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Stigma Perceptions of Adolescents with Emotional and/or Behavioral Difficulties

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Abstract

The current study sought to better understand how adolescents with serious mental health problems participating in inpatient psychiatric treatment experience self- and perceived public stigma, using demographic and clinical factors to help further explain adolescents' experience of self- and perceived public stigma. Participants reported moderate levels of both self- and perceived public stigma, though these adolescents did not report significantly higher levels of self- or perceived public stigma than community/outpatient based samples. Although neither the three demographic nor three clinical factors were able to account for a significant amount of reported self- or perceived public stigma, the current research examined an understudied, acute population not previously found in the literature. This study begins to fill the gap in research about stigma experiences from the most acute populations.

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CHAPTER 1

INTRODUCTION

Stigma Perceptions of Adolescents with Emotional and/or Behavioral Difficulties

Research suggests that half of all lifelong mental health problems start between the ages of 11 and 15, with mood disorders typically beginning between the ages of 13 and 14 years (Kessler et al., 2005; Merikangas et al., 2010). A recent, nationally representative study of adolescent mental health prevalence rates found that nearly 50% of the 10,000 adolescent participants reported symptoms that would have met diagnostic criteria for a mental health disorder. Twenty percent of those surveyed were affected by severe mental health problems (Merikangas et al., 2010) which negatively impacted their ability to function socially and emotionally on a day to day basis. Further, 20% of adolescents will seriously contemplate attempting suicide sometime during their adolescent years and 8% of adolescents actually attempt suicide. The high rates of suicidal ideation and attempts among adolescents have led to suicide being the third leading cause of death among individuals between the ages of 10 and 19 (Grunbaum et al., 2001). With the percentage of adolescents being impacted by mental health problems out numbering the most common physical conditions (asthma or diabetes) and the potential mortality risk in this age group, more research is needed to better understand the daily impact of mental health problems on the lives of adolescents (Merikangas et al., 2010).

In addition to a high number of adolescents experiencing mental health problems, those with mental health problems often face additional stereotypes, prejudice, and misconceptions, which often result in a reduced quality of life. Stigma can be felt in the absence of any direct discrimination and may critically affect disclosure of mental health problems or help-seeking behaviors (Jacoby, 1994). The United States Surgeon General reported that stigma was a major problem facing those suffering from mental health problems (U.S. Department of Health and Human Services, 1999). However, there is little data focused on the experience of adolescents with mental health problems, specifically addressing levels of perceived stigma from others (public stigma) and/or stigma directed toward themselves (self-stigma; Hinshaw, 2005; Moses, 2009b; Pescosolido, 2007; Wahl, 2002). Moreover, the National Stigma Study-Children found that adults tend to stigmatize adolescents who demonstrate mental health problems (Martin, Pescosolido, Olafsdottier, & McLeod, 2007), which may increase the negative effects of mental health problems that adolescents suffer. Previous attempts have been made to measure attitudes toward mental health problems and stigma from the perspective of unaffected members of society (Bhugra, 1989; Byrne, 1997; Corrigan et al., 2000; Wolff, Pathare, Craig, & Leff, 1996); however, few studies have systematically addressed fundamental issues of “bias, distrust, stereotypes, fear, embarrassment, anger and/or avoidance” facing adolescents with mental health problems (U.S. Department of Health and Human Services, 1999) or adolescent’s own experience of stigma related to mental health problems.

The current research will focus on measuring stigma in an inpatient adolescent sample, and given that data suggests short-term inpatient psychiatric stays between 1996 and 2007 increased 83% for children between the ages of 5 and 12 (from 155 to 283 per 100,000 children) and 42% for adolescents between the ages of 13 and 18 (from 683 to 969 per 100,000), (Blader, 2011), this research is vitally important and will contribute to the larger field of mental health research and stigma. These findings will also extend the research completed by Moses (2009b) by providing additional data to assess the trend of stigma experiences for adolescents. An understanding of how adolescents with severe mental health problems experience self- and perceived public sigma may lead to further research on the effects of stigma on this population.

Defining Stigma

Goffman (1963) described stigma as an attitude or perception involving negative social evaluation that taints, discredits, or leads someone to reject an individual because of stereotypes associated with a mental disorder, ethnicity, drug use, or physical disability. Austin, MacLeod, Dunn, Shen, & Perkins, (2004) defined stigma as involving personal attitudes and beliefs, secrecy and disclosure, and social and cultural influences. Martin et al. (2007) defined stigma as the presence of negative attitudes (prejudice), and predispositions to exclude others based on their problems (discriminatory potential). There are many other definitions of stigma and for the purpose of this study Martin et al.'s definition will be used. Defining stigma as negative attitudes resulting in exclusion of others based on problems is a clear, yet broad, explanation that best aligns with what the current study is seeking to better examine. However, stigma can be more specifically defined by where it is occurring and by whom.

Public Stigma

Corrigan and Watson (2007) defined public stigma as the general public's reaction toward people with mental health problems, including a negative belief about those with mental health problems. Specifically, the authors noted the public responds with fear or anger and actively tries to avoid or refuse help to the stigmatized person. Moses (2009) defined public stigma as a sense of powerlessness related to stereotyping, rejection, discrimination, and other negative behaviors from others with and without mental health problems. As such, adolescents' perceptions of devaluation and rejection from others may strengthen the negativity associated with a serious mental health problem and undermine the belief that it can be overcome. The increased negativity associated with mental health problems can complicate the adolescent's ability to recover from, or be resilient to, a mental health problem. This study will use Moses'

(2009) definition of public stigma as it highlights the adolescent's perception of external assessment.

Self-Stigma

Self-stigma, or internalized stigma, is defined as the negative reactions of stigmatized individuals towards themselves (Corrigan, Watson, & Barr, 2006). Alternatively, self-stigma can be defined as being composed of negative beliefs about one's self, low self-esteem and negative emotional reactions, and a lack of effort to pursue new opportunities due to low self-worth or fear of failure (Corrigan & Watson, 2007). Moses (2009b) provides a third definition of self-stigma as an individual's sense of shame, embarrassment, and worry about others' responses to their mental health problems, resulting in negative feelings about one's self, lowered sense of personal mastery, and a narrowed future outlook. Herein, the definition of self-stigma proposed by Moses (2009b) will be used as it most closely relates to the present study's topic and is most independent of the definition of public stigma.

Stigma Models

Modified Labeling Theory

Link and Phelan (2001) developed the Modified Labeling Theory (MLT) to focus on the self as constructed by others through day-to-day contact and interaction. MLT hypothesizes that an individual given a mental health label is susceptible to a negative self-concept if that label and its stereotypes are internalized. This theory is a framework that accounts for the effects of stigma associated with devalued labels such as "mentally ill." MLT indicates that social expectations and judgments related to labeling can have large negative effects. Even if the perceived rejection is seemingly minimal, the rejections over time can drastically alter self-concept. MLT suggests that both internalized beliefs (self-stigma) and rejection from others based on a mental health label or visible behaviors associated with a mental health problem (public stigma) contribute to both self-protective and self-defeating coping strategies. Self-protective factors are thought to be abilities to engage with others in healthy, proactive ways. Examples are the ability to tolerate stress, low emotionality, sociability, self-help skills, impulse control, motivation, etc. (Werner, 2000). On the contrary, self-defeating factors are those that limit one's ability to engage socially, with examples such as: increasing secrecy, disclosure, and withdrawal; feeling or acting less competent and more unpredictable or harmful; and diminished capacity for independent action (Link, 1987; Link, Mirotznik, & Cullen, 1991).

Etiology and Effects of Stigma (EES) Model

Martin et al. (2007) studied social reactions to children with mental health problems using the Etiology and Effects of Stigma (EES) Model. The EES model suggests sociodemographic characteristics of both the person with the mental health problem and those in a position to accept or reject the person with mental health problems shape attributions and evaluations that reflect the non-affected individual's beliefs about underlying causes, the nature of the problem, possible outcome, and treatment engagement. For example, the EES model suggests that those demographically presumed to be of minority status are more likely to have negative labels attached to them and experience rejection from non-affected individuals. However, Moses (2009b) found that Caucasian adolescents reported more personal rejection and self-stigma than minority adolescents. Currently, research is mixed regarding the likelihood of race or minority status impacting an adolescent's self-stigma and/or experience or perception of public stigma (Moses, 2009b; Martin et al., 2007).

Attribution Theory and Stigma

According to Weiner, Perry, and Magnusson’s (1988) attribution theory of stigma, controllability is closely linked to blame. The theory suggests that individuals are assigned greater responsibility for their conditions with increases in perceptions of controllability. Attribution theory also suggests the more a person is held responsible for their condition, the more likely it is that they will be met with negative reactions. This theory differentiates between people who have controllable versus uncontrollable conditions; those perceived as having more control are considered to be more responsible and are viewed more negatively. In fact, research conducted by Crisafulli, Thompson-Brenner, Franko, Eddy, & Herzog (2010) found evidence to suggest when people believe a disorder is due to biological conditions (outside a person’s control) they are less likely to engage in blaming and more likely to engage in helping behaviors.

Adult Stigma Research

Physical Ailments and Stigma

It is not surprising to think that people with obvious physical differences may experience stigma at a higher rate than those who do not appear obviously physically different. Much of the research on physical ailments and stigma has focused on controllability. For example, Menec and Perry (1995) used vignettes to differentiate the level of stigma associated with controllable versus uncontrollable situations. Individuals with visible differences such as paraplegia, obesity, amputation, and blindness were significantly more stigmatized when respondents believed these conditions were due to personal choices. Even individuals with ailments that were not visible, such as AIDS, heart disease, lung cancer, and unemployment were more stigmatized when presented as a consequence of a personal choice rather than an uncontrollable circumstance or outcome. These findings are consistent with Weiner, Perry, and Magnusson’s (1988) attribution theory. In addition to controllability of the ailment, Menec & Perry (1995) also found that the age of the person significantly impacted the levels of stigma for those with physical disorders. These results highlight the tendency for non-affected people to evaluate based on assumptions, often leaving the affected person feeling the negative effects of perceived (public) stigma from others.

Mood Disorders and Stigma

Public stigma. There is a large body of research focused on adults with mental health problems and their experience of stigma and its effects, highlighting significant impacts on self-concept, quality of life, economic opportunities, and participation and belief in treatment (e.g., Corrigan et al., 2001; Rusch, Angermeyer, & Corrigan, 2005; Chung, 2005). Additionally, researchers have found that adults who report both perceived and experienced public stigma endorse lower self-esteem and increased self-stigma (Hayward, Wong, Bright, & Lam, 2002; Link, Struening, Rahav, Phelan, & Nuttbrock, 1997).

Research addressing perceived stigma among individuals with mental health problems has suggested stigma experiences are more prevalent in those with demographics such as low education, unemployment, and increased social isolation (Alonso et al., 2009). Additionally, in a study addressing the association between perceived stigma and mood disorders, Alonso et al. (2008) found that those suffering with depression and/or anxiety were more than twice as likely to experience stigma as those with no mental disorder. In King et al.’s (2007) development and standardization of The Stigma Scale with adults with mental health problems, researchers found that scores on the Stigma Scale and its sub-scales were negatively correlated with global self-esteem.

Self-stigma. In the last 15 years self-stigma has gained attention due to the recognition of its effects on self-esteem. For example, self-stigma theory suggests that those who have high self-stigma and low self-esteem often internalize public stigma by devaluing themselves based on others' beliefs and reactions (Link & Phelan, 2001). Research with adults suggests self-stigma and fear or rejection deters those with mental health problems from pursuing positive life opportunities (Link, Cullen, Frank, & Wozniak, 1987 & Link et al., 1997). The consequences of stigma on the self-esteem of adults with mental health problems are significant. Link, Struening, Neese-Todd, Asmussen, & Phelan (2001) conducted a study addressing the relationship between stigma and self-esteem of adults with mental health problems. The study found that those participants whose stigma scores were in the 90th percentile were seven to nine times more likely than those with stigma scores at the 10th percentile to have low self-esteem.

The probability of stigmatization increases when a mental health problem is perceived as severe and when it is associated with behavior that lies outside conventional norms (Martin et al., 2007). Dinos, Stevens, Serfaty, Weich, and King (2004) conducted interviews with 46 adults with mental health problems. The aim of the study was to determine the relationship between stigma and mental health problems, psychiatric diagnoses, and treatment. The results suggested that stigma and discrimination were pervasive experiences for most people using mental health services. This experienced and/or perceived stigma caused significant distress, which ultimately prevented those struggling with mental health problems from: accessing care, following through with treatment, admitting there is a problem, and accepting a diagnosis as helpful and accurate. It is interesting to note that a small minority of those in Dinos et al.'s research found that their mental health problems enhanced their experience of life and relationships with others. It was hypothesized that this group of participants used their mental health problems as a way to build relationships, help others, and view themselves as more well-rounded individuals.

Menec and Perry (1995) examined the emotional reactions to adults of varying ages with stigmatizing illnesses such as AIDS, depression, and physical disabilities. Using attribution theory to guide the research, they found that age and perceived controllability did not significantly impact levels of stigma for those who were experiencing depression. Depression was the only mental health factor presented in the research and the only factor across all those measured that did not exhibit a relationship between controllability and level of stigma. These results are interesting given that one would anticipate higher levels of stigma if depression is thought to be caused by personal choice. The current study does not specifically address controllability factors, but they are considered when evaluating the outcomes of levels of stigma experienced by those who are hospitalized due to mental health problems.

Yen et al. (2005) identified demographic variables that influence self-stigma. These researchers examined self-stigma among more than 200 adult outpatients with depressive disorders in an attempt to better understand factors related to self-stigma. Results indicated that adults who have a combination of severe depression and low education had higher levels of self-stigma. Given that adolescents (versus adults) are in earlier cognitive development stages, the relationship between education/age, depression and stigma are examined in the present study.

Youth Stigma Research

Development and Stigma

There is a significant body of research focused on children’s and adolescents’ perceptions of others with mental health problems (Secker, Armstrong, & Hill, 1999; Spitzer & Cameron, 1995; Wahl, 2002; Weiss, 1985, 1986, 1994). There is no doubt a developmental sequence wherein young children gradually perceive and handle both prejudice and issues of mental health problems in increasingly sophisticated ways. Research in this area has largely focused on children between the ages of three and seven. Research on childhood development of prejudice and discrimination has highlighted the tendency for children between the ages of 3 and 5 to recognize cues that signal group differences, as well as the ability to identify with the in-group. However, children of this age are not yet aware of the racial concepts or stereotypes that accompany in-group and out-group populations (Aboud, 1988; Goodman, 1964).

Research suggests that by five years of age children are knowledgeable about out-group stereotypes and report that they personally believe these stereotypes (Aboud, 2003). More than two decades ago, Weiss (1985, 1986, & 1994) conducted several studies with more than 500 children of elementary school age and followed them for nearly 10 years to examine prejudice in children toward people with mental health problems. In general Weiss found that children's attitudes toward those with mental health problems were stable and enduring from the time the child is in kindergarten through eighth grade. However, researchers Katz, Sohn and Zalk (1975) believed that children between the ages of five and seven report lower prejudice toward those with mental health problems due to increased social desirability effects and the limitation of admissions of prejudicial beliefs. Interestingly, seven year olds tend to show the same level of stereotype knowledge but much lower levels of prejudice (Corrigan & Watson 2007).

Spitzer and Cameron (1995) examined how age and gender impact the ways children define, characterize, and understand mental health problems. Spitzer and Cameron found that children under the age of seven do not possess an adequate knowledge of mental health problems, stereotypes, and/or understand terms related to mental health problems. More emotionally mature children, who tend to be older than seven, often have a better understanding of mental health problems, viewing them as emotional and thought disorders. However, most of the literature in this area (Aboud, 2003; Corrigan & Watson 2007; Katz, Sohn, & Zalk, 1975;

Weiss, 1985, 1986, 1994) suggested children and adolescents have a limited understanding of mental health problems or its treatment, and any attitudes, judgment, or overt behaviors displayed toward those with mental health problems are derived from the behavior of parents, caregivers, and trusted adults. Given the mixed findings, more research is needed to clarify young children's understanding of mental health problems and factors such as parental influence and social desirability need to be further refined.

Research has consistently found that adolescents between the ages of 11 and 18 have a comprehensive understanding of mental health problems and many have personally experienced symptoms. Kessler et al. (2005) used data from a nationally representative survey of 9,282 adults to examine the lifetime prevalence and age-of-onset of mental health problems. Results suggested half of all lifetime cases of mental health problems start by the age of 14. Merikangas et al. (2010) used data from a nationally representative study of more than 10,000 adolescents between the ages of 13 and 18 to find the lifetime prevalence of mental health problems among adolescents. Researchers found that nearly half of the sample reported symptoms meeting diagnostic criteria for at least one mental health disorder and 40% of those meeting criteria for one disorder also met criteria for at least one additional mental health disorder. Secker, Armstrong, & Hill (1999) used vignettes with 102 subjects aged 12-18 to better understand how adolescents develop their understanding of mental health problems. The researchers found that adolescents draw on their own experiences to determine behaviors and attitudes that seem normal and those that are outside the norm. Those behaviors and attitudes that were outside the norm were labeled mental health problems. The results were consistent across gender and age of respondents. These results indicate that adolescents are typically verbally equipped to describe personal experiences and perceptions of those with mental health problems.

Public Stigma

In child and adolescent focused stigma research, public stigma appears to be condition-specific, meaning the general adult public responds differently to the child or adolescent according to the presumed mental health problem (Pescosolido, Fettes, Martin, Monahan, & McLoed, 2007; Pescosolido et al., 2008; Walker, Coleman, Lee, Squire, & Friesen, 2008). Pescosolido et al. (2007) found that negative public responses included blaming the child's family for mental health problems, social distancing from the child and his/her family, and preference for severe treatment (e.g., social isolation, punishment) of the child without consideration of the impact of treatment.

Research in the area of public stigma suggests that more than half of adolescents between the ages of 13 and 17 have stigmatizing attitudes about mental health problems (Corrigan & Watson, 2007). A significant amount of research has focused on the level of understanding one can anticipate given a child's age and maturity, though relatively little is known about how this public stigma affects adolescents struggling with mental health problems.

Research conducted by Moses (2009b) suggests adolescents who report both perceived and experienced public stigma endorse lower self-esteem and increased self-stigma. To measure the construct of public stigma, Moses used a sub-group of 14 items on a self-report questionnaire targeting social devaluation, exclusion, and disrespect. Moses' complete measure derives from existing adult stigma scales and youth stigma scales for other types of illnesses. The study included 60 adolescents between the ages of 12 and 17, the majority of which were either adjudicated or living in an out-of-home placement and had at least one internalizing or externalizing disorder. Results suggested that adolescents with mental health problems were likely to be teased or harassed for receiving treatment and felt disrespected by peers on account of their mental health problems.

Link et al. (1987) used vignettes to determine if behavior or stigmatized status better accounted for rejection of those with serious mental health problems. Results suggested that labels play a bigger role in how those with mental health problems are perceived than the individual's observable behaviors. Pescosolido et al.'s (2007) research is based on a sample of 1,152 adult participants who were asked to share their beliefs regarding the potential for a child with a mental health problem to harm self and others. The results from these studies, conducted two decades apart, both found that even when symptoms and conditions are effectively treated and controlled, public stigma continues to negatively impact the child or adolescent experiencing mental health problems.

The adult and adolescent experience of stigma might be different. That is, adults are thought to be better equipped to distinguish mental health problem traits and/or subclinical symptoms of mental health problems from less stable emotional states (Moses, 2009b). Adults are thought to have a better understanding that emotional traits are more stable across time whereas emotional states tend to change frequently. Adults' increased emotional awareness does not take away from the adolescent experience of mental health problems. Rather, the distinction highlights how developmental differences will likely impact the results of similar studies. In fact, instead of using adult research to understand adolescent experiences, researchers are now developing age-specific theories.

Several researchers have found that stigma is a primary reason for underuse and lack of treatment adherence among youth with mental health problems (Hack & Chow, 2001; Kazdin, 1996; Penn et al., 1994; Vogel, Wester, & Larson, 2007). Researching the self-reported stigma of mental health problems may help determine how (and if) people seek help for mental health problems, their level of engagement in treatment, and outcome.

Self-Stigma

Little is known about adolescent experiences of stigma related to either mental health problems or the risk/protective factors that impact self-stigma**.** Moses has been the most active researcher in this area and has found mixed results across studies (2009; 2009b; 2010). In 2009, using five items from a self-report questionnaire targeting shame, embarrassment, and worry about others responses to mental health problems (self-stigma), Moses found that adolescents with mental health problems who have experienced stigma did not let it impact their outlook toward the future or ability to overcome challenges. This finding would suggest that adolescents who are resilient to stigma are more likely to become adults who view their mental health problems as a challenge they have dealt with and something that will help them to face other challenges in order to lead more productive and healthy lives. However, if those same adolescents participated in treatment from an early age, they were more likely to report increased personal rejection, self-stigma, and secrecy about their problems and treatment (Moses, 2009).

Kranke, Floersch, Kranke, and Munson (2011) qualitatively evaluated self-stigma among adolescents taking psychiatric medications. The results suggested that adolescent experiences of self-stigma are slightly different than adults. Adult literature suggests adults experience self-stigma in the form of stereotypes (exposure to negative beliefs about the self), prejudice (agreement with stereotype and internalizing it as a negative insult), and discrimination (a behavioral response to the prejudice) from others. Adolescents and adults experience stereotypes related to self-stigma similarly; however, research has found that these stereotypes more profoundly impact adolescents due to their developmentally appropriate desire and attempt to be accepted by peer groups on a more intense and regular basis. Instead of prejudice, adolescents experience differentiation, or the fear of being different, which can severely impact adolescents' social experience and identity development. Finally, adolescents work hard to protect themselves from discrimination and taunting. For example, an adolescent might lie to peers about the purpose of their medication in order to protect their developing identities and conceal their mental health problem. Due to the differences between adolescents and adults, researchers found it is important to consider that adolescents are significantly more impacted by self- and perceived public stigma due to their limited life experience and under-developed sense of identity, self-efficacy, and lack of independence (Kranke et al, 2011). These differences highlight that adolescents are often less able to protect themselves from the effects of stigma and are often more prone to the negative effects of both self- and public stigma. Given the discrepant results of Moses (2009) and Kranke et al. (2011) on the ability of adolescents to withstand self-stigma, it is important to continue to evaluate protective factors.

Unfortunately, those diagnosed with mental health problems early in life will likely experience significant distress related to ongoing mental health treatment and will tend to experience more distress throughout adolescence and adulthood, than those who did not engage in treatment before adulthood (Moses, 2009b). These results point to the double-edged sword of mental health treatment; on the one hand, treatment has been found to be beneficial for those who experience mental health problems at all ages, while on the other hand, participating in treatment at an early age is linked to poorer long-term outcomes related to stigma. However, it would seem logical to infer that early and long-term treatment occurs most often for those who have early onset mental health problems and poorer long-term outcomes. Even with poorer long-term outcomes, compared to those who do not require early treatment (i.e., later onset and less severe), early treatment is linked with better quality of life compared to similar early onset cases who did not receive early diagnosis and treatment.

Using depression as an example to support the inference above, Dekker et al. (2007) studied depression in a cohort of children between the ages of 4 and 18 from early childhood to adolescence (younger participants) and from adolescence to young adulthood (older participants) to examine developmental trajectories of depression. The study found that most participants who experienced depression at a younger age continued to experience increasing depressive symptoms into adolescence and early adulthood, leading to poor outcomes during various stages of life. Similarly, Hammen, Brennan, Keenan-Miller, and Herr (2008) found that youth first diagnosed with depression at an early age (prior to age 15) had more chronic and persistent depressive symptoms than youth diagnosed with depression after age 15. In addition, children and adolescents diagnosed with “early-onset” depression were more likely to experience additional symptoms of psychopathology, poor psychosocial adjustment, poor social functioning and suicidal ideation. Both studies highlight the importance of treatment to curtail the negative effects of depressive symptoms. Although this study will not be addressing depression alone, these studies highlight the importance of early treatment and understanding the experience of youth with mental health problems.

Physical Ailments and Stigma

Youth stigma research suggests that when asked to compare stigma associated with physical and mental conditions, adolescent participants had higher negative views and stigma toward a family member with mental health problems (25.9%) than a family member who required use of a wheelchair (5.5%; Arbour-Nicitopoulos, Faulkner, Paglia-Boak, & Irving, 2010; Adlaf et al., 2009). Younger adolescents tend to be more stigmatized by a family member's physical disability than older adolescents. Specifically, students in seventh and eighth grades were more than two times as likely as twelfth grade students to have stigmatizing attitudes toward a family member who required use of a wheelchair (Arbour-Nicitopoulos et al., 2010), with a similar pattern resulting for family members with mental health problems. Researchers hypothesize that the greater stigma toward mental health problems in younger adolescents may be due to the perception that mental health problems are a personal choice or moral failure rather than a true medical condition (Arbour-Nicitopoulos et al., 2010; Adlaf et al., 2009).

Austin et al. (2004) measured stigma in youth between the ages of 9 and 14 with epilepsy through self and parental report and found it difficult to fully assess and understand stigma and its impact. They defined stigma as involving personal attitudes and beliefs, secrecy and disclosure, and social and cultural influences. It was hypothesized, and supported, that greater perceptions of stigma would be associated with a more negative attitude toward having epilepsy, poorer self-concept, and more symptoms of depression. Research on the negative impact of chronic illness suggests that because of the importance and development of self-identity and peer relationships in adolescence, self- and perceived public stigma encountered at this time in development may greatly impact psychosocial health and self-esteem (Adlaf et al., 2009). Adolescence is also a period of identity development, creating a need for a sense of competence, social acceptance, and autonomy (Leavey, 2005; Wisdom, Clarke, & Green, 2006). It is believed the same is true for adolescents who are dealing with mental health problems, especially those with more severe symptoms or associated suicidality. This is also an important life stage to examine because attitudes from adolescence often continue into adulthood and can ultimately become life-long prejudices and discriminatory behaviors (Adlaf et al., 2009). This research focused on non-outwardly visible physical ailments provides evidence that the presence of non-outwardly visible mental health problems will show similar stigmatizing results.

Mood Disorders and Stigma

Research by Arbour-Nicitopoulos et al. (2010) addressing attitudes toward various physical and mental health conditions, suggested stigma related to mental health problems is significantly greater than stigma related to physical problems, and significantly less than stigma related to drug problems across all adolescents in the study. Depending on how a person views drug addiction, one could say that stigma related to mental health problems would also include addictions. Similar results were found when depression was compared to ADHD and asthma, with depression being the strongest predictor of stigmatizing beliefs (Coleman, Walker, Lee, Friesen & Squire, 2009). Additionally, adolescents who experience depression are likely to continue to experience depression into adulthood, leading to further difficulties in terms of employment, relationships, and many other facets of daily and long-term living (Pine, Cohen, Cohen, & Brook, 1999). These results suggest adolescents would feel stigmatized if they or one of their family members were diagnosed or struggling with mental health problems.

Self-concept. Moses (2009b) researched the extent to which adolescents diagnosed and treated for psychiatric disorders experienced stigma and how stigma relates to self-concept and demographic characteristics. The results suggest a strong relationship between self-stigma and self-concept, such that adolescents who experienced personal rejection and self-stigma also reported that other adolescents with mental health problems were devalued and rejected by others, getting at the concept of public stigma. Higher self-stigma ratings were related to the level of secrecy about one’s own mental health problems and rate of personal rejection experiences. This research also found that higher perceived public stigma and self-stigma were associated with increased depression and lower self-esteem. Older adolescents tended to have higher self-stigma and social devaluation of other adolescents with mental health problems. Interestingly, Caucasian adolescents reported more personal rejection and self-stigma than minority youth, which differs from previously reported research indicating that minority status increases the perceived effect of personal rejection and self-stigma (Martin et al, 2007).

Another area of interest is age of initial diagnosis and duration of treatment for mental health problems. In 2009(b), Moses conducted research with 54 adolescents between the ages of 12 and 18 and found that those who began treatment at a young age reported more personal rejection, higher self-stigma, and more secrecy about their problems and treatment. Moreover, Moses found that adolescents taking more than one psychotropic medication tended to experience greater personal rejection. Surprisingly, the Moses study revealed that participants reported relatively low levels of stigma despite the reported negative effects. This result may be attributed to the number of adolescents participating in mental health treatment and adolescents' tendency to view their symptoms as part of a mood or behavior problem that is not out of the ordinary.

