What Do African American Youth With a Mental Illness Think About Help-Seeking and Psychiatric Medication?: Origins of Stigmatizing Attitudes

Derrick Kranke PhD MA, Joseph Guada PhD MSW, Bridget Kranke MSSA LSW & Jerry Floersch PhD MSW

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What Do African American Youth With a Mental Illness Think About Help-Seeking and Psychiatric Medication?: Origins of Stigmatizing Attitudes

DERRICK Kranke, PhD, MA
Mandel School of Applied Social Sciences, Cleveland, Ohio, USA

JOSEPH Guada, PhD, MSW
College of Social Work, Ohio State University, Columbus, Ohio, USA

BRIDGET Kranke, MSSA, LSW
Child Guidance & Family Solutions, Akron, Ohio, USA

JERRY FLOERSCH, PhD, MSW
College of Social Work, Rutgers University, New Brunswick, New Jersey, USA

Stigma greatly impacts African Americans’ underutilization of mental health treatment. Stigmatizing attitudes are attributed to racial mistrust and familial, religious, and cultural beliefs. However, most research on influences of these attitudes has been conducted with adults. Origins among adolescents may be unique because they have different competing influences relative to development. Identifying these influences is crucial to promoting utilization of psychiatric services as well as positive mental health outcomes among youth. The present article applies qualitative methods to explore the origin of stigmatizing attitudes among African American adolescents with psychiatric disorders. Adolescents reported similar origins of stigmatizing attitudes toward mental illness as adults, and also identified peer perceptions and media messages as influences. The findings promote the need to develop family psychoeducation programs that account for familial, racial, cultural, community, and religious influences.

Address correspondence to Derrick Kranke, PhD, MA, Mandel School of Applied Social Sciences, 11235 Bellflower, Cleveland, OH 44106, USA. E-mail: dakranke@gmail.com
The U.S. Department of Health and Human Services reports that African Americans have similar rates of mental illness as Whites (2000). However, among certain severe mental illnesses, African Americans are overrepresented. For instance, African Americans are three to four times more likely than Whites to have a diagnosis of schizophrenia (Bresnahan et al., 2007). These estimates are quite alarming, especially since African Americans are much less likely to seek mental health treatment than Whites. They are also often underserved by the larger mental health system (Dixon & Vaz, 2005; Snowden, 2001).

AFRICAN AMERICANS AND MENTAL ILLNESS PERCEPTIONS

There are many factors that can influence the utilization of mental health services among African Americans. Some factors are related to geography or socioeconomic status as recent research continues to demonstrate (Logan, 2007). Nonetheless, some African Americans are influenced by familial beliefs, and cultural norms (Williams, Costa, & Leavell, 2010) that encourage self-reliance (Mathews, Corrigan, Smith, & Aranda, 2006) and strong ties to faith (Bolden & Wicks, 2005). The African American culture endorses alternative coping strategies and informal support systems to manage mental health issues (Mathews et al., 2006). For instance, many African Americans seek mental health counseling from church ministers and clergy, because it is believed that prayer can solve all problems (Bolden & Wicks, 2005). In addition, African Americans rely on their family to cope with mental health issues because the mental illness label is shameful, and knowledge of the diagnosis outside of the family could cause negative reactions, and a double stigma, which could lead to further discrimination (Newhill & Harris, 2007). As a result, they do not endorse disclosure or seeking formal help for mental health problems, often leaving individuals to cope on their own (Mathews et al., 2006). It is worth noting that most work conducted on factors that impact utilization of mental health services among African Americans pertains to adults (Bolden & Wicks, 2005).

Those African Americans that utilize the mental health system may have pessimistic views toward treatment because of negative experiences. In particular, one study (Mathews et al., 2006) illustrated how African Americans believed that their concerns and mental health needs were not adequately addressed within the medical establishment. In addition, participants reported that mental health providers were not competent enough to work effectively with them, and African American parents felt they were
Origins of Stigmatizing Attitudes

being blamed and interrogated for their child’s illness rather than assisted. These negative experiences likely perpetuate the sequence of stigmatizing views and mistrust toward mental illness treatment for some African American adults, youth, and families.

