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What if they think I'm crazy : clinical interventions to help adolescents manage stigma following a psychiatric hospitalization

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CHAPTER I

INTRODUCTION

The purpose of this study is to answer the following question: "How do clinicians intervene to help adolescents manage stigma following a psychiatric hospitalization?" For the purpose of this study, *stigma* is defined as a term conveying deep shame towards an individual or group of people who are viewed as flawed or socially unacceptable. Stigma is comprised of negative stereotypes, prejudicial attitudes, and discriminatory behavior towards a devalued group. The painful repercussions of stigma are often experienced within intrapersonal, interpersonal, cultural, and institutional contexts. The term *adolescents* refers to young people, age 11-17. While some individuals between the ages of 18-22 may be considered late adolescents, for practical reasons, this study limits the age group and refers to those individuals 18 years and older as adults. In an effort to avoid using stigmatizing language in the present study, I will refer to the research population as *recently hospitalized adolescents* or *adolescents with a psychiatric condition* as opposed to terms like mentally ill that refer to individuals as ill or diseased.

Following a psychiatric hospitalization, many adolescents return home to their communities and are often faced with the challenge of confronting and managing stigma from family members, peers, teachers, and mental health professionals. Given the vulnerability of recently hospitalized teens, the additional burden of social stigma may further serve to alienate and marginalize these adolescents. The purpose of this study is to gather narrative information on how skilled clinicians and mental health professionals assist teens in dealing with stigma in order to help guide useful, future interventions with

this population. Stigma will also be analyzed from a social psychological and sociological framework.

Recent studies have depicted the ubiquity and intensity of stigma directed towards individuals with a psychiatric condition in the United States (Corrigan, Lurie, Goldman, Slopen, Medasani & Phelan, 2005; Watson, Miller & Lyons, 2005). Hinshaw (2007) described the historical construction of stigma and argued that individuals with a psychiatric condition often experience the most severe societal reactions. While there is a growing body of literature about stigma and teens with a psychiatric condition, the majority of research has been conducted on parallel adult populations. Less is known about adolescents' views towards peers with psychiatric conditions and whether stigma is a major component in teens' reactions. There is also a scarcity of literature on specific, empirically based clinical interventions to help targeted teens manage stigma.

The present study consists of a qualitative, exploratory design using interviews administered to twelve licensed, master's level mental health professionals who work with recently hospitalized adolescents. These interviews provide rich narrative data on clinical interventions used to help teens manage stigma. The research participants were all located in the Northeastern United States and purposive, snowball sampling methods were utilized to recruit clinicians with a breadth of knowledge and expertise in this topic. The intended audience for this study includes social workers, therapists, and other mental health professionals that work with teens struggling with a psychiatric condition.

The importance of the present study consists of its practical, clinical utility for use with a specific population. In accordance with social work principles, this research aims to increase clinicians' competence in addressing the social injustice of stigma as it affects

a vulnerable population, recently hospitalized teens. The ultimate aim of the study is to find ways to help empower particular adolescents to manage and combat stigma, thus affirming their worth and dignity as individuals. Due to the paucity of literature on the topic, the current study aims to fill a gap in research on this important issue.

CHAPTER II

LITERATURE REVIEW

The following literature review presents previous research on issues related to stigma directed towards adolescents who have experienced a psychiatric hospitalization. The first section of the literature review focuses on stigma, including a definition of stigma, the factors and effects of stigma, different types of stigma, and a discussion of stigmatized populations, including adolescents. The second portion of the literature review describes adolescent development with a discussion of the culturally accepted goals of the adolescent developmental stage in modern American society, specific factors within the stage, and the particular challenges of teens with a history of psychiatric hospitalization. The third section consists of a theoretical discussion, highlighting the contributions of social psychology and sociology in conceptualizing stigma. The fourth section includes an overview of psychiatric hospitalization for adolescents, including a brief history of psychiatric hospitalization for teens, reasons for hospitalizations, diagnostic and statistical trends regarding hospitalization, and the prevalence of stigmatized attitudes towards hospitalization. The final section of the literature review focuses on clinical interventions to help adolescents manage stigma, including descriptions of individual and family-based interventions as well as peer support and self help group treatment modalities.

Stigma

Stigma is often defined as a symbol of shame, disgrace, or unacceptability. Particular individuals or groups of people become marginalized by mainstream culture and are targeted for stigma. The term *stigma* was historically associated with the act of

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physically branding individuals from a marginalized group so that they carried a physical mark of shame (Hinshaw, 2007). Stigma then became generalized to that which is damaged, disgraceful, or unwanted.

Various groups of people have been targeted in this way throughout history. One such highly stigmatized group consists of people with a psychiatric condition or individuals necessitating psychiatric hospitalization (Connor-Greene, 2006; Corrigan, Lurie, Goldman, Slopen, Medasani & Phelan, 2005; Hinshaw, 2007; Jamison, 2006). Corrigan, Lurie, Goldman, Slopen, Medasani and Phelan (2005) described how psychiatric conditions are stigmatized to a far greater degree than physical illnesses. Hinshaw (2007) argued that individuals with a psychiatric condition are one of the most stigmatized groups in our society, both presently and historically. While this generalization is widely accepted, stigma may impact various age groups differently.

Hinshaw (2005) described the historical "plight of children and adolescents" as youth were traditionally viewed as lower status citizens and were given less respect and power within society. While conceptions of childhood and adolescence have changed a great deal with the emergence of research into child development and changes in labor laws to protect young people, youth continue to occupy a vulnerable position within society. Young people are dependent on adults for care and are not given certain rights or liberties because of their age. In this way, children or adolescents with a history of psychiatric hospitalization may be doubly vulnerable to the effects of stigma given their lack of power and respect within American culture and the extreme prejudice and discrimination directed towards individuals with a psychiatric condition.

According to Corrigan and Watson (2002), stigma is comprised of three factors: stereotypes, prejudice, and discrimination. A *stereotype* is defined as an "efficient means of categorizing information about social groups" (Corrigan & Watson, 2002, p. 37). Stereotypes are socially constructed and disseminated. They can be either positive or negative. In either case, stereotypes exist as a means to quickly, and often inaccurately, judge a person or group of people. *Prejudice* is defined as an endorsement or acceptance of harmful stereotypes, leading to negative, emotional reactions towards the stigmatized group. Prejudice refers to an overall negative attitude towards a particular group of people. This negative attitude conveys a sense that the stigmatized group is defined as dangerous, deviant, or flawed. Lastly, *discrimination* exists as a negative behavior or action towards the stereotyped group. Discrimination may take various forms, including violent or hostile actions. Corrigan and Watson (2002) clearly stated the three factors that comprise stigma and they described how these factors interact to produce an overall negative reaction towards stigmatized populations.

Types of Stigma

A number of different types of stigma exist for marginalized individuals. *Public* or *social stigma* is experienced as a negative reaction from others. This type of stigma might include negative portrayals of psychiatric patients in the media, disparaging comments from peers, or discrimination in the workplace. Corrigan and Watson (2002) also posited the notion of *self-stigma* which they described as a circumstance wherein marginalized individuals, specifically people struggling with a psychiatric condition, accept and believe negative stereotypes about their own group. The results of self-stigma may include poor self-esteem and diminished personal agency, which, notably, are

similar to the effects of internalized racism. Corrigan and Watson (2002) noted that such

individuals experiencing social stigma do not necessarily internalize those negative

messages and develop self-stigma. Corrigan and Watson also described various examples

of how individuals might not internalize stigma, stating:

> People who view the negative responses of others as unjust or irrelevant to them
> will experience no reduction in self-esteem due to stigma. Persons with intact
> self-esteem will respond to stigma with indifference or indignation depending on
> their identification with the generic group of people with mental illness. Those
> with high group identification will show righteous anger. Those who do not
> identify with the group will be indifferent to stigma (Corrigan & Watson, 2002, p.
> 47)

Corrigan and Watson's research on protective factors against self-stigma directly applies

to the current study in terms of providing a potential framework for a protective process.

Their research also illuminates the range of responses that individuals might have

towards being stigmatized.

Erving Goffman (1963), a well known sociologist who wrote about stigma and

issues of identity, posited the notion of *discredited* and *discreditable* stigma (Goffman,

1963, p. 4). These two terms correspond to the notion of visible and invisible forms of

stigma. According to Goffman, discredited individuals are those who carry obvious

markers of stigma. They are immediately discredited or discounted as being marked by

an inherent flaw that clearly differentiates them as "not quite human" in the eyes of the

average, non-stigmatized person (Goffman, 1963, p.5). When individuals carry visible

stigma, they must be constantly aware of how they will be perceived and treated by

others and they live with the experience that in every moment of "contact there will be

some consequences" (Goffman, 1963, p. 48). The visibly stigmatized individual often

maintains a defensive position or a type of bravado in the face of stigma. Goffman also

stated that individuals may try to ameliorate the effects of stigma by attempting to correct

or hide the aspect of their identity that is stigmatized. Regardless of their reactions and

the reactions of those around them, stigma plays a powerful role in individuals' lives.

Goffman (1963) also discussed the discreditable or invisible forms of stigma and

the subsequent effects on a person's identity. Goffman described the ways in which

individuals with an invisible form of stigma may live with a secret aspect of their identity

that they may or may not divulge to others. Individuals may also live with the fear that

the stigmatized part of them will be somehow exposed and that typical, negative reactions

will result. Goffman highlighted the "precariousness" of a person's situation as she or he

tries to negotiate if and when to disclose a full identity, as well as anticipating any

possible consequences of this disclosure (Goffman, 1963, p. 77). In Goffman's view,

both visible and invisible forms of stigma play a significant role in the life of a

marginalized individual. Stigma profoundly impacts a person's sense of identity and

ability to authentically and safely connect with others in the larger society.

Stephen Hinshaw (2007) also wrote about an individual's history of mental illness

and psychiatric hospitalization as a history that is "usually concealable" or invisible

(Hinshaw, 2007, p. 147). Hinshaw noted the way in which this concealable history placed

an individual in a state of apprehension about the issue of disclosure. According to

Hinshaw, individuals with an invisible form of stigma often use tactics of "secrecy and

withdrawal" in order to avoid the stigma and shame that results from others knowing

about the person's psychiatric condition (Hinshaw, 2007, p. 148). While adaptive,

Hinshaw acknowledged that these tactics serve to further isolate an individual from

sources of support and social contact. These attempts to conceal this painful personal

history may also cause "intrusive thoughts about the concealed attribute in question," thus leading to greater social anxiety (Hinshaw, 2007, p. 148).

Goffman's (1963) concepts of discredited and discreditable forms of stigma have implications for adolescents with psychiatric conditions. These conditions may only be readily apparent at certain times or in certain cases. Depressed teens may stabilize, return to school, and appear relatively "normal" to their peers and community. This may serve as a discreditable or invisible form of stigma in that a particular teen may or may not feel comfortable disclosing experiences of depression and psychiatric hospitalization. On the other hand, a teen who is suffering from active psychosis cannot usually hide this type of stigma. People may perceive this teen hallucinating, talking to himself/herself, or engaging in other unusual behaviors. This type of psychiatric condition, especially when untreated, represents a more readily apparent or discredited form of stigma. Both types of stigma have serious implications for how teens view themselves and how they will be treated by others. For the purpose of the present study, interview questions will be directed towards understanding clinical interventions to help adolescents manage both visible and invisible forms of stigma.

Effects of Stigma

The effects of stigma on marginalized groups can be profound. There are numerous internal and external effects of stigma for individuals dealing with a psychiatric condition or recent psychiatric hospitalization. Corrigan and Watson (2002) described the way in which a person might internalize negative stereotypes and stigmatized attitudes. The individuals suffering from self-stigma experienced decreased self-efficacy and self-confidence. One major external effect of stigma is its interference with help seeking

behaviors for individuals with a psychiatric condition (Esters, Cooker & Ittenbach, 1998; Jamison, 2006; Watson, Miller & Lyons, 2005). Ironically, stigma is a major factor in keeping people from treatments that could help, thereby continuing a cycle of additional exposure to stigma. For youth of racial or ethnic minority groups, especially low rates of treatment utilization may lead to increased stigmatization as a young person's psychiatric condition is left untreated (Yeh, McCabe, Hough, Dupuis, and Hazen, 2003, as quoted in Hinshaw, 2005).

Stigma can also affect a person's ability to obtain employment, housing, social contact, and other crucial opportunities (Corrigan & Watson, 2002; Leete, 1992). According to Hinshaw (2007), individuals with a history of psychiatric hospitalization and mental illness may develop "rejection sensitivity," anticipating social rejection and stigma (Hinshaw, 2007, p. 150). This anticipatory fear may further fuel a cycle of stigmatization in which a marginalized individual expects rejection and acts accordingly, becoming defensive or withdrawn. Stigma may also decrease self-esteem, overall achievement, and physical health (Hinshaw, 2007).

Additionally, stigma impacts health policy and limits individuals' access to important services, such as health insurance (Jamison, 2006; Leete, 1992). Individuals may be afraid to seek treatment because they fear stigmatizing responses from their community and/or mental health professionals. As referenced in Hinshaw (2005), Sartorious (1998) noted that stigma may limit research funding for psychiatric conditions. Policy makers may view psychiatric conditions as hopeless, chronic illnesses with few possibilities for recovery, thus limiting research for new treatments. Stigmatized notions of psychiatric conditions as less treatable than physical illnesses may also contribute to

the lack of parity in insurance reimbursements as compared with diagnoses for physical conditions. Additionally, individuals with a history of psychiatric hospitalization may be completely denied insurance coverage due to their condition.

Over the past few decades, a growing awareness of the negative impacts of stigma for people with a psychiatric condition has lead to calls for action on the part of government leaders and health experts. Yet, while greater attention is being paid to the problem of stigma, the existence of high quality, affordable mental health care is not yet a reality. This lack of access to appropriate treatment is also compounded by issues of poverty and racism for poor people of color who are struggling with a psychiatric condition (Hinshaw, 2007). Hinshaw referred to a "double stigma" experienced by individuals contending with multiple layers of oppression such as racism, classism, homophobia, etc. (Hinshaw, 2007, p. 175).

Esso Leete (1992) described her personal experience of living with schizophrenia for 20 years and she discussed the intense stigma she experienced due to her psychiatric condition. Leete depicted the "devastating, discrediting, and disabling" power of stigma in her life (Leete, 1992, p. 18). She detailed her experience of being hospitalized 16 times, receiving 10 different diagnoses, and 20 different medications for her condition. Although Leete described the difficulty of her experiences in the mental health system she stated that stigma was the most powerful "psychic cruelty" that interfered with her process of recovery (Leete, 1992, p. 18). Leete stated that she experienced stigma from employers, landlords, friends, insurance companies, psychiatrists, and mental health providers. Stigma damaged her self-esteem, self confidence, and self-efficacy. Stigma also profoundly impacted her hope in her own recovery and she stated that this was one

of the most challenging aspects of stigma. Leete remarked that "hope is crucial to recovery, for our despair disables us far more than our disease ever could" (Leete, 1992, p. 24).

Aside from the current research on stigma, the personal stories of individuals with a psychiatric condition offer an intimate portrayal of the devastating, multi-faceted effects of stigma. Such first person accounts of stigma support this researcher's assertion that stigma powerfully impacts recently hospitalized adolescents. Not only must teens be treated by professionals with non-stigmatizing views of their condition but these professionals must also assist adolescents in understanding and managing the many effects of stigma. For teens in particular, these effects could include social isolation, low academic performance, and poor self-esteem, to name a few.

Adolescent Development

Due to their particular developmental stage, adolescents may be especially vulnerable to the negative effects of stigma. According to Erik Erikson, one pioneer of the ego psychological psychosocial theory of human development through the life cycle, adolescence exists as an especially challenging period of development. As cited in Berzoff, Flanagan and Hertz (2002), Erikson (1964) described this stage as filled with identity fluctuation, physical changes, and increased peer influence. Adolescents (age 11-18) are characterized as struggling with "a pivotal crisis around the development of a sense of a personal identity" (Berzoff, et al., 2002, p. 113). In an attempt to separate from their parents or caregivers, Erikson (1964) noted how teens begin to rely more heavily on peers to help define themselves. Erikson depicted the main psychosocial crisis of adolescence as one of *identity vs. role confusion*. Given this developmental crisis, the

goal of adolescence is identified as the achievement of a steady sense of self that is congruent with an individual's history, present circumstance, and future. Adolescents must achieve the sense that their identities will be stable over time in order to develop a certain confidence in their role and place in the world.

Erikson (1959), as quoted in Berzoff, Flanagan, and Hertz (2002), noted that there are many risks associated with this developmental stage. In the act of developing an individual identity, adolescents are depicted as particularly vulnerable to peer influence, including negative judgments or pressure. In breaking away from their parents or caregivers, teens put themselves at risk for increased influence from the outside world. Physical and hormonal changes also complicate adolescence. Erikson (1959) described how adolescents are at risk for developing a *negative identity* during this developmental stage. A negative identity is depicted as an adoption of a role that incorporates what is most deviant or dangerous, while also appearing as a realistic option depending on an individual's context. Given the particular vulnerabilities of this developmental stage, an adolescent dealing with the burden of psychiatric condition may face additional developmental challenges.

Stephen Hinshaw (2007) reiterated many of Erikson's notions of adolescent development as it relates to the experience of teens with a psychiatric condition. Hinshaw described the way in which mental illness and psychiatric hospitalization may negatively affect a teen's emerging identity. Hinshaw noted adolescents' extreme sensitivity to issues of "conformity and difference," remarking on how behaviors and attitudes that isolate a teen from mainstream peer culture could result in damaged self-esteem and diminished social status (Hinshaw, 2007, p. 171). Hinshaw paid particular attention to the

experience of psychiatric hospitalization for teens, commenting on how the label of "mental patient" could create a lifelong negative self-concept if mental health providers and caregivers were not sensitive to a teen's experience of difficult symptoms and "invasive treatments" (Hinshaw, 2007, p. 171). In this way, Hinshaw reiterated Erikson's description of a negative identity that is created when a teen adopts the role of the mental patient or crazy person.

Adolescents and Stigma

While the adult experience of stigma has often been the focus in literature on mental health, less is known about children's and adolescents' perceptions of individuals with psychiatric conditions. Hinshaw referred to the lack of current research on this topic as a "crucial omission" (Hinshaw, 2005, p. 723). Given young people's particular vulnerability to the negative effects of stigma, there is a growing body of literature that examines whether children and adolescents also endorse stigmatizing views.

Otto Wahl (2002) contributed a literature review of research conducted on children's views of individuals with a psychiatric condition. Wahl found that, according to the literature, children tend to view these individuals in a negative light and they often associate them with danger. As presented in Wahl (2002), Spitzer and Cameron (1995) demonstrated that seventh graders preferred psychiatric hospitalization for individuals with a psychiatric condition. These seventh graders preferred this as the most appropriate intervention as it allowed for care of the individual while it also protected the public, implying that those individuals would otherwise be threats to public safety.

