Published in final edited form as:

Stigma Health. 2018 August ; 3(3): 241–252. doi:10.1037/sah0000092.

Self-stigma among Criminal Offenders: Risk and Protective Factors

Kelly E. Moore, Ph.D.[1], **Katherine C. Milam, B.A.**[2], **Johanna B. Folk, M.A.**[2], and **June P. Tangney, Ph.D.**[2]

[1]Yale University School of Medicine

[2]George Mason University

Abstract

Those involved in the criminal justice system are swiftly identified as "criminals." Receipt of this label may promote self-stigma, a process wherein criminal stereotypes are internalized and produce negative psychological and behavioral consequences. Research has yet to identify which types of offenders are at risk for, or in contrast, protected from, experiencing self-stigma. The current study examines whether risk and protective factors predict multiple components of the self-stigma process (i.e., perceived stigma, stereotype agreement, internalized stigma, anticipated stigma) in a sample of male jail inmates ($N = 111$). Results showed that mental health symptoms were a consistent risk factor across three of four self-stigma components, whereas antisocial characteristics were a risk factor for stereotype agreement and internalized stigma. Self-esteem was a protective factor for internalized and anticipated stigma. Implications for preventing self-stigma among offenders are discussed.

Keywords

self-stigma; internalized stigma; criminal offenders; jail inmates; mental health

Stigmatized individuals are exposed to pervasive stereotypes about their group, discriminatory treatment from others, and laws that restrict their participation in community activities, all of which have the potential to influence their self-concept. In order to understand and prevent deterioration in the psychosocial, behavioral, and emotional functioning of already at-risk, marginalized groups, researchers have focused on self-stigma, a process through which negative stereotypes are internalized and believed to accurately reflect oneself (Corrigan, Watson, & Barr, 2006). Self-stigma is considered maladaptive, as it is associated with psychosocial and behavioral maladjustment among numerous stigmatized groups, including people with mental illness (Livingston & Boyd, 2010), individuals who are dependent on alcohol (Schomerus et al., 2011), and those who have chronic physical illness (Rao et al., 2009). Not all stigmatized people experience self-stigma (Crocker & Quinn, 2000), however. Some individuals deflect stereotypes away from the self and retain a positive self-concept (Corrigan et al., 2006). Identification of risk and protective

*Correspondence concerning this article should be addressed to Kelly E. Moore, Yale University School of Medicine, 389 Whitney Ave, New Haven, CT 06511.

factors for experiencing self-stigma may inform targeted interventions to prevent associated maladjustment.

Criminal offenders are considered one of the more stigmatized of marginalized populations (LeBel, 2012; Dijker & Koomen, 2003), thought to be culpable for their identity as a "criminal" and as such, may experience more discrimination or other negative consequences as a result of their identity (Corrigan et al., 2003). At the structural level, laws sometimes permanently restrict former offenders from participating in certain forms of employment, housing, and community activities after they are released from jail/prison (Pogorzelski, Wolff, Pan, & Blitz, 2005). Further, community members tend to endorse negative stereotypical beliefs about offenders, such as that they are untrustworthy, unintelligent, and dangerous (Hirschfield & Piquero, 2010) and employers are less likely to hire individuals with criminal records (Pager, 2003). The experience of acquiring a criminal record (i.e., getting arrested and incarcerated for a crime) has great potential to negatively affect the self-concept. Indeed, research shows criminal offenders do experience self-stigma (Moore, Tangney, & Stuewig, 2016). In turn, self-stigma could have a significant negative impact on behavior during reentry into the community after incarceration; negative perceptions of community members' attitudes, expectations about discrimination, and poor self-concept as a result of stigma may promote avoidance or withdrawal, hindering employment searches, treatment seeking, and adherence to probation requirements, all of which may increase the risk of recidivism. Risk and protective factors associated with self-stigma among criminal offenders are unknown. Given that self-stigma may have pivotal implications for offenders' reintegration in the community after release from jail (Moore et al., 2016) and risk for recidivism, it is important to identify factors that increase vulnerability to self-stigma.

The Self-stigma Process

Self-stigma is conceptualized as a process including several responses to stigma. Each component is distinct and likely accompanied by unique risk and protective factors. The process begins with perceived stigma, the awareness that others hold negative beliefs about one's group membership (i.e., also referred to as *stereotype awareness* by Corrigan et al., 2006, and *discrimination/devaluation* by Link, 1987). Although research shows perceived stigma is negatively associated with well-being among those living with HIV/AIDS (Holzemer et. al, 2009; Greeff et al., 2010), those with various physical (Else-Quest, LoConte, Schiller, & Hyde, 2009) and mental illnesses (Link, Struening, Neese-Todd, Asmussen, & Phelan, 2001), and among sexual minorities (Lewis, Derlega, Griffin, & Krowinski, 2003), it is not considered universally harmful (Corrigan et al., 2006). If a person accepts the stereotype(s) they perceive as being an accurate description or representation of the group, *stereotype agreement* occurs. At this point in the process, research suggests the psychological effects of stereotype agreement are still relatively benign, as these cognitions generally focus on the stigmatized group as a whole and are not reflective of the self. Perceived stigma and stereotype agreement can have negative consequences if stereotypes become internalized (Corrigan et al., 2006).

Once *perceived stigma* and *stereotype agreement* occur, individuals then determine whether or not those stereotypes hold true for the self; accepting negative stereotypes as descriptive

of the self results in *internalized stigma* (i.e., also referred to as *stereotype concurrence* by Corrigan et al., 2006). In short, people who internalize stigma are thought to perceive a great deal of stigma from community members (i.e., perceived stigma), agree with negative stereotypes about their group as a whole (i.e., stereotype agreement), and believe that stereotypes accurately reflect the self (Corrigan et al., 2006). Internalized stigma is considered detrimental to functioning because it is associated with low self-esteem (Corrigan et al., 2006), poor mental health/well-being (Levy, Celen-Demirtas, Surguladze, & Sweeney, 2014; Fuster-Ruizdeapodaca, Molero, Holgado, & Mayordomo, 2014), anticipated stigma (Earnshaw & Quinn, 2012), and risky behavior (Earnshaw, Bogart, Dovidio, & Williams, 2015). Compared to the other self-stigma components (i.e., perceived stigma, stereotype agreement), internalized stigma correlates most strongly with poor psychological well-being (Corrigan et al., 2006; Schomerus et al., 2011; Boyle, 2015), highlighting the importance of identifying risk and protective factors for this particular component of the self-stigma process.

Researchers have also considered *anticipated stigma*, the expectation of experiencing future discrimination from others (Quinn & Chaudoir, 2009). Having perceived stigma towards one's group, a person may anticipate further discriminatory treatment in the future, whether or not they agree with and internalize associated negative stereotypes. Thus, anticipated stigma is thought to occur outside the process through which stereotypes are internalized (Moore et al., 2016). Nonetheless, anticipated stigma is a self-relevant response shown to be associated with distress among people with concealable stigmas (Quinn & Chaudoir, 2009), decreased access to medical care among those with chronic health conditions (Earnshaw & Quinn, 2011), and with poor community adjustment among criminal offenders (Moore et al., 2016). Therefore, anticipated stigma can be harmful even when stereotypes are not internalized and represents a unique element of the stigma process that may also have its own risk and protective factors.

Risk and Protective Factors for Self-stigma

Research has primarily focused on non-offending stigmatized groups and it is unclear whether factors associated with self-stigma among other groups operate similarly among criminal offenders. Some factors may increase vulnerability to self-stigma (or protect against it) across stigmatized groups, regardless of the stigmatized attribute. For example, high self-esteem may be a protective factor for stigmatized individuals in general. Such factors will be referred to here as global risk and protective factors; those that apply to any stigmatized person. On the other hand, other factors may depend on the nature of the stigmatized attribute (Corrigan, Markowitz, Watson, Rowan, & Kubiak, 2003). For instance, the degree to which one engages in criminal thinking may only be a pertinent risk factor for self-stigma among offenders and would likely be irrelevant among other stigmatized individuals. For this reason, it is crucial to examine global factors as well as those specifically relevant to each stigmatized group.

