Parents' Stigmatizing Attitudes Toward Psychiatric Labels for ADHD and Depression

Jeneva L. Ohan, Ph.D.
Troy A. W. Visser, Ph.D.
Rachael G. Moss, M.Psych.
Nicholas B. Allen, Ph.D.

Objective: **There is concern that diagnostic labels for psychiatric disorders may invoke damaging stigma, especially for children. This study compared parents' stigma toward children with the symptoms of attention-deficit hyperactivity disorder (ADHD) or depression versus the same symptoms plus a psychiatric label.** ***Methods:*** **Parents (N=225) rated their stereotypes, prejudice, and social distance toward vignettes of children with a developmentally typical range of behaviors, symptoms that met *DSM-IV-TR* criteria for ADHD or depression, and the same symptoms plus a label of ADHD or depression.** ***Results:*** **Children described as having symptoms only were more stigmatized than children with typical behaviors (d=.97–2.69). Adding a diagnostic label resulted in significant but small increases in stigma (d=.12–.23).** ***Conclusions:*** **Parents highly stigmatized children with psychiatric problems, but adding a diagnostic label made only a small contribution to worsening the stigma. The benefits of seeking psychiatric services—accessing treatment and providing validation—may outweigh fears of labeling. (*Psychiatric Services* 64:1270–1273, 2013; doi: 10.1176/appi.ps.201200578)**

Parents of children with mental illness are acutely aware of the stigma that they and their child might encounter, and they often fear that a diagnosis will label their child, causing further stigma (1). Parents are not alone in these concerns; in fact, trepidation about psychiatric labels is common among professionals and the lay public, and it underlies most antipsychiatry movements (1–5). The belief that diagnostic labels cause stigma is concerning because seeking a diagnosis is an important step that often provides validation, treatment access, and feelings of relief (6). However, a critical lack of research makes it difficult to evaluate concerns about the use of psychiatric labels to diagnose children with mental health problems (7).

This study tested the hypothesis that parents of school children attach stigma to psychiatric labels for attention-deficit hyperactivity disorder (ADHD) and depression over and above the symptoms of the disorders alone. To guide our investigation, we used an explicit framework, beginning by defining stigma as representing a socially devalued status (8). We also employed a tripartite conceptualization of stigma as consisting of stereotypes (negative beliefs that are used to categorize a socially devalued group of people), prejudice (adverse emotional responses toward a socially devalued group), and social distance (behaviors that have a negative impact on a socially devalued group) (9).

Most previous research has examined stigma held by the general public toward symptoms of a mental disorder rather than diagnostic labels. For example, a large survey of American adults compared their perceptions of children described as having symptoms of depression, ADHD, asthma, or "normal daily troubles" (10,11). The adults were more than twice as likely to associate stereotypes of potentially violent behavior with the children with symptoms of ADHD or depression than with the children with normal daily troubles (11). Results were similar for social distance, with more than twice the number of participants wanting to maintain social distance from children with symptoms of ADHD or depression as from children with normal daily troubles (10).

Whether or not diagnostic labels engender stigma in excess of concerns about a disorder's symptoms is a serious issue that has yet to be empirically examined in children. We addressed this gap by investigating stereotypes, prejudice, and social distance among parents of school-age children toward vignettes of children with symptoms

Dr. Ohan and Dr. Visser are with the School of Psychology, University of Western Australia, 35 Stirling Hwy., Crawley, Western Australia 6009, Australia (e-mail: jeneva.ohan@uwa.edu.au). Ms. Moss is with the School of Psychology and Counseling, Queensland University of Technology, Kelvin Grove, Queensland, Australia. Dr. Allen is with the Department of Psychology, ORYGEN Research Centre, University of Melbourne, Parkville, Victoria, Australia.

of ADHD or depression that did or did not include a diagnostic label. We focused on the attitudes of parents because they affect the daily lives of children with mental health problems and their families. Parents influence children's social milieus by supporting (and discouraging) friendships and play opportunities. Parents also determine the families with whom they socialize (or marginalize) and whether to support families who are faced with mental health–related challenges. Most important, parents influence the emerging attitudes, feelings, and behaviors of their children toward people with mental illness (12).