Wahl (2002) also found that children tend to develop a more nuanced understanding of psychiatric conditions as they aged but that this increase in knowledge

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did not necessarily correspond with a decrease in stigmatizing attitudes. As quoted in Watson, Miller and Lyons (2005), Wahl reported that stigmatizing attitudes towards people with a psychiatric condition or a history of hospitalization tended to increase with age. If this is the case, recently hospitalized adolescents might experience more severe forms of stigma as opposed to their younger peers.

Corrigan, Lurie, Goldman, Slopen, Medasani, and Phelan (2005) conducted a quantitative study to measure adolescents' views towards individuals with a psychiatric condition. The results showed that adolescents endorsed stereotypical ideas about this specific population, namely that they are dangerous and unpredictable. These negative stereotypes lead to discomfort and a desire to avoid such individuals. Corrigan et al. also argued that teens viewed people with a psychiatric condition in a more stigmatized manner if they believed that an individual was responsible for his/her illness, as opposed to having a brain tumor that was the cause of the psychiatric condition.

One interesting finding from Corrigan et al.'s study highlighted the issue of familiarity. A fairly large percentage of the adolescents surveyed reported contact with individuals with a psychiatric condition. According to Corrigan et al., research on stigma conducted with adults found that familiarity tended to decrease stigmatizing attitudes. Yet, amongst the teens surveyed, familiarity had the opposite effect. Teens with greater contact with individuals with a psychiatric condition tended to report more stigmatizing attitudes then adolescents with less familiarity. This finding might indicate that adolescents would experience greater stigma from friends or peers, as opposed to strangers.

While stigma appeared to be a serious problem amongst adolescent perceptions of people with psychiatric conditions, Watson, Miller, and Lyons (2005) noted that there is some difference in endorsement of stigma based on gender. Watson et al. conducted quantitative research in a survey with high school students and concluded that "girls and women tend to have less negative attitudes than boys and men" (Watson, et al., 2005, p. 771). They also noted some difference in attitudes based on race and ethnicity. As opposed to the Corrigan et al. (2005) study, Watson et al. found that teens with closer association to individuals with a psychiatric condition endorsed less stigmatizing attitudes. This finding was supported by previous research by Corrigan (2001) and Penn (1994), as quoted in Watson et al. (2005).

Research into adults' perceptions of children and adolescents with a psychiatric condition also provides evidence that teens may be stigmatized by adults, as well as by their same-aged peers. In a quantitative research study, Martin, Pescosolido, Olafsdottir, and McLeod (2007) found that a large minority of American adults were hesitant to have contact with children or teens believed to be suffering from a psychiatric condition. According to their findings, "one in five adults is unwilling to have these children living next door, in his or her child's classroom, or as his or her child's friend (Martin, Pescosolido, Olafsdottir, & McLeod, 2007, p. 61). Specifically, when youth were given the label of "mental illness" in vignettes given to adult participants, the adults' desire for social distance significantly increased. This was also the case when adults believed the young person was dangerous. In the study, adults rejected teens labeled mentally ill, especially teen boys, to a higher degree as compared to younger children. While a large number of adult participants endorsed such stigmatizing attitudes, Martin et al. (2007)

found that women and those who were better educated were less likely to stigmatize or reject mentally ill children in research vignettes. These findings point to fact that teens with a psychiatric condition may not only be stigmatized by peers, but they may also be judged and rejected by teachers, coaches, neighbors, family members, employers, mental health professionals, and other community members.

Stigma appears to be a significant issue facing adolescents with a psychiatric condition. While there may be variation in the intensity of stigmatizing attitudes based on the perceivers' age, gender, education level, or ethnicity, recently hospitalized teens will probably encounter stereotypes about the unpredictability and dangerousness of "crazy" people. Such stigmatizing attitudes can yield negative effects, such as social avoidance, fear, and discrimination. Following a psychiatric hospitalization, a teen might be met with greater or lesser stigma from same-aged peers. In either case, the threat and burden of stigma is a well-documented one.

Theoretical Understanding of Stigma

Social psychology and sociology provide helpful theoretical frameworks for understanding stigma, including an analysis of its construction, maintenance, and purpose in society. Hinshaw (2007) described the traditional understanding of stigma as originating from certain individual characteristics within the perceiver, such as an authoritarian personality type or psychopathology. This understanding of stigma placed the blame on an individual for engaging in prejudicial thoughts and discriminatory behaviors. According to Hinshaw, new conceptions of stigma acknowledge the ubiquity of stigma within society and its relation to issues of social power. In this way, stigma is embedded into "everyday psychological functions (e.g., tendency to categorize), social

processes (e.g., ingroup versus outgroup identification), and structural variables (e.g., unequal social power and justice)" (Hinshaw, 2007, p. 29). This conceptualization recognized the ubiquity of stigma as a powerful force operating in daily life. Hinshaw's construction of stigma also acknowledged the individual, cultural, and structural aspects of stigma as they overlap and support the perpetuation of stigma.

According to Hinshaw (2007), social psychologists and sociologists have developed many different theories for understanding the causes of stigma. Labeling theory and evolutionary biology both provide different means of conceptualizing stigma. The theoretical framework chosen for this current project stems from basic social psychological theory which analyzes the formation of *ingroups* and *outgroups,* and the role of stigma within a social context. This particular theoretical understanding of stigma appears most relevant to a stigmatized adolescent population given teens' natural developmental tendencies to form strong social groups and to explore identity within a social context. The formation of *ingroups* and *outgroups* in adolescence is a common, and often painful, process – most particularly for the outgroup members distanced from their peers, though there may be costs to the ingroup members as well.

Hinshaw (2007) described the basic human tendency to form *ingroups*, or social groupings in which individuals are connected by birth or geography. According to Hinshaw, ingroups are formed based on notions of perceived similarity of members. These perceived similarities might include sharing geographical, cultural, or familial backgrounds, as well as reflecting a shared racial or ethnic identity. Hinshaw stated that these ingroups are clearly distinguished from *outgroups,* "clans, tribes, or communities viewed as foreign, who may pose a threat to survival" (Hinshaw, 2007, p. 29). Hinshaw

noted that there appears to be a deep human tendency to distinguish one's own group from outsiders.

Hinshaw also described the benefits of belonging to an ingroup such as having increased access to "resources, status, and even survival" (Hinshaw, 2007, p. 37). In terms of cognitive and behavioral processes, ingroup members tend to think more positively of other group members, showing increased care and empathy for individuals within the social grouping, while also being more apt to assist other members. Hinshaw noted that these cognitive and behavioral tendencies highlight the clear distinction between ingroup and outgroup members. While stigma does not necessarily result from strong ingroup identification, the presence of competition, social instability, and limited resources serve as clear catalysts for increased stigma towards outgroup members. Hinshaw described how groups which were perceived as threatening to social or economic stability were increasingly stigmatized. For example, individuals with a psychiatric condition may be perceived as unpredictable, weak, or needy, serving as a drain on a community's resources. Such negative stereotypes lead to increased stigma towards individuals with a psychiatric condition.

Hinshaw (2007) described one important ingroup identification process that further serves to stigmatize outgroup members. People within an ingroup often reinforce their own group identity by differentiating themselves from outgroup members, engaging in what social psychologists refer to as a *downward comparison* (Hinshaw, 2007, p. 37). Hinshaw described how ingroup members compare themselves to those of lower social status, thereby not only reinforcing their ingroup membership but also increasing their own self-esteem. Downward comparisons enhance an ingroup member's self-esteem

while existing negative stereotypes about outgroup members serve as easily accessible means for engaging in the process of stigmatization. While the interpersonal process of enhancing an ingroup member's self-esteem does not explain the existence and perpetuation of stigma at a structural level, it does provide insight into the personal gains involved for ingroup members as they stigmatize those of perceived lower status. This process appears especially relevant to adolescents, as they often struggle with feelings of insecurity and instability, while also gaining meaning and acceptance from strong social group identifications.

Hinshaw (2007) provided additional conceptualizations of stigma as offering a means for justifying the status quo and maintaining existing social, economic, and political structures. Ingroup members, or those in positions of power, justify their own higher status through negative appraisals of outgroup members. Hinshaw described how stigma serves as a "consequence rather than a cause of social injustice" when it is used to justify inequality (Hinshaw, 2007, p. 39). Hinshaw also noted the importance of stigma in protecting ingroup members' belief in a just, stable world. Ingroup members stigmatize those individuals that appear to threaten the dominant worldview, thereby maintaining a perceived sense of stability and keeping anxiety at bay. Hinshaw (2007) stated that this use of stigma is included within the social psychological concept of *terror management theory*.

Given the numerous conceptualizations of stigma within social psychology, the abovementioned theoretical frameworks provide a general understanding of the function of stigma on individual, social, and structural levels. An exhaustive account of the many theoretical explanations for stigma would be beyond the scope of this research project,

and the frameworks contained were chosen specifically for their relevance to the possible experience of stigmatized adolescents. Stigmatized adolescents may be used to bolster the self-esteem of higher status peers, while stigmatization may also be utilized to maintain the social status quo. Adolescents who have experienced a psychiatric hospitalization may be further stigmatized as they may represent a perceived threat to a sense of stability and order, as mentioned in terror management theory. A psychiatric hospitalization may likely further stigmatize an already marginalized teen.

<p align="center">*Psychiatric Hospitalization for Adolescents*</p>

History of Psychiatric Hospitalization

The history of psychiatric care for children and adolescents was traced to the creation of orphanages, homes, and asylums for abandoned, poor, sick, developmentally delayed, or mentally ill children, according to Leichtman (2006). These institutions were originally created by European churches during the medieval period and were later maintained by reformers in the 18th and 19th centuries in the United States. Leichtman (2006) described the creation of psychiatric hospitals in the beginning of the 20th century. In the mid-1900's, efforts to diminish poverty for children and families reduced the need for institutions for poor, vagrant children. Leichtman noted that these programs, along with the growing influence of social work and psychiatry, shifted the emphasis to providing mental health programs for youth. At this same time, research into the fields of child development and child welfare gained popularity (Hinshaw, 2007). The psychiatric hospital emerged as one institution which provided mental health care for troubled children and teens.

Reasons for Hospitalization

Psychiatric hospitals are currently used as the "treatment of last resort" for children and teens needing a more contained, structured environment (Harpaz-Rotem, Leslie, Martin & Rosenheck, 2005, p. 642.) Often, young people are treated on an outpatient basis by numerous mental health professionals before arriving on an inpatient psychiatric unit. Psychiatric hospitalization represents the highest level of care and children and adolescents are only admitted if their safety, or the safety of those around them, is at risk (Balkin, 2006). Patients are generally in the midst of a crisis when admitted. According to the Surgeon General, a total of 4 million youth "suffer from a major mental illness that results in significant impairments at home, at school, and with peers" (Surgeon General, Chapter 3 Children and Mental Health, para. 5, 2008). While not all of these significantly impaired youth will experience a psychiatric hospitalization, many of them will necessitate inpatient treatment in order to address their psychiatric condition and to reduce safety risks.

In his well-known article on treatment for disturbed adolescents, Donald Rinsley (1990) discussed three factors that necessitated hospitalization or residential admission for troubled teens. Rinsley stated that adolescents may be admitted when they exhibit "bizarre, disruptive, or dangerous" behaviors, when they have not responded to outpatient treatment, and their families and communities are no longer able to safely support them (Rinsley, 1990, p. 4). Rinsley posited that these three factors justified admission but he also differentiated between adolescents that needed short-term versus longer term treatment. For Rinsley, teens necessitating longer term treatment are those that are deemed psychotic or suffer from personality disorders. Rinsley goes on to discuss

treatment considerations given diagnostic and developmental criteria. Although Rinsley laid important groundwork for a discussion of psychodynamic hospital or residential treatment for disturbed adolescents, more recent research identifies current trends in patterns of admission.

Trends in Psychiatric Hospitalization for Adolescents

Hinshaw (2005) described the overall low rates of treatment utilization for children and teens with a psychiatric condition. A young person may be left untreated until a mental health condition necessitates immediate intervention. This problem is even more severe for youth of color. As quoted in Hinshaw (2005), Yeh, McCabe, Hough, Dupuis, and Hazen (2003) noted that for teens of racial or ethnic minority groups, rates of treatment usage are very low. Teens of color may not receive mental health treatment until their psychiatric condition necessitates hospitalization; however, earlier treatment interventions might be able to prevent this level of crisis.

Harpaz-Rotem, Leslie, Martin, and Rosenheck (2005) detailed recent trends in the admission diagnoses of adolescents in psychiatric hospitals. Harpaz-Rotem et al. analyzed patterns in admission diagnoses from 1995 to 2000 using a national health insurance database and they noticed a number of significant trends in terms of what types of psychiatric conditions were most often being treated in an inpatient setting. Harpaz-Rotem et al. noted that the number of youth hospitalized for bipolar and eating disorders doubled within the five year period. The increase in rates of bipolar disorder mirrored an increase in rates of bipolar diagnoses for children and adolescents in outpatient treatment as well, although the researchers did not posit reasons for this increase. Harpaz-Rotem et al. also noted that there was in an increase in the number of females admitted to

psychiatric hospitals and that this increase corresponded to growing numbers of eating disorder diagnoses. Depression remained the most common diagnosis for inpatient admission and these rates remained relatively stable over the five year period.

Harpaz-Rotem, Leslie, Martin, and Rosenheck (2005) also noted that rates of oppositional defiant, adjustment reaction, and substance abuse diagnoses decreased over the five years. A decrease in the number of adolescents being admitted for substance abuse mirrored national trends of declining teen drug use. Harpaz-Rotem et al. posited that the managed care system significantly impacts admission criteria in that only patients with the most severe diagnoses, those associated with higher fatality levels, are being authorized for inpatient treatment. To this end many insurance companies utilize "cost-control efforts aimed at reducing the number of children receiving inpatient services" (Harpaz-Rotem et al., 2005, p. 645). Overall, the number of adolescents being admitted to psychiatric hospitals has greatly decreased. This trend seems to be fueled by both the deinstitutionalization movement as well as by economic pressure from insurance companies in the current age of managed care.

Rinsley (1990) was already aware of this trend in the early 1990's. Rinsley attributed trends in shorter hospital stays to pressures from the deinstitutionalization movement. He described the deinstitutionalization movement as a social change movement designed to protect patients' rights. This movement, which began in the 1960's, aimed to reduce civil commitments in which individuals with psychiatric conditions were committed to long term care in institutions such as state hospitals. Rinsley described how this movement affected child and adolescent treatment in that it created a "revolving door" and a "patch-and-dismiss" approach to hospitalization

(Rinsley, 1990, p. 8). Rinsley implied that adolescents with a psychiatric condition often necessitated numerous psychiatric hospitalizations but that they would be quickly discharged, creating a negative cycle of numerous short hospitalizations rather than receiving in-depth, adequate treatment. Rinsley argued that this pattern was dangerous for patients.

Richard Balkin (2006) also noted trends in decreased length of stay in hospital admissions for adolescents. Balkin described how psychiatric hospitalizations are currently designed to be short-term, crisis intervention programs in which adolescents receive constant supervision. He noted that, due to the impact of managed care, the average length of stay in these programs has greatly decreased over the past decade. Balkin stated that ten years ago typical admissions were three to four weeks in length but that now the average length of stay is one week or less. This change implies a shift in focus wherein the goal of hospitalization is now simply the stabilization of adolescent inpatients. Teens are rarely hospitalized in order to receive longer term treatment. Balkin identified this pressure to reduce length of stay as directly related to the impact of managed care. Hospitals experience growing financial pressures to discharge patients sooner and Balkin depicted this change in treatment as having negative effects on adolescent patients although he did not provide specific data to substantiate his claims.

In terms of the present study, a pattern of repeated, short hospitalizations may prove very disruptive in the life of an adolescent with a psychiatric condition. Teens undergoing several hospitalizations may have to reintegrate into their schools and communities after each admission. Patterns of multiple hospitalizations undoubtedly affect an adolescent's academic experience, social and familial relationships, outpatient

treatment, and overall self-esteem and self confidence. These challenging experiences may be further impacted by the force of stigma. While the deinstitutionalization movement ideally offers positive benefits for patients, in actuality many people with psychiatric conditions now depend on a patchwork of outpatient services for treatment. Teens in this position may then experience greater stigma as they attempt to recover within their communities without the support of comprehensive, well-funded, and easily accessible out-patient treatments.

Stigma and Psychiatric Hospitalization

Adolescents with a psychiatric condition may experience greater stigma if they are hospitalized given cultural stereotypes about the psychiatric hospital as a frightening institution. Robert Gibson, the president of the Sheppard-Pratt Hospital, (1992) wrote about stigmatized views of psychiatric hospitals and discussed the ways in which hospitals might attempt to combat stigma. Gibson noted how, over the centuries, psychiatric hospitals became "the symbol for all the frightening characteristics of the inmates of these hospitals, reinforcing the fear and adding to the stigma" (Gibson, 1992, p. 186).

Historically, hospitals were constructed in remote areas and were built as "fortress-like structures that emphasized security, with bars on the windows" (Gibson, 1992, p. 186). In this way, psychiatric hospitals were similar to prisons in their location, structure, and focus. Gibson noted that this trend began to change in the 1960s with the onset of the community mental health movement. Even as administrators and providers worked to change the image of the psychiatric hospital it still remained a "symbol of mental illness" (Gibson, 1992, p. 186). Gibson depicted the symbolic meaning of the

psychiatric hospital as a marker of stigma. Patients were not only stigmatized for having a psychiatric condition but were further stigmatized for being admitted to such an institution.

Gibson (1992) also discussed the ways in which psychiatric hospitals perpetuated stigma by creating an air of secrecy and mystery about patients in the guise of protecting their confidentiality. For instance, hospitals would often use a post office box number as a return address so that the receiver would not be associated with a psychiatric hospital. Any inquiries about patients would be ignored. Gibson stated that these efforts at "invisibility" further stigmatized patients and the hospital (Gibson, 1992, p. 186). While Gibson clearly documented the negative stereotypes about psychiatric hospitals, he also provided a number of suggestions as to how to ameliorate the public's perception of the psychiatric hospital as a frightening symbol of mental illness.

Clinical Interventions

There appears to be a scarcity of literature on specific, empirically based clinical interventions to help targeted teens manage stigma. To date, this researcher has located no research studies which document the effectiveness of particular methods in helping teens cope with stigma following a psychiatric hospitalization. Hinshaw (2007) provided descriptions of theoretically supported and possibly efficacious therapies which involve individual, family, peer support or self help group interventions. While Hinshaw's discussion of such treatments is helpful in beginning to raise awareness on therapeutic models to address the problem of stigma, the clinical interventions described do not appear to be supported by extensive research.

Stigma, as such, is not a diagnosable condition as contained in the Diagnostic and Statistical Manual of Mental Disorders-IV-TR (2000), but it would represent a significant Axis IV psychosocial stressor that could likely lead to increased symptoms of depression and anxiety in a marginalized teen. Stigma may exacerbate a teen's preexisting psychiatric condition, while it may also generate higher levels of stress. A number of empirically based clinical interventions have been shown to effectively reduce symptoms of depression and anxiety in adolescents, thereby possibly reducing the impact of stigma on a marginalized teen. Descriptions of such empirically based interventions will also be included in the following sections, along with Hinshaw's (2007) discussions of theoretically supported and possibly efficacious treatments.

