Compassionate Advocacy: Predictors of Mental Health Stigma and Empowerment Among Public Defenders and Law Students

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Abstract

Individuals with psychiatric diagnoses are often stigmatized, and they are also markedly overrepresented in the criminal justice system. Public defense attorneys may be the final line of defense against incarceration, although they tend to receive little, if any, training on mental health during law school. A combination of education and contact has been shown to reduce psychiatric stigma-related attitudes in many fields, although a defense attorney's ability to zealously advocate for their disadvantaged clients may also be explained through the psychological construct of compassion. Samples of public defense attorneys and law students were surveyed to examine to what degree familiarity (i.e., a combination of contact and education) and compassion would predict stigmatizing and empowering attitudes towards individuals with mental health diagnoses. Compassion was a powerful inverse predictor of stigmatizing and empowering attitudes, that appeared to exert greater influence than contact and education in both populations. In attorneys, lower levels of compassion as a moderator increased the influence of familiarity on stigma, and mean and higher levels of compassion were associated with lower stigma, regardless of the level of familiarity in either population. These findings could be used to better tailor law school and continuing legal education curriculum to increase mental health and compassion-focused training to potentially improve attorneys' abilities to advocate for their clients.

Keywords: stigma, compassion, mental health, attorneys

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Where social institutions grapple to delineate and classify various deviations of "acceptable" versus "unacceptable" human behavior, the criminal justice system and the mental health system find frequent overlap. New York City, home to the Rikers Island jail complex, stands as a useful example. Of the city's 9,500 average daily jail population in 2017, 42% were classified as having a "mental health diagnosis," while 10.3% were diagnosed with a "serious mental illness" (New York City Mayor's Office of Operations, 2017). National rates are similar, with 37% of prisoners and 44% of jail inmates reporting a history of a mental health diagnosis; a prevalence rate of three to five times that found in the general U.S. population (Bronson & Berzofsky, 2017). As the burden to address mental health needs shifts from community and state-funded mental health facilities to the nation's over 6,000 jails and prisons, the criminal justice system has become the nation's *de facto* mental health system (Wagner & Sawyer, 2018). With considerations of the often-slow-moving shifts that must happen on many fronts to change this trend (e.g., government funding, public attitudes, legal regulations), there are – and will continue to be for the foreseeable future – a large number of individuals struggling with psychological difficulties, who find themselves arrested and facing a complicated road ahead through the criminal justice system.

Criminal Defendants with Mental Health Needs

Navigating the criminal justice system post-arrest can be daunting, especially for those who may be simultaneously experiencing significant psychological distress. Throughout the legal process, there exist several points at which mental health-related intervention and diversion from criminal incarceration can occur (Council of State Governments, 2002; Munetz & Griffin,

2006). A pivotal point in a criminal defendant's legal timeline – and likely the first involving meaningful interaction with non-law enforcement personnel – is the appointment of counsel (Broner, Lamon, Mayrl, & Karopkin, 2002). All criminal defendants have the right to competent legal counsel, regardless of their ability to afford representation (*Gideon v. Wainwright*, 1963; *Strickland v. Washington*, 1984), and indigent defenders (counsel appointed to defendants who cannot afford private attorneys) account for approximately 80 to 90% of representation in criminal felony cases (Harlow, 2001; Spangenberg & Beeman, 1995).

Public defenders face burdensome financial constraints, high caseloads, and inadequate resources, with estimates that in some jurisdictions, legal needs are not met for as many as 80% of low-income individuals (American Bar Association, 2016; Marcus, 1994). These conditions can have a significant negative impact on defendants with disproportionately low incomes, such as those with higher levels of psychological distress and/or diagnosed with more severe mental disorders (Cook, 2006; Kessler, Chiu, Demler, & Walters, 2005; Levy & Rowitz, 1973; Regier et al., 1993).

Public defense counsel serve an extremely wide variety of clients, although it is unclear what typical percentage of their case load might include individuals with mental health concerns. However, a survey of members of the South Carolina bar found that public defenders were 6.8 times more likely than private defense attorneys to have worked on greater than six mental health-related cases (Frierson, Boyd, & Harper, 2015). While more experienced attorneys (i.e., those who had worked on more than six mental health-related cases) were less opposed to working with this population, half of all surveyed attorneys stated that they would prefer to work with individuals without a psychiatric diagnosis.

The desire to avoid clients who have a psychiatric diagnosis may negatively affect an attorney's abilities (especially less experienced attorneys) to advocate for them (Frierson et al., 2015). This desire may be difficult to reconcile with the American Bar Association's Model Rules of Professional Conduct (2018), which states that attorneys must zealously advocate for their clients. This issue may be partially due to the education, or lack thereof, provided on mental health and mental health law throughout law school. In a sample of South Carolina prosecutors, public and private defense attorneys, and judges, 74% reported never receiving instruction in law school about mental illness, 83% never received instruction in law school on mental health law, and 83% believed their education about mental health issues was inadequate (Frierson et al., 2015). A similar study with Mississippi public defenders, prosecutors, and judges found that 81% reported not having received any formal instruction on issues related to mental health during law school, and 76% reported receiving training on the matter after completing law school (Batastini, Lester, & Thompson, 2017). Many states are actively focused on improving these outcomes, with a recent census of the 28 state-based public defense agencies (and the District of Columbia) conducted by the Bureau of Justice Statistics finding that almost all (23) offered professional development training on "mental illness" (Strong, 2016, p. 26). Additionally, many attorneys have recognized the importance of mental health education, noting that clients with psychiatric diagnoses often receive inadequate attention "because they are stigmatized by criminal justice officials with little experience dealing with mental illness" (Denckla & Berman, 2001, pp. 6–7).

Psychiatric Stigma

The stigmatization of individuals exhibiting psychological distress has a long history (see Foucault, 2009). Goffman's (1963) definition of stigma refers to an "attribute that is deeply

discrediting," which causes the bearer to be "reduced in our minds from a whole and usual person to a tainted, discounted one" (p. 3). Importantly, Goffman adds that contact with stigmatized others can be so potentially uncomfortable to both parties, that each would seek to avoid such interactions, leading to many obvious negative consequences. Stigma is a complex social phenomenon, with both interpersonal and intergroup processes based on affective, cognitive, and behavioral responses (Dovidio, Major, & Crocker, 2000). Stigma processes can be understood as consisting of *stereotypes* (e.g., perceptions or beliefs about groups of people), *prejudice* (e.g., negative affective reactions, evaluations, or attitudes based on stereotypes), and *discrimination* (e.g., negative behaviors informed by prejudice) (Corrigan, Roe, & Tsang, 2011; Ottati, Bodenhausen, & Newman, 2005).

Stigmatizing stereotypes are prevalent among the general public, with mass media accounting for the large majority of information people receive about mental health (Reavley, Cvetkovski, & Jorm, 2011), much of it negative (Ma, 2017; Wahl, 2003). The stereotype most commonly associated with the "mental illness" label is that these individuals are dangerous and unpredictable (Link, Phelan, Bresnahan, Stueve, & Pescosolido, 1999; Parcesepe & Cabassa, 2013). With this association of dangerousness comes prejudicial feelings of fear, which, in turn, drive a desire to maintain social distance (Angermeyer & Matschinger, 1996; Corrigan, Markowitz, Watson, Rowan, & Kubiak, 2003). An additional commonly held stereotype about individuals with psychiatric diagnoses is a belief that to some degree, they are accountable for the development or course of their "illness." This stereotype contributes to subsequent attributions of blame and pity, as well as the favor of restrictive, controlling, or involuntary treatment (Corrigan et al., 2002; Lepping, Steinert, Gebhardt, & Röttgers, 2004).

Through stereotypes, prejudice, and discrimination, stigma towards individuals with psychiatric diagnoses has been related to many adverse outcomes. For example, those with mental health diagnoses experience difficulty in finding housing and employment (Page, 1996; Wahl, 1999), and tend to receive generally lower quality of care in medical and mental health settings (Daumit et al., 2006; Dickerson, Sommerville, Origoni, Ringel, & Parente, 2002; Druss, Rosenheck, Desai, & Perlin, 2002; Parks, Svendsen, Singer, Foti, & Mauer, 2006; Schulze, 2007). The discriminatory outcomes in mental healthcare likely stem from some of the prejudicial attitudes held by mental healthcare providers (see Wahl & Aroesty-Cohen, 2010 for a review). Several studies have found that mental health professionals (e.g., psychiatrists, psychologists, mental health nurses, assertive community treatment staff, and other therapists) endorsed negative stereotypes and attitudes similar to those of the general public (Lauber, Nordt, Braunschweig, & Rossler, 2006; Mittal et al., 2014; Stull, McGrew, Salyers, & Ashburn-Nardo, 2013). Moreover, some studies found that specific professional groups, including primary care physicians, primary care nurses, and psychiatrists, endorsed more stigmatizing attitudes than other professionals (Mittal et al., 2014; Smith, Mittal, Chekuri, Han, & Sullivan, 2016).

Stigmatizing attitudes and behavior in criminal justice. In the criminal justice system, psychiatric stigma is frequently seen in harsher sentencing, increased rates of wrongful accusation and conviction, and disproportionately larger arrest rates (Rabkin, 1979; Slate, Buffington-Vollum, & Johnson, 2013; Sosowsky, 1980; Steadman, 1981; Teplin, 1984, 2000). Research by Ruiz and Miller (2004) and Watson, Corrigan, and Ottati (2004) found that while police officers seem to be generally ambivalent towards individuals with psychiatric diagnoses, they also tend to endorse similar attitudes to the general public in associating a diagnosis of schizophrenia with “dangerousness.” Similarly, a study of correctional officers found that only

one in four believed that an individual with a history of violence and schizophrenia would be able to make his own treatment decisions (Callahan, 2004). More than 85% of the correctional officers surveyed indicated that an individual with a diagnosis of schizophrenia should be forced to receive treatment, regardless of whether he had a history of violence (Callahan, 2004).

Attorneys and other courtroom personnel have endorsed similar attitudes. Australian samples of lawyers and community members responded that a vignette character diagnosed with schizophrenia should have legal coercion for treatment, and that the character posed a risk of violence to others (Minster & Knowles, 2006). Over 50% of a sample of Mississippi judges, prosecutors, and public defenders endorsed feeling that they should be constantly on guard with mentally ill offenders. Although only about 3% of these professionals agreed with statements that most people with mental illness are dirty and unkempt or dangerous, almost 30% agreed that most persons with mental illness are unpredictable (Thompson, Paulson, Valgardson, Nored, & Johnson, 2014).

