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Psychosocial Outcomes of Mental Illness Stigma in Children and Adolescents: A Mixed-Methods Systematic Review.

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Authors:

Jamie Ferrie^{1,a}, Hannah Miller^{2,b}, and Simon C. Hunter³.

¹MSc Clinical Health Psychology, University of Strathclyde, School of Psychological Sciences and Health, 40 George Street, Glasgow, UK. Corresponding Author - Contact: jamie.ferrie@outlook.com

²MSc Clinical Health Psychology, University of Strathclyde, School of Psychological Sciences and Health, 40 George Street, Glasgow, UK. Contact: hannah.mairi@gmail.com

³PhD, Senior Lecturer, University of Strathclyde, School of Psychological Sciences and Health, UK. Contact: simon.hunter@strath.ac.uk.

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^aPresent Address: NHS Tayside, UK.

^bPresent Address: NHS Lanarkshire, UK.

Abstract

Background: Mental illness stigma has serious psychological and social consequences for adults, and remains a significant barrier to help-seeking. The aim of this review was to synthesise findings from qualitative and quantitative studies investigating the psychosocial effects of mental illness stigma in youth with mental health problems who access services.

Methods: Four databases were searched resulting in 3,353 abstracts with 27 studies included for synthesis. Participants ranged from 8-19 years old across studies. Synthesis was conducted by consolidating qualitative data to be re-analysed in a meta-thematic analysis with qualitative data being additionally tabulated into qualitative codes to facilitate a narrative synthesis.

Results: The review identified various deleterious stigma-related outcomes amongst youth such as: accepting or rejecting labels, experiencing poorer mental health, feeling socially rejected or fearful of the need to 'fit in', not seeking help, shame, and remaining secretive of their difficulties/medication use. Perceptions of mental illness were also influenced negatively by family and healthcare professionals. Finally, youth limited their interactions with young people experiencing mental health problems, enhancing their perceived sense of acceptance amongst social groups.

Conclusions: Young people experience detrimental stigma-related outcomes which are linked to their need to preserve social identity and social capital. The need for models of mental illness stigma which are developmentally appropriate is essential for the effective development of effective intervention strategies.

Key words: *Mental Health, Self-stigma, Public stigma, Psychosocial, Children, Adolescents.*

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1.1 Introduction

It is estimated that 20% of youth experience a mental health (MH) difficulty in any given year (World Health Organisation, 2003); yet this group underutilises professional help (Polanczyk, Salum, Sugava, Cave, & Rohde, 2015) and MH-associated stigma may be a significant barrier for young people who want or need such support (Clement et al., 2015). This is particularly concerning due to the deleterious effects MH difficulties have on youth long-term if not intervened with (Post et al., 2010). In order to design effective intervention programs, it is important that theoretical models which seek to explain these relationships are appropriate and relevant to young people's unique developmental experiences (Chen, Koller, Krupa, & Stuart, 2016).

Stigma is the consideration of a personal characteristic in a devaluing way, altering a 'normative' identity to an 'abnormal' or 'deviant' identity in that individual's societal context (Goffman, 1963). 'Public stigma' relates to the stereotypical attitudes towards certain sub-groups held by individuals in society (Corrigan & Kosyluk, 2014) and this may lead to 'self-stigma', a process whereby the stigmatised individual accepts and internalises such attitudes. Self-stigma then influences an individual's own behaviours and attitudes (Corrigan & Shapiro, 2010). Experiences of stigma can involve shame (Kranke & Floersch, 2009), lowered self-esteem (Kaushik et al., 2017), and less likelihood of disclosing difficulties (Lindsey, Joe & Nebbitt, 2010) or seek help (Keyes, Nolte & Williams, 2017). Stigma is present in the context of MH difficulties (Clement et al., 2015) and is prevalent across developmental stages (O'Driscoll, Heary, Hennessy, & McKeague, 2012). Within this, MH-related stigma can be a 'layered stigma' (holding multiple stigmatising identities) which is held in addition to a young person's ethnicity (Elkington, 2012) and gender (Moses, 2010b).

Recent reviews have highlighted the unique position of young people within society and have emphasised the need to understand stigma experiences as potentially differing in important ways from those of adults (DeLuca, 2019; Heary, Hennessy, Swords & Corrigan, 2017). For example, young people fundamentally hold less power than adults, have lower social status, and their behaviours are less likely to be tolerated (Hinshaw, 2005). In addition, during adolescence young people seek to become more independent and autonomous from adults (Ryan & LaGuardia, 2000; Steinberg, 1989) which involves a reduction in the degree to which help and support are sought from parents/guardians. This may narrow support options open to adolescents as compared to earlier childhood, potentially exacerbating negative outcomes associated with MH difficulties. Also, during adolescence, young people have a heightened concern with being 'different' from their peers (Moses, 2015) and this may further reduce the coping options open to them if they fear peer-rejection (Gulliver, Griffiths, & Christensen, 2010). Issues concerning social identity as derived from group membership (Turner, 1982) are particularly salient here as is access to shared social capital (the beneficial resources that individuals hold from mutual engagement within social networks) (Kawachi, Kim, Coutts, & Subramanian, 2004).

Several related reviews have been conducted in the MH stigma field that have investigated measures which explore stigma experiences in adults (Brohan, Slade, Clement, & Thornicroft, 2010), experiences of self-stigma among adults (Livingston & Boyd, 2010), risk factors for stigma (Kaushik, Kostaki, & Kyriakopoulos, 2016), and barriers to help-seeking amongst youth (Gulliver et al., 2010). These reviews focus mainly on adult populations, are from the perspective of the stigmatiser, and are largely quantitative in nature. This highlights a lack of focus on the qualitative narratives of youth. To date, no review has systematically considered the various psychosocial effects of MH stigma among youth with MH problems who access services.

Outcomes of MH stigma among adults have been well documented, but the scope and nature of such associations among children and young people is less clear. Here, we consider these issues utilising data from both quantitative and qualitative research. The inclusion of qualitative research allows for the exploration of subjective narratives of young people's stigma experiences that would be restricted through solely quantitative study (Yang, Wonpat-Borja, Opler, & Corcoran, 2010). This review will therefore synthesise findings from both qualitative and quantitative data to investigate the psychological and social outcomes of mental illness stigma in children and adolescents.

2.1 Method

2.2 Search Strategy

This review was registered in PROSPERO (CRD42018082647). The electronic databases used were EBSCO*host* (British Education Index, Child Development and Adolescent Studies, PsycINFO) and Web of Science. Searches were conducted between January-February 2018 with no date restrictions. The following main keywords were used: mental health, public stigma, self-stigma, children, adolescent, and psycho-social (see Table 1 for full list). The truncation symbol (*) was used to increase search sensitivity.

Mental Health	Type of Stigma	Population	Outcomes of Stigma
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“Mental Health”	Stigma*	Child*	“Psycho-social”
OR	OR	OR	OR
“Mental Illness*”	“Public Stigma*”	Adolescen*	“Psychological
OR	OR	OR	outcome*”
“Psychological	“Social Stigma*”	“Young People”	OR
difficult*”	OR	OR	“Psychological
OR	“Self-stigma*”	Kids	effect*”
“Mental distress”	OR	OR	OR
OR	“Self stigma*”	Pupil*	“Social outcome*”
“Mental Wellbeing”	OR	OR	OR
	“Perceived	Youth	“Social effect*”
	Stigma*”		OR
	OR		Experience*
	Discriminat*		
	OR		
	Prejudice*		
	OR		
	Stereotyp*		

*= refers to the use of wild cards used to generate records which include variants of certain words. All databases used process them appropriately.

Table 1. *Complete List of Search Terms Used in Database Searching.*

Database searching retrieved 3,253 abstracts and 147 additional articles were retrieved through hand-searching reference lists of included articles and relevant reviews. A forward citation search of previously included studies was conducted on Web of Science on March 2019 to update the review with relevant papers. This yielded a further three studies for inclusion: two new (Flack, 2018; van de Water, Rossouw, van de Watt, Yadin, & Seedat, 2018) and one (Wiener & Daniels, 2016) missed by the review’s initial search.