There is also a tendency among some African Americans to be reluctant to use psychotropic treatment because of negative consequences (Mathews et al., 2006; Newhill & Harris, 2007). In particular, some African Americans fear the use of medications will cause people to be dependent on them; they also worry about safety issues of medication and the belief that it might make people “crazy” (Mathews et al., 2006). Research attributes these negative perceptions to a “pervasive lack of knowledge in the community about mental illness and the services to treat it. . . . Often what people think they know (in the African American community) is inaccurate” (Newhill & Harris, p. 116).

Reliance on alternative sources for mental health services might have unintentional detrimental consequences. First, church officials may not have the proper training to assist people with mental illness. Inadequate training of some ministers could be harmful to the individual’s well-being and greatly impede functioning. Second, many African Americans seek treatment in emergency settings for mental health needs because of their resistance to utilize counselors or providers (Snowden, Catalano, & Shumway, 2009). Ultimately, waiting to utilize emergency services could have negative implications for prolonging and exacerbating the illness as well as greatly increasing costs (Hampton, 2007). These alternative sources can be attributed to the lack of trust and racial differences between African Americans and care providers (Dixon & Vaz, 2005).

STIGMA

An influential factor that impacts utilization of mental health services is stigma. The extant literature pertaining to mental health stigma applies mostly to adults; however, there is concern that stigma experiences might have the same or a worse impact on youth (Hinshaw, 2007). Goffman (1963) describes stigma as “possessing an attribute that makes him/her different from others. . . . He/she is thus reduced in our minds from a whole and usual person to a tainted, discounted one. . . . Sometimes it is also called a failing, a shortcoming, a handicap” (p. 3). Research describes stigma in two forms: public stigma and self-stigma. Public stigma pertains to the negative and discriminatory attitudes and behaviors of society toward people with mental illness. Self-stigma pertains to the individual with mental illness internalizing rejection from society, and often leads to lower self-esteem and shame (Corrigan & Kleinlein, 2005). Some people with psychiatric disorders conceal their mental illness/treatment and internalize (self-stigma) rejection
to preserve meaningful opportunities in employment, education, housing, and formation of relationships (Corrigan & Kleinlein, 2005; Link, Cullen, Struening, Shrout, & Dohrenwend, 1989; Wahl, 1999). This select group does not want to be associated with mental illness because of the discrimination experienced by people with psychiatric disorders (public stigma). Ultimately, the disassociation with mental illness can negatively impact an individual’s engagement and use of services (Corrigan & Kleinlein, 2005).

Recent work (Chandra & Minkovitz, 2006; Kranke, Floersch, Townsend, & Munson, 2010) that examined the subjective experience of stigma among adolescents taking psychiatric medication found that both White and African American youth are stigmatized by both a mental illness diagnosis and psychiatric medication. They also had a similar reaction to mental health stigma similar to that of adults. They used coping mechanisms of secrecy and limiting interaction to hide the shame felt by taking psychiatric medication for a mental illness diagnosis. Although youth coped with stigma similarly to adults (i.e., secrecy, shame, and limiting interaction), the data suggests that adolescents experienced different limited opportunities than adults, particularly those associated with social interaction and peer acceptance, which are common developmental work of adolescents. In addition, a study of self-stigma among adolescents indicated that their self-stigma process differed from the adult process (Kranke, Floersch, Kranke, & Munson, 2011). In particular, statements from African American adolescents revealed more negative stereotypes of people with mental illness and that many of these stereotypes were intensified by important relational figures, such as parents. The stigma experience among African American youth warrants further study because parental influence and mistrust among African American adolescents could intensify the effects of stigma.