Empowering attitudes. The concept of empowerment has been proposed as both a personal and societal response to stigma in that it can allow a stigmatized individual to feel worthy and effective, and can drive interest in diminishing stigma in the community (Corrigan, Faber, Rashid, & Leary, 1999). Early research established five distinct components of empowerment: (a) power and powerlessness; (b) community activism and autonomy; (c) optimism and control over the future; (d) righteous anger; and (e) self-esteem and self-efficacy (Rogers, Chamberlin, Ellison, & Crean, 1997). The self-esteem and self-efficacy component of empowerment has been found to significantly inversely correlate with stigmatizing attitudes in samples of mental health consumers, high school and college students, community members, health care providers, and mental health providers (Corrigan, Gause, Michaels, Buchholz, &

Larson, 2015; Corrigan, Powell, & Michaels, 2014; Michaels & Corrigan, 2013). Many researchers believe that an affirming stance of empowerment in mental health care can be important in promoting positive outcomes and combating the damaging effects of stigma. To achieve these ends, Corrigan (2002) posits that treatment providers must shift their focus from poor prognosis to the potential for recovery, replace coercive treatment methods with collaborative partnerships designed to meet the consumer's goals, and utilize community-based treatment outside of institutional settings. In criminal justice, the increasingly popular (but not perfect) use of mental health courts and other forensic diversion programs as a means to address the "criminalization" of mental illness has helped to advance this agenda (Bernstein & Seltzer, 2003). Consistent with these views, a recent study found that 89% of members of the Mississippi bar felt that mental health services for defendants with mental health needs should be provided in community-based facilities whenever possible (Batastini et al., 2017).

The effects of contact and education on stigma. Contact and education are considered to be two of the most successful components in stigma reduction interventions (Corrigan, Morris, Michaels, Rafacz, & Rüsch, 2012; Corrigan & Penn, 1999). While levels of prior general education have been shown to relate to overall lower levels of psychiatric stigma (Corrigan & Watson, 2007; Stull et al., 2013), educational interventions have not been as successful at reducing discriminatory behavior or producing long-lasting attitude change (e.g., Corrigan, 2004). However, certain types of education about mental health, especially promoting biogenetic causes (Angermeyer, Holzinger, Carta, & Schomerus, 2011; Kvaale, Haslam, & Gottdiener, 2013), or attempting to "warn" about the spurious relationship between violence and mental illness for the sake of increasing funding for treatment (Corrigan, Watson, Warpinski, & Gracia, 2004), can have paradoxical increases in stigmatizing attitudes and discriminatory behavior. In

addition to the negative effects of biogenetic interventions, increased stigma is also found in populations whose education promotes these views, such as in a samples of medical students (whose education may overestimate the importance of genetics in mental health), who tended to stigmatize more after completing a psychiatric rotation (Totic et al., 2012).

A recent meta-analysis of 79 interventions aimed at psychiatric stigma reduction found that while both education and contact led to significant improvements in increasing empowering attitudes and reducing stigmatizing attitudes, contact-based interventions produced significantly larger outcome effect sizes compared to education interventions (Corrigan et al., 2012). In addition, increased contact or experience with individuals who have psychiatric diagnoses has also been linked to lower stigmatizing attitudes in the general population (Angermeyer & Matschinger, 1996), college students (Corrigan, Green, Lundin, Kubiak, & Penn, 2001; Corrigan et al., 2002), and medical and mental health professionals (Kopera et al., 2015; Mittal et al., 2015). A history of education and contact has also been shown to reduce stigmatizing and increase empowering attitudes specifically regarding criminal offenders with mental health diagnoses in mental health and criminal justice professionals and laypersons (McDougall et al., 2012). Professional experience also seems to be more effective at increasing knowledge about mental health than traditional didactic methods (Frierson et al., 2015).

Compassion for Others

For many court-appointed counsel, the burdens of high caseloads, limited funding, and inadequate resources create a difficult and stressful work environment. Yet, above all, the duty of criminal defense lawyers is rooted in their singular devotion to their client (King, 2008). One's ability to show unwavering advocacy in the face of such difficulties may be explained the psychological construct of compassion. With established roots in both Eastern and Western

philosophy, “compassion” is a term that is commonly equated with empathy, love, kindness, and wisdom. Developing compassion, for both oneself and others, is considered by many to be a central component to the enhancement of well-being (Dalai Lama, Thurman, & Singh, 2015; Gilbert, 2005; Tirch, Schoendorff, & Silberstein, 2014). A useful conceptualization of compassion entails “being touched by the suffering of others, opening one’s awareness to others’ pain and not avoiding or disconnecting from it, so that feelings of kindness towards others and the desire to alleviate their suffering emerge” (Neff, 2003, pp. 86–87).

In her definition of compassion, Pommier (2011) delineates three bi-directional components that relate to and facilitate each other: (a) kindness versus indifference; (b) common humanity versus isolation; and (c) mindfulness versus disengagement. The concept of kindness in compassion can be contrasted with indifference, such that acting with kindness connotes a sense of warmth and understanding towards another in instances of failure or suffering (Gilbert, 2005; Pommier, 2011). Secondly, common humanity is defined as one’s ability to recognize that suffering in others is part of the greater human experience (of which the observer is a part), and it acknowledges that suffering allows all individuals, despite their differences, to relate, understand, and connect with each other (Blum, 1987; Dalai Lama, 1984). Conversely, isolation “allows for a sense of separation from others, particularly in instances where others are suffering” (Pommier, 2011, p. 26). Thirdly, mindfulness has been described as “a kind of nonelaborative, nonjudgmental, present-centered awareness in which each thought, feeling, or sensation that arises in the attentional field is acknowledged and accepted as it is” (Bishop et al., 2004, p. 232). In acting compassionately, mindfulness means being able to balance one’s own emotional response so as not to deny or disengage from the pain and suffering of others (Neff, 2003; Pommier, 2011).

Just as contact and education have been shown to influence stigma-related attitudes, so may compassion. Through kindness, common humanity, and mindfulness, connecting with a sense of compassion for others may buffer the socially-shaped stigma attitudes that have become so prevalent in western society. In public defense attorneys, specifically, compassion may also mitigate the additional distress imposed by excessive caseloads and poor funding.

The Current Study

The current study aimed to explore the impact of familiarity (i.e., contact and education) and compassion for others on the attitudes of attorneys and law students toward individuals with psychiatric diagnoses. Specifically, compassion for others was examined as a moderating factor on the relationship between familiarity (as measured by previous contact and psychoeducation) and the endorsement of stigmatizing or empowering attitudes towards individuals with psychiatric diagnoses.

Study 1

The first study involved a survey of public defense attorneys in the northeastern United States. The following research questions were examined.

Hypothesis 1: Familiarity will predict levels of endorsed stigma-related attitudes among attorneys, such that: 1a) attorneys with greater familiarity about individuals with mental health diagnoses will hold less stigmatizing attitudes about them; 1b) attorneys with greater familiarity will hold more empowering attitudes.

Hypothesis 2: Compassion will predict levels of endorsed stigma-related attitudes among attorneys, such that: 2a) attorneys with greater levels of compassion will endorse lower levels of stigmatizing attitudes; 2b) attorneys with greater levels of compassion will endorse higher levels of empowering attitudes.

Hypothesis 3: Reported levels of compassion for others among attorneys will moderate the influence of familiarity on attitudes about individuals with psychiatric diagnoses, such that: 3a) attorney reported compassion will moderate the influence of familiarity on stigmatizing attitudes; 3b) attorney reported compassion will moderate the influence of familiarity on empowering attitudes.

Method

Participants. Attorney participants were drawn from three public defense organizations in a large metropolitan city in the northeast United States (N = 110). The sample was 66.4% female (n = 73) and 74.5% Caucasian (n = 82) and ranged in age from 25 to 72 years (M = 39.7, SD = 12.4). The remaining identified race or ethnic background were: 9.1% African-American/Black; 6.4% Bi-racial/Multi-racial; 4.5% Latino-a/Hispanic; 3.6% Asian-American/Pacific Islander; and 1 person each identified as Other or chose not to respond. The majority of participants (69.1%) indicated that criminal law was their primary area of practice, with only 30.9% predominantly practicing civil law. Participants indicated an average of 12.1 years practicing law, ranging from 1 to 45 years (SD = 11.6). Psychoeducation was predominantly gained post-law school, with 61.5% of the attorney participants stating they received no education about mental health in law school and 89% reporting completion of mental health-focused CLE after law school.

Procedure and materials. Contracts were signed by each of the three participating legal organizations, and institutional review board approval was obtained. No compensation was offered for participation. One sample was recruited entirely by email and completed the survey online using Qualtrics, and the remaining two samples were given the option between Qualtrics or paper administration. All participants received notice of the survey via email from their

respective supervisors and signed an informed consent online or on paper before completing the survey.

Familiarity. Familiarity was defined as a combination of contact and education and was assessed using self-report items built into the demographics questionnaire. Attorneys responded to questions regarding their history of: (a) representing a client with a psychiatric diagnosis; (b) using a client's psychiatric diagnosis in their defense; (c) having a client in a designated mental health court; (d) having close work or school colleagues, or (e) friends or family with a psychiatric diagnosis; (f) personally receiving services from a mental health professional; or (g) having a psychiatric diagnosis. Similarly, attorney participants' level of relevant education was assessed through questions about (a) continuing legal education (CLE) classes, and (b) law school or (c) college classes that involved education on mental health. Following commonly used methods of assessing contact using common experiences and interactions (e.g., Corrigan, Edwards, Green, Diwan, & Penn, 2001; Corrigan, Green, et al., 2001; Holmes, Corrigan, Williams, Canar, & Kubiak, 1999), familiarity was calculated by counting one point for each affirmative response, resulting in a possible score ranging from 0 to 10.

Compassion. The total score of the 24-item Compassion Scale (Pommier, 2011) was used to assess overall levels of compassion, with higher values suggesting higher levels of compassion. The items are designed to measure how people typically act towards others, using questions such as "I like to be there for others in times of difficulty" on a 5-point Likert scale (1 = *almost never*; 5 = *almost always*). The total score is reported using a mean of the items across subscales (with specific items reverse-coded), with a range of 1 to 5. The scale has good psychometrics, with Cronbach's alpha reported at .90 in the original publication (Pommier, 2011).

Psychiatric stigma. An established 9-item adaptation of the Attribution Questionnaire (AQ-9; Corrigan et al., 2003, 2014) was used to assess the presence of explicit stigmatizing attitudes. The AQ-9 is comprised of the nine items with strongest factor loadings from the original 27-item scale: blame, anger, pity, help, dangerousness, fear, avoidance, segregation, and coercion. The questionnaire includes a brief vignette about Harry, who is a "30-year-old single man with schizophrenia. Sometimes he hears voices and becomes upset… He has been hospitalized six times because of his illness." Respondents answered questions about Harry, such as "How dangerous would you feel Harry is?" or "I think it would be best for Harry's community if he were put away in a psychiatric hospital" on a 9-point Likert scale (1 = *not at all*; 9 = *very much*). Higher AQ-9 scores represent more stigmatizing views. Internal consistencies for the AQ-9 in college students, community members, health care providers, and mental health providers are good, with Cronbach's alphas ranging from .62 to .82 (Corrigan, Gause, et al., 2015; Corrigan et al., 2014), although some studies using the AQ-9 have removed items following factor analysis or to improve internal consistency (e.g., Corrigan, Bink, Fokuo, & Schmidt, 2015; Mittal et al., 2015). Consistent with these past publications by the measure's author, the current study removed the item regarding pity, which can be interpreted in both stigmatizing and nonstigmatizing ways (e.g., with paternalistic intention). The range of possible AQ-9 scores (using only 8 of the 9 items) is 8 to 72. For the current study, Harry's employment was changed from the author's original, "a large law firm," to the modified, "a large insurance institution," to better control for participant attributions and maintain a more neutral character.

