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The stigma of childhood mental disorders: A conceptual framework

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Abstract

Objective—To describe the state of the literature on stigma associated with children’s mental disorders and highlight gaps in empirical work.

Method—We reviewed child mental illness stigma articles in (English only) peer-reviewed journals available through Medline and PsychInfo. We augmented these with adult-oriented stigma articles that focus on theory and measurement. 145 articles in PsychInfo and 77 articles in MEDLINE met search criteria. The review process involved identifying and appraising literature convergence on the definition of critical dimensions of stigma, antecedents, and outcomes reported in empirical studies.

Results—We found concurrence on three dimensions of stigma (negative stereotypes, devaluation and discrimination), two contexts of stigma (self, general public), and two targets of stigma (self/individual, family). Theory and empirics on institutional and self stigma in child populations were sparse. Literature reports few theoretic frameworks and conceptualizations of child mental illness stigma. One model of help-seeking (the FINIS) explicitly acknowledges the role of stigma in children’s access and utilization of mental health services.

Conclusions—Compared to adults, children are subject to unique stigmatizing contexts that have not been adequately studied. The field needs conceptual frameworks that get closer to stigma experiences that are causally linked to how parents/caregivers cope with children’s emotional and behavioral problems such as seeking professional help. To further research in child mental illness, we suggest an approach to adapting current theoretical frameworks and operationalizing stigma highlighting three dimensions of stigma, three contexts of stigma (including institutions), and three targets of stigma (self/child, family and services).

Keywords

Stigma; Child mental disorders; Conceptual framework; Caregiver help-seeking

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Introduction

Stigma has been identified as a likely key factor in mental health services access and utilization, particularly under-utilization of existing services by some segments of society, most notably minority racial/ethnic children.¹⁻³ In child mental health services research, the role of stigma has not been well-conceptualized though it is presumed to be significant. Literature on caregiver strain and burden of care has explored processes and implications of coping with children's emotional and behavioral disorders.⁴ Although considering perceptions (including concerns about public attitudes) and acknowledging the social implications of childhood mental disorders, caregiver strain and burden of care literature has not adequately considered the implications of public stigma. Few stigma researchers address child mental illness.^{5, 6} Therefore, the field lacks suitable and empirically tested theoretic frameworks and conceptualizations. Particularly, lacking are conceptual frameworks addressing help-seeking that adequately account for the role of stigma among barriers to care⁷ or caregiver strain variables.⁴ Our premise is that the field needs conceptual frameworks that link stigma to how parents/family caregivers cope with children's emotional and behavioral problems such as seeking professional help.

One way parents/family caregivers cope with children's mental health problems is to seek mental health services.⁸ Hence, stigma likely compounds the burden of care and affects caregiver's help-seeking behavior. For example, caregiver strain literature indicates an association between caregiver depression and child symptomatology.⁹ Depression has been shown to be related to the under-use of mental health service.¹⁰

In this paper we first review the state of the literature on stigma and child mental disorders and highlight gaps in empirical work. Next, we describe a suggested framework for operationalizing the stigma experience in the area of child mental disorders highlighting three constructs: a) dimensions of stigma, b) context of stigma, and c) targets of stigma. This approach is needed for developing measures and increasing the relevance of theoretical models for assessing the relationship between stigma associated with children's emotional and behavioral problems and caregivers' help seeking for the child. The framework helps to conceptually link the public and private spheres of child mental disorders – how negative public attitudes might have an impact on parents' personal responses, strain and care-giving decisions.

Method

We reviewed child mental illness stigma literature in peer-reviewed journals available through MEDLINE and PsychInfo from the earliest through 2008. The search for “mental illness stigma” or “attitudes towards mental illness” and “children” or “adolescents” yielded 145 articles in PsychInfo and 77 articles in MEDLINE (the latter overlapped with those identified through PsychInfo). From these we selected articles that primarily described (1) the theory and empirics of stigma by association with mental disorders in children and adolescents, and (2) children's and/or family perceptions and experiences of stigma. There were few such articles. Therefore, we augmented these with adult mental illness stigma articles that focus on theory and measurement. We also drew on insights from prejudice literature relevant to this population, particularly the stigmas of race/ethnicity, non-heterosexual sexual orientation, HIV/AIDS, neighborhood identification and socio-economic status. We searched for empirics on interactions between mental disorders and some of these stigmas.

Results

The review process involved identifying and appraising literature convergence on the definition of critical dimensions of stigma, antecedents, and outcomes reported in empirical studies.

