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Stigma towards Peers with Mental Health Disorders in Childhood and Adolescence: An Investigation into Explicit & Implicit Stigma & Social Reasoning about Exclusion

Thesis submitted for the National University of Ireland, Galway in fulfilment of the requirements for the degree of Degree of Doctor of Philosophy (Psychology)

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Submitted September 2012
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I would also like to thank the Health Research Board for funding this research.
Publications & Conference Presentations

Detailed below are works, stemming from this thesis, that have been published or have been presented at conferences.

Publication:


See Appendix A. The definitive version is available at www.blackwell-synergy.com

Conference Presentations:


I declare that this thesis has not been submitted as an exercise for a degree at this or any other University. I declare that this thesis is entirely my own work.

Signed: ____________________________

Claire O’Driscoll
Abstract

Children and adolescents with mental health disorders are widely reported to have problems with peer relationships; however, few studies have explored the way in which their peers regard these young people. The literature that exists exclusively focuses on explicit measures to evaluate stigma and provides an incomplete assessment of the many aspects of stigma. The aim of this body of research was to provide a comprehensive insight into mental health disorder stigma in childhood and adolescence by exploring how young people perceive peers with mental health problems. Specifically, this research assessed all known dimensions of stigma (stereotypes, prejudice, discrimination, power and social status) and implicit attitudes towards peers with disorders. In addition, it also investigated how young people reason about the exclusion of peers with disorders. In doing so, this research programme consisted of two studies. In the first study, patterns of explicit and implicit stigmatisation of peers with depression and attention deficit hyperactivity disorder (ADHD) were explored. The sample was 385 children ($M = 10.21$ years) and adolescents ($M = 15.36$ years). Questionnaire data indicated that the peer with ADHD was perceived more negatively than the peer with depression on all dimensions of stigma, except perceived dangerousness and fear. In contrast, the implicit data, detected by the Implicit Association Test (IAT), suggested that some participants had more negative views of the peer with depression than the peer with ADHD. Specifically, the findings demonstrated that adolescent males exhibited significantly stronger negative implicit evaluations of depression compared to younger males and adolescent females. Overall, the findings of Study One demonstrated that the nature and extent of stigmatising responses depends on the type of clinical disorder, the type of measure used and also the perceivers’ age and gender. In Study Two, group interviews with 150 children ($M = 10.76$ years) and adolescents ($M = 15.5$ years) were conducted to investigate evaluations of dyadic and group exclusion scenarios involving peers with ADHD and depression.
Abstract

Explanations for why the target peers were rejected were also explored. Thematic analysis of the data showed that evaluations of peer exclusion were often multi-faceted, with participants frequently explaining that legitimacy of exclusion hinged on many factors. In general, young people believed that such peers were rejected because their disordered behaviour violated the expectations that they apply to their friendships. Overall, Study Two provided an insight into the reasons why young people with mental health problems are likely to be excluded by their peers. The findings from this body of research provide a valuable insight into how children and adolescents with mental health disorders are perceived by their peers. This information can be used in the development of anti-stigma interventions.
Chapter 1: Overview of the Thesis

1.1 Aim of Chapter

Chapter One sets the scene for this body of research. It briefly addresses the current status of the existing literature and outlines the principle aims of this research programme. A summary of the chapters contained in this thesis is also provided.

1.2 Current Status of the Research Literature

The stigmatisation of mental disorders is one of the most important and challenging issues facing all who are attempting to understand, prevent and treat mental illness (Crisp, Gelder, & Rix, 2000; Sartorius, 1998; US Department of Health and Human Services, 1999). Stigmatisation is a phenomenon that overcomes cultural and national boundaries and creates significant barriers to both personal development and treatment access (Tsan, Tam, Chang, & Cheung, 2003; World Health Organisation, 2001). In adult populations, stigmatised individuals face many social and emotional challenges, including social withdrawal, loss of productivity, lowered self-esteem, and increased levels of negative affect (Heatherton, Kleck, Hebl, & Hull, 2000). Although the nature and consequence of stigma has been studied in-depth in adulthood, stigma during childhood and adolescence is relatively under-researched. The data that does exist suggests that stigma is a widespread problem (Walker, Coleman, Lee, Squire, & Friesen, 2008), with young people with mental health problems not only experiencing stigma from their peers, but also from adults (Pescosolido, Fettes, Martin, Monahan, & McLeod, 2007). Young people with mental health problems often report experiencing teasing or harassment from their peers for having a disorder or for receiving treatment (Moses, 2010). Consistent with findings in the adult literature, stigma contributes to the under-
utilisation of mental health services and treatment non-adherence among adolescents (Ghaziuddin, King, Hovey, Zaccagnini, & Ghaziuddin, 1999; Hack & Chow, 2001; Kazdin, 1996). In addition, it may cause feelings of shame or embarrassment and fear of being rejected by their peers (Moses, 2009). Thus, the indirect effects of stigma have far reaching social, emotional, and health consequences. Future research needs to develop sophisticated interventions that change misconceptions about mental disorders and promote positive cognitive, emotional, and behavioural responses to all persons with mental health problems. However, the development of such interventions cannot be done without a comprehensive understanding of stigma.

Although the available research provides important evidence on peer stigmatisation there are some notable empirical gaps in the literature. Hinshaw (2005) highlights some methodological shortcomings including the need to explore stigma towards specific mental health problems and not towards the general term mental illness. Assuming that all mental health problems are stigmatised in the same manner limits our knowledge of how stigma may operate across disorders. Hinshaw also notes that addressing the lack of research that utilises implicit measures to assess stigma is a priority. The wider social cognitive literature has witnessed a surge in research on implicit attitudes towards outgroups. This trend has trickled into the adult mental health stigma literature (see Lincoln, Arens, Berger, & Rief, 2008; Teachman, Wilson, & Komarvoskaya, 2006); however, no published research has assessed implicit attitudes towards peers with mental health problems in childhood and adolescence. Furthermore, stigma is a complex construct, consisting of cognitive, emotional, and behavioural elements, that is a challenge to empirically measure in its entirety in psychological research. For stigma to be comprehensively understood the cognitive dimension of stereotypes, the emotional dimension of prejudice and the behavioural dimension of
discrimination need to be thoroughly investigated. The multi-dimensional make-up of this construct ensures that research frequently fails to operationalise and measure stigma sufficiently (Hinshaw, 2007). Study One will aim to address these limitations.

A further area of study that has been notably absent from the mental health stigma literature is research that explores young people’s social reasoning about the exclusion of peers with mental disorders. Research investigating social reasoning about exclusion has received much attention in the racial and gender stigma literature, providing an insight into the types of considerations young people attend to when determining whether to exclude or include a target peer. Killen, Mulvey, and Hitti (in press) suggest that this approach is useful as it permits an exploration of stigma from an intergroup perspective; it provides an insight into whether social conventional issues, such as norms, rules, and identity are involved in determining exclusion. Given that in childhood and adolescence, peer exclusion is the most salient form of discrimination (Brown & Bigler, 2005), adapting this research approach to the domain of mental health disorders is likely to provide a novel perspective on stigma towards peers with mental disorders.

Overall, the body of research presented in this thesis aims to enhance our general understanding of stigma towards peers with ADHD and depression in childhood and adolescence. Investigating young people’s perceptions of peers with ADHD and depression will provide an insight into the unique or shared ways in which peers with externalising and internalising disorders are stigmatised. ADHD and depression were chosen as the disorders to be investigated, as they are two of the most common externalising and internalising mental health disorders in childhood and adolescence (CAMHS, 2008; Goodman, Meltzer & Ford, 2000; Lynch, Mills, Daly, & Fitzpatrick, 2006), and therefore are most socially relevant to young people.
Specifically, Study One consists of a quantitative study concerned with comprehensively investigating stigma by exploring stereotypes, prejudice, and discrimination. This study is also the first study, to the researcher’s knowledge, that explores implicit attitudes towards peers with mental health disorders. It also examines whether the nature and extent of stigmatising responses varies across the age and gender of the perceiver and type of mental health disorder that the target individual has. These independent variables were included as a growing body of research suggests that self-reported responses towards a peer with a mental health disorder not only varies depending upon the type of disorder the target individual has, but is also dependent on the respondents’ age and sex (Jorm & Wright, 2008; Reavley & Jorm, 2011a).

Study Two is a qualitative group interview study that explores children and adolescents’ social reasoning about exclusion of peers with mental health problems. Specifically, it explores young people’s evaluations and justifications of exclusion of peers with mental disorders and perceptions about why children and adolescents with disorders are excluded. A qualitative research design was employed for Study Two as it is a useful means of exploring participants’ understanding of social phenomena (Elliott, Fisher, & Rennie, 1999). Given that no research has investigated young people’s views of exclusion of peers with disorders, it was anticipated that qualitative findings would facilitate our understanding of consistent quantitative findings that show that children and adolescents with mental health disorders are victims of peer rejection (Chen & Li, 2000; Coplan, Bowker, & Cooper, 2003).

This thesis incorporates both qualitative and quantitative methods, thus when considered as a whole body of work, this thesis can be described as a mixed methods research programme. However, it is important to note neither study adopted a mixed methods design. According to Johnson and Onwuegbuzie (2004), qualitative and
quantitative research findings must be mixed or integrated into a single study to qualify as a mixed methods design. Instead in this thesis, both studies were designed as two separate pieces of work that serve to advance understanding of stigma towards peer with mental health problems in childhood and adolescence. In line with this, the results pertaining to each study will be presented and interpreted separately, with some general conclusions on the findings of the thesis presented in the concluding chapter. This thesis acknowledges the value of both qualitative and quantitative research as both independent and complementary approaches for enhancing knowledge on social phenomena.

Advocates call for the development of interventions to change attitudes and educate young people about mental disorders while their cognitions and knowledge about mental health issues are less ingrained and more embryonic than that in adulthood (European Commission, 2008). However, there is much still to be learned on mental disorder stigma in childhood and adolescence. It is hoped that the research presented in this thesis will provide an important step towards advancing knowledge on stigma and will offer valuable information for anti-stigma interventions.

1.3 Outline of the Thesis

Chapter Two provides an insight into the prevalence rates of mental disorders in childhood and adolescence, before reviewing the developmental importance of peer acceptance. A review of the literature on the experience of children and adolescents with ADHD and depression is provided. Chapter Three introduces the concept of stigma. It describes the theoretical conceptualisation of stigma and the multiple components that it encapsulates (social status and power, prejudice, stereotypes, discrimination, and implicit attitudes). Theories that account for stigma towards peers with mental disorders are described before turning to developmental theories that are put forward to explain racial
and gender stigma in childhood and adolescence. A critical review of the applicability of these theories to account for mental disorder stigma is also provided. Chapter Four provides a critical overview of the existing literature on stigma towards peers with disorders in childhood and adolescence. It explores factors that influence the nature and extent of stigma, while rigorously assessing the quality of the available research. It also explores the limited research on implicit mental disorder stigma in adolescence and adulthood. A general overview of the limitations of the existing literature will be provided.

Chapter Five provides the rationale for Study One, describes the role of theory in the Study One, and presents the aims and objectives of this study. Chapter Six presents the methodological principles adhered to in the design of Study One, before describing the development of vignettes that were used in Study One and Two and the implicit measure employed in Study One. Details pertaining to the pilot study and changes made to the study design are also provided in Chapter Six. The method describing the study design, participants, the measures, and the procedure for Study One is presented in Chapter Seven. The results pertaining to Study One are presented in two chapters. Chapter Eight describes the procedure involved in analysing the data from the explicit measures, the primary aim of which was to explore the nature of responses across the multi-components of stigma, while also exploring if responses vary depending on demographic variables (age and gender) and the target mental health condition (ADHD or depression). The implicit results are provided in Chapter Nine. This chapter explores the nature of implicit attitudes across the afore-mentioned variables, while it also assesses the psychometric properties of the implicit measure. In addition, the predictive validity of implicit and explicit attitudes to account for self-reported behavioural intentions is explored. The results provided in Chapter Eight and Chapter Nine are discussed in
relation to previous research in Chapter Ten. Limitations of Study One and recommendations for future research are also provided.

Chapter Eleven introduces Study Two by providing a rationale for exploring peer exclusion. It reviews research from the Social Domain Theory literature on peer exclusion and provides an overview of research on Attribution Theory, the two theories that are employed in Study Two. It concludes with a rationale for conducting a qualitative study and the aims and objectives of Study Two. Chapter Twelve describes the pilot study and method for the main data collection employed in Study Two. Details about the design, participants, assessment tools, procedure, and data analysis plan are provided. The results of Study Two are presented in Chapter Thirteen. Firstly, participants’ evaluations of exclusion of peers with mental disorders are presented, followed by themes relating to justifications of their evaluations. Finally participants’ beliefs about why a peer with a mental disorder would be excluded are thematically presented. In Chapter Fourteen, the findings of Study Two are discussed by reflecting on existing literature and the limitations of the study are highlighted. A general discussion about the findings from this body of research is provided in Chapter Fifteen. The theoretical contribution and practical implications of the findings are discussed.
Chapter 2: Peer Acceptance & Mental Health Problems

Chapter 2: The Developmental Importance of Peer Acceptance & the Experience of Young People with Mental Health Disorders within the Peer Group

2.1 Aim of Chapter

This chapter lays the foundations for the proposed body of research. Firstly, the prevalence of mental disorders in childhood and adolescence is highlighted. An insight into the importance of acceptance into the peer group for psychosocial adjustment and development is then provided. Following on from this, research exploring the experience of children and adolescents with mental disorders within the peer group is discussed. By addressing these issues this chapter provides a rationale for assessing stigma towards peers with mental health disorders.

2.2 Prevalence of Mental Health Disorders in Childhood and Adolescence

Traditionally, research into mental disorder stigma focused on adult populations; however, there is evidence to support the exploration of this social phenomenon within a child and adolescent cohort. For example, 15.6% of 12 to 15-year-olds in a community sample in Ireland met the criteria for a current psychiatric disorder (Lynch et al., 2006). Recently, a study of 6,085 Irish 12 to 19-year-olds indicated that 11% of the sample were classified as having mild depression, 11% had moderate depression, while 8% had severe depression (Headstrong, 2012). This finding suggests that an overwhelming 30% of young people experience some level of depression. In addition, the study found that the prevalence of these disorders generally increased with developmental age. In other European countries it is estimated that 9.5% of children and adolescents have a clinically significant psychiatric condition (Meltzer, Gatward, Goodman, & Ford, 2003; Van Roy, Groholt, Heterdahl, & Clench-Aas, 2006). Furthermore, statistics from the World Health Organisation estimate that
Chapter 2: Peer Acceptance & Mental Health Problems

20% of children and adolescents worldwide have a mental health problem that causes “personal distress and impaired functioning” (2001, p.21). Based on these prevalence rates it is reasonable to claim that psychiatric disorders exist in every classroom. Mental health disorders in childhood and adolescence often persists across the lifespan with research estimating that 74% of 26-year-olds with a current psychiatric diagnosis experienced their condition before they were 18 years of age (Kim-Cohen, Caspi-Moffitt et al., 2003). Furthermore, 50% of participants in that study suffered from their condition prior to 15 years of age, thus it is possible that they experience life-long stigmatisation, which originated in childhood.

2.3 The Developmental Importance of Peer Acceptance

Social participation and friendships with others are a fundamental aspect of child development. The peer group is a vital source of social information and an important learning environment for young people. In childhood, peers provide each other with the primary tools and knowledge to form and maintain relationships, such as cooperation and leadership skills and an understanding of social structures and group dynamics (Fine, 1987). According to Parker and Gottman (1989), the function of friendships within the peer group are contingent upon the child’s developmental stage. For example, in early childhood, they argue that friendships function to increase excitement and amusement during play and organise behaviour during arousal. While in middle childhood, friendships facilitate the acquisition of knowledge of behavioural norms and social skills to aid appropriate social behaviour. In adolescence, friendships are thought to help integrate logic and emotions, and aid individuals in identity development. Although developing friendships and social participation are key aspects of the peer context, it is also marked by the existence of peer conflict. Conflict and subsequent resolution is adaptive, as it provides children with an opportunity to develop
language, interpersonal and social organisational skills, and knowledge (Goodwin & Goodwin, 1988). Thus, the ups and downs that accompany friendships facilitate development across cognitive, behavioural, and social domains. Ultimately, the peer group has a strong socialisation influence (Kinderman, 1993).

The social and emotional connections made within the peer group provide a valuable source of social support at times of stress and adjustment (Hartup, 1992). In addition, peer acceptance has been found to cultivate high-quality friendships, which in turn improve countless developmental outcomes, such as improved emotional adjustment and lower internalising symptoms (Demir & Urberg, 2004; Nangle, Erdley, Newman, Mason, & Carpenter, 2003). Other research indicates that peer acceptance predicts social competence, self-esteem, and academic achievement (Vandell & Hembree, 1994). Although research stresses the developmental importance of peer acceptance, not all children are successful at gaining access into the peer group (Parker & Seal, 1996), and thus the role of negative peer experiences in the development of adverse outcomes has received much attention in the literature.

The peer relations literature recognises two types of children that are not accepted into the peer group; rejected and neglected children (Newcombe, Bukowski, & Patte, 1993). Meta-analytical research indicates that rejected and neglected children have distinct behavioural repertoires that influence the quality of their social interactions (Newcombe et al., 1993). Young people who are rejected tend to be more aggressive, more withdrawn, less sociable, and have poorer cognitive abilities than popular, average, controversial, and neglected children. In contrast, Newcombe and colleagues found that neglected children typically engage in the lowest levels of aggression, are more withdrawn and less sociable than popular and controversial children. Neglected peers also have more sophisticated cognitive abilities than rejected and controversial children and experience less anxiety and
depression than popular children. While neglected children emerged as a distinct group, their emotional and behavioural repertoires were not overly dissimilar to that of popular peers. The results of this meta-analysis indicate that neglected peers are not an “at-risk” group, which is supported by other research that suggests that membership of this category is unstable (Cillessen, Bukowski, & Huselager, 2000; Coie et al., 1982; Newcombe & Bukowski, 1983). Subsequently, research has predominately focused on the behavioural profiles and developmental trajectories of rejected children. Reflecting on the known behavioural repertoire of rejected children it is likely that some of these behaviours are symptomatic of mental disorders. In fact, a growing body of literature supports this (see section 2.3.1 for research pertaining to the experience of children with ADHD and depression), thus young people with mental health problems may be a dominant subgroup among rejected, but not neglected children. In line with these findings, research on rejected children only will be explored.

The association between externalising behaviour and peer rejection is well documented (see Deater-Deckard, 2001 for an annotation). Longitudinal research by Dodge and colleagues (2003) found that rejection at 6 to 8 years of age lead to hostility and aggression at a 4-year follow up. They also found that rejection was associated with anti-social behaviour, regardless of the level of anti-social behaviour the child engaged in at the time of being rejected; similar findings have also been reported by others (Ladd, 2003; 2006; Ladd & Burgess, 2001; Sturaro, van Lier, Cuijpers, & Koot, 2011; Wentzel, 2003). Peer rejection in middle childhood is also a predictor of delinquency behaviour in adolescence (Miller-Johnson, Coie, Maumary-Gremaud, Lochman, & Terry, 1999). Rejection has also been found to predict drug use in adulthood (Reinherz, Giaconia, Hauf, Wasserman, & Paradis, 2000). Furthermore, peer rejection predicted unemployment and educational underachievement, even when other risk factors, such as IQ, attention, or SES were
controlled for (Woodward & Fergusson, 2000). Other research has indicated that 9-year-olds who experienced high levels of peer relationship problems were at risk of developing elevated externalising but not internalising problems at 18 years of age (Woodward & Fergusson, 1999).

While strong empirical support exists for the relationship between rejection and externalising behaviour, inconsistent support prevails for the predictive validity of rejection in the development of internalising symptoms. For example, longitudinal research by Kiesner (2002) indicated that rejection predicted depression after controlling for baseline levels of the disorder. While others also revealed similar findings (Keisner, 2002; Lochman & Wayland, 1994; Panak & Garber, 1992; Schwartz, 2005; Vernberg, 1990), some research has indicated that rejection does not predict internalising symptoms at follow up (Kochel, Ladd, & Rudolph, 2012; Prinstein, Borelli, Cheah, Simon, & Aikins, 2002). For example, Prinstein and colleagues followed 6th to 8th-graders over an 11-month period and found that after controlling for baseline depression, peer rejection did not predict subsequent internalising symptoms. However, experimental manipulation studies, in which participants are excluded by hypothetical peers, indicate that individual and group rejection increases negative affect in 8 and 10-year-olds (Nesdale & Lambert, 2007) and self-esteem in 8 to 12-year-olds (Thomaes et al., 2010). Despite this inconsistency, research suggests that peer acceptance may have a protective effect for children at risk of behavioural problems. Keiley, Bates, Dodge, and Pettit (2000) noted a decrease in problem behaviour from kindergarten to middle childhood and adolescence among children who did not experience peer rejection in kindergarten. Conversely, rejected kindergarten children exhibited consistently high levels of problem behaviours or strong increases in such behaviour over the same developmental period. Reflecting on this body of research the findings tend to suggest that peer rejection has a potent negative influence on development.
Chapter 2: Peer Acceptance & Mental Health Problems

This body of research indicates that peers play a critical role in the lives of children. As highlighted above, the profiles of rejected peers suggest that young people who display atypical behaviour, characteristic of mental disorders, are vulnerable to adverse peer experiences. However, whether atypical behaviour precipitates or is a consequence of exclusion, or whether poor peer relations and psychological problems transact overtime, are questions developmental psychologists are continually striving to answer. In a review Hay, Payne, and Chadwick (2004) compare the bi-directional relationship between emotional and behavioural disorders and negative peer relations to a “chicken-egg” conundrum. They conclude that regardless of which comes first, “children’s problems with peers may contribute to the genesis of disorder…conversely, children with disorders may find themselves at odds with their peers from the very first years of life” (p. 84). What is certain is that experiencing negative peer interactions is likely to make young people more vulnerable to emotional and behavioural difficulties and exacerbate any difficulties a young person has. Most research on the rejection of peers with emotional and behavioural disorders has focused on the experience of children with conduct problems and aggression; however, for the purpose of this thesis the research relevant to ADHD and depression only will be explored. The following section will discuss some of the available research that has documented the experience of children and adolescents with ADHD or depression within the peer group.

2.3.1 Children and Adolescents with Mental Health Disorders within the Peer Group.

Researchers hypothesise that the poor attention skills, resistance to controlled behaviour and strong attention towards rewarding stimuli displayed by children with ADHD make pleasurable peer interactions difficult, and consequently cause them to be rejected by their peers (Coplan, Bowker, & Cooper, 2003; Patterson & Sanson, 2001). Children with
depression are vulnerable to peer rejection because they exhibit social deficits (Rudolph, Flynn, & Abaied, 2008) and behavioural styles, such as passivity, fearfulness, and withdrawal (Harrington, 1993), that are judged unfavourably by peers.

The experience of young people with ADHD in the peer group is well documented, with research consistently indicating that many experience peer rejection (Bagwell et al., 2001; Hinshaw & Melnick, 1995; Hodgens, Cole, & Boldizar, 2000; Mikami & Lorenzi, 2011). Specifically, research by Hoza, Mrug, and Gerdes (2005) found that relative to 10-15% of non-disordered youth, 52% of children with ADHD were classified as rejected and less than 1% were perceived as popular. Observational research also noted that when children with ADHD were placed in settings with unfamiliar peers they were rejected by the end of the first day (Erhardt & Hinshaw, 1994) and peers began to complain about their behaviour within minutes (Pelham & Bender, 1982). In addition, elementary school aged children with ADHD are twice as likely not to have a mutual friend compared to healthy controls (Blachman & Hinshaw, 2002; Hoza et al., 2005). Specifically, using a sociometric nomination method, Hoza and colleagues found that 56% of children with ADHD did not have a reciprocal friend, 33% had one friend, and only 9% had two mutual friends. In comparison, among non-ADHD youth 32% had no friends, 39% had two friends, while 22% had more than two friends. In addition, the friendships that youth with ADHD have tend be of lower quality and are less-stable compared to friendships made by peers without disorders (Blachman & Hinshaw, 2002). According to Mikami (2010), experiencing poor peer relations has an additive effect on the adverse developmental outcomes typically associated with youth with ADHD. Longitudinal research to support this indicates that adolescent boys with ADHD and peer problems have higher levels of depression and anxiety, and engage in more criminality and substance use, compared to boys with ADHD who do not have peer problems (Greene, Biederman, Faraone, Sienna, & Garcia-Jetton, 1997). In addition, a 5-year
Chapter 2: Peer Acceptance & Mental Health Problems

Longitudinal study found that ADHD symptoms and peer rejection independently predicted academic underperformance, bulimia nervosa symptoms, and externalising and internalising behaviours in adolescent girls with ADHD (Mikami & Hinshaw, 2007). Thus, the adverse consequences of peer rejection for children with ADHD may not only expose them to other negative outcomes, but also exacerbate the externalising symptoms of their condition.

With regards young people with depression, research indicates that young people with internalising problems, such as poor emotional regulation, anxious behaviours, and those who are withdrawn and behaviourally reticent in the peer group, are frequently rejected (De Rosier, Kupersmidt, & Patterson, 1994; Coie, Lochman, Terry, & Hyman, 1992; Rubin, Coplan, Fox, & Calkins, 1995). Thus it is not surprising that research indicates that, in general, children and adolescents with depression experience difficulties in their peer interactions and relationships (Chen & Li, 2000; Parker, Rubin, Price, & De Rosier, 1995). However, when compared to peers with ADHD much less is known about the experience of youths with depression in the peer group. No published research has exclusively explored the break-down of sociometric ratings of samples of young people with depression. However, when compared to peers without a disorder, those with clinical depression scores are significantly less likely to be categorised as popular (McCabe, Ricciardelli, & Banfield, 2011). Cross-sectional research indicates a strong negative relationship between depression and peer rejection among 9 to 13-year-olds (Zimmer-Genbeck, Hunter, & Pronk, 2007). In contrast, a 2-year longitudinal study by Chen and Li found that depression predicted social status within the peer group. Furthermore, other research suggests that adolescents with depression may also be at risk of being bullied (Uba, Yaacob, & Juhari, 2009). Recently, Kochel and colleagues (2012) explored whether depressive symptoms antecedent the development of poor peer relations, or vice-versa, or whether a transactional relationship exists across time, among 4th-grade students through to 6th-grade. The results indicated that
depressive symptoms forecasted peer difficulties but did not provide any support for the hypotheses that poor peer relations predicted depression or that an interactive relationship existed between them. In addition, they found that depressive symptoms predicted victimisation in 5th-grade, which in turn predicted peer rejection a year later. The authors concluded that:

“depression does not reflect a transient experience; rather, depressive symptoms leave a lasting scar that undermines the normative maturation of developmental skills and the achievement of key milestones (e.g., establishing healthy peer relationships). This process may fuel a self-perpetuating cycle of psychological dysfunction and peer adversity that forecasts increasing dysfunction across the life course” (p. 648).

While research on the social experience of young people with ADHD is more established than evidence on the experiences of those with depression, in general, one can conclude that rejection from the peer group is a reality for children and young people with ADHD and depression. Consequently, exclusion may have an additive effect on the behavioural and emotional difficulties experienced by these young people, thus exacerbating the social difficulties they encounter.

2.4 Summary & Conclusion

Epidemiological research indicates that a notable proportion of young people are likely to experience a mental health disorder over the course of their childhood and adolescence, which may persist into adulthood. These young people face resistance in gaining acceptance into the peer group. The peer group is not only an important social agent for all children but is also thought to have a protective influence in times of stress and from potentially adverse outcomes. Rejection limits the amount of age appropriate socialisation peers can experience,
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thus placing children at risk of future problem behaviour. For children and adolescents with mental health disorders, peer rejection may facilitate maintenance and growth of their condition as well as other adverse outcomes over and beyond that incurred by their disorder.

In conclusion, when considered in the context of the developmental importance of peer acceptance it is imperative that the nature of peer stigma is comprehensively understood, so that effective anti-stigma campaigns can be developed to facilitate acceptance of young people with mental disorders.
Chapter 3: Stigma Theory

Chapter 3: Explicit & Implicit Stigma Concepts & Theory

3.1 Aim of Chapter

In this chapter, stigma, and the multi-dimensional components (prejudice, stereotypes, discrimination, social status and power) that it incorporates, will be defined and described. The concept of implicit dimensions of attitudes will then be introduced. Theoretical accounts of stigmatisation of peers with mental disorders will be explored. In addition, a review of the available theories that explain racial and gender stigma will be provided. A discussion on the applicability of these theories to explain and account for the development of mental disorder stigma will be presented. Finally, a rationale for the importance of exploring stigma towards peers with mental disorders in childhood and adolescence will be presented.

3.2 What is Stigma?

The study of stigma is rooted in the discipline of social psychology, which strives “to understand and explain how the thoughts, feelings, and behaviour of individuals are influenced by the actual, imagined or implied presence of others” (Allport, 1985, p.3). The term stigma originates from ancient Greece where it was used to denote a physical mark applied to social outcasts to indicate their socially devalued status (Goffman, 1963). People with disabilities, illness, or any other atypical physical or psychological characteristics were branded with this mark to guarantee segregation from society. Today, those who violate the accepted norms and rules of social interaction are no longer physically branded. Instead, stigma is socially constructed and thus has a psychological meaning; persisting as an internal mark of shame related to being a member of a deviant or castigated outgroup (Goffman, 1963; Hinshaw, 2007). As a result, all of the target individual’s attributes are interpreted and perceived in light of their mark or flaw, which ensures that perceivers form negative degenerative views of the individual (Goffman, 1963). The power of stigma to taint the
whole individual in such a light (Goffman, 1963) and the far-ranging effects it has on targets (Crocker, Major, & Steele, 1998; Link & Phelan, 2001) are evidence of its insidious nature. While stigmatisation hinges on being perceived as socially deviant, this alone does not provide adequate insight into its depth and complexity. Extensive research on this phenomenon has led researchers to believe that “stigma is born when elements of labelling, stereotyping, separation, status loss, and discrimination co-occur in a power situation that allows them to unfold” (Link & Phelan, 2001, p.376). The construct of stigma is complex and multifaceted, making it a challenging construct to alter. To tease out the construct further, the core dimensions of stigma: prejudice, stereotypes, and discrimination will now be explored in greater detail.

There is much debate on how prejudice should be conceptualised, as reflected in inconsistent applications of the term in the social cognitive literature. Killen and Rutland define prejudice broadly as the “negative evaluation of somebody because they belong to a certain social group” (2010, p.37). Others use prejudice as an alternative term for stereotypes, perceiving it as cognitive in nature involving perceptions, attributes, beliefs, and judgments about members of an outgroup (Tropp & Pettigrew, 2005). Prejudice is also conceived as an affective construct that refers to the emotional response of imagined or actual contact with outgroup members (Allport, 1954). Furthermore, in both the adult and the developmental social cognitive literature it is sometimes used to collectively describe any negative orientation towards an individual or outgroup along the dimensions of negative cognitive and affective evaluations and discriminatory behaviour (Dovidio & Gaetner, 1986; Raabe & Beelmann, 2011). In the present research, prejudice and stereotypes are proposed as distinct dimensions of attitudes. Before exploring research that supports this claim, both constructs will be defined and described.
Chapter 3: Stigma Theory

Prejudice was originally defined as “an antipathy” that is either “felt or expressed” towards outgroups (Allport, 1954 p. 9). The conviction that prejudice is an emotional response to an outgroup member is generally endorsed by mental health stigma researchers (Corrigan, Markowitz, Watson, Rowan, & Kubiak, 2003; Hinshaw, 2007; Stier & Hinshaw, 2007; Thornicroft, Rose, Kassam, & Sartorius, 2007). Consistent with this, the present research suggests that prejudice involves affective laden negative attitudes that influence behaviour toward the stigmatised person or group (Weiner, Perry, & Magnusson, 1988). Hinshaw defines prejudice as “unreasoning, unjustifiable, over-generalised and negatively tinged attitudes” that “connotes a darker affective laden tone” (2007, p.22). Common prejudicial emotions experienced when evaluating an individual with a mental health problem are pity, fear, anxiety, anger, or irritation (Corrigan & Watson, 2002; Corrigan et al., 2007; Thornicroft et al., 2007).

While arguing that prejudice is the emotional aspect of attitudes, this thesis proposes that stereotypes represent the respective cognitive component. Stereotypes are schemas or beliefs about members of a social group (Hamilton, Stroessner, & Driscoll, 1994) that develop as a result of cognitive and social experience (Bigler & Liben, 1992). They are “traits that are assigned to an individual based solely on group membership without consideration of intragroup variables” (Killen & Rutland, 2011, p. 38). Stereotypes are a natural human response to help alleviate overload of our cognitive resources from the social environment by organising the world into social categories (Macrea, Milne, & Bodenhausen, 1994). For example, upon meeting a new member of a group we draw on information we already know about other members of that group, thus reducing the amount of new information that has to be learned. Processing social information in such an efficient and effortless manner ensures that people frequently employ stereotypes to navigate the social world (Macrae et al., 1994). However, engaging in stereotyping can have pejorative effects.
on the target individual as these beliefs ignore unique differences that may exist among individuals in the group (Jussim, McCauley, & Lee, 1995). That is, they tarnish all group members with the one brush. Although there may be some element of truth in these characterisations, they are inflexible, universal, and formed despite lack of knowledge of the members of the target group (Campbell, 1967). The rigidity and over-generalisation of stereotypes can cause them to acquire a derogatory flavour, especially when projected towards members of marginalised groups, such as people with mental disorders. The most frequently endorsed stereotypes about children and adults with mental disorders are that they are dangerous or violent, unpredictable and personally responsible for their illness (Corrigan et al., 2007; Pescosolido, Fettes, Martin, Monahan, & McLeod, 2007; Reavley & Jorm, 2011b; Rose, Thornicroft, Pinfold, & Kassam, 2007).

Thus far, this thesis has addressed the nature of stereotypes and prejudice, as independent constructs. As highlighted earlier, prejudice is often used to describe both cognitive and affective aspects of attitudes and sometimes behavioural components. However, it is of empirical value to acknowledge that stereotypes and prejudice are distinct constructs. A series of studies by Crites, Fabrigar, and Petty (1994) provides empirical evidence to support this claim. Based on initial analysis, the authors aimed to establish a new scale that measured cognitive, affective, and general attitudes towards the following attitude objects: literature, math, capital punishment, birth control, church, and snakes using a variety of response formats (e.g. dichotomous, semantic, multi-response format, thought listing, word variation). The results from 200 participants indicated that the cognitive and affective dimensions of these scales displayed acceptable reliability coefficients that were maintained in response to all attitude objects. Subsequent exploratory factory analysis of this scale supported the distinction between cognitive and affective components of attitudes, revealing that the respective components loaded onto separate factors for all scales exploring attitudes.
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towards the target attitude objects, except those using the word variation response format. In addition, discriminant validity of the constructs was supported by structural equation modelling of the data that revealed that cognitive and affective attitudes independently predicted general attitudes towards all target objects with all scales, but once again except when a word variation response format was used.

To further test the validity of the distinction between cognitive versus affective attitudes, participants ($N = 145$) were provided with either cognitive or affective loaded information about attitude objects and subsequently administered affective, cognitive, and general attitudes scales. The results revealed that the affective or cognitive measure of attitudes were better predictors of general attitudes depending on what type of information participants had received. Specifically, the affective measure was a better predictor of attitudes when participants had formed an affectively driven impression of the attitude object from the affective information provided. A comparable trend was observed with the cognitive measure, for those who received cognitive information. Drawing on their findings the authors concluded that prejudice (a) is composed of qualitatively distinct emotions; (b) fluctuates along an evaluative dimension; (c) can be experienced towards any attitude object; (d) can be measured verbally. The same assumptions are applied to stereotypes with the exception that they are primarily derived from traits, attributes, or beliefs and not emotions. The distinction between cognitive and affective components of attitudes has been repeatedly demonstrated in research that explores health decision-making, general attitudes, and persuasion techniques (Fabrigar & Perry, 1999; Keer, van den Putte, & Neijens, 2010; Trafimow & Sheeran, 1998; Ya, Petty, & Fabrigar, 2008). Although distinct, research indicates that prejudice and stereotypes function in a reciprocal relationship (Eagly, Mlandic, & Otto, 1994). Eagly et al., coin this as a synergistic relationship with an individual’s cognitive beliefs having some degree of affect and vice versa. While this may be the case, the aforementioned research
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suggests that some attitudes are more affective than cognitive and vice-versa. Thus, acknowledging the important role of beliefs and emotions in determining responses towards social outgroups is imperative if stigma is to be fully understood. Throughout this thesis the cognitive and affective components of attitudes will be referred to as stereotypes and prejudice, respectively. The term attitudes will only be used as an all-encompassing term for both constructs or to unspecified general responses that may be cognitive and/or emotional in nature.

Discrimination is the behavioural component of stigma that involves the differential treatment of one group/individual relative to another. According to Fishbein, discrimination “involves harmful actions towards others because of their membership in a particular group” (1996, p.70). This simple definition fails to capture the complexity of discrimination experienced by people with mental illness. In adulthood, people with mental illness are often denied access to equal employment opportunities, have less legal rights, and are more likely to be avoided and shunned by communities (Corrigan et al., 2004; Hinshaw, 2005; Satorious 1998; Thornicroft, 2006; US Dept Human Serv., 1999). In childhood, discrimination is most salient in the form of peer rejection and exclusion (Brown & Bigler, 2005).

Stereotypes, prejudice, and discrimination tap into the cognitive, affective, and behavioural aspects of stigma respectively. One might argue that these concepts function in a somewhat linear manner; in that stereotypes and prejudice induce discrimination. However, meta-analytical research on racial stigma suggests a significant moderate association between general attitudes and discrimination (Dovidio, Brigham Johnson, & Gaertner, 1996; Dovidio, Esses, Beach, & Gaertner, 2002; Glasman & Albarracin, 2006; Talaska, Fiske, & Chaiken, 2008). When prejudice and stereotypes were analysed separately, Dovidio et al. and Talaska et al. found that prejudice was a stronger predictor of discriminatory behaviour. Specifically, Talaska et al. found that while stereotypes and prejudice were related to self-reported
discrimination, prejudice was twice as strongly related to observed discrimination compared to stereotypes. The authors concluded that while both beliefs and emotions are important in determining behavioural intentions, prejudice has a more potent influence on what people actually do. Thus, research demonstrates that a perfect linear relationship between attitudes and behaviour does not exist and instead the relationship is much more complex.

Disassociations between attitudes and behaviour are often explained by moderating effects of inter-personal and societal factors (Godin, Sheeran, Conner, & Germain, 2008; Guccuardi, Jallen, & Donovan, 2010). While it is beyond the scope of this thesis to explore factors that influence associations between attitude and behaviour, it is reasonable to argue that the relationship between stereotypes, prejudice, and discrimination hinge upon a multitude of factors that operate in highly complex manner.

