Dear mama, these cops don’t understand me: The influence of mental health stigma on youth incarceration

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Dear mama, these cops don’t understand me:

The influence of mental health stigma on youth incarceration

A Thesis Presented to the Graduate Faculty
of the Fort Hays State University in
Partial Fulfillment of the Requirements for
the Degree of Master of Science in Clinical Psychology

by

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Date April 1, 2020
Approved
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Approved
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ABSTRACT

Youth within the juvenile justice system have a higher prevalence of mental illness when compared to the general population, with some literature revealing up to 80% of incarcerated youth possess a diagnosable disorder (Shufelt & Cocozza, 2006; Underwood & Washington, 2016). Today, mental health stigma is widely prevalent and results in prejudice, discrimination, lowered self-esteem, and other negative outcomes for individuals struggling with mental health related issues (Corrigan & Watson, 2002; Dalgin & Gilbride 2003). With this in mind, the role mental health stigma plays in the lives of youth in the juvenile justice system should not be overlooked. Although stigma towards adult mental health is a well-studied area, stigma of child and adolescent mental health is an area that remains largely under-conceptualized and under-researched (Heflinger & Hinshaw, 2010). Thus, the current study seeks to examine the perceptions of youth within the juvenile justice system regarding their own experience with mental illness stigma.

Participants were sampled from the Kansas Juvenile Correctional Facility (KJCC). Youth were asked to complete several questionnaires to assess their views toward mental illness as a whole, personal experiences with stigma, adverse childhood experiences (ACE), feelings toward available mental health resources at the facility, and the role of mental illness stigma in their incarceration. First, researchers hypothesized youth with greater self-stigma would indicate stigma played a greater role in their incarceration than those youth who indicate less self-stigma. Next, researchers hypothesized youth with a high number of adverse childhood experiences would indicate stigma had a greater influence on their incarceration. Finally, researchers hypothesized perceived self-stigma would be positively correlated with perceived stigma of mental illness overall.
The hypotheses of the current study were found to be non-significant. Thus, exploratory analyses were conducted. When assessing only those youth indicating an experience with internalized stigma of a mental illness, ACEs were able to predict the influence mental health stigma had on incarceration. The more a youth indicated feeling the presence of internalized stigma, the more they felt treatment surrounding their mental illness influenced their incarceration.

Despite lacking support for original hypotheses, the current study begins to shine light into mental health, trauma, and treatment experiences of juvenile justice-involved youth. While youth perceptions of mental illness were overall positive in the current study, stigma of mental illness continues to plague society as a whole (see Corrigan & Watson, 2002; Muralidharan et al., 2017). Future studies in this area should continue to examine how these experiences and others guide youth into the system.

*Keywords:* Juvenile mental health, mental health stigma, adverse childhood experiences, self-stigma, youth incarceration
ACKNOWLEDGEMENTS

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Dear mama, these cops don’t understand me: The influence of mental health stigma on youth incarceration

Introduction

In today’s society, as many as 70,000 children under the age of 18 years are confined in the justice system (Alcorn, 2014). A majority of these individuals meet the criteria for at least one mental health disorder (Shufelt & Cocozza, 2006). When compared with the general public, juvenile justice youth have a substantially higher prevalence of mental illness (Underwood & Washington, 2016). Although the rate of mental illness among a community sample of youth ranges up to about 20%, various studies have reported this number as high as 50% when considering youth within the juvenile justice system (Alcorn, 2014; Cauffman, 2004; Teplin, Abram, McClelland, Dulcan, & Mericle, 2002), with some studies revealing nearly 80% of incarcerated youths with at least one diagnosable mental illness (Underwood & Washington, 2016). Due to this, the juvenile justice system is inevitably assigned the task of providing mental health treatment for these individuals. Heilbrun, Lee, and Cottle (2005) argue it is imperative to examine the link between mental health difficulties and youth offending, as evidence supports the idea these difficulties may be linked, either directly or indirectly, to later offenses and delinquency.

The role mental health stigma may play here should not be overlooked. Research on adult mental health stigma is abundant and well discussed. However, stigma of child and adolescent mental health services, even before accounting for those individuals within the juvenile justice system, is an area that remains largely under-conceptualized and under-researched (Heflinger & Hinshaw, 2010). Children and adolescents who are diagnosed with a mental illness sometimes experience stigma from their peers or members of their community.
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(Heary, Hennessy, Swords, & Corrigan, 2017). Although there are likely similarities between consequences of adult and child/adolescent mental health stigma, it is not appropriate to generalize adult findings to a youth population. Due to the heightened sense of identity formation and developing autonomy, stigma of mental illness may have an increased detriment to youth (Hinshaw, 2005).

**Defining Stigma**

Early definitions of stigma stem from the work of Erving Goffman (1963) who cites the concept as an attribute that reduces an individual “from a whole and usual person, to a tainted, discounted one” (p. 3). Goffman goes on to describe stigma as causing individuals experiencing it to view themselves as discredited or undesirable. Since Goffman’s seminal work, stigma has been discussed in a multitude of scholarly works across multiple disciplines (e.g., sociology, psychology, and criminal justice) (Corrigan, 2004; Heflinger & Hinshaw, 2010; Pescosolido, 2013), and has been broken down into both public and self-stigma. Public stigma may be defined as the societal response to individuals with stigmatizing attributes, while self-stigma represents the often-internalized result of these negative responses over time (Bathje & Pryor, 2011).

**Public Stigma**

Perhaps the most commonly discussed type of stigma results from those without the stigmatized status, or in this case those without a mental health issue, discriminating against those with the stigmatized status (Parcesepe & Cabassa, 2013; Ritsher & Phelan, 2004). Literature suggests many individuals in the general public are unable to properly recognize mental illness and sometimes misunderstand diagnostic terms (Jorm, 2000). Instead, much of Western society upholds stigmatic views toward mental illness, often stemming from misconceptions portrayed in the media and ultimately resulting in the belief individuals with a
mental illness should be excluded, are violent, childlike, or a combination of the three (Corrigan & Watson, 2002). This type of stigma is problematic—widespread acceptability of these views by society leads to negative treatment of individuals who are diagnosed (Corrigan, 2004). For example, individuals with a mental illness are less likely to benefit from health services than those individuals without a mental illness label. Additionally, an individual with a mental illness may struggle to find housing, a good job, or may be more likely to become involved with and be treated differently by the criminal justice system.

In a study by Dalgin and Gilbride (2003), the concerns about seeking employment were examined among a sample of individuals with a psychiatric diagnosis. Participants completed a semi-structured interview process assessing their perspectives. Results from the study brought forth several stigma-related themes. Individuals expressed they were comfortable acknowledging the need for accommodations for individuals with a physical disability such as a wheelchair or raised desk. However, they were less comfortable discussing accommodations necessary for individuals with a psychiatric disability, with one participant stating, “There is too much stigma right now…if there was no longer stigma, I would feel comfortable talking about it” (p. 308). Additionally, many of the participants noted disclosing their diagnosis to an employer was not desirable. They reported concerns about stigma and fear from the general public, often worrying they would be viewed violently like individuals with a mental illness portrayed by the media. Participants voiced concerns about being isolated from coworkers, being terminated, or not being hired at all.

For youth, public stigma may have an impact at school. During school, youth rely on teachers and peers to shape their sense of belonging and to aid in their identity formation (Cameron & Sheppard, 2006). However, research suggests teachers often distance themselves
from students they perceive as challenging or difficult in comparison to peers. Moses (2010) assessed youth perceptions of stigmatization from school staff. Within the study, adolescents diagnosed with at least one mental health diagnosis were asked to respond to questions exploring their experience with stigmatization from staff at school. Of the students who responded, over half indicated being treated differently by school staff. While some of the students indicated being treated differently in a positive way (e.g., extra support), approximately one-third of the respondents reported being treated in a negative or stigmatizing way by school staff. Youth cited these experiences as causing them to feel underestimated or like they should be isolated from others.

