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Perceived Stigma and Depression among Black Adolescents in Outpatient Treatment

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1. Introduction

Depression is widely studied among adolescents due to its potential negative impact on future life choices and experiences (Lewinsohn, Hops, Roberts, Seeley, & Andrews, 1993), correlation to future depression (Canals, Domènech-Llaberia, Fernández-Ballart, & Martí-Henneberg, 2002; Monroe, Rohde, Seeley, & Lewinsohn, 1999), co-occurrence with other disorders such as anxiety and substance abuse (Hjemdal, Aune, Reinfjell, Stiles, & Friborg, 2007; Petersen et al., 1993), connection to suicide attempts in adolescents (Joe, Baser, Neighbors, Caldwell, & Jackson, 2009; Petersen et al., 1993), and its contribution to the global disease burden (Merry, McDowell, Wild, Bir, & Cunliffe, 2004). Extant research suggests that by the age of 18, up to 24% of adolescents will have experienced at least one incident of major depressive disorder (Kowalenko et al., 2002). Though mental disorders are evident in adolescents in general, Black adolescents have been characterized as a particularly vulnerable group especially regarding the occurrence of depression (Gibbs, 1990; Myers, 1989; Rosella & Albrecht, 1993). Indeed, studies indicate that Black adolescents experience depression at disproportionately higher levels than adolescents from other racial/ethnic groups (Roberts, Roberts, & Chen, 1997; Wu et al., 1999).

1.1 Mental health service use among adolescents

Numerous alternatives for the treatment of depression exist; however, service use among the adolescent population remains low (SAMHSA, 2009a). In general, approximately 80% of young people that need mental health treatment are not accessing suitable, appropriate care (National Advisory Mental Health Council, 1990; US Department of Health and Human Services [USDHHS], 1999). Moreover, ethnic minority youth represent a notably susceptible group regarding the lack of treatment for depression. According to the U.S. Surgeon General's report on mental health, ethnic minority children are less likely than

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white children to receive mental health services (USDHHS, 2001), and this disparity is particularly pronounced for black children and adolescents (Flisher et al., 1997). SAMHSA reported that 9.5% and 9.7% of Black and Hispanic adolescents, respectively, as compared to 12.7% of white adolescents utilized outpatient mental health services in 2008 (SAMHSA, 2009b). Similarly, Kodjo and Auinger (2004) found that emotionally distressed Black adolescents received mental health counseling significantly less than their white or Hispanic counterparts.

1.2 Stigma, mental health service use, and mental disorders

Stigma is one of the main patient level deterrents to mental health service utilization, and may take various forms (e.g., public stigma, self-stigma) (Moses, 2009). Perceived public stigma is defined as the anticipation of negative attitudes and possible prejudice from others based on having a mental disorder or using treatment services (Link, Cullen, Struening, Shrout, & Dohrenwend, 1989; Sirey et al., 2001). Conversely, self-stigma is an individual's negative concept of self, based on their internalization of society's view of their condition (Barney, Griffiths, Jorm, & Christensen, 2006; Corrigan & Watson, 2002).

The stigmatization of people with mental disorders remains a key obstacle to the advancement of prevention, treatment, and illness recovery efforts (Corrigan, 2007; Mann & Himelein, 2004; Pescosolido, Perry, Martin, McLeod, & Jensen, 2007; USDHHS, 1999). Stigma is negatively associated with seeking, using, and complying with treatment for mental health issues (Sirey et al., 2001). Elsewhere, Perry, Pescosolido, Martin, McLeod, and Jensen (2007) found that depressed children and adolescents may be more susceptible to mental illness stigma than adults. Stigmatizing responses and subsequent social distance have also been reported to be strongest towards adolescents (Martin, Pescosolido, Olafsdottir, & McLeod, 2007).

Corrigan (2007) proposed that clinical diagnoses labels and their associated criteria can increase public stigma by prompting stereotypes about, and promoting prejudice and discrimination against, people dealing with mental illnesses. Prior research, on mostly adult populations, reveals that specific types of a disorder or greater levels of a disorder also impact stigma. Dinos, Stevens, Serfaty, Weich, and King (2004) reported that psychiatric outpatients with anxiety, depression, and personality disorders were more impacted by subjective feelings of stigma even without the experience of obvious prejudice. In addition, Yen et al. (2005) reported that Taiwanese outpatients with more severe depression reported greater levels of self-stigma. Furthermore, Raguram, Weiss, Channabasavanna, and Devins (1996) and Pyne et al. (2004) found that higher levels of depressive symptoms and greater depression severity, respectively, were significantly related to greater perceived stigma in psychiatric outpatients.

