Social Science & Medicine 109 (2014) 26–34

Contents lists available at ScienceDirect

Social Science & Medicine

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

Determinants of mental illness stigma for adolescents discharged from psychiatric hospitalization

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ARTICLE INFO

Article history:
Available online 25 January 2014

Keywords:
USA
Adolescents
Mental illness
Psychiatric hospitalization
Peers
Social groups
Stigma
Social rejection

ABSTRACT

Little is known about the factors that increase the risk for enacted mental illness stigma (i.e. rejection, devaluation and exclusion) as perceived by the stigmatized person. This is particularly true for the population of adolescents diagnosed with a mental illness. The aim of this study was to address this question and examine select social and clinical factors that predict enacted stigma (self-reported) with research that follows eighty American adolescents for 6 months following a first psychiatric hospitalization. Drawing on social identity theory, and research on stigma-threatening environments, social group identification and social support, this study tested four hypotheses: affiliation or identification with higher status and lower status peers predicts more and less stigma respectively (H1); a greater and more supportive social network, and more perceived family support predict less stigma (H2); greater severity of internalizing and externalizing symptoms predicts more stigma (H3); and poorer school functioning predicts more stigma (H4). Results indicated that about 70% of adolescents reported experiencing enacted stigma (at 6 months); disrespect or devaluation was more common than outright social rejection. Using OLS regression analyses, the results provided partial support for H1, H3 and H4, while H2 was not supported. The baseline factors found to be most predictive of enacted stigma ratings at 6-months were: affiliating with more friends with mental health problems, identifying with the 'populars' peer group, higher internalizing symptom ratings, and self-reported disciplinary problems at school. These four factors remained significant when controlling for initial enacted stigma ratings, pointing to their importance in determining changes in social stigma experiences in the follow-up period. They also remained significant when controlling for perceived public stigma ratings at follow-up, indicating that the findings were not due to generalized perceptions of stigma of youth with mental illness.

Introduction

Youth treated for psychiatric disorders are at risk of experiencing mental illness stigma, typically expressed as devaluation, teasing, under-estimation, and social exclusion by peers, teachers, and even by family members (Bicksler, 2002; Chandra & Minkovitz, 2007; Elkington et al., 2012; Huphrey, Storch, & Geffken, 2007; Hutzler, Fliess, Chacham, & Van den Auweele, 2002; Moses, 2010b). Behaviors associated with psychiatric conditions, diagnostic labels, and association with treatment all incur stigma. For instance, a recent prospective study finds that depression symptoms in young adolescents predict more social helplessness (e.g., little initiative, lack of conflict resolution), which, in turn, predicts more teacher-observed peer rejection and peer neglect (Agoston & Rudolph, 2013). A number of experimental studies demonstrate the power of mental illness labels in tainting peers' perceptions of and subsequent behavior toward the labeled child (Juvonen, 1991; Milich, McAninch, & Harris, 1992). Unfortunately, peer denigration and rejection exact a heavy price; a large body of literature attests to the damaging consequences of peer rejection in adolescence for long-term mental and physical health (Boulard, Quertemont, Gauthier, & Born, 2012; Graham, Bellmore, & Juvonen, 2003; Masten et al., 2009). The far smaller body of literature specifically focused on mental illness stigma in childhood and adolescence indicates that stigma generates emotional pain that adds substantially to the burden of illness (for a review, see Hinshaw, 2005). Moreover, the anticipation of stigma from peersis very costly as it keeps youth from seeking help when needed (Draucker, 2005; Yap, Wright, & Jorm, 2011). For these reasons, a better understanding of the social dynamics of mental illness stigma in adolescence is vital.

Although the lion's share of research on mental illness stigma and its effects has focused on adult mental health (MH)

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http://dx.doi.org/10.1016/j.socscimed.2013.12.032

consumers (Hinshaw, 2005; Mukolo, Heflinger, & Wallston, 2010), in recent years, public awareness of the high rates of diagnosable or treated MH conditions among youth (Burnett-Zeigler et al., 2012; Kessler et al., 2012) has led to greater interest in exploring stigma related to childhood mental illness, both in terms of public attitudes and the perspectives of young MH consumers (Hinshaw, 2005). Still, little is known about the stigma experiences of adolescent MH consumers. Even less is known about the individual attributes and social conditions that relate to more/less stigma.

Generally, the coherence of the literature on mental illness stigma is hampered by the use of the concept "stigma" to refer to different aspects of this experience. The most commonly studied aspects of stigma involve assessing the public's negative attitudes toward individuals with mental illnesses (e.g., as weak, dangerous, socially unacceptable) and desire to maintain social distance (termed public stigma) (Coleman, Walker, Lee, Friesen, & Squire, 2009; Martin, Pescosolido, Olafsdottir, & McLeod, 2007). Also, some studies specifically focus on mental health consumers' own *perceptions of* public stigma directed toward people with mental illness (perceived public stigma); most focus on adults, but several do target the perceptions of young people with a mental illness (Draucker, 2005; Meredith et al., 2009; Walker-Noack, Corkum, Elik, & Fearon, 2013). The least commonly studied aspect of stigma, and the focus of this research, concerns experiences of outright degradation, social rejection or discriminating behavior directed at oneself (termed enacted stigma). The study of stigma is further complicated by recent recognition that stigma-related attitudes and behaviors vary by the type of disorder: psychotic and substance use disorders are often associated with stereotypes of dangerousness and are most stigmatized; anxiety and depressive disorders are often associated with notions of 'weakness, not sickness'; while ADHD and other disruptive behavior often engender anger or irritation and desire for social and physical distance (Jorm & Wright, 2008; O'Driscoll, Heary, Hennessy, & McKeague, 2012; Pescosolido, Perry, Martin, McLeod, & Jensen, 2007; Reavley & Jorm, 2011; Yap et al., 2011).