For youth in the juvenile justice system, public stigma may be even more detrimental than for individuals within the general public (Moore, Milam, Folk, & Tangney, 2018). For example, individuals formerly released from the justice system are often restricted from participating in certain employment, or activities. However, when combined with a mental health diagnosis or presenting symptom, stigmatization has the potential to increase. For example, research suggests when individuals encounter law enforcement while exhibiting symptoms of a mental illness, arrest rates are much higher than when law enforcement encounters individuals not exhibiting symptoms, possibly due to the stigma associated with mental illness (Corrigan, 2004).

Self-Stigma

Individuals who repeatedly experience stigma from the public often begin to internalize negative labels and adopt these views when thinking about themselves (Corrigan & Watson, 2002). Not surprisingly, individuals who perceive an increased amount of public stigma have been found to report an increased amount of personal stigma, as well (Eisenberg, Downs,
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Golberstein, & Zivin, 2009). Although the public aspect of stigma undoubtedly should be addressed, it is also necessary to consider how stigma may result in internal perceptions, beliefs, and emotions (Ritsher & Phelan, 2004). According to Corrigan and Rao (2012), self-stigma occurs when individuals internalize negative public views, ultimately leading to negative consequences and feelings. Unfortunately, applying stereotypes and demoralization to oneself is only a short leap from being exposed to stereotypes and demoralization in the public. Individuals who grow up in a society that portrays their mental illness as dangerous or violent may begin to internalize the idea they actually possess this quality. Doing so may lead individuals to develop feelings of hopelessness and helplessness, and further negative consequences that will be discussed.

Researchers have surveyed college-aged students on their perceptions of public and self-stigma (Vogel, Bitman, Hammer, & Wade, 2013). Results support previous findings, speaking to the relationship between public and self-stigmas. Additionally, findings from the study indicate higher perceptions of public stigma predict higher subsequent perceptions of self-stigma. This supports the idea that as the amount of public stigma an individual is exposed to increases, so does the amount of stigma they begin to internalize.

Consequences of internalized stigma were explored in a sample of outpatients of one mental health center (Ritsher & Phelan, 2004). Researchers assessed perceptions of devaluation and loss of morale (measured in terms of self-esteem and depressive symptoms) associated with internalized stigma. Results indicated a substantial amount of the individuals surveyed had experienced internalization of stigma. Not surprisingly, these increased levels of internalized stigma were also related to decreased morale, suggesting persistent stigma may eventually erode an individual’s confidence or self-esteem. Additionally, researchers also found alienation to be a
harmful consequence for these individuals. Unfortunately, individuals who reported feeling alienation from others showed more distress in a four month follow up, as well as showing further decreases in morale.

In a study by Vogel, Wade, and Hackler (2007), the relationship between public and self-stigma was examined. The researchers were interested in the development of self-stigmatization from perceived public stigma, as well as the negative consequences these perceptions of oneself might have on willingness to seek mental health treatment. A positive relationship was found between public and self-stigmas. That is, an individual’s perception of stigma from the public grew, so did their self-stigma toward their own mental health. Additionally, researchers concluded this self-stigma was negatively related to seeking mental health counseling, such that those individuals experiencing more self-stigma were less likely to seek counseling.

**Impact of Mental Health Stigma**

The above literature outlines not only the relationship of public and self-stigma, but also the negative influence self-stigmatization has on those experiencing it. This research suggests the need for increased discussion and conceptualization of the impacts mental health stigma may have when it continues to be endorsed by the individual being forced to endure it. Stigma is acknowledged as interfering with life opportunities or hindering the willingness to seek or adhere to treatment (Kondrat, Sullivan, Wilkins, Barrett, & Beerbower, 2018). Stigma may negatively impact self-esteem and deter individuals from seeking or adhering to medication and treatment. Additionally, exposure to stigma may negatively influence an individual’s social support system or create distress among family relationships.
Self-Esteem

Research suggests a link between levels of perceived stigma and individual self-esteem. Specifically, mental health stigma, “leads a substantial proportion of people who develop such illnesses to conclude they are failures or that they have little to be proud of” (Link, Struening, Neese-Todd, Asmussen, & Phelan, 2001, p. 1621). Link and colleagues measured perceived stigma and self-esteem in individuals with a mental health diagnosis at a baseline, a 6-month follow up, and at a 24-month follow up appointment. As expected, results indicated that individuals who perceived higher levels of stigma also reported lower levels of self-esteem. Specifically, individuals who scored higher on the perceived stigma scales were seven to nine times as likely to have low self-esteem as an individual who scored low on the stigma scales.

Berge and Ranney (2005) further examined the link between perceived mental health stigma and self-esteem in a group of individuals diagnosed with Schizophrenia. Participants were selected from three outpatient mental health clinics and were asked to indicate their own self-esteem along with information about their diagnosis and perceived mental health stigma. Results from the study revealed a correlation between the individual’s perceived stigma and their self-esteem. Additional research on the link between stigma and level of self-esteem was completed by Lysaker, Tsai, Yanos, and Roe (2008). Researchers were interested in examining the impact of mental illness stigma on self-esteem in a population of individuals diagnosed with Schizophrenia. Participants were asked to complete questionnaires assessing their own self-esteem as well as the amount of internalized (self) stigma of mental illness they experienced. Consistent with literature above, results from the study suggest internalized stigma of mental illness is related to self-esteem. Specifically, researchers found those individuals who experience greater levels of mental illness stigma also reported lower self-esteem. Results also indicated
that those individuals who internalized stereotypic beliefs about mental illness tended to view themselves as being incompetent or had less self-approval than individuals who endorsed fewer stereotypic beliefs.

In a study by Wahl (1999), researchers interviewed consumers of mental health services about their experience with stigma and its impact. Results from the study shed light onto the negative consequences of stigma toward those with a mental illness. According to the respondents, stigma experienced had a variety of lasting effects. Most commonly, interviewees reported feelings of sadness, anger, or feelings hurt as a result of the experience. Within the sample interviewed, more than half of the individuals interviewed discussed lowered self-esteem as a result of stigma experiences. Additionally, several of the individuals interviewed described the lasting impression these experiences had on their feelings and expectations toward others, ultimately resulting in them being more sensitive. Finally, 14% of the respondents openly noted these stigmatic experiences had resulted in increased depression symptoms. Linked with one another, these consequences reflect the negative impact stigma may have on self-esteem.

Help-Seeking

Stigma serves as a pervasive barrier for mental health treatment seeking and as such, the link between perceived stigma and treatment seeking is discussed within vast amounts of existing literature (Corrigan, 2004). The presence of discrimination and prejudice, which comprise mental health stigma, play a substantial role in deterring individuals from reaching out for help (Corrigan, Druss, & Perlick, 2014). The undermining impact of stigma on treatment seeking is specified by the Substance Abuse and Mental Health Administration (2012) who state that despite progress over recent years, nearly half of all individuals struggling with a severe mental illness continue to live without treatment. Research suggests that approximately 40% of
individuals with a diagnosis choose not to seek treatment, despite being informed of its benefit, likely due to concern their diagnosis will be disclosed, leading to stigmatization (Andrews, Issakidis, & Carter, 2001).

According to Corrigan and colleagues (2014), “stigma impacts care seeking at personal, provider, and system levels” (p. 43). When faced with the perceived need for help when managing their mental health symptoms, individuals are tasked with deciding if they should reach out for professional treatment. Unfortunately, both public and self-stigma may influence the individual’s choice to seek necessary treatment. For example, utilization of medications or professional help may increase stigmatizing labels. Additionally, individuals’ internal views toward their own mental health diagnosis, likely as a result of consistent public stigma, may lead them to believe they are not worthy of treatment, they will not be able to fully participate, they will not benefit from services, and so forth.