The Dimensions of Stigma

Though diverse, literature converges on Erving Goffman's¹¹ definition, in which stigma is an actual/inferred attribute that damages the bearer's reputation and degrades him/her to a socially discredited status.^{12–14} Social devaluation and rejection are customary experiences of the stigmatized. Affiliation with the stigmatized confers a secondary stigma – courtesy stigma.¹¹

Extensive literature reviews on the stigma construct and how it is operationalized in adult mental illness research are provided elsewhere.^{13–18} The stigma construct is generally attributed to Erving Goffman¹¹ and Thomas Scheff.¹⁹ These early frameworks have been criticized for presuming that stigma is located entirely in the person,²⁰ a view attributed to focusing research on stigmatizers' viewpoints and less on the perspective of the stigmatized.¹³ Modified labeling theory,¹⁶ a variant of Scheff's labeling theory, however, recognizes the socio-cultural context of stigma,¹³ a social construct that reflects relations of power operating at societal levels.²⁰ Within modified labeling theory, powerful groups in society impose stereotypically negative labels on those they deem undesirable, whom they subsequently devalue and discriminate.²⁰ This conceptualization of stigma corresponds with a social psychology grounded perspective that stigmatization is linked to human cognition via stereotyping and prejudice.^{14, 15, 21} For example, some studies have observed that clinicians demonstrate 'unintentional biases' in their judgment and reactions to patients and their families, despite genuine commitments to providing patient-centered and culturally sensitive care.²² More detailed discussion of the relationship between stigma and prejudice are given elsewhere.¹⁸ It suffices, however, to note that literature converges on negative stereotypes (or attitudes), behavioral predispositions such as discrimination and devaluation behavior¹⁷ as critical dimensions of stigma.

Stereotypes—Most public stigma studies assess variance in stereotype awareness, in particular, dangerousness, incompetence and disruptiveness stereotypes.^{23–26} Even though these constructs are of concern to the field of child mental health, few child-focused stigma studies explicitly assess negative stereotypes. For example, dangerousness has been reported in child focused studies.^{5, 27} Therefore, we do not know the extent to which there exist other more or less salient stereotypes of child mental disorders than dangerousness, such as those acknowledged in a recent conceptual framework by Pescosolido and her colleagues.¹⁷ The dangerousness stereotype might not apply to all stigmatized childhood mental disorders, as observed in adult studies that have compared stereotypes typically applied to schizophrenia vs. depression.²⁸ Identifying negative stereotypes that are particularly salient to these conditions is advantageous for a comprehensive understanding of stigma experiences of children and their caregivers, particularly within widely acknowledged stigma frameworks.^{16, 17} Literature on adult mental illness and racial/ethnic prejudice provides a broad array of relatable stereotypes and misconceptions, e.g., associating mental illness with minority racial/ethnic status, poverty, unpredictability, character defect or mental retardation.^{29–32} Therefore, the focus on dangerousness might skew stigma research towards certain mental disorders, particularly those characterized by externalizing problems.³³ However, youth in the study reported by Walker and colleagues³⁴ considered other youth with attention deficit hyperactivity disorder (ADHD) and depression to be potentially violent and likely to engage in antisocial behavior. Therefore, the salience of the dangerousness stereotype in the stigmatization of mental disorders should not be underrated.

Discrimination and devaluation—According to labeling theory, stigmatization is largely a sequential process that begins with labeling and (negative) stereotyping by others, which leads to separation and status loss (or devaluation) of the labeled entity, and subsequently discrimination.²⁰ Self-stigma theory further postulates that some among the socially devalued and discriminated internalize public stigma by devaluing themselves and deleteriously altering

their behavior and attitudes. For example, one might convince her/himself that s/he is unable to work or live independently as a result of the stigma.¹⁵ However, not all persons with potentially stigmatized conditions are concerned and negatively impacted by public stigma. A study among a sample of Somali immigrants in Canada raises the counterintuitive possibility of ‘reverse stigmatization’ and ‘counter devaluation’ of stigmatizers by the stigmatized.³⁵ Furthermore, not all people who are concerned about public stigma self-stigmatize. The risk factors for self-stigmatization, in particular, are not adequately explored in adult literature. Although not yet extended to courtesy stigma, it is plausible to presume that while a primary caregiver might agree with generalized negative stereotypes of child mental illness⁵ s/he might not apply those stereotypes to her/his child, let alone discriminate against the child. However, negative parental responses to children and their deleterious outcomes are well known. What is missing from the literature, though, are explorations of the relationship between public stigmatization of children and/or parents and parental coping strategies, such as self-stigmatization.

