may present itself in various ways (Ahlmeyer et al., 2003; Chen et al., 2016; Cochrane et al., 2001; Raymond et al., 1999; Abel et al., 1988).

On the other hand, findings revealed similar attitudes towards incarceration despite mental illness and mental health treatment while incarcerated, regardless of the type of offender. In fact, on average, participants “mostly agreed” that mental health treatment should be made available to both sexual offenders and non-sexual offenders while imprisoned. At the same time, they “mostly disagreed” with the statement “Jack should not be in prison, because he is mentally ill.” Whereas prior research has shown a preference for harsh punishment over rehabilitation for sex offenders (Rogers & Ferguson, 2010), findings from this study suggest a preference for both punishment *and* the availability of treatment while incarcerated, for all offenders. In other words, when the public is not forced to choose between two options, their attitude towards the rehabilitation of sex offenders is similar to that of non-sex offenders. The availability of mental health treatment for this population in prison could be essential to their recovery, as some have suggested that treating the underlying mental illness may effectively reduce recidivism rates for sex offenders (Gordon & Grubin, 2004).

Results did indicate a belief that all offenders displaying psychotic symptoms should be afforded an alternative to incarceration, as compared to those offenders with depressive symptoms or those without mental health symptoms. Similarly, findings suggest a belief that all offenders demonstrating psychotic symptoms should not be in prison because of their mental

illness, as compared to those displaying symptoms of depression, pedophilia, ASPD, or no symptoms. In support of Crisp and colleagues' (2000) findings, it appears that the public does feel differently towards those with psychotic symptoms, but in a way that affords them more treatment options and alternatives to incarceration. Importantly, these findings remain true regardless of the type of offender.

Mental Illness as an Aggravating Factor

Results did not indicate a belief that sex offenders displaying psychotic symptoms or symptoms of substance abuse should have the most severe prison sentences or be civilly committed post-release. Such illnesses are perceived as especially unpredictable (Crisp et al., 2000) and sex offenders are thought of as dangerous "superpredators" (Campregher & Jeglic, 2016). It was believed that these two factors may work in tandem to aggravate public opinion concerning their incarceration and/or civil commitment, in the hopes of keeping such offenders out of society for as long as possible. In fact, findings suggest a belief that all offenders with symptoms of psychotic disorder should have significantly *less* severe prison sentences than those with any other mental illness presentations. In short, the results of this study do not support Berkman's (1989) hypothesis that symptoms of mental illness may actually aggravate sentence severity when it is believed that these symptoms render the offender particularly dangerous.

Furthermore, there were no significant findings regarding civil commitment procedures for sex offenders based on their symptoms of mental illness. In fact, responses regarding civil commitment procedures demonstrated a "neutral" attitude on average. These findings are particularly interesting considering the association between SMI, substance use and violence (Elbogen & Johnson, 2008; Fazel et al., 2009). Indeed, substance use is associated with violence (Boles & Miotto, 2003), and SMI and substance use are often comorbid with one another

(Blanchard et al., 2000). Just as it may be necessary to consider how a mental illness can mitigate a defendant's culpability (Roseman, 1997), it is also important to consider how evidence of certain mental illnesses may be indicative of an increased risk of violence for these offenders. However, these findings suggest that public opinion is at odds with beliefs about what factors should contribute to civil commitment (Adam Walsh Act, 2006). Alternatively, it is possible that respondents simply did not have a clear idea of what treatment at a forensic hospital would entail, which may also explain the relatively neutral findings concerning civil commitment.

It is also possible that respondents simply had a difficult time imagining sex offenders with schizophrenia, as some research suggests that SMI, such as psychotic disorders, is relatively uncommon in this population (Ahlmeyer et al., 2003). In other words, it may have been difficult to imagine how these symptoms would be aggravating in the sex offender population, because they are rare. On the other hand, substance abuse disorders are common to sex offenders (Chen et al., 2016; Cochrane et al., 2001). Indeed, these results are contrary to Crisp and colleagues' (2000) finding that individuals with substance abuse problems are also considered "dangerous" and "unpredictable" by the public. Based on these beliefs, it is imaginable that community members would prefer to keep such offenders out of society even post-release, but results did not support this hypothesis.