Empowering attitudes. The 3-item Empowerment Scale (ES; Corrigan, Powell, & Michaels, 2013; Corrigan et al., 2014) was used to assess self-reported feelings of personal empowerment and perceived social worth of people in general who have psychiatric diagnoses,

using items such as “People with mental illness are able to do things as well as most other people.” Responses are gathered on a 9-point Likert scale (1 = *strongly agree*; 9 = *strongly disagree*), where higher scores represent more negative attitudes regarding the social worth of people with mental illness, with a possible range of 3 to 27. The ES has demonstrated good internal consistencies in samples of college students, community members, health care providers, and mental health providers, with Cronbach’s alphas ranging from .80 to .88 (Corrigan et al., 2014). This scale was used as a more global outcome measure in addition to the AQ-9, as it does not contain a vignette, and may be less susceptible to defensive or socially desirable responding. As participants were not asked to think about a specific person, which has been shown to evoke stronger levels of stigma, they may be more forthcoming in their general attributions. The ES has been found to inversely relate to stigma (as measured by the AQ-9), and significantly predict AQ-9 outcomes (Corrigan et al., 2013, 2014).

Results

Preliminary analyses. Data were analyzed using SPSS version 21. One case was removed due to over 50% missing data, resulting in a total sample size of 109. Two cases were missing one value each on CS items. Compassion Scale subscale mean scores were imputed for these missing values. Race, gender, and age differences were found between groups the AQ-9, whereas only gender differences were found between groups on the ES. Both race and gender differences were found on the CS variable. No demographic differences were found between groups on their ratings of familiarity. Empowerment Scale outcomes were significantly positively skewed, indicating very high frequencies of empowering attitudes, and the CS also had a slight negative skew, indicating higher frequencies of compassionate attitudes. To address these issues, analyses were conducted using 5,000 bootstrap samples and controlling for race,

gender, and age where appropriate. Minimums, maximums, means, standard deviations, and Cronbach's alphas are reported in Table 1. Stigmatizing attitudes on the AQ-9 were found to correlate with ES scores (r = .487, p < .001), meaning that higher stigmatizing scores correlated with more negative attitudes about social worth. Compassion was also significantly inversely correlated with stigma (r = -.469, p < .001) and empowering attitudes (r = -.392, p < .001), meaning that higher levels of compassion correlated with lower stigmatizing attitudes, and higher feelings of empowerment, respectively. No significant correlations were found with the familiarity variable.

Primary analyses. Using a hierarchical multiple regression analysis, and controlling for race, gender, and age, levels of familiarity did not significantly contribute to the prediction of stigmatizing attitudes, ΔR^2 = .025, F(1,104) = 2.949, p = .089. Together, all 4 predictors explained 12% of the variance. In the context of this model, the coefficient for familiarity did not reach significance, B = -0.677, p = .105, 95% CI [-1.516, 0.105]. When controlling for gender, familiarity also did not significantly add to the prediction of empowering attitudes, ΔR^2 < .001, F(1,106) = .025, p = .874. Together, both predictors explained 10% of the variance. In this model, the coefficient for familiarity did not reach significance, B = -0.026, p = .881, 95% CI [-0.402, 0.326].

A hierarchical multiple regression analysis showed that compassion, when controlling for race, gender, and age, did significantly contribute to the prediction of stigmatizing attitudes, ΔR^2 = .149, F(1,104) = 20.558, p < .001. Together, all 4 predictors accounted for 24.5% of the variance in the model, with a significant coefficient for familiarity, B = -6.929, p < .001, 95% CI [-10.465, -3.658]. Compassion also significantly inversely predicted ES scores (meaning increased empowering attitudes), when controlling for race and gender, ΔR^2 = .083, F(1,105) =

10.835, $p = .001$. These 3 predictors accounted for 19.6% of the total variance in the model, also with a significant coefficient for familiarity, $B = -2.141$, $p = .006$, 95% CI [-3.644, -0.594].

Moderation analyses using PROCESS v3 (Hayes, 2018) indicated that compassion significantly moderated the inverse relationship between familiarity and stigmatizing attitudes, when controlling for race, gender, and age, $\Delta R^2 = .031$, $F(1, 102) = 4.566$, $p = .035$. Probing the interaction using the Johnson-Neyman technique revealed that familiarity significantly predicted stigmatizing attitudes at lower levels of compassion, but not at mean or higher levels. A visual representation of these findings is presented in Figure 1. Using the same moderation procedure, but controlling only for race and gender, compassion did not significantly moderate the relationship between familiarity and empowering attitudes, $\Delta R^2 = .008$, $F(1, 103) = 0.981$, $p = .324$.

Discussion

In contrast with common findings in the literature regarding professionals who work with mental health consumers (see Corrigan et al., 2012 for a meta-analysis; McDougall et al., 2012; Mittal et al., 2015), the present study reveals that familiarity does not predict stigma nor empowerment-related attitudes in a sample of public defense attorneys. Compassion, however, was found to inversely predict stigmatizing attitudes and directly predict empowering attitudes, meaning that attorneys with high levels of compassion tended not to hold stigmatizing attitudes, and tended to have empowering attitudes towards individuals with psychiatric diagnoses.

While familiarity did not directly predict stigmatizing attitudes without compassion in the model, it is not necessary to have evidence of a significant relationship between a predictor and criterion variable in order to justify the exploration of moderation effects (Hayes, 2018; MacKinnon, 2011). Indeed, the addition of compassion as a moderator revealed a predictive

impact of familiarity on stigma at lower levels of compassion but not at mean or higher levels of compassion. In other words, when overall compassion is low, familiarity (i.e., contact and education) may contribute significantly to lower stigmatizing attitudes. When compassion for others is in the moderate to high range, however, contact and education do not influence stigmatization. While compassion also significantly predicted empowering attitudes, it did not serve to moderate the relationship between familiarity and empowerment. In this instance, it appears that the influence of compassion on the relationship between familiarity and stigmatizing attitudes is greater than its influence on the relationship between familiarity and empowering attitudes.

These findings show that compassion is a powerful inverse predictor of stigma and that it appears to exert greater influence than contact and education. Additionally, while compassion was a significant predictor of empowering attitudes in this study, it exerted greater influence on stigmatizing attitudes than on empowerment. This may be because individuals endorsing higher levels of compassion may desire to protect those with psychiatric diagnoses from the harmful effects of stigma, potentially in a paternalistic sense, but may be somewhat less likely to view them as autonomous and capable of equality and independence. Also, for those endorsing lower levels of compassion, contact and education appear to influence stigmatizing attitudes (i.e., those low in compassion but having familiarity may be less judgmental than those low in compassion without familiarity), but contact and education do not exert this differential influence on empowering attitudes (i.e., the effect of familiarity on beliefs in autonomy or equality does not vary according to level of compassion).

Study 2

Given that familiarity was not a unique predictor of stigma-related attitudes in this extensively experienced public defender sample, a second study was conducted to examine stigmatizing and empowering attitudes among law students who had relatively little client experience and who were not focused exclusively on the defense of disadvantaged clients. The goal of Study 2 was to discern whether contact and education would contribute significantly to stigmatizing attitudes in this sample and to assess the relative contribution of compassion to these attitudes among those who have not worked in public defense. For the second study, the following research questions were examined.

Hypothesis 1: Familiarity will predict levels of endorsed stigma-related attitudes among law students, such that: 1a) students with greater familiarity about individuals with mental health diagnoses will hold less stigmatizing attitudes about them; 1b) students with greater familiarity will hold more empowering attitudes.

Hypothesis 2: Compassion will predict levels of endorsed stigma-related attitudes among law students, such that: 2a) students with greater levels of compassion will endorse lower levels of stigmatizing attitudes; 2b) students with greater levels of compassion will endorse higher levels of empowering attitudes.

Hypothesis 3: Reported levels of compassion for others among law students will moderate the influence of familiarity on attitudes about individuals with psychiatric diagnoses, such that: 3a) student reported compassion will moderate the influence of familiarity on stigmatizing attitudes; 3b) student reported compassion will moderate the influence of familiarity on empowering attitudes.

Methods

Participants. The student participants were drawn from students across both a traditional 3-year program, and a part-time 4-year program, at a large private law school in the northeast United States (N = 120). The participants were 58.3% female (n = 70) and 70.8% Caucasian (n = 85) and ranged in age from 21 to 42 years (M = 25.9, SD = 3.1). The remaining identified race or ethnic backgrounds were: 8.3% Asian-American/Pacific Islander; 6.7% Latino-a/Hispanic; 5.8% African-American/Black; 4.2% Bi-racial/Multi-racial; 2.5% chose not to respond, and 1.7% identified as Other. The majority were full-time students (90%, n = 107) and currently in their second year (37.5%, n = 45). Although all respondents were still in school, 87.5% indicated that they had not taken any classes in law school that included education on mental health.

Procedure and materials. Institutional review board approval was obtained from both universities (i.e., the author's and the law school). No compensation was offered for participation. Participants were enlisted through recruitment emails sent by the law school's marketing department that linked to a Qualtrics online survey with an informed consent form.

Familiarity. As in the previous study, familiarity was defined as a combination of contact and education. Students responded to questions regarding their history of: (a) contact with a client with a psychiatric diagnosis through a legal clinic or lawyering class; (b) having close work or school colleagues, (c) or friends or family with a psychiatric diagnosis; (d) personally receiving services from a mental health professional; or (e) having a psychiatric diagnosis. Similarly, student's level of relevant education was considered by a history of receiving mental health-focused curriculum (a) during law school classes or clinics, or (b) in any previous educational settings. As in Study 1, contact and education items were tallied for each affirmative response, resulting in a possible score ranging from 0 to 7.

Compassion, psychiatric stigma, and empowering attitudes. All scales measuring these constructs were identical to those used in Study 1.

Results

Preliminary analyses. Data were analyzed using SPSS version 21. One case was removed due to over 50% missing data, resulting in a total sample size of 119. Between group differences were found for race on the familiarity variable. Gender differences were found between groups on ES and CS variables. No demographic differences were found between groups on the AQ-9. Outcomes on the AQ-9 were slightly positively skewed, and ES outcomes were significantly positively skewed, indicating lower frequencies of stigmatizing, and very high frequencies of empowering attitudes, respectively. Compassion Scale scores were also slightly negatively skewed, indicating higher frequencies of compassionate attitudes. To address these issues, analyses were conducted using 5,000 bootstrap samples and controlling for race and gender where needed. Minimums, maximums, means, standard deviations, and Cronbach's alphas are reported in Table 1. Stigmatizing attitudes on the AQ-9 were found to correlate with ES scores ($r = .456$, $p < .001$), meaning that higher stigmatizing scores correlate with more negative attitudes about social worth. Compassion was also significantly inversely correlated with stigma ($r = -.373$, $p < .001$) and ES scores ($r = -.324$, $p < .001$), meaning that higher levels of compassion correlated with lower stigmatizing attitudes, and higher feelings of empowerment, respectively. Familiarity also inversely correlated with ES scores ($r = -.236$, $p = .01$), meaning that greater familiarity is related to more empowering attitudes.