Help seeking. When looking at stigma related to depression and suicidal ideation, Saunders, Resnick, Hoberman & Blum (1994) found that adolescents with the most severe depression and suicidal ideation were less likely to seek help than those adolescents who had less severe depression and suicidal ideation. For adolescents who experienced depression or suicidal ideation, between 33% and 44% of participants did not seek any kind of treatment in their lifetime to specifically address issues related to their depression or suicidal ideation (Pirkis et al., 2003; Arria et al., 2011). For those who did seek treatment or other forms of help, they were more likely to be younger at first episode, have chronic episodes of psychological distress, and seek treatment in the future (Arria et al., 2011). Of those who sought treatment or other forms of help, the majority sought help from friends/family rather than professional support or treatment from a medical doctor, social worker, psychologist, or psychiatrist (Arria et al., 2011). These results highlight the stigmatizing nature of seeking psychological treatment. It seems reasonable to anticipate that those with mental health problems experience higher levels of stigma. The current study addresses adolescents' self- and perceived public stigma related to participating in an inpatient psychiatric program meant to address mental health problems.

Self-labeling. Wisdom and Green (2004) found that adolescents experience difficulty accepting mental health diagnoses for a variety of reasons, including lack of understanding, fear of future implications, and misinterpreting the diagnosis and/or proposed treatment. Even when adolescents find comfort or clarity in a diagnosis, they continue to report negative consequences among peers, including feeling socially ostracized and/or pitied. In research focused on the relationship between self-labeling and stigma, Moses (2009) found that adolescents who avoided self-labeling endorsed less depression, self-stigma, and tended to view themselves as more able to face the future. Those adolescents who endorsed self-labeling reported more experiences of rejection from peers.

Demographic differences. Research has found that Caucasian females who have attempted suicide in the last year are more likely to participate in inpatient and outpatient treatment than those from other ethnicities. In the earlier adolescent years, Major Depressive Disorder becomes more than twice as common in females as in males, possibly due to differing coping styles, societal expectations of males and females, or hormonal changes (Angold, Costello, Erkanli, & Worthman, 1999). Moses (2009) found that Socioeconomic status (SES) also contributed to the tendency for adolescents to self-label. Results suggest adolescents from low SES families, from families with no higher education, or of a minority status were less likely to use self-labeling compared to higher SES and Caucasian participants. The current study uses similar demographic indicators to assess the impact of self-stigma related to mental health problems.

Demographically, adolescents of minority status were more likely to receive negative labels and experience rejection. Research is mixed as to the likelihood of race or minority status having an impact on adolescent self-stigma and/or experience or perceived public stigma (Moses, 2009b; Martin et al., 2007; Wu, Katic, Liu, Fan, & Fuller, 2010). However, Wu et al. (2010) found that adolescents from minority racial-ethnic groups were significantly less likely than Caucasians to participate in inpatient mental health treatment. Using Wu et al.'s (2010) sample, approximately 56% of both male and female adolescents between the ages of 12 and 17 do not utilize any form of treatment. Although Wu et al.'s (2010) research suggested males were more likely to participate in inpatient services, the actual percentage of males accessing treatment remains below 45%.

To date there is sparse information regarding the extent to which stigma is experienced by adolescents diagnosed with mental health problems and stigma's effects on their well-being. This is an important area of research considering 49.5% of adolescents between the ages of 13 and 18 have had one or more mental health disorders diagnosed in their lifetime; 27.6% have been diagnosed with a severely debilitating mental disorder; and approximately 20% have two or more mental health diagnoses (Merikangas et al., 2010). For example, at any given time, up to 15% of children and adolescents demonstrate some symptoms of depression, with 5% of children between the ages of 9 and 17 meeting criteria for Major Depressive Disorder (Birmaher et al., 1996; Shaffer et al., 1996).

Current Study

There is a paucity of research on the subjective perspectives and experiences of adolescent psychiatric inpatients. To date, a number of researchers have measured attitudes toward mental health problems and stigma, most of which have focused on attitudes toward mental health problems held by the public, or those not specifically asked about their own mental health problems (Byrne, 1997; Corrigan et al., 2000; Wolff et al., 1996). Indeed, the literature to date has not included person-first research targeting adolescents with significant mental health problems, where adolescents with mental health problems are the participants in the research. Few studies have systematically addressed fundamental issues of "bias, distrust, stereotypes, fear, embarrassment, anger and/or avoidance" facing adolescents with mental health problems (U.S. Department of Health and Human Services, 1999).

Furthermore, the lack of research into the consequences of stigma among adolescents with mental health problems is surprising given the national concern that the majority of adolescents with behavioral or emotional disorders do not have access to, or choose not to, participate in available treatment (Kataoka, Zhang, & Wells, 2002). The current study takes a first step toward understanding the consequences of stigma among adolescents with severe mental health problems in a short-term inpatient psychiatric hospital by examining the extent to which this population both experiences and perceives stigma, as well as further clarifying the relationships between self- and perceived public stigma and various demographic and clinical characteristics.

Research Questions

Research Area One: Demographic Factors. This study attempted to determine which demographic factors are most closely associated with adolescent stigma ratings. Because none of the previously cited results came from studies using psychiatric populations or similarly focused research questions, the results of previous research are only considered a guideline for what might be expected in the study.

Research question one. Does age demonstrate significant relationships with levels of self- or perceived public stigma? Previous research addressing the relationship between age and self-and perceived public stigma found that older adolescents tend to experience more self-stigma and perceive more public stigma than younger adolescents (Moses, 2009). Corrigan and Watson (2007) found that more than half of the adolescents between the ages of 13 and 17 in their study had stigmatizing attitudes about mental health problems, but did not determine if levels of stigma were related to age. Researchers have found that younger youth are more apt to feel stigmatized by receiving mental health services (Cauce et al., 2002; Lindsey, Korr, & Broitman, 2006; Rizzo et al., 2007). Although there has been research to suggest a directional hypothesis, the available research does not address adolescents in psychiatric hospitals. Given the lack of comparable research, this study seeks to determine the relationship between age and both self- and perceived public stigma.

Research question two. Does gender demonstrate significant relationships with levels of self- or perceived public stigma? Current available research does not specifically address the relationship between gender and self- or perceived public stigma. However, research suggests that females are more than twice as likely to be diagnosed with a mental health disorder (Angold et al., 1999) and are more likely to seek professional help for mental health problems than males (Chandra & Minkovitz, 2006; Raviv et al., 2009; Rickwood et al., 2007). However, Wu et al. (2010) determined that males make up the majority of those participating in inpatient care, which may suggest males are referred for treatment when they or their families feel there are no other options, their level of distress has become acute, and/or serious destructive behaviors are accompanying their mental health problems. Given the lack of comparable research, this study seeks to determine the relationship between gender and levels of self- and perceived public stigma.

Research question three. Does SES demonstrate significant relationships with levels of self- or perceived public stigma? Moses (2009) found that adolescents from families with low SES (e.g., public insurance, no college for parents, minimum wage earning parents) were less likely to be impacted by self-stigma compared to adolescents from families with higher SES. However, Merikangas et al. (2010) found that children from families with low SES (e.g., living at or below poverty level, no college for parents) are at an increased risk for having mental health problems. This study seeks to reconcile these discrepant findings and clarify the relationship between SES and levels of self- and perceived public stigma.

Research Area Two: Clinical Factors. This study will attempt to determine which clinical factors are most closely associated with adolescent stigma ratings. The clinical factors of interest in this study are current disorder/diagnosis, time with diagnosis (time between initial diagnosis and present), and number of psychiatric admissions.

Research question four. Does time with diagnosis demonstrate significant relationships with levels of self- or perceived public stigma? Moses (2009) and Hammen, Brennan, Keenan-Miller, and Herr (2008) found that adolescents who had early onset mental health problems reported more personal rejection, higher self-stigma, and more secrecy about their problems and treatment. These results seem consistent with the idea that more time in treatment suggests a more serious mental health problem and is often associated with less positive long-term self-evaluation. However, Moses (2009b) looked specifically at the relationship between time in treatment and the level of self-stigma and found no relationship. Given the mixed findings, this study will seek to clarify the relationship between time with diagnosis and levels of self-and perceived public stigma.

In order to more fully understand the relationship between time in treatment and self- or perceived public stigma, the relationship will be evaluated using SES, age, and gender as moderating factors. There is no research specifically addressing the moderating effects of SES, age, or gender on time in treatment and levels of self- or perceived public stigma. This area of research is exploratory.

Research question five. Does number of psychiatric admissions demonstrate significant relationships with levels of self- or perceived public stigma? Moses (2009b) found there is no relationship between self-stigma and the number of psychiatric hospitalizations, though one would hypothesize that each time a person is hospitalized they may begin to feel more negatively impacted and hopeless about their mental health problems. This study seeks to clarify the relationship between the number of psychiatric admissions and levels of self- and perceived public stigma, though a directional hypothesis was not supported in the available literature.

In order to more fully understand the relationship between number of psychiatric admissions and self- and perceived public stigma, the relationship will be evaluated using SES, age, and gender as moderating factors. No available research has evaluated the moderating effects of SES, age, or gender on the number of psychiatric admissions and self- and perceived public stigma. This area of research is exploratory.

Research question six. Does mental health disorder demonstrate significant relationships with levels of self- or perceived public stigma? Previous research addressing clinical factors effect on self-and public stigma found that adolescents with depression and/or anxiety are more likely to experience self-and public stigma than those with other mental health problems (Pine et al., 1999; Rickwood et al., 2005). Data analysis will include the two categories of Depression and Other (which includes those with Mood Disorder, NOS, Anxiety, and other diagnoses).

In order to more fully understand the relationship between mental health disorder and self- and perceived public stigma, the relationship will be evaluated using SES, age, and gender as moderating factors. No available research has evaluated the moderating effects of SES, age, or gender on the mental health disorder and self- and perceived public stigma. This area of research is exploratory.

CHAPTER 2

METHODS

Participants

Research suggests that adolescents tend to deny mental health problems and/or refuse treatment (Carlton & Deane, 2000; Chandra & Minkovitz, 2006; Moses, 2010; Raviv et al., 2009; Wilson & Deane, 2012). Thus, adolescents already admitted to a psychiatric hospital were recruited for the present study (see Appendix A for letter for support from the psychiatric hospital). Using this high-needs population provides an important perspective missing from the currently available research. These participants have greatly contributed to the general understanding of stigma and mental health problems due to their own and their parent’s willingness to recognize signs and symptoms of mental health problems and seek appropriate treatment. More specifically, participants in the current study are the first known group of adolescents admitted in a psychiatric hospital to share their experiences regarding self- and perceived public stigma. This population is unique due to the serious nature of their mental health problems and their current participation in a short, yet intensive, stay at an inpatient psychiatric hospital focused on stabilization, assessment, and discharge planning for ongoing outpatient treatment.

Prior to beginning the study, a power analysis was conducted using GPower 3.1 (Faul, Erdfelder, Buchner & Lang, 2009) and Cohen's (1988) Power Tables for Effect Size r to determine an adequate sample size for this study. The power analysis indicated a need for a total sample of approximately 75 participants in order to provide enough power to determine differences among the groups. The power analysis was conducted based on an expected correlation coefficient effect size of approximately .4. This value was selected based on Cohen's (1988) suggested medium effect size and prior research on correlations of stigma and demographic and/or clinical variables indicating effect sizes between .20 and .61 (Austin et al., 2004; Broadbent et al., 2006; Corrigan et al., 2010; Moses, 2009b; Moses, 2010; & Perlick et al., 2011).

Over the course of the data collection period, 128 adolescents and their parents indicated interest in the current study and granted consent, but due to discharging from the hospital prior to completing all research material, or parents failing to return all of the completed research materials, 51 of the initial 128 participants were considered ineligible for the study and were excluded from the analyses. Of those who completed all research materials, every participant (n=77) met study eligibility (Between 13-18 years old; English Speaking, No known Intellectual Disabilities; No Active Psychosis), formally gave informed consent and assent, and completed all research materials (demographic questionnaire, semi-structured interview, YSR/CBCL, and stigma survey). Thus, 60% of those initially interested in the current study completed all research materials. No participants withdrew from the study.

The sample consisted of more females (n=50 or 65%) than males. The majority were Caucasian (n=62 or 81%) and the average age was 15.3 years (range 13 to 18, *SD*= 1.4). Most parents/guardians (81%) had completed at least one year of college and had private insurance (84%). Further information on demographic factors of the sample is shown in Table 1. The participants are thought to be a representative sample, based on previous experience as a UNI clinician, of those who are hospitalized at the University Neuropsychiatric Institute, though a specific comparison was not calculated due to lack of access to data on those who did not choose to participate in, or qualify, for the current study.

Table 1. *Participant's Demographics (N = 77)*

Demographic Factors	Frequency	%
Age in years (Range 13-18)		
13	8	10
14	19	25
15	17	22
16	14	18
17	17	22
18	2	3
Gender		
Male	27	35
Female	50	65
Race		
Caucasian	62	81
African American	3	4
Hispanic/Latino	8	10
Other	4	5
SES Level		
Insurance		
Private	65	84
State/Public	12	16
Parent Education		
Some High School to Some College	33	56
Completed College to Graduate School	32	42
Unknown	2	2

When looking at clinical factors, adolescents had relatively extensive histories of mental health problems; on average, parents/guardians indicated youth were 10.3 years old (*SD* = 4.2) when mental health problems were first diagnosed and had been diagnosed with some kind of mental health problem for 4.9 years (*SD* = 4.2). Additionally, a large majority (73%) of the sample had been hospitalized only once in a psychiatric hospital, however the entire sample averaged 1.6 (*SD* = 1.4) lifetime hospitalizations. The sample was largely diagnosed with depression (70%) followed by Mood Disorder, NOS (18.2%), Anxiety (7.8%) and other disorders (4%). The diagnostic grouping is consistent with the historical population of the hospital, with the large majority of those hospitalized having some kind of depressive diagnosis including: Major Depressive Disorder, Dysthymic Disorder, and Depression Disorder, NOS. Data analysis will include the two categories: Depression and Other (which includes those with Mood Disorder, NOS, Bipolar 1 Disorder, and Anxiety disorders). Additional clinical factors were assessed on the entire sample and can be found in Table 2 below.

Table 2. *Participant's Clinical Factors*

Clinical Factor	Frequency	%
Number of Admissions (range 1 to 9)		
1	56	73
2	11	14
3	5	6
4+	5	6
Mental Health Disorders		
Depression	54	70
Other	23	30
Mood Disorder NOS (15)		
Anxiety (7)		
Other (1)		

Procedures

Participants were recruited to participate in this study during the intake process at University Neuropsychiatric Institute (see Appendix A for letter of support from hospital). During the intake process, guardians were informed about the purpose of the study and provided with an informational flyer describing the research (see Appendix B). Guardians and adolescents were both asked to give consent to participate in research currently happening on the unit. If guardians gave permission on the University Neuropsyciatric Institute intake form, they were contacted by the primary investigator (Camille Barraclough, MA) to review the current research and schedule a meeting to meet with the guardian on the unit to gather parental consent (see Appendix C), and ask the parent(s) to complete a brief demographic questionnaire (see Appendix D), along with a behavioral checklist regarding their child (see Appendix E). The family was given the opportunity to opt out of the study at any point and thanked for their willingness to hear about the study even if they ultimatly chose not to participate.

Within 48 hours of parental consent being granted, the primary investigator informed the adolescent about the current study. The adolescent was given adequate time to review study information and ask questions before being asked to sign an assent (or consent if 18) form (see Appendices F & G). Once assent/consent was granted, the adolescent participated in a semi-structured interview with the primary investigator exploring their experiences related to self- and perceived public stigma (see Appendix J). Upon completion of the interview, the adolescent was given an ASEBA-YSR (Achenbach, 2009) behavioral checklist (see Appendix H) to complete along with a stigma survey developed for the current study (Appendix I). The stigma survey had several parts: 1) a vignette about a character with a mental health disorder (with or without the word “depression”; which depended on vignette order presentation that varied between participants), 2) 15 perceived public stigma questions, 3) 16 self-stigma questions, and 4) a second, very similar, vignette about a character with the same mental health disorder (the alternate vignette from the first vignette presented). The participants were typically able to complete the interview and questionnaires in approximately 30 minutes. Because no research has previously assessed the levels of self- and perceived public stigma adolescents with severe mental health problems experience, the current study was primarily exploratory in nature and examined two general areas of inquiry: demographic and clinical factors as they are related to self- and perceived public stigma.

If at any point participants wished to stop answering questions they were free to do so without consequence. If the participant experienced any sort of distress or discomfort related to this study, therapeutic support was immediately available by the primary investigator and within 24-48 hours by the primary therapist. The primary investigator debriefed with each participant to assess and limit the possibility of ongoing distress or discomfort. For safety, a suicide assessment (see Appendix L) was available if the participant reported or endorsed any symptoms of suicidality on the ASEBA-YSR behavioral checklist. Fifty-one participants required the formal assessment due to indicating “somewhat” or “very true” to the one question specifically related to suicidal ideation. Unit staff and primary therapists were informed of those who participated in the study to ensure all safety concerns were preemptively in place; however no participants required additional support due to discomfort related to the study.

If all materials were completed and returned prior to discharge, a brief file review took place upon discharge to ensure the accuracy of the diagnosis given that a significant portion of inpatients are given an initial diagnosis of Mood Disorder, NOS upon admission. Completing the file review at discharge was an attempt to broaden the range of diagnostic criteria included in the analysis and ensure the most accurate and up-to-date information was used for the study. The file review gathered demographic and clinical information including age, gender, race/ethnicity, diagnosis, number of hospitalizations, and type of insurance (see Appendix K). During the file review, special attention was paid to eligibility criteria, in order to ensure the participant was between the ages of 13 and 18, without intellectual disabilities, and not currently diagnosed with a psychotic disorder. If a participant completed the study but did not meet inclusion criteria, their data were eliminated from the data pool/analysis.

Using the previously described sampling method, data were collected between July 2012 and August 2013 over the course of eight data collecting periods (July 8-August 19, 2012; September 1-3, 2012; September 22-23, 2012; November 21-25, 2012; February 9-10, 2013; February 23-24, 2013; March 30-April 7, 2013; July 8-August 15, 2013). All participants were recruited during an inpatient psychiatric hospitalization at the University Neuropsychiatric Institute.

Measures

Demographic questionnaire. Parents completed a brief demographic questionnaire about their level of education and the age of onset of their child's emotional and/or behavioral difficulties (see Appendix D). Age of onset of emotional and/or behavioral difficulties was measured in months to reduce the limitations of using restricted range variables and during analysis was split into dichotomous variables 0-48 months and 49+ months. Insurance and level of education were gathered as general indicators of SES. Insurance was noted as either private or public. Level of education was initially gathered using five levels (Some High School; Completed High School; Some College; Completed College; Graduate School), however those were condensed into 2 levels for evaluation purposes: those who have completed up to two years of college, and those who have completed more than two years of college. Using information from the United States Department of Labor, Bureau of Labor Statistics (2014), those who complete up to grade 12 make $472-651 per week, those who attended college but did not graduate make $727-777 per week, and those who complete college make between $1108-1623 per week, with a median salary across all education levels of $827 per week. Even with the two categories used in the current study, there is still a substantial difference between those who complete college ($1108-1623) and those who complete less than 2 years of college ($472-777).

All other demographic (age, gender) and clinical (number of hospitalizations, diagnosis) information was gathered during the file review (see Appendix K). Participant's age at the time of the study was measured in months to reduce the limitations of using restricted range variables, and for analysis was split into dichotomous variables of 13-15 and 16-18. Gender was evaluated using the dichotomous variables of male and female. Number of hospitalizations remained a continuous variable to reduce the limitation of using restricted range variables and for analysis was split into dichotomous variables of one hospitalization and two or more hospitalizations. At study initiation it was anticipated there would be at least three levels of primary diagnosis (Depression (Depression Disorder NOS, Dysthymic Disorder, and Major Depressive Disorder); Anxiety (Anxiety Disorder NOS, Generalized Anxiety, Obsessive-Compulsive Disorder, Panic Attack, Panic Disorder, Posttraumatic Stress Disorder, Social Phobia, and Specific Phobia); and Mood Disorder, NOS) by which to compare the data. However, the participant group rendered only two levels of primary diagnosis, Depression (including: Depression Disorder NOS, Dysthymic Disorder, and Major Depressive Disorder) and Other (including: Mood Disorder, NOS, Anxiety Disorder, NOS, Generalized Anxiety, Obsessive-Compulsive Disorder, Posttraumatic Stress Disorder, and Bipolar 1 Disorder) that allowed for meaningful analysis.

Semi-structured stigma interview. Adolescent participants engaged in a semi-structured interview including quantitative rating scales and qualitative questions designed to elicit their experiences and perceptions of self- and perceived public stigma. The interview queried participants' beliefs about their admission and assessed their perceptions about the presence of emotional/behavioral problems that might have contributed to their hospitalization. Next, the participant was asked to complete the quantitative portion of the research.

Qualitative questions addressing the self-stigma portion of the survey included: "Do you think you have an emotional and/or behavioral issue?" If the participants responded "Yes" then three follow-up questions were asked: "How, if at all, does having an emotional and/or behavioral issue affect how you think about yourself?," "Is there anyone in your life that you do not want to know about your being here at the hospital? Why?" and "How do you think people, who know you are in treatment, will treat you when you get home?" Additionally, there was one qualitative question addressing perceived public stigma: "What do you think other people think about teens that have emotional and/or behavioral issues?" (See Appendix J).

Stigma Survey. Participants completed a modified version of the Stigma Scale developed and validated by Moses (2009b) for adolescents between the age of 13 and 18 receiving wraparound mental health treatment through a school or community-based program. The majority of the questions are based on previously used stigma surveys with adults and children with physical health problems (Austin et al., 2004; Fife & Wright, 2000; Link et al., 1991; Link et al., 1997) with the addition of a few questions developed by Moses (2009b). The measure demonstrates construct validity by significant, positive correlations across stigma subscales (r = .29 to .64), and discriminant validity by accurately discriminating between self- from public stigma experiences (a = .76 to .84; Moses, 2009b).

Modifications to Moses' Survey. For the current study, only a portion of the original questions and wording of Moses' (2009b) Self-Stigma and Secrecy sub-scales were used to address adolescents' personal experiences with emotional and/or behavioral problems (see Appendix I). The original Likert scale was modified to include neutral midpoints (sometimes/undecided), positive anchors (always/strongly agree), and negative anchors (never/strongly disagree) for each sub-scale. Finally, the Public Stigma portion of the scale was the most significantly modified, as described below.

First, nine items were omitted from the Societal Devaluation portion of the Public Stigma survey as they were deemed to be overly negative for the purposes of the current study. Second, nine questions from the Social Skills Improvement System (SSIS; Gresham & Elliott, 2008) were added to incorporate strength-based questions to the survey, all of which are indicated with a (**) in the body of the survey (see Appendix I). The decision to add to the strength-based questions was to protect the participants from thinking that emotional and/or behavioral issues are only related to negative experiences, outcomes, or reactions from others. And third, modified National Stigma Study-Children vignettes (Pescosolido et al., 2007) were added to assess adolescents' perceived public stigma toward an adolescent depicted to have a mental health problem.

Vignettes were used instead of asking direct questions about self- and perceived public stigma as a way to protect the participant from unnecessary emotional stress. Vignettes are considered a method to introduce sensitive topics that might otherwise be considered too difficult to ask directly (Barter & Renold, 2000). They are also thought to provide a safe emotional distance from personal experiences (Ganong & Coleman, 2006; Prior, Chun, & Huat, 2000), and elicit more authentic responses from individuals than if they were asked the questions directly (Ganong & Coleman, 2006; Hughes & Huby, 2004).

Each participant read both vignettes, with the vignette presentation counterbalanced to control for order effects. The first vignette depicts an adolescent with a mental health problem that is explicitly labeled “depression.” The second vignette is identical to the first but without the diagnostic category. That is, the label “depression” is removed from the text. Two versions of the vignette were included in an attempt to determine if higher levels of stigma were reported when the participant read symptoms of a mental health problem and a diagnostic label versus symptoms of a mental health problem without a label. Below is the exact wording of the vignettes (which can also be seen in Appendix I in the context of the larger survey):

> **Vignette: 1 (Labeled):** Sam is a 14 year old with depression. In the last few months, Sam has been increasingly moody, isolating in the bedroom after school, and seems to have lost interest in favorite hobbies and friends. Sam often complains of feeling very tired even though Sam has been sleeping more than normal, and doesn’t feel like eating. Sam has been having trouble concentrating in school and at home. Sam has said “I wish I hadn’t been born” to family members. One of Sam’s friends has also heard Sam talk about engaging in self-harming behaviors.
>
> **Vignette: 2 (Non-Labeled):** Sam is a 14 year old who in the last few months, has been increasingly moody, isolating in the bedroom after school, and seems to have lost interest in favorite hobbies and friends. Sam often complains of feeling very tired even though Sam has been sleeping more than normal, and doesn’t feel like eating. Sam has been having trouble concentrating in school and at home. Sam has said “I wish I hadn’t been

> born" to family members. One of Sam's friends has also heard Sam talk about engaging in self-harming behaviors.

After reading each vignette the participant answered 15 perceived public stigma questions (10 from the Moses Stigma Scale and 5 from the SSIS) and 16 self-stigma questions (12 from the Moses Stigma Scale and 4 from the SSIS) and after the second vignette completed an additional 15 perceived public stigma questions (10 from the Moses Stigma Scale and 5 from the SSIS). All questions were answered using a 0-5 scale regarding their perception of the adolescent described and their own stigma beliefs/experiences. A total "perceived public stigma" score was derived by tallying the 0-5 response on each of the 10 perceived public stigma questions from the Moses Stigma Scale. Similarly, a total "self-stigma" score was derived by tallying the 0-5 response on each of the 12 self-stigma questions from the Moses Stigma Scale. The SSIS questions were omitted as they were added to the survey as a way to protect participants from an overly negative experience. Additionally the SSIS have not been shown to be specific indicators of self- or perceived public stigma.

Behavioral checklist. Parents and adolescents completed an Achenbach System of Empirically Based Assessment (ASEBA) behavioral checklist. The ASEBA is a comprehensive multi-informant, evidence-based assessment system that assesses competencies, adaptive functioning, and behavioral, emotional and social problems (Achenbach, 2009). The parents completed the ASEBA- Child Behavior Checklist (CBCL) for ages 6-18 (see Appendix E) and adolescents completed the ASEBA- Youth Self-Report (YSR) for ages 11-18 (see Appendix H). Each checklist included qualitative questions and more than 110 quantitative questions which align with six DSM-IV categories and eight factor analyzed syndromes (Achenbach, 2009). This checklist measured depression and other emotional and/or behavior problems in the participating adolescents and provided additional information about the whole adolescent, including strengths and hobbies. The CBCL and YSR offered a picture of the adolescent above and beyond their stigma experiences and emotional and/or behavioral problems.

Suicide assessment. Because one of the ASEBA questions explicitly probes for current suicidal thought, a suicide assessment was included to ensure the safety of participants. If the adolescent endorsed suicidality on the YSR or verbalized suicidality during the debriefing, a suicide assessment was available to take place immediately. When answering the question "I think about killing myself" 26 participants indicated "not true," 25 indicated "somewhat true," and 26 indicated "very true." The primary investigator asked seven questions to the 51 participants indicating "somewhat true" or "very true" (see Appendix L) specifically assessing for current level of suicidality. If the suicide assessment indicated a suicide risk, the results of the assessment were to be shared with the participant's primary therapist and unit staff were to closely observe the adolescent until the suicidality has been reassessed and mitigated. Although 51 participants were assessed for level of suicidality, none indicated a suicide risk and the aforementioned precaution was not needed for any study participants. Given that the adolescents were already participating in an inpatient psychiatric treatment program, all safety precautions were in place and they did not have access to harmful materials and were not allowed to leave the secure unit before being cleared by their primary therapist and/or psychiatrist, as per standard protocol.

CHAPTER THREE

Results

All statistical analyses were run using SPSS Version 20.0. Multiple regression, ANOVA, and Bivariate statistics were used to determine if demographic and clinical factors predict self-and perceived public stigma. Moderated regression analysis was used to determine if demographic factors (age, gender, SES) moderate the relationship between clinical factors (time in treatment, number of psychiatric admissions, diagnosis) and level of self- and perceived public stigma.

Demographic factors were operationalized into both categorical and continuous variables. Age was measured in months to reduce the limitations of restricted range and gender was evaluated by two levels (male, female). SES was initially proposed to be measured using level of parental education and insurance type; however, the insurance data did not add significant meaning to SES beyond level of parental education alone. Therefore, level of parental education was used as the general indicator of SES.

Clinical factors were operationalized into both categorical and continuous variables. Time in treatment was measured using age of onset of emotional and/or behavioral difficulties and measured in months in order to reduce limitations of using restricted range variables. Number of hospitalizations was used as a continuous variable. Diagnosis had two levels: Depression (including: Depression Disorder NOS, Dysthymic Disorder, and Major Depressive Disorder) and Other (including: Mood Disorder, NOS, Anxiety Disorder, NOS, Generalized Anxiety, Obsessive-Compulsive Disorder, Posttraumatic Stress Disorder, and Bipolar 1 Disorder).