Individual Interventions

While Hinshaw (2007) mainly focused on the importance of family treatment and education in helping youth manage stigma, he also briefly mentioned individual interventions aimed at addressing the same issue. As quoted in Hinshaw (2007), Hinshaw (2002) stated that "a mental illness that takes place during adolescence may be particularly devastating for one's self-esteem, independence, and sense of fundamental 'normality' in the world" (Hinshaw, 2007, p. 725). If psychiatric hospitalization is required for a teen, hospital staff must work to support a hospitalized teen's sense of personal agency and ability to make informed decisions about his/her treatment (Hinshaw, 2007). Mental health professionals must also attend to building a strong therapeutic connection with the youth.

Aside from mental health professionals' stance towards teen clients, Hinshaw described the importance of effectively treating a young person's psychiatric condition,

thus changing behaviors and symptoms that may have been contributing to the stigmatization of the teen. While he discussed treating symptoms within the context of ameliorating a child or teen's suffering, he argued against the notion that treatment served to "eliminate differences or deviancy" as its primary goal (Hinshaw, 2007, p. 226). Hinshaw briefly described the importance of utilizing evidence-based treatments for specific psychiatric conditions as a means to address teens' symptoms and thereby reduce their experience of stigmatization. He also noted the efficacy of combining medication and therapy. While the use of evidence-based treatments and the combination of medication and therapy may address an adolescent's psychiatric condition, such treatments were not created and researched for the primary purpose of reducing stigma. Instead, effective treatments could alleviate the negative impact of stigma as it exacerbates an adolescent's preexisting psychiatric condition or contributes to higher levels of depression and anxiety, symptom clusters most likely to result from stigma. Hinshaw discussed the use of such treatments as providing a secondary purpose in the reduction of stigma and he went on to state that "a combination of societal tolerance, treatment access, personal knowledge and acceptance, and parity of healthcare coverage" are necessary in order "to promote the kinds of treatment seeking that are necessary for both personal benefit and stigma reduction" (Hinshaw, 2007, p. 228).

Hinshaw (2007) also briefly discussed methods for helping children and teens cope with discrimination and stigma. He focused on the importance of coping strategies in mediating the negative impact of stigma. Hinshaw defined *Problem-focused coping* as a form of coping that is "directed primarily toward the source of conflict or stress; these involve planning, as well as gathering instrumental and emotional support" (Hinshaw,

2007, p. 230). Miller and Major (2000) also described problem-focused or active coping strategies as attempts to alter "the nature of the relationship between the person and the environment, and hence eliminating the source of stress" (Miller & Major, 2000, p. 251). According to both definitions, problem-focused coping involves taking an active stance in addressing and altering the factors that produce stress for a stigmatized person. Specifically, for individuals with a psychiatric condition, Hinshaw (2007) mentioned involvement in a self-help or social advocacy group as a means to directly combat the problem of stigma. The growth of the consumer movement has created more options for individuals and families who wish to utilize problem-focused coping skills.

Hinshaw described *emotion-focused coping* as "mental and behavioral disengagement from the stress" (Hinshaw, 2007, p. 230). Miller and Major (2000) further elaborated on emotion-focused coping as having the goal of regulating difficult, negative emotions without addressing environmental factors causing the stress. While there may be some benefit to this type of coping, Hinshaw stated that emotion-focused coping is often correlated with increased distress and negative outcomes for individuals with psychiatric conditions. The positive ability to understand one's experience of stigma and discrimination as a problem of prejudice rather than stemming from internal flaws represents a cognitive and emotional strength. This type of understanding consists of a combination of "emotional reframing and problem-focused strategizing" and would likely be more beneficial then denial or other forms emotion-focused coping (Hinshaw, 2007, p. 230).

Additionally, Hinshaw (2007) discussed the issue of disclosure of a psychiatric condition as an important issue related to stigma. Hinshaw noted that more research is

needed to study how individuals decide when and how they disclose their conditions to others. Disclosure exists as an important aspect of stigma management, given the fact that disclosure can often lead to discrimination or greater marginalization for individuals. While Hinshaw acknowledged the importance of discussing the issue of disclosure with children and teens with a psychiatric condition, he did not clearly identify any therapeutic methods or interventions to support an individual through the decision making process.

Hinshaw (2007) also briefly alluded to the fact that some types of psychotherapy might be particularly advantageous in terms of helping an individual cope with stigma. Cognitive-Behavioral Therapy, a behavioral model which focuses on altering maladaptive patterns of thoughts, emotions, and behaviors, may be particularly effective in helping individuals address negative beliefs and cognitive distortions about themselves and their psychiatric condition. Cohen, Mannarino, and Deblinger (2006) developed an empirically validated cognitive-behavioral model for use with traumatized children and adolescents. This model, called trauma-focused cognitive-behavioral therapy (TF-CBT), utilizes a components based approach to increase both skills and knowledge for traumatized children and their caregivers. Components provide young people and their parents with the following skills: "Psychoeducation and parenting skills; Relaxation; Affective modulation; Cognitive coping and processing; Trauma narrative; *In vivo* mastery of trauma reminders; Conjoint child-parent sessions; Enhancing future safety and development" (Cohen et al., 2006, p. 45). As an empirically based treatment model, TF-CBT aims to increase children and adolescents' functioning and to decrease symptoms of trauma, anxiety, and depression, while it also may serve a secondary purpose of alleviating the effects of stigma on a marginalized teen. In contrast to other models that

only intervene with the young person, TF-CBT includes a parent component that appears to increase positive outcomes for the child and family.

Therapy could ideally serve as a means to support adolescents and their families in externalizing the causes of stigma, attributing stigma to prejudice and ignorance, rather than to personal flaws. While Hinshaw (2007) did not directly associate this process of externalization with any particular form of psychotherapy, Narrative Therapy techniques may be utilized effectively in externalizing problems. Narrative Therapy, an application of post-modern theory to psychotherapeutic practice, was originally created by Michael White and David Epston. White and Epston (1990) discussed the process of "externalizing the symptom" as follows:

> Externalizing is an approach to therapy that encourages persons to objectify and, at times, to personify the problems that they experience as oppressive. In this process, the problem becomes a separate entity and thus external to the person or relationship that was ascribed to the problem. Those problems that are considered to be inherent, as well as those relatively fixed qualities that are attributed to persons and relationships, are rendered less fixed and less restricting (White & Epston, 1990, p. 38).

In this way, the therapeutic process of externalization allows stigmatized teens and their families to successfully avoid over identification with a psychiatric condition and its resultant stigma. Stigma then becomes a force separate from the self of the teen, and the family may unite in their efforts against this force.

While such therapeutic interventions may be helpful in the reduction of stigma, these treatment modalities have not been empirically validated as such. Cognitive-Behavior Therapy has been empirically validated in terms of its effectiveness in treating depression and anxiety in adolescents, yet it has not been applied directly to the problem of stigma (Cohen, Mannarino, & Deblinger, 2006). Hinshaw (2007) also discussed a

number of potentially helpful interventions aimed at reducing a teen's psychiatric symptoms and thereby decreasing the experience of stigma, but he did not provide research to support such claims. Focused research on specific therapeutic interventions to combat stigma is still sorely needed.

Family-based Interventions

Hinshaw (2007) focused on the importance of family-based treatments in helping a child or adolescent and their family combat social stigma deriving from a psychiatric condition. Initial interventions should be aimed at educating the young person and his or her family about the causes of mental illness. According to Hinshaw, mental health professionals should discuss a number of issues with the family, including "facts about not only the moderate to strong genetic propensities for many forms of mental disorder but also the role of life stressors and social supports as related to outcome, the importance of family advocacy in obtaining responsive treatments" (Hinshaw, 2007, p. 217). This type of balanced presentation of the various factors involved in understanding and treating psychiatric conditions may help a family to feel empowered to support the child or teen, rather then feeling the disorder is due to faulty parenting or that there is no hope for recovery. Hinshaw (2007) noted that interventions aimed at increasing a family's understanding of psychiatric conditions also reduced the sense of shame and guilt that many families experience when their child is diagnosed or hospitalized due to such a condition. Through this type of education, Hinshaw believed that a family's experience of stigma may be reduced.

Fristad, Gavazzi, and Soldano (1999) discussed the importance of psychoeducation as an effective clinical tool for use with a family in which a child or

adolescent is suffering from a mood disorder. Studies have shown that psychoeducation

serves as an effective treatment method in terms of increasing individual family

member's awareness of mood disorders and reducing levels of expressed emotion (EE)

within the family (Fristad et al., 1999). In their 1999 study, Fristad et al. utilized

psychoeducation as an adjunctive treatment, in addition to medication management and

psychotherapy for the teen and family, while also incorporating a narrative therapy

framework. The narrative therapy method of externalization used by the researchers

allowed families to differentiate between the symptoms of the mood disorder and the self

of the adolescent that experienced those symptoms. The blending of psychoeducation and

narrative techniques supported families in clearly distinguishing between normal

developmental issues and mood disorder symptoms that necessitated treatment. Lastly,

the technique of identifying the mood disorder as "the enemy" served to create a useful

metaphor that helped families unite in a common struggle against the condition, not the

adolescent (Fristad et al., 1999, p. 84).

The importance of actively involving parents, caregivers, and other family

members in treatment has been explored in a number of research studies. Cohen,

Mannarino, and Deblinger (2006) discussed the importance of including parents in the

treatment of traumatized children, stating that this inclusion is "optimally helpful" and

enhances "parenting efficacy, parent-child communication, and familial attachments"

(Cohen, Mannarino, & Deblinger, 2006, p. 37). Parental or caregiver involvement could

include supporting family members in understanding the treatment plan and goals for the

affected teen and helping the young person maintain their treatment regimen. Hinshaw

(2007) described the importance of family members engaging in family-based therapies

that address family patterns of interaction, communication styles, and boundaries. As cited in Hinshaw (2007), Butzloff and Hooley (1998) depicted how negative, antagonistic patterns of family communication serve as a major predictor for rehospitalization. In this way, family communication styles play a powerful role in an adolescent's treatment outcomes. Patterns of open, direct, and sensitive communication appear much more beneficial for the affected child or teen and the family.

While a number of researchers have explored the efficacy of family-based interventions in helping a teen recover from a psychiatric condition, the goal of stigma reduction appears secondary to the treatment of the condition. Hinshaw (2007) stated that improving a family's understanding of their teen's psychiatric condition could help reduce stigma for that young person and the family, and while this argument appears realistic, he did not provide specific research to validate these claims. There is a great need for future research to directly investigate family-based interventions that aim to help a family and their affected teen manage stigma following a psychiatric hospitalization.

Group Treatment Interventions

Hinshaw (2007) described the importance of self-help and advocacy groups in increasing awareness of mental health treatment and policy while also serving as important sources of support for individuals and families coping with psychiatric conditions. Hinshaw (2007) referred to Wahl's (1999) study in which a large, national survey conducted in the 1990's determined that individuals with psychiatric conditions viewed self-help and advocacy groups as important venues for providing greater support and opportunities for positive coping. Hinshaw further noted the benefits derived from such groups as they provide opportunities for individuals and families to break barriers of

silence and shame that surround stigmatized views of mental illness. Groups also allow for greater social support, thus reducing the sense of isolation that can so often accompany the experience of a psychiatric condition. Other members might model positive coping strategies and share helpful resources. Many groups also include an educational portion which assists members in developing a more accurate understanding of psychiatric disorders and their effective treatments. Lastly, Hinshaw (2007) commented upon the opportunity for social activism offered by advocacy groups and he noted that such efforts could assist individuals and families in utilizing active, problem-focused coping techniques.

One adolescent group treatment model that has been proven effective in helping teens manage anxiety and trauma is Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS). The National Child Traumatic Stress Network (2007) reported that SPARCS serves as a group treatment method for use with traumatized teens and that the goals of the program include improved coping, self-efficacy, supportive relationships, self-awareness, and positive life meaning. SPARCS has been utilized in a variety of treatment settings with diverse groups of adolescents and has been proven effective as documented in published case studies and pilot trials (National Child Traumatic Stress Network, 2007). SPARCS is primarily a cognitive-behavioral intervention, while it also utilizes skills and concepts from Dialectical Behavior Therapy, a cognitive-behavioral approach developed by Marsha Linehan that incorporates dialectics and mindfulness practice. While the primary goal of SPARCS is to reduce the severity of trauma and anxiety symptoms, the program may have a secondary benefit of reducing stigma for marginalized adolescents. As teens develop

increased coping strategies, support networks, and self-esteem through group therapy, they may less vulnerable to the damaging effects of stigma. Their symptoms may also decrease which would likely reduce their risk of being stigmatized.

While the benefits of involvement in such groups appear numerous, the reduction of stigma appears as a secondary effect of participation. Hinshaw (2007) did not describe any empirically-based group treatment models in which the reduction of stigma was the primary goal. Such models may exist but there is little research on group therapy treatments that focus directly on the management of stigma for recently hospitalized adolescents.

Summary

Stigma exists as a well-documented phenomenon affecting marginalized groups throughout society. The negative effects of stigma are keenly felt by individuals diagnosed with a psychiatric condition. Stigma consists of negative stereotypes of people with a psychiatric condition as potentially dangerous and unpredictable. Prejudicial attitudes and discriminatory behavior are also components of stigma. Such negative views towards individuals with a psychiatric condition are endorsed by adults and adolescents alike.

According to the fields of social psychology and sociology, stigma exists in multiple contexts, functioning on psychological, social, and structural levels. Within the broader cultural context, a psychiatric hospitalization is seen as further stigmatizing given the historic perception of psychiatric hospitals as mysterious, frightening institutions for "crazy" people. For teens experiencing a psychiatric condition and recent hospitalization, the impact of stigma is especially difficult. Teens occupy a less powerful position in

society and they are often stigmatized for being moody, rebellious, insecure, or otherwise difficult to get along with. Adolescents' developmental vulnerabilities and reliance on their peer group may serve to further increase a marginalized teen's susceptibility to the damaging effects of stigma. Clinicians working with a recently hospitalized teen must intervene to help manage or reduce the harmful effects of stigma and the frequent increases in symptoms of depression and anxiety that may follow experiences of stigmatization.

The current study aims to identify particular clinical interventions that experienced clinicians have found helpful in assisting adolescents to manage various forms of stigma following a psychiatric hospitalization. While a great deal of research has been written about the deleterious effects of stigma, there is a scarcity of literature that directly identifies clinical interventions for use with this particular population and identified problem. While Hinshaw (2007) pointed to a number of individual, family, and group-based interventions to combat stigma, his claims are not support by research and do not serve as empirically-based treatments. Given what we know about the negative effects of stigma, clinicians who are prepared to address this issue within treatment may greatly help clients in the process of returning to their communities and developing ongoing methods to manage stigma.

CHAPTER III

METHODOLOGY

The purpose of this study was to explore the following question: How do clinicians intervene to help adolescents manage stigma following a psychiatric hospitalization? Little research has been conducted on clinical interventions for use with this specific population although the negative effects and widespread prevalence of stigma have been clearly documented. A qualitative, exploratory research design was utilized, allowing for the development of a rich, complex understanding of particular, lesser known phenomena (Anastas, 1999).

Given that there is little research on the proposed question, a qualitative, exploratory research design allowed the researcher to access participants' narratives that included descriptions of specific, nuanced clinical interventions. Semi-structured, in-depth interviews were conducted with twelve mental health professionals who had worked with at least three recently hospitalized adolescents in a clinical capacity. The findings from these interviews were then analyzed according to major, recurrent themes and divergent findings.

Recruiting a Sample

A non-probability, purposive, expert sample was recruited for the current study. The target sample size was twelve to fifteen master's or doctorate level social workers and other licensed mental health specialists. Selection criteria included state licensure in social work, psychology, school guidance counseling, or mental health counseling and at least three years of experience working with hospitalized adolescents. Participants also had to speak English in order to take part in the study due to the researcher's limitations

as a monolingual English speaker. Individuals who were not licensed or who had less than 5 years of experience were excluded from the study.

A snowball sampling method was utilized in order to obtain participants and to ensure diversity amongst subjects. Snowball sampling provided the bulk of the research participants, with many participants referring colleagues as potential participants. First, calls were made to clinicians working at a Northeastern psychiatric hospital where the researcher had interned during her first year field placement. Two clinicians agreed to participate in the current study and one of those clinicians additionally referred three other participants who were professional contacts at a state Department of Mental Health in the Northeastern Region. Second, a professional colleague agreed to be interviewed and, through his work as a high school guidance counselor, was able to refer five more clinicians who agreed to be interviewed at high schools in a large metropolitan area. Finally, one participant responded to an email sent by the researcher to public high school social workers in a Northeastern state and this individual agreed to be interviewed.

All participants received a recruitment letter either in the mail or via email that detailed the purpose and scope of the research project and requested the clinician's participation in the research (Appendix B). Participants were then screened by phone or email to ensure that they met the study's criteria and to schedule the interviews. Every effort was made to ensure diversity amongst the participants in regards to race, ethnicity, socioeconomic status, and gender. Additionally, clinicians were recruited from a variety of different agencies and geographical areas including rural, suburban, and urban settings.

A total of sixteen clinicians were contacted to participate in the present study. Of the clinicians contacted, twelve agreed to participate and four declined, stating that their

schedules did not permit participation or they did not have the type of professional experience needed for the purpose of the study. Of the final sample of twelve clinicians, eleven were obtained through the use of snowball sampling methods as participants referred professional colleagues.

<div align="center">*Participants*</div>

This study included twelve participants from three different types of agencies. A brief demographic questionnaire was given to participants prior to the interview and all demographic information was gathered from participant responses to this questionnaire (Appendix D). Of the total sample, seven identified as female (58%) and five identified as male (42%). In terms of the racial and ethnic composition of the sample, six participants identified as white or Caucasian (50%), two participants identified as white and Jewish (17%), three participants identified as black or African-American (25%), and one participant identified as Hispanic (8.33%). Due to the fact that all participants were mental health professionals, the socioeconomic status of the sample did not vary greatly. Of the twelve participants, ten identified as middle-class (84%) and two identified as upper-middle class (16%). In terms of professional degrees held by participants, five participants were Licensed Independent Social Workers (42%), four participants were Licensed Social Workers (33%) with two of those four participants also being certified School Adjustment Counselors, one participant was a Licensed Mental Health Counselor (8.33%), one participant was a master's level School Guidance Counselor (8.33%), and one participant was a doctoral level, state certified School Psychologist (8.33%). All twelve participants (100%) were licensed in one Northeastern state. Seven participants schools worked in a public high school setting (58%), three worked for a state

Department of Mental Health (25%), and two participants had previously worked at a psychiatric hospital (17%). Average number of years experience working with recently hospitalized adolescents was 11 (range 4 to 30 years).