Anglin, Link, and Phelan (2006) note that “racial and ethnic differences in stigmatizing attitudes have received remarkably little attention” (p. 857). Furthermore, “less is known about the role of stigma in the mental health service utilization of minority teens. . . . It is important to explore the origins of stigmatizing attitudes” (Chandra & Minkovitz, 2007, p. 764). Identifying the origins of youth attitudes would provide essential knowledge about stigma across racially diverse populations and inform social workers about ways to make treatment for African American youth more culturally relevant and beneficial. There are plausible reasons why youth origins of stigmatizing attitudes may be unique, particularly because of their social networks and competing influential figures relative to adolescent development. And such stigma may make youth even more vulnerable to not receiving the care that they need. Families play a significant role in conveying the information associated with mental illness and treatment (Hoagwood, Burns, Kiser, Ringeisen, & Schoenwald, 2001). Additionally, youth are in the midst of transitions, as adolescence is a nascent period of identity formation, engagement in peer relations, and use of the school environment as a site for developing a sense
of self-esteem, independence, and self-efficacy (Brockman, 2003). They are preoccupied with being accepted by peers (Kranke et al., 2010) and do not want to feel different (Leavey, 2005). Consequently, in an effort to fit in with the school environment consisting of peers and community members, adolescents may feel more pressure to conform to negative perceptions toward mental illness (Kranke & Floersch, 2009). Over time, problematic peer perceptions toward those with psychiatric disorders may cause youth with mental illness to develop a negative self-image and internalize feelings of shame (Hinshaw, 2007). There has been minimal research on the impact of families and peers of youth with mental illness and how such perceptions may contribute to the stigmatization of mental health treatment (Lindsey et al., 2006).

One study (Lindsey et al., 2006) examined help-seeking behaviors and depression among African American adolescent boys, both in treatment and not in treatment. Those not in treatment cited stigma and cultural issues as barriers to seeking treatment. The young males felt embarrassment, shame, and exclusion for receiving mental health care, and had too much pride to go to treatment. Furthermore, cultural issues, such as seeking treatment from a provider of a different race, were a barrier because the (White) therapists did not have an understanding of their background. However, that study was limited because it consisted only of adolescent boys with a diagnosis of depression.

PURPOSE OF STUDY

Therefore, this article asks: (1) What sources influence stigmatizing attitudes toward help-seeking for mental illness and use of psychiatric medication among African American adolescents? and (2) Are the origins of stigmatizing attitudes toward help-seeking for mental illness and psychiatric medication among African American adolescents the same as African American adults?

METHODS

This study is a qualitative investigation of African American adolescent mental health stigma. Mathews et al. (2006) suggest that qualitative research could lend relevant insight into some of the cultural determinants of behaviors and attitudes associated with mental illness stigma. The study recruited participants through convenience sampling in a midsized Midwestern city, and consisted of a single interview. The Institutional Review Board for Human Investigation at a large university hospital reviewed and approved the protocol. The original sample consisted of 40 adolescents, but was reduced to 17 as this article focuses on African American adolescents within
the dataset. This sample was drawn from a secondary dataset gathered by the principal investigator of an NIMH K08 award to develop the methods and conduct research on subjective medication experience of psychotropic treatment.

Recruitment and Interview Procedures

Participants were recruited through fliers and posters targeted at patients seen at either community mental health settings, an alternative high school for adolescents with behavioral and emotional problems, or an outpatient clinic with the Division of Child & Adolescent Psychiatry at a University hospital. Adolescents between the ages of 12–17 who currently met *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition (DSM-IV) criteria for a psychiatric illness and who were currently being prescribed at least one psychotropic medication were eligible. Since the study focused on adolescents taking psychiatric medication, participants that had not taken medication at least one of the past 30 days were excluded. In addition, adolescents with an organic brain disorder, seizure disorder, a pervasive developmental disorder, or a developmental disability (i.e., IQ lower than 70) were not enrolled. General information regarding psychiatric/medication treatment history and adolescent and family demographics were collected in addition to data produced by a semi-structured instrument (Teen Subjective Experience of Medication Interview [TeenSEMI]). The parents/guardians of the research participants provided written informed consent and all adolescents provided written informed assent prior to study participation. Parents received $50 and adolescents $65 as honoraria. This study examines only the youth data.