1.3 The present study

Stigma adversely impacts mental health service utilization and recovery for those suffering from mental disorders (Perlick, 2001). However, scant scientific attention has been given to exploring factors that may contribute to increased stigma, especially among adolescents who may be more susceptible to mental illness stigma. The previous findings regarding depression and stigma in adults, along with the high prevalence rates and low service usage in adolescent populations, particularly among Black adolescents, signify the importance of exploring the relationship within this population. As such, the purpose of this study was to explore the relationship between Black adolescents' perceived stigma and their current level of depression severity in an outpatient sample. We hypothesized that depression severity will be positively associated with greater perceived stigma. Examining this relationship will

improve our understanding of factors that underlie the process of mental health service utilization in this population.

2. Method

2.1 Participants

Participants were recruited from a community mental health agency in a metropolitan, Midwestern city. The agency has provided services for low-income and at-risk children and families for over 80 years. Services include an education program for teenage parents, a support program for incarcerated women and their children, a support program for high risk infants, and a family bereavement program for families whose sons or daughters have been killed, and for children who witness violent crimes. Outpatient programs include child, adolescent, and family counseling, an adolescent sexual abusers program, and chemical dependency treatment and services for youth who are both emotionally and mentally impaired. Special outpatient psychiatric services, residential treatment, and case management are also offered. The agency receives formal client referrals from local schools, hospitals, and the juvenile justice system. A sample of 108 adolescents and their caregivers participated in the study. Of the 108 adolescents, 102 identified as African American, two identified as mixed race, two identified as Latino, and two identified as American Indian. Approximately 54% of the sample was female.

2.2 Procedure

During an initial intake and assessment session, agency staff presented an explanation of the study to eligible participants (ages 12-17) and invited adolescent and caregiver dyads to participate. Invitations to participate were presented separately to caregivers and adolescents to reduce any semblance of coercion. Each caregiver provided written consent to allow the adolescent to participate in the research study, while adolescents provided written assent. Study eligible participants who declined invitation to participate in the study were asked to complete a refusal form, which enabled them to indicate a reason for refusal. Information regarding the demographics of the participants who refused to be in the study was not obtained. There is no suggested difference between those who refused and those who consented as the main reasons given for refusal were “not enough time” and “not interested.” Any adolescent who, in the opinion of the professional staff, was unstable or unfit to participate in the study due to their mental or physical status was to be excluded from the study. No one was refused for this reason.

The study protocol was approved by the Institutional Review Board at the University of Michigan and the agency's Board on Evaluation and Quality. Agency staff at the community mental health agency received a detailed training regarding study rationale, goals, data collection, HIPAA compliance, and recruitment procedures. A follow-up training was held eight months post study initiation to provide a review of important study procedures, introduce procedural changes, and address recruitment challenges being faced by agency staff.

2.3 Measures

2.3.1 Depression severity—Depression severity was measured by the 30-item Reynolds Adolescent Depression Scale 2nd edition (RADS-2) (Reynolds, 2002) which was developed to evaluate the severity of depressive symptoms in adolescents, ages 11-20. The RADS-2 was designed for individuals with at least third grade reading ability. Adolescents answered 30 items on a 4-point likert scale that requires a response of whether a symptom-related item occurred: almost never, hardly ever, sometimes, or most of the time. These items are framed in the present tense which requires the adolescent to respond based on how they currently