Primary analyses. Using a hierarchical multiple regression analysis, and controlling for race, familiarity was not found to significantly predict stigmatizing attitudes, $\Delta R^2 = .023$, $F(1,116) = 2.730$, $p = .101$. Race and familiarity together accounted for 2.4% of the variance. In

this model, the coefficient for familiarity did not reach significance, B = -0.896, p = .132, 95% CI [-2.053, 0.231]. When controlling for race and gender, familiarity did significantly contribute to the direct prediction of empowering attitudes, ΔR^2 = .041, F(1,115) = 5.192, p = .025. The combination of familiarity, race, and gender account for 9.4% of the variance in the model, with a significant coefficient for familiarity found in inversely predicting ES scores (meaning increased empowerment attitudes), B = -0.495, p = .022, 95% CI [-0.928, -0.077].

A hierarchical multiple regression analysis found that compassion significantly contributed to the inverse prediction of stigmatizing attitudes, when controlling for gender, ΔR^2 = .129, F(1,116) = 17.476, p < .001. Compassion and gender together accounted for 14.2% of the variance in the model, with the coefficient of compassion significantly inversely predicting stigma scores, B = -6.431, p = .001, 95% CI [-9.632, -3.294]. When controlling for gender, compassion also significantly contributed to the prediction of empowerment, ΔR^2 = .084, F(1,116) = 11.306, p = .001. Both variables accounted for 13.5% of the variance, with the coefficient of compassion significantly inversely predicting ES scores (meaning higher empowering attitudes), B = -2.124, p = .002, 95% CI [-3.698, -1.059].

PROCESS v3 (Hayes, 2018) moderation analyses showed that when controlling for race and gender, compassion did not significantly moderate the inverse relationship between familiarity and stigmatizing attitudes (ΔR^2 = .013, F(1, 113) = 1.716; p = .193), or between familiarity and empowering attitudes (ΔR^2 < .001, F(1, 113) = .045; p = .832).

Discussion

While students' reported amount of contact or education did not inversely predict stigmatizing attitudes, it did directly predict empowering attitudes towards individuals with mental health diagnoses, although the predictive strength of familiarity was quite weak. The non-

significant predictive power of familiarity for stigmatizing attitudes goes against some related literature in populations of medical students (Abramowitz, Bentov-Gofrit, Khawaled, Bauer, & Cohen, 2011; Eksteen, Becker, & Lippi, 2017), and social work students (Church, Baldwin, Brannen, & Clements, 2009), but is congruent with a previous study that examined attitudes of Israeli law students who had similarly low levels of interaction with a mental health population, but endorsed stigmatizing attitudes (Abramowitz et al., 2011). The predictive significance of familiarity on increasing empowerment attitudes is congruent with available literature assessing attitudes among students, generally (Corrigan, Gause, et al., 2015). It is possible that this difference between stigma and empowerment may be due to the empowering perspectives that this relatively inexperienced group has encountered in relevant education and training, versus beliefs that would be attained through real-world experience that may undermine empowerment ideals. Similar to attorneys, students' compassion for others inversely predicted stigmatizing attitudes and directly predicted empowering attitudes, meaning that students with higher levels of compassion for others tended to hold fewer stigmatizing, and more empowering attitudes. While familiarity did not predict stigma and compassion did, compassion was not found to moderate the relationship between familiarity and stigma. Similarly, compassion did not moderate the significant relationship between familiarity and empowering attitudes.

General Discussion

Overall, the findings across both studies suggest that it may be compassion, not familiarity, that is the more important factor in the holding or development of stigmatizing attitudes towards individuals with mental health diagnoses. Notably, in an experienced sample of public defenders, compassion exerted a predictive effect on stigma and empowerment that familiarly did not. Conversely, in the less experienced sample of law students, whose levels of

compassion predicted the same (stigma and empowerment), there *was* a significant predictive effect of familiarity on empowering attitudes. This difference between populations in the finding that very high levels of contact and education (i.e., in attorneys) was not significant in predicting empowerment, but lower levels of familiarity (i.e., in law students) was, may be due to a combination of the nature of the empowerment construct and the real-world experience that is gained from law practice.

Empowerment was assessed through agreement with statements such as "People with mental illness are able to do things as well as most other people." It may be that students, who have not yet had extensive experience working with individuals who struggle with more severe psychiatric symptoms, hold these affirming, but potentially idealistic, attitudes. Conversely, the more experienced attorney sample held roughly the same level of empowerment attitudes as students (mean ES scores of 5.73 and 6.52, respectively), but it may be that their increased contact with the population made them more aware of the potential functional limitations that clients with mental health issues may face, and therefore their levels of familiarity were not significant predictors of empowerment. Given the established support of contact as a means of reducing stigma and increasing empowerment (Corrigan, Gause, et al., 2015), the current findings in groups of students and attorneys suggest that education may be a more powerful tool for changing empowerment attitudes, and contact may be a more powerful tool against stigma.

Findings across both studies, however, suggest that compassion prevails as a predictor of lower stigmatizing attitudes and higher feelings of worth towards individuals with mental health diagnoses. In public defense attorneys, a moderating effect of compassion was found, meaning that only when overall compassion was low did increased familiarity predict lower stigmatizing attitudes. However, mean and higher levels of compassion were associated with lower stigma,

regardless of the level of familiarity, and compassion in both samples predicted lower stigmatizing and higher empowerment attitudes.

Due to its importance in alleviating stigmatizing attitudes, it follows that compassion should be fostered among those who work with frequently stigmatized populations. Although the construct of compassion has a deep-rooted history, only recently has it been critically researched in the field of psychology as a state, trait, and intervention target (e.g., Boellinghaus, Jones, & Hutton, 2014; Hofmann, Grossman, & Hinton, 2011; Hutcherson, Seppala, & Gross, 2008; Kirby, 2017; Sinclair et al., 2016). Many studies have shown the effectiveness of increasing compassion and other-focused concern using targeted mindfulness meditation and other forms of compassion cultivation. Interventions have been successful among the general public (Jazaieri et al., 2013; Klimecki, Leiberg, Lamm, & Singer, 2013), experienced meditators (Boellinghaus, Jones, & Hutton, 2013), novice meditators (Hutcherson et al., 2008; Seppala, Hutcherson, Nguyen, Doty, & Gross, 2014), college students (Matos et al., 2017), healthcare student trainees (Boellinghaus et al., 2013), and healthcare providers (Amutio-Kareaga, García-Campayo, Delgado, Hermosilla, & Martínez-Taboada, 2017; Boellinghaus et al., 2014).

Legal advocates who demonstrate compassionate concern for others may have the potential to change the lives of clients who rely on their services (Gerdy, 2008; Morrison, 2010). Being treated with respect, care, and emotional investment was found to be more important to convicted offenders than their attorneys' advocacy skills or even the outcome of their case (Kruse, n.d., as cited in Breger, Calabrese, & Hughes, 2003). Morrison, a defense attorney and law professor, echoes this finding, stating that client-focused compassion is not only "the most important aspect of representation," (2010, p. 44) but it can also improve the reputation of the field, increase referral numbers, and reduce the likelihood of malpractice lawsuits. Promotion of

compassion is a potential area for psychologists to assist in law student and attorney training regarding mental health, both in law school and as continuing education. Psychologists are in a unique position to design, implement, and evaluate interventions designed to target education about mental health and strategies to foster compassion.

Limitations

There are several limitations to the current studies. The total population of the attorney sample is unknown, but based on available personnel estimates, the response rate was approximately 7%. The student sample achieved a response rate of approximately 8%. Given these relatively low response rates, results were likely influenced by a selection bias, meaning that those who did choose to respond may have done so because they are more inherently interested in or sympathetic towards issues involving mental health. This trend, combined with the localized nature of the samples to one city, also decreases generalizability of these findings to other public defense attorneys and law students. In addition, due to the voluntary self-report nature of the study, the accuracy and validity of the reported attitudes or histories of the participants are unknown. Due to the sensitive and face-valid nature of the survey items, it is possible that respondents answered items in a way that might minimize negative attitudes, as these professionals and students may naturally not want to portray their group as holding stigmatizing attitudes towards their own clients or potential future clients.

Furthermore, participants responded to items asking about attitudes and willingness to engage in behaviors in response to people, generally (i.e., Compassion Scale; Pommier, 2011), those with mental illness, generally (i.e., Empowerment Scale; Corrigan et al., 2013, 2014), or to a specific vignette character who was not charged with a crime and is not a potential client (i.e., Attribution Questionnaire-9; Corrigan et al., 2003, 2014). Therefore, caution must be taken in

generalizing attorney's and student's reported responses, as the endorsed stigma-related attitudes may not translate to client-directed behaviors. While prejudicial attitudes can, and tend to, inform discriminatory behavior towards individuals with mental health diagnoses (see Corrigan & Penn, 1999 for a review and theoretical explanation), that was not directly assessed in these studies. In addition, given the cross-sectional design of the studies, inferences cannot be directly drawn between endorsed attitudes and the causational effects of contact and education.

Future Directions

Conducting follow-up analyses with the current data would be useful to better understand which of the Compassion Scale (Pommier, 2011) subscales of Kindness, Common Humanity, and Mindfulness may be most applicable to held stigmatizing or empowering attitudes. Data collection from more relevant and specialized samples could also lead to more relevant and generalizable findings, for example, surveying social justice-focused "feeder" law schools, with students who have early intentions to pursue public defense work, along with assessing specialized mental health attorneys, who are more likely to handle cases in mental health courts. Similar research questions would also be relevant to administer to samples of judges, especially those presiding over court parts who handle higher volumes of mental health-related cases. Studies using these types of samples may provide useful cross-sectional information as to the specific benefit of client contact, above and beyond law school education and individual qualities common to those pursuing a legal career.

This information can be useful to better tailor law school education and CLE to increase focus on social causes, rather than biological or genetic causes, of psychological distress, as these explanations tend to have paradoxical increases in stigma (Kvaale et al., 2013). In addition, better tailored law school and continuing education focused on fostering compassion and other-

focused concern may show benefits to legal populations and their clients, as it has in other helping professions (Amutio-Kareaga et al., 2017), including mental health (Bibeau, Dionne, & Leblanc, 2016). In their meta-analysis, Amutio-Kareaga and colleagues (2017) provide thoughtful suggestions for implementing mindfulness and compassion training in healthcare, including ideas that could be easily implemented in law school curriculum and CLE. Freshman and colleagues (2002) and Gerdy (2008) each provide thoughtful examples of how mindfulness and compassion can be successfully, and usefully, integrated into law school curriculum. Additional studies should be conducted to support and tailor the effectiveness of these types of curriculum changes.