The negative impact of stigma on help-seeking is exemplified in a multitude of research studies. In a study by Gulliver, Griffiths, and Christenson (2010), researchers examined various barriers to help seeking associated with mental illness. Researchers identified thirteen common themes among several different studies. Out of the thirteen most commonly identified barriers, the most mentioned was stigmatizing attitudes to mental illness. This barrier was reported in three-quarters of the studies and was not limited to the general public; rather, participants cited doctors or counselors as sources of perceived stigma, as well. Further, Lannin, Vogel, Brenner, Abraham, and Heath (2016) hypothesized individuals with high self-stigma would be less likely to seek help for mental health issues. Participants were provided with a scale designed to measure their self-stigma, including items such as “If I went to a therapist, I would be less satisfied with myself.” As expected, results indicated increased levels of self-stigma were
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associated with decreased likelihood of seeking help. This builds on the previously discussed research and further suggests stigma may impact individual willingness to seek help for their mental health needs.

**Treatment and Medication Adherence**

Similar to the damaging role stigma may play in help seeking, stigma towards those with mental health issues may also impact how individuals participate in treatment and how closely they adhere to their medication regimen. For example, one study found individuals who begin mental health care or treatment often drop out, with 70% of these individuals ceasing care after just the first or second visits (Substance Abuse and Mental Health Services Administration, 2012). Preliminary research on adherence to treatment indicates the perceptions of those utilizing the treatment may play an important role in predicting outcomes and treatment success. When individuals choose to stop taking their medications or participating in treatment, it may be due to the notion they belong to a devalued group or to avoid rejection. For example, “perceived social barriers may be particularly important in predicting treatment behaviors, such as taking an antidepressant, to remedy an illness whose victims may experience social stigma” (Sirey et al., 2001, p. 1616). Additionally, the impact of stigma on treatment adherence was examined. Results concluded the less stigma individuals perceived, the better they adhered to their medication regimen. However, as expected, individuals who perceived their mental illness to be more highly stigmatized were found less likely to adhere to medication and treatment plans.

Sirey and colleagues (2001) further examined the role of stigma in treatment discontinuation in a sample of individuals struggling with depression. Researchers measured the participants perceived mental health stigma as well as gathered information about their diagnosis and treatment process. The dependent variable for the study was measured dichotomously as
either “continued in treatment” or “discontinued treatment.” Researchers concluded perceived stigma to be predictive of treatment continuation. That is, results revealed individuals who perceived stigma toward individuals diagnosed with a mental illness were less likely to continue treatment than those who indicated less perceived stigma.

**Impact on Family/Caregivers**

The impact of mental health stigma is not limited to those who have been diagnosed; rather, it is far reaching and touches the lives of those close to the diagnosed individual. In fact, stigma faced by family members of individuals with a mental illness has been described as, “the most pervasive subjective burden faced by families of persons with mental illness” (Greenberg, Greenley, McKee, Brown, & Griffin-Francell, 1993, p. 205). Often times, family members and caregivers of individuals who have a mental illness experience their own stigma (Muralidharan, Lucksted, Medoff, Fang, & Dixon, 2016; Wahl & Harman, 1989). These individuals may develop feelings of shame and guilt stemming from the stigma felt by those close to them. Furthermore, these individuals may experience loss of support from their own friends and community, resulting in isolation or concealment of their loved one’s diagnosis.

In a 1989 study by Wahl and Harman, researchers sought to explore family experiences of stigmatization and to identify major contributors linked to heightened stigmatization. Researchers mailed 1,475 questionnaires to affiliates of the National Alliance for the Mentally Ill (NAMI), now called the National Alliance on Mental illness (NAMI.org). Affiliates were asked to distribute questionnaires at regular meetings, typically attended by many family members of individuals struggling with a mental illness. A total of 487 questionnaires, encompassing 20 states within the United States, were completed and returned to the researchers. Majority of the respondents (73%) identified being a parent of an individual with a mental illness, with 11%
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identifying having a sibling with a mental illness, and only three percent acknowledging a
spousal relationship with a mentally ill individual. These findings speak to the magnitude of
stigma acknowledged by family of individuals with a mental illness, as family members were
consistent in their indication that stigma accompanies mental illness r(Wahl & Harman, 1989).
Furthermore, 56% of the respondents identified stigma as impacting them “much or very much,”
with a shocking 89% describing stigma as a least somewhat a problem for families. Most often,
family members reported stigma disrupting family relationships, with 22% of respondents citing
their family as “much or very much” affected by stigma. Additionally, 21% of the family
respondents reported their own self-esteem being impacted by the stigmatization of their family
members. In a more recent study, Muralidharan and colleagues (2016) explored stigma within a
sample of family members of individuals with a mental illness. Researchers found nearly two-
thirds reported thinking about and being aware of stigma-related caregiver experiences.
Additionally, these stigma-related thoughts were found to be associated with distress for each of
the family members, highlighting the impact stigma might have.

Impact on Peer Relationships

Stigma has the potential to impact peer relationships. Like its impact on family, stigma
may lead peers to ostracize individuals with a mental health diagnosis, ultimately leading to lack
of social supports (McKeague, Hennessy, O’Driscoll, & Heary, 2015). For adolescents
specifically, the impact of stigma can be particularly detrimental, as research suggests
adolescents with a mental illness are likely to be excluded.

McKeague and colleagues (2015) sought to study the impact of mental health stigma on
peer relationships in individuals diagnosed with Attention-Deficit/Hyperactivity Disorder
(ADHD) or Depression. To assess stigma’s impact, the researchers retrospectively interviewed
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young adults to examine their experience as an adolescent with a mental health diagnosis. Questions asked included difficulties faced related to their diagnosis, how these challenges impacted the individuals, whether the individuals felt comfortable sharing their diagnosis with peers, and how their diagnosis may have impacted their friendships. Results of the study indicated that during adolescence, interviewees felt “different” to others in their peer group, which often contributed to negative self-views. One participant acknowledged how this impacted their teenage years, stating “…as a teenager, you don’t want to be judged or classified or thought of as in some way defective” (p.161). Another participant stated, “…It kind of made me feel quite low at times,” with another participant sharing the perception of peers regarding him as, “a weirdo” or labeling his diagnosis as a “weakness.”

In a 2007 study by Chandra and Minkovitz, researchers explored perceptions of mental health in a sample of eighth-grade adolescents. Youth participated in hour-long interview sessions. Results uncovered several themes outlined within the interviews. Although some of the youth described positive experiences discussing mental health needs with a counselor, the majority spoke about negative experiences or lack of services they associated with having a mental illness. Additionally, many of the youth surveyed agreed that after an individual was diagnosed with a mental illness, their peers would react negatively or would perceive that individual as having a weakness. When asked if these perceptions would hold true for an individual with a physical diagnosis, many of the youth cited differences in views. The youth also expressed sensing discomfort from teachers and adults in engaging youth with a mental illness.
Mental Health of Juvenile Justice Youth

Research suggests the relationship between prevalence of mental health issues within the juvenile justice population is complex and not easily understood (Hovey, Zolkoski, & Bullock, 2017). Research indicates untreated mental health issues may contribute to juvenile delinquency, placing youth with presenting symptoms at a greater risk for detainment (Stoddard-Dare, Mallett, & Boitel, 2011). For example, research suggests youth displaying symptoms of a mental illness are more likely than those without to be detained when encountering law-enforcement officers (Hovey et al., 2017). Despite the possible causes, literature outlining the increased prevalence of mental health symptoms within the incarcerated youth population is plentiful (Espinosa, Sorenson, & Lopez, 2013; Foster, Qaseem, & Connor, 2004; Rosenblatt, Rosenblatt, & Biggs, 2000).

