Spring 6-1-2022

Stigma related to criminal justice history: The role of offense type, mental health treatment, mental illness, and race from formerly incarcerated persons' perspective

Lindsey Ryan-Jones
CUNY John Jay College, lryanjones13@gmail.com

Stigma related to criminal justice history: The role of offense type, mental health treatment, mental illness, and race from formerly incarcerated persons' perspective

A Thesis Presented in Partial Fulfillment of the Requirements for the Degree of Master of Arts in Forensic Psychology
John Jay College of Criminal Justice
City University of New York

Lindsey Ryan-Jones

May 2022

Stigma related to criminal justice history: The role of offense type, mental health treatment, mental illness, and race from formerly incarcerated persons' perspective

Lindsey Ryan-Jones

This Thesis has been presented to and accepted by the Office of Graduate Studies, John Jay College of Criminal Justice in Partial Fulfillment of the Requirements for the Degree of Master of Arts in Forensic Psychology

Thesis Committee

Thesis Advisor: Philip T. Yanos, PhD

Second Reader: Rebecca Weiss, PhD

External Reader: Zoe Berko, PhD

Thesis Committee Signature Page

Stigma related to criminal justice history: The role of offense type, mental health treatment, mental illness, and race from formerly incarcerated persons' perspective

Lindsey Ryan-Jones Thesis Author	5/25/2022 Date

This Thesis has been presented to and accepted by the Office of Graduate Studies, John Jay College of Criminal Justice in Partial Fulfillment of the Requirements for the Degree of Master of Arts in Forensic Psychology.

Philip T. Yanos Thesis Advisor	5/25/2022 Date
Rebecca Weiss Second Reader	5/25/2022 Date
Zoe Berko Third Reader	5/25/2022 Date
Abbie Tuller Program Director	6/06/2022 Date

Abstract

Research has shown that offenders perceive stigma and anticipate stigma once they are released from incarceration, especially regarding employment and housing (LeBel et al., 2012). However, there is limited information about offense type, mental health treatment, mental illness and race affect how formerly incarcerated persons perceive, anticipate and experience stigma. While research has shown that those with mental illness are more likely to have recidivate and sex offenders are viewed negatively by the public, there are gaps in understanding reasons why this occurs (Bureau of Justice Statistics, 2017; Sample & Bray, 2006; Levinson et al., 2007; Rade, Desmarais & Mitchell, 2016). Stigma might serve as one potential explanation for these findings. This thesis sought to gain more knowledge from the formerly incarcerated persons perspective on multiple stigmatized identities and evaluate how they impact perceived, anticipated, and experienced stigma. Results showed that people who committed sexual offenses reported higher rates of perceived and anticipated stigma. However, offense type did not affect discrimination experiences. Participants with likely serious mental illness did not report significantly different anticipated or perceived stigma scores. Those who did received mental health while incarcerated reported more discrimination experiences due to past incarcerations and mental illness. There were no significant differences in white and people of color responses for perceived or anticipated stigma. Although, persons of color reported more discrimination in housing but not employment contexts. The results are one of the first studies to specifically evaluate offense-type related stigma from the formerly incarcerated persons' perspective. Conclusions discuss policy recommendations and future research.

Keywords: stigma, offense type, self-stigma, mental illness, race, formerly incarcerated persons, offenders, inmates, sexual offenses

Acknowledgements

I would like to thank my advisor, Dr. Philip T. Yanos, for his amazing support through this journey. I have learned so much from him as a researcher, as a student and as a person. I would also like to thank Dr. Rebecca Weiss and Dr. Zoe Berko for their support as faculty members on my committee and their feedback on my work. I would like to thank my mom, who has always rooted for me in my long journey to get here. She has helped me push through adversity and kept my eye on my goals. I am so grateful for that kind of support. This one is for you mom.

Introduction

Reentry is one of the biggest challenges in the criminal justice system as at least 95% of all state prisoners will be released from prison at one point in time. The total prison population consists of approximately 1.4 million individuals (Bureau of Justice Statistics, 2021; Bureau of Justice Statistics, 2019). The prison population increased 2.6% in 2002 and the rate of incarceration was 1 in every 110 men and 1 in 1,656 women (Bureau of Justice Statistics, 2002). The reoffending rate within three years of release is two-thirds (English, 2018). These statistics tell a concerning story of "the revolving door" of the criminal justice system. Even though many individuals are released every year, more often than not, they are returned to an environment where a number of "criminogenic" risk factors are present, placing them at risk of reoffence. Therefore, it is imperative to understand the challenges of reentry and how to overcome them.

Research has shown that formerly incarcerated individuals who successfully reenter society obtain full-time employment and housing (Bahr et al., 2010). It has also been found that those who feel connected to their community and family are less likely to re-offend compared to those who felt connected to a criminal community (Folk et al., 2016). Although there are positive variables that help successful community transition, there are many barriers and challenges formerly incarcerated persons face after release. About 80% of persons will be released under parole supervision (Bureau of Justice Statistics, 2002). Parole supervision requires individuals to reenter themselves back into their community while also finding employment, housing and checking in with their parole officer (Bahr et al., 2010). Logistically, parole can be difficult. Programs (ex: anger management, substance abuse) and parole check-ins are often during work hours, increasing the chance they miss sessions if they are employed. If the individual misses an

appointment with their officer or does not complete their parole requirements, they could be punished further by stricter conditions or more incarceration time.

In addition, ex-offenders have also reported that having a criminal record makes it harder to find employment (Bahr et al., 2010). Substance use also plays a factor in reentry. The majority of one sample of ex-offenders who re-offended stated that drug use was the biggest challenge they faced while on parole (Bahr et al., 2010). This response has been echoed in other prior literature (Ward & Merlo, 2016). However, others stated that lack of job skill was the reason they had difficulty finding employment (Bahr et al., 2010). Other research has found reasons such as mental health problems, inability to pay fines, and transportation (Ward & Merlo, 2016). These findings were consistent between urban and rural samples (Ward & Merlo, 2016). Overall, employment is hard to find when there are many factors against the individual.

Literature Review

Mental Illness in the Inmate Population and Recidivism

The Bureau of Justice Statistics conducted a study in 2017 analyzing mental illness and mental health history within the jail and prison population. They found that 14% of prison inmates and 26% of jail inmates meet the threshold for having current serious psychological distress (SPD) and they were more likely than the United States general population to have SPD. Also, women were more likely to have current SPD. The report also found that 36.9% of the prison population and 44.3% of the jail population has had mental health problems in their past (ex: major depressive disorder, bipolar disorder, schizophrenia, etc.). One of the most interesting findings of this report was that inmates who had served five years or more before their current sentence were more likely to have a mental health problem. This is significant because offenders

with mental illness were more likely to have previous incarceration time. Therefore, mental illness is a further barrier to successful community transition.

One of the largest studies conducted on individuals with mental illnesses and recidivism was conducted in 2009 with 79,211 inmates incarcerated in the Texas Department of Criminal Justice prison system. The participants had one of four categories of psychiatric disorders: major depressive disorder, bipolar disorders, schizophrenia, and nonschizophrenia psychotic disorders (schizoaffective disorder, delusional disorder, substance-induced psychosis, and psychotic disorder not specified) (Baillargeon et al., 2009). The researchers recorded demographic information, mental illness history, and history of incarceration for the following six years after release from their sentence between 2006 and 2007 (Baillargeon et al., 2009). The researchers defined the inmates' offenses as violent and non-violent. 7,878 inmates had one of the four categories of mental illness and those who had a psychiatric disorder reported committing more violent offenses (assault, homicide, and robbery) and property crimes (Baillargeon et al., 2009). Overall, those who had bipolar disorders, schizophrenia, and psychotic disorders were more likely to have multiple incarcerations during the follow-up period (Baillargeon et al., 2009). The results show those with psychiatric disorders in the criminal justice system were more likely to re-offend. The article gives possible explanations for this as a limited number of mental health resources in the community and a smaller capacity of the system to handle cases with mental illness individually.

Although this study clearly showed that offenders with mental illness had a higher risk of reoffending, it relied heavily on the intake evaluation based on the Diagnostic and Statistical Manual of Mental Disorders - IV (DSM-IV) and the reliability of rater. It did not include other common comorbid disorders such as anxiety or substance use disorder. Also, this study does not

account for different racial experiences with mental illness and reentry. It does not address other sociological reasons for reoffending such as stigma and the effect it has on the individual reentering society.