Data Collection

The design of the current study was approved by the Human Subjects Review Board of the Smith College School for Social Work (Appendix A). An Informed Consent form was signed by all participants prior to their involvement in the research interview (Appendix C). The Informed Consent form clearly described the purpose of the study, the inclusion criteria and participation responsibilities for subjects, and any potential risks and benefits related to taking part in the research. Careful attention was paid to safeguarding participant confidentiality and these efforts were clearly detailed in the Informed Consent.

An open-ended, semi-structured interview served as the primary method for data collection. Interviews were largely conducted in person at the participant's office, while one interview was conducted at a café and another was conducted over the telephone. The length of the interviews ranged from 25 to 65 minutes with the average length around 45 minutes. A semi-structured interview guide containing thirteen open-ended questions was utilized to gather data (Appendix E). In addition, probing or clarifying questions were also used to ensure the researcher's comprehension of a participant's response or to encourage the participant to provide some additional elaboration on a particular theme. In this way, each interview varied in terms of participant responses and follow up questioning, although thirteen main questions provided a consistent overall interview structure. Each interview was recorded and later transcribed by the researcher.

All identifying information was removed from the transcriptions and the researcher's field notes, and interviews were numerically coded to ensure confidentiality. No one except the researcher had access to participants' identifying information and all confidential information will be stored in a locked file for a minimum of three years.

Data Analysis

Interview transcripts were analyzed thematically for the purpose of identifying major themes and divergent opinions. Interview questions aimed to elicit rich, narrative descriptions of clinical interventions used with recently hospitalized adolescents who were struggling with stigma. Content theme analysis was then applied to these narrative descriptions and a number of common interventions and clinical themes emerged through the data analysis process. Additionally, transcripts were analyzed for divergent themes or important issues raised by participants that were not initially considered by the researcher or specifically elicited by the interview questions. Participant quotations were used to illustrate important themes and to provide a more personalized, nuanced description of clinical interventions.

While the current study provides rich, in-depth descriptions of clinical interventions used with a specific population, major generalizations cannot be made from these results. A qualitative, exploratory research design was chosen for the purpose of investigating an aspect of clinical practice that had not been previously studied. While the research design achieved this aim, generalizing these results to a larger population or a different type of stigma would not be appropriate. Limitations of the study include the small sample size (n = 12) and the narrow geographical location of participants (one Northeastern state).

CHAPTER IV

FINDINGS

This chapter contains findings from interviews conducted with twelve master's or doctorate level mental health professionals who work with recently hospitalized adolescents. The interview guide utilized by the researcher was designed to elicit rich, narrative data on how clinicians intervene to help recently hospitalized teens manage stigma (Appendix E). Interview questions asked participants to define stigma and to discuss its impact on recently hospitalized adolescents. The majority of the questions directly addressed the types of interventions utilized with recently hospitalized teens, including how these interventions were conceptualized, what clinical issues influenced the use of a particular intervention, and what interventions appeared most successful according to the participants. In this way, the interview guide provided a conceptual framework for the type of data obtained. The findings reported in this chapter will follow in roughly the same order as the questions contained in the interview guide. Participant quotes will be included in order to provide in depth information about major themes that emerged from the data. Participants were randomly assigned a number between one and twelve in order to identify their responses across questions.

Participants' Clinical Experience

All general participant demographic information is included in the Methodology Chapter. In addition to participants' personal information, the demographic questionnaire also contained one question about participants' academic or professional training related to the issue of stigma (Appendix D). Of the twelve participants, eight of them reported having had graduate or professional training on the topic of stigma of psychiatric patients

(66.6%). Three other participants stated that they had not received any specific training on the topic (25%) and one participant did not answer the question (8.3%).

The demographic questionnaire also assessed for the number of recently hospitalized adolescents on participants' caseloads in the past five years. This number ranged from 3 to 90, with the average number being about 31. The number of recently hospitalized adolescents on participants' caseloads varies greatly due to the fact that participants worked in a variety of settings and served diverse client populations. Two participants answered the above question using percentages to denote what portion of their caseload was comprised of recently hospitalized adolescents, and they answered 70% and 97%, respectively. Lastly, one participant did not answer the above question and did not report any specific reason for this omission. In order to be included in the study, participants had to have worked with recently hospitalized adolescents for at least three years, having at least three such teens on their caseload. All twelve participants met inclusion criteria.

<div align="center">Conceptualizations of Stigma and Its Impact</div>

Participants were initially asked about their understanding of stigma, including their definition of stigma and their observations about how stigma impacts recently hospitalized adolescents. A number of main themes emerged from their responses. Of the twelve mental health professionals interviewed, seven talked about stigma as a form of bias or discrimination. One participant described stigma in the following way:

> I think a synonym that comes to mind for me is bias. I also kind of think about it as being marked in some way, because of an experience or like an identity or something else someone experiences discrimination or bias towards them (Participant 1).

Six participants also discussed the connection between stigma and the use of stereotypes and negative labels to describe a group of people. One individual specifically described stigma as a "negative identification based on stereotype" (Participant 4). Additionally, five participants highlighted the negative connotation of stigma, with one participant describing stigma as a "demeaning" or "belittling" force (Participant 11). Four participants mentioned various aspects of an individual's identity that could be the target of stigma, including race, ethnicity, gender, mental health status, and sexual orientation. In terms of mental health status specifically, one participant described the stigmatization of individuals with psychiatric condition as evident when "People look at someone who has mental health issues as being lower than them, being lower class and being not up to their level" (Participant 7). Responses generally highlighted stigma as a negative social belief based on stereotypes and bias. Participants also clearly mentioned discrimination as an important aspect or manifestation of stigma.

In terms of stigma directed towards recently hospitalized adolescents, four participants discussed the centrality of ignorance or stereotypes about psychiatric hospitalization as being a major cause of stigma. One participant described this phenomenon in the following way:

> They don't really know what a hospitalization is like so they're assuming that only really crazy people go into the hospital. So, I think that there's a lot of stigmatizing. I think that, if they'd had a hospitalization themselves, they would clearly have a much better understanding of it (Participant 4).

According to these participants, a general lack of education about the purpose, function, and experience of psychiatric hospitalization fuels a stigmatizing, stereotypical perception of individuals necessitating this level of care. One participant briefly discussed

the internalization of stigma for a recently hospitalized teen as the belief that "I am bad and I am flawed in some way" (Participant 10). Overall, participants' understanding of stigma was similar to general descriptions of this phenomenon as presented in the literature.

Effects of Stigma on Recently Hospitalized Adolescents

When asked about their observations on the effects of stigma on recently hospitalized adolescents, a variety of themes emerged from participants' responses. Nine participants discussed the impact of stigma on a recently hospitalized teen's social identity, specifically describing the prevalence of pejorative labels and gossip and the resultant negative impact. Three participants specifically described how a teen became known as "crazy" following a hospitalization (Participant 4, 7, & 12). One participant discussed an incident in which a teen was being described as "the next Unabomber" by the other students at school (Participant 7). These types of stigmatizing labels were described as directly resulting from a teen's psychiatric condition and hospitalization.

Another participant depicted the negative labeling that occurred for recently hospitalized adolescents when they become thought of as "Those are the kids who have problems" (Participant 5). This type of negative labeling was reiterated by another participant who described the shift in the perception of a teen following a psychiatric admission. This participant stated that, "I think for a lot of students that we see, after their first hospitalization it's a real transition from being a 'normal' high school adolescent to one with 'mental health issues'" (Participant 9). This participant did not specifically state whether this new label was adopted by the teen as well as being perpetuated by the teen's

community. Another participant discussed the negative labels and stereotypes about adolescents with psychiatric conditions in the following way:

> There's a whole stigma about mental health, kids don't want to comply with services, they don't want to do anything. They just want to sit around the house. They don't want to go to school. They're not complying with authority figures (Participant 6).

This participant described the way in which mental health providers and other adults also sometimes perpetuate such stigmatizing views and that the labeling and gossip is not only confined to a teen's peer group.

In addition to being viewed and talked about in a negative way, four participants discussed how a recently hospitalized adolescent might also be treated differently due to the presence of stigma. One participant described the impact of a hospitalization and the resultant stigma as follows:

> I would just think that suddenly people might have different behaviors towards them, different beliefs about them, different kinds of reactions to a…young person's behaviors that previously there had been a different reaction [to]. Even a different kind of way of talking about the person. Sometimes things can be very subtle and other times I think that they're really quite obvious (Participant 1).

In this way, the participant describes how a teen might be reacted to in a completely different manner following a psychiatric admission. Another participant reiterated this notion, stating "I think that kids feel that they're going to be looked at differently, treated differently" and that this concerns teens (Participant 3). One participant described a reaction of social avoidance towards recently hospitalized adolescents. This participant described the impact of stigma, saying that "You lose your popularity, your friends, and your coolness disappears so you don't want to be one of those kids" (Participant 7). According to participants, a teen's relational experience may be negatively impacted by

stigma in that they are perceived and treated differently following a psychiatric admission.

In discussing the impact of stigma on recently hospitalized teens, five participants mentioned the experience of shame and the fear of disclosure that results for adolescents returning to their communities. One participant said, "I think there's a fair amount of shame for some kids, for most kids, in letting other people know that they've been hospitalized -- both peers and teachers" (Interview 4). This experience of shame appears directly related to the stigmatization of psychiatric conditions as described by one participant who said, "I think there's a lot of secrets around mental health and feeling like you can't expose that part of your life because of how your peers will react, or even teachers" (Participant 9). Due to this stigmatization, participants describe how teens then experience anxiety and fear when returning to their communities and grappling with how to talk about their experiences. One participant specifically described it as "Anxiety provoking situations! Whether you tell the truth or lie or whatever you're still at that point" (Interview 11). Throughout participant interviews, the issue of disclosure emerged as an important theme and the topic will be discussed in greater detail later in this chapter.

In addition to the main themes described above, three participants discussed the stigma's negative impact on teens' self concept and self-efficacy. One participant described how recently hospitalized adolescents "Also start to question their own self worth in terms of, where they're at, and what they mean to the world, to themselves, and it starts to bring up a whole host of issues" (Participant 3). Two other participants described how stigmatized teens felt "powerless" or "bad" and that this impacted their

self-esteem (Participants 6 & 10). Two participants also discussed the experience of some

marginalized adolescents who avoid treatment due to the effects of stigma. One

participant specifically depicted this process, stating "It makes kids back off. They don't

want anyone to know even when they're having problems, difficulties in school, they'd

rather not go to the counselor because if someone sees them in the counselor's office

then, 'What is going on?'" (Participant 7). This same participant then went on to describe

how treatment avoidance places stigmatized teens at greater risk when they are willing to

run away from home or conceal their "true self" in order not to stand out.

Two divergent themes emerged during the exploration of the impact of stigma on

recently hospitalized teens. Two participants stated that they do not believe stigma exists

as a major problem for recently hospitalized teens in their specific school setting. One

participant stated:

> I have not experienced, as their primary advocate…a lot of stigmatization in this environment certainly…among the staff. It's a very small school and our teachers tend to be quite aware of our students and observant of our students and genuinely concerned (Participant 2).

In discussing the specific response of staff and teachers to a recently hospitalized teen,

this participant felt that compassion and concern were elicited as a result of a

hospitalization. This participant also noted that the size of the school helped to create a

more supportive and caring environment. Another participant reiterated this experience:

> I haven't had an issue, though, with a kid coming out of the hospital that has been negative. I haven't had that experience of kids feeling like everyone's talking about me, everyone's looking at me… .I almost think it's because adolescents are so self-involved and this is a big high school, that life goes on (Participant 3).

This participant did not describe stigma as impacting teens' reactions to a hospitalized

peer and the participant also noted that the large size of the school also decreased the

amount of stigma present. Both participants stated that stigma did not appear to be a

problem for the recently hospitalized adolescents that they had worked with.

Another divergent theme was related to an unexpected positive effect of the

hospitalization and stigmatization experiences. One participant discussed the strong

bonds created between recently hospitalized adolescents, stating:

> A lot of times it ends up creating a situation in which kids who have been recently hospitalized are drawn to other kids who have been recently hospitalized and they kind of share that common bond and develop friendships… .It's really interesting that, a lot of times, it brings kids together who are extremely different, kids who would never connect outside of that situation or that kind of common knowledge, and might not even have, literally, anything in common except for that… .I think it's definitely about relating to kids who had a unique experience and whether they're hospitalized for the same reason, or it could be a different reason, but just having a mental health problem to the extent that you were hospitalized is a common thread. They can relate to that with each other (Participant 12).

While this participant went on to discuss how recently hospitalized teens might

negatively reinforce one another at times, this participant generally viewed these

unexpected friendships as positive and supportive. The hospitalization and stigmatization

experience allowed teens to connect with one another around a shared experience and this

contributed to the creation of strong bonds amongst diverse groups of adolescents. This

finding appeared unusual in that it was the only positive effect of stigma discussed by any

participant.

Factors Impacting Stigma for Recently Hospitalized Adolescents

In discussing the various factors that impact the experience of stigma for recently

hospitalized adolescents, participants discussed the individual presentation and

characteristics of the teen as well as looking at the teen's social and familial supports.

When discussing these factors, the majority of participants talked about an individual

teen's presentation as being a primary indicator to the intensity of stigma directed

towards the young person. Five participants discussed a teen's personality and behavior

as having a direct impact on the amount of stigmatization experienced. One participant

described the interaction of personality, behavior, and stigma in the following way:

> I would say that the kids who are bigger behavior problems are more likely to attract attention and be more stigmatized. And the kids who are quiet and kind of go about their own business are usually a lot less identifiable… .It's usually outward behaviors that draw attention to any kid. The kids who are more acting out in some way are going to get more attention than the kids who are quiet (Participant 5).

These five participants described teens that exhibit loud, aggressive, odd, or unusual

behaviors as being more likely to be stigmatized. Teens that were seen as quiet and/or

well liked were seen as less likely to be stigmatized in such a severe manner.

In addition to personality and behavioral factors, a teen's psychiatric condition

and functioning status also may impact the severity of stigma directed towards that young

person. One participant discussed the effects of a psychiatric condition as it causes a teen

to become overwhelmed and to present differently from peers:

> I would say, just the nature of their functioning, the nature of their illness, makes them stand out a lot… .Some kids are prone to being overwhelmed where a lot of symptoms come out when they're given, let's say, a lot of work in school. Kids like teasing each other and some of them can't read social cues depending on how their functioning is, that creates a problem… .When it comes to being pushed into the corner they react in a manner that the other students wouldn't react which, of course, puts them in a completely awkward place (Participant 7).

Another participant noted a similar pattern, stating "Sometimes the symptoms that are

building up can really ostracize them because they're perceived as very, very strange and

different from the rest in ways that can be scary" (Participant 10). These participants

noted the ways in which psychiatric conditions and their resultant symptomatology

contributed to recently hospitalized teens being ostracized or stigmatized in a more severe manner. Three participants stated that this was especially true for teens experiencing psychosis, while one participant noted higher levels of stigma for adolescents with substance abuse disorders.

According to participants, an adolescent's physical appearance and dress also impacts stigmatization. Four participants discussed appearance as a factor that could potentially increase levels of stigma for a teen. One participant described the role of appearance in the following way, saying:

> The kids who look unusual are probably going to get more attention than the kids who don't. I mean if a kid's wearing a black trench coat to school they're obviously going to get more stigmatized than a kid who is dressed like [famous football player], right? (Participant 5).

Another participant described a similar phenomenon for urban youth of color who dress in a particular manner, stating:

> I know for some young men that I have worked with, just because they come from the urban city, the way they dress and how they conduct themselves, it's been a stigma when they leave the hospital…because his pants is hanging off his butt, wearing his hat tipped off to the side, or wearing a rag across his head. I think some people look at that as a stigma, 'Who is he? This kid looks like trouble. I don't know if I'm going to be able to reach him. He has his own agenda' (Participant 6).

In this way, particular urban youth are viewed in a negative, stigmatized manner based on their appearance. Another participant described this as an issue of "conformity versus non-conformity" and that non-conformist teens may be at higher risk for stigmatization (Participant 12).

An adolescent's sociocultural identity may also elicit greater stigma, according to participants. Three participants discussed a teen's socioeconomic status, race and

ethnicity, and sexual orientation as potentially stigmatizing aspects of identity. This issue will be discussed at greater length later in the chapter as part of participants' responses to a question on the interaction of sociocultural identity and its impact on stigma.

In addition to a recently hospitalized adolescent's presentation, two participants discussed the issue of academic ability as impacting a teen's experience of stigma. Both participants stated that teens with greater ability may experience less stigma as they are able to complete their work in a timely manner and this may elicit more respect and support from teachers. In addition to academic performance, one participant mentioned the responsiveness of the school environment as affecting a young person's level of stigmatization. The participant stated that "Some students really, if they have some mental health issues, they function well in a small classroom with some therapeutic support" and that this type of support reduces the stigmatization they might otherwise experience in a mainstream public school setting (Participant 7).

According to participants, another major factor impacting a teen's experience of stigma relates to their level of social support. Four participants stated that they believed teens with greater social supports are less likely to be stigmatized or to experience as many negative effects from stigma. One participants described how "The stronger, larger their peer network…I think the less likely for them to be stigmatized" (Participant 2). Conversely, participants stated that teens with few social supports were more likely to be stigmatized and isolated from peers. One participant described this phenomenon, stating, "I would say that kids who come back and were isolated from their peers prior to hospitalization, that they are concerned [and] are feeling more stigmatized when they do

come back" (Participant 8). This participant appeared to imply that a hospitalization may

create greater social anxiety for an already marginalized teen.

In addition to the importance of social support, four participants discussed the role

of familial and/or parental support as it affects a teen's experience of stigma. Participants

noted that parents and families could play a very positive role in mitigating the effects of

stigma. One participant described the importance of this support in the following way:

> I think part of it is probably the support they're getting at home. I think it starts
> there. What I've found is that when kids come back from a hospitalization and
> their parents are really supportive and understanding that that certainly makes
> them feel more comfortable when they're coming back to school (Participant 8).

This participant noted the importance of parental support in helping teens to be more

comfortable in their transition back into the community. Participants also acknowledged

that not all families take such an open, supportive stance and that some families believe

that a psychiatric condition is something the "family tried to hide" (Participant 9). One

participant specifically talked about the role of cultural beliefs as they affect a family's

response to the teen's condition and hospitalization, stating "I think that so much of it has

to do with our immediate environment in which we grow up and what the beliefs are, say,

in our families, our communities, or cultural beliefs on different issues" (Participant 1).

Another participant discussed the profound impact of a family's past experiences with

hospitalization and psychiatric conditions. According to this participant, a past experience

of a hospitalization of a family member that resulted in a beneficial outcome could

positively impact the family's ability to support their teen child through a similar crisis,

while a negative experience of hospitalization could cause family members to have a

much different approach to their adolescent.