Prior to testing the hypotheses, the normality of the data was considered. Measures meet standard criteria for univariate normality with skewness for all measures less than 3 and kurtosis less than 4. Univariate outliers were defined as cases more than 3 standard deviations from the means. None of the cases was deemed an outlier.

Prior to examining the data to address specific research questions, initial analyses were conducted to better understand the sample as a whole by exploring (a) response differences based on order effects of vignettes used to evaluate perceived public stigma and self-stigma and subsequent surveys, (b) reported self- and perceived public stigma levels by participants, (c) social, activity, school, and total competency rated by adolescents and their parents, and (d) differences between adolescent and parent ratings of current functioning.

First, an analysis of variance procedure examined order effects of the vignettes. Results were non-significant, F (1,75) = 2.28, *p*= .135 suggesting no difference in total stigma score based on order of vignette presentation (Vignette 1 then 2 OR Vignette 2 then 1). Furthermore, a mean comparisons analysis tested differences in post vignette survey responses to public stigma questions based on the word “depression” used in one survey but not the other. Results were non-significant, F (1,152) = 1.91, *p*= .171. Therefore, only data from the vignette survey using the word “depression” were used for the remainder of vignette survey analyses.

Second, differences between reported self- and perceived public stigma levels were assessed. On average, participants reported fairly moderate levels (sometimes/unsure) of self- and perceived public stigma on each of the questions. Individual question means ranged from 2.74 (sometimes/unsure) to 3.97 (often/agree), these results are more varied than what was reported by Moses (2009b) using a community based sample. A mean comparisons analysis tested differences between self- and perceived public stigma scores using a paired samples t-test. Results were non-significant t(76) = -1.898, *p*= .061, Although there was not a significant difference between self- and perceived public stigma, the results are nearing statistical significance and both scales support the notion that adolescents are experiencing a moderate level of stigma related to their emotional and behavioral problems that have led to their psychiatric hospitalization. Figures 1 and 2 show histograms for self- and perceived public stigma total scores. Figure one represents perceived public stigma total scores across the sample and shows a generally normal distribution. Figure two represents self-stigma total scores across the sample and shows a slightly positively skewed sample with more participants reporting higher total scores of self-stigma than would be expected in a normally distributed sample. This slight skewedness is not statistically different than the perceived public stigma scores but does reflect slightly higher self-stigma responses by the participants.

Figure 1. *Perceived Public Stigma Histogram.*

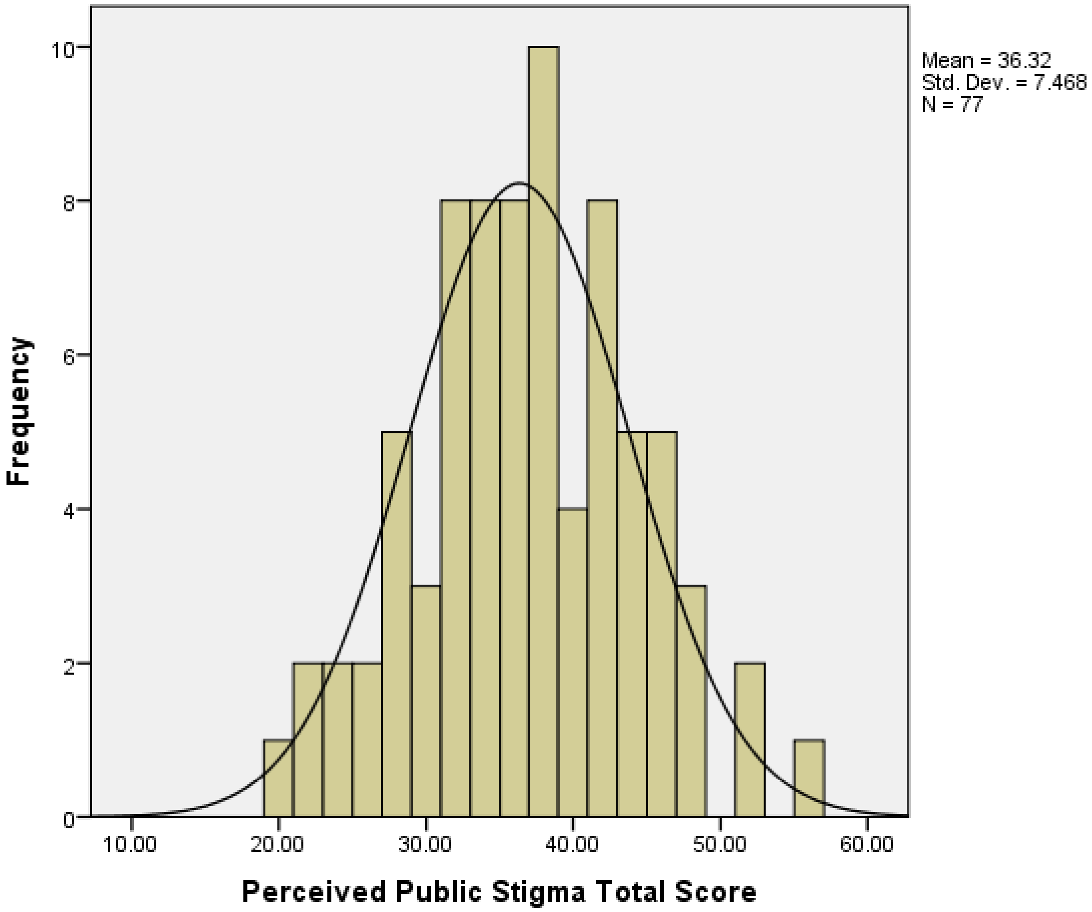
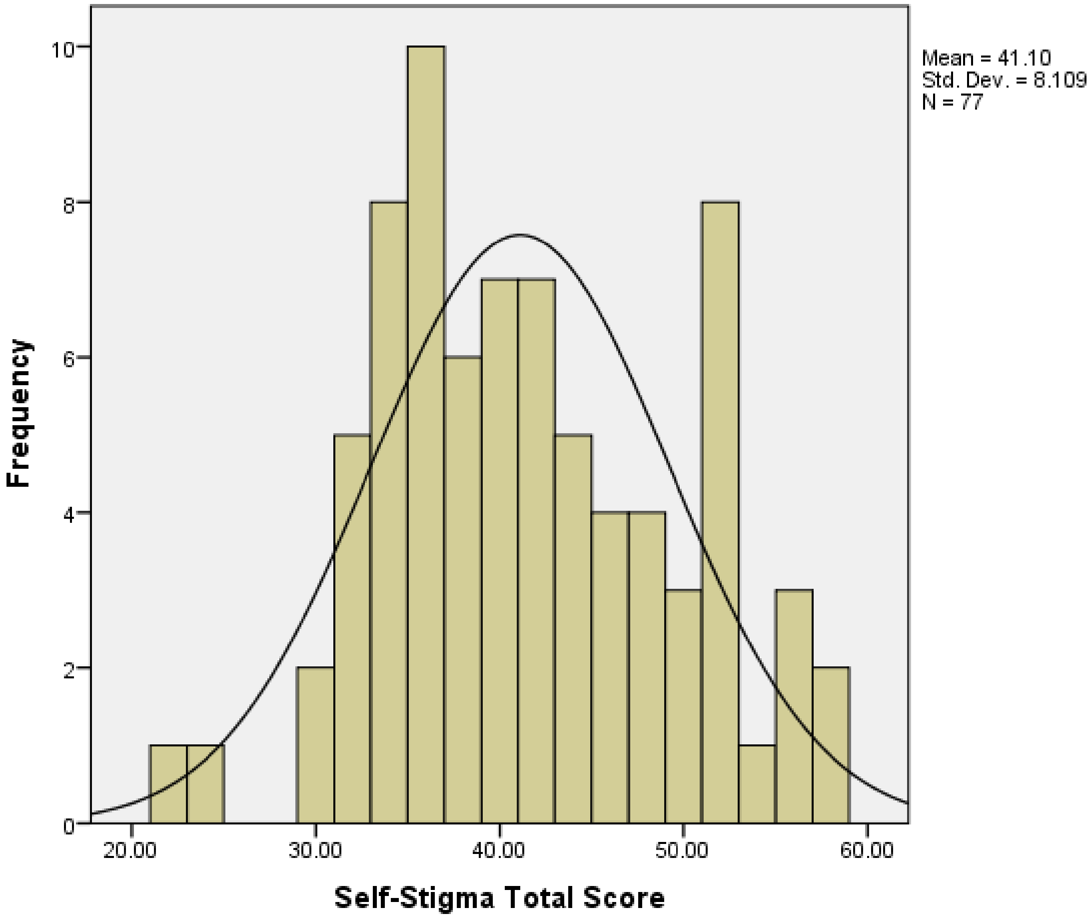


Figure 2. *Self-Stigma Histogram.*



The average response per self- and perceived public stigma question was derived by calculating the mean of each question across the sample of Stigma Scale questions used (omitting SSIS questions), adding the means together, and then dividing the total by the number of questions asked. Table 3 shows the mean response across the sample for each question and histograms for each question can be found in Appendix M. Self-stigma questions resulted in a mean of 3.43 (*SD*=1.20; sometimes/undecided) with a range from 2.74 to 3.97. Perceived public stigma resulted in a mean of 3.30 (*SD*=1.08; sometimes/undecided) with a range from 2.84 to

3.62. Post hoc analyses were run on individual stigma items with bimodal distributions in order to determine if relationships between demographic/clinical variables and level of stigma were different than the larger group of questions and can be found at the end of the Results section.

Table 3. *Description of Stigma Items by Scale*

Scale	Mean (SD)	Frequency (1)	(2)	(3)	(4)	(5)
Perceived Public Stigma Scale						
1. How often do you think Sam feels disrespected because of Sam's emotional or behavior problems?	3.51 (0.9)	2	8	23	37	7
2. How often do you think people have used the fact that Sam is in treatment to hurt Sam's feelings?	3.04 (1.02)	6	16	28	23	4
4. How often do you think people would look down on Sam if they find out Sam is in treatment?	3.38 (1.05)	2	14	27	21	13
5. How often do you think Sam is avoided when people know that Sam is in treatment?	3.36 (1.0)	4	8	30	26	9
7. How often do you think teachers and other adults treat Sam differently because of Sam's emotional or behavioral problems?	3.48 (1.17)	7	6	22	27	15
8. How often do you think some of Sam's own friends reject Sam after they find out Sam is in treatment?	2.84 (1.11)*	11	16	29	16	5
9. Teens my age would tease or harass Sam if they found out Sam was receiving treatment for emotional or behavioral problems.	3.34 (0.98)	2	16	19	34	6

11. Other adolescents believe that adolescents, like Sam, with emotional or behavioral issues are to blame for their problems.	2.94 (1.21)	12	16	20	23	6
12. Teens would not want to hang out with somebody who has emotional or behavioral problems.	3.40 (1.08)	3	15	18	30	11
14. Other adolescents tend to give kids with emotional or behavioral problems, like Sam, a hard time.	3.62 (1.05)**	3	9	17	33	15
Avg. Perceived Public Stigma Response	***3.30 (1.08)***					
Self-Stigma Scale						
1. There is no reason for a person to hide the fact that he/she is receiving treatment for emotional or behavioral issues.***	3.07 (1.27)	6	27	13	17	14
2. I usually wait until I know a person really well before I tell them I am getting treatment for emotional and/or behavioral issues.	3.97 (1.1)**	1	11	8	26	31
3. When I meet people for the first time, I make a special effort to keep the fact that I am in treatment to myself.	3.68 (1.07)	3	9	15	33	17
5. I often fear that someone will tell others about my emotional or behavioral problems without my permission.	3.95 (1.13)	2	10	9	25	31
6. I feel like I need to hide the fact that I have emotional or behavioral issues from my peers.	3.53 (1.13)	1	18	15	25	18

7. I often feel the need to hide the fact that I am in treatment.	3.58 (1.06)	0	17	14	30	16
9. If you are getting treatment, the best thing to do is to keep it to yourself.	2.74 (1.15)*	12	20	28	10	7
10. How often do you feel different from others your age because you have emotional or behavioral problems?	3.56 (1.11)	2	13	20	24	18
12. How often do you feel others may not like you if they know you have emotional or behavioral problems?	3.38 (1.17)	6	8	31	15	17
13. How often do you feel others will not want to be friends with you if they know you have emotional or behavioral problems?	3.16 (1.14)	5	17	28	15	12
15. How often do you worry that other adolescents are uncomfortable with you because of your emotional or behavioral problems?	3.03 (1.19)	9	16	26	16	10
16. How often do you feel embarrassed about your emotional or behavior problems?	3.45 (1.24)	6	11	22	18	20
Average Self-Stigma Response	***3.43 (1.20)***					

* Lowest Average Response
**Highest Average Response
***Reverse Coded
^{a} All SSIS questions were removed from table and analysis

Third, in addition to basic demographic factors outlined earlier, the ASEBA, YSR, and CBCL provide both a Competence scale and a Syndrome scale. The ASEBA Competence scale data allows for a larger picture to come into view when considering how parents and participants rated participation in structured groups and activities, social interactions, and total competence.

In general, the responses were similar between raters and signified that the majority of this sample was considered in the "normal" range for all three areas (see Table 4). The Syndrome Scale indicates three Internalizing areas (Anxious/Depressed, Withdrawn/Depressed, and Somatic Complaints), Social Problems, Thought Problems, Attention Problems, and two Externalizing areas (Rule-Breaking Behavior and Aggressive Behavior). In general, parents rated the adolescents as having far more clinical problems than did the adolescents themselves. In summary, a typical adolescent in this study would generally fit the profile of an adolescent who is considered "normal" or "average" (when compared to a larger non-clinical sample used in the norming of the ASEBA, which is thought to be representative of an average adolescent in the community) in terms of their participation in activities and social engagement, though is thought to have "clinical" levels of Anxiety/Depression.

Table 4. *ASEBA (CBCL & YSR) Competence & Syndrome Summary*

Variable	Rater	% Rating Clinical	 At Risk	 Normal
Competence				
Activities				
	YSR	10.4	9.1	80.5
	CBCL	1.0	10.5	88.2
Social				
	YSR	19.7	10.5	69.7
	CBCL	25.0	17.1	57.9
Total Competence				
	YSR	15.5	16.9	67.6
	CBCL	18.2	24.2	57.6
Syndrome Scale				
Anxious/Depressed				
	YSR	41.6	20.8	37.7
	CBCL	71.0	11.8	17.1
Withdrawn/Depressed				
	YSR	23.7	23.7	53.2
	CBCL	57.9	19.7	22.4
Somatic Complaints				

	YSR	20.8	18.2	61.0
	CBCL	47.4	13.1	39.5
Social Problems				
	YSR	28.6	14.3	57.1
	CBCL	28.9	25.0	46.1
Thought Problems				
	YSR	23.7	16.9	59.7
	CBCL	55.3	22.4	22.4
Attention Problems				
	YSR	22.1	15.6	62.3
	CBCL	34.2	21.1	44.7
Rule-Breaking Behavior				
	YSR	22.1	18.2	59.7
	CBCL	32.9	18.4	48.7
Aggressive Behavior				
	YSR	14.3	14.3	71.4
	CBCL	32.9	23.7	43.4
Total Problems				
	YSR	61.0	9.1	29.9
	CBCL	89.5	5.3	9.2

Finally, a comparison between adolescent and parent perceptions of general level of functioning was conducted by using their respective responses on the CBCL and YSR. Generally, the adolescent participants rated themselves as more competent and with fewer problems than did parent participants across the entire sample (see Table 5). Statistically, there was no difference in the way adolescents and parents rated Total Competence (F (1,151) = 0.53, *p* = .468.) However, there were statistically significant differences between adolescent and parent ratings with adolescents rating themselves lower than parents for Depression (F (1,151) = 26.34, *p*<.001); Anxiety (F (1,151) = 17.35, *p*<.001); and Total Problems (F (1,151) =16.02, *p*<.001). These results may be related to the adolescents underestimating their problems as a way to self-protect or speak to a potential lack of insight and to parents being forthcoming which has been documented as a “positive illusory bias” in children and adolescents with ADHD and learning disabilities (Heath & Glen, 2005; Owens et al., 2007; Volz-Sidiropoulou, Boecker, &

Gauggel, 2013). A correlational analysis indicated a moderate relationship (*r* =.41) between responses on the CBCL and YSR. According to the ASEBA manual (Achenbach & Rescorla, 2001) correlations for the YSR and the CBCL averaged .49, ranging from .37-.60. Meta-analyses of many studies (Achenbach et al., 1987; Achenbach et al., 2005) using different instruments revealed a mean correlation of .22 between self-ratings and ratings by others, such as parents and teachers. Thus, the current correlation between raters is consistent with previous studies.

Table 5. *ASEBA Rater Summary Data.*

Variable	YSR Mean (*SD*)	CBCL Mean (*SD*)
Total Competence	40.8 (12.3)	39.5 (9.7)
DSM Depression	68.8 (12.0)	77.6 (9.0)
DSM Anxiety	62.3 (9.0)	68.0 (7.9)
Total Problems	64.4 (10.6)	70.5 (8.1)

Research Area One: Demographic Factors

In order to fully understand the relationships between demographic factors and self- and perceived public stigma it is important to know the mean level of each type of stigma. The participants as a group yielded a moderate (sometimes/unsure) self-stigma mean response across all 15 questions of 3.43 (*SD*=1.20) and a moderate (sometimes/unsure) perceived public stigma mean of 3.30 (*SD*=1.08). Study results did not indicate a significant difference between self- and perceived public stigma levels (F(1, 152) = 3.43, p= 0.061), however the difference is verging on statistical significance and is a trend that will be highlighted in the discussion section. See summary of all demographic and clinical factors in Table 14.

Research Question One. ***Does age demonstrate significant relationships with levels of self- or perceived public stigma?*** Across the sample, participants averaged 15.3 (*SD*=1.4) years old, ranging from 13-18. For analyses, age was dichotomized, with participants between 13 and 15 (n=44) representing one group and those between 16 and 18 (n=33) representing the second. Thirteen to fifteen year olds reported a mean self-stigma response of 3.39 (*SD*=0.69; sometimes/undecided) and mean perceived public stigma response of 3.37 (*SD*=0.65; sometimes/undecided). Sixteen to eighteen year olds reported a mean self-stigma response of 3.47 (*SD*=0.66; sometimes/undecided) and mean perceived public stigma response of 3.21 (*SD*=0.71; sometimes/undecided).

Research Question One-A. Does age demonstrate a significant relationship with level of self-stigma? An analysis of variance revealed that the relationship between age and level of self-stigma was not significant, F (1,77) = 1.104, p=.297.

Research Question One-B. Does age demonstrate a significant relationship with level of perceived public stigma? An analysis of variance showed that the relationship between age and level of perceived public stigma did not reach statistical significance, F (1,77) = 3.12, p=.051, but is trending toward significance.

Neither of these findings was consistent with Moses (2009) who found that older adolescents tend to experience more self-stigma or with the researchers who found that younger youth are more apt to feel stigmatized when participating in community based mental health treatment (Cauce et al., 2002; Lindsey, Korr, & Broitman, 2006; Rizzo et al., 2007).

Research Question Two. ***Does gender demonstrate significant relationships with levels of self- or perceived public stigma?*** For analyses, gender was dichotomized, with males representing one group and females representing the second. Across the sample participants were 65% female (n=50) and 35% male (n=27). Females reported a mean self-stigma response of 3.43 (*SD*=0.66; sometimes/undecided) and mean perceived public stigma response of 3.28

(*SD*=0.69; sometimes/undecided). Males reported a mean self-stigma response of 3.43 (*SD*=0.71; sometimes/undecided) and mean perceived public stigma response of 3.33 (*SD*=0.67; sometimes/undecided).

Research Question Two-A. Does gender demonstrate a significant relationship with level of self-stigma? The results from an analysis of variance showed that the relationship between gender and level of self-stigma was not significant, *F* (1,77) = .000, *p*=.995. This result is not consistent with the finding by Vogel et al. (2007) using non-hospitalized college students, that males experience higher levels of self-stigma than females.

Research Question Two-B. Does gender demonstrate a significant relationship with level of perceived public stigma? An analysis of variance showed that the relationship between gender and level of perceived public stigma was not significant, *F* (1,76) = .014, *p*=.905.

Research Question Three. ***Does SES (level of education) demonstrate significant relationships with levels of self- or perceived public stigma?*** Across the sample population 81% of participants had parents who had completed at least one year of college. Given the huge group size difference between public (16%) and private (84%) insurance, and more documented correlation between education and SES (Merikangas et al., 2010; Moses, 2009; Winkleby et al., 1992), parent education was used as the SES factor. For the purposes of analyses SES was dichotomized, parental education of less than or equal to 2 years of college (n=43) representing one group and parental education of a Bachelor’s degree or above (n=32) representing the second. This allowed for similarly sized groups and was also supported in the research. Those with parental education of less than or equal to 2 years of college reported a mean self-stigma response of 3.37 (*SD*=0.74; sometimes/undecided) and mean perceived public stigma response of 3.17 (*SD*=0.66; sometimes/undecided). The second group of those with parental education of a

Bachelor's degree or above reported a mean self-stigma response of 3.48 (*SD*=0.59; sometimes/undecided) and mean perceived public stigma response of 3.48 (*SD*=0.68; sometimes/undecided).

Research Question Three-A. Does SES demonstrate a significant relationship with level of self-stigma? An analysis of variance showed that the relationship between SES (parent education) and level of self-stigma was not significant, *F* (1,76) = .476, *p*=.492. This study did not replicate the findings of Moses (2009), in which adolescents with mental health problems from low SES were less likely to be impacted by self-stigma compared to adolescents from families with higher SES.

Research Question Three-B. Does SES demonstrate a significant relationship with level of perceived public stigma? An analysis of variance showed that the relationship between SES (parent education) and level of perceived public stigma was not statistically significant, *F* (1,76) = 3.427, *p*=.068, though one could argue a statistical trend is emerging.

Self-Stigma. Because none of the demographic factors predicted self-stigma individually, all three were used together in a simple standard regression model to determine a combined predictive quality, based on the fact that there were no significant relationships between any of the demographic factors and level of self-stigma. A significant model did not emerge when using the three predictors together, $R^2 = .022$, *F(*3,76) = .553, *p*= .648, see Table 6.

Table 6. *Multiple Regression Analysis for Self-Stigma (N=77)*

Variable	B	SE(B)	*β*	*T*	Sig. (p)
Age	-.062	.057	*–.127*	*-1.084*	.282
Gender	-.029	1.996	*–.002*	*-.014*	.989
SES	1.425	1.907	*.088*	*.747*	.475

Note: R^2*=.022*

Perceived Public Stigma. Because none of the demographic factors predicted perceived public stigma individually, all three were used together in a simple standard regression model to determine a combined predictive quality, based on the fact that there were no significant relationships between any of the demographic factors and level of perceived public stigma. A nearly significant model emerged when using the three predictors together, $R^2 = .100$, *F(3*,76) = 2.70, *p= .052, see Table 7.*

Table 7. *Multiple Regression Analysis for Perceived Public Stigma (N=77)*

Variable	B	SE(B)	β	*T*	Sig. (p)
Age	-.105	.050	*–.238*	*-2.125*	.037*
Gender	-.089	1.741	*–.006*	-*.051*	.959
SES	3.310	1.664	*.224*	*1.989*	.050*

Note: $R^2=.100$
**Statistically significant factors within the three factor model*

Research Area Two: Clinical Factors

In order to fully understand the relationships between clinical factors and self- and perceived public stigma it is important to know the mean level of each type of stigma. The participants as a group yielded a mean self-stigma response of 3.43 (*SD*=1.20; sometimes/undecided) and mean perceived public stigma response of 3.30 (*SD*=1.08; sometimes/undecided). See a summary of all demographic and clinical factors in Table 14.

Research Question Four. ***Does time with diagnosis (time between initial diagnosis and time of study) demonstrate significant relationships with levels of self- or perceived public stigma?*** Across the sample, participants had been diagnosed with a mental health disorder for an average of 59 (*SD*=50.6) months or 4.92 (*SD*=4.22) years. For analyses, time with diagnosis was dichotomized, with those diagnosed between 0 and 48 months (n=38) representing one group and those diagnosed between 49 and 192 months (n=37) representing the second. Those diagnosed up to 48 months reported a mean self-stigma response of 3.46 (*SD*=0.67; sometimes/undecided) and mean perceived public stigma response of 3.26 (*SD*=0.75; sometimes/undecided). Those diagnosed more than 48 months reported a mean self-stigma response of 3.38 (*SD*=0.70; sometimes/undecided) and mean perceived public stigma response of 3.34 (*SD*=0.61; sometimes/undecided).

Research Question Four-A. Does time with diagnosis demonstrate a significant relationship with level of self-stigma? An analysis of variance indicated time with diagnosis does not demonstrate a significant relationship with level of self-stigma, *F* (1,75) = .691*, p=.408*. These results, though only an approximation of early onset mental health problems, do not mirror Moses' (2009) and Hammen, Brennan, Keenan-Miller, and Herr's (2008) findings that adolescents who had early onset mental health problems reported higher self-stigma.

Moderated regression is used to determine if the relationship between two variables changes as a function of the third (Aiken & West, 1991; Frazier, Tix & Barron, 2004), and was used in this study to determine if the relationship between time with diagnosis and self-stigma changed as a function of a moderating demographic variable (SES, Age, Gender). The model is depicted in Figure 3 below, where X= time with diagnosis, M= demographic variables (SES/Age/Gender), and Y= self-stigma. The interaction term XM is used to determine if the nature of the relationship between time with diagnosis and self-stigma changed a function of the moderator. This procedure was done using the Process Procedure for SPSS, a moderated regression analysis program, developed by Hayes (2012).

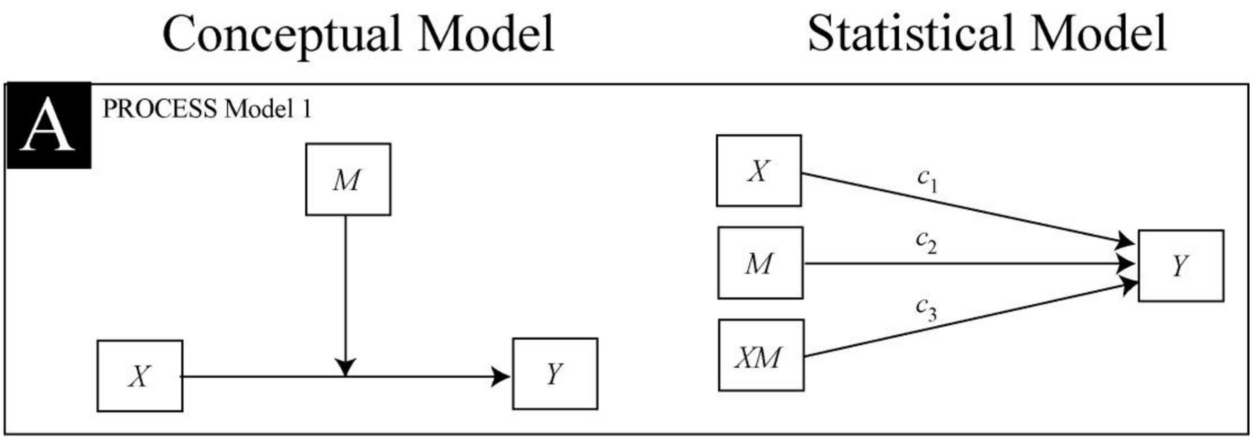


Figure 3. Conceptual and statistical models of simple moderated regression.

Three separate regression models, each with one interaction term, were run and results indicated that the strength of the relationship between time with diagnosis and self-stigma did not change as a function of SES (R^2 = .028, F(3, 74) = .674, p=.571), Age (R^2 = .029, F(3,74) = .715, p=.546), or Gender (R^2 = .024, F(3, 74) = .586, p=.626). Thus, none of the demographic factors were significant moderators of the relationship between time in treatment and self-stigma, see Table 8.

Table 8. *Moderated Regression Analysis for Time w/ Diagnosis & Self- Stigma (N=77)*

Variable	B	SE(B)	β	*T*	Sig. (p)
Time*Age	.000	.001	*–.177*	-*.142*	.888
Time*Gender	-.041	.010	*–.443*	*-1.030*	.307
Time*SES	.039	.040	*.367*	*.973*	.334

Research Question Four-B. Does time with diagnosis demonstrate a significant relationship with level of perceived public stigma? An analysis of variance indicated time with diagnosis does not have a relationship with level of perceived public stigma, F (1,75) = .682, p=.412.

Moderated regression was used to determine if the relationship between time with diagnosis and perceived public stigma changed as a function of a moderating demographic variable (SES, Age, and Gender). Three separate regression models, each with one interaction term, were run and results indicated that the strength of the relationship between time with diagnosis and perceived public stigma did not change as a function of the moderator variables of Age (R^2 = .059, F(3, 72) = 1.501, p=.643), or Gender (R^2 = .044, F(3, 71) = 1.102, p=.109) but did change as a function of the moderator variable of SES (R^2 = .104, F(3, 71) = 2.739, p=.049), see Table 9.