Existing research has examined correlates of self-stigma using cross-sectional designs, and thus it is unclear whether correlates are actually outcomes or risk and protective factors for self-stigma (Corrigan et al., 2006). For instance, poor psychological well-being is often

considered an outcome of self-stigma in cross-sectional research, but it may also be a risk factor for self-stigma, increasing the tendency that stigmatized people will internalize negative stereotypes. We draw upon cross-sectional research on the correlates of self-stigma to identify global and specific risk and protective factors among criminal offenders.

Global risk and protective factors

Certain risk and protective factors identified among other stigmatized populations likely generalize across stigmatized groups, and hence extend to criminal offenders. A primary risk factor for perceived stigma is strong identification as a member of one's stigmatized group. Research by Major, Quinton, and Schmader (2003) indicates that among women who strongly identify with their gender, group membership can enable hypersensitivity to discrimination in ambiguous situations, increasing negative expectancies about future discrimination and the tendency to internalize stereotypes. As such, offenders who strongly identify with the label of "criminal" may be more likely to perceive stigma as well as internalize negative stereotypes about offenders into their self-concept (i.e., "I am a criminal, therefore stereotypes about criminals apply to me"). Another general risk factor seems to be participation in higher education. Having completed more years of education is associated with more perceived stigma among individuals with substance abuse problems (Luoma et al., 2007) as well former prisoners (LeBel, 2012), possibly due to higher exposure to individuals who endorse negative stereotypes of such populations. Therefore, having completed more education may put offenders at risk for perceived, internalized, and anticipated stigma.

Conversely, high self-esteem (i.e., general positive outlook on oneself and abilities) and satisfaction with life (i.e., global satisfaction with life events/choices) may be global protective factors that prevent perceived and internalized stigma across stigmatized groups. Among people with mental illness, high self-esteem is associated with less perceived (Brown, 2015) and internalized stigma (Corrigan et al., 2006), and satisfaction with life (i.e., global life satisfaction) is associated with less internalized stigma (Rüsch, Corrigan, Todd, & Bodenhausen, 2010). Satisfaction with life is also related to less perceived stigma among people who are HIV positive (Holzemer et al., 2009). These findings may generalize to criminal offenders, such that offenders with high self-esteem and satisfaction with life are less likely to perceive stigma from others or internalize negative stereotypes into their self-concept. In addition, though there is considerably less research on other global protective factors for self-stigma, spirituality may play a particularly important role in preserving one's self-concept and inspiring hope, thereby preventing internalized stigma. Indeed, research suggests religious involvement may act as a protective factor in various areas of one's life, both within the community and while incarcerated (Clear & Sumter, 2002). Among criminal offenders, spirituality may be associated with less perceived, internalized, and anticipated stigma.

Risk and protective factors specific to criminal offenders

In contrast to the aforementioned global factors expected to function similarly across stigmatized groups, some risk and protective factors may operate differently among criminal offenders. For instance, age has been identified as a protective factor among most

stigmatized groups, but may be a risk factor for criminal offenders. Studies on people with schizophrenia show that older individuals reported less perceived stigma and stereotype agreement, which may be partially due to employing coping mechanisms acquired over the lifetime (Werner, Aviv, & Barak, 2008). With regard to criminal offenders, research demonstrates an age-crime curve (Farrington, 1986) in which criminal behavior peaks in young adulthood and decreases as individuals age; therefore, as crime may be less normative, older offenders may report higher levels of perceived stigma, internalized stigma, and anticipated stigma than younger offenders. In addition, being a racial/ethnic minority has been identified as a risk factor for internalized stigma among people with depression (Latalova, Kamaradova, & Prosky, 2014), however, in studies of former prisoners, being White is a risk factor for perceived (Winnick & Bodkin, 2008) and personal stigma (LeBel, 2012). Because White offenders may possess fewer coping skills (e.g., deflecting stereotypes away from the self-concept) than Black offenders due to lack of experience managing racial stigma, and because incarceration may be viewed as less normative among White offenders due to the overrepresentation of racial minorities in the justice system, White offenders may experience greater damage to the self-concept. Therefore, being White may be a risk factor for perceived, internalized, and anticipated stigma among criminal offenders.

The relationship between mental health problems and self-stigma among criminal offenders may differ from that found among other stigmatized groups as well. Mental health problems have the propensity to operate as both a risk and protective factor for self-stigma in criminal offenders. Most mental health problems, such as anxiety, depression, and emotion dysregulation, are characterized by negative expectancies and thoughts about the self and environment, which may place undue focus on the self or negative outcomes, exacerbating the effects of stigma on the self-concept. Indeed, cross-sectional studies show that anxiety is associated with perceived stigma and depression is associated with internalized stigma among people with mental illness (Corrigan et al., 2006; Markowitz, 1998), and psychological distress is related to anticipated stigma among people with concealable stigmatized identities (Quinn & Chaudoir, 2009). Therefore, offenders with more mental health problems may be more vulnerable to the negative effects of stigma, and hence more likely to perceive, internalize, and anticipate stigma. Alternatively, offenders with mental illness may not view themselves as “criminals,” especially if they attribute their involvement in the legal system to their mental illness rather than their own behavior. Therefore, offenders with mental health problems may be less likely to internalize negative stereotypes. Similarly, although substance use severity has been identified as a risk factor for perceived stigma among people who use illegal drugs (Luoma et al., 2007), offenders with more substance use problems may view their criminal justice experience(s) as a primary function of maladaptive drug use, and may deflect stereotypes about people with a criminal record away from their self-concept. Following this rationale, offenders who have a history of substance dependence may be less likely to internalize stereotypes about criminal offenders.

Finally, connectedness to the community at large (e.g., people not involved in the criminal justice system) has the potential to be a risk or protective factor among criminal offenders. On one hand, offenders who are participating members of society may distance themselves from “criminals,” reject stereotypes about offenders, and have prosocial influences and relationships that protect against internalizing negative stereotypes. Alternatively, being

closely connected with the community at large may expose offenders to more negative stereotypes, leading to social exclusion or shame upon acquiring a criminal record. Therefore, it may be that offenders who are highly connected to the community at large not only perceive and anticipate more stigma, but also experience stereotypes as more damaging to the self-concept and thereby internalize stereotypes more readily.

There may be several additional risk and protective factors for self-stigma that are uniquely relevant to criminal offenders. One study with former prisoners examined such risk and protective factors, primarily focusing on antisocial characteristics, for experiencing perceived stigma and "personal stigma" (i.e., offenders' beliefs that community members held negative views toward them personally; LeBel, 2012). LeBel (2012) found that committing a violent felony, identifying strongly with other offenders, and growing up in a neighborhood where incarceration was common were associated with higher perceived stigma. In addition, weaker social bonds with family, having more parole violations, identifying more strongly with other offenders, growing up in a neighborhood where incarceration was common, and having more pro-criminal attitudes (i.e., "To get ahead in the world, you may have to do some things that are illegal") were associated with higher personal stigma. In sum, LeBel (2012) found that a higher degree of antisocial characteristics is a risk factor for perceived and personal stigma.

