Young People's Stigmatization of Peers With Depression and ADHD

In 2005, the influential final report from the President's New Freedom Commission on Mental Health identified a series of national priorities for transforming mental health care in the United States.[1] At the very top of the list was the need to reduce the stigmatization that people experience if they have mental health difficulties or if they seek mental health care. The report noted that stigmatization imposes further burdens on people even as they struggle to cope with mental health challenges, by reducing their opportunities to participate fully in social and economic life; contributing to low self-esteem, isolation, and hopelessness; and deterring help seeking.

Of course, designing effective strategies to reduce stigmatization requires first knowing something about how and why stigmatization occurs: What are the thought processes that result in avoidance, distrust, bias, and/or anger directed toward people who experience mental health difficulties? Recent research has helped make significant progress in answering this question with respect to stigmatization toward adults with mental illnesses. The growing knowledge base about the nature of stigmatizing attitudes and beliefs among adults has contributed to the development and evaluation of new theories to explain stigmatization processes, new strategies for reducing stigmatization, and new approaches to reducing barriers to help seeking.

In contrast, the knowledge base about the stigmatization experienced by children and adolescents with emotional and behavioral difficulties is far less developed. One large-scale national study examined stigmatization of children by adults (see page 8), but until very recently there had been no similar research examining the stigmatization of children and adolescents by their peers. In 2006, the Research and Training Center on Family Support and Children's Mental Health collaborated with the polling firm Harris Interactive to explore this topic. The result was the first-ever national survey examining children's stigmatization of peers with depression and attention-deficit hyperactivity disorder (ADHD), two of the most common mental health disorders of childhood. Our survey instrument was developed collaboratively by children's mental health researchers, staff from Harris Interactive, and young people who had experienced emotional and behavioral disorders.

The survey was administered online by Harris Interactive. The survey participants—1,318 young people between the ages of 8 and 18—reflected the demographic characteristics of the broader US youth population in the same age range. Survey participants received one of three versions of the survey, focusing on depression, ADHD, or asthma. Participants read a brief story about Michael, a fictional peer who was described as having one of the three conditions. Participants then answered questions focusing on

- positive and negative attributions about Michael (i.e., assumptions about Michael's personality or character),
- the causes of Michael's condition,
- their family's attitudes about a child with Michael's condition, and preferences for social distance from Michael (i.e., how willing participants thought their peers would be to interact with Michael in different ways).

Participants were also asked whether or not they had ever been diagnosed with the same condition that Michael had, and what sorts of help they would seek if they thought they had Michael's condition.

Levels of Stigmatization

Our survey examined stigmatization through the questions about attributions, social distance, and family attitudes. A relatively positive message to emerge from the survey findings on attributions was that only a minority of respondents thought that Michael with ADHD or depression was lazier, more violent, or more likely to get into trouble than the average peer (Figure 1). However, the comparison with asthma shows that negative attributions were significantly more common toward Michael with depression or ADHD.

In fact, differences with asthma on the questions about "is more violent" and "gets into trouble more often" were some of the most significant effects we found when analyzing the survey data. This is potentially important, since studies on stigmatization of adults have found that people who see the mentally ill as dangerous in some way are much less willing to interact with them.[2] In reality, the rates of dangerous, antisocial acts committed by people with mental illness are relatively rare, and most antisocial acts are committed by people without mental illness.[3] Our study found that, for Michael with depression, participant ratings of likelihood of violence were far higher than the "real world" association of depression and violence. However, for ADHD, par-

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FIGURE 1. PERCENTAGE OF RESPONDENTS WHO THINK THAT, COMPARED TO AVERAGE PEER, MICHAEL...

