The Stigma of Mental Illness in Children & Adolescents: 

A Systematic Review

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**Abstract**

One in ten children and adolescents suffer with mental health difficulties at any given time, yet less than one third seek treatment. Untreated mental illness predisposes to longstanding individual difficulties and presents a great public health burden. Large scale initiatives to reduce stigmatization of mental illness, identified as a key deterrent to treatment, have been disappointing. This indicates the need for a clearer understanding of the stigmatizing processes faced by young people, so that more effective interventions are employed. A systematic review of the literature, assessing public stigma and self-stigma (i.e. internalized public stigma) specifically in children and adolescents with mental health difficulties (YP-MHD), was conducted. Forty-two studies were identified, confirming that stigmatization of YP-MHD is a universal and disabling problem, present amongst both children and adults. There was some variation by diagnosis and gender, and stigmatization was for the most part unaffected by labelling. Self-stigmatization led to more secrecy and an avoidance of interventions. The findings confirm that stigmatization of mental illness is poorly understood due to a lack of research and methodological discrepancies between existing studies. Implications for the findings are discussed, and suggestions made for future research.
1. Introduction

1.1. Mental health difficulties in children and adolescents

Mental health difficulties in children and young people are prevalent, estimated to affect 10%-20% of 5-18 year olds (Green et al., 2004; U.S. Public Health Service., 2000). Indeed, half of all lifetime cases of mental illness begin by age 14 (Sawyer at al., 2000; Kessler et al., 2005a; Kessler et al., 2005b). Untreated, they present a profound and longstanding impact on the individual and society (Patel et al., 2007; Jokela et al., 2009; Moses T., 2009a; Post et al., 2010). Having a mental health difficulty from a young age is associated with educational underachievement, family disruption, substance misuse and violence. Young sufferers experience poorer physical and sexual health than peers without mental health problems (Farina and Felner, 1973; Barkley, 2002; Donenberg and Pao, 2005), and have increased mortality rates from suicide and accidental injury (Gould et al., 2003; Aaron et al., 2004; Commission on Adolescence Suicide Prevention, 2005; Vijayakuma et al., 2005). On a societal level, public sector spending on untreated young sufferers presents a significant socioeconomic burden at £59,000 per child per year (Department of Health, 2001; Green et al., 2004) - 10 times higher than spending on unaffected peers (Scott et al. 2001; Romeo et al., 2006). For the purpose of this paper, YP (young persons) will be used to describe ‘children and adolescents without mental health difficulties’, and YP-MHD will be used to describe ‘children and adolescents under 18 with mental health difficulties’.

1.2. What is stigma?

Stigma has been defined as a deeply discrediting attribute associated with a given condition, directed towards those of considered lower social standing (Goffman, 1963). It consists of three key components: Stereotypes, prejudice and discrimination (Corrigan, 2005; Thornicroft, 2006). Stereotypes are learned, oversimplified and often negative attitudes embedded in society,
which allow individuals to generate quick impressions of specific subgroups (e.g. psychiatrists are eccentric), without necessarily believing in them (Jussim, 1995). Prejudices are endorsed stereotypes, meaning they are accompanied by negative emotional reactions. This inevitably leads to avoidance and social distancing, resulting in discrimination. Public stigma refers to the reaction of the general public towards stigmatized groups; it can be further differentiated into personal stigma (an individual’s own views of a stigmatized group) and perceived stigma (an individual’s perception of how others view a stigmatized group).

The extent to which a stigmatized individual is aware of public stigma has been termed stigma consciousness (Pinel, 1999; Thornicroft et al., 2007). The greater one’s stigma consciousness, the more likely they are to internalize public stigma, i.e. to self-stigmatize (Corrigan and Watson, 2002b). This makes them more likely to exhibit unfavorable behaviors in line with stereotypes (such as withdrawing from the general public), resulting in a perpetuating, negative cycle (Pinel, 1999). The result is one of impaired self-esteem and avoidance of treatment, leading to poorer long-term outcomes (Corrigan and Watson, 2002a).

1.3. Stigma in YP-MHD

It is increasingly evident that YP-MHD experience stigmatization, from both adults and children (Weiss, 1986; Adler and Wahl, 1998; Rose et al., 2007). Research has shown that YP-MHD are more stigmatized than children with physical illness or learning disability (Wilkins and Velicer, 1980) and that stigmatizing views and behaviors can develop from early childhood. Children as young as 6 appear to grasp everyday terms associated with mental illness and are well familiarized with cultural stereotypes by age 10, or even earlier if they themselves form part of a stigmatized group (Costello et al., 2006; Gale, 2007).

Stigmatizing views in YP are believed to develop as an assimilation of parent/carer views (Gale, 2007), media representation and cognitive development (Donenberg and Pao, 2005); and children are also more vulnerable to stigmatization due to their lower social status (Phares, 2003). There are key developmental considerations as to why understanding and targeting the stigmatization of YP-MHD, by both adults and children, is paramount. Firstly, the use of mental health services by YP-MHD is remarkably low (Sawyer et al., 2001; Essau, 2005; Zachrisson et al., 2006).
and stigma has been identified as an especially important barrier to help-seeking (Penn et al., 2005; Pescosolido et al., 2007b; Gulliver et al., 2010; Mukolo et al., 2010; Clement et al., 2014). Early intervention can result in long-term benefits (Barrett et al. 2001, Biederman, 2003; Hazell, 2007), which highlights the importance of accessing early effective care.

Secondly, stigmatization of YP-MHD may influence personal identity and independence in the long-term, as adolescence in particular is a key stage in the development of autonomy (Hinshaw S.P., 2005). Positive peer relationships are important not only for promoting self-esteem, adjustment and resilience (Brown and Lohr, 1987; Parker et al., 1995; Azmitia, 2002), but also result in better outcomes in YP-MHD (Bagwell, et al., 1989). Hence, if YP-MHD are stigmatized by peers, they are more likely to avoid seeking support (Chandra and Minkovitz, 2006), and less likely to do well in the future.

1.4. The purpose of this study

Unfortunately, stigmatization of YP-MHD is under-researched and not well understood (Hinshaw, 2005; McKeague et al, 2015), yet children are not necessarily stigmatized as their adult counterparts, and stigma is likely to have different long-term implications based on a child’s development. This lack of a more specific understanding has resulted in expensive large scale national initiatives with predominantly disappointing results (Rickwood et al., 2004). A clearer understanding of the origins and constructs of the stigmatization of YP-MHD could better inform future stigma reduction policies and improve engagement, peer relationships and outcomes. This paper sets out to systematically review the literature examining the stigmatization of YP-MHD by adults and peers. Specifically, the objectives of the review were to identify how stigmatization of YP-MHD was affected by diagnosis, age and demographics and which key themes identified in the adult literature pertained to YP-MHD. We hypothesized, in line with the adult literature, that:

- Not all conditions would be stigmatised equally and that certain stigmatizing views would be more prominent in certain conditions e.g. dangerousness in psychosis.

- females and individuals of higher education attainment would be less stigmatising towards YP-MHD;

- Stigmatisation of YP-MHD would increase with increasing age of unaffected peers
- Children and adolescents experience self-stigma and that this would have a detrimental effect on their emotional wellbeing.

2. Methods

Following PRISMA guidelines (Moher et al., 2009), Pubmed, PsycINFO, and the Cochrane Library were searched by 2 authors working collaboratively (AK and EK) for original research papers published between 1980 and 2015, examining stigmatization of YP-MHD. Search terms used were:

- Stigma: stigma, self-stigma, discrimination, prejudice, attitude, stereotype
- Mental illness: mental, psychiatric, psychological, AND illness OR disorder OR disturbance OR difficulty; Individual searches were also conducted for commonly diagnosed or significant conditions in childhood.
- Children and adolescents: adolescent* OR child* OR young person*

For a full list of the individual searches conducted please refer to supplement 1.