There have been other studies that have looked at reoffending rates within the inmate population who have mental illnesses. In 1991, a study of 547 inmates in New York State prison found that those who had mental illnesses had similar rearrest rates compared to those without mental illnesses (Feder, 1991). Although, this study used an 18-month follow-up period compared to a six-year follow-up period as Baillargeon et al. (2009) used and that could explain some differences. Also, Feder (1991) used a smaller sample size and was conducted in a different state with different criminal justice mandates and treatment resources. Another study by Lovell et al. (2002) sampled 337 inmates with mental illnesses from the Washington State prison system released between 1996 and 1997 found that their reoffending felony rates were only slightly higher (41%) than all inmates (37%) during the average follow up 39 months. These differences could also be explained by small sample size and different methodology, but it does not answer the question as to why ex-offenders with mental illness recidivate and what specific challenges they face for reentry.

Stigma and Modified Labeling Theory

Stigma could provide further explanation for the increased recidivism rates among those with mental illness. Link et al. (1989) discuss the idea of modified labeling theory and how stigmatized groups are aware of their status and act to cope with public rejection. Stigma is an umbrella term for multiple processes of discrimination, stereotyping, social rejection, and more. It is further defined as the exploitation and domination (keeping people down); norm enforcement (keeping people in); and disease avoidance (keeping people away) (Yanos, 2018;

Phelan, Link & Dovido, 2008). Yanos (2018) described the concept of "stigma concern" and how those diagnosed with mental illness could worry they would be stigmatized by others for having a mental illness. Evidence of this can be found in research done with the "devaluation-discrimination," scale by Link (1989) which measures how much a person agrees that the public would reject someone with a mental illness compared to a close friend or family and others. Studies with the scale have found that persons highly agree that individuals with mental illness would not be accepted by others (Brohan et al., 2010; Rosenfield, 1997).

Furthermore, stigma has been found to affect self-esteem (Link et al., 2001). The researchers sampled 70 individuals with mental illness in a clubhouse program (where one group had an intervention on how to cope with stigma and one group did not have an intervention) and measured their self-esteem, perceived devaluation-discrimination, and stigma-withdrawal six months and 24 months after the program (Link et al., 2001). The most common diagnosis the sample had was schizophrenia (Link et al., 2001). The results found that 73% of the sample indicated low self-esteem on two or more questions on the measure and 69%-74% believed that they would be discriminated against by employers, romantic interests, and close friends (Link et al., 2001). Also, 63% of the sample said they would avoid persons if they thought the person would think less of them because they had psychiatric treatment (Link et al., 2001). This is an example of social withdrawal. This shows that there could be a connection between individuals with mental illness, stigma concern, and social withdrawal. With the ex-offender population, they might be affected by low self-esteem leading to other internal problems such as low motivation as noted by Ward and Merlo (2016).

Ex-offenders with mental illness who believe that they will be discriminated against and have low motivation could socially withdrawal and not participate in treatment or try to find a

job which both have been found to be a protective factor for recidivism (Makarios, Steiner & Travis, 2010). A meta-analysis using the modified labeling theory model found that stigma was the fourth highest ranked barrier to help-seeking for mental illness (Clement et al., 2015). Ethnic minorities, young persons, and men were found to be especially affected by stigma related to help-seeking for mental illness (Clement et al., 2015). Therefore, people with mental illness are affected by stigma and this could avoidance of mental health treatment. This could be amplified if the person also has a criminal justice background. Especially for people on parole, withdrawing could result in incomplete parole-mandated programs, and result in further penalties. It makes sense that if one believes they will be discriminated against due to their mental illness or criminal justice background, they will not be motivated to be part of the community.

Offender Perceptions of Stigma

The transition from incarceration to the community is extremely difficult. On top of juggling employment and housing difficulties, formerly incarcerated persons also must learn how to cope with the stigma related to their criminal justice history. Prior research has shown that stigma impacts a person's self-esteem and social involvement and could lead to changes in self-image and impact a person's ability to reintegrate into society (Link et al., 1989; Rosenfield, 1997; Prince & Prince, 2002). One study explored how expected stigma affects community integration with a sample of individuals with mental illnesses such as schizophrenia, affective disorders, personality disorders, and more (Prince & Prince, 2002). Similar to Link et al., (1989), the researchers found that on the devaluation-discrimination scale, participants scored similar means (49.66, *SD*= 10.49) to the prior studies (49.8, *SD*= 10.68) meaning that individuals agreed that persons with mental illness will be rejected by the public (Link et al., 1989; Prince & Prince,

2002). Those who perceived stigmatization from the community also had less sense of belonging, especially in individuals who perceived less social support and had lower psychosocial functioning (Prince & Prince, 2002). However, this relationship had a modest correlation, and the study did not look at other factors that would impact a person's feeling of belongingness and sense of community. Even though this study does not use a sample of offenders, as shown in previous sections, offenders who have mental illnesses are likely to re-offend and be incarcerated again. Therefore, there are problems with community reintegration and stigma could be a factor, especially for those with mental illness.

Prior literature has explored to what extent offenders experience stigma as anticipated stigma, self-stigma, and enacted stigma (Link et al., 2004; LeBel, 2012). Anticipated stigma being the amount of stigma a person believes they will receive while enacted stigma is the exposure to actual experiences of stigma (Link et al., 1989; Wright et al., 2000). Self-stigma is when a member of a stigmatized group internalizes stigmatizing social attitudes by the public (Corrigan et al., 2010; West, 2015).

Winnick and Bodkin (2008) test modified labeling theory by giving a self-report survey to 450 male ex-offenders asking about their level of perceived stigma and predictors of perceived stigma, use of stigma management strategies, social bonds, and exclusion experiences. Responses found that ex-offenders anticipate rejection, especially in white participants, especially regarding obtaining employment (Winnick & Bodkin, 2008). The participants' most common stigma management strategy was to preventatively tell others about their status. Factors associated with withdrawal are discrimination beliefs and anticipated difficulty obtaining employment and prior time served (Winnick & Bodkin, 2008). On the other hand, factors associated with inclusion are social support and preventative telling (Winnick & Bodkin, 2008).

So, we can see that perceived stigma affects one's behavior in the community and therefore should be an integral part of reentry resources. Social bonds reveal to be helpful to cope with public stigma. An element that could be important that this article does not include is why white participants anticipate more stigma, especially when looking for a job. Pager (2003) explores this concept and found that white participants with a criminal record are more likely to be hired than Black participants without a criminal record. Further research is needed to find why this occurs. Also, perceived and anticipated stigma could differ depending on offense type. People who committed violent crimes could perceive stigma differently than those who have committed sex offenses and this relationship is not explored.

LeBel et al. (2012) explored how ex-offenders experience stigma and what factors are related to perceptions of stigma. The researchers took a sample of 229 formally incarcerated persons from New York State who participated in a prison reentry service. They completed self-report measures about what they think the public thinks about ex-offenders as a group and individually, personal experiences of discrimination because they were an ex-offender, and their social bonds with their family and friends (LeBel et al., 2012). Results showed that ex-offenders have strong beliefs that the public discriminates against formally incarcerated persons (LeBel et al., 2012). However, for individual stigma, the sample mean rating was significantly lower (3.79) than the neutral score (4) (LeBel et al., 2012). About 25% of the sample reported they experienced discrimination involving housing and employment (LeBel et al., 2012). For individuals who felt more strongly that ex-offenders were devalued and discriminated against had more parole violations, were violent offenders, identify strongly with former prisoners, had more formal education, and grew up in an environment where incarceration was more common

(LeBel et al., 2012). Also, the researchers found that non-Hispanic white ex-offenders perceive higher levels of stigma and reported having more discrimination experiences.

Those who had more parole violations and lived in a neighborhood where incarceration was common, held stronger beliefs of perceived stigmatization. This could be because these communities were more aware of how ex-offenders are treated in the public and are sensitive to it (LeBel et al., 2012). Also, some individuals indicated they felt a stronger bond and connection to other ex-offenders were more likely to have stronger beliefs of stigma and discrimination while stronger bonds with family and friends were a small predictor of fewer discrimination experiences (LeBel et al., 2012). This is an example of the importance of social bonds and group identification and how it can affect a person's perceptions of stigma.