Methods

Participants were 225 parents of children in elementary school living in Queensland or New South Wales, Australia, who were recruited through advertisements in school newsletters, community billboards, and word of mouth. The parents' mean age was 39.17±5.42 years, and 200 (89%) were female. They had 1.73±.80 children aged 7.44±1.88 years. Participants' ethnicity was Australian (N=207, 92%), New Zealander (N=6, 3%), Indian (N=4, 2%), North American (N=4, 2%), English (N=2, 1%), and Pacific Islander (N=2, 1%). Annual family income ranged from under $20,000 to over $150,000, and education ranged from less than high school to postgraduate.

Each participant read three vignettes (control, symptoms only, and symptoms plus label) and then completed three measures of stigma. The vignettes were modeled after prior research (10,11) and contained 130–144 words. The control vignette described a child who displayed developmentally typical depression (mild, nonimpairing sadness) or ADHD (mild, nonimpairing inattention). It was intended to assess parents' attitudes toward a typically developing child, not an unrealistically perfect child.

The vignettes describing symptoms only and symptoms plus label depicted a child who met *DSM-IV-TR* symptom criteria (13). The ADHD vignette described a child who met criteria for ADHD, combined type (six or more symptoms of inattention and six or more symptoms of hyperactivity-impulsivity). The depression vignette described a child who displayed four symptoms required for diagnosis of major depressive episode. The vignettes describing symptoms plus label also included the statement, "[Child's name] has recently been diagnosed with [attention-deficit hyperactivity disorder (ADHD) or major depressive disorder (depression)]."

Participants rated the child in each vignette on a stereotypes subscale, a prejudice subscale, and a social distance subscale. The subscale items were derived from existing measures of stigma (10,11) and developed on the basis of theory and a literature review. The stereotypes subscale asked participants to evaluate the likelihood that the child was aggressive, was dangerous, tried to avoid hard work, functioned poorly, and lived in a stressful home. Possible ratings ranged from 1, not at all likely, to 7, extremely likely. Items had good internal consistencies for each of the three vignettes (Cronbach's α=.70–.74).

The prejudice subscale asked participants to rate their likelihood of feeling anxious, compassionate (reverse scored), and irritated toward the child. Possible ratings ranged from 1, not at all likely, to 7, extremely likely. Internal consistencies were very good for the three vignettes (Cronbach's α=.80–.83).

The social distance subscale asked participants to rate their willingness to move next door to the child, encourage a friendship between the child and their own child, spend an evening socializing with the child's family, have a child in the same classroom as the child, invite the child to play at their house, and involve a child in a group project with the child. Possible ratings ranged from 1, definitely unwilling, to 7, definitely willing. Scores were reversed so that higher scores would reflect greater social distance, which keeps interpretation of the subscales consistent (higher scores indicate more stigma). Internal consistencies were excellent for the three vignettes (Cronbach's α=.92–.93).

This study was approved by our university's ethics committee. A Web-based software program was used to distribute the survey online from 2010 to 2011. Participants were presented with an information sheet that described the study, along with buttons to provide written consent or decline participation. The three vignettes were presented randomly by the child's gender (only boys or only girls), the order of the control and symptoms-only vignettes (vignettes with a label attached always came last to avoid sensitizing participants' ratings for symptoms-only vignettes), and the diagnostic label (the label was placed on each symptom vignette half the time to avoid the effect of label being due to a particular symptom vignette). Participants were free to skip questions if they desired. Upon completion, participants could enter their e-mail address for a prize drawing.

Results

A 3×2×2 (vignette type × disorder type × gender) repeated measures analyses of variance was run for each subscale. Vignette type is a within-participants factor, and disorder type and gender are between-participants factors. A Bonferroni correction yielded an alpha level of .017.

Results for each subscale are shown in Table 1. For stereotypes, there was a significant main effect of vignette type ($F=530.60$, $df=2$ and 217, $p<.001$, $\eta^2=.83$). Participants held significantly more stereotypes toward the vignettes describing symptoms only ($t=31.22$, $df=1,223$, $p<.001$, $d=2.69$) and symptoms plus label ($t=29.00$, $df=1,221$, $p<.001$, $d=2.76$) than toward the control vignettes. Stereotypes were significantly greater toward the vignettes describing symptoms plus label versus symptoms only ($t=2.54$, $df=1,221$, $p<.012$, $d=.17$).