Crime Severity

Lastly, results indicate that possession of child pornography is a significantly more severe crime than physical assault. The question assessing crime severity was designed as a control, in the hopes that these two offenses would be considered of equal severity by the participants. While a significant result for this question is a weakness to this study (see **Limitations and Future Directions**), it is also further indicative of the disdain of sex offenders. In an attempt to

combat the intense stigma towards sex offenders, a non-contact offense was used for the sexual offense conditions, while a contact offense was utilized for the non-sexual offense conditions; however, respondents still found the sexual offense to be significantly more severe. In other words, even those sexual crimes that are not “highly sensationalized” by the media (Ducat et al., 2009) are still subject to disdain. The fact that these results suggest a belief that a non-contact, non-violent offense (i.e., possession of child pornography) is more severe than physical assault may again have implications towards media and legal treatment of the sex offender population.

Limitations and Future Directions

Because the researchers designed the vignettes used in the study, one question assessed opinions of crime severity as a measure of control. If the results were not significant, it could be assumed that the offenses described (i.e. *physical assault* and *possession of child pornography*) were comparable in their severity. However, results indicated that respondents did view these two offenses as significantly different in their severity, with the sexual offense being considered more severe. While the effect size was very small ($\omega^2 = 0.0067$), results should be interpreted cautiously, while keeping in mind that some results may be partially attributable to differences in perceived crime severity, rather than differences in the type of offender or the type of mental illness being portrayed. For example, the question measuring sentence severity produced significant results, suggesting that participants viewed sex offenders as deserving of more severe sentences; however, these results could be credited to the fact that possession of child pornography is simply a more severe crime than physical assault, regardless of the fact that they are sexual versus non-sexual crimes. With that being said, a limitation to this study was the fact that there was no recent existing literature on perceived crime severity. Future research may

attempt to find more comparable sexual/non-sexual crimes, to ascertain that the severity of the crime is not responsible for any differences in response.

Another limitation is the small individual group sizes. While the average group size was 44 participants, some groups had as low as 29 participants. This makes it difficult to make comparisons between these groups. In particular, Hypothesis 3 dealt with differences between sex offenders with psychotic symptoms and symptoms of substance abuse, in comparison to the other groups. While there were no significant results regarding Hypothesis 3, this aspect of the study might produce more valid results with larger group sizes.

Additionally, the question regarding civil commitment procedures may have produced different results with some education of the participants. As these results suggest, respondents were generally “neutral” toward indefinite commitment procedures, which may simply suggest that they need more information before having definitive opinions about civil commitment. A future study may focus more on this aspect of the study, by educating participants on civil commitment procedures or treatment of sex offenders at forensic hospital before asking for opinions.

Lastly, due to limited resources and time, this study was only able to examine two conditions for the Type of Offender variable, offering no comparison between specific types of sex offenses (e.g. rape, molestation, etc.) and non-sex offenses. A future study might vary the sex offenses committed. This would provide a clearer idea about how the public thinks about sentencing decisions for specific types of sex offenders.

Conclusions

This is the first study to examine the effect of mental illness on sentencing decisions for sex offenders. The notion that sex offenders are a homogeneous, dangerous group overlooks the

prevalence and wide range of mental illnesses in this population, the effects of which may have influenced an offender's actions. Indeed, results of this study suggest that the public is less likely to consider evidence of mental illness for sex offenders when making sentencing decisions. While findings do not indicate that mental health symptoms are aggravating for this population, they are significantly less likely to be considered mitigating factors. In other words, identical symptomatology differentially affects societal opinion for sex offenders as compared to non-sex offenders, resulting in desires for harsher sentencing and differing beliefs concerning culpability. On the other hand, sex offenders presenting with mental illnesses that may indeed render an offender more prone to commit violence, did not result in opinions supporting more severe sentencing or civil commitment procedures. Such findings suggest a disconnect between societal opinion and actual factors which may contribute to dangerousness.

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Table 2			
<i>ANOVA: Crime Severity</i>			
	df	F	Sig.
CrimeType	1	4.497	0.034*
MHPresentation	5	1.904	0.092
CrimeType*MHPresentation	5	1.410	0.219
Error	520		
*Significant at the p<0.05 level.			

Table 3			
<i>ANOVA: Culpability</i>			
	df	F	Sig.
CrimeType	1	1.009	0.316
MHPresentation	5	3.225	0.007*
CrimeType*MHPresentation	5	2.292	0.045*
Error	520		
*Significant at the p<0.05 level.			