Abstracts (and where necessary full reports) were screened independently by AK and EK. Only English language, original research papers, assessing adults’ and YP stigmatizing views towards YP-MHD (specified age range 0-18) or self-stigma in YP-MHD were included in the review. Papers were excluded if:

- They did not address any component of mental health stigma
- They examined stigmatization towards individuals outside the 0-18 specified age range. If the papers concerned a wider age range but had extractable data for the 0-18 age group, these were included.
- They reviewed stigmatization following a stigma reducing intervention.
- The paper was a review article
- There was no extractable data
- They focused on stigmatization of mental health treatment, which we considered to be important enough to warrant a separate review.
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Eligible papers were hand-searched for relevant references meeting the same criteria. Data was extracted using a predetermined data extraction sheet. Methodological quality was assessed using the Effective Public Health Practice Project “Quality Assessment Tool for Quantitative Studies (EPHPP), which gave ratings of either strong, moderate or weak quality. Qualitative studies were assessed using the Critical Appraisal Skills Programme (CASP) (Public Health Resource Unit, 2006), resulting in ratings of either good or weak methodological rigor. Data and quality were assessed independently by two of the authors (AK and MK) and discrepancies were discussed until a consensus was reached.

Qualitative data was analyzed using a thematic analysis approach (Liamputtong and Ezzy, 2005). An initial coding framework was manually created by AK, deduced from examination of this literature and background reading on stigma in mental health disorders. AK and MK then applied the coding template to the papers, revising the framework as was necessary until themes were identified.

3. Results

The database searches returned 5925 items after the removal of duplicates. Screening titles and abstracts identified 27 studies which met all 3 inclusion criteria (Fig. 1). A hand-search of reference lists resulted in a further 15 relevant studies, resulting in a total of 42 studies for the purpose of this review.

Thirty-two papers examined YPs’ stigmatizing views towards YP-MHD (Table 1) and 7 papers examined adults’ stigmatizing views towards YP-MHD (Table 2). Of these 39 papers, 31 reported on quantitative findings, ranging in quality from strong (10 studies), to moderate (15 studies) and weak (6 studies). Eight papers were qualitative in nature, and all of good methodological rigour, but one (Poster et al, 1986). Only 3 papers were found, by the same author, examining self-stigmatization. These were mixed methods papers of robust methodological means.

Studies were mainly conducted in the USA, followed by the United Kingdom, Ireland, Israel, Australia, Iran, Canada, Greece and Japan. Papers were published between 1985 and 2015 and participant numbers varied from 24 to 55,520. The age of participants in papers examining YP views was 6-18. Papers examining adults’ views did not all specify participants’ age range. All
studies but one (Harris et al., 1992) included male and female participants. The following results summarize the main findings.

3.1. Key themes in the relationship between mental illness and stigma in YP-MHD

All 42 identified studies examining adults’ and YPs’ views evidenced that YP-MHD experienced stigmatization (Table 1). Most identified papers measured personal stigma. Regardless of assigned quality ratings, YP-MHD were consistently more stigmatized than unaffected peers (Peterson et al., 1985; Poster et al., 1986; Harris et al., 1992; Friedrich et al., 1996; Brook et al., 2000; Brook and Geva, 2001; Campbell et al., 2004.; Corrigan et al. 2005.; Ghanizadeh et al., 2006; Pescosolido et al., 2007a; Mukolo and Heflinger, 2011; O’Driscoll et al., 2012; Ohan et al., 2013; Swaim and Morgan, 2001; Bellanca and Pote, 2013). They were more stigmatized than peers with learning difficulties (Brook and Geva, 2001; Bellanca and Pote, 2013) and peers with physical health conditions and disability (Corrigan et al., 2005; Martin et al., 2007; Pescosolido et al., 2007a; Walker et al., 2008; Mukolo and Heflinger, 2011). The only condition more stigmatizing than mental health difficulties was alcohol misuse (Corrigan et al., 2005).

Interestingly, the only study that compared the same mental health condition in adults and children reported childhood depression to be considered more severe than adult depression (Perry et al., 2007). The key, identified themes related to stigmatization were consistent with findings in the adult literature. These were as follows:

3.1.1. Blame and responsibility

Ten studies commented on the role of ‘blame/responsibility’ on stigmatization. Seven examined YP views (Peterson et al., 1985; Corrigan et al., 2005; Coleman et al., 2009; Swords et al., 2011; O’Driscoll et al., 2012; Dixon et al., 2013; Dolphin and Hennessy, 2014; O’Driscoll et al., 2015) and two examined adults’ views (Martin et al., 2007; Mukolo and Heflinger, 2011). The degree of blame varied by diagnosis (e.g. Corrigan et al., 2005). High caliber qualitative and quantitative means found that where causal attributions were identified as beyond the child’s control, YP-MHD were not blamed (Peterson et al., 1985; Dolphin and Hennessy, 2014; O’Driscoll et al., 2015).

3.1.2. Behavioral Intentions and Social Distance
Eighteen studies, of varying scientific rigor, examined social distance/behavioral intentions, making it the most frequently assessed construct of stigmatization (Table 1). Blaming views were associated with a desire for greater social distance (Corrigan et al., 2005; Coleman et al., 2009; Dixon et al., 2013). The desire for social distance was also reliably related to diagnosis (Martin et al., 2007; Walker et al., 2008; Mukolo and Heflinger, 2011; Ohan et al., 2013); ethnicity (Mukolo and Heflinger, 2011); participant age (Martin et al., 2007) and identification with YP-MHD (Secker et al., 1999). Negative beliefs and attitudes were mirrored with negative behavioral responses (Harris et al., 1992; Moses T., 2010b). Positively, negative emotions and attitudes were not always predictive of peer exclusion (Friedrich et al., 1996; Swaim and Morgan, 2001; Campbell et al., 2004; O’Driscoll et al., 2012; Washington et al., 2012; Dolphin and Hennessy, 2014; Mavropoulou and Sideridis, 2014). Being white, female, and educated resulted in less social distance (Martin et al., 2007).

3.1.3. Dangerousness

Dangerousness was endorsed more frequently in YP-MHD than in YP with physical disorders or normal troubles (Pescosolido et al., 2007a). Participants rated female mental health sufferers as less dangerous than their male counterparts, and fourteen year olds as less dangerous than eight year olds (Poster et al., 1986). ‘Dangerousness’ was most often, but not always (O’Driscoll et al., 2012), associated with psychotic or behavioral disorders (Secker et al., 1999; Yoshioka et al., 2013), though it was also identified as a stigmatizing belief in depression (Reavley and Jorm, 2011). Children aged 12-13 more commonly reported perceptions of dangerousness than children aged 6-7 (Spitzer and Cameron, 1995). Surprisingly, greater familiarity increased perceptions of dangerousness in some YP-MHD (Corrigan et al., 2005). Adult studies mirrored the above findings (Martin et al., 2007; Pescosolido et al., 2007a) with some adults believing depressed children to be more dangerous than depressed adults (Perry et al., 2007).

3.1.4. Familiarity

Six studies commented on the role of familiarity (i.e. experiencing or knowing someone with a mental illness) in shaping attitudes towards YP-MHD (Secker et al., 1999; Corrigan et al., 2005; Law et al., 2007; Martin et al., 2007; Bellanca and Pote, 2013; Mavropoulou and Sideridis, 2014). Results were inconsistent: familiarity was identified as decreasing (Bellanca and Pote,
2013; Mavropoulou and Sideridis, 2014; Secker et al., 1999), increasing (Corrigan et al., 2005) or not affecting stigmatizing attitudes (Law et al., 2007). These differences could not be explained based on quality ratings. Amongst adult participants, personal contact with YP-MHD only reduced stigmatization if this contact was rated as positive (Martin et al., 2007).

3.2. Stigmatization varies by mental health diagnosis

In order to examine the first hypothesis, the authors searched the identified literature for stigmatizing views related to specific disorders. Eleven papers, of predominantly robust methodological means, looked at stigmatization by diagnosis (Table 1 & Table 2). Nine papers looked at depression (Poster et al., 1986; Secker et al., 1999; Walker et al., 2008; Coleman et al., 2009; Swords et al., 2011; O’Driscoll et al., 2012; Bellanca and Pote, 2013; Dixon et al., 2013; Ohan et al., 2013); 6 papers examined Attention deficit and hyperactivity disorder (ADHD) (Walker et al., 2008; Coleman et al., 2009; Swords et al., 2011; O’Driscoll et al., 2012; Bellanca and Pote, 2013; Ohan et al., 2013); 3 papers examined anxiety (Poster et al., 1986; Dixon et al., 2013; Yoshioka et al., 2013), 3 papers examined schizophrenia (Poster E., 1992; Secker et al., 1999; Yoshioka et al., 2013) 1 paper examined anorexia (Secker et al., 1999) and 1 paper studied Borderline personality disorder (Catthoor et al., 2015).