2.3 Selection of Studies

Figure 1 represents a summary of the stages of study selection in accordance to PRISMA guidelines (Moher, Liberati, Tetzlaff, & Altman, 2009). Records were included if they satisfied the following criteria: participants are children or adolescents (0-19 years), participants have accessed or currently access MH interventions (medication and/or therapy) or exhibits emotional and or behavioural problems, study measures psychological and/or

social outcomes of MH stigma (pre-intervention), stigma relates to psychological/neurodevelopmental difficulties (e.g. schizophrenia, depression). As noted earlier, MH stigma experiences were noted as relevant for the review if relating to social processes and how youth communicate (social interaction, help-seeking, disclosure) as well as the psychological processes (shame, lowered self-esteem).

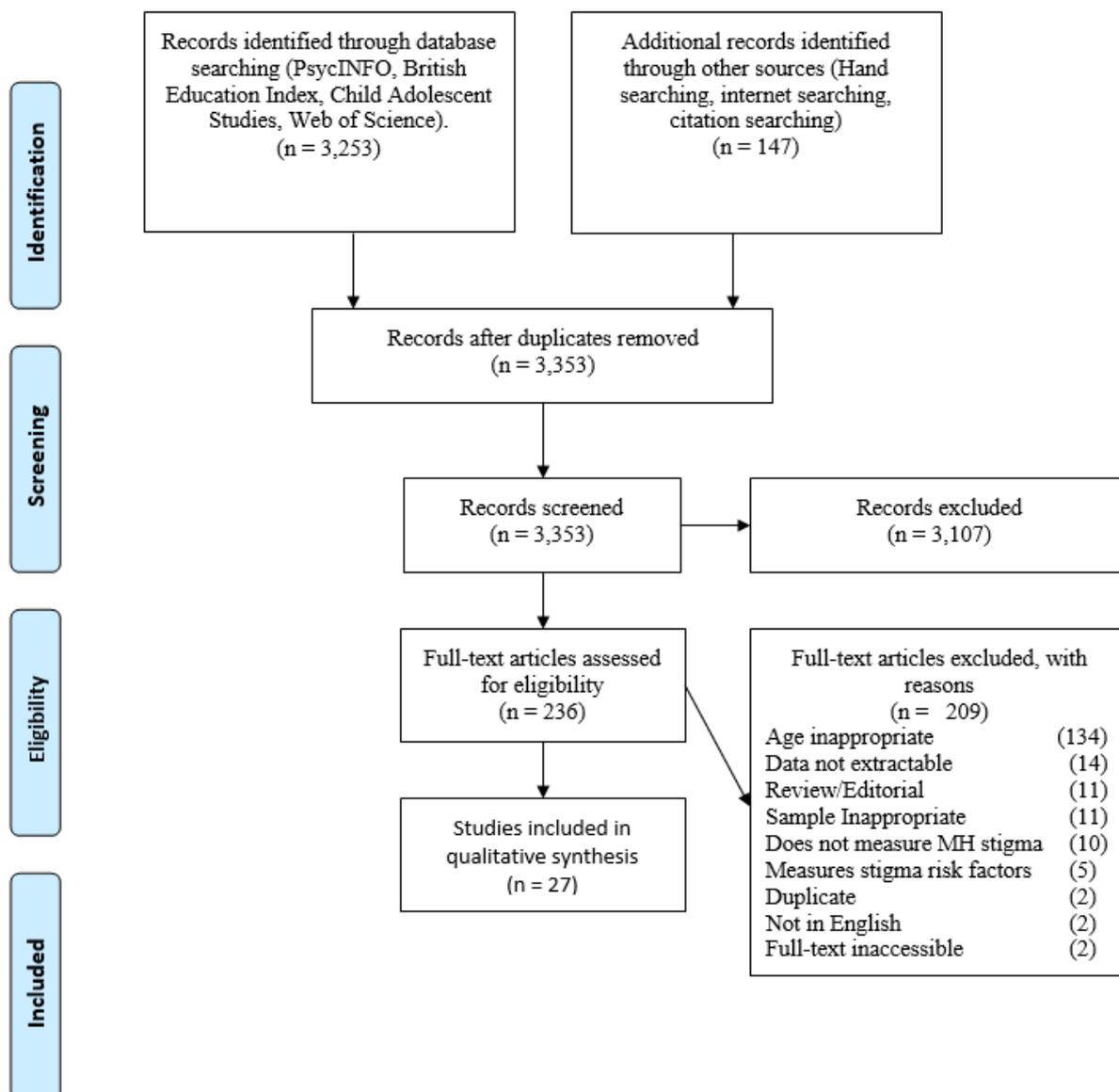


Figure 1. PRISMA diagram.

Records were excluded if they failed to meet these criteria and if they also satisfied the following: participants were 20 years or older (if records concerned a wider age range but

had extractable data for the 0-19 age group, these were included); does not address the effects of MH stigma on young person/s; stigma experiences are retrospective accounts from adult samples; study is not a primary research article (reviews, conference abstracts); study not in English; stigma relates to neurological/physical conditions (e.g. epilepsy, cerebral palsy, chronic pain).

Although Cohen's kappa has been used widely as a marker of inter-rater agreement, issues with its use concern 'prevalence' and 'bias' (PI and BI respectively: Byrt, Bishop, & Carlin, 1993). Therefore, this review calculated the prevalence-adjusted bias-adjusted kappa (PABAK) score alongside kappa to exhibit more confidence in validity. Titles and abstracts from the search ($n = 3,353$) were screened by the primary investigator (JF) with 10% blind-coded by a secondary rater (HM) ($k = .50$; $BI = .01$; $PI = -.86$; $PABAK = .96$). After disagreements were resolved, full-text articles were screened ($n = 236$) by JF with 10% blind-rated by HM ($k = .82$; $BI = .02$; $PI = -.59$; $PABAK = .88$). This resulted in a total of 27 records relevant for inclusion.

2.4 Data Extraction, Analysis and Synthesis

Data extraction was performed by JF using a predetermined data extraction template including: author, aims/objectives, demographics, stigma source, identified MH conditions, psychological outcomes, social outcomes, outcome measures, and summary findings (see Table 2). Pilot testing of the data extraction tool and inclusion/exclusion criteria were conducted to gauge efficacy and potential for further refinement.

Author	Relevant Aims	Demographics	Stigma source	Clinical Factors	Psychological outcomes	Social outcomes	Outcome measure/s	Summary of Key Findings
1.Kranke et al. (2011).	Develop a model that can be useful to future research on the self-stigma of adolescents. Qualitative Design.	Participants (n = 27). Age (12-17). Gender (F = 18, M = 8). Ethnicity (White = 15, African American = 10, Other Ethnicity = 2).	Self-Stigma, Perceived Public Stigma (peers, family).	Received prescriptions for three or fewer medications (n = 26), received for three or more (n = 1). Mood disorder (n = 20). ADHD (n = 15).		Secrecy of Medication Use. Concern with being 'Different'. Stereotype Endorsement.	Semi-structured interview using the TeenSEMI.	Self-stigma relating to psychiatric medication use was related with a need for secrecy, concern with being different from others, and endorsement of negative stereotypes related to medication use. Evidence supports that stigma processes differ within adolescents relative to adults.
2.Moses et al. (2009a).^a	Examine the extent to which adolescents diagnosed with psychiatric disorders indicate they self-label as mentally or psychologically disturbed, and the impact of self-labelling on their psychological wellbeing. Mixed Design.	Participants (n = 56). Age (12-18). Gender (F = 21, M = 35) Ethnicity (White = 34, Other Ethnicity = 22).	Perceived Public Stigma (Peers). Self-Stigma.	RAD (11.3%). OCD (3.8%). Schizophrenia (1.9%). More than one disorder (83%). Affective Disorder (70.4%). DBD (70.4%). PTSD (22.2%). Alcohol and Other Drug Abuse (20.4%).	Endorsement of Psychiatric Labelling. Rejection of Psychiatric Labelling. Self-Esteem. Self-Mastery. Depression.		<i>Self-labelling</i> (semi-structured interview). <i>Self-esteem</i> (Rosenberg Self-esteem scale, $\alpha = .81$) <i>Mastery</i> (Pealin Mastery Scale, $\alpha = .70$) <i>Depression</i> (Centre for Epidemiological Studies Depression Scale, $\alpha = .90$). <i>Self-stigma</i> (Self-Stigma Scale – Adapted, $\alpha = .81$). <i>Public Stigma</i> (Rejection Experiences Scale – Adapted). <i>Functioning</i> (Child and Adolescent Functional Assessment Scale).	Findings indicate that only a minority of adolescent's self-label. Most conceptualised their problems non-pathologically and or demonstrated uncertainty about the nature of their problems. Adolescents who self-labelled scored higher on self-stigma and depression, and a trend towards a lower sense of mastery, but there

was no correlations with self-esteem.