For prejudice, there was a significant main effect of vignette type ($F=154.11$, $df=2$ and 219, $p<.001$, $\eta^2=.59$). Prejudice ratings were significantly higher for vignettes describing symptoms only ($t=15.20$, $df=1,223$, $p<.001$, $d=1.19$) and symptoms plus label ($t=17.14$, $df=1,223$, $p<.001$, $d=1.43$) than for the control vignettes. Prejudice was significantly greater toward the vignettes describing symptoms plus label versus symptoms only ($t=4.67$, $df=1,223$, $p<.001$, $d=.23$). There was a significant main effect of disorder type ($F=5.73$, $df=1$ and 220, $p<.017$, $\eta^2=.025$), with higher mean

Table 1

Ratings of stigma by 225 parents, by type of vignette[a]

	Control		Symptoms only		Symptoms plus label	
Subscale	M	SD	M	SD	M	SD
Stereotypes	2.21	.75	4.47	.92	4.63	.98
Prejudice	1.76	1.05	3.31	1.51	3.67	1.57
Social distance	1.94	.94	3.22	1.53	3.40	1.60

[a] All subscales have a possible range of 1 to 7, with higher numbers representing more stigma.

scores for prejudice for vignettes describing children with ADHD (3.09±1.50) versus depression (2.74±1.43).

For social distance, there was a significant main effect of vignette type ($F=134.88$, df=2 and 217, $p<.001$, $\eta^2=.55$). Social distance ratings were significantly higher for vignettes describing symptoms only ($t=14.05$, df=1,221, $p<.001$, $d=.97$), and symptoms plus label ($t=14.61$, df=1,221, $p<.001$, $d=1.16$) than for the control vignettes. Social distance was significantly greater toward the vignettes describing symptoms plus label versus symptoms only ($t=2.94$, df=1,223, $p<.04$, $d=.12$). There was a significant effect of disorder type ($F=24.87$, df=2 and 217, $p<.001$, $\eta^2=.10$), with higher mean scores for social distance for vignettes describing children with ADHD (3.20±1.39) versus depression (2.48±1.27). There was also a significant interaction of vignette type and disorder type ($F=11.93$, df=2 and 217, $p<.001$, $\eta^2=.10$), indicating there was no difference in levels of social distance toward children with ADHD and depression compared with children in the control vignettes. However, social distance among children with ADHD was greater than among children with depression for vignettes that described symptoms only ($t=4.65$, df=1,222, $p<.001$, $d=.61$) and symptoms plus label ($t=5.65$, df=1,222, $p<.001$, $d=.70$).

Discussion

The primary aim of this research was to evaluate the extent to which a psychiatric label would worsen stigma associated with ADHD and depression, as is often feared (1–5). As expected, even when a diagnosis was not disclosed, parents held high levels of stigma toward children with ADHD or depression symptoms. Including a diagnostic label with a description of symptoms led to small but consistent additional increases in parents' stereotypes, prejudice, and social distance. This implies that parents experience highly stigmatizing reactions when they encounter a child with symptoms of ADHD or depression; telling the parents that the child "has ADHD" or "has depression" has a small effect in furthering these stigmas. These findings suggest that the small increase in stigma arising from attaching a psychiatric label to symptoms may well be outweighed by the benefits that psychiatric diagnoses can provide, namely, treatment access, validation, and feelings of relief (6).

The consistent but relatively small magnitude of the labeling effect invites speculation about its origins. One likely option is that parents correctly guess a child's diagnosis when confronted with just the symptoms (10). This process may be sufficient to trigger their preexisting beliefs and facilitate categorization almost as much as presenting the label directly (14). Put in real-world terms, many parents may assume that a child with particularly high levels of hyperactivity "has ADHD," thus triggering associated negative stigma.

Another interesting aspect of our results is that parents reported more prejudice and social distance toward children with ADHD than depression. Past studies of adults in the general community have shown the reverse, although those depression vignettes intimated suicidal ideation (10,11), whereas our vignettes did not. It may be that suicidality is a key symptom that engenders stigma. Parents may be more concerned about keeping a child away from peers who have difficulty controlling their activity (ADHD) than from those who feel sad (depression) but are not suicidal.

One limitation of our study was that we did not include a "label-only" vignette and, therefore, were unable to observe the effect of diagnostic status, in the absence of any symptom information, on parents' stigma. In addition, the sample consisted primarily of mothers of European descent. However, we did not find significant differences on the basis of participant gender, and past research in this area has shown that demographic variables are weak, often nonsignificant, predictors of stigma (11). Another concern is social desirability, the tendency to present one's self in an unduly positive light, which could result in underreporting stigma to look more tolerant (15). If social desirability influenced our results, it indicates that stigma is even greater than reported here. Finally, although aligned with previous work, the vignette methodology may have limited ecological validity. This must be weighed against the benefits of vignettes, which provide control over extraneous variables, such as symptom severity and gender.