Antecedents of Stigma

Type of condition that elicits stigma—The role of the construct “condition” is included in most of the prominent conceptual frameworks guiding stigma research as a factor that influences public stigma.^{17, 36} Condition in this case refers to diagnostic labels such as those derived from Diagnostic Statistical Manuals or related diagnostic protocols. Most mental health stigma research explores the extent to which an identification with a diagnostic label (real or imagined) triggers and/or compounds public stigma. Hence the research focus on major mental disorders such as schizophrenia, depression and bipolar disorders associated with adult populations.^{28, 37, 38} It has been observed, for example, that discriminatory attitudes (‘unintentional biases’ included) among mental health professionals likely vary by patients’ psychiatric conditions; people with drug and substance use disorders and those with schizophrenia being most likely to be regarded as less deserving of interventions than others.³⁹ The hierarchy of worthiness-for-intervention often reflects the degree to which the condition (i.e., its current status or method of contagion) is socially perceived as attributable to personal conduct, e.g., irresponsibility that reflects an underlying character weakness, moral defect, or compromised hygiene standards.

In child-focused stigma research, we know that public stigma is condition specific--i.e., the general public reacts and responds differently according to the mental disorder (label) that the person/child is presumed to have, e.g., depression vs. ADHD in children,^{34, 40} similar to the distinction in adults between mental illness vs. substance abuse²⁷ and Bipolar I vs. Bipolar II.³⁷ However, stigmatization tends to persist even when the condition is known to be under control, and/or treatments are known to be effective or unnecessary.^{40, 41} This partially explains anticipatory aspects of stigma that are signaled by the often reported burden of managing information (or strategic disclosure), particularly about inconspicuous disorders.⁴²

The media has been shown to influence public stigma, particularly reinforcing negative stereotypes and promoting unfounded fear and precautionary responses. Extensive literature reviews on media portrayal of mental illness are available elsewhere.^{43–45} Although media research is focused largely on adult mental illness, two studies are particularly relevant to children. Slopen and colleagues⁴⁶ found media coverage of mental illness in adults to be more stigmatizing than that describing children. They observed that media reports on children were more likely to meet criteria for ‘responsible journalism’ than reports on adults. Morgan & Jorm⁴⁷ found an association between what youth in an Australian sample recalled from news stories about mental illness and their attitudes towards mental illness. For example, recall of stories depicting crime and violence was associated with reluctance to disclose one’s mental illness. Youth who recalled news stories about celebrities with mental illness were more likely

to view people with mental illness as sick rather than weak. However, both studies note the importance of the media in de-stigmatizing mental illness and influencing constructive public policy.

The Outcomes of Stigma

The outcomes or effects of stigma also form a substantial portion of the research literature. In adult mental health, social withdrawal and secrecy are typically considered outcomes of public stigma awareness.⁴¹ However, not all who experience public stigma exhibit these outcomes. The area of self-esteem decrement has begun to be the focus of fruitful and informative modeling and empirical work in recent times.^{48, 49} One major product of self-stigma research is a social psychology framework, advanced by Corrigan and colleagues,¹⁵ describing the internalization of public stigma through stereotype awareness, agreement and concurrence, and how that process might result in self-esteem decrement, and ultimately social withdrawal and secrecy.^{15, 49, 50} Empirical testing of that framework is ongoing, and partial support for the framework has been reported among adult samples.^{51, 52} However, the utility of the Corrigan et al. framework for understanding public stigma effects among children with emotion and behavior problems and their caregivers is undetermined.

Outside of a handful of studies^{5, 7, 34, 53} little is documented about the stigma related to child mental disorders and the consequences of this stigmatization process. Emerging literature has confirmed negative public attitudes towards mental disorders in children.^{5, 40} This literature also suggests that the public stigma of child mental illness might be just about as unforgiving as that of adult mental illness.^{26, 38, 49, 54} For example, we know from this literature that when adults are presented with vignettes of children with emotions and behaviors that the respondents regard as dangerous (or identify as indicating mental illness), they are likely to respond negatively and punitively to the hypothetical child and condition.⁴⁰ Pescosolido and colleagues⁴⁰ have found that negative public responses include preference for social distance from the child/family, the distancing of the child from other children, blaming the child's family for the child's problems, and preference for severe treatment modalities for the child including treatment in restrictive settings. However, the study found more public support for the coercion of parents of children with asthma than mental health conditions considered.