Sample Demographics

As previously stated, the original dataset consisted of 40 adolescents. However, the number was reduced to 17 because this study consists exclusively of African American adolescents. The average age of the adolescents was slightly less than 14 years ($M = 13.76; SD = 1.79$). The study consisted of 11 (65%) young females and 6 (35%) young males. The participant diagnoses were attention deficit hyperactivity disorder (ADHD) ($n = 7$), mood disorder ($n = 7$), eating disorder ($n = 1$), posttraumatic stress disorder (PTSD) ($n = 1$), and schizophrenia ($n = 1$). Furthermore, each participant had an average of less than two prescribed psychiatric medications ($M = 1.76; SD = .90$).

Interview Instrument

A semi-structured instrument, the Teen Subjective Experience of Medication Interview (TeenSEMI), was used to obtain narrative data. The TeenSEMI
was developed by modifying an instrument originally designed to produce medication/stigma data from adults diagnosed with schizophrenia (Jenkins, 1997). Questions pertaining to adults, such as work, marriage, or recovery, were eliminated or modified. In addition, questions appropriate and relevant to adolescents, such as school, peer, and family interactions were used to develop the instrument.

Data Analytic Strategy

The objective of this exploratory study was to identify contributing factors, and origins of stigmatizing attitudes toward help-seeking for mental illness and medication among adolescents with psychiatric disorders. When adolescents endorsed a stigma theme (i.e., secrecy, shame, or limiting interaction) sequential responses were analyzed to determine the origin of their attitudes. The interview instrument allowed for the interviewer to probe the respondent for further clarification (see Figure 1).

The first analytic step was to discover a priori themes in the adolescent data. The significance of the themes were determined by “substantive significance” (Patton, 2002, p. 467) rather than frequency. This significance refers to increasing depth of existing knowledge about the topic of study (Floersch, Longhofer, Kranke, & Townsend, 2010). In this first analytic step, an adolescent quotation was coded as self-reliance when they demonstrated the need to rely on the self rather than the help of medication (Mathews et al., 2006). Next, adolescent responses were coded as cultural beliefs when beliefs “were related to cultural attitudes and misconceptions about mental health treatment” (Mathews et al., p. 259). Third, adolescent quotations were coded as familial beliefs when they indicated that “mental health problems . . . should be kept within the family” (Newhill & Harris, 2007, p. 116). Fourth, youth responses were coded as faith beliefs when they indicated “mental illness as curable and attributed this to religious intervention” (Mathews et al., p. 257). In the second analytic step, open coding for emerging themes, codes were attached to respondent answers to any of the adolescent’s exact words and phrases that referenced the origins of: (1) their perceptions of how others (peers, teachers, or parents) perceive the need for medication; (2) their perceptions of the need for treatment; (3) their perceptions of the needs for psychiatric medications. The third coding step utilized the constant comparative method (Boeije, 2002) to compare and contrast the coded quotations, then sorting them by shared content (e.g., “People on TV make jokes about it,” and “I was watching South Park, it was funny. . . every kid had ADHD”). The resulting group codes were compared, contrasted, and sorted into themes that referenced origins of stigmatizing attitudes toward mental health help-seeking and psychiatric medication.
**FIGURE 1** Data analytic strategy.
Reliability

To establish coding reliability, the first author analyzed and coded eight respondents, and the codes were reviewed by the third and fourth authors. The three authors then discussed differences and similarities, and as a team created a master codebook. The remaining nine respondents were then analyzed and coded by the first author, using the master codebook. New codes that were not in the master codebook where then added when appropriate.