According to Link and Phelan (2001), a description of stigma is incomplete without a commentary on the role of social power and status in determining whether stigma emerges. Many differences exist between individual groups, however, not everyone is stigmatised. For example, you might think that all politicians are corrupt (stereotype), feel disgust and anger towards them (prejudice) and avoid contact with them (discrimination) but politicians are not a stigmatised group. For stigmatisation to occur, the perceivers must be of higher social status and of a more powerful position to imbue their world-view of what is socially acceptable or deviant behaviour on others. Although minority group members may stereotype and experience prejudice towards majority outgroup members, they do not have the social, political or cultural power to influence others’ perceptions and inflict serious discriminatory behaviour against them. Link and Phelan (2001) note that without reference to social status and power, the concept of stigma could be applied to, for example, celebrities, politicians, and White people, and thus, would assume a very different meaning.
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In sum, stigma is contingent on the cognitive phenomena of stereotypes, the affective nature of prejudice, behavioural acts of discrimination, status loss and power (Hinshaw, 2007). Stigmatisation encompasses all of these components but also transcends this; the stigmatised individual will often internalise this degradation (Hinshaw, 2005), fuelling a vicious cycle of societal rebuff and personal internalisation of the rejecting messages. While the internalisation of stigma (self-stigma) must be acknowledged when reviewing the concept, this thesis will focus on public stigma; the way in which the affected individual is regarded by others (Corrigan, 2002). From a public perspective, stigma represents the endorsement of negative emotional and cognitive attitudes, discriminatory behaviours and biased social structures towards individuals with mental disorders (Corrigan, 2000).

3.3 Limitations of Explicit Attitude Measurement

The previous section described explicit dimensions of stigma, however, psychologists are also interested in more subconscious aspects of social cognition, such as implicit attitudes. Before describing this dimension of cognition, the limitations of explicit measures that instigated investigation into implicit attitudes will be discussed.

To date, self-report measures, which require respondents to report on their own attitudes, are the main method of assessing both child and adult attitudes. Self-report measures tap into explicit stereotypes and/or prejudices that are defined as attitudes that “people can report and whose expression can be consciously controlled” (Rydell, McConnell, Mackie, & Strain, 2006, p. 954). These methods assume that respondents are not only aware of their own attitude but are honest and accurate reporters. Despite the prevailing popularity of these measures it is widely agreed that explicit measures have many methodological flaws. The limitations associated with explicit measures can be categorised as either introspective limits or response factors (Egloff & Schmulke, 2002). Introspective limits refer to
participants’ ability (or inability) to provide accurate responses to the subject under investigation due to confounding factors with the research setting, such as one’s personal evaluations of the researcher or not being aware of one’s attitude towards the target object. While response factors refer to participants’ willingness (or reluctance) to explicitly provide responses that may violate acceptable norms.

One response factor that has received considerable attention is self-presentation. Self-presentation biases occur when participants are motivated to reject an evaluation that they believe is not acceptable and to offer a more socially and personally tolerant attitude instead (the MODE model; Fazio, 1990; Fazio & Olson, 2003; Fazio & Towles-Schwen, 1999). Self-presentation biases are perceived as responses or behaviour that are driven by a desire to make a particular impression on others (Vohs, Baumeister, & Ciarocco, 2005) and occur when an individual is motivated to control or alter his/her response and able to do so (Rohner & Bjorklund, 2006). Support for the influence of motivation to control one’s stigmatising responses is seen in the adult literature (Dunton & Fazio, 1997; Dovidio & Gaertner, 2000). Presentation biases are also evident among children and thought to explain some of the decline in the use of stereotypes and prejudice that is witnessed from about 7 years of age (see section 3.4.4). Evidence to support the existence of responses biases in children indicates that when children are aware that they are publically accountable for their stigmatising responses, they are motivated to control them and their expression of prejudice subsequently declines (Abrams, Rutland, Cameron, & Ferrell, 2007; Monteiro, Franca, & Rodrigues, 2009; Rutland, Cameron, Milne, & McGeorge, 2005). Self presentation biases are problematic in attitudinal research towards socially sensitive outgroups and are considered to be one of the main reasons why floor effects are often the norm and weak relationships are observed between attitudes and behaviour (Azjen, 1991).
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Such limitations spurred researchers to develop measures that assess individuals’ automatic associations of social outgroups in a manner that is less likely to be susceptible to introspective limits and response factors by tapping into attitudes indirectly, i.e. without asking people directly about their beliefs. While implicit cognition has been theorised and discussed for decades (e.g. Devine, 1989; Shiffrin & Schneider, 1977), the development of implicit measures provided concrete evidence for this dimension of social cognition (Devine, 1989; Fazio, Jackson, Dunton, & Williams, 1995; Greenwald & Banaji, 1995). The data obtained from implicit measures has indicated that implicit cognition is often behaviourally and neurologically distinct from explicit cognition (Fazio et al., 1995; Dovidio et al., 2002; Phelps et al., 2000; Cunningham, Raye, & Johnson. 2004). These less conscious evaluations are known as implicit attitudes, which are defined and elaborated in detail below. Evidence for implicit social cognition has further complicated stigma research as now there are not just different types of attitudes (emotional and cognitive), but they also may have multiple entities (explicit and implicit; see Dovidio, Kawakami, Smoak, & Gaertner, 2009; Greenwald, Poehlman, Ulhmann, & Banaji, 2009). For example, it is possible to have more than one evaluation of the same subject and one of these evaluations may be more accessible than the other (Wilson, Lindsey, & Schooler, 2000 Dunham, Baron, & Banaji, 2008).

3.3.1 Defining Implicit Attitudes

There is an ongoing debate in the literature on an exact definition of implicit attitudes; the lack of agreement on a definition can be explained by conflicting theoretical accounts for this phenomenon. In the published literature, implicit cognition is most commonly described in terms of the tests used to measure this phenomenon. Implicit tests generally fall into one of the following three categories; memory tests, reaction time assessments (RT), or physiological techniques. The common thread across these measures is that, “they seek to
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provide an estimate of the construct of interest without having to directly ask the participant for a verbal report” (Fazio & Olson, 2003, p.300). By not explicitly asking participants their attitude, implicit measures avoid introspection and thus reduce confounding self-presentation biases. RT measures are the most popular types of implicit tests; the data produced by these tests are measures of automatic cognition (deHouwer, 2006). Specifically, Greenwald et al. define RT implicit tests as “measures of the strength of automatic association” (2002, p.9).

To overcome response and introspective limits, RT measures limit the amount of available cognitive control to produce responses by informing participants that the task is timed and instructing them to complete it as quickly as possible. Thus, when applied to RT assessments, the term implicit is used to describe methods that “avoid requiring introspective access, decrease the mental control available to produce the response, reduce the role of conscious intention, and reduce the role of self-reflective, deliberative processes” (Nosek, Greenwald, & Banaji, 2007, p. 267). Since the unveiling of the Implicit Association Test (IAT; Greenwald, McGhee & Schwarz, 1998) the popularity of these measures has exploded and other RT tests have emerged including the Go/No Go Association Task (GNAT; Nosek & Banaji, 2001), the Extrinsic Affective Simon Task (EAST; De Houwer, 2003), the Implicit Relational Assessment Procedure (IRAP; Barnes-Holmes et al., 2006; Vahey, Boles, & Barnes-Holmes, 2010), the Lexical Decision Task (LDT; Wittenbrink, Judd, & Park, 2001), the Concept Association Task (CAT; Steffens, Kirschbaum, & Glados, 2008), the Action Interference Paradigm (AIP; Banse, Gawronksi, Rebetez, Gutt, & Morton, 2010) and priming measures (Degner & Wentura, 2010; Degner, Wentura, Gniewosz, & Noack, 2007). To date, the IAT, the AIM, the IRAP, and priming measures have been used with children to explore implicit attitudes. Of these tests, the IAT has been employed more often and has been adapted to meet the developmental needs of younger participants (Baron & Banaji, 2006; Cvencek, Greenwald, & Meltzoff, 2011). For the remainder of this thesis, unless otherwise stated, it
can be assumed that the empirical findings for implicit attitudes were uncovered using the IAT. See Chapter 6 section 6.5 for a detailed discussion on the IAT.

3.4 Theoretical Accounts of Stigma
The previous sections described the elements involved in stigma; this section will discuss theories proposed to account for mental disorder stigma. It will also discuss theories that describe the development of stigma towards racial and gender outgroups. No theories have been proposed or tested to account for the development of mental health stigma in childhood and adolescence. While attribution theory and psychological essentialism theory often feature in research that explores the nature or existence of childhood stigma (e.g. Corrigan et al., 2007; Swords et al., 2011a; Watson, Miller, & Lyons, 2005; Watson, Otey, Corrigan, & Fenton, 2004), these theories do not assume a developmental approach for the emergence of mental disorder stigma across childhood. Instead, these theories explain relationships between specific beliefs about a disorder and stigma. As a whole, the published literature on children and adolescents’ perception of peers with mental health problems is typically void of theoretical frameworks. In comparison, in the wider social cognitive literature there are many proposed theories to account for the development of stigma towards racial and gender outgroups. Although a diverse range of perspectives exist on how children acquire and process stigmatising responses, some of these theories may have the potential to inform the development of mental health stigma. It is important to note, however, that the following theories are mostly presented to facilitate understanding of the nature of stigma and its development. While tentative discussions on the applicability of the general stigma theories to the domain of mental disorders will be provided, it is not the aim of this thesis to empirically test any specific theory.
3.4.1 Attribution Theory

Attribution theory (Weiner, et al., 1988) claims that when adverse behaviours are ascribed to personal control, negative reactions are invoked on the part of the observer. Conversely, if such adverse behaviours are attributed to non-controllable causal factors, empathic reactions will be expressed towards the individual. Specifically, responsibility and control attributions are linked with disparate affective and emotional reactions, such as anger, fear, and sympathy. In turn, these emotions influence the perceiver’s discriminatory or altruistic behaviour towards the target individual. There is considerable support for the attribution model in both the adult and child mental disorder stigma literature (Corrigan et al., 2002; Corrigan, Markowitz, Watson, Rowan, & Kubiak, 2003; Corrigan et al., 2007; Swords, Heary, & Hennessy, 2011a). For example, a series of studies by Juvonen (1991) found that children’s beliefs about the causality of hypothetical and real peers’ deviant behaviour influenced their affective responses towards them. In addition, such beliefs influenced the level of acceptance and social support provided to these peers. Research by Swords et al. (2011a) found that perceived responsibility was the most important predictor of acceptance of male peers with ADHD and depression. Corrigan (2000) also claims that beliefs that people with mental disorders are dangerous are important in determining stigmatising responses. Empirical support for Corrigan’s attribution model has been demonstrated with children and adolescents. In a study of 11 to 16-year-olds (N = 1,391) Corrigan et al., (2007) demonstrated that young people who perceived the peer as being responsible for his mental disorder expressed more anger and less pity towards him. These emotional responses were related to being less willing to help the peer and to endorse treatment in a segregated setting. The study also found that those who perceived the peer with a mental disorder as dangerous were more fearful of the peer and would try to avoid him.
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Attribution theory holds promise for stigma reduction interventions; providing people with accurate information about personal responsibility and dangerousness of people with mental disorders should reduce stigma. Peterson, Mullins, and Ridley-Johnson (1985) noted that children who were told that a depressed female had experienced recent life stress perceived her as more likeable than if they were not told this information, whereas children who attributed the depression to external causes perceived the individual more favourably. Intervention research on attribution theory found small but significant improvements in middle school children’s attitudes towards mental disorders following a school based educational program (Watson et al., 2004). Noteworthy, was the finding that, participants’ perceptions of how dangerous the individual with the mental health problem was, significantly improved following the intervention. While challenging specific false attributions may diminish some aspects of stigma, recently academics have questioned whether manipulating attributions is the most effective means of diminishing stigma (Pescosolido et al., 2010; Read, 2007; Read, Haslam, Sayce, & Davies 2006). The rationale for this argument is founded on research that indicates that the general public are more educated about mental disorders than ever before, and yet, stigma has not diminished (Angermeyer & Matschinger, 2005; Pescosolido et al., 2010; Read, 2007). Instead of exclusively focusing on education based interventions, the effectiveness of contact based interventions is now being explored (see Chapter 15 section 15.2.2 for a more detailed discussion on stigma intervention).

3.4.2 Psychological Essentialism

Psychological essentialism is a reasoning heuristic employed by children and adults that channels the belief that categories of people have underlying qualities and values that cannot be directly observed (Gelman, 2004). These underlying characteristics are thought to
determine the identity of group members and commonality among them (Medin & Ortony, 1989). Children’s tendency to categorise their social world ensures that essentialist inferences about members of a particular group are generalised to other members of the group (Heyman & Gelman, 2000; Waxman, 2010). Research indicates that children not only use essentialist thinking when categorising social and arbitrary groups (Gelman, 2004) but also when evaluating psychological traits, such as shyness, meanness, or aggression (Giles & Heyman, 2002; Cain, Heyman, & Walker, 1997). Furthermore, research indicates that when children view a particular characteristic, for example aggression, in an essentialist way, they believe that the behaviour is enduring and resistant to change (Giles, 2003; Martin & Parker, 1995).

Recent research indicated that children and adolescents’ beliefs that ADHD was not pervasive and stable were associated with greater acceptance (Swords et al., 2011a). While Swords and colleagues’ study specifically tested Attribution theory, the findings demonstrate that essentialist constructs, pervasiveness and stability, are important in shaping attribution beliefs. Similarly, Norman & Malla (1983) found that adolescents, who believed that a person with a mental health disorder could recover, endorsed less social distance than those who believed that the mental disorder was stable. Thus, the aspects of psychological essentialism that are most relevant to mental disorder stigma are beliefs about prognosis and timeline of disorders. Intervention research is also beginning to recognise the importance of changing beliefs about prognosis. Recently, Spagnolo, Murphy, and Librera (2008) found that presenting adolescents with positive recovery-oriented depictions of mental disorders improved related attitudes.
3.4.3 Implicit Social Cognitive Theory

The previous sections reviewed theories that have been applied to explain stigmatisation of mental disorders. This section will discuss implicit theory that is not specific to mental health disorders, but general implicit cognition. Implicit social cognition is now an empirically established field of both adult and developmental cognitive science that explores the existence of thoughts, feelings, and attitudes outside conscious control and awareness. Research utilising various implicit cognitive measures supports a dual processing model, known as the MODE model (Fazio, 1990; Fazio & Towles-Schwen, 1999), to explain human social cognition, which demonstrates that implicit forms of stereotypes, prejudice, group and self-identities are distinct and sometimes independent from explicit cognition (see Fazio & Olson, 2003 for a review). That said however, the MODE model suggests that the relationship between implicit and explicit cognitive variables is moderated by participants’ motivation or opportunity to deliberate about responses (Fazio & Olson, 2003). Therefore, according to the MODE model, behaviour can be the result of either conscious processing or spontaneous reactions. While explicit intergroup cognition has been researched and theorised in depth, little is known about the developmental course of implicit intergroup cognition. Traditionally, theories on the acquisition of implicit social cognition largely assumed a slow learning system approach (Devine, 1989; Smith & DeCoster, 2000; Fazio, Sanbonmatsu, Powell, & Kardes, 1986). These theories claim that implicit cognition gradually forms through the internalisation of information acquired through repeated exposure and experience with the environment. However, with the emergence of empirical research on implicit cognition in childhood and adulthood authors have begun to contest this theory. In fact, implicit attitudes towards novel groups can be formed rapidly (Dunham, Baron, & Carey, 2011; Gregg, Seibt, & Banaji, 2006; Ranganath & Nosek, 2008) and subsequently generalised to other members of that group (Dunham et al., 2011; Ranganath & Nosek,
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2008), thus providing evidence that challenges slow learning theories. In addition, recent empirical research utilising implicit measures notes that implicit attitudes towards social and non-social categories are evident in children as young as 3 and 4 years of age (Cveneck et al., 2011; Thomas, Burton-Smith & Ball, 2007). Implicit attitudes not only exist for salient attitude objects but can also be detected in the presence of subtle group differences. For example, research by Dunham, and colleagues (2011) demonstrated that implicit preferences based on minimal group membership, as determined by t-shirt colour, can be measured in children as young as 5-years-old. Dunham and colleagues (2008) argue that rapid formation of implicit attitudes can be explained by our early awareness of our own social status in societal dominance hierarchies and our evolutionary tendency to quickly form ingroup favouritism.

Research indicates that 6-year-olds and adults have the same pattern of implicit attitudes towards racial outgroups (Baron & Banaji, 2006). It also notes an asymmetrical developmental pattern between implicit and explicit attitudes, with negative explicit attitudes towards out-groups weakening between 6 and 10 years of age and disappearing by adulthood. Whereas, implicit preference for one’s ingroup relative to a contrasting outgroup remains stable across childhood and into adulthood (Baron & Banaji, 2006; Dunham, Baron, & Banaji, 2006; Dunham, Baron, & Banaji, 2007). The evidence thus far suggests that explicit and implicit attitudes display divergent developmental patterns. While recent research demonstrates that implicit attitudes can be acquired quickly, it also shows that they are resistant to change (Gregg et al., 2006). This finding has yet to be tested with children but suggests that implicit attitudes are durable, lasting cognitions. Many open questions remain on the developmental theory of implicit cognition; however the current popularity of implicit measures means that it is likely that many of these questions will be addressed in the not so distant future.
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3.4.4 Racial, Gender, and Ethnic Stigma Developmental Theories

Theoretical and empirical work on the development of stereotypes, prejudice and discrimination towards, gender, racial, and ethnic outgroups has historically been, and continues to be, the focus of developmental social cognitive science. The result is a massive body of empirical studies and theories on the development of outgroup stigma. While it is not the aim of this thesis to test the applicability of these theories to the domain of mental disorders, it is reasonable to suggest that aspects of this work can inform the development of mental disorder stigma. In light of this, a brief insight into the dominant theories will be provided.

Classic social psychological theory claims that children are not born with stereotypes and/or prejudice but acquire these beliefs through incremental learning processes through interactions with parents, peers, and other significant figures in their lives (Adorno, Frenkel-Brunswik, Levinson, & Sanford, 1950; Allport, 1954). While it is reasonable to argue that stigma is a learned phenomenon, research has failed to support its essential elements. If children learn stigmatising responses from their parents a significant correlation between parent and child views should exist, however, this has not been found (Aboud & Doyle, 1996; Branch & Newcombe, 1986). Also, if stigmatising attitudes are acquired incrementally younger children should display lower scores on measures of prejudice and discrimination. However, the opposite is sometimes evident; at about 7 years of age there is a notable decline in self-reported stigma towards out-groups (e.g. Aboud & Skerry, 1984; Asher & Allen, 1969; Augustinos & Rosewarne, 2001; Black-Gutman & Hickson, 1996).

From a domain general cognitive perspective the developmental decline in explicit negative attitudes is attributed to children’s emerging cognitive capacity to simultaneously weigh multiple classifications (Aboud, 2008; Bigler & Liben, 2006). This approach can be traced to some aspects of Piaget’s (1985) classic theories of cognitive development.
According to Aboud (2003) negative correlations exist between 4 to 7-year-olds classification skills and their scores on an explicit racial attitude measure. Research by Bigler & Liben (1992), in which they taught 5 to 10-year-olds classification skills, found that classification skills could decrease stereotyping. They also found that classification skills facilitated processing and recall of counter stereotypic information even when children held stereotypic attitudes. A possible explanation for these findings is that children with more sophisticated classification skills may simultaneously attribute both positive and negative attributes to the same child. These children understand that multiple categories can be assigned to the same person and so focus less on a single category, thereby decreasing out-group negativity. To date, no research has explored the relationship between classification skills and mental disorder stereotypes in childhood. However, it is reasonable to argue that enhancing children’s multiple classification skills may reduce mental disorder stigma. Theoretically, with more sophisticated classification skills children would not just perceive a target individual in light of their disorder (she’s depressed) but also in light of their other attributes (she has depression, is a sister and a student). However, although stereotypes are undoubtedly important in determining stigma towards peers with mental health problems they are not likely to be the sole factor. For example, as noted earlier (see section 3.2), there are frequently unexplained dissociations between stereotypes, prejudice, and discriminatory behaviour. Furthermore, developmentally, it is undisputable that across the lifespan children and adolescents become more competent classifiers, and yet stereotyping continues to prevail in adulthood (Nesdale, 2004; Rutland, 2004), thus classification skills are not the primary determinant of stereotypes. Specifically, mental health disorder stigma research suggests that the relationship between age and stereotypes is complex; with some stigmatising attitudes decreasing with age while others remaining stable or assume a more distasteful flavour (e.g. Jorm & Wright, 2008; see Chapter 4 section 4.2.2.1). Furthermore, the developmental
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decline in stigma, that domain general theory attempts to account for, can largely be explained by children’s emerging social awareness and perceived importance of social desirability rules (Katz, Sohn, & Zalk, 1975). Thus, it is more likely that classification skills are but one of the many factors involved in the development of stigma and instead attention must be heeded to the empirical value of social experience or context in determining stigma (McGlothlin & Killen, 2005; 2006).

Domain specific approaches, such as Turiel’s (1983, 1998) Social Domain Theory (SDT), are founded on Piaget’s (1932) claims that children’s reasoning and judgments about fairness and equality play an essential role in shaping peer social interactions. While the aim of the aforementioned theories was to account for the development of stereotypes and prejudice, when applied to intergroup relations, SDT specifically explores social reasoning about exclusion; the behavioural component of stigma. This theory draws on the development of moral, social conventional, and psychological reasoning domains about the social world to explain why exclusion occurs. Developmentally, research indicates that younger children tend to perceive peer exclusion as immoral but with age they draw on social conventional and psychological reasons to justify exclusion (Smetana, 1995; Killen, 1991; Killen & Stangor, 2001). SDT has provided valuable insight into the complexity of peer exclusion, indicating that exclusion is not uniformly evaluated as immoral but is often a legitimate form of social regulation (Killen, Kelly, Richardson, Crystal, & Ruck, 2010; McGlothlin & Killen, 2006), especially if inclusion of the target peer would violate expected group norms or cohesion (see Chapter 11 section 11.2 for a detailed discussion of the literature). Ultimately, research indicates that exclusion occurs depending on the relative importance of each or multiple domains in a given context. The main contribution of SDT to understanding stigma is that it provides an insight into the type of reasoning children and adolescents use when evaluating, interpreting, and making decisions about excluding peers.
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Developmental psychologists also draw on Social Identity Theory (SIT; Tajfel & Turner, 1979) to understand how group identity might influence racial and gender stigma, however, again this theory has yet to be applied to the domain of mental disorders. SIT argues that group membership is an essential part of one’s self-concept and contends that individual group members seek to uphold their ingroup identity by perceiving their own social group as more positive than other social outgroups. Motivated to maintain positive perceptions of one’s ingroup, prejudice and stereotypes are projected towards outgroup members (Tajfel & Turner, 1979). While SIT is not explicitly a developmental theory, it suggests that as a child’s social identity becomes more indoctrinated with age, bias towards outgroups is likely to increase. Drawing on SIT, Nesdale (2004) developed the Social Identity Developmental Theory (SIDT), while this theory claims that social identity and context determine outgroup stigma, it also advocates a distinction between stigma towards an outgroup and mere bias towards one’s ingroup. In contrast to cognitive developmental theories, this approach claims that between 4 and 5 years of age children display preference towards their racial ingroup, however, stigma is likely to develop later (between 6 and 7 years), when children identify with their social group. Thus, as children’s identification with their social group intensifies so too does their tendency to endore prejudice, stereotypes, and discriminatory actions. Support for this theory demonstrates positive relationships between in-group identification and intergroup bias (Bennett et al., 2004; Pfeifer et al., 2007; Verkuyten, 2001). While social identity driven theories claim that negative attitudes and discrimination towards an outgroup are dependent upon how much a child identifies with his or her in-group, identification alone is not likely to entirely explain stigma; instead this theory also recognises the important role of other factors, such as the norms endorsed by the group (Nesdale & Dalton, 2011; Nesdale & Flessser, 2001; Nesdale, Maass, Durkin, & Griffiths, 2005a), level of threat perceived by the ingroup from members of the outgroup (Nesdale,
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Durkin, Maass, & Griffiths, 2005b), and the target outgroup in question (Bennett et al., 2004). In conclusion, SIDT has provided valuable information on the group processes involved in outgroup stigma.

Developmental Subjective Group Dynamics (Abrams, Rutland, Cameron, & Marques, 2003) is an extension of SIT, and the developmental stream of Subjective Group Dynamics Theory (SGD; Marques, Abrams, Pàez, & Hogg, 2001), which focuses on group identity and the relationship between judgments about ingroups and outgroups. In line with SIT, this theory claims that people display ingroup preferences, however, it also expands on this stating that in an attempt to uphold the distinctiveness of one’s ingroup, members monitor the behaviour of other ingroup members to ensure that they adhere to the expectations of the group. Thus, the importance of group functioning is imperative in this theory. Specifically, research on this theory explores children’s reasoning about ingroup and outgroup members who either engage in normative or deviant behaviour. Such research tends to indicate that young people prefer ingroup and outgroup members who conform to the norm of their group compared to deviant ingroup and outgroup members (Abrams et al., 2003; Abrams, Rutland, Ferrell, & Pelletier, 2008). Given the cognitive complexity involved in evaluating individual ingroup and outgroup members in light of group norms, values, and identity, young people’s ability to do this increase with age (Abrams et al., 2003). Ultimately, research from this perspective suggests that many competing group processes underpin stigma, thus highlighting the sheer complexity of peer relationships.

Together, social domain and social identity theories demonstrate the importance of group identity, moral, social conventional and psychological reasoning in determining stigma. Although the two clusters of theories provide different approaches for studying stigma, a move is currently in motion to integrate the two approaches to bring about a comprehensive understanding of social cognitive development. The Social Reasoning
Developmental perspective (SRD; Rutland, Killen, & Abrams, 2010) argues that whether a peer is excluded or not hinges on the intimate interplay between moral reasoning, beliefs about group functioning, and the desire to integrate fully into a social group. When deciding whether to exclude a peer, for example, children evaluate their concerns about identity against their emerging moral principles (Killen, Rutland, & Jampol, 2008). Research to support this indicates that while moral and social identity evaluations are independent constructs, children employ both when making judgments about peer exclusion (Abrams et al., 2008). Further support for SRD was provided in recent research that indicated that inclusion decisions were dependent upon whether one’s group endorses moral or social conventional norms (Killen, Rutland, Abrams, Mulvey, & Hitti, in press). This research also found that compared to membership traits, such as gender, group norms were more important in determining group identity. In addition, this theory acknowledges that whether stigma occurs also depends on whether or not young people have contact with outgroup members, the context of the stigmatisation, perceived threat of the target individuals, and social norms.

Another contemporary theory that attempts to explain children’s social stereotyping and prejudice is Developmental Intergroup Theory (DIT; Bigler & Liben, 2006). DIT is grounded in social identity (Tajfel & Turner, 1979), self-categorisation theories (Turner, Hogg, Oakes, Reicher, & Wetherell, 1987), and cognitive developmental theory drawing on the work of Piagetian and contemporary approaches to cognitive development (e.g. domain general approaches). This theory argues that stereotypes and prejudice development are driven by children’s sensitivity to note perceptually salient aspects of people, such as gender, age, and race, compared to other perceptually indistinct features, such as nationalities or religious beliefs. This tendency ensures that stereotyping is largely formed on the basis of psychologically salient traits. The theory also claims that proportional group size influences the psychological salience of social groups, in that minority groups are more distinct than
majority groups. Given the distinctiveness of minorities within the social environment they are more likely to be subjected to stereotypes and prejudice (Brown & Bigler, 2002). Research to support this theory indicates that distinctions between groups become more salient through labelling, which is usually initiated by adults (Patterson & Bigler, 2006). In addition, this theory advocates that implicit mechanisms within the environment increase the salience of social groups. For example, children observe similarities among people who work, live, and socialise together and subsequently deduce that the grouping of these individuals stems from important differences between them (Bigler, Brown, & Markell, 2001). While categorisation is contingent upon the psychological salience of the target group, the categorisation process is also influenced by classification skills of the individual child and his/her past environmental experience or exposure to the target group. Categorisation of differences between people attaches meaning to social groups, which in turn facilitates the development and maintenance of stereotypes and prejudice. In explaining the meaning attached to social groups, the theory proposes that children draw on both internal and external processes. Internal processes involve self-generation of relationships between attributes and affect and social groups. In doing so, children tend to engage in essentialist thinking, believing that members of their in group are united by less salient, but important characteristics, and believe their ingroup is superior. So ultimately, children construct associations between groups and attributes that support favouritism of their own in group (Bigler, Jones, & Lobliner, 1997). External processes involve exposure and/or imitation of explicit stereotyped physical or verbal behaviour in their environment. For example, a child may hear an adult say “people with mental illness are dangerous” (verbal behaviour) or observe their parent cross the street when approaching a man who is talking to himself (non-verbal behaviour). Ultimately, DIT strives to explain the processes involved in the
development of stigma and explains why some aspects of human variation become the foundations of stigma and not others.

3.4.5 The Applicability of Gender & Racial Stigma Theories to the Domain of Mental Health Disorders: Conceptual & Structural Differences

It is possible that the above theories proposed for the development of general stigma can be offered to explain mental disorder stigma. The fundamental principles of these theories suggest that children are programmed to organise their social world into categories through classification of similarities and differences among people, and subsequently identify with a particular group, ensuring preference for that ingroup. However, as highlighted above, these theories have yet to be applied to the stigma of mental disorders. There are many structural differences that differentiate mental disorder stigma from gender or race stigma, that need to be considered. Specifically, unlike race or gender, mental health disorders incorporate subtle, and sometimes hidden, cues denoting their existence. Mental health disorders cannot be inferred by skin colour, gender, accent, or age. Instead, research within the adult literature suggests that the public detect mental illness with social cues, such as psychiatric symptoms, social skill deficits, physical appearance, and labels (Corrigan, 2000; Penn & Martin, 1998). Some argue that mental disorders are the most difficult disabilities for children and adolescents to recognise (Conant & Budoff, 1983). For example, research indicates that adolescents have difficulty labelling and accurately recognising symptoms of depression in their peers (Burns & Rapee, 2006). In addition, young people often display difficulty comprehending what it means to be mentally healthy (Armstrong, Hill, & Secker, 2000).

Another argument for why the development of mental disorder stigma is different from other stigma is that unlike other stigmatised conditions mental disorders are less likely
to incorporate any positive attributes. Research by Corrigan and Garman (1997), that compared positive and negative group-related beliefs and experiences of African Americans with those of people with mental disorders, demonstrated that participants were able to attribute both positive and negative beliefs and experiences to African Americans but could only attribute negative beliefs and experiences to people with mental disorders. Thus, it is possible that while a developmental increase in positive attributions towards racial and gender outgroups are exhibited by children with age, a similar pattern might not be evident towards disordered peers or labels of mental disorders. Instead, when evaluating mental illness, it is likely that children will report fewer negative attributes to people with mental illness but may not show comparable increases in positive attributes. Furthermore, the absence of positive attributes might explain why children and adolescents with disorders face persistent peer rejection.

Given that inferring deviance involves acute cognitive skills, such as the ability to interpret emotions, extract valence information from behaviour, as well as sophisticated categorisation and classification skills; some argue that children may not be able to distinguish a peer with a mental disorder from the ingroup, as young as they can with ethnic or gender outgroups (Corrigan & Watson, 2007). In their theoretical commentary, Corrigan and colleagues suggest that 5-year-olds are less likely to endorse stigmatised attitudes towards people with mental disorders compared to people of different ethnic background, as they may be less attuned to the subtle cues that denoted a mental disorder. Research to support this can be seen in the work of Spitzer and Cameron (1995) that indicated that 6 and 7-year-olds experienced difficulty recognising deviant behaviour in their peers. Specifically, the authors concluded that children rejected that mental disorders can exist in childhood by normalising the target peers’ deviant behaviour. Other research has found similar results with children aged 9 to 12 years of age (Hoffman, Marsden, & Katler, 1977). However, these
findings are likely to be explained by the fact that the target behaviours were not characteristic of disorders found in childhood and the small sample sizes employed. Instead, there is a notable body of empirically strong research that suggests that children and adolescents are active perceivers and interpreters of their peers’ behaviour, thus they may recognise atypical or unusual patterns of behaviour, as opposed to mental disorders per se (see below, e.g. Younger & Boyko, 1987; Younger & Piccinin, 1989; Younger, Schneider, & Daniels, 1991; Younger, Schwartzman, & Ledingham, 1985, 1986). Thus, while young people may not be able to accurately label or fully explain psychiatric conditions, or recognise adult disorders, the symptomatic behaviour exhibited by peers with disorders is evaluated as unusual and used to denote differences.

Early research suggests that while children perceive externalising behaviour as deviant, social withdrawal is not recognised as maladaptive until late childhood or pre-adolescence (Coie & Pennington, 1976; Ledingham & Younger, 1985; Younger, et al., 1985, 1986). Younger and colleagues hypothesised that these findings were due to age related differences in children’s cognitive ability to process information or social schemas pertaining to externalising versus internalising behaviour. In a series of studies they comprehensively assessed how 6 to 13-year-olds perceived hypothetical peers, who engaged in socially withdrawn or externalising behaviour (aggression), using free-recall and recognition-memory tasks (Younger & Boyko, 1987; Younger & Piccinin, 1989). The findings indicated that older children (from 10 years of age) were better able to recall internalising behaviour exhibited by hypothetical peers compared to younger participants, but no age differences emerged in the recall of externalising behaviour. These findings suggested that social schemas pertaining to the acceptability of externalising behaviour develops earlier than social withdrawn schemas. The authors concluded that aggression was a well-defined social category in both younger and older children’s peer groups, while the category of social withdrawal only becomes
established with age. In addition, Younger and Piccinin (1989) found a developmental trend in the likability of these target peers; younger children evaluated the withdrawn peer more positively than older children, while no differences emerged in evaluations of the externalising peer. Thus, peers with externalising conditions are likely to be perceived by all children as deviant, while perceptions of deviance of peers with internalising disorders become psychologically salient in late childhood. Further research indicates that children as young as 7 and 9 years discriminate between typically developing peers and peers with disorders, subsequently perceiving the latter as being significantly different to them (e.g. Coie & Pennington, 1976; Novak, 1974; Harnum, Duffy, & Ferguson, 2007). This body of research indicates that children and adolescents use behavioural and emotional cues to identify deviant peers.

The ability of young people to recognise mental disorders in their peers also hinges on the behavioural norms endorsed by their peer group. Sociometric research has shown that aggressive children are rated as popular in playgrounds or social contexts in which aggressive behaviour is prevalent (Wright, Gimmaro, & Parad, 1986; Bovin, Dodge, & Coie, 1995; Stormshak et al., 1999). These findings imply that the behavioural norms of particular groups influence perceptions of the acceptability of target behaviours. Adopting this perspective, Chang (2004) specifically investigated the role of norms in the acceptance of peers. Conceptualising the class as a group, Chang found that class norms about aggression and withdrawn behaviour influenced acceptance of peers who displayed these peers. In groups where the norm of aggression or withdrawn behaviour existed, children who exhibited such behaviours were accepted, whereas they were rejected when these behavioural norms were not strongly endorsed. Thus, while young people have the ability to recognise deviant behaviours in their peers, group processes, such as behavioural norms have a significant
impact on the meaning and interpretation of deviant behaviour and produce different outcomes.

Along with age, gender, ethnicity, and group identity factors, these findings highlight that social skills are a core category upon which the peer group is organised. The large body of research that indicates that children with mental disorders are frequently categorised as rejected further supports this claim (see Chapter 2 section 2.3.1). In light of the above findings and sociometric research discussed in Chapter 2, it is reasonable to hypothesise that young children form crude judgements of the behaviour of others and reject those who consistently display salient deviant behaviour. Over time, children become more differentiated in their judgements of their peers’ behaviour, and thus their ability to detect other forms of unusual behaviour becomes more acute (Chassin & Coughlin, 1983; Poster, 1992; Younger et al., 1986, 1985). From a theoretical perspective, one can draw on the importance of social categorisation; as advocated by social identity based theories, children compare the behaviour of peers with disorders with the actions of non-disordered peers. In doing so, the deviant behaviour exhibited by peers with mental health problems becomes psychologically salient within the peer group, and subsequently a rationale for stigma is constructed. In addition, as DIT outlines, the identification of peers with disorders may also be facilitated by children’s tendency to reflect on how influential others such as parents, siblings, teachers, and media sources respond to, label or portray people with mental illness. It is likely that the stigmatising responses of influential others reinforces the “us versus them” mentality that young people already project towards peers with disorders.

The role of group identity among children and adolescents with mental health disorders has not yet been researched, which may be a reflection of uncertainty about applying a group status to these individuals. While research frequently refers to adults and children with mental disorders as social outgroups, Corrigan and Watson (2007) argue, that
children or adults with mental illness do not constitute a group within society, in the same way as race or gender groups. As a crude race example, Black children view White people as the outgroup and other Black people as the ingroup. For racial groups, a unique sense of culture, shared ethnic history and commonality are at the core of determining groupness. As of yet, these principles do not explain groupness for people with mental disorder, or if they do, research has not explored this sense of identity. From a sociometric perspective, by deviating from normative emotional and behavioural expectations, children and adolescents become members of an outgroup of socially rejected children within the classroom (see Chapter 2 section 2.3.1 for research on the experience of children and adolescents with ADHD and depression within the peer group). Research from this perspective also suggests that the rejected status of peers with ADHD is more established compared to that of peers with depression (see Chapter 2 section 2.3.1), which may be due to the enduring nature of ADHD condition across childhood. In comparison, the nature of depression is often transient, which may permit movement from being rejected to accepted, and vice-versa. Thus, it could be possible that group status of individuals with disorders differs across the mental disorder in question. However, the concept of group used in sociometric research is different to that adopted in social identity theory driven approaches (Killen & Rutland, 2010), as membership of this rejected group within the classroom environment is not homogenous, and a sense of group identity is unlikely; thus the classroom does not form an ingroup or an outgroup for these individuals. Thus, in order to apply a social identity approach to the domain of mental health, research needs to explore whether groupness and identity exist between peers with mental health disorders in childhood and adolescence, to determine whether such individuals constitute social identity theories’ conceptualisation of a group.

While much on the group status of children and adolescence is unexplored, a DSGD intragroup approach may be useful for accounting for the stigmatisation of ingroup peers who
develop a mental health condition. If having a mental disorder deviates from the behavioural norms within a particular group and we prefer people who conform to ‘normative behaviour’, regardless of the group they belong to, DSGD may explain why research indicates that children and adults with mental disorders tend to be more stigmatised than any other minority groups or individuals (e.g. Albrecht, Walker, & Levy, 1982; Martin, Pescosolido, Olafsdottir, & Mcleod, 2007; Walker, et al., 2008). In particular, this theory may explain why many people become ostracised from their family, friends, and society following the onset of a mental health condition (Social Exclusion Unit, 2004).

Given the uniqueness of peers with mental disorders as a ‘group’ and insufficient knowledge on how peers with disorders threaten the identity of accepted children and adolescents, research is needed before social identity theories can be applied to explain mental disorder stigma. However, when one postulates that generally, children and adolescents with mental health disorders violate behavioural and emotional norms, social identity perspectives provide a framework for exploring why people who develop a mental health condition are discriminated against in the form of rejection or exclusion. Given the vast research that needs to be conducted to further our understanding of stigma towards peers with disorders, adopting a SDT approach to exclusion is a valid first step. We know that children and adolescents rationalise about their social world by reflecting on moral, psychological, and social conventional domains. We also know that exploring children and adolescents’ reasoning about exclusion of peers provides a valuable insight into when and why exclusion occurs (see Chapter 10 section 10.2 for a more comprehensive review). Study Two aims to explore social reasoning about exclusion, in doing so it is anticipated that it will provide foundational knowledge on these matters and open conduits for the development of further research to test the utility of the discussed theories. However, while the theories for the development of stigma towards racial and gender outgroups have much to
Chapter 3: Stigma Theory

offer in explaining the development of stigma towards peers with mental health disorders, they may not be able to wholly account for this type of stigma.