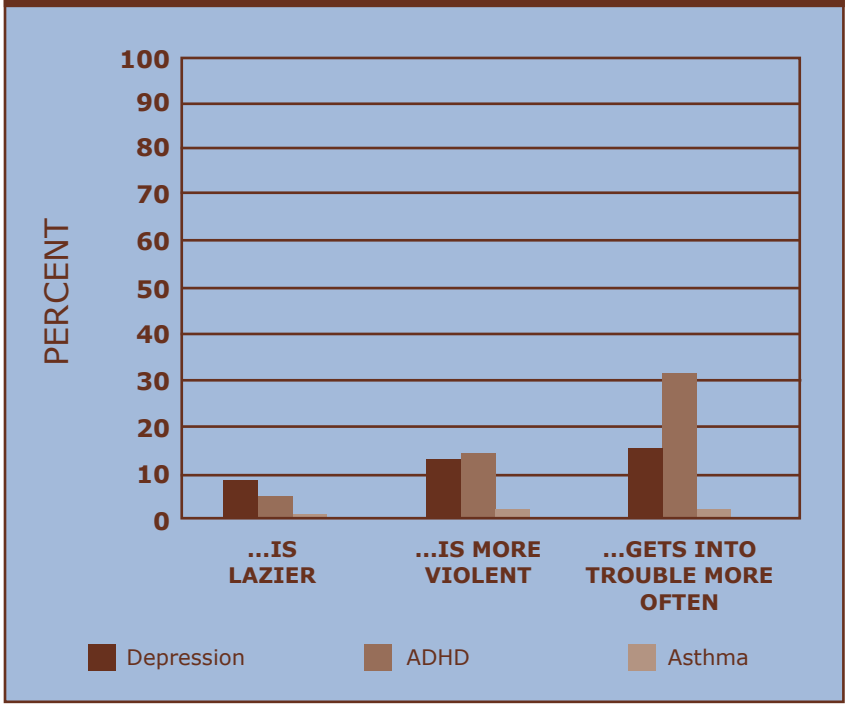
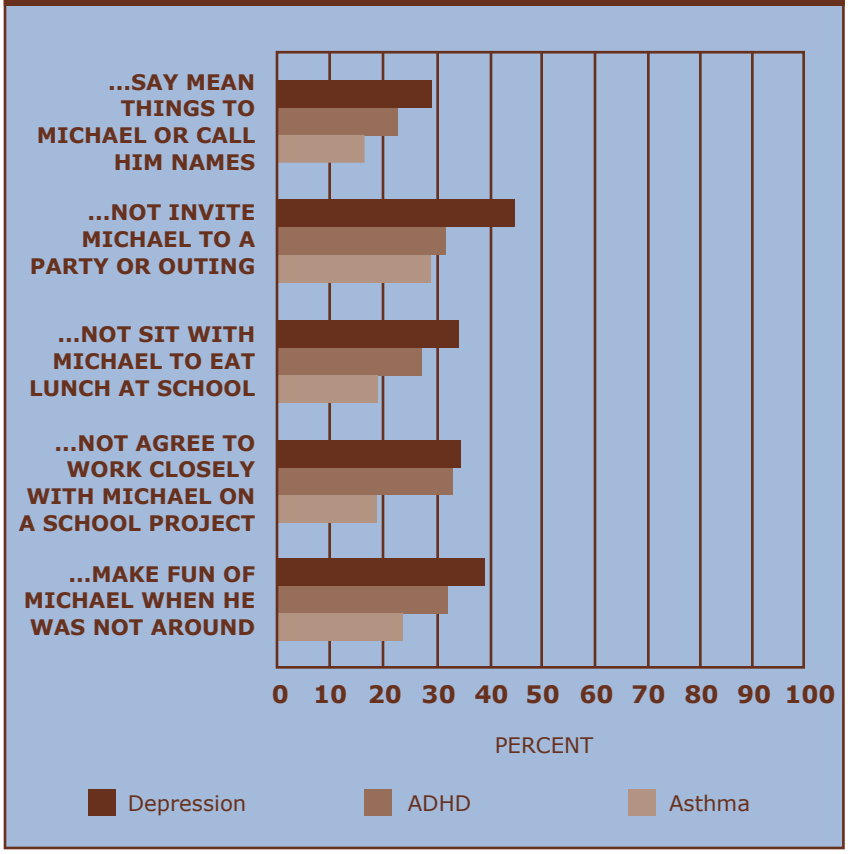


FIGURE 2. PERCENTAGE OF RESPONDENTS WHO THINK THEIR PEERS WOULD...



ticipant ratings of the likelihood of violence or getting in trouble were at a level similar to the real world association of ADHD and these types of behavior problems.

The findings regarding positive attributions provided some contrasts to the general pattern of the negative attributions. For example, though Michael with asthma was slightly more likely to be seen as smarter than average and much more likely to be seen as more caring, Michael with ADHD or depression was thought to be more creative. Michael with ADHD was seen as more likely to have a good sense of humor, on par with Michael with asthma; however Michael with depression was not as likely to be seen as having a good sense of humor.

The most common way that researchers have assessed stigmatization is by measuring social distance. In our survey, overall social distancing was much larger for Michael with depression—and somewhat larger for Michael with ADHD—as compared to asthma (Figure 2).

With regard to family attitudes, only about 10-15% of our participants thought that their families perceived young people with depression and ADHD negatively; however both of these conditions were perceived more negatively than asthma, with depression the most negatively perceived.

Overall, we found no significant differences when we examined attributions, social distance, or family attitudes by sex, and only a few when we looked at differences by race. For example, as compared to White respondents, Hispanic respondents reported somewhat more negative attributions towards peers with ADHD. The largest differences were found for Asian/Pacific Islander respondents who, relative to other respondents, reported more negative attributions toward a peer with depression and more negative family attitudes towards a child with ADHD or depression.