Applicability of Adult Stigma Research to Children

The dearth of child mental health stigma research^{34, 40} suggests, among others, a prevailing view that findings from, and conceptual frameworks developed for, adult mental health stigma are transferable to and informative about the stigma of children's emotional and behavioral health problems. That is, the deleterious effects of stigma observed among actual or potential consumers of adult mental health services-- such as socio-economic exclusion, social withdrawal and secrecy, and reluctance to seek needed help⁴¹ --are thought to apply equally to children with emotional and behavioral problems. For example, older adolescents, particularly males, have been found to have similar concerns about stigma consequences on social role expectations as do adult males.^{55, 56}

On the other hand, there is an expressed view that findings from stigma research conducted among adults might not be generalizable to children and adolescents and their families.^{23, 40, 53} Hinshaw has noted that, unlike adults, children have far less power and are accorded far less social status in most societies and their behavior is more likely to be less tolerated by adults than adult behavior.²³ Furthermore, although it is thought that children suffer many of the consequences of stigma directly,^{34, 55} they rarely seek professional help on their own--parents or other family caregivers act as their agents and, thus, play a unique role that must also be acknowledged and examined. Therefore, the traditional tendency to blame child misconduct on poor parenting,^{57, 58} compounded by vulnerability of children (including insufficient legal

protections)²³ and the role of family caregivers in help-seeking,^{25, 55, 59} places children and their families under unique stigmatizing contexts, most of which have not been adequately studied.

Major Gaps in the Current Literature

Vignette-based public stigma studies are informative about the cultural context in which people respond to mental health problems.⁵ These need to be augmented with studies of behavior towards children with mental disorders and their caregivers. We also lack clarity on what makes some people (adults/children/parents) more susceptible to public and self-stigma than others. Furthermore, we do not know the extent to which parents/caregivers stigmatize their own children, particularly young children. Some children/caregivers might be subject to multiple stigmas or hold several socially devalued identities/statuses aside from the mental illness label. For example, an increasing number of children, particularly among racial/ethnic minorities, are cared for by kin foster parents. Regardless of mental health status, being cared for by a biological parent might confer a different social status on a child than being cared for by other types of caregivers. The notion of ‘master’ and ‘secondary’ status is well developed in relation to racial prejudice, disability discrimination and gender inequality. Sex stigma literature has explored potential interactions between internalized homophobia and mental health problems.^{60, 61} However, it has been noted that literature on mental illness stigma often does not incorporate insight from the prejudice or disparities literature.^{18, 62} Therefore, we do not know from the literature about the interaction effects of mental illness labels and other socially devalued statuses or which status exerts the gravest stigma on the individual and his/her associates.

Consequently, the arenas for stigmatization remain unclearly defined, though we have multi-level models for understanding how children and parents cope with child mental disorders by seeking professional healthcare.^{63–66} From the findings we are concerned that current research and theoretical models are not adequate to address some of the pressing issues regarding stigma in children’s mental health. That, in order to define the “what” (stigma), we need to know “who” does “what” to “whom” - this translates into “context” “dimensions” and “targets” of stigma (see Figure 1).

A Framework for Operationalizing the Stigma Experience in Child Mental Disorders

Three inter-related constructs kept coming to our attention in their relevance to understanding stigma and its relationship to child mental disorders: a) the dimensions of stigma, described above, b) the context of stigma, or where is the stigmatizing event taking place, and c), the targets or victims of stigma. We noted the dynamic effects of the relationship among the context in which stigma is perceived and experienced (self, institutional, and general public), the different dimensions of stigma acknowledged in stigma literature (negative stereotypes, devaluation, and discrimination), and victims of the stigma (i.e., the child, family associates, and services). We generated a matrix that potentially accounts for twenty seven unique combinations of dimensions and domains of stigma of child mental disorders (see Figure 1). Here we focus on the constructs of stigma context and targets as they could enhance current theory, practice, and research related to stigma in children’s mental health services.