The prevalence of mental health diagnoses existing within the juvenile justice system is startling, with some studies citing nearly two-thirds of these youth having at least one diagnosable disorder, with a substantial portion of youth presenting with at least one comorbid psychiatric disorder (Alcorn, 2014). This finding is supported by various research studies. For example, in a study by Kretschmar, Butcher, Flannery, and Singer (2016), researchers assessed the prevalence of mental health diagnoses in a sample of approximately 2000 juvenile justice involved youth. Results from the study indicated nearly all youth involved in the study presented with at least one mental health diagnosis. Of these youth, nearly 40% presented with a co-occurring substance abuse disorder. Welty and colleagues (2016) drew similar conclusions. In this study, researchers surveyed 1,829 youth held at a juvenile detention center to assess present mental health disorders. Results indicated almost 27% of the males and 14% of the females surveyed struggled with at least one comorbid psychiatric disorder.
Burke, Mulvey, & Schubert (2015) assessed mental illness within the juvenile justice system, finding high rates of diagnosed mental illness within the sample. Of the youth sampled, 74% met the criteria for at least one diagnosable disorder. This rate is consistent with previously mentioned studies. Furthermore, 50% of these youth also met the criteria for at least one comorbid disorder. Rates of anxiety, Oppositional Defiant Disorder, and Conduct Disorder were found to be higher than those typical of the general public. Uniquely, this study sought information from both the youth and their parents. Although these collected rates are not surprising and closely mimic previous literature, this study speaks to the possibly underreported rates of mental health within the juvenile justice system. Despite the high rates of self-reported mental illness within the juvenile justice system, it is possible youth asked to participate in various other studies may have downplayed or failed to disclose their own diagnosis. Within this study specifically, if child-report alone had been analyzed, results would have indicated approximately half the number of diagnoses reported when parent reports were included.

**Adverse Childhood Experiences**

Youth within the juvenile justice system have a higher exposure to child maltreatment and previous abuse, often linked with their mental illness. Specifically, juvenile justice youth are more likely to have experienced physical, emotional, or sexual abuse, along with household adversities like parent substance abuse, exposure to domestic violence, and so forth (Baglivio & Epps, 2016). Previous literature suggests a history of childhood trauma and adversity are predictive of engagement in delinquent behaviors, as well as increased recidivism. Research has examined the relationship between Adverse Child Experiences (ACE) and violence in adolescents. Data were collected from approximately 600 students in the 6th, 9th, and 12th grades. Results indicate a five-fold increase in violence in females when even one ACE was present.
(Duke, Pettingell, McMorris, & Borowsky, 2010). For males in the study, the increased risk of violence greatly outweighed females and indicated a 44-fold increase with the presence of an adverse childhood experience. Additionally, a significant positive relationship was found between ACEs and delinquent behaviors between both males and females within the study. That is, as the number of ACEs reported grew, so did the number of reported delinquent behaviors engaged in. This suggests a strong link between these traumatic childhood events and engagement in delinquent behaviors.

Unfortunately, individuals who have experienced adverse childhood experiences are also likely to receive negative treatment and develop mental health issues (Craig, Baglivio, Wolff, Piquero, & Epps, 2016; Schilling, Aseltine, & Gore, 2007). The prevalence of mental health needs, coupled with traumatic childhood experiences, within the juvenile justice system emphasizes the need for appropriate treatment and care. However, these high rates of diagnosis may also bring about increased rates of stigma for these youth. Individuals within this population may have faced stigma prior to their confinement in the facility or may still continue to face stigma during their incarceration. This stigma may have a role in their delinquency.

**Linking Stigma and Juvenile Delinquency**

**Self-Esteem**

For youth with a mental health diagnosis, the impact stigma has on self-esteem may serve to prevent delinquent acts. According to Redding, Goldstein, and Heilbrun (2005), among the most common mental health diagnoses within the juvenile justice system is depression. Although risk factors for depression among adolescents make up a large list, perhaps at the forefront is low self-esteem. When addressing the number of incarcerated juveniles, it may be prudent to first address the mental health needs of the individuals in question. With increases in perceived
Mental Health Stigma

...come decreased levels of self-esteem, potentially leading to an increased likelihood for juvenile arrest.

The link between delinquency and low self-esteem was examined by Donnellan, Trzesniewski, Robins, Moffitt, and Caspie (2005). In a several-part study, researchers first examined the relation between self and teacher reports of youth self-esteem with engagement in delinquency. Next, a longitudinal study was conducted to further explore the role self-esteem may play in youth internalizing problems, such as aggression. Results of the study suggest self-esteem is negatively correlated with engagement in delinquency, such that individuals with lower self-esteem reported participation in more delinquent acts. Studies two and three also supported the hypothesis that self-esteem is related to internalizing youth behaviors.

Trzesniewski and colleagues (2006) further examined the role of low self-esteem on youth outcomes. Researchers of the study measured self-esteem in a sample of youth at ages 11, 13, and 15. The self-esteem scores from each of these times were then standardized and averaged, resulting in the overall self-esteem score of the youth. Later, researchers gathered self-report data from the youth at age 26, including information about mental health, substance use, and court records of adult convictions. Results of the study suggest low self-esteem as an adolescent is not only predictive of mental health issues as an adult, but also of adult criminal convictions. That is, youth who reported lower self-esteem when measured as adolescents were found to be 1.48 times more likely to be convicted of a violent crime as an adult, and 1.32 times more likely to be convicted of any adult crime overall. In summation, results from this study, coupled with those previously mentioned, suggest low self-esteem is not only impactful to youth in the juvenile justice system, but may also impact youth outcomes, resulting in adult recidivism.
Help-Seeking and Unmet Treatment Needs

Regarding delinquency, and juvenile mental health as a whole, limits to help seeking may be particularly unfavorable. Studies suggest within the juvenile justice system, many barriers exist for mental health help-seeking, with one study reporting 85% of youth with a psychiatric disorder reporting at least one barrier to reaching out for services (Abram, Paskar, Washburn, & Teplin, 2008). Among these barriers are the fear they would be mistreated, or concern about what others might think of them for reaching out.

Rates for Conduct Disorder among the juvenile justice system range from 10% to 91%, with most studies citing the prevalence at 50% to 90% (Edens & Otto, 1997), making the diagnosis one of the most prevalent among juvenile justice populations (Redding et al., 2005). Symptoms of this disorder are often externalizing and may result in aggression or violation of norms (Stoddard-Dare et al., 2011). These violations often include stealing and other behaviors likely to lead these youth to arrest. With proper treatment and services, some of these symptoms may be avoidable. However, when youth, and possibly their families, are unwilling to seek help due to fear of being stigmatized, the risk for delinquency increases. Unfortunately, research suggests individuals with a conduct disorder may be even less likely to seek or adhere to help than youth diagnosed with a different disorder (Burke et al., 2015).

Although failure to adhere to mental health care and medication poses an issue for all, unmet treatment goals may be particularly unfortunate for youth. Foster and others (2004) emphasize the role of efficient treatment in reducing juvenile justice system involvement. The researchers suggest appropriate community care for mental health needs may reduce, or at the least delay, entry into the juvenile justice system. Furthermore, appropriate mental health treatment may reduce recidivism among those who have previously been involved in the system.
However, when treatments needs are unmet, previously mentioned diagnoses of conduct disorder, along with substance abuse, ADHD, and other diagnoses, may increase the risk of deviant or criminal behaviors in youth.

**Family and Peer Support**

Unfortunately, the burden felt by family and friends of stigmatized individuals may result in poor relationships and lack of support (Moses, 2010). For youth, this lack of support may create larger issues, sometimes placing them at risk for delinquent behaviors. Research outlines the critical role of supportive and stable family relationships in protecting at-risk youth and reducing the level of impairment.

On the other hand, risk factors for delinquency also include parental depression and lack of appropriate supervision (Redding et al., 2005). Consistent self-blaming by parents and caregivers for the stigma experienced by their youth may take a toll on self-esteem. This cyclical role of stigma may impact the mental health of the family or caregivers, as well as the youth, ultimately placing the child at a higher risk for juvenile delinquency.

**Purpose and Research Questions**

Youth within the juvenile justice system experience a high prevalence of mental health related issues, as well as childhood exposure to traumatic events (Dierkhising et al., 2013; Shufelt & Cocozza, 2006). Collectively, the research detailed above suggests mental health stigma may play a role in juvenile delinquency. While previous literature has worked to conceptualize adult and youth mental health stigma, little research exists examining the stigma experienced by incarcerated juveniles. The current study examines the perceptions of youth within the juvenile justice system regarding their own experience with mental health stigma.