Building on LeBel's (2012) study, certain factors specific to criminal offenders (i.e., criminogenic cognitions, psychopathy, Antisocial Personality Disorder (ASPD) features, connectedness to the criminal community, antisocial network of peers) may increase vulnerability to other components of the self-stigma process (i.e., stereotype agreement, internalized stigma, and anticipated stigma). There is reason to believe certain antisocial characteristics may protect against internalized stigma. Researchers posit that "hard core" offenders may be less likely to integrate negative labels into their self-concept (LeBel, 2012, p. 92) because a deviant label may hold less weight for people and/or communities in which criminal behavior is frequent and normative (Hirschfield, 2008). Consistent with this theory, engaging in more frequent or serious criminal behavior (i.e., as measured by ASPD features and Factor 2 psychopathy), may be associated with less internalized stigma. In addition, other theory suggests justifying criminal behavior and minimizing its effect on others (i.e., referred to as criminogenic cognitions, criminal thinking styles, techniques of neutralization) serves to protect the self-concept and facilitate recurrent offending (Walters, 1995). Thus, offenders high in criminogenic cognitions may deflect stereotypes away and be less inclined to internalize stereotypes. In addition, feeling connected to other offenders and having more antisocial friends in one's social network may lead offenders to feel more accepted and as such, less likely to agree with or internalize stereotypes. Finally, through a distinct mechanism, individuals high on Factor 1 psychopathy (defined in measures section) may also be protected from internalizing stereotypes. Because Factor 1 psychopathy involves emotional deficits and "an overinflated view of the self" encompassed by self-centeredness, superficial charm, manipulation, and deceitfulness (Douglas, Nikolova, Kelley, & Edens, 2015, p. 259), offenders high on Factor 1 may agree more with stereotypes about other offenders, but experience less internalized stigma.

Current Study

Research has yet to identify risk and protective factors for self-stigma among criminal offenders. There are factors associated with self-stigma among other groups that may extend to criminal offenders, whereas others may function differently. Further, certain antisocial characteristics may be specifically relevant to examine as risk factors. With the exception of a handful of studies (Oexle et al. 2016; Calveti, Rusch, & Vauth, 2014), research among other stigmatized groups has mostly been cross-sectional, which limits our ability to determine whether correlates of self-stigma are outcomes or risk and protective factors. The current study utilizes a longitudinal approach to examine risk and protective factors for multiple components of self-stigma (i.e., perceived stigma, stereotype agreement, internalized stigma, anticipated stigma) associated with having a criminal record. A longitudinal design is utilized to examine which factors at the onset of incarceration predict self-stigma components just prior to release.

Method

Participants and Procedures

Participants were 111 male inmates recruited from an adult detention center between 2008 and 2010 as part of a randomized controlled trial of a restorative justice intervention (Folk et al., 2016). The university institutional review board approved this study. Exclusionary criteria were developed to facilitate participation in the intervention and availability for post-incarceration assessments. Inmates were not eligible to participate if they had yet to be sentenced, were unlikely to serve their sentence at the host jail (i.e., due to transfer to the state Department of Corrections, assignment to electronic incarceration), had Immigrations and Customs Enforcement detainers, were housed outside the general population (e.g., due to serious psychopathology or medical problems), or were female (i.e., too few females were incarcerated, preventing randomization). Inmates were informed participation was voluntary and data were confidential, protected by a Certificate of Confidentiality from Department of Health and Human Services. Inmates received a $20 honorarium for participating in assessments before, during, and after treatment and $25 for the assessment prior to release.

Timepoints for this study include entry into the jail/pre-treatment (Time 1) and just prior to release into the community (Time 2). Risk and protective factors were assessed at Time 1 via face-to-face interviews and computer-administered measures. Self-stigma was assessed at Time 2 via face-to-face interviews. Of the 285 inmates who consented, 213 were eligible for randomization to the intervention (108 in treatment, 105 in control). Of those randomized, three participants withdrew from the study, four were dropped due to being ineligible, two were unexpectedly transferred, and one refused to participate in the next assessment, leaving 203 participants who completed the Time 2 assessment prior to release (length of incarceration: Range = 80 – 2,542, $M = 345.7$, $SD = 233.4$). Because stigma measures were added into the study mid-way through, 111 participants completed these measures, comprising the current sample. Participants ($n = 111$) were male, about 33 years old on average (*range* = 18 – 65 years, S.D. = 11 years), and racially/ethnically diverse (45.9% Black, 34.2% White, 11.7% Mixed race/other race, 4.5% Asian/Pacific Islander, and 3.6% Hispanic).

Measures

Descriptive statistics are presented in Table 1. Variables with skew under 3 and kurtosis under 10 were considered normally distributed (Kline, 2009); all variables met this criterion.

Time 1 (baseline)

Demographics: Race was coded as 0 (*White*) (*n* = 38; 34.2%), 1 (*Black*) (*n* = 51; 45.9%). The number of participants from other racial/ethnic groups was too few for separate analysis, so these individuals were dropped from analyses of racial differences. On average, participants were 33 years old (*S.D.* = 11 years) and had 11.66 years of education (*S.D.* = 1.89).

Criminal identity: Using a single-item measure (Moore, Stuewig, & Tangney, 2016), participants were asked to what degree they agreed with the statement "I am a criminal" on a 6-point Likert scale ranging from 1 (*totally disagree*) to 6 (*totally agree*). Higher scores reflected a stronger criminal identity.

Self-esteem: Self-esteem was assessed using the Rosenberg Self-esteem scale (RSE; Rosenberg, 1965), a well-validated (Robins, Hendin, & Trzesniewski, 2001) 10-item measure of global self-worth (α = .88). Answers ranged from 1 (*false, not at all true*) to 4 (*very true*). Higher scores reflect higher levels of self-esteem.

Satisfaction with life: The Satisfaction with Life Scale (SWLS; Diener, Emmons, Larsen, & Griffin, 1985) is a well-validated (Pavot & Diener, 1993) 5-item measure (α = .84). Answers ranged from 1 (*strongly disagree*) to 7 (*strongly agree*). Higher scores reflect greater satisfaction with life.

Spirituality: The Spiritual Transcendence Index (STI; Seidlitz et al., 2002) is an 8 item assessment of perceived spirituality (e.g., "My spirituality gives me a feeling of fulfillment."). Items (α = .97) are rated from 1 (*false, not at all true*) to 4 (*very true*). This measure has been shown to be both reliable and valid among both community members and seminary students (Seidlitz et al., 2002). Higher scores reflect greater spirituality.

Mental health symptoms: Mental health problems were assessed with a shortened version of the Personality Assessment Inventory (PAI; Morey, 1991), a widely used, well-validated 344-item self-report measure that captures psychopathology and personality features. We averaged available clinical scales (i.e., depression, anxiety, borderline personality disorder features, anxiety-related disorders, mania, paranoia, schizophrenia) to create a continuous variable, *Mental Health Symptoms* (α = 89). Item responses ranged from 1 (*false, not at all true*) to 4 (*very true*). The PAI uses T-scores, which are normed on a census sample of adults. Higher scores reflect endorsement of more symptoms of mental illness.

Substance dependence symptoms: Substance dependence symptoms were assessed at Time 1 using the Texas Christian University Correctional: Residential Treatment Form, Initial Assessment (TCU-CRTF; Simpson & Knight, 1998). For each substance, participants rated the frequency with which they experienced symptoms of substance dependence in the

domains specified by the DSM-IV-TR (American Psychiatric Association, 2000) during the three months prior to arrest. Item responses ranged from 0 (*never*) to 4 (*7 or more times*). For domains with multiple items (e.g., different withdrawal symptoms), responses were averaged and a total score was computed by taking the mean across the seven domains (six in the case of marijuana because withdrawal is not considered part of the criteria). Each scale had acceptable reliability (alcohol, 17 items, $\alpha = .90$; marijuana, 8 items, $\alpha = .89$; cocaine, 14 items, $\alpha = .96$; and opiates, 18 items, $\alpha = .98$). Responses were averaged within domain and a total score was computed by taking the mean across the domains to form the variable, *substance dependence symptoms*. The TCU-CRTF has been shown to be reliable with jail inmates (Stuewig et al., 2009). Higher scores reflect greater dependence upon substances.

Connectedness to the community at large and the criminal community: The Inclusion of Community in Self scale (ICS; Mashek, Cannaday, & Tangney, 2007) was used to assess connectedness to the community at large and the criminal community (considered distinct risk/protective factors). Participants rate their connectedness on a visual scale with six pairs of circles overlapping to various degrees (representing “not at all connected” to “as connected as possible”). One item is used to assess connectedness to the community at large and another single item assesses connectedness to the criminal community. Higher scores reflect higher levels of community connectedness. Convergent, discriminant, and predictive validity of the ICS has been demonstrated with jail inmates (Folk, Mashek, Tangney, Stuewig, & Moore, 2016; Mashek, Cannaday, & Tangney, 2007; Mashek, Stuewig, Furukawa, & Tangney, 2006).