One divergent theme that emerged in the discussion of familial support is related to the specific experience of military families. One participant noted that there appeared to be increased stigmatization for recently hospitalized teens whose parents work for the military. This participant had worked with a number of such teens and described the situation as follows:

> Families perceive that it can interfere with the adult's status with the military to have had a child in the hospital. I don't know if there's any reality to that but I have had experiences where parents feel that if it's found out, which it would be because they go through military-provided health insurance, that it would adversely impact the parent's own career (Interview 4, p. 3).

This participant felt that military families were impacted by stigma in a variety of unique ways, potentially resulting in greater negative effects for the family. The participant did not elaborate on how stigma may affect the parents' ability to support their child or whether military parents tended towards any particular types of responses towards the hospitalized teen.

Issues of Diversity and Impact on Experiences of Stigma

When asked about the impact of issues of diversity on the experience of stigma, the majority of participants stated that sociocultural issues such as race, ethnicity, socioeconomic status, sexual orientation, and gender do impact a recently hospitalized teen's experience of stigma. Nine of the twelve participants described how these factors could cause a teen to experience heightened levels of stigma and marginalization given the overlapping effects of oppression.

In terms of the impact of a recently hospitalized adolescent's race and ethnic background, four participants described how racial and ethnic differences could cause recently hospitalized teens to be targeted for stigma in a more extreme way. One

participant stated that "Generally the more identities that one has….it becomes more multi-problemed…I think it's helpful because there's more awareness to it but there's more complexity to it" (Participant 1). Another participant discussed the specific experience of recently hospitalized Latino youth in which "Cultural norms are misunderstood. I think that sometimes the teachers with very good intentions may actually be devaluing the students who already feel devalued" and that this causes teens to feel "marginalized which puts them at higher risk" (Participant 10). Another participant discussed a similar devaluation and stigmatization of African-American adolescents who struggle with psychiatric conditions, stating:

> I would say, in some cases with African-American kids, what I've seen is, "Let's remove he or she from the public school system, let's get them into that alternative school. Let's contain them, let's warehouse them. Let's put them in a place where we know they can be accountable. We can say from an educational perspective that we've done our job now" (Interview 6, p. 3).

This participant specifically noted the way in which African-American youth may be warehoused or tracked into the juvenile justice or into alternative school systems where they would be separated from other students. In this way, participants describe how teens of color may be at greater risk of being stigmatized by the larger systems involved in their lives.

Two participants specifically addressed the stigmatization that sometimes occurs within the mental health system in which poor Latino adolescents may be misdiagnosed or otherwise given substandard psychiatric treatment. One participant who worked for the department of mental health for a number of years stated that:

> I also think that sometimes Latino…they tend to be misdiagnosed…the lower the socioeconomic status, the more that we tend to see these multiple diagnosing or a piling up of labels. Sometimes not understanding the adolescent in the larger

context of the family… .So, I think that the research continues to show that Latino clients tend to have worse outcomes… .I think that it really is about this lack of cross cultural understanding, a misunderstanding of symptoms… .It can be trying to normalize symptoms that shouldn't be normalized as being culturally normative or actually over-responding to the symptoms and pathologizing those in a more acute way (Participant 10).

In this description, Latino youth may be further stigmatized by mental health professionals who misdiagnose teens based on a lack of cultural competency. Another participant noted a similar pattern in Latino teens were labeled as "bad" and were misdiagnosed as having a Conduct Disorder when they were, in fact, experiencing their first psychotic break (Participant 11). According to both participants, Latino adolescents often experience greater levels of stigmatization both from the larger culture and from mental health professionals

Additionally, four participants discussed the importance of ethnic and cultural differences as they shape an individual or a family's concepts about psychiatric conditions and their treatment. Four participants described various experiences working with Asian, Haitian, Latino, African-American, and white families in which understandings of psychiatric conditions and their treatment affected the teen's ability to receive necessary services and to be supported by their family. Participants' comments depicted how families can often feel that their cultural values are not respected or shared by mainstream American culture and that this complicates a young person's experience of stigma. One participant noted the ways in which these parents or caregivers may feel "disempowered, marginalized, oppressed" and that this can impact their "capacity to really advocate [for] and protect their children" (Participant 10). Another participant talked about specific experiences working with recently immigrated families who

experienced "great shame" in having their adolescent child hospitalized (Participant 4). This participant described how differing cultural beliefs and expectations greatly affected the teen's ability to receive necessary services and created an air of secrecy about the hospitalization.

In terms of the impact of sexual orientation, four participants stated that lesbian, gay, bisexual, and transgender (LGBT) recently hospitalized youth experienced greater levels of stigmatization than their heterosexual peers. One participant described how LBGT adolescents "have a much more difficult time fighting the stigma [of a hospitalization] because they're already fighting a stigma [about their sexuality]" (Participant 3). Another participant depicted how LGBT teens are often taunted and called names such as 'faggot' which negatively impacts their self-concept and self-esteem (Participant 7), while another discussed the prevalence of homophobia and talked about how adolescents are afraid to disclose their sexual orientation because "They're afraid of what their peers might say" (Participant 6). In contrast, one participant stated that LGBT teens did not report greater levels of stigmatization due to their sexual orientation. This participant said that LGBT teens she had worked with "didn't necessarily speak so much as to experiences of being discriminated against, although there was maybe one occasion in which it was mentioned as a trigger for their aggressive behavior" (Participant 10). Despite the last dissenting opinion, recently hospitalized LGBT adolescents were viewed as experiencing higher levels of stigmatization due to their sexual orientation.

Four of the twelve participants also mentioned socioeconomic status as impacting a recently hospitalized teen's stigmatization. Three participants discussed how

adolescents from a lower socioeconomic background had greater difficulty accessing psychiatric services and obtaining health insurance, thus potentially exacerbating their psychiatric condition. One participant stated that "It's always the availability of services. Can you get the services to people? The people who have access to things really get the treatment" (Participant 11). Another participant talked about how wealthy, educated parents are often able to "advocate for the best hospitals and the best doctors and the best team" and how this creates a "different reaction to [treatment] than parents that can't access those services" (Participant 9). In each description, socioeconomic factors played a central role in the ability to access the appropriate services for their recently hospitalized adolescent.

A smaller number of participants mentioned gender as an aspect of a teen's identity that could affect their experience of stigma. One participant stated:

> I think, just in my experience, that girls have had a somewhat easier time dealing with [a hospitalization] and acknowledging their problems and processing their feelings. A lot of boys don't want to go there and discuss it or acknowledge it or seek help for it (Participant 9).

According to this participant, gender differences contributed to decreased experiences of stigma for female recently hospitalized teens as opposed to male peers. Another participant discussed gender differences as they related to peers' conceptions about why someone needed to be hospitalized (Participant 12). In both cases, the two participants noted a difference in the experience of stigma based on gender but this theme appeared less prevalent than the impact of other aspects of a teen's sociocultural identity.

In contrast to the nine participants that described the impact of issues of diversity on experience of stigma, three participants stated that they were unsure if these factors

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affected recently hospitalized teens. These participants described how they felt they did not have clear examples of how race, ethnicity, socioeconomic status, sexual orientation or gender impacted a teen's stigmatization. Additionally, one participant said that issues of diversity did not impact a teen's experience of stigma and that experiences of stigmatization had more to do with the "characteristics of the student" (Participant 3).

Clinical Interventions

Talking about Stigma with Recently Hospitalized Adolescents

When asked about how they talk about stigma with recently hospitalized teens, four participants said they address the issue in various ways. Two participants described how a conversation about stigma depended on the experience of that specific teen. One participant described his approach, stating, "I really try to meet a kid where they're at and I kind of try to help them anticipate some situations that might come up that they might not expect" (Participant 12). Another participant said that her discussions about stigma were not "pre-rehearsed" and that it depended on the circumstances of the hospitalization and how the teen is doing when he or she returns to school (Participant 3).

Two participants described how, in discussions about stigma, they would focus on the specific strengths of the recently hospitalized adolescent as well as exploring that teen's supports. One participant depicted how his "General approach with kids anyway is to try to reinforce their strengths…and talk to them about which of their friends…seem to be the most understanding or supportive" (Participant 4). For these participants, an exploration of a teen's personal strengths and social supports accompanied a discussion of stigma associated with psychiatric hospitalization.

Other participants talked about stigma in the context of exploring teens' own concerns about their hospitalization experience and their transition back to their community. One participant described how she utilized a conversation about stigma as an opportunity for "consciousness raising" and for facilitating teens' ability to reflect "on their own experience" (Participant 1). This participant stated that she would have these types of consciousness raising discussions with both individual adolescents and groups of teens, exploring their perspectives on psychiatric hospitalization and reflecting on wider cultural beliefs about psychiatric conditions. Another participant described how conversations about stigma often accompanied a discussion of a teen's fears about disclosing his or her psychiatric hospitalization to others. This participant described how "The main concern for the student is always – who knows? Who doesn't know? Should I tell my teachers?" (Participant 3). According to this participant, the issue of stigma emerged when talking about the process of disclosure and exploring an adolescent's concerns about that process.

In contrast, three participants described how they did not directly discuss stigma with recently hospitalized adolescents. One participant stated that this was due to the fact that the teens he worked with did not experience stigma (Participant 2). Another participant stated that he did not use the word 'stigma' directly when talking with teens (Participant 12). Additionally, another participant stated that the adolescents she worked with tended to have long histories of psychiatric hospitalization and that "The hospitalization is almost like a drop in the bucket because of everything else they're bringing with them" (Interview 10). This participant did not address the stigma associated with a hospitalization due to the fact that the adolescents had other serious, more pressing

issues to focus on. For these three participants, reasons for not addressing social stigma varied greatly and were often dependent on the specific experiences of the adolescent clients.

Individual Interventions with Recently Hospitalized Adolescents

When asked about the types of interventions utilized with recently hospitalized teens, all twelve participants discussed the importance of working directly with the individual teen. Interventions ranged from utilizing therapeutic techniques aimed at increasing coping and emotion regulation skills and normalizing an adolescent's hospitalization experience, while also intervening directly in an adolescent's environment.

Seven of the twelve participants discussed coping and emotion regulation skills as important therapeutic techniques to practice with a recently hospitalized teen who is managing stigma. One participant described how he might speak with a teen about this, stating, "Looking at the things you do, looking at what your triggers are…What do you do when you get triggered? How do you cope when you get triggered?" (Participant 11). Another participant also referred to a similar theme of managing emotional "triggers" (Participant 6). Dealing with challenging emotions was another common theme in the following description from another participant:

> Coping skills that I talk about with kids are "if you're feeling frustrated or angry what can you do to process that? Is it exercise? Is it doing something creative? Is it writing or hitting a punching bag? To talk about how it's important to not turn those feelings inward, to not necessarily turn them outwards towards other people necessarily, but just find a way to kind of work through them in a way that works for you and helps you acknowledge that they're real (Participant 12).

This participant discussed how he would identify specific skills with teens that helped them release difficult emotions in a safe way. Another participant described the importance of having effective means for dealing with emotions, saying:

> I'd want to make sure that they had, that we had discussed some strategies for there handling their emotions or behavior throughout the day so that, you know, they wouldn't be doing things that would necessarily be drawing a huge amount of attention to them (Participant 2).

In this quote, not only are emotion regulation and coping skills helpful in terms of supporting the teen in getting through the day, they also serve to minimize negative attention that could result in further stigmatization.

In terms of coping and emotion regulation skills, participants mentioned helping teens practice these skills and asking for help when they need it. One participant described how she supported teens, saying "I would say, as far as coping skills, again encouraging, not waiting for them to come to us and say that they're experiencing stigma" (Participant 8). This participant clearly identified help seeking behavior as an important coping skill, especially when things weren't going well. In a similar manner, another participant discussed the importance of helping an adolescent realize when things weren't going well and then finding resources to improve the situation. This participant stated that he would focus on "Anything to increase the awareness of when things are going bad. Anything to help cope when things are going bad and to help you mend" (Participant 11).

Another commonly used therapeutic intervention was to help recently hospitalized adolescents develop plans and strategies to manage their transition back into their communities and to deal with any stigma they might experience. Five participants

discussed the importance of helping teens use the skill of anticipation, which has been described as a mature psychological defense mechanism. One participant described how she would develop a "gradual plan" with teens that included "forecasting with them about how things might play out over time" (Participant 8). A different participant echoed a similar theme in terms of working to put a "plan in place" that could be adjusted to manage "unforeseen things that happen on the fly" (Participant 12). This participant also described how we would model being "proactive" by helping the teen try to "anticipate what might happen" and then having a "strong reactive approach when anything does happen" that stigmatizes a teen (Participant 12). From this description, the skills of strategizing and planning were also balanced with knowing how to react when a situation warranted direct intervention.

Another participant who had worked at psychiatric hospitals described how he would develop specific "safety plans" with adolescents, detailing their coping skills and supports to access when in crisis (Participant 11). This participant also brainstormed with teens about how they could receive much needed support without calling negative attention to themselves. Through conversations with recently hospitalized adolescents, he began using code words that signified to a support person that a teen was in crisis. The participant described it as follows:

> Having that code word is always important to them because you may not want people to know that you're losing it. "So, who knows the code word and who can you trust? Who's the one person in school you know you can trust?" (Participant 11).

In this way, a teen could access help in a more confidential manner and could receive support without necessarily having to describe everything that he or she was experiencing.

A number of participants also utilized the technique of normalizing an adolescent's experiences of a psychiatric condition and hospitalization. Five participants discussed the importance of helping teens to feel that they are not alone, describing how other young people and adults struggle with similar issues. One participant who works as a school social worker described how she would tell returning teens, "You're not the only student that has returned from a hospitalization" (Participant 8). Another participant would challenge a young person to realize that his/her peers are faced with similar issues, saying, "You may look at Sally and think that she has a normal, perfect life and she could be struggling with the same stuff" (Participant 9) or "There's other kids who are walking around in the school who are either going through this now or have recently or are about to" (Participant 12). In a similar manner, a participant focused on normalizing psychiatric conditions as similar to other health problems, stating, "What I always tell them is, 'we all have problems. Having mental health issues is just like having a chronic illness which we all do.' I could have arthritis, I could have asthma, all those….I always try to diffuse it" (Participant 7). This participant focused on normalizing psychiatric conditions while also conveying the sense that everyone has problems.

One participant discussed the normalization process by describing the services that other teens receive, saying:

> I think talking about how they're not the only ones, we really do normalize it for
> kids that, "You wouldn't know it but there are a lot of kids who have been
> through similar situations. There are a number of kids that have out-patient

therapists. There are a number of kids who are seeing psychiatrists. Right now it feels very unique to your own experience but there are other kids who have been through that and we've been through it with other kids" (Interview 8, p. 5).

This participant attempted to normalize the experience of hospitalization and follow up mental health treatment, while she also conveyed to the teen that the program had been through the reintegration process with other teens as well. On the whole, participants stressed the importance of normalizing a teen's hospitalization experience and helping that teen to realize that peers have similar struggles.

In addition to utilizing specific therapeutic techniques, participants also discussed the importance of intervening in a concrete way in a recently hospitalized adolescent's life. Five participants described the importance of making academic adjustments and accommodations for recently hospitalized teens as they reintegrate into their school community. Participants described working with teachers, school administration, and guidance counselors to help devise an appropriate re-entry plan. One participant who works at a high school depicted the types of accommodations that could be made for returning teens, saying:

> We can adjust things, adjust the workload, maybe change their level of classes, give them passes instead of letter grades, adjust our tardy policy so if your kid can't get to school on time for related reasons then, not to worry… .Having a different protocol for kids who have been hospitalized and knowing that we may need to take those steps (Participant 4).

Other participants discussed making "accommodations for kids so that they have less work to do" (Participant 5) and "giving them permission to take time" before working up to a full course load (Participant 8). One participant who serves as a mental health worker said that she would help teens transition back into their communities and would also advocate for an alternative placement if the public school could not meet a teen's

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"academic and emotional needs" (Participant 7). Participants described how making

academic adjustments was crucial for teens as they transitioned back to school as it

allowed students to catch up on work without becoming too overwhelmed.

In addition to adapting a teen's workload, five participants discussed providing

more general advocacy for teens in schools. Three participants specifically discussed

intervening in a recently hospitalized teen's social context if other adolescents were

harassing that young person. One participant described this intervention in the following

way:

> I think it's very important, in your role as an advocate for a student, to take them
> very seriously and to follow up on what you say you'll follow up on. So, if you
> say to a kid, "if you're being harassed by other kids in school or if you're getting
> a hard time, to be comfortable to say something to an adult." You know, I think
> that sometimes kids are afraid of doing that because they don't want to be seen as
> a tattle tale so I always make sure and let them know that there's ways to address
> the problem without making you seem like a tattle tale… .Making kids know that
> they can report things in a way that's safe (Participant 12).

This participant discussed the process of reporting harassment with a recently

hospitalized teen and he worked to ensure that the teen would not be further targeted by

reporting. Similarly, a participant would intervene by attempting to minimize gossip and

verbal harassment, saying "It's more about kind of working with the rumors, separating

the fact from the fiction" in an attempt to minimize the stigma for a recently hospitalized

teen (Participant 5).

Two other participants described the importance of advocating for young people

in therapeutic schools. One participant described his role as an advocate as follows:

> I am always really cognizant of the fact, and I try to advocate, I want to make sure
> those kids can read and write before they graduate from school… .I want them to
> have learned something when they leave there. I don't want them to be in the
> quiet room all the time, to be in the containment room all the time (Participant 6).

This participant discussed the importance of therapeutic schools in terms of keeping teens safe when they were struggling with severe psychiatric conditions, but he also wanted to ensure that these young people were being educated and not simply contained. Another participant described the process of advocating for a young person to transfer to a therapeutic school in an attempt to find the "right environment" (Participant 11). This participant acknowledged that advocating for this type of transfer was often difficult due to budget constraints and lack of resources in some public school systems.

Interventions Targeting Recently Hospitalized Adolescents' Support Networks

In addition to individual therapeutic interventions, participants discussed the need to intervene in a recently hospitalized teen's community. Eleven participants discussed intervening with teachers and other school personnel, working with families, providing group treatment, and collaborating with other mental health professionals. Of these eleven participants, three individuals discussed the importance of providing broader interventions that included different members of a teen's support network. One participant stated, "I think any intervention works best the more people you have involved in it... .It takes a village to raise the child. If the community is based in the treatment, the treatment goes a lot better" (Participant 11). Another participant discussed her value of intervening in a young person's support systems, saying "I'm really kind of a systemic thinker and clinical worker because I feel you can do a bazillion things with the teenager; however, you've gotta push their systems too otherwise…they're really in such a vulnerable position" (Participant 1). In this way, participants described the importance of addressing a recently hospitalized teen's larger social and familial context, as well as supporting the individual young person on a one to one basis.

Seven participants specifically discussed working with a young person's teachers to minimize any potentially stigmatizing views about that student's hospitalization or psychiatric condition. One participant described "contextualizing the student's experience" for the teacher in an effort to create more "empathy" and to develop "a better overview of the student's experience" (Participant 1). Another participant depicted a similar process of providing the teacher with non-confidential information in an effort to "open their compassion" towards the student (Participant 2). Other participants discussed giving "advice to the teachers" on how to manage questions about a hospitalized student's situation (Participant 5) and "educating teachers" about how a student's psychiatric condition might affect their ability to complete schoolwork (Participant 8). Other participants reiterated similar themes of working with teachers to create realistic expectations for returning students and collaborating with schools in an effort to reduce stigmatizing views from school personnel.