Causes

On the survey, participants were given a list of possible causes and were asked to rate how likely it was that each one might actually be a cause of Michael's condition (Figure 3). Respondents' ratings for three of

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the causes—Michael's fault, bad parenting, and substance abuse—were correlated with each other and with stigmatization (as measured by social distancing). Thus, people who endorsed these causes appeared to have a moralistic and blaming view of the causation of mental health difficulties. These causes were more likely to be endorsed for depression than ADHD and more likely for ADHD than asthma.

Seeing mental health difficulties as caused by "brain differences" appeared to reduce stigmatization (although this effect was small). Seeing mental health difficulties as caused by stress or by God's will was consistent with higher levels of stigmatization, though these effects were modest. Children who said they had been diagnosed with a condition were more likely to endorse stigmatizing causes. Asian/Pacific Islander and Hispanic youth were more likely than others to endorse "bad parenting" as a cause, and African American and Hispanic were more likely to endorse "God's will."

Coping and Help-Seeking

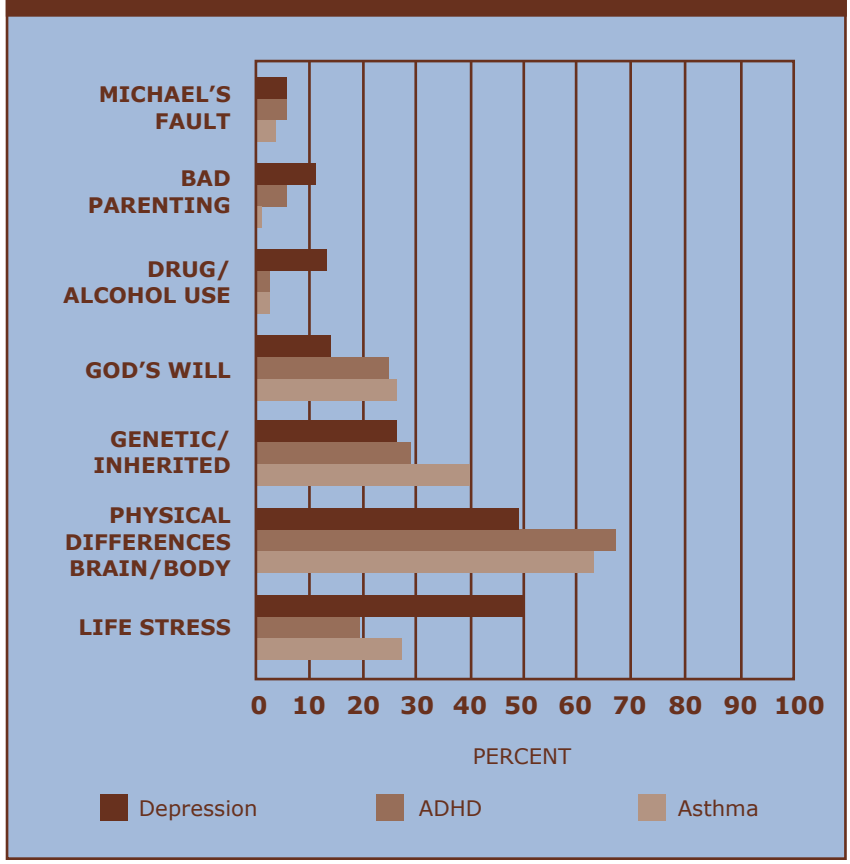
We are still working on analyzing the data about coping and help-seeking; however, even the preliminary analyses have yielded some interesting findings. For example, respondents reported that they would be far less willing to talk to their parents, talk to a doctor, or take medication if they thought they had depression (versus asthma) and somewhat less willing if they thought they had ADHD (versus asthma). Respondents were much more likely to say they would "try harder to act normal" and somewhat more likely to pray if they thought they had depression or ADHD (versus asthma). More respondents in the depression condition predicted that they would "wait for it to go away" or try to change their habits (as compared to ADHD and asthma). Finally, more respondents in the depression condition said they would talk to friends (as compared to ADHD and asthma). Generally, our analyses also showed that respondents with higher scores on the social distance scale (i.e., respondents who reported that peers were less likely to interact with Michael than with an average peer) were also less likely to report they would seek help.