Conclusion

Compassion is "the state of mind that inspires the attorney to be a zealous advocate for the client in every task the attorney performs" (Morrison, 2010, pp. 44–45). The results of the present studies suggest that it may be compassion, not familiarity, that serves to buffer the naturally-occurring, socially-shaped stigma that arises in response to psychiatric distress in populations of public defenders and law students. Compassion, empathy, and other-focused concern are easily targeted, with increases found in novice meditators following meditation practices as brief as seven to 10 minutes (Hutcherson et al., 2008; Seppala et al., 2014). Because fostering compassion among healthcare providers has led to a variety of significant improvements in patient outcomes (see Amutio-Kareaga et al., 2017), it follows that fostering compassion for public defense attorneys may increase positive outcomes for criminal defendants with mental health concerns, as these attitudes may allow attorneys to best serve as zealous advocates for their clients.

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Figure 1

Probing the Interaction of Different Levels of Compassion on the Conditional Effect of Familiarity on Stigmatizing Attitudes

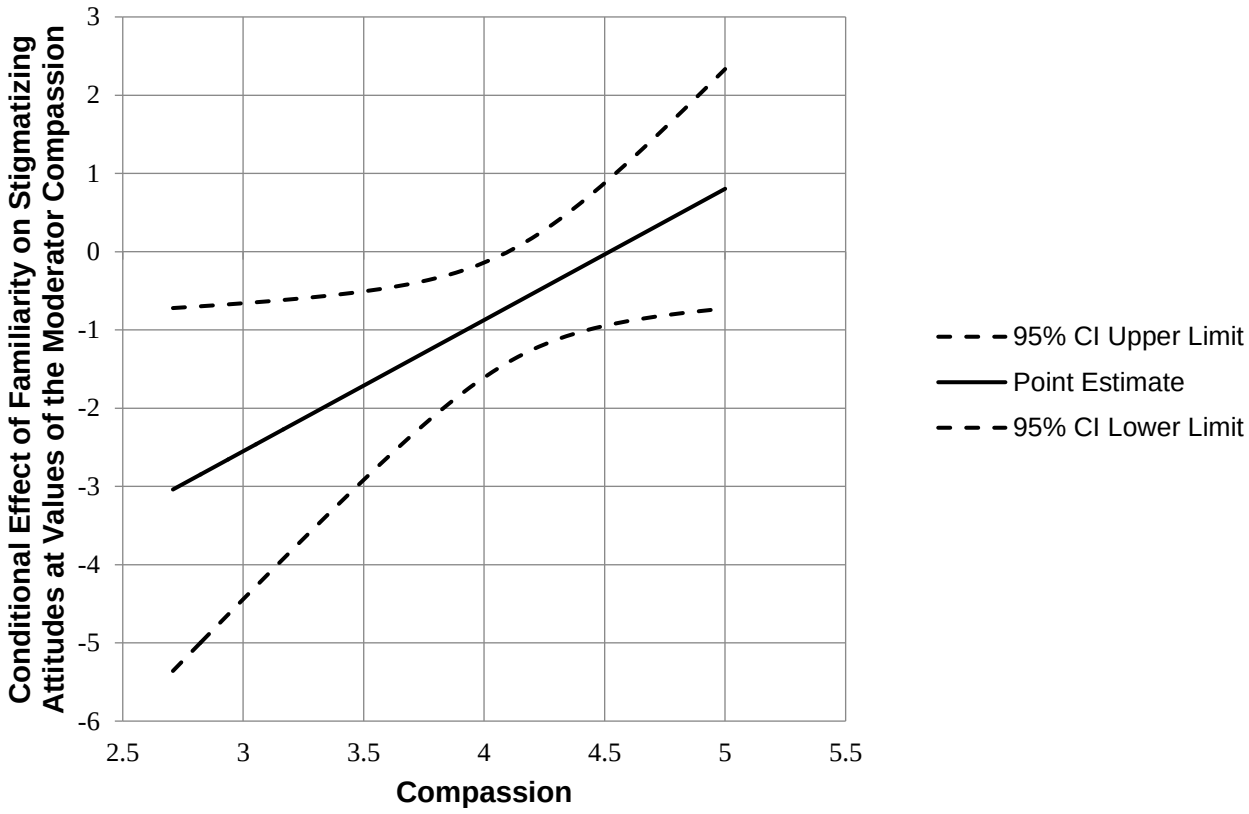

Figure 1. At lower levels of compassion, the inverse relationship between familiarity and stigmatizing attitudes is stronger (i.e., further from 0). As compassion approaches mean and higher levels, the point estimate weakens (as it approaches 0).

Table 1

Summary of Minimums, Maximums, Means, Standard Deviations, and Cronbach's Alphas Across Study 1 and Study 2 for Familiarity, CS, AQ-9, and ES

	Minimum	Maximum	Mean	*SD*	α
Study 1					
Familiarity	3	10	6.88	1.59	-
CS	3.51	4.75	4.18	0.41	.82
AQ-9	8	36	18.02	6.75	.67
ES	3	14	5.73	2.82	.71
Study 2					
Familiarity	0	6	3.02	1.52	-
CS	3.52	4.61	4.11	0.50	.91
AQ-9	9	51	25.82	8.81	.77
ES	3	19	6.52	3.60	.73

Note. *SD* = Standard Deviation; α = Cronbach's Alpha; CS = Compassion scale; AQ-9 = Attribution Questionnaire-9; ES = Empowerment Scale.

Appendix

Compassionate Advocacy: Exploring Attitudes Surrounding Psychiatric Diagnoses in a Legal Environment

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May 31, 2017

A Dissertation Proposal

Submitted to

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Abstract

Healthcare providers who hold stigmatizing attitudes towards individuals with psychiatric diagnoses can engage in prejudicial practices and provide poorer quality of care. Research on psychiatric stigma has typically focused on beliefs held by mental and physical healthcare providers, as well as the general public. Individuals with mental health concerns are disproportionately over-represented in the criminal justice system in the United States, and have historically received unfair treatment and subpar psychiatric care. In effort to understand the respective roles of contact and compassion for others on psychiatric stigma, this study will examine explicit attitudes to assess both stigmatizing and empowering attitudes among law students and public defenders. A sample of approximately 119 law students from a private law school, and approximately 119 public defenders from three agencies in the northeast United States will be asked to respond to items assessing their previous contact with and psychoeducation about individuals with psychiatric diagnoses, as well as stigmatizing and empowering attitudes towards this population. Demographics and compassion for others will be analyzed as additional variables. It is predicted that students and attorneys will endorse stigmatizing attitudes towards this population, and this outcome will be inversely correlated with familiarity, such that participants who have received psychoeducation or know someone with a psychiatric diagnosis will hold less stigmatizing attitudes. The inverse relationship is predicted for familiarity and empowering attitudes. It is also hypothesized that compassion for others will moderate the relationship between familiarity and attitudes. These results will be discussed as they pertain to the importance of reducing psychiatric stigma for legal professionals to best serve in an advocate role for their clients.

Keywords: stigma, compassion, mental health, law

While various social institutions grapple to delineate and classify various deviations of "acceptable" versus "unacceptable" human behavior, the criminal justice system and the mental health system find frequent overlap. New York City, home to the infamous Rikers Island jail complex, stands as a useful example. Of the city's near 10,000 average daily jail population in 2016, 42% were classified as having a "mental health diagnosis," while 11% of detainees were diagnosed with a "serious mental illness" (New York City Mayor's Office of Operations, 2016). As the burden to address mental health needs shifts from community and state-funded mental health facilities to the nation's over 6,000 jails and prisons, the criminal justice system has become the nation's *de facto* mental health system (Wagner & Rabuy, 2016).

In the ongoing battle to advance social justice and human rights, our nation has created over 350 mental health courts (Migliozzi Jr. & Muhametaj, 2016), in response to the concerning overrepresentation of individuals with psychiatric diagnoses in the criminal justice system (Bernstein & Seltzer, 2003). While reform-focused legal-advocacy organizations such as The Bazelon Center for Mental Health Law hold that mental health courts are but one component aimed at this social dilemma, they maintain that wider, multi-system community reform is necessary to "address the causes of the problem, not just its symptoms" (Bernstein & Seltzer, 2003, p. 161). With considerations to the often-slow-moving shifts that must happen on many fronts (e.g. government funding, public attitudes, legal regulations), there are – and will continue to be for the foreseeable future – a large number of individuals struggling with psychological difficulties, who find themselves arrested and facing a complicated road ahead through the criminal justice system.

Criminal Justice Involvement for Defendants with Mental Health Needs

Navigating the criminal justice system post-arrest can be a daunting task, especially for those who may simultaneously be experiencing significant psychological distress. Throughout the legal process, there exist several points at which mental health-related intervention and diversion from criminal incarceration can occur (Council of State Governments, 2002; Munetz & Griffin, 2006). A pivotal point in a criminal defendant's legal timeline – and likely the first involving meaningful interaction with non-law enforcement personnel – is their appointment of counsel (Broner, Lamon, Mayrl, & Karopkin, 2002). All criminal defendants have the right to competent legal counsel, regardless of their ability to afford representation (*Gideon v. Wainwright*, 1963; *Strickland v. Washington*, 1984), and indigent defenders (counsel appointed to defendants who cannot afford private attorneys) account for approximately 80 to 90 percent of representation in criminal felony cases (Harlow, 2001; Spangenberg & Beeman, 1995). According to data from the U.S. Department of Justice Bureau of Justice Statistics, conviction rates are nearly identical for defendants with court appointed or private counsel (75.4% versus 77.1% in large State courts, and 92.3% versus 91% in Federal courts, respectively) (Harlow, 2001). However, defendants with publicly financed counsel who were found guilty were incarcerated at much higher rates, with differences in incarceration sentences in large State courts as pronounced as 71% for defendants with public counsel versus only 54% for defendants with private attorneys (Harlow, 2001).

There are myriad unknown economic, social, psychological, and practical factors that may lead to this sentencing discrepancy. Financial constraints, high caseloads, and inadequate resources account for a large portion of the problem, with estimates that in some jurisdictions, legal needs are not met for as many as 80% of low-income individuals (American Bar

Association, 2016; Marcus, 1994). These conditions can significantly negatively impact defendant outcomes, especially defendants with disproportionately low income, such as those with significant psychological distress and diagnosed with more severe mental disorders (Cook, 2006; Kessler, Chiu, Demler, & Walters, 2005; Levy & Rowitz, 1973; Regier et al., 1993).

