



## Stigma experience among adolescents taking psychiatric medication

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### ABSTRACT

This study investigated the experience of stigma among adolescents taking psychiatric medication for the treatment of a diagnosed mental illness. Although medications are intended to improve functioning and reduce mental disorder symptoms, little research has examined the potential stigma associated with taking them. This study recruited forty adolescents, ages 12–17, who met DSM-IV criteria for a mental health disorder and who were taking a psychiatric medication at the time of the study. Data were collected using a semi-structured interview instrument and were thematically analyzed using Link, Cullen, Struening, Shrout, and Dohrenwend's (1989) modified model of labeling theory. Results indicate that many adolescents did experience stigma. In particular, 90% of the sample endorsed at least one of Link et al.'s (1989) constructs of secrecy, shame, and limiting social interaction; four endorsed no stigma themes. Additional themes emerged indicating that the perceptions of adolescents' family members and school environments can accentuate their experience of stigma or serve as a protective barrier against it. The thematic findings of secrecy and shame were used to construct hypothetical models for how adolescents limited their social interaction.

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### 1. Introduction

Research has shown how people who live with a mental illness can be stigmatized (Corrigan & Kleinlein, 2005). A diagnosis of mental illness, when associated with negative reactions such as stereotyping and prejudice, results in being assigned an undesirable social status (Goffman, 1963; Hinshaw, 2007; Link & Phelan, 2001; Scheff, 1966). Second, the use of psychiatric medication can be stigmatizing because it marks some as 'psychiatric patients,' which opens up the social space for others to react in a negative manner (Karp, 1997, 2006; Pescosolido, Perry, Martin, McLeod, & Jensen, 2007). Research demonstrates that stigma can produce negative short and long-term effects such as social withdrawal, shame (Link, Cullen, Struening, Shrout, & Dohrenwend, 1989), and limited employment and housing opportunities (Wahl, 1999).

The literature on stigma describes two types: public stigma and self-stigma (Corrigan & Kleinlein, 2005). Public stigma refers to instances in which society discriminates against individuals because they have a mental illness. In contrast, self-stigma, pertains to behaviors and responses of the stigmatized individual, such as internalizing negative social responses that lead to feelings of rejection (Corrigan & Kleinlein, 2005). Common examples of self-stigma include being secretive, feeling shame, and limiting interaction with others.

Most of the research on stigma, however, has been conducted on adults (Hinshaw, 2007). Review of the existing literature on youth indicates that little research has been conducted on the relationship of mental illness stigma and youth outcomes (Hinshaw, 2005, p. 723). Due to this dearth of research, the present study sought to identify whether stigma concepts drawn from the adult literature (secrecy, shame, and limiting social interaction) are applicable to the youth experience of stigma. The principal aim was to analyze adolescents' experience with mental illness and daily psychotropic medication treatment and assess, from their perspective, whether or not they experience stigma, and if so, whether the constructs used in adult research are useful to study mental illness stigma in youth.

#### 1.1. Empirical literature

The extant adult literature demonstrates that the negative effects associated with mental illness stigma may have serious ramifications for self-esteem, as well as opportunities to integrate in society and participate in meaningful activities. In particular, people who are targets of stigma often are secretive about their condition in order to avoid rejection and potential negative social, emotional, and functional (e.g., employment, housing) consequences. Potentially, secrecy protects (Corrigan, 2005). Goffman (1963) compares secrecy to "managing information about his failing... it is not that he must face prejudice against himself, but rather that he must face unwitting acceptance of himself by individuals who are prejudiced against persons of the kind he can be revealed to be" (p. 42). In addition to secrecy, stigma may lead to social withdrawal, which limits individuals' social circles to only those

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who know about and empathize with the experience. This effect may protect the stigmatized individual from rejection, but simultaneously limits the person from developing relationships that may increase career and educational opportunities (Link et al., 1989).

Related to secrecy is the feeling of shame. When shame is experienced, even though it is not a universal mental illness experience (Hinshaw, 2007), it can have powerful effects (Link et al., 1989); it can delimit the individual from engaging in intimate relationships. Shame results from rejection and its internalization (Hinshaw, 2007), which lowers self-esteem. Shame is also described as the effect of defeat, alienation, and transgression. It strikes deeply at the heart of a person and makes him or her feel naked and lacking in worth or dignity (Sedgwick & Frank, 1995).

There are only a few studies that have examined adolescents' experience of mental illness stigma. First, Moses (2009) found that youth did not think that people would discriminate against them, nor did most report self-stigma. In contrast, Watson, Kelly, and Vidalon (2009) found that youth hid their diagnosis from individuals in their social network. Rappaport and Chubinsky (2000) report that youth in psychotherapy talked about their medication in ways that suggested stigma like effects. For instance, "children are often apprehensive about taking medication and commonly believe that it is proof they are defective... At some point, they call themselves 'crazy,' 'bad,' or 'stupid,' as an explanation for why they are taking medicine" (Rappaport & Chubinsky, 2000, p. 1199).