Peers had a powerful influence on this group regarding the admission of emotional or psychological problems, as well as acknowledgement of the receipt of formal MH services. Those in treatment stated that they received emotional support from their friends, and they were able to talk to friends about their problems. However, they also felt reluctant to admit to friends that they were receiving formal MH treatment.

The average adolescent did not report a great deal of public and self-stigma. On average, adolescents did not believe that the public blame, mistrust, or hold low expectations of them. Most claimed they do not frequently experience self-stigma in the form of

3.Lindsey et al. (2006).^b

Explore MH-related help-seeking attitudes and behaviours amongst African American boys.

Qualitative Design.

Participants (n = 18).
Age (14-18).
Gender (M = 18).
Ethnicity (African American = 18).

Self-Stigma.
Perceived Public Stigma (Peers).

Depression.

Shame.

Secrecy Regarding Difficulties.
Secrecy Regarding Treatment.
Social Exclusion.

Depression (Centre for Epidemiologic Studies Depression Scale).
Help-seeking (semi-structured interview, 45 mins – 1 hour 45 mins).

4.Moses et al. (2009b).^a

Explore the extent to which adolescents with psychological difficulties experience stigma. Secondly assess the extent to which stigma is associated with self-concept.

Participants (n = 56).
Age (12-18).
Gender (F = 21, M = 35)
Ethnicity (White Caucasian = 34, Other Ethnicity = 22).

Public Stigma (Peers).

ADHD (53%).
Depression/Anxiety (34%).
CD (31%).
Bipolar Disorder-NOS (16%).
ODD (19%).
RAD (12%).
OCD (5%).
Schizophrenia (1.9%).
DBD (70.4%).
PTSD (22.2%).

Self-Worth (Self-esteem).
Self-Mastery.
Future Outlook.
Depression (Demoralisation).
Shame (Embarrassment).

Perceived Rejection.
Secrecy.

Measures were adapted from existing stigma scales used in adult literature and youth stigma scales relevant to other illnesses:
Public-Stigma: Societal Devaluation (Adapted Perceived Devaluation/Discrimination Scale, $\alpha = .76$)
Public-Stigma: Personal Rejection (Adapted Rejection Experiences Scale, $\alpha = .78$).

Mixed Design.

Alcohol and Other Drug Abuse (20.4%).
Prescribed one or more psychotropic medications (83%).
Psychiatrically hospitalised at least once (58%).

Self-Stigma (Adapted Child Stigma Scale, $\alpha = .81$).
Secrecy (Adapted Internalised Stigma Scale, Adapted Secrecy Scales, Adapted Withdrawal Scale, $\alpha = .84$).
Self-Worth (Rosenberg Self-esteem Scale, $\alpha = .84$).
Self-Mastery (Pearlin Mastery Scale, $\alpha = .70$).
Future Outlook (Future Outlook Scale, $\alpha = .77$).
Depression (Centre for Epidemiologic Studies Depression Scale, $\alpha = .84$).
Semi-Structured Interview (60-90 mins).

apprehension that others would not accept them. Among those who did report stigma, there was agreement that peers tease or harass youths known to be receiving treatment.

*5.Kranke et al. (2009).^c	Examine the prevalence of MH stigma within a school context. Qualitative Design.	Participants (n = 40). Age (12-17). Gender (F = 24, M = 16). Ethnicity (White Caucasian = 19 African American = 17, Others = 4).	Public Stigma (Teachers, Peers).	Mood Disorder (77.5%) ADHD (67.5%). ODD/Conduct Disorder (45%). Anxiety Disorder (15%). Other (20%). Prescribed one psychiatric medication (40%). Prescribed two psychiatric medications (25%). Prescribed three psychiatric medications (27.5%). Prescribed four (or more) psychiatric medications (7.5%).	Social Exclusion/Ostracism. Limiting Interactions.	Semi-structured Interview using TeenSEMI.	Findings suggest adolescents experience school-related stigma through ostracism from peers and lack of awareness and understanding from teachers.
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6.Kranke et al. (2012).^c	Investigate what sources influence and the origin of stigmatising attitudes toward help-seeking for mental illness and use of psychiatric medication among African American adolescents.	Participants (n = 17). Age (12-17). Gender (F = 6, M = 11). Ethnicity (African American = 17)	Public Stigma (Family, Culture, Media, Peers). Self-stigma.	ADHD (n =7) Mood Disorder (n = 7) Eating Disorder (n = 1) PTSD (n = 1) Schizophrenia (n = 1). Each (n = 17) had less than two prescribed psychiatric medications.	Secrecy.	Semi-structured Interview using TeenSEMI.	African American adolescents have similar origins of stigmatising attitudes as African American adults toward help-seeking. The majority of stigmatising attitudes were directed towards medication.	
*7.Kranke et al. (2010).^c	Identify whether stigma concepts drawn from adult literature (secrecy, shame, social interaction) are applicable to youth experiences of stigma. Main aim was to analyse adolescents' experiences with MH and daily psychotropic medication and assess if they	Participants (n = 40). Age (12-17). Gender (F = 24, M = 16). Ethnicity (White = 19 African American = 17, Others = 4).	Public Stigma (Family, Peers, Teachers).	Mood Disorder (77.5%) ADHD (67.5%). ODD/Conduct Disorder (45%). Anxiety Disorder (15%). Other (20%). Prescribed one psychiatric medication (40%). Prescribed two psychiatric medications (25%). Prescribed three psychiatric medications (27.5%). Prescribed four (or more) psychiatric medications (7.5%).	Shame of Diagnosis. Shame of Medication.	Secrecy of Diagnosis. Secrecy of Medication. Limiting Interactions.	Semi-structured Interview using TeenSEMI.	Many adolescents did experience stigma with 90% endorsing at least secrecy, shame, and/or limiting interactions. Four endorsed no stigma themes however. It was apparent that the perceptions of adolescents' family members and school environments can accentuate their experience of stigma or serve as a protective barrier against it.

experience
stigma.

Qualitative
Design.

8.Lindsey et al. (2010).^b	Examine the influence of MH stigma and social support on depressive symptoms and subsequent help-seeking behaviours for this population.	Participants (n = 18). Age (14-18). Gender (M = 18). Ethnicity (African American = 18).	Public Stigma (Family, Peers).	Depression.	Depression.	Mistrust of Professionals. Secrecy.	Semi-structured Interview (45-90 mins). <i>Depression</i> (Centre for Epidemiologic Studies Depression Scale, $\alpha = .84$). <i>Mental Illness Stigma</i> (The Attitudes Towards Seeking Professional Help Scale $\alpha = .65$). <i>Social Support</i> (The Social Support Scale, $\alpha = .90$).	Results indicate that MH stigma and social support both influence depressive symptoms among African American adolescent boys. Social support was negatively associated with depressive symptoms, supporting it as a protective factor.
9.Moses et al. (2010a).^a	Examine the extent to which adolescents diagnosed with mental disorders experience self-stigma and to also identify individual and familial factors associated with it.	Participants (n = 56). Age (12-18). Gender (F = 21, M = 35) Ethnicity (White Caucasian = 34, Other Ethnicity = 22).	Self-Stigma. Public Stigma (Family).	ADHD (53%). Depression/Anxiety (34%). CD (31%). Bipolar Disorder-NOS (16%). ODD (19%). RAD (12%). OCD (5%). Schizophrenia (1.9%). DBD (70.4%). PTSD (22.2%).	Perceptions of Their Illness.		Semi-structured interview (60-90 mins). <i>Self-Stigma</i> (Adapted Child Stigma Scale). <i>Beliefs about Causes</i> (The Adolescents' Beliefs About Causes Scale). <i>Perceived Controllability</i> (Adapted Illness Perceptions Questionnaire-Revised, $\alpha = .64$). <i>Anticipated Chronicity</i> (Adapted Illness Perceptions Questionnaire-Revised, $\alpha = .69$).	Approximately 20% of adolescents and parents reported significant concerns related to self-stigmatisation. The three most prominent factors associated with adolescents' self-stigma ratings were adolescents' perceptions of social skill deficits and trauma as causal factors in their

Mixed Design.