RESULTS

The thematic analysis identified the following origins of stigmatizing attitudes: family beliefs; cultural beliefs; autonomy/self-reliance; images/peer perceptions; and media messages. This section will provide examples of each theme. In contrast to the adult literature, the youth did not endorse faith beliefs as an origin. The discrepancy will be discussed at the end of this section.

Family Beliefs

Negative beliefs and reactions of family members to youth utilization of psychiatric services promoted stigmatizing attitudes (Newhill & Harris, 2007):

My sister, she gets on my nerves. She calls it Ritalin, like she says I shouldn’t take it, or I think I should because I’m crazy and stuff like that. . . . I don’t really talk to them (family) about serious stuff because they’re quick to judge. . . . They’re quick to say I’m just being lazy or I’m just being bad.

In addition, these adolescents protected their self-esteem by not disclosing their illness to family members:

Everything is mostly kept to me and my doctor and my mom, because I don’t like a lot of people in my business and I don’t want people to look at me, like my family members to look at me like “You’re crazy.” I don’t want that, ‘cause I’m not crazy. So I just keep it to myself.

I thought medication was only for crazy people, because like as growing up, my dad, he had a few girlfriends that take medicine and I heard my family saying that’s for the mental, crazy people, so I really had resented it with taking medication. . . . And with my family, it’s a sad thing to be around. . . . Like at this age taking medication, it’s a sad thing to your family.
Furthermore, youth responded how the input from a parent was more important than a psychiatrist:

She was about to sue them (psychiatrists) for putting me on Ritalin because the higher they had gave me, gave me 75% dose, and that made me act crazy and stuff and started hearing stuff, and that made me act crazy, so Mama got mad and she was crying and stuff. So she didn't want me on medication. She stopped, pulled me off, then she put me back on.

Cultural Beliefs
This theme was consistent with Mathews et al. (2006) as it exemplifies how beliefs within the African American community impacted perceptions, particularly of medication, among adolescents. These youth evaluated their situation with their fit within the African American community:

My culture is like, “Ha, I don’t like medication. Who does?” . . . Black cultures think they’re a little too good to take medication. Like certain Black cultures think they’re like a little too god-like or this too high and mighty person to do anything, to take that, “Cause I’m not crazy.” They stereotype all the way.

You won’t find that many girls that are Black that have eating disorders, and then really you won’t find that many, so it’s kind of like you’re the Black girl with the eating disorder type of thing. I’m not trying to make a stigma, but that’s what it is kind of like. . . . Yeah, ‘cause as a society, you see Black girls are supposed to be, you know, all secure with their bodies, and most of them are overweight anyway. . . . So if you are on the opposite side of the fence and you’re not trying to be like they are, that makes you different. If you have concerns about your body, that means you’re insecure, you know.

Autonomy/Self-Reliant
These responses demonstrate how autonomy and self-reliance contributed to stigmatizing attitudes (Mathews et al., 2006). The adolescents believed it was their obligation to recover on their own. Consequently, participants had negative views about the role of the medication.

Um, I think it’s okay to take medication to fix yourself but then I don’t at the same time because um, like you shouldn’t have to take medication like to help yourself, like you should just try on your own to make yourself better.
Just as long as you’re in control and you’re not letting the medication, using it as an excuse or letting it run over you and control you. You know like you’ve got to be in control about it, ‘cause anybody could stop taking pills. It’s just like people who use drugs or who smoke or who drink alcohol, you know, like they can stop.

Medication can never fix the real problem. It only takes away the problem, but it can never fix that. If you have a real problem and you try to fix it on your own, can nothing ever fix it except for you, cause you’ve got to do it, not no medication.

One adolescent expressed long-term concern about relying on medications:

I hope it goes away. I don’t want my body depending on medication for me to feel better or for me to do better. I don’t want my body to need medication for the rest of my life.

This adolescent expressed how the need for medications and inability to handle problems on his own caused shame:

‘Cause there are no kids that know about my medicine, only my one friend. Her name is L. L, I think she knows. I keep telling her, but she’s like, “You’re not on medicine.” “Yes I am.” But I’m not proud of it, because I want to be able to handle that myself, my own behavior myself.

