Social Science & Medicine 216 (2018) 88–96

Contents lists available at ScienceDirect

Social Science & Medicine

journal homepage: www.elsevier.com/locate/socscimed

Parental recognition of preadolescent mental health problems: Does stigma matter?

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ARTICLE INFO

Keywords:
Stigma
Mental health
Help-seeking
Adolescents
Parents
USA

ABSTRACT

Rationale: Parents are one of several key gatekeepers to mental health (MH) services for adolescents with MH problems. Parental MH stigma is a significant barrier to treatment, yet little is known about how stigma may bias parental recognition of mental illness in youth.

Objective: This study examines how stigma influences a critical and early stage of the help-seeking process—the recognition of MH problems in preadolescents by their parents.

Method: Parents from a school-based anti-stigma intervention study were analyzed. Logistic regressions examined the association of stigma with parental recognition of MH problems in their preadolescent child (10–12 years old) and that of two preadolescent vignette characters described as having bipolar disorder and social anxiety disorder.

Results: The more parents desired their preadolescent child to avoid interaction with individuals with a mental illness—that is, to be more socially distant—the less likely these parents believed their child had a MH problem, controlling for parent-reported MH symptoms and other covariates. This pattern was prominent among parents who reported high symptoms in their child. Social distance had no bearing on whether parents recognized the vignette characters as having a problem. Avoidance of individuals with a mental illness and knowledge/positive MH attitudes were not associated with problem recognition.

Conclusion: Stigmatizing attitudes of parents may be detrimental when trying to understand the psychopathology of their own preadolescent children but not preadolescents outside their family. Stigma may present itself as a barrier to problem recognition because it may impose a significant personal cost on the family, thereby affecting the help-seeking process earlier than considered by previous work.

1. Introduction

The burden of mental health problems has steadily increased over time and become a growing concern in adolescent populations across the world (Bor et al., 2014; Polanczyk et al., 2015). Although treatment is most common among adolescents with severe psychiatric problems (Merikangas et al., 2009), fewer than half of adolescents with a disorder receive treatment (Merikangas et al., 2009, 2011; Olfson et al., 2015). Left untreated, poor mental health can negatively impact adult outcomes, including unemployment, low income, and limited social mobility (Egan et al., 2016; Goodman et al., 2011; Smith and Smith, 2010). These substantial consequences highlight the need to understand the factors that impede and/or encourage adolescents to receive care, especially considering the availability of effective treatments (Chorpita et al., 2011). However, adolescent help-seeking is complex because adolescents often require adult gatekeepers to facilitate entry into formal mental health care. The ways in which gatekeepers, particularly parents, perceive mental illness in adolescents may significantly influence the help-seeking and illness trajectories of adolescents with mental health problems. This study examines an early stage of the help-seeking process—parents' recognition of mental health problems in adolescents.

Generally, mental health stigma is negatively associated with help-seeking and treatment use (Clement et al., 2015; Gaddis et al., 2018; Ohan et al., 2015). For adolescents especially, parental stigmatizing attitudes are strong barriers to help-seeking (Gronholm et al., 2015); however, little is known about how stigma may impact earlier stages of

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https://doi.org/10.1016/j.socscimed.2018.09.040
Received 18 December 2017; Received in revised form 12 September 2018; Accepted 21 September 2018
Available online 22 September 2018
0277-9536/

this process. The purpose of this study is to assess whether stigma among parents plays a role in their recognition of mental health problems in preadolescents (aged 10–12 years).

1.1. Mental health problem recognition

The parent-mediated pathway to adolescent help-seeking can be summarized in three steps: (1) problem recognition—the realization that observed symptoms/behaviors are problematic; (2) decision to seek help—recognizing the benefits of treatment; and (3), treatment selection—choosing to seek informal and/or formal care (Cauce et al., 2002). While progression through these stages is not always linear, many studies point to the importance of problem recognition—appraisals and perceptions of mental health problems—as it is strongly and positively linked with willingness to seek help and treatment utilization (Godoy et al., 2014; Logan and King, 2002; Oh and Bayer, 2015; Pescosolido et al., 2008; Teagle, 2002; Thurston et al., 2015).

Cauce et al. (2002) note that problem recognition can be assessed in two ways: as an objective measure of epidemiologically defined need (e.g., mental health screening, clinical assessments) or as a subjective measure of perceived need (i.e., belief that someone has a mental health problem). Although objective and subjective need are correlated features of the problem recognition construct, each is conceptualized separately (Fleishman and Zuvekas, 2007). Objective need measures provide specific information about the type, severity, and/or persistence of mental health problems, whereas subjective need taps into global perceptions of illness and indicates whether individuals identify with the sick/patient role. The presence of symptoms can inform global perceptions of adolescent mental illness among parents; yet, symptoms may not always align with the way parents perceive mental illness in their children and whether they consider specific symptom patterns as problematic (Cauce et al., 2002). For example, two-thirds of parents of children with mental health symptoms do not perceive these symptoms as part of an underlying mental health problem (Logan and King, 2002; Teagle, 2002). For the current study, we conceptualize problem recognition as a perceived need because the global belief that a mental health problem exists is related to help-seeking intentions among parents and is one of the strongest predictors of help-seeking in young populations (Oh and Bayer, 2015). Objective need measures are conceptualized as predictors of perceived problem recognition.