				Alcohol and Other Drug Abuse (20.4%). Prescribed one or more psychotropic medications (83%). Psychiatrically hospitalised at least once (58%).			mental health challenges, as well as parents' inclination to conceal their child's MH problems from others.
10.Moses et al. (2010b).^a	Examine how youth diagnosed and treated for psychiatric disorders describe being stigmatised by family, peers, and school staff. Mixed Design.	Participants (n = 56). Age (12-18). Gender (F = 21, M = 35) Ethnicity (White Caucasian = 34, Other Ethnicity = 22).	Public Stigma (Family, Peers, Teachers).	ADHD (53%). Depression/Anxiety (34%). CD (31%). Bipolar Disorder-NOS (16%). ODD (19%). RAD (12%). OCD (5%). Schizophrenia (1.9%). DBD (70.4%). PTSD (22.2%). Alcohol and Other Drug Abuse (20.4%). Prescribed one or more psychotropic medications (83%). Psychiatrically hospitalised at least once (58%).	Treated Differently by Family. Rejection/Social Isolation. Limiting Interactions. Bullying. Treated Differently by School Staff.	Semi-structured Interview related to MH challenges, treatment experiences, and perceptions of being treated differently.	Largest number of participants experienced stigmatisation in relationships with peers (62%) often leading to friendship losses. Forty-six percent experienced family stigma which took the form of unwarranted assumptions, distrust, avoidance and pity. About 35% of participants reported stigma perpetrated by school staff, who expressed fear, dislike, avoidance and underestimation of their abilities.

11. Wiener et al. (2012).	<p>Determine whether 9-14-year-old children with ADHD underestimate the number of ADHD symptoms they have compared with parent ratings. Compare the attributions of children with and without ADHD for their self-reported most problematic behaviour. Examine the degree to which children with ADHD viewed their problem behaviours and their disorder as stigmatising.</p>	<p>Participants (n = 86). Age (9-14). Gender (M = 78%)</p>	<p>Public Stigma (Family, Peers, Teacher).</p>	<p>20 ADHD children had comorbid diagnoses (learning disabilities, n = 12; learning disabilities and depression, n = 1; ODD, n = 3; ODD and CD, n = 4). Taking ADHD Medication (72%)</p>	<p>Self-esteem/Self-Efficacy.</p>	<p><i>Self-Esteem/Self-Perceptions of Competency</i> (Self-perception of behavioural conduct, $\alpha = .71-.77$; Global self-worth, $\alpha = .78-.84$). <i>Attributions/Stigma</i> (Attributions for ADHD Questionnaire).</p>	<p>Results showed that children with ADHD experience stigma that is associated with their symptoms and the disorder. They believed their most problematic behaviours were likely to bother their parents, peers and teachers; they are treated differently as a result of their behaviour, and they and their parents are embarrassed because of their behaviours. Stigmatisation was also associated with lower self-esteem and lower perceptions of behavioural conduct.</p>
<p>Quantitative Design.</p>							

12. Bussing et al. (2011).	Explore the clinical need and attitudes relevant to ADHD care from perspective of adolescents. Explore how these influences the likelihood of receiving MH services.	Participants (n = 168). Gender (F = 89, M = 79). Ethnicity (White = 110, African American = 58).	Public Stigma (Family).	High-Risk for ADHD	Mental Health Service Use.	<i>Clinical Need</i> (Behaviour Assessment System for Children Self-Report of Personality). <i>Treatment Receptivity</i> (Child and Adolescent Services Assessment). <i>MH Service Usage</i> (Child and Adolescent Services Assessment). <i>ADHD Stigma</i> (ADHD Stigma Questionnaire, $\alpha = .93$).	Results suggest that a substantial proportion of children who are at a high risk for ADHD drop out of care, and that adolescent perceived stigma about ADHD is influential beyond the perspective of parents.	
13. Welsh et al. (2012).	Explore the understanding and experiences of adolescents categorised as having an ARMS.	Participants (n = 6). Age (13-18). Gender (F = 3, M = 3).	Public Stigma (Family, Peers).	ARMS.	Self-Labeling.	Disclosure/Secrecy.	<i>ARMS Diagnosis</i> (Melbourne ultrahigh-risk criteria, and Comprehensive Assessment of At-Risk Mental States). Semi-structured interview (25-40 mins) to gather qualitative data.	The participants experiences of being labelled were particularly positive with limited instances of stigmatisation by family and friends. Like most psychiatric diagnoses, the ARMS label has the potential to generate stigma. However, this sample of adolescents appeared to respect being told about their experiences with MH professionals and significant others.

14.Lindsey et al. (2013).	Explore the factors that may promote treatment engagement from MH care among black adolescents.	Participants (n = 16). Age (11-14). Gender (F = 8, M = 8). Ethnicity (African American = 16).	Public Stigma (Peers).		Mental Health Service Use.	Secrecy.	Focus Group Interviews.	Adolescents expected emotional difficulty in seeking MH treatment due to fears that friends might stigmatise them for seeking services.
15.Mitten et al. (2016).	Explore the perceptions of stigma of adolescents who have self-harmed and have received MH care in a psychiatric hospital setting. Mixed Design.	Participants (n = 12, Dropout rate was 73%). Age (15-19). Gender (F = 10, M = 1, Other = 1). Ethnicity (Canadian = 10, Aboriginal Canadian = 1, Other = 1).	Public Stigma (Peers, Healthcare Staff).	Participants who were discharged from a Child and Adolescent Inpatient Psychiatric Unit for self-harm.	Illness Perceptions. Label Resistance. Label Endorsement. Help-Seeking.	Social Distancing. Being Treated Differently from Healthcare Staff.	Semi-structured Interviews (approx. 1 hour) on demographics, stigma experiences and receipt of care.	Youth reported feeling stigmatised by healthcare providers, and youth also reported stigmatising others with MH disorders. Many youth also experienced negative effects of labelling with being treated as different and abnormal. This labelling had significant social consequences for the youth at school. Alternatively, others felt that the label helped them validate their experiences.

16.Clark et al. (2018).	Obtain the perspectives of adolescent males aged 12-18 years, both with and without experience of clinical anxiety, on the barriers and facilitating factors to help-seeking for anxiety.	Participants (n = 8). Age (12-18). Gender (M = 8).	Sources of professional help: School counsellor (n = 1%). Private Psychologist (n = 2). Child and Adolescent Mental Health Clinic (n = 4).	Help-Seeking.	Embarrassment/Secrecy.	Semi-structured Interviews and Focus Groups (43-67 mins) to identify knowledge of and preferences regarding help-seeking options.	Primary barriers to help-seeking included stigma related to social norms of masculinity and mental illness.
17.Moses (2015).	Explore how the stigma-coping strategies that recently discharged youth anticipate using in response to a hypothetical social stigma incident predict self-stigmatisation as follow-up.	Participants (Time 1: 102, 61.5% dropout. Time 2: 80, further 21.6% dropout). Age (13-18). Gender (F = 63%). Ethnicity (Caucasian = 74%).	Self-Stigma.	<i>Time 1 (Admission):</i> 20% admitted following active suicide attempt. 60% admitted for suicidal ideation. 9.8% admitted for aggressive behaviour. <i>Time 2 (Discharge):</i> Mood and/or Anxiety Disorders (67%). ADHD (7%). Alcohol/Drug Abuse Disorder (8%). ODD/Conduct Disorder (5%).	Maladaptive Coping (Disengagement and Disconfirming Stereotypes).	Semi-structured Interview (approx. 2 hours). <i>Coping with Stigma</i> (Coping with Stigma Questionnaire). <i>Coping Style</i> (Responses to Stress Questionnaire: Primary Control Engagement Coping, $\alpha = .72$; Secondary Control Engagement Coping, $\alpha = .86$; Disengagement, $\alpha = .70$; Aggression, $\alpha = .68$; Disconfirming Stereotypes, $\alpha = .75$). <i>Self-Stigma</i> (Adapted Child Stigma Scale, $\alpha = .85$).	Youth expecting to use less Secondary Control Engagement Coping was most robust in predicting youths' higher reported levels of self-stigma at 6 months follow-up. Bidirectional relationship found between higher self-stigma scores and expecting to use Disengagement Coping and Disconfirming Stereotypes.