Media Messages

_messages in the media and the television about help-seeking for mental illness and psychiatric medication influenced some African American adolescents. They were vulnerable to negative perceptions, and endorsed stereotypes because they believed the messages were credible:

Prozac is for crazy people. I see it on TV. People make jokes about it, “Don’t you need some Prozac?” or something like that.

On TV last night, it was about 11:00. I was watching South Park, it was funny, and every single kid in the whole school had ADHD and everybody took Ritalin. It was just on last night, and it’s like a funny little cartoon, but kids started taking Ritalin and they had their waters walking around just taking it a whole lot of times, and he told Carl to take ‘cause it felt good, ‘cause at first he was ashamed.
In addition, some media messages instilled fear in the youths because of their lack of knowledge pertaining to their situation:

Yeah, ‘cause I be seeing the commercials on TV. . . . Like the lawsuit commercials against Seroquel, how it caused people to have heart attacks and suffer from death and stuff like that, and I’m like I’m taking it, so it’s kind of scary.

I was kind of scared because I never seen one (psychiatrist) before and unaware of like what’s going to happen or something. They might put me like on medicine or something. Well ‘cause I had been seeing a couple of movies and stuff. A girl, she was taking a whole bunch of meds. They stuck her in an asylum.

Images/Peer Perceptions

Stigmatizing peer perceptions and the task of developing a self-image while coping with a psychiatric disorder negatively impacted attitudes toward mental illness. African American youth wanted to fit in with their environment and be accepted by peers; however, their use of psychiatric medication marked them as different. Consequently, they protected their reputation by not disclosing their use of medications because they did not want to be rejected or excluded by peers. As Goffman (1963) describes, medication for mental illness represents a “symbol . . . a sign that conveys social information . . . especially effective in drawing attention to a debasing identity discrepancy” (pp. 43–44):

Because I don’t think that, “Oh D, you can’t behave? Oh D, you’re bad. You’re on medicine,” ‘cause kids like in my school, they’ll make fun of you.

The reason why I might try to get more bad is because I try to fit in, don’t get bullied on and all that. . . . I hide it ‘cause some people think it’s for stupid people, something like that, like bullies, and if it’s a rumor, it gets spread around and the next thing you know the bullies got something to pick with you on.

These adolescents took measures to assure that peers would not find out about their use of psychiatric medication:

I honestly don’t know what I would say, ‘cause I honestly won’t want nobody my age to know that I’m on medication. I would never want nobody my age to know that. . . . I’m scared to be around kids my age, that’s why I don’t want to be in a normal school, ‘cause I don’t want to get teased again and laughed at, so I love being home schooled.
Yeah, like when I’m with my friends, all I’m on is meds. I can be able to control it. I can be able to laugh and have fun. You know, I’m able to control it. I’m not losing temper and you know just snapping, I’m able to be like a normal kid. I’m able to be trusted, just hang out with my friends without them knowing nothing.

When some of the kids found out, or sometimes I forgot my meds and my mom bring them up, and some of the other kids see me, they’ll start making fun of me like, “Why you got to take your meds and stuff?” Then in the summer I stopped taking meds. I started to steal and things, doing stuff that wasn’t me.

Faith Beliefs

African American adolescents differed from adults in their faith beliefs. Numerous youth believed that adherence to medicine and treatment was acceptable because it was created by God. Thus, religion plays a lesser role as a negative influence to stigmatizing attitudes among adolescents. This varied somewhat from the adult literature (Mathews et al., 2006) because youth attributed and justified the use of treatment to religious intervention; whereas, adults believed mental illness is curable through religious intervention, and less to do with treatment:

I’m really religious, so I feel like God put it man’s mind to make medicine to help us. He don’t want us to just go around like hearing stuff and seeing stuff. He wants us to be cured, so we should take it. If something’s wrong with you and you’ve got an illness, you need to take it, ‘cause God put it there for a reason.