Public defense counsel serve an extremely wide variety of clients, although it is unclear what typical percentage of their case history might include individuals that have mental health concerns. However, judging by New York City's report of 49% of jail inmates having some mental health diagnosis (New York City Mayor's Office of Operations, 2016), it is not a stretch to imagine that the city's public defenders are tasked with representing a large portion of these individuals. This trend is evident in the findings of a recent survey of 492 members of the criminal bar in South Carolina, which revealed that public defenders were 6.8 times more likely than private defense attorneys to have worked on greater than six mental health-related cases (Frierson, Boyd, & Harper, 2015). The same study also found that attorneys with a more extensive history (i.e. having worked on more than six mental health-related cases) were less opposed to working with this population, although half of all surveyed attorneys stated that they would prefer to work with individuals who do not have a psychiatric diagnosis. Unfortunately, the authors suggest that this preference may negatively affect an attorney's abilities (especially less experienced attorneys) to advocate for defendants with mental health concerns (Frierson et al., 2015). With an understanding of the importance of education on addressing this issue, 83% of all respondents of Frierson and colleagues' (2015) study felt that their mental health instruction in law school was inadequate. However, many states are actively focused on improving these outcomes, with a recent census of the 28 state-based public defense agencies (and the District of Columbia) conducted by the Bureau of Justice Statistics finding that almost

all (23) offered professional development training on “mental illness” (Strong, 2016, p. 26). The move towards increased education about psychiatric distress is shared by defense attorneys and defendants, alike, with attorneys suggesting that these clients are often treated the same or worse than other defendants, “because they are stigmatized by criminal justice officials with little experience dealing with mental illness” (Denckla & Berman, 2001, pp. 6–7). Similarly, one ex-offender whose case was handled outside of a designated mental health court, but benefited from court-involved mental health treatment, felt better education was a necessity:

> Defense attorneys aren’t thinking about me as an individual who has a mental illness. They’re not thinking about my best interests, my need for long-term treatment or how to keep me from coming back to court tomorrow… If they knew more about mental illness, they would do things differently. (Denckla & Berman, 2001, p. 20)

However important psychoeducation for attorneys may seem to be, there is a careful line that must be considered in the paradoxical harm that comes from promoting biological or genetic theories of psychological distress. Indeed, much research has shown that individuals who subscribe to biogenetic causes of “mental illnesses” hold significantly more stigmatizing attitudes towards these individuals, endorse engaging in harsher behavior (Mehta & Farina, 1997), believe them to be more dangerous and unpredictable, and seek to maintain social distance from them (Angermeyer, Holzinger, Carta, & Schomerus, 2011; Magliano et al., 2011; Pattyn, Verhaeghe, Sercu, & Bracke, 2013; Phelan, Yang, & Cruz-Rojas, 2006; Read, Haslam, Sayce, & Davies, 2006; Schomerus et al., 2012). The study of the connection of negative outcomes such as these, in response to beliefs about psychiatric disorders has found a home within the multi-disciplinary construct of stigma.

Stigma

Erving Goffman is largely credited with bringing the stigma construct to social science in his book *Stigma: Notes on the Management of Spoiled Identity* (1963). He proposed that stigma refers to an "attribute that is deeply discrediting," which causes the bearer to be "reduced in our minds from a whole and usual person to a tainted, discounted one" (Goffman, 1963, p. 3). Importantly, Goffman notes that contact with stigmatized others can be so potentially uncomfortable to both parties, that each would seek to avoid such interactions, leading to many obvious negative consequences (1963). Indeed, discrimination and prejudice towards stigmatized groups has been well documented in many social arenas – especially those with a notable power hierarchy. As members of a stigmatized group, individuals with psychiatric diagnoses have suffered prejudicial treatment in important life areas such as renting apartments, receiving medical care, and seeking employment (Dickerson, Sommerville, Origoni, Ringel, & Parente, 2002; Parks, Svendsen, Singer, Foti, & Mauer, 2006).

For example, when study confederates responded to classified advertisements regarding rooms for rent in newspapers throughout the United States and Canada, rooms were less likely to be available when the caller conveyed that they were receiving psychiatric treatment (conveyed via a statement such as "I am currently receiving some mental health treatment in a hospital, but would need a place to live soon") (Page, 1996). Individuals with psychiatric diagnoses have also reported that they have experienced discrimination by being turned down for a job for which they were qualified after their mental health consumer status was revealed (Dickerson et al., 2002; Wahl, 1999). Studies have also shown that individuals with comorbid psychotic and medical disorders (e.g. diabetes, cardiovascular disease, obesity) receive poorer quality of care, substandard preventative care and monitoring, and have poorer postoperative outcomes than

those without a psychiatric diagnosis (Daumit et al., 2006; Desai, Rosenheck, Druss, & Perlin, 2002; Druss, Bradford, Rosenheck, Radford, & Krumholz, 2000; Druss, Rosenheck, Desai, & Perlin, 2002; Frayne et al., 2005; Parks et al., 2006).

Conceptualizing stigma. Notably, all of the above examples describe social relationships in which there exists a hierarchical power structure; persons labeled "mentally ill" can be stigmatized against only if the stigmatizing party holds a more powerful social position in the relative context of said relationship. This dependence of stigma on power is one of several interrelated components of the stigma construct proposed by Link and Phelan (2001). Their conceptualization of this social phenomenon was designed in response to decades of post-Goffman (1963) criticisms that stigma was vaguely defined, focused too greatly on problems at an individual level, and relied too heavily on cognitive processing rather than relational outcomes. To this effort, Link and Phelan describe stigma as a co-occurrence of the components outlined below (2001).

Distinguishing and labeling differences. Through the use of comparative language, humans possess the ability to identify and label characteristics in each other (e.g. height, race, sexual preference, disability), determine levels of said characteristic (e.g. tall/short, black/white, gay/straight, blind/sighted), and assign weight based on social salience and perceived importance. These labels are often gross oversimplifications of complex and varying factors, and their social salience differs dramatically according to context. Link and Phelan propose that the social selection of salient characteristics and the creation of related labels that sustain them are essential components of stigma (2001; Link, Yang, Phelan, & Collins, 2004). Further, they suggest that the "taken-for-granted nature" of labels explains why such designations "carry such weight" (Link & Phelan, 2001, p. 367).

Associating differences with negative attributes. Following and reinforcing the identification and assignment of labels comes the connection between labels and stereotypes (Link & Phelan, 2001). Differing psychological and sociological theories exist as to the mechanism through which this association is created and maintained. However, many studies have shown that negative stereotypes are often strongly linked with stigmatizing groups such as those who carry psychiatric diagnoses (Cohen & Struening, 1962; Mittal et al., 2014; Wahl & Aroesty-Cohen, 2010). The most commonly associated stereotype with the "mental illness" label is that these individuals are dangerous and unpredictable (Link, Phelan, Bresnahan, Stueve, & Pescosolido, 1999; Parcesepe & Cabassa, 2013). With this association of dangerousness comes feelings of fear, which, in turn, drives a desire to maintain social distance (Angermeyer & Matschinger, 1996; Corrigan, Markowitz, Watson, Rowan, & Kubiak, 2003). An additional commonly held stereotype about individuals with psychiatric diagnosis is a belief that they are, to some degree, accountable for the development and/or course of their "illness," which feeds concerns regarding blame, pity, and the consideration of involuntary treatment (Corrigan et al., 2002; Lepping, Steinert, Gebhardt, & Röttgers, 2004).

Separating "us" from "them." The utility of social labels serves as an additional component to the stigmatizing process when labeled individuals can be easily de-contextualized as mere members of a larger group. With this group designation, differentiating stigmatized others ("them") from members of one's own group ("us") becomes an efficient mental heuristic (Link & Phelan, 2001). Unfortunately, this process can be performed so readily, that when labeled persons are believed to be so distinctly different than "us," there exists little harm in attributing any sort of negative characteristic to "them" (Corrigan, Bink, Fokuo, & Schmidt, 2015; Link & Phelan, 2001). This phenomenon is further perpetuated and blatantly apparent in

the discourse surrounding psychiatric diagnoses. Although organizations like the National Alliance on Mental Illness and the American Psychological Association push for "person-first" language (e.g. "a person with schizophrenia" versus "a schizophrenic person"), many lay people, including media, medical professionals, legal professionals, and law enforcement, continue to use – often with benign intentions – phrases such as "mentally ill" and "schizophrenic." In fact, exposure to negative journalism about mental health has been shown to not only increase stigmatizing beliefs, but to decrease attitudes of social acceptance, such as self-determination, personal empowerment, and recovery potential (Corrigan, Powell, & Michaels, 2013).

Emotional responses. In an expansion on Link and Phelan's original conceptualization of stigma (2001), an additional focus was placed on the emotional responses it entails (Link et al., 2004). This component provides an important supplemental understanding to the behavior of both individuals who hold stigmatizing attitudes, and those who are recipients of stigmatizing reactions. Link and colleagues (2004) propose that the aforementioned processes of labeling, stereotyping, and separating can give rise to emotions of anger, irritation, anxiety, pity, and fear. These emotional responses are important in understanding stigma for two reasons. Firstly, emotional responses can be detected by the person who is stigmatized, thereby creating a notion about the responses of stigmatizers to members of their own group. Secondly, these emotional responses create a context that may shape future behavior regarding that stigmatized group (Link et al., 2004).

Status loss and discrimination. When stigmatized groups are consistently labeled and set apart with negative stereotypes, Link and Phelan propose that a rationale is constructed for devaluing, rejecting, and excluding them (2001). They cite this factor as an imperative component in their stigma definition, as it is the combination of the above components that leads

stigmatized individuals to experience the effects of stigma in the form of various types of status loss and discrimination. At the individual level, this can be experienced as discrimination in attempting to find housing or employment, and the receipt of generally lower quality of care in medical and mental health settings (Daumit et al., 2006; Dickerson et al., 2002; Druss et al., 2002; Page, 1996; Parks et al., 2006; Schulze, 2007; Wahl, 1999). Link and colleagues note that there are additional, and less apparent, mechanisms by which the labeling and stereotyping of stigmatized groups can lead to negative outcomes (2001; 2004).

Less overt in nature, the stigmatized individual's internalizing of these culturally apparent stigmas is manifested as *self-stigma*. Explained through a modified labeling theory, discrimination can operate through the stigmatized person when the socially propagated concepts and stereotypes about "mental illness" become personally relevant to them following their own diagnosis or labeling (Link, 1982; Link & Phelan, 2001; Link, Struening, Cullen, Shrout, & Dohrenwend, 1989; Link et al., 2004). Self-stigma and avoidance of the "mentally ill" label is linked to a plethora of negative outcomes, including lower rates of treatment seeking and adherence (for both mental and physical health), higher rates of substance use, higher rates of suicide, and lower-self-esteem (Link, 1987; Page, 1996; Parks et al., 2006; Slate, Buffington-Vollum, & Johnson, 2013; Wahl, 1999). At the macro level, structural discrimination and reduction of social status is perpetuated by private or governmental organizations through rules, laws, policies and procedures that restrict opportunities or unfairly disadvantage members of the "mentally ill" group (Corrigan, Markowitz, & Watson, 2004; Link & Phelan, 2001). In the criminal justice system, this is frequently seen in the harsher sentencing, increased rates of wrongful accusation and conviction, and disproportionately large arrest rates compared to

individuals who do not hold a psychiatric diagnosis or exhibit "typical signs of mental illness" (Rabkin, 1979; Slate et al., 2013; Sosowsky, 1980; Steadman, 1981; Teplin, 1984, 2000).