LeBel et al., (2012) give some perspective to how formally incarcerated persons experience and stigma and is consistent with findings that offenders experience discrimination, especially regarding employment and housing. It does define which offense type is more likely to hold beliefs about stigma and touches upon which race reports more discrimination experiences. However, it could not represent all experiences of ex-offenders and does not explore why there are racial differences. It also does not account for different offense types moderating the amount of perceived or anticipated stigma or social bonds.

Moore, Stuewig and Tangney (2016) build on their prior research (Moore, Stuewig, & Tangney, 2013) which found that ex-offenders perceived stigma predicted more employment for African Americans but not for whites, and perceived stigma predicted fewer arrests for whites but not for African Americans. Moore, Stuewig and Tangney (2016) expanded on their work by investigating how stigma affects ex-offender functioning including substance use, community adjustment, mental health as well as employment and recidivism. The researchers surveyed 163

inmates from jails in an urban area from 2002-2007 when they entered jail before they were released and a year after release about their perceptions of stigma, shame-proneness, social identity, mental health, recidivism, and community functioning. Results showed that the higher the individual perceived stigma predicted more anticipated stigma which predicted worse community functioning. Therefore, perceived stigma affects community adjustment when an ex-offender anticipates personal discrimination or stigmatization (Moore, Stuweig & Tangney, 2016). The researchers suggest that since formally incarcerated persons who expect stigmatization could withdraw from their community and could have less motivation to reintegrate and participate in the community. One of the most important findings of the study was that community adjustment varied by race. White formerly incarcerated persons perceived more stigma which predicted more anticipated stigma which predicted worse community adjustment (Moore, Stuweig & Tangney, 2016). However, African Americans perceived stigma and were less predictive of anticipated stigma, which did not significantly predict community adjustment (Moore, Stuweig & Tangney, 2016). The paper suggests that African Americans could be facing stigma from being a minority along with being an ex-offender and therefore could not affect their cognitions, emotions, and community functioning as much as white persons. This article begins to explain why there are racial differences for anticipated stigma and how it affects community stigma however more is needed to understand more of the minority experience of reentry. It does not look at the offense type and how different offenders could have different experiences with perceived and anticipated stigma.

Race and Stigma in the Offender Population

Minority offenders could face different challenges to reentry as well as perceived and anticipate stigma differently due to being part of a marginalized group. As seen with Winnick

and Bodkin (2008) and Moore, Stuweig and Tangney (2016), white ex-offenders report anticipating more stigma than African Americans. While white persons may anticipate more stigma, it begs the question as to who experiences more discrimination experiences and how that affects their reentry process. Pager (2003) explored how a criminal record could affect employment after release and how race could impact employment outcomes. She had pairs of white and Black participants apply in person to similar entry-level jobs with one person in each pair indicating they had a criminal record (drug offense), and one did not. The study measured the number of call-backs the participants received. For whites, having a criminal record decreased their number of callbacks by 50%, from a 34% callback rate without a record to a 17% callback rate with a record (Pager, 2003). For Black participants without a criminal record had a 14% callback rate compared to a 5% callback rate for those with a criminal record (Pager, 2003). This shows how persons with criminal records are less likely to be considered for jobs, in general, and the difference intensifies taking into account racial differences. Black people in general are less considered for jobs and on three occasions Black participants were asked if they had a criminal history before applying while white participants were not (Pager, 2003). This is a blatant showing of bias and inequality and reveals that criminal records and minority status together exacerbate stigma toward ex-offenders (Pager, 2003). However, there are limits to generalizability, especially regarding location and time. Now, many people apply to jobs online and the differing process could yield different results of bias if any. Also, this data could be true for the Milwaukee area and not representative of other areas. Also, this only looks at drug offense history and offense type could play a role in the amount of stigma an ex-offender feels and experiences while applying for jobs. It is also limited in the scope of reentry because it only focuses on employment.

In a replication of Pager (2003), Decker et al. (2015) investigated the same ideas further with in-person job applications and online job applications. They found interesting and different results. For online job applications, race and criminal history did not show to affect hiring decisions. Although for in-person jobs, being Black and having a criminal history did negatively affect job callbacks (Decker et al., 2015). Even though the effect of race and criminal history were smaller, they still affected minorities compared to white applicants. Therefore, race plays a role in discrimination experiences especially regarding employment and should be studied further with different reentry aspects such as community involvement.

Present Study

Research has shown that offenders perceive stigma and anticipate stigma after release, especially regarding employment and housing (LeBel et al., 2012). However, there is limited information about how variables such as offense type, mental health treatment, and race affect how ex-offenders perceive, anticipate and experience stigma. While research has shown that sex offenders are viewed negatively by the public, there are gaps in understanding reasons why this occurs (Bureau of Justice Statistics, 2017; Sample & Bray, 2006; Levenson et al., 2007; Rade, Desmarais & Mitchell, 2016; Viki et al., 2012). Stigma might serve as one potential explanation for these findings. There is limited research on the offender perspective of stigma compared to how the public perceives them.

The purpose of this study is to expand on the existing knowledge of how formerly incarcerated persons perceive stigma, anticipate stigma, and experience stigma and how offense type, mental health treatment, mental illness, and race affect these forms of stigma.

The first aim of the study was to explore how offense type affects a formerly incarcerated person's experience of perceived stigma, anticipated stigma, and discrimination experiences. We

hypothesize that ex-offenders who committed violent or sex offenses will perceive and anticipate more stigma and will have more discrimination experiences after release.

The second aim of the present study was to understand how mental illness and mental health treatment moderates stigma experiences and feelings after release. Prior literature has shown that persons with mental illnesses believe they will be discriminated against by the public and possibly have higher rates of reoffending. We hypothesized that those with mental illness would perceive and anticipate more stigma and would report more discrimination experiences after release.

The third aim of the study was to see how the variable race impacts the likelihood of experiencing stigma. We hypothesize that those who belong to minority groups will report more discrimination experiences.

Methods

Participants

A total of 219 participants were recruited through Prolific, an online recruitment platform. 5 individuals were removed from the sample because they did not complete the consent form. 14 individuals were removed from the sample because they were not previously incarcerated. 6 participants were removed from the sample because they did not respond to any questions on the survey. Therefore, the sample consisted of 194 participants. Individuals sign up on Prolific to complete surveys for monetary compensation. The website allows for inclusion criteria to show the survey to a specific population. Prolific only displayed the survey to those who met the screening criteria. The inclusion criteria for participation in the study was to be at least 18 years of age and have been previously incarcerated. A total of 190 participants

completed the SSMIS Aware subscale, 189 completed the SSMIS Agree subscale, 192 participants completed the IPES anticipated stigma items and 194 completed the IPES perceived stigma items. 118 participants completed the EDS measure. This was because the EDS measure was added later when data collection had begun and therefore has fewer participants.

The sample was majority male, white and middle aged. The most common offense types committed were drug offenses and property offenses. The most common psychiatric disorders were depressive disorders and bipolar and related disorders. Table 1 includes more detailed demographic information for the participants in this study.

Table 1
Participant Demographics

	Frequency (n = 194)	Percentage
Gender		
Male	120	63.2%
Female	70	36.8%
Missing	4	
Race		
Hispanic or Latino(a)	9	4.6%
Black or African American	19	9.8%
White	152	78.4%
Asian or Pacific Islander	4	2.1%
Bi/Multiracial	8	4.1%
Other	12	1.0%
Primary Psychiatric Diagnoses		
Bipolar and Related Disorders	23	11.9%
Depressive Disorders	48	24.7%
Anxiety Disorders	17	8.8%
Obsessive Compulsive and Related Disorders	1	0.5%
Trauma and Related Disorders	12	6.2%
Substance Use Disorder	4	2.1%
Other Disorder	21	10.8%
No Disorder	68	35.1%
Offense Type		
Violent Offense	26	13.4%
Sex Offense	18	9.3%
Drug Offense	84	43.3%
Property Offense	44	22.7%
Other Offense	21	10.8%

Note. Categorical demographic information

	Range	**Mean**	**Standard Deviation**
Age (Years)	21 – 99	41.15	11.63
Length of Incarceration (Months)	< 1– 342	26.59	36.65
Age of First Hospitalization (Years)	4 – 55	20.53	8.91
Number of Past Hospitalizations	0 – 20	1.4	2.66

Note. Continuous demographic information

Measures

The Qualtrics survey consisted of four parts. The first part recorded demographic information of the participants. This would be age, race, sex, employment, offense type, and type of mental health treatment completed during incarceration (if any). The second part of the survey used The Inmate Perceptions and Expectations of Stigma measure (IPES), a 12-item scale created by Mashek et al. (2002) that assesses anticipated and perceived stigma. The third part of the survey used the Self-Stigma of Mental Illness Scale – Short Form (SSMIS-SF) created by (SSMIS-SF; Corrigan, Watson, & Barr, 2006) a 20-item scale that assesses self-stigma and internalization of stigma. The fourth part of the survey used the adapted Experience of Discrimination Scale (EDS; Sanders, Thompson, Noel, & Campbell, 2004) assessing discrimination experiences specifically within different groups.