3.5 Why do Researchers not Study Stigma towards Peers with Mental Health Disorders in Childhood & Adolescence: Some Possible Explanations

As stressed above there is a disproportionate focus on stigma towards gender and racial outgroups compared to youth with mental health disorders in the empirical literature. Firstly, it is essential to acknowledge that developmental researchers recognise the difficulties children with emotional and behavioural problems experience within the peer group. A solid history of sociometric research profiling the behaviour of rejected children consistently highlights that children and adolescents with mental health disorders are excluded by their peers and warns against the negative life outcomes associated with exclusion (see Chapter 2 section 2.3 & 2.3.1). However, this research tradition situates peer problems within the child and mostly focuses on enhancing acceptance through clinical interventions that enhance social skills. Without undermining the value of this research, this interpersonal approach broadly assumes that behaviours exhibited by these children and adolescents invite exclusion. While one can argue that this is largely true, much can be learned from exploring stigma from the perspective of the perceiver. However, while researchers do acknowledge that negative peer experiences are a reality of the lives of young people with mental health disorders, little effort has been made to further understanding and subsequently help ameliorate mental disorder stigma. Thus it appears that mental health stigma in childhood and adolescence is not high on developmental scientists’ research agenda. Possible reasons for this might tap into methodological challenges associated with mental health stigma research, the lack of developmental theories on mental health stigma, or the historical underpinnings driving superior interest in gender and racial stigma.
While gender and racial differences can be presented to children in pictorial format, mental health disorders rely on descriptive information, either delivered through a story vignette or video documentary. The information describing a mental health condition also needs to be clinically valid and reliable, thus mental health disorders are more difficult to depict than more physically salient categories (see Chapter 5 section 5.8 for a discussion pertaining to this in relation to vignettes and implicit measures). As racial and gender stigma have been researched in-depth, clear research pathways have been formed for other researchers to expand and develop the existing literature. However, the vast research possibilities pertaining to mental health stigma may overwhelm interested researchers.

It could be suggested that much of social cognitive research agenda is shaped by historical social injustices and associated protest movements, such as the suffragette movement (circa 1906-1971) and Luther King’s civil rights’s movement (1957-1968), that both strived to ensure social change. Historically, movements for people with mental health problems have not had the same impact and thus are not as salient in memory. This is likely to ensure that the social injustices suffered by people with mental disorders are not prioritised on individual, political and research agenda to the same extent as racial and gender inequality.

That said however, change from a political level, at least, is occurring. Since the US Attorney General report (1999) that highlighted that reducing stigma is essential to improve access to mental health care, and the lives of people with disorders, stigma has emerged as an important public health issue on policy and political agendas in many western countries. Over the past decade campaigns, such as Time to Change in the UK, See me in Scotland, Like Minds, Like Mine in New Zealand and Opening Minds in Canada and have all strived to reduce stigma by busting myths and increasing accurate knowledge about mental disorders. Noteworthy, Ireland and Australia are the only English speaking countries within the
Organisation for Economic Co-operation and Development (OECD) without formal anti-stigma social inclusion campaigns (Queensland Alliance, 2010). Without undermining the value of these public campaigns there is a notable disproportionate focus on campaigns to tackle stigma among adults and not children. As reiterated throughout this thesis, a grass-root understanding of the development of stigma in childhood and adolescence, and targeting stigma at an early age is likely to be a more fruitful approach to tackling the problem.

3.6 Why is it Important to Study Stigma towards Peers with Mental Health Disorders in Childhood & Adolescence?

Stereotypes, prejudice, and acts of discrimination do not merely appear in adult social cognitive and behavioural repertoire but instead are evident early in development. Investigating stigma in childhood and adolescence will not just inform the discipline itself but contribute to knowledge of adult social cognitive theories. Social cognition has been researched in-depth in adult populations; however, it cannot be assumed that children engage in the same cognitive processes as adults. The work of Piaget was imperative in highlighting that children reason in unique ways to that of adults, and subsequently, can have a different understanding of their social world. Thus, knowing that differences exist in how adults and children perceive, and cognitively navigate the world, researchers cannot use the evidence on the acquisition of social cognition in adults (Fazio, Esier, & Shook, 2004; Gregg, et al., 2006) as a model for the ways in which it develops in childhood. It is also likely that the essence of stereotypes and prejudices are acquired in childhood and, therefore, may be a result of cognitive mechanisms that are only available in the early years of development. Research in this area has the unique potential to constrain or expand theories of adult end-state cognition that have yet to be explored in social cognitive research.
Furthermore, the differences between child and adult mental disorders are also likely to ensure that findings specific to adult mental health stigma are not wholly applicable to children and adolescents. For example, the most prevalent mental health problems in childhood and adolescence are ADHD, conduct disorder and affective disorders, such as anxiety and depression (Meltzer, et al., 2003), while schizophrenia, affective disorders, personality and phobic disorders, addictions and eating disorders are more prevalent in adulthood (Bijl, Ravelli, & vanZessen, 1998). In addition, the prevalence of childhood disorders also varies greatly across age and gender. For example, Meltzer and colleagues found that, in general, mental health problems were more prevalent in adolescence and boys, and that externalising problems were more common among boys. Also, stereotypes attached to the respective child and adult disorders may differ. For example, while perceptions of dangerousness and incompetence are frequently cited as stereotypes of adults with serious mental illness (Phelan, Link, Stueve, & Pescosolido, 2000), it is possible that these cognitions are less applicable to childhood disorders. Likewise, the means by which adults discriminate against peers with mental health problems and the environment in which this discrimination takes place is distinct from the ways in which children discriminate against peers with disorders, and the places in which this occurs. Children discriminate through exclusion and rejection in school and social settings (Brown & Bigler, 2005), while adults also discriminate against people with mental health problems by excluding them, they also prevent them from obtaining promotions and employment in the workplace or adequate housing by refusing to rent property to them (Corrigan, Roe, & Tsang, 2011). In general, research indicates that adults hold unfavourable attitudes towards children with ADHD or depression (Martin, Pescosolido, Olafsdottir, Mcleod, 2007; Mukolo & Heflinger, 2011; Perry, Pescosolido, Martin, Mcleod, & Jensen, 2007; Pescosolido, Fettes, Martin, Monahan, & Mcleod, 2007; Pescosolido, Perry, Martin, Mcleod, & Jensen, 2007). However, one cannot
assume that adults’ perceptions of children with mental health problems can be generalised to those of young people. Despite this, in a review by Link, Yang, Phelan, & Collins (2004), they noted that only 4 (3.7%) of the 109 empirical studies that met the criteria for inclusion used a child or adolescent sample. While the amount of studies exploring stigma in childhood has increased since 2004, a disparate focus on adult versus child research prevails.

As outlined in the previous chapter, the prevalence of mental health problems in childhood and adolescence ensures that mental disorders exist in nearly every classroom. In addition, research indicates that young people with mental health problems are frequently rejected by their peers (Hay et al., 2004; Hodgens, et al., 2000). Rejection from the peer group can put individuals at risk of greater adverse developmental outcomes over and beyond that incurred by their disorder (see Deater-Deckard, 2001). Conversely, research indicates that acceptance by the peer group can improve deficits associated with mental health problems (Sasso, Mundschenk, Melloy, & Casey, 1998). Furthermore, research indicates that when compared to other disabilities mental disorders are perceived as less acceptable by children and adolescents (Adler & Wahl, 1998; Parish, Ohlsen, & Parish, 1978, Royal & Roberts, 1987). Thus, it is imperative to investigate the nature of the stigma experienced by young people with mental health problems.

3.7 Summary & Conclusion

Stigma is a multi-dimensional construct consisting of complex explicit and implicit negative emotional, cognitive, and behavioural aspects, which are frequently not simultaneously explored in the mental disorder stigma literature. This ensures that a fractured empirical understanding of how stereotypes, prejudice, discrimination, and implicit attitudes operate in relation to mental illness remains. In addition, while theory exists to explain why some cognitions can induce stigma towards peers with mental disorders in childhood and
adolescence (e.g. attribution theory and psychological essentialism), no theories have been applied to explain this stigma from a developmental point of view. Much can be potentially learned about the development of mental disorder stigma by reflecting on the available theories that explain racial and gender stigma and adapting them to the domain of childhood mental disorders. Despite the fact that mental disorder stigma in childhood and adolescence is not a burning priority on the developmental research agenda, the potential for researchers to improve the lives of young people with disorders warrants research on this topic.
Chapter 4: Empirical Evidence for Stigma towards Peers with Mental Health Disorders in Childhood & Adolescence

4.1 Aim of Chapter

The aim of this chapter is to provide a critical reflection on the existing research on explicit stigma and implicit attitudes towards mental disorders in childhood and adolescence. Specifically, research on stigma towards psychiatric labels, adults or peers labelled as having a mental disorder, and adults or peers described with symptoms of a mental illness will be explored. A review of socio-demographic, contextual, and other factors that affect the nature and extent of stigmatising responses will also be presented. In addition, a review of implicit attitudes towards mental disorder from the adult literature will be provided. Finally, an overview of the limitations of the existing research will be presented.

4.2 Research on Stigma towards Peers with Mental Health Disorders in Childhood & Adolescence

Research on mental disorder stigma in childhood and adolescence suggests that comparable with the adult literature, perceptions of peers with mental health problems are mostly negative (Adler & Wahl, 1998; Weiss, 1986, 1994). Qualitative insights into affected young people’s peer experiences indicate that most report stigmatising experiences in relationships with peers (Moses, 2010). Research shows that they frequently go to great lengths to protect their privacy or uphold secrecy about their condition to avoid teasing and taunting (Kranke, Floersch, Kranke, & Munson, 2011). The authors note that while such efforts may protect against teasing it may also perpetuate isolation. In addition, Karp (2006) noted that acceptance from peers is adolescents’ greatest concern when talking about their medication and concluded that “the respect and acceptance of their peers becomes their most important obsession” (p.178). Furthermore, adolescents also report that the shame they attach to their
mental health condition prevents them from engaging socially with peers (Kranke, Floersch, Townsend, & Munson, 2010). While the internalisation of peer stigma among children and adolescents with disorders (self-stigma) is an important issue for consideration the focus of this body of research is on public stigma.

Generally, research on mental disorder stigma explores perceptions of generic terms of mental health disorders, such as ‘mental illness’, or people labelled as mentally ill, or as having a specific diagnostic condition, such as schizophrenia or depression. Research also often investigates perceptions of individuals who are described with symptoms of a mental health problem, but no diagnostic labels are used. Occasionally, combinations of these approaches are used. The variability in approaches ensures it is difficult to derive concrete conclusions about stigma in childhood and adolescence. In an attempt to present a coherent overview of the empirical literature, the findings are divided into distinct sections as per the overriding themes. Research that contributes to our knowledge about whether the use of psychiatric or slang terms of mental illness exacerbate stigmatising responses will be presented first. Following on from this, a thematic presentation of the factors found to influence the nature of stigma will be presented.

4.2.1 Research using Diagnostic Labels & General Terms of Mental Illness & Disorders

Research tends to indicate that young people respond negatively to terms used to describe mental disorders. For example, Spitzer and Cameron (1995) noted that 7 to 9-year-olds attributed negative qualities to behaviours that were labelled as mental illness. Furthermore, research by Wilkins & Velicer (1980) revealed that children associated more negative qualities to the label ‘crazy’, compared to ‘crippled’ and ‘retard’. Respondents also rated the crazy person as less understandable and more unpredictable. Weiss (1986) assessed 5 to 14-year-olds desired social distance from the following: convict, mentally retarded person,
normal person, and mentally ill, crazy person, physically handicapped, and emotionally disturbed. The results indicated that children wanted more social distance from the person labelled ‘crazy’ and ‘convict’ than any other target. Specifically this research suggested that slang terms of mental disorders are more stigma provoking than politically correct terms. Together these studies suggest that stigmatising effects of the general term mental illness and slang labels are potent in middle childhood.

Experimental research has explored whether assigning a psychiatric label to a peer induces stigmatising responses. This research is driven by labelling theory (Scheff, 1966, Link, Cullen, Struening, Shrut, & Dohrenwend, 1989), that claims mental illness labels alone are powerful enough to induce stigma. Gilmore and Farina (1989) had 5th and 8th-grade (10-11 years and 13-14 years, respectively) boys interact with a peer who was described as an ‘ordinary child’, an ‘emotionally disturbed child’ or a ‘mentally retarded child’. The stigmatising effects of labels were such that participants exhibited greater social distance from the labelled peers, were less friendly, and more anxious towards them compared to the ordinary child. Similarly, in an interaction study, where elementary school children interacted with children who were labelled as having a ‘behaviour problem’, (ADHD) or no label (no diagnosis), labels negatively influenced participants’ responses to the peer (Harris, Milich, Corbitt, Hoover, & Brady, 1992). While both studies captured incidents of actual stigmatising behaviour towards real, and not hypothetical peers, the findings are limited by the fact that the samples were exclusively male. However, Law, Sinclair, and Fraser (2007) noted that the addition of a diagnostic label to a vignette describing a peer with ADHD did not influence attitudes or behavioural intentions towards the hypothetical peer. Instead, the study indicated that regardless of whether the label was included or not participants had negative attitudes and behavioural intentions towards the described peer. One possible explanation is, that when combined with a vignette, a psychiatric label does not induce more negative responses. In
Gilmore and Farina and Harris and colleagues’ studies, labels were used but the target peer did not engage in associated symptomatic behaviour. Thus, it is possible that in the absence of symptoms, labels are sufficient triggers to influence attitudes and behaviour. However, when behavioural descriptions are provided, children’s interpretation of the target behaviour is potent enough to influence responses, regardless of the label. One could therefore argue that interventions should not only target perceptions of psychiatric labels, but also perceptions of symptomatic behaviours. The findings also suggest that targeting the latter is probably very important for children who have direct contact with peers with disorders.

Furthermore, recent research by Wright, Jorm, and Mackinnon (2011) indicated the stigmatising effect of labels is contingent upon the type of mental health condition that is being described and whether specific diagnostic labels, or general terms, are used. Their findings suggested that using correct psychiatric labels were associated with perceptions that adolescent peers with depression, psychosis, and social phobia were “sick” rather than “weak”. However, the labels “schizophrenia/psychosis”, “mental illness”, and “psychological problem” were associated with perceptions that the peer with psychosis was “dangerous/unpredictable”, with the accurate term “schizophrenia/psychosis” producing the strongest effects. The authors concluded that using psychiatric labels with adolescents may inhibit some stigmatising responses, but stressed the persistent importance of addressing stereotypes associated with severe mental disorders.

The issue of whether the labelling of mental health problems is gravely stigmatising remains to be explored in-depth, however, when using diagnostic terms and labels with children one has to be mindful that they might not understand their meaning. Comprehension and knowledge of diagnostic labels is a possible confound in labelling research that has not been controlled for in the aforementioned research. However, research by Alder and Wahl (1998) explored the influence of knowledge of mental disorders and labels on stigmatising
responses. They noted that 8 to 9-year-olds displayed more negative attitudes and behaviours to characters that were labelled as mentally ill compared to physically disabled or regular grown up characters. In addition, they found that although children were not able to articulate concrete trait differences between the target characters, they attributed more negative characteristics to the character with a mental health problem. Thus, their study suggested that the term mental illness was more likely to illicit negative perceptions, regardless of knowledge or understanding of the term.

4.2.2 Factors that Influence Mental Disorder Stigma:

4.2.2.1 Age

While age is thought to be an important factor in determining stigmatising responses, research pertaining to the effect of age shows variable findings. Inconsistent findings can be attributed to differences in research design and methodologies employed. In an attempt to tease out the pattern of findings, the literature exploring age differences pertaining to general terms of mental disorders and psychiatric labels will be explored first, followed by research on the age differences associated with perceptions of peers who are not labelled, but described as having a mental disorder.

Research by Weiss (1985) found a developmental decrease in beliefs that people with mental illness are inferior and a threat to society, among 8, 10, 12 and 14-year-olds. Specifically, Weiss noted that a greater decrease in stigmatising attitudes between 8 and 10-year-olds, while positive changes between 12 and 14 years were more inconsistent. In subsequent research with 5 to 14-year-olds, using a projective measure of social distance towards deviant groups, Weiss (1986) noted that the label ‘crazy’ replaced convict as the least acceptable category with increasing age. Follow up data, 8-years post, revealed remarkably similar findings, leading Weiss (1994) to conclude that responses towards people with mental illness solidify in early adolescence. Together this body of work demonstrates
that attitudes and behaviour can show disparate developmental patterns, however, tentative comparisons can only be made, as the target objects were semantically different (mental illness versus crazy). While Weiss’ studies are the first empirical work to document developmental changes in perceptions of mental illness, the ecological validity of his (1986) study is questionable given that the term mental illness is not likely to be socially meaningful in mid-childhood. In addition, the generic descriptions of crazy and mental illness used in these studies do not control for whether participants attributed the description to their peers or adults. While his social distance studies are the only longitudinal studies to explore developmental changes in stigmatising responses, the findings were derived from one single item measure of social distance. Furthermore, the study did not assess the contexts in which young people would like social distance from the target, which is likely to have been an important factor in determining their responses. As research has adopted more sophisticated designs, methods, and conceptualisations of stigma, recent findings suggest that developmental changes in stigmatising response are not straightforward.

Vignette-based research indicates that age differences tend to be contingent upon the type of disorder in question. For example, Whalen, Henker, Dotemoto, and Hinshaw (1983) observed an increase in acceptance of anti-social male peers, but not boys with intellectual disability or boys who were described as being hyperactive among 10 to 15-year-olds. More recently, research suggests that when the gender and disorder of the target peer are taken into account, the relationship between age and acceptance is more complex. Swords et al. (2011a) showed that while acceptance towards peers described as having ADHD or depression increased across 5 to 18-year-olds, there was an exception to this trend towards boys with depression. Instead, older participants had less favourable attitudes towards this peer. This finding may be explained by perceptions and stereotypes that emotional behaviour violates expected norms of the male gender role, which become increasingly indoctrinated with age.
Chapter 4: Research on Stigma

(Watts & Borders, 2005; MacLean, Sweeting, & Hunt, 2010). The study also found that older participants perceived males with ADHD or depression as being less personally responsible for their mental health problem. This study highlights the importance of exploring differences in stigmatising responses towards same and different sex-peers with a variety of mental health disorders.

When stigma is conceptualised as a multi-dimensional construct, research indicates that the influence of age is contingent upon the dimension of stigma being explored (Jorm & Wright, 2008; Reavley & Jorm, 2011a). For example, Jorm and Wright (2008) found that 12 to 25-year-olds’ beliefs that peers described as having depression, depression with alcohol misuse, social phobia or psychosis are ‘weak not sick’ and desired social distance from such peers decreased with age. However, cognitive attitudes such as perceived dangerousness and unpredictability increased. In addition, reluctance to disclose if they had a mental health problem, and beliefs that the public endorse stigma, increased with age. These findings demonstrate that complex age differences in stigmatising responses exist. Subsequent research also reinforces these findings; Reavley and Jorm (2011a) found that while beliefs that depression is a weakness not a sickness decreased with age, across early to mid adolescence (12-15 years), participants endorsed a stronger reluctance to disclose to others if they were depressed. Age patterns were not found in beliefs that the peer with depression was dangerous and unpredictable. This may be explained by the smaller age range of participants in this study compared to participants in former study and the fact that this study specifically explored responses towards depression only.

Not all research that has explored the role of age has found similar trends. Walker et al. (2008) did not find significant developmental differences between 8 to 18-year-olds attitudes and social distance towards male peers with ADHD or depression. The absence of age trends in this study could be explained by differences in the study design and
methodologies used. For example, Walker and colleagues did not explore differences across specific cognitions but instead explored variability between summed items of positive versus negative attitudes. As demonstrated by Jorm and Wright (2008) and Reavley and Jorm (2011a), age trends differ across particular cognitions, thus, by collating attitudes as either positive or negative potential, age patterns may have been missed.

What can be concluded from the above research is that age differences in stigmatising responses are largely dependent upon the aspect of stigma being measured and the target of mental health condition. In general, studies that measure multi-dimensional aspects of stigma suggest that some dimensions of stigma decrease whilst others become more negative or ingrained.

4.2.2.2 Gender

Considerable attention has been given to the role of gender in determining stigmatising responses. This is due to the importance of gender in mental health research in general, as research consistently indicates that young females report experiencing more mental health problems (Hankin, Mermelstein, & Roesch, 2007), while males perceive psychological symptoms as feminine (MacLean, et al., 2010) but are more likely to die by suicide (Centre for Disease Control and Prevention, 2009). Thus, it is relevant to consider that gender may influence perceptions of mental illness and peers with disorders. Much of the research that has explored gender differences in childhood and adolescence has either specifically explored perceptions of depression or peers with depression or includes depression as one of a variety of target disorders. Therefore, this section will firstly present research on gender difference towards depression, before attending to mental illness in general and other disorders.
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Overall research tends to suggest that males are more negative towards depression and peers with depression compared to females (Arbanas, 2008; Calear, Griffiths, & Christense, 2011; Jorm & Wright, 2008; Reavley & Jorm, 2011a). For example, research by Reavley and Jorm (2011a) found that being male predicted stronger beliefs that peers with depression are dangerous and unpredictable, and that depression is not a sickness but a personal weakness. This tendency to view depression negatively is not just specific to males; however, recent research indicates that females endorse negative perceptions of adolescent males with depression but not females with depression (Swords et al., 2011a). These overwhelming findings suggest that depression is not a disorder that is compatible with perceptions of the male gender role. In particular, Swords and colleagues’ work challenges research that suggests that females are more tolerant of mental illness in general (e.g. Jorm & Wright, 2008), highlighting the complexity of the gender issue.

That said however, research also suggests that boys generally display more negative attitudes towards mental health and people labelled as mentally ill (Andersson, Bjorngaard, Kaspersen, Wang, Skre, & Dahl, 2009; Ng & Chan, 2000; Pinfold, et al., 2003; Sheffield, Fiorenza, & Sofronoff, 2004; Watson, et al., 2005; Watson, et al., 2004; Williams & Pow, 2007). For example, Williams and Pow found differences between specific stigmatising attitudes; 15 to16-year-olds boys were less likely to believe that one could recover from a mental health problem and more likely to endorse the attitude that society should be better protected from people with mental illness. They also reported that they would find it harder to talk to a person with a mental disorder compared to girls. Furthermore, this study found that boys had a poorer understanding and knowledge specific of mental health problems. Although the relationship between knowledge and attitudes was not assessed in this study, the authors speculated that it might play a role in facilitating this gender pattern.
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While most studies have revealed that stigmatising responses vary depending on the gender of the perceiver, other research does not recognise gender as an important factor (Law, et al., 2007; Schulze, Dietrich-Werling, Matschinger, & Angermeyer, 2003; Walker, et al., 2008). It is possible that the absence of gender related differences could be due to the disorder of the target peer or differences in methodologies used.

Overall, males tend to be more unforgiving of depression and generic terms of mental illness. However, the variability in gendered responses observed in more sophisticated stigma research (e.g. Swords et al., 2011a) suggests that the gender differences are not straightforward but instead are likely to be contingent upon the age, the type of disorder, and the dimension of stigma being assessed.

4.2.2.3 Type of Mental Health Disorder

As discussed in the previous sections, the nature and extent of stigma is contingent upon the type of mental health condition under investigation (Arbanas, 2008; Swords et al., 2011a). For example, research by Walker et al. (2008) indicated that children and adolescents stigmatised peers with depression to a greater degree than peers with ADHD. One explanation for this finding is that children may be familiar with the term ADHD, compared to depression, or they might have highly developed schemas for the acceptability of externalising behaviour, thus leading to more positive responses towards the former peer. Jorm and Wright (2008) found that stigmatisation of disorders differs across the multiple components of stigma. When compared to depression, they found that peers with psychosis were thought to be more dangerous and unpredictable and young people requested greater social distance from these peers. Young people also believed that peers with social phobia were less dangerous and unpredictable, but were more ‘weak not sick’ and more likely to be stigmatised by others compared to peers with depression. Insight into the complexity of
stigma was also reiterated in subsequent research by Reavley and Jorm (2011b), they explored stigma towards hypothetical peers with depression, depression with suicidal thoughts/alcohol use, psychosis, social phobia, and PTSD. Their findings revealed that respondents wanted more social distance from peers with psychosis and least from peers with PTSD. They also found that young people were more likely to agree that peers with psychosis and depression with alcohol use are unpredictable compared to the other disorders. Young people were also more likely to believe that social phobia was a weakness and not a condition, compared to the other target conditions. In addition, in comparison to the other disorders, young people were more likely to believe that psychosis was not a real mental illness and people with this condition are violent.

This body of research not only strengthens the argument for assessing stigma towards specific mental health problems but also for exploring the experience of differentiated disorders across multiple components of stigma.

### 4.2.2.4 Other Factors that Effect Stigma: Contact & Perceived Similarity & Mental Health Literacy

According to Allport’s (1954) ‘contact hypothesis’, interactions between ingroup and outgroup members can potentially reduce stigmatising attitudes and improve intergroup behaviour. The role of contact in reducing stigma towards social outgroups has received much attention in the wider social cognitive literature. Research conducted in various contexts has demonstrated that direct contact is associated with lower outgroup stigmatisation among children from 3 years of age to adolescence (e.g. Aboud, Mendelson, & Purdy, 2003; Feddes, Noack, & Rutland, 2009; Rutland, Cameron, Bennett, & Ferrell, 2005). In the adult mental health literature, research supports the contact hypothesis. A meta-analysis by Pettigrew & Troop (2000) provides evidence that contact with persons with mental illness is
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successful in reducing stigma. Similarly, a review by Couture and Penn (2003) concluded that retrospective and prospective contact is associated with lower stigmatising attitudes. The potential for contact with people with disorders to reduce mental disorder stigma in childhood and adolescence is receiving growing support (e.g. Spagnolo, Murphy, & Librera, 2008; Stuart, 2006) and now is the recommended intervention strategy for this group (Schachter et al., 2008; see Chapter 14 section 14.2.2).

There is strong consistent evidence to show that perceived similarity is associated with greater likelihood to form friendships (see Fehr, 1996). In addition, Brown and Hewstone (2005) argue that when one attributes traits associated with the self to an outgroup member it “is likely to lead to a more positive evaluation of her or him, which may then generalize to the outgroup as a whole” (p. 293). While the effect of perceived similarity on the responses towards peers with mental disorders has yet to be explored, research shows that perceived similarity is related to more positive perceptions of racial and ethnic groups (McGlothlin & Killen, 2005; Wright & Troop, 2005) and children with disabilities (Bak & Siperstein, 1987; Siperstein & Chatillion, 1982).

4.3 Implicit Mental Disorder Stigma

The research discussed above all pertains to data derived from explicit measures of stigma. Implicit measures of mental disorder stigma are becoming more popular in adult research as they overcome social desirability biases (see Chapter 3 section 3.3), which is especially commonplace in mental disorder stigma (Link & Cullen, 1983). Despite the advantages of implicit measures, only one published study has employed an implicit measure to assess stigma towards mental illness in adolescence. Saporito, Ryan, and Teachman (2011) used a paper-pencil version of the IAT to explore changes in 15 to 19-year-olds’ implicit attitudes following a video-contact based intervention. While the intervention did not produce
significant changes in participants’ implicit attitudes, data on the direction of implicit attitudes were not provided nor were differences across demographic variables explored. Thus, neither the nature nor the extent of adolescents’ implicit attitudes towards people with mental illness can be inferred. Furthermore, the IAT employed in this study assessed implicit responses towards the term ‘mentally ill people’ and not specific disorders, thus limiting our ability to generalise findings to specific conditions. Given the lack on research with children and adolescents, it is necessary to turn to the adult literature to obtain a general overview of the state implicit stigma research.

In the adult literature, eight published studies have assessed implicit attitudes towards mental illness or people with mental health problems (Teachman, Wilson, & Komarvoskaya, 2006; Lincoln, Arens, Berger, & Rief, 2008; Monteith & Pettit, 2011; Norman et al., 2010; Peris, Teachman, & Nosek, 2008; Rüsch, Corrigan, Todd, & Bodenhausen, 2010; Rüsch, Corrigan, Todd, & Bodenhausen, 2011; Takahashi, et al., 2009). However, no studies have explored implicit attitudes towards people who are described as having symptoms of mental disorders, but are not given a psychiatric label. Research shows that, in general, the public have negative implicit evaluations of mental illness (Teachman et al., 2006; Rüsch et al., 2010). However, when pitted against people on social welfare, Peris and colleagues found more positive attitudes toward people with mental illness. While these studies did not reveal associations between implicit and explicit attitudes, a recent study using the Lexical Decision Task (LDT) found, that among healthy participants, stronger negative associations with the word ‘crazy’ were associated with self-reported feelings of shame about a potential mental illness and anger towards individuals with mental health problems (Rüsch, et al., 2011). Furthermore, Rüsch and colleagues found that, compared to participants with mental health problems, healthy participants had stronger negative associations with the term ‘crazy’.
Research that targets specific disorders shows similar negative perceptions. For example, Monteith and Pettit found that participants had a more negative implicit attitude towards depression compared to physical illness, however, they also found that participants implicitly believed that depression was more temporary than physical illness. Furthermore, they did not observe any differences in implicit beliefs about controllability between the two disorders. Lincoln and colleagues assessed implicit attitudes towards depression and schizophrenia revealing that the latter was perceived more negatively. This finding supports the need to assess responses towards specific disorders.

Only one study has explored the utility of an implicit measure to predict behaviour. Employing an alternative implicit measure to the IAT, the Concept Association Task (CAT; Steffens et al., 2008), Norman and colleagues (2010) assessed whether cortisol responses and implicit and explicit attitudes predicted social distance from an individual with schizophrenia. The results showed that cortisol and explicit attitudes predicted behaviour, but implicit attitudes did not. The authors attributed the failure of implicit attitudes to contribute to social distance to the type of implicit measure used, as in comparison to the IAT, the CAT is relatively under-developed.

Overall, this body of research suggests that adults have negative implicit attitudes towards general mental illness and specific disorders. While it also suggests that implicit attitudes vary depending on the type of disorder in question, no research has explored the influence of socio-demographic variables on implicit responses. In general, research on implicit attitudes towards mental illness in adulthood is under-developed.

The fact that implicit measures have not yet been used to examine mental health stigma in childhood is probably due to their reliance on visual representations of the target attitude object. This is a challenge in mental health research, as there is no obvious way to provide a visual image that depicts a specific disorder. In the adult research, the measures
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used the written terms of ‘mental illness’ or ‘schizophrenia’ as the target objects, thus avoiding the problem of presenting these concepts in pictorial form. However, using psychiatric labels is problematic with children as many may not be familiar with them or have incorrect knowledge of the terms. In addition, using psychiatric terms to describe peers with mental health problems may produce potentially contaminating labelling effects (see section 3.6.2). Despite this challenge, the advantages of implicit measures, and the potential for them to further our understanding of stigma, warrant efforts to create a measure that unearths implicit attitudes towards peers who are not explicitly labelled having as a mental disorder, but who by nature of their behaviour, are perceived as socially deviant.

4.4 Interpreting the Findings: A Note of Caution

The explicit research discussed above overwhelmingly suggests that young people perceive peers with mental health problems and mental illness in a negative light. While this may in fact be accurate, one should heed caution when interpreting findings. The variance in measurement, absence of standardised cut-off points, and reliance on mean difference scores to estimate the extent of stigma, ensures it is difficult to interpret the actual meaning of published findings. In addition, many studies do not assess responses towards healthy peers and thus fail to provide a baseline of responses upon which perceptions of peer with mental illness can be assessed. For example, the research typically compares responses towards different mental health problems and demonstrates that psychosis is more stigmatised than depression (e.g. Arbanas, 2008; Jorm & Wright, 2008; Reavley & Jorm, 2011b). Yet, whether responses towards people with depression are more negative than responses towards healthy individuals is unknown. Although research that utilises a healthy peer as a control may still create difficulties when interpreting results, more positive responses towards the
healthy peer, compared to the peer with a disorder, may be construed as stigma. Yet, the true degree of such stigma would remain ambiguous.

In addition, the presentation of findings often tends to be presented in a biased manner, supporting the existence of global stigma. One particular example can be seen in research by Reavley and Jorm (2011b), which states that, in general, young people are more likely to want more social distance from a peer with psychosis, compared to other disorders; whilst the data supports this, on closer inspection, only a minority of participants (10-20% approximately) endorsed or strongly endorsed social distance from this peer across the contexts assessed. While most studies do not comment on the level of stigma found (e.g. Arbanas, 2008; Walker et al., 2008; Swords et al., 2011a), some researchers have attempted to tackle this issue and subsequently inferred that children and adolescents do not report extremely negative attitudes towards peers with mental health problems (Martin, 2006; Watson, et al, 2005; Watson et al., 2004; Schulze, et al., 2003; Walker, et al., 2008). Yet, the authors all noted that there is room for improvement across all dimensions of stigma, with particular attention needed on some aspects of cognition. For example, Martin (2006) noted that only 9% and 7% of 8 to 18-year-olds believed that depression and ADHD are conditions to be ashamed of. On paper it would appear that participants have positive perceptions of these conditions, however, 28% endorsed that if they had depression they would “wait for it to go away”. A further 40% and 43% would “try to think harder and act like normal” if they had depression or ADHD respectively.

Overall, there is a need for researchers to provide accurate interpretation of descriptive data on stigma measures. While negative minority views are important to acknowledge, attention should also be given to the viewpoint of participants who endorse more positive perceptions of mental illness. It is also important, however, to cautiously
interpret positive responses towards mental disorders in the absence of social desirability scales or implicit measures.

4.5 Limitations of the Existing Research

It is over a decade since the US General Attorney Report (1999) on mental illness that stressed the importance of understanding stigma if people with mental illness are to live full and meaningful lives. This report kick started much international research on mental health stigma, however, despite the increase in empirical investigations on the topic, Hinshaw’s (2005) conclusion that little is known about the stigma experienced by children and adolescents remains true. The research that does exist is hindered by methodological shortcomings that characterise child and adolescent mental health research. As described earlier, stigma is a complex social phenomenon that has proven difficult to measure empirically. This is reflected in many frequently cited works that claim to investigate stigma, but on closer inspection, only assess sub-aspects of the phenomenon. For example, in their study on stigma towards ADHD and depression, Walker and colleagues assessed stereotypes and discrimination but not prejudice or perceptions of status and power. Similarly, a series of studies that explored stigma towards depression, psychosis, and social phobia in adolescence assessed stereotypes and discrimination only (Wright, Jorm, & Mackinnon, 2011; Reavley & Jorm, 2011a, 2011b). In addition, none of the studies discussed in this thesis address the issue of social status and power. Failing to explore whether children and adolescents perceive themselves to be of higher social status, and more powerful than others with mental health problems ensures that, theoretically, these studies do not provide us with a complete insight into whether stigma exists. Drawing on Hinshaw’s (2007) comment, that stigma is rarely operationally defined and measured, it can be argued that until all dimensions of stigma are empirically assessed, the prospect of fully understanding stigma is restricted.
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Furthermore, a primary issue that limits our understanding of stigma is the vast range of assessment techniques and absence of standardised stigma measures, thus ensuring that findings from the existing literature across time, disorder, and population, are difficult to compare (Hinshaw, 2007). While vignettes are the most common method employed to elicit perceptions of people with mental disorders, a range of methods have been used to assess such responses from interview (e.g. Poster, 1992; Whalen, et al., 1983), questionnaires (Corrigan et al., 2007; Swords et al., 2011a; Reavley & Jorm, 2011), projective measures of social distance (e.g. Weiss, 1986, 1992), analyses of drawings and stories (e.g. Poster, Betz, McKenna, & Mossar, 1986) and peer nomination procedures (e.g. Milich, Landau, Kilby, & Whitten, 1982). Despite the variability in measurement, in general, findings indicate that children stigmatise peers with mental disorders.

While vignettes are an effective means of assessing perceptions of socially sensitive groups (see Chapter 5 section 5.7 for a detailed discussion on the utility of vignettes) their ecological validity to capture realistic clinical disorders is often questionable. Many published papers rarely provide details on the criteria that were adhered to when designing the vignettes nor do they inform on whether external validation from clinicians was sought (e.g. Coleman, Walker, Lee, Squire, & Friesen, 2009; Corrigan et al., 2007; Harnum, Duffy, & Ferguson, 2006; Norman & Malla, 1983; Walker et al., 2008). Exceptions to this are studies by Jorm and Wright (2008), Law et al. (2007), Reavley and Jorm (2011a, b), Swords et al. (2011a, b, c), and Wright et al. (2011). During the design stages of the present study the researcher noted that most of the vignettes used in stigma research with children and adolescents failed to provide a description of the target disorders that met DSM-IV criteria for accurate diagnosis. Frequently, those that stated that the vignettes met diagnostic criteria did not when reviewed for this research. Assessing perceptions of vignettes, that provide an
incomplete description of the person with a mental health problem, jeopardises the reliability and validity of results.

Another limitation of the existing literature is witnessed in research that explores perceptions of the general term mental illness and not specific disorders (Pinfold et al., 2003; Williams & Pow, 2007; Ronzoni, Dogra, Omigbodun, Bella, & Atitola, 2010). By investigating stigma towards broad references, such as ‘psychological disorder’ or ‘psychiatric problems’ or ‘mental illness’, one assumes that the nature of the conditions that these labels encapsulate is uniform. However, the opposite is true, depression, psychosis, schizophrenia and ADHD, for example, all entail distinct diagnostic criteria and have varying disabling personal and social consequences for the affected individual. Thus, it is more likely that the public perceives these disorders as individual and unique and not in a universal manner. In addition, by using the term mental illness it is impossible to gauge what type of condition people use or construct to pitch their responses against. For example, some respondents may automatically think of depression when presented with this term, while others may summon an image of a person with schizophrenia. Exploring how the public perceive individual disorders permits us to explore the unique and shared ways in which they are stigmatised, which will thus further our understanding of stigma.

While stigma in childhood and adolescence is, in general, an under-researched area, within the literature, emphasis has been placed on stigma in adolescence and not childhood. The rationale for exploring stigma in adolescence and not among younger children may be a response to the increasing prevalence of mental disorders and emergence of adult disorders, such as schizophrenia across the adolescent period (Maggini, Zwaanswijk, vanDijk, & Verheij, 2011). Differences in the prevalence of disorders between childhood and adolescence may ensure that mental health disorders and associated stigma are more socially relevant to the older cohort. Another reason stigma is of more concern in adolescence relates
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to adolescents’ emerging sense of identity, their increasing tendency to engage in peer relations outside the family context, and to use the peer context as a haven within which they develop independence, self esteem, and self-efficacy (Brockman, 2003; Gralinski-Bakker, Hauser, Billings, & Allen, 2005; O’Connor, Allen, Bell, & Hauser, 1996). Given the potential of stigma to initiate rejection from the peer group and to hinder self-development in adolescence, stigma experiences within this developmental period have been prioritised. However, as discussed in Chapter 3 section 3.6, a strong rationale exists to establish a greater understanding of stigma in childhood. The existence of mental health disorders in pre-adolescent populations, and children as young as 5 years of age (OSN, 2005), and the vast body of research that stresses the importance of peer acceptance in childhood (Chapter 2 section 2.3), all provide a powerful rationale for the investigation of mental health stigma among younger youths.

Finally, a notable methodological shortcoming of the existing literature is the absence of implicit measures to assess stigma. As highlighted earlier implicit measures help overcome some of the challenges of assessing stigma (see Chapter 3 section 3.3). The advantages of implicit measures and the potential for them to further our understanding of stigma, warrant efforts to create a developmentally appropriate implicit stigma measure (Hinshaw, 2005).