Context of Stigma

Our literature review suggests that most research on stigma has concentrated on the general public as stigmatizers and the child/direct consumer (or their condition) as the target.^{5, 16, 36} Within the general public context for stigmatization, the focus tends to be on adults’ negative attitudes and behavior towards children and their families. However, some research has also

focused on children as stigmatizers,^{27, 34, 67–69} albeit with mixed findings. The generalizability of findings from these studies is limited, as was noted in an earlier review of youth studies.⁷⁰

The public as stigmatizers—Some emerging findings about public attitudes towards mental disorders in children suggest the probability for greater stigmatization of younger than older children,⁴⁰ which seems to contradict conventional attitudes towards children. However, the relationship between child age and attitudes towards child mental disorders might be related more to the stigmatizer than the target of stigma. For example, Taylor and Dean⁷¹ found public attitudes towards mental illness to vary by the life-cycle stage of respondents, i.e., older families (persons with children aged between 6 and 18) had more sympathetic attitudes on each of Taylor & Dean's four scales (i.e., authoritarianism, benevolence, social restrictiveness and community based mental health ideology) than younger families (persons with children under 6 years). They conclude that this might be due to older families having less concern about people with mental illness and the likelihood of their children coming into contact with them than younger families.

The self as stigmatizer—Self-stigmatization by the person with the disorder has also been the subject of recent research and publications in adult mental health,^{15, 49, 50, 72, 73} but few such studies have involved children/young adolescents. Similarly, self-stigmatization by the parent/family caregiver of the child/adult with the condition has not been adequately conceptualized and/or empirically demonstrated. Some emerging research explores potential self-stigmatization by children and their primary caregivers.³⁴

The intersection of the 'self' arena of stigmatization and 'child' as target for stigmatization in Figure 1 raises both conceptual and methodological questions that have not been adequately explored. We know that young school-age children can have negative perceptions of mental illness^{34, 70} and that older adolescents might not differ from adults in their responses to their own or others' mental illness.^{27, 67–69} What we do not know, and we need to investigate, is the stage in children's development when self-stigmatization might begin to occur. Stigma frameworks need to cater for the probability that children will be stigmatized although not mature enough to pick-up such cues from their environment or interpret them as such. On the other hand, a parent/caregiver might perceive the stigma being directed at the child and respond to it in ways that have implications on the child's access and use of services.

Theoretically, mental disorder is separate (or separable) from the child/self.⁷² Some anti-stigma interventions endeavor to ensure that the general public appreciates the distinction.^{25, 39} Therefore, it is plausible to anticipate a situation in which the disorder but not the child or his/her parent/family is stigmatized. The disorder reflects deviance from some normal state. Separating the disorder from the disordered is premised on the view that the disorder blemishes the child; as in biomedical literature, the disorder is an assault on the otherwise normal body. This also augers with lay views of the young child as an angel, pure and without blemish but vulnerable to external forces. Young children are, therefore, assumed to be less responsible for their way of being and its related outcomes than older children and adults.⁶⁵ However, somewhere along the developmental trajectory from childhood into adolescence and adulthood the distinction of 'person/self' from 'condition' becomes blurred in the public mind. The condition might then assume a central place in the definition (or characterization) of the person/self. Thus the stigma towards the condition likely becomes synonymous with the stigma towards the child. This also might affect the stigma directed at the child's parent/family, to the extent that the assignment of blame might be linked to the developmental stage of the child.

The distinction between 'self' and 'condition' might also have implications on parents' (and children's) beliefs about the legitimacy of public stigma, a key factor in the self-stigma model. Variance in the perceived legitimacy of public stigma has been hypothesized to explain

variance in the tendency to internalize public stigma and in self-esteem/efficacy decrement among adult mental health consumers.⁵² Emerging findings by Watson and colleagues⁵² support the view that adults with mental illness who view public stigma as legitimate are at risk of internalizing public stigma and experiencing decrement in self-esteem/efficacy. Strong views that public stigma is illegitimate predict involvement in anti-stigma initiatives and seeking professional mental health services. The likelihood of such outcomes occurring among young children and/or their parents has implications for those who rely on behavioral models of service access and utilization^{64, 66} to examine patterns in child mental health services use.