Demographic Information

Participants completed a demographics survey. This included age, sex, race/ethnicity, most recent convicted offense, diagnosis, mental health treatment length while incarcerated, education level, number of psychiatric hospitalizations, and age at first treatment for mental health problem. The demographic section of the survey asked participants of their most recent offense type using the following categorical options: violent offense, sex offense, drug offense, property offense, and other offense. If the participants indicated they committed an "other," offense, they specified in a text box their offense. The survey specifically asked to list any psychiatric diagnoses the individual have received from a mental health professional.

Self-Stigma of Mental Illness Scale – Short Form

The Self-Stigma of Mental Illness Scale – Short Form (SSMIS-SF) was created by Corrigan, Watson, and Barr (2006) to measure the assess to what degree a person with mental

illness anticipates and internalizes stigma. It is a 20-item scale with two subscales that is rated on a 9-point agreement scale. 1 is strongly disagree and 9 is strongly agree. The first subscale is "stereotype awareness" in which participants agree or disagree if the participant thinks that *other* people hold the stereotype (ex: I think the public believes that people with mental illnesses are dangerous). The second subscale is "stereotype agreement" where participants agree or disagree with the stereotype (ex: I think that people with mental illnesses are dangerous). In previous research, "stereotype awareness" and "stereotype agreement" subscales demonstrated good internal consistency, with a Cronbach's alpha of 0.73, 0.75, respectively (Corrigan et al., 2013). In the present study both subscales also demonstrated good internal consistency, with has a Cronbach's alpha of .822 for "stereotype awareness" and .793 for "stereotype agreement."

Inmate Perceptions and Expectations of Stigma Measure

The Inmate Perceptions and Expectations of Stigma Measure (IPES) was created by Mashek et al., (2002) to assess perceived and anticipated stigma felt by ex-offenders. The 12-item scale is set up into two different parts. The first part asks the participants to think about how people in society would feel toward "criminals," (perceived stigma) and the second part asks participants to think about how they would be treated once they were released (anticipated stigma) (Moore, Stuewig & Tangney, 2013). The reliability of the first part of the measure has a Cronbach's alpha of 0.83 and the second part of the measure has a Cronbach's alpha of 0.81 (Moore, Stuewig & Tangney, 2013). The present study's reliability the subscales to have good internal consistency. The perceived stigma subscale had a Cronbach's alpha of .85 and the anticipated stigma subscale had an alpha of .90.

Experiences of Discrimination Scale

The Experiences of Discrimination Scale (EDS) was created by Sanders, Thompson, Noel and Campbell (2004) as an adaption of prior racial discrimination scales and discrimination scales due to group identity. The scale consists of three items. The first item asks the individual if they have ever been discriminated against in a form of a "yes" or "no" question. If the participants respond "yes," they complete the second item. The second item asks if the individual has been discriminated against due to different group identities (ex: race, gender, sexual orientation, mental disability, past incarcerations, etc.). This item is measured on scale from 0 to 5; 0 indicates that discrimination due to this aspect never happens, 1 indicates that discrimination has occurred 1 to 2 times, 2 indicates that discrimination has occurred 3 to 4 times, 3 indicates that discrimination has occurred 4 to 5 times, 4 indicates that discrimination occurs daily, and 5 indicates that discrimination occurs multiple times a day. The third item asks the individual where the discrimination occurred (ex: employment, housing, law enforcement, etc.). This item is also scored the same as the previous item.

Procedure

A survey through Qualtrics was created and distributed through Prolific with the three measures described above. Analysis of Covariance was used to examine the relationship between type of offense history, mental health and treatment history, and race and the stigma measures controlling for gender and age. Further correlational analyses were also used to understand to the relationship among study variables.

Results

Data Preparation and Analysis

Data analyses were completed using IBM SPSS 28 statistical analysis package. Missing data points were coded as "-99." For the purposes of analyses, there were not enough participants

in demographic groups to allow for certain comparisons. Therefore, ethnic groups were coded into two groups: white and People of Color. Two subcategories of mental illnesses were created: primary and secondary diagnoses.

Participants listed psychiatric diagnoses, if they had any, in a text box as part of the survey. The first diagnosis they listed were coded as their primary diagnosis. Then, their primary diagnosis was further categorized into the following categories: bipolar and related disorders, depressive disorders, anxiety disorders, obsessive compulsive and related disorders, trauma and related disorders, substance use disorder, other disorder and no disorder. For purpose of statistical analyses, a new variable was created named, "Serious Mental Illness," with three categories: no diagnosis, likely serious mental illness and other mental illness. The category "likely serious mental illness," included participants who indicated their primary diagnosis as bipolar and related disorders, obsessive compulsive and related disorders, and trauma and related disorders. "Other mental illness," included participants whose disorders fell into depressive disorders, anxiety disorders, and substance use disorder. "No diagnosis," included participants that did not indicate any psychiatric diagnoses.

Offense type was categorized into the following groups: violent offense, sex offense, drug offense, property offense, and other offense. If participants indicated an "other," offense that did fit into the other offense type categories, they were recategorized into the appropriate category.

The following results explore relationships among offense types and perceived stigma, anticipated stigma and discrimination experiences, the relationship between mental illnesses and discrimination experiences and the relationship between race and different forms of stigma and discrimination experiences.

Analyses of Scale Properties

Self-Stigma of Mental Illness Scale- Short Form (SSMIS-SF)

Scores on the SSMIS-SF Stereotype Agree subscale ranged from 5 to 32 (M = 15.87, SD = 6.29). Scores on the SSMIS-SF Stereotype Aware subscale ranged from 10 to 45 (M = 27.07, SD = 7.26). This suggests that individuals were more aware of mental illness stereotypes than in agreement with the stereotypes.

Inmate Perceptions and Expectations of Stigma Measure (IPES)

Scores on the IPES anticipated stigma average scores ranged from 1.75 to 7 (M = 4.84, SD = 1.33). Scores on the IPES perceived stigma average scores ranged from 2.13 to 7 (M = 5.23, SD = .90). The participants therefore typically endorsed that they "agreed" more with statements of perceived public stigma.

Experiences of Discrimination Scale

For the part of the sample that completed the EDS (n = 118), 102 individuals (86.4%) endorsed that they have been discriminated against. 23 out of 112 participants (79%) of the sample endorsed that they have been discriminated against due to past incarcerations at least once. 49 out of 111 individuals (44.1%) stated they have been discriminated due to mental illness at least once. 56 participants out of 111 (50.5%) stated they have been discriminated due to their race. 50 out of 110 (45.5%) stated they have been discriminated against due to their gender. 25 of 111 (22.7%) stated they were discriminated due to sexual orientation. 33 out of 110 (30%) reported discrimination due to religion. 22 out of 110 (20%) reported discrimination due to ethnicity, 78 out of 111 (70.3%) reported discrimination due to socioeconomic status, 21 out of 110 (19.1%) reported discrimination due to their physical disability, 46 out of 111 (41.4%)

reported discrimination due to their age and 13 out of 102 (12.7%) reported discrimination for other reasons.

In regards to where the discrimination took place, 94 out of 111 (84.7%) reported discrimination in employment, 41 out of 111 (36.9%) reported discrimination in education, 61 out of 110 (55.5%) reported discrimination in housing, 85 out of 108 (78.7%) reported discrimination in law enforcement (police, courts), 30 out of 111 participants (27%) reported discrimination in public accommodations, 23 out of 111 participants (20.7%) reported discrimination in consumer-operated mental health services, 46 out of 110 participants (41.8%) reported discrimination in other agencies and 24 out of 111 (21.6%) reported discrimination in traditional mental health services.