4.6 Summary & Conclusion

Research on stigma towards peer with mental health problems is diverse in both quality and methodological approaches, ensuring that it is difficult to draw broad conclusions on the findings. Notably the research has many methodological failings, for example, (a) stigma is rarely assessed in its entirety; (b) many studies assess responses to psychiatric terms and labels that may not be understood or socially relevant to children and adolescents; (c) no research has employed a measure that assesses implicit attitudes towards peers with
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disorders; (d) a disproportionate amount of research assesses stigma in adolescence compared to childhood. Despite the limitations of the existing literature, general conclusions about the findings can be made. Females tend to be more positive towards peers with disorders; however, the nature of responses depends on how stigma is assessed and the characteristic of the target individual, such as their disorder and gender. Stigmatising responses also vary depending on the disorder under investigation, with depression being more accepted than schizophrenia. Age differences appear to be less consistent; again patterns of responses depend on the measure, disorder, and gender of the perceiver.

In conclusion, the avenues for advancing this field of research are many. Some of the most pertinent directions that need to be pursued will be addressed in the present body of research. The following chapter will highlight the specific limitations to be explored in Study One of this thesis.
Chapter 5: The Aims & Objectives of Study One & the Development and Selection the Vignettes & Implicit Measure

5.1 Aim of Chapter

This chapter will highlight the gaps in the literature that will be addressed in Study One. The chapter will also summarise the theoretical frameworks that are driving this study in an effort to bridge the range of explicit and implicit theoretical positions discussed in Chapter Three. The aims and objectives of Study One will be presented. Issues to be considered when developing and selecting measures to be used with children will also be discussed. Then a detailed account of the development of the vignettes used in this study will be provided. A discussion on the rationale for the Implicit Association Test (IAT) as an implicit measure and the modifications made to this measure will follow.

5.2 The Present Study (Study One)

The present status of the literature on peer stigmatisation of mental health problems in childhood and adolescence can be summarised in the following key points:

1. Research often fails to comprehensively explore the concept of stigma fully. Instead, sub-aspects of the construct are measured.
2. The type of mental health condition being investigated influences children and adolescents’ stigmatising responses towards peers with mental health problems.
3. Perceptions of peers with mental health problems tend to vary along individual
variables, such as participants’ gender and age. Females tend to report being more accepting of peers with disorders, while mixed findings prevail on the developmental progression of stigma.

4. All findings on peer stigma have exclusively relied on explicit measures of assessment. The development of a child friendly implicit measure is imperative to further our understanding of stigma and keep pace with advancements underway in the wider social cognitive literature.

This study sets out to address the shortcomings of the existing literature as outlined above. It is anticipated that the findings will empirically advance our understanding of children and adolescents’ perceptions of peers with mental health problems. Understanding the nature and extent of explicit and implicit peer stigma can provide valuable information for the development of interventions that aim to eliminate stigma and promote acceptance. Details of the present study are described in the paragraphs below.

This body of research involves a quantitative study with young people of 10-11 and 15-16 years of age. The two developmental cohorts, late-childhood and mid-adolescence, were chosen as evidence suggests changes in responses towards peers with mental disorders from childhood to adolescence (Swords et al., 2011a). Epidemiological data also highlights changes in the prevalence of mental health difficulties from pre-adolescence to adolescence (Lynch et al., 2006). Data were collected on participants’ individual emotional and behavioural profiles and on their responses on a stigma questionnaire, which included vignettes describing age, and gender matched peers displaying the target behaviours (depression or ADHD) and a peer who engaged in ‘normative’ behaviour. Implicit data were gathered using a modified version of the IAT.
5.3 Why ADHD & Depression?

Mental health problems or mental illness are umbrella terms that incorporate a wide range of disorders, which differ in terms of their presentation and impact severity on social functioning. As stated earlier, exploring stigma towards the general terms of mental illness potentially limits our knowledge on the nature of stigma towards different disorders. Hinshaw (2007) advises against the undifferentiated approach to mental health stigma research, claiming that it implicitly assumes sameness among all people with mental health problems. Exploring peer stigma towards two contrasting mental health problems; ADHD and depression will provide us with an insight into the unique and shared stigmatisation profile of an internalising and externalising disorder. ADHD and depression were the disorders chosen as research shows that these are the two of the most prevalent disorders in childhood and adolescence (CAMHS, 2008; Goodman, Meltzer & Ford, 2000; Lynch, et al., 2006) and therefore, are most socially relevant to young people.

5.4 The Role of Theory in Study One

In Chapter 3, sections 3.4. to 3.4.5, the theoretical approaches adopted in the literature specific to mental disorder stigma and the development of implicit and explicit stigma towards racial and gender outgroup members were discussed. This body of literature draws on a variety of theories to provide potential insight into the development of stigma in childhood and adolescence and the application of these theories to mental disorder stigma was critically reviewed. However, it is beyond the scope of this thesis to empirically test any one model of stigma to the domain of mental disorder stigma. Instead, theory plays a more conceptual role. Study One is primarily guided by the dual processing model of cognition (see Chapter 3 section 3.4.3). This study recognises that children and adolescents have explicit and implicit attitudes towards peers with mental health problems and thus, both
dimensions of social cognition need to be assessed. Theory has a more obvious and direct role in Study Two; this research will draw on Social Domain theory to explain why young people with mental health problems experience peer discrimination (see Chapter 3 section 3.4.5 and Chapter 10 section 10.3 for a discussion on SDT).

5.5 Aims & Objectives of Study One

Primary Aim:

• To explore the nature and extent of explicit and implicit peer stigma towards children and adolescents with mental health disorders.

Specific Research Aims:

• To explore the hypothesis that peers with mental disorders are perceived more negatively than peers without mental health problems.

• To examine the hypothesis that the nature and extent of stigma varies across the age and gender of the perceiver and the type of mental health problem of the target peer.

• To assess implicit attitudes towards peers with mental health disorders, compared to peers without mental health problems, and test the hypothesis that implicit attitudes are contingent upon the age and gender of the perceiver and the target peer’s mental health disorder.

• To examine the reliability and validity of the implicit measure used in this study.

• To explore the relationships between explicit measures of stigma and implicit attitudes.

• To examine the predictive validity of the explicit and implicit attitude measures
to account for self-reported behavioural intentions towards the peers with mental disorders.

The following chapter will describe the pertinent issues to consider when designing research with children and young people and the development of key tools utilised in Study One.

5.6 Special Considerations when Researching Children: Factors Effecting the Format and Content of the Measures

For Study One the questionnaire booklet, the content of the vignettes and the implicit attitude measure were all influenced by the following principles and considerations. These principles were also adhered to when selecting the materials employed for Study Two of this research.

- Developmental appropriateness: As the present study targets two stages in child and adolescent development, late-childhood (10 to 11-year-olds) and mid-adolescence (15 to 16-year-olds), it was vital that two versions of the questionnaire were developed. This was to ensure that the instrument was sensitive to cognitive and social differences that may exist between the two target age groups. Piloting the study and requesting feedback on the assessments ensured that they were suitable for use with both target participant groups.

- Content Validity: Most items in the questionnaire were chosen from previous research on peer stigmatisation of mental health problems in childhood and adolescence; therefore, most of the items had been previously validated and reflected some key themes of the stigma process. As this study was the first of its kind to explore all the dimensions of stigma some of the items employed were novel, in that they have not previously been used in the context of stigma research with children. These items were adapted either from the adult literature on mental
disorder stigma or from other child attitudinal research as they theoretically represent the target dimensions of stigma.

• *Construct Validity*: To ensure that the questionnaire employed in Study One assessed stigma, all scales included in the questionnaire booklet represent dimensions of the construct as identified in the existing literature (see Chapter 3 section 3.2).

5.7 Use of Vignettes

Most research assessing perceptions of peers with mental health disorders use vignettes to elicit responses. Vignettes are advantageous as they avoid the ethical issues involved in asking children to respond to actual peers. Singling out specific individuals in the classroom as different or problematic may cause unnecessary distress for the target child and exacerbate stigmatising responses towards him or her, after the research has been completed. Another advantage of using vignettes is that they allow us to assess the perceptions of children and young people who do not have contact with peers with the disorders of interest. Thus, the responses gathered are not limited to children who have contact but instead are reflective of a wide spectrum of children and adolescents and are hence more generalisable. Vignettes also avoid potentially polluting the data with the confounding influence of labelling effects and mental health literacy. Vignettes not only create an environment against which attitudes can be formed but also set limits of preference. This is achieved by providing participants with the same contextual framework, thus enabling the researcher to compare their responses (Poulou, 2001). Ultimately, vignettes assume both non-directive and concrete elements that attempt to facilitate participants to not only create their own individual interpretation of the phenomenon but also guide the participants by precisely depicting the phenomenon. This allows researchers to obtain both individualised and comparable responses.
Although vignettes are useful methodological tools, caution should be employed when interpreting the data of studies that use this technique. As discussed earlier, researchers should pay particular attention to whether the clinical status of the disorder presented in vignette has been validated when interpreting the results of vignette studies (see Chapter 3 section 3.8). One should also always remember that although vignettes strive to provide a proxy description of actual peers, the subsequent data might not always be generalised to them.

5.7.1 Selection and Development of the Vignettes

Three vignettes were developed to provide behavioural descriptions of children and adolescents with ADHD, depression, and a peer without a mental health problem. The clinical vignettes were modelled on previously validated vignettes employed by Swords et al. (2011a,b, c) and Hennessy and Heary (2009; presented below). While the original vignettes were validated by clinical psychologists, a review of the content of the vignettes highlights that they failed to meet the DSM IV diagnostic criteria for the target disorders. In addition, the comparative vignette used in their research described a peer who was academically talented, however, in the present study a peer who exhibited both strengths and weakness was developed for comparison.

5.7.1.1 Original Clinical Vignettes

**ADHD Primary School**¹

Jake finds it very difficult to pay attention to what the teacher says and finds it difficult to concentrate on doing sums² or reading or other work that the teacher gives him. Jake also finds it hard to stay sitting down when he is supposed to and often get up or fidgets a lot. Often he has trouble waiting his turn in games and often interrupts

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¹ male and female versions of both vignettes were provided
² ‘sums’ was replaced with ‘maths’ in the post-primary school vignettes
when other people are doing things.

**Depression Primary School Female**

Lauren usually does okay in school. However, recently she began to think that she is stupid and not good at anything. She doesn’t smile and she spends a lot of time thinking about all the things that she is not able to do and other sad thoughts. Sometimes she finds it hard to sleep at night so she is very often tired and troubled during the day.

**5.7.1.2 Criteria for Designing the Vignettes**

Apart from the key aforementioned considerations (see section 6.2), specific criteria were adhered to in the development of the vignettes for the present research, as follows:

1. The diagnostic criteria according to DSM IV for ADHD and depression must be adhered to.

2. The tone or wording of the vignettes depicting the characters in the vignettes should not be overly negative or positive as this may potentially bias participants’ responses to the characters (Wason, Polonsky, & Hyman, 2002).

3. The vignettes should not contain responses of others towards the hypothetical children (e.g. Jake often annoys his classmates) as this may influence responses.

4. The modified vignettes must be validated by clinical psychologists and trainees to ensure internal validity (Flaskerud, 1979).
5.7.1.3 Validation of the Clinical Vignettes

Qualified clinical psychologists and trainee clinical psychologists assessed the internal validity of the clinical vignettes to ensure the clinical disorders of interest were accurately depicted. Second and Third year clinical trainee students at the National University of Ireland, Galway and clinical psychologists listed on the Health Service Executive (HSE) website working in Galway were emailed requesting assistance in the validation of the vignettes. Twelve trainees and qualified psychologists agreed to take part and were sent an email containing both an electronic copy of the validation questionnaire and a link to an online questionnaire. All participants were provided with an information letter providing a brief synopsis of the research aims (see Appendix B). For simplicity, the gender of the vignettes was counterbalanced and raters were informed that male and female versions of the vignettes would be employed in the study. Raters were required to evaluate the accuracy of the vignettes to describe a child with a clinical diagnosis of ADHD and depression on a 6-point Likert scale, ranging from ‘very inaccurate description’ to ‘very accurate description’. Higher scores denoted more accuracy. Specific feedback or comments regarding the vignettes were also requested. Mean accuracy and percentage scores are displayed in Table 5.1 and Table 5.2.
Table 5.1

*Mean Validation Scores for the Depression and ADHD Vignettes*

<table>
<thead>
<tr>
<th></th>
<th>Depression</th>
<th>ADHD</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>M</em></td>
<td>5.25</td>
<td>4.83</td>
</tr>
</tbody>
</table>

Table 5.2

*Percentage Validation Accuracy Scores for the Depression and ADHD Vignettes*

<table>
<thead>
<tr>
<th></th>
<th>Depression %</th>
<th>ADHD %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Slightly Inaccurate</td>
<td>0</td>
<td>8.3</td>
</tr>
<tr>
<td>Slightly accurate</td>
<td>16.6</td>
<td>25</td>
</tr>
<tr>
<td>Accurate</td>
<td>41.7</td>
<td>41.7</td>
</tr>
<tr>
<td>Very accurate</td>
<td>41.7</td>
<td>25</td>
</tr>
</tbody>
</table>

Overall, feedback and validations on the vignettes were positive. An example of feedback for the ADHD vignette was as follows:

“I like the fact that it doesn't prompt feelings in the respondent e.g. by saying that others find this behaviour difficult but rather that the material is presented in a neutral manner allowing the respondent to react in their own way” (Principal Clinical Psychologist).

An example of feedback on the depression vignette was “I would consider depression as being my first hypothesis in going in to conduct an assessment with this child” (Principal Clinical Psychologist). Overall, the content of the proposed vignettes was maintained,
Chapter 5: Study One: Aims & Development

however, minor changes were made to some of the phrasing, e.g. ‘Larry’s results in school have deteriorated’ to ‘Larry has fallen behind in his school work’. Slightly more changes were made to ADHD vignette. An example of a modification made to the ADHD vignette is as follows: ‘In school Jane seems to be more interested in other people’s work than her own’ to ‘In school Jane seems to pay more attention to other things going on around her than her own work’.

Final versions of the vignettes are presented below (see section 5.4.1.4). In response to evidence that shows that children and young adolescents tend to have gender segregated peer groups (Archer & Lloyd, 2002), two versions of each vignette were developed so that gender of the vignette peers were matched to the gender of the participant.

5.7.3.1 Vignettes Used in the Present Study

Male and female versions of each vignette were developed so that participants read about a peer who was the same gender as them. The content of the vignettes was consistent across both age groups, except the words ‘teenagers’ and ‘hangs out’ were substituted with ‘children’ and ‘plays’ in the vignettes for younger children.

‘Normal Issues’ Primary School

David is in the same year as you. He likes school because he has good friends in his class, but would like it better if his teachers didn’t give him so much homework. He plays with his friends after school one or two times during the week and at weekends. He has several hobbies, including playing sports and listening to music. David usually gets on well with other children, but sometimes they have arguments. However, he always makes up with them. Most of the time, David does well in school but has to work hard at some subjects especially Maths and Irish. He is well behaved in school and rarely gets in trouble from his teachers.
Chapter 5: Study One: Aims & Development

ADHD Primary School
Jake is in the year class as you. In school he seems to pay more attention to things going on around him than his own work. Sometimes he forgets what his teacher has told him to do and needs to be reminded. When the teacher asks the class a question Jake often blurts out the answer before the teacher has a chance to finish. Jake often finds it hard to stay sitting down when he is supposed to and gets up or fidgets a lot. He has difficulty waiting his turn and butts into his classmates’ conversations. In his spare time, Jake likes to play his computer and train with his athletics club. When his parents ask him to help around the house he sometimes doesn’t seem to hear them. He often does not finish his homework or chores. Jake talks non-stop when his family is watching TV. He finds it hard to organise his bedroom and regularly loses his books, computer games and other things he needs.

Depression Post-Primary school
Larry is in the same year as you. He used to love playing sports and hanging out with his friends after school. Last year, he was the captain of his football team, however, recently he has stopped going to training. His classmates have noticed that he isn’t interested in anything lately and doesn’t hang out with them anymore. He doesn’t smile or laugh as much as he used to. Larry is falling behind in his schoolwork. When Larry’s teacher asked him about this, Larry explained that he is feeling tired all the time and is finding it difficult to sleep at night. He wants to do better but thinks that he is not good at anything. Larry spends a lot of time thinking about all the things that he is not able to do and other sad thoughts.
5.8 Selection and Development of the Implicit Measure: The Implicit Association Test (IAT)

Given that, (a) no implicit measure has been developed to assess implicit attitudes towards peers who are described as having a mental health disorder without using psychiatric labels; and (b) notable modifications were made to the implicit measure in the design of this study, particular attention will be heeded to the development of this measure. As all the explicit measures have been previously used in research with children and adolescents, a comparable discussion on any modifications or adaptations applied to the explicit items will not be presented here.

The IAT is a computer-based program that “seeks to measure implicit attitudes by [assessing participants’] underlying automatic evaluations” (Greenwald et al., 1998, p.1464) of stimuli presented on a computer screen. The IAT is the most widely used measure of implicit social cognition with both adults and children. This response latency measure is a dichotomous categorisation task, that taps into attitudes by requiring participants to sort four types of stimuli into two response options by pressing the correct response on a keyboard or response pad (e.g., either the ‘d’ or ‘k’ key in the adult IAT or coloured buttons in the child IAT). The stimuli are exemplars of two target categories (e.g. mental health disorder versus no mental health disorder) and two contrasting attribute categories (e.g. good versus bad). Based on timed response latencies between stimulus presentation and participants’ subsequent reaction, the task rests on the assumption that it is easier to sort stimuli from two categories that are associated with one another compared to categories that are not associated. Baron and Banaji (2006) state that the rationale for the IAT is that “the more strongly two concepts have become associated with one another, the faster and more accurately they can be paired” (p.54). In Greenwald et al.’s pioneering research on the IAT, they first explored people’s attitudes towards ‘flowers’ and ‘insects’ using a sequence of five tasks. In Task 1,
which they termed the initial target concept discrimination trial, participants were required to
discriminate between flowers and insects. In Task 2, the attribute concept discrimination
trial, participants distinguished between words with either a pleasant or unpleasant
connotation. Task 3, the compatible combined trial, involved participants mapping specific
combinations of target and attribute words onto the same response key (e.g., flowers +
pleasant words and insects + unpleasant words). In Task 4, the reversed target concept
discrimination trial, the response keys used to denote flowers and insects in Task 1 were
changed. In the final trial, the incompatible combined trial, the pairing of words used in Task
3 was switched. Greenwald and colleagues hypothesised that because the concept of flowers
and pleasant attributes, and insects and unpleasant attributes, are associated in memory,
participants would be faster during Task 3, when flowers and pleasant words shared the same
response option, compared to Task 5 when flowers and unpleasant words had matching
responses. They concluded that the difference between response latencies for Task 3 and
Task 5 were indicative of an “implicit attitudinal difference between the target categories”
(1998, p. 1466), which is commonly referred to as the IAT effect. In the final study in his
seminal paper, Greenwald assessed participants’ racial preference for Black or White people.
The findings not only showed that racial implicit attitudes could be measured but that these
attitudes were independent of explicit attitudes. Since 1998, the IAT has been adapted and
modified; improving its sophistication and accuracy.

Compared to other implicit instruments, the IAT is the most popular implicit measure
to be used thus far with child samples; this can be credited to Baron & Banaji (2006) who
adapted the IAT to meet the cognitive capacities of child participants. The principles of the
traditional adult IAT remain intact; however, in the Child IAT (CH-IAT) the stimuli used are
presented as either visual images and/or auditory representations, and responses are made by
touching visually salient coloured response buttons or via a touch screen. Recently, further
modifications have been made to ensure this measure is suitable for preschool children. The Preschool IAT (PS-IAT; Cvencek et al., 2011a) is shorter than the traditional IAT and the CH-IAT and all the stimuli remain present on the screen throughout the task to remind participants of the categories they belong to. These adapted versions have been used to assess implicit gender preference (Cvencek et al., 2011a), gender stereotypes (Cvencek, Meltzoff, & Greenwald, 2011b), obesity attitudes (Thomas, Barton-Smith, & Ball, 2007), racial preferences and stereotypes (Baron & Banaji, 2006; Rutland, Cameron, Milne, & McGeorge, 2005; Dunham, Baron & Banaji, 2006, 2007), and recently, minimal group difference preferences (Dunham, Baron, & Carey, 2011). Although most research with children use modified IATs, the traditional ‘adult’ IAT has been used with child and adolescent samples, with no difficulties reported (e.g. Skowronski & Lawrence, 2001; Sinclair, Dunn, & Lowery, 2005; van Goethem, Scholtem, & Wiers, 2010).

Although a popular implicit measure, the IAT has been subject to criticism. Two of its most vocal critiques are DeHouwer (2002) and Barnes-Holmes and colleagues (2006). Both argue that the IAT does not assess attitudes per se, but merely associations between concepts in memory. Although this is an aspect of attitudes, they argue that the nature and direction of these associations is an imperative dimension. Specifically, the IAT does not shed light on how the elements are associated; instead it only assesses the strength of the association. A further criticism of the IAT is that it does not assess conditional attitudes; a considerable limitation given that attitudes often involve multiple concepts and associations. Despite its criticisms, the IAT continues to persist as the most popular implicit measure in the published literature.

As research into the IAT with child populations is in its infancy, there is limited published data on its psychometric properties, however, the research that does exist suggests that it has good internal reliability, $\alpha = .72-.93$ (van Goethem et al., 2010; Cvencek et al.,
2011a; Cvencek et al., 2011b). Only one study has published on the test-retest reliability of the IAT with children and adolescence, demonstrating weak stability ($r = .20$ and $r = .29$
Andrews, Hampson, Greenwald, Gordon, & Widdop, 2010). Research on the predictive validity of child friendly IATs showed it predicted gender-typed activities of 4-year-olds ($r = .53$; Cvencek et al., 2011a) and the allocation of resources to ingroup and outgroup members ($r = .41$; Dunham et al., 2011). Analysis of the IAT’s psychometric properties in the adult literature shows that the IAT has acceptable levels of internal reliability ($\alpha = .7 - .9$; Greenwald & Nosek, 2001; Schmukle & Egloff, 2004) and stable test re-test reliability (median $r = .56$; see Nosek, Greenwald, & Banaji, 2007 for a review). A recent meta-analysis of 122 studies (14,900 subjects) concluded that the IAT has an average $r = .27$ for the prediction of behavioural, self report, and physiological measures (Greenwald, Poehlman, Ulham, & Banaji, 2009). The IAT has also been shown to be flexible in its applicability to a wide range of psychological specialties, from its origins in social and cognitive psychology (Fazio & Olson, 2003; Greenwald & Nosek, 2001) to clinical psychology (deJong, Pasman, Kindt, & van den Hout, 2001; Teachmann, Gregg, & Woody), developmental psychology (Baron & Banaji, 2006; Rutland, et al., 2005; Dunham, et al., 2006; 2007), neuroscience (Phelps et al., 2000; Richeson et al., 2003), market research (Maison, Greenwald, & Bruin, 2001) and health psychology (Teachman, Gapinski, Brownell, Rawlins, & Jeyaram, S., 2003). Due to the prevailing evidence for the IAT as a psychometrically sound measure, its applicability across psychological specialties and as it has been successfully adapted to developmental research; it was deemed the most appropriate implicit measure for this study.

5.8.1 Modifying the IAT for the Present Study

The IAT for this study was developed using Superlab software for MAC by a technician in the School of Psychology in University College Dublin.
5.8.1.2 Name-Behaviour Training

In the present study, the IAT was employed to assess implicit attitudes towards the peers described in the vignettes. Thus, as the target peers in this study were novel to all participants it was essential to provide participants with a training phase during which they learned about the peers’ behavioural characteristics. This was to ensure that the implicit attitudes assessed were towards the vignette characters and not other variables, such as name preference. Previous IAT research assessing implicit attitudes towards novel characters or social groups has demonstrated that implicit attitudes can be formed quickly, are generalisable to other members of the same target group and are durable across time if an attitude training technique is utilised (Gregg, et al., 2006; Ranganath & Nosek, 2008). The name-behaviour training technique employed in this study was based on that used by Ranganath and Nosek. The vignettes, describing two of the target characters (one mental health disorder and a peer without a mental disorder), were presented on a computer screen, one at a time. After participants had read the vignette, they pressed the next button on the response pad to continue. Participants were instructed that a series of sentences describing the two characters would appear on the screen. They were asked to read them carefully as their knowledge of these children would be assessed. They were required to press the next button after reading each name-behaviour pair. Fourteen name-behaviour pairs appeared one at a time on the computer screen. For example, ‘Larry isn’t interested in anything lately.’

After participants were presented with all 14 name-behaviour pairs, they were required to complete a brief identifying task in which the behavioural descriptions were presented again, however, the names of the characters were masked. For example ‘__________ isn’t interested in anything lately.’ Participants were instructed to correctly identify which character was being described by pressing the assigned response button. For example, blue for Larry and yellow for David. The allocation of response key colours were
counterbalanced half way through the task, to prevent participants developing an association between the characters name and a response key. It was thought that this could possibly influence response times on the IAT. The researcher observed responses and ten correct responses were required before completing the IAT. Participants who did not achieve this mark were asked to read the vignettes again and repeat the name-behaviour training procedure.

### 5.8.1.2.1 Target & Attribute Words

The ability of the IAT to assess implicit attitudes hinges on the following: (a) the efficacy of the stimuli exemplars to accurately represent two target categories and two attribute categories; and (b) participant’s ability to identify which category each exemplar belong to as quickly as possible. Thus, much consideration is required when identifying and choosing suitable stimuli. Typically, the stimuli exemplars for the target and attribute categories are either presented as printed words, auditory words, or images. According to Nosek, Greenwald, and Banaji (2007), to ensure that the category membership of the stimuli exemplars is clear and used for categorisation the stimuli exemplars must be identifiable as belonging to one category only. Ambiguous stimuli, or stimuli that have the potential to belong to more than one category, could increase inaccurate responding and induce slow reaction times. Where there is a possibility of confusion over category membership, the distinctiveness of the categories can be enhanced by using different stimulus modalities, e.g. images versus words, different font, or colours.

To avoid using psychiatric labels and overcome the impossibility of capturing ADHD and depression in an image, the names of the vignette peers were the chosen stimuli exemplars for the target categories. Participants responded to the names of target characters (see Table 6.3 below) of one of the following combinations of vignettes: ADHD and ‘normal issues’ or depression and ‘normal issues’. Consistent with the traditional IAT the two
attribute categories were contrasted along good versus bad dimensions. To ensure that the implicit cognitions assessed reflected mental disorder stigma, the stimuli exemplars represented key beliefs and emotions pertaining to the stigmatisation of people with mental illness. The exemplars employed in the bad category were dangerous, scary, guilty, and weak. Contrasting exemplars for the good category were safe, friendly, innocent, and strong. The negative exemplars were chosen to reflect the most pungent stereotypes and prejudices that people with mental disorders are dangerous, are personally responsible for their condition, are weak not sick and should be feared (Corrigan et al., 2002; Corrigan et al., 2007). The magnitude and reliability of IAT effects are mostly unaffected by the number of stimuli representing each category, except when one stimulus exemplar per category is used (Nosek, Greenwald, & Banaji, 2005). However, typically four stimuli per category are employed and thus, the present study adhered to this. For the target categories, the names of the vignette characters were presented in different colours to ensure they constituted four different stimuli. Another important issue to consider when selecting stimuli to represent the target categories is to ensure that stimuli will be sorted on the basis of the hypothesised feature of the study and not another unintended feature (Nosek et al., 2007). In the present study, respondents’ gender was matched to that of the vignette characters, for example, the target categories presented to female participants were the names of the female vignette characters. Gender matching ensured that preference for one character over another was not made on preference for one gender over another. This coupled with the name-behaviour training procedure attempted to ensure that implicit attitude preference was formed on the basis of the target vignette character’s behaviour. In addition, prior to completing the IAT participants were required to sort the attribute stimuli exemplars as either good or bad to ensure that valence of the words were understood.
Table 5.3

Names of the Target Vignette Characters

<table>
<thead>
<tr>
<th>Vignette Type</th>
<th>Depression</th>
<th>ADHD</th>
<th>‘Normal Issues’</th>
</tr>
</thead>
<tbody>
<tr>
<td>Names</td>
<td>Larry/Lauren</td>
<td>Jake/Jane</td>
<td>David/Davina</td>
</tr>
</tbody>
</table>

5.8.1.2.2 Developmental Modifications Made to the IAT

Following the recommendations by Baron and Banaji (2006) to use a developmentally appropriate version with children, modifications were made to the traditional IAT. In the present study, to control for variance across reading ability, the stimuli exemplars were presented simultaneously as written words on the computer screen and auditory words played via headphones. To control for possible variances in fine motor abilities, two large coloured buttons on a response-pad attached to a computer were used instead of the ‘e’ and ‘i’ keys, which are typically used with adult populations. See Figure 5.1 below for a depiction of the IAT used in this study. The words selected to represent the dimensions of stigma were chosen on the basis that they are child friendly exemplars of the construct. The words were piloted to explore participants’ understanding of them. Although the task instructions appeared on the screen, the researcher read the instructions aloud to each participant to ensure that he or she fully understood what was being asked of them. The researcher was also available throughout the administration of the IAT to answer any questions participants had.
Figure 5.1 Examples of the blocks of the IAT used in this study. (Picture modified from Cvencek et al., 2011b)
Chapter 6: Method for Study One

6.1 Aim of Chapter
The aim of this chapter is to illustrate the method employed in the main data collection of Study One. Firstly, this chapter will describe the research design, the participants, and the measures used to assess stigma. Ethical issues will also be discussed. Finally, an overview of the proposed statistical analysis will be discussed.

6.2 Research Design
A cross-sectional quantitative design was employed for this study. However, for a subgroup of participants, a test-retest with a one-month interval was employed. The study incorporated two cohorts of young people that represented 10 to 11-year-olds and 15 to 16-year-olds. Together these age groups provided a snapshot of stigma towards peers with mental health problems, as they exist in late-childhood and mid-adolescence (see Chapter 5 section 5.2 for a rationale). The study was piloted with 38 children and adolescents and minor modifications were made (see Appendix C for details pertaining to the pilot study).

An estimated sample size was calculated using a statistical power package (G*Power) and by reviewing existing literature on mental disorder stigma. The anticipated analysis plan was to conduct a 2x2x2 ANOVA on the data using between subject variables (mental health condition; [ADHD/depression], age [10 to 11-year-olds and 15 to 16-year-olds] and gender of participants) on each dependent variables. Thus, in line with the primary analysis the study was conceptualised as consisting of 8 subgroups. Previous studies assessing attitudes towards peers with mental health disorders have reported effect sizes ranging from .16 to .46 (Cohen’s $D$), thus suggesting small to large effect sizes (Walker et al., 2008). However, it must be noted, these effect sizes are based primarily on single item scales, and do not reflect
the range of independent and dependent variables within the current study. Given that previous studies have not incorporated the range of stigma measures proposed in the current study, and the absence of research involving implicit measures of attitudes towards mental health difficulties in children, it is not possible to accurately justify sample size based on statistical power. However, as the study is a cross sectional design, with 8 subgroups, statistical power analysis using G*Power suggest that a minimum of 240 participants, with equal number of males and females and 10-11 and 15-16 year olds, was needed to yield medium power. It is estimated that this sample and an a priori alpha level of 0.05 will ensure that power will exceed 0.80.

6.3 Participants

Participants were 203 children (96 boys and 107 girls) and 182 adolescents (86 boys and 96 girls), attending primary and post-primary, Board of Education schools in Galway, Ireland ($N = 385$). Participants ranged in age from 10 to 11 years ($M = 10.21$ years, $SD = .72$) and 15 to 16 years ($M = 15.36$ years, $SD = .50$) and were in either year 7 or 12 of education. A proxy measure of participants’ socio-economic status (SES) was calculated from the highest level of education achieved by their consenting parent/guardian. Breakdown of SES among participants was approximately 50% low, 30% middle, and 20% high. All participants had written parental consent and verbally assented to take part in the study.

6.4 Measures

6.4.1 Demographic Information

All consenting parents/guardians completed a demographic questionnaire (see Appendix E). The questionnaire collected information on the following demographic variables:
Chapter 6: Method (Study One)

parent/guardian’s age, level of education, employment status and job title if applicable, participant’s date of birth, and the number of children in the family.

SES was calculated based upon the highest level of education reached by either parent/guardian. Educational categories were as follows: schooling up to Leaving Certificate Level was indicative of low SES, post-Leaving Certificate Education, such as the completion of a Diploma, City and Guild Certificates indicated middle SES, while a Bachelor Degree and higher were considered to be indicative of high SES. Coding of these categories was categorical (Low SES = 1, Middle SES = 2, High SES = 3). According to Elo & Preston (1996), educational attainment is a superior index of SES, when compared to other measures, such as income or occupation, due to the stability of education status over the lifespan and social context.

6.4.2 The Strengths and Difficulties Questionnaire

The Strength and Difficulties Questionnaire (SDQ; Goodman, 1997) is a self-report measure that identifies children and adolescents who may be at risk of experiencing an emotional or behavioural disorder. The SDQ was included in the questionnaire booklet to identify children and adolescents who exhibit behaviours similar to the peers described in the vignettes, as previous research shows that people with disorders have different perceptions of disorders, compared to those without a diagnosis (Rusch et al., 2011). The scale asks participants to respond to questions about their own typical behaviour. The SDQ is a 25-item scale comprising of one Prosocial Scale and five problem-specific subscales (Conduct Problems, Peer Problems, Hyperactivity, and Emotional Problems), which can be summed to produce a Total Difficulties Score. Responses are scored on a 3-point Likert scale, ranging from ‘Not True’ to ‘Certainly True’. This score was dichotomised using recommended cut-off scores for ‘normal/borderline’ (≤ 19) versus ‘abnormal’ (≥ 20) (Goodman, Gatward, & Meltzer, 2000).
Participants with an ‘abnormal’ score on the SDQ were removed from the analysis to ensure that responses obtained were limited to participants without emotional or behavioural difficulties. Previous research has shown that the SDQ is psychometrically sound, with an average internal reliability of $\alpha = .72$ and test re-test reliability of mean =.62 (Goodman, 2001). Internal reliability for this study was $\alpha = .71$

### 6.4.3 Vignettes
The vignettes described peers with ADHD, depression, and a peer with ‘normal issues’ (see Chapter 5 section 5.7.3.1). Psychiatric labels did not accompany the clinical vignettes. There were four versions of each vignette, so that participants received vignettes describing peers who were the same age and gender as them.

### 6.4.4 Contact & Similarity
Two items, assessing contact with peers similar to those described in the vignettes, were employed for descriptive purposes only. The items were employed in previous research (Magiati, et al., 2002; Swords, 2006) and were as follows: ‘Do you know someone who is like [target child]?’ and ‘If yes, how often do you see this person?’ The respective response options were ‘Yes’ or ‘No’ and ‘Every day’, ‘Every week’, ‘Once every few weeks’ and ‘Once every few months’. Responses for the latter item were scored from 1-4, with higher scores reflecting more frequent contact.

Perceived similarity with the target peers was assessed using a single item (Maieron, et al., 1996; Swords, 2006): ‘Do you think that you are like [target child]?’ Response options ranged from ‘a lot’, ‘a little’, ‘not really’, or ‘not at all’. Responses were scored from 1-4, with higher scores indicative of greater perceived similarity to the target child.
6.4.5 Explicit Stigma Measures

6.4.5.1 Social Status & Power

Participants’ perceived social status and the social status of the vignette peers, within the school environment, were assessed using a modified version of the MacArthur Scale of Subjective Social Status-Youth Version (Goodman, et al., 2001). This visual scale consists of a depiction of a ladder; participants were asked to imagine that the ladder represented their school and were told that: ‘At the top of the ladder are the people who are liked the most. At the bottom of the ladder are the people who no one listens to and no one wants to hang around/play with.’ Participants rated their own perceived social status and that of the target peers on three separate ladders that were scored as individual items. Scores ranged from 1 to 10, with higher scores denoting a higher social status. The reliability of this scale is good with interclass correlation coefficients ranging from .73 to .79 (Goodman, et al., 2001).

Power and social dominance were assessed using a paired comparison procedure (Lease, et al., 2002). This procedure is typically used in sociometric nomination studies to assess the profile of children who socially dominate others in the classroom. Participants were told: ‘Some kids/teenagers have influence and power over other kids/teenagers-they get others to do what they want.’ Considering this, participants were asked to ‘Circle the name of the person who you think has more power and influence over the other: Me or Jake; (Jake is a example of a name used to described a peer with ADHD in the vignettes). Each pair was treated as an individual item and scored dichotomously as 0 (peer with mental disorder) or 1 (me).

6.4.5.2 Explicit Attitudes

6.4.5.2.1 Adjective Checklist (ACL; Siperstein, 1980)

The ACL assesses young people’s beliefs, feelings, and expectancies towards a target peer (Siperstein, 2006) and was employed as a general measure of attitude in this study.
Chapter 6: Method (Study One)

Thirty-four adjectives of positive and negative valence, such as ‘crazy’, ‘clever’, unhappy’, and ‘greedy’ were presented to participants. They were asked to circle as many or as few words that they would use to describe the target child to their friends. Subtracting the total number of negative adjectives from the total number of positive adjectives, and adding a constant of 20, produced the ACL. Total scores of 20 or above are indicative of a positive attitude. Cronbach’s alpha for the ACL has been reported to range from 0.76 to 0.91 (Vignes, Coley, Grandjean, Godeau, & Arnaud, 2008). Cronbach’s alpha in this study was 0.85.

6.4.5.2.2 Explicit Stereotypes

Perceptions of ‘Responsibility’ and ‘Dangerousness’ were assessed using single items from the revised Attribution Questionnaire (r-AQ; Corrigan et al., 2007). ‘Responsibility’: ‘It is not [target child’s] fault that he/she acts like this’. ‘Dangerousness’: [target child] is not dangerous’. Scores ranged from 1-7 and items were coded so that higher scores indicated stronger stereotypes.

6.4.5.2.3 Explicit Prejudice

Emotional responses to the peers were also assessed using two individual modified r-AQ single items. ‘Anger’: ‘[target child] would make me angry’. ‘Fear’: ‘I would be scared of [target child]’. Scores ranged from 1-7, with higher scores indicating more prejudice.

6.4.5.3 Discrimination

6.4.5.3.1 Shared Activity Questionnaire (SAQ; Morgan, et al., 1996)

The SAQ was used to assess participants’ behavioural intentions to engage in social, academic, and recreational activities with the target peer. The SAQ consists of 24 items, and scores range from 24-72. Higher scores indicated greater behavioural intentions to include the
target peer in activities across the following three domains: general social: ‘Be good friends with [target child] at school’, academic: ‘Study spelling words with [target child] at school’ and active recreational: ‘Pick [target child] to be on my soccer team’. Response options range from no, maybe, yes. The SAQ demonstrates good internal consistency (α = .95; Vignes, Coley, Grandjean, Godeau, & Arnaud, 2008). Internal consistency for this study was α = .94.

6.4.5.3.2 Social Distance

Two indices of social distance were explored: relationship social distance and physical social distance. Relationship social distance was assessed with the Classroom Social Distance Scale (Horace Mann-Lincoln Institute of School Experimentation, 1957). Participants indicated the type of relationship he/she wanted with the peer by selecting one response option. Responses ranged from ‘I would like to have [target child] as one of my best friends’ to ‘I wouldn’t want [target child] in my class’, on a scale of 1-5. Higher scores reflected greater relationship social distance.