In addition to school-based interventions, five participants talked about the importance of intervening with a recently hospitalized adolescent's family. One participant described how she met with the family on at least a monthly basis to discuss "the issues with the kids and the family at the same time" (Participant 7). Another participant noted the importance of family therapy to change the family system, while suggesting that "some families are sicker than others" and may need extra support (Participant 11).

In addition to providing family therapy or monthly check-ins, two participants specifically discussed a parent group that they co-facilitate at a high school. Both of these participants described the importance of this group in reducing the stigma that parents

experience when they have a child hospitalized for a psychiatric condition. The

participants described the importance of this group in the following ways:

> As far as with the families, one thing that we've started is a parent group and it's been fantastic! We just found that our parents felt really isolated. They couldn't always talk to their other family members about what was going on with their child. They couldn't talk to their friends, necessarily. They couldn't talk to their coworkers. I think they felt embarrassed. They felt like they had failed their child in some way. So, creating a space, a time when parents can come together to talk about what they're going through… .We just found that parents just come in and they just want to talk. I think what's nice is that you've got parents who are at different stages of the crisis. You might have a parent whose child was hospitalized 6 months ago and there's someone who's coming whose child is currently in the hospital. Also for parents to know that they can come out on the other end as well. Right now it feels like this is it and this is how it's going to be forever but knowing that things will change over time and that things will feel better. I think that's been very helpful as well (Participant 8).

> I think a lot of work is with the parents... .I think it's a process for the parents to realize that, "You know what, it's great that they're alive and they're able to come to school and they're functioning so let's not worry about getting an A in English and let's focus on having a healthy, happy child (Interview 9, p. 3).

Both participants discussed the importance of supporting parents and caregivers as they

struggle with their own reactions to their children's psychiatric condition and

hospitalization as well as providing a space where they can speak with other parents

about their experiences. These participants noted the importance of reducing the sense of

stigma and isolation for families struggling to support a child with a psychiatric

condition.

Another participant described the importance of providing culturally competent

family therapy services. She talked about her commitment to working with families in the

following way:

> I think that if we do the right work with a parent and if we try to work with them rather than impose ourselves on them and give them ample room to try to divert a hospitalization whenever possible then I think the parent is in a much better place

to accept the hospitalization as something that was needed and a much better place, in turn, to help their child understand… .That's more of a wraparound kind of philosophy model that works with family partners in which truly it is about allowing the family to identify their goals and to assign their interventions… .We are helping the family come up with a definition of the problem that they can own and that they can then solve in a way that is, when we talk about culture, not only ethnically but culturally sensitive to the culture of that family (Interview 10, p. 5).

This participant noted that it is crucial to not only respect families' broader cultural values but to also attend to the specific culture of an individual family. In this way, interventions can be crafted with the family's input which, in turn, may yield better outcomes for the hospitalized teen.

In addition to family-based interventions, four participants also discussed utilizing group treatment methods to support recently hospitalized adolescents. Participants all shared that these groups gave teens an opportunity to share their experiences and receive support from their peers. One participant described "weekly community meetings" held in an alternative program and he stated that these meetings helped "get kids to relate to each other in that setting and kind of break down some barriers and also share some common experiences" (Participant 12). Additionally, another participant talked about meeting with the friends of a hospitalized adolescent once she received permission to do so (Participant 4). This participant described these groups as follows:

I sometimes have to do debriefing with some of the hospitalized kid's friends because their friends think that this is such a terrible thing that happened to their friend and, "How could you adults do that?!" You just have this snake pit vision of what a hospitalization is like… .Their friends don't understand what it's like that when they get there and they see that it's really an okay place and their friend might be feeling fine, or feeling okay, and they're not saying these scary things anymore about killing themselves or cutting themselves. Friends can need support when a kid gets hospitalized (Participant 4).

All four participants noted the importance of providing groups as a means to support teens and to help build a more cohesive, accepting community.

Lastly, one participant discussed the necessity of collaborating with other mental health providers. This participant described meeting with "the doctor, the therapist, the school, with mom" and even attending "the individual therapy sessions sometimes when I hear about the kids having trouble at school" (Participant 6). This participant, who works as a mental health case manager, talked about taking a collaborative stance in an effort to provide the best possible care for recently hospitalized adolescents.

Utilizing Teens' Language & Experience when Conceptualizing Interventions

When questioned about how they crafted interventions, participants discussed using teens' specific language, comments, and experiences to inform treatment. Seven participants stated that they referred to adolescents' stories and descriptions when developing interventions. One participant described her process, saying she develops interventions based "directly from the language of the young person" (Participant 1). . Another participant used conversations with teens and parents to devise useful interventions such as 'safety plans' and 'code words,' both of which rely heavily on the language and input of the teen in order to be successful (Participant 11). A different participant described a similar concept, discussing how she began using the word 'stuck' which was a term often used by her teen clients. She depicted the importance of using teen's own language in the following comment:

> I think a lot of adolescents use the word 'stuck' and then I started using the word a lot and I think, you know, it's not a positive word but it helps get things going. So, if a kid comes back from school, saying, "I don't want to go back to class," and I'll say, "What are you stuck on?" And it helps to sort of weave out what is the problem. Is the problem going to class? Is the problem the teacher? It was a

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good sort of jumping off point for helping them to figure out what they need next. I think it's really easy to shut down and go global and, you know, go from 0 to 60, not wanting to be in school, not wanting to live at home, not wanting to have their friends when it may just be that they need a break for 45 minutes and then they can go back. So, I think that word helped me to sort of tease apart what the real problem was (Participant 9).

According to this participant, utilizing a term like 'stuck' in an effective way helped teens be able to reflect on their experiences and emotions in a new, positive way

When asked about comments of recently hospitalized adolescents that informed their work, a number of participants described specific phrases that stuck with them over the years. One participant described how adolescents hospitalized for substance abuse would return to school and say "I'm having a really hard time being with the people I was with" (Participant 5). Another participant recalled teens asking, "Please, will you stop listening to my mother? Will you listen to me?" (Participant 6). Similarly, a participant was impacted by a teen sharing that other students at school called him "the next Unabomber" and that this helped galvanize the participant into action to address the harassment (Participant 7). Other participants conveyed similar stories of listening closely to the language and statements of teens in order to craft interventions that were relevant and appropriate.

In contrast to the participants who utilized teens' language, four participants could not recall any specific examples of phrases or stories that helped to inform interventions. These participants stated that they could not remember particular words, comments, or scenarios that directly guided their clinical work with teens.

Differences in Interventions for Teens with Visible & Invisible Psychiatric Conditions

In terms of variations in interventions, eight participants described using different interventions with teens based on the visibility of their psychiatric condition. Four participants talked about the impact of visibility and invisibility in a more general manner. One participant stated, "I'm sure that I would come up with a few more [interventions] if things were much more visible," implying that the might put more supports in place for a teen with a more visible psychiatric condition (Participant 11). Similarly, a participant stated that she may put more interventions in place for an adolescent openly struggling with a psychiatric condition, stating, "I think it can be harder" for teens in that circumstance (Participant 1). On a different note, one participant described that interventions may be more successful for teens with visible conditions because people are more aware of the fact that the young person is struggling. This participant depicted this situation as follows:

> The visible one is easier because the teachers are pretty well aware that this kid
> was pretty strange to start with, are much more sympathetic when the kid is
> falling asleep in class because oftentimes with anti-psychotics, until they get the
> right dose for the particular kid, the kid is really tired… .We don't get lots of
> psychotic kids, but we have had had some. That's a little bit easier. With the kids
> that kept it all under wraps and then went home and took an overdose, that's much
> harder because teachers are less aware that the kid has been seriously hurting
> (Participant 4).

This participant described differences in interventions based on the visibility of an adolescent's psychiatric condition, while she also conveyed how interventions may be more effective when other people in the environment are more aware of and sympathetic to the teen's situation.

Five other participants talked about differences in interventions using more specific examples. For instance, according to participants, if a teen is visibly depressed or anxious, prone to cutting, or acting out in an obvious way, interventions may be utilized to address the specific symptoms of that young person. One participant used the example of cutting, saying:

> I mean if it's a kid who's prone to cutting, then my interventions would be different because I would want to give the teachers some cues to look for. If the kid is sitting under her desk with a paper clip or something… .I would hope that we could work with the teacher around noticing some of that (Participant 3).

This participant describes pulling other people in to help notice and intervene with visible manifestations of a teen's psychiatric condition, such as cutting. Another participant described intervening differently with a young person suffering from obvious anxiety, saying, "I think when kids are visibly struggling with anxiety and sometimes it's happening in class that we're much more specific about what their [the teachers'] response should be. I would say it's different in that way" (Participant 8). A different participant told a story about working with a teenage boy who often wore tee shirts with automatic weapons on them to school. He described working closely with the young man and his father, saying, "I've been working with him to stop wearing those tee shirts because other kids have told me that he's scaring them. And one of the concerns that we're having is that he's having trouble making friends" (Participant 5). This participant supported the teen in making positive changes that helped other students feel more comfortable around the young man and that aimed to increase his social supports. In each description, participants altered their interventions based on a teen's visible psychiatric condition.

In contrast, one participant depicted using different interventions with teens that had invisible psychiatric conditions. This participant discussed the presence of "invisible mental retardation" and described how she had to take a different approach with these teens, advocating for the appropriate services within school departments and mental health systems. The participant described how she had to argue that "This is not behavioral dysregulation, this is not Bipolar, this is not the fact that they don't want to follow directions, really there is a severe cognitive impairment" (Participant 10). As described by the participant, persistent advocacy was needed in order to ensure that a teen's cognitive disability was correctly identified and that he or she was provided with appropriate treatment.

In addition to the above-mentioned psychiatric conditions, three participants discussed the presence of visible thought disorders as necessitating specific, community-based interventions. All four participants described how they would work closely with a teen's milieu or peer group in order to minimize fearful or stigmatizing reactions to the teen's psychosis. One participant stated that when a teen is "floridly psychotic there is a lot of work to be done within the milieu, as well as within the family and others, about why this young person is behaving as they are" (Participant 1). Another participant discussed working with the psychotic teen's peer group, saying, "I feel like there's a benefit to helping other people process it so they understand things more, again, while respecting confidentiality, trying to kind of help manage other kids' responses" (Participant 12). Similarly, a different participant described "calming" other students down when they reacted to a thought disordered teen and that this lead to a more "open and supportive" response to the troubled teen (Participant 9).

In contrast to the majority of participants that altered their interventions due to the visibility or invisibility of a teen's psychiatric condition, one participant stated that she did not change her interventions based on this particular factor. The participant stated that all teens should ideally receive the same type of care and attention, saying:

> If you're in this system it doesn't matter how severe it is because you can benefit from anything. Even if your condition is not critical you might get as well the information soon enough so that you'll be able to prevent it (Participant 7).

According to this participant, a variety of interventions could be useful with all teens regardless of whether their psychiatric condition was visible or invisible to others. In this way, she attempted to provide the same therapeutic opportunities to all of her clients regardless of the overall severity of their condition.

Interventions to Help Recently Hospitalized Adolescents Manage Disclosure Process

Of the various types of interventions discussed, participants talked about the primary importance of supporting a recently hospitalized teen as they make decisions about when, how, and with whom they will discuss their psychiatric condition and hospitalization. Participants utilized a variety of interventions to help adolescents explore the possible outcomes of disclosure, as well as helping to prepare teens for how they might respond to questions from peers, teachers, family members, and other people in the community. A number of participants also addressed issues of confidentiality as another factor to be considered in the disclosure process.

Of the twelve participants interviewed, eight discussed asking questions when talking with a teen about disclosure. One participant said that she often began conversations about disclosure by asking a simple question like, "What are you comfortable sharing?" (Participant 9). Another participant described asking questions that

increased a young person's "capacity to self-reflect" about their thoughts and feelings

around disclosure (Participant 1). Examples of the types of questions this participant

might ask in a session are as follows:

> How might you talk to them about this experience when you leave? Are you
> talking to them about it now? Do you want to tell people at school about where
> you've been? So, do want to talk to your teachers about it? What would be the
> positives? What would be the negatives? What are your fears? What else could
> tell them in terms of where you were? (Participant 1).

Another participant described a similar line of questioning aimed at helping an adolescent

think about the potential outcomes of disclosing their experiences to different people, as

well as considering their own reactions to the process. This participant asked questions

like:

> What are the difficulties you're anticipating? Are you wanting to disclose this or
> are you not? If you are, then to who and what are the responses you think you
> might get? What are you worried about in this situation? What do you feel like
> might go well? What do you feel like might not go well? (Participant 12).

In this way, asking questions served to help teens consider many different aspects of

disclosure, including exploring their own hopes and fears around disclosure and

preparing for different reactions from others.

Similarly, one participant helped recently hospitalized teens think about the types

of questions they might be asked by peers. This participant would ask "What kinds of

questions do you think kids are going to ask you?" in an attempt to begin a conversation

around disclosure and how a teen might respond (Participant 5). Other participants asked

questions intended to help a teen explore different types of responses, for example,

asking "What's another way that you can talk about needing to be in the hospital?"

(Participant 2). This participant wished to support a teen in responding in ways that did

not further stigmatize the young person by sharing frightening details or information that was very personal. Lastly, one participant specifically described asking teens about whom they could trust and how they wanted to ask for help when they needed it. This participant said that she would ask questions such as "Who needs [information] if you want them to provide support to you, to nurture you, to be emotionally available to you when you're not doing well? Who can you trust? And how do you make those trusting decisions?" (Participant 10).

In addition to asking questions, over half of the participants stated that they would support a teen's right to self-determination in terms of disclosing the experience of psychiatric hospitalization. Seven participants stated that they would respect all teens' ultimate decisions to choose how they wished to share their personal information. One participant simply stated that "giving them power over their information seems to really make a difference" to teens (Participant 8). Four of the seven participants supported the teens in deciding whatever they felt "comfortable" sharing (Participants 1, 7, 9, & 11). One participant specifically described finding every teen's "comfort zone" in terms of the specific "environment they're in" and then helped them in navigating the process of disclosure in that environment (Participant 7). Another participant modeled support of a teen's right to self-determination over their information by asking the teen, with the parents present, what he/she wished to share and what they wished to keep private (Participant 8). This participant stated that parents often followed this lead and allowed the teen to make most of the decisions regarding disclosure. In supporting a teen's process of reflection on disclosure, one participant would tell adolescents "You have to trust yourself and what you think is right here and you know yourself really well, better

than anybody. What's your heart telling you?" (Participant 12). In all of the examples, participants elicited teens' own thoughts and feelings about the disclosure process and then empowered each young person to make the ultimate decision.

In addition to asking teens questions and supporting an adolescents' decisions regarding disclosure, participants also discussed confidentiality and personal boundaries as part of the disclosure process. Six participants talked with teens about respecting their own confidentiality and exercising judgment when disclosing to others. One participant encouraged teens to exercise boundaries in the following manner:

> You can have boundaries around this information… .It is your business and you can say that you were out with Mono, that you were out sick. You can say whatever you feel comfortable with and then kids will really move on (Participant 8).

This participant conveyed that she wanted teens to feel they had permission to share whatever they felt comfortable sharing. In a similar vein, another participant encouraged recently hospitalized adolescents to come up with straightforward responses to questions without providing too much information. She also described telling teens "You don't need to make up a whole elaborate story like you were off in Hawaii" (Participant 3).

One participant talked about her perspective on issues of confidentiality with teens returning to school, highlighting the fact that people may have different and sometimes stigmatizing views of the experience of a psychiatric hospitalization. This participant described her viewpoint as follows:

> I don't want them to feel that this is something to be ashamed of, but the reality is that it's private business and not everybody's going to understand or know what a psychiatric hospitalization is. So, they have to exercise some judgment in who they tell (Participant 4).

This participant tried to help teens be realistic about some of the potential negative responses and to use judgment when deciding to disclose. Another participant also discussed some of the potential risks of sharing private information too freely. This participant described saying to teens, "If you do decide to share stuff with your friends, just know that that's not confidential. And that friends change and secrets go out and secrets are told" (Participant 9). The participant felt that it was important for adolescents to understand the risks involved with telling friends about their hospitalization. Lastly, another participant talked about the importance of letting teens know they could disclose to varying degrees, saying "There's choices about the degrees to which you come out" (Participant 1). In these examples, participants discussed the potential pitfalls of disclosure as well as reminding teens that a continuum existed in terms of how much or how little they wished to share and with whom.

Within the larger discussions about disclosure, four participants stated that they would give feedback or advice to recently hospitalized adolescents on how they might manage the process. One participant described how he might "take a more directive approach" with a teen based on that young person's "cognitive development" and ability to "think abstractly" (Participant 12). For teens that were more concrete thinkers, this participant talked about how he would develop specific guidelines that they could follow when considering how and when to disclose. Another participant gave teens specific "advice and some feedback on how to answer questions and to handle any kind of nosiness that comes their way" (Participant 5). One participant in particular encouraged teens to avoid labeling themselves due to their psychiatric condition or hospitalization. This participant would say that experiences and diagnoses are "a part of you but [they]

don't define you. It's a part of you that you can keep to yourself or share with a close group" (Participant 9). In all instances, these participants felt that it was sometimes helpful to take a more directive approach with teens and to provide them with advice on how to manage disclosure.

Another aspect of disclosure discussed by four participants related to some recently hospitalized adolescents' practice of indiscriminate disclosure. Participants noted how some teens were very "open" and were very "comfortable sharing" or "broadcasting" their hospitalization experiences to everyone (Participants 3, 9, & 12). Another participant described a similar theme, saying, "Some kids who come out of the hospital who want to advertise that they've been in the hospital will continue to wear their little hospital bracelet and will have various reasons why they haven't removed it yet" (Participant 4). In these cases, three of the four participants felt that this indiscriminate disclosure was not necessarily healthy or helpful. One participant stated that he would intervene with teens by asking, "Do you really want everyone to knowing your business?" in an attempt to inspire teens to think about the consequences of this type of disclosure (Participant 12). In contrast, one participant considered teen's open attitudes more understandable and less risky when they attended therapeutic programs (Participant 9). In each instance, teens' indiscriminate disclosure appeared surprising to adult participants.

In considering the various aspects of disclosure, participants also acknowledged that the process may differ based on the particular environment of the recently hospitalized adolescent. Five participants supported teens in managing disclosure specifically based on context. One participant described the importance of "looking at the

different communities [teens] participate in…because most times it will play out differently among each group" (Participant 1). Three other participants talked about attempting to protect a young person's confidentiality by providing school systems with only the necessary information regarding a teen's hospitalization and re-entry process. One participant stated that "You never knew what was going to happen with the information" once it was shared with the school (Participant 11), while another participant had observed confidential information being used "against the student" (Participant 7). Another participant who worked in a public high school stated that it was important for young people have "control of their information because teachers don't really need to know all the nitty gritty" and this participant assured students that no confidential information about a hospitalization was included in a student's school record (Participant 8). In each example, participants attempted to help the teen control how much information was given to school personnel and to protect the teen's privacy.