Relationship Between Offense Type, SSMIS-SF, IPES and EDS

An Analysis of Covariance was conducted to examine whether stigma scores differed by offense type groups controlling for the demographic factors age and gender (Hypothesis 1; see Table 2). Overall, there was no relationship between offense type and the SSMIS-SF Aware subscale. However, pairwise Post-Hoc tests were conducted to determine differences in offense type mitigating stereotype awareness, and results showed that those who committed sex offenses reported higher awareness of serious mental illness stereotypes compared to those who committed other offenses (p = .017). However, those who committed violent offenses did not report higher SSMIS-SF Agree scores than others. Thus, there was only partial support for Hypothesis 1.

However, the means for the SSMIS-SF Agree subscale, which represent potential internalization of negative stereotypes among those diagnosed with mental illnesses, were not

significantly different based on offense type. Therefore, offense type predicted awareness of, but not agreement with mental illness stereotypes.

For the IPES and offense type, offense type scores were significantly different for the perceived stigma subscale [$F(5,181) = 2.482$, $p = .033$, eta squared = .064]. Pairwise Post-Hoc tests also revealed that those who committed sex offenses reported higher perceived stigma related to having a criminal justice history, compared to those who committed violent offenses ($p = .033$), drug offenses ($p = .004$), and other offenses ($p = .022$). Offense type scores were approaching significance for the anticipated stigma subscale [$F(5, 179) = 2.218$, $p = .054$). Post-hoc tests showed that those who committed sex offenses reported higher anticipated stigma related to being an offender compared to those who committed violent offenses ($p = .036$), drug offenses ($p = .003$), property offenses ($p = .048$) and other offenses ($p = .002$). These results partially supported Hypothesis 1, although our prediction that persons charged with violent offenses would endorse more stigma related to being an offender was not supported.

Contrary to Hypothesis 1, there were no significant differences for offense type with the Experiences of Discrimination Scale (EDS). Specific analyses were run for the questions, “Do you believe you have ever been discriminated against?” “If you have responded ‘yes’, have you been discriminated against due to your past incarcerations?” “If you have responded ‘yes’, have you been discriminated against due to your mental illness?” “This discrimination occurred in the following type of situation: employment.” No significant differences due to offense type were found.

Table 2

Analysis of Covariance Table of Offense Type with Adjusted Marginal Means controlling for Gender and Age

Variable	1. Violent Offense (*n* = 26) *M* (*SD*)	2. Sex Offense (*n* = 18) *M* (*SD*)	3. Drug Offense (*n* = 84) *M* (*SD*)	4. Property Offense (*n* = 44) *M* (*SD*)	5. Other Offense (*n* = 21) *M* (*SD*)	F	*p*-value	Tukey's HSD
IPES Perceive (range = 1 – 7)	5.20 (.83)	5.77 (.85)	5.09 (.87)	5.31 (.96)	5.14 (.87)	2.48	.033	2>3,1
IPES Anticipate (range = 1 – 7)	4.86 (1.33)	5.84 (.96)	4.62 (1.29)	4.99 (1.41)	4.46 (1.22)	2.21	.054	2>3,1,4,5
SSMIS -SF Agree (range = 5 – 45)	17.4 (6.14)	17.5(7.43)	15.80 (5.88)	15.00 (6.73)	14.2 (6.86)	.853	.514	
SSMIS -SF Aware (range = 5 – 45)	27.32 (5.51)	30.43 (6.77)	26.39 (7.59)	27.45 (7.30)	25.05 (7.62)	1.31	.263	2>5
EDS (range = 0 – 1)	1.12 (.33)	1.11 (.33)	1.15 (.36)	1.12 (.33)	1.23 (.44)	.355	.878	

Note. IPES = Inmate Perceptions and Expectations of Stigma Measure, SSMIS -SF = Self-Stigma of Mental Illness Short Form, EDS = Experiences of Discrimination Scale, EDS (First Item, 0 = No, 1 = Yes), HSD= Honestly Significant Difference

Mental Illness and Mental Health Treatment and SSMIS, IPES, and EDS

An Analysis of Covariance was conducted to examine the relationship between stigma and self-reported mental illness controlling for the demographic factors age and gender (Hypothesis 2; see Table 3). As stated above, mental illness was categorized into three categories: no diagnosis, likely serious mental illness (SMI), and other mental illness. Mental illness diagnoses and the SSMIS-SF Aware subscale scores were analyzed and approached significance [$F(2, 180) = 2.205$, $p = .113$). However, post-hoc tests revealed that those who were likely to have serious mental illness endorsed higher awareness of mental illness stereotypes compared to those who did not have a mental illness diagnosis ($p = .046$). However, the SSMIS-SF Agree subscale, IPES perceived stigma average scores, IPES anticipated stigma average scores and EDS scores were not found to be significantly different among the three groups of mental illness. Therefore, hypothesis 2 was only partially supported.

Furthermore, we analyzed using an ANCOVA how mental health treatment while incarcerated could mitigate the amount of discrimination experiences an individual faces after release. Table 4 describes these results. The question, "Have you received mental health treatment while incarcerated?" were tested against the following two questions from the EDS: "Have you been discriminated against due to previous incarcerations?" and "Have you been discriminated against due to mental illness?" Results showed that those who stated they had received mental health treatment while incarcerated also had reported *more* discrimination experiences due to their past incarcerations [$F(1,104) = 7.590$, $p = .007$, eta squared = .068]. Also, those who stated they received mental health treatment while incarcerated also reported experiencing more discrimination due to their mental illness ($F(1,103) = 7.842$, $p = .006$]. When

testing if receiving mental health treatment while incarcerated was related to experiencing discrimination in housing or employment contexts, there were no significant differences found.

Table 3

Analysis of Covariance Table of Mental Illness with Adjusted Marginal Means controlling for Gender and Age

Variable	1. No Diagnosis (*n* = 68) *M* (*SD*)	2. Likely Serious Mental Illness (*n* = 51) *M* (*SD*)	3. Other Mental Illness (*n* = 70) *M* (*SD*)	F	*p*-value	Tukey's HSD
IPES Perceive (range = 1 – 7)	5.26 (.89)	5.31 (.91)	5.15 (.82)	.411	.663	
IPES Anticipate (range = 1 – 7)	4.92 (1.42)	4.97 (1.28)	4.63 (1.24)	1.05	.351	
SSMIS -SF Agree (range = 5 – 45)	16.56 (7.01)	16.20 (5.10)	14.94 (6.46)	1.415	.246	2>1
SSMIS – SF Aware (range = 5 – 45)	25.54 (7.34)	28.49 (6.86)	27.13 (7.31)	2.20	.113	
EDS (range = 0 – 1)	1.11 (.32)	1.19 (.40)	1.14 (.35)	.849	.878	

Note. IPES = Inmate Perceptions and Expectations of Stigma Measure, SSMIS -SF = Self-Stigma of Mental Illness Short Form, EDS = Experiences of Discrimination Scale, EDS (First Item, 0 = No, 1 = Yes), HSD= Honestly Significant Difference

Table 4

Analysis of Covariance Table of Mental Health Treatment while Incarcerated with Adjusted Marginal Means controlling for Gender and Age

Variable	1. Received MHT while Incarcerated (n = 30) *M* (*SD*)	2. No MHT while Incarcerated (n = 78) *M* (*SD*)	F	*p*-value
EDS (range = 0 – 1)	1.11 (.32)	1.19 (.40)	.849	.878
EDS due to PI (range = 1 – 10)	5.07 (3.30)	3.53 (2.56)	7.59	.007
EDS due to MI (range = 1 – 10)	3.33 (2.58)	1.94 (1.92)	7.84	.006
EDS in Employment (range = 1 – 10)	3.93 (2.96)	3.31 (2.19)	2.15	1.46
EDS in Housing (range = 1 – 10)	2.89 (2.53)	2.40 (2.20)	1.01	.317

Note. EDS = Experiences of Discrimination Scale, EDS (First Item, 0 = No, 1 = Yes), PI = Previous Incarcerations, MI = Mental Illness

Race and Stigma

Table 5 describes the relationship between race and stigma. There were no significant differences in white and Persons of Color for scores on the SSMIS-SF Aware subscale, SSMIS-SF Agree subscale, IPES anticipated stigma average and IPES perceived stigma average. However there was a non-significant trend for People of color respondents to report they had more discrimination experiences due to their past incarcerations [$F(1,104) = 3.212$, $p = .076$]. There was no significant different between persons of Color and white respondents regarding if they experienced discrimination due to mental illness. Furthermore, people of color endorsed experiencing more discrimination in housing contexts [$F(1, 102) = 4.224$, $p = .042$] but not employment situations.