Antisocial personality disorder (ASPD) features: Antisocial personality features were assessed with a 24-item scale on the PAI ($\alpha = .87$) capturing the symptoms of antisocial personality disorder as listed in DSM-IV-TR. An example item is “My behavior is pretty wild at times.” The antisocial features scale of the PAI has been found to be reliable and valid among offenders (Gardner, Boccaccini, Bitting, & Edens, 2015). Higher scores reflect higher levels of antisocial personality features.

Criminogenic cognitions: The Criminogenic Cognitions Scale (CCS; Tangney, Meyer, Furukawa, & Cosby, 2002) assesses thinking styles that justify and perpetuate criminal behavior, and includes six domains: short term orientation, notions of entitlement, failure to accept responsibility, negative attitudes toward authority, insensitivity to the impact of crime, and reparation intentions. The CCS is a 25-item scale ($\alpha = .74$) with responses ranging from 1 (*strongly disagree*) to 4 (*strongly agree*). The CCS predicts recidivism among former inmates (Caudy et al., 2015), demonstrating good construct validity. Higher scores reflect greater criminal thinking.

Psychopathy: Psychopathy was assessed with the screening version of Hare’s Psychopathy Checklist (PCL:SV). This measure involved an in-depth psychosocial history interview and collateral criminal history and jail records. The PSL:SV provides a total psychopathy score as well as two factor scores (sometimes referred to as “part scores” on the PCL:SV) Factor 1 assesses a personality style defined by glibness and superficiality, egocentric grandiosity,

deceit and manipulation, lack of remorse and empathy, and shallow emotions. Factor 2 assesses a chronically unstable and antisocial lifestyle, focusing on criminal and other problematic behaviors characteristic of ASPD. Training of PCL:SV interviewers is described in Hastings et al. (2008). The reliability and validity of the PCL: SV have been well established (Cooke, Michie, Hart, & Hare, 1999; Hart, Cox, & Hare, 1995). In the current study, Factor 1 (α = .65) and Factor 2 (α = .69) were just below the threshold of acceptable internal consistency. Higher scores reflect higher levels of psychopathy.

Control variables: This sample is drawn from a randomized controlled trial; about half of the 111 participants (n = 55) completed a restorative justice intervention aimed at reducing and repairing harm caused by crime, and restoring one's place and social connections within the community. Because of this program's intended effect on reintegration into the community, we expect offenders who participated to report lower levels of perceived stigma, stereotype agreement, internalized stigma, and anticipated stigma, and therefore control for this in all analyses.

Time 2 (Pre-release)

Antisocial network of peers: We asked participants 10 questions about whether their peer network engaged in criminal and drug-related activities during the year prior to incarceration. Responses ranged from 0 (*none*) to 5 (*all*). Reliability was low (α = .51), however, this was driven by the question asking about whether participants' friends used alcohol; when this item is deleted, reliability is high (α = .90). This approach to assessing friends' participation in antisocial activities has been used in other studies (Malouf, Stuewig, & Tangney, 2012) and is a valid predictor of future substance use and antisocial behavior (Marcos, Bahr, & Johnson, 1986). Higher scores reflect association with more antisocial peers.

Self-stigma: The Self-Stigma of Individuals with Criminal Records scale (SSICR; Moore, Tangney, & Stuewig, 2016) was adapted from the Self-Stigma of Mental Illness scale (SSMI; Corrigan, Watson, & Barr, 2006) which assesses perceived stigma, stereotype agreement, internalized stigma, and self-esteem decrement (this scale was not administered). The SSICR assesses nine stereotypes about criminal offenders (i.e., cannot be trusted, disgusting, unwilling to get or keep a job, dirty/unkempt, below average intelligence, unpredictable, to blame for their problems, cannot be rehabilitated, dangerous, bad people) with clauses to capture perceived stigma ("The public thinks most people with a criminal record are…"), stereotype agreement ("I think most people with a criminal record are…"), and internalized stigma ("Because I have a criminal record, I am…"). Responses ranged from 1 (*strongly disagree*) to 4 (*strongly agree*). Each scale had 9 items and acceptable reliability: perceived stigma α = .92, stereotype agreement α = .84, internalized stigma α = .73. Anticipated stigma was assessed by adapting the 5-item Discrimination Experiences subscale of the Internalized Stigma of Mental Illness scale (ISMI; Ritsher et al., 2003). One item, "People often patronize me, or treat me like a child because I have a mental illness" was not applicable. Items were reworded to capture *expectations* (e.g., "People discriminate against me…" was changed to "I expect people to discriminate against me…"). Responses

range from “1” Strongly Disagree to “4” Strongly Agree. Higher scores on these assessments reflect stronger endorsement of self-stigma.

Results

We first examined bivariate correlations among self-stigma components. Perceived stigma was positively correlated with stereotype agreement ($r = .28$, $p = .003$), internalized stigma ($r = .23$, $p = .015$), and anticipated stigma ($r = .33$, $p = .003$), suggesting inmates who perceive the public as having negative attitudes are more likely to agree with those stereotypes, accept those to be true of themselves, and expect to be discriminated against. Stereotype agreement was correlated with internalized stigma ($r = .48$, $p = .00$), suggesting that inmates who agree with stereotypes about people with criminal records also tend to accept those stereotypes as being true of themselves; stereotype agreement and anticipated stigma were unrelated ($r = .02$, $p = .85$). Internalized stigma and anticipated stigma were positively related ($r = .25$, $p = .03$), suggesting inmates who accept stereotypes as true of themselves tend to expect to be discriminated against. Inmates who participated in the restorative justice treatment perceived less stigma ($M = 2.26$, $SD = .58$) than those assigned to treatment as usual ($M = 2.62$, $SD = .79$; $t(109) = 2.74$, $p = .01$. Partial correlations controlling for treatment status were conducted to examine the degree to which risk and protective factors assessed at baseline predicted perceived stigma, stereotype agreement, internalized stigma, and anticipated stigma prior to release. Results are presented in Table 2.

Global Risk and Protective Factors

Age predicted less perceived stigma ($r = -.19$, $p = .05$). Higher self-esteem at Time 1 predicted less internalized ($r = -.25$, $p = .008$) and anticipated stigma ($r = -.47$, $p < .001$). Mental health symptoms at Time 1 predicted more stereotype agreement ($r = .28$, $p = .004$), internalized ($r = .41$, $p < .001$), and anticipated stigma ($r = .32$, $p = .004$) prior to release. No significant relations were found between criminal identity, substance dependence symptoms, satisfaction with life, spirituality, connectedness to the community at large, race, or years of education with any components of the self-stigma process.

Risk and Protective Factors Specific to Criminal Offenders

Higher levels of criminogenic cognitions predicted more perceived ($r = .26$, $p = .02$) and internalized ($r = .22$, $p = .002$) stigma. When examining specific criminogenic cognitions subscales, notions of entitlement (e.g., “When I want something, I expect people to deliver”) predicted stereotype agreement ($r = .26$, $p = .007$) and internalized stigma ($r = .20$, $p = .04$); failure to accept responsibility (e.g., “My crime[s] did not really harm anyone”) predicted perceived stigma ($r = .23$, $p = .017$), stereotype agreement ($r = .23$, $p = .016$), and internalized stigma ($r = .45$, $p < .001$); and reparation (e.g., “Part of being responsible for my actions means repairing the harm caused by my crime[s]”) predicted anticipated stigma ($r = .23$, $p = .04$). The criminogenic cognitions subscale negative attitudes toward authority (e.g., “People in positions of authority generally take advantage of others”) also predicted perceived stigma ($r = .21$, $p = .03$). Furthermore, Factor 2 Psychopathy predicted internalized stigma ($r = .27$, $p = .005$). Endorsement of more ASPD features predicted stereotype agreement ($r = .27$, $p = .004$) and internalized stigma ($r = .38$, $p < .001$). Having

antisocial peers predicted anticipated stigma ($r = .27$, $p = .016$). Connectedness to the criminal community predicted perceived stigma ($r = .21$, $p = .03$). Factor 1 psychopathy was unrelated to any of the self-stigma components.