18.Gaziel et al. (2015).	Examine the relationships among insight into mental illness, self-stigma, parental insight and the SwL of adolescents with mental disorders.	Participants (n = 30). Age (M = 13.9). Gender (F = 56.6%,). Ethnicity (Native Israelis).	Self-Stigma	Major Depressive Disorder (n = 6). Bipolar Mood Disorder (n = 5). DBD (n = 5).	Satisfaction with Life. Insight to Mental Illness.	Social Distancing.	<i>Self-Stigma</i> (Internalised Stigma of Mental Illness Questionnaire, $\alpha = .88$). <i>Insight</i> (Schedule for Assessment of Insight-Expanded), $\alpha = .55$). <i>Satisfaction with Life</i> (Multi-Dimensional Students' Life Satisfaction Scale Questionnaire, $\alpha = .70$).	Insight into the disorder was positively correlated with self-stigma and both of them were negatively correlated with previous findings among adults with mental illness that insight is positively correlated to self-stigma.
19.Hassett et al. (2017).	Explore how young men, who have successfully accessed formal help for self-harm, understand their journey of help-seeking and how their experiences led them to continue to seek help after initial access.	Participants (n = 8) Age (16-18). Gender (M = 8).	Public Stigma (Peers). Self-Stigma.	Self-Harm.	Stigma Resistance. Help-seeking.	Semi-structured Interviews (40-60 mins) to assess how young men made sense of their journey to seeking help for self-harm.	Participants indicated stigma as a challenge to help seeking behaviours. There was also a secondary stigma relating to being male with perceptions of needing to maintain a masculine identity. However, some participants reported that by having their problems normalised, they felt readier to engage with services.	

20.Keyes et al. (2017).	Contribute qualitative insight into young person's experiences of living with OCD. Qualitative Design.	Participants (n = 10) Age (13-18). Gender (M = 5, F = 5). Ethnicity (White British = 9, South American = 1).	Public Stigma (Peers, Family, Teachers, Healthcare Staff). Self-Stigma.	Participants recruited from CAMHS who were formally diagnosed with OCD.	Help-Seeking. Label Endorsement.	Secrecy. Feeling Different from Others.	Semi-structured Interview (approx. 1 hour) exploring the experiences of the initial signs of OCD and if there were any stressful life events at the time.	Young people with OCD described how self-stigmatisation and the fear of stigma led them to keep their experiences a secret and made them feel different and 'crazy'. This led to a delay in help-seeking described by many. They also reported that accessing help was further delayed due to the lack of understanding of others, including medical professional and educators.
21.Davison et al. (2017).	Explore the perceptions and experiences of a group of vulnerable young people using CAMHS. Mixed Design.	Participants (n = 42) Age (11-16). Gender (M = 26%, F = 74%). Ethnicity (White British).	Public Stigma.	48% currently receiving support from CAMHS.	Help-seeking.	<i>Service Experience</i> (Service Experience Questionnaire). Semi-structured Interviews (10-25 mins) to understand the factor young people value in their care, and their wider service experience.	Adolescents identified stigma as being a significant barrier to accessing CAMHS.	

22.Khesht-Masjed et al. (2017).	Explore social factors of mental illness stigma in adolescents diagnosed with mental 'diseases'.	Participants (n = 113) Age (x = 15.56). Gender (M = 58.4%, F = 41.6%).	Public Stigma (Family).	Schizophrenia (12.4%). Mood Disorders (5.3%). Substance-Induced Psychosis (13.3%). Depression (13.3%). Anxiety (13.3%). OCD (5.6%). Hyperactivity (20.4%). No history of psychiatric hospitalisation (69.9%). Hospitalised once (24.7%). Hospitalised more than once (3.5%).	Secrecy.	<i>Experiences of MH Disorders</i> (Experience of Caregiving Inventory).	Some adolescents stated that they would hide their illness from family members and not engage in conversations with them surrounding it. However, this was mediated by the type of mental illness reported.
23.Kaushik et al. (2017).	Develop and validate a new instrument, the Paediatric Self-Stigmatisation Scale.	Participants (n = 156) Age (8-12). Gender (M = 60.9%, F = 39.1%).	Self-Stigma.	37 participants were inpatients at a national children's unit. 119 were outpatients from community clinics. Emotional and/or Behavioural Disorder (31.4%). Neurodevelopmental Disorder (42.3%). Both (26.3%).	Self-Perception. Quality of Life. MH Symptom Severity.	<i>Self-Stigma</i> (The Paediatric Self-Stigmatisation Scale: Societal Devaluation Scale, $\alpha = .86$; Personal Rejection Scale, $\alpha = .72$; Self-Stigma Scale, $\alpha = .86$; Secrecy Scale, $\alpha = .79$). <i>Perceived Self-Concept</i> (Self-Perception Profile for Children). <i>Quality of Life</i> (Paediatric Quality of Life Inventory version 4.0). <i>Diagnosis/Medication</i> (Children's Global Assessment Scale).	Those who self-stigmatised according to the scale also exhibited higher severity of MH symptoms, functional impairment, and poorer quality of life.

24. Rose et al. (2011).	Explore the relationships between Black adolescents' perceived stigma and their current level of depression severity in an outpatient sample.	Participants (n = 108) Age (16-18). Gender (M = 46%, F = 54%). Ethnicity (African American = 102, Mixed = 2, Latino = 2, American Indian = 2).	Perceived Stigma.	Depression.	Depression.	<i>Depression Severity</i> (Reynolds Adolescent Depression Scale 2 nd Ed.), <i>Perceived Stigma</i> (Attitudes Towards Psychological Help Scale 5-Item), $\alpha = .67$), <i>Perceived Need for MH Services</i> (Two self-report questions).	Just under half of participants who experienced mild-severe depressive symptoms also experienced higher perceived stigma.
25. van de Water et al. (2018).	Explore the experiences of stigma in adolescents participating in an intervention for PTSD symptoms. Mixed Design.	Participants (n = 10) Age (13-18).	Public Stigma (Peers, Family, Teachers).	PTSD.	Lack of help-seeking. Embarrassment/Shame.	Semi-structured Interview. <i>PTSD</i> (Child Post trauma Stress Scale: CPSS).	Adolescents described a mixed range of perceived poor, ambivalent, and good support experiences when accessing treatment, and were particularly motivated when they had access to a caring adult. During the trial, adolescents used calculated disclosure strategies to reduce their vulnerability to marginalisation and stigma. School-based therapy was well received but could be improved if sessions were offered after school hours.

26. Flack (2018).	Explore how secondary-age school boys with ADHD experience their ADHD.	Participants (n = 9) Age (11-15). Gender (M = 9) Ethnicity (White British = 7, Mixed White/Black Caribbean = 1, British/Other Mixed = 1).	Public Stigma (Peers).	Autism Spectrum Disorders Dyslexia Sensory Processing Developmental Delay Dyspraxia ADHD Learning Difficulties	Perception of illness (perceived as a disability) Lack of help-seeking.	Secrecy/Disclosure. Social-Relational Difficulties (bullying).	Semi-structured Interview.	The findings highlight the complexity of ADHD, heterogeneity of its symptoms and pros and cons of the impact of the label on young people and their families
27. Wiener et al. (2016).	Explore school experiences of adolescents with ADHD in the context of adolescent self-appraisals and relationships with peers and parents.	Participants (n = 12) Age (14-16). Gender (M = 9, F = 3).	Public Stigma (Peers).	ADHD		Secrecy/Disclosure. Social-Relational Difficulties (bullying).	Semi-structured Interview (2hrs – 3hrs 15 mins). <i>ADHD Symptoms</i> (Conners Rating Scale-Revised).	Three themes emerged: (a) support for a performance deficit, (b) academic and social engagement, and (c) moving from dependence to independence. What is most striking is the low level of agency students demonstrated; that is, rather than acting with purpose on their environments, they seemed to react to things that happened to them.

^a Moses et al. (2009a; 2009b; 2010a; 2010b) all use the same participant pool but conduct varying analyses across studies. Due to the diversity in outcomes across each, these studies will be seen as independent but sample demographics will only be reported from Moses et al. (2010b).

^b Lindsey et al. (2006; 2010) use the same participant pool but conduct varying analyses across studies. Due to the diversity in outcomes across each, these studies will be seen as independent but sample demographics will only be reported from Lindsey et al. (2006).

