Stigma associated with mental health difficulties during childhood and adolescence: Lessons to be Learned?

Caroline Heary
Overview

- Peer relations of children/adolescents with mental health issues
- Public stigma:
  - How individuals with emotional / behavioural issues are regarded by their peer group?
- Personal Narratives
- Peer perspectives – reasons for exclusion
- Key conclusions
Social Functioning & Peer Relations

• Formation of close friendships & acceptance in the larger peer group are essential for children’s psychosocial development (Hartup, 1996; Hay, 2005; Ladd, 2005).
Peer relationships

- Children with mental health difficulties experience:
  - greater exclusion from their peer group than typically-developing peers (Hoza, et al., 2005; Parker, Rubin, Price & De Rosier, 1995).
  - more likely to be identified as victims of bullying by their mothers than children who did not have such difficulties (25.1% v 10.6%) (Reulbach, 2013).
Prevalence of mental health issues

• Approximately 20% of young people are affected by a mental health disorder (NIMH, 2010).

• 75% of all serious mental health difficulties first emerge between the ages of 15 and 25 (Hickie, 2004; Kessler et al, 2005; Kim-Cohen et al, 2003).
Stigma widely recognized as a problem in adult mental health

- World Health Organization (2013-2020)
  - ‘To reduce stigmatization and discrimination and promote human rights across the lifespan’ (p. 15)

- Experience of stigma is not confined to the adult years
  - However we know much less about stigma in childhood…

- Stigma has a negative impact on help-seeking (Clemente et al. 2015)
· ‘Stigma is a socio-cultural process by which members of marginalised groups are labelled by others as abnormal, shameful or otherwise undesirable’ (Jones & Corrigan, 2014, p.9).

· The problem of stigma does not reside within the individual
  – but rather in the stigmatising communities in which individuals find themselves (Jones & Corrigan, 2014, p.9).
Meaning of Stigma

- Stigma involves:
  - cognitive processes (stereotypes)
  - negative emotion-laden judgments (prejudice)
  - behavioural responses (discrimination).
Terminology

- Obesity
  - Weight Bias
  - Anti-fat prejudice
  - Obesity Stigma / Weight Stigma

- Developmental Science
  - Prejudice

- Psychiatry / Mental Health Services
  - Stigma

NUI Galway OÉ Gaillimh
Focus on Stigma: Developmental science vs. Health Services Literature

Stigma research
- Gender √
- Race √
- Mental health disorders X
- Obesity X

Developmental science

Health Services/Mental Health / Psychiatry

Strong focus on mental health stigma

School of Psychology, NUI, Galway
Understanding Patterns of Stigma

How children/teenagers with emotional / behavioural issues are regarded by their peer group?
Comparison of Peers with Mental Health Issues versus Those Without


<table>
<thead>
<tr>
<th>Stereotypes</th>
<th>Depression Depressed</th>
<th>Depression Comparison</th>
<th>ADHD</th>
<th>ADHD Comparison</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dangerousness</td>
<td>3.28 (2.26)</td>
<td>2.84 (2.30)*</td>
<td>3.51 (2.17)</td>
<td>2.64 (2.25)**</td>
</tr>
<tr>
<td>Responsibility</td>
<td>3.67 (2.00)</td>
<td>3.84 (2.00)</td>
<td>4.48 (2.02)</td>
<td>3.95 (1.96)**</td>
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<table>
<thead>
<tr>
<th>Prejudice</th>
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<tbody>
<tr>
<td>Fear</td>
<td>1.74 (1.10)</td>
<td>1.51 (1.00)**</td>
<td>1.95 (1.18)</td>
<td>1.52 (1.03)**</td>
</tr>
<tr>
<td>Anger</td>
<td>2.50 (1.51)</td>
<td>2.17 (1.58)*</td>
<td>3.34 (2.01)</td>
<td>1.92 (1.33)**</td>
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<thead>
<tr>
<th>Discrimination</th>
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<tbody>
<tr>
<td>Behavioural intentions</td>
<td>52.20 (12.18)</td>
<td>59.66 (10.70)**</td>
<td>47.76 (13.55)</td>
<td>61.50 (10.00)**</td>
</tr>
<tr>
<td>Relationship social distance</td>
<td>2.31 (1.07)</td>
<td>1.56 (0.81)**</td>
<td>2.72 (1.90)</td>
<td>1.58 (0.83)**</td>
</tr>
<tr>
<td>Physical social distance</td>
<td>2.55 (1.77)</td>
<td>1.67 (1.32)**</td>
<td>3.16 (2.03)</td>
<td>1.75 (1.65)**</td>
</tr>
</tbody>
</table>
• Factors that influence mental health stigma:
  – Age
  – Gender
  – Type of mental health issue

• Method of assessment
  – Implicit / explicit
Attribution Theory (Weiner, 1993)

- Attribution of responsibility
  - Meaningfully related to personal feelings towards a peer whose behaviour is problematic

- **Perceived responsibility = key predictor of acceptance** (when the target character male)

- (Swords, Heary & Hennessy, 2011).
ADHD is more explicitly stigmatised than depression (O’Driscoll et al., 2012).

Implicit assessment:

- Adolescent males demonstrated significantly stronger negative implicit evaluations of depression compared with younger males and adolescent females.
- Male adolescents had more negative implicit attitudes towards depression than ADHD.