With previous research in mind, the following research question was developed: Do youth within
the juvenile justice system perceive unmet mental health needs and stigma as playing a role in their incarceration? The researcher was in assessing the perceptions juvenile justice youth hold toward mental health stigma as a factor in their incarceration. The following research hypotheses were developed:

1. Youth who indicate a greater perceived self-stigma of mental health will also indicate stigma played a greater role in their incarceration.
2. Youth with a greater number of adverse childhood experiences will indicate stigma has played a greater role in their incarceration than youth with fewer adverse childhood experiences.
3. Self-stigma will be positively correlated with perceived stigma of mental illness overall.
4. Youth who report being told they have a mental illness will indicate less stigma of mental illness than those youth who indicate no diagnosis.

Method

Participants

Forty-one adjudicated youth (40 males, 1 female) from the Kansas Juvenile Correctional Facility (KJCC) participated in the current study. Youth housed at the facility range in age from 10 to 22 years of age (per Kansas statutes), with majority of youth falling between the ages of 14 to 19 years of age. However, per recommendation of the Kansas Department of Corrections (KDOC), only those youth aged 18 years and up (Mage = 18.67) were allowed to participate, resulting in an age range of 18-20 years for the current sample. The majority of the participants (38.5%) identified as Caucasian, followed by African American (20.5%), Hispanic (12.8%) and Native American/Alaskan Native (2.6%) The rest of the sample (20.5%) identified their ethnicity
as “other”. Of the youth surveyed, 17 indicated having some mental health diagnosis, with 20 reporting no diagnosis and the rest indicating a preferred choice as not to say. Among those surveyed, the median ACE score was four ($M=3.71$). The majority of the youth indicated living in an urban county (22), followed by semi-urban (6), densely-settled rural (5), rural (2), and frontier (2), with five youth indicating no location. Over one quarter (36.6%) of youth surveyed indicated a sentence length of 36 months or greater. This was followed by a sentence of 6-12 months (9.8%), 12-18 months (7.3%) and 3-6 months (7.3%), and 0-3 months (2.4%).

Over half of the youth surveyed (63.4%) disagreed or strongly disagreed with the statement: “The officer(s) who arrested me understood me.” Further, nearly half of the youth indicated feeling neutrally that the mental health services in the state were beneficial to them (47.5%) and that the information they were told about their mental illness were different than before coming to the facility (45%). Among the youth sampled, nearly one-third (29.3%) indicated strong disagreement that the way people treated them because of their mental illness was part of the reason they were placed at the facility.

**Recruitment and Procedures**

Following IRB and KDOC approval (Appendices A and B), the principal investigator contacted the juvenile facility to obtain consent to conduct research. The principal investigator visited all units at the facility across a span of two days to read the recruiting script and introduce the study to all youth aged 18 years and up. Interested youth were escorted to the small classroom on the unit.

After being read the consent form (Appendix C), youth interested in participating were given the opportunity to ask questions about the study. Then, youth spent approximately 20
minutes completing a paper-and-pencil survey. The principal investigator read the questions to youth to account for possible low reading levels and to promote understanding.

**Materials**

**Demographic Questionnaire.** Participants answered a series of demographic questions to assess basic information (e.g. gender, age, ethnicity). Additionally, participants were asked to indicate where they resided while growing up prior to incarceration and whether or not they have been diagnosed with a mental illness. Questions assessing the participants’ views on their own experience with mental health treatment both in the community and while at the juvenile correctional facility were also included. Short answer questions were included to allow participants to reflect on the mental health services they have received.

**Attitudes about Child Mental Health Questionnaire (ACMHQ).** Participants completed an adapted version of the ACMHQ (Heflinger, Wallston, Mukolo, & Brannan, 2014), a 30-item scale examining various aspects of mental health stigma. Scale questions were broken into four categories: Child Dangerousness/Incompetence, General Stereotypes, Community Devaluation/Discrimination, and Personal Attitudes. For the current study, items measuring Dangerousness/Incompetence and General Stereotypes were included. The internal consistency of these subscales, measured by Cronbach’s alpha, is high (.81 and .87, respectively). Items were measured on a 5-point Likert scale (1 = Strongly disagree; 6 = Strongly agree). Questions were adapted to include perceptions of peers at the facility, rather than youth in general. Additionally, questions were adapted to fit the reading level of the respondents at the facility. One example from the adapted questionnaire includes: “My peers who have a mental illness are troublemakers.”
Mental Health Knowledge and Attitude Test (MHKAT). Participants also completed an adapted version of the MHKAT (Penn, Esposito, Stein, Lacher-Katz, & Spirito, 2005; (0.94), a 12-item scale assessing individual knowledge and attitudes about mental health needs among youth in the juvenile justice system. Items were measured on a 5-point Likert scale (1 = Strongly agree; 5 = Strongly disagree). Negative items were reverse scored and then added with positive items to create an overall total MHKAT score. Again, items from the scale were adapted to fit the reading level of the respondents. Additionally, some scale items were not included, as the original scale was targeted at juvenile correctional staff, rather than youth within the facility, and are not relevant for the purpose of the current study. One example from the original questionnaire includes: “Better mental health care fosters rehabilitation.” This was adapted to “Better mental health care would help kids improve their behaviors and prevent reoffending.”

Adverse Childhood Experience (ACE) Questionnaire. Participants responded to the ACE Questionnaire, a 10-item retrospective scale designed to measure negative childhood experiences, including sexual, physical, and/or emotional abuse, household mental illness, parental separation, household substance abuse, a household member with a history of jail/imprisonment, domestic violence, and substance abuse. The scale is dichotomized into yes/no answers measured from zero to 10. That is, respondents responded yes or no to each of the 10 items. A “yes” answer indicates exposure to the adverse event and was scored as a one; a “no” answer indicates the respondent had not been exposed to this event and will be scored as a zero. The total number of exposures were added at the end to derive the respondent’s overall ACE score. An example from the questionnaire includes: “Did a parent or other adult in the household often push, grab, slap, or throw something at you?”
Internalized Stigma of Mental Illness (ISMI) Scale. Participants completed a shortened version of the ISMI scale, a 29-item questionnaire intended to measure internalized mental illness stigma (Chang, Wu, Chen, Wang, & Lin, 2014). The original scale was made up of five unique subscales: Alienation, Stereotype Endorsement, Discrimination Experience, Social Withdrawal, and Stigma Resistance. Participants in the current sample responded to items assessing only the Alienation subscale (α = 0.94), as these items were most closely linked with the current research question. Items were measured on a 4-point Likert type scale (1 = Strongly agree; 4 = Strongly disagree). One example from the questionnaire includes: “I am embarrassed or ashamed that I have a mental illness.” Participants who did not identify as having a mental illness were instructed to skip this portion of the survey.

Dependent Variable. To assess the influence mental health stigma may have had on youth incarceration, a self-constructed item was created. Participants were asked to indicate their agreement toward the statement: The way people treated me because of my mental illness was part of the reason I was placed at KJCC. Responses to this statement were measured on a 5-point Likert scale (1 = Strongly agree; 5 = Strongly disagree).

Results

Hypothesis Testing

Mean scores were calculated for the perceived stigma subscales (dangerousness and general stereotypes) and the MHKAT. Youth indicated overall positive perceptions of youth mental health in areas of dangerousness \((M = 3.11, SD = 1.08)\) and general stereotypes \((M = 3.94, SD = .73)\). Additionally, youth indicated overall positive beliefs on the MHKAT \((M = 2.83, SD = -.89)\). Youth either felt neutral or somewhat agreed with statements assessing items like need for better mental health care, screening, or suicide precautions. Youth scores on the
internalized stigma measure indicated that youth experiencing self-stigma either felt neutral or disagreed that it impacted their life ($M = 3.68, SD = .81$).

A series of bivariate correlations were performed to test the hypotheses (Table 1). First, the relationship between internalized stigma ($M = 3.96, SD = .92$) and the belief that stigma played a role in incarceration ($M = 4.19, SD = 1.08$) was assessed and found to be not significant, $r(21) = .18, p = .44$. It was hypothesized that youth who indicated a greater perceived self-stigma of mental health would also indicate stigma played a greater role in their incarceration. However, no significant correlation between these variables were found indicating no significant relationship.