Table 5

Analysis of Covariance Table of Race with Adjusted Marginal Means controlling for Gender and Age

Variable	1. White (n = 148) M (SD)	2. People of Color (n = 41) M (SD)	F	p-value	Tukey's HSD
IPES Perceive (range = 1 – 7)	5.23 (.90)	5.25 (.75)	.380	.538	
IPES Anticipate (range = 1 – 7)	4.83 (1.32)	4.8 (1.36)	.166	.684	
SSMIS - SF Agree (range = 5 – 45)	15.98 (6.01)	15.55 (7.53)	.911	.341	
SSMIS - SF Aware (range = 5 – 45)	27.00 (6.73)	25.59 (8.99)	.457	.500	
EDS (range = 0 – 1)	1.14 (.354)	1.13 (.34)	.351	.555	
EDS due to PI (range = 1 – 10)	3.66 (2.54)	5.04 (3.65)	3.21	.076	
EDS due to MI (range = 1 – 10)	2.50 (2.40)	1.70 (1.11)	1.531	.291	
EDS in Employment (range = 1 – 10)	3.26 (2.34)	4.26 (2.92)	1.23	.269	
EDS in Housing (range = 1 – 10)	2.29 (2.08)	3.39 (2.82)	4.22	.042	2>1

Note. IPES = Inmate Perceptions and Expectations of Stigma Measure, SSMIS -SF = Self-Stigma of Mental Illness Short Form, EDS = Experiences of Discrimination Scale, EDS (First Item, 0 = No, 1 = Yes), PI = Previous Incarcerations, MI = Mental Illness, HSD= Honestly Significant Difference,

Correlations

Bivariate Pearson's correlations were computed to determine the relationship among study variables and outcome variables as shown in Table 6. The SSMIS-SF Aware and Agree subscales, the IPES anticipated and perceived averages and EDS scale were not correlated or significant with the variable offense type. The IPES perceive subscale was significantly correlated with the IPES anticipate subscale (r = .484, n = 192, p = <.001) and the SSMIS-SF Aware subscale (r = .381, n = 190, p = <.001). The IPES anticipate subscale was also significantly correlated with the SSMIS-SF Aware subscale (r = .413, n = 190, p = <.001).

Mental illness was positively correlated with discrimination due to having mental illness (r = .262, n = 111, p = .005), experiencing discrimination in consumer operated mental health services (r = .212, n = 111, p = .026), and traditional mental health settings (r = .223, n = 111, p = .018).

Receiving mental health treatment while incarcerated was negatively correlated with discrimination due to religion (r = -.300, n = 110, p = .001), discrimination due to mental illness (r = -.276, n = 111, p = .003), discrimination due to past incarcerations (r = .271, n = 112, p = .004), discrimination in consumer operated mental health services (r = -.322, n = 111, p = <.001) and discrimination in traditional mental health services (r = -.310, n = 111, p = <.001).

Race was positively correlated with discrimination due to race (r = .568, n = 111, p = <.001), discrimination due to religion (r = .202, n = 110, p = .034), discrimination due to country of origin (r = .280, n = 110, p = .03), discrimination due to past incarcerations (r = .118, n = 112, p = .048), discrimination in education (r = .332, n = 111, p = <.001), discrimination in housing (r = .191, n = 110, n = .046), law enforcement (r = .311, n = 108, p = .001), public accommodation (r = .270, n = 111, p = .004), and other agencies (r = .226, n = 110, p = .018).

Table 6

Correlations of Study Variables

Variable	Offense Type	SMI	Race	IPES Perceive	IPES Anticipate	SSMIS Aware	SSMIS Agree	EDS
Offense Type	-							
SMI	.078	-						
Race	.048	.002	-					
IPES Perceive	.092	-.047	-.030	-				
IPES Anticipate	-.010	-.102	-.004	.484**	-			
SSMIS – SF Aware	.068	.100	-.032	.381**	.413**	-		
SSMIS – SF Agree	.068	-.116	-.022	-.066	.053	.150*	-	
EDS	.043	.032	-.024	.044	-.163	-.065	.009	-

Note. IPES = Inmate Perceptions and Expectations of Stigma Measure, SSMIS -SF = Self-Stigma of Mental Illness Short Form, EDS = Experiences of Discrimination Scale, EDS (First Item, 0 = No, 1 = Yes)

**. Correlation is significant at the 0.01 level (2-tailed).

*. Correlation is significant at the 0.05 level (2-tailed).

Discussion

Results of this study add to our understanding of formerly incarcerated persons' perspective on anticipated stigma, perceived stigma, and discrimination experiences. We found that formerly incarcerated persons charged with sex offenses anticipated more stigma related to be an offender than formerly incarcerated persons charged with other types of offenses, including violent offenses. This gives the public a greater understanding of the interpersonal adjustment challenges formerly incarcerated persons face after release. This is the first known study to investigate how offense type, mental health treatment, mental illness, and race impact criminal justice-involved individuals. This study included self-stigma measures, perceptions, and expectations of stigma measures for the incarcerated population, and actual discrimination experiences measures. Consistent with Winnick and Bodkin (2008), LeBel (2012), and Moore, Stuewig and Tangey (2013), individuals perceived higher stigma (M = 5.23, SD = .89) compared to anticipated stigma (M = 4.83, SD = 1.32) after release.

This study showed that those who committed sex offenses perceived and anticipated higher stigma after release. Even though there were only 18 (9.3%) out of 240 participants who committed sexual offenses, their scores were still significantly higher compared to other offense types. This finding is similar to Viki et al. (2012) who evaluated the public reaction to sex offenders. The authors found that the more the public dehumanized sex offenders, the more likely they were to support social exclusion of them. Sex offenders are excluded from the community, and this could affect participation in rehabilitation and reentry programs if they already anticipate stigmatization from the public. Prior research has found that higher perceived and anticipated stigma predicted less community worse community functioning (Moore, Stuweig

& Tangney, 2016). Therefore, sex offenders could isolate with others and not integrate into the community.

Additionally, those who were charged with sex offenses reported higher awareness of serious mental illness stereotypes. This is an interesting finding as this could be part of the stigma they anticipate after release. The public could think that sexual offenders have mental illnesses to explain why they could have committed their crimes. Therefore, sexual offenders could be more aware of these stereotypes due to their own anticipation of stereotypes due to the nature of their crime. This makes sense because the public has a poor view of sex offenses. Sex offense related stigma has been found to be linked with vigilante behavior by the public and social withdrawal by the individual (Cubellis et al., 2019; Mingus & Burchfield, 2012). This prior knowledge partially explains why they would have heightened awareness of offense related stigma and therefore anticipate and perceived more stigma.

It was surprising that committing a violent offense was not significantly associated with higher levels of anticipated and perceived past incarcerated related stigma. This is unexpected as prior literature has found that people who have committed violent felonies were more likely to be discriminated against for employment opportunities (Pager, 2007). This is also inconsistent with LeBel et al. (2012), as they found those who strongly agreed that formerly incarcerated persons are devalued and discriminated against committed violent felonies. However, LeBel and colleagues dichotomized offense type into violent and non-violent felonies and therefore encompassed drug, property, and other offenses.

Interestingly, offense type was not found to be associated with general discrimination experiences. This is contrary to hypothesis 1. This finding could suggest that offense type may not predict discrimination experiences, or that multiple identities could predict discrimination

experiences (ex: race, mental illness). Overall, there is some evidence that offense type mitigates how formerly incarcerated persons understand stigma related to their past incarcerations. In the study design, it is impossible to know where each discrimination experience (ex: due to past incarcerations, mental illness, age, etc.) took place. Instead, the EDS measured overall experiences. Therefore, partial explanation of this finding could be due lack of specificity of the measure. For example, if we had asked specific questions about each discrimination experience, that could be related to offense type, but we do not know if this relationship exists.