Benjamini-Hochberg Correction

Given the large number of predictors examined, a Benjamini Hochberg (B-H) correction (Benjamini & Hochberg, 1995) was applied to control for familywise error (Williams, Jones, & Tukey, 1999). Following a B-H correction, no predictors remained significant for perceived stigma. For stereotype agreement, mental health symptoms and ASPD features remained significant risk factors. For internalized stigma, self-esteem remained a significant protective factor, and mental health symptoms, criminogenic cognitions, failure to accept responsibility (a subscale of criminogenic cognitions), ASPD features, and Factor 2 psychopathy remained significant risk factors. Self-esteem remained a significant protective factor and mental health symptoms remained a significant risk factor for anticipated stigma.

Discussion

Using a longitudinal framework, this is the first study to examine risk and protective factors for multiple components of the self-stigma process among criminal offenders.

Global Risk and Protective Factors

Mental illness was a significant risk factor for all components of self-stigma except perceived stigma. Offenders with more mental health problems upon entry into the jail, such as depression, anxiety, or emotion regulation difficulties, were more prone to agree with negative stereotypes about other offenders, internalize these stereotypes as being accurate descriptions of the self, and anticipate discrimination from community members prior to their release from jail. This is consistent with research among people with mental illness and various concealable stigmatized identities demonstrating higher levels of psychological distress/anxiety/depression are associated with greater internalized and anticipated stigma (Corrigan et al., 2006; Quinn & Chaudoir, 2009). Our competing hypothesis that offenders with mental health problems are able to protect their self-concept by attributing criminal justice involvement to their mental illness (i.e., “I got incarcerated because I went off my meds”) was not supported.

Unlike mental health symptoms, substance dependence symptoms were neither a risk nor protective factor for self-stigma associated with having a criminal record. Substance dependence symptoms may only be a relevant risk factor for self-stigma associated with *addiction*, which carries its own set of psychological and behavioral consequences (Luoma et al., 2013). Mental health symptoms may represent a more universal risk factor for self-stigma across stigmatized groups. The intersectionality of having multiple stigmatized identities is not well understood, and more research is needed to examine how risk and protective factors operate for individuals with multiple stigmatized identities.

Since many mental health problems involve cognitive distortions (e.g., catastrophizing, jumping to conclusions, overgeneralization; Beck, 2011), offenders with mental illness may interpret ambiguous environmental situations as discriminatory and then believe

discrimination is justified due to personal flaws, such as being dangerous, untrustworthy, incapable of holding a job, etc. In addition, overly pessimistic thinking characteristic of depression and anxiety may lead offenders with mental illness to "expect the worst" when envisioning their release from jail, their ability to obtain employment, and treatment by others in the community. As is well-known in cognitive-behavioral theory and research, such thoughts in turn prompt more negative emotions as well as maladaptive behaviors such as avoidance or withdrawal (Beck, 2011; Ottenbreit & Dobson, 2004). For stigmatized populations, including criminal offenders, avoidance of and withdrawal from situations involving discrimination is particularly detrimental to functioning, as it prevents individuals from learning how to restructure and/or manage thoughts about stigma and serves to confirm original negative beliefs. Indeed, a recent study shows anticipated stigma prior to release predicts social withdrawal three months post-release, which in turn predicts poor community adjustment one year post-release (Moore & Tangney, under review). In addition, once offenders agree with and internalize stereotypes, this may lead to stereotype-consistent behavior due to "cognitive fusion" with the self-concept (see Luoma, Kohlenberg, Hayes, & Fletcher, 2012), in which individuals act in ways that are consistent with and further confirm beliefs they hold about themselves. Thus, among criminal offenders, internalized stigma may prompt subsequent illicit or risky behavior. This idea highlights the importance of identifying inmates with preexisting mental health problems, who are at risk of internalized stigma, upon entry into jail. Brief interventions that assist offenders with identifying how depression and other mental health problems affect the way they respond to perceived stigma may reduce internalized or anticipated stigma in this population, and ultimately reduce the likelihood that offenders return to jail in the future. Mindfulness and cognitive-focused interventions developed to reduce internalized stigma among people with mental illness may be beneficial toward this end (Yanos, Lucksted, Drapalski, Roe, & Lysaker, 2014).

As found among people with mental illness (Link et al., 2001), self-esteem in the current study was a protective factor for multiple self-stigma components. Offenders with higher self-esteem upon entry into jail were less likely to internalize and anticipate stigma. This supports our hypothesis that individuals with positive views of the self will be less likely to think stereotypes apply to them personally and form negative expectancies about future discrimination. It is not surprising that internalized and anticipated stigma shared this protective factor given both constructs are perhaps the most self-relevant of the self-stigma components. Whereas perceived stigma captures one's beliefs about how *the public* views a stigmatized group, internalized and anticipated stigma capture how one feels about his or herself. This finding also suggests offenders with low self-esteem may be especially at risk for internalized and anticipated stigma and would likely benefit from clinical assessment and tailored intervention addressing stigma.

Risk and Protective Factors Specific to Criminal Offenders

Several antisocial factors, including criminogenic cognitions (total score and failure to accept responsibility subscale), ASPD features, and Factor 2 psychopathy scores were identified as risk factors for self-stigma components. ASPD features were a risk factor for stereotype agreement. We did not formulate many specific hypotheses regarding risk and

protective factors for stereotype agreement (as there is less research on this particular component of self-stigma) with the exception that we predicted individuals high on Factor 1 psychopathy would be more likely to agree with stereotypes about other offenders (e.g., in a narcissistic fashion). However, our results suggest that offenders who more closely fit the stereotypical prototype of a "criminal" (i.e., those who are more antisocial) tend to believe negative stereotypes accurately describe other criminal offenders. This may reflect the greater degree of exposure that individuals high on antisocial features likely have to other, highly antisocial individuals who do engage in stereotypical behavior, such as violence, lying/conning, and failing to fulfill responsibilities.

ASPD features, Factor 2 psychopathy, and criminogenic cognitions were risk factors for internalized stigma among jail inmates in this sample. ASPD features and Factor 2 psychopathy are conceptually similar, as they both involve persistent failure to adhere to laws and social norms with little regard for the welfare of others (Skilling, Harris, Rice, & Quinsey, 2002). Offenders with ASPD features and Factor 2 psychopathy engage in more criminal behavior and have more extensive criminal/incarceration histories than individuals without these personality traits, which means that their behavior more closely fits prototypical criminal stereotypes capturing dangerousness, untrustworthiness, inability to keep a regular job, and unpredictability, thereby increasing the personal relevance of stereotypes and internalized stigma.

The fact that criminogenic cognitions predicted higher internalized stigma contradicts criminology theory suggesting offenders often justify and minimize their criminal behavior, thereby protecting their self-concept (Walters, 1995). Our results suggest the opposite: offenders who have distorted thoughts that promote criminal behavior are at greater risk for internalizing stereotypes about criminal offenders. Criminogenic cognitions are thought to facilitate criminal behavior because they justify and minimize its effect on others (Tangney et al., 2012). Thus, possessing these cognitions likely facilitates criminal behavior, which in turn informs self-perceptions (i.e., "I do these criminal behaviors, so stereotypes do apply to me"). Interestingly, the criminogenic cognitions subscale, failure to accept responsibility, was also a significant predictor of internalized stigma. Certain items in the failure to accept responsibility scale (e.g., "I am just a born criminal") that are meant to capture blaming one's genetics for criminal behavior, may explain this relationship, as these items share conceptual overlap with internalized stigma.