Previous studies reveal several influential factors that contribute to the recognition of problematic adolescent mental health among parents, including the nature of the problem, prior exposure to mental illness, mental health literacy, and familial dynamics. First, severe mental health symptoms may inflict functional impairments in adolescents and substantially burden families, prompting parents to believe their adolescent child is experiencing psychological difficulties (Godoy et al., 2014; Logan and King, 2001, 2002; Teagle, 2002). Additionally, although internalizing symptoms are perceived as more severe than externalizing symptoms (Pescosolido et al., 2008), the latter are more identifiable (Thurston et al., 2015). Second, problem recognition assumes that parents have a working knowledge of the causes of mental disorders (Godoy et al., 2014). Likewise, parents who have personal experience with mental illness (family history of illness/treatment, contact with people with a mental illness) are better able to acknowledge the signs of moderate to severe psychological distress, depression (at both the symptom and disorder level), and diagnosable internalizing/externalizing problems among children/adolescents (Logan and King, 2002; Thurston et al., 2015). Lastly, characteristics of families are important. Close parent-adolescent relationships can facilitate trust in communicating mental health concerns between parents and adolescents, making parents more aware of their symptoms and helping them frame these symptoms as part of a larger psychiatric problem (Logan and King, 2002). Existing research, however, has overlooked the potential role of stigma in affecting how parents view adolescent mental health.

1.2. Stigma and problem recognition

Link and Phelan (2013) broadly conceptualize stigma as the convergence of the following interrelated components: labeling, stereotyping, separation, status loss, and discrimination. In the first component, differences between persons are distinguished and labeled (e.g., someone has a mental illness versus not). Undesirable characteristics and negative stereotypes are then applied to labeled persons, creating a sense of separation between groups ("us" versus "them"). The culmination of these components leads to labeled persons experiencing negative social consequences including diminished social status and increased discrimination.

This conceptualization informs the domains that are relevant to measuring mental health stigma. One of the most common approaches is to measure the desire for "social distance"—a person's level of willingness to interact with a stigmatized person in different types of relationships (Link et al., 2004). Social distance captures the separation and discrimination components of stigma. Assessments of mental health knowledge and attitudes, in contrast, examine the pervasiveness of stereotypes (e.g., mental illness as a weakness) as cognitive knowledge structures in the general public (Link et al., 2004). Lastly, the labeling component relates to distinguishing differences between persons with and without a mental illness. Labeling can lead to stereotypes and discrimination or treatment engagement or both. Because of this potential dual consequence, Link and Phelan (2013) have referred to labeling as involving a "package deal" that can simultaneously confer positive and negative consequences.

Corrigan (2004) postulates that stigma influences help-seeking among persons with mental illness in two ways. First, public stigma—negative public attitudes and actions (e.g., social distance, avoidance) towards persons with a mental illness may deter individuals with a mental illness from seeking treatment to avoid being labeled or to escape deleterious consequences like prejudice and discrimination. The second way is through self-stigma—internalized public stigma—-where persons may eschew treatment to elude stigma's negative effects on their sense of self. This framework, however, presumes stigma is a consequence of recognizing a mental illness. It does not consider whether preexisting stigmatizing attitudes disrupt problem recognition in oneself, close family members, and others early in the help-seeking process.

Research on stigma and psychiatric labeling in adolescents is less developed than in adults. The primary concerns of existing research have been to examine the ways labels affect stigmatizing attitudes, rather than the reverse: Whether stigma affects labeling (problem recognition). For example, among Australian youth, schizophrenia/psychosis labels perceived in vignette characters were associated with the belief that these characters were dangerous or unpredictable (stereotypes), but these labels did not worsen social distance attitudes (separation and discrimination) (Wright et al., 2011). In contrast, accurate labeling of psychiatric disorders by young populations decreased stigmatizing attitudes linked to beliefs that these conditions were a sign of weakness and not illness, thereby negating certain stereotypes, but not other stigma outcomes (Yap et al., 2013).

This study builds on such past research to further understanding of stigma and problem recognition in three ways. First, prior research has generally focused on the youth perspective—how youth label a mental illness—and has neglected to consider the role parents play in recognizing mental health problems in young people. As a key gatekeeper to mental health services, it is vital to understand how stigma may affect parents' recognition of these conditions in adolescents.

Second, the central question in past studies has been whether psychiatric labels increase stigma, not the reverse: Does stigma influence recognition of mental health problems? For the current study, we propose that stigma may influence parental recognition of mental health problems in adolescents because stigma may push parents to deny their adolescent child's symptoms or reframe their perceptions of