Having likely serious mental illness was more likely to endorse higher awareness of serious mental illness stereotypes. This makes sense because many people who have mental illnesses may have experienced stigma experiences related to prevalent negative stereotypes. It is also notable that, in further analysis, if the person had received mental health treatment while incarcerated, they also reported more discrimination experiences due to their past incarcerations. Treatment quality and messages from clinicians could contribute to this finding. There is increased attention to the individual, interdependent if the treatment received was helpful or harmful, since they suffer from mental illness. They could attract more attention to themselves, and their previous incarcerations could be highlighted.

We need to understand more about how different variables could also affect stigma such as length of mental health treatment. We know that mental illness stigma exists, and people have been discriminated against due to their mental illness. Mental health treatment length could be a protective factor for release. Offense-specific treatment could also be a protective factor for stigma experiences. Specifically for sex offenders, if they received sex offender treatment while incarcerated, they might be less discriminated against in society because they completed specific treatment.

From the current study, we now understand an often-overlooked aspect of reentry from the individual's experience. Stigma can affect how they act within the community and can affect participation in programs and parole conditions. The next study regarding this research should measure internalized stigma related to offense type, mental illness, and race. A further exploration is needed to understand the scope of how stigma affects previously incarcerated individuals convicted of different offenses so that we can have informed programs in and out of incarceration to learn stigma-related coping mechanisms.

One implication of the current study is for reentry programs for formerly incarcerated persons to include anti-stigma awareness education, especially for those who committed sex offenses. These programs should help teach individuals how public stigma and self-stigma are related to their transition to the community and learn coping mechanisms for discrimination, microaggressions, and other forms of stigma within employment, education and personal contexts. Additionally, peer support within the program should be encouraged as people can learn from each other further coping mechanisms and develop social bonds with others who are in similar situations. Therefore, it can help the transition to the community with peer support.

Limitations

There are several limitations to the present study. First, the participants were not similar to the racial demographics of the United States prison population. Black or African American participants were only 9.8% of the sample, compared to 38.3% of the national prison population (Federal Bureau of Prisons, 2022). Therefore, the present study does not necessarily represent the Black or African American experience of the types of stigma or discrimination experiences measured.

Furthermore, there is a potential lack of accuracy in data due to using an online recruitment website. Although Prolific only showed the survey to people who were 18 years of age or older and had past incarceration time, participants might not necessary be entirely truthful about their experiences. Also, there is a risk with online surveys that the participants could be distracted or not pay attention to the questions. However, there was high internal consistency for the SSMIS-SF and the IPES. This suggests the participants were attentive to the questions.

In the survey, the participants reported their most recent offense type. This limits the scope of the results as people can have multiple offenses at one time or previous offenses that could affect individual perceived, anticipated and experiences stigma.

Also, participant incarceration times ranged from one day to 28.5 years. Those who spent one night in jail compared to almost 30 years will differ in anticipated expectations of stigma. Ideally, we would have liked to have a sample that has been incarcerated for a longer period of time so that they would have the possibility of receiving mental health treatment.

One question was misunderstood in the survey: “how long did you receive mental health treatment while incarcerated?” Many participants answered time longer than they had reported being incarcerated. Therefore, the time was not accurate for incarceration mental health treatment. We wanted to examine how the length of mental health treatment could mitigate the outcome measures. However, due to the misunderstanding, we lost further information about their experiences.

Also, there was a lack of specificity with the EDS. It was not specific to after incarceration discrimination experiences related to reentry. Therefore, their responses could be before and/or after incarceration time. Further, due to a measure added to the survey later, we

were unable to record 122 responses to the EDS scale. Therefore, there is further information lost in understanding experiences of discrimination.

Additionally, time since incarceration was not measured. This information could be relevant because it could affect reporting discrimination experiences. If someone has been in the community for longer, then they could have more time to experience discrimination. On the other hand, they could have more time to learn and develop coping techniques for discrimination experiences so that they experience less discrimination.

Finally, there is a lack of consistency on the definition of mental illness and diagnosis of mental illness. The Bureau of Justice Statistics (2017) state serious psychological distress and mental health problems. While the survey asked for psychiatric diagnoses given to the participant by a mental health care provider. Diagnoses are difficult as the DSM-V operates on a categorical method of diagnoses compared to the extent of symptoms. A mental health care provider could diagnose an individual with a disorder, but they also experience comorbid symptoms that do not reach the threshold of another disorder. Therefore, this question is limiting as mental illness does not have a clear definition. Participants could have also reported disorders that they have self-diagnosed themselves compared to a mental health professional.

Conclusion

Despite these limitations, these results are intriguing as it is one of the first studies to specifically evaluate offense-type related stigma from the formerly incarcerated persons' perspective. Further exploration of how offense type affects anticipated, perceived and discrimination experiences would add to the current body of knowledge. Also, follow-up studies examining self-stigma would be beneficial in understanding the reentry process from an internal point of view. Stigma will not disappear if we choose to ignore its impact on reentry. Especially

for those who suffer from mental illness and have past incarcerations, multiple stigmatizing identities can affect their individual development and outside opportunities. Therefore, reentry programs should focus on support for stigma experiences, coping mechanisms and techniques to advocate for themselves in the community.

References

Baillargeon, J., Binswanger, I. A., Penn, J. V., Williams, B. A., & Murray, O. J. (2009). Psychiatric disorders and repeat incarcerations: The revolving prison door. *American Journal of Psychiatry, 166*, 103–109.

Baillargeon, J., Hoge, S.K. & Penn, J.V. Addressing the Challenge of Community Reentry Among Released Inmates with Serious Mental Illness. *Am J Community Psychol* **46,** 361–375 (2010). https://doi-org.ez.lib.jjay.cuny.edu/10.1007/s10464-010-9345-6

Bahr, S., Harris, L., Fisher, J., & Harker Armstrong, A. (2010). Successful Reentry: What Differentiates Successful and Unsuccessful Parolees? International Journal of Offender Therapy and Comparative Criminology, 54(5), 667–692. https://doi.org/10.1177/0306624X09342435

Brohan, E., Elgie, R., Sartorius, N., & Thornicroft, G. (2010). Self-stigma, empowerment and perceived discrimination among people with schizophrenia in 14 European countries: The GAMIAN-Europe study. Schizophrenia Research , 122 (1 – 3), 232 – 238 ; E., Gauci, D.,

Sartorius, N., & Thornicroft, G. (2011). Self-stigma, empowerment and perceived discrimination among people with bipolar disorder or depression in 13 European countries: The GAMIAN – Europe study. Journal of A ff ective Disorders , 129 , 56 – 63.

Clement, S., Schauman, O., Graham, T., Maggioni, F., Evans-Lacko, S., Bezborodovs, N., . . . Thornicroft, G. (2015). What is the impact of mental health-related stigma on help-seeking? A systematic review of quantitative and qualitative studies. *Psychological Medicine, 45*(1), 11-27. doi:10.1017/S0033291714000129

Corrigan, P. W., Michaels, P. J., Vega, E., Gause, M., Watson, A. C., & Rüsch, N. (2012). Self-stigma of mental illness scale--short form: reliability and validity. *Psychiatry research*, *199*(1), 65–69. https://doi.org/10.1016/j.psychres.2012.04.009

Corrigan, Morris, S., Larson, J., Rafacz, J., Wassel, A., Michaels, P., Wilkniss, S., Batia, K., & Rüsch, N. (2010). Self-stigma and coming out about one's mental illness. *Journal of Community Psychology*, *38*(3), 259–275. https://doi.org/10.1002/jcop.20363

Corrigan, P.W., Watson, A.C., & Barr, L. (2006). The self-stigma of mental illness: Implications for self-esteem and self-efficacy. Journal of Social & Clinical Psychology, 25(8), 875-884.

Cubellis, M. A., Evans, D. N., & Fera, A. G. (2019). Sex offender stigma: An exploration of vigilantism against sex offenders. *Deviant Behavior*, *40*(2), 225–239. https://doi-org.ez.lib.jjay.cuny.edu/10.1080/01639625.2017.1420459).