^c Kranke et al. (2009; 2010; 2012) studies use the same participant pool but conduct varying analyses across studies. Due to the diversity in outcomes across each, these studies will be seen as independent but sample demographics will only be reported from Kranke et al. (2009).

Notes: MH = Mental Health; ADHD = Attentional Deficit Hyperactivity Disorder; ARMS = At-Risk Mental State; SwL = Satisfaction with Life; OCD = Obsessive Compulsive Disorder; CAMHS = Child and Adolescent Mental Health Services; n = Number; F = Female; M = Male; x = Mean; PTSD = Posttraumatic Stress Disorder; NOS = Not Otherwise Specified; ODD = Oppositional Defiant Disorder; DBD = Disruptive Behaviour Disorder; RAD = Reactive Attachment Disorder; CD = Conduct Disorder; TeenSEMI = Teen Subjective Experiences interview.

Table 2. *Detailed analysis of studies investigating the psychosocial effects of MH stigma among children and adolescent*

Quality appraisal of the records was conducted by JF using the Mixed Methods Appraisal Tool (MMAT; Pluye et al., 2011). This tool has been developed and content validated (Souto et al., 2015) particularly to concomitantly measure quality in quantitative, qualitative, and mixed-method research. Qualitative studies were assessed on items 1-4, quantitative studies on items 5-8, and Mixed Method studies on items 1-11 (see Table 3).

Research Study	Qualitative Criterion				Quantitative Criterion				Mixed Methods Criterion			Quality Percentage (%)
	1	2	3	4	5	6	7	8	9	10	11	
Kranke et al. (2011).	●	●	●	○								75%
Moses et al. (2009a).	●	●	●	○	○	●	●	●	○	●	○	64%
Lindsey et al. (2006).	●	●	●	○								75%
Moses et al. (2009b).	●	●	●	○	○	●	●	●	○	●	○	64%
Kranke et al. (2009).	●	●	●	○								75%
Kranke et al. (2012).	●	●	●	○								75%
Kranke et al. (2010).	●	●	●	○								75%
Lindsey et al. (2010).	●	●	●	○	●	●	●	●	●	○	●	82%
Moses et al. (2010a).	●	●	●	○	○	●	●	●	●	○	○	64%
Moses et al. (2010b).	●	●	●	○	○	●	●	●	●	●	●	82%
Wiener et al. (2012).					●	●	●	●				100%
Bussing et al. (2011).					○	●	●	○				50%
Welsh et al. (2011).	●	●	●	○								75%
Lindsey et al. (2013).	●	●	●	○								75%
Mitten et al. (2016).	●	●	●	○	○	●	●	○	○	○	○	45%
Clark et al. (2018).	●	●	●	○								75%
Moses (2015).	●	●	●	○	○	●	●	○	○	○	○	45%
Gaziel et al. (2015).					○	●	●	○				50%
Hassett et al. (2017).	●	●	●	●								100%
Keyes et al. (2017).	●	●	●	●								100%
Davison et al. (2017).	●	●	●	○	○	●	●	●	●	●	●	82%
Khesht-Masjed et al. (2017).					○	●	●	●				75%
Kaushik et al. (2017).					●	●	●	●				100%
Rose et al. (2011).					○	●	●	●				75%
van de Water et al. (2018).	●	●	○	○	○	○	●	●	●	●	○	55%
Flack (2018).	●	●	●	●	●	○	○	●	●	●	○	73%
Wiener et al. (2016).	●	●	●	○	●	○	○	●	●	●	○	64%

● Criteria Met ○ Criteria Not Met/Not Reported

Notes: 1) Are the sources of qualitative data relevant to address the research question? 2) Is the process for analysing qualitative data relevant to address the research question? 3) Is appropriate consideration given to how findings relate to context? 4) Is appropriate consideration given to how findings related to researchers' influence? 5) Is the sampling strategy relevant to address the quantitative research question? 6) Is the sample representative of the population under study? 7) Are measurements appropriate? 8) Is there an acceptable responses rate (60%)? 9) Is the mixed methods design relevant to address the qualitative and quantitative research questions? 10) Is the integration of qualitative and quantitative data relevant to address the research question? 11) Is appropriate consideration given to the limitations associated with this integration in a triangulation design.

Table 3. Summary of quality appraisals based on the Mixed Methods Appraisal Tool (MMAT; Pluye et al., 2011).

Narrative synthesis was undertaken due to the methodological and clinical heterogeneity between studies under the framework of the 'ERSC Guidance on Conducting Narrative Synthesis' (Popay et al., 2006). Similar to previous mixed-method reviews, a meta-thematic analysis was conducted by JF whereby qualitative data (both researcher interpretations and direct quotations) from relevant studies were collated into a single document to be re-analysed. Line-by-line coding was performed to elicit emerging themes through an iterative process. Quantitative data was synthesised separately and tabulated to compare with tabulated themes from qualitative data where they were then integrated. These were checked with author-reported themes to gauge consistency of interpretation with a majority satisfying this. Some themes were reworded to be congruent with the aims of this review as not all records intended to explore stigma outcomes. Outcomes were categorised as psychological if processes were considerably internalised, and social if externalised. Where possible, differences in stigma effects were examined in subgroups relating to ethnicity and gender.

3.1 Results

Of the 27 studies, ten contributed entirely qualitative data, six contributed entirely quantitative data, and eleven contributed both. Publication dates ranged from 2006-2018. Study characteristics and range of measures used are presented in Table 2.

3.2 Study Characteristics

Prevalence of stigma varied across papers with 23 studies referring to public stigma, whereas ten made reference to self-stigma. Studies identified various sources of stigma from wider society (n = 23), peer groups (n = 18), family (n = 12), school staff (n = 6), healthcare staff (n = 2), and the youth themselves (n = 10). In terms of the sample, the total number of youth included across 21 studies (avoiding duplicated participant samples) was 1,037. The

age of youth ranged between 8-19 years old, with 15 studies with independent samples including both male and female youth, five male only, and one not reporting gender. The ethnic diversity of youth ranged from: White Caucasian (White British), African American, Canadian, Aboriginal Canadian, Israelis, 'Mixed', South American (Latino), American Indian, Mixed White/Black Caribbean, and 'Other'; nine studies did not report on ethnicity. Most studies reported satisfactory internal reliability scores ($\alpha > .70$) though several were lower (.64-.68: Lindsey et al., 2010; Moses, 2010a; Moses, 2015; Rose, Joe, & Lindsey, 2011), one was below .60 (Gaziel et al., 2015), and others did not report reliability. The scope of MH difficulties explored in relation to stigma was comprehensive though literature pertaining mood and anxiety symptomology, and ADHD behaviours, was overrepresented.

3.3 Subgroup Analyses

Male adolescents were more likely to view emotional expression as 'weak' from both African American (Lindsey et al., 2006) and Caucasian (Clark, Hudson, Dunstan & Clark, 2018) ethnicities and this inhibited help-seeking behaviours. However, youth reported that having their experiences normalised (particularly for boys) reduced feelings of social isolation and reduced the need to be secretive (Hassett & Isbister, 2017). Quantitative data found either that girls report less stigmatisation experiences (Moses, 2010b) or that there are no gender differences (Khesht-Majedi, Shokrgozar, Abdollahi, Golshahi, & Zamiri, 2017; Moses, 2009a).

African Americans and Caucasians both reported being secretive as a result of stigma experiences (Kranke et al., 2011). However, African American adolescents endorsed more negative stereotypes with use of stigmatising labels such as 'crazy' and 'psycho' likely due to familial and cultural influence (Kranke et al., 2011). Quantitative data revealed that young people from minority ethnic communities reported less peer stigmatisation (Moses, 2010b)

and were less likely to self-label (Moses, 2009a). Further, Caucasian adolescents reported more experiences of personal rejection and self-stigma than ethnically diverse youth (Moses, 2009b).

All 27 studies examining the psychosocial effects of MH stigma evidence that young people do experience adverse challenges. The outcomes are explored below:

3.4 Psychological Outcomes

3.4.1 Label Endorsement/Resistance

Five studies identified associations between stigma experiences and either label rejection or label endorsement. Young people felt relief when diagnosed with OCD discounting their beliefs that they were ‘mad’ (Keyes et al., 2017). The benefits of having a label were attributed to facilitating help-seeking (Mitten, Preyde, Lewis, Vanderkooy, & Heintzman, 2016; Welsh & Tiffin, 2012), being more accepted (Mitten et al., 2016), and having their experiences normalised (Welsh et al., 2012). Eleven youth felt being assured of having a MH condition heightened their understanding of the disorder (Moses, 2009a). Those who self-labelled were more likely to have experienced personal rejection and self-stigma suggesting the process to be a product of both public and self-stigma (Moses, 2009a). Lastly, those who endorsed labelling were also more likely to be depressed (Moses, 2009a); however, the direction of this association is uncertain.