Physical social distance was assessed with a modified version of Weiss’ (1986) paper-and-pencil projective figure placement test. Participants were presented with a stick image of the peer sitting at a desk and selected a seat where they would feel relaxed working with him/her. Scores ranged from 1-7, with higher scores indicating more physical social distance.

6.4.6 Implicit Measure

6.4.6.1 Equipment

Two 13-inch MacBooks and two MLE1305 Response Pads were used.
6.4.6.2 Name-Behaviour Training (NBT)

To ensure assessed implicit attitudes were towards the vignette peers, and not name preference, a NBT procedure similar to Ranganath and Nosek’s (2008) attitude induction procedure was used. Participants read the vignettes and fourteen named behavioural descriptions on a laptop. They then identified the peers by matching the names and unnamed behavioural descriptions. Ten correct responses were required before completing the IAT.

6.4.6.3 Implicit Association Test (IAT; Greenwald, et al., 1998)

Following Baron and Banaji’s (2006) recommendations to use a developmentally appropriate IAT with children, the standard IAT was modified to assess participants’ implicit attitudes. This computer response latency measure is a dichotomous categorisation task that requires participants to sort four types of stimuli into two response buttons. The stimuli are exemplars of two target categories (e.g. mental health disorder versus no mental health disorder) and two contrasting attribute categories (e.g. good versus bad). The task rests on the assumption that it is easier to sort stimuli from two categories that are associated with one another, compared to categories that are not associated. In a typical IAT, the stimuli are presented as images or labels. To avoid using psychiatric labels, and overcome the impossibility of capturing ADHD and depression in an image, the names of the vignette peers were used as the target stimuli and were presented in four different colours. Consistent with the condition that participants were assigned to, participants responded to the names of one of the following combinations of vignettes: ADHD and ‘normal issues’ or depression and ‘normal issues’. See Table 6.1 below for details of the names of the peers described in the vignettes. The attribute stimuli were chosen to reflect dimensions of stigma: bad (dangerous, scary, guilty, weak) and good (safe, friendly, innocent, strong). All stimuli were presented simultaneously as written and auditory words. Prior to completing the IAT, participants were
required to sort the attribute stimuli as either *good* or *bad*, to ensure that valence of the words was understood.

Table 6.1

*Names of the Target Vignette Characters*

<table>
<thead>
<tr>
<th>Vignette Type</th>
<th>Depression</th>
<th>ADHD</th>
<th>‘Normal Issues’</th>
</tr>
</thead>
<tbody>
<tr>
<td>Names</td>
<td>Larry/Lauren</td>
<td>Jake/Jane</td>
<td>David/Davina</td>
</tr>
</tbody>
</table>

First, participants practiced target categorisation (the peer with a disorder versus the peer with normal issues), with a blue and yellow response button (20 trials). In the second block, they practiced attribute categorisation (*good* versus *bad* words, 20 trials) using the fore-mentioned response buttons. After this, they completed two combined discrimination blocks, during which participants mapped specific combinations of target and attribute stimuli onto the same response button. For example, if Jake (ADHD) or *bad* words were presented, participants pressed the blue response button and if David (normal issues) and *good* words were presented, the yellow response button was pressed (20 practice trials; 40 test trials). Next participants practiced matching names of the peers with the opposite response buttons (20 trials). If Jake (ADHD) was previously paired with the blue response button, the yellow button was pressed when presented with this name. Finally, they completed two more combined discrimination blocks whereby the previous pairing of the combined blocks was reversed; for example, David and *bad* words shared the blue response button and Jake and *good* words shared the yellow response button (20 practice trials; 40 test trials). A correct response was required before progressing to the next stimulus presentation,
and response latencies were recorded from the presentation of the stimulus to the correct response. The initial pairing of the names of vignette peers and good/bad words was counterbalanced across participants. The inter-stimulus interval was 300ms. A single IAT $D$-score for the task was calculated using the improved scoring algorithm recommended by Greenwald, Nosek, and Banaji (2003). A score of zero indicated a neutral attitude towards both peers, while positive scores indicated a negative evaluation of the peer with the mental health disorder. Further information on the scoring of the implicit measure is available in Chapter 8 section 8.2.

6.5 Procedure
6.5.1 Recruiting Participants

Participants were recruited through their schools. To control for the possibility of social and economic factors influencing children’s responses, the present research was framed within the context of diversity. The initial selection of schools reflected the distribution of advantaged versus disadvantaged schools registered in this region of Ireland (disadvantaged primary: 16.2%; disadvantaged post primary: 24%).

Eighteen schools were invited to take part in the study. Information packages were sent to each of the selected schools. The information package consisted of a letter addressed to the school principal, which described the aims and objectives of the study, the anticipated procedure, and information about the researchers (See Appendix D). The schools were then contacted a week after the letters had been received. In most schools the principal was not the direct person of contact; instead a designated teacher was the liaison person between the researcher, principal, and students. Schools that were unable to participate in the study were thanked for their time and removed from the list. Consent was obtained from ten schools (7 primary and 5 post-primary schools), with an overall consent rate of 66.67%. Among
students who took part in the study, 16.88% and 12.4% of primary students and secondary students, respectively attended disadvantaged schools. The average proportion of participants recruited from any one school was 7.21% ($SD = 3.46$) of the total sample.

A date for data collection was agreed upon with the schools that were willing to participate. Information letters and consent forms for parents/guardians and information letters for students were delivered to the school by the researcher a week prior to commencing data collection (see Appendix E and F). School staff requested that students bring the study information home to their parents. The parents of 467 children and adolescents were invited to provide consent for their child to take part. From this 84.80% ($n = 396$) of parents provided written consent while 4.28% ($n = 20$) did not and a further 10.71% ($n = 51$) did not respond. The final participant count was 385 (11 absences).

From the schools selected, one primary and one post-primary school were invited to take part in the test-retest phase of the research. Both selected schools agreed to take part and students from one class from each school were invited to take part. A total of 34 students (20 primary students and 14 post primary students) with parental consent verbally assented to take part.

### 6.5.2 Introducing the Study

The class teacher introduced the participants to the researcher. The researcher explained that she was a postgraduate student in the School of Psychology in the National University of Ireland. She told the class that psychologists were interested in finding out about how people think, feel, and act. She said that she was interested in learning about what young people in Ireland think of other people their own age, and why they become friends with some people, and not others. They were told that they would be given a questionnaire to complete and would also complete a computer task on the researcher’s laptop. They were informed that the
first part of the questionnaire asked them questions about themselves, they would then be instructed to read two stories about two young people and answer questions on their own feelings and thoughts towards the person they read about. They were then told that, during the computer task, they would match the names of the peers they read about with words that may or may not describe them. Participants taking part in the test-retest were told that in 4-weeks time they would be asked to complete the computer task again. To ensure all ethical considerations, (see section 6.7), were adhered to, the following points were emphasised:

- Participation is entirely voluntary and participants can withdraw their participation at any time, without consequence.
- Participation is anonymous. Any identifying information provided by the parents/guardians on the demographic questionnaire would be stored securely in a filing cabinet. Names linking participants and their families to personal information will be stored separately and each participant will be given a code number. This code number would be used to link the demographic questionnaire to participants’ response booklets and IAT output sheets.
- A full debriefing report and a summary of the findings would be sent to their schools after the data has been analysed.

After these ethical considerations were outlined to potential participants, their assent was sought. Participants were randomly assigned to an ADHD or depression condition and provided with one of eight versions of the questionnaire booklet that comprised of the SDQ, two vignettes, and a stigma questionnaire. Specifically, participants received a booklet consisting of stories and questions pertaining to an age and gender matched peer with ‘normal issues’ and a peer with a mental health disorder, either ADHD or depression (see Appendix G). The presentation of the vignettes was counterbalanced across participants. Participants’ attention was then directed to the booklets, they were instructed to write their
age and initials on the booklet. The researcher then read aloud the instructions outlined on the booklet as follows:

- The first part of the questionnaire asks you questions about how you feel, think and behave. Answer the questions by ticking the response box that best matches how you usually are.

- You will then read about two children/young people and answer questions about your thoughts and feelings towards them.

- You might know other children/young people with the same names as the boys and girls/young people described in the stories, but these children/teenagers are not children/teenagers that you know and they do not go to your school or live near you.

- This is not a test. There are no right or wrong answers but please answer the questions honestly.

### 6.5.3 Completing the Study

Participants completed the questionnaire booklet independently in their classrooms. After this, participants read the vignettes again and individually completed the NBT and the IAT in a quiet empty room on a laptop. The presentation order of implicit and explicit measures does not affect explicit and implicit mean scores (Nosek, Greenwald, & Banaji, 2005). Participants who completed the test re-test phase completed the NBT and IAT only at the repeat time point (4-weeks later).
6.6 Ethical Issues & Considerations

The National University of Ireland, Galway Ethics Committee granted ethical approval for this study by on the 16th March 2010. The key ethical considerations for this study are presented below.

The primary ethical concern was obtaining informed voluntary consent of parents and assent of participating children and adolescents. The information letter and leaflet given to parents specifically detailed the aims of the research project and the role expected of their child. The procedure was explained; parents were informed that their child would only have to participate once during the study. An exception to this however, was participants who were invited to take part in the test re-test phase of the IAT. The parents of these children were told that their son/daughter would take part in the study twice, over a one-month interval. The information leaflet explained that children would have to read two vignettes describing different children and complete a questionnaire about these children. They were also informed that they would complete a word association task on the researcher’s laptop. The leaflet explained that children would also have to complete a questionnaire asking them about their own behaviour. A rationale for including this questionnaire was provided and the protocol for participants who scores exceed the cut off point for being at risk of having an emotional or behavioural problem was also outlined. A guarantee of confidentiality and anonymity was provided, and parents were reassured that their child could withdraw from the study at any time during the research process, without consequence. The researcher’s contact details were also provided if any parent required more information on the study.

With regards to the information sheet provided to participants, the aims and procedure of the research were clearly explained (Appendix F). Children were told that their participation was voluntary and that they had a right to withdraw from the study at anytime. They were also told they could skip any questions that they did not want to answer.
Confidentiality and anonymity were explained. Prior to commencing the research a verbal description of protocol was also provided. All the above information was reiterated and participants were encouraged to voice any concerns or questions they had to the researcher.

An additional ethical concern was the possibility that the vignettes describing peers with mental health problems could be interpreted as descriptive of specific children in the schools where the research was being conducted. Another concern was the possibility that individual participants would identify themselves as similar to a child described in the vignettes and subsequently feel that he/she is being singled out as different or problematic. In an attempt to eliminate these possibilities, all participants were explicitly told that the children described in the vignettes did not attend their school and were not from their area. It was also thought that by including a vignette describing a ‘typically’ developing child the emphasis on ‘atypical’ behaviour would be reduced, as participants were asked their views on a range of children and behaviours. Labelling the behaviours of the characters described in the vignettes was also avoided. This allowed participants to not only formulate their own views on the behaviours of the target children, but also avoided any pejorative labelling of behaviours that participants may identify themselves with.

The final ethical issue that was addressed in this study was the use of The Strengths and Difficulties Questionnaire (SDQ; Goodman, 1999). This questionnaire is a pre-screening assessment tool to identify children and adolescents who may experience symptoms associated with emotional and behavioural problems. Asking participants about their emotions and behaviour could induce possible distress. Participants were reassured that they could skip any questions that they were not comfortable answering. Utilising this scale posed the possibility of identifying children at possible risk of an undiagnosed mental health disorder. A protocol for addressing this issue was developed to ensure that parents of such children were informed of this possibility and provided with information to seek subsequent
professional assessment for their child if they so wished. The protocol was as follows: parents of the identified child or adolescent were informed of this possibility by the researcher via a telephone call and a subsequent letter (see Appendix H). The letter and telephone call stressed that the questionnaire is not a diagnostic tool and recommended that if the parent had concerns, they should contact their local General Practitioner to discuss further assessment and steps that should be taken.

6.7 Debriefing

Following both the implicit and explicit assessments, participants were thanked for their participation and an informal debriefing was carried out, during which the researcher answered any questions they had. Participants were also told that when data collection was completed and analysed, an official debriefing report and summary would be sent to their school and given to them by their teachers.

6.8 Statistical Analysis

The data were analysed using PASW (SPSS) for Windows version 18. The Expectation Maximization (EM) algorithm was applied to the data set to control for missing responses. The assumptions of the proposed statistical test were assessed prior to performing each analysis, where assumptions were violated, steps were taken to normalise the data. Differences between explicit responses towards the peer with ‘normal’ issues and the comparative peer with a mental health disorder were explored using a series of paired samples $t$ tests. IAT $D$-scores were analysed using one-sample $t$ tests. A series of 2x2x2 between subjects factorial ANOVAs were calculated using participants’ gender and age and the disorder of the vignette peer as the between group factors. Implicit attitudes, explicit attitudes, stereotypes, prejudice and discrimination were the dependent variables. Effect sizes
were calculated using partial $\eta^2$ ($p\eta^2$). Interactions were explored with simple effect $F$ tests. Pearson’s Product Moment bi-variate correlations were performed to assess the stability of the IAT. Internal consistency of the IAT was assessed using Spearman-Brown Correction split half correlations. To assess the relationship between the implicit and explicit measures, Pearson’s bi-variate correlations between implicit and explicit attitudes were conducted. Multivariate linear regression equations were calculated to explore whether implicit attitudes, explicit prejudice, and stereotypes predicted behavioural intentions towards the target peers. Results specific to the explicit measures are presented in Chapter 7, while results pertaining to the implicit measures are presented in Chapter 8.
Chapter 7: The Results of the Explicit Measures from Study One

7.1 Aim of Chapter

This chapter presents the explicit results from Study One. Firstly, preliminary analysis of the participant groups and the treatment of missing data will be presented. Following a series of paired samples $t$ tests, a rationale for excluding the comparative peer without a mental health problem will be presented. Then, reliability of the measures and the assumptions for the proposed statistical tests will be explored. Results from the analysis of all the stigma related variables will then be presented, which includes an assessment of whether stigma can occur by exploring social status and power, followed by a comprehensive assessment of the nature and extent of stigmatisation using a series of 2x2x2 factorial ANOVAs. The dependent stigma variables were as follows; general attitudes, stereotypes, prejudice, and discrimination (behavioural intentions, relationship and physical social distance). The independent variables were the participants’ age and gender, and the type of mental health problem described in the vignette.

7.2 Preliminary Analysis

7.2.1 Randomisation

Chi-square analyses of the data revealed no significant differences between participants’ gender, age, SES, or the order in which the vignettes were presented across the two experimental conditions (see Table 7.1). Thus, demonstrating that randomisation of participants to the experimental conditions was effective.
Table 7.1

*Characteristics of Participants and Order of Vignettes in Each Experimental Condition*

<table>
<thead>
<tr>
<th>Experimental Condition</th>
<th>Depression</th>
<th>ADHD</th>
<th>$\chi^2$</th>
</tr>
</thead>
<tbody>
<tr>
<td>n</td>
<td>n</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gender</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>88</td>
<td>94</td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>106</td>
<td>97</td>
<td>.57</td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10-11 years</td>
<td>102</td>
<td>101</td>
<td></td>
</tr>
<tr>
<td>15-16 years</td>
<td>92</td>
<td>90</td>
<td>.004</td>
</tr>
<tr>
<td>Order of Vignettes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Experimental first</td>
<td>80</td>
<td>83</td>
<td></td>
</tr>
<tr>
<td>Control first</td>
<td>81</td>
<td>76</td>
<td>.202</td>
</tr>
<tr>
<td>SES</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low (second level</td>
<td>75</td>
<td>93</td>
<td></td>
</tr>
<tr>
<td>completion only)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Middle (post-second</td>
<td>52</td>
<td>48</td>
<td></td>
</tr>
<tr>
<td>level diploma or</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>certificate)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High (degree or higher)</td>
<td>38</td>
<td>29</td>
<td>3.22</td>
</tr>
</tbody>
</table>
7.2.2 Screening the Sample

7.2.2.1 The Strengths & Difficulties Questionnaire (SDQ)

The SDQ was included in this study to identify children and adolescents who exhibit behaviours similar to the peers described in the vignettes. Descriptive analysis of the SDQ revealed a mean score of 10.33 ($SD = 4.89$) on the Total Difficulties Scale (see Table 7.2 below). This was deemed within the normal range, as per the standardised scores for the SDQ (Meltzer, Gatward, Goodman, & Ford, 2000). Ten participants obtained ‘abnormal’ Total Difficulties scores and were subsequently removed from the analysis ($n = 375$). These participants were removed as research in the adult literature suggests that people with mental health problems often have different views about mental disorders compared to those without a diagnosis (Rüsch et al., 2011). Thus, this study attempted to ensure that the data represented the views of peers without emotional and behavioural problems only.

Table 7.2
Total Mean, Standard Deviations, and Reliability for the Strengths & Difficulties Questionnaire

<table>
<thead>
<tr>
<th>Strengths &amp; Difficulties Questionnaire</th>
<th>M</th>
<th>SD</th>
<th>$\alpha$</th>
<th>Minima-Maxima</th>
</tr>
</thead>
<tbody>
<tr>
<td>SDQ TD Scale</td>
<td>10.33</td>
<td>4.89</td>
<td>.70</td>
<td>0-25</td>
</tr>
</tbody>
</table>

7.2.3 Treatment of Missing Data

Preliminary screening of the explicit stigma questionnaire data revealed that the nature of the missing data were missing completely at random (MCAR). As no participants had more than 10% missing data, all participants were preserved in the analysis. Missing data were imputed using the Expectation Maximization (EM) algorithm (Schafer, 1997). EM is an iterative
estimation statistical procedure that replaces missing data with maximum likelihood estimates over the spread of missing values (Schafer, 1997). It rests on the premise that observed values provide indirect information on missing values. As a result of these implied relations, values are estimated for missing cells. Research by Graham, Hofer, and McKinnon (1996) demonstrated that the degree of imprecision for this method is negligible. In addition, EM is a more superior method than traditional approaches, such as pairwise deletion or listwise deletion (Bunting, Adamson, & Mulhall, 2002).

### 7.2.4 Differences between Responses toward the Peers with and without a Mental Health Disorder

Paired sample $t$ tests revealed that participants exhibited significantly more positive responses toward the ‘typical’ peer, compared to the peer with ADHD, across all the dependent variables. Furthermore, significantly more positive responses were found in response to the ‘typical’ peer, when compared to the peer with depression, on all the dependent variables, except perceived responsibility (see Table 7.3). Given these established differences in how young people view those with mental health issues versus those without, this research from here on in, will conduct a more in-depth analysis on the type of mental health disorder (along with participants’ age and gender) and how these impact on stigma. Therefore, the explicit findings pertaining to the ‘typical’ peer were excluded from the subsequent analysis.
Table 7.3

*Overall Means (SD) for Comparative Vignettes in Both Experimental Conditions*

<table>
<thead>
<tr>
<th>Experimental Condition</th>
<th>Depression</th>
<th>ADHD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vignette: Depression</td>
<td>ACL</td>
<td>Stereotypes</td>
</tr>
<tr>
<td></td>
<td>18.50 (4.63)</td>
<td>3.28 (2.26)</td>
</tr>
<tr>
<td>Vignette: Normal issues</td>
<td>28.19 (16.09)**</td>
<td>2.84 (2.30)*</td>
</tr>
<tr>
<td></td>
<td>18.26 (4.13)</td>
<td>3.51 (2.17)</td>
</tr>
<tr>
<td>Vignette: ADHD</td>
<td>26.76 (3.67)**</td>
<td>2.64 (2.25)**</td>
</tr>
<tr>
<td>Vignette: Normal issues</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Stereotypes*
- Dangerousness
  - Depression: 3.28 (2.26)
  - ADHD: 3.51 (2.17)
- Responsibility
  - Depression: 3.67 (2.00)
  - ADHD: 4.48 (2.02)

*Prejudice*
- Fear
  - Depression: 1.74 (1.10)
  - ADHD: 1.95 (1.18)
- Anger
  - Depression: 2.50 (1.51)
  - ADHD: 3.34 (2.01)

*Discrimination*
- Behavioural intentions
  - Depression: 52.20 (12.18)
  - ADHD: 47.76 (13.55)
- Relationship social distance
  - Depression: 2.31 (1.07)
  - ADHD: 2.72 (1.90)
- Physical social distance
  - Depression: 2.55 (1.77)
  - ADHD: 3.16 (2.03)

*Note.* *p < 0.05, **p < 0.001

7.2.5 Examining the Psychometric Properties of the Variables & Assumptions of

*Parametric Tests*

Initial analysis of the skewness scores demonstrated that the ACL, fear, and physical social distance were positively skewed. All other variables were normally distributed. While there is no consensus on the recommended standardised cut-off values for skewness and kurtosis, scores greater than 1.96 are statistically significant, as determined by dividing the output score by its corresponding standard error. Scores below +/- 3 and +/- 7 are considered acceptable skewness and kurtosis values, respectively (Finney & DiStefano, 2006; Mindrila, 2010). However, examining graphical depictions of the spread of scores and using personal
judgement in determining the severity of abnormality is also recommended, as skewness and kurtosis can vary with sample size (Howell, 2007). Examining the spread of scores across each variable showed that the distribution of scores for the ACL was reasonably normally distributed, thus, data for this variable were not transformed. For scrutiny, log transformations were performed on all other skewed variables. All analyses were conducted with the untransformed and transformed data. The results pertaining to the transformed data for the variables fear and physical social distance did not differ from the original data, thus results of the untransformed data for this variable are presented in this thesis.

Initial investigations also showed the Levene’s test for equality of variance was significant for the following variables; behavioural intentions, relationship social distance, physical social distance, and fear. ANOVA is generally conceptualised as a robust test that can be used when assumptions are violated. According to Howell (2007), ANOVA can handle differences in variance up to four times between the smallest and largest. Analysis of the variance of these variables showed that the variance between the smallest and largest was less than fourfold, on all independent variables. In addition, the default Levene’s test (1960) produced by PASW 18 assesses heterogeneity of variance using mean scores, which runs the risk of type I and type II errors (Carrol & Schneider, 1985; Nordstokke & Zumbo, 2007; Shoemaker, 2003; Zimmerman, 2004). Nordstokke and Zumbo showed that when compared to the $F$-test of equal variance, which Levene’s intended to originally replace, the latter was often equivocally as poor a detector of homogeneity. Instead, a non-parametric Levene’s test that assesses median scores has been shown to be a more accurate and reliable assessment of heterogeneity and is especially recommended for when data is not normally distributed (Nordstokke & Zumbo, 2007; Nordstokke & Zumbo, 2010). Individual non-parametric Levene’s tests were conducted on the aforementioned skewed dependent variables across all
groups (age, gender, mental health condition) and revealed homogeneity of variance ($p > 0.05$).

### 7.2.6 Descriptive Statistics and Reliability of the Explicit Measures

Means, standard deviations, range, and scale score reliabilities (where applicable) are presented in Table 7.2 above and Table 7.4 below. The mean scores for the overall sample show that participants’ responses to measures of general attitude towards the peers, as measured by the ACL, are below 20, the cut-off point for positive attitudes. Mean scores for perceived dangerousness of the target peers fell at the mid-point indicating that participants displayed neutral attitudes on this construct. Average scores for perceived responsibility resided below and above the mid-point for peers with depression and ADHD respectively. This indicated that participants thought that the peer with depression was not personally responsible for his or her condition, while they believed the peer with ADHD was slightly responsible for his or her disorder. Mean scores for prejudicial anger and fear towards both target peers fell below the mid point, indicating that participants disagreed that they would be afraid of these peer or that the peer would make them angry. For behavioural intentions towards the character with depression, the mean score resided above the mid-point, suggesting slightly positive acceptance of that peer. Conversely, the mean score for behavioural intentions towards the character with ADHD fell below the mid-point, indicating low acceptance. For relationship social distance towards the peer with depression and ADHD, the means were above the mid-point; this indicated that participants reported that they would only like to be in the company of the target peer every so often. For physical social distance from both peers, the means were below the mid-point, suggesting that participants did not want great physical social distance from the peers. For perceived social status of the target peers, the means were again below the mid-point, which indicated that
participants perceived that the peers had low social status. Finally, for perceived power, the majority of scores were greater than zero, indicating that participants perceived themselves to be more powerful and influential than the target peers. Average scores across the DVs for the whole sample were more negative towards the peer with ADHD, except for social status; the peer with depression was rated as having lower social status than the peer with ADHD.

Pearson’s Product Moment Correlations for the explicit stigma measures are presented in Tables 7.5 and 7.6 below. The results showed that in response to the peer with depression, the strength of most correlations was low to moderate; however, strong correlations were found between the discrimination measures. Similar patterns of correlations were found in response to the peer with ADHD; however, strong negative correlations were also found between the social status and the three discrimination measures.
Table 7.4
Total Mean, Standard Deviations, and Reliability for the Explicit Measures

<table>
<thead>
<tr>
<th></th>
<th>Depression Condition</th>
<th></th>
<th>ADHD</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
<td>SD</td>
<td>α</td>
<td>Minima-Maxima</td>
</tr>
<tr>
<td>ACL</td>
<td>18.52</td>
<td>4.67</td>
<td>.85</td>
<td>6-25</td>
</tr>
<tr>
<td>Dangerousness</td>
<td>3.28</td>
<td>2.26</td>
<td>_</td>
<td>1-7</td>
</tr>
<tr>
<td>Perceived Responsibility</td>
<td>3.67</td>
<td>1.97</td>
<td>_</td>
<td>1-7</td>
</tr>
<tr>
<td>Anger</td>
<td>2.50</td>
<td>1.51</td>
<td>_</td>
<td>1-7</td>
</tr>
<tr>
<td>Fear</td>
<td>1.78</td>
<td>1.10</td>
<td>_</td>
<td>1-5</td>
</tr>
<tr>
<td>Behavioural Intentions</td>
<td>52.18</td>
<td>12.49</td>
<td>.94</td>
<td>24-72</td>
</tr>
<tr>
<td>Relationship Social Distance</td>
<td>2.30</td>
<td>1.07</td>
<td>_</td>
<td>1-5</td>
</tr>
<tr>
<td>Physical Social Distance</td>
<td>2.54</td>
<td>1.77</td>
<td>_</td>
<td>1-7</td>
</tr>
<tr>
<td>Social Status</td>
<td>4.35</td>
<td>2.33</td>
<td>_</td>
<td>1-10</td>
</tr>
</tbody>
</table>
Table 7.5

Pearson’s Product Correlations among the Explicit Measures for the Peer with Depression

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. ACL</td>
<td></td>
<td>-</td>
<td>-05</td>
<td>-05</td>
<td>-.12</td>
<td>-.14</td>
<td>.18*</td>
<td>-.18*</td>
<td>-.18*</td>
</tr>
<tr>
<td>2. Dangerousness</td>
<td>-.05</td>
<td>-</td>
<td></td>
<td>.90</td>
<td>.17*</td>
<td>.02</td>
<td>-.11</td>
<td>.12</td>
<td>.03</td>
</tr>
<tr>
<td>3. Responsibility</td>
<td>-.05</td>
<td>.09</td>
<td>_</td>
<td>-.01</td>
<td>.08</td>
<td>-.30**</td>
<td>.12</td>
<td>.13</td>
<td>-.18*</td>
</tr>
<tr>
<td>4. Anger</td>
<td>-.11</td>
<td>.17*</td>
<td>-.01</td>
<td>_</td>
<td></td>
<td>.32**</td>
<td>-.20**</td>
<td>.31**</td>
<td>.20**</td>
</tr>
<tr>
<td>5. Fear</td>
<td>-.14</td>
<td>.02</td>
<td>.08</td>
<td>.32**</td>
<td>_</td>
<td>-.12</td>
<td>.10</td>
<td>.18*</td>
<td>-.11</td>
</tr>
<tr>
<td>6. Behavioural Intentions</td>
<td>.18*</td>
<td>-.11</td>
<td>-.30**</td>
<td>-.20**</td>
<td>-.12</td>
<td>_</td>
<td>-.63**</td>
<td>-.62**</td>
<td>-.41**</td>
</tr>
<tr>
<td>7. Relationship Social Distance</td>
<td>-.18*</td>
<td>.03</td>
<td>.12</td>
<td>.31**</td>
<td>.10</td>
<td>-.63**</td>
<td>_</td>
<td>.55**</td>
<td>-.38</td>
</tr>
<tr>
<td>8. Physical Social Distance</td>
<td>-.18*</td>
<td>.03</td>
<td>.13</td>
<td>.20**</td>
<td>.18*</td>
<td>-.62**</td>
<td>.55**</td>
<td>_</td>
<td>-.37**</td>
</tr>
<tr>
<td>9. Social Status</td>
<td>.27**</td>
<td>-.14</td>
<td>-.18*</td>
<td>-.18*</td>
<td>-.11</td>
<td>.41</td>
<td>-.38*</td>
<td>-.37**</td>
<td>_</td>
</tr>
</tbody>
</table>

*Note. *p < 0.05, **p < 0.01.*
Table 7.6

*Pearson’s Product Correlations among the Explicit Measures for the Peer with ADHD*

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. ACL</td>
<td>-</td>
<td>-.05</td>
<td>-.10</td>
<td>-.12</td>
<td>-.12*</td>
<td>.35**</td>
<td>-.32**</td>
<td>-.26**</td>
<td>.27**</td>
</tr>
<tr>
<td>2. Dangerousness</td>
<td>-.05</td>
<td>-</td>
<td>.24**</td>
<td>-.05</td>
<td>.12</td>
<td>-.18*</td>
<td>.08</td>
<td>.20**</td>
<td>-.10</td>
</tr>
<tr>
<td>3. Perceived Responsibility</td>
<td>-.10</td>
<td>.24**</td>
<td>-</td>
<td>-.04</td>
<td>.00</td>
<td>-.30**</td>
<td>.14</td>
<td>.27**</td>
<td>-.12</td>
</tr>
<tr>
<td>4. Anger</td>
<td>-.12</td>
<td>-.05</td>
<td>-.04</td>
<td>-</td>
<td>.25**</td>
<td>-.40**</td>
<td>.30**</td>
<td>.26**</td>
<td>-.36**</td>
</tr>
<tr>
<td>5. Fear</td>
<td>-.19*</td>
<td>.12</td>
<td>.00</td>
<td>.25**</td>
<td>-</td>
<td>-.25**</td>
<td>.07</td>
<td>.17*</td>
<td>-.18*</td>
</tr>
<tr>
<td>6. Behavioural Intentions</td>
<td>.35**</td>
<td>-.18*</td>
<td>-.30**</td>
<td>-.40**</td>
<td>-.25**</td>
<td>-</td>
<td>.66**</td>
<td>-.61**</td>
<td>.62**</td>
</tr>
<tr>
<td>7. Relationship Social Distance</td>
<td>-.32</td>
<td>.08</td>
<td>.14</td>
<td>.30**</td>
<td>.07</td>
<td>-.64**</td>
<td>-</td>
<td>.64**</td>
<td>-.46**</td>
</tr>
<tr>
<td>8. Physical Social Distance</td>
<td>-.26**</td>
<td>.20**</td>
<td>.27**</td>
<td>.26**</td>
<td>.17*</td>
<td>-.61**</td>
<td>.64**</td>
<td>-</td>
<td>-.55**</td>
</tr>
<tr>
<td>9. Social Status</td>
<td>.27**</td>
<td>-.10</td>
<td>-.12</td>
<td>-.36**</td>
<td>-.18*</td>
<td>.62**</td>
<td>-.46**</td>
<td>-.55**</td>
<td>-</td>
</tr>
</tbody>
</table>

*Note. *p < 0.05, **p < 0.01.*
7.2.7 An Exploratory Investigation into Perceived Familiarity, Contact, and Similarity

Of the two mental health disorders, ADHD was more familiar to participants than depression. Sixty-four percent of participants in the ADHD condition reported knowing somebody like the peer with ADHD, whereas only 35% of participants in the depression condition reported knowing someone like the peer with depression. Chi-square analysis revealed that significantly more participants reported knowing a peer similar to the vignette character with ADHD compared to depression. There were no significant differences in the frequency with which participants had contact with peers with the target disorders. Participants were not significantly more likely to perceive themselves as similar to one particular disorder (see Tables 7.7 below for frequency and \( \chi^2 \) statistics for familiarity, contact and similarity with the target peer).

A further set of chi-square analyses were conducted to investigate whether any age or gender groups, or age by gender groups, had more contact with or perceived themselves as similar to the target peers. The analysis showed that adolescents were significantly more likely than younger children to know a person with ADHD \( [\chi^2(1, 186) = 6.01, p = 0.01] \). Neither age group were significant more likely to know a peer with depression \( [\chi^2(1, 186) = .53, p > 0.05] \). Males were significantly more likely to report knowing a peer with ADHD compared to females \( [\chi^2(1, 186) = 4.07, p = 0.04] \). No significant differences were in were found between the frequency with which males and females reported knowing a peer with depression \( [\chi^2(1, 186) = 6.6, p > 0.05] \). There were no significant differences in the frequency in which either age group believed they were similar to the peer with depression \( [\chi^2(1, 186) = 3.50, p > 0.05] \) or ADHD \( [\chi^2(1, 186) = 5.2, p > 0.05] \). Likewise, neither gender group were more likely to report being similar to either the peer with depression \( [\chi^2(1, 186) = 8.60, p > 0.05] \) or ADHD \( [\chi^2(1, 186) = .40, p > 0.05] \). No significant differences in
familiarity or similarity with the target peers were observed between the gender groups in each age cohort (see Table 7.8 below).

Table 7.7
Participants Perceived Familiarity, Contact, and Similarity With the Target Peers

<table>
<thead>
<tr>
<th>Experimental Condition</th>
<th>Depression</th>
<th>ADHD</th>
<th>(\chi^2)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(n (%))</td>
<td>(n (%))</td>
<td></td>
</tr>
<tr>
<td>Do you know someone like [target child]?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>66 (34.9%)</td>
<td>113 (60.8%)</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>123 (65.1%)</td>
<td>73 (39.2%)</td>
<td>25.07*</td>
</tr>
<tr>
<td>If so, how often do you see him/her?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Once every few months</td>
<td>13 (19.1%)</td>
<td>13 (11.50%)</td>
<td></td>
</tr>
<tr>
<td>Once every few weeks</td>
<td>10 (14.70%)</td>
<td>18 (15.90%)</td>
<td></td>
</tr>
<tr>
<td>Once every week</td>
<td>18 (26.50%)</td>
<td>27 (23.90%)</td>
<td></td>
</tr>
<tr>
<td>Once every day</td>
<td>26 (38.20%)</td>
<td>55 (48.70%)</td>
<td>4.65</td>
</tr>
<tr>
<td>Do you think you are like the [target child]?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not at all</td>
<td>103 (55.10%)</td>
<td>84 (45.20%)</td>
<td></td>
</tr>
<tr>
<td>Not really</td>
<td>53 (28.30%)</td>
<td>53 (28.50%)</td>
<td></td>
</tr>
<tr>
<td>A little</td>
<td>24 (12.80%)</td>
<td>41 (22.0%)</td>
<td></td>
</tr>
<tr>
<td>A lot</td>
<td>7 (3.70%)</td>
<td>8 (4.3%)</td>
<td>.64</td>
</tr>
</tbody>
</table>

*Note. * \(p < 0.001\)
Table 7.8 Chi-square Values for Familiarity and Similarity with the Target Peers across Participants’ Gender within Each Age Group

<table>
<thead>
<tr>
<th></th>
<th>Depression</th>
<th>( \chi^2 )</th>
<th>ADHD</th>
<th>( \chi^2 )</th>
<th>Depression</th>
<th>( \chi^2 )</th>
<th>ADHD</th>
<th>( \chi^2 )</th>
</tr>
</thead>
<tbody>
<tr>
<td>10-11 yrs</td>
<td>16</td>
<td>21</td>
<td>30</td>
<td>22</td>
<td>12</td>
<td>17</td>
<td>32</td>
<td>29</td>
</tr>
<tr>
<td>15-16 yrs</td>
<td>29</td>
<td>34</td>
<td>.07</td>
<td>18</td>
<td>29</td>
<td>3.72</td>
<td>27</td>
<td>33</td>
</tr>
<tr>
<td>Male</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Do you know someone like [target child]?

- Yes: 16, 21, 30, 22, 12, 17, 32, 29
- No: 29, 34, .07, 18, 29, 3.72, 27, 33, .10, 22, 15, 3.75

Do you think you are like the [target child]?

- Not at all: 27, 28, 23, 23, 23, 25, 16, 22
- Not really: 13, 15, 10, 14, 11, 14, 17, 12
- A little: 2, 9, 12, 10, 3, 10, 9, 10
- A lot: 3, 3, 3.65, 3, 4, .90, 1, 0, 3.88, 1, 0, 2.85
7.3 Analyses of Explicit Stigma

7.3.1 Social Status & Power

Theoretically, for stigmatisation of the target peers to occur, participants must perceive the peers to be of lower social status and have less power and influence than them. To explore whether participants believed that the peers with disorders were of lower social status two paired samples $t$ tests were carried out. The results revealed that participants believed that they personally were of significantly higher social status than the peer with depression [$t(193) = 14.63, p < 0.001$] and ADHD [$t(190) = 9.03, p < 0.001$]. See Table 7.9 below for descriptive statistics.

<table>
<thead>
<tr>
<th>Experimental Condition</th>
<th>Depression</th>
<th>ADHD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal Social Status</td>
<td>7.27 (1.91)</td>
<td>7.23 (2.07)</td>
</tr>
<tr>
<td>Target Peers’ Social Status</td>
<td>4.34 (2.33)</td>
<td>4.96 (2.46)</td>
</tr>
</tbody>
</table>

*Note. Standard deviations are in parenthesis*

Chi-square analyses showed that participants believed they had significantly more power and influence over others than the peer with depression [$\chi^2(1, 186) = 71.22, p < 0.001$] and ADHD [$\chi^2(3, 186) = 165.2, p < 0.001$]. Descriptively, 18% ($n = 31$) of participants believed the peer with depression would be more powerful compared to them, while 82% ($n = 142$) of participants believed they were personally more powerful. In response to the peer with ADHD, 60% ($n = 100$) of participants thought that they had more power and influence over others compared to this peer.
As participants thought that the target peers were of lower social status and had less social power and influence than them, the scene for stigma to occur was set. Given that it was possible for participants to stigmatise the target peers, an investigation into the stigma variables was conducted.

7.3.2 Analysis of the Dependent Stigma Variables

A series of 2x2x2 between subjects ANOVAs were performed to explore whether the type of mental health problem described in the vignettes (ADHD or depression), gender or age of the participants impacted responses on the following dependent variables; general attitudes, stereotypes, prejudice, behavioural intentions, and relationship and physical social distance.