It is unclear whether ADHD or depression in children is more stigmatized by YP (Walker et al., 2008; Coleman et al., 2009; Swords et al., 2011; O’Driscoll et al., 2012; Bellanca and Pote, 2013). Adults appear to stigmatize depression more than ADHD (Ohan et al., 2013). Children with anxiety were favored over children with depression (Dixon et al., 2013). YP generally recognized schizophrenia as a mental illness (Poster E., 1992; Secker et al., 1999; Yoshioka et al., 2013), but were less clear about anorexia (Secker et al., 1999) and social phobia (Yoshioka et al., 2013). In Catthoor et al. (2015), borderline personality disorder was the highest rated condition with regards to stigmatizing experiences.

3.2.1. A mental health label does not necessarily increase stigma, but a negative behavioral description does.

Six studies looked at the interaction between mental health labels and actual/described behavior on stigmatizing attitudes towards YP-MHD; 4 studies examining YPs’ views (Harris et al., 1992;
Friedrich et al., 1996; Swaim and Morgan, 2001; Law et al., 2007) and 2 studies looked at adults (Martin et al., 2007; Ohan et al., 2013). The 4 studies examining YPs views found that the addition of a diagnostic label did not increase stigmatization but rather that participants were reacting to the behaviors present or described in the target children. This finding was consistent, despite varying methodological considerations. In the 2 carefully considered adult studies, despite using different quantitative tools, the addition of a mental health label or the recognition of the child as “mentally ill” did result in an increase in stigmatization. Although there appears to be a difference in the way adults and YP responded to the addition of a label, overall it is the delivery of a negative description and actual behavior that results in the most discrimination.

3.3. The impact of demographic factors on stigmatization

3.3.1. Age

The authors hypothesized that stigmatization of YP-MHD would increase with increasing age. Looking at the evidence, 15 papers studied the relationship between participants’ age and stigmatizing attitudes (Table 1). Despite different quality ratings, knowledge of mental health difficulties improved with increasing age, (Poster, 1992; Spitzer and Cameron, 1995; Brook and Geva, 2001). However, knowledge did not equate to acceptance. A number of high quality studies, predominantly comparing primary school children of 2 different ages, identified younger children to be more accepting than older children (Peterson et al., 1985; Swaim et al., 2001; Campbell et al., 2004; Bellanca and Pote, 2013; McKeague et al, 2015). This contrasted with the carefully considered work of Swords et al (2011), who found that adolescents aged 14-18 were more positive than children aged under 12, towards peers with ADHD and depression. Some studies found no differences in beliefs about YP-MHD (O’Driscoll et al., 2015).

Amongst adult participants, participant age did not impact on endorsed beliefs (Mukolo and Heflinger, 2011). In other studies the observed relationships were much more complex and dependent on other variables (O’Driscoll et al., 2012; Mavropoulou and Sideridis, 2014;). In two studies, attitudes were similar across grades, with subtle differences depending on the specific construct being measured (Mavropoulou and Sideridis, 2014). A comparison of 13-17 year olds with 18-24 year olds found that adolescents and their families had greater difficulty with disclosure and
acceptance than the older age group and their families (Elkington et al., 2012). Identifying with the character based on age was helpful in reducing stigma (Secker et al., 1999).

3.3.2. Gender

The relationship between gender and stigmatization was examined in twenty-three papers. As predicted in the hypothesis and identified in many studies of adults’ views, several robust studies identified more positive attitudes amongst female participants (Peterson et al., 1985; Martin et al., 2007; Reavley and Jorm, 2011; Swords et al., 2011; O’Driscoll et al., 2012; Dolphin and Hennessy, 2014; Yoshioka et al., 2014). At the same time, two well executed experiments, looking at Tourette Syndrome and Autism, found male participants to be more positive than females on certain measures of stigma (Friedrich et al., 1996; Swaim and Morgan, 2001) and a third study found boys to be better at recognizing deviant behavior (Spitzer and Cameron, 1995). Females were more likely to endorse stress as a causal factor for mental illness (Swaim and Morgan, 2001) and children were more likely to draw a “crazy person” as male, particularly if they were female (Poster et al., 1986). In some cases, participant gender had no impact on attitudes (Corrigan et al., 1995; Law et al., 2007; Mukolo and Heflinger, 2011; Washington et al., 2012; O’Driscoll et al., 2015) or findings were mixed (Mavropoulou and Sideridis, 2014). Being of the same sex as the child increased identification and reduced stigmatization (Secker et al., 1999). Boys reported more perceived peer stigmatization (Moses T., 2010b). There was some suggestion that children of both genders more often identified a child with psychological difficulties to be male, whereas children with physical difficulties were more often thought of as female (Roberts et al., 1981; Roberts et al., 1984).

3.3.3. Ethnicity

Few studies examined the role of ethnicity in this age group and findings are not comparable due to the quality of the studies and different ethnicities considered (Martin et al., 2007; Walker et al., 2008; Coleman et al., 2009; Moses T., 2010b; Mukolo and Heflinger, 2011; Elkington et al., 2012). There may be a trend towards ethnic minority groups holding more stigmatizing views but this requires further exploration.

3.3.4. Socioeconomic status
Despite hypothesizing that the evidence would find less stigmatizing attitudes amongst individuals of higher educational attainment, only 2 moderately rated papers (Roberts et al., 1984; McKeague et al., 2015) specifically examined the role of socio-economic status in children’s perceptions of psychological disturbance. These did not find significant differences between the beliefs of participants in high and low socioeconomic groups.

3.4. Self-Stigma

Only 3 studies were identified to examine the effects of self-stigma on emotional wellbeing in YP-MHD. These were all moderately rated and are summarized in Table 3 (Moses, 2009a; 2009b; 2010a). They looked at the same sample of sixty 12-18 year old YP-MHD. Self-labelling resulted in increased levels of self-stigma and depression and a trend towards a lower sense of self-mastery, but no impact on self-esteem (Moses, 2009a). Self-labelling practices were also more prominent in those with greater perceived public stigma, younger age at initiation of treatment and a higher socio-economic status. Older adolescents; lower age at treatment onset; and being of white ethnicity were linked to higher self-stigma. Less self-stigmatization was noted in those with externalizing disorders e.g. conduct disorder. Parental factors were also of relevance, in that parental optimism and a greater faith in the child’s ability to control behavior was protective against self-stigmatization, whereas parental secrecy increased self-stigma (Moses, 2010a), resulting in greater personal rejection and shame.

Correlations were also identified between adolescents understanding/perceptions of mental illness and self-stigma (Moses T., 2010a). Self-stigma increased in adolescents who perceived less control over their mental health difficulties and believed their problems to be life-long. Perceived causal explanations for illness that correlated with increased self-stigmatization were social problems, family problems, trauma, personality/way of thinking, and biological causes. The more causal factors identified per patient, the higher their self-stigma rating. Perceived economic difficulties as a causal factor were not correlated to self-stigmatizing beliefs. Parental secrecy regarding a child’s mental health problems also increased self-stigmatization among adolescents.

3.5. Perceived Stigma

Several reliable lines of evidence suggest that perceived stigma is greater than personal stigma (Friedrich et al., 1996; Moses T., 2010b; Elkington et al., 2012; Yoshioka et al., 2014). Girls
and participants aged 12 (as compared to participants aged 9) gave lower ratings for their classmates’ behavioral intentions (i.e. perceived stigma) towards a peer with autism than their own (personal stigma) (Swaim and Morgan, 2001). Greater peer stigmatization was also perceived by Whites, males, those receiving treatment from a younger age and youth with at least one mood disorder (Moses T., 2010b). A study examining whether children with ADHD viewed their behaviors as stigmatizing found that diagnosed children reported more perceived stigmatization on all fronts—teachers, parents and peers (Wiener et al., 2012), which had knock on effects on their global self-worth.