DISCUSSION

The results demonstrated consistency with the findings in the adult literature (Mathews et al., 2006; Newhill & Harris, 2007), with the exception of faith beliefs, that African American adolescents have similar origins of stigmatizing attitudes as African American adults toward help-seeking for mental illness and psychiatric medication. The majority of these stigmatizing attitudes were directed towards medication. These youth perceived mistrust among African American adults with the mental health system: for example, youth endorsed adult attitudes that mental health treatment, particularly medication and prescribing practices, were undesirable and for “crazy people.” Mathews et al. (2006) suggest “stigma associated with mental illness was thought to have evolved from the beliefs of older generations and is being passed down to subsequent generations by direct messages . . . in coping with life problems”
Research attributes this mistrust to negative experiences with institutions and public agencies (Franklin, 1992). These experiences instill fear in members of the African American community that previous negative experiences with the system will be repeated (Scott, McCoy, Munson, Snowden, & McMillen, 2010). Consequently, these youth felt less trustful of the mental health system, and more trusting on faith, family, and the self.

Second, stigmatizing attitudes toward help-seeking and psychiatric medication were consistent with the extant literature on adolescents (Karp, 2006; Kranke et al., 2010), as these youth were influenced by a need to fit in with their community (i.e., school, peers, media, faith based). African American youth valued community member perceptions, as these perceptions were paramount to developing relationships and social inclusion. As a result, there was added social pressure to conform to perceptions of people they respected in their community because losing social opportunities at their age could be devastating to these adolescents’ social image. Ultimately, this study has serious implications about the impact of family and community on the origins of stigmatizing attitudes, which in turn can contribute to poor or underutilization of needed mental health care.

Implications for Practice

As this study demonstrates, there are multiple factors that can influence a youth’s perception of mental health treatment, including the stigma that accompanies a diagnosis and treatment for mental health problems. Decreasing stigma is a key strategy in reducing barriers to adequate treatment for this population. Nonetheless, the sources of that stigma are multi-systemic and thus social work intervention models and social policy must target several system levels such as community, family, and the individual. Indeed, the literature clearly illustrates how African American communities are not knowledgeable about mental illness and have little access to culturally informed mental health services (Snowden, 2001).

Mathews et al. (2006) believe the improvement of attitudes through understanding and knowledge about mental illness diagnoses and psychiatric treatment, such as taking psychiatric medications, for example, could reduce stigma. Previous research with African American consumers and their families demonstrate that this population desires innovative ways of educating their families and communities, as a means to decreasing stigma, through outreach at neighborhood fairs, locating psychoeducation groups in places other than in mental health clinics, and tailoring educational materials (including family psychoeducation programs) to reflect the concerns and experiences of African American consumers and their families (Lindsey et al., 2006; Matthews et al., 2006).

Additionally, there is a vital need to tailor family psychoeducational programs for African American families given the importance these families
have on attitudes regarding mental illness for youth. The vast majority of the interventions in use were originally developed primarily with White groups (Dixon & Lehman, 1995; McFarlane et al., 1995). In fact, there are few examples of culturally informed family or individual psychoeducation models for African American consumers and their families in the literature (Connery & Brekke, 1999; Kaslow et al., 2010).

Psychoeducation models targeting this population should include additional topics as identified by African American consumers and their families in previous research, such as: stigma related to a mental health diagnosis and the receipt of mental health treatment within the African American community, religious attitudes about mental illness, advantages and disadvantages with taking psychiatric medications, and common barriers to treatment experienced by African American consumers and their families. Additionally, these programs should include the unique strengths and resources of this population. For example, one psychoeducation intervention designed for African American women receiving services for Intimate Partner Violence (IPV) included topics such as faith and spirituality, the history of strong African and African American women that members could use as role models of resiliency, and the benefits of an extended, kinship family form for people in crisis (Kaslow et al., 2010). Likewise, interventions should be sensitive to possible issues of stigma for similar youth as well as other issues typical for adolescents (e.g., identity formation, peer issues). Certainly, psychoeducation should not be limited to adults as it can be useful when intervening with youth about issues of diagnosis, treatment, and stigma (Munson, Floersch, & Townsend, 2009). In this way, culturally informed family psychoeducation models and social work practice can assist families and their youth to better understand issues associated with help-seeking for mental illness and psychiatric medication while also identifying the sources of resiliency and support already present within their community and within the family itself.