Despite label endorsement, some youth explicitly rejected the use of labels as a result of stigma. Some male participants stated that they would prefer help resources to utilise less ‘diagnostic’ language and be more generic (Clark et al., 2018). Others felt that they were not perceived as ‘normal’ and only seen with the diagnosis affecting their identity (Mitten et al., 2016). Twenty youth also rejected the idea of being ‘emotionally disordered’, using terms such as ‘not caring’ or having ‘outbursts’ to help normalise experiences (Moses, 2009a).

Lastly, older youth were more likely to avoid labelling as opposed to younger youth (Moses, 2009a). This highlights how the perceptions of labelling are determined by context as they offer benefits and consequences in different circumstances.

3.4.2 Shame/Embarrassment

Nine studies found associations between stigma experience and shame. Feelings of shame with having a MH condition were associated with a lack of service use amongst Black adolescents (Lindsey et al., 2006; Lindsey et al., 2010). Youth also felt shame when accepting a ‘medicated’ self-image (Kranke et al., 2011), as well as feeling a need to ‘handle’ their own behaviours (Kranke et al., 2011; Kranke et al., 2012; Moses, 2009b).

Embarrassment was reported when taking medication in front of other people (Kranke et al., 2011) and being removed from class to see a school counsellor (Clark et al., 2018). Young people stated that they kept their problems and medication use a secret to avoid embarrassment (Kranke et al., 2010; Lindsey, Chambers, Pohle, Beall, & Luckstead, 2013) and feelings of ‘differentness’ (Kranke et al., 2010). However, one youth reported not feeling ashamed when with others experiencing similar issues but not exhibiting shame (Kranke et al., 2009). Additionally, one participant felt embarrassed about accessing counselling but decided to tell friends who were supportive thereafter (van der Water et al., 2018).

Furthermore, another adolescent explicitly stated he did not feel shame as he felt MH difficulties were becoming more validated as an illness within the media (Hassett et al., 2017).

3.4.3 Perceptions of Illness

Seven studies found that stigma experiences affected the way adolescents perceived their own experiences of MH difficulties. Family stigma concerning medication use caused youth to have a negative attitude towards taking medication due to feelings of shame and

embarrassment (Kranke et al., 2010). Others also endorsed self-stigmatising labels such as ‘crazy’ and ‘psycho’ to conceptualise their illness due to family modelling (Kranke et al., 2010), as well as feeling disbelieved by parents (Moses, 2010b). Further, two participants with ADHD viewed their condition as a disability due to stigma, however, seven others saw ADHD to have positive qualities (Flack, 2018).

Others reported stigma from healthcare services which made them feel their illness was not validated as genuine making them feel belittled and unsupported when accessing care (Mitten et al., 2016). In one study, higher self-stigma scores were associated with perceptions of loss of control over their condition and belief of it being chronic (Moses, 2010a). Moreover, less self-stigma was reported when family members endorsed more optimistic beliefs about their MH condition (Moses, 2009a). Lastly, those who scored higher on self-stigma had more awareness and insight into their condition resulting in a decreased perception of quality of life (Gaziel et al., 2015).

3.4.4 Worsening Mental Health

Six studies found associations between higher stigma experiences/scores and worsening of MH difficulties. Perceived stigma associated with MH service use (Lindsey et al., 2010; Rose et al., 2011) as well as self-stigma (Moses, 2009b) were associated with higher depression severity. Experiences of self-labelling and self-stigma were also associated with more depressive symptoms and lower scores on self-mastery (Moses, 2009a). Among youth with ADHD, higher self-stigma scores were associated with lower global self-worth (Wiener et al., 2012). Lastly, children with MH difficulties scoring high on self-stigma experienced lower scores of self-efficacy and self-esteem (Kaushik et al., 2017).

3.4.5 Choice of Coping

One study explored the coping strategies adolescents used as a result of MH stigma. The most commonly endorsed strategy across the sample was Primary Control Engagement Coping (PCEC) which uses problem solving, help seeking and expression of one's feelings to regain control of the situation (Moses, 2015). Samples reporting more self-stigma scores were more likely to endorse 'Disengagement Coping' through social avoidance and 'disconfirming stereotypes' by acting opposite to what was stereotypically expected of them (Moses, 2015). These were endorsed as opposed to PCEC as more maladaptive strategies to cope.

3.4.6 Lack of Help-Seeking

Ten studies found stigma to impede on help-seeking behaviours amongst youth. Some youth exhibited self-stigmatising attitudes and fear towards seeking treatment for MH difficulties (Keyes et al., 2017; Kranke et al., 2012). Two participants felt they could not seek help for fear of what others may think (Flack, 2018), with adolescents in another study reporting reluctance to access a post-traumatic stress intervention due to peers not wanting attention brought to the friend group (van der Water et al., 2018). Others reported that seeking counselling was 'weird' or 'crazy' and would encourage social exclusion or judgement (Davison, Zamperoni, & Stain, 2017; Lindsey et al., 2013), contrasting with others' views of help-seeking as encouraging independence in youth (Lindsey et al., 2013). A lack of understanding of OCD-related difficulties was found to delay help seeking in adolescents from 3 months to 8 years (Keyes et al., 2017). Feelings of shame also contributed to the lack of help-seeking seen in youth (Keyes et al., 2017).

Youth also endorsed more discrete pathways to help-seeking which may reflect a need to be secretive regarding MH treatment (Clark et al., 2018). Amongst children with ADHD, exhibiting self-stigma was associated with lower MH service use in the past year (Bussing, Zima, Mason, Porter, & Garvan, 2011).

3.5 Social Outcomes

3.5.1 Secrecy/Disclosure

In 13 studies, youth reported being unwilling to disclose their use of MH services for fear of being bullied (Kranke et al., 2010; Lindsey et al., 2010), judged (Kranke, Guada, Kranke, & Floersch, 2012) or being seen as ‘weak’ (Lindsey et al., 2010; Lindsey et al., 2013). One adolescent even mentioned not wanting to be at a ‘normal school’ for fear of being teased (Kranke et al., 2009). Seventy-percent of one sample disagreed that one should hide one’s MH treatment from others with a further 60% of another sample reporting that they would wait until they knew someone well enough to disclose (Moses, 2009b). Lastly, one study found higher self-stigma scores to be associated with secrecy regarding one’s problems and treatment (Moses, 2009b).

Feelings of shame contributed to the need to be secretive of their MH diagnosis and medication use (Kranke et al., 2010) which affected peer relationships and the prospect of help-seeking (Clark et al., 2018; Keyes et al., 2017). At the same time, keeping medication use secret was a protective method of limiting how ‘different’ young people felt towards their peers and family (Kranke et al., 2010; Kranke et al., 2011; Kranke et al., 2012; Keyes et al., 2017; Moses, 2010b), thereby maintaining self-image (Lindsey et al., 2013; Welsh et al., 2012). Moreover, those with ADHD were found to hide their diagnosis from peers due to fear of stigma (Flack, 2018). However, not all adolescents endorsed the need to feel secretive (Clark et al., 2018). Some youth reported positive experiences when disclosing to peers they felt ‘close to’ (Kranke et al., 2010; Welsh et al., 2012). Further, eleven adolescents reported comfort in going to their family for disclosure before going to ‘outsiders’ (Lindsey et al., 2010).