Further, the relationship between ACEs ($M = 3.71, SD = 2.44$) and the belief that stigma played a role in incarceration ($M = 4.19, SD = 1.08$) was assessed to test the second hypothesis. It was hypothesized youth with a greater number of adverse childhood experiences would indicate stigma has played a greater role in their incarceration than youth with fewer adverse childhood experiences. However, analyses revealed the correlation between these variables was not significant ($r[41]= -.28, p = .21$).

It was hypothesized that self-stigma and perceived stigma would be positively correlated. However, only marginal significance was found between self-stigma ($M = 3.96, SD = .92$) and perceived stigma of dangerousness ($M = 3.11, SD = 1.08$), $r[21]= .39, p = .08$. Further, the relationship between self-stigma ($M = 3.96, SD = .92$) and perceived stigma of general stereotypes ($M = 9.94, SD = .73$) was revealed to be not significant, $r[21]= .22, p = .32$. Thus, the third hypothesis of the current study was not supported.

Finally, individuals who reported a being told they have a mental health diagnosis were compared with those who did not. Independent samples t-tests revealed no difference in
perceived stigma between those youth who indicated being told they have a mental health diagnosis ($M = 3.00, SD = .88$) and those who did not ($M = 3.32, SD = 1.30$) on perceived stigma of dangerousness ($t[33.53] = -.88, p = .39$). Similarly, no difference was found between those youth who indicated being told they have a mental health diagnosis ($M = 3.78, SD = .83$) and those who did not ($M = 4.06, SD = .71$) on perceived stigma of general stereotypes ($t[35] = -1.09, p = .29$).

Table 1

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Exploratory Analyses

Because the original hypotheses failed to be supported, a series of exploratory analyses were conducted. ACE scores for those youth indicating an experience with self-stigma on the ISMI scale ($n=21$) were filtered and then analyzed separately using a series of simple linear regressions. When assessing whether ACEs were able to predict the belief that mental health treatment had an influence on incarceration, the regression analysis became significantly predictive, $r = -.50, t(20) = -2.49, p = .02$. The $R^2$ for this equation was .25, indicating about 25% of the variance in the belief that mental health treatment had an influence on incarceration was
able to be predicted by ACEs. Of this small group, those who indicated a higher ACE score also indicated a stronger belief that the way they were treated because of their mental illness played a role in their incarceration. The 95% confidence interval for this prediction ranged from -.486 to -.042. For each increase in ACE scores, the belief that the way they were treated because of their mental illness increased by about .04 to .50.

Further, the influence of ACE scores on sentence length was also examined. For the purpose of exploration, the researcher examined only those youth who indicated a sentence of 36 months or greater (n=13, \( M = 60.08, SD = 20.79 \)). Interestingly, ACE scores were predictive of sentence length among those youth who indicated a sentence of 36 months or longer, \( r = .77, t(12) = 4.02, p = .002 \). The regression equation for predicting sentence length based on ACEs was found to be \( Y' = 37.06 + 5.89+X \). The \( R^2 \) for this equation was .60; thus, 60% of the variance in sentence length was able to be predicted by ACE scores. The 95% confidence interval for the slope to predict sentences longer than 36 months from ACEs ranged from 2.667 to 9.117; thus, for each one increase in ACE scores, length of sentence increased from about three months to about nine months.

Discussion

The current study sought to conceptualize experiences of juvenile justice-involved youth related to mental health stigma, trauma, and their incarceration. The hypothesis that youth who indicated a greater perceived self-stigma would indicate stigma played a greater role in their incarceration was not supported. Additionally, the hypothesis that youth with a higher number of ACE experiences would indicate stigma has played a greater role in their incarceration was also found to be not significant. The third hypothesis was not supported — self-stigma was not related to perceived stigma of mental illness overall.
No difference was found between youth who reported a diagnosed mental illness and those who did not on perceived stigma measures, failing to support the fourth hypothesis. When making sense of these pieces, it is important to note the minimal presence of stigma within the sample. Overall, the sample indicated minimal stigmatic perceptions of youth with a mental illness — an important finding not often referenced in previous literature and perhaps able to explain the lack of significant differences in this area. Readers should consider the possibility of underreported mental illness within the sample. Burke, Mulvey, and Schubert (2015) assessed mental illness among juvenile justice-involved youth and compared this to reports from parents, finding youth often downplayed or failed to report a diagnosis. Youth within the current sample may have falsely indicated no diagnosis, skewing the results in this area.

Despite lacking support for the original research hypotheses, exploratory analyses revealed interesting contributions. When assessing only those youth indicating an experience with self-stigma of a mental illness, ACEs were able to predict the influence mental health stigma had on incarceration. The more a youth indicated feeling the presence of self-stigma, the more they felt treatment surrounding their mental illness influenced their incarceration. To the authors knowledge, this finding is unique to the current sample of data and should be further examined in future studies. Similar to the role of public stigma in increased self-stigma (Corrigan & Watson, 2002), negative experiences resulting from early life trauma may lead to an increase in internalized feelings. Future literature should work to conceptualize links between internalized stigma and ACEs.

Further exploratory findings revealed ACE scores were predictive of sentence length for those youth with a sentence of 36 months or longer. This finding mimics earlier research by Duke and colleagues (2010) – even the addition of one ACE may lead youth to engage in more
violent or aggressive acts, sometimes leading to incarceration. As a result of traumatic experiences prior to the age of 18 years, these youth are thrust deeper into the system. These findings underscore the need to provide interventions to at-risk individuals early in life to decrease delinquent behavior, reoffending, and overall life outcomes.

The current study is not without limitations. Due to KDOC recommendations, only those youth above the age of 18 years were allowed to participate in the study. As such, the sample was small, limiting the generalizability of the findings. Valuable information would be gleaned from examining experiences of younger youth in the system. Future studies should continue to examine perceptions of mental health treatment, stigma, and abuse in conjunction with juvenile justice variables. Additionally, the current study fell short when attempting to conceptualize gender differences — only one female took part in the study. At the facility, only one unit is used to house females. Of this small number, only one female was 18 years of age at the time the survey took place. It is imperative future studies dive deeper into gendered experiences of youth mental health attitudes, treatment, and trauma. Previous literature speaks to differences in male and female trauma experiences and the pipeline to incarceration (see Saar, Epstein, Rosenthal, & Vafa, 2015).

**Conclusion**

In the United States, the criminal justice system continues to serve as the nation’s largest mental health institution — both for juveniles and for adults (see Al-Rousan, Rubenstein, Sieleni, Deol, & Wallace, 2017; Torrey, Kennard, Lamb & Pavle, 2010). As such, knowledge on juvenile justice youth perceptions of youth mental illness is both timely and imperative for treatment improvement when working with this understudied group. While findings from the current study only begin to shed light unto mental health experiences of youth, literature outlining the
influence of trauma on juvenile delinquency continues to flourish (see Baglivio Epps, 2016). Increased trauma experiences push youth deeper into the system. Yet, society appears to place minimal emphasis on helping youth receive proper resources prior to incarceration and upon reentry (Farn & Adams, 2016), especially for youth with learning or emotional disabilities (Mathur, Griller Clark, Hartzell, LaCroix, & McTier, 2019). While youth perceptions of mental illness were overall positive in the current study, stigma of mental illness continues to plague society as a whole (see Corrigan & Watson, 2002; Muralidharan et al., 2017). Increased knowledge on how to reach youth avoiding treatment or improving unmet treatment, both prior to and following incarceration, may help to improve behaviors and prevent delinquent activities.

