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Perceived stigma and depression among black adolescents in outpatient treatment

Theda Rose [a,*], Sean Joe [b], Michael Lindsey [c]

[a] National Catholic School of Social Service, The Catholic University of America, 620 Michigan Ave., NE, Washington, DC, 20064, United States
[b] School of Social Work, University of Michigan, 1080 S. University, Ann Arbor, MI 48109, United States
[c] Schools of Social Work and Medicine, University of Maryland at Baltimore, Louis L. Kaplan Hall, 525 W. Redwood Street, Baltimore, MD 21201, United States

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ABSTRACT

Despite the high prevalence of depression among children and adolescents, most that need mental health treatment do not seek care. This is especially true for ethnic minority adolescents. Prior research has shown that perceived stigma may act as a barrier to the initiation of and adherence to depression treatment, yet few studies have examined the relationship between stigma and depression among Black adolescents. This exploratory study examined the relationship between Black adolescents' depression severity and their current level of perceived stigma in an outpatient sample. Face-to-face interviews were conducted with a clinical sample of adolescents referred for mental health services at a community-based outpatient clinic ($n = 108$), participating in a prospective pilot study on adolescents' patterns of mental health service use. The analyses revealed that greater depression severity was significantly associated with higher perceived stigma ($p < .05$), particularly among females. The results also suggest that Black adolescents appear to exhibit an appropriate level of self-assessment regarding their need for mental health services. These results are interpreted in relation to previous literature, and limitations and directions for future research are discussed.

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 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-

* Corresponding author. Tel.: +1 202 319 5458; fax: +1 202 319 5093.
E-mail addresses: 27rose@cardinalmail.cua.edu (T. Rose), sjoe@umich.edu (S. Joe), mlindsey@ssw.umaryland.edu (M. Lindsey).

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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