Institutions and service providers as stigmatizers—The institutional context for the stigmatization of the direct consumer has also been explored in a number of reported studies.^{74, 75} Most institutional stigma research has focused on individual service providers, i.e., psychiatric and primary physicians, psychologists, other healthcare professionals—as stigmatizers rather than the institutions themselves (and decision processes therein) as stigmatizers.⁷⁶ Among child focused studies, the stigmatizing attitudes of primary health care providers such as pediatricians are not widely explored, though utilization of primary care services is extensively reported in child mental health literature.^{77, 78} The school setting as a context for stigmatization is also explored, in particular family views of teachers' attitudes.^{34, 67} It has been acknowledged, though not empirically verified, that the institutional context for stigmatization goes far beyond attitudes of professionals in direct contact with consumers and their associates but is reflected also in policies and practices of public institutions that result in the devaluation and discrimination of participants in the mental health sector.^{13, 75, 79} Examples might include policies and practices that result in lack of parity between physical and mental health, and the critical shortage of mental health professionals (perhaps linked to disparities in the attractiveness of careers in mental vs. physical healthcare).⁸⁰

Targets of Stigma

The stigma literature available for both adult and child populations have concentrated almost exclusively on stigma towards the person with the condition (i.e., the child with the mental disorder). However, we also highlight two other targets that appear to be relevant and critical to understanding the experience of stigma, particularly in the area of child mental disorders: stigma by association towards family members, and stigma related to the use of mental health services.

Stigma by association with child mental disorders—Literature on caregivers' perspectives on stigma focuses on family caregivers of adults with mental disorders, both parents of adult children with mental disorders^{37, 81, 82} and adult children of parents with mental disorders.³⁸ Stigma by association with children with autism has been reported. Gray⁵³ observed that mothers perceived more stigma than fathers and that parents with younger children (< 12 years old) perceived especially high levels of stigma by association. Although studying an adult population, Gonzalez and colleagues³⁷ also noted the influence of child age, primarily by extrapolating from their observations regarding associations with early age of onset of a patient's disorder. Apart from studies of other stigmatized childhood conditions, e.g., mental retardation⁸³ or epilepsy,¹² stigma by association for parents of children with mental disorders is under-researched. Some have encouraged focus on generalized mental health conditions such as emotional and behavioral problems rather than specific disorders, particularly for school age children or school-based mental health support programs.⁸⁴

Among caregivers of adults with bipolar disorders, awareness of stigma by association has been shown to be linked to reports of depression.³⁸ Previous research in caregiver strain has shown an association between child symptomatology and caregiver depression.⁴ This is attributed to the strain of coping with not only the family member's condition but also with

others' response to the condition and the family. Birenbaum's⁸³ qualitative studies detailed parents' daily struggles with negative public reactions to their children's autism and the negative psychological impact of these experiences. Brannan and Heflinger⁴ included items about stigma (fear that the child would be labeled, fear of what family and friends would think) in their family perceptions subscale; greater endorsement of these perceptions was associated with higher reports of caregiver strain among parents of children with serious emotional disorders. Casting a broader net into the child health literature, we know from some studies of physical health conditions such as epilepsy that young children and their families are at risk of being stigmatized and that they might respond to both anticipated and experienced stigma in ways that compromise their own quality of life, such as social withdrawal and/or reluctance to seek help.¹² Delineating the process by which these effects occur, such as the Corrigan et al self-stigmatization model,¹⁵ might be a fruitful area of research.

A key premise of our interest in explicating this framework of the stigma experience is to develop a better understanding of the link between stigma and the use (or barriers to use) of mental health services. Among families of children with serious emotional disorders, stigma has been documented as a potential barrier to receiving mental health services primarily because of the influence of stigma on parents.⁴ Stigma was demonstrated to be a significant issue among a rural group of parents and the most often endorsed barrier to services in that study (McMurry, Heflinger & VanHooser, in review). Half of the participants were concerned that people in their community would likely find out if a child received professional help and thought that people would blame parents for their children's problems. Apprehension that the community would marginalize them if they knew that their children had been officially diagnosed with emotional or behavior problems was also a barrier to seeking mental health services for their children. Mothers whose children had more severe problems were more sensitive to stigma as a barrier to care, which may have reflected their personal experiences with community members' responses.

Stigma towards mental health services—In addition, and consistent with emerging conceptual literature,¹⁷ our framework begins to acknowledge that mental health services can also be the target of stigma. In adult mental health, Taylor and Dear⁷¹ have revised and tested scales for assessing public attitudes towards community based mental health services for adults. They found, from the responses of a sample of adults in Toronto, Canada, that attitudes towards people with mental illness (clustered under subscales of authoritarianism, benevolence, social restrictiveness and community mental health ideology) predicted the acceptability of mental health facilities within a block of homes.⁷¹ In the area of child mental health, for example, the stigmatization of mental healthcare providers⁸⁵ and services by the general public has been proposed as a significant barrier to the utilization of mental health services. Some studies on the stigmatization of specialist mental health vs. primary health services are underway, e.g. Polaha and Williams at East Tennessee State University. However, healthcare professionals' experiences of stigma have not been documented, though this is not difficult to conceptualize and some of its likely effects are not that difficult to imagine and even appreciate--e.g., reported reluctance among medical students to disclose help-seeking for mental health problems⁸⁰ and/or specialize in psychiatry as a direct result of the stigma of psychiatry within the professions⁸⁵ and the widely acknowledged lack of parity between mental and physical health care providers.^{74, 79}