Dependence of stigma on power. The abilities to label, stereotype, separate, emotionally respond, and discriminate are not solely reserved for those in positions of power – anybody can engage in these social and mental behaviors. However, when these behaviors exist in a social, economic, or political power hierarchy, the more powerful individual then possesses the ability to perform them in a stigmatizing way (Link & Phelan, 2001; Link et al., 2004). In fact, members of stigmatized groups; patients in psychiatric facilities, for example, often label and stereotype individuals around them, such as doctors and hospital staff. A psychiatric patient's stereotype of a hospital psychiatrist as a "pill pusher," for instance, may foster stereotypes that they are cold, paternalistic, and arrogant. These beliefs may even result in modifications of the patient's behaviors towards these individuals; perhaps avoiding contact, making derogatory comments, jokes, etc. However, even if a hospital psychiatrist were to receive each of the previously explained components of stigma from psychiatric patients (i.e., labels, negative stereotypes, separation, emotional reactions, and even discriminatory behaviors), they would still not be considered a stigmatized group according to Link and Phelan's description (2001). They maintain that in this example situation, the potentially stigmatizing group (e.g., psychiatric patients) does not hold sufficient social, cultural, economic, or political power to result in seriously damaging, discriminatory consequences for the more powerful group (e.g., psychiatrists).

The effects of contact and education on stigma. With such damning representations of psychiatric disorders in the news and entertainment media, it is not surprising that exposure to negative media leads to endorsement of general stigmatizing attitudes, as well as specific beliefs

that individuals diagnosed with psychiatric disorders are dangerous, should be forced to receive treatment, should be monitored and restricted, and should not receive community care (Corrigan et al., 2013; Corrigan, Watson, Warpinski, & Gracia, 2004; Dietrich, Heider, Matschinger, & Angermeyer, 2006; Thornton & Wahl, 1996). With mass media accounting for the large majority of information people receive about mental health (Reavley, Cvetkovski, & Jorm, 2011), it is important to explore what other factors may offset the otherwise generally negative tone of media portrayals (Ma, 2017).

Education and contact are considered to be two of the most successful components in stigma reduction studies (Corrigan, Morris, Michaels, Rafacz, & Rüsch, 2012; Corrigan & Penn, 1999). While levels of prior general education were shown to relate to overall lower levels of psychiatric stigma (Corrigan & Watson, 2007; Stull, McGrew, Salyers, & Ashburn-Nardo, 2013), certain types of education about mental health (especially promoting biogenetic causes) can have paradoxical increases in stigma (Angermeyer et al., 2011), and education interventions have not been found to produce long-lasting attitude change (e.g., Corrigan, 2004). A recent meta-analysis of 79 interventions aimed at psychiatric stigma reduction found that while both education and contact led to significant improvements in increasing empowering attitudes and reducing stigmatizing attitudes, contact-based interventions produced significantly larger outcome effect sizes compared to education interventions (Corrigan et al., 2012). In addition to its success as a stigma-reduction intervention, increased amounts of contact with individuals who have “lived experience” (that is, are diagnosed with a psychiatric disorder) has also been linked to overall lower stigmatizing attitudes in the general population (Angermeyer & Matschinger, 1996), college students (Corrigan et al., 2002; Corrigan, Green, Lundin, Kubiak, & Penn, 2001), and medical and mental health professionals (Mittal et al., 2015).

Implications of psychiatric stigma in more salient contexts. Despite the potentially mitigating factors of increased familiarity (e.g. education and contact), many professionals involved with "mental health consumers" continue to hold stigmatizing attitudes and engage in discriminatory practices (Schulze, 2007; Wahl & Aroesty-Cohen, 2010). Lauber and colleagues (2006) compared responses of Swiss mental health professionals (psychiatrists, psychologists, nurses, and other therapists) and found that while all groups endorsed both positive and negative traits (e.g. unpredictable, weird, threatening, dangerous; responsible, highly skilled, creative), no differences were found between mental health professionals and the general population with respect to the 'dangerous,' 'weird,' and 'highly skilled' stereotypes. However, psychiatrists were more likely than all other professionals to endorse stereotypes of 'dangerous,' less 'skilled,' and more 'socially disturbing' (Lauber et al., 2006). A group of similar studies examined differences among providers across Veterans Affairs (VA) hospitals, and found that primary care physicians, primary care nurses, and psychiatrists endorsed more negative attitudes towards a vignette character with schizophrenia than mental health nurses and psychologists (Mittal et al., 2014; Smith, Mittal, Chekuri, Han, & Sullivan, 2016). In a study of practitioners in an evidence-based mental health intervention, Stull and colleagues (2013) examined both implicit and explicit attitudes among Assertive Community Treatment (ACT) staff, and found that despite endorsing overall positive attitudes ('good,' 'innocent,' 'competent'), latent factor modeling revealed that implicit bias predicted greater endorsement of restrictive and treatment control mechanisms.

Stigmatizing attitudes and behavior in criminal justice settings. While police officers seem to be generally ambivalent towards individuals with psychiatric diagnoses, some studies suggest that they endorse similar attitudes to the general public in associating a diagnosis of schizophrenia with "dangerousness" (Watson, Corrigan, & Ottati, 2004a, 2004b). Similarly, Ruiz

and Miller (2004) found among a sample of Pennsylvania police officers that over half of the sample self-reported that they ‘disagree’ or ‘strongly disagree’ that persons diagnosed with a mental illness are dangerous, while 43% indicated that they ‘agree’ or ‘strongly agree.’ A study of correctional officers, however, suggested that they endorse less positive attitudes, with only one in four believing that an individual with a history of violence and diagnosis of schizophrenia would be able to make his own treatment decisions, and over 85% of correctional officers felt that an individual with a diagnosis of schizophrenia should be forced to receive treatment, regardless of whether or not he had a history of violence (Callahan, 2004). Results from Frierson and colleagues’ (2015) survey of members of the South Carolina criminal bar found that over half of all respondents would prefer to work on a case with someone who does not have a mental health diagnosis, with 69% of prosecuting attorneys and 43% of public defenders endorsing this position.

Psychiatric stigma in the legal relationship. The dependence on power is a crucially important social mechanism by which stigmatizing contexts can be created and maintained in the criminal justice system. A defendant’s course from arrest to release can find a psychiatrically diagnosed individual placed in a lower relative power position (that is, a “stigmatizable” one) in numerous potential relationships: with the arresting officer(s), booking staff, arraignment judge, correction officers, court-appointed or hired legal counsel, opposing counsel, diversion organization staff, forensic evaluators, trial judge, jury, and so on.

As outlined above, a defendant’s relationship with their legal counsel (often publicly funded) marks a pivotal point in their journey through the criminal justice system. This relationship is subject to innumerable conditions in both the defendant’s context, their attorney’s, and the reciprocal nature of their interactions. For many court-appointed counsel, the burdens of

high caseloads, limited funding, and inadequate resources create a difficult and stressful work environment. Yet, above all, the duty of criminal defense lawyers is rooted in their singular devotion to their client (King, 2008). One's ability to show devotion and unwavering advocacy in the face of such difficulties may be explained by unique psychological constructs.

The Impact of Compassion on Interactions with Others

With well-established roots in both Eastern and Western philosophy, "compassion" is a term that many equate with concepts such as empathy, love, kindness, and wisdom. Developing compassion, for both oneself and others, is considered by many to be a central component to the enhancement of well-being (Dalai Lama, Thurman, & Singh, 2015; Gilbert, 2005, 2010; Tirch, Schoendorff, & Silberstein, 2014). A useful conceptualization of compassion entails "being touched by the suffering of others, opening one's awareness to others' pain and not avoiding or disconnecting from it, so that feelings of kindness towards others and the desire to alleviate their suffering emerge" (Neff, 2003, pp. 86–87). Within this definition are three key components that relate to and facilitate each other: kindness, common humanity, and mindfulness. In this conceptualization, these three factors each have a notable opposite: indifference, separation, and disengagement, respectively (Pommier, 2010).

Kindness. The concept of kindness in compassion can be contrasted with indifference, such that acting with kindness connotes a sense of warmth and understanding towards another in instances of failure or suffering (Gilbert, 2005; Pommier, 2010). Considered in relation to the components of stigma, it may be through an "absence" of kindness that the facilitation of negative stereotyping and discrimination may occur. In a legal context, a defendant has, by definition, failed, in that they have been accused of failing to abide by the law. In this "failure" in the eyes of the court, and by proxy, society, the defendant can be more easily associated with

negative qualities, and has already experienced status loss and discrimination. The presence of kindness and/or a lack of indifference may reduce one's felt need to employ negative stereotypes and facilitate a stronger desire to reverse or remedy status loss and discrimination in relationships with stigmatized others.

Common humanity. Secondly, the construct of common humanity in compassion is defined as one's ability to recognize that suffering in others is part of the greater human experience (of which the observer is a part), as opposed to considering it as a separate event (Neff, 2003; Pommier, 2010). Common humanity involves the appreciation that the experience of suffering is one that allows all individuals, despite their differences, to relate, understand, and connect with each other, as we are all capable of suffering (Blum, 1987; Dalai Lama, 1984). Isolation, the opposite of compassion's common humanity, then easily facilitates the stigma constructs of distinguishing and labeling differences as well as separating "us" from "them." Pommier operationalizes the construct of isolation in the context of compassion such that it "allows for a sense of separation from others, particularly in instances where others are suffering" (2010, p. 26). Indeed, regardless of mental health concerns, criminal court proceedings undoubtedly contribute some degree of suffering. In a more specific context relevant to this study, not only is an attorney tasked with advocating for one who is suffering due to the charges against them, but also one who may have long been struggling with psychological distress, as well. A strong sense of common humanity may serve to drive compassionate advocacy for potentially stigmatized others who are in a position to be seen as different and separated from those without a label.

Mindfulness. "Broadly conceptualized, mindfulness has been described as a kind of nonelaborative, nonjudgmental, present-centered awareness in which each thought, feeling, or

sensation that arises in the attentional field is acknowledged and accepted as it is" (Bishop et al., 2004, p. 232). In acting compassionately, mindfulness means being able to balance one's own emotional response so as not to deny or disengage from the pain and suffering of others (Neff, 2003; Pommier, 2010). Disengagement or denial, as opposed to mindfulness, in the face of distress is likely observable by the suffering party, thus equating to the stigma construct of "emotional reactions." As noted in Goffman's (1963) original conceptualization, the mere contact with stigmatized others can elicit discomfort, which one would naturally seek to avoid. However, in an attorney-client relationship, options for avoidance are severely limited, and repeated contact in some form is virtually unavoidable. Thus, for an attorney, this relationship provides as many options to come into contact with their client – already often labeled as "criminal," "mentally ill," or both – as well as their own, and their client's distress. One's ability to adopt a mindful, accepting, awareness of his or her experience with potentially stigmatized others can be crucially important, especially if that experience may naturally give rise to feelings or thoughts of discomfort. While stigmatizing thoughts, beliefs, or attitudes may arise as strong, automatic, associations from media, education, or cognitive rationalizations, a more mindful perspective may allow for a more flexible behavioral response (S. C. Hayes, Strosahl, & Wilson, 2011).