7.3.2.1 Attitudes

7.3.2.2 ACL

The results of the ANOVA revealed a significant gender by age interaction for general attitudes towards the target peers \(F(1, 367) = 6.42, p < 0.05, \eta^2 = .02\]. Follow up simple effects \(F\) test showed that 10 to 11-year-old girls had significantly more positive attitudes towards the peers compared to adolescent girls \(F(1, 371) = 9.75, p < 0.01\]. In addition, 10 to 11-year-old males had significantly more negative attitudes towards the peers compared to same aged girls \(F(1, 371) = 9.93, p < 0.01\]. No main effects were found for this variable. Descriptive statistics are presented in Table 7.10 and the interaction is depicted in Figure 7.1 below.
Figure 7.1. Vignette mental health disorder by participants’ age and gender interaction for general attitudes. In the figure higher scores denote more positive attitudes.
Table 7.10

Mean scores (SD) for ACL (General Attitudes) by Mental Health Condition, Age, and Gender of Participants

<table>
<thead>
<tr>
<th>Experimental Condition</th>
<th>10-11 yrs</th>
<th>15-16 yrs</th>
<th>Overall</th>
<th>10-11 yrs</th>
<th>15-16 yrs</th>
<th>Overall</th>
<th>10-11 yrs</th>
<th>15-16 yrs</th>
<th>Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression</td>
<td></td>
<td></td>
<td></td>
<td>ADHD</td>
<td></td>
<td></td>
<td>Combined Depressions &amp; ADHD conditions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10-11 yrs</td>
<td>17.73 (4.54)</td>
<td>18.38 (3.62)</td>
<td>18.04 (4.12)</td>
<td>17.83 (4.38)</td>
<td>18.04 (2.47)</td>
<td>17.93 (3.56)</td>
<td>17.80 (4.43)</td>
<td>18.21 (3.05)</td>
<td>17.98 (3.84)</td>
</tr>
<tr>
<td>15-16 yrs</td>
<td></td>
<td></td>
<td></td>
<td>Overall</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ACL</td>
<td></td>
<td></td>
<td></td>
<td>18.46 (5.45)</td>
<td>18.24 (2.40)</td>
<td>18.36 (4.30)</td>
<td>18.84 (5.56)</td>
<td>18.00 (2.75)</td>
<td>18.44 (4.48)</td>
</tr>
<tr>
<td>Male</td>
<td>20.42 (6.25)</td>
<td>17.26 (2.45)</td>
<td>18.91 (5.06)</td>
<td>19.06 (6.28)</td>
<td>18.43 (2.47)</td>
<td>17.93 (3.60)</td>
<td>19.76 (6.27)</td>
<td>17.80 (2.44)</td>
<td>18.85 (5.00)</td>
</tr>
<tr>
<td>Female</td>
<td>19.21 (5.70)</td>
<td>17.75 (3.05)</td>
<td>18.52 (4.70)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overall</td>
<td>19.21 (5.70)</td>
<td>17.75 (3.05)</td>
<td>18.52 (4.70)</td>
<td>18.46 (5.45)</td>
<td>18.24 (2.40)</td>
<td>18.36 (4.30)</td>
<td>18.84 (5.56)</td>
<td>18.00 (2.75)</td>
<td>18.44 (4.48)</td>
</tr>
</tbody>
</table>

Note. Standard deviations are in parentheses.
7.3.2.3 Stereotypes: Dangerousness & Perceived Responsibility

No significant interactions or main effects emerged for the stereotype that the target peers were dangerous ($p > 0.05$). Similarly, no significant interactions were found for the belief that the target peers were personally responsible for their disorder. Significant main effects for the disorder described in the vignettes ($F(1, 367) = 14.1, p < .01, \eta^2 = .04$) and participants’ gender ($F(1, 367) = 6.20, p < .05 \eta^2 = .01$) were found for perceived responsibility. The peer with ADHD was perceived as being more personally responsible for his/her disorder than the peer with depression. Compared to females, males perceived the peer being more responsible for his disorder (see Table 7.11 below).

7.3.2.4 Prejudice: Anger & Fear

For prejudicial anger, the ANOVA revealed main effects for the disorder described in the vignette ($F(1, 367) = 24.60, p < .0001, \eta^2 = .06$) and participants’ age ($F(1, 367) = 17.15, p < 0.001, \eta^2 = .05$), which were qualified by a significant disorder by age interaction ($F(1, 367) = 5.37, p < 0.05, \eta^2 = .01$). As shown in Figure 7.2, adolescents reported significantly stronger feelings of anger towards the peer with ADHD compared to the peer with depression ($F(1, 371) = 24.06, p < 0.001$). In comparison to children, adolescents reported more anger towards the peer with ADHD ($F(1, 371) = 21.06, p < 0.001$).

For perceived fear towards the target peers, the ANOVA revealed a significant main effect for participants’ age ($F(1, 367) = 7.60, p < .05, \eta^2 = .01$). Adolescents reported being more afraid of the peers compared to younger participants. Descriptive statistics are presented in Table 7.12.
<table>
<thead>
<tr>
<th>Experimental Condition</th>
<th>Depression</th>
<th>ADHD</th>
<th>Combined Depression &amp; ADHD scores</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>10-11 yrs</td>
<td>15-16 yrs</td>
<td>Overall</td>
</tr>
<tr>
<td><strong>Dangerousness</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>2.96 (2.34)</td>
<td>3.72 (2.19)</td>
<td>3.31 (2.28)</td>
</tr>
<tr>
<td>Female</td>
<td>3.00 (2.32)</td>
<td>3.54 (2.16)</td>
<td>3.62 (2.16)</td>
</tr>
<tr>
<td>Overall</td>
<td>2.98 (2.32)</td>
<td>3.62 (2.16)</td>
<td>3.28 (2.26)</td>
</tr>
<tr>
<td><strong>Responsibility</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>3.97 (1.88)</td>
<td>4.00 (1.81)</td>
<td>3.99 (1.83)</td>
</tr>
<tr>
<td>Female</td>
<td>3.30 (2.24)</td>
<td>3.70 (1.70)</td>
<td>3.51 (1.86)</td>
</tr>
<tr>
<td>Overall</td>
<td>3.60 (2.10)</td>
<td>3.83 (1.75)</td>
<td>3.67 (1.97)</td>
</tr>
</tbody>
</table>

*Note. Standard deviations are in parentheses.*
Table 7.12
*Mean Scores (SD) for Prejudicial Anger and Fear by Mental Health Condition, Age, and Gender of Participants*

<table>
<thead>
<tr>
<th>Experimental Condition</th>
<th>Depression</th>
<th>ADHD</th>
<th>Combined Depression &amp; ADHD scores</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>10-11 yrs</td>
<td>15-16 yrs</td>
<td>Overall</td>
</tr>
<tr>
<td>Anger</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>2.42 (1.76)</td>
<td>2.44 (1.21)</td>
<td>2.43 (1.52)</td>
</tr>
<tr>
<td>Female</td>
<td>2.24 (1.50)</td>
<td>2.88 (1.51)</td>
<td>2.54 (1.51)</td>
</tr>
<tr>
<td>Overall</td>
<td>2.32 (1.60)</td>
<td>2.66 (1.40)</td>
<td>2.50 (1.51)</td>
</tr>
<tr>
<td>Fear</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>1.70 (1.14)</td>
<td>1.87 (1.10)</td>
<td>1.77 (1.12)</td>
</tr>
<tr>
<td>Female</td>
<td>1.38 (0.76)</td>
<td>2.08 (1.24)</td>
<td>1.71 (1.07)</td>
</tr>
<tr>
<td>Overall</td>
<td>1.52 (.95)</td>
<td>2.00 (1.18)</td>
<td>1.74 (1.10)</td>
</tr>
</tbody>
</table>

*Note.* Standard deviations are in parentheses.
Figure 7.2. Vignette mental health disorder by age interaction for perceived fear.

In the figure higher scores are indicative of more anger towards the target peers.

7.3.3 Discrimination

7.3.3.1 Behavioural intentions

No significant interactions emerged for behavioural intentions ($p > 0.05$). A significant effect for the disorder described in the vignettes was found [$F(1, 367) = 10.64, p < 0.01, \eta^2 = 0.03$], such that the peer with ADHD was discriminated against more than the peer with depression. A significant age effect also emerged for behavioural intentions [$F(1, 367) = 14.14, p < 0.001, \eta^2 = 0.04$]. Compared to 10 to 11-year-olds, adolescents reported that they would exclude the target peers from activities more. A significant main effect for gender was also found [$F(1, 367) = 15.95, p < 0.001, \eta^2 = 0.04$], such that males were less inclusive of the target peers. All descriptive statistics for the between subject variables on the discrimination measures are described in Table 7.13 below.
Table 7.13  

Mean Scores (SD) for the Discrimination Variables by Mental Health Condition, Age, and Gender of Participants

<table>
<thead>
<tr>
<th>Experimental Condition</th>
<th>Depression 10-11 yrs</th>
<th>Depression 15-16 yrs</th>
<th>Depression Overall</th>
<th>ADHD 10-11 yrs</th>
<th>ADHD 15-16 yrs</th>
<th>ADHD Overall</th>
<th>Combined Depression &amp; ADHD scores 10-11 yrs</th>
<th>Combined Depression &amp; ADHD scores 15-16 yrs</th>
<th>Combined Depression &amp; ADHD scores Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioural Intentions</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>50.07 (14.67)</td>
<td>47.10 (11.24)</td>
<td>48.70 (13.20)</td>
<td>50.35 (13.20)</td>
<td>40.58 (10.20)</td>
<td>45.74 (13.05)</td>
<td>50.22 (14.11)</td>
<td>43.68 (11.11)</td>
<td>47.15 (13.17)</td>
</tr>
<tr>
<td>Female</td>
<td>56.23 (12.33)</td>
<td>54.62 (9.73)</td>
<td>54.98 (11.20)</td>
<td>51.67 (16.20)</td>
<td>47.41 (10.11)</td>
<td>49.70 (13.80)</td>
<td>54.03 (14.42)</td>
<td>50.71 (10.35)</td>
<td>52.75 (12.75)</td>
</tr>
<tr>
<td>Overall</td>
<td>53.45 (13.71)</td>
<td>50.76 (10.86)</td>
<td>52.18 (12.50)</td>
<td>51.03 (14.97)</td>
<td>44.03 (10.64)</td>
<td>47.76 (13.55)</td>
<td>52.25 (14.27)</td>
<td>47.44 (11.24)</td>
<td>50.00 (13.20)</td>
</tr>
<tr>
<td>Relationship Social Distance</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>2.50 (1.14)</td>
<td>2.51 (1.05)</td>
<td>2.50 (1.10)</td>
<td>2.30 (1.10)</td>
<td>3.12 (1.00)</td>
<td>2.68 (1.27)</td>
<td>2.40 (1.26)</td>
<td>2.83 (1.06)</td>
<td>2.60 (1.20)</td>
</tr>
<tr>
<td>Female</td>
<td>2.00 (1.21)</td>
<td>2.34 (0.77)</td>
<td>2.15 (1.04)</td>
<td>2.67 (1.18)</td>
<td>2.84 (1.01)</td>
<td>2.74 (1.10)</td>
<td>2.31 (1.24)</td>
<td>2.57 (0.92)</td>
<td>2.60 (0.92)</td>
</tr>
<tr>
<td>Overall</td>
<td>2.21 (1.20)</td>
<td>2.42 (0.90)</td>
<td>2.31 (1.07)</td>
<td>2.50 (1.28)</td>
<td>3.00 (1.01)</td>
<td>2.72 (1.90)</td>
<td>2.35 (1.35)</td>
<td>2.70 (1.00)</td>
<td>2.51 (1.15)</td>
</tr>
<tr>
<td>Physical Social Distance</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>3.30 (2.12)</td>
<td>2.42 (1.83)</td>
<td>2.88 (1.91)</td>
<td>3.04 (2.20)</td>
<td>3.09 (1.80)</td>
<td>3.07 (2.01)</td>
<td>3.16 (2.15)</td>
<td>2.77 (1.70)</td>
<td>2.00 (1.96)</td>
</tr>
<tr>
<td>Female</td>
<td>2.42 (1.82)</td>
<td>2.12 (1.33)</td>
<td>2.28 (1.61)</td>
<td>3.53 (2.30)</td>
<td>2.91 (1.70)</td>
<td>3.24 (2.05)</td>
<td>2.95 (2.13)</td>
<td>2.00 (1.63)</td>
<td>2.84 (1.93)</td>
</tr>
<tr>
<td>Overall</td>
<td>2.81 (2.00)</td>
<td>2.25 (1.42)</td>
<td>2.55 (1.77)</td>
<td>3.30 (2.25)</td>
<td>3.00 (1.73)</td>
<td>3.16 (2.03)</td>
<td>2.81 (2.14)</td>
<td>2.00 (1.63)</td>
<td>3.84 (0.60)</td>
</tr>
</tbody>
</table>

*Note.* Standard deviations are in parentheses
8.3.3.2 Social Distance

For relationship social distance, the ANOVA revealed main effects for the vignette disorder \([F(1, 367) = 11.97, p < .001, \eta^2 = .03]\) and participants’ age \([F(1, 367) = 9.00, p < .01, \eta^2 = .03]\), which were superseded by a significant disorder by age by gender interaction \([F(1, 367) = 4.57, p < 0.05, \eta^2 = .01]\). As depicted in Figure 7.3 below, greater relationship social distance from the peer with ADHD, compared to the peer with depression, was reported among adolescent males \([F(1, 367) = 6.06, p < 0.05]\) and adolescent females \([F(1, 367) = 4.78, p < 0.05]\) and 10 to 11-year-old females \([F(1, 367) = 10.11, p < 0.001]\). Among 10 to 11-year-olds, boys reported significantly greater relationship social distance from the peer with depression \([F(1, 367) = 5.18, p < 0.05]\), compared to girls. Furthermore, among males in the ADHD condition, adolescents wanted more relationship social distance compared to children \([F(1, 367) = 12.56, p < 0.001]\).

For physical social distance, significant effects for the disorder described in the vignettes \([F(1, 367) = 8.75, p < .01, \eta^2 = .02]\) and participants’ age emerged \([F(1, 367) = 4.97, p < .05, \eta^2 = .01]\). These findings suggested that participants felt comfortable working in a classroom environment at a closer distance to the peer with depression compared to the peer with ADHD. They also suggested that adolescents wanted less physical social distance from the target peer compared to younger participants. Descriptive statistics for relationship and physical social distance are presented in Table 7.13 above.
Figure 7.3. Vignette mental health disorder by age by gender interaction for relationship social distance. In this figure higher scores represent more relationship social distance.

7.4 Summary of the Explicit Findings

The explicit findings suggest that children and adolescents perceive themselves as being of higher social status and having more social power than the peers with either ADHD or depression. Thus, the foundation for the stigmatisation of these peers was laid. The subsequent results showed that the nature and extent of stigmatisation projected towards peers with mental health problems is contingent upon the aspect of stigma being assessed, the age and gender of the perceiver, and the type of mental health condition that the target individual has. In general, the peer with ADHD was perceived more negatively. For example, participants wanted more physical and relationship social distance from the peer with ADHD and were more accepting of the peer with depression. In addition, they perceived the peer with ADHD as more personally responsible for his/her disorder and thought he/she would be
more likely to make them angry, compared to the peer with depression. Adolescents were often more negative towards both peers, the results showed that they were less inclusive of the target peers compared to younger participants. When compared to 10 to 11-year-olds, adolescents also reported that the peer with ADHD would make them angry and they would be afraid of both peers. However, on the physical social distance measure adolescents felt more comfortable working at a closer proximity to the target peers, compared to younger participants. Furthermore, general attitudes towards both peers were more positive among adolescent females compared to younger females, but were more negative among 10 to 11-year-olds boys compared to same age girls. While all other groups wanted greater relationship social distance from the peer with ADHD compared to the peer with depression, 10 to 11-year-old males reported the opposite.
Chapter 8: Implicit Results from Study One

8.1 Aim of Chapter

This chapter presents findings pertaining to participants’ implicit attitudes towards the peers with ADHD and depression, and the comparative peer without a mental health problem. Specifically, this chapter presents findings on the psychometric properties and reliability of the IAT. The results of a 2x2x2 ANOVA, that explored whether patterns of implicit attitudes are contingent upon the age and gender of participants and the type of mental health disorder in question, will also be presented.

8.2 Scoring Procedure for the IAT

An IAT score is a form of Cohen’s $d$ that is referred to as a $D$ IAT score (Greenwald, Nosek, & Banaji, 2003). For this study, $D$ IAT scores for consistent order IATs (i.e. where the character with a mental health problem and the bad attributes, and ‘typical’ peer and good attributes, are paired first) were calculated for each participant by determining the difference between the mean response latencies for specific IAT blocks as follows: subtracting the mean response time of block 3 (Mental Disorder + Bad/’Typical’ + Good) from the mean response time of block 6 (‘Typical’ + Bad/Mental Disorder + Good) and then subtracting the mean response time of block 4 (‘Typical’ + Bad/Mental Disorder + Good) from the mean of block 7 (Mental Disorder + Bad/’Typical’ + Good). The resulting figures were then divided by pooled $SD$s of the two corresponding blocks. Finally, a single IAT score was computed by averaging the two quotients. A $D$ IAT score of zero indicated a neutral attitude towards the target peers. In this study, $D$ IAT scores with a positive number represented a negative implicit evaluation of the peer with a mental health problem, whereas a negative score indicated a negative implicit evaluation of the ‘typical’ peer. For the inconsistent order IATs the same scoring procedure was followed, however, a positive score represented a negative
implicit attitude towards the ‘typical’ peer, whereas a negative score indicated a negative implicit evaluation of the peer with a mental health disorder. To account for this, in the inconsistent order IATs, the final score was transformed so that interpretation of implicit attitudes was congruent with the scores produced in the consistent IAT (i.e. positive scores represented a negative attitude towards the peer with a mental health condition, negative scores represented a negative attitude towards the ‘typical’ peer).

Prior to calculating $D$ IAT scores, preliminary screening of the data was performed. Following recommendations by Greenwald et al. (2003), trials longer than 10,000 milliseconds were deleted. Four participants, who engaged in rapid responses of <300 milliseconds on more than 10% of trials, were not included in the analyses in an effort to control for passive responding. A further five did not complete this phase due to other school commitments ($n = 366$).

8.3 Psychometrics

8.3.1 Internal Consistency

Internal consistency reliability was assessed by calculating split-half reliability scores with the two $D$-IAT scores of the combined trials of the IAT. Using the Spearman-Brown correction, split half correlations between the $D$-IAT scores were good .67 and fair .50 for the depression and ADHD IAT respectively (George & Mallery, 2003; Kline, 1999).

To explore whether the order of presentation of combined tasks (peer with a mental disorder/Bad first or ‘typical peer/Bad first) influenced implicit attitudes, one-way ANOVAs were performed. A main effect for order of the combined tasks was found on the ADHD IAT, $[F(1, 174) = 2.42, p < 0.01]$, but not the depression IAT $[F(1, 178) = 1.86, p > 0.05]$. This indicated that participants displayed a stronger negative attitude towards the peer with ADHD when they completed the peer with ADHD/Bad + ‘typical’ peer/Good first $[D = 0.32, SD =$
0.57]. To explore whether this order effect could determine the overall direction of implicit attitudes, follow-up $t$ tests were performed. The analysis revealed significant negative attitudes towards the peers with mental disorders when both the peer with ADHD/\textit{Bad} and the peer with ADHD/\textit{Good} were presented first [$t(86) = 5.53, p < 0.001$, and $t(87) = 1.70, p < 0.05$, respectively]. Suggesting that, regardless of the order in which the IAT was presented, participants had negative implicit attitudes towards the peers with disorders.

### 8.3.2 Test Re-Test Reliability

The consistency of the IAT to measure attitudes towards the characters with mental health problems over time was assessed using a test-retest procedure. A subgroup of twenty 10 to 11-year-olds and fourteen 15 to 16-year-olds ($N = 34$) completed the IAT again, after a 4-week interval. Analysis of the $D$ IAT scores revealed a Pearson’s bivariate correlations of $r = 0.53, p < 0.05$ and $r = 0.43, p < 0.05$ for the depression and ADHD IAT respectively, indicating moderate stability of implicit attitudes.

### 8.4 Implicit Analyses

A one-way $t$ test on the $D$ IAT indicated that participants’ mean implicit attitude scores significantly differed from zero, where zero indicated a neutral attitude towards the peers in the vignettes. Participants had negative implicit attitude towards the peer with mental health disorder compared to the control peer [$D = .23, SD = 61, t(323) = 5.38, p < 0.001$]. In other words, they were faster at responding on Mental Disorder/\textit{Bad} + ‘Typical’/\textit{Good} trials compared to Mental Disorder/\textit{Good} + ‘Typical’/\textit{Bad} trials. There was not a significant difference between how participants responded on the depression IAT and ADHD IAT. Specifically, the results showed that participants displayed an implicit preference for the typical peer over the peer with depression, [$t(183) = 5.38, p < 0.001$] and the peer with
ADHD, \( [t(181) = 4.70, p < 0.001] \). See figure 8.1 below for means for the depression and ADHD IAT.

![Figure 8.1. Implicit attitudes for the Depression and ADHD IAT. In this figure error bar represent standard errors.](image)

D IAT scores were normally distributed and had homogeneity of variance, thus the data met the assumptions of ANOVA. The 2x2x2 ANOVA, with age, gender, and mental health disorder as the between-subjects variables, revealed a main effect for participants’ gender \( [F(1, 366) = 12.25, p < 0.01, \eta^2 = .03] \), which was qualified by a disorder by age by gender interaction \( [F(1, 366) = 4.25, p < 0.05, \eta^2 = .01, \text{see Figure 8.2}] \). Male adolescents’ implicit attitudes towards depression were significantly more negative than comparative implicit responses towards ADHD \( [F(1, 358) = 5.62, p < 0.05] \), younger males \( [F(1, 358) = 8.37, p < 0.01] \) and female adolescents’ implicit attitudes towards the peer with depression \( [F(1, 358) = 23.32, p < 0.001] \). Of note here are female adolescents’ scores on the depression IAT, which indicated that they had positive implicit attitudes towards the peer with depression. Descriptive statistics are presented in Table 8.1 below.
Table 8.1

*Mean Scores (SD) for Implicit Attitudes by Mental Health Condition, Age, and Gender of Participants*

<table>
<thead>
<tr>
<th>Implicit Attitude</th>
<th>Experimental Condition</th>
<th>10-11 yrs</th>
<th>15-16 yrs</th>
<th>Overall</th>
<th>10-11 yrs</th>
<th>15-16 yrs</th>
<th>Overall</th>
<th>10-11 yrs</th>
<th>15-16 yrs</th>
<th>Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Depression</td>
<td></td>
<td></td>
<td></td>
<td>ADHD</td>
<td></td>
<td></td>
<td>Combined Depression &amp; ADHD scores</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>.23 (.61)</td>
<td>.61 (.54)</td>
<td>.41 (.60)</td>
<td>.23 (.58)</td>
<td>.30 (.61)</td>
<td>.26 (.60)</td>
<td>.23 (.60)</td>
<td>.44 (.60)</td>
<td>.33 (.60)</td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>.21 (.55)</td>
<td>-.01 (.62)</td>
<td>.11 (.60)</td>
<td>.16 (.51)</td>
<td>.14 (.66)</td>
<td>.15 (.58)</td>
<td>.19 (.52)</td>
<td>.06 (.64)</td>
<td>.13 (.58)</td>
<td></td>
</tr>
<tr>
<td>Overall</td>
<td>22 (.57)</td>
<td>.26 (.66)</td>
<td>.24 (.61)</td>
<td>.19 (.54)</td>
<td>.22 (.64)</td>
<td>.20 (.58)</td>
<td>.21 (.56)</td>
<td>.24 (.64)</td>
<td>.22 (.60)</td>
<td></td>
</tr>
</tbody>
</table>
Figure 8.2. Vignette mental health disorder by participants’ age and gender interaction for implicit attitudes.

8.4.1 Implicit-Explicit Correlations

Pearson’s bivariate correlations were performed to primarily explore the relationship between implicit and explicit attitudes towards the peer with depression and ADHD, but also to explore the relationship between behavioural intentions and explicit and implicit attitude measures. Implicit attitudes were not significantly related to any of the explicit variables, when explored in relation to the peer with depression. Towards the peer with ADHD, significant positive correlations were found between implicit attitudes and the following variables: perceived dangerousness, perceived responsibility, and fear. Perceived responsibility and anger were negatively related to behavioural intentions towards the peer with depression. All the explicit attitudes variables were inversely related to behavioural intentions towards the peer with ADHD. In response to the control peer in the depression
condition, perceptions of dangerousness and anger were significantly negatively related to
behavioural intentions towards this peer. No significant correlations were found between
implicit attitudes and explicit attitudes in response to this peer. In response to the control peer
in the ADHD condition, significant negative correlations were found between beliefs about
responsibility and anger and behavioural intentions. Significant positive correlations emerged
between implicit attitudes and the following explicit variables: dangerousness and
responsibility. All correlations are present in Tables 8.2 and 8.3 below.

Table 8.2

Correlations between Implicit Attitudes and Explicit Prejudice, Stereotypes, and Behavioural
Intentions in Response to the Target Peers with Depression or ADHD

<table>
<thead>
<tr>
<th></th>
<th>Depression</th>
<th>ADHD</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>1 Implicit Attitude</td>
<td>_</td>
<td>-.01</td>
</tr>
<tr>
<td>2 Dangerousness</td>
<td>-.01</td>
<td>_</td>
</tr>
<tr>
<td>3 Responsibility</td>
<td>-.06</td>
<td>.90</td>
</tr>
<tr>
<td>4 Anger</td>
<td>-.07</td>
<td>.17*</td>
</tr>
<tr>
<td>5 Fear</td>
<td>-.06</td>
<td>.02</td>
</tr>
<tr>
<td>6 Behavioural Intentions</td>
<td>-.01</td>
<td>-.11</td>
</tr>
</tbody>
</table>

**Note.** *p < 0.05, **p < 0.001**
Table 8.3

*Correlations between Implicit Attitudes and Explicit Prejudice, Stereotypes, and Behavioural Intentions in Response to the Control Peers*

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
</tr>
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<tbody>
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<td><strong>Control Peer in the Depression Condition</strong></td>
<td></td>
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<tr>
<td>1 Implicit Attitude</td>
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<td>.18*</td>
<td>.10</td>
<td>.16</td>
<td>.05</td>
<td></td>
</tr>
<tr>
<td>2 Dangerousness</td>
<td>.05</td>
<td></td>
<td>.01</td>
<td>-.07</td>
<td>-.10</td>
<td>.01</td>
</tr>
<tr>
<td>3 Responsibility</td>
<td>.18*</td>
<td>.01</td>
<td></td>
<td>.12</td>
<td>.22**</td>
<td>-.20**</td>
</tr>
<tr>
<td>4 Anger</td>
<td>-.10</td>
<td>-.07</td>
<td>.12</td>
<td></td>
<td>.20**</td>
<td>-.30**</td>
</tr>
<tr>
<td>5 Fear</td>
<td>.16*</td>
<td>-.10</td>
<td>.23**</td>
<td>.20**</td>
<td></td>
<td>-.02</td>
</tr>
<tr>
<td>6 Behavioural</td>
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<td>.01</td>
<td>.20**</td>
<td>-.30**</td>
<td>-.02</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
</tr>
</thead>
<tbody>
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<td><strong>Control Peer in the ADHD Condition</strong></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 Implicit Attitude</td>
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<td></td>
<td>.18*</td>
<td>.10</td>
<td>.16</td>
<td>.05</td>
</tr>
<tr>
<td>2 Dangerousness</td>
<td></td>
<td></td>
<td>.01</td>
<td>-.07</td>
<td>-.10</td>
<td>.01</td>
</tr>
<tr>
<td>3 Responsibility</td>
<td>.18*</td>
<td>.01</td>
<td></td>
<td>.12</td>
<td>.22**</td>
<td>-.20**</td>
</tr>
<tr>
<td>4 Anger</td>
<td>-.10</td>
<td>-.07</td>
<td>.12</td>
<td></td>
<td>.20**</td>
<td>-.30**</td>
</tr>
<tr>
<td>5 Fear</td>
<td>.16*</td>
<td>-.10</td>
<td>.23**</td>
<td>.20**</td>
<td></td>
<td>-.02</td>
</tr>
<tr>
<td>6 Behavioural</td>
<td>.05</td>
<td>.01</td>
<td>.20**</td>
<td>-.30**</td>
<td>-.02</td>
<td></td>
</tr>
</tbody>
</table>

*Note.* *p < 0.05, **p < 0.001

8.4.2 Predictive Validity

To explore whether explicit stereotypes, prejudice, and implicit attitudes would predict behavioural intentions towards the peers with disorders, hierarchical regression analyses were performed. All the variables were normally distributed and had homoscedasticity. Linear relationships were observed between the predictor variables and the outcome variable. Thus,
the assumptions of hierarchical regression were met. In all models, explicit stereotypes (dangerousness and responsibility) and prejudice (fear and anger) were entered in Step 1, while D-IAT scores were entered in Step 2. For behavioural intentions towards the peer with depression, a significant model was found \( F(3,183) = 9.47, p < 0.001, \text{Adjusted } R^2 = 0.12 \). Among the explicit variables, perceived responsibility \( \beta = -0.28, p > 0.001 \) and anger \( \beta = -0.20, p > 0.001 \) significantly predicted behavioural intentions. However, dangerousness and fear did not significantly contribute to the model \( p < 0.05 \). D-IAT scores produced no increment in the predictive validity \( \beta = -0.04, p > 0.05, R^2 \text{ change} = 0.002 \). This model explained 12% of the variance of intended behaviour towards the peer with depression. For behavioural intentions towards the peer with ADHD, a significant model was also found \( F(4, 183) = 7.31, p < 0.001, \text{Adjusted } R^2 = 0.28 \). Perceived responsibility \( \beta = -0.29, p < 0.05 \), anger \( \beta = -0.36, p < 0.05 \), and fear \( \beta = -0.13, p < 0.05 \), significantly predicted behavioural intentions. Similar to the depression model, D-IAT scores did not increase predictive validity \( \beta = 0.003, p > 0.05, R^2 \text{ change} = 0.00 \). Altogether, the model predicted 27% of behavioural intentions towards the peer with ADHD. A further series of regression models were explored, in which the implicit scores were entered into the model at Step 1. These models also showed that implicit attitudes did not significantly contribute to the variance of behavioural intentions towards either peer.
Table 8.4

Summary of Hierarchical Regression Analysis for Explicit and Implicit Attitudes Predicting Behavioural Intentions towards Peers with Depression & ADHD.

<table>
<thead>
<tr>
<th>Variable</th>
<th>B</th>
<th>SE B</th>
<th>β</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Depression Condition</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Step 1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dangerousness</td>
<td>-.40</td>
<td>.39</td>
<td>-1.02</td>
</tr>
<tr>
<td>Responsibility</td>
<td>-1.77</td>
<td>.44</td>
<td>-.30***</td>
</tr>
<tr>
<td>Fear</td>
<td>-.37</td>
<td>.84</td>
<td>-.03</td>
</tr>
<tr>
<td>Anger</td>
<td>-1.66</td>
<td>.61</td>
<td>-.20**</td>
</tr>
<tr>
<td>Step 2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dangerousness</td>
<td>-.40</td>
<td>.40</td>
<td>-.07</td>
</tr>
<tr>
<td>Responsibility</td>
<td>-1.80</td>
<td>.44</td>
<td>-.28***</td>
</tr>
<tr>
<td>Fear</td>
<td>-.40</td>
<td>.84</td>
<td>-.03</td>
</tr>
<tr>
<td>Anger</td>
<td>-1.68</td>
<td>.61</td>
<td>-.21**</td>
</tr>
<tr>
<td>Implicit Attitude (IAT D score)</td>
<td>-.84</td>
<td>1.42</td>
<td>-.04</td>
</tr>
<tr>
<td><strong>ADHD Condition</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Step 1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dangerousness</td>
<td>0.72</td>
<td>.41</td>
<td>-.12</td>
</tr>
<tr>
<td>Responsibility</td>
<td>-1.98</td>
<td>.44</td>
<td>-.30***</td>
</tr>
<tr>
<td>Fear</td>
<td>-1.54</td>
<td>.76</td>
<td>-.13*</td>
</tr>
<tr>
<td>Anger</td>
<td>-2.54</td>
<td>.44</td>
<td>-.38***</td>
</tr>
<tr>
<td>Step 2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dangerousness</td>
<td>-.72</td>
<td>.42</td>
<td>-.12</td>
</tr>
<tr>
<td>Responsibility</td>
<td>-1.97</td>
<td>.45</td>
<td>-.30***</td>
</tr>
<tr>
<td>Fear</td>
<td>-1.55</td>
<td>.78</td>
<td>-.14*</td>
</tr>
<tr>
<td>Anger</td>
<td>-2.54</td>
<td>.45</td>
<td>-.38***</td>
</tr>
<tr>
<td>Implicit Attitude (IAT D score)</td>
<td>.078</td>
<td>1.60</td>
<td>.003</td>
</tr>
</tbody>
</table>

8.5 Summary of Implicit Findings

The results of the implicit data showed that, in general, this modified IAT has moderately acceptable psychometric properties. Moderate stability was found for both IATs. Internal consistency and test-retest reliability of the depression IAT were stronger than those found
for the ADHD IAT. Analysis of the implicit scores showed that the sample displayed negative implicit attitudes towards peers with ADHD and depression. A notable exception to this was adolescent female’s implicit attitude towards peers with depression, which were positive. Adolescent males displayed significantly stronger negative implicit attitudes towards the peer with depression compared to the peer with ADHD and compared to other gender and age groups’ implicit evaluations of this peer. Implicit attitudes did not produce any increment in predictive validity of behavioural intentions towards the peers with mental health problems. The findings pertaining to both the explicit and implicit results are discussed in the following chapter.

8.6 A Reflection on the Combined Results: Who Displayed the Most Negative Responses?

Reflecting on the explicit results, the findings showed that while responses towards the peers with ADHD and depression were, in general, significantly more negative than responses towards a peer without a disorder, the samples’ overall responses towards the peers with mental health problems were not overly negative. For example, the target peers were not perceived as very responsible for their symptoms nor were they perceived as dangerous. Most participants were not afraid of the target peers nor would the peers make them angry. In addition, extreme negative responses on the discrimination measures were not found. Conversely, the implicit findings indicated that participants exhibited negative attitudes towards the peers with disorders, compared to the peer without a disorder. The only exception to this was female adolescents’ implicit attitudes towards the peer with depression, which was positive in nature.

The significant differences in responses on the explicit and implicit measures across participants’ personal characteristics (see Table 8.5 below) evoked curiosity about whether
negative responses towards the target peers were unique to specific individuals within these age and gender groups, or unanimous among the group as a whole. This was examined descriptively by exploring the individual scores within the groups with the most negative responses. In relation to adolescent males’ implicit attitudes towards the peer with depression, all but 4 individuals (5%) exhibited negative implicit evaluations of this peer. Fifty percent ($n = 41$) of adolescent males believed the peers were personally to blame for their conditions. For relationship social distance towards the peer with ADHD, 61% ($n = 27$) of adolescent females, 78% ($n = 33$) of adolescent males and 55% ($n = 28$) of younger girls would not want this peer as one of their best friends or want him or her to be part of their peer group. There is no standard cut-off point for positive versus negative behavioural intentions on the SAQ. However, a score of 36, as an estimated cut-off point was selected on the basis that participants who scored 36 or below refused to engage with the target peers on a minimum of approximately 11 or 12 items on this 24-item scale. Twenty-five percent of males had behavioural intentions below this imposed cut-off score. Nineteen percent ($n = 34$) of adolescents reported behavioural intentions below the aforementioned cut-off point. Fifty-one percent ($n = 44$) of adolescents agreed that the peer with ADHD would make them angry, while 31% ($n = 55$) of all adolescents agreed that both target peers would make them angry. Finally, 27% ($n = 48$) of adolescents agreed that they would be afraid of the target peers. These findings further enhance our understanding of the pattern of responses that emerged in this study, thus this discussion provides useful information about the characteristics of young people who are likely to exhibit the most negative reactions to peers with disorders.
Table 8.5

*Nature of Stigmatising Responses: Significant Main Effects & Interactions*

<table>
<thead>
<tr>
<th>Stereotypes</th>
<th>Condition</th>
<th>Gender</th>
<th>Age</th>
<th>Interactions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dangerousness</td>
<td>_</td>
<td>_</td>
<td>_</td>
<td>_</td>
</tr>
<tr>
<td>Responsibility</td>
<td>ADHD</td>
<td>Male</td>
<td>_</td>
<td>_</td>
</tr>
<tr>
<td>Prejudice</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anger</td>
<td>ADHD</td>
<td>_</td>
<td>_</td>
<td>15-16 yrs (ADHD Condition)</td>
</tr>
<tr>
<td>Fear</td>
<td>_</td>
<td>_</td>
<td>15-16 yrs</td>
<td></td>
</tr>
<tr>
<td>Discrimination</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Behavioural Intentions</td>
<td>ADHD</td>
<td>Male</td>
<td>15-16 yrs</td>
<td></td>
</tr>
<tr>
<td>Relationship Social Distance</td>
<td>ADHD</td>
<td>_</td>
<td>_</td>
<td>Male &amp; Females 15-16 yrs</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Females 10-11 yrs (ADHD Condition)</td>
</tr>
<tr>
<td>Physical Social Distance</td>
<td>ADHD</td>
<td>_</td>
<td>10-11 yrs</td>
<td></td>
</tr>
<tr>
<td>Implicit Attitudes</td>
<td>_</td>
<td>Male</td>
<td>_</td>
<td>Males 15-16 yrs (Depression Condition)</td>
</tr>
</tbody>
</table>

*Note.* Table shows which disorder, age and gender group and combinations were significantly more negative on each on the stigma variables $p < 0.05$.  

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Chapter 9: Discussion for Study One

9.1 Aim of Chapter

This chapter will discuss the explicit and implicit findings of Study One of this research programme. The findings will be discussed by reflecting on the results in published stigma literature. A commentary on the psychometric properties of the IAT will also be provided. Limitations of this study and suggestions for future research will be discussed.

9.2 A Brief Re-Cap of the Aims of the Current Study

The aim of this study was to explore how children and adolescents stigmatise peers with internalising and externalising mental health problems. This study focused on explicit accounts of general attitudes, stereotypes, prejudice and discrimination and implicit attitudes towards peers with ADHD and depression. In doing so, this study examined whether the nature of implicit and explicit stigma are contingent upon the type of mental health condition experienced by the target peer, and the age and gender of the perceiver.

9.3 Interpreting the Explicit Findings in Light of Previous Research

In light of the conceptualisation that stigma hinges on a power imbalance between the perceiver and the target (see Chapter 3 section 3.2), the explicit results showed that young people perceived the peer with a mental disorder (either ADHD or depression) as being less powerful and of lower social status than them. Therefore, the results suggest that young people with ADHD and depression are in the position to be stigmatised by their peers. While it is theorised that stigma is dependent on the target individual being of lower social status and less socially powerful than the perceiver (Link & Phelan, 2001), no stigma research has explored this with children and adolescents. Research from the disability literature attributes
the low social status of children with learning disability to majority peers’ perceptions that they have inadequate social skills to successfully navigate the social ladder within the peer environment (Estell et al., 2008; Kavale & Forness, 1996). Although children with learning disabilities are distinct from those with mental disorders, the social deficits associated with ADHD and depression may also explain why participants believed they were of lower social status and less socially dominant.

The findings indicated that when compared to ‘typical’ peers, without assessing subgroup responses, the samples’ explicit and implicit responses towards the peers with disorders were significantly more negative. The only exception to this trend related to participants’ beliefs about the peer with depression and the ‘typical’ peers’ responsibility for their behaviour, no differences were found. Thus, on a whole range of variables, young people with externalising and internalising disorders fared worse in the eyes of their peers, than those without mental health problems. While most research on mental disorder stigma in childhood and adolescence does not incorporate a control peer for comparison, the research that includes a comparative peer without mental health problems also reports a similar trend (e.g. Walker et al., 2008; Younger et al., 1989). The implication of this finding is that regardless of the nature of the disorder (internalising or externalising) children and adolescents’ perceive peers with mental disorders as being different and less favourable to others without mental health difficulties.