Implications

Our analyses of the survey data have consistently found that both depression and ADHD are more stigmatized than asthma, and that depression is overall even more stigmatized than ADHD. These findings highlight a particular need to develop strategies for reducing the stigmatization of depression among children and adolescents. Our analyses further suggest that many young people believe that peers with ADHD and depression may be dangerous. For depression, these fears appear to be out of line with real-world risk, though for ADHD these beliefs more closely reflected actual rates of problematic behavior among children with ADHD. Of course, this does not justify stigmatization of ADHD, since the great majority of children with ADHD do not develop antisocial behavior and even among those who do get into trouble, for the large majority the trouble is relatively minor.[4]

Thus, for both depression and ADHD, our findings suggest that strategies for reducing stigmatization should address young people's fear that their peers with emotional or behavioral difficulties are dangerous. The link between mental health difficulties and dangerousness is reinforced in children's media, which depict characters with mental illnesses as violent, criminal, and unattractive.[5] It may thus be worthwhile to explore these depictions further, to develop strategies for changing depictions, and to determine whether changing how children's media portray characters with mental health difficulties can impact stigmatization. In England, a novel anti-stigmatization effort called Shift is taking exactly this approach. Project staff provide training to journalism students and work with the Royal College of Psychiatrists and

FIGURE 3. PERCENTAGE OF RESPONDENTS ENDORSING POSSIBLE CAUSES FOR MICHAEL'S CONDITION



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STIGMA VS. STIGMATIZATION

The word stigmatization *has twice as many syllables and more than twice as many letters as* stigma. *In addition, using* stigmatization *leads to relatively more complicated phrases such as "the* stigmatization *of people with depression" (versus "the* stigma *of depression"). And* stigma *is far more commonly used by advocacy groups, researchers, and the media. So why have we at the RTC made the decision in our own writing to use the longer word with the more complicated constructions?*

Our current thinking about this issue began with an angry email we received a few years ago. The writer was firmly opposed to the use of stigma *in connection with mental health conditions, though he was not very specific about why or about what an acceptable alternative would be. My own first reaction was essentially to ignore his comments—why make a change on the basis of one complaint? There did not seem to be any broad-based movement objecting to the use of* stigma *and promoting an alternative.*

As a writer and editor, however, it seemed that the least I could do was to check its definition. The dictionary says that stigma *is a stain, mark, or brand of shame. With this definition in mind, it became easier to see why someone might object to a phrase like the* stigma *of depression. The phrase could be interpreted as saying that depression is a mark of shame. Even though this is clearly not what many people mean when they use* stigma, *the RTC eventually decided that our own policy would be to avoid the word. Instead, we use* stigmatization, *which is the act of casting shame onto others. We feel that this difference, though perhaps subtle, is an important one, and that using* stigmatization *is more consistent with our Center's mission and values.*

Putting together this issue raised the question for us once more, since most of the articles submitted for the issue used stigma. *Ultimately, we decided not to ask our contributors to change their wording, and we were left wondering whether the distinction we were trying to make was meaningful to anyone besides ourselves.*

We hope to gain some insight into this issue from our readers. If you have thoughts on stigma *vs.* stigmatization, *go to the Featured Discussions page on our website (www.rtc.pdx.edu/FeaturedDiscussions/pgFD00main.php), where you can vote for your preference and leave comments. We look forward to hearing from you and we'll let you know what we find out.*

- Janet S. Walker, Editor

leading mental health charities to change how news is reported when people with mental health difficulties commit violent acts. The project's intention is to have news stories stress that most people with mental health problems are not violent and do not pose a risk to others.

Our findings regarding the moralistic and blaming beliefs about the causes of mental health difficulties provide further evidence of stigmatization. They also demonstrate how beliefs about causation are related to young people's willingness to interact with peers who experience emotional or behavioral difficulties. These findings too have implications for stigma reduction programs, suggesting that it may be productive to target beliefs about causation, particularly the beliefs that having emotional or behavioral difficulties results from bad parenting, substance abuse, or not trying hard enough to get better.

Anti-stigmatization efforts should be careful not to overlook the need to address possible self-stigmatization among young people who have actually been diagnosed with a mental health condition. Our findings indicate that self-stigmatization may be significant, and that, for example, professionals and family members should be aware that children with ADHD or depression are even more likely than their peers to hold stigmatizing beliefs about the causes of their own conditions.

Both self-stigmatization and the fear of stigmatization by others appear to deter young people from seeking help for mental health difficulties. Our findings support the idea that strategies to address these barriers to help-seeking are needed. For depression in particular, it may be fruitful to build on the finding that talking to a friend was the avenue for help-seeking or coping that most respondents predicted they would use.

Finally, our studies show some apparently culture-based differences in various attitudes and beliefs that are related to stigmatization. These findings caution against adopting a "one size fits all" approach to anti-stigmatization efforts. Instead, strategies should be developed and tested with possible cultural differences in mind.

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