This six-month follow-up study of adolescents discharged from their first psychiatric hospitalization, an event that has historically been highly stigmatized (Verhaeghe, Bracke, & Bruynooghe, 2007), addressed the question of *enacted stigma* or youths' personal experiences of devaluation and social rejection. To address the gap in knowledge of individual and social factors that relate to enacted stigma, we draw on insights from social identity theory, and research on threatening environments, and group identification to develop hypotheses regarding the influence of social affiliation and identification, social support, clinical attributes, and school-functioning factors that may relate to mental illness stigma. As the majority of participants in this study have been diagnosed with a mood disorder, the literature reviewed here focuses on depression and bipolar disorders rather than the more common ADHD literature (e.g., Bussing, Zima, & Perwien, 2000; Harris, Milich, Corbitt, Hoover, & Brady, 1992; Kellison, Bussing, Bell, & Garvan, 2010).

Public stigma

The public tends to view youth with mental illnesses including depression and bipolar disorder unfavorably, expressing a punitive or distancing response toward these youth (Martin et al., 2007; Pescosolido et al., 2007). Likewise, children, adolescents, and young adults, the primary reference group for young MH consumers (Crosnoe & McNeely, 2008), also tend to express more negative attitudes, including more blaming attributions and avoidance toward peers with a mental illness relative to peers with a physical health condition (Adler & Wahl, 1998; Coleman et al., 2009; Law, Sinclair, & Fraser, 2007; Milich et al., 1992; O'Driscoll et al., 2012). Studies comparing youths' attitudes toward ADHD vs. depression find depression to be more stigmatized (Coleman et al., 2009; O'Driscoll et al., 2012; Walker, Coleman, Lee, Squire, & Friesen, 2008). Studies probing such attitudes indicate that youth often have little accurate knowledge about depression and other MH conditions, and that they are quite susceptible to adopting peers' stigmatizing attitudes (Pinto-Foltz & Logsdon, 2009; Wahl, Susin, Lax, Kaplan, & Zatina, 2012; Wisdom & Agnor, 2007). At the same time, the absolute levels of reported negative attitudes toward 'mental illness' and desire for social distance among youth are modest across studies (e.g., Reavley & Jorm, 2011; Wahl et al., 2012).

Research is limited on the frequency or nature of mental illness stigma experienced by youth diagnosed with severe MH conditions. The few available studies yield a mixed and nuanced story. Qualitative research indicates that youth identified with MH illnesses do report outright rejection or negative changes in some social and family relationships upon disclosure of a diagnosis or treatment (e.g., mistrust, under-estimation); but they also report receiving support and acceptance in the same relationships or from others (Elkington et al., 2012; Moses, 2010b). Youth with anxiety and mood disorders tend to report less stigma and more support in their personal relationships relative to peers with psychotic or behavioral disorders (Elkington et al., 2012). In any case, youth with a variety of MH conditions including depression often anticipate or fear social rejection should peers learn about their condition/symptoms (Marcell & Halpern-Felsher, 2007; Moses, 2011; Wisdom & Agnor, 2007).

An important question yet to be addressed concerns the individual and clinical attributes and social or environmental conditions that make some youth more likely to experience enacted stigma than others (Mukolo et al., 2010). As noted above, some conditions generate more negative, stereotyped attitudes than others. Also, individuals with less first-hand experience with mental illness are more inclined to report stigmatizing attitudes (Angermeyer & Matschinger, 2003; Boyd, Katz, Link, & Phelan, 2010; Couture & Penn, 2003; Jorm & Wright, 2008). However, we have very little information about the individual and social circumstances that that make adolescent MH consumers themselves more likely to report experiencing enacted stigma. Because the consequences of social ostracism are severe for adolescents (Bagwell, Newcomb, & Bukowski, 1998; Brown & Dietz, 2009; Crosnoe & McNeely, 2008; Sussman, Pokhrel, Ashmore, & Brown, 2007), understanding the social context of mental illness stigma is particularly critical for this age population.

The social context of stigma

Researchers have examined the qualities that make environments more stigma-"threatening" (i.e. signal the potential for being devalued or discriminated against). Generally, settings that are heterogeneous, with the stigmatized individuals comprising a small minority can create a sense of being outnumbered and 'otherness'; such environments lead to greater preoccupation with one's social status and the stereotypes associated with it (Inzlicht & Good, 2006). This dynamic is particularly true in contexts that have narrow standards for success (e.g., intelligence, beauty, artistic talent) (Inzlicht & Good, 2006; Murphy & Taylor, 2012). For example, public school populations often hold values that mirror the existing social structure and privilege 'normalcy'. This can be experienced as a threatening environment by a student who struggles with a mental illness or a learning disability (McNulty & Roseboro, 2009).