Despite these perceptions, at a global level the explicit results suggest that young people are not as negative towards peers with disorders as expected. For example, the target peers were not perceived as overly responsible for their behaviour nor were they perceived as dangerous. Like-wise most participants believed that they would not be afraid of the target peers nor would the peers make them angry. In addition, on the discrimination measures extreme negative responses was not found. Other research notes similar findings (Wahl,
Susin, Lax, Kaplan, & Zatina, 2012; Watson et al., 2004; Schulze, Richter-Werling, Matschinger, & Angermeyer, 2003). As discussed in Chapter 4 section 4.2, the absence of standardised measures and reliance on mean scores as a proxy of stigmatisation severity ensures that it is often difficult to interpret the severity of stigma in cross sectional research.

In the present study, the ACL was the only measure to have a standardised cut-off point for positive versus negative attitudes and the results indicated that participants had negative attitudes towards the target peers. While most responses towards the peer with mental disorders were not overly unkind, frequently responses from sub-groups of participants were significantly more negative than others, which will be discussed later. Furthermore, when perceptions of the target peers were tested in a less controlled manner via the IAT, negative evaluations of target peers were consistently found among all participants, except adolescent females’ implicit attitudes towards peers with depression. Thus, the findings indicate that globally controlled responses towards peers with mental health problems are not exceptionally stigmatising, however, this trend changes upon the type of disorder, and the age and gender of the perceiver. The findings also indicate that when participants’ ability to tailor their evaluations is removed a notably negative pattern of responses frequently emerges.

Developmentally, the findings show that by 10 years of age children evaluate peers with mental health problems as distinct from peers without disorders, as inferred by their unique responses towards the former. This supports the findings of previous research that shows that by middle to late childhood, children perceive peers with mental disorders as deviant (e.g. Coie & Pennington, 1976; Novak, 1974; Harnum, et al., 2007). The findings also support an earlier claim that psychiatric terms about mental disorders are not necessarily needed for children and adolescents to infer that a peer is deviant. Instead, children and adolescents acutely tune into the emotional and behavioural repertoire exhibited by peers, note typical and atypical behaviour and respond to and differentiate between accordingly.
Although the cues that young people use to infer uniqueness was not explored in this study, it is reasonable to state that the atypical behaviours exhibited by the target peers acted as cues to warrant stigmatisation.

In general, the results suggested that ADHD is more explicitly stigmatised than depression. As discussed in Chapter 2 section 2.3.1 this is likely due to the externalising nature of ADHD (Coplan, et al., 2003; Patterson & Sanson, 2001). Thus, the intrusive nature of ADHD compared to depression elicits more negative perceptions. Another possible interpretation is that peers with ADHD are perceived more negatively than peers with depression because the deviant behaviours associated with the former are more perceptually salient. The present findings contract the only published study that has explored differences in young people’s response towards peers with ADHD and depression (Walker et al., 2008). While Walker and colleagues found that depression was more stigmatised, they did not provide participants with behavioural descriptions of the target disorders and used labels instead so direct comparisons cannot be made. Other research shows that children who engage in externalising behaviour tend to be perceived more negatively than other children with internalising or delusional behaviour (Novak, 1974; Roberts et al., 1981). For example, Novak (1974) explored 10 to 12-year-olds’ perceptions of peers described as depressed, aggressive, phobic, schizoid, immature, and normal, and showed that the peer who exhibited aggression, the most externalising behaviour, was rated the least attractive. Although the peer with ADHD tended to be perceived more negatively, the results also showed that the extent of stigmatisation is often dependent on the perceivers’ age and gender or the measure of stigma. Specifically, the peer with ADHD was not perceived as significantly more negative on the general measure of attitudes (ACL), dangerousness stereotypes, and prejudicial fear, compared to the peer with depression. In addition, while all other age and gender groups wanted more relationship social distance from the peer with ADHD, 10 to 11-year-old boys
Chapter 9: Discussion (Study One)

wanted significantly more relationship social distance from the peer with depression. Thus, the findings from the present research support other research that suggests that stigma is a multi-dimensional construct and its expression is often dependent upon the characteristics of the perceiver and the target (Jorm & Wright, 2008; Wolf, Pathare, Craig, & Leff, 1996; Watson et al., 2005).

The general measure of attitude, the ACL, showed that 10 to 11-year-olds females reported more positive attitudes towards the peers with disorders compared to males. While this gender difference supports previous research (Andersson, et al., 2009; Calear, et al., 2010; Jorm & Wright, 2008), the gender difference was not observed among adolescents. Instead, among females, adolescents had significantly more negative attitudes compared to children. These findings highlight how gender effects may be contingent upon the type of measure used. While response options are provided the ACL is not a forced choice response measure in the conventional sense, as participants are free to select as many responses as they wish. The format is notably different to other measures employed in this study and requires greater effort on part of the participants to process and select responses. Thus, the differences could be due to the measure or participants’ motivation to engage with this type of measurement tool.

Gender differences were not consistently found across the discrimination measures. Males reported significantly less positive behavioural intentions towards the target peers, compared to females. Comparable gender effects were not observed on the relationship and physical social distance measures. These differences may be explained by operational distinctions between these constructs. Behavioural intentions tap into inclusion and exclusion contexts across academic, recreational, and social domains, while relationship and physical social distance, respectively, explore participants’ desired relationship with, and avoidance of or physical proximity from, the target peer in the school context. Thus, when pitting the
findings against the specific meaning of the measures, males appear to be more likely to engage in greater exclusion of peers with disorders, in a variety of contexts, compared to females. However, no differences emerged between girls and boys when exploring the type of relationship they would like with peers with disorders or the distance at which they would feel most comfortable from such peers. Males’ lower behavioural intentions could be explained by other findings that show that boys tend to perceive peer rejection as more acceptable than girls (Killen & Stangor, 2001; Park & Killen, 2010).

Although this study did not explore whether participants believed that the behaviour exhibited by the peers with ADHD or depression conformed to the identity of their own age or gender groups, the findings that younger participants were often more positive towards the target peer with ADHD may be explained by insights from a social identity perspective. Specifically, the findings showed that, compared to children, adolescents were less accepting and more prejudiced towards both disorders, especially ADHD. This could be explained by the greater importance of the peer group in adolescence, compared to childhood. Research shows that adolescents’ perceive peer exclusion as a justifiable form of social regulation and thus, advocate for the exclusion of peers who might impinge on successful group functioning (Horn, 2003, 2006; Horn, Killen, & Stangor, 1999; Killen, Kelly, Richardson, Crystal, & Ruck, 2010). Research also suggests that group identity and associated norms are more meaningful in mid-adolescence and it is during this developmental period that social conventions are used to police membership of the peer group (Turiel, 1983). The symptomatic behaviour exhibited by young people with depression or ADHD may violate the expected norms of peer behaviour, and adolescents may believe that inclusion of these individuals will disrupt cohesion within the social group. Therefore, it is reasonable to suggest that adolescents’ preference for social order within the peer group ensures they are more motivated than younger children to reject peers with mental health problems. However,
adolescents also reported less physical social distance from the target peers, highlighting that they acutely differentiate between the social consequences of interacting with peers across contexts. The differences noted across the discrimination measures emphasises the importance of assessing multiple dimensions of stigma.

The results also suggested that 10 to 11-year-old males had more positive perceptions of the peer with ADHD and 15 to 16-year-old females were more positive towards peers with depression, as inferred by scores on the relationship social distance measure and the IAT, respectively. Research shows that ADHD is more prevalent among boys in childhood (Agency for Health Care Policy and Research, 1999) and some of the symptoms associated with this condition, such as hyperactivity may be more characteristic of the child male gender role. Thus, the symptoms associated with ADHD may be perceived as normative behaviours among young boys. While the present data partially supports this suggestion, as males were significantly more likely to report knowing a peer with ADHD than females, younger boys, however, were not more likely to report knowing such peers compared to other older boys or same age girls. The fact that depression is more prevalent among adolescent girls than adolescent boys or children of either sex (Torsheim et al., 2006; Twenge & Nolen-Hoeksema, 2002) and some symptoms of depression may be more normative behaviours of the female gender role, may explain adolescent girls’ positive implicit perceptions of peers with depression. For example, research exploring gender differences in the emotional expression of healthy adolescents showed that contempt was the most salient negative emotion reported by adolescent boys, while depressive states, such as shyness, shame, sadness, self-hostility, and guilt were more salient among girls (Stapley & Haviland, 1989). Other research shows that 9 to 16-year-old girls report crying more frequently and are more prone to crying than age matched boys (Jellesma & Vingerhoets, 2012; van Tilburg, Unterberg, & Vingerhoets, 2002). While these factors might explain adolescent females’ positive implicit evaluation of
the peer with depression, the study did not find that this group were more likely to report knowing a peer with depression or perceive themselves to be more similar to this peer, compared to other groups.

9.3.1 Theoretical Implications of the Explicit Findings

Beliefs about dangerousness of people with mental disorder and beliefs about how personally responsible individuals with disorders are for their conditions are thought to be the two most important stereotypes in determining stigmatising responses (Corrigan, 2002; Corrigan et al., 2007; Jorm & Wright, 2008). However, in contrast to previous research, in the present study dangerousness stereotypes were not dependent on socio-demographic variables or the type of mental health disorder (Reavley & Jorm, 2011b). The type of disorders examined in the present study may explain this finding. Typically, research that explores dangerousness stereotypes focus on these beliefs towards disorders that are more prevalent in adulthood (Angermeyer & Matschinger, 2003; Corrigan, Edwards, Green, Diwan, & Penn, 2001) and not childhood disorders, such as ADHD and childhood or adolescent depression. While Corrigan and colleagues reported that adolescents’ beliefs about dangerousness of a hypothetical peer with depression predicted self-reported behaviour, they did not explore whether such beliefs were strongly endorsed. Other research with adolescents and young adults shows that significantly less people believe that people with depression are dangerous, compared to other disorders, such as schizophrenia (Crisp, Gelder, & Rix, 2000; Jorm & Wright, 2008). Thus, the ecological validity of exploring perceptions of dangerousness of peers with childhood and adolescent disorders such as ADHD or depression is questionable. Differences did emerge, however, for responsibility stereotypes, such that the peer with ADHD was viewed as being more responsible for his or her condition compared to the peer with depression. Males also believed that the target peers were more responsible for
their behaviour, which is consistent with findings from other research (Williams & Pow, 2007). While the relationship between such variables was not causally explored in the present study, research on attribution theory shows that young people who perceive a person with depression as not personally responsible for his condition will be sympathetic towards this individual and engage in help-seeking behaviour towards him (Corrigan et al., 2007). Conversely, those who perceive the individual with depression as personally responsible will not be sympathetic toward his cause and advocate segregation from society. Therefore, it is possible that differences in participants’ beliefs about responsibility might explain some of our findings that showed that the peer with ADHD was perceived more negatively. The results pertaining to the attribution variables suggest that beliefs about responsibility, but not dangerousness, might be useful to explore in relation to child and adolescent disorder. Thus highlighting that applying models and theory developed for adult populations may not always inform the target phenomenon, as it exists in childhood and adolescence.

9.4 Interpreting the Implicit Findings in Light of Previous Research

A particular strength of this study was that it is the first study to explore implicit attitudes towards peers who are described as engaging in behaviours associated with mental health disorders. The implicit results suggest that adolescent males are motivated to inhibit their explicit negative evaluations of depression, as inferred by their significantly stronger negative implicit attitude towards the peer with depression compared to other groups. Again, these gender and age related findings may be explained by the social norms about emotional and behavioural expression that exist among boys and changes in such expectancies across development. We know from the gender development literature that, with age, young people’s beliefs about gender appropriate behaviour and expectancies become more sophisticated and solidify in adolescence (Martin & Ruble, 2004; Montgomery, 2005).
Research on gender expectancies show that acceptance into popular male peer groups is dependent on individuals exhibiting masculine traits, such as competitiveness and toughness, while admissions of weakness, such as crying and failure are perceived as feminine (Swain, 2004). Recent research by Maclean et al. (2010) found that 10 to 15-year-old boys and girls engage in policing of appropriate gender behaviour and failure to adhere to gender expectancies jeopardises the target individual’s gender identity. Specifically, the findings of their study showed that boys who reported or exhibited symptoms associated with psychological distress would be subjected to the most severe consequences from their peers, such as name-calling and bullying. Participants also claimed that males who engage in this behaviour would be labelled as “sissies”, “wimps”, or “girls”. Thus the findings of these studies may explain adolescent boys’ negative implicit attitude towards the peer with depression. Together, the age and gender related findings of the present study tentatively provide empirical support for identity based stigma theories (e.g. when peers with disorders violate gender roles, worse perceptions of them are formed). Empirical research is needed to test the above interpretations; however, reflecting on the knowledge offered by social identity theories these explanations are relevant to consider.

The difference in negative implicit attitudes towards depression between younger and older males is worthy of consideration, as this indicates differences in the acceptability of emotional symptoms from childhood to adolescence. Furthermore, suicide is the second leading cause of death among male adolescents and depression is a major risk factor (Centre for Disease Control and Prevention, 2009). In addition, young people report peers as vital sources of social support when distressed (Swords, Hennessy, & Heary, 2011c). It is possible that negative implicit evaluations of depression could influence the quality of support young male provided to such peers. Research should investigate possible relationships between implicit mental health attitudes and behaviour. These implicit findings highlight the
importance of combining implicit and explicit measures in stigma research. Together the explicit and implicit data provide unique take-home messages about children and adolescents’ perceptions of peers with mental disorders that have not been offered by previous research.

9.4.1 Theoretical Implications of the Implicit Findings

The published literature on the relationship between implicit and explicit attitudes in childhood and adolescence typically shows that they are unrelated (Baron & Banaji, 2006; Dunham et al., 2006; Cvencek et al., 2011a); while in the adult literature the relationship between implicit and explicit measures is generally mixed. In the present study, a mixed picture of the relationship between implicit and explicit measures also emerged. Positive relationships were observed between implicit attitudes and dangerousness, responsibility, and fear towards the peer with ADHD, suggesting that stronger negative implicit attitudes were associated with stronger endorsements that the peer with ADHD was dangerous, responsible for his or her behaviour and that participants would be afraid of him or her. One possible explanation for this finding is that participants engaged in more controlled and perhaps, social desirable responding on the explicit measures towards the peer with depression than the peer with ADHD. Gawronski and De Houwer (in press) note, that often disassociations between implicit and explicit measures can be attributed to a miss-match between the attitude objects, used in both measures. As the target attitude object (peer with depression) was consistent across the two measures, this is not likely to explain the disassociations. However, given that the IAT is a relative measure of attitude and the explicit measures were not, it is possible that correlations would have been detected if an explicit relative measure had been employed.
When exploring the predictive validity of the explicit and implicit measures to account for behavioural intentions towards the peers with depression or ADHD, perceived responsibility and anger were the only variables to predict behaviour. Previous research consistently shows that beliefs about responsibility predict social distance and acceptance (Corrigan et al., 2007; Sword et al., 2011). Furthermore, as mentioned earlier, Corrigan and colleagues have modelled that beliefs about responsibility predict prejudicial anger which in-turn predict social distance towards peers with depression. While the relationship between these variables were not modelled in the present study, it is possible that a similar relationship exists within the data. The inability of perceived dangerousness and fear to contribute to the model calls into the question the ecological validity of these variables in child and adolescent stigma. As discussed earlier, these variables were adapted from adult models of mental disorder stigma; therefore, it is possible that dangerousness stereotypes and associated fear may be more relevant to adult disorders. The failure of implicit attitudes to account for behavioural intentions is worthy of consideration. Research shows that implicit measures are better predictors of spontaneous behaviour rather than deliberate behaviour (see Perugini, Richetin, & Zogmaister, 2010 for a review). Thus, implicit attitudes inability to contribute to the variance explained by the explicit measures may be attributable to the behavioural measure employed in this study.

Despite the weaknesses of the implicit measure, which are discussed in detail below, the study demonstrated that implicit attitudes towards peers with mental health problems can be measured with modifications to the IAT. The findings challenge the slow learning model of implicit attitudes (e.g. Smith & DeCoster, 2000) and support growing evidence that implicit attitudes are formed quickly in childhood (Dunham et al., 2011). Theoretically, the findings partially support the dual-process theory of social cognition (Fazio, 1990; Fazio & Towles-Schwen, 1999; Schuette & Fazio, 1995; Chapter 3 section 4.3.2), which highlights
that implicit attitudes are a valuable dimension of human cognition. From a developmental perspective on implicit attitudes, this study challenges the consistent findings in the literature on implicit racial attitudes, which shows that the strength of implicit attitudes towards racial outgroups remains stable between 6 to 10 years of age and into adulthood (Baron & Banaji, 2006; Dunham, et al., 2006). Instead, the finding that implicit attitudes towards peers with depression differed as a function of gender from childhood to adolescence, proposes that the development of implicit attitudes towards peers with mental disorders is unique compared to the development of implicit evaluations towards racial outgroups. Together, the trends on both the implicit and explicit measures stress the importance of exploring gender specific developmental trends in relation to mental disorder stigma.

This study demonstrated that implicit mental illness attitudes, that are free from potentially contaminating labeling effects (Harris et al., 1992) and confounding effects of mental health literacy (Wahl, 2002), can be measured by incorporating a name-behaviour training procedure into the IAT. Specifically, this study created a novel way of assessing implicit attitudes towards peers who are not explicitly labeled as having a disorder but who, by nature of their behaviour, are perceived as socially deviant. Future research should adapt the IAT used in the present study, as per the below recommendations, to improve the psychometric properties of the IAT. Following such alternations the IAT may be potentially useful for research on implicit cognition towards other ostracised individuals, such as aggressive peers, or peers with developmental disabilities.

A notable strength of this study was that it explored explicit and implicit responses towards peers who were described as engaging in behaviours symptomatic of mental health problems without the use of psychiatric labels. This approach increases the ecological validity of the data collected as it ensures that participants responded to clinically accurate and realistic depicts of peers with mental health problems and not terms that they may not
accurately understand. Furthermore, this is the first study to comprehensively assess the concept of stigma in childhood and adolescence. It is also the first study to modify an IAT so that it could be used to assess implicit attitudes towards peers with mental health problems.

While the findings showed that most young people did not exercise overly negative explicit responses towards peers with mental health problems, the negative perceptions towards these individuals, when compared with peers without a mental health problem, suggests that children and adolescents with mental health problems are likely to experience negative social interactions with their peers. It is also important to note that within the most stigmatising groups, a noteworthy proportion of each target group endorsed negative responses on most variables. In addition, implicit responses towards all of the target peers were considered negative, except female adolescents’ implicit attitudes towards peers with depression. Reflecting on these findings, it appears that there is a need for intervention within these groups, with a specific emphasis on adolescents, and in particular adolescent males, to reduce stigma towards young people with mental health problems (see Chapter 14 section 14.2.2 for a discussion on stigma interventions).

9.5 Limitations & Recommendations

9.5.1 General Methodological Issues

Although this research has addressed important gaps in the stigma literature, the results are in response to hypothetical peers and thus caution must be exercised when generalising the findings to actual peers. Juvonen (1991) is the only study to have compared children’s responses to real and hypothetical peers. The findings of her study showed that children were more positive towards hypothetical peers with mental disorders compared to actual peers.

Another possible limitation of this study is the use of single item measures. Although practical, the psychometric properties of these measures may be questionable as they are
vulnerable to random measurement error. A further limitation of single item scales is that when used to assess multi-element constructs the content validity of the item is compromised. However, research shows that if constructs are conceptualised as singular and concrete, single-items are appropriate (Rossiter, 2002). Thus, the issue of content validity was unlikely to be problematic in this study as all single-item measures assessed uni-dimensional constructs, such as specific stereotypes or emotional beliefs. While much of the research supporting single items over multiple-item measures has been conducted within marketing academia (Bergkvist & Rossiter, 2007; Diamantopoulos, Sarstedt, Fuchs, Wilezynski, & Kaiser, 2012), research in social, health, and clinical psychology have also demonstrated that single-items are useful and psychometrically sound (Brown & Grice, 2011; Elo, Leppanen, & Jahkola, 2003; Hoeppner, Kelly, Urbanoski, & Slaymaker, 2011). Single-items also have ethical and practical advantages over multi-item measures as they reduce participant burden and are less monotonous (Gardner, Cummings, Dunham, & Pierce, 1998), which is a particular concern in research with child participants. Thus, the use of single-item measures may lead to better questionnaire effectiveness. Finally, all the single items used in this study have been adopted or modified from published studies and therefore have been subjected to peer review.

The discrimination measures utilised in this study were self-report and not actual behaviour. While capturing incidents of peer discrimination in real-life situations is challenging, experimental behavioural techniques that attempt to capture proxy measures of actual behaviour should be used. Examples of fruitful measures of behaviour that should be incorporated into stigma research are Cyberball (Williams, Cheung, & Choi, 2000) or Chatroom Interact Task (Silk, et al., 2011). Both computer-based tasks stimulate interactions between participants and virtual peers and could be modified to make participants believe they are interacting with a peer with a mental health problem.
While this study highlighted the important role of gender in the stigma process, it only explored responses towards same sex peers. As discussed in Chapter 4 section 4.2 research that explores attitudes and behavioural intentions towards other gender peers shows that patterns of responses not only differ across the sex of the perceiver but also depend on that of the target peer (Swords et al., 2011a). Therefore, future research exploring stigma towards different sex peers would enhance knowledge on this area.

### 9.5.2 Psychometric Properties & Methodological Issues Specific to the Implicit Measure

Given that research has yet to develop an implicit measure of attitudes towards mental disorders for children and adolescents, the psychometric properties of the implicit measure used in the present study were explored. The present study found that both the depression and ADHD IAT demonstrated medium stability. Only one published study, with adolescents, has reported test-retest reliability for the IAT. Assessing the stability of smoking versus healthy food and smoking versus sweet food IATs over a 1-week interval, respective reliabilities of $r = .20$ and $r = .29$ were found (Andrews, et al., 2010). Thus, when compared to Andrews and colleagues study, the IAT used in the present study demonstrated considerably better stability. A review by Schmukle and Egloff (2004) on the anxiety IAT, reported a test-retest reliability of $r = .56$. Although the correlations found in the present study was lower than that found in Schmukle and Egloff’s review, the present study was not concerned with a personality trait so a direct comparison is not possible. In addition, the review only explored research with adult participants. The medium correlations in the present study could be explained by the challenge imposed by incorporating the concept of child and adolescent mental health problems into the IAT. Low stability is indicative that the measure has a large amount of measurement error, creating noise in the data, which concurrently reduces the
stability of the measure (Schmidt & Hunter, 1996). The stability of implicit attitude measures has been highlighted as an issue for concern among social scientists (LeBel & Paunonen, 2011).

The internal consistency of both the depression and ADHD IAT were notably weaker than the reliability cited in other research utilising the IAT with children and adolescents (e.g. Cvencek et al., 2011a, 2011b: $\alpha = .74 - .89$; van Goethem, Scholte, & Wiers, 2010: $\alpha = .72 - .84$). However, Andrews et al. found similar reliability scores of between .37 and .51 for IATs assessing implicit attitudes towards smoking versus healthy food and smoking versus sweet food. The internal consistency found in the present study may be explained by the fact that the target attitude objects were novel subjects that young people did not have established attitudes towards prior to participating in this study. While other research shows that implicit attitudes towards novel groups are formed quickly, the published data on the internal consistency of these assessments are not available (Dunham et al., 2011). Perhaps the name-behaviour training was not strong enough to initiate reliable associations between the names of the target peers and the attribute exemplars. Although it is difficult to capture mental disorders in pictorial form, in future research, the vignettes and the name-behaviour training procedure could be paired with pictures of the target peer, which could be used as the target category in the subsequent IAT (Mann, Hamamitsu, Schenk, & Prioty, 2012).

It is also possible that more reliable associations will be formed between depictions of the target peer and the attribute exemplar, compared to the names of the target peers and the attribute exemplars. Furthermore, in attempting to choose words that represent the concept of stigma it is possible that the valence of the exemplars used in this study were not automatically evaluated as distinctively good or bad. In addition, the words were chosen from readings on stigma in adulthood, thus, as noted with the explicit measures some of the words may not be relevant to stigma towards peers with mental disorders in childhood and
adolescence. Furthermore, the IAT used in the present study was a global measure of stigmatising attitudes, incorporating both stereotypes and prejudice. It is possible that the reliability of the measure would be enhanced if it assessed either stereotypes or prejudice, thus future research should explore this possibility. Ultimately, future research should explore alternative exemplars to represent the good versus bad attribute exemplars and explore the effect of these on the reliability of similar IATs.

While the reliability of the IAT tends to be higher than other implicit measures, IAT studies do not routinely cite the internal consistency of their implicit measure, nor are test-retests routinely evaluated, or if they are this data does not feature in published work. This makes it difficult to assess the relative reliability of this measure in comparison to other implicit measures and thus difficult to infer more concrete conclusions about the utility of the present measure. However, as Blanton and Jaccard (2008) highlight, creating reliable implicit measures is a greater challenge than designing reliable explicit measures, therefore, this study provided a good first attempt at developing a psychometrically sound implicit measure, which can be modified and improved in future research.

As mentioned earlier, future work should explore the relationship between implicit attitudes and behaviour. The inability of implicit attitudes to predict behaviour may be explained by the type of behaviour employed in this study. Research using implicit measures shows that implicit measures are more successful at predicting spontaneous behaviour, rather than deliberate behaviour (see Perugini et al., 2010 for a review). Similarly, research shows that implicit measures are better at predicting behaviour when cognitive resources are depleted or stressed, whereas explicit measures better predict behaviour in unconstrained conditions (Hoffman, Rauch, & Gawronski, 2007). The behavioural intentions measure used in this study was not only just a proxy measure of behaviour but completion involves controlled and deliberate responding. Thus, future research should investigate the ability of
the IAT used in this study to predict automatic behaviour towards peers with mental disorders. The predictive validity of implicit attitudes may have also been hindered by the absence of a relative explicit measure of both attitude and behaviour. Although, explicit relative measures of attitude and behaviour are not always employed in work on implicit attitudes (e.g. Brochu & Morrison, 2007; Roddy, Stewart, & Barnes-Holmes, 2010, 2011) this work also tends to show that implicit attitudes do not predict behaviour. However, research shows that implicit attitudes predict behaviour when explicit relative measures of behaviour are used (e.g. Cvencek et al., 2011a; Dunham et al., 2011). Therefore, to gain a potentially more valuable insight into implicit attitudes, corresponding relative explicit measures should be utilised in subsequent research.

While the presentation order of implicit and explicit measures has not been found to affect explicit and implicit mean scores (Nosek, et al., 2005), the order in which the target attitude objects and attribute stimuli are paired during the IAT has shown to influence $D IAT$ scores. Such order effects are commonly observed in both adult and child IAT studies (Cvencek et al., 2011; Greenwald & Nosek, 2001). To overcome this limitation Nosek, Greenwald, and Banaji (2007) recommend counterbalancing the order of combined blocks across participants. While this was adhered to in the present study an order effect was still found. Drawing on Cvencek and colleagues’ interpretation of order effects, performance on the first combined blocks strengthens associations throughout the measure, which in turn enhances the measured strength of associations in the first block. They also argue that order effects are likely to be strongest when associations are initially weak; this may be the case in the present study as the target peers were novel to all participants. Whereas order effects may be weaker or less likely to occur in studies that explore gender or racial attitudes where attitudes are already established (Cvencek et al., 2011a, 2011b). However, in the present study the results revealed significant negative attitudes towards the peers with mental health
problems regardless of the order of the combined task. Thus, participants’ implicit associations between the target peers and attribute exemplars were strong enough not to be entirely influenced by order effects. Future research using this IAT with children should follow Nosek, Greenwald, and Banaji’s (2005) recommendation to increase the number of practice trials from 20 to 40 in the second set of combined trials to reduce the impact of the order of combined trials on responses.

9.5.3 Theoretical Issues

The present study drew on Link and Phelan’s conceptualisation of stigma; that stigma is projected towards individuals, who are perceived as being of low social status, in the form of stereotypes, prejudice, and discrimination. While this is an adult model of stigma, evidence from literature beyond the mental health domain shows that these constructs are evident in childhood and adolescence. However, as suggested earlier in relation to dangerousness stereotypes, the nature of beliefs, emotions, and behaviour within these constructs in childhood might be uniquely different to those that exist in adulthood. Upon reflection, the applicability of the stereotypes and prejudice measures used in this study to capture relevant beliefs and emotional responses towards peers with mental disorders in childhood and adolescence is questionable. While the r-AQ (Corrigan et al., 2007), the measure used to measure stereotypes and prejudice in the present study, was previously used with young people, the original authors adapted this scale from research with adults. In doing so, few modifications were made to enhance the ecological validity of this measure for use with children and adolescents. While the present study is guilty of the same approach, the findings raise the important issue of whether adult models of stigma are applicable to stigma in childhood and adolescence.
As discussed in Chapter 3 section 3.6, the phenomenon of mental illness stigma in childhood and adolescence is relatively under-researched compared to mental illness stigma in adulthood. Thus, when designing research methodologies and constructing research questions researchers have traditionally looked to the adult stigma literature for inspiration and recommendations. One can argue that it is empirically important to explore whether adult models of stigma are generally applicable to younger people, as this method can potentially provide an insight into the unique and shared means in which people with mental health problems are stigmatised by their peers. Such knowledge may contribute to a lifespan perspective and provide important information for stigma intervention. However, it can be argued that the applicability of these models may be hindered by cognitive differences in how adults and children navigate their social world (Aboud, 2008). Furthermore, there are vast differences in the presentations of mental health problems across development and the means in which discrimination occurs in childhood compared to adulthood (Chapter 3 section 3.6). Such factors are relevant when considering whether adult stigma models can be successfully applied to childhood and adolescence. In addition, as shown in the wider literature on stigma towards gender and racial outgroups, adult models have not been particularly useful (Dunham et al., 2008; Killen et al., 2010). Instead, unique developmental models have vastly improved our understanding of racial and gender stigma in childhood and, consequently, have contributed to our knowledge of such stigma in adulthood.

The findings of the presented study suggest that future research should move away from applying adult stigma models to child populations. Instead, in-depth research investigating the exact nature of stigma and how it prevails in childhood and adolescence is needed. One rational first step is to openly explore young people’s perceptions of people with mental disorders and analyse common stereotypes and prejudice. For example, qualitative research on 14-year-olds’ perceptions of people with mental health problems revealed that
common beliefs were that individuals were ‘nuts’, ‘psychos’, ‘spastic’, or ‘freaks’ (Rose et al., 2007). The evidence from this type of research should be used to inform the development of stigma scales for younger populations.

### 9.5.4 Other Recommendations for Future Research

Another way of enhancing understanding of stigma as it exists in childhood and adolescence is to adapt some of the indirect methods that are widely used in racial and gender stigma literature to the domain of mental health. For example, the Ambiguous Situation Task (McGlothin et al., 2005) holds much promise for advancing knowledge on stigma towards peers with mental disorders. The task consists of pictures that usually depict a White and Black character in a scene in which a transgression (e.g. stealing, pushing) may or may not have occurred. Typically, two versions of the task are developed, in which the White character is potentially the perpetrator and the Black character is the victim and vice versa. Participants are then asked a series of questions that assess their interpretations of the situations. Studies using this approach reveal that in ambiguous situations children often reflect on stereotypes and prejudice to explain their interpretations (McGlothin & Killen, 2006, 2010; McGlothin et al., 2005). Thus, this type of assessment has the potential to advance knowledge on how children think and feel about peers with mental health disorders. The subsequent findings may in turn facilitate the design of developmentally appropriate measures to assess stigma.

While this study and previous research indicates that children and adolescents reject and exclude peers with mental health problems, what is not understood, however, is why these peers are excluded and how children think about it. There is growing body of research that explores young people’s evaluations and reasons for excluding racial and gender outgroup peers (e.g. Park & Killen, 2010; Killen & Stangor, 2001). Utilising the methods
employed in these studies will help further understanding of the cognitive processes involved in discrimination and enhance knowledge of the nature on stigma. Research concerned with young people’s evaluations of the exclusion of outgroup peers will be discussed in the following chapter.

9.6 Summary & Conclusion

This study showed how children and adolescents implicitly and explicitly stigmatise peers with ADHD and depression. The findings support and extend existing research that suggests the nature of stigma is contingent upon the disorder in question and the gender and age of the perceiver. The results also show that stigma is dependent on the dimension of stigma being investigated and how it is measured. The unique patterns of stigma highlight the importance of conceptualising stigma as a multi-dimensional construct with stereotypes, prejudice and discrimination components. The findings also highlight the importance of employing both explicit and implicit assessments in stigma research. The utility of employing both implicit and explicit measures in advancing our understanding of stigma was also demonstrated.

While this study was an important step towards understanding mental disorder stigma in childhood and adolescence, more research in this area is undoubtedly necessary. One possible avenue of research to further understanding of this topic is to explore why young people exclude peers with mental health problems. Study Two of this body of research provides a qualitative investigation on this topic, which will be introduced in the next chapter.
Chapter 10: Introduction (Study Two)

10.1 Aim of Chapter

The aim of this chapter is to introduce Study Two. Firstly, a rationale for this study will be presented. Following this, research from the wider social cognitive literature on young people’s social reasoning about peer exclusion will be explored. Research on children and adolescents’ attribution beliefs about mental health disorders will also be discussed. Finally, the aims and objectives of the present study will be presented.

10.2 From Study One to Study Two: A Practical Note

Pitched under the umbrella topic of stigma, Study One and Study Two aim to advance knowledge on peer experiences of children and adolescents with mental health disorders, from the perspective of their peers. In the rationale for Study Two below, some of the findings from Study One are discussed, however, it is important to note that these results did not play a pivotal role in the development and design of this study. While the studies were conducted sequentially, Study Two was designed while the data for the previous study was still being analysed. Therefore, both studies are not explicitly intended to inform one another, but instead were designed to independently address the pertinent gaps in the stigma literature. However, in an effort to bridge the findings from Study One and Study Two, a general overview of the unique and shared patterns of results are tentatively discussed in Chapter 14 section 14.2.
10.3 Why Investigate Social Reasoning about Exclusion of Peers with Mental Health Disorders?

As discussed in Chapter 3 section 3.2, during childhood and adolescence, peer discrimination manifests as exclusion from activities and social groups, friendship rejection or avoidance (Brown & Bigler, 2005). Peer relations research on the experience of children and adolescents with mental health disorders suggests that they are some of the most chronically excluded individuals in the school environment (e.g. Chen & Li, 2000; Hoza, et al., 2005; Parker et al., 1995 see Chapter 2 section 2.3.1). Indeed, stigma research also tends to present a similarly negative picture of how these individual are perceived by their peers (Jorm & Wright, 2008; Reavley & Jorm, 2011a; Walker et al., 2008). While it is challenging to accurately deduce just how negative perceptions of peers with disorders are, it is sufficient to state that young people with mental health problems experience more difficulty gaining acceptance from their peers compared to individuals without disorders. The results from Study One support this claim; children and adolescents were more accepting in academic, social and recreational contexts of peers without mental health problems compared to those with such problems. In addition, they also reported wanting a closer relationship with the peer without a disorder (as measured by the Classroom Social Distance Scale) and sought less avoidance (as measured by the Physical Social Distance Scale) from such peers when compared to peers with mental disorders. In general, these findings imply that, when pitted against majority classmates (those without a mental health disorder), children and adolescents with mental health problems are at risk of greater negative social experiences in the form of peer exclusion and rejection.

Investigating exclusion in detail is not only important because it is the behavioural component of stigma, but also because in the wider peer relations literature, exclusion is often perceived as a form of bullying, which is reported to occur as frequently as physical
aggression (Seals & Young, 2003). From a bullying perspective, exclusion is conceptualised as an indirect form of bullying (Bjorkqvist, Lagerspetz, & Kaukiainen, 1992; Olweus, 1991). Exclusion is also conceptualised as a form of relational aggression, instead of using physical force, it uses relationships to inflict harm (Crick, Casas, & Mosher, 1997; Crick & Grotpeter, 1995; Onishi, Kawabata, Kurokawa, & Yoshida, 2011). However, from a social reasoning perspective exclusion is not always unilaterally intended to inflict harm, but can also be a legitimate form of social regulation and one’s personal choice (Killen, Mulvey, & Hitti, in press). Common to all perspectives is that exclusion is a central aspect of children and adolescents’ social world and regardless of the intention, exclusion inflicts harm on its victims and puts them at risk of negative developmental outcomes (Deater-Deckard, 2001; Hay et al., 2004; see Chapter 2 section 2.3). Given the perceived importance of peer exclusion across multiple research areas, advancing our understanding of exclusion in the context of mental health stigma will undoubtedly further knowledge of peer exclusion in general. Thus, there is strong empirical value in investigating social reasoning about exclusion.

At present, the literature that investigates the experiences of young people with mental disorders within the peer group is generally influenced by an interpersonal rejection approach, which assumes personality traits and behavioural profiles are the root cause of rejection (Bierman, 2004; Rubin, Bukowski, & Parker, 2006). Interpersonal rejection approaches posit that children with ADHD, for example, are excluded because their externalising behaviour is perceived as troublesome, while children with depression are excluded because their internalising behaviour ensures they initiate little social contact or are quiet and easy victims of exclusion (Coplan, et al., 2003; Harrington, 1993; Patterson & Sanson, 2001; Rudolph, et al., 2008). An interpersonal rejection approach to peer rejection has undoubtedly provided invaluable information on the behavioural profile of rejected
Chapter 10: Introduction (Study Two)

children and individual differences that may put children at risk of rejection. It has also been influential, if only at an implicit level, in shaping the research design of most of the published literature on mental disorder stigma in childhood and adolescence. For example, it assumes that the behaviour associated with these disorders illicit stereotypes and prejudice that influence discrimination. The first study in this body of research was implicitly guided by an interpersonal approach to stigma. It hypothesised that participants would interpret the behaviour of the target peers with ADHD and depression as deviant, and as inferred by unique patterns of responses elicited by the stigma measures, the hypothesis was supported. Crudely, from a theoretical perspective, research that assumes an interpersonal approach posits that the symptomatic behaviour exhibited by these youth invites rejection (Hodges, Boivin, Vitaro, & Bukowski, 1999). However, this approach does not take into account important interactions between individuals and social groups that facilitate acceptance or rejection (Chang, 2004).

An intergroup exclusion approach offers an alternative perspective to exploring peer rejection. As described in a recent review by Killen and colleagues (in press), this perspective challenges the assumption that the behaviours exhibited by the ostracised peer elicit such rejection. Whilst acknowledging the importance of individual temperament and behaviour, this approach advocates the significance of social cognitive reasoning (moral, social conventional and psychological), societal structures, norms, and biases in determining exclusion. Killen and colleagues argue that an intergroup approach should not undermine the value of identifying personal factors that put an individual at risk of exclusion or the influence of these personal factors on stigmatising responses, but should stand as a complementary perspective that will facilitate further understanding of peer exclusion in general. An intergroup perspective involves investigating children’s evolving comprehension of multiple factors that influence their social world including their sense of group identity,
peer norms and conventions, and other societal conventions that maintain social hierarchies and relationships (Killen et al., in press). This approach also involves exploring perceptions of fairness and equality pertaining to exclusion. The multitude of factors deemed important within an intergroup approach are reflected in research that shows that sometimes stereotypes, bias, violation of group and societal norms or conventions justify exclusion, whereas, other times moral judgements about fairness of exclusion are employed to condemn exclusion (Abrams et al., 2003; Killen & Stangor, 2001; Killen et al., 2010). Intergroup approaches to stigma draw on research guided by Social Domain Theory (STD) and Social Identity Theories such as Social Identity Development Theory and Developmental Subjective Group Dynamics and more recently Social Reasoning Developmental Theory (see Chapter 3 section 3.4.4 for an explanation of these theories).