3.5.2 Social-Relational Difficulties

Fourteen studies identified social difficulties with others to be salient when experiencing stigma. Fear of social exclusion, rejection, bullying, and being seen as ‘weak’ were reported to be a fear amongst African American male adolescents (Lindsey et al., 2006; Lindsey et al., 2010) and other ethnicities (Keyes et al., 2017) in uptake of MH services. One adolescent reported eating in the guidance counsellor’s office at lunchtime because of feeling ostracised due to her condition (Kranke et al., 2009), where others have reported explicit verbal and physical bullying experiences (Moses, 2010b; Wiener et al., 2012). Some youth actively isolated themselves from their peers due to feeling ‘different’ from them (Kranke et al., 2010; Kranke et al., 2011) as well as fear of not being accepted (Kranke et al., 2010). Adolescents’ peer relationships were found to be affected by their need to be secretive as a result of feeling shame regarding their MH diagnosis and medication use (Kranke et al., 2009; Kranke et al., 2010; Kranke et al., 2011; Kranke et al., 2012; Welsh et al., 2012). Quantitative data reported associations between personal rejection experiences and feeling disrespected due to their MH identity (Moses et al., 2009b). Lastly, children who scored high on self-stigma scales were found to endorse lower scores of feeling socially accepted (Kaushik et al., 2017).

Adolescents believed that others were scared of people with mental illness and five believed this led to people avoiding the young person themselves as a result (Mitten et al., 2016; Moses, 2010b). Twenty-five adolescents reported experiencing rejection by some peers leading them to seek others who were more accepting (Moses, 2010b). Thirteen youth reported losing one or more friends due to disclosing their psychological difficulties (Moses, 2010b). A further eight stated that their friends’ parents created further problems for them as they feared they would ‘negatively influence their children’ (Moses, 2010b). Youth also experienced exclusion and a lack of empathy from extended family due to information passed from immediate family (Moses, 2010b) leading to youth feeling alienated and demoralised in

this context. Five adolescents reported that their siblings ‘feared’, ‘teased’, and ‘avoided’ them ‘as much as possible’ (Moses, 2010b). Young people also stated feeling excluded in school settings from teachers who wanted to isolate ‘trouble-makers’ from the others (Moses, 2010b). However, not all youth experienced negative social outcomes as 21 youth reported positive or no incidences of being stigmatised amongst peers (Moses, 2010b).

3.5.3 Limiting Interactions

Six studies reported that some adolescents found social benefits when engaging with others with similar MH experiences as a result of previous stigma. Some youth felt more belonging (Kranke et al., 2009; Kranke et al., 2010) and genuine empathy (Welsh et al., 2012) when interacting with others who experienced a MH problem and/or took psychiatric medication (Hassett et al., 2017; Kranke et al., 2009; Moses, 2010b). Others felt misunderstood by healthcare professionals, eventually finding relief when meeting other patients with similar difficulties (Keyes et al., 2017). Some explicitly stated that their stigmatising experiences helped them identify who their ‘real friends’ were (Moses et al., 2010b).

4.1 Discussion

This review is the first to systematically examine the psychological and social effects of MH stigma amongst youth. Outcomes of stigma were multifaceted and mainly negative though some protective factors were also identified. Although outcomes were categorised into psychological or social outcomes both concepts commonly overlap with one another (Corrigan et al., 2006). This was evident in the current review, reflecting the inherent difficulty in compartmentalising people’s lived experiences into such categories (Livingston & Boyd, 2010).

Young people may have even less power by virtue of simply being children, but also because their sense of identity and social belonging is still developing (Hinshaw, 2005). Neurological research further supports that an adolescents' brain may be hypersensitive to social contact (Burnett et al., 2011), underscoring the importance of social identity and social capital amongst this group's developmental trajectory. An overarching theme across most outcomes was a fear of social rejection and need for belonging from peers, in particular, suggesting that theoretical models relating to children and young people must include these. Concern with social exclusion may lead to a need to be secretive of their MH difficulties fostering feelings of shame and self-stigma. This self-stigma was then related to youth perceptions of losing control hindering help-seeking (Moses, 2009a). Experiencing stigma was also associated with low self-esteem, increased depression (Rose et al., 2011; Moses, 2009b) and using maladaptive coping such as avoidance (Moses, 2015). Some youth rejected being labelled with a MH condition as they felt that it threatened their self-identity (Mitten et al., 2016). Lastly, fear of social exclusion led youth to limit their interactions to those who had similar MH difficulties. Although these associations between outcomes are not robust, the complex trajectory underscores the complex and unique stigma experiences young people experience. This may be different from adult experiences as an emphasis on identity preservation and maintenance of social relationships are salient.

Subgroup analyses revealed ethnically diverse and male adolescents think that accessing MH treatment itself reflects weakness (Clark et al., 2018) and African Americans were more likely to endorse self-stigmatising language such as 'crazy' (Lindsey et al., 2006). These differences may be subject to certain socio-cultural processes as Western ideals of masculinity as being 'resilient' and 'stoic' are pervasive (Yousaf, Popat, & Hunter, 2015). Adolescents may also hold more than one stigmatising identity as African American youth may face discrimination for their ethnicity (Elkington, 2012) and male youth for not

conforming to societal ideals of masculinity (Tyler & Williams, 2014). It is unknown if this ‘layered stigma’ extends to youth from other ethnicities, gender of sexual identities or ability levels. Furthermore, a lack of child-centred research was also apparent with only two studies assessing this demographic exclusively. The lack of child stigma research may be attributed to notions that children are unable to accurately identify when they are being stigmatised (Mukolo et al., 2010) making the investigation of stigma experiences difficult. Modified Labelling Theory (MLT) assumes that stigmatised individuals have access to cognitive processes that allow one to recognise stigma and the impact this is having on them. Additionally, MLT does not account for the processes of layered stigma which can be experienced across the lifespan.

Despite the common trajectory of stigma leading to worse outcomes for youth, some felt that the process of labelling was beneficial in that it helped validate experiences and enabled them to seek help. Also, some youth identified limiting their interactions to those who shared similar experiences with MH, creating a more cohesive social support network. This highlights the complexity of stigma’s effects, and supports a call for more research on positive or neutral reactions and experiences of young people.

In summary, there are both similarities and differences between adults and youth in the outcomes associated with MH stigma. This underscores the importance of considering the social and cognitive developmental contexts within which young people exist (DeLuca, in press; Heary et al., 2017). Understanding the effects of MH stigma for young people is more than simply contrasting those outcomes with outcomes among adults; it necessitates the interpretation of those outcomes within developmental theoretical frameworks if effective intervention and prevention programs are to be developed. At the same time, there are important theoretical developments in the adult literature which have yet to be examined

among children and young people (e.g., the “Why try?” effect: Corrigan, Larson, & Ruesch, 2009) and exploration of these issues will also be important as the field progresses.

Despite such insights, this review’s findings are limited by the heterogeneity seen across studies with inconsistencies in methodology, sampling, outcomes and quality in reporting thereby making the data synthesis process challenging. These inconsistencies may result from the lack of standardised measures available for testing stigma outcomes among youth though such measures are now emerging (e.g. Kaushik et al., 2017). Moreover, the diversity of language used to refer to overlapping concepts in this field makes it challenging to conclusively review all relevant literature. The quality appraisal process yielded mostly moderate-high records, yet, the MMAT itself has limitations. Most of the studies failed to meet full criteria on quality appraisals potentially due to reporting of key quality assurance characteristics being omitted or inexplicit. However, the developers recommend contacting authors for missing data to satisfy the criteria as the MMAT is not designed for appraising quality in reporting (Pluye et al., 2011).

Regarding the review’s inclusion criteria, the experiences of youth from non-clinical samples and those who have accessed services are uncertain. This limitation is significant with regards to comprehensively capturing the experiences of mental illness stigma for those who may not present to services to seek help. Moreover, the sparsity of data available, especially from minority groups warrants the need for larger, more diverse clinical samples to compliment the current review’s outcomes. Additionally, this review was not able to include non-English or unpublished articles and so conclusions about groups in non-English speaking territories may not be warranted. Despite such limitations, by using a mixed-methods review approach a wider scope of studies was possible for the synthesis. However, the process of conducting a meta-thematic analysis on qualitative studies resultingly decontextualizes the

findings of each study (Thomas & Harden, 2008). Nevertheless, some context of the studies was preserved through the use of a data extraction template to maintain context.

This review highlights a number of factors which should be taken seriously when developing models of the ways in which young people are stigmatized by mental health and how this can influence their behaviour and adjustment. Stigma models which are sensitive to the complex developmental (and cultural) trajectories of youth may allow for more effective and responsive stigma interventions. Research exploring experiences of stigma with more adolescents who hold multiple stigmatised identities and with younger children are also recommended. This will help inform a clearer understanding of the process of mental illness stigmatisation amongst young people, and importantly, may aid future intervention work.

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