Table 9. *Moderated Regression Analysis for Time w/ Diagnosis & Perceived Public Stigma (N=77)*

Variable	B	SE(B)	*β*	*T*	Sig. (p)
Time*Age	.000	.001	*.568*	*.465*	.643
Time*Gender	-.053	.033	*–.692*	*-1.625*	.109
Time*SES	.064	.032	*.727*	*2.005*	.049**

****Statistically significant factor*

Research Question Five. ***Does number of psychiatric admissions demonstrate significant relationships with levels of self- or perceived public stigma?*** Across the sample, participants had been admitted to the psychiatric hospital an average of 1.61 (*SD*=1.44) times, with less than one third (27.2%) of the sample being admitted more than once. For analyses, number of psychiatric admissions was dichotomized, with those hospitalized once (n=56) representing one group and those hospitalized more than once (n=21) representing the second. Those with one admission reported a mean self-stigma response of 3.44 (*SD*=0.69; sometimes/undecided) and mean perceived public stigma response of 3.25 (*SD*=0.66; sometimes/undecided). Those with more than one admission reported a mean self-stigma response of 3.38 (*SD*=0.62; sometimes/undecided) and mean perceived public stigma response of

3.43 (*SD*=0.72; sometimes/undecided).

Research Question Five-A. Does number of psychiatric admissions demonstrate a significant relationship with level of self-stigma? An analysis of variance indicated number of psychiatric admissions does have a significant relationship with level of self-stigma, *F* (1,76) = 1.184, *p*=.280. These results align with research by Moses (2009b) that found there is no relationship between self-stigma and the number of times a person has been hospitalized.

Moderated regression was used to determine if the relationship between number of psychiatric admissions and level of self-stigma changed as a function of a moderating demographic variable (SES, Age, Gender). Three separate regression models, each with one interaction term, were run and results indicated that the strength of the relationship between number of psychiatric admissions and self-stigma did not change as a function of SES (R^2 = .037, *F*(3, 73) = .929, *p*=.431), Age (R^2 = .031, *F*(3, 76) = .785, *p*=.506), or Gender (R^2 = .016, *F*(3, 76) = ..390, *p*=.761). Thus, none of the demographic factors were significant moderators of the relationship between number of psychiatric admissions and self-stigma, see Table 10.

Table 10. *Moderated Regression Analysis for # of Hospitalizations & Self- Stigma (N=77)*

Variable	B	SE(B)	β	*T*	Sig. (p)
#Hosp*Age	.025	.047	*.844*	*.524*	.602
#Hosp*Gender	.160	1.328	*.050*	*.121*	.904
#Hosp*SES	-1.342	1519	*–.469*	-*.883*	.380

Research Question Five-B. Does number of psychiatric admissions demonstrate a significant relationship with level of perceived public stigma? An analysis of variance indicated number of psychiatric admissions does not have a significant relationship with level of perceived public stigma, *F* (1,77) = .044, *p*=.835.

Moderated regression was used to determine if the relationship between number of psychiatric admissions and level of perceived public stigma changed as a function of a moderating demographic variable (SES, Age, Gender). Three separate regression models, each with one interaction term, were run and results indicated that the strength of the relationship between number of psychiatric admissions and self-stigma did not change as a function of SES (R^2 = .067, F(3, 73) = 1.747, p=.320), Age (R^2 = .046, F(3, 74 = 1.200, p=.498), or Gender (R^2 = .007, F(3, 73) = .170, p=.759). Thus, none of the demographic factors were significant moderators of the relationship between number of psychiatric admissions and perceived public stigma, see Table 11.

Table 11. *Moderated Regression Analysis for # of Hospitalizations & Perceived Public Stigma (N=77)*

Variable	B	SE(B)	β	*T*	Sig. (p)
#Hosp*Age	-.027	.039	*–1.082*	-*.682*	.498
#Hosp*Gender	-.343	1.116	*–.129*	-*.307*	.759
#Hosp*SES	1.253	1.251	*.524*	*1.001*	.320

Research Question Six. ***Does mental health disorder demonstrate significant relationships with levels of self- or perceived public stigma?*** Across the sample, and consistent with the historical population of the hospital, 70% of participants were diagnosed with Depression. For analyses, diagnostic categories were dichotomized to account for the vast discrepancy between groups, with those diagnosed with Depression (n=54) representing one group and those diagnosed with other mood disorders (e.g., Mood Disorder, NOS; Anxiety; Bipolar I Disorder) (n=23) representing the second. Those diagnosed with depression reported a mean self-stigma response of 3.46 (*SD*=0.71; sometimes/undecided) and mean perceived public stigma response of 3.33 (*SD*=0.69; sometimes/undecided). Those in the second group, diagnosed with other mood disorders, reported a mean self-stigma response of 3.35 (*SD*=0.62;

sometimes/undecided) and mean perceived public stigma response of 3.24 (*SD*=0.68; sometimes/undecided).

Research Question Six-A. Does mental health disorder demonstrate a significant relationship with level of self-stigma? An analysis of variance indicated mental health disorder does not have a significant relationship with level of self-stigma, F (1,76) = .389, p=.535. Previous research suggested adolescents with depression and/or anxiety are more likely to experience self-stigma than those with other mental health problems (Pine et al., 1999; Rickwood et al., 2005); this was not substantiated in the current study.

Moderated regression was used to determine if the relationship between mental health disorder and level of self-stigma changed as a function of a moderating demographic variable (SES, Age, and Gender). Three separate regression models, each with one interaction term, were run and results indicated that the strength of the relationship between mental health disorder and self-stigma did not change as a function of SES (R^2 = .013, F(3, 73) = .318, p=.812), Age (R^2 = .042, F(3, 73) = 1.075, p=.365), or Gender(R^2 = .012, F(3, 73) = .288, p=.834). Thus, none of the demographic factors were significant moderators of the relationship between number of psychiatric admissions and self-stigma, see Table 12.

Table 12. *Moderated Regression Analysis for Self- Stigma (N=77)*

Variable	B	SE(B)	β	*T*	Sig. (p)
Dx*Age	-.158	.115	*–1.780*	*-1.370*	.175
Dx*Gender	-3.130	4.531	*–.413*	*-.691*	.492
Dx*SES	-1.032	4.110	*–.126*	*-.251*	.802

Research Question Six-B. Does mental health disorder demonstrate a significant relationship with level of perceived public stigma? An analysis of variance indicated mental health disorder does not have a significant relationship with level of perceived public stigma, *F*

(1,76) = .428, p=.515. Previous research suggested adolescents with depression and/or anxiety are more likely to experience public stigma than those with other mental health problems (Pine et al., 1999; Rickwood et al., 2005); this was not substantiated in the current study.

Moderated regression was used to determine if the relationship between mental health disorder and level of self-stigma changed as a function of a moderating demographic variable (SES, Age, and Gender). Three separate regression models, each with one interaction term, were run and results indicated that the strength of the relationship between mental health disorder and perceived public stigma did not change as a function of SES (R^2 = .056, F(3, 73) = 1.447, p=.906), Age (R^2 = .046, F(3, 73) = 1.168, p=.799), or Gender (R^2 = .026, F(3, 73) = .646, p=.313). Thus, none of the demographic factors were significant moderators of the relationship between mental health disorders and perceived public stigma, see Table 13.

Table 13. *Moderated Regression Analysis for Perceived Public Stigma (N=77)*

Variable	B	SE(B)	β	*T*	Sig. (p)
Dx*Age	-.027	.096	*–.365*	*-.282*	.799
Dx*Gender	-3.820	3.763	*–.602*	*-1.015*	.313
Dx*SES	.397	3.362	*.058*	*.118*	.906

Table 14. *Relationships between demographic and clinical characteristics and self and public stigma.*

Demographic Characteristic	N	Self-Stigma: Mean (sd)	p-value	Public Stigma: Mean (sd)	p-value
Total sample	77	3.43 (1.20)		3.30 (1.08)	
Age			.297		.051*
13-15	44	3.39 (0.69)		3.37 (0.65)	
16-18	33	3.47 (0.66)		3.21 (0.71)	
Gender			.995		.905
Males	27	3.43 (0.71)		3.33 (0.67)	
Females	50	3.43 (0.66)		3.28 (0.69)	
Parental Education (SES)			.492		.068*
Up to 2 years college	43	3.37 (0.74)		3.17 (0.66)	
At least Bachelor's degree	32	3.48 (0.59)		3.48 (0.68)	

Clinical Characteristics	N	Self-Stigma: Mean (sd)	p-value	Public Stigma: Mean (sd)	p-value
Total sample	77	3.41 (1.20)		3.30 (1.08)	
Time with diagnosis			.408		.412
0-48 Months	38	3.46 (0.67)		3.26 (0.75)	
49-192 Months	37	3.38 (0.70)		3.34 (0.61)	
Number of psychiatric admissions			.280		.835
1	56	3.44 (0.69)		3.25 (0.66)	
>1	21	3.38 (0.62)		3.43 (0.72)	
Diagnosis			.535		.515
Depression	54	3.46 (0.71)		3.33 (0.69)	
Other	23	3.35 (0.62)		3.24 (0.68)	

* Nearing statistically significant

Self-Stigma. Because none of the clinical factors predicted self-stigma individually, all three were used together in a simple standard regression model to determine a combined predictive quality, based on the fact that there were no significant relationships between any of the clinical factors and level of self-stigma. A significant model did not emerge when using the three predictors together, $R^2 = .026$, *F(*3,74) = .625, *p*= .601, see Table 15.

Table 15. *Multiple Regression Analysis for Self-Stigma (N=77)*

Variable	B	SE(B)	β	*T*	Sig. (p)
Time w/Dx	-.014	.020	*–.089*	-*.727*	.470
# Hosp	-.652	.675	*–.117*	-*.966*	.338
Diagnosis	-.558	2.276	*–.031*	-*.245*	.807
Note: R^2*=.026*					

Perceived Public Stigma. Because none of the clinical factors predicted perceived public stigma individually, all three were used together in a simple standard regression model to determine a combined predictive quality, based on the fact that there were no significant relationships between any of the clinical factors and level of perceived public stigma. A significant model did not emerge when using the three predictors together, R^2 = .019, *F(3*,73) = .446, *p= .721, see Table 16.*

Table 16. *Multiple Regression Analysis for Perceived Public Stigma (N=77)*

Variable	B	SE(B)	β	*T*	Sig. (p)
Time w/Dx	-.009	.017	*–.065*	-*.530*	.597
# Hosp	-.254	.564	*–.055*	-*.451*	.654
Diagnosis	-1.182	1.900	*–.079*	-*.622*	.536
Note: R^2*=.019*					

Stigma Item Post Hoc Analysis. Because there were very limited significant results when using self- and perceived public stigma total scores, and due to significant variability in the response patterns on several of the questions, regression analyses were run on three self-stigma questions with bimodal distributions to determine if any of the demographic or clinical factors had significant relationships with level of stigma. It should be noted that the large majority of questions had unimodal or flat distributions (Appendix M).

Zero questions on the perceived public stigma scale had bimodal distributions, however three questions on the self-stigma scale had moderate bimodal distributions. Further regression analysis on questions one ("There is no reason for a person to hide the fact that he/she is receiving treatment for emotional or behavioral issues"), six ("I feel like I need to hide the fact that I have emotional or behavioral issues from my peers") and seven ("I often feel the need to hide the fact that I am in treatment") found that gender, age, SES, diagnosis, number of hospitalizations, and time with diagnosis did not have a significant relationship with level of self-stigma.

Further post hoc analysis on each of the 22 stigma questions found that none of the demographic or clinical factors had relationships with level of self-stigma reported on any of the 12 self-stigma questions. However, a few significant findings resulted when looking at the perceived public stigma responses. Age had a significant relationship with level of reported perceived public stigma on question nine ("Teens my age would tease or harass Sam if they found out Sam was receiving treatment for emotional or behavioral problems;" F (1,76) = 2.325, p=.005) and question fourteen ("Other adolescents tend to give kids with emotional or behavior problems, like Sam, a hard time;" F (1,76) = 1.435, p=.017). Both of these questions speak to taunting from peers based on emotional or behavioral problems and suggest that younger adolescents are more likely to endorse perceived public stigma. Additionally, SES had a significant relationship with level of reported perceived public stigma on question eight ("How often do you think some of Sam's own friends reject Sam after they find out Sam is in treatment?;" F (1,76) = 1.363, p=.036) and question eleven ("Other adolescents believe that adolescents, like Sam, with emotional or behavioral issues are to blame for their problems;" F (1,76) = 1.788, p=.005). These significant findings suggest that participants from lower SES families are more likely to endorse perceived public stigma. These findings support the need for replication and possibly specific research questions and qualitative follow-up for these four questions to see if similar findings result. Age and SES are both factors that have been found to be significant indicators of level of stigma in community based samples and may be able to be replicated in acute/hospitalized populations in the future.

Qualitative Data

Although qualitative assessment was not primary, participants were asked open-ended questions, adopted from Moses (2009), to gain a more comprehensive understanding. In particular, these questions allowed the researcher to gain participants' insight about their hospitalizations, which may have implications for future research. The first two questions were more quantitative and stood out from the semi-structured interview. When asked, "do you believe you have emotional or behavioral problems" more than half of the participants (n=53) stated "yes." The next question asked, "Is there anyone in your life that you do not want to know about your being in the hospital?" and just over half of the participants (n=40) stated "yes." Most of those who stated "yes" spoke about not wanting their friends and acquaintances to know as they were afraid of how the information could be used against them (see Table 17). Others noted that they had family members who would not be supportive of them seeking help.

The two remaining qualitative questions, also adopted from Moses (2009), were not quantifiable but responses were very insightful. When asked "how will others treat you when you return home?" the responses were split nearly in half with 39 participants expecting people to treat them the same, 34 participants expecting people to treat them differently and 6 feeling unsure of what to expect. Within these responses, 39 participants expected positive treatment, 14 expected negative treatment and 20 expected to be treated the same way. On the final question, "what do other people think about teens with social and emotional problems?" the majority of responses (n=45) had a negative tone and the remaining (n=28) had more neutral perceptions (see Table 17 for common responses).

Table 17. *Qualitative Responses & Themes*

Question	Themes/Responses	
Is there anyone in your life that you do not want to know about your being in the hospital?	*Negative Peer*	*Negative Family*
	"Most people wouldn't understand, they might use it against me or spread rumors."	"My sister, she looks up to me and I want be a good example."
	"I don't want people at work or friends to know because I don't want them to think I'm crazy and judge me."	"My extended family shouldn't know it's too hard to explain and they wouldn't understand anyway."
	"I don't want my best friends to know because I don't want to be embarrassed or have them think I'm a bad person or make a bad impression on them or their families."	"I don't want my dad to know, he would be too critical."
How will others treat you when you return home?	*Positive*	*Negative*
	"My family will be more accepting and safe"	"Like I'm a bit different—more distant."
	"They will be more cautious at first, then normal with time."	"My parents will be awkward and scared."
	"The same, yet more sensitive to how I feel"	"My extended family will think 'she needs help' and won't understand but will be critical."
What do other people think about teens with social and emotional problems?	*Neutral*	*Negative*
	"They will think the teens are just weird or have no idea there is a problem."	"They are messed up."
	"They are just regular teenagers."	"Something is wrong, something needs to be done about it"
	"They blame hormones and	"They must have a hard life or just want attention."

think all people go through it."

CHAPTER 4

Discussion

The purpose of the current study is to better understand the subjective perceptions and experiences of adolescents participating in mental health treatment at an inpatient psychiatric hospital. The current study takes a first step toward understanding the consequences of stigma among adolescents with severe mental health problems in a short-term inpatient psychiatric hospital by examining the extent to which this population both experiences and perceives stigma, as well as further clarifying the relationships between self- and perceived public stigma and various demographic and clinical characteristics. The study is also important to stigma research broadly as the most acute populations have not been studied extensively to this point. This extends the research completed by Moses (2009b) by providing additional data to assess the trend of stigma experiences for adolescents. The results suggest that stigma attached to child and adolescent mental health problems is complex and not easily deduced from adult studies nor easily inferred from demographic or clinical characteristics.

The participants as a whole were engaged in the research process and very open about their experiences with stigma through the use of the semi-structured interview as well as completing the survey thoughtfully and asking relevant follow up/clarifying questions as they arose. Participants shared personal experiences of stigma and their sense of how the large community views adolescents with similar social and/or emotional problems. Based on the data gathering experience, specifically completing the semi-structured interviews and orientation to the study, it seemed that the participants were willing to share very personal experiences of stigma and rejection related to social and/or emotional problems as a way to further the general understanding of stigma experiences of adolescents participating in inpatient psychiatric treatment. As a group, the participants were adept in their ability to communicate their stigma experiences. If this study would have been set up to be more focused on qualitative experiences, these participants, based on their willingness to share during the semi-structured interview, would have been great candidates to get more in-depth information about their experiences of stigma and social and/or emotional problems. Additionally, based purely on interpersonal experiences with research participants, it is felt that this population would offer insight into how society can change to allow for more open communication, education, and decreased stigma related to treatment seeking behaviors from adolescents experiencing social and/or emotional problems to an acute degree, given their reported experiences of both self- and perceived public stigmas.

Overall, the results suggest that adolescents participating in an inpatient psychiatric hospitalization experience a moderate level of both self- and perceived public stigma. Although there was no statistical difference between level of self- and perceived public stigma, the nearly significant difference (p=.061) suggests that future research utilizing a larger sample may provide more confident/revealing/? results. When comparing these results to previous research with community based samples (Moses, 2009), it suggests adolescents are experiencing stigma at nearly the same level as adolescents participating in outpatient therapeutic care. It is encouraging that this inpatient population did not feel more stigmatized than an outpatient population, but it continues to be worrisome that adolescents are experiencing both self and perceived public stigma related to their emotional and/or behavioral problems Additionally, it is entirely possible that this population may not be all that different from outpatients as the majority are first time admissions and as such the true effects of stigma might not have been experienced to this point in their mental health treatment.

Other trends arose in this study including nearly significant relationships between the following factors: age and perceived public stigma; SES and perceived public stigma; age, gender, SES and public stigma; as well as time in treatment, SES, and perceived public stigma. Each of these trends, or nearly significant results, will be addressed later in the discussion section.

As indicated in the Methods section, the obtained sample included a sufficient number to justify the type of analyses conducted. This investigation was undertaken to examine six general exploratory hypotheses. Each of these hypotheses will be discussed in the order in which they were explored after the general level of stigma in the current sample is explored.

Level of Stigma

The current research did not reveal statistically significant differences in level of self- or perceived public stigma on a self-report stigma questionnaire using both personal experiences and a vignette to assess level of stigma. This finding was inconsistent with several previous studies which found that Caucasian females report more self- than perceived public stigma (Moses, 2009b) and older adolescents, consistent with the sample used in this study, report more self-stigma than younger children or older adults (Cauce et al., 2002; Lindsey, Korr, & Broitman, 2006; Moses, 2009; Rizzo et al., 2007). Also, level of stigma can vary considerably on a number of dimensions, such as severity, concealability, and social disruptiveness (Jones et al., 1984). Other research has found that adolescents internalize public stigma by devaluing themselves based on others’ beliefs and reactions (Link & Phelan, 2001; Vogel, Wade, & Hackler, 2007), which may have contributed to the slightly higher levels of self-stigma reported in the current study and would be an area to consider for future research.

In addition to stigma negatively impacting an individual's willingness to seek or participate in mental health treatment, research has found the negative effects of stigma increase when a diagnostic label is given to the problems described by the individual, even in the absence of any overt marker of a mental illness (Link, Cullen, Frank, & Wozniak, 1987; Link, Mirotznik, & Cullen, 1991; Link, Struening, Cullen, Shrout, & Dohrenwend, 1989; Weinstein, 1983). Although there was not a comparison group as part of this study and the effects of stigma were not specifically examined, one would expect level of stigma to be positively correlated with mental health and behavioral problems (Drapalski et al., 2013). The current study presented two vignettes in alternate orders, by participant, in an attempt to eliminate order bias. The first included a mental health diagnosis. The second merely described symptoms of a mental health diagnosis. No significant differences were found between Vignette 1 and Vignette 2. Additionally, the respondents did not have more or less stigmatizing views depending on the order in which they read the vignettes. This may offer insight into the fact that giving a label to emotional and behavioral problems is not as stigmatizing as previously thought and may allow for more open communication about mental health problems in our larger communities outside of psychiatric populations.

The fact that no difference was found between the two vignettes may have been related to the participants not recognizing the addition of the label to the description vignette as more stigmatizing than the description alone or only skimming the second vignette and thinking it was the exact same as the first. Several participants asked if it was a mistake to have both vignettes and required prompting to read the words carefully. There may have also been a fatigue factor in that the adolescents had completed an interview with the primary investigator, the ASEBA-YSR, read one vignette and answered more than 25 questions prior to reading the second vignette.

Demographic Factors

Age. The study participants averaged 15.3 years old (range 13-18; *SD*= 1.4) and were initially diagnosed with a mental health disorder at the mean age of 10 years, 3 months (range: 6 – 204 months), with more than 74% of participants being diagnosed before the age of 14. The current research did not find that age alone was related to levels of self-stigma but did find that age is trending toward a significant relationship with level of perceived public stigma which is consistent with several available studies that suggest general level of undifferentiated stigma (not breaking stigma experiences into the two categories of self- and perceived public stigma as was done in the current study) increases with age (Arbour-Nicitopoulos et al., 2010; Adlaf et al., 2009; Moses, 2009; Corrigan & Watson, 2007; Moses, 2009b).

Indeed, previous research has suggested that more than half of adolescents between the ages of 13 and 17 have stigmatizing attitudes about mental health problems (Corrigan & Watson, 2007) and older adolescents report higher levels of self-stigma (Moses, 2009b). Although the current sample (range 13-18; mean=15.3; *SD*=1.4) was similar in age (range 12-17; mean=14.8; *SD*=1.6) to the participants in Moses's studies (2009; 2009b; 2010) the results are very different in regards to self-stigma and only slightly different in regards to perceived public stigma. Moses has consistently found that older adolescents report both more self- and perceived public stigma, which may be due to Moses' participants being diagnosed with mental health problems nearly two years earlier than the current study's participants. On the contrary, it could be possible that being slightly older, may have allowed the current study's participants more time to learn to devalue negative feedback/outcomes, find comfort in understanding their social/emotional problems, and attribute negative outcomes and negative feedback from others to the stigmatizing condition not them as a person (Crocker & Major, 1989). Thus, one could argue that the current study's slightly older sample may have acquired more self-protective strategies and as a result perceive and experience self-stigma at the same levels of those same-aged peers participating in much lower levels of therapeutic support.

Gender. The current sample consisted of 65% female participants, which is inconsistent with previous research using a similar population of adolescents with mental health diagnoses (anxiety, depression), behavior problems, and suicidality, which found that males are more likely to participate in inpatient treatment (Moses, 2009b; Wu et al, 2010). If males are least likely to seek and participate in community based treatments, but make up the majority of those in inpatient services, more research should be done to determine barriers to participating less intensive levels of mental health treatment. This highlights the need for a larger sample size to see if the ratio of males to females participating in treatment would even out when more participants are used and speaks to the importance of future studies gathering patient census data as part of the research.

Although gender was not found have statistically significant relationships with self- or perceived public stigma, these findings, though inconsistent with previous research, speak to the universality of mental health problems and the importance of intervention. Previous research has found that males have higher mental health stigma than females (Chandra & Minkovitz, 2006) and the current finding that males and females experience similar levels of stigma argues against the idea that one gender is "thicker skinned" or more able to "let things roll of their backs" and highlights the need for widespread psychoeducation about mental health, social, and emotional problems as well as ways to seek support and treatment through friends, mental health professionals, and/or treatment facilities.

SES. Level of parental education was used as an indicator of SES and is supported in the literature as a credible proxy primarily due to the high degree of accuracy in self-reported data (Donaldson, Lichtenstein, & Sheppard, 2008; Fletcher-Janzen & Daniel, 2006; Hauser, 1994; Rodriguez, et al., 2004). More than 80% of participants had parents who completed at least some college, which results in a group with somewhat higher SES than the comparative literature (Koydemir-Ozden & Erel, 2010; Merikangas et al., 2010; Moses, 2010). Previous findings suggest stigma experiences are more prevalent in those coming from families with low education (Alonso et al., 2009) and level of self-stigma is related to SES (Moses, 2009) , but the current study found that SES was trending toward significance in relation to level of perceived public stigma.

The fact that SES did not have a significant relationship with level of self-stigma and was only trending toward statistically significant relationship with level of perceived public stigma may speak to the possibility that families from all SES backgrounds cannot protect their loved ones from the perceptions of others and can only insulate their children from their own self-criticism to a certain degree. This finding may be skewed by the large number of families with at least some college education, or the large number of families with private insurance, leading to an underrepresented population of those with no post-secondary education and limited financial security often associated with private insurance. It would be interesting to replicate this study with the addition of other SES indicators (e.g., employment status, salary, etc.) and more information about insurance providers given that the Affordable Care Act in now in place and may offer privatized insurance for those who would otherwise not be able to afford private insurance.

Combined Demographic Factors. A combined demographic factor model approached statistical significance for level of perceived public stigma. This is particularly interesting given that, independently, both age and SES approached statistical significance when looking at level of perceived public stigma. This finding may suggest that younger adolescents from lower SES backgrounds are more impacted by the beliefs and opinions of those around them (Garcia, 2010); less secure in their identities (Longmore, Manning, Giordano, 2004); and have fewer skills by which to manage negative perceptions by others (Rew, 2005) and speak to the importance of targeting younger adolescents from lower SES families with early intervention and psychoeducation (Rusch, Angermeyer, & Corrigan, 2005). This is in line with previous research examining these factors, however with more public service announcements and general education about mental health problems, there may be a cultural shift where stigma and these variables are not as strong as previously thought (Chan, Mak, & Law, 2009; Corrigan & Shapiro, 2010). More research is needed to confirm these results and further assess ways to target interventions directed at decreasing perceived public stigma through psychoeducation and normalizing the prevalence of mental health problems in society.

Clinical Factors

The current research did not observe independent clinical factors (e.g., time with diagnosis, number of psychiatric admissions, mental health disorder) that were statistically significant indicators of self- or public stigma when used independently or as moderators. This means that the likelihood of an adolescent experiencing self-stigma or perceived public stigma cannot be anticipated using the clinical factors presented in this study.

Time with diagnosis. The current sample was first diagnosed with a mental health disorder at the mean age of 10.3 years old and had been diagnosed for a mean of 4.2 years. This sample is consistent with Kessler et al.'s (2005) findings that half of all lifetime cases of mental health problems start by the age of 14. Although the current sample was considered highly acute, given that were hospitalized for their mental health and/or behavioral problems, it is interesting to note that the early onset is consistent with samples used in several other stigma-focused studies (Corrigan, 2010; Kessler et al., 2005; Moses, 2009; Moses, 2009b; Moses, 2010). Previous research that suggests those who begin treatment at a young age, consistent with the current participants, report more personal rejection, higher self-stigma, and more secrecy about their problems and treatment (Corrigan & Watson, 2007; Moses, 2009b) was not replicated in the current study. The factor of "time with diagnosis" proved to be a difficult indicator to measure and link to the underlying issue of level of stigma, as it was not a factor that could be confirmed with a chart review and parents often commented that they "could not remember exactly" when their child was initially diagnosed with an emotional or behavioral problem . It is important to consider that the type of onset and elapsed time since the stigma was perceived or experienced may be more important than the duration of diagnosis or age at which stigma was experienced or perceived. Jones et al. (1984) suggested that stigmatizing conditions that have a more gradual onset may be more endurable to the person experiencing or perceiving the stigma than those stigmas that occur suddenly as the former scenario permits time to adapt. The gradual onset may have also allowed participants more time to acquire additional self-protective strategies and, as a result, perceive and experience stigma at the same levels of those same-aged peers participating in lower levels of therapeutic support.

Number of psychiatric admissions. Although there were no statistically significant findings it was interesting to find that 73% of the participants were participating in inpatient psychiatric help for the first time, with a sample mean of 1.6 admissions. It is important to consider that the majority of the participants had only one admission which may have restricted the range of the predictor variable and contributed to the non-significant findings. Given that the large majority of the sample was first time admits, it seems reasonable to surmise that there may be an increase in short-term inpatient psychiatric stays (Blader, 2011) and by default more adolescents needing treatment are getting it. If the current finding of nearly three of four admissions being first time hospitalizations were replicated in future studies, it could speak to the possibility that initial hospitalizations are providing the patients and their families with needed resources to manage mental health needs at lower levels of care. The goal of hospitalization from the multidisciplinary team at the University of Utah Neuropyschiatric Institute includes: stabilizing acute psychological needs; setting up effective lower levels of care; teaching skills to help adolescents cope with their social and emotional problems more effectively; informing families of other treatments available; teaching parents how to better understand their adolescents' needs as well as strategies to provide structure outside of the hospital; and empowering families to set limits and ask for help before crisis occurs.