It is essential to examine mental health experiences and attitudes of those youth in the system and to use this information to inform and improve standing policies and trainings. However, what may be more vital is a preventative approach to juvenile incarceration. Future studies in this area should continue to examine how these experiences guide youth into the system. Efforts for a societal initiative providing more trauma-informed training and better understanding of youth experiences among those working with youth in the community continues to be warranted.
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Mental Health Stigma


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Appendix A – IRB Approval Letter

Thank you for your submission of New Project materials for this research study. Fort Hays State University IRB has APPROVED your submission. This approval is based on an appropriate risk/benefit ratio and a study design wherein the risks have been minimized. All research must be conducted in accordance with this approved submission.

- The IRB committee recommends removing the line from the assent that youth may include their name on the assent form.

This submission has received Full Committee Review based on the applicable federal regulation.

Please remember that informed consent is a process beginning with a description of the study and insurance of participant understanding followed by a signed consent form unless documentation of consent has been waived by the IRB. Informed consent must continue throughout the study via a dialogue between the researcher and research participant. Federal regulations require each participant receive a copy of the signed consent document. The IRB-approved consent document must be used.

Please note that any revision to previously approved materials must be approved by this office prior to initiation. Please use the appropriate revision forms for this procedure.

All SERIOUS and UNEXPECTED adverse events must be reported to this office. Please use the appropriate adverse event forms for this procedure. All FDA and sponsor reporting requirements should also be followed.

Please report all NON-COMPLIANCE issues or COMPLAINTS regarding this study to this office.

Please note that all research records must be retained for a minimum of three years.

Based on the risks, this project requires Continuing Review by this office on an annual basis. Please use the appropriate renewal forms for this procedure.
Appendix B – DOC Approval Letter

July 30, 2019

Ashley Lockwood
Department of Criminal Justice
Fort Hays State University
600 Park Street

Subject: Research request KJCC Mental Health and Stigma

Dear Ashley,

After being reviewed by the Management team of the Kansas Department of Corrections (hereafter KDOC), I am writing to you to inform you of the KDOCs decisions in regards to your research application.

In responses to your application it was noted that the KDOC IMPP 06-101D that governs research requests and what research the KDOC will allow or deny states the following in Section III:

C. Use of subjects who are legally unable to give the informed consent (e.g., under the age of 18 or mentally incompetent) shall be prohibited. (ACO 2-4E-01, ACI 3-4372, NCCHC P-70)

In light of this, it was decided to permit the research to proceed, with the provision/alteration to the research that only those aged 18 years old or older (The participants must have passed their 18th birthday at the time of participation in this research) are to be participants in this research.

If you have any questions or concerns, please contact Sean Christie (sean.christie@ks.gov).

Yours

Jeff Zmuda
Acting Secretary of Corrections

cc: Sean Christie, Director of Research and Behavior Analytics
Appendix C – Consent Form

CONSENT TO PARTICIPATE IN RESEARCH
Department of Psychology, Fort Hays State University

Study title: Perceptions of Mental Health of Incarcerated Youth

Name of Researcher: Ashley Lockwood
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You are being asked to participate in a research study. Before you give your consent it is important that you read the following information and ask as many questions as necessary to be sure you understand what you will be asked to do. It is your choice whether or not to participate in the study. Your decision to participate will have no impact on your standing at KJCC or your length of time spent there.

What is the purpose of this study?
The current study seeks to examine the perceptions of individuals within the juvenile justice system regarding their own experience with mental illness stigma. Specifically, researchers are interested in assessing the mental health services youth have received and the role mental health stigma may have played in their journey to incarceration.

What does this study involve?
If you decide to participate in this research study, you will be asked to sign this consent form after you have had all your questions answered and understand what will happen to you. The length of time for participation in this study is about 20 minutes. Approximately 100 participants will be in this study.

Are there any benefits from participating in this study?
The findings from this study may help to improve conceptualizations of youth mental health stigma in comparison to stigma felt by adult individuals. Results from the study could be used to promote policy changes or improve training for those providing services to youth within the juvenile justice system. Finally,
knowledge gained from the study will help to promote better treatment of youth both prior to and during their time incarcerated. Improved treatment and mental health resources may be beneficial in decreasing engagement in delinquent activities.

**Will you be paid or receive anything to participate in this study?**
Participants will receive no compensation from the research team for participation in the study.

**What are the risks involved with being enrolled in this study?**
It is unlikely that participation in this project will result in any harm to you. However, survey questions included in this study may be distressing to some participants. Questions determined to be personal will include a “prefer not to say” option. Participants may skip any questions they do not feel comfortable answering and may withdraw from the study at any point without penalty. You may contact the faculty research team and/or the Psychology Department Ethics Chair with. Please see below for contact information for these resources.

**How will your privacy be protected?**
No names or identifying information will be asked. Responses to survey questions will be entered into a computer program and stored for 3 years, after which the data will be deleted. Only the principal investigator and faculty advisor will have access to the database. Results of the survey will be shared with the scientific community through presentation and possible publication. When results are shared, information will be presented in aggregate form and will contain no names or identifying information.

Permission granted on this date to use and disclose your information remains in effect indefinitely. By signing this form you give permission for the use and disclosure of your information for purposes of this study at any time in the future.

**Other important items you should know:**
- **Withdrawal from the study:** You are free to withdraw your consent and to discontinue his/her participation at any time and without any penalty. Your decision to stop your participation will have no effect on your standing at KJCC or impact them in any way.
• **Funding:** There is no outside funding for this project.

**Whom should you call with questions about this study?**
Questions about this study may be directed to the researcher in charge of this study: Ashley Lockwood (avlockwood@mail.fhsu.edu) or the faculty advisor of the project (bmmann@fhsu.edu).

If you have questions, concerns, or suggestions about human research at FHSU, you may call the Office of Scholarship and Sponsored Projects at FHSU (785) 628-4349 during normal business hours.

**CONSENT**
I have read the above information about *Perceptions of Mental Health of Incarcerated Youth* and have been given an opportunity to ask questions. By signing this I agree to participate in this study. I have been given a copy of this signed consent document for my own records. I understand I can change my mind and withdraw my consent at any time. By signing this consent form I understand that I am not giving up any legal rights.

Participant’s signature and date
Appendix D – Demographic Questionnaire

Please answer the following questions about your general background.

1. Gender
   1 - Male
   2 - Female
   3 – Other __________

2. Age ______

3. Sexual Orientation
   1 - Lesbian
   2 - Gay
   3 - Bisexual
   4 - Straight
   5 – Other __________

4. Ethnicity
   1 - Caucasian
   2 - African American
   3 - Asian/Pacific Islander
   4 - Hispanic
   5 - Native American/Alaskan Native
   6 – Other

5. What is the name of the Kansas county where you spent most of your youth (If you do not know the county, what town did you live in?)

______________________________

6. What ages did you spend living in the above location?

______________________________

7. At what age were you placed at KJCC?

______________________________

Please briefly describe why you were placed at KJCC.
8. How long is your sentence at KJCC?
   1 – 0-3 months
   2 – 3- 6 months
   3 – 6-12 months
   4 – 12 - 18 months
   5 – 18- 36 months
   6 – 36+ (please specify:___________)

9. Have you ever been told you have a mental illness?
   1 - yes
   2 - no
   3 - prefer not to say

10. If you answered yes to the above question, what have you been told about the mental illness(es) you have?

11. Prior to coming to KJCC, did you receive any mental health services in the state of Kansas?
   1 - yes
   2 - no
   3 - prefer not to say
   4 – not applicable

12. If you answered yes to the above question, what services did you receive?
13. The mental health services in the state of Kansas were beneficial to me.
   1 - Strongly Agree
   2 - Somewhat Agree
   3 - Neutral
   4 - Somewhat Disagree
   5- Strongly Disagree
   6 - Not applicable

14. The things I have been told about my mental health at KJCC are different than what I was told before being at KJCC.
   1 - Strongly Agree
   2 - Somewhat Agree
   3 - Neutral
   4 - Somewhat Disagree
   5- Strongly Disagree
   6- Not applicable

15. The officer(s) who arrested me understood me.
   1 - Strongly Agree
   2 - Somewhat Agree
   3 - Neutral
   4 - Somewhat Disagree
   5- Strongly Disagree