Conclusions

Despite fears about the potential for children to be stigmatized by a label arising from psychiatric diagnosis (1–5), little empirical research has addressed whether a psychiatric label adds to the stigma associated with symptoms alone. The effect of a label was reliable across all measures of stigma (stereotypes, prejudice, and social distance), although the size of the effect may not be large enough to justify the high degree of concern about labeling that is sometimes expressed. These results should not be interpreted to mean that psychiatric labels do not lead to stigma; rather, the stigma that parents attach to a child with a psychiatric diagnosis is primarily due to the symptoms of the disorder, not to the label. Therefore, parents may find that the advantages of seeking help for a child—in the form of validation, support, and treatment access—outweigh the disadvantages of stigma due to disclosing the diagnosis to other parents. Further work to replicate these findings and extend them to other populations and disorders will help to address fears of labeling.

Acknowledgments and disclosures

This research was supported by a grant from Women in Research to Dr. Ohan.

The authors report no competing interests.

References

1. Sayal K, Tischler V, Coope C, et al: Parental help-seeking in primary care for child and adolescent mental health concerns: qualitative study. British Journal of Psychiatry 197:476–481, 2010
2. Corrigan PW: How stigma interferes with mental health care. American Psychologist 59:614–625, 2004
3. Link BG, Phelan JC: Stigma and its public health implications. Lancet 367: 528–529, 2006
4. Probst B: When the Labels Don't Fit: A New Approach to Raising a Challenging Child. New York, Three Rivers, 2008
5. Shannon SM: Please Don't Label My Child. New York, Rodale, 2007
6. Clarke D, Winsor J: Perceptions and needs of parents during a young adult's first psychiatric hospitalization: "We're all on this little island and we're going to drown real soon". Issues in Mental Health Nursing 31:242–247, 2010
7. Heflinger CA, Hinshaw SP: Stigma in child and adolescent mental health services research: understanding professional and institutional stigmatization of youth with mental health problems and their families. Administration, Policy, and Mental Health 37:61–70, 2010
8. Goffman E: Stigma: Notes on the Management of Spoiled Identity. New Jersey, Prentice Hall, 1963
9. Corrigan PW: Mental health stigma as social attribution: implications for research methods and attitude change. Clinical Psychology: Science and Practice 7:48–67, 2000
10. Martin JK, Pescosolido BA, Olafsdottir S, et al: The construction of fear: Americans' preferences for social distance from children and adolescents with mental health problems. Journal of Health and Social Behavior 48:50–67, 2007
11. Pescosolido BA, Fettes DL, Martin JK, et al: Perceived dangerousness of children with mental health problems and support for coerced treatment. Psychiatric Services 58:619–625, 2007
12. Jorm AF, Wright A: Influences on young people's stigmatising attitudes towards peers with mental disorders: national survey of young Australians and their parents. British Journal of Psychiatry 192:144–149, 2008
13. Diagnostic and Statistical Manual of Mental Disorders, 4th ed, text revision. Washington, DC, American Psychiatric Association, 2004
14. Macrae CN, Bodenhausen GV, Milne AB, et al: On the activation of social stereotypes: the moderating role of processing objectives. Journal of Experimental Social Psychology 33:471–489, 1997
15. Hinshaw SP, Stier A: Stigma as related to mental disorders. Annual Review of Clinical Psychology 4:367–393, 2008

Psychiatric Services Invites Short Descriptions of Novel Programs

Psychiatric Services invites contributions for Frontline Reports, a column featuring short descriptions of novel approaches to mental health problems or creative applications of established concepts in different settings.

Text should be 350 to 750 words. A maximum of three authors, including the contact person, can be listed; one author is preferred. References, tables, and figures are not used. Any statements about program effectiveness must be accompanied by supporting data within the text.

Material to be considered for Frontline Reports should be sent to one of the column editors: Francine Cournos, M.D., New York State Psychiatric Institute, 1051 Riverside Dr., Unit 112, New York, NY 10032 (e-mail: fc15@columbia.edu), or Stephen M. Goldfinger, M.D., Department of Psychiatry, SUNY Downstate Medical Center, Box 1203, 450 Clarkson Ave., Brooklyn, NY 11203 (e-mail: smgoldfingermd@aol.com).