feel. The 30 items provide scores on four factorally derived subscales and a total raw score. The subscales assessed symptoms of (1) Dysphoric Mood (e.g., sadness and crying behavior) (2) Anhedonia/Negative Affect (e.g., disinterest in having fun, and engaging in pleasant activities with other students (3) Negative Self-Evaluation (e.g., negative feelings about oneself such as low self worth, and self-denigration) and (4) Somatic Complaints (e.g., somatic or vegetative complaints such as stomachaches, feeling ill, fatigue, and sleep disturbance). The RADS-2 total raw score provides the clinical severity of depressive symptomatology in adolescents, but does not provide a formal DSM-IV diagnosis for Major Depressive Disorder. Of the 30 items, 7 items are scored in reverse order. These items are phrased in a positive manner so that reversing the scoring key represents greater depression. Adolescents' responses are weighted 1 to 4 points, so that the RADS-2 total raw score ranges from 30-120. Adolescents who scored within the range of 30-75 were considered to be in the normal clinical depression range, 76-81 in the mild clinical depression range, 82-88 in the moderate clinical depression range, and 83-120 in the severe clinically depressed range. For the purpose of the current study, the total raw score was used for analysis and scores were calculated into two categories: normal (30-75) and mild to severe (76-120).

2.3.2 Perceived stigma—Perceived stigma was measured using the 5-item Attitudes toward Psychological Help (ATPH) scale. This scale was adapted from the perceived stigma scale (Pyne et al., 2004), which was modified from the Stigma Scale for Receiving Psychological Help (SSRPH) (Komiya, Good, & Sherrod, 2000), developed to assess individuals' awareness of social stigma associated with receiving psychological services. Validation studies of the SSRPH indicated a reliability coefficient of $\alpha = 0.72$. The ATPH scale used in this study was adapted to reflect attitudes toward mental health treatment services. For example, the first item in the perceived stigma scale “Receiving treatment for depression carries social stigma,” was changed to “Receiving mental health services is something people look down upon.” Similar to the perceived stigma scale and the Stigma Scale for Receiving Psychological Help, there were 4 Likert-type responses (“strongly disagree”, “disagree”, “agree”, and “strongly agree”) with scores from each item ranging from 0 to 3. The total raw score range was 0 to 15 with higher scores indicating greater perceived stigma. The average raw score for each participant was calculated and categorized into low (0-3), medium (4-6), and high (7-13) stigma for the purpose of bivariate analyses. The scores were further categorized into low (0-3) and high (4-15) stigma for multivariate analysis. The reliability coefficient for the modified scale was determined to be $\propto = .67$.

2.3.3 Perceived need for mental health services—Perceived need for mental health services was measured by two questions asking the adolescent to respond to whether they have needed an emotional counselor or a psychiatrist within the last six months. Participants answered either yes (1) or no (0) to both questions. The variable was then recoded into three categories: none, psychiatrist or counselor, and both.

2.4 Analysis

Bivariate analyses were conducted to examine the associations between the clinical, socio-demographic, and stigma variables. Logistic regression analysis was used to measure the effect of depression severity on perceived stigma. Statistical significance was determined at the $p < .05$ level. All analyses were conducted using PASW Statistics version 18 (formerly SPSS) (SPSS, 2009).

3. Results

3.1 Bivariate analyses

Two separate chi-square analyses were conducted. The first analysis (Table1), examined the associations between depression severity (RADS-2) and all the socio-demographic variables in the study. Results indicate that gender ($\chi^2 = 9.75$; $p < .01$) was significantly associated with depression severity, with females having higher depressive symptom levels than males. Approximately 77% of the adolescents categorized as mild to severely depressed were girls. In contrast, 56% of the adolescents reporting in the normal range for depression were boys.

Findings also indicate a statistically significant relationship between perceived service need and depression severity ($\chi^2 = 12.49$; $p < .001$). Approximately 77% of the adolescents who reported mild to severe depressive symptoms perceived a need for treatment from a psychiatrist, counselor, or both. Surprisingly, within the group categorized as normal based on their depression severity scores, approximately 51% of adolescents reported a need for treatment from one or both types of mental health providers (Table 1). Among adolescents indicating no perceived need for treatment, 84% were in the normal range for depression severity, which suggests an appropriate level of self-assessment (Figure 1).

The second chi-square analysis explored the associations between perceived stigma and depression severity along with the socio-demographic characteristics of the sample. The results indicate a statistically significant association between perceived stigma and depression severity ($\chi^2 = 7.86$; $p < .01$) (Table 2). Approximately 48% of adolescents with mild to severe depressive symptoms, as compared to 29% of those in the normal depressive symptom range, exhibited the greatest level of perceived stigma.