4. Discussion

4.1 Summary of findings

This paper is, to the best of the authors’ knowledge, the first systematic review examining stigma specifically towards YP-MHD. With this in mind, the authors investigated a number of predetermined hypotheses guided by the adult literature, and conducted a thematic analysis to start to build a picture of stigmatization in this age group.

Most notably, the evidence for stigmatization in YP-MHD was found to be significant, universal and multifaceted, with levels of stigmatization varying depending on the characteristics of both the stigmatizers and the stigmatized. There were several parallel themes between stigmatization of YP-MHD and adult patients. Specifically, YP-MHD, like their adult counterparts, suffered more discrimination than peers with other health needs; and themes such as familiarity and blame/responsibility had discreet effects on the degree of stigmatization individuals experienced. Consistent with the adult literature (Chandra and Minkovitz, 2006; Burke et al., 2008; Andersson et al., 2010) and our hypothesis, males were both more stigmatized and more stigmatizing than females, possibly as a result of the same widely held belief that males should be self-sufficient at managing mental health difficulties, leading to a lower uptake of treatment by male children. Also consistent with the hypotheses, there was evidence of variation in stigmatizing views based on participants’ diagnosis; and stigmatizing beliefs for the most part appeared to increase with age, possibly as children’s awareness of mental health difficulties increased. It was not felt possible to
comment on the impact of socioeconomic status and ethnicity, as studies were too few and varied in their methodology.

At a rate of 25%, Moses (2009a) found the prevalence of self-stigmatizing attitudes to be lower than adult self-stigmatization figures. The strongest evidence for stigmatization due to ‘labeling’ was also amongst adults. Today’s youth may be more open and supportive of YP-MHD, and the media’s role in normalizing MHD may be filtering through to YP-MHD such that they no longer feel as “singled out”. Although encouraging, this leaves much room for improvement for the 25% who will suffer self-stigmatizing attitudes, resulting in secrecy, denial and possible poorer outcomes (Moses T., 2010b).

4.2. Limitations

Whilst this review represents a promising start to our understanding of stigma towards YP-MHD, it has some limitations. Firstly, although 42 papers were identified, the rich variation in methodology, sample size and subsequent quality presented a challenge in comparing the data, as the concepts being investigated were not always like-for-like. This is in part due to the absence of standardized, validated tools, to compare experiences of stigma in YP-MHD, until recently (McKeague et al, 2015). Hence, this made it difficult to both draw comparisons between groups, and also investigate change over time. Secondly, the studies only reviewed a limited number of stigma components. Thirdly, due to the specific age range reviewed for the purposes of this paper, recent studies which overlapped with our age range but from which we could not readily extract child-specific data were excluded. Fourthly, most studies also looked at self-reporting of stigmatizing attitudes and this may not reflect true behavioral intentions. Finally, evidence regarding self-stigmatization came from only one sample of YP-MHD.

4.3. Future directions

It was very positive to identify that YP may present as more accepting than adults of YP-MHD. YP reacted to the behaviors displayed by their peers rather than any labels attached,
which suggests that naming the concern, so that appropriate interventions can be sought, may not have such a negative impact on YPs’ attitudes.

Future studies will need to further investigate sex-related aspects of stigmatizing attitudes and in particular why females have less stigmatizing views than males, and at what point self-stigmatization develops in both sexes. It is also important to understand why familiarity and knowledge do not necessarily equate to a reduction in stigmatizing views, as this may often be an assumption when designing projects to reduce stigmatization. There is a need to replicate the above work to ensure findings are reproducible and more widely applicable, and to invest in longitudinal studies to understand how stigma evolves across the developmental trajectory of children and adolescents.

Based on our findings, future investment should aim at

• Targeting gender differences with special emphasis on males e.g. working with boys’ schools and providing better pastoral care.
• Targeting worries associated with specific diagnoses e.g. dangerousness in psychosis.
• Offering tailored psychoeducation following diagnosis to YP-MHD and their family. The evidence has shown that those with a greater sense of responsibility for their illness have a higher level of self-stigma, so specific psychoeducation programs around this may reduce the impact of this false notion.
• Offering family orientated interventions. Unless stigma is addressed within families, transgenerational transmission of stigmatizing attitudes will continue to affect access to services and appropriate treatment of YP with mental health problems. Families in lower socioeconomic groups may be in greater need of intervention of this kind.
• Setting up anti-stigma campaigns led by individuals with an understanding of the wider cultural context. A ‘one size fits all’ approach is likely to fail in an ethnically diverse society, as different cultural beliefs come into play from childhood, influencing attitudes and discrimination.

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Table 1:
Detailed analysis of studies investigating young persons (YP) stigmatizing views towards young people with mental health difficulties (YP-MHD)
<table>
<thead>
<tr>
<th>No.</th>
<th>Studies</th>
<th>Country</th>
<th>Sample Size</th>
<th>Sex</th>
<th>Ethnicity</th>
<th>Purpose</th>
<th>Methods</th>
<th>Outcome Measures</th>
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<tbody>
<tr>
<td>1</td>
<td>Bellanca et al 2013</td>
<td>UK</td>
<td>273</td>
<td>11</td>
<td>9.2 yrs</td>
<td>To examine social distance (conative attitudes) and attitudes towards a peer with one of: no difficulties, ADHD, depression, learning disabilities (LD)</td>
<td>Children listened to 4 vignettes describing a peer with either depression, ADHD, LD or no concerns. Questionnaires completed in school.</td>
<td>ACL, SAI², QST¹</td>
</tr>
<tr>
<td>2</td>
<td>Brook et al 2001</td>
<td>Israel</td>
<td>104</td>
<td>14-18</td>
<td>50%</td>
<td>To investigate knowledge and attitudes towards ADHD and LD</td>
<td>Pupils completed an anonymous questionnaire in class, designed by the authors and validated by a panel of professionals.</td>
<td>Author designed Questionnaire, validated by other professionals.</td>
</tr>
<tr>
<td>3</td>
<td>Campbell et al 2004</td>
<td>USA</td>
<td>576</td>
<td>6-12</td>
<td>Mean 10</td>
<td>To assess behavioral intentions towards an unfamiliar peer with autism.</td>
<td>Pupils randomly assigned to watch same videos as in Swaim et al. Each pupil watched 2 videos: one of a typical peer with a description, and one of a 12 year old male peer with a description and without an explanation for autism.</td>
<td>Pupils perceived more tolerance and positive towards peers with LD than ADHD and LD. Higher knowledge however did not necessarily mean greater tolerance.</td>
</tr>
<tr>
<td>4</td>
<td>Catthoor et al 2015</td>
<td>Belgium</td>
<td>133</td>
<td>Mean age 16.6</td>
<td>85%</td>
<td>To investigate a stigmatization in YP-MHD diagnosed with a personality disorder, as compared to YP diagnosed with other mental health difficulties.</td>
<td>YP-MHD admitted to an inpatient unit underwent a standardized assessment process and also completed the stigma measures.</td>
<td>S T I G - M A C O N S C I O U S N E S S Q U E S T I O N N A I R E P E R C E I V E D D E V A L U A T I O N - S T I M U L A T I O N - D I S C R I M I N A T I O N</td>
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</tbody>
</table>
## The Stigma of Mental Illness in Children and Adolescents: A Systematic Review