Interestingly, though several antisocial characteristics were risk factors for stereotype agreement and internalized stigma, only possessing an antisocial network of peers was a significant risk factor for anticipated stigma. It is possible those with a more antisocial network of peers know about the stigma their peers are facing and expect they will experience the same. The pattern of differential correlations between risk and protective factors with anticipated stigma compared to the other components of the self-stigma process is consistent with research showing anticipated stigma occurs outside the process through which stereotypes are internalized among criminal offenders (Moore et al., 2016). Specifically, global risk and protective factors that apply to any stigmatized group seem more relevant to anticipated stigma, which applies more broadly across the diverse group of

criminal offenders, whereas the factors more unique to criminal offenders, such as degree of antisocial features, are more relevant to internalized stigma.

No risk or protective factors emerged for perceived stigma in this study, and thus it remains unclear which types of offenders are most vulnerable to believing that others hold negative stereotypes about their group in the first place. Of note, LeBel (2012) identified several risk factors for perceived stigma among former prisoners, including having parole violations, identifying strongly with other offenders, living in a place where incarceration is normative, having weaker familial bonds, and being White. This discrepancy may reflect sample differences, as the current study investigated self-stigma among jail inmates, many of whom had misdemeanor convictions, and thus may have had a less severe criminal record.

Limitations and Future Directions

There are several limitations to the current study. Participants were all male inmates in a single county jail, meaning it is likely they are not representative of all current and formerly incarcerated inmates. Inmates in federal prison, for example, may experience higher levels of internalized stigma due to having more extensive and/or severe criminal histories. Criminal history is an important factor to examine in future studies of self-stigma associated with a criminal record, as having a more extensive criminal history (i.e., more charges, more severe types of charges) is likely a risk factor for multiple components of the self-stigma process. Additionally, self-stigma experienced during incarceration may have different risk and protective factors than which is experienced in the community. For example, while in the community, rejection experiences, employment status, or perceived social support may be more important risk and protective factors for self-stigma. More sophisticated models testing the multivariate effects of risk and protective factors for self-stigma are needed. For instance, offenders who have both mental health problems and high ASPD features/psychopathy may be especially at risk for internalized stigma. This group is already at a high risk for recidivism, and internalized stigma may play an important role in this due to the cyclical way in which thoughts about the self inform behavior and vice versa. Future research should also examine the consequences of internalized stigma utilizing the factors examined in this study as moderating variables. For instance, people who internalize stigma and have high levels of criminogenic cognitions may be more likely to have substance abuse problems upon release from jail. These are all directions for future research.

Conclusions and Clinical Implications

In many ways, the risk and protective factors associated with self-stigma among criminal offenders parallel those demonstrated in other stigmatized groups. Low self-esteem, more mental health symptoms, and a higher degree of antisocial characteristics put offenders at risk of internalizing negative stereotypes about their group, and thus warrant early identification and intervention to prevent internalized stigma. Identifying risk and protective factors of self-stigma is the first step in understanding which criminal offenders may be most vulnerable to the psychological and behavioral consequences of stigma, which potentially involve avoidance of important activities (e.g., court dates, meetings with probation officer, seeking treatment for addiction or mental health), withdrawal from prosocial others and institutions such as those that offer legal employment or financial/housing assistance, and

further engagement in risky illicit behavior during the reentry period after release from incarceration. Further research is needed to assess the long-term psychological, behavioral, and social consequences of self-stigma in criminal offenders, especially with regard to community integration and criminal behavior, which will inform efforts to prevent and intervene with self-stigma in this unique population. Cognitive-behavioral treatment strategies used to combat low self-esteem, depression, and avoidance used in other self-stigma interventions (e.g., for people with mental illness; Yanos et al., 2014) could be merged with cognitive-behavioral interventions addressing criminogenic risk factors in correctional settings (Golden, Gatchel, & Cahill, 2006) to prevent and intervene with multiple risk factors associated with self-stigma.

Acknowledgments

This research was supported by the National Institute on Drug Abuse grants #R01DA14694 awarded to June P. Tangney, #5F31DA035037 awarded to Kelly E. Moore, and #F31DA039620 awarded to Johanna B. Folk. Many thanks to the members of the Human Emotions Research Lab for their assistance with this research, and the inmates who participated in this research.

References

Beck J. Cognitive-behavioral therapy: Basics and beyond. New York, NY: Guilford Press; 2011.

Benjamini Y, Hochberg Y. Controlling the false discovery rate: A practical and powerful approach to multiple testing. Journal of the Royal Statistical Society, Series B (Methodological). 1995; 57:289–300.

Boyle MP. Identifying correlates of self-stigma in adults who stutter: Further establishing the construct validity of the Self-Stigma of Stuttering Scale (4S). Journal of Fluency Disorders. 2015; 43:17–27. [PubMed: 25614323]

Brown RL. Perceived stigma among people with chronic health conditions: The influence of age, stressor exposure, and psychosocial resources. Research on Aging. 2015; 37:335–360. [PubMed: 25651574]

Cavelti M, Rüsch N, Vauth R. Is living with psychosis demoralizing?: Insight, self-stigma, and clinical outcome among people with schizophrenia across 1 year. Journal of Nervous and Mental Disease. 2014; 202:521–529. [PubMed: 24933416]

Caudy MS, Folk JB, Stuewig JB, Wooditch A, Martinez A, Maass S, Tangney JP, Taxman FS. Does substance misuse moderate the relationship between criminal thinking and recidivism? Journal of Criminal Justice. 2015; 43:12–19. [PubMed: 25598559]

Clear TR, Sumter MT. Prisoners, prison, and religion: Religion and adjustment to prison. Journal of Offender Rehabilitation. 2002; 35:125–156.

Cooke DJ, Michie C, Hart SD, Hare RD. Evaluating the Screening Version of the Hare Psychopathy Checklist—Revised (PCL:SV): An item response theory analysis. Psychological Assessment. 1999; 11:3–13.

Corrigan P, Markowitz FE, Watson A, Rowan D, Kubiak MA. An attribution model of public discrimination towards persons with mental illness. Journal of Health and Social Behavior. 2003; 44:162–179. [PubMed: 12866388]

Corrigan PW, Watson AC, Barr L. The self-stigma of mental illness: Implications for self-esteem and self-efficacy. Journal of Social and Clinical Psychology. 2006; 25:875–884.

Crocker J, Quinn DM. Social stigma and the self: Meanings, situations, and self-esteem. In: Heatherton TF, Kleck RE, Hebl MR, Hull JG, editorsThe social psychology of stigma. New York, NY: Guilford Press; 2000. 153–183.

Diener E, Emmons RA, Larsen RJ, Griffin S. The Satisfaction with Life Scale. Journal of Personality Assessment. 1985; 49:71–75. [PubMed: 16367493]

Dijker AJ, Koomen W. Extending Weiner's attribution-emotion model of stigmatization of ill persons. Basic and Applied Social Psychology. 2003; 25:51–68.

Douglas KS, Nikolova NL, Kelley SE, Edens JF. Psychopathy. In: Cutler BL, Zapf PA, editorsAPA handbook of forensic psychology, Vol. 1: Individual and situational influences in criminal and civil contexts. Washington, DC: American Psychological Association; 2015. 257–323.

Earnshaw VA, Quinn DM. The impact of stigma in healthcare of people living with chronic illness. Journal of Health Psychology. 2012; 17:157–168. [PubMed: 21799078]

Earnshaw VA, Bogart LM, Dovidio JF, Williams DR. Stigma and racial/ethnic HIV disparities: Moving toward resilience. Stigma and Health. 2015; 1:60–74.

Else-Quest NM, LoConte NK, Schiller JH, Hyde JS. Perceived stigma, self-blame, and adjustment among lung, breast, and prostate cancer patients. Psychology and Health. 2009; 24:949–964. [PubMed: 20205038]

Farrington DP. Age and crime. Crime and Justice. 1986; 7:189–250.