Interaction between age, gender & type of disorder
Stigma may also involve a process of internalization, whereby the targeted individual will internalize negative responses (Hinshaw, 2005).

SELF-STIGMA
Retrospective accounts: The experiences of having a mental health problem during childhood and/or adolescence

- Dominant characterization was of being ‘different’ to others.
  - Being different was characterized negatively
  - ‘Weak’ ‘broken’ ‘damaged’

Coping Strategies to Stigmatization

• Gravitating towards those with similar problems can sometimes protect against the experience of stigma.
  
  – “I feel when you have it [a mental health problem] it’s like you just kind of hone in to other people that have it.” (Amy, 18, depression)

• Standing up to bullies

• Attempts to normalise mental health issues

• Selective disclosure / hiding the ‘stigmatised identity’
Disclosure – Children with ADHD
Qualitative study of primary school boys (Lagendijk & Heary)

• Many participants expressed that they would not disclose they attended CAMHS or took medication,

• Some expressed that they had told a limited number of friends.
  • “No I didn't tell anyone because mammy said ‘Don't tell anyone’, because they might tell their mum. Because it's a family secret, means that I can't tell anyone at all. It's none of their business.
    
    What would happen if you told someone?’
    
    Very, very mad.”
Parents’ perspectives on the stigma associated with childhood ADHD and depression

- Failure to view the disorder as legitimate appears to be associated with stigmatising views
  - “A lot of people’s attitude is it’s just a makey-uppy thing, you know, for wild kids.” (Meredith, daughter, 16, ADHD)
  - “Most of them would think in general that the child is spoiled and being over-indulged.” (Kathleen, daughter, 14, depression).
- Perceived intolerance of the child’s behaviour
  - (McKeague, L., Hennessy, E., O'Driscoll, C. & Heary, C.)
Medicating the child: Perceptions of negativity and personal concerns

- Experiences of stigmatisation in relation to the parental decision to medicate the child
  - Meredith (daughter, 16, ADHD): “‘Oh my God! She’s got her child on drugs to keep her quiet!’ That seems to be a more negative thing than having ADHD.”
  - Kathleen (daughter, 14, depression): “Very few people know that she’s on Prozac, because, again, that’s because of the stigma thing.”
The Perspective of Peers…….

Adolescents’ Explanations for the Exclusion of Peers With Mental Health Problems: An Insight Into Stigma

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Abstract
Young people with mental health problems are often excluded from their peer group; however, research has not specifically explored their peers’ explanations for this exclusion. Drawing on data from group interviews with Irish adolescents (N = 146), this study explores the reasons offered for rejecting young people with mental health problems. Such reasons include perceived violation of expectations of friendships, and perceived social and personal risks to members of the peer group. The implications of these findings for the development of interventions to combat the stigma of mental health problems are discussed.
Reasons for Exclusion: Risk & Reciprocity

• Violation of reciprocity expectations
  – Peer with depression: concern that friendships are unreciprocated
    • need to “put an effort into” friendships
  – Peer with ADHD:
    • Domination of interactions
    • Concern regarding unreciprocated support

Reasons for Exclusion: Risk & Reciprocity

• Risk
  – ADHD:
    • Threat to their social reputation.
    • Would not behave in accordance to social norms
    • Disciplinary consequences
  – Depression:
    • Emotional contagion
What works?

• Mental Health Stigma Reduction (Adolescents):
  – Both education & contact have been found to significantly affect stigma
    • Education yielded significantly greater effects on attitudes than contact (the opposite was found for adults).

(Corrigan, Morris, Michaels, Rafacz, Rüscher, 2010).
Further Systematic reviews

- Interventions to reduce ethnic prejudice (early childhood)
  - Contact
  - Media/instruction forms of intervention showed some success (Aboud et al. 2012).

- Strongest effects on Intergroup attitudes:
  - Direct contact experiences
  - Social-cognitive training to promote empathy and perspective
    - (Beelmann & Heinemanns (2013).)
Lessons to be Learned

• Caution in transferring adult measures and concepts to research with children / adolescents

• From the perspective of young people, stigmatised conditions are not a homogeneous entity
  – A lot to be learned from consultations with children/young people (both those with the health issue and the broader peer group)

• Need for diverse methodologies to understand experience and expression of stigma during childhood & adolescence
Feasibility of stigma reduction programmes for individual health conditions?
Conclusion

• A lot of unanswered questions in terms of the best way forward for stigma reduction during childhood/adolescence

• Attitudes once formed are difficult to change (Bigler and Liben, 2007).
  – children under age 12 are rarely the focus of stigma change (Corrigan, Morris, Michaels, Rafacz, Rüsch, 2010).

• Need for evidence-based approaches to stigma reduction.
Some Useful Resources
Research Team

- Eilis Hennessy (University College Dublin)
- Lynn McKeague (Winchester University, formerly University College Dublin)
- Claire O’Driscoll (NHS, formerly NUI, Galway)
- Malie Lagendijk (NUI, Galway)
- Charlotte Silke (NUI, Galway)
- Lorraine Swords (Trinity College Dublin)

Funders:

- Health Research Board, Ireland
- Irish Research Council
Thank you
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