<table>
<thead>
<tr>
<th>Study</th>
<th>Country</th>
<th>Age</th>
<th>Gender</th>
<th>Ethnicity</th>
<th>Purpose</th>
<th>Methods</th>
<th>Outcome Measures</th>
<th>Quality</th>
<th>Questionnaire (PDDQ)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coleman et al 2009</td>
<td>USA</td>
<td>8-18</td>
<td>926 F (48.7%)</td>
<td>61.2% White, 14.8% African American, 17% Hispanic, 3.6% Asian, 1% Pacific Islander</td>
<td>To investigate: 1. what is causal attribution about childhood mental illness by age, race, ethnicity and gender. 2. To assess social distance</td>
<td>Children were randomly assigned vignettes depicting a child with one of: ADHD, depression, or a child who responded to an online survey.</td>
<td>Weak</td>
<td>SDS*</td>
<td></td>
</tr>
<tr>
<td>Corrigan et al 2005</td>
<td>USA</td>
<td>13 to 19 years (mean ±SD age, 16.4±2.5 years)</td>
<td>171 F (56%)</td>
<td>16% Asian American, 19% Black, 3% Hispanic, 2% Native American</td>
<td>To investigate: 1. differences in stigmatization between mental and physical health conditions; 2. the effect of causal attributions and beliefs about dangerousness on discriminatory behaviors; 3. The role of familiarity on stigmatizing views</td>
<td>Adolescents were presented with one of 4 vignettes, peers with mental illness; peer with mental illness peer with mental illness; peer with alcohol misuse; peer with leukemia.</td>
<td>Moderate</td>
<td>Revised Level of Contact Report</td>
<td></td>
</tr>
<tr>
<td>Dixon et al 2013</td>
<td>UK</td>
<td>8 and 9 (Year 4)</td>
<td>84 M and F</td>
<td>100% White British Childen</td>
<td>To explore children’s understanding of peers with emotional difficulties.</td>
<td>Children were read vignettes of non-gender specific experiencing anxiety and depression, e.</td>
<td>Interpretaive phenomenological analysis (IPA) to assess children's understanding of peers with emotional difficulties.</td>
<td>Good</td>
<td></td>
</tr>
</tbody>
</table>

### Notes
- **No. of Bar Qualitative studies**: The number of studies included in the systematic review.
- **Views of Young People**: The perspective of children and adolescents on mental illness.
- **Country**: The geographic location of the study.
- **Age**: The age range or specific age group of participants.
- **Gender**: The gender composition of the sample.
- **Ethnicity**: The ethnic diversity within the sample.
- **Purpose**: The research question or objective of the study.
- **Methods**: The methods used to collect and analyze data.
- **Outcome Measures**: The measures used to assess the outcomes of the intervention or study.

### Questions
- **Questionnaire (PDDQ)**: The assessment tool used to measure the level of stigma.
- **Quality**: The methodological quality of the study.*
<table>
<thead>
<tr>
<th>No.</th>
<th>Study</th>
<th>Country</th>
<th>Year</th>
<th>Grade/ Age</th>
<th>Participant</th>
<th>Gender</th>
<th>Ethnicity</th>
<th>Purpose</th>
<th>Methods</th>
<th>Outcome Measures</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>8</td>
<td>Dolphin et al 2014</td>
<td>Ireland</td>
<td>2014</td>
<td>14.75 - 17.08 years</td>
<td>Male &amp; Female</td>
<td>50</td>
<td>To investigate adolescents' perceptions of a peer with depression, looking at causal attributions and views of personal responsibility</td>
<td>Structural Equation Modeling used to calculate the relationship between causal attributions and perceived responsibility and social acceptance or exclusion</td>
<td>Personal Control Subscale of Revised Causal Dimension Scale (CDS II)</td>
<td>Responsibility: Peers with depression were more likely to be pilloted and socially accepted if they were not felt to be responsible for their depression. Gender: Female participants were more accepting than males. Also, depressed female peers were more accepted than depressed male peers. Social distance: Unlike previous research, negative emotional reactions did not necessarily predict peer exclusion.</td>
<td></td>
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<tr>
<td>9</td>
<td>Elkington et al 2012</td>
<td>USA</td>
<td>2012</td>
<td>13-24</td>
<td>Female</td>
<td>5% Latino</td>
<td>To investigate mental illness related stigma in a hospital outpatient treatment</td>
<td>Young people were interviewed and thematic analyses conducted to look at stigma at individual and structural levels</td>
<td>Thematic analysis of individual interviews</td>
<td>Stigmatization of YP-MHD: Children rated the child with TS more favorably than the child with TS &amp; explanatory behavior; or child with TS and no explanatory information. ACL: The Activity Preference Scale The (Modiﬁed) Four-Item Questionnaire</td>
<td>Perceived stigma in YP-MHD: 13-17 year old specifically reported experiences whereby their families denied or rejected their illness or need for treatment.</td>
</tr>
<tr>
<td>10</td>
<td>Friedrich et al 1996</td>
<td>USA</td>
<td>1996</td>
<td>9-11</td>
<td>Male</td>
<td>55.5%</td>
<td>To investigate differences in attitudes and behavioral intentions towards a hypothetical peer with and without Tourette Syndrome (TS); and to look at differences by gender and grade</td>
<td>Children were presented with a video depicting either a child without TS; child with TS &amp; explanatory information; or child with TS and no explanatory information.</td>
<td>ACL: The Activity Preference Scale The (Modiﬁed) Four-Item Questionnaire</td>
<td>Stigmatization of YP-MHD: Children reported global negative features of the vignettes. Gender: Boys rated the child more negatively than girls. Perceived stigma: Children reported greater perceived stigmatization than personal stigmatization. Social distance: Behavioral intentions did not vary between groups and reported that they were just as likely to include each child in activities.</td>
<td></td>
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<tr>
<td>11</td>
<td>Harris et al 1992</td>
<td>USA</td>
<td>1992</td>
<td>Grades 3-6 (9-12 years)</td>
<td>Male</td>
<td>70%</td>
<td>To examine the effects of stigmatizing information and actual diagnosis on peer interactions</td>
<td>A perceivers’ child and target child of similar age were paired to play. 'The perceivers' were told their partner (target) had a hyperactive behavior. The instructor once again played the game and children responded to questions on the stigma of negative expectancy.</td>
<td>9-point Likert scale questionnaire used to rate ‘meanness’ affect and performance</td>
<td>Social distance: Perceivers told that their partner had ADHD behaviors were less friendly, talked less and reported global negative features about their partner. The authors report this as the ‘hate effect’ i.e. information about a single negative characteristic resulted in a global negative impression of the target, tainting the perceivers’ entire perception. In summary, the stigmatizing information affected both general impressions and actual behavior.</td>
<td></td>
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<tr>
<td>12</td>
<td>Law et al 2007</td>
<td>UK</td>
<td>2007</td>
<td>11-12</td>
<td>Male &amp; Female</td>
<td>8% Caucasian</td>
<td>To investigate the impact of labeling on attitudes and behavioral intentions of children towards a hypothetical peer with ADHD.</td>
<td>Children were randomly assigned a vignette of a child with ADHD: without any label; with an ‘attention deﬁcit hyperactivity’ label; or with an ‘attention deﬁcit hyperactivity disorder’, after which they completed the outcome measures</td>
<td>ACL: SAQ</td>
<td>Stigmatization of YP-MHD: General attitudes were negative towards the hypothetical child in all 3 vignettes, and mainly consisted of beliefs that the child was ‘careless’, ‘lonely’, ‘crazy’ and ‘stupid’. There were no significant differences in findings between the children in the 3 groups, indicating that children were predominantly responding to the ADHD behaviors described rather than to the label in 2 of the vignettes i.e. independent of labeling. Familiarity: Familiarity with the child did not have an effect on behavioral intentions or attitudes. Gender: No significant gender differences noted. The vignette child was more commonly assumed to be male than female. Social distance/behavioral intentions: The more positive children...</td>
<td></td>
</tr>
</tbody>
</table>
### The Stigma of Mental Illness in Children and Adolescents: A Systematic Review