Mental health disorder. With 70% of the sample population being diagnosed with some kind of depressive disorder, the sample is much less varied than was anticipated prior to data collection. Kelly and Jorm (2007) found that those with depressive symptoms reported higher levels of self- than perceived public stigma. Additionally, those with high perceived public stigma had poor social outcomes, even controlling for symptom severity. There were no significant differences between those with depressive disorders and those in the "other" disorders category in terms of their level of self-or perceived public stigma. If the current study had a matched control group it would have been able to determine if an inpatient population reports similar levels of self- and public stigma as an outpatient population. Alonso et al. (2008) found that those suffering with depression and/or anxiety were more than twice as likely to experience stigma as those with no mental disorder.

Although the majority of those hospitalized receive some kind of depressive disorder diagnosis, the variety of mental health disorders presented on the inpatient psychiatric unit is much more diverse than this sample reflects. Looking back, if the study could have collected data on all adolescents hospitalized during the data-collection periods, it would have been much easier to determine the similarities between the research subsample and the larger sample on the adolescent inpatient unit over the course of the study.

Combined Clinical Factors. All three clinical factors were used together in order to determine if they offered a stronger combined predictive quality, however, no significant model emerged for self- or perceived public stigma. This lack of finding speaks to the importance of using a multipronged approach to treating adolescents with acute social and/or emotional problems and not relying too heavily on one factor or another. At times, it may be thought that one’s diagnosis might be indicative of level of stigma based on the observability of the problem (Menec & Perry, 1995; Pescosolido, Fettes, Martin, Monahan, & McLoed, 2007; Pescosolido et al., 2008; Walker, Coleman, Lee, Squire, & Friesen, 2008), however these results suggest that stigma does not vary based on diagnostic category.

Moderated Variables

In summary, this research study found that the three demographic factors (age, gender, SES) alone, or together as moderators, are not statistically significant predictors of self- stigma.

However, a statistically significant model emerged for level of perceived public-stigma when using the two demographic factors of age and SES. Similarly, clinical factors (time with diagnosis, number of psychiatric admissions, mental health disorder) were not statistically significant predictors of self- or public- stigma when used independently or together as moderators.

Unfortunately, a model did not emerge to help determine the level of an adolescent's self-stigma or perceived public stigma by the demographic or clinical factors used in this study, which speaks to the importance of clinical exploration of stigma experiences. That is, attention remains focused on the importance of clinical expertise and relationship with the patient when evaluating and treating mental health problems and any resulting stigma. Although models provide helpful frameworks and guide intervention, they are not substitutes for clinical expertise. Additionally, psychoeducation continues to be an important strategy to inform adolescents about mental health problems and normalize participating in mental health treatment for any problems they may be experiencing (Chan, Mak, & Law, 2009; Corrigan & Shapiro, 2010; Rusch, Angermeyer, & Corrigan, 2005).

Combined clinical and demographic factors. One statistically significant model emerged for level of perceived public stigma when using the demographic factor SES and clinical factor of time with diagnosis, indicating low SES and less time with diagnosis were related to higher levels of perceived public stigma. Although other significant mixed models did not emerge, , knowing that SES and time with diagnosis have a significant relationship with level of perceived public stigma speaks to the importance of early intervention and psychoeducation. This finding gives hope to the possibility that with a larger, more varied sample, more statistically significant findings may materialize and offer a more clear comparison between inpatient population results and prior examinations of community-based populations (Adlaf et al., 2009; Alonso et al., 2009; Arbour-Nicitopoulos et al., 2010; Corrigan & Watson, 2007; Crocker & Major, 1989; Koydemir-Ozden & Erel, 2010; Merikangas et al., 2010; Moses, 2009; Moses, 2009b; Moses, 2010; Wu et al., 2010). This model may also speak to the possibility that those participating in inpatient therapeutic care are in fact significantly different than the community based samples to which the results are compared and support the push for more research to be done using similarly acute patients.

Qualitative Findings. The qualitative portion of this study gleaned important information about the way adolescents experience self- and public stigma. It was surprising that adolescents were generally optimistic about participating in treatment and changes that would result for themselves and their families. Any negativity about participating in treatment or uncertainty of others' perceptions of their social/emotional problems seemed steeped in legitimate concerns about feeling ostracized. The participants' own words seemed to evoke more stigma experiences than their quantitative responses. It would be interesting for future research to determine if qualitative (versus quantitative) responses result in higher levels of reported stigma. It will be important to replicate this study in its current or only slightly modified form to further understand adolescents' perspectives related to stigma as well as to seek replication of the current findings.

Limitations

Findings of this research study should be interpreted in light of the following limitations: selection bias, inconsistent data collection, consistency/accuracy of the instrumentation and measurement variables, lack of follow-up data, lack of teacher input when assessing the general functioning of the adolescent and lack of control group. Although procedures were in place to reduce the threat of self-selection (all incoming hospital admissions during specified time periods were recruited), participation in the study was voluntary and required parental consent and participation. Thus, interested adolescents, with parents who allowed participation and followed through with their own participation, joined in the study. There were many potential participants who did not respond to attempts to reach them by phone, mail, or email even after they had given consent to participate in the study. Although it is unknown how the demographics of this sample compare with the larger demographics of those on the adolescent inpatient unit during data-collection, it is possible that participants differed in important ways (e.g., increased motivation to please adults, desire to get out of group therapies, increased motivation to help others by way of participation). Only 60% of eligible adolescents participated in this study. Thus, a large portion of the eligible participants did not participate and those who did may not be representative of all adolescents participating in inpatient treatment during the data-collection period.

Level of Stigma. Level of stigma is difficult to measure in a population participating in mental health treatment as research has found that stigma toward mental illness may act as a significant barrier to actually seeking mental health care (Amato & Bradshaw, 1985; Cooper, Corrigan, & Watson, 2003; Corrigan, 2004; Kushner & Sher, 1991; Rüsch, Angermeyer, & Corrigan, 2005). As many as 20% of individuals surveyed by the American Psychological Association reported that stigma negatively impacted treatment-seeking (Kirchheimer, 2004) which may skew the overall level of stigma reported both in the current sample and in previous studies assessing stigma in community based samples, and if the opposite is true that belief in treatment is associated with lower stigma, one might surmise that parents who hospitalize their children likely believe that treatment will work. Despite the large number of individuals affected by inadequate treatment utilization, the empirical literature concerning the effects of stigma on treatment-seeking is somewhat limited for adults and virtually non-existent for children and adolescents. Initiatives, such as the Presidential Task Force (New Freedom Commission on Mental Health, 2003), are attempting to address the negative association between stigma and seeking mental health treatment, and there has been some question about whether these initiatives effectively reduce stigma, though research specific to these national initiatives are not currently available in the literature, but research does support the use of anti-stigma programs in schools (Chan, Mak, & Law, 2009). The current results contribute to the efforts to assess stigma using an adolescent sample with acute mental health problems. If the literature is accurate that 20% of the general population does not seek or participate in treatment due to stigma, one may never truly be able to measure stigma and its impact in a complete and meaningful way.

Data Gathering. Additionally, improved data-gathering consistency may have resulted in a different distribution with regard to participant gender. Because 500 miles separated the research site from the primary investigator's residence, and all data needing to be collected by primary researcher, data was collected at inconsistent intervals over the 13-month data collection period which may have altered the sample profile. Additionally, given that the researcher had limited ability to make face-to-face follow-up contacts, participants may have been excluded due to parents not getting an in-person reminder to complete the research materials. The present protocol of collecting data at irregular intervals and for short windows of time may have led to a sample that is significantly different than the general population of adolescents participating in inpatient treatment during the same time.

The decision to use an adolescent inpatient population makes data gleaned less generalizable and comparable to currently available community based data, but will add to the larger data base of stigma research which was the primary goal of the study. This population may also explain why several analyses did not replicate previous findings. Due to the lack of a true control/comparison sample and lack of similar studies currently available in the research, results were compared to non-inpatient and non-mental health samples available in the literature.

Surveys. Duplicating the vignettes and perceived public stigma questions may have contributed to lack of findings. The fact that no difference was found between the two vignettes may have been related to the participants only skimming the second vignette and thinking it was the exact same as the first. Several participants asked if it was a mistake to have both vignettes and required prompting to read the words carefully. There may have also been a fatigue factor in that the adolescents had completed an interview with the primary investigator, the ASEBA-YSR, read one vignette and answered more than 25 questions prior to reading the second vignette.

Some instruments used in this study were not validated after changes were made to the wording of the question or after the addition of new variables. In addition, it is possible that self-report measures are amenable to produce socially desirable responses specifically when asking about the very personal experiences of emotional and behavioral problems. Self-report measures utilized in this study, Stigma Vignettes and corresponding questions, have not been validated with actual behavior and emotional responses among adolescents prior to this study. Given the dearth of research on stigma experiences of adolescents with emotional and behavioral problems participating in inpatient psychiatric treatment, the results of this study are difficult to assess. In other words, among inpatient psychiatric adolescents, it is unknown what factors are most likely to change levels of self-and perceived public stigma.

SES. The current study obtained parent level of education and insurance provider though it may have been more beneficial to include household income in addition to those factors. Research indicates that having more than two factors is best practice when using proxy indicators of SES (Currie et al., 1997; Durkin et al., 1994; Lien, Friestad, & Klepp, 2001; Mueller & Parcel, 1981). In the current study, level of education was coded dichotomously: those with two or fewer years of college and those with a Bachelor's degree and higher, which may have contributed to the nonsignificant results as most studies using education split into more than two levels as a proxy for SES (Currie et al., 1997; Donaldson, Lichtenstein, & Sheppard, 2008; Durkin et al., 1994; Fletcher-Janzen & Daniel, 2006; Hauser, 1994; Lien, Friestad, & Klepp, 2001; Mueller & Parcel, 1981; Rodriguez, et al., 2004). If the sample would have allowed, it likely would have been beneficial to be able to break those levels down to include at least three categories: K-12, 1-2 years of college; and 2+ years of college, as there is often a difference in lifetime SES between those who attend college, those who complete college, and those who do not attend any post high school education.

Strengths

Despite the limitations of this study, there are notable strengths involving the design, significance of the topic under study, setting, and sample. Additionally, this study was a cooperative venture between The University of Montana, University of Utah, and University Neuropsychiatric Institute on an issue that is a priority of national health. Included in this study was a sample of participants who were diverse in race, time with diagnosis, and age.

The study found no difference in level of experienced self-stigma and perceived public stigma, suggesting current and future generalized stigma interventions will likely be impactful for both types of stigma. It will be important to replicate the study and use comparative analyses to review the results. Researchers will benefit from more information about stigma to help guide intervention. Additionally, the qualitative portion of the study gleaned important information in the adolescents' own words. Giving them a voice in similar research will continue to guide the development of interventions, treatments, and psychoeducation for adults and peers.

Future Directions

Future research in this area should collect follow-up data. It would be beneficial for future researchers to have contact with participants after discharge from the hospital to reassess general functioning and stigma levels. Due to the relatively short hospital stays of the participants, it would be difficult to have in-person follow-up and would require contact by email, phone, or postal mail which may change the responses as they would be collected in a different format. Additionally, it would be important to include teacher input when assessing the adolescents' general functioning to ensure a full picture was presented on each participant. Future research should utilize psychometrically sound measuring tools to ensure the research is measuring what it intends to measure. Finally, adding a control group would be helpful in determining a "typical" level of stigma in non-hospitalized adolescents for comparison.

Additionally, prior research suggests that those diagnosed with mental health problems early in life will likely experience significant distress related to ongoing mental health treatment and will tend to experience more distress throughout adolescence and adulthood, than those who did not engage in treatment before adulthood (Moses, 2009b). Unfortunately, this study was not set up to be longitudinal in nature; however, the need for more longitudinal research is vital to furthering our understanding of the impact of stigma and social and emotional problems on adolescents over time.

The results suggest that although this is an acute sample population, level of self- and perceived public stigma were not significantly different from those from a community-based sample. Stigma is a highly studied and validated field so the fact that these findings suggest no difference in the experience of stigma between two highly different sample groups. Could this mean that stigma does not proportionally increase with mental health problems? Could the data be skewed by the number of first time admissions (73%) and be a closer approximation to a community sample than a more acute and/or chronic sample?

Future research should build upon the current study to determine if there is a relationship between self- and perceived public stigma that may have confounded the results. Vogel, Wade, and Hackler (2007) demonstrated that self-stigma is a result of public stigma and directly mediates the relationship between public stigma and attitudes towards seeking and participating in mental health treatment.

Conclusions

The study is important as it begins to fill the gap in research about stigma from acute populations and to extend the research completed by Moses (2009b) by providing additional data to assess the trend of stigma experiences for adolescents. It was hoped that data gleaned from this sample could be used by other researchers to further evaluate stigma as it relates to participating in mental health treatment because research has noted that the majority of adolescents with behavioral or emotional disorders do not have access to, or choose not to participate in, available treatment (Kataoka, Zhang, & Wells, 2002; (Rickwood et al., 2005; Rickwood et al., 2007; Sirey et al., 2001; Walker et al., 2008). Many people could benefit from psychological services but do not seek them or actively avoid participating (Corrigan, 2004; Kessler et al., 1994, 2005; Shapiro et al., 1984; Wang et al., 2005). The stigma associated with seeking and engaging in psychological treatment has been shown to be a significant barrier to people who needing services (Cooper, Corrigan, & Watson, 2003; Corrigan, 2004; Corrigan & Kleinlein, 2005; Link & Phelan, 2001; Satcher, 1999; Vogel, Wade, & Haake, 2006).

The current study sought to better understand the relationship between self- and perceived public stigma in adolescents participating in inpatient psychiatric treatment. Although none of the demographic or clinical factors accounted for a significant proportion of variance in levels of self- or perceived public stigma, the current research examined an understudied, acute population not previously been found in the literature. Additionally, this study found that this group of adolescents did not report significantly higher levels of self- or perceived public stigma than community/outpatient based samples, which speaks to the possibility that adolescents participating in mental health care may not experience higher stigma related to their mental health problems than those in outpatient care. It will be important for more research to address both self- and perceived public stigma and adolescents in psychiatric hospitals in order to fine tune available interventions and preventative measures that can be implemented at lower levels of care.

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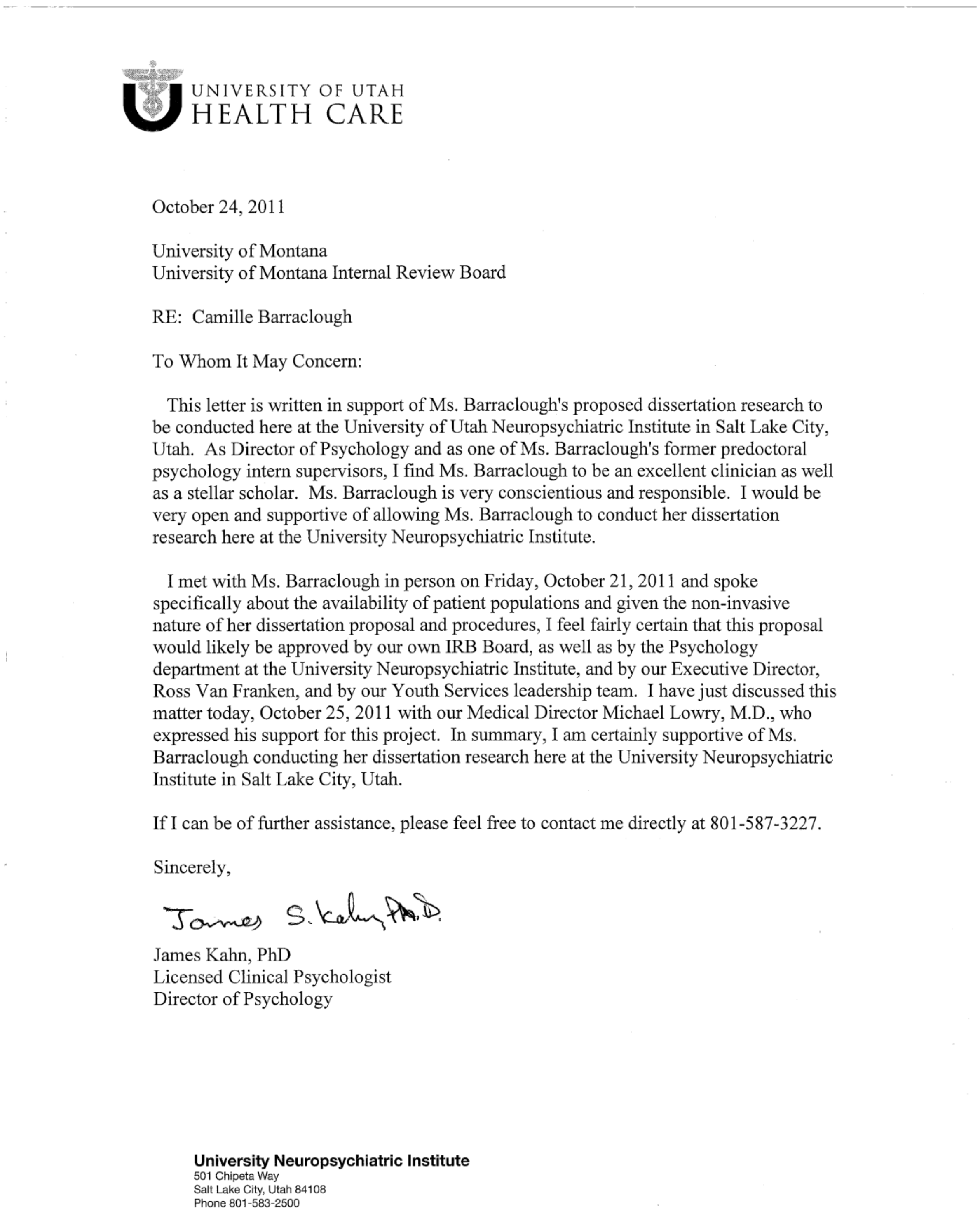
Appendix A.



UNIVERSITY OF UTAH
HEALTH CARE

October 24, 2011

University of Montana
University of Montana Internal Review Board

RE: Camille Barraclough

To Whom It May Concern:

This letter is written in support of Ms. Barraclough's proposed dissertation research to be conducted here at the University of Utah Neuropsychiatric Institute in Salt Lake City, Utah. As Director of Psychology and as one of Ms. Barraclough's former predoctoral psychology intern supervisors, I find Ms. Barraclough to be an excellent clinician as well as a stellar scholar. Ms. Barraclough is very conscientious and responsible. I would be very open and supportive of allowing Ms. Barraclough to conduct her dissertation research here at the University Neuropsychiatric Institute.

I met with Ms. Barraclough in person on Friday, October 21, 2011 and spoke specifically about the availability of patient populations and given the non-invasive nature of her dissertation proposal and procedures, I feel fairly certain that this proposal would likely be approved by our own IRB Board, as well as by the Psychology department at the University Neuropsychiatric Institute, and by our Executive Director, Ross Van Franken, and by our Youth Services leadership team. I have just discussed this matter today, October 25, 2011 with our Medical Director Michael Lowry, M.D., who expressed his support for this project. In summary, I am certainly supportive of Ms. Barraclough conducting her dissertation research here at the University Neuropsychiatric Institute in Salt Lake City, Utah.

If I can be of further assistance, please feel free to contact me directly at 801-587-3227.

Sincerely,

James S. Kahn, Ph.D.

James Kahn, PhD
Licensed Clinical Psychologist
Director of Psychology

University Neuropsychiatric Institute
501 Chipeta Way
Salt Lake City, Utah 84108
Phone 801-583-2500

Appendix B

RESEARCH FLYER

A Research Study About:
Adolescent's Experiences and Perceptions Related to Emotional and/or Behavioral Difficulties

Researchers at the University of Montana and the University Neuropsychiatric Institute want to find ways to better understand adolescent's perceptions as they relate to emotional and/or behavioral issues. This research study is for adolescents and their parents. Research is always voluntary!

Would the study be a good fit for me?

This study might be a good fit for you if:

- Your child is between 13 and 18
- Your child has emotional and/or behavioral difficulties
- You and your child are English speaking

What would happen if I took part in the study?

If you decide to participate in the research study:

- You would complete a background questionnaire & behavioral checklist
- Your child would complete a behavioral checklist & a semi-structured interview/survey about their perceptions of emotional and/or behavioral difficulties

There may be possible benefits if you take part in the study, including helping treatment providers better understand adolescent's perceptions related to emotional and/or behavioral difficulties and developing better treatment in the future.

The principal researcher for this study is Camille Barraclough, MA a doctoral student at
The University of Montana & Therapist at The University Neuropsychiatric Institute.
Email: camille.barraclough@hsc.utah.edu
Phone: 406-396-2953 or 801-587-2500

☐ I want to learn more about this research study
My name is: ________________________
Please contact me at the following number: _______________
The best time to reach me is: ___________________________

Appendix C

PARENTAL PERMISSION and CONSENT TO PARTICIPATE

Title: Perceptions of Adolescents with Emotional and/or Behavioral Difficulties

Project Director(s):

Camille Barraclough, MA University of Montana 32 Campus Drive, Skaggs 143 Department of Psychology Missoula, MT 59812 406-396-2953	Gregory R. Machek, PhD University of Montana 32 Campus Drive, Skaggs 143 Department of Psychology Missoula, MT 59812 406-243-5546

Special instructions: This consent form may contain certain technical words that are new to you. If any words are not clear to you, please ask the person who gave you this form to explain them.

Purpose: You are being asked to give permission for your child to take part in a research study focused on gathering information from adolescents currently experiencing emotional and/or behavioral difficulties. In this study, the researcher will ask about adolescent's "perceptions" which will include the view your child has of him/herself and the view your child has of other adolescents with emotional and/or behavioral problems. We are asking you to allow your child be in the study because he/she is currently participating in an inpatient treatment program focused on stabilization, assessment, and discharge planning. His/Her participation will help researchers better understand the way adolescents perceive themselves in relation to their emotional and/or behavioral difficulties and how they perceive others with emotional and/or behavioral difficulties, as well as inform changes that can be made to improve said experience.

Procedures: If you agree you will be given a brief questionnaire asking your education level and your child's age at first experience of emotional and/or behavioral difficulties. You will also be asked to complete a behavior checklist about your child. Within 48 hours of granting permission for your child to participate in the study, he/she will be asked to complete a behavioral checklist and a semi-structured interview/survey addressing his/her perceptions related to emotional and/or behavioral difficulties. The study will take place at the Utah Neuropsychiatric Institute (UNI) on the adolescent inpatient unit and will take about 30 minutes to complete. A brief file review will take place to gather demographic and clinical data including your child's: age, gender, race/ethnicity, diagnosis, number of psychiatric admissions, and type of insurance provider.

Risks/Discomforts: There is limited anticipated discomfort for those contributing to this study, so risk to participants is minimal. Your child may stop answering questions at any time. There is a small possibility answering the questions may cause your child to become emotional or think about difficult experiences from his/her past. The primary investigator (Camille Barraclough, MA) will assess distress and answer questions or concerns about their experience as a participant. If your child experiences any sort of distress related to this research, therapy will be available on the unit by the primary investigator (Camille Barraclough, MA) or your child's primary therapist at UNI.

Benefits: Your child's participation in this study will help inform treatment providers and the general public about the way adolescents perceive themselves and others in relation to emotional and/or behavioral difficulties. There is no promise that your child will see any immediate changes or receive any immediate benefits from taking part in this study.

Confidentiality: Only the researcher (Camille Barraclough, MA) and her faculty supervisor (Gregory R. Machek, PhD) will have access to the files and all will remain stored in a locked file cabinet in a secure location. Your signed consent form will be stored in a cabinet separate from the data. You or your child's name will never be attached to the information gathered and all other identifying information will only be used in group statistics. No case studies will result from this research. If the results of this study are written in a scientific journal or presented at a scientific meeting, your child's individual identifying information will not be used. Five years after data collection is complete this information will be destroyed.

Compensation for Injury: Although we do not foresee any risk in taking part in this study, the following liability statement is required in all University of Montana consent forms.

> In the event that you are injured as a result of this research you should individually seek appropriate medical treatment. If the injury is caused by the negligence of the University or any of its employees, you may be entitled to reimbursement or compensation pursuant to the Comprehensive State Insurance Plan established by the Department of Administration under the authority of M.C.A., Title 2, Chapter 9. In the event of a claim for such injury, further information may be obtained from the University's Claims representative or University Legal Counsel. (Reviewed by University Legal Counsel, July 6, 1993)

Voluntary Participation/Withdrawal: Your decision to allow your child to take part in this research study is entirely voluntary. You may refuse to allow your child to take part in it or you may withdraw your child from the study at any time without penalty or loss of benefits. You may leave the study for any reason.

Questions: If you have any questions about the research now, during, or after the study, contact:

Camille Barraclough, MA	Gregory R. Machek, PhD
University of Montana	University of Montana
32 Campus Drive, Skaggs 143	32 Campus Drive, Skaggs 143
Department of Psychology	Department of Psychology
Missoula, MT 59812	Missoula, MT 59812
406-396-2953	406-243-5546

If you have any questions regarding you or your child's rights as a research subject, you may contact the Chair of the IRB through The University of Montana Research Office at 243-6670.

Parent's Statement of Permission: I have read the above description of this research study. I have been informed of the risks and benefits involved, and all my questions have been answered to my satisfaction. Furthermore, I have been assured that any future questions I may have will also be answered by a member of the research team. I voluntarily agree to have my child take part in this study. I understand I will receive a copy of this consent form.

____
Printed Name of Subject

____________________________________ ______________________
Signature of Parent or Legally Authorized Representative Date

Authorization to Use and Disclose Protected Health Information for Research Purposes

---

Purpose. I authorize *University Neuropsychiatric Institute* to disclose the following protected health information to *Camille Barraclough, MA*: age, gender, race/ethnicity, diagnoses, type of insurance provider, and number of psychiatric admissions.

This protected health information is to be used/disclosed by *Camille Barraclough, MA* and the researcher's staff only for the purpose of conducting the research project entitled *"Perceptions of Adolescents with Emotional and/or Behavioral Difficulties."*

Camille Barraclough, MA may use/disclose my existing protected health information (PHI), or any created within the next six (6) months for up to thirty (30) months from the date of my signing this authorization.

Right to Refuse. I may refuse to sign this authorization if I so choose. If I decide not to sign the Authorization, I will not be allowed to participate in this study. However, my decision not to sign this authorization will not affect my current or future other treatment, current or future payment, enrollment in health plans, or eligibility for benefits at University Neuropsychiatric Institute.

Right to Revoke. At all times, I retain the right to revoke this Authorization. If I wish to revoke the authorization to use protected health information before this authorization expires in thirty (30) months, I will need to contact the primary investigator (Camille Barraclough, MA) who will provide me with a form requesting the revocation of authorization that will need to be signed and maintained by the researcher. Withdrawal of this Authorization shall be effective *except* to the extent that *Camille Barraclough, MA* has already used or disclosed information released prior to receiving notice of the revocation.

Potential for Re-disclosure. I understand that once my health information is disclosed under this Authorization, there is a potential that it could be re-disclosed outside this study and no longer covered by this Authorization. I also understand that there are laws that may require my individual health information to be disclosed for public purposes, such as if required for mandated reporting of abuse or neglect, judicial proceedings, health oversight activities and public health measures.

I am the research participant or personal representative authorized to act on behalf of the participant. I have read this information, and I will receive a copy of this authorization form after it is signed.