Decker, Ortiz, N., Spohn, C., & Hedberg, E. (2015). Criminal stigma, race, and ethnicity: The consequences of imprisonment for employment. *Journal of Criminal Justice*, *43*(2), 108–121. https://doi.org/10.1016/j.jcrimjus.2015.02.002

Education and Correctional Populations. Bureau of Justice Statistics (BJS). (n.d.). https://www.bjs.gov/index.cfm?ty=pbdetail&iid=814.

English, Katherine (2018) "Conflicting Approaches to Addressing Ex-Offender Unemployment: The Work Opportunity Tax Credit and Ban the Box," Indiana Law Journal: Vol. 93 : Iss. 2 , Article 7.

Feder, L. (1991). A comparison of the community adjustment of mentally ill offenders with those from the general prison population: An 18-month followup. *Law and Human Behavior, 15*, 477–493.

Folk, J. B., Mashek, D., Tangney, J., Stuewig, J., & Moore, K. E. (2016). Connectedness to the criminal community and the community at large predicts 1-year post-release outcomes among felony offenders. *European journal of social psychology*, *46*(3), 341–355. https://doi.org/10.1002/ejsp.2155

Grossi, L. (2017). Sexual offenders, violent offenders, and community reentry: Challenges and treatment considerations. Aggression and Violent Behavior, 34, 59–67. https://doi.org/10.1016/j.avb.2017.04.005

Education and Correctional Populations. Bureau of Justice Statistics (BJS). (n.d.). https://www.bjs.gov/index.cfm?ty=pbdetail&iid=814.

Federal Bureau of Prisons. BOP Statistics: Inmate Race. (n.d.). https://www.bop.gov/about/statistics/statistics_inmate_race.jsp.

LeBel, T. P. (2012a). "If one doesn't get you another one will": Formerly incarcerated persons' perceptions of discrimination. The Prison Journal, 92, 63-87. doi: 10.1177/0032885511429243

LeBel, T. P. (2012). Invisible stripes? Formerly incarcerated persons' perceptions of stigma. Deviant Behavior, 33, 89–107.

Levenson, J. S., Brannon, Y., Fortney, T., & Baker, J. (2007). Public perceptions about sex offenders and community protection policies. *Analyses of Social Issues and Public Policy*, **7**, 1–25.

Link, B. G., Cullen, F. T., Struening, E., Shrout, P. E., & Dohrenwend, B. P. (1989). A modifi ed labeling theory approach to mental disorders: An empirical assessment. American Sociological Review, 54, 400-423 ,

Link , Bruce G. , Lawrence H. Lawrence HLawre Yang , Jo C. Phelan , and Pamela Y.Collins . 2004 . “Measuring Mental Illness Stigma.” *Schizophrenia Bulletin* 30 (3): 511 – 541 .

Lovell, D., Gagliardi, G., & Peterson, P. (2002). Recidivism and Use of Services Among Persons With Mental Illness After Release From Prison. Psychiatric Services (Washington, D.C.), 53(10), 1290–1296. https://doi.org/10.1176/appi.ps.53.10.1290

Mashek, D., Meyer, P., McGrath, J., Stuewig, J., & Tangney, J. P. (2002). Inmate Perceptions and Expectations of Stigma (IPES). George Mason University, Fairfax, VA.

Mingus, W., & Burchfield, K. B. (2012). From prison to integration: Applying modified labeling theory to sex offenders. *Criminal Justice Studies: A Critical Journal of Crime, Law & Society*, *25*(1), 97–109. https://doi-org.ez.lib.jjay.cuny.edu/10.1080/1478601X.2012.657906

Moore, K., Stuewig, J., & Tangney, J. (2013). Jail inmates’ perceived and anticipated stigma: Implications for post-release functioning. *Self and Identity, 12*(5), 527–547. https://doi.org/10.1080/15298868.2012.702425

Moore, K. E., Stuewig, J. B., & Tangney, J. P. (2016). THE EFFECT OF STIGMA ON CRIMINAL OFFENDERS' FUNCTIONING: A LONGITUDINAL MEDIATIONAL MODEL. *Deviant behavior*, *37*(2), 196–218. https://doi.org/10.1080/01639625.2014.1004035

Pager, D. (2003). The mark of a criminal record. *The American Journal of Sociology*, *108*(5), 937–975. https://doi.org/10.1086/374403

Pager , Devah. 2007 . *Marked: Race, Crime, and Finding Work in an Era of Mass Incarceration* . Chicago : The University of Chicago Press .

Phelan, J. C., Link, B. G., & Dovidio, J. F. (2008). Stigma and prejudice: one animal or two?. *Social science & medicine (1982)*, *67*(3), 358–367. https://doi.org/10.1016/j.socscimed.2008.03.022

Prince, P. N., & Prince, C. R. (2002). Perceived stigma and community integration among clients of assertive community treatment. Psychiatric Rehabilitation Journal, 25, 321-331.

Prisoners in 2002. Bureau of Justice Statistics (BJS). (n.d.). https://www.bjs.gov/index.cfm?ty=pbdetail&iid=921.

Prisoners in 2019. Bureau of Justice Statistics (BJS). (n.d.). https://www.bjs.gov/index.cfm?ty=pbdetail&iid=7106.

Rade, C. B., Desmarais, S. L., & Mitchell, R. E. (2016). A Meta-Analysis of Public Attitudes Toward Ex-Offenders. *Criminal Justice and Behavior*, *43*(9), 1260–1280. https://doi.org/10.1177/0093854816655837

Recidivism. Bureau of Justice Statistics (BJS). (n.d.). https://www.bjs.gov/content/reentry/recidivism.cfm.

Recidivism of Prisoners Released in 30 States in 2005: Patterns from 2005 to 2010. Bureau of Justice Statistics (BJS). (n.d.). https://www.bjs.gov/index.cfm?ty=pbdetail&iid=4986.

Releases from state prison. Bureau of Justice Statistics (BJS). (n.d.). https://www.bjs.gov/content/reentry/releases.cfm#number.

Rosenfield, S. (1997). Labeling mental illness: The e ff ects of received services and perceived stigma on life satisfaction. American Sociological Review , 62 , 660 – 672 ; Link, B. G., Cullen, F. T., Struening, E., Shrout, P. E., & Dohrenwend, B. P. (1989). A modi fi ed

labeling theory approach to mental disorders: An empirical assessment. American Sociological Review , 54 , 400 – 423.

Sample, L. L., & Bray, T. M. (2006). Are sex offenders different? An examination of rearrest patterns. *Criminal Justice Policy Review*, **17**, 83–102.

Sanders Thompson, Vetta & Noel, Jeffrey & Campbell, Jean. (2004). Stigmatization, discrimination, and mental health: The impact of multiple identity status. *The American journal of orthopsychiatry*. 74. 529-44. 10.1037/0002-9432.74.4.529.

Schwartz, R. C., & Blankenship, D. M. (2014). Racial disparities in psychotic disorder diagnosis: A review of empirical literature. *World journal of psychiatry*, *4*(4), 133–140. https://doi.org/10.5498/wjp.v4.i4.133 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4274585/

Ward, K. C., & Merlo, A. V. (2016). Rural Jail Reentry and Mental Health: Identifying Challenges for Offenders and Professionals. *The Prison Journal*, *96*(1), 27–52. https://doi.org/10.1177/0032885515605473

West, Michelle Leigh, "Triple Stigma in Forensic Psychiatric Patients: Mental Illness, Race, and Criminality" (2015). *CUNY Academic Works.* https://academicworks.cuny.edu/gc_etds/1185

Winnick, T. A. & Bodkin, M. (2008). Anticipated stigma and stigma management among those to be labeled “ex-con.” Deviant Behavior, 29, 295-333. doi:10.1080/016396207 01588081

Wright , Eric R. , William P. Gronfein , and Timothy J. Owens . 2000 . “Deinstitutionalization, Social Rejection, and the Self-Esteem of Former Mental Patients.” *Journal of Health and Social Behavior* 41 : 69 – 90

Viki, G., Fullerton, I., Raggett, H., Tait, F., & Wiltshire, S. (2012). The Role of Dehumanization in Attitudes Toward the Social Exclusion and Rehabilitation of Sex Offenders. *Journal of Applied Social Psychology*, *42*(10), 2349–2367. https://doi.org/10.1111/j.1559-1816.2012.00944.x

Yanos, P. T. (2018). *Written-off : mental health stigma and the loss of human potential*. Cambridge University Press.