<table>
<thead>
<tr>
<th>Study</th>
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<th>Outcome Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>13.</td>
<td>Greece</td>
<td>4-6</td>
<td>10.57</td>
<td>Caucasians</td>
<td>To examine the knowledge, attitudes and empathy of children with and without classroom contact with ASD peers.</td>
<td>ACL-SAQ E S (Basic Empathy Scale)</td>
<td>Age &amp; Gender: There were positive changes for both boys and girls, with gender differences based on the specific construct being measured. Subtle differences in the strength of positive findings were noted between gender and grades. Familiarity: Children who had had actual classroom contact with peers with ASD held more positive attitudes and behavioral intentions and were more empathic than children who hadn't had classroom contact. This difference was maintained at 3 months. Social Distance/behavioral intentions: See above.</td>
</tr>
<tr>
<td>14.</td>
<td>Ireland</td>
<td>9-16</td>
<td>56%</td>
<td>White</td>
<td>Develop a questionnaire assessing stigmatizing views in children and adolescents towards peers with mental health difficulties.</td>
<td>The Peer mental Health Stigmatization Questionnaire (PMHSS) was developed for this study and administered in class. It measures stereotypes, prejudice, discrimination and lower status.</td>
<td>The PMHSS showed good validity and reliability. Stigmatization of YP-MHD: YP were able to distinguish between personal stigma (their own stigmatizing views) and societal stigma (other people's stigmatizing views) towards YP-MHD. Socioeconomic status (SES): Did not show any differences in stigmatizing views. Age: Older participants were more stigmatizing of YP-MHD than younger children.</td>
</tr>
<tr>
<td>15.</td>
<td>USA</td>
<td>12-18</td>
<td>50.76</td>
<td>White</td>
<td>To examine adolescents perceptions of being “treated differently” by family, peers and school staff as a result of a mental health difficulty.</td>
<td>Qualitative analysis of mixed method, semi-structured interviews</td>
<td>Qualitative analysis of mixed method, semi-structured interviews</td>
</tr>
<tr>
<td>16.</td>
<td>Ireland</td>
<td>10-21</td>
<td>52%</td>
<td></td>
<td>To investigate implicit and explicit stigma towards peers with ADHD or depression.</td>
<td>Participants were given a booklet containing two vignettes about age and gender matched peers: one peer with “normal issues” and a second peer with either depression, or ADHD. Data was collected from qualitative analyses of narratives from mixed</td>
<td>IAT “AQ” SAQ SIDS paper-and-pencil projective figure placement test (to assess physical social distance)</td>
</tr>
<tr>
<td>Study</td>
<td>Country</td>
<td>Sample Size</td>
<td>Age</td>
<td>Gender</td>
<td>Ethnicty</td>
<td>Purpose</td>
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</tr>
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</tr>
<tr>
<td>17</td>
<td>O’Driscoll et al 2015</td>
<td>Ireland</td>
<td>148</td>
<td>10 - 11 years (n = 72) and 15 - 16 years (n = 76)</td>
<td>White</td>
<td>To explore adolescents beliefs about fairness of excluding peers with ADHD or depression. To examine any age and sex patterns in responses to the above.</td>
<td>Qualitative group study consisting of same-sex groups of 3-5 participants interviewed in school. Participants were randomly assigned to either the depression or ADHD groups and read to age and sex matched vignettes.</td>
</tr>
<tr>
<td>18</td>
<td>O’Driscoll et al 2015b</td>
<td>Ireland</td>
<td>148</td>
<td>10 - 11 years (n = 72) and 15 - 16 years (n = 76)</td>
<td>White</td>
<td>To provide a detailed understanding of the nature and function of discriminatory behaviors in YP without mental health problems (social exclusion) towards YP-MHD.</td>
<td>Qualitative group study consisting of same-sex groups of 3-5 participants interviewed in school. Participants were randomly assigned to either the depression or ADHD groups and read to age and sex matched vignettes.</td>
</tr>
<tr>
<td>19</td>
<td>Peterson et al</td>
<td>USA</td>
<td>163</td>
<td>9-27 and 11 - 16</td>
<td>Predominantly male</td>
<td>To investigate children who were shown one of 4 AAI-SAQ and SDS. Stigmatization of YP-MHD: Children rated the depressed child less favorably.</td>
<td></td>
</tr>
</tbody>
</table>

Stigmatization of YP-MHD: The only study in the review which sought to explore YP views of excluding peers with a mental illness. Those participants appeared to recognize the pros and cons of exclusion for YP-MHD. They appeared to respond that justifying for excluding peers would depend on an extent to which their relationship with YP-MHD. They also recognized the benefits of positive peer relationships for YP-MHD but were concerned with the social costs for themselves of including them.

Blame/Responsibility: Those participants who recognized the hypothetical peers in the vignettes as having a mental illness as opposed to no illness attributed less blame to their situation. Participants were also less likely to justify excluding the hypothetical children in the vignettes where they felt that there was a cause for their depression. Age: No age differences identified between the 2 age groups in responses and views. Gender: No gender differences identified in either of the 2 age groups.
The Stigma of Mental Illness in Children and Adolescents: A Systematic Review

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<tr>
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<td>1985</td>
<td>Self-reported and Personal stigma</td>
<td>USA</td>
<td>3-6 (8-11)</td>
<td>56% (58%)</td>
<td>Predominantly white</td>
<td>To examine children's perceptions of the mentally ill</td>
<td>Responses to peer's with childhood depression, with and without life stressors</td>
<td>To examine the role of peer's with childhood depression, with and without life stressors.</td>
</tr>
<tr>
<td>1986</td>
<td>Poster et al</td>
<td>USA</td>
<td>3-6 (8-11)</td>
<td>Not stated</td>
<td>Predominantly white</td>
<td>To examine children's concepts of individuals displaying behaviors commonly associated with mental illness</td>
<td>To assess attitudes towards peers with mental illness.</td>
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</tr>
<tr>
<td>1992</td>
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<td>USA</td>
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<td>Predominantly white</td>
<td>To assess attitudes towards peers with mental illness</td>
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</tr>
</tbody>
</table>

### Notes
- **Stigma of Mental Illness**: Children were more likely to display behaviors commonly associated with mental illness than boys, particularly when stressors were present.
- **Dangerousness**: Younger children were more likely to blame the depressed target peer for depression in the vignette and to display more aggressive behavior towards the depressed target peer than older children.
- **Perceived stigma**: Children between 10-13 years of age were more likely to perceive stigma than younger children. 
- **Gender**: Girls overall rated all children more positively than boys, particularly when stressors were present, whereas this effect was not seen with boys.

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**Table 1**: Summary of Studies

<table>
<thead>
<tr>
<th>Year</th>
<th>Authors</th>
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</tr>
</tbody>
</table>

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**Table 2**: Summary of Studies

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<tr>
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<td>To examine children's perceptions of the mentally ill</td>
<td>Responses to peer's with childhood depression, with and without life stressors</td>
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<td>Poster et al</td>
<td>USA</td>
<td>3-6 (8-11)</td>
<td>Not stated</td>
<td>Predominantly white</td>
<td>To examine children's concepts of individuals displaying behaviors commonly associated with mental illness</td>
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<td>To assess attitudes towards peers with mental illness.</td>
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<td>Poster EC</td>
<td>USA</td>
<td>3-6 (8-11)</td>
<td>Not stated</td>
<td>Predominantly white</td>
<td>To assess attitudes towards peers with mental illness</td>
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</table>

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**Table 3**: Summary of Studies

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<tr>
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<th>Authors</th>
<th>Country</th>
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<td>Poster EC</td>
<td>USA</td>
<td>3-6 (8-11)</td>
<td>Not stated</td>
<td>Predominantly white</td>
<td>To assess attitudes towards peers with mental illness</td>
<td>To assess attitudes towards peers with mental illness.</td>
<td>To assess attitudes towards peers with mental illness.</td>
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<td>Number</td>
<td>Views of Young People</td>
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<tr>
<td>24</td>
<td>Young people's views of mental illness</td>
<td>USA</td>
<td>9-13</td>
<td>Not stated</td>
<td></td>
<td>To investigate children's perceptions towards imaginary peers with mild or severe psychological and medical disorders</td>
<td>Children read 4 vignettes each depicting a peer with minor or moderate psychological or medical difficulties. Perceived desirability or likableness of the stories and drawings of the vignette character overall. The mild psychologically disturbed peer was described as the least desirable character to be like in both SES groups. The psychologically disturbed characters were rated as less attractive than the physically ill characters.</td>
<td>Gender: Psychologically disturbed peers were viewed as being male whereas medically ill peers were more often perceived as female. This was independent of the participants' gender. Perceived desirability: The mild psychologically disturbed peer was described as the least desirable potential friend (presented as a child who played mean tricks; shouted; screamed and kicked out). The child with severe psychological disorder (psychotic like symptoms) was described to be as desirable a friend as the children with physical ailments.</td>
</tr>
</tbody>
</table>
The Stigma of Mental Illness in Children and Adolescents: A Systematic Review