3.2 Multivariate analysis

Logistic regression was conducted to further examine the relationship between depression severity and stigma, in particular, whether depression severity predicted low or high perceived stigma. Findings show that depression severity was significantly related to an increase in perceived stigma ($p<.05$) (Table 3). Controlling for relevant socio-demographic variables, results indicate that adolescents who were mild to severely depressed were 4.8 times more likely than those in the normal range for depression severity to perceive stigma related to the use of mental health services.

4. Discussion

This study examined the relationship between depression severity and perceived stigma regarding mental health treatment. Results support a statistically significant association between depression severity and perceived stigma. Approximately half of the adolescents classified as being mild to severely depressed experienced higher perceived stigma associated with receiving mental health treatment. This is a noteworthy contribution to the mental health service use literature because this phenomenon has been rarely examined among Black adolescents, a population with disproportionately higher vulnerability to depression. Our findings, however, are consistent with prior research on adults (e.g., Pyne et al., 2004), which found that depression severity was a predictor of greater perceived stigma.

The results also indicate that gender and depression severity were significantly associated. More Black female adolescents were mild and severely depressed than their male counterparts. This finding is consistent with much of the literature on gender differences in adolescent depression (e.g., Peterson et al., 1993).

Concomitantly, results revealed a significant association between perceived need for treatment and depression severity, an indication that this sample of Black adolescents was able to aptly identify their need for mental health services. Approximately 77% of adolescents characterized as mild or severely depressed perceived a need for treatment from a psychiatrist, counselor, or both. More surprising, and somewhat unexpected, was that 51% of adolescents characterized as normal, based on their depression severity score, perceived a need for treatment from one or both mental health service providers. It is possible that those adolescents considered below the cut-off for clinical endorsement of depression, according to the RADS-2, have other unmet mental health or psychosocial needs that they believe necessitate formal treatment.

Other research has reported a relationship between perceived need, mental health status, and service use. Wu et al. (1999) found that children with depressive disorders (with or without disruptive disorders) were more likely to report a need for services than those who reported a disruptive disorder only. Additionally, the same study reported that child perceived service need significantly predicted their use of mental health services, school based mental health services, and any service. Correspondingly, in a Dutch adolescent sample, Zwaanswijk and colleagues (2004) reported that only 6.4% of adolescents who perceived an emotional or behavioral problem (425; 10.9% of total sample) were referred for mental health services. The current research supports the need to continue to explore adolescents' perceptions of their own need for mental health services in a Black adolescent population, as perceived need may significantly impact their service utilization.

This study has several limitations. First, the data were collected using cross-sectional survey design methods, limiting any ability to infer causality or directionality. For example, a recent study among Black adolescents found that higher levels of public stigma increased depressive symptoms, but that having higher levels of social support moderated this relationship (Lindsey, Joe, & Nebbitt, in press). Thus, longitudinal research may be required to show causality or determine directionality among these constructs. Second, the small sample size and non-probability sample limits generalizability. Therefore, we are unable to determine whether our findings are consistent with the general population of Black adolescents. Finally, although the findings explicated an association between perceived service need and depression severity, the study did not measure factors that may account for the adolescent's underlying reason for identifying or perceiving that need. This is important to consider as many of the adolescents in the normal range for depression severity identified a need for service.

Though exploratory, this study has important practice and research implications for mental health service delivery targeting Black adolescents. As stigma has been related to seeking, utilizing, and maintaining mental health services (Sirey et al., 2001), Black adolescents in outpatient treatment may benefit from interventions that integrate stigma reduction techniques in order to decrease anticipation of negative treatment by others. Additionally, Black adolescents in both groups (normal and mild to severe) were able to recognize their need for services. From a practice standpoint, referrals to treatment services may need to consider the adolescents own acknowledgment of need along with clinical diagnoses. Furthermore, results from this study could inform the development of services appropriate for adolescents who may not meet the criteria for a clinical diagnosis of depression, but have identified mental health or other psychosocial needs.