In addition, one participant discussed the difficulties of a young person looking for work and not knowing how to discuss their psychiatric condition with potential employers. This participant stated that teens are "afraid to tell someone in the private sector that they have mental health issues" which, he said, can often lead adolescents to accept a job that is not realistic for that teen given their psychiatric condition (Participant 6). In this case, the participant attempted to serve as an advocate for teens, helping them find appropriate employment and making decisions about disclosure to their supervisors.

Another participant described the specific challenges of recently hospitalized adolescents whose families are "particularly concerned about privacy" (Participant 8).

This participant depicted the challenges involved in certain family contexts in the following way:

> We've worked with some families that feel like the emotional issues should be dealt with at home, that other people shouldn't be brought into the conversation or brought into the picture when it comes to mental health issues. And so, I would say that when kids are getting that message at home then that's something that they're really concerned about when the come to school because they're not really getting permission to talk about it. They're not comfortable sharing it with adults because their parents have given them that message that it's not something that they should share (Interview 8, p. 2).

In this case, the participant described working with the family in a way that respected the family culture while also balancing the needs of the adolescent in regards to receiving treatment and support. According to the participant, this process could often be tricky.

Lastly, a particular divergent theme emerged when talking with participants about the process of disclosure. Two participants discussed the benefits of adolescents disclosing their psychiatric condition and hospitalization to others. This positive view contrasted the overall tone of how participants approached the subject of disclosure with recently hospitalized adolescents. One participant described how disclosure can be "very freeing" for some teens when they can say "I just got out of the psych hospital" (Participant 11). Another participant discussed the benefits of the disclosure process as it helped to develop a teen's "sense of self" and the ability to "reflect on their understanding of their illness and whether or not they feel stigmatized" (Participant 10). This participant also described conversations about disclosure as "incredibly healthy and productive" for it forced teens to practice "larger skills of becoming a young adult" (Participant 10). In both descriptions, the disclosure process was viewed as a positive,

healthy opportunity to practice skills and to experience freedom in being honest.

Resources that Support Recently Hospitalized Adolescents

When asked about various resources that support recently hospitalized adolescents in managing stigma, participants discussed the importance of individual therapy and psychiatric services, group treatments, family-based supports, and social networks for recently hospitalized teens and their families. Of the twelve participants interviewed, six discussed the necessity of individual therapy and psychiatric services as valuable resources to help teens combat stigma and manage the re-entry process. One participant described the importance of therapy, saying "Almost every kid comes out of a hospitalization having been connected to a therapist, so I would assume that their therapist is essential and really plays the main role in helping them cope with the stigma" (Participant 4). Other participants echoed a similar theme and also mentioned that psychiatric services and medication monitoring was also a necessity for recently hospitalized adolescents. Other participants mentioned the efficacy of other types of therapeutic and psychiatric services such as partial day programs at hospitals, therapeutic after-school programs, department of mental health services, and school-based supports.

In addition to more individualized therapeutic treatments, five participants discussed the value of groups for teens. Four participants specifically discussed the utility of group treatments as a means to help marginalized adolescents receive greater social support while also combating the effects of stigma. One participant described how "groups are always, if you can get the kid to go,…great for dealing with [stigma]" (Participant 9). Another participant reiterated a similar theme saying:

> The best community resource…is any type of group for teens that have been through the same thing, that is always best… .It's the age where they're supposed to be pushing away from adults because that's that development point. So, if they can talk to other teenagers it allows them to have the support that they so desperately need but they rebel against when they get it from adults (Participant 11).

This participant felt that groups offered the best form of support for recently hospitalized teens, especially given their developmental stage. Other participants mentioned specific groups as being helpful, including eating disorder support groups, Alateen, AA, and other twelve step groups, and self-esteem building groups. One participant described the benefit of groups as providing "valued authentication" for adolescents and she described this as acceptance from people that that the teen values and respects (Participant 1). Overall, participants felt that groups offered teens with similar experiences the opportunity to be heard, respected, and supported by their peers.

Additionally, four participants commented on the benefits of helping create community amongst recently hospitalized adolescents. Informal opportunities for building connections with other teens was seen as another effective way to reduce the impact of stigma and to increase social supports for marginalized youth. One participant discussed the benefits of the giving teens "a community of kids that have been through similar situations" and that this is invaluable in terms of helping to "combat the stigma" (Participant 8). Another participant specifically talked about building relationships between recently hospitalized adolescents, as part of "finding out who the kid's support network is, if there are friends that know that they've been hospitalized, how they can utilize their supports" (Participant 3). While one participant noted that there could be some negative consequences for teens developing close relationships with other recently

hospitalized adolescents, he stated that the benefits of mutual support and understanding generally outweighed the risks (Participant 12). Other participants noted that, in order to build community amongst marginalized teens, they must feel they have a safe, supportive place to be with each other. One participant commented that it is crucial to have "places they can come to during the day if they are feeling overwhelmed" (Participant 4) and that these places offer a "comfortable and safe environment about these issues" related to hospitalization (Participant 8). Based on the context, this might mean having a special place in school where teens can eat, talk, study, and congregate as well as finding similar safe places in the general community.

A number of participants also discussed family-based treatment as being helpful in mitigating the negative effects of stigma for recently hospitalized adolescents. Four participants talked about the benefits of supports such as parent groups, family stabilization services, mental health department programs, and parent organizations such as the National Association for Mental Illness (NAMI) or the Parent Professional Advocacy League (PAL). One participant described the benefits of parents and caregivers receiving services, saying "They really need support, and understanding what it means to have a child with a serious mental illness" (Participant 4). Another participant echoed a similar theme and described how caregivers need an opportunity to talk "about issues and the skills that the child is going to need, educating them on what they need and how they need to follow through on things" (Participant 7). This participant felt that services for parents and caregivers helped families be better able to support their recently hospitalized adolescent cope with their psychiatric condition and their return to the community.

Interventions Reported as being Most Helpful by Recently Hospitalized Adolescents

As part of the interview process, participants were asked about interventions that teens had reported as being most helpful in managing stigma and returning to their community. Participants discussed a variety of interventions, including individual, group, and community-based treatments. Four participants discussed individual therapeutic techniques such as coping and planning skills as being helpful, according to their teen clients. One participant described using a variety of skills with teens such as "partializing and distinguishing, identifying areas of strength…time management…and setting limits" (Participant 2). He stated that these more concrete skills were very effective for particular adolescents. Another participant discussed coping skills as specifically taught in Cognitive Behavior Therapy (CBT) and Dialectical Behavior Therapy (DBT) and stated that teens often found these skills to be especially helpful. Two other participants described the benefits of a teen developing a plan for how they will deal with questions about their absence from school and who they will talk to when feeling overwhelmed.

In addition to these individually based skills, three participants also noted that teens found groups to be the most helpful treatment in terms of reducing stigma and receiving support. One participant described attending a panel of youth that had struggled with psychiatric conditions and were discussing their experiences. Many of these teens talked about how it was helpful to realize "I'm not just the only one here with these kinds of problems. My peers are here, too" (Participant 6). The participant described how these young people stated that they wanted more supportive services to help them cope, including groups with other teens.

Three participants also reported that teens found it helpful to have a supportive relationship with a caring adult, such as a guidance counselor, therapist, coach, mentor, or teacher. One participant stated that adolescents needed to "have support, an adult in the building that they can trust and communicate with" as they readjust to their life at school (Participant 5). Another participant described the importance of having an adult ally, saying that "I think without a connection, without feeling they have some sort of choice, it could be the best intervention in the world but it's not going to work for a kid" (Participant 9). To this participant, a positive relationship with the teen is the foundation for any interventions or treatment that the participant hoped to implement.

As an aspect of forming supportive relationships with recently hospitalized adolescents, two participants discussed the value of conveying respect, acceptance, and positivity when approaching young people. One participant stated that "positive messages and positive acceptance" helped teens feel safe in relationships with others, while also helping to reduce to the impact of social stigma (Participant 1). Another participant described her belief about respect, saying, "I think that what people respond to the most is that they have been seen and been respected and that they are just not being reduced to a cluster of symptoms" (Participant 10). In this way, adolescents felt valued for who they were and were not being labeled or marginalized due to their struggles or experiences. In both cases, participants said that teens described this aspect of the relationship as being most helpful.

In addition to the more relational interventions, participants reported that teens found it useful to have a safe place to spend time at school and that they also appreciated academic accommodations to allow them to catch up on their work in a reasonable

manner. One participant who works in a smaller therapeutic program within a large, urban high school said that her program created a "kind of home base in a much larger school" and that teens appreciated having somewhere comfortable to hang out (Participant 8). Another participant also reiterated the importance of having a "safe space" for recently hospitalized teens (Participant 12). According to participants, teens also reported that academic accommodations such as scheduling changes and long term extensions on work were crucial in helping them return to school without becoming too overwhelmed (Participants 3 & 4). In both cases, interventions aimed at increasing adolescents' sense of comfort and support were viewed as effective and helpful in improving the re-entry process for teens.

Participants' Experiences, Beliefs, & Theories Informing Interventions

When asked about their personal and theoretical framework for approaching interventions with recently hospitalized adolescents, participants discussed the impact of personal belief, knowledge, and experience as it impacts their clinical work. Participants also discussed their theoretical perspective and general approach to treatment. Six of the twelve participants discussed personal beliefs and experiences as directly affecting their work to reduce stigma for teens. One participant talked about acting from the belief that "All kids deserve a chance" no matter what they are struggling with (Participant 7). Another participant stated that her decades of work with adolescents have helped her to develop "knowledge and empathy" and that she maintains a generally "positive point of view of hospitalization" (Participant 4). This participant also described working from the assumption that a psychiatric hospitalization could happen to anybody given "an accumulation…of stressors" (Participant 4). Another participant talked about a similarly

destigmatizing belief in a psychiatric condition as a form of "health problem," requiring

treatment just like any other illness or injury (Participant 12). Additionally, this

participant also depicted his beliefs about stigma in the following way:

> …believing in the good nature of people and on both sides of the stigma situation. Believing in the good nature of someone who is being stigmatized, like this is a person who does not deserve to be stigmatized, no one deserves to be stigmatized. But, on the other end, I think the people who are doing the stigmatizing, I like to believe that it rarely comes from a place of strict maliciousness, a lot of times it's from like misinformation or naiveté or uncomfortableness or confusion or your own issues that you're working through or your own issues that it brings up when you hear these things. I guess that's a belief that kind of informs how I think about stigma (Participant 12).

In this description, the participant conveys his belief in the good nature of people and

works to maintain an open stance towards all teens involved in the stigma equation. In

each instance, basic beliefs about psychiatric conditions and hospitalizations and the

fundamental nature of people helped participants approach their work in an informed and

compassionate manner.

In addition to personal beliefs, five participants discussed their theoretical

approach to supporting teens in managing stigma. Participants mentioned various

treatment frameworks such as ego supportive counseling, psychodynamic theory,

Motivational Interviewing, and feminist theory as informing their work. One participant

specifically talked about the impact of Carl Roger's concept of "unconditional positive

regard" towards clients and he described how he attempted to maintain that therapeutic

stance in his work with recently hospitalized adolescents (Participant 2). Another

participant discussed the utility of psychodynamically oriented family therapy as a

"culturally appropriate" treatment framework for work with Latino families (Participant

10). This participant specifically discussed how this theoretical framework informed her treatment around stigma as she described in the following excerpt:

> I think it's about taking or asking the question, "What is the stigma standing for? What is the metaphor?" Because the stigma does not represent the same thing for any two people so it's really finding out their definition of what is happening to them as a result of their illness, how they're perceived, or limitations that others are imposing on them or that they may be imposing on themselves because they're stigmatizing themselves -- and where is that coming from? Trying to understand how they've internalized those perceptions of themselves. Trying to help them narrate or develop an understanding of the self that is much more reflective of their strengths and who they can be and want to be (Participant 10).

In this example, the participant described how her theoretical approach guided the types of questions she would ask about stigma, as well as providing a larger framework for addressing the family's specific experience and understanding of marginalization. Another participant talked about the importance of maintaining a strengths-based approach in her work with teens, saying "I think it's really easy to look at a kid in crisis and figure out what's going wrong" but that it is crucial to tease out "what is going right?" (Participant 9). This participant depicted how a strengths-based perspective allowed her to support the teen while also maintaining her own sense of hope for positive change.

In addition to specific theoretical frameworks, four participants discussed their general approach to their work with recently hospitalized teens. One participant described his goal in terms of interactions with adolescents, saying "Be approachable. Be somebody that they feel is not judgmental, somebody who is supportive, somebody that they feel respects who they are and respects them" (Participant 5). Another participant stated that his approach is to be "down to earth" and to not "label kids" in any particular,

minimizing way (Participant 6). One participant discussed her efforts to be open to a

teen's experience and to not make assumptions about them, saying:

> They really should have the power over their information. It's their experience. I
> shouldn't make any assumptions about what that experience is like for them. I
> don't make any assumptions about what that experience is like for a family. So, I
> definitely believe in letting a student tell their story, giving, not trying to give
> them too many words but really letting them express themselves in the way that
> they're most comfortable with (Participant 8).

For this participant, avoiding assumptions served as a foundational approach to working

with teens and families. As with all the examples, participants shared beliefs, theories,

and perspectives on treatment that served to respect and honor the individual experiences

and identities of recently hospitalized adolescents while also trying to avoid perpetuating

stigma in the therapeutic relationship.

CHAPTER V

DISCUSSION

The purpose of this qualitative, exploratory study was to acquire information about how mental health professionals intervene to help adolescents manage stigma following a psychiatric hospitalization. Interview questions served to elicit data on what types of clinical interventions are being utilized and what factors impact the conceptualization and implementation of these interventions. Additionally, participants were asked about how they assist recently hospitalized teens in managing the disclosure process, what interventions and resources appear most supportive for this population, and whether the visibility of an adolescent's psychiatric condition impacts the types of interventions used.

This chapter will contain a discussion of some of the major findings as they relate to the literature, implications for social work research and clinical practice, limitations of the study, and recommendations for future research.

Major Findings

In general, participants presented an understanding of the nature and impact of stigma consistent with current research on the topic. Participants discussed the role of stereotype, bias, and discrimination as fundamental aspects of stigma and this corresponds directly to Corrigan and Watson's (2002) discussion of the three factors of stigma being stereotype, prejudice, and discrimination. Participants also noted the overwhelmingly negative connotations of stigma which Hinshaw (2007) discussed as being attributed to factors, experiences, or identities that are disgraced, shamed, or rejected. In terms of the impact of stigma on recently hospitalized teens, participants

noted that adolescents are often treated differently by their peers due to their experience and their psychiatric condition. This negative social impact was also described by Corrigan and Watson (2002), and Leete (1992) in their discussions of the many negative effects of stigma. Participants' focus on the social consequences of stigma appeared especially relevant to teens given their particular developmental stage and focus on peer networks and identity formation. Participants also noted that stigma may be further complicated by other aspects of a teen's sociocultural identity such as race, ethnicity, socioeconomic status, gender, and sexual orientation. Yeh, McCabe, Hough, Dupuis, and Hazen (2003) depicted the particularly negative impact of stigma for youth of color as it directly interferes with treatment utilization and may contribute to increased marginalization.

In regards to the overlapping impact of stigma and other forms of oppression, a number of participants talked about how poor youth of color are often tracked into the juvenile justice or child welfare systems. One participant spoke about how poor Latino youth are often misdiagnosed and given substandard mental health treatment due a lack of cultural competency on the part of providers. Another participant discussed how urban African-American teens are more readily "warehoused" or locked up due to certain negative assumptions about these teens, their behavior, and their appearance. This type of negative treatment or lack of access to effective services for poor youth of color is discussed by Hinshaw (2007) when he referred to a "double stigma" experienced by individuals who are contending with multiple layers of oppression such as racism and classism. Similarly, a number of participants described how lesbian, gay, bisexual, and

transgender youth also experienced overlapping form of stigma due to their psychiatric condition and sexual orientation.

In terms of interventions utilized with recently hospitalized teens, participants discussed individual, family, group, and community-based treatment modalities. Due to the overwhelming lack of research on specific clinical interventions to reduce the negative effects of stigma, participants generally utilized personal beliefs and experiences, theoretical perspectives, and general approaches to treatment to inform interventions with this population. Research participants discussed a number of interventions utilized with individual teens, including supporting the use of coping and emotion regulation skills, planning and brainstorming, normalizing the teen's experience, and discussing the disclosure process. Similarly, Hinshaw (2007) discussed the importance of helping a teen develop and utilize coping skills to manage stress and to effectively address stigma.

Related to the issue of disclosure, Hinshaw stated that "decisions about when and how to disclose productively constitute an important topic but one that has been seldom investigated" (Hinshaw, 2007, p. 230). The issue of disclosure emerged as one of the main themes discussed by participants when addressing how they support teens in returning to their communities. The majority of participants asked questions about what teen clients felt comfortable sharing and what kinds of questions they were anticipating from others. A number of participants stated that they would support a teen's right to self-determination in terms of deciding what kinds of personal information they would share. Additionally, participants often discussed issues of confidentiality and personal boundaries as important considerations for adolescents when navigating the disclosure

process. These findings represent an important contribution to social work research as they fill a gap in the existing literature on how to address the process of disclosure with a particularly vulnerable population.

Participants also discussed the importance of providing interventions aimed at improving familial, social, and community supports for recently hospitalized adolescents. Interventions included working with teachers to increase their understanding and empathy towards their students, providing ongoing family support services, offering parent groups, and support groups for teens. Participants' attention to improving familial, educational, and social supports for recently hospitalized teens is consistent with Hinshaw's (2007) focus on providing family and group treatment options as a means to reduce isolation and stigma. Cohen, Mannarino, and Deblinger (2006), in their formulation and implementation of the TF-CBT model, also emphasized the importance of including families in treatment. Overall, participants described a number of individual, family, school, and group level interventions aimed at reducing the effects of stigma and supporting a teen in the process of reentering their community after a hospitalization.

Implications for Social Work Research, Clinical Practice, & Policy

The current study aimed to fill a particular gap in social work research, namely to investigate how clinicians support recently hospitalized adolescents in managing stigma. A great deal of research is still needed in terms of directly assessing how adolescents with psychiatric conditions are impacted by stigma and how they respond to it using their own language, culture, and belief system. Additionally, future research may also investigate the experience of particular groups of teens. For instance, particulars factors such as diagnoses and number and/or frequency of hospitalizations may be considered in

reference to the specific sample of teens included in a study. Adolescents with a history of multiple hospitalizations and significant psychiatric treatment might have different responses to an admission, as well as having different experiences of stigma. Similarly, teens with little to no history of treatment might have particular reactions to their first hospitalization and to the re-entry process once they are discharged. Future research might investigate the experiences of these different populations in order to assess how interventions might best be implemented according to the specific needs of the teens.