<table>
<thead>
<tr>
<th>Study</th>
<th>Country</th>
<th>No. of Participants</th>
<th>Age</th>
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<th>Purpose</th>
<th>Methods</th>
<th>Outcome Measures</th>
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<tbody>
<tr>
<td>Spitzer et al</td>
<td>USA</td>
<td>80</td>
<td>9-12</td>
<td>51%</td>
<td>White 61%, Black 39%</td>
<td>To examine 1: School-age children's perception of deviant behavior in relation to causality and autism. Children were assigned to view three vignettes depicting peers with either normal or psychotic behavior.</td>
<td>Qualitative analysis of case vignettes and interviews.</td>
<td></td>
</tr>
<tr>
<td>Swaim et al</td>
<td>USA</td>
<td>233</td>
<td>9-12</td>
<td>93% White, 6% Black</td>
<td>To examine factors affecting children's attitudes (cognitive components) and behavioral intentions towards a peer with autism.</td>
<td>Children were assigned to view one of three videos depicting a boy with autism, with or without autism, and with or without autistic features.</td>
<td>Qualitative analysis of case vignettes &amp; interviews.</td>
<td></td>
</tr>
<tr>
<td>Swords et al</td>
<td>Ireland</td>
<td>595</td>
<td>6, 9, 12, 14, 16</td>
<td>51% Female</td>
<td>Transactions &amp; symptoms of peers with depression &amp; ADHD</td>
<td>To examine the factors that contribute to or hinder acceptance of peers with depression &amp; ADHD</td>
<td>Qualitative analysis of case vignettes.</td>
<td></td>
</tr>
</tbody>
</table>

Stigmatization of YP-MHD: Crazy adults were thought to behave inappropriately, whereas crazy children were thought to disobey parents/teachers. Children recognized both physical and psychological symptoms, with a greater emphasis on psychological symptoms with increasing age. Gender: Older children more frequently characterized violence as a main presentation in “crazy adults.”

Gender: Boys were better at identifying deviant behavior than girls. Stigmatization of YP-MHD: Children at both grade level were less positive about children with autism than children without a diagnosis. This was the same, whether or not an explanation was provided. Gender: Younger children rated the target more favourably than older children. Gender: Boys generally held similar views about the children in all 3 vignettes, on ratings of social activity, recreation and academia. Girls on the other hand were less positive about the children with autism than without autism. Perceived stigma: Older children and girls rated their classmates' intentions toward the peer with autism as less positive than their own. Social distance/Behavioral intentions: Diagnosis did not alter children's own behavioral intentions.
<table>
<thead>
<tr>
<th>Study</th>
<th>Year</th>
<th>Country</th>
<th>Sample Size</th>
<th>Gender Distribution</th>
<th>Method</th>
<th>Measures</th>
<th>Purpose</th>
<th>Key Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Walker et al 2008</td>
<td>2008</td>
<td>USA</td>
<td>1318</td>
<td>51.3%</td>
<td>To examine stigmatizing attitudes towards children with ADHD or depression, and to investigate differences by age, sex, and ethnic background.</td>
<td>Respondents were gathered via an online survey. Participants were randomly assigned one of the vignettes representing a peer with depression, ADHD or asthma.</td>
<td>Social distance: Respondents indicated a desire for more social distance from peers with depression, followed by ADHD and then asthma.</td>
<td>Stigmatization by diagnosis: Depression and ADHD were more stigmatized than asthma. Depression was less stigmatized than ADHD. Depression and ADHD were more stigmatized than autism.</td>
</tr>
<tr>
<td>Washington et al 2012</td>
<td>2012</td>
<td>USA</td>
<td>89</td>
<td>Unknown</td>
<td>To investigate whether typically developing first graders are more rejecting towards peers with autistic behavior.</td>
<td>Children watched a video of a male peer of the same age playing with a car and then interacting with an adult female.</td>
<td>Social distance/Behavioral intentions: There were no differences in behavioral intentions identified towards the video of the child displaying autistic behaviors and the video of the normally developing child. Gender: There were no differences identified based on gender.</td>
<td>Social distance: Respondents indicated a desire for more social distance from peers with depression, followed by ADHD and then asthma.</td>
</tr>
<tr>
<td>Wiener et al 2012</td>
<td>2012</td>
<td>Canada</td>
<td>152</td>
<td>22%</td>
<td>To study the 3 main goals, only one of which was related to stigma as follows: Do children with ADHD overthink their problems behaviors and disorders as stigmatizing?</td>
<td>Children recruited from primary, secondary, and tertiary care; schools, community centers, and libraries. They completed a battery of questionnaires.</td>
<td>Perceived stigmatization was linked to lower self-esteem. The findings suggested that children with ADHD are vulnerable to self-stigmatization and greater perceived stigma. Self-stigma: Children with ADHD perceived the most problematic ADHD behaviors as more stigmatizing (i.e. more troublesome to others, more embarrassing) than children without ADHD. They reported more stigmatization from parents, teachers, and peers.</td>
<td>Stigmatization by diagnosis: Social phobia was most commonly considered 'not a real illness' and schizophrenia was least likely to be considered 'not a real illness.' Regarding measures of perceived stigma...</td>
</tr>
</tbody>
</table>
The Stigma of Mental Illness in Children and Adolescents: A Systematic Review

<table>
<thead>
<tr>
<th>Quality: Moderate</th>
<th>phobia and psychosis, schizotypy, paranoia, psychosis or social phobia.</th>
</tr>
</thead>
</table>

- Items about dangerousness in schizophrenia were most likely to be endorsed.
- Items relating to social phobia being a personal weakness were most likely to be endorsed.
- Items relating to 'not telling anyone' about depression were most likely to be endorsed.

**Dangerousness:** Beliefs about dangerousness were more commonly held about schizophrenia. **Gender:** Males were more stigmatizing than females for all scales (statistically significant difference)

**Perceived stigma:** Personal stigma was lower than perceived stigma for all disorders.

**KEY**

- *Qualitative studies are starred*
- Quality: Quality rating for paper based on either CASP for qualitative studies or EPHPP for quantitative studies

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1. **The Adjectives checklist (ACL):** A 32 item list which measures positive and negative cognitive attitudes towards target people. **Children's Attributions about Psychological Problems in their Peers**

2. **CAPPP:** Children's Attributions about Psychological Problems in their Peers

3. **Revised Attribution Questionnaire (r-AQ):** Measure stereotypes (Responsibility, dangerousness) and prejudice (emotional responses, such as fear, anger, pity, avoidance) **Shared Activity Questionnaire (SAQ):** Measures behavioral intentions (i.e. discrimination) of elementary school children towards a target child. **Social Distance Scale (SDS):** A scale which measures desire for social distance from people with mental illness

4. **Implicit Association Test (IAT):** Measures the strength of automatic associations between an individuals' mental representations of concepts in memory.

5. **Similarity Rating Form (SRF):** This is a single item that served as a manipulation to determine whether typical children recognized the presence of autism in both AUT-D and AUT-D + E conditions - from Campbell YP-MHD = Young people with mental health difficulties

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**Table 2:**
Detailed analysis of studies investigating adults’ stigmatizing views towards young people with mental health difficulties (YP-MHD)