17. Since being at KJCC, have you received mental health services?
   1 - yes
   2 - no
   3 - prefer not to say
   4 – Not applicable

18. The mental health services at KJCC are helpful to me.
   1 - Strongly Agree
   2 - Somewhat Agree
   3 - Neutral
   4 - Somewhat Disagree
   5- Strongly Disagree
   6 – Not applicable
19. I have been treated differently at KJCC because of my mental illness.
   1 - Strongly Agree
   2 - Somewhat Agree
   3 - Neutral
   4 - Somewhat Disagree
   5 - Strongly Disagree
   6 - Not applicable

20. I have been treated differently because of my mental health in general.
   1 - Strongly Agree
   2 - Somewhat Agree
   3 - Neutral
   4 - Somewhat Disagree
   5 - Strongly Disagree
   6 – Not applicable

21. The way people treated me because of my mental illness was a part of the reason I was placed at KJCC.
   1 - Strongly Agree
   2 - Somewhat Agree
   3 - Neutral
   4 - Somewhat Disagree
   5 - Strongly Disagree
   6 – Not applicable
Appendix E – Attitudes about Child Mental Health Questionnaire (ACMHQ) - Adapted

When my peers have problems with a mental illness it is because their parents did not raise them well.
1 - Strongly Agree
2 - Somewhat Agree
3 - Neutral
4 - Somewhat Disagree
5- Strongly Disagree

When my peers have problems with a mental illness it is due to lack of mental health help.
1 - Strongly Agree
2 - Somewhat Agree
3 - Neutral
4 - Somewhat Disagree
5- Strongly Disagree

My peers with a mental illness are not as smart as other youth.
1 - Strongly Agree
2 - Somewhat Agree
3 - Neutral
4 - Somewhat Disagree
5- Strongly Disagree

My peers with a mental illness don’t do as well in school.
1 - Strongly Agree
2 - Somewhat Agree
3 - Neutral
4 - Somewhat Disagree
5- Strongly Disagree

My peers with a mental illness are not hard workers.
1 - Strongly Agree
2 - Somewhat Agree
3 - Neutral
4 - Somewhat Disagree
5- Strongly Disagree

My peers who have a mental illness will not be successful as adults.
1 - Strongly Agree
2 - Somewhat Agree
3 - Neutral
4 - Somewhat Disagree
5- Strongly Disagree
My peers who have a mental illness are trouble makers.
1 - Strongly Agree
2 - Somewhat Agree
3 - Neutral
4 - Somewhat Disagree
5 - Strongly Disagree

Some parents of youth with a mental illness are not fully accepted by their relatives.
1 - Strongly Agree
2 - Somewhat Agree
3 - Neutral
4 - Somewhat Disagree
5 - Strongly Disagree

Families of youth with a mental illness should be discouraged from attending community events.
1 - Strongly Agree
2 – Somewhat Agree
3 - Neutral
4 - Somewhat Disagree
5 - Strongly Disagree

Youth with a mental illness should be discouraged from attending community events.
1 - Strongly Agree
2 – Somewhat Agree
3 - Neutral
4 - Somewhat Disagree
5 - Strongly Disagree

Some teachers at KJCC would rather not have a youth with a mental illness in their classroom.
1 - Strongly Agree
2 - Somewhat Agree
3 - Neutral
4 - Somewhat Disagree
5 - Strongly Disagree

Some teachers do not want to deal with parents of youth who have a mental illness.
1 - Strongly Agree
2 - Somewhat Agree
3 - Neutral
4 - Somewhat Disagree
5 - Strongly Disagree
Some teachers think less of parents of youth with a mental illness.
1 - Strongly Agree
2 - Somewhat Agree
3 - Neutral
4 - Somewhat Disagree
5- Strongly Disagree

Some adults treat my peers with a mental illness differently.
1 - Strongly Agree
2 - Somewhat Agree
3 - Neutral
4 - Somewhat Disagree
5- Strongly Disagree

A youth with a mental illness will do something violent to him/herself.
1 - Strongly Agree
2 – Somewhat Agree
3 - Neutral
4 - Somewhat Disagree
5- Strongly Disagree

A youth with a mental illness will do something violent to others.
1 - Strongly Agree
2 – Somewhat Agree
3 - Neutral
4 - Somewhat Disagree
5- Strongly Disagree
Appendix F - Mental Health Knowledge and Attitude Test (MHKAT) - Adapted

For each question, circle the appropriate number indicating your degree of agreement toward each statement in general.

In general, mental illness has an influence on juvenile delinquency.
1 - Strongly Agree
2 - Somewhat Agree
3 - Neutral
4 - Somewhat Disagree
5 - Strongly Disagree

In general, my peers use suicide to con/manipulate others.
1 - Strongly Agree
2 - Somewhat Agree
3 - Neutral
4 - Somewhat Disagree
5 - Strongly Disagree

When my peers feel suicidal, they should be sent for an evaluation.
1 - Strongly Agree
2 - Somewhat Agree
3 - Neutral
4 - Somewhat Disagree
5 - Strongly Disagree

There is a need for increased mental health treatment for youth in the juvenile justice system.
1 - Strongly Agree
2 - Somewhat Agree
3 - Neutral
4 - Somewhat Disagree
5 - Strongly Disagree

Better mental health care would help kids improve their behaviors and prevent recidivism.
1 - Strongly Agree
2 - Somewhat Agree
3 - Neutral
4 - Somewhat Disagree
5 - Strongly Disagree
Appendix G - Adverse Childhood Experience (ACE) Questionnaire

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household often…
   Swear at you, insult you, put you down, or humiliate you?
   or
   Act in a way that made you afraid that might be physically hurt?
   Yes  No

2. Did a parent or other adult in the household often…
   Push, grab, slap, or throw something at you?
   or
   Ever hit you so hard that you had marks or were injured?
   Yes  No

3. Did an adult or person at least 5 years older than you ever…
   Touch or fondle you or have you touch their body in a sexual way?
   or
   Try to or actually have oral, anal, or vaginal sex with you?
   Yes  No

4. Did you often feel that…
   No one in your family loved you or thought you were important or special?
   or
   Your family didn’t look out for each other, feel close to each other, or support each other?
   Yes  No

5. Did you often feel that…
   You didn’t have enough to eat, had to wear dirty clothes, and had no one to protect you?
   or
   Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
   Yes  No

6. Were your parents ever separated or divorce?
   Yes  No

7. Was your mother or stepmother:
   Often pushed, grabbed, slapped, or had something thrown at her?
   or
   Sometimes or often kicked, bitten, hit with a fist, or hit with something hard?
   Yes  No
8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?
   Yes  No

9. Was a household member depressed or mentally ill or did a household member attempt suicide?
   Yes  No

10. Did a household member go to prison?
    Yes  No
Appendix E – Internalized Stigma of Mental Illness (ISMI) Questionnaire – Adapted

For each question, circle the appropriate number indicating your degree of agreement toward each statement in general. If you have not been diagnosed with a mental illness or do not feel you struggle with symptoms of a mental illness, please skip the following questions.

I feel out of place in the world because I have a mental illness.
   1 - Strongly Agree
   2 - Somewhat Agree
   3 - Neutral
   4 - Somewhat Disagree

Having a mental illness has spoiled my life.
   1 - Strongly Agree
   2 - Somewhat Agree
   3 - Neutral
   4 - Somewhat Disagree

People without a mental illness could not possibly understand me.
   1 - Strongly Agree
   2 - Somewhat Agree
   3 - Neutral
   4 - Somewhat Disagree

I am embarrassed or ashamed that I have a mental illness.
   1 - Strongly Agree
   2 - Somewhat Agree
   3 - Neutral
   4 - Somewhat Disagree

I am disappointed in myself for having a mental illness.
   1 - Strongly Agree
   2 - Somewhat Agree
   3 - Neutral
   4 - Somewhat Disagree

I feel inferior to others who don’t have a mental illness
   1 - Strongly Agree
   2 - Somewhat Agree
   3 - Neutral
   3 - Somewhat Disagree
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