

Culture, Children, and Mental Health Treatment: Special Section on the National Stigma Study—Children

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Stigma—the prejudice and discrimination linked to individuals with mental illness—has been a mainstay of psychiatric and social science research. Yet a resurgence of academic, policy, and provider interest began in the mid-1990s and culminated in 1999 with the White House Conference on Mental Health and the first-ever Surgeon General's report on mental illness. Interest has continued, with several programmatic efforts surrounding the recommendations of the President's New Freedom Commission on Mental Health. As a result, we now have a solid, if not complete, knowledge base about the nature, levels, and correlates of community-based attitudes, beliefs, and behavioral dispositions toward adults with schizophrenia, depression, and addictive disorders.

Importantly, no such foundation had existed on the stigma that may accompany the serious emotional disorders that children and adolescents experience or on the attitudinal barriers to and social ramifications of seeking care. Given the high level of media and professional discussion about the rise in children's use of psychiatric medication, there is a surprising lack of empirical evidence about public perceptions of child and adolescent disorders, the parents and children who experience them, and the need for or reaction to available treatments.

In the absence of such data, the tendency is to fall back on what is

known about adults' mental illness and to transfer to our research our own impressions of how cultural subgroups—for example, different racial or ethnic groups or those with more education—think and feel about medical care and the mental health system. Sociologists and other social scientists have long predicted that as modern society became more complex, allowing greater freedom in social interactions, sociodemographic characteristics would be increasingly weak substitutes for culture or socioeconomic status. Indeed, the new wave of stigma research revealed the poor predictive power of these kinds of sociodemographic characteristics to tell us about public knowledge, the tendency to use services, and the willingness to fully engage persons with mental illness in their communities.

Even more important, we have come to see these characteristics as “culture,” forgetting that culture is a stockpile of beliefs, values, attitudes, predispositions, and norms held in the community. Equating culture with only those in poverty or members of minority groups is a serious misstep. All individuals in every society have a reservoir of embedded knowledge and attitudes that they use to address problems in their lives and the lives of their family members and friends. These beliefs, values, and norms create a cultural climate in which children and their parents experience the onset of mental health

problems, seek advice, come to or fail to come to the attention of the mental health system, and follow or do not follow medical recommendations.

In the special section that follows, we take an initial step in closing our knowledge gap by reporting the results of the first large-scale, nationally representative survey of public knowledge, attitudes, and beliefs on children's mental health. The National Stigma Study—Children (NSS-C) was developed as part of an ongoing series of special stigma-related modules of the General Social Survey (GSS), the longest-running monitor of American opinions. The GSS is a 90-minute face-to-face interview survey of the noninstitutionalized U.S. population. The NSS-C was fielded to one of two national samples as a 15-minute portion of the 2002 GSS (administered between February and June 2002; response rate 70%, margin of error $\pm 3.5\%$).

In this sample of 1,393 participants, 78% of respondents were white, 15% were African American, and 7% reported belonging to another racial or ethnic category (such as Asian American). Respondents' mean $\pm$ SD age was 46 ± 17.2 years. They had slightly more than a high school education (13.4 years) and a family income of $\$50,000 \pm \$39,500$. Married individuals constituted 48% of the sample, 50% of the sample worked full-time, and 71% of respondents were parents. With the exception of the slight overrepresentation of women (59%), the sample mirrored the U.S. population profile within sampling error.

The NSS-C uses a vignette technique developed in the GSS stigma studies to describe four children and

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adolescents. Vignettes [available at ps.psychiatryonline.org] were developed by the team's psychiatrist (Jensen) and revised for use in the survey format by the team's survey methodologist (Martin). Two vignettes describe children who meet diagnostic criteria for the *DSM-IV* mental health disorders of attention-deficit hyperactivity disorder (ADHD) and major depression. Control vignettes describe children who have asthma or routine but subclinical problems ("daily troubles"). No child is ever described as having a mental health problem.

Respondents were randomly assigned to one vignette condition, received a printed card describing the condition, and were read the description aloud by the interviewer. Vignettes were assigned as follows: ADHD, 340 respondents (24% of the sample); depression, 374 respondents (27%); asthma, 327 respondents (23%); daily troubles, 352 respondents (25%). The child's gender, ethnicity, and age were randomly varied across the vignettes. The NSS-C interview schedule is organized into three sections—evaluation of the situation and outcomes, general opinions of children with mental health problems and available treatment, and feelings of trust in physicians.

This special section addresses basic issues related to the provision of services for child and adolescent mental health problems. The first article takes on the general issue of public perception of the stigma associated with receiving services (1). The U.S. public appears to be almost evenly split on whether treatment has immediate and lasting social ramifications for children and their families, with just under half expecting rejection in school and later life. Attitudes on use of psychiatric medication for children are more uneven, with more than two-thirds of the public harboring negative sentiments about their effects. What shaped these attitudes was whether respondents saw psychiatric medications as effective and whether they trusted the physicians who provide services. Sociodemographic characteristics

gave only an occasional, and often inconsistent, inkling into attitudes.

We also explored issues of dangerousness and coercion (2). As with our earlier studies of adults, we found that the public associates mental illness, particularly depression, with the likelihood of engaging in violent behavior. Tragically, if individuals labeled the problem in the vignette as a "mental illness," they were more likely to perceive danger at a level beyond a sound evaluation of the behaviors described in the vignette. However, by including the case of asthma, we learned something more about what underlies public support for forced treatment. That is, the public is even more willing to use legal means to ensure that the child with asthma receives care, suggesting that concerns about parental (ir)responsibility may also underlie willingness to use legal means when it comes to minors.

Jane McLeod and her collaborators (3) explored public knowledge about ADHD, finding that about half of the population reported that they either had not heard of ADHD or were uncertain about what it is. The knowledge gap was greater among certain subgroups of the population, specifically men, African Americans, and those with less education. However, among those who reported greater knowledge, it was their evaluation of whether ADHD is a "real" disorder that shaped their endorsement of treatment. Not surprisingly, given societal discussion of psychiatric medications for children, more individuals supported the use of only counseling, although many supported a combination of counseling and medication. Here, cultural subgroups did not discriminate between the two options, suggesting that individuals' evaluations of ADHD are key to the acceptance of care.

Finally, Brea Perry and her colleagues (4) took advantage of a unique opportunity to compare public responses to adult and childhood depression. The news here is both encouraging and discouraging. The public holds a set of cultural beliefs and attitudes that suggests more

recognition of and support for treatment of childhood depression. More respondents saw childhood depression as serious, as needing treatment, and as resulting from underlying genetic or biological problems. However, these responses may be a result of the public's seeing children and adolescents with depression as more dangerous to others and as the result of bad character and poor parenting. On the one hand more respondents endorsed coerced care for children, but on the other hand they recommended that these problems not be discussed with family and friends.

Until now, we have known more about the stigma surrounding the occurrence of leprosy, diabetes, epilepsy, and developmental disabilities among children than we have about serious emotional disorders. This gap offered little scientific basis to understand the scope of the problem, the nature of cultural beliefs and norms, or the barriers of prejudice and discrimination. Our results suggest that the stigma attached to child and adolescent mental health problems is complex and not easily deduced from adult studies nor easily inferred from sociodemographic characteristics. This is a first step. We need to continue to understand the cultural climate surrounding child and adolescent mental health problems—the role it plays in facilitating or decreasing access and recovery for children with different disorders.

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