Folk JB, Mashek D, Tangney J, Stuewig J, Moore KE. Connectedness to the criminal community and the community at large predicts 1 year post-release outcomes among felony offenders. European Journal of Social Psychology. 2016; 46:341–355. [PubMed: 27524842]

Folk JB, Blasko BL, Warden R, Schaefer K, Ferssizidis P, Stuewig J, Tangney JP. Feasibility and acceptability of an impact of crime group intervention with jail inmates. Victims & Offenders. 2016; 11:436–454. [PubMed: 27239168]

Fuster-Ruizdeapodaca MJ, Molero F, Holgado FP, Mayordomo S. Enacted and internalized stigma and quality of life among people with HIV: The role of group identity. Quality of Life Research. 2014; 23:1967–1975. [PubMed: 24585185]

Gardner BO, Boccaccini MT, Bitting BS, Edens JF. Personality Assessment Inventory scores as predictors of misconduct, recidivism, and violence: A meta-analytic review. Psychological Assessment. 2015; 27:534–544. [PubMed: 25528162]

Golden LS, Gatchel RJ, Cahill MA. Evaluating the effectiveness of the National Institute of Corrections "Thinking for a Change" program among probationers. Journal of Offender Rehabilitation. 2006; 43:55–73. DOI: 10.1300/J076v43n02_03

Greeff M, Uys LR, Wantland D, Makoae L, Chirwa M, Dlamini P, Kohi TW, Mullan J, Naidood JR, Cuca Y, Holzemer WL. Perceived HIV stigma and life satisfaction among persons living with HIV infection in five African countries: A longitudinal study. International Journal of Nursing Studies. 2010; 47:475–486. [PubMed: 19854440]

Hart SD, Cox DN, Hare RD. The Hare Psychopathy Checklist: Screening Version (PCL: SV). Toronto: Multi-Health Systems, Inc; 1995.

Hirschfield PJ. The declining significance of delinquent labels in disadvantaged urban communities. Sociological Forum. 2008; 23:575–601.

Hirschfield PJ, Piquero AR. Normalization and legitimation: Modeling stigmatizing attitudes toward ex-offenders. Criminology. 2010; 48:27–55.

Holzemer WL, Human S, Arudo J, Rosa ME, Hamilton MJ, Corles I, Robinson L, Nicholas PK, Wantland DJ, Moezzi S, Willard S, Kirksey K, Portillo C, Sefcik E, Rivero-Méndez M, Maryland M. Exploring HIV stigma and quality of life for persons living with HIV infection. Journal of the Association of AIDS Care. 2009; 20:161–168.

Kline RB. Becoming a behavioral science researcher: A guide to producing research that matters. New York, NY: Guilford Press; 2009. Practical data analysis; 225–250.

Latalova K, Kamaradova D, Prasko J. Perspectives on perceived stigma and self-stigma in adult male patients with depression. Neuropsychiatric Disease and Treatment. 2014; 10:1399–1405. [PubMed: 25114531]

LeBel TP. Invisible stripes? Formerly incarcerated persons' perceptions of stigma. Deviant Behavior. 2012; 33:89–107.

Levy B, Celen-Demirtas S, Surguladze T, Sweeney KK. Stigma and discrimination: A socio-cultural etiology of mental illness. The Humanistic Psychologist. 2014; 42:199–214.

Lewis RJ, Derlega VJ, Griffin JL, Krowinski AC. Stressors for gay men and lesbians: Life stress, gay-related stress, stigma consciousness, and depressive symptoms. Journal of Social and Clinical Psychology. 2003; 22:716–729.

Link BG. Understanding labeling effects in the area of mental disorders: An assessment of the effects of expectations of rejection. American Sociological Review. 1987; 52:96–112.

Link BG, Struening EL, Neese-Todd S, Asmussen S, Phelan JC. Stigma as a barrier to recovery: The consequences of stigma for the self–esteem of people with mental illness. Psychiatric Services. 2001; 52:1621–1626. [PubMed: 11726753]

Livingston JD, Boyd JE. Correlates and consequences of internalized stigma for people living with mental illness: A systematic review and meta-analysis. Social Science & Medicine. 2010; 71:2150–2161. [PubMed: 21051128]

Luoma JB, Kohlenberg BS, Hayes SC, Fletcher L. Slow and steady wins the race: A randomized clinical trial of acceptance and commitment therapy targeting shame in substance use disorders. Journal of Consulting and Clinical Psychology. 2012; 80:43–53. [PubMed: 22040285]

Luoma JB, Nobles RH, Drake CE, Hayes SC, O'Hair A, Fletcher L, Kohlenberg BS. Self-stigma in substance abuse: Development of a new measure. Journal of Psychopathology and Behavioral Assessment. 2013; 35(2):223–234. [PubMed: 23772099]

Luoma JB, Twohig MP, Waltz T, Hayes SC, Roget N, Padilla M, Fisher G. An investigation of stigma in individuals receiving treatment for substance abuse. Addictive Behaviors. 2007; 32:1331–1346. [PubMed: 17092656]

Major B, Quinton WJ, Schmader T. Attributions to discrimination and self- esteem: Impact of group identification and situational ambiguity. Journal of Experimental Psychology. 2003; 39:220–231.

Malouf E, Stuewig J, Tangney JP. Self-control and jail inmates' substance misuse post-release: Mediation by friends' substance use and moderation by age. Addictive Behaviors. 2012; 37:1198–1204. [PubMed: 22727787]

Marcos AC, Bahr SJ, Johnson RE. Test of a bonding/association theory of adolescent drug use. Social Forces. 1986; 65:135–161.

Markowitz FE. The effects of stigma on the psychological well-being and life satisfaction of persons with mental illness. Journal of Health and Social Behavior. 1998; 39:335–347. [PubMed: 9919855]

Mashek D, Cannaday LW, Tangney JP. Inclusion of Community in Self Scale: A single-item pictorial measure of community connectedness. Journal of Community Psychology. 2007; 35:257–275.

Mashek D, Stuewig J, Furukawa E, Tangney J. Psychological and behavioral implications of connectedness to communities with opposing values and beliefs. Journal of Social and Clinical Psychology. 2006; 25:404–428. [PubMed: 21532983]

Moore K, Stuewig J, Tangney J. Jail inmates' perceived and anticipated stigma: Implications for post-release functioning. Self and Identity. 2013; 12:527–547. [PubMed: 25045324]

Moore KE, Stuewig J, Tangney JP. The effect of stigma on criminal offenders' functioning: A longitudinal mediational model. Deviant Behavior. 2016; 37:1–24. [PubMed: 26806988]

Moore KE, Tangney JP. Jail inmates' anticipated stigma predicts post-release adjustment via social withdrawal. 2016 Manuscript submitted for publication.

Moore KE, Tangney JP, Stuewig J. The self-stigma process in criminal offenders. Stigma and Health. 2016. Advance online publication,

Morey LC. The Personality Assessment Inventory Professional Manual. Odessa, FL: Psychological Assessment Resources; 1991.

Ottenbreit ND, Dobson KS. Avoidance and depression: The construction of the Cognitive-Behavioral Avoidance Scale. Behaviour Research and Therapy. 2004; 42:293–313. [PubMed: 14975771]

Oexle N, Rüsch N, Viering S, Wyss C, Seifritz E, Xu Z, Kawohl W. Self-stigma and suicidality: A longitudinal study. European Archives of Psychiatry and Clinical Neuroscience. 2016. http://dx.doi.org.mutex.gmu.edu/10.1007/s00406-016-0698-1

Pager D. The mark of a criminal record. American Journal of Sociology. 2003; 108:937–975.

Pavot W, Diener E. Review of the Satisfaction with Life Scale. Psychological Assessment. 1993; 5:164–172.

Pogorzelski W, Wolff N, Pan KY, Blitz CL. Behavioral health problems, ex-offender reentry policies, and the "Second Chance Act". American Journal of Public Health. 2005; 95:1718–1724. [PubMed: 16131635]

Quinn DM, Chaudoir SR. Living with a concealable stigmatized identity: The impact of anticipated stigma, centrality, salience, and cultural stigma on psychological distress and health. Stigma and Health. 2009; 1:35–39.