Besides family psychoeducation social workers can reach out and help educate clergy to reduce the potential impact of another negative influence toward mental illness (Mathews et al., 2006). Some adolescents expressed a belief in God that factored into their belief system of treatment. As previously noted, religion plays a major role in the outlook of mental health treatment among some African Americans. Since many African Americans seek guidance from clergy before they would providers, educated clergy that provide useful mental health information could encourage both African American youth and adults to trust providers. Collaborative efforts by social workers, such as implementing psychoeducation programs in churches, as well as including clergy in developing educational material pertinent to their community, can assist in educating as well as including this important constituency for this population (Mathews et al., 2006).

Finally, Newhill and Davis (2007) suggested the concept of African American role models for younger populations. African American men who
have positive experiences in the mental health system could be influential sources for seeking treatment. Recent research (Munson, Kranke, Frese & Farkas, in press) proposes that recovery role models are in fact different than peer support, specifically because of desired outcomes. Having role models could be crucial to the improvement, recovery, and reintegration of African American adolescents because they would recognize that mental illness can be overcome, to normalize their condition, and exemplify trust in the mental health system (Newhill & Davis, 2007).

Limitations
Since this study was qualitative, the results cannot be generalized. In addition, this study was a secondary analysis, therefore, some important issues could not be extracted. In particular, the dataset had minimal information regarding adolescent perspectives of receiving treatment from White clinicians. This may have been very relevant in conceptualizing trust and family willingness to utilize services. In addition, this study consisted only of youth who had taken medication at least once in the past thirty days. Consequently, all of the study participants were in treatment. The experience of those not in treatment may be a valuable comparison group.

Future Research
Future research should investigate the impact of interventions, specifically psychoeducation among African American families who have children with mental illness. There is a clear need for social workers to develop psychoeducation that accounts for cultural beliefs of African American communities and the unique issues that might contribute to stigmatizing attitudes towards mental illness and treatment, such as medications. A longitudinal study could demonstrate the positive impact of psychoeducation on the stigmatizing attitudes, receipt of needed services, outcomes and reintegration efforts of African American youth.

Second, research (Lindsey et al., 2006) emphasizes how cultural barriers may impact the willingness of African American youth to utilize treatment. Since racial mistrust causes some African American adults to convey negative messages to youth about treatment, social work research that investigate African American adolescents who have positive experiences seeking treatment from White therapists could provide vital information to the mental health treatment and engagement among African American youth and families. Ultimately, the impact of positive treatment experiences among youth and White therapists may cause African American adults to alter their views and be more trusting of the mental health system.
CONCLUSION

The following study sought to examine the origins of stigmatizing attitudes toward help-seeking for mental illness and use of medication among African American adolescents with psychiatric disorders. It used qualitative methodology to explore potential issues of stigma regarding mental illness and care given evidence that some African American adults have similar issues (Newhill & Harris, 2007). It also examined whether there were unique themes for youth that contribute to a sense of stigma. The study demonstrated that there were many similar themes for this sample of youth regarding contributing factors to stigma as seen in previous research for adults. One unique finding was that religious beliefs did not contribute to stigmatizing attitudes among these youth as has been found with adults. Likewise, given the unique developmental issues, the implications for intervention with such attitudes is unique compared to adults. Understanding both the issue of stigma and the unique needs for youth, particularly for youth from ethnic minority communities, helps to address a critical need in developing much needed mental health services for this underserved population.

REFERENCES