Relationship of this Framework to Other Theoretical Models

Arguably our framework is limited by the three dimensional space in which it is currently described. As we explained, our work on this framework was to explicate the stigma experience itself so that we and the field could develop better measures and develop more comprehensive theoretical and practical understanding of stigma in child mental disorders. However, a

comprehensive stigma theory needs to also address the factors that influence stigma as well as the consequences of stigma. Here we place our framework into several recently published theoretical models as an example of the type of theory adaptation that is needed.

Conceptual frameworks from social and cognitive psychology are useful for analyzing predictors of public attitudes, particularly frameworks related to social perception, how individuals acquire and maintain knowledge of the public mind and how the public mind might interact with and influence the private mind. In this regard the self-stigma framework is particularly helpful. Equally insightful are behavioral health models that recognize the social-ecological context of individuals, precisely that individuals are nested within social units which are structured hierarchically, from small social units like the family to larger units like administrative communities and/or society at large.⁶⁶

While a number of healthcare access and use models (e.g., Network Episode Model⁶³ and the Gateway Provider Model⁶⁴) are advantageous for studying pathways to formal mental healthcare, the Framework Integrating Normative Influences on Stigma (FINIS)¹⁷ specifically notes the salience of stigma in the help seeking process. FINIS facilitates research on multi-level factors that likely influence stigma and their consequences. As noted by Pescosolido et al, “the FINIS framework focuses on the central theorem that several different levels of social life – micro or psychological and socio-cultural level or individual factors; meso or social network or organizational level factors; and macro or societal-wide factors – set the normative expectations that play out in the process of stigmatization” (Pescosolido, Martin, Lang & Olafsdottir, 2008, p. 433).¹⁷

Reminiscent of predecessor models, the FINIS incorporates the ecology of public attitudes towards mental illness and delineates linkages among antecedent factors and their consequences on service access and use. The framework is congruent with social psychology theories of child development and behavioral models of service use. The FINIS allows for developing structural models delineating processes by which public stigma likely influences mental health outcomes among direct consumers. FINIS helps to understand how an adult or adolescent might deal with or be impacted by multiple forces that engender and sustain stigma. However, Pescosolido’s framework omits what we believe are crucial constructs/domains that are necessary to better understand stigma and its consequences for children with mental disorders and their families.

The overarching implications from this literature review and our proposed framework for understanding the stigma experience using dimensions of stigma, context of stigma, and targets of stigma is that recognition of these is critical for practice and research. Focusing on our own behavior and attitudes towards the children we work with and their families – and paying attention to the policies and procedures in our offices and agencies, including the use of person first language – will help not only identify potential institutional stigmatization, but help sensitize us to the everyday experiences of stereotypes, devaluation, and discrimination experienced by children and their families. Helping them identify these stressors could improve treatment planning and their goals for improved community functioning. Furthermore, understanding that family members are targets of stigma by association and exploring the resulting barriers may improve treatment compliance and follow up with referrals. Stigma researchers should consider insights from literature exploring cultural, racial and ethnic portrayals and understandings of mental illness. In culturally diverse contexts, the framework has to account for socio-culturally defined idiosyncrasies of mental disorders as well as potential interactions between mental illness and other socially devalued statuses such as AIDS-orphanhood,⁸⁶ skin color, ethnicity, gender, disability, non-heterosexual sexual orientation,⁶⁰ social economic status or neighborhood affiliation.^{1, 29–32}

Theoretical models and associated plans for research also need to include these constructs. We propose specifically that existing models be adapted by: (a) adding family members and services as potential targets of stigma; and (b) acknowledging courtesy stigma, as reviewed in our framework above. Furthermore, we propose that the models also recognize delay or avoidance of help-seeking as a potential response to stigma. These adaptations allow the examination of the two consequences we mentioned earlier that are of particular relevance in child mental disorders, (a) caregiver strain as a response to stigma, and (b) the effects of stigma on help-seeking. Ultimately, we want to generate more knowledge about this phenomenon in order to design and test effective anti-stigma interventions primarily targeting caregivers of children and young adolescents with mental disorders. While we promote the development of measures of stigma dimensions, context, and targets suitable for child mental health services research, we also want to acknowledge the important role that qualitative methods can play in explicating these constructs and better understanding the experience of stigma for children with mental disorders and their families.