________________________________ Signature of research participant or research participant's personal representative	______________________________ Date
________________________________ Printed name of research participant or research participant's personal representative	______________________________ Description of personal representative's authority to act on behalf of research participant

Appendix D

Demographic Questionnaire

I. General Information

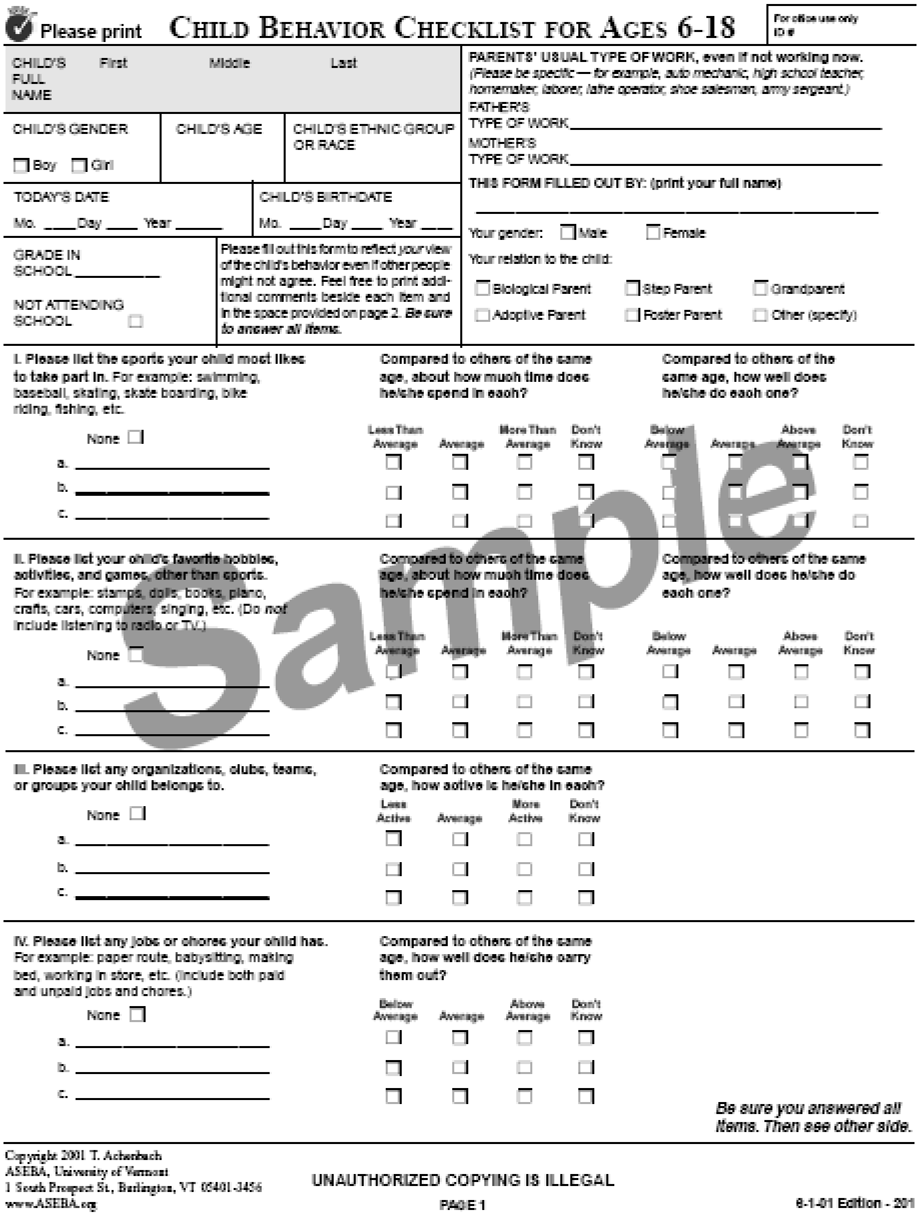
1. What is your highest level of completed education? (check one)

    _____Some High School
    _____Completed High School
    _____Some College
    _____Completed College
    _____Graduate School

2. At what age was your child first diagnosed with or experience emotional and/or behavioral difficulties? __________

Appendix E

ASEBA- CBCL



Please print **CHILD BEHAVIOR CHECKLIST FOR AGES 6-18**

For office use only
ID #

CHILD'S FULL NAME First Middle Last

CHILD'S GENDER ☐ Boy ☐ Girl

CHILD'S AGE

CHILD'S ETHNIC GROUP OR RACE

TODAY'S DATE Mo. ____ Day ____ Year ______

CHILD'S BIRTHDATE Mo. ____ Day ____ Year ____

GRADE IN SCHOOL __________

NOT ATTENDING SCHOOL ☐

Please fill out this form to reflect *your* view of the child's behavior even if other people might not agree. Feel free to print additional comments beside each item and in the space provided on page 2. ***Be sure to answer all items.***

PARENTS' USUAL TYPE OF WORK, even if not working now. *(Please be specific — for example, auto mechanic, high school teacher, homemaker, laborer, lathe operator, shoe salesman, army sergeant.)*

FATHER'S TYPE OF WORK ______________________________

MOTHER'S TYPE OF WORK ______________________________

THIS FORM FILLED OUT BY: (print your full name)

____

Your gender: ☐ Male ☐ Female

Your relation to the child:

☐ Biological Parent ☐ Step Parent ☐ Grandparent

☐ Adoptive Parent ☐ Foster Parent ☐ Other (specify)

I. Please list the sports your child most likes to take part in. For example: swimming, baseball, skating, skate boarding, bike riding, fishing, etc.

None ☐

	Compared to others of the same age, about how much time does he/she spend in each?				**Compared to others of the same age, how well does he/she do each one?**			
	Less Than Average	Average	More Than Average	Don't Know	Below Average	Average	Above Average	Don't Know
a. ____________	☐	☐	☐	☐	☐	☐	☐	☐
b. ____________	☐	☐	☐	☐	☐	☐	☐	☐
c. ____________	☐	☐	☐	☐	☐	☐	☐	☐

II. Please list your child's favorite hobbies, activities, and games, other than sports. For example: stamps, dolls, books, piano, crafts, cars, computers, singing, etc. (Do *not* include listening to radio or TV.)

None ☐

	Compared to others of the same age, about how much time does he/she spend in each?				**Compared to others of the same age, how well does he/she do each one?**			
	Less Than Average	Average	More Than Average	Don't Know	Below Average	Average	Above Average	Don't Know
a. ____________	☐	☐	☐	☐	☐	☐	☐	☐
b. ____________	☐	☐	☐	☐	☐	☐	☐	☐
c. ____________	☐	☐	☐	☐	☐	☐	☐	☐

III. Please list any organizations, clubs, teams, or groups your child belongs to.

None ☐

	Compared to others of the same age, how active is he/she in each?			
	Less Active	Average	More Active	Don't Know
a. ____________	☐	☐	☐	☐
b. ____________	☐	☐	☐	☐
c. ____________	☐	☐	☐	☐

IV. Please list any jobs or chores your child has. For example: paper route, babysitting, making bed, working in store, etc. (Include both paid and unpaid jobs and chores.)

None ☐

	Compared to others of the same age, how well does he/she carry them out?			
	Below Average	Average	Above Average	Don't Know
a. ____________	☐	☐	☐	☐
b. ____________	☐	☐	☐	☐
c. ____________	☐	☐	☐	☐

Be sure you answered all items. Then see other side.

ASEBA, University of Vermont
1 South Prospect St., Burlington, VT 05401-3456
www.ASEBA.org

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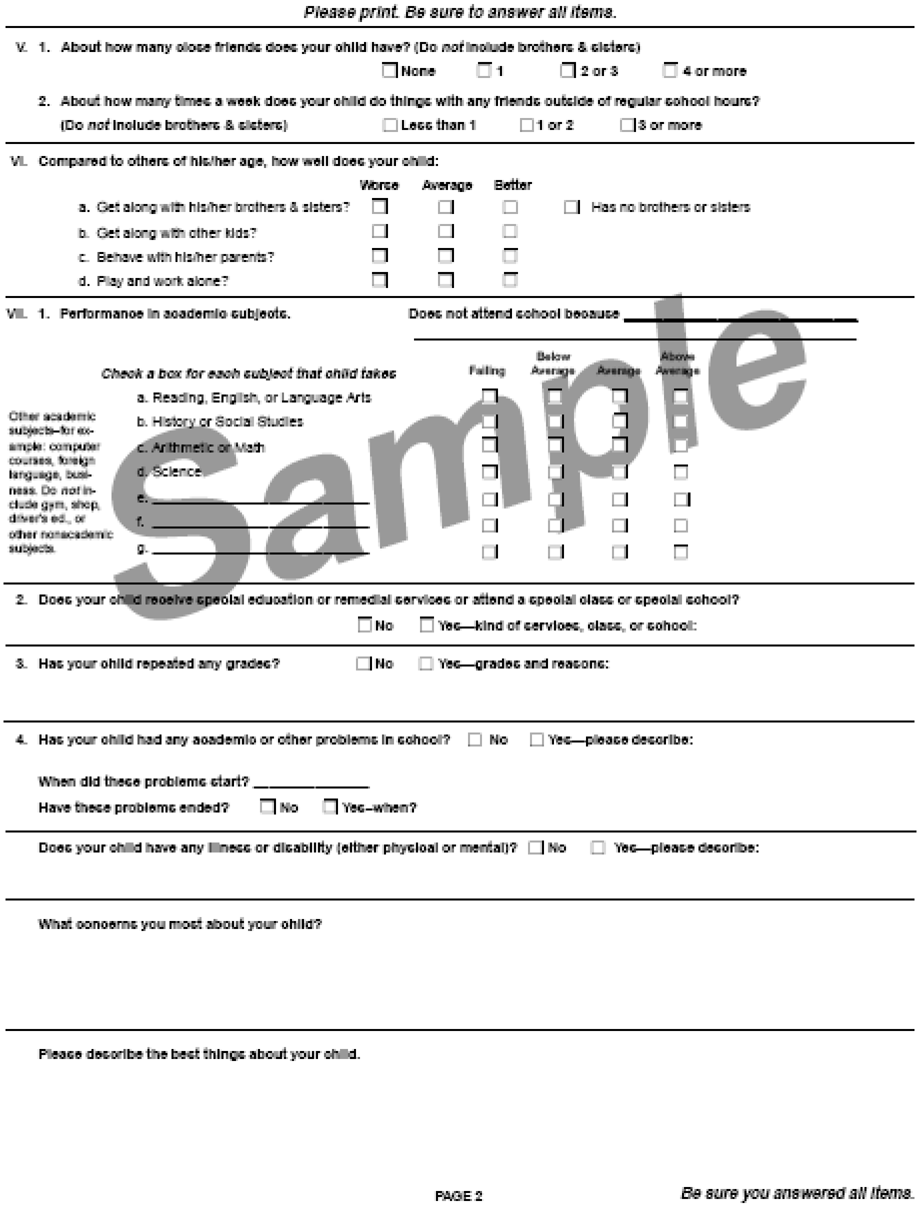
PAGE 1

6-1-01 Edition - 201



Please print. Be sure to answer all items.

V. 1. About how many close friends does your child have? (Do *not* include brothers & sisters)
☐ None ☐ 1 ☐ 2 or 3 ☐ 4 or more

2. About how many times a week does your child do things with any friends outside of regular school hours?
(Do *not* include brothers & sisters) ☐ Less than 1 ☐ 1 or 2 ☐ 3 or more

VI. Compared to others of his/her age, how well does your child:

	Worse	Average	Better	
a. Get along with his/her brothers & sisters?	☐	☐	☐	☐ Has no brothers or sisters
b. Get along with other kids?	☐	☐	☐	
c. Behave with his/her parents?	☐	☐	☐	
d. Play and work alone?	☐	☐	☐	

VII. 1. Performance in academic subjects. Does not attend school because ____________

Check a box for each subject that child takes

		Failing	Below Average	Average	Above Average
	a. Reading, English, or Language Arts	☐	☐	☐	☐
Other academic subjects—for example: computer courses, foreign language, business. Do *not* include gym, shop, driver's ed., or other nonacademic subjects.	b. History or Social Studies	☐	☐	☐	☐
	c. Arithmetic or Math	☐	☐	☐	☐
	d. Science	☐	☐	☐	☐
	e. ____________	☐	☐	☐	☐
	f. ____________	☐	☐	☐	☐
	g. ____________	☐	☐	☐	☐

2. Does your child receive special education or remedial services or attend a special class or special school?
☐ No ☐ Yes—kind of services, class, or school:

3. Has your child repeated any grades? ☐ No ☐ Yes—grades and reasons:

4. Has your child had any academic or other problems in school? ☐ No ☐ Yes—please describe:

When did these problems start? ____________

Have these problems ended? ☐ No ☐ Yes–when?

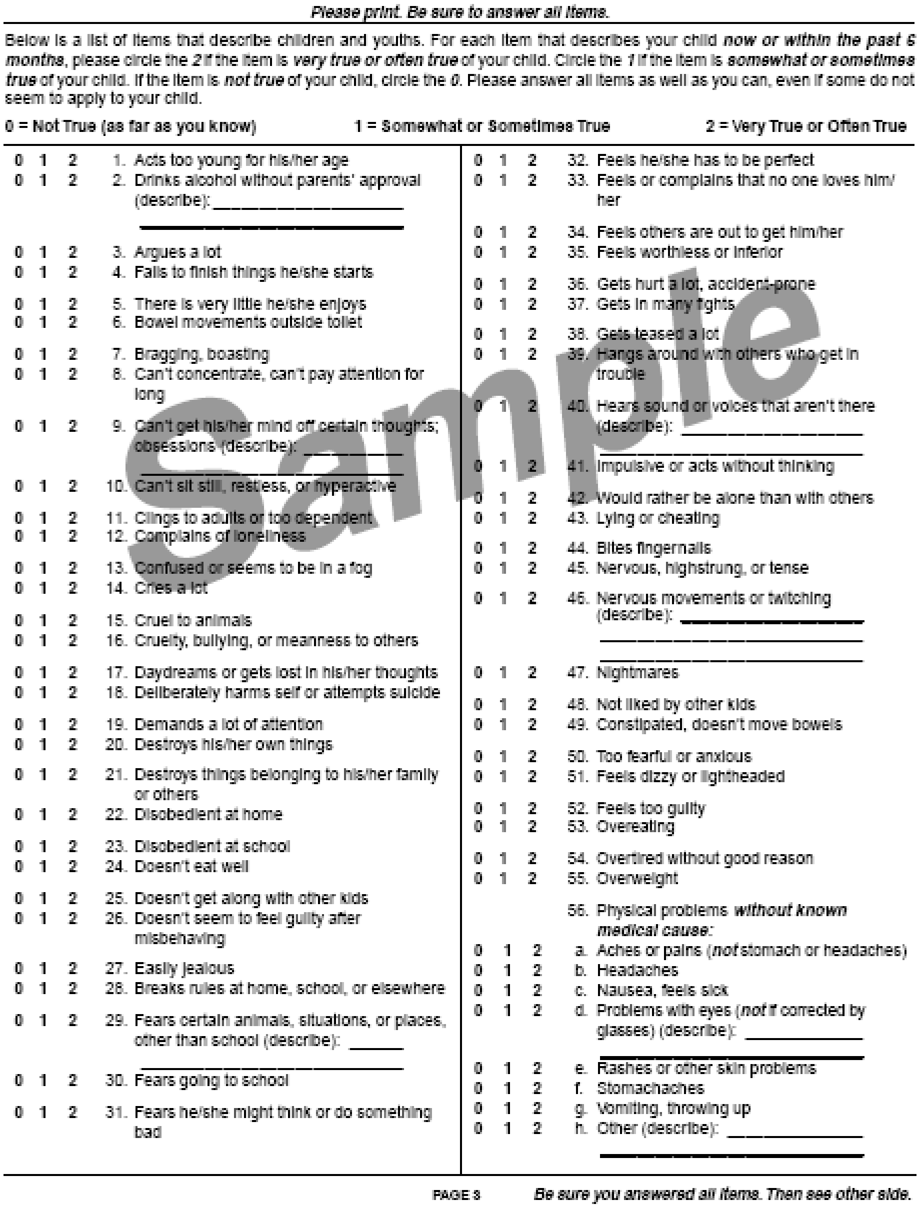
Does your child have any illness or disability (either physical or mental)? ☐ No ☐ Yes—please describe:

What concerns you most about your child?

Please describe the best things about your child.

PAGE 2

Be sure you answered all items.



Please print. Be sure to answer all items.

Below is a list of items that describe children and youths. For each item that describes your child ***now or within the past 6 months***, please circle the ***2*** if the item is ***very true or often true*** of your child. Circle the ***1*** if the item is ***somewhat or sometimes true*** of your child. If the item is ***not true*** of your child, circle the ***0***. Please answer all items as well as you can, even if some do not seem to apply to your child.

0 = Not True (as far as you know) **1 = Somewhat or Sometimes True** **2 = Very True or Often True**

0 1 2 1. Acts too young for his/her age
0 1 2 2. Drinks alcohol without parents' approval (describe): ______________________
____

0 1 2 3. Argues a lot
0 1 2 4. Fails to finish things he/she starts

0 1 2 5. There is very little he/she enjoys
0 1 2 6. Bowel movements outside toilet

0 1 2 7. Bragging, boasting
0 1 2 8. Can't concentrate, can't pay attention for long

0 1 2 9. Can't get his/her mind off certain thoughts; obsessions (describe): ___________
____
0 1 2 10. Can't sit still, restless, or hyperactive

0 1 2 11. Clings to adults or too dependent
0 1 2 12. Complains of loneliness

0 1 2 13. Confused or seems to be in a fog
0 1 2 14. Cries a lot

0 1 2 15. Cruel to animals
0 1 2 16. Cruelty, bullying, or meanness to others

0 1 2 17. Daydreams or gets lost in his/her thoughts
0 1 2 18. Deliberately harms self or attempts suicide

0 1 2 19. Demands a lot of attention
0 1 2 20. Destroys his/her own things

0 1 2 21. Destroys things belonging to his/her family or others
0 1 2 22. Disobedient at home

0 1 2 23. Disobedient at school
0 1 2 24. Doesn't eat well

0 1 2 25. Doesn't get along with other kids
0 1 2 26. Doesn't seem to feel guilty after misbehaving

0 1 2 27. Easily jealous
0 1 2 28. Breaks rules at home, school, or elsewhere

0 1 2 29. Fears certain animals, situations, or places, other than school (describe): ______
____
0 1 2 30. Fears going to school

0 1 2 31. Fears he/she might think or do something bad

0 1 2 32. Feels he/she has to be perfect
0 1 2 33. Feels or complains that no one loves him/her

0 1 2 34. Feels others are out to get him/her
0 1 2 35. Feels worthless or inferior

0 1 2 36. Gets hurt a lot, accident-prone
0 1 2 37. Gets in many fights

0 1 2 38. Gets teased a lot
0 1 2 39. Hangs around with others who get in trouble

0 1 2 40. Hears sound or voices that aren't there (describe): ____________________
____
0 1 2 41. Impulsive or acts without thinking

0 1 2 42. Would rather be alone than with others
0 1 2 43. Lying or cheating

0 1 2 44. Bites fingernails
0 1 2 45. Nervous, highstrung, or tense

0 1 2 46. Nervous movements or twitching (describe): ____________________
____
____
0 1 2 47. Nightmares

0 1 2 48. Not liked by other kids
0 1 2 49. Constipated, doesn't move bowels

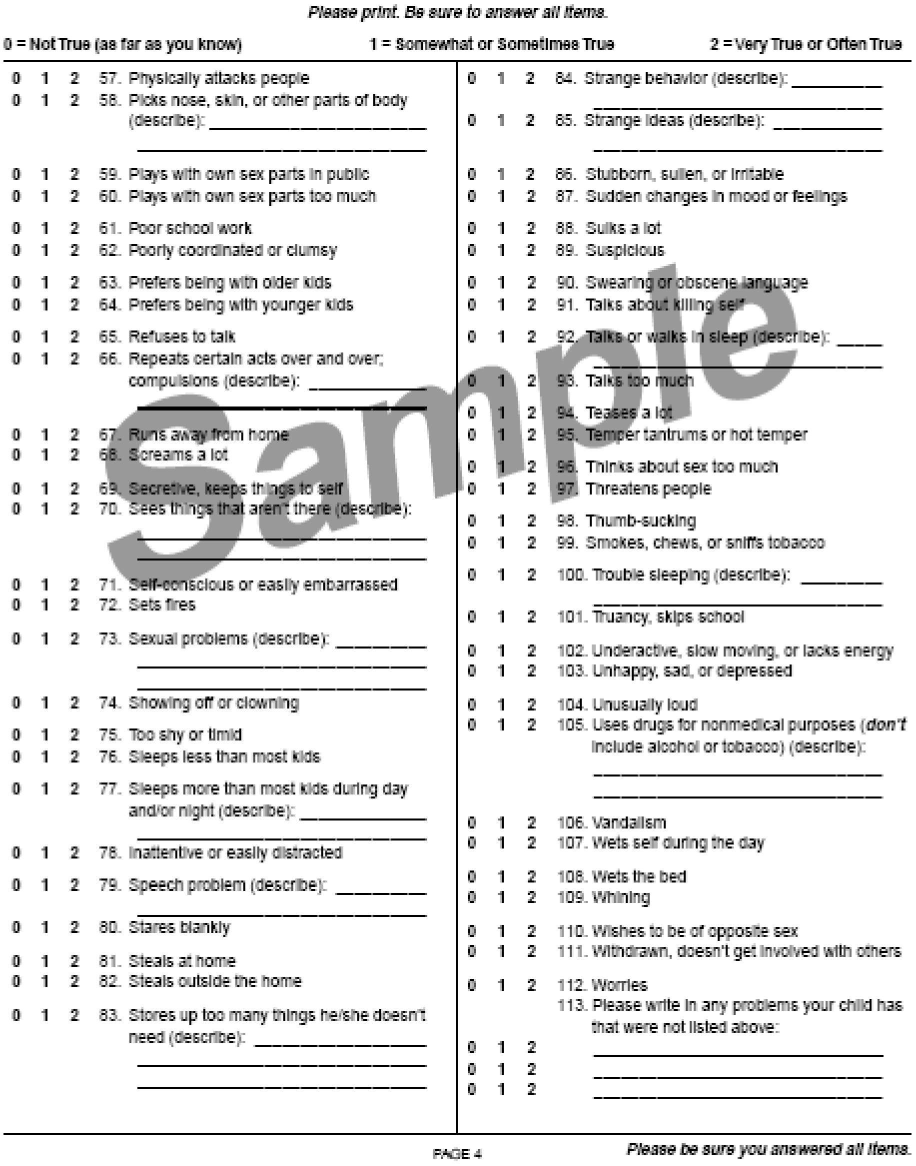
0 1 2 50. Too fearful or anxious
0 1 2 51. Feels dizzy or lightheaded

0 1 2 52. Feels too guilty
0 1 2 53. Overeating

0 1 2 54. Overtired without good reason
0 1 2 55. Overweight

56. Physical problems ***without known medical cause:***
0 1 2 a. Aches or pains (***not*** stomach or headaches)
0 1 2 b. Headaches
0 1 2 c. Nausea, feels sick
0 1 2 d. Problems with eyes (***not*** if corrected by glasses) (describe): ______________
____
0 1 2 e. Rashes or other skin problems
0 1 2 f. Stomachaches
0 1 2 g. Vomiting, throwing up
0 1 2 h. Other (describe): ________________
____

PAGE 3 ***Be sure you answered all items. Then see other side.***



Please print. Be sure to answer all items.

0 = Not True (as far as you know) 1 = Somewhat or Sometimes True 2 = Very True or Often True

0 1 2 57. Physically attacks people
0 1 2 58. Picks nose, skin, or other parts of body (describe): ____________
0 1 2 59. Plays with own sex parts in public
0 1 2 60. Plays with own sex parts too much
0 1 2 61. Poor school work
0 1 2 62. Poorly coordinated or clumsy
0 1 2 63. Prefers being with older kids
0 1 2 64. Prefers being with younger kids
0 1 2 65. Refuses to talk
0 1 2 66. Repeats certain acts over and over; compulsions (describe): ____________
0 1 2 67. Runs away from home
0 1 2 68. Screams a lot
0 1 2 69. Secretive, keeps things to self
0 1 2 70. Sees things that aren't there (describe): ____________
0 1 2 71. Self-conscious or easily embarrassed
0 1 2 72. Sets fires
0 1 2 73. Sexual problems (describe): ____________
0 1 2 74. Showing off or clowning
0 1 2 75. Too shy or timid
0 1 2 76. Sleeps less than most kids
0 1 2 77. Sleeps more than most kids during day and/or night (describe): ____________
0 1 2 78. Inattentive or easily distracted
0 1 2 79. Speech problem (describe): ____________
0 1 2 80. Stares blankly
0 1 2 81. Steals at home
0 1 2 82. Steals outside the home
0 1 2 83. Stores up too many things he/she doesn't need (describe): ____________
0 1 2 84. Strange behavior (describe): ____________
0 1 2 85. Strange ideas (describe): ____________
0 1 2 86. Stubborn, sullen, or irritable
0 1 2 87. Sudden changes in mood or feelings
0 1 2 88. Sulks a lot
0 1 2 89. Suspicious
0 1 2 90. Swearing or obscene language
0 1 2 91. Talks about killing self
0 1 2 92. Talks or walks in sleep (describe): ____________
0 1 2 93. Talks too much
0 1 2 94. Teases a lot
0 1 2 95. Temper tantrums or hot temper
0 1 2 96. Thinks about sex too much
0 1 2 97. Threatens people
0 1 2 98. Thumb-sucking
0 1 2 99. Smokes, chews, or sniffs tobacco
0 1 2 100. Trouble sleeping (describe): ____________
0 1 2 101. Truancy, skips school
0 1 2 102. Underactive, slow moving, or lacks energy
0 1 2 103. Unhappy, sad, or depressed
0 1 2 104. Unusually loud
0 1 2 105. Uses drugs for nonmedical purposes (*don't* include alcohol or tobacco) (describe): ____________
0 1 2 106. Vandalism
0 1 2 107. Wets self during the day
0 1 2 108. Wets the bed
0 1 2 109. Whining
0 1 2 110. Wishes to be of opposite sex
0 1 2 111. Withdrawn, doesn't get involved with others
0 1 2 112. Worries
113. Please write in any problems your child has that were not listed above:
0 1 2 ____________
0 1 2 ____________
0 1 2 ____________

PAGE 4

Please be sure you answered all items.

Appendix F
ASSENT FORM

Title: Perceptions of Adolescents with Emotional and/or Behavioral Difficulties

Why am I here?
You are being asked to take part in a research study because we are trying to learn more about the way adolescents perceive emotional and/or behavioral difficulties. Additionally, we hope to determine ways to improve treatment providers understanding of adolescent's perceptions related to emotional and/or behavioral difficulties. In this study, "perceptions" will include the view you have of yourself as well as the view you have of others with emotional and/or behavioral problems. You are invited to be in the study because you are currently participating in an inpatient treatment program.

Why are we doing this study?
The primary goal of this study is to understand how adolescents perceive emotional and/or behavioral difficulties. There is very little information about the way adolesents perceive emotional and/or behavioral difficulties or the impact those difficulties have on adolescent's well-being. This is important because nearly 50% of adolescents between the ages of 13-18 will experience emotional and/or behavioral difficulties.

What will happen to me?
If you agree to take part in this research study, you will be asked to complete a behavior checklist and engage in a semi-structured interview/survey addressing your perceptions about emotional and/or behavioral difficulties. The study will take place at the Utah Neuropsychiatric Institute (UNI) on the adolescent unit and will take about 30 minutes to complete. A brief file review will take place to gather demographic and clinical data including: age, gender, diagnosis, number of psychiatric admissions, and type of insurance provider.

Will the study hurt?
This study should not cause any pain or discomfort, but if at any point you wish to stop answering the questions please feel free to do so. The primary investigator (Camille Barraclough, MA) will assess distress and answer questions or concerns about your experience at the end of the semi-structured interview/survey. If after you complete the questions you experience any discomfort related to the study, therapy will be available on the unit by the primary investigator (Camille Barraclough, MA) or your primary therapist at UNI.

Will the study help me?
Your help with this study will help treatment providers and the general public better understand the way adolescents perceive emotional and/or behavioral difficulties. There is no promise that you will see any immediate changes or receive any immediate benefits from taking part in this study.

What if I have any questions?
You can ask any questions that you have about the study. If you have a question later that you didn't think of now, you can call me 406-396-2953 or ask me next time you see me on the unit.

Do my parents [guardians] know about this?
This study was explained to your parents [guardians] and they said that you could be in it. You can talk this over with them before you decide.

Do I have to be in the study?
You do not have to be in the study. No one will be upset if you don’t want to do this. If you don’t want to be in this study, you just have to tell me. You can say yes now and change your mind later. It's up to you.

Writing your name on this page means that that you agree to be in the study, and know what will be asked of you. If you decide to quit the study all you have to do is tell the person in charge, Camille Barraclough, MA.

____
Name of Minor (printed)

____ ___________________
Signature of Minor Date

____ ___________________
Signature of Researcher Date

Appendix G

INFORMED CONSENT

Title: Perceptions of Adolescents with Emotional and/or Behavioral Difficulties

Project Director(s):

Camille Barraclough, MA	Gregory R. Machek, PhD
University of Montana	University of Montana
32 Campus Drive, Skaggs 143	32 Campus Drive, Skaggs 143
Department of Psychology	Department of Psychology
Missoula, MT 59812	Missoula, MT 59812
406-396-2953	406-243-5546

Special instructions: This consent form may contain technical words that are new to you. If any words are not clear to you, please ask the person who gave you this form to explain them.

Purpose: You are being asked to participate in a research study focused on gathering information from adolescents currently experiencing emotional and/or behavioral difficulties. In this study, researchers will ask about your "perceptions" which will include your view yourself and your view of others with emotional and/or behavioral problems. We are inviting you to be in the study because you are currently participating in an inpatient treatment program focused on stabilization, assessment, and discharge planning. Your participation will help researchers better understand the way adolescents perceive emotional and/or behavioral difficulties, as well as inform changes that can be made to improve said experience.