<table>
<thead>
<tr>
<th>Views of Adults</th>
<th>Country</th>
<th>No. participants</th>
<th>Age</th>
<th>Gender</th>
<th>Purpose</th>
<th>Methods</th>
<th>Outcome Measures</th>
<th>Summary of key findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Brook et al 2000</td>
<td>Israel</td>
<td>46</td>
<td>30-50</td>
<td>40 F (87%)</td>
<td>To investigate teachers' knowledge and attitudes towards ADHD and LD.</td>
<td>An author designed questionnaire of 54 questions in total, assessed, amongst other things, teachers' attitudes towards pupils with ADHD</td>
<td>Newly piloted questionnaire of demographics and teacher knowledge &amp; attitudes about ADHD &amp; LD (learning difficulties)</td>
<td>Stigmatization of YP-MHD: 1/2 teachers responded that pupils with ADHD should be taught in a special setting and 1/2 favoured mainstream education. Most teachers believed that students with ADHD have similar IQs to students without ADHD. 87% felt that children with ADHD required psychological support; and 85% would be more lenient towards students with ADHD. Teachers wanted to be informed if a child had ADHD. 15% thought that pupils with ADHD were less likely to be less successful in the future. 1/2 believed that children with ADHD would continue to struggle with peer relations and family life in the future. In summary, the authors reported that attitudes and understanding of ADHD were relatively poor.</td>
</tr>
<tr>
<td>Views of Adults</td>
<td>Country</td>
<td>No. participants</td>
<td>Age Mean</td>
<td>Gender</td>
<td>Race</td>
<td>Purpose</td>
<td>Methods</td>
<td>Outcome Measures</td>
</tr>
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</tr>
<tr>
<td>2 Ghanizadeh et al 2006</td>
<td>Iran</td>
<td>196</td>
<td>38.92</td>
<td>Not stated</td>
<td>108 F (54%)</td>
<td>To survey knowledge and attitudes of teachers towards elementary school pupils in Iran</td>
<td>Elementary school teachers from a stratified random sample on Shiraz anonymously completed a questionnaire on ADHD.</td>
<td>Self-report true/false Questionnaire assessing participant demographics, ADHD knowledge and attitudes</td>
</tr>
<tr>
<td>3 Martin et al 2007</td>
<td>USA</td>
<td>1393</td>
<td>Adults 18-89</td>
<td>794 F 14% Black 7% Other</td>
<td>To investigate adults' social reactions to children with mental health difficulties. The study assessed attitudes towards 4 children described in non-labelled vignettes depicting children representing meeting DSM-IV criteria for ADHD, major depression, asthma and physical disabilities</td>
<td>2002 General Social Survey (GSS) data on the stigmatization of children analysed. Respondents were each read 1 vignette and asked a series of specifically designed questions assessing causal attributions, labelling, perceptions of dangerousness &amp; stigma associated with receiving mental health treatment.</td>
<td>National Stigma Study-Children (NSS-C) was administered, and bivariate analysis used to assess perceptions of dangerousness.</td>
<td>Blame/Responsibility: Social distance preferences were not reduced when the underlying causality was seen as biological. When causality was related to bad character or home life, the desire for social distance increased. Respondents were significantly more likely to reject a child whom they labelled “mentally ill.” Dangerousness: Children believed to be dangerous to self or others are more likely to be rejected. Children labelled as mentally ill also more likely to be perceived as violent. Ethnicity: Non-whites and non-blacks more likely to reject child. Familiarity: Those who reported having known someone with MHD where the relationship improved indicated a desire for less social distance. Gender: Women were more accepting of YP-MHD than men. Social distance/Behavioral intentions: Respondents preferred significantly greater social distance from children with ADHD and depression than the other 2 conditions (p &lt; 0.001). 1 in 5 did not want their children to have contact with children with behaviors consistent with ADHD or depression. Children described ADHD and depressive symptoms were 2-3 time more rejected than the other children.</td>
</tr>
<tr>
<td>Views of Adults</td>
<td>Country</td>
<td>No. participants</td>
<td>Age</td>
<td>Gender</td>
<td>Race</td>
<td>Purpose</td>
<td>Methods</td>
<td>Outcome Measures</td>
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<tr>
<td>Mukolo et al 2011</td>
<td>USA</td>
<td>1372</td>
<td>Not stated</td>
<td>800 F</td>
<td>Black: 14.6%</td>
<td>White: 79.5%</td>
<td>Other: 5.6%</td>
<td>Secondary analysis of data from the GSS 2002 National Stigma Study-Children (NSS-C).</td>
</tr>
</tbody>
</table>
| Ohan et al 2013 | Australia | 225 | 39.17 +/- 5.42 | 200 F | Australian: 92% | Other: 8% | To examine the impact of labeling on children with ADHD or depression. | Stigmatization of YP-MHD: Parents were significantly more stigmatizing (more stereotypes and prejudices held) towards children with symptoms of ADHD or depression than without. There was a further small significant increase in stigmatizing views when a label was attached. | Stigmatization by diagnosis: ADHD was more stigmatized than depression on measures of prejudice and social distance. Social distance as above. | Personal stigma | }
<table>
<thead>
<tr>
<th>Views of Adults</th>
<th>Country</th>
<th>No. participants</th>
<th>Age</th>
<th>Gender</th>
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<th>Methods</th>
<th>Outcome Measures</th>
<th>Summary of key findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>6 Perry et al 2007</td>
<td>USA</td>
<td>505</td>
<td>Adults</td>
<td>18-89 years</td>
<td>302 (60%)</td>
<td>To compare public attributions and attitudes of the general population towards children and adults with depression, with a focus on causality, perceptions of violence and the use of coercion</td>
<td>Participants responded to questions assessing the described construct, following a vignette description of either a child or adults with depression</td>
<td>Descriptive &amp; bivariate logistic analysis of 5 sets of binary variables, comparing public attitudes and attributions toward child/adult depression</td>
<td>Stigmatization of YP-MHD: Childhood depression was perceived as more serious than adult depression (83% v 51%). Causal attributions: Both adult and childhood depression were attributed to stress. More people recognised childhood depression as a genetic condition, a chemical imbalance or a consequence of child rearing. Dangerousness: Respondents believed children with depression to be more dangerous than adults with depression (40% v 30%). They perceived the 2 groups to be of equal risk to themselves. In summary, authors concluded that children with depression may be more vulnerable to stigmatization than adults with the same condition.</td>
</tr>
<tr>
<td>7 Pescosolido et al 2007</td>
<td>USA</td>
<td>1152</td>
<td>Adults</td>
<td>44 +/- 16.4 years</td>
<td>78% White, 15% African American; 7% Other</td>
<td>To examine the public’s beliefs of dangerousness in children with ADHD, depression, asthma, and daily troubles, and willingness to support coerced treatment</td>
<td>Data from the NSBC analyses, whereby adults were presented with vignettes describing children with either ADHD, major depression, asthma or daily troubles.</td>
<td>Multivariate analysis of predictors dangerousness &amp; willingness to enforce treatment</td>
<td>Dangerousness: Beliefs about dangerousness to self or others were endorsed by 81% of the sample for children with major depression, 33% for children with ADHD, but only 15% and 13% respectively for children with asthma and daily troubles. The child with depression was assessed as over twice as likely to be dangerous to others and 10 times more likely to be dangerous to themselves than the child with “daily troubles”. Individuals who labelled the child as mentally ill were 5 times more likely to endorse beliefs about violence.</td>
</tr>
</tbody>
</table>
Table 3: Factors influencing self-stigmatization in young people with mental health difficulties (YP-MHD)

<table>
<thead>
<tr>
<th>Factors correlated with increased self-stigmatization in YP-MHD</th>
<th>Factors correlated with decreased self-stigmatization in YP-MHD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical factors</td>
<td>Clinical Factors</td>
</tr>
<tr>
<td>Younger age at first treatment</td>
<td>Externalising disorder e.g. conduct</td>
</tr>
<tr>
<td>Demographic factors in YP-MHD</td>
<td>Parental factors</td>
</tr>
<tr>
<td>Older participant age</td>
<td>Parental optimism</td>
</tr>
<tr>
<td>White ethnic background</td>
<td>Beliefs in ability of YP-MHD to control symptoms</td>
</tr>
<tr>
<td>Parental factors</td>
<td></td>
</tr>
<tr>
<td>Secrecy over child’s diagnosis</td>
<td></td>
</tr>
<tr>
<td>Perceptions of causal factors</td>
<td></td>
</tr>
<tr>
<td>Trauma, social skills deficits, family problems</td>
<td></td>
</tr>
<tr>
<td>Personality/way of thinking</td>
<td></td>
</tr>
<tr>
<td>Biological factors</td>
<td></td>
</tr>
<tr>
<td>Perceptions about illness</td>
<td></td>
</tr>
<tr>
<td>Lack of control over symptoms</td>
<td></td>
</tr>
<tr>
<td>Life-long course</td>
<td></td>
</tr>
</tbody>
</table>

Highlights

- Stigmatization of young people with mental health difficulties is widespread and starts from childhood.

- Young people seemed to be more accepting than adults’ of children and adolescents with mental health difficulties.

- Current evidence suggests that young people may be reacting more to the behaviours displayed in peers with mental health difficulties, rather than to mental health labels.

- More research, and validated instruments measuring stigma, are needed to better understand stigma and self-stigma, so that it can be targeted effectively in the future.
Figure 1. Flow Chart of systematic identification of papers examining stigma in children and adolescents with mental health difficulties, following PRISMA Guidance