Table 4			
<i>ANOVA: Sentence Severity</i>			
	df	F	Sig.
CrimeType	1	6.360	0.012*
MHPresentation	5	4.177	0.001*
CrimeType*MHPresentation	5	1.810	0.109
Error	518		
*Significant at the p<0.05 level.			

Table 5			
<i>ANOVA: Likelihood to Consider Mental Health Symptoms</i>			
	df	F	Sig.
CrimeType	1	4.898	0.027*
MHPresentation	5	5.033	<0.001*
CrimeType*MHPresentation	5	1.182	0.317
Error	517		
*Significant at the p<0.05 level.			

Table 6			
<i>ANOVA: Mental Health Treatment While Incarcerated</i>			
	df	F	Sig.
CrimeType	1	0.327	0.568
MHPresentation	5	1.693	0.135
CrimeType*MHPresentation	5	0.582	0.714
Error	520		
*Significant at the p<0.05 level.			

Table 7			
<i>ANOVA: Alternatives to Incarceration</i>			
	df	F	Sig.
CrimeType	1	3.876	0.0495*
MHPresentation	5	4.642	<0.001*
CrimeType*MHPresentation	5	0.499	0.777
Error	518		
*Significant at the p<0.05 level.			

Table 8			
<i>ANOVA: Imprisonment of Mentally Ill</i>			
	df	F	Sig.
CrimeType	1	0.851	0.357
MHPresentation	5	4.247	0.001*
CrimeType*MHPresentation	5	0.447	0.815
Error	519		
*Significant at the p<0.05 level.			

Table 9			
<i>ANOVA: Civil Commitment</i>			
	df	F	Sig.
Between Groups	5	0.436	0.823
Within Groups	263		
Total	268		
*Significant at the p<0.05 level.			

Table 10						
<i>Average Ratings of Crime Severity</i>						
	Psychotic	Mood	Paraphilia	Substance	Personality	None
Non-Sexual Offender	2.82	2.98	3.34	2.93	2.94	3.02
Sexual Offender	3.14	3.34	3.16	3.11	2.95	3.19

Table 11						
<i>Average Ratings of Culpability</i>						
	Psychotic	Mood	Paraphilia	Substance	Personality	None
Non-Sexual Offender	2.71	3.08	3.34	3.22	3.27	3.36
Sexual Offender	3.19	3.31	3.23	3.20	3.02	3.45

Table 12						
<i>Average Ratings of Sentence Severity</i>						
	Psychotic	Mood	Paraphilia	Substance	Personality	None
Non-Sexual Offender	2.36	2.72	3.00	2.67	2.90	2.71
Sexual Offender	2.59	2.94	2.98	3.09	2.74	3.11

Table 13						
<i>Average Ratings of Likelihood to Consider Mental Health Symptoms</i>						
	Psychotic	Mood	Paraphilia	Substance	Personality	None
Non-Sexual Offender	3.36	2.69	3.14	2.69	2.75	2.64
Sexual Offender	2.93	2.37	2.77	2.77	2.79	2.55

Table 14						
<i>Ratings of Agreement Concerning Mental Health Treatment</i>						
	Psychotic	Mood	Paraphilia	Substance	Personality	None
Non-Sexual Offender	4.42	4.08	4.14	3.82	4.04	3.93
Sexual Offender	4.33	4.16	4.09	4.16	3.93	4.09

Table 15						
<i>Ratings of Agreement Concerning Alternatives to Incarceration</i>						
	Psychotic	Mood	Paraphilia	Substance	Personality	None
Non-Sexual Offender	3.62	2.90	2.97	3.20	2.75	2.73
Sexual Offender	3.24	2.94	2.71	2.74	2.67	2.59

Table 16						
<i>Ratings of Agreement Concerning Imprisonment of the Mentally Ill</i>						
	Psychotic	Mood	Paraphilia	Substance	Personality	None
Non-Sexual Offender	3.16	2.33	2.59	2.67	2.53	2.36
Sexual Offender	2.98	2.53	2.31	2.42	2.50	2.31

Table 17						
<i>Ratings of Agreement Concerning Civil Commitment</i>						
	Psychotic	Mood	Paraphilia	Substance	Personality	None
Sexual Offender	3.31	3.03	3.11	3.00	3.17	2.98