Procedures: If you agree to take part in this research study, you will be asked to complete a behavior checklist and a semi-structured interview/survey addressing your perceptions of emotional and/or behavioral difficulties. The study will take place at the Utah Neuropsychiatric Institute (UNI) on the adolescent inpatient unit and will take about 30 minutes to complete. A brief file review will take place to gather demographic and clinical data including your: age, gender, race/ethnicity, diagnosis, number of psychiatric admissions, and type of insurance provider.

Risks/Discomforts: There is limited anticipated discomfort for those contributing to this study, so risk to participants is minimal. If at any point you wish to stop answering questions please feel free to do so. There is a small possibility answering the questions may cause you to become emotional or think about difficult experiences from your past. The primary investigator (Camille Barraclough, MA) will assess distress and answer questions or concerns about their experience as a participant. If you experience any sort of distress related to this research, therapy will be available on the unit by the primary investigator (Camille Barraclough, MA) or your primary therapist at UNI.

Benefits: Your help with this study will help inform treatment providers and the general public about the way adolescents perceive emotional and/or behavioral difficulties. There is no promise that you will see any immediate changes or receive any immediate benefits from taking part in this study.

Confidentiality: Only the researcher (Camille Barraclough, MA) and her faculty supervisor (Gregory R. Machek, PhD) will have access to the files and all will remain stored in a locked file cabinet in a secure location. Your signed consent form will be stored in a cabinet separate from the data. Your name will never be attached to the information you provide and all other identifying information will only be used in group statistics, no case studies will result from this research. If the results of this study are written in a scientific journal or presented at a scientific meeting, your name will not be used.

Compensation for Injury: Although we do not foresee any risk in taking part in this study, the following liability statement is required in all University of Montana consent forms.

> In the event that you are injured as a result of this research you should individually seek appropriate medical treatment. If the injury is caused by the negligence of the University or any of its employees, you may be entitled to reimbursement or compensation pursuant to the Comprehensive State Insurance Plan established by the Department of Administration under the authority of M.C.A., Title 2, Chapter 9. In the event of a claim for such injury, further information may be obtained from the University's Claims representative or University Legal Counsel. (Reviewed by University Legal Counsel, July 6, 1993)

Voluntary Participation/Withdrawal: Your decision to take part in this research study is entirely voluntary. You may refuse to take part in it or you may withdraw from the study at any time without penalty or loss of benefits. You may leave the study for any reason. If you decide to withdraw please inform the researcher and your information will be withdrawn from the data that will be analyzed as part of this study.

Questions: If you have any questions about the research now or during the study contact:

Camille Barraclough, MA	Gregory R. Machek, PhD
University of Montana	University of Montana
32 Campus Drive, Skaggs 143	32 Campus Drive, Skaggs 143
Department of Psychology	Department of Psychology
Missoula, MT 59812	Missoula, MT 59812
406-396-2953	406-243-5546

If you have any questions regarding your rights as a research subject, you may contact the Chair of the IRB through The University of Montana Research Office at 243-6670.

Statement of Consent: I have read the above description of this research study. I have been informed of the risks and benefits involved, and all my questions have been answered to my satisfaction. Furthermore, I have been assured that any future questions I may have will also be answered by a member of the research team. I voluntarily agree to take part in this study. I understand I will receive a copy of this consent form.

____
Printed Name of Participant

_____________________________________ ________________________
Participant's Signature Date

Authorization to Use and Disclose Protected Health Information for Research Purposes

---

Purpose. I authorize *University Neuropsychiatric Institute* to disclose the following protected health information to *Camille Barraclough, MA*: age, gender, race/ethnicity, diagnoses, type of insurance provider, and number of psychiatric admissions.

This protected health information is to be used/disclosed by *Camille Barraclough, MA* and the researcher's staff only for the purpose of conducting the research project entitled *"Perceptions of Adolescents with Emotional and/or Behavioral Difficulties."*

Camille Barraclough, MA may use/disclose my existing protected health information (PHI), or any created within the next six (6) months for up to thirty (30) months from the date of my signing this authorization.

Right to Refuse. I may refuse to sign this authorization if I so choose. If I decide not to sign the Authorization, I will not be allowed to participate in this study or receive any research related treatment that is provided through the study. However, my decision not to sign this authorization will not affect my current or future other treatment, current or future payment, enrollment in health plans, or eligibility for benefits at University Neuropsychiatric Institute.

Right to Revoke. At all times, I retain the right to revoke this Authorization. If I wish to revoke the authorization to use protected health information before this authorization expires in thirty (30) months, I will need to contact the primary investigator (Camille Barraclough, MA) who will provide me with a form requesting the revocation of authorization that will need to be signed and maintained by the researcher. Withdrawal of this Authorization shall be effective *except* to the extent that *Camille Barraclough, MA* has already used or disclosed information released prior to receiving notice of the revocation.

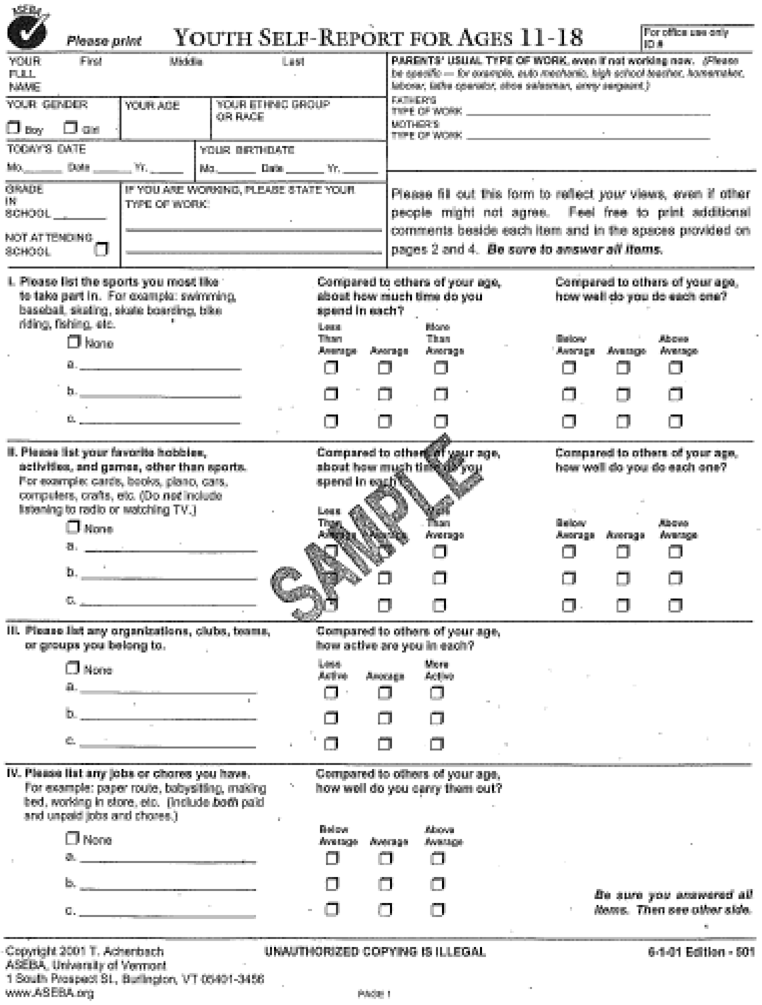
Potential for Re-disclosure. I understand that once my health information is disclosed under this Authorization, there is a potential that it could be re-disclosed outside this study and no longer covered by this Authorization. I also understand that there are laws that may require my individual health information to be disclosed for public purposes, such as if required for mandated reporting of abuse or neglect, judicial proceedings, health oversight activities and public health measures.

I am the research participant or personal representative authorized to act on behalf of the participant. I have read this information, and I will receive a copy of this authorization form after it is signed.

______________________________	______________________________
Signature of research participant or research participant's personal representative	Date
______________________________	______________________________
Printed name of research participant or research participant's personal representative	Description of personal representative's authority to act on behalf of research participant

Appendix H

ASEBA-YSR



ASEBA

Please print **YOUTH SELF-REPORT FOR AGES 11-18**

For office use only
ID #

YOUR FULL NAME First Middle Last

YOUR GENDER ☐ Boy ☐ Girl

YOUR AGE

YOUR ETHNIC GROUP OR RACE

TODAY'S DATE Mo.______ Date ______ Yr. ______

YOUR BIRTHDATE Mo.______ Date ______ Yr. ______

GRADE IN SCHOOL ________

NOT ATTENDING SCHOOL ☐

IF YOU ARE WORKING, PLEASE STATE YOUR TYPE OF WORK:

____

____

PARENTS' USUAL TYPE OF WORK, even if not working now. *(Please be specific — for example, auto mechanic, high school teacher, homemaker, laborer, lathe operator, shoe salesman, army sergeant.)*

FATHER'S TYPE OF WORK ______________________________

MOTHER'S TYPE OF WORK ______________________________

Please fill out this form to reflect *your* views, even if other people might not agree. Feel free to print additional comments beside each item and in the spaces provided on pages 2 and 4. ***Be sure to answer all items.***

I. Please list the sports you most like to take part in. For example: swimming, baseball, skating, skate boarding, bike riding, fishing, etc.

☐ None

Compared to others of your age, about how much time do you spend in each? / **Compared to others of your age, how well do you do each one?**

	Less Than Average	Average	More Than Average	Below Average	Average	Above Average
a. __________________	☐	☐	☐	☐	☐	☐
b. __________________	☐	☐	☐	☐	☐	☐
c. __________________	☐	☐	☐	☐	☐	☐

II. Please list your favorite hobbies, activities, and games, other than sports. For example: cards, books, piano, cars, computers, crafts, etc. (Do *not* include listening to radio or watching TV.)

☐ None

Compared to others of your age, about how much time do you spend in each? / **Compared to others of your age, how well do you do each one?**

	Less Than Average	Average	More Than Average	Below Average	Average	Above Average
a. __________________	☐	☐	☐	☐	☐	☐
b. __________________	☐	☐	☐	☐	☐	☐
c. __________________	☐	☐	☐	☐	☐	☐

III. Please list any organizations, clubs, teams, or groups you belong to.

☐ None

Compared to others of your age, how active are you in each?

	Less Active	Average	More Active
a. __________________	☐	☐	☐
b. __________________	☐	☐	☐
c. __________________	☐	☐	☐

IV. Please list any jobs or chores you have. For example: paper route, babysitting, making bed, working in store, etc. (Include *both* paid and unpaid jobs and chores.)

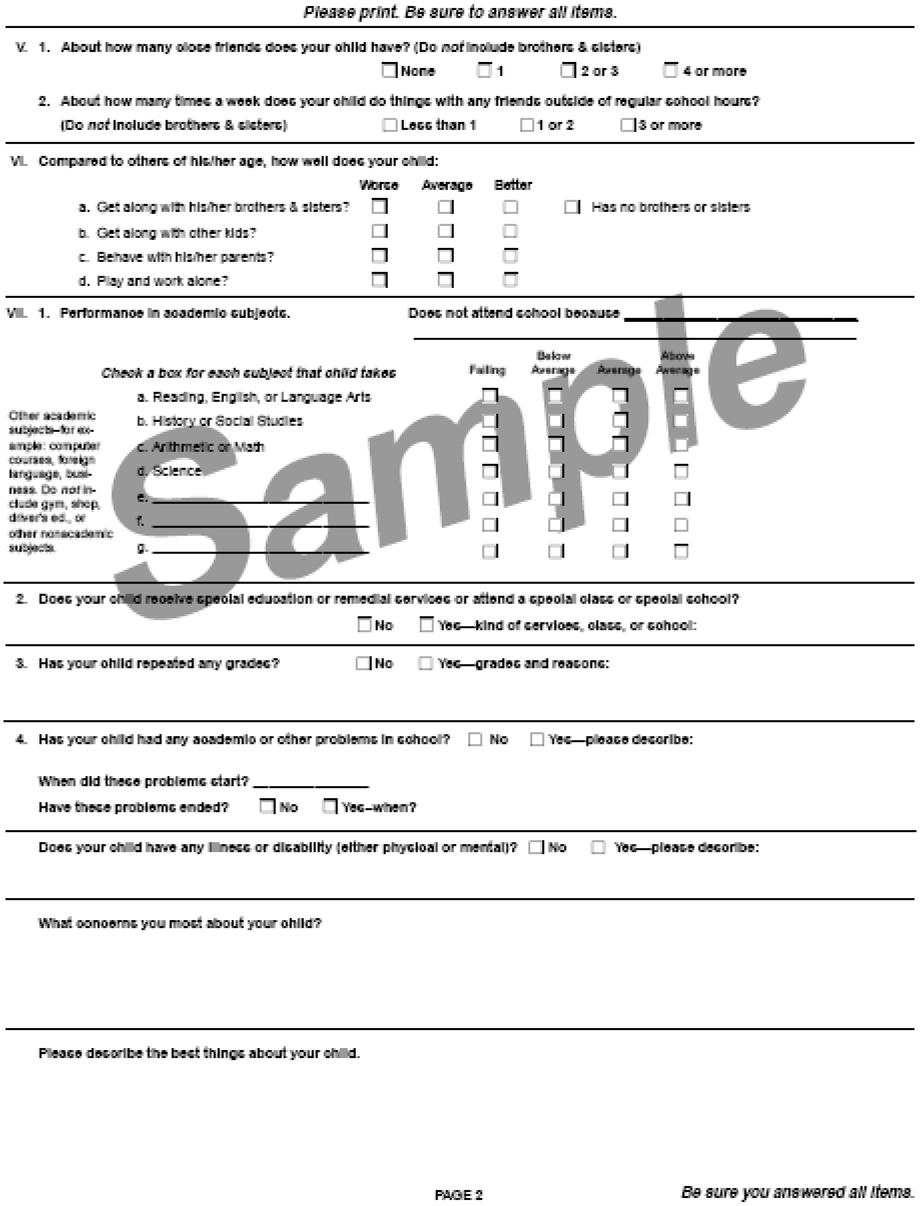
☐ None

Compared to others of your age, how well do you carry them out?

	Below Average	Average	Above Average
a. __________________	☐	☐	☐
b. __________________	☐	☐	☐
c. __________________	☐	☐	☐

Be sure you answered all items. Then see other side.

6-1-01 Edition - 501



Please print. Be sure to answer all items.

V. 1. About how many close friends does your child have? (Do *not* include brothers & sisters)
☐ None ☐ 1 ☐ 2 or 3 ☐ 4 or more

2. About how many times a week does your child do things with any friends outside of regular school hours?
(Do *not* include brothers & sisters) ☐ Less than 1 ☐ 1 or 2 ☐ 3 or more

VI. Compared to others of his/her age, how well does your child:

	Worse	Average	Better	
a. Get along with his/her brothers & sisters?	☐	☐	☐	☐ Has no brothers or sisters
b. Get along with other kids?	☐	☐	☐	
c. Behave with his/her parents?	☐	☐	☐	
d. Play and work alone?	☐	☐	☐	

VII. 1. Performance in academic subjects. Does not attend school because ____________________

Check a box for each subject that child takes

	Failing	Below Average	Average	Above Average
a. Reading, English, or Language Arts	☐	☐	☐	☐
b. History or Social Studies	☐	☐	☐	☐
c. Arithmetic or Math	☐	☐	☐	☐
d. Science	☐	☐	☐	☐
e. ____________	☐	☐	☐	☐
f. ____________	☐	☐	☐	☐
g. ____________	☐	☐	☐	☐

Other academic subjects—for example: computer courses, foreign language, business. Do *not* include gym, shop, driver's ed., or other nonacademic subjects.

2. Does your child receive special education or remedial services or attend a special class or special school?
☐ No ☐ Yes—kind of services, class, or school:

3. Has your child repeated any grades? ☐ No ☐ Yes—grades and reasons:

4. Has your child had any academic or other problems in school? ☐ No ☐ Yes—please describe:

When did these problems start? ____________

Have these problems ended? ☐ No ☐ Yes–when?

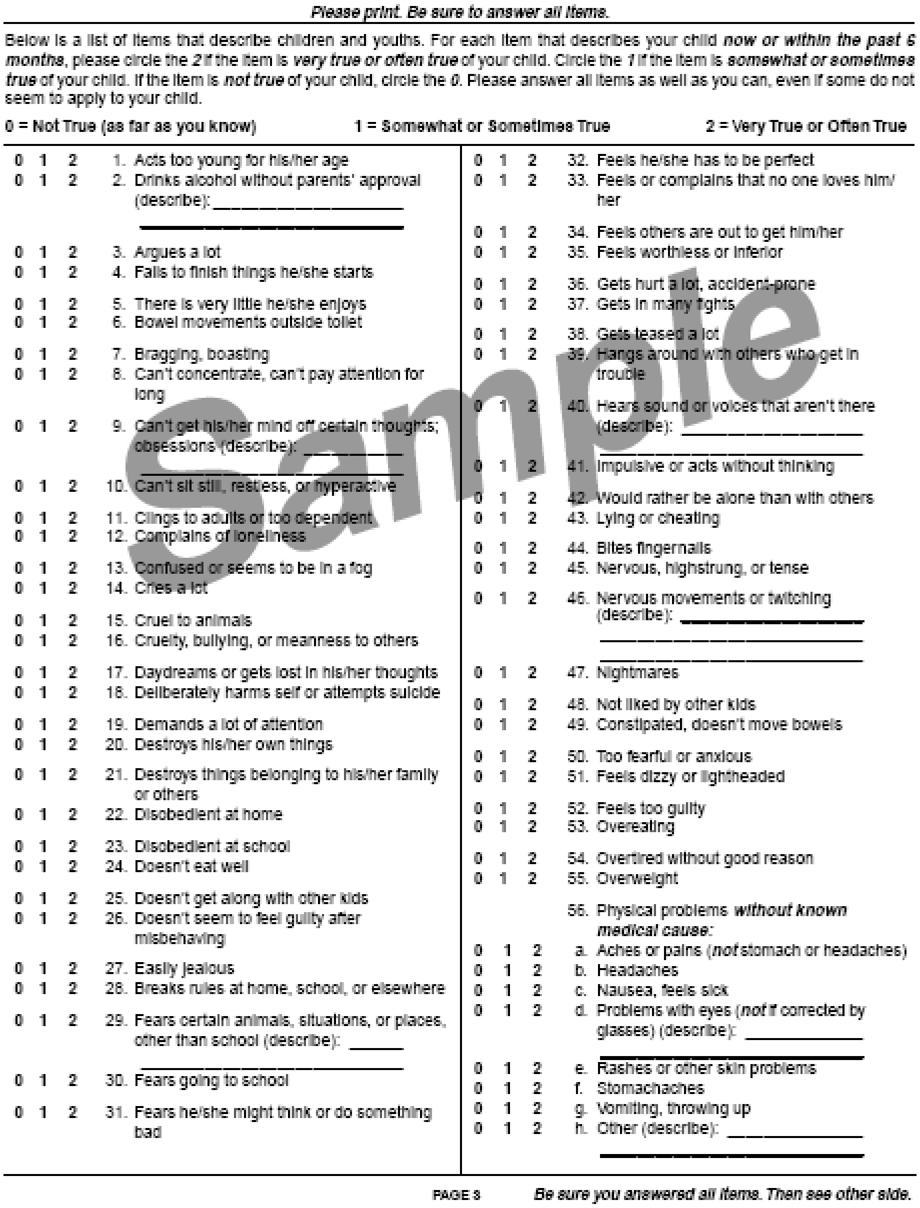
Does your child have any illness or disability (either physical or mental)? ☐ No ☐ Yes—please describe:

What concerns you most about your child?

Please describe the best things about your child.

PAGE 2

Be sure you answered all items.



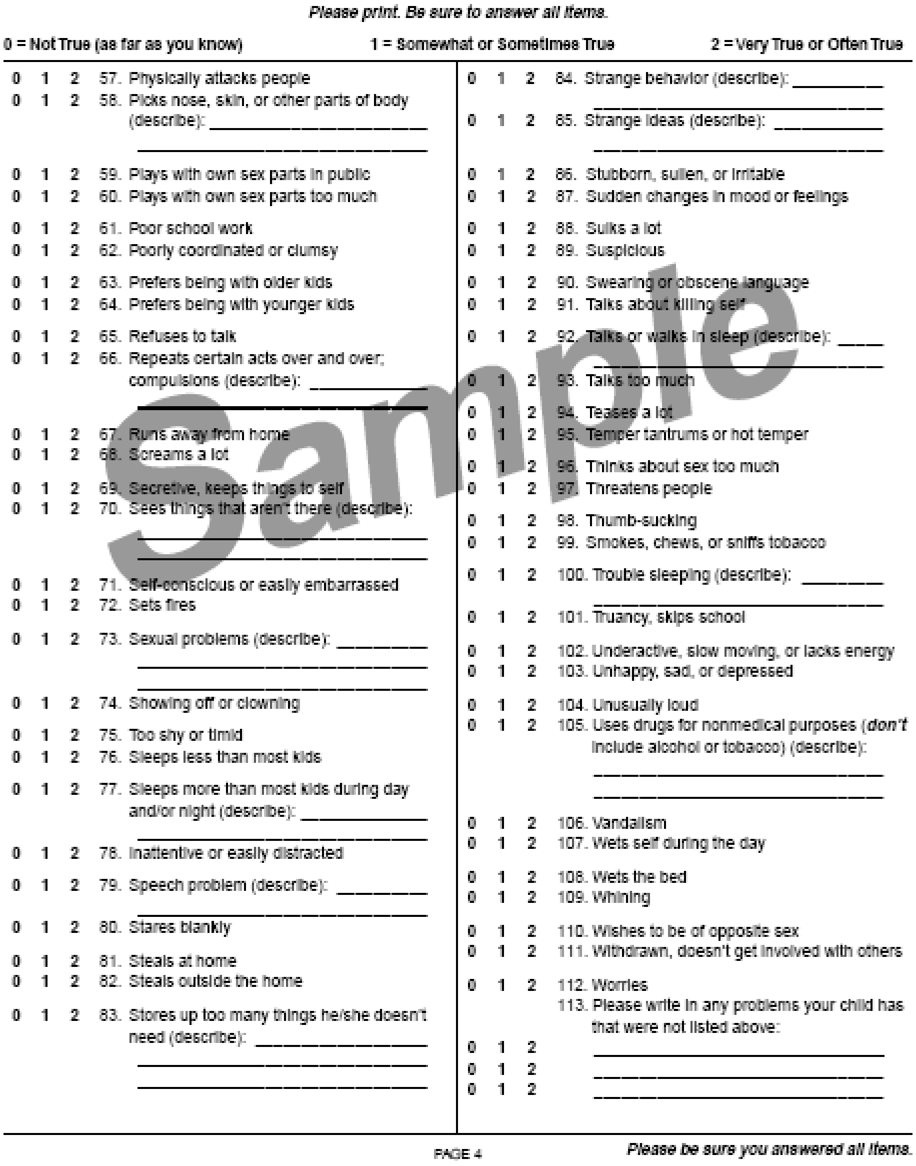
Please print. Be sure to answer all items.

Below is a list of items that describe children and youths. For each item that describes your child ***now or within the past 6 months***, please circle the ***2*** if the item is ***very true or often true*** of your child. Circle the ***1*** if the item is ***somewhat or sometimes true*** of your child. If the item is ***not true*** of your child, circle the ***0***. Please answer all items as well as you can, even if some do not seem to apply to your child.

0 = Not True (as far as you know) **1 = Somewhat or Sometimes True** **2 = Very True or Often True**

0 1 2 1. Acts too young for his/her age
0 1 2 2. Drinks alcohol without parents' approval (describe): ____________________
0 1 2 3. Argues a lot
0 1 2 4. Fails to finish things he/she starts
0 1 2 5. There is very little he/she enjoys
0 1 2 6. Bowel movements outside toilet
0 1 2 7. Bragging, boasting
0 1 2 8. Can't concentrate, can't pay attention for long
0 1 2 9. Can't get his/her mind off certain thoughts; obsessions (describe): ____________________
0 1 2 10. Can't sit still, restless, or hyperactive
0 1 2 11. Clings to adults or too dependent
0 1 2 12. Complains of loneliness
0 1 2 13. Confused or seems to be in a fog
0 1 2 14. Cries a lot
0 1 2 15. Cruel to animals
0 1 2 16. Cruelty, bullying, or meanness to others
0 1 2 17. Daydreams or gets lost in his/her thoughts
0 1 2 18. Deliberately harms self or attempts suicide
0 1 2 19. Demands a lot of attention
0 1 2 20. Destroys his/her own things
0 1 2 21. Destroys things belonging to his/her family or others
0 1 2 22. Disobedient at home
0 1 2 23. Disobedient at school
0 1 2 24. Doesn't eat well
0 1 2 25. Doesn't get along with other kids
0 1 2 26. Doesn't seem to feel guilty after misbehaving
0 1 2 27. Easily jealous
0 1 2 28. Breaks rules at home, school, or elsewhere
0 1 2 29. Fears certain animals, situations, or places, other than school (describe): ____________________
0 1 2 30. Fears going to school
0 1 2 31. Fears he/she might think or do something bad
0 1 2 32. Feels he/she has to be perfect
0 1 2 33. Feels or complains that no one loves him/her
0 1 2 34. Feels others are out to get him/her
0 1 2 35. Feels worthless or inferior
0 1 2 36. Gets hurt a lot, accident-prone
0 1 2 37. Gets in many fights
0 1 2 38. Gets teased a lot
0 1 2 39. Hangs around with others who get in trouble
0 1 2 40. Hears sound or voices that aren't there (describe): ____________________
0 1 2 41. Impulsive or acts without thinking
0 1 2 42. Would rather be alone than with others
0 1 2 43. Lying or cheating
0 1 2 44. Bites fingernails
0 1 2 45. Nervous, highstrung, or tense
0 1 2 46. Nervous movements or twitching (describe): ____________________
0 1 2 47. Nightmares
0 1 2 48. Not liked by other kids
0 1 2 49. Constipated, doesn't move bowels
0 1 2 50. Too fearful or anxious
0 1 2 51. Feels dizzy or lightheaded
0 1 2 52. Feels too guilty
0 1 2 53. Overeating
0 1 2 54. Overtired without good reason
0 1 2 55. Overweight
56. Physical problems ***without known medical cause:***
0 1 2 a. Aches or pains (***not*** stomach or headaches)
0 1 2 b. Headaches
0 1 2 c. Nausea, feels sick
0 1 2 d. Problems with eyes (***not*** if corrected by glasses) (describe): ____________________
0 1 2 e. Rashes or other skin problems
0 1 2 f. Stomachaches
0 1 2 g. Vomiting, throwing up
0 1 2 h. Other (describe): ____________________

PAGE 3 *Be sure you answered all items. Then see other side.*



Please print. Be sure to answer all items.

0 = Not True (as far as you know) 1 = Somewhat or Sometimes True 2 = Very True or Often True

0 1 2 57. Physically attacks people
0 1 2 58. Picks nose, skin, or other parts of body (describe): ____________________

0 1 2 59. Plays with own sex parts in public
0 1 2 60. Plays with own sex parts too much

0 1 2 61. Poor school work
0 1 2 62. Poorly coordinated or clumsy

0 1 2 63. Prefers being with older kids
0 1 2 64. Prefers being with younger kids

0 1 2 65. Refuses to talk
0 1 2 66. Repeats certain acts over and over; compulsions (describe): ____________________

0 1 2 67. Runs away from home
0 1 2 68. Screams a lot

0 1 2 69. Secretive, keeps things to self
0 1 2 70. Sees things that aren't there (describe): ____________________

0 1 2 71. Self-conscious or easily embarrassed
0 1 2 72. Sets fires

0 1 2 73. Sexual problems (describe): ____________________

0 1 2 74. Showing off or clowning

0 1 2 75. Too shy or timid
0 1 2 76. Sleeps less than most kids

0 1 2 77. Sleeps more than most kids during day and/or night (describe): ____________________

0 1 2 78. Inattentive or easily distracted

0 1 2 79. Speech problem (describe): ____________________

0 1 2 80. Stares blankly

0 1 2 81. Steals at home
0 1 2 82. Steals outside the home

0 1 2 83. Stores up too many things he/she doesn't need (describe): ____________________

0 1 2 84. Strange behavior (describe): ____________________

0 1 2 85. Strange ideas (describe): ____________________

0 1 2 86. Stubborn, sullen, or irritable
0 1 2 87. Sudden changes in mood or feelings

0 1 2 88. Sulks a lot
0 1 2 89. Suspicious

0 1 2 90. Swearing or obscene language
0 1 2 91. Talks about killing self

0 1 2 92. Talks or walks in sleep (describe): ____________________

0 1 2 93. Talks too much

0 1 2 94. Teases a lot
0 1 2 95. Temper tantrums or hot temper

0 1 2 96. Thinks about sex too much
0 1 2 97. Threatens people

0 1 2 98. Thumb-sucking
0 1 2 99. Smokes, chews, or sniffs tobacco

0 1 2 100. Trouble sleeping (describe): ____________________

0 1 2 101. Truancy, skips school

0 1 2 102. Underactive, slow moving, or lacks energy
0 1 2 103. Unhappy, sad, or depressed

0 1 2 104. Unusually loud
0 1 2 105. Uses drugs for nonmedical purposes (*don't* include alcohol or tobacco) (describe): ____________________

0 1 2 106. Vandalism
0 1 2 107. Wets self during the day

0 1 2 108. Wets the bed
0 1 2 109. Whining

0 1 2 110. Wishes to be of opposite sex
0 1 2 111. Withdrawn, doesn't get involved with others

0 1 2 112. Worries
113. Please write in any problems your child has that were not listed above:
0 1 2 ____________________
0 1 2 ____________________
0 1 2 ____________________

PAGE 4 *Please be sure you answered all items.*

Appendix I

Perceptions of Adolescents with Emotional and/or Behavioral Difficulties

I. Perceptions of Others

Vignette: 1 (Labeled)

Sam is a 14 year old with depression. In the last few months, Sam has been increasingly moody, isolating in the bedroom after school, and seems to have lost interest in favorite hobbies and friends. Sam often complains of feeling very tired even though Sam has been sleeping more than normal, and doesn't feel like eating. Sam has been having trouble concentrating in school and at home. Sam has said "I wish I hadn't been born" to family members. One of Sam's friends has also heard Sam talk about engaging in self-harming behaviors.