A participant in the current study also suggested that additional research is needed to investigate adolescents' experiences of hospitalization as it involves the use of physical and/or chemical restraints. This participant stated:

> I think it would be interesting to not merely look at the hospitalization itself but two kids hospitalized in the hospital and one with chemical and/or physical restraints and the type of frequency and also the feelings that the staff in the hospital can have towards a client can also be part of the stigma that the child feels. So, I think looking at the admission and looking at the hospitalization itself is certainly important but being able to go in and look at the different elements that are taken in by the teens can also be important (Participant 9).

According to the participant, the lived experience of a psychiatric hospitalization, and the resulting stigma, may be largely impacted by the use of restraints during an admission as well as the hospital staff's responses towards a particular teen. Future research might consider such factors in their role in a teen's responses to stigma.

In terms of clinical practice research, future studies might assess the efficacy of interventions used to manage stigma from a variety of different theoretical orientations and in a variety of settings. In the present study, participants were recruited from three different sectors; public schools, psychiatric hospitals, and a state department of mental health. Recruiting a larger number of participants from a single setting might allow for

more specific data on how interventions are created and implemented within that particular environment.

The present study also informs social work practice in regards to working with recently hospitalized adolescents who are dealing with stigma. Participants' responses point to the importance of providing a variety of therapeutic supports for teens, including individual treatment to increase coping and emotion regulation skills, to foster adolescents' ability to anticipate and plan for their re-entry, and to support them through the disclosure process. Additionally, participants point to the need for family supports, group treatment options, and general advocacy for the needs of recently hospitalized teens. While participants named a number of theoretical orientations that inform their practice with this population, Cognitive Behavior Therapy and Dialectical Behavior Therapy may be most helpful in helping teens build coping and emotion regulation skills. A strengths-based approach was also presented as an effective means to increase an adolescent's sense of confidence and empowerment in managing stigma. Psychodynamic theory, Narrative Therapy, and feminist theory were also mentioned as being helpful for clinicians in their formulation of interventions and their understanding of stigma.

In their discussion of the specific experiences of some low income teens of color, participants described ongoing problems with these youth being poorly treated and further marginalized by some mental health providers and systems. The misdiagnosis of adolescents due to misunderstandings about what is culturally normative for some teens implies that greater cultural competency training is needed for clinicians. Included in this training would be an emphasis of the multiple layers of stigma experienced by particular adolescents due to their socioeconomic status, their race or ethnicity, their sexual

orientation, and their psychiatric condition. This training should increase all mental health professionals' ability to recognize and address the impact of stigma as it affects oppressed populations.

In terms of social work services needed to support recently hospitalized teens, some participants stated that school-based mental health services often play a crucial role in helping marginalized adolescents manage stigma as well as supporting their re-entry process. While public school systems are often constrained by limited budgets and increasing demands, some schools have been able to partner with local mental health agencies or have created alternative programs within school settings in order to meet the needs of returning teens. Such programs serve a number of important functions in that they provide the teen with greater social, academic, and clinical supports, they build a sense of community, and they allow for a more gradual re-entry process. Such programs might also serve a preventative role in that services are provided that might help a teen avoid a potential hospitalization.

One policy level change that has begun to alter the types of services provided to recently hospitalized teens has to do with the creation of wraparound, home-based services for families. One participant, who had worked at a state mental health department for a number of years, discussed how wraparound, home-based family support services often allowed families to maintain their child in the home and to avoid hospitalizations and out of home placements. Some states are beginning to recognize the benefits of wrap around services for families with children with psychiatric conditions as they help to divert costly treatments such as psychiatric admissions, while they also utilize natural support networks and may provide better long term outcomes for youth.

Intensive, home-based services may assist an adolescent and his or her family in managing the teen's psychiatric condition within the home, avoiding disruptive out of home treatments that may elicit greater social stigma.

Limitations of Current Study

A qualitative, exploratory research design was chosen for the current study in order to develop information about how clinicians intervene to help recently hospitalized adolescents manage stigma. Given that this aspect of social work practice has not been previously investigated, the study aims to fill a gap in the current literature on social stigma and clinical practice. While the research design achieved this aim, generalizing these results to the larger population would not be appropriate. Limitations of the current study include the small sample size (n = 12) and the narrow geographical location of participants (one Northeastern state). Broad differences existed in terms of participants' experience levels working with recently hospitalized teens and this may have impacted participants' responses about the types of interventions used as well as their familiarity with the specific population. Including participants from a variety of settings may have allowed for a greater range of responses. However, increasing the participants' setting types might further reduce the ability to generalize from the findings as participants worked in a variety of settings and in very different capacities with recently hospitalized teens.

In addition to the more general limitations of the study, the researcher also had her own biases in terms of the impact of stigma on recently hospitalized adolescents given her previous experience as a social work intern on an adolescent in-patient psychiatric unit. While the researcher made every effort to examine her own

preconceptions and to analyze the research data in a thorough, objective manner, her past experience working with the population may have influenced her in the research process.

Conclusions

The researcher's hope for the utility of the current study is that it will fill a gap in current social work research, while also contributing to the clinical practice knowledge base for practitioners who work with recently hospitalized adolescents. While the study provides practical, clinical information about working with recently hospitalized teens, broader social change efforts will be needed in order to reduce social stigma towards all marginalized populations, especially individuals with psychiatric conditions. These efforts may take the form of educational programs, social norms campaigns, public awareness projects, grassroots efforts, and consumer activism. Yet, as these efforts are gaining increasing support and attention, recently hospitalized adolescents must be supported in the ongoing process of returning to their communities and dealing with the impact of social stigma. Whether this takes the form of discussing the disclosure process, advocating for youth in their academic setting, or providing ongoing family or group therapy services, these interventions are vital in terms of reducing the effects of stigma on a vulnerable population.

<div align="center">*References*</div>

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (Revised 4th ed.). Washington, DC: Author.

Balkin, R.S. (2006). A reexamination of trends in acute care psychiatric hospitalization for adolescents: Ethnicity, payment, and length of stay. *Journal of Professional Counseling: Practice, Theory, and Research, 34*(1&2), 49-58.

Balkin, R.S., & Roland, C.B. (2007). Reconceptualizing stabilization for counseling adolescents in brief psychiatric hospitalization: A new model. *Journal of Counseling & Development, 85*, 64-72.

Berzoff, J., Flanagan, L.M., & Hertz, P.H. (2002). *Inside out and outside in: Psychodynamic clinical theory and practice in contemporary multicultural contexts*. Lanham: Rowman & Littlefield Publishers, Inc.

Butzloff, R.L., & Hooley, J.M. (1998). Expressed emotion and psychiatric relapse: A meta-analysis. *Archives of General Psychiatry, 55*, 547-552.

Cohen, J.A., Mannarino, A.P., & Deblinger, E. (2006). *Treating trauma and traumatic grief in children and adolescents*. New York: The Guilford Press.

Connor-Greene, P.A. (2006). Interdisciplinary critical inquiry: Teaching about the social construction of madness. *Teaching of Psychology, 33*(1), 6-13.

Corrigan, P.W., Edwards, A.B., Green, A., Diwan, S.L., & Penn, D. (2001). Prejudice, social distance and familiarity with mental illness. *Schizophrenia Bulletin, 27*, 219-225.

Corrigan, P.W., Lurie, B.D., Goldman, H.H., Slopen, N., Medasani, K., & Phelan, S. (2005). How adolescents perceive the stigma of mental illness and alcohol abuse. *Psychiatric Services, 56*(5), 544-550.

Corrigan, P.W., & Watson, A.C. (2002). The paradox of self-stigma and mental illness. *Clinical Psychology: Science and Practice, 9*(1), 35-53.

Erikson, E. (1959). Identity and the life cycle: selected papers. *Psychological Issues Monograph, 1*(1).

Erikson, E. (1964). *Insight and responsibility*. New York: Norton.

Esters, I.G., Cooker, P.G., & Ittenbach, R.F. (1998). Effects of a unit of instruction in mental health on rural adolescents' conceptions of mental illness and attitudes about seeking help. *Adolescence, 33*(130), 469-475.

Fristad, M.A., Gavazzi, S.M., & Soldano, K.W. (1999). Naming the enemy: Learning to differentiate mood disorder "symptoms" from the "self" that experiences them. *Journal of Family Psychotherapy*, *10*(1), 81-88.

Gibson, R. (1992). The psychiatric hospital and reduction of shame. In P.J. Fink & A. Tasman (Eds.), *Stigma and mental illness* (pp. 185-188). Washington, DC: American Psychiatric Press, Inc.

Goffman, E. (1963). *Stigma: Notes on the management of spoiled identity*. New York: Simon & Schuster, Inc.

Harpaz-Rotem, I., Leslie, D.L, Martin, A., & Rosenheck, R.A. (2005). Changes in child and adolescent inpatient psychiatric admission diagnoses between 1995 and 2000. *Social Psychiatry and Psychiatric Epidemiology*, *40*, 642-647.

Hinshaw, S.P. (2002). *The years of silence are past: My father's life with bipolar disorder*. New York: Cambridge University Press.

Hinshaw, S.P. (2005). The stigmatization of mental illness in children and parents: Developmental issues, family concerns, and research needs. *Journal of Child Psychology and Psychiatry*, *46*(7), 714-734.

Hinshaw, S.P. (2007). *The mark of shame: Stigma of mental illness and an agenda for change*. Oxford: Oxford University Press.

Jamison, K.R. (2006). The many stigmas of mental illness. *The Lancet*, *367*, 533-534.

Leete, E. (1992). The stigmatized patient. In P.J. Fink & A. Tasman (Eds.), *Stigma and mental illness* (pp. 17-25). Washington, DC: American Psychiatric Press, Inc.

Leichtman, M. (2006). Residential treatment of children and adolescents: Past, present, and future. *American Journal of Orthopsychiatry*, *76*(3), 285-294.

Martin, J.K., Pescosolido, B.A., Olafsdottir, S., & McLeod, J.D. (2007). The construction of fear: Americans' preferences for social distance from children and adolescents with mental health problems. *Journal of Health and Social Behavior*, *48*(March), 50-67.

Miller, C.T., & Major, B. (2000). Coping with stigma and prejudice. In T.F. Heatherton, R.E. Kleck, M.R. Hebl & J.G. Hull (Eds.) *The social psychology of stigma* (pp. 243-272). New York: The Guilford Press.

Penn, D.L., Guynan, K., Daily, T., Spaulding, W.D., Garbin, C., & Sullivan, M. (1994). Dispelling the stigma of schizophrenia: What sort of information is best? *Schizophrenia Bulletin*, *20*, 567-578.

Rinsley, D.B. (1990). The severely disturbed adolescent: Indications for hospital and residential treatment. *Bulletin of the Menninger Clinic, 54*(1), 3-12.

Sartorius, N. (1998). Stigma: What can psychiatrists do about it? *Lancet, 352*, 1058-1059.

Spitzer, A., & Cameron, C. (1995). School-age children's perceptions of mental illness. *Western Journal of Nursing Research, 17*, 398-415.

Surgeon General (1999) *Mental health: A report of the Surgeon General*. Retrieved April 19, 2008 from http://www.surgeongeneral.gov/library/mentalhealth/chapter3/sec1.html

The National Child Traumatic Stress Network (2007). *Structured Psychotherapy for Adolescents Responding to Chronic Stress*. Retrieved April 19, 2008 from http://www.nctsnet.org/nctsn_assets/pdfs/promising_practices/SPARCS_fact_sheet_3-21-07.pdf

Wahl, O.F. (1999). *Telling is risky business: Mental health consumers confront stigma*. New Brunswick, NJ: Rutgers University Press.

Wahl, O.F. (2002). Children's views of mental illness: A review of the literature. *Psychiatric Rehabilitation Skills, 6*(2), 134-158.

Watson, A.C., Miller, F.E., & Lyons, J.S. (2005). Adolescent attitudes toward serious mental illness. *The Journal of Nervous and Mental Disease, 193*(11), 769-772.

White, M., & Epston, D. (1990). *Narrative means to therapeutic ends*. New York: Norton.

Yeh, M., McCabe, K., Hough, R.L., Dupuis, D., & Hazen, A. (2003). Racial/ethnic differences in parental endorsement of barriers to mental health services for youth. *Mental Health Services Research, 5*, 65-77.

Appendix A

Human Subjects Review Committee Letter

SMITH COLLEGE
School for
Social Work

Smith College
Northampton, Massachusetts 01063
T (413) 585-7950
F (413) 585-7994

November 5, 2007

Megan McKenna

Dear Megan,

Your revised materials have been reviewed and all is now in order. We are glad to give final approval to this interesting and useful study. The fact that you have had such difficulty finding material on this subject underlines how useful the pursuit of this topic will be.

Please note the following requirements:

Consent Forms: All subjects should be given a copy of the consent form.

Maintaining Data: You must retain signed consent documents for at least three (3) years past completion of the research activity.

In addition, these requirements may also be applicable:

Amendments: If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

Renewal: You are required to apply for renewal of approval every year for as long as the study is active.

Completion: You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Good luck with your project.

Sincerely,

Ann Hartman, D.S.W.
Chair, Human Subjects Review Committee

CC: Gael McCarthy, Research Advisor

Appendix B

Recruitment Letter

Dear Potential Participant,

My name is Megan McKenna and I am a second year graduate student at the Smith College School for Social Work. For my master's thesis, I am conducting a qualitative research study asking clinicians about interventions they have found helpful for use with adolescents managing stigma following a psychiatric hospitalization. I am writing to ask you to consider participating in the study given your expertise in working with this population.

Your participation would include a taped face to face or telephone interview lasting about 45 minutes. During the interview, you would be asked to sign an Informed Consent Form, to complete a basic demographic questionnaire and then to answer open-ended questions about your experience providing clinical interventions for this vulnerable population. Prior to the interview process, you would have the opportunity to ask questions and to discuss any concerns you may have about participation.

Throughout the research process, I will make every effort to protect your confidentiality if you should choose to participate. Your identifying information would be kept confidential and your responses would not be identified as your own.

I will be contacting you via telephone in about one week to see if you have any questions about the study and if you would be willing to be interviewed. I realize your time is a most valuable resource and I would be very appreciative of the opportunity to be able to speak with you further.

In the meantime, if you should have any questions please do not hesitate to contact me. Thank you for considering my request.

Sincerely,

Megan McKenna, MSW Candidate
Smith College School for Social Work

Appendix C

Informed Consent Form

Dear Participant,

My name is Megan McKenna and I am a master's level graduate student at the Smith College School for Social Work. I am conducting a qualitative research study for my master's thesis in social work and I am asking clinicians about interventions they have found helpful for adolescents managing stigma following a psychiatric hospitalization.

You are being asked to participate in this study if you are a licensed, master's level social worker or therapist with at least 3 years of experience working with adolescents who have experienced a psychiatric hospitalization. As a participant in this study, you will be asked to complete a basic demographic questionnaire and to take part in a face to face or telephone interview. Questions will focus on how you help mentally ill teens manage or combat social stigma. The interview will take about 45 - 60 minutes. Interviews will be tape recorded with your consent. Tapes and transcripts will be coded numerically to ensure your confidentiality. Interview tapes will be transcribed and I will be doing all of the transcription myself.

The potential emotional risks of participating in this study are likely to be minimal given the topic area and the nature of the questions being asked. The benefits of participation may include knowing that you have directly contributed to the body of clinical research that informs our practice with vulnerable populations while also having the opportunity to reflect upon past or current clinical experiences. There will be no financial compensation provided for participation in this study.

Strict confidentiality of the data obtained will be maintained, as consistent with federal regulations and the mandates of the social work profession. Confidentiality will be protected by removing your identifying information from the tapes and transcripts of the interviews, coding the information, and storing the data in a locked file for a minimum of three years. If I should need to keep these data beyond the three year period, the information will be kept in a secure location and will be destroyed when no longer needed. Your identity and that of your clients will be protected, as no actual names will be used in the analysis of the data. In the academic use of this research, data will be presented as a whole and any quotes or vignettes will be carefully disguised. The data will be used in preparation for my master's thesis and for possible publication and presentations. My research advisor will be the only other person with access to the data, and this will only happen once all identifying information has been removed.

Your participation in this study is completely voluntary. You are free to refuse to answer specific questions and to withdraw from the study at any time before April of 2008 by contacting me by phone. If you decide to withdraw, all data relating to you or

your interview will be immediately destroyed. Should you have any concerns about your rights or any aspect of this study, you are sincerely encouraged to contact me or to notify the Chair of the Smith College School for Social Work Human Subjects Review Committee.

YOUR SIGNATURE INDICATES THAT YOU HAVE READ AND UNDERSTAND THE ABOVE INFORMATION AND THAT YOU HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS ABOUT THE STUDY, YOUR PARTICIPATION, AND YOUR RIGHTS AND THAT YOU AGREE TO PARTICIPATE IN THE STUDY.

_____   _____

SIGNATURE OF PARTICIPANT   SIGNATURE OF RESEARCHER

_____   _____

DATE   DATE

Appendix D

Demographic Questionnaire

Please provide the following information. I am asking these questions in order to be able to address inquiries from readers or listeners about the diversity of my sample. Please feel free, as we discussed earlier, to skip any questions you do not wish to answer. Thank you.

1. What is your gender? _____ Male   _____Female   _____Transgender

2. How do you identify your race/ethnicity?_____

3. What is your socioeconomic status? _____

4. What mental health professional license do you currently hold? _____

5. What state are you licensed in? _____

6. How many years of experience do you have working with recently hospitalized teens? _____

7. Within the past five years, how many individuals on your caseload have been recently hospitalized teens? _____

8. Please describe any training you have received related to the issue of stigma associated with psychiatric patients either during graduate school or while on the job? _____

   _____

   _____

Appendix E

Interview Guide

1. How do you conceptualize or define stigma?

2. What are the ways in which stigma affects recently hospitalized adolescents?

3. What are the factors, if any, that lead to some teens being more stigmatized than others?

4. How do issues of diversity affect teen clients' experiences of stigma? More specifically, how might a client's race, ethnicity, socioeconomic status, gender, and sexual orientation impact stigma?

5. How do you talk about stigma with recently hospitalized adolescents?

6. What types of interventions do you use with recently hospitalized adolescents to help them deal with stigma? Are your interventions primarily individually-based? Family-based? Group treatments?

7. Were there particular words or experiences that a client shared which helped you to come up with an intervention?

8. Are your interventions different based on whether the teen's condition is visible or invisible to others?

9. How do you discuss when and how a teen client should disclose his/her psychiatric condition to others?

10. What particular coping skills or community resources support your adolescent clients in terms of managing stigma?

11. What interventions have teens reported as being most helpful in managing stigma?

12. What particular beliefs, experiences, or theories inform your practice in regards to how you work with teens who are dealing with stigma?

13. Is there anything else you would like to add? For example, can you think of any questions which I should have asked but did not? Or are there any suggestions you would like to make about this project?