The study should be replicated to further examine stigma as a barrier to mental health service use among depressed Black adolescents based on their susceptibility to negative mental health outcomes and their level of unmet need. Future research can explore depression severity and stigma through longitudinal study to further understand the

relationship between the variables over time and with larger samples of adolescents. Additionally, studies are needed that examine the role of perceived service need in determining Black adolescents access to and use of mental health services.

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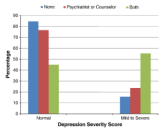

Figure 1. Perceived service need and depression severity

Table 1
Clinical and socio-demographic characteristics of subjects

	Depression Severity		
	Normal (n=77)	**Mild/Severe (n=31)**	**pValue**
	N (%)	**N (%)**	
Age			
Child (0-12)	19 (90.48)	2 (9.52)	
Early Adolescence (13-14)	27 (65.85)	14 (34.15)	
Late Adolescence (15-17)	29(69.05)	13 (30.95)	
x^2_2			2.22; 0.14
Gender			
Male	43 (86.00)	7 (14.00)	
Female	34 (58.62)	24 (41.38)	
x^2_1			9.75; 0.002**
Grade			
Elementary (1-6)	10 (100.00)	0 (0.00)	
Intermediate (7-8)	26 (70.27)	11 (29.73)	
High School (9-12)	36(66.67)	18 (33.33)	
x^2_2			3.12; 0.08
Perceived Service Need			
None	38 (84.44)	7 (15.56)	
Psychiatrist or Counselor	26 (76.47)	8 (23.53)	
Both	13 (44.83)	16 (55.17)	
x^2_2			12.49; 0.0004***

* $p < .05$;

** $p < .01$;

*** $p < .001$

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Table 2

Perceived stigma, depression severity, and socio-demographic characteristics

		Perceived Stigma			
	Total	**0-3 Low**	**4 to 6 Medium**	**7 to 15 High**	**pValue**
		N (%)	**N (%)**	**N (%)**	
Age					
Child (0-12)	21	6 (28.57)	8 (38.10)	7 (33.33)	
Early Adolescence (13-14)	41	12 (29.27)	15 (36.59)	14 (34.15)	
Late Adolescence (15-17)	42	13 (30.95)	14 (33.33)	15 (35.71)	
x^2_2					0.0000; 1.00
Gender					
Male	50	15 (30.00)	21 (42.00)	14 (28.00)	
Female	58	17 (29.31)	18 (31.03)	23 (39.66)	
x^2_1					0.64; 0.42
Grade					
Elementary (1-6)	10	3 (30.00)	5 (50.00)	2 (20.00)	
Intermediate (7-8)	37	10 (27.03)	12 (32.43)	15 (40.54)	
High School (9-12)	54	18(33.33)	20 (37.04)	16 (29.63)	
x^2_2					0.12; 0.73
Perceived Service Need					
None	45	16 (35.56)	12 (26.67)	17 (37.78)	
Psychiatrist or Counselor	34	12 (35.29)	16 (47.06)	6 (17.65)	
Both	29	4 (13.79)	11 (37.93)	14 (48.28)	
x^2_2					2.06; 0.15
Depression Severity					
Normal (30-75)	77	29 (37.66)	26 (33.77)	22 (28.57)	
Mild to Severe (76-120)	31	3 (9.68)	13 (41.94)	15 (48.39)	
x^2_1					7.86; 0.005**

*p < .05;

** p < .01;

*** p < .001

Table 3
Logistic regression of the effect of depression severity on perceived stigma

	Perceived Stigma		
	ODD Ratio	**95% CI**	**pValue**
Age			
Child (0-12)	1.00		
Early Adolescence (13-14)	0.92	0.25 – 3.33	0.88
Late Adolescence (15-17)	0.98	0.18 – 5.19	0.98
Gender			
Male	1.00		
Female	0.83	0.32 – 2.15	0.70
Grade			
Elem/Intermed (1-8)	1.00		
High School (9-12)	0.62	0.17 – 2.23	0.46
Perceived Service Need			
None	1.00		
Psychiatrist or Counselor	0.84	0.31 – 2.29	0.29
Both	2.07	0.54 – 7.90	0.21
RADS-2 Score			
Normal (30-75)	1.00		
Mild to Severe (76-120)	4.80	1.17 – 19.69	0.03*

* p < .05;

** p < .01;

*** p < .001