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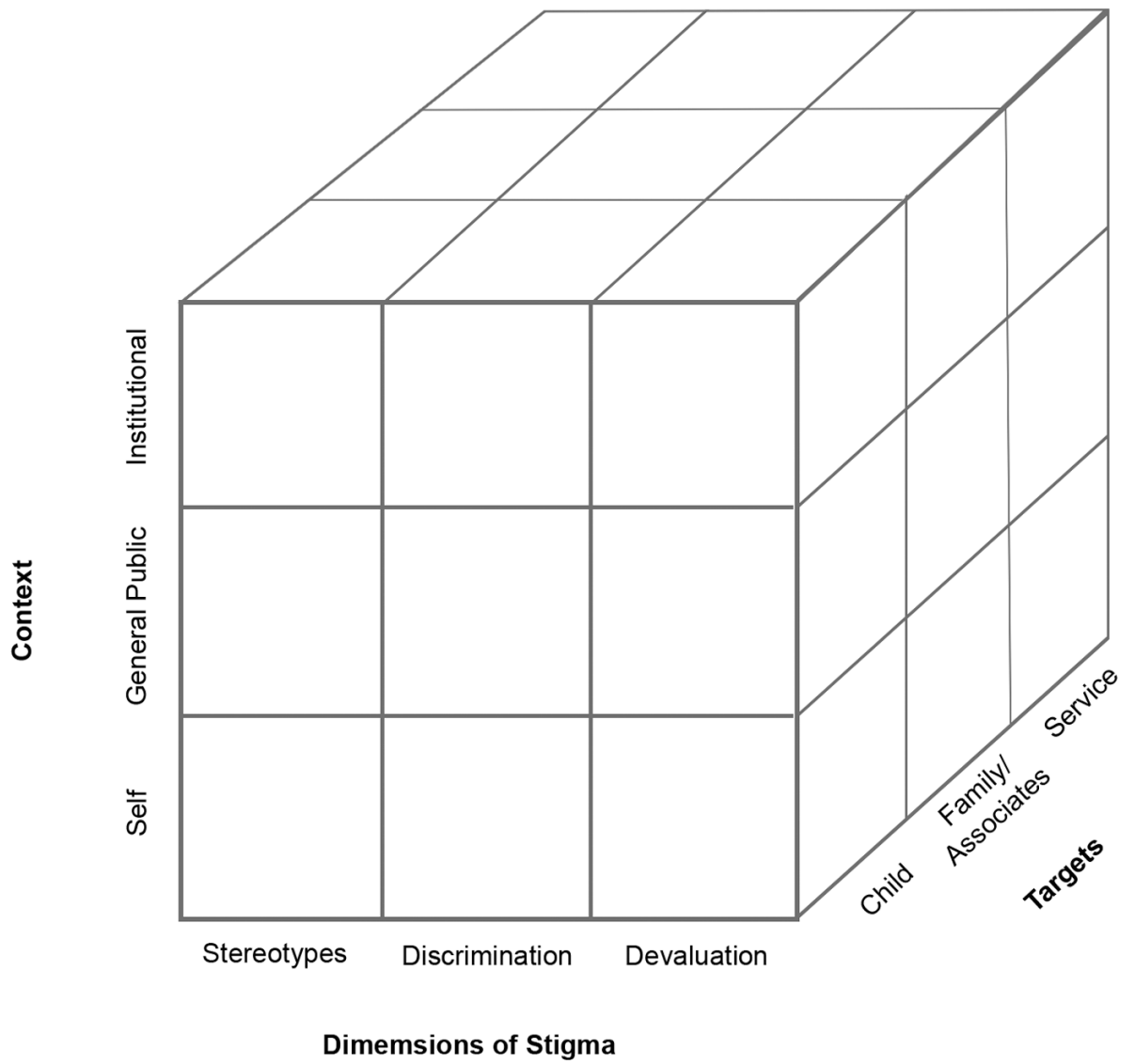


Figure 1.
Relationship among child mental disorder stigma dimensions, contexts and targets