Or

Vignette: 2 (Non-Labeled)

Sam is a 14 year old who in the last few months has been increasingly moody, isolating in the bedroom after school, and seems to have lost interest in favorite hobbies and friends. Sam often complains of feeling very tired even though Sam has been sleeping more than normal, and doesn't feel like eating. Sam has been having trouble concentrating in school and at home. Sam has said "I wish I hadn't been born" to family members. One of Sam's friends has also heard Sam talk about engaging in self-harming behaviors.

	Never	**Rarely**	**Sometimes**	**Often**	**Always**
1. How often do you think Sam feels disrespected because of Sam's emotional or behavior problems?	1	2	3	4	5
2. How often do you think people have used the fact that Sam is in treatment to hurt Sam's feelings?	1	2	3	4	5
3. How often do you think Sam asks to join others when they are doing things Sam likes?**	1	2	3	4	5
4. How often do you think people would look down on Sam if they find out Sam is in treatment?	1	2	3	4	5
5. How often do you think Sam is avoided when people know that Sam is in treatment?	1	2	3	4	5
6. How often do you think Sam works well with classmates?**	1	2	3	4	5
7. How often do you think teachers and other adults treat Sam differently because of Sam's emotional or behavioral problems?	1	2	3	4	5
8. How often do you think some of Sam's own friends reject Sam after they find out Sam is in treatment?	1	2	3	4	5
	Strongly Disagree	**Disagree**	**Undecided**	**Agree**	**Strongly Agree**
9. Teens my age would tease or harass Sam if they found out Sam was receiving treatment for emotional or behavioral problems.	1	2	3	4	5

10. It is easy for Sam to make friends.**	1	2	3	4	5
11. Other adolescents believe that adolescents, like Sam, with emotional or behavioral issues are to blame for their problems.	1	2	3	4	5
12. Teens would not want to hang out with somebody who has emotional or behavioral problems.	1	2	3	4	5
13. It would be easy for Sam to stay calm when peers tease or harass Sam.**	1	2	3	4	5
14. Other adolescents tend to give kids with emotional or behavioral problems, like Sam, a hard time.	1	2	3	4	5
15. Other adolescents are afraid of adolescents who are getting psychological treatment. **	1	2	3	4	5
Self Perceptions- Thinking about your own experiences	**Strongly Disagree**	**Disagree**	**Undecided**	**Agree**	**Strongly Agree**
1. There is no reason for a person to hide the fact that he/she is receiving treatment for emotional or behavioral issues.	1	2	3	4	5
2. I usually wait until I know a person really well before I tell them I am getting treatment for emotional and/or behavioral issues.	1	2	3	4	5
3. When I meet people for the first time, I make a special effort to keep the fact that I am in treatment to myself.	1	2	3	4	5
4. I let people know when there is a problem.**	1	2	3	4	5
5. I often fear that someone will tell others about my emotional or behavioral problems without my permission.	1	2	3	4	5
6. I feel like I need to hide the fact that I have emotional or behavioral issues from my peers.	1	2	3	4	5
7. I often feel the need to hide the fact that I am in treatment.	1	2	3	4	5
8. I show others how I feel.**	1	2	3	4	5
9. If you are getting treatment, the best thing to do is to keep it to yourself	1	2	3	4	5
	Never	**Rarely**	**Sometimes**	**Often**	**Always**
10. How often do you feel different from others your age because you have emotional or behavioral problems?	1	2	3	4	5
11. How often do you ask others to do things with you?**	1	2	3	4	5
12. How often do you feel others may not like you if they know you have emotional or behavioral problems?	1	2	3	4	5
13. How often do you feel others will not want to be friends with you if they know you have emotional	1	2	3	4	5

or behavioral problems?					
14. How often do you consider yourself well-behaved and do things without being asked?**	1	2	3	4	5
15. How often do you worry that other adolescents are uncomfortable with you because of your emotional or behavioral problems?	1	2	3	4	5
16. How often do you feel embarrassed about your emotional or behavior problems?	1	2	3	4	5

III. Perceptions of Others

Vignette: 1 (Labeled)

Sam is a 14 year old with depression. In the last few months, Sam has been increasingly moody, isolating in the bedroom after school, and seems to have lost interest in favorite hobbies and friends. Sam often complains of feeling very tired even though Sam has been sleeping more than normal, and doesn't feel like eating. Sam has been having trouble concentrating in school and at home. Sam has said "I wish I hadn't been born" to family members. One of Sam's friends has also heard Sam talk about engaging in self-harming behaviors.

Or

Vignette: 2 (Non-Labeled)

Sam is a 14 year old who in the last few months has been increasingly moody, isolating in the bedroom after school, and seems to have lost interest in favorite hobbies and friends. Sam often complains of feeling very tired even though Sam has been sleeping more than normal, and doesn't feel like eating. Sam has been having trouble concentrating in school and at home. Sam has said "I wish I hadn't been born" to family members. One of Sam's friends has also heard Sam talk about engaging in self-harming behaviors.

	Never	**Rarely**	**Sometimes**	**Often**	**Always**
1. How often do you think Sam feels disrespected because of Sam's emotional or behavior problems?	1	2	3	4	5
2. How often do you think people have used the fact that Sam is in treatment to hurt Sam's feelings?	1	2	3	4	5
3. How often do you think Sam asks to join others when they are doing things Sam likes?**	1	2	3	4	5
4. How often do you think people would look down on Sam if they find out Sam is in treatment?	1	2	3	4	5
5. How often do you think Sam is avoided when people know that Sam is in treatment?	1	2	3	4	5
6. How often do you think Sam works well with classmates?**	1	2	3	4	5
7. How often do you think teachers and other adults treat Sam differently because of Sam's emotional or behavioral problems?	1	2	3	4	5
8. How often do you think some of Sam's own friends reject Sam after they find out Sam is in treatment?	1	2	3	4	5

	Strongly Disagree	**Disagree**	**Undecided**	**Agree**	**Strongly Agree**
9. Teens my age would tease or harass Sam if they found out Sam was receiving treatment for emotional or behavioral problems.	1	2	3	4	5
10. It is easy for Sam to make friends.**	1	2	3	4	5
11. Other adolescents believe that adolescents, like Sam, with emotional or behavioral issues are to blame for their problems.	1	2	3	4	5
12. Teens would not want to hang out with somebody who has emotional or behavioral problems.	1	2	3	4	5
13. It would be easy for Sam to stay calm when peers tease or harass Sam.**	1	2	3	4	5
14. Other adolescents tend to give kids with emotional or behavioral problems, like Sam, a hard time.	1	2	3	4	5
15. Other adolescents are afraid of adolescents who are getting psychological treatment. **	1	2	3	4	5

Appendix J
Semi-Structured Qualitative Survey

Participant # _____________

1. What brought you to the hospital?

Self-Perceptions

Do you believe you have emotional and/or behavioral problems? (if yes, continue)

YES NO

1. How, if at all, does having an emotional and/or behavioral issue affect how you think about yourself?

2. Is there anyone in your life that you do not want to know about your being here at the hospital? Why?

Perceptions of Others

1. How do you think people in Sam’s life, who know Sam is in treatment, will treat Sam when Sam gets home?

2. What do you think other people think about teens that have emotional and/or behavioral issues?

Appendix K

File Review Form

Participant # ________

Birth date: ____________________

Gender: Male Female Other

Race: ______Latino/Hispanic

_____White/Non-Hispanic

_____Asian American

_____African American

_____Native American

_____Other ________________

Insurance Provider: __Private State

Number of hospitalizations: _________________

Current Diagnoses: ________________________________

____

____

Met Inclusion Criteria: Yes No

Appendix L

Suicide Assessment

1. Are you thinking of hurting yourself (committing suicide)?

2. How long have you been thinking about suicide (frequency, intensity, duration)?

3. Do you have a plan? (if yes, get specifics)

4. Do you have the means to carry out the plan?

5. Have you attempted suicide in the past?

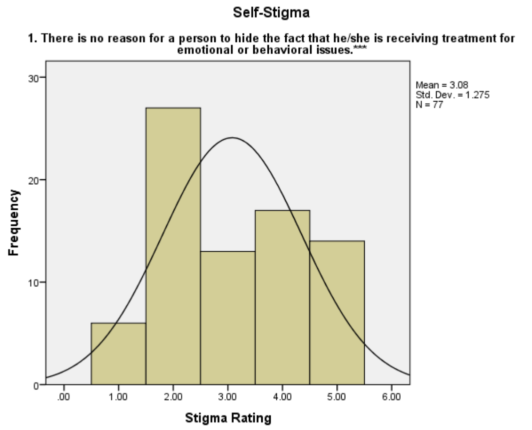
6. Has someone in your family committed suicide?

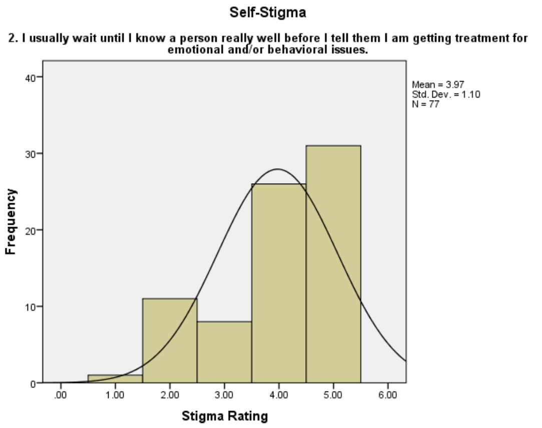
7. Is there anything or anyone to stop you (religious beliefs, pets, parents, etc.)?

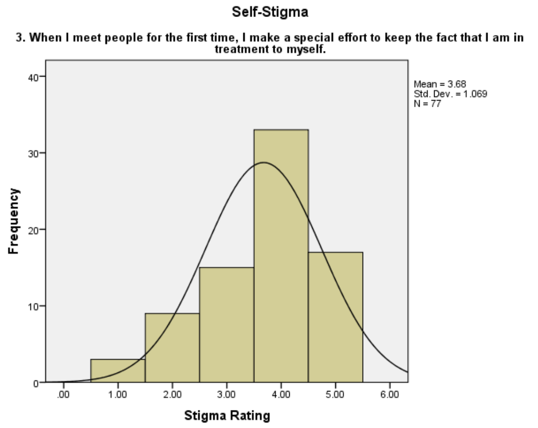
Depending on the responses:

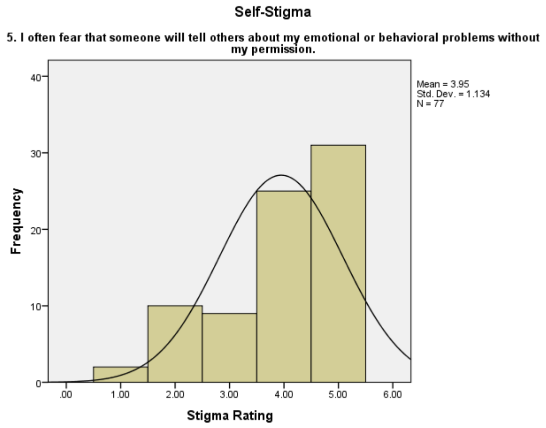
- Develop verbal safety contract
- Inform primary therapist
- Inform unit staff of increased risk
- Request close observation until adolescent is able to contract for safety and has met with primary therapist or psychiatrist

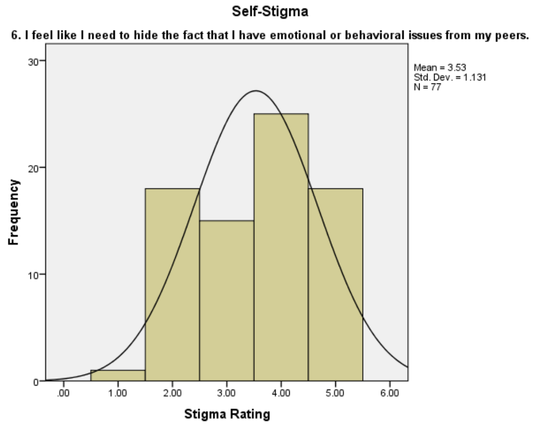
Appendix M: Stigma Histograms

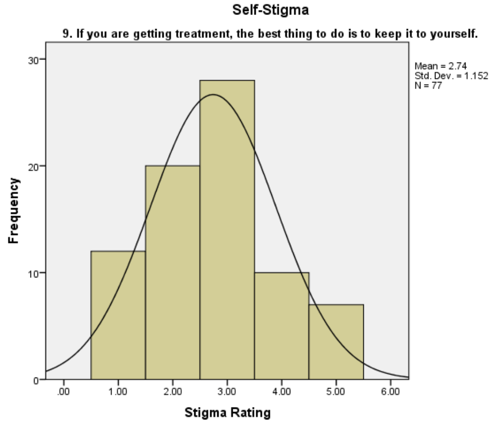




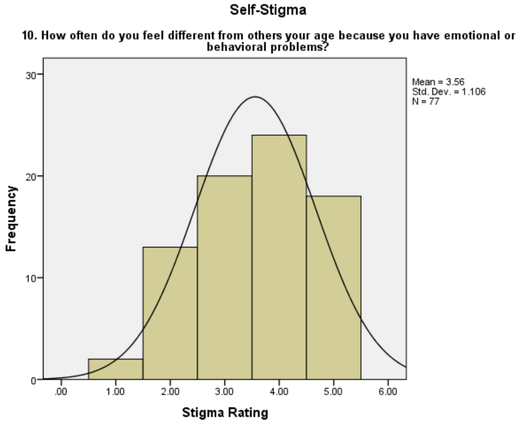




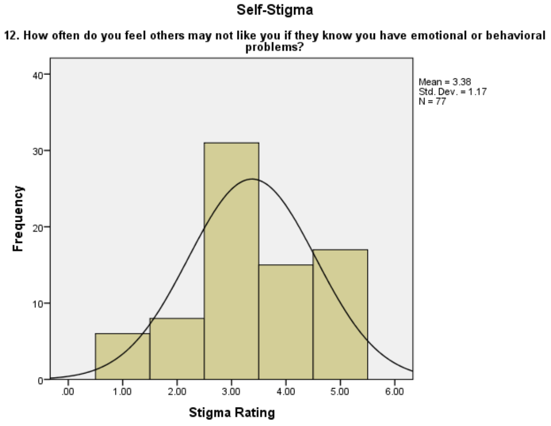



Self-Stigma

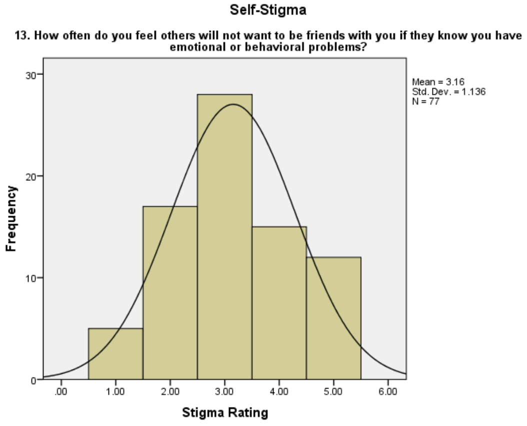
9. If you are getting treatment, the best thing to do is to keep it to yourself.


Self-Stigma

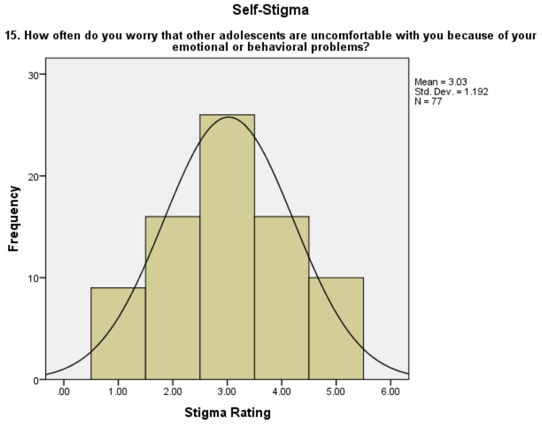
10. How often do you feel different from others your age because you have emotional or behavioral problems?


Self-Stigma

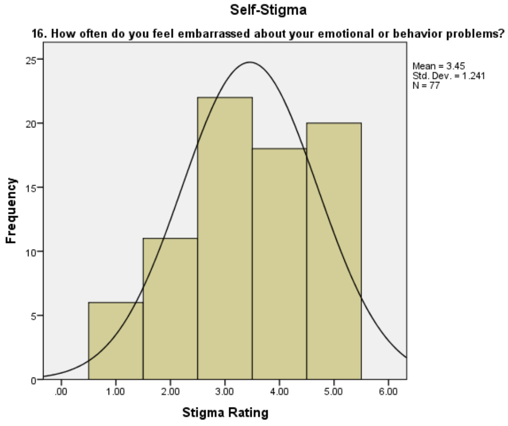
12. How often do you feel others may not like you if they know you have emotional or behavioral problems?


Self-Stigma

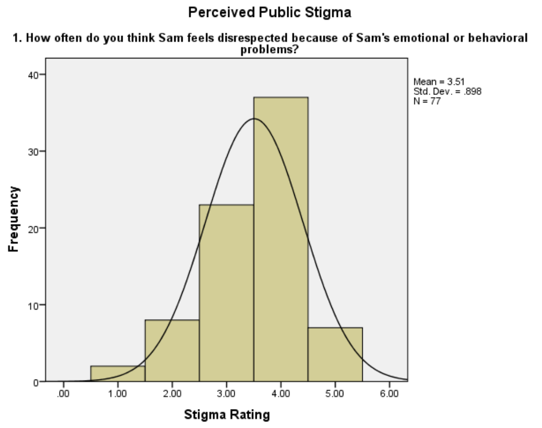
13. How often do you feel others will not want to be friends with you if they know you have emotional or behavioral problems?

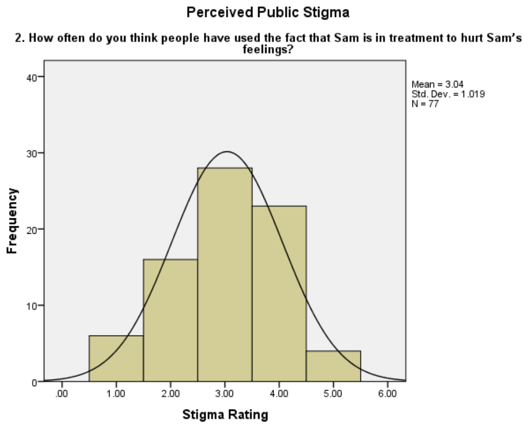

Self-Stigma

15. How often do you worry that other adolescents are uncomfortable with you because of your emotional or behavioral problems?


Self-Stigma

16. How often do you feel embarrassed about your emotional or behavior problems?


Perceived Public Stigma
1. How often do you think Sam feels disrespected because of Sam's emotional or behavioral problems?
Mean = 3.51
Std. Dev. = .898
N = 77
Frequency
0
10
20
30
40
.00
1.00
2.00
3.00
4.00
5.00
6.00
Stigma Rating


Perceived Public Stigma
2. How often do you think people have used the fact that Sam is in treatment to hurt Sam's feelings?
Mean = 3.04
Std. Dev. = 1.019
N = 77
Frequency
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20
30
40
.00
1.00
2.00
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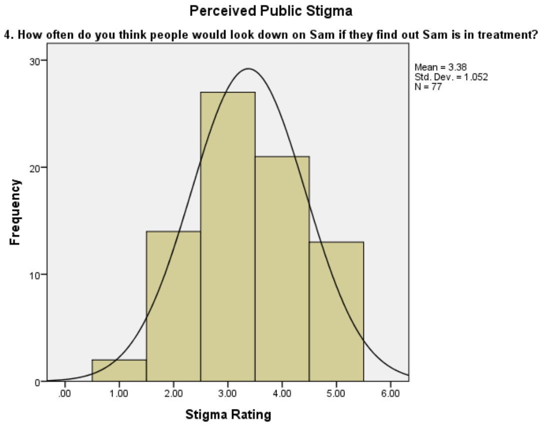
4.00
5.00
6.00
Stigma Rating


Perceived Public Stigma
4. How often do you think people would look down on Sam if they find out Sam is in treatment?
Mean = 3.38
Std. Dev. = 1.052
N = 77
Frequency
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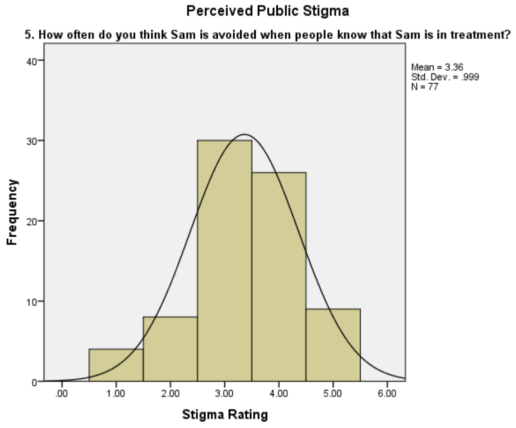
10
20
30
.00
1.00
2.00
3.00
4.00
5.00
6.00
Stigma Rating


Perceived Public Stigma
5. How often do you think Sam is avoided when people know that Sam is in treatment?
Mean = 3.36
Std. Dev. = .999
N = 77
Frequency
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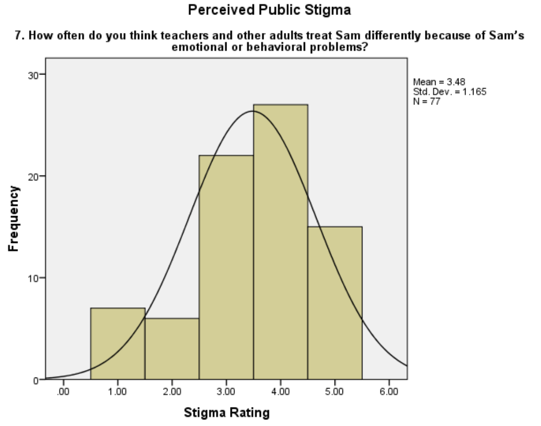
20
30
40
.00
1.00
2.00
3.00
4.00
5.00
6.00
Stigma Rating


Perceived Public Stigma
7. How often do you think teachers and other adults treat Sam differently because of Sam's emotional or behavioral problems?
Mean = 3.48
Std. Dev. = 1.165
N = 77
Frequency
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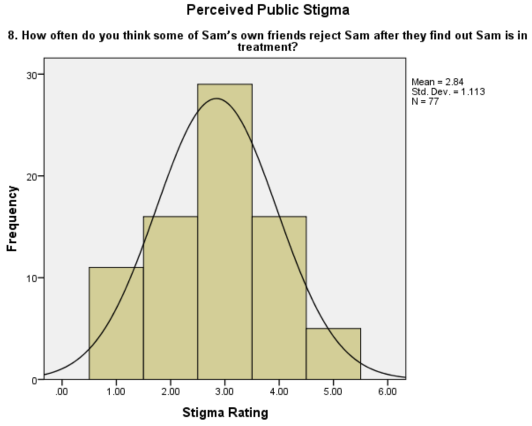
10
20
30
.00
1.00
2.00
3.00
4.00
5.00
6.00
Stigma Rating


Perceived Public Stigma
8. How often do you think some of Sam's own friends reject Sam after they find out Sam is in treatment?
Mean = 2.84
Std. Dev. = 1.113
N = 77
Frequency
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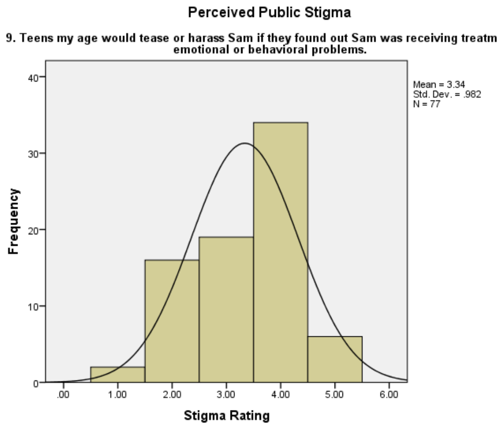
10
20
30
.00
1.00
2.00
3.00
4.00
5.00
6.00
Stigma Rating


Perceived Public Stigma
9. Teens my age would tease or harass Sam if they found out Sam was receiving treatment for emotional or behavioral problems.
Mean = 3.34
Std. Dev. = .982
N = 77
Frequency
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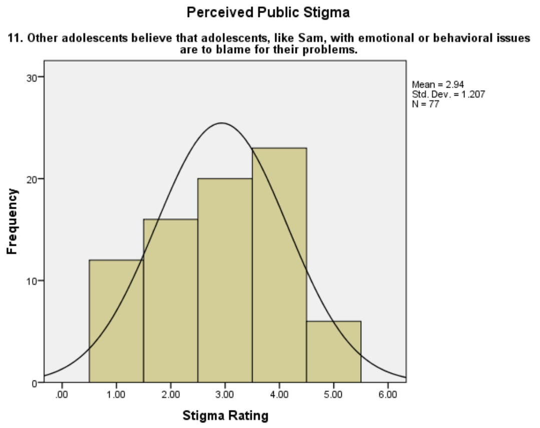
10
20
30
40
.00
1.00
2.00
3.00
4.00
5.00
6.00
Stigma Rating


Perceived Public Stigma
11. Other adolescents believe that adolescents, like Sam, with emotional or behavioral issues are to blame for their problems.
Mean = 2.94
Std. Dev. = 1.207
N = 77
Frequency
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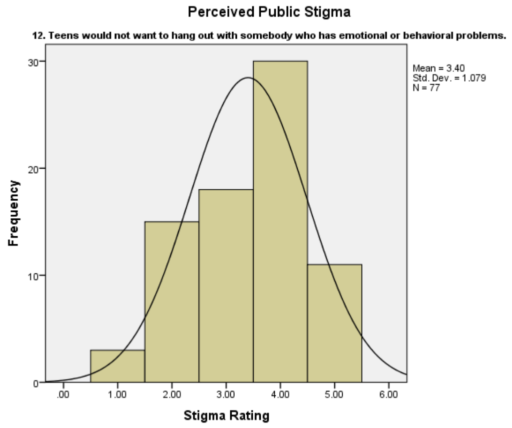
20
30
.00
1.00
2.00
3.00
4.00
5.00
6.00
Stigma Rating


Perceived Public Stigma
12. Teens would not want to hang out with somebody who has emotional or behavioral problems.
Mean = 3.40
Std. Dev. = 1.079
N = 77
Frequency
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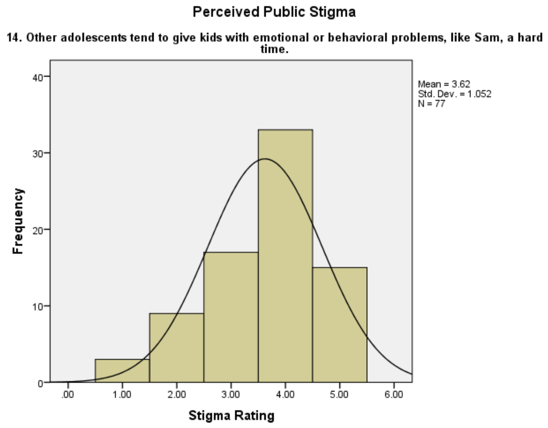
20
30
.00
1.00
2.00
3.00
4.00
5.00
6.00
Stigma Rating


Perceived Public Stigma
14. Other adolescents tend to give kids with emotional or behavioral problems, like Sam, a hard time.
Mean = 3.62
Std. Dev. = 1.052
N = 77
Frequency
0
10
20
30
40
.00
1.00
2.00
3.00
4.00
5.00
6.00
Stigma Rating