Examining the Components of Psychiatric Stigma in a Legal Environment

The current study aims to explore the impact of compassion among law students and public defense attorneys who may have previous experience with and/or hold certain attitudes regarding individuals diagnosed with psychiatric disorders. Specifically, compassion for others will be examined as a moderating factor on the relationship between familiarity (as measured by previous contact with individuals diagnosed with mental disorders and previous psychoeducation

regarding this population) and the endorsement of stigmatizing or empowering attitudes towards individuals with psychiatric diagnoses. The following hypotheses are predicted:

Study 1. Hypothesis 1: Familiarity will predict levels of endorsed stigma-related attitudes among law students, such that: 1a) students with greater familiarity about individuals with mental health diagnoses will hold less stigmatizing attitudes about them; 1b) students with greater familiarity about individuals with mental health diagnoses will hold more empowering attitudes about them. Hypothesis 2: Reported levels of compassion for others among law students will moderate the influence of familiarity on attitudes about individuals with psychiatric diagnoses, such that: 2a) student reported compassion will moderate the influence of familiarity on empowering attitudes; 2b) student reported compassion will moderate the influence of familiarity on stigmatizing attitudes.

Study 2. Hypothesis 1: Familiarity will predict levels of endorsed stigma-related attitudes among attorneys, such that: 1a) attorneys with greater familiarity about individuals with mental health diagnoses will hold less stigmatizing attitudes about them; 1b) attorneys with greater familiarity about individuals with mental health diagnoses will hold more empowering attitudes about them. Hypothesis 2: Reported levels of compassion for others among attorneys will moderate the influence of familiarity on attitudes about individuals with psychiatric diagnoses, such that: 2a) attorney reported compassion will moderate the influence of familiarity on empowering attitudes; 2b) attorney reported compassion will moderate the influence of familiarity on stigmatizing attitudes.

Method

Study 1

Participants. Following IRB approval from both institutions (i.e., the investigator's and the law school), the student sample will be drawn from the attendees of a traditional three-year program at a large private law school in the northeast United States (n = 119). Demographic information will be collected regarding age, gender, race/ethnicity, and year in law school. Data will be gathered online using Qualtrics via mass email distributed by administrators and/or faculty at the university.

Measures. ***Familiarity*.** Familiarity is defined as a combination of contact and education. Students will be asked if they have ever had contact with a client with a psychiatric diagnosis through a legal clinic or lawyering class, as well as if they have participated in mental health-focused law classes or clinics during law school, as well as psychology classes in any previous educational settings. They will also be asked if they have any friends or family with a psychiatric diagnosis, or if they have ever personally received a diagnosis, or treatment from a mental health professional. Endorsement of contact and education items will be operationalized as the addition of all responses to the questions in these categories, which will be posed in ways to elicit numerical responses (e.g. 5 mental health law-related CLE credits, 8 clients in mental health court, etc.).

Compassion Scale (CS). The 24-item Compassion Scale measures how people typically act towards others, and the total score will be used to assess overall levels of compassion, with higher values suggesting higher levels of compassion (Pommier, 2010). The scale has six subscales, which are considered in three pairs: kindness and indifference; common humanity and separation; mindfulness and disengagement. Participants will respond to questions such as "I like to be there for others in times of difficulty" on a five-point Likert scale (1 = *almost never*; 5 =

almost always). The scale has good psychometrics, with Cronbach's alpha reported at .90 (Pommier, 2010).

Empowerment Scale (ES). The Empowerment Scale (Corrigan et al., 2013; Corrigan, Powell, & Michaels, 2014) is used to assess self-reported feelings of personal empowerment regarding people who have psychiatric diagnoses. The three-item adaptation assess attitudes towards the social worth of these individuals and includes items such as "People with mental illness are able to do things as well as most other people." Responses are gathered on a nine-point Likert scale (1 = *strongly agree*; 9 = *strongly disagree*), where higher scores represent enhanced views of empowerment. The ES has demonstrated good internal consistencies in samples of college students, community members, health care providers, and mental health providers (Cronbach's alphas ranging from .80 to .88) (Corrigan et al., 2014). This scale will be used as a more global outcome measure in addition to the AQ-9, as it does not contain a vignette, and may be less susceptible to defensive or socially desirable responding. As participants are not asked to think about a specific person, which has been shown to evoke stronger levels of stigma, they may be more forthcoming in their general attributions. The ES has been found to inversely relate to stigma (as measured by the AQ-9), and significantly predict AQ-9 outcomes (Corrigan et al., 2013, 2014).

Attribution Questionnaire (AQ-9). This brief adaptation of the Attribution Questionnaire (Corrigan et al., 2003, 2014) will be used to assess the presence of stigmatizing attitudes. The AQ-9 is comprised of the nine items with strongest factor loadings onto the nine stigma-related factors from the original questionnaire: blame, anger, pity, help, dangerousness, fear, avoidance, segregation, and coercion. Participants will read a brief vignette about Harry, who "is a 30-year-old single man with schizophrenia," before responding to questions (e.g. "How dangerous would

you feel Harry is?) on a nine-point Likert scale (1 = *not at all*; 9 = *very much*). Higher AQ-9 scores represent more stigmatizing views. Internal consistencies for the AQ-9 in college students, community members, health care providers, and mental health providers are good, with Cronbach's alphas ranging from .62 to .82 (Corrigan, Gause, Michaels, Buchholz, & Larson, 2015; Corrigan et al., 2014), although some studies using the AQ-9 have removed items following factor analysis or to improve internal consistency (e.g., Corrigan et al., 2015; Mittal et al., 2015). For the current study, Harry's employment was changed from the author's original, "a large law firm," to the modified, "a large insurance institution," to better control for participant attributions and maintain a more neutral character.

Study 2

Participants. Attorney participants will be drawn from three public defense organizations in a large metropolitan city in the northeast United States (n = 119), using a combination of online surveys through Qualtrics and printed surveys, depending on the preference and atmosphere of each organization. Demographic information will be collected regarding age, gender, race/ethnicity, and number of years in law practice.

Measures. Attorneys will complete the Compassion Scale, Empowerment Scale, and Attribution Questionnaire as outlined in Study 1. The familiarity construct will also be assessed using an author-created self-report survey as in Study 1, with the following modifications relevant to the attorney sample. Attorneys will be asked if they have ever represented a client with a psychiatric diagnosis, used a client's psychiatric diagnosis in their defense, or practiced in a designated mental health court. Attorney participants' level of relevant education will be assessed through questions about continuing legal education (CLE) classes or other specialized training regarding mental health. Attorneys will answer the same questions as in Study 1

regarding psychiatric diagnosis and treatment, and/or participation in mental health-focused law classes, clinics, or psychology classes.

Anticipated Results and Discussion

Anticipated Results

Preliminary analyses. Descriptive statistics will be gathered to examine data for normality, homoscedasticity, independence, and linearity, as well as to identify trends in demographic variables and group membership.

Hypothesis testing. Hypotheses 1 a) and b) will be tested using linear regression. Hypotheses 2 a) and b) will each be tested using moderation analyses in PROCESS model 1 (A. F. Hayes, 2013). The Johnson-Neyman method will be used to plot the zone of significance for the moderation effects. Results from G*Power with a medium effect size ($f^2 = 0.15$) suggest a sample size of $n = 77$ for each group to examine these moderation analyses with $\alpha \leq .05$ and $1 - \beta = .80$. A larger group sample ($n = 119$) would allow for higher power ($1 - \beta = .95$). For Study 1, it is expected that higher reported compassion among law students will strengthen both the inverse predictive relationship between familiarity and the predictive relationship between familiarity and empowering attitudes. Similarly, in Study 2, it is expected that higher reported compassion among attorneys will strengthen the inverse relationship between familiarity and stigma and the predictive relationship between familiarity and empowering attitudes.

Anticipated Discussion

The findings from this study will be discussed to explore stigmatizing and empowering attitudes endorsed by attorneys and law students in regards to individuals with mental health diagnoses. The relative impact of contact and compassion on empowering and stigmatizing attitudes will be explored as possible moderating and predicting variables, respectively. While

explicitly assessed attitudes cannot perfectly predict engagement in prejudicial behavior or even necessarily accurate accounts of stigmatizing attitudes (for example, due to socially desirable responding), there has been support for the use of well-formulated questionnaires, such as those used in the proposed study, to assess stigma (Graves, Cassisi, & Penn, 2005; Link et al., 2004; Michaels & Corrigan, 2013; Stier & Hinshaw, 2007). In fact, in a study examining the relationship between psychophysiological responses to negative affect in response to stigmatized others, the authors found that higher levels of psychophysiological reactivity predicted higher global self-reported attitudes of psychiatric stigma (Graves et al., 2005).

The importance of thoughtful contact and engendering compassionate values should inform future directions in law school education and CLE focus, particularly for public defenders. Increasing empowering attitudes and reducing stigmatizing attitudes among legal professionals may increase positive outcomes for criminal justice involved individuals with mental health concerns, as these attitudes may allow attorneys to best serve in an advocate role for their clients. Hopefully, future courts will see less psychiatrically distressed defendants, and there will no longer be a need for problem solving courts, when the social difficulties associated with psychological distress will be better addressed in restorative, inclusive, and dignified community settings.

Limitations. There are several anticipated limitations to this study. It is anticipated that response rates will be low for both Study 1 and Study 2, which means that results may be influenced by a selection bias. In addition, due to the voluntary self-report nature of the study, it cannot be known for certain whether the responses collected are accurate and valid representations of the beliefs or experiences of the surveyed group. As the sample is only a small portion of the larger population, the findings of this study should also be generalized with

caution to the larger groups of law students and public defense attorneys, as a whole. Finally, due to the sensitive and face-valid nature of the survey items, it is possible that respondents answered items in a way that might minimize negative attitudes, as these professionals and students may naturally not want to portray their group as holding stigmatizing attitudes towards their own clients or potential future clients.

Future Directions. Follow-up analyses with the current data and/or new samples could be examined to assess how student samples and attorney samples may relate to each other, in a cross-sectional study design. Data collection from more relevant and specialized samples could also lead to more relevant and generalizable findings, for example, surveying social justice-focused "feeder" law schools, with students who have early intentions to pursue public defense work, along with assessing specialized mental health attorneys, who are more likely to handle cases in mental health courts. Similar research questions would also benefit from administration to a sample of judges, especially judges in court parts who handle higher volumes of mental health-related cases. Further information examining the impact of various educational methods and topics should also be examined to uncover the relationship between biogenetic beliefs and stigmatizing attitudes. This area is important to consider in order to better tailor law school education and continuing education credits to increase focus on social causes, rather than biological or genetic causes, of psychological distress.

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