Some literature has found that stigma is moderated by gender. For example, male adolescents have more negative attitudes than females toward mental illness (Komiya, Good, & Sherrod, 2000; Leong & Zachar, 1999). A study of help-seeking behaviors (Timlin-Scalera, Ponterotto, Blumberg, & Jackson, 2003) revealed that males, in order to avoid their perceived in-group from learning of their condition, tended to seek help from a person not affiliated with the school setting; when males sought help they asked mothers, coaches, friends, and girlfriends. Male attitudes and help-seeking behaviors have been associated with traditional attitudes about the role of the male, a concern about expressing affection toward other men, and an overall restricted emotionality (Blazina & Watkins, 1996). In contrast, Williams (1999) showed that adolescent girls managed their own care and more easily accommodated the illness as part of their identity; boys, on the other hand, relied on their mothers to take care of the illness. Although these studies have yielded important findings, the samples did not include adolescents who took psychiatric medication for a mental illness. In the Timlin et al. (2003) study, the focus was upon help-seeking behavior attitudes, and Williams (1999) studied female adolescents who were prescribed medication for diabetes.

Because school is a key site where youth developmental tasks are accentuated and enacted, particularly peer relationships and identity formation, research has also examined its environmental influence. Karp (2006) described acceptance as adolescents' biggest concern when they talked about their psychiatric medication: "The respect and acceptance of their peers becomes their most important obsession" (p. 178). Studies have documented that youth with mental illness have difficulty integrating into school settings because they worry about being different (Chandra & Minkovitz, 2006; Inzlicht & Good, 2006). Although mental illness is not the same as a 'learning disability,' placement in segregated classrooms significantly affects the segregated student (Crocker & Blanton, 1999; Crocker, Major, & Steele, 1998). For example, a learning disability label, poor self-esteem, and social comparison with others who do not have a learning disability have been associated with depression among people with intellectual disabilities (Dagnan & Sandhu, 1999; Swallow & Kuiper, 1988). As a result of negative treatment and images, Crabtree and Rutland (2001) argued that disability and segregated experiences contribute to negative psychological, economic, and social consequences.

Finally, families play a prominent role in not only supporting youth with mental illness, but also in conveying the information associated

with diagnosis and treatment (Hoagwood, Burns, Kiser, Ringeisen, & Schoenwald, 2001). Pescosolido et al. (2007) have argued that families greatly influence how youth perceive their illness. Thus, when parents do not help the adolescent understand the meaning of the diagnosis, or if they do not believe in the diagnosis (e.g., "she will grow out of it, like I did."), they may unintentionally contribute to a sense of being a 'bad kid' or a teenager with a 'brain disorder.' For the adolescent who internalizes the latter understandings from parents and siblings, they may be vulnerable to peer prejudicial perceptions and actions (Chandra & Minkovitz, 2006).

### 1.2. Why study the mental illness stigma experience of adolescents?

Stigma experiences among adolescents are of importance for at least three reasons. First, already in 1994 the fourth edition of the *Diagnostic and Statistical Manual of Mental Disorder* (APA, 1994) reported that the use of psychiatric medications by adolescents had increased. In 1999, the Surgeon General estimated that one in five children and adolescents suffered from a DSM-IV disorder every year. More recently, Moreno et al. (2007) have shown that the number of youths diagnosed with bipolar disorder increased forty fold between 1994 and 2003. In addition, Frank and Glied (2006) estimate that the use of psychostimulants to treat ADHD has increased between two to six fold. Between 1994 and 2001, among all psychiatric medication categories, prescriptions for youth have increased 2.5 fold (Thomas, Conrad, Casler, & Goodman, 2006). Because medications may mark individuals as different, the increased use of psychiatric medications for a mental illness may expose youth to prejudicial perceptions and stigma.

Second, the Surgeon General (2000) approximated that between six and nine million children who have DSM-IV disorders are not receiving proper treatment. Stigma for adults and children can prevent proper treatment (Corrigan, 2004; Owens et al., 2002) because they fear being labeled "crazy" (Kadison & Digeronimo, 2004). Youth, moreover, may resort to risky behaviors, such as alcohol, drugs or dropping out of school to cope with their mental illness; one study estimated that as much as 50% of dropouts in schools are attributed to psychiatric disorders (Stoep, Weiss, Kuo, Cheney, & Cohen, 2003).

The third reason stigma is of particular concern is that developmental theory suggests that adolescents form an identity, engage in peer relations outside the family, and use the school environment as a site for developing a sense of self-esteem, independence, and self-efficacy (Brockman, 2003; Gralinski-Bakker, Hauser, Billings, & Allen, 2005; O'Connor, Allen, Bell, & Hauser, 1996). How does mental illness stigma affect adolescent development? The adult literature focuses upon delimited employment and housing opportunities, for example. But from a youth developmental standpoint, it may be peer relations and identity formation that are delimited or negatively affected.

What we empirically know about the mental illness stigma experiences of adolescents is limited because few studies have focused on their perspective and few studies ask about medication experience (Floersch et al., 2009). Thus, using qualitative methods, this study aims: (1) to address the paucity of stigma data on adolescents by investigating how a diagnosis and daily medication are experienced; and (2) to explore lived experience of both mental illness and psychiatric medication use to assess if youth report experiences that could be characterized as stigma.

## 2. Methods

A university hospital Institutional Review Board for Human Investigation reviewed and approved the research protocol. The parents/guardians of the research participants provided written informed consent and all adolescents provided written informed assent prior to study participation. The interviews conducted (2006–2007) under the auspices of this study took approximately 6 h each. Parents received \$50

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