Rao D, Choi SW, Victorson D, Bode R, Peterman A, Heinemann A, Cella D. Measuring stigma across neurological conditions: The development of the Stigma Scale for Chronic Illness (SSCI). Quality of Life Research: An International Journal of Quality of Life Aspects of Treatment, Care & Rehabilitation. 2009; 18:585–595.

Robins RW, Hendin HM, Trzesniewski KH. Measuring global self-esteem: Construct validation of a single-item measure and the Rosenberg Self-Esteem Scale. Personality and Social Psychology Bulletin. 2001; 27:151–161.

Rosenberg M. Society and the adolescent self-image. Princeton, NJ: Princeton University Press; 1965.

Rüsch N, Corrigan PW, Todd AR, Bodenhausen GV. Implicit self-stigma in people with mental illness. The Journal of Nervous and Mental Disease. 2010; 198:150–153. [PubMed: 20145491]

Schomerus G, Lucht M, Holzinger A, Matschinger H, Carta MG, Angermeyer MC. The stigma of alcohol dependence compared with other mental disorders: A review of population studies. Alcohol and Alcoholism. 2011; 46:105–112. [PubMed: 21169612]

Seidlitz L, Abernethy AD, Duberstein PR, Evinger JS, Chang TH, Lewis BL. Development of the spiritual transcendence index. Journal for the Scientific Study of Religion. 2002; 41:439–453.

Simpson DD, Knight K. TCU data collection forms for correctional residential treatment. Fort Worth: Texas Christian University, Institute of Behavioral Research; 1998.

Skilling TA, Harris GT, Rice ME, Quinsey VL. Identifying persistently antisocial offenders using the Hare Psychopathy Checklist and DSM antisocial personality disorder criteria. Psychological Assessment. 2002; 14:27–38. [PubMed: 11911046]

Tangney JP, Meyer P, Furukawa E, Cosby B. Criminogenic Beliefs and Attitudes Scale. George Mason University; Fairfax, VA: 2002.

Tangney JP, Stuewig J, Furukawa E, Kopelovich S, Meyer P, Cosby B. Reliability, validity, and predictive utility of the 25-item Criminogenic Cognitions Scale (CCS). Criminal Justice Behavior. 2012; 39:1340–1360. [PubMed: 24072946]

Walters GD. The psychological inventory of criminal thinking styles part I: Reliability and preliminary validity. Criminal Justice and Behavior. 1995; 22:307–325.

Werner P, Aviv A, Barak Y. Self-stigma, self-esteem and age in persons with schizophrenia. International Psychogeriatrics. 2008; 20:174–187. [PubMed: 17451617]

Williams VS, Jones LV, Tukey JW. Controlling error in multiple comparisons, with examples from state-to-state differences in educational achievement. Journal of Educational and Behavioral Statistics. 1999; 24:42–69.

Winnick TA, Bodkin M. Anticipated stigma and stigma management among those to be labeled “ex-con. Deviant Behavior. 2008; 29:295–333.

Yanos PT, Lucksted A, Drapalski AL, Roe D, Lysaker P. Interventions targeting mental health self-stigma: A review and comparison. Psychiatric Rehabilitation Journal. 2014; 38:171–178. [PubMed: 25313530]

Table 1

Univariate Statistics.

Variable	*N*	*M/%*	*SD*	Range	Skew	Kurtosis
Stigma Variables						
Perceived Stigma	111	2.44	0.72	1.00 – 4.00	0.23	−0.38
Stereotype Agreement	111	1.56	0.42	1.00 – 2.67	0.68	−0.43
Internalized Stigma	111	1.12	0.23	1.00 – 2.11	2.54	6.58
Anticipated Stigma	79	1.99	0.72	1.00 – 4.00	0.20	−0.11
Global Risk and Protective Factors						
Age (years)	111	32.67	10.93	18.15 – 65.24	0.59	−0.60
Race (Black)	89	45.95	-	-	-	-
Years of Education	110	11.66	1.89	7.00 – 18.00	−0.08	0.98
Criminal Identity	110	2.86	1.89	1.00 – 6.00	0.51	−1.27
Self-esteem	110	3.35	0.62	1.30 – 4.00	−1.10	0.56
Satisfaction with Life	111	3.28	1.50	1.00 – 7.00	0.44	−0.41
Spirituality	110	2.81	1.05	1.00 – 4.00	−0.42	−1.17
Mental Health Symptoms (T)	110	55.7	8.66	40.43 – 78.57	0.64	−0.21
Substance Dependence Symptoms	111	0.54	0.60	0.00 – 2.84	1.45	2.29
Connectedness to Community at Large	111	2.49	1.58	1.00 – 6.00	0.84	−0.42
Unique Risk and Protective Factors						
ASPD Features (T)	110	67.55	12.02	42.00 – 96.00	0.35	−0.63
Criminogenic Cognitions Total	110	2.12	0.30	1.52 – 3.00	0.13	−0.17
Short-Term Orientation	110	1.91	0.44	1.00 – 3.20	0.28	0.14
Notions of Entitlement	110	2.18	0.46	1.20 – 3.20	0.34	−0.33
Failure to Accept Responsibility	110	2.00	0.48	1.00 – 3.20	0.12	−0.43
Negative Attitudes Toward	110	2.51	0.44	1.40 – 3.80	0.37	0.63
Authority						
Insensitivity to Impact of Crime	110	1.99	0.52	1.00 – 3.40	0.33	−0.29
Reparation	108	2.99	0.64	1.60 – 4.00	−0.30	−0.53
Psychopathy Total Score	111	12.60	4.13	4.00 – 21.00	−0.19	−0.32
Psychopathy Factor 1	111	5.23	2.69	0.00 – 11.00	0.34	−0.57

Variable	*N*	*M*/%	*SD*	Range	Skew	Kurtosis
Psychopathy Factor 2	111	7.38	2.45	1.00 – 11.00	−0.44	−0.63
Connectedness to Criminal Community	111	2.70	1.71	1.00 – 6.00	0.57	−1.04
Antisocial Peers	107	1.21	1.21	0.00 – 8.00	2.21	8.56

Table 2

Partial Correlations Controlling for Treatment Status.

	Perceived Stigma	Stereotype Agreement	Internalized Stigma	Anticipated Stigma
Global Risk and Protective Factors				
Age	−.19*	−.10	−.01	−.10
Race	.01	−.11	−.13	−.05
Years of Education	.02	.01	−.08	.06
Criminal Identity	.04	−.12	−.02	−.01
Self-esteem	−.15	−.17t	**−.25****	**−.47*****
Satisfaction with Life	.06	.06	−.01	−.07
Spirituality	−.04	−.13	.06	.09
Mental Health Symptoms	.16	**.28****	**.41*****	**.32****
Substance Dependence Symptoms	.08	.13	.13	.19t
Connectedness to Community at Large	.04	.03	−.09	−.03
Unique Risk and Protective Factors				
Antisocial Personality Disorder Features	.15	**.27****	**.38*****	.07
Criminogenic Cognitions	.26**	.22*	**.29****	.10
Short Term Orientation	.14	.11	.15	.22t
Notions of Entitlement	.14	.26**	.20*	.04
Failure to Accept Responsibility	.23*	.23*	**.45*****	.15
Negative Attitudes Toward Authority	.21*	.08	.11	−.05
Insensitivity to Impact of Crime	.11	.05	.02	.01
Reparation	.05	−.07	−.04	.23*
Total Psychopathy	.06	.04	.15	.01
Factor 1 Psychopathy	.01	−.01	−.02	.08
Factor 2 Psychopathy	.09	.07	**.27****	−.07
Connectedness to Criminal Community	.21*	.06	.05	.17
Antisocial Network of Peers	.10	.09	.08	.27*

Notes: *N*s range from 57 to 108 due to missing data on the race and anticipated stigma variables as shown in Table 1. Bolded correlations reflect those that remained significant after the Benjamini-Hochberg correction for family-wise error.

t $p < .10$.

* $p < .05$.

** $p < .01$.

*** $p < .001$, two-tailed.