Acknowledging the breadth of the theoretical approaches that underpin an intergroup perspective, and the reluctance of existing research to define children and adolescents with mental health disorders as a group, the present study provides an exploratory insight into how adopting an intergroup perspective towards mental health stigma can advance knowledge on why young people with ADHD and depression are rejected by their peers. Theoretically, this study will draw on Social Domain Theory to explore children and adolescents’ perceptions of fairness of exclusion of peers with mental disorders and the justifications they provide for exclusion. Research pertaining to children and adolescents perceptions of peer exclusion from an intergroup perspective will be explored next, followed by an review of the research on the role of Attribution Theory in determining attitudes towards mental disorders.
10.4 Understanding Peer Exclusion in Childhood & Adolescence

Research within the developmental social cognitive literature is currently witnessing a surge of empirical studies that explore the reasoning involved in discriminating against outgroup peers. This review will predominantly focus on research pertaining to SDT as it mostly influences the present study. In addition, this review will also draw on Attribution Theory, as attribution beliefs and stereotypes are likely to provide a context for the type of social reasoning that young people use when discussing exclusion of peers with disorders (see section 10.5 below). Research on social reasoning of peer exclusion typically employs experimental vignette methodologies that feature an exclusion scenario involving hypothetical peers. Depending on the focus of the study, target variables are manipulated, such as the context of the exclusion, the target peers ethnic or gender identity, personality traits, group norms or group status (e.g. Horn, 2006, 2008; Killen, Kelly, Richardson, Crystal, & Ruck 2010; Killen, Rutland, Abrams, Mulvey, & Hitti, in press; Park & Killen, 2010). Participants’ views on exclusion or inclusion of the target peer are then assessed. Asking children and adolescents why other individuals exclude or include specific peers is conceptualised as an indirect way of tapping into stereotypes and prejudices that young people may have towards a target individual or group, as well as assessing social reasoning about exclusion.

SDT posits that children and adolescents reason about their social world by reflecting on moral, social conventional, and psychological considerations. The weight they give to each domain is highly dependent upon their social experience and the exclusion context in question. Tisak (1995) describes the moral domain as including “prescriptive judgements about how individuals ought to behave towards one another” (p.96). Moral considerations are prioritised in situations where rights, justice, and welfare of others or the self are threatened. An example of a moral reason for including a peer in one’s group would be, “It’s not ok to
Chapter 10: Introduction (Study Two)

exclude Jake because it will hurt his feelings”. The social conventional domain include rules, norms, customs, and common perspectives that are constructed and agreed upon by members of a society or group that enable a society or group to function. Given the nature of social conventions, stereotypes are likely to feature in social conventional reasoning about exclusion of stigmatised individuals (Mulvey, Hitti, & Killen, 2010). The psychological domain incorporates considerations pertaining to personal autonomy, choice, and preference (Tisak, 1995). The psychological domain is differentiated from moral and social conventional domains, as it does not focus on reasoning associated with potential harm to the self or others or reasoning related to social expectations. Instead, psychological reasons mostly centre on personal choice, for example, “it is ok for me to decide not to invite that boy because it is my choice who I play with”.

In general, results from SDT research indicate that peer exclusion is complex. Unlike conventional forms of bullying such as name-calling or physical aggression, children and adolescents do not unilaterally perceive exclusion as immoral. Instead, perceptions of peer exclusion are multifaceted and highly context and content dependent (Brown & Bigler, 2005; Killen, Stangor, Price, Horn, & Sechrist, 2004; Killen, 2007). When asked to evaluate gender exclusion, from about 3.5 years of age, children use moral reasons to condone exclusion (Killen, Pisacance, Lee-Kim, & Ardila-Rey, 2001). From 6 years of age, developmental increases are observed in the frequency in which children employ social conventions justifications when reasoning about exclusion. Specifically, children increasingly rationalise about exclusion by reflecting on group functioning and group identity consequences (Aboud, 2008). Consequently, exclusion tends to become more acceptable with age (e.g. Malti, Killen, & Gasser, 2012; Moller & Tenenbaum, 2011; Park & Killen, 2010). Given that group identity and knowledge of societal, group, and cultural norms become ingrained in adolescence, research shows that adolescents refer to norms, identity, group cohesion, and functioning
when explaining exclusion (Horn, 2003). This developmental trend of moving from focusing on moral to social conventional considerations when assessing exclusion is not unanimous in every exclusion context. For example, research by Horn (2008) found that 14 to 16-year-olds were more likely to employ social conventional reasons when evaluating exclusion based on sexuality (gay or lesbian) in school contexts, while 16 to 18-year-olds were more likely to reject such exclusion on moral grounds. The findings of this study highlighted how developmental patterns can differ depending on characteristics of the target of exclusion.

This body of research has revealed consistent gender differences in social reasoning about exclusion, whereby females tend to show greater concern for inclusivity of peers across a variety of exclusion contexts (e.g. Killen & Stangor, 2001; Malti et al., 2012; Park & Killen, 2010). For example, Killen and Stangor (2001) found that when both female and male characters were excluded from groups on the basis of their gender, female respondents evaluated rejection of this peer as unfair. These findings suggest that females are more likely to evaluate exclusion of peers as wrong and subsequently rationalise their evaluations by employing moral justifications. Such gender differences are frequently explained by research that indicates that, compared to boy, girls perceive caring and helping as more mandatory peer behaviour (Killen & Turiel, 1998).

Social reasoning about exclusion also hinges on the context of exclusion or the perpetrator’s rationale for the act. In studies where the perpetrator’s rationale for exclusion was manipulated, exclusion based on race was evaluated as more unfair than non-race based exclusion (Killen & Stangor, 2001; Killen et al., 2010). Similarly, adolescents are more likely to condone and justify racial exclusion as an issue of personal choice in intimate contexts compared to less intimate contexts. However, in some contexts young people justify exclusion by reflecting on race or sex based reasons to maintain group cohesion (Killen, 2002). Research has also shown that contact with an outgroup influences the types of
reasoning young people use when discussing exclusion decisions involving members of this group. For example, Killen and colleagues (2010) found that children and adolescents attending heterogeneously diverse schools were more likely to evaluate interracial exclusion as wrong and use fewer stereotypes in their discourse on such exclusion.

Research that has adopted this approach to explore dyadic and group exclusion of aggressive and shy peers shows that exclusion based on personality traits is more acceptable than gender or nationality based exclusion (Park & Killen, 2010). Exclusion of a shy peer was less acceptable than exclusion of the aggressive peer. Furthermore, a developmental pattern was found; compared to 10-year olds, 13-year-olds evaluated rejection of the aggressive peer as more legitimate. They also found that participants used group functioning reasons, such as “this is ok because the group might not want someone to disrupt their peace”, to justify exclusion of aggressive or shy peers, whereas they were more likely to reject gender or ethic based exclusion by drawing on moral reasons. Recently, research by Malti and colleagues (2012) showed that exclusion based on shyness was more acceptable than nationality, but not gender based exclusion. Although these studies did not explore social reasoning about the exclusion of peers with mental health disorders, some general conclusions can be drawn that may be applicable to the exclusion of peers with mental disorders. Firstly, exclusion of peers who engage in deviant behaviour is more acceptable than exclusion of peers on race and gender based reasons. Furthermore the acceptability of exclusion of deviant peers tends to vary as a function of the target behaviours, with more externalising behaviour being perceived as less acceptable. Thus, is it possible that the present study will uncover unique patterns of social reasoning about exclusion contexts involving peers with ADHD and depression.

The type of exclusion (dyadic or group) also influences the type of reasoning children employ; young people tend to reflect on the psychological domain, drawing on personal
choice when evaluating dyadic friendship exclusion (Nucci, 1996; Smetana, Killen, & Turiel, 1991). However, in situations when young people are evaluating a potential friendship with a peer who exhibits unusual or deviant behaviour they may also reflect on moral (will this person hurt me?) or social conventional (will this person affect my reputation?) considerations. Group exclusion, on the other hand, tends be perceived as more social conventional in nature. However, evaluations are not primarily made on social convention reasons, moral considerations also come into play. Overall, this body of research shows that with age, children’s reasoning about exclusion becomes increasingly complex. Sometimes young people perceive exclusion as wrong by drawing on moral reasons, whereas other times, young people provide social conventional reasons and or draw on personal choice to condone exclusion (Horn, 2006; Killen & Stangor, 2001; Killen, Margie, & Sinno, 2006).

Recently, research not only explores evaluations of peer exclusion but also investigates the stereotypes young people employ to justify exclusion (Killen et al., 2010). By asking participants “what is it about race that makes people uncomfortable?” Killen and colleagues indirectly tapped into stereotypes, their results showed that the use of stereotypes declined across developmental age from 9 to 15 years of age. The novel aspect of posing such questions is that they permit researchers to explore all participants’ perceptions about why a target individual or group may be discriminated against (both those who believe exclusion is unfair and those who believe it is unfair). While responses provided by these two groups might be similar, by exploring all participants’ beliefs about discrimination and attitudes towards the target individual or group, a more in-depth insight into exclusion can be obtained. It is also reasonable to suggest that investigating children and adolescents’ beliefs about why others might not want to engage in social interactions with the peers with mental disorders may tap into particular prejudicial or stereotypical attitudes about childhood mental health disorders.
Chapter 10: Introduction (Study Two)

Taken together, the above research highlights that stigma and, in particular, exclusion is complex. As of yet, no studies have explored reasoning about exclusion of peers with mental health problems. Quoting Killen and colleagues (in press) adopting a SDT perspective “provides an explanation for the types of norms that matter to children, which include moral norms about fairness, social conventional norms about traditions, and considerations of the personal domain, such as autonomy”. Children and adolescents may perceive the behaviours associated with ADHD and depression as a legitimate basis on which to exclude a peer due to the potential of this individual to unsettle normal group functioning. On the other hand, they may perceive exclusion as unacceptable, as inclusion might provide an opportunity for socialization and perhaps bring about change in these individuals. Thus, exploring children and adolescents’ perceptions of exclusion of peers with mental health problems will provide a valuable insight into why these peers are excluded. This approach will further our understanding of discrimination as it permits us to explore both interpersonal (X is excluded because he is hyper) and intergroup (X is excluded because the group will not be able to have fun if he is included) factors relating to discrimination of peers with disorders.

10.5 Research on Attribution Theory

This study will also draw on Attribution Theory (e.g. Weiner, et al., 1988; see Chapter 3 section 3.4.1), which posits that beliefs about responsibility or controllability for a target peer’s deviant behaviour influence affective responses of anger or sympathy towards the peer. These disparate emotions in turn influence behaviour towards this peer. As discussed earlier (see Chapter 3 section 3.4.1), attribution theory is the most frequently researched stigma theory with both child and adult populations.

Experimental manipulation and intervention studies that have adopted this theory consistently show that if children attribute the cause of a mental health problem to an external
factor, such as a stressful life event, the target peer is perceived as less responsible for his or her behaviour, and is perceived more favourably (Goossens et al., 2002; Graham & Hoehn, 1995; Juvonen, 1991; Peterson, et al., 1985; Sigelman & Begley, 1987; Watson et al., 2004). Juvonen conducted one of the most comprehensive investigations into acceptance of both hypothetical and real peers with mental health problems. The findings of her study showed that the level of acceptance and support provided to target peers varied as a function of participants’ beliefs about responsibility for their deviant behaviour and affective responses that were associated with these beliefs. Similarly, in a study with 6 to 11-year-olds, Graham & Hoehn (1995) found that participants’ believed that an aggressive peer was more responsible for his behaviour compared to a socially withdrawn peer. They also found that the former peer elicited more anger, less sympathy, was less socially accepted, and participants were less willing to help him. Specific to mental disorders, Peterson and colleagues found that children were more positive towards a peer with depression who had experienced a stressful life event than a peer with depression who had not experienced a similar life event. Furthermore, using modelling techniques research consistently shows that beliefs about responsibility for disorders such as ADHD and depression significantly predict stigmatising reactions and behaviour (Corrigan et al., 2007; Swords et al., 2011a). Given the strong empirical evidence for Attribution Theory to account for stigma, it is possible that children and adolescent’s attribution beliefs might inform their responses towards the exclusion of peers with disorders.

10.6 Rationale for Study Two

Children and adolescents with disorders are some of the most persistently excluded individuals in our school playgrounds (see Chapter 2 section 2.3.1). While dyadic and group exclusion are important peer relationship experiences in childhood and adolescence, no
studies have explored how young people reason about exclusion when it involves a peer with a mental health problem. Given that research on mental disorder stigma in childhood and adolescence has largely evolved in the absence of developmental theory, applying SDT to explain exclusion of these peers is a valid first step in advancing our knowledge of discrimination. In addition, given that Attribution Theory has shown that beliefs about responsibility can influence cognitions and action towards peers with disorders, it is reasonable to suggest that attribution stereotypes may influence reasoning about exclusion.

This study will develop the prevailing literature on stigma towards peers with mental health problems in childhood and adolescence in a number of ways. It will explore what children and adolescents think about the exclusion of peers with disorders. In doing so, it will provide a comprehensive insight into discrimination, the behavioural aspect of stigma. Overall, it is anticipated that this study will inform us about why children and adolescents with mental health problems are actively rejected, from the perspective their peers. Using a qualitative approach, this study will consider whether beliefs about the target peer and reasoning about exclusion varies across socio-demographic variables (age and gender), the exclusion context (group and dyadic), and whether an externalising or internalising disorder is under investigation.
Chapter 10: Introduction (Study Two)

10.6.1 The Present Study (Study Two)

The present status of the literature on children and adolescents’ social reasoning about exclusion, as well as a reflection on some of the key points pertaining to research on the stigmatisation of peers with mental health problems in childhood can be summarised in the following key points:

1. No research has explored children or adolescents’ perceptions of exclusion of peers with mental health problems.

2. Research shows that reasoning about exclusion differs depending on the behaviour exhibited by the victim. In addition, mental disorder stigma research shows that attitudes and behaviour vary depending on the type of mental health condition being investigated.

3. The types of social reasoning children and adolescents employ when discussing exclusion is dependent upon individual variables, such as participants’ age and gender. Females tend to be less accepting of exclusion than males, while exclusion generally becomes more acceptable with age. Research from the stigma literature also tends to show that females report being more positive towards peers with disorders. However, mixed findings prevail on the developmental progression of stigma.

4. Attribution beliefs about personal responsibility tend to influence attitudes and behaviour towards peers with disorders.

This study is a qualitative investigation with young people of 10 to 11-years and 15 to 16 years of age. The two developmental cohorts, late-childhood and mid-adolescence, were chosen to be consistent with the sample used in Study One. As outlined in Chapter 5 section 5.2, the initial rationale for targeting these age groups was made on the basis that research not
only suggests changes in responses from childhood to adolescence (Swords et al., 2011a), but changes in the prevalence of mental health difficulties from pre-adolescence to adolescence (Lynch et al., 2006). Through group interviews, data were collected on participants’ perceptions of dyadic and group exclusion scenarios involving age and gender matched peers who displayed symptoms associated with depression or ADHD.

10.6.2 Analysing this Topic Qualitatively

The present body of research acknowledges the empirical value of both quantitative and qualitative methods in enhancing knowledge of human phenomena, perceiving them as complementary and not competitive methodologies (Pope & Mays, 1995). As the focus of this research was to explore young people’s understanding and interpretation of a complex phenomenon a qualitative methodology was deemed an appropriate method (Johnson & Onwuegbuzie, 2004). In addition, as highlighted earlier, young people’s perceptions of exclusion of peers with mental disorders has yet to be explored; thus, an in-depth, rich understanding of this phenomenon is warranted.

10.6.2.1 Why use Qualitative Group Interviews?

The advantages of group interviews as a method of collecting data on young people’s perspectives has been well documented (Heary & Hennessy, 2002; Hill, Laybourn, & Borland, 1996). Group Interviews acknowledge that children are experts on their own social worlds (Levine & Zimmerman, 1996) and give children an opportunity to inform researchers about their social worlds. In comparison to individual interviews, the group structure attempts to dilute any power imbalances that exist between the researcher and the participant, creating a less threatening environment in which to engage in discussion (Hill et al., 1996). Group Interviews achieve this by ensuring that individual participants are not pressured to respond
Chapter 10: Introduction (Study Two)

to the researcher’s questions if he or she wishes not to. The group context also offers the opportunity for participants to take their time to ‘warm’ up to the group interview environment, answering questions when they feel most comfortable doing so, and ensures that the group interview does not have to end when any one individual child decides not to respond (Lewis, 1992).

Group Interviews were not only chosen for the aforementioned advantages, but primarily for the type of data they potentially yield. Children and adolescents are social beings who generally spend much time within a peer group (Dwivedi, 1993). Thus, the group context is a familiar and important setting for most young people (Heary & Hennessy, 2002). Hyde, Howlett, Brady, and Drennan (2005) also highlight groups ‘ethnographic potential’ to tap into cultural norms of target participant cohorts. These advantages are of particular importance given the topic of this research. Replicating the peer group context may help participants draw on the reality of the peer group environment during the discussions, thus, potentially increasing the ecological validity of their responses. The environment created during the small group discussions is also thought to provide the researcher with credence to explore participants’ emotional and cognitive responses in detail that is often missed by quantitative research (Heary & Hennessy, 2002). This is particularly relevant in the present study, as it is anticipated that young people will provide emotional and cognitive responses when reflecting on legitimacy and justifications for excluding peers with mental health disorders. Group Interviews are also considered to be useful methods to acquire introductory knowledge on new research areas (Peterson-Sweeney, 2005), and therefore are appropriate for the current research.
10.7 Aims & Objectives

Primary Aim:

- To advance understanding of discrimination towards peers with ADHD and depression by exploring children and adolescents’ social reasoning about dyadic and group exclusion of peers with ADHD and depression.

Specific Research Aims:

- To explore children and adolescents’ evaluations of fairness of exclusion scenarios involving peers with ADHD and depression.
- To explore young people’s justifications for their evaluations of fairness of exclusion of the target peers.
- To explore, from participants’ perspectives, why children and adolescents with ADHD and depression are excluded by their peers and unveil any associated stereotypes.
- To investigate any developmental and gender differences that exist in relation to evaluations and justifications of exclusion of peers with ADHD and depression.
- To investigate whether there are common or unique factors in participants’ explanations for, and evaluations of, exclusion of peers with different disorders.

The method employed in the present study will be presented in the next chapter.
Chapter 11: Method for Study Two

11.1 Aim of Chapter

The aim of this chapter is to present the method used for the pilot and main data collection of Study Two of this research programme. The research design will be presented first, followed by a description of the pilot study. A detailed account of the data collection for this study will then be presented, along with a description of the ethical issues pertaining to this research. Finally, an account of the proposed plan of analyses will be presented.

11.2 Research Design

A cross-sectional qualitative group interview study of 10 to 11-year-olds and 15 to 16-year-olds was conducted. These age groups were consistent with the cohorts used in Study One, thus permitting an insight into exclusion of peers with mental health problems, in late-childhood and mid-adolescence.

11.3 Piloting Study Two: Aims & Objectives

The primary objective of the pilot study was to explore the viability of carrying out the present study within a group interview context. Of particular interest was the anticipated length of the study procedure. The procedure involved presenting participants with two vignettes and required them to discuss two exclusion scenarios relating to the target child described in the preceding vignette. Thus, the purpose of the pilot study was to gauge an estimated length of an average group interview and to monitor participant fatigue, which could influence the quality of data.
11.3.1 Participants

The sample consisted of 15 primary school students (7 male, 8 female; $M = 10.87$ years, $SD = .42$) and 5 adolescents (2 male, 3 female; $M = 15.76$, $SD = .80$). The children and adolescents were respectively attending a primary school and youth group in Galway City ($N = 15$).

11.3.2 Materials used in the Pilot Study

Vignettes: The three vignettes employed in Study One that each described either a peer with ADHD, depression, or peer with ‘typical’ issues were used in the pilot. The clinical vignettes did not have psychiatric labels. There were four versions of each vignette: male and female, child peer and adolescent peer.

Exclusion scenarios:

Dyadic and group exclusion scenarios were employed as follows: “Paul/Paula, another boy/girl in [target peer’s] class, does not want to be his/her friend” and “In school, [target peer] overhears his/her classmates planning a trip to the cinema but they do not invite him/her”.

Qualitative Questions: After each scenario participants were asked the following questions:

- Legitimacy of the Exclusion: Is ok or not ok for Paul/Paula to decide that he/she does not want to be friends with [target peer]? Why?
- Justifications for Evaluations of Exclusion: Why is it ok or not ok for Paul/Paul to decide that he/she does not want to be friends with [target peer]?
- Reasons for Exclusion Specific to the Mental Health Disorder: What is it about [target peer] that makes Paul/Paula not want to be friends with him/her? Or What is it about [target peer] that makes the classmates not invite him/her to the cinema?
11.3.3 Procedure for the Pilot Study

Recruitment letters were sent to the principal of one primary school and youth programme officers at four youth centres in Galway city inviting them to take part in the pilot study (See Appendix J). The pilot study was carried out in June 2011 therefore adolescents were recruited through youth centres as post-primary schools had already closed for the summer. When contacted one week after receiving the invitation letter, the primary school, and one youth centre agreed to help with the recruitment.

In the primary school and youth group, one 5th class group and a group of adolescents between the ages of 15 and 16 years were respectively invited to take part in the study. The researcher distributed the information sheets and consent form to potential participants (see Appendix K and L). In the primary school, fifteen consent forms were returned (50% consent rate) permitting participation in the study. In the youth group, 5 consent forms were signed (33% consent rate). All those with parental consent assented to take part following a description of the study. All group interviews consisted of 5 participants, the gender of which was mixed.

The instructions participants received were consistent across all group interviews. The researcher told participants that she was a student of Psychology in NUI, Galway and explained that she was interested in understanding why young people become friends with some people and not others. The procedure was explained; participants would listen to stories about two peers and were asked to respond to questions about these stories, they could talk as little or as much as they wanted to. Confidentiality and the rationale for why the discussion was recorded were also explained.

Each group interview was assigned to either an ADHD or depression condition. Each group listened to two vignettes. Depending on which group they were assigned to, participants were either read about a peer with depression or ADHD and a ‘typical’ peer.
Chapter 11: Method (Study Two)

Participants were told that the peers described in the vignettes were the same age as them; however, the gender was set so that each group heard about one female and one male peer. Following each vignette they were told about two exclusion encounters (dyadic and group) involving the peer in the vignette. Participants were asked to discuss the fairness of each exclusion scenario and justify their evaluations. They were also asked to explain why the exclusion occurred.

11.3.4 Pilot Study Results

Piloting the study revealed that the proposed procedure whereby participants respond to two exclusion scenarios (dyadic and group) after each vignettes (ADHD/depression and ‘typical’) was too long and induced participant fatigue, as inferred by repetitive responding. All group interviews were between 40-60 minutes in length. Given that the main data collection would occur during class time and thus the study needed to be as least disruptive as possible, this was deemed too long for students to be absent from class. To ensure high quality responding, it was decided that for the main data collection, participants would discuss one exclusion scenario (either dyadic or group) in response to the two vignettes describing either a peer with ADHD or depression. The decision to reduce the exclusion scenarios was also informed by the analysis of the participants’ responses, which revealed similarities and substantial overlap between views on dyadic and group exclusion in response to the same vignette. Thus it was decided that the type of exclusion scenario that followed each vignette would be counterbalanced across participants. The ‘typical’ peer was removed from the study procedure, as the focus of this study was towards peers with mental health disorders thus an in-depth analysis of responses towards this peer would not be conducted.
Chapter 11: Method (Study Two)

11.5 The Main Data Collection Phase

11.5.1 Participants

The sample consisted of 150 children \((n = 72)\) and adolescents \((n = 78)\) in year 7 and 12 of education in three primary and post-primary public schools in the Connacht region of Ireland. Among 10 to 11-year-olds there were 34 boys and 38 girls, while among 15 to 16-year-olds there were 34 boys and 44 girls. The mean ages of participants within these two cohorts were 10.75 years \((SD = 0.46)\) and 15.50 years \((SD = 0.50)\) respectively. The highest level of education received by the consenting parent was used as a proxy measure of SES. Breakdown of SES was approximately 42% low, 28% medium, and 29% high.

11.5.2 Materials

11.5.2.1 Demographic Information

All consenting parents/guardians completed a demographic questionnaire (see Appendix K). The questions contained within the questionnaire were consistent with those used in Study One. Information was collected on the following demographic variables: parent/guardian’s age, level of education, participant’s date of birth, and the number of children in the family. Consistent with the approach used in Study One, SES was calculated on the education level achieved by the consenting parent.
11.5.2.2 Vignettes

The clinical vignettes were the same as those used in Study One. They described a peer who displayed behaviours associated with ADHD and a peer who engaged in behaviour that was characteristic of a person with depression. There were four versions of each vignette: male and female, child peer and adolescent peer. The vignettes were clinically validated (see Chapter 5 section 5.7.1.3). Psychiatric labels did not accompany the vignettes and the presentation was counterbalanced across participants.

11.5.2.3 Rejection/Exclusion Scenarios

Social cognitive research on stigma towards other race and gender peers has demonstrated that utilising scenarios that describe exclusion can act as vivid stimuli for exploring intergroup judgments and attitudes (Abrams et al., 2009; Killen, 2007). Scenarios in which the vignette peer experienced either dyadic or group exclusion were used. The dyadic exclusion scenario was: “Paul/Paula, another boy/girl in [target peer’s] class, does not want to be his/her friend.” The group exclusion scenario was “In school, [target peer] overhears his/her classmates planning a trip to the cinema but they do not invite him/her”. An example of the ADHD-dyad exclusion vignette and scenarios is provided below (see Appendix I for a full presentation of vignette and exclusion scenario combinations).

11.5.2.4 ADHD Vignette & Dyad Exclusion Scenario Example

Vignette:

Jake is in the same class as you. In school he seems to pay more attention to things going on around him than his own work. Sometimes he forgets what his teacher has told him to do and needs to be reminded. When the teacher asks the class a question Jake often blurts out the answer before the teacher has a chance to finish. Jake often finds it hard to stay sitting down when he is supposed to and gets up or fidgets a lot. He has difficulty waiting his turn and butts into his classmates’ conversations. In his spare time, Jake likes to play his
computer and train with his athletic club. When his parents ask him to help
around the house he sometimes doesn't seem to hear them. He often does not
finish his homework or chores. Jake talks non-stop when his family is watching
TV. He finds it hard to organise his bedroom and regularly loses his books,
computer games and other things he needs.

Exclusion Scenario:

Peter another boy in Jake's class doesn't want to be his friends

11.5.2.5 Qualitative Questions:

The following questions were posed to each group:

• Legitimacy of the Exclusion: Is ok or not ok for Paul/Paula to decide that he/she
does not want to be friends with [target peer]?

• Justifications for Evaluations of Exclusion: Why, is ok or not ok for Paul/Paula to
decide that he/she does not want to be friends with [target peer]?

• Reasons for Exclusion Specific to the Mental Health Disorder: What is it about
[target peer] that makes Paul/Paula not want to be friends with him/her? What is
it about [target peer] that makes the classmates not invite him/her to the cinema?

• Probes and clarifications were used throughout the discussions when necessary. A
full list of question posed that were not analysed in this study are presented in
Appendix I.

11.5.2.6 Equipment:

An Olympus DS-3400 audio recorder was used to record the discussions.
11.5.3 Procedure

11.5.3.1 Recruiting Participants for the Main Data Collection of Study Two

All participants were recruited through their schools. Information packages, consisting of an invitation letter and a leaflet outlining the aims and procedure of the study were sent to five schools inviting them to take part (see Appendix K and L). The researcher contacted the schools a week later and three agreed to take part (1 primary and 2 post-primary schools; 60% consent rate). In the primary schools the principal was the direct person of contact, however, in the secondary schools a designated teacher was the liaison person between the researcher, principal and students. When a date for data collection was agreed with schools, information packages for parents/guardians and students were delivered to the school one week before data collection was due to commence.

The parents of 193 children and adolescents were invited to provide consent for their son or daughter to take part. Written consent was received from 83% \((n = 160)\) of parents, while 17.1% \((n = 33)\) did not respond. Ten students were absent or unavailable to take part in the study on the day of data collection.

11.5.3.2 Completing the Study

During class time, 38 same-sex group interviews were conducted. Participants were provided with the opportunity to self-select their groups to form friendship groups. According to Morgan (1997), friendship groups create a sense of security among participants so that they should feel safe sharing convergent and divergent thoughts on the research topic. Each group consisted of between 2-5 participants. Specifically, there was 1 group with two participants, 3 groups with three participants, 31 groups with four participants and 3 groups with five participants. The researcher (COD) facilitated all of the group interviews. Each group interview was randomly assigned to either an ADHD-dyad/depression-group condition or depression dyad/ADHD-group condition. In total there were 9 male and 10 female group
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interviews in the ADHD-dyad/depression-group condition and 8 male and 11 female group interviews in the depression-dyad/ADHD-group condition. Table 11.1 below shows that randomisation was successful. The age and gender of the vignette peers were matched to that of participants. Thus, 8 versions of the materials described above were utilised in this study. Following each vignette participants were told about an exclusion encounter involving the vignette peer. The type of exclusion scenario was contingent upon the condition the group were assigned to. For example, participants in the ADHD-dyad/depression-group condition heard about a young person with ADHD who was rejected by a peer and a young person with depression who was excluded by his/her peer group. Thus, every group heard about the same mental health disorders but the associated exclusion scenarios differed in every second group. The order of the vignettes and exclusion scenarios were counterbalanced across group interviews within each condition. Following each exclusion scenario, participants’ evaluation of the fairness of the exclusion, justifications for their evaluations and beliefs about why the exclusion occurred were explored using the interview schedule described above. Details on the verbal description provided to participants are presented in Appendix M.
Table 11.1

*Characteristics of Participants and Order of Vignettes in Each Group Interview Condition*

<table>
<thead>
<tr>
<th></th>
<th>Depression Friendship &amp; ADHD Group</th>
<th>ADHD Friendship &amp; Depression Group</th>
<th>$\chi^2$</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$n$</td>
<td>$n$</td>
<td></td>
</tr>
<tr>
<td><strong>Gender</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>37</td>
<td>31</td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>38</td>
<td>44</td>
<td>.97</td>
</tr>
<tr>
<td><strong>Age</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10-11 years</td>
<td>34</td>
<td>38</td>
<td></td>
</tr>
<tr>
<td>15-16 years</td>
<td>41</td>
<td>37</td>
<td>.43</td>
</tr>
<tr>
<td><strong>Order of Vignettes</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depression first</td>
<td>36</td>
<td>41</td>
<td></td>
</tr>
<tr>
<td>ADHD first</td>
<td>39</td>
<td>34</td>
<td>.97</td>
</tr>
<tr>
<td><strong>SES</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low (second level completion only)</td>
<td>31</td>
<td>32</td>
<td></td>
</tr>
<tr>
<td>Middle (post-second level diploma or certificate)</td>
<td>22</td>
<td>20</td>
<td></td>
</tr>
<tr>
<td>High (degree or higher)</td>
<td>20</td>
<td>24</td>
<td>.47</td>
</tr>
</tbody>
</table>

*Note. All $\chi^2$ were non-significant $p > 0.05$*
11.6 Ethical Issues & Considerations

The National University of Ireland, Galway Ethics Committee granted ethical approval for this study on the 10\textsuperscript{th} May 2011. The key ethical considerations for this study are presented below.

Obtaining informed voluntary consent from parents and assent from participating children and adolescents was the primary ethical concern of this study. The aims of the research, the role of their child and the research procedure were explained to parents in the information letter and leaflet. Specifically, the information leaflet explained that the researcher would read two vignettes describing hypothetical peers who engage in behaviours associated with concentration difficulties and low mood, and participant would be asked questions about the story characters in groups with other students. Parents were informed that their child would take part in the study at one time point only. The rationale for audio recording the discussions and a guarantee of confidentiality, once the data was collected, were provided. Parents were also reassured that their child’s contribution was voluntary and therefore could withdraw from the study without consequence at any time. The researcher’s contact details were also provided if more information was needed.

The aims and procedure of the research were also explained on the participant information sheet (See Appendix L). Children and adolescents were told that their participation was voluntary and they had a right to withdraw from the study at anytime. They were also told they did not have to contribute to the group discussions. Confidentiality was explained. Prior to seeking assent, a verbal description of the afore-mentioned information was provided.

As in Study One there was an ethical concern that participants would identify themselves as similar to the target peers or interpret the target peers as descriptive of specific individuals in their school. To avoid any individual participants or pupils being singled out as
different, all participants were told that the peers described in the vignettes do not attend their school and are not from their neighbourhood. Consistent with Study One, psychiatric labels did not accompany the vignettes. Unlike Study One, a vignette describing a ‘typical’ peer was not included during the main data collection for this study (see section 11.3.4 above for rationale).

The issue of confidentiality during the group interview was another important ethical concern. Prior to commencing the discussions the researcher requested all participants not to disclose group discussions to others outside of the group interview. The importance of trust and respect for others during the group interview was explained and the value of participant’s individual comments was stressed. The researcher encouraged participants to truthfully contribute to the discussions by informing them that no individual feedback regarding the discussions would be given to their parents or teachers. They were also told that the audio-recordings of each discussion would be used for research purposes only and their names would not be attached to any individual comments. Reinforcing the significance of these issues at the beginning and end of each group interview was essential to ensure, as far as possible, that these principles would be upheld after each group interview.

The final ethical issue to be discussed is in relation to storing, analysing, and presenting the data pertaining to this study. The audio-recordings were transferred to the researcher’s computer that was secured with a personal password. Identifying labels linking the participants to individual schools were removed and replaced with a unique code. After transcribing the discussions, names of individual participants were replaced with pseudo-names. In presenting the findings, names of the participants or schools were not linked to any comments. Any data containing identifying information, such as interview notes, audio recordings and consent forms were kept in a locked file that can be accessed by the researcher only.
11.7 Debriefing

Following each discussion, the audio-recorder was turned off and participants were encouraged to ask the researcher any questions about the research process. Participants were thanked for their contribution. The researcher explained that individual feedback on the study would not be provided but when the results were analysed an official debriefing report and summary would be sent to their school and given to them by their teachers.

11.8 About the Researcher

In light of recommendations that all qualitative researchers should make any professional or personal details, that may influence the interpretation of the data, known to the reader (Elliot et al., 1999; Long & Godfrey, 2004; Meyrick, 2006), details about the researcher are provided here. The researcher is a PhD candidate in psychology with an interest in children and adolescents’ perceptions of peers with mental health problems and their understanding of the presentation of psychiatric symptoms in their peers. She does not strictly conform to either positivist or constructionist epistemology, but instead recognises the value of associated quantitative and qualitative approaches in enhancing knowledge of psychological phenomena. Specifically, she believes that children are valuable informants on social phenomena, such as peer exclusion as they are living experts of their social world. Endorsing this belief, she acknowledges that the means by which researchers obtain this information from children should hinge on the aims and goals of the research question.

She has no personal experience of mental illness or peer stigma and exclusion. She also does not have any children of her own. Acknowledgement of this is important as it is possible that lived experience of mental illness or being a parent of a child without or without mental health problems may influence analysis of the data. Her training to date has been in quantitative research and she has no prior experience of conducting qualitative research.
11.9 Analysis Plan

11.9.1 Thematic Analysis

Thematic analysis was chosen as the most suitable method upon which to analyse the data as it provides a rich description of the data by identifying themes or patterns within the data. Unlike other qualitative approaches, thematic analysis is independent from theory and epistemology lending itself applicable to all theories and epistemological approaches within psychology (Braun & Clarke, 2006). Through “careful reading and re-reading of the data” (Rice & Ezzy, 1999 p. 258) patterns of responses become evident and are coded. These patterns are then labelled as themes that are used to categorise the data.

Generally, themes are identified through either inductive or deductive coding. Inductive reasoning is a data driven method that is often described as a ‘bottom up’ or theory building approach where by the emerging themes are driven by the data and may not reflect the questions asked in the method or the researchers existing theoretical stance on the research topic (Boyatzis, 1998; Braun & Clarke, 2006). In contrast, deductive coding is a theoretically and analytically driven approach, used to explore a hypothesis or whether an established theory is generalisable to the research area in question. (Braun & Clarke, 2006; Crabtree & Miller, 1999). Traditionally, the type of coding method applied to the analysis is usually determined by the aim of the study. For example, where the researcher has a specific research question deductive coding is more appropriate whereas, inductive coding is suitable if the aim of the research is to allow the themes to emerge from the data. However, recently a hybrid approach of both inductive and deductive coding has been advocated to enhance the rigour and quality of qualitative research (Fereday & Muir-Cochrane, 2006).

As discussed in Chapter 10 sections 10.3 and 10.4 there is extensive research on children and adolescents’ social reasoning about exclusion of outgroup peers. However, there is no research on young people’s views of the exclusion of peers with mental disorders.
Neither deductive or inductive coding were exclusively suitable to analyse this data as (a) a body of empirical research and theory on young people’s perceptions of peer exclusion exists; (b) the research specific to peers with mental disorders is non-existent; (c) the distinctiveness denoted by mental disorders is unique compared to the cues that signal gender and racial outgroup peers as different. Thus, adopting this hybrid approach of both deductive and inductive coding complemented the research questions by permitting the knowledge offered by the established literature to be drawn upon, while allowing novel findings specific to mental disorders to be unveiled.

11.9.1.1 Coding the Data & Unveiling Themes

Stage 1: Developing the coding manual

An a priori coding manual was developed based on previous research to facilitate coding and to assist in the management, organisation, and interpretation of the data (Crabtree & Miller, 1999). This was particularly important given the large sample size and correspondingly large data set. The development of the code manual was based on the steps outlined in Fereday and Muir-Cochrane (2006) and Braun and Clarke (2006).

The coding manual consisted of three broad codes, moral, psychological and social conventional reasons, which assessed evaluations of fairness of exclusion and justifications for exclusion. Examples of a priori codes, arising from previous research, included, empathy (evaluating exclusion as unfair by drawing on possible negative affective and cognitive reactions of target characters as a result of the exclusion) or group functioning (justifying exclusion as fair on the basis that including the target character would disrupt group cohesion). Codes were identified and categorised by employing the following steps: (a) principle codes were labelled; (b) descriptions of each code were constructed; (c) when
necessary sub-codes were developed; (d) detailed descriptions of how the codes were linked to the data set were developed.

Another aim of the study was to explore any gender or age differences across responses towards the two vignette characters. The same coding framework and analytical steps were applied to all data sets. Details of the four data sets specific to each vignette character are presented in Table 11.2 below.

Table 11.2

A Breakdown of the Sub-groups Within the Data Set

<table>
<thead>
<tr>
<th>Scenarios: Depression</th>
<th>ADHD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Friendship Exclusion &amp; Group Exclusion</td>
<td>Friendship Exclusion &amp; Group Exclusion</td>
</tr>
<tr>
<td>Participant Groups:</td>
<td></td>
</tr>
<tr>
<td>10-11 year olds</td>
<td>15-16 year olds</td>
</tr>
<tr>
<td>Male</td>
<td>Male</td>
</tr>
<tr>
<td>Female</td>
<td>Female</td>
</tr>
</tbody>
</table>

Stage 2: Familiarisation of the data

Before analysing the data, the researcher became immersed in the transcripts by initially reading and listening to each group interview, taking note of key points made by participants and writing a summary of each group interview. These summaries constituted the first phase of the data analysis. It also provided the researcher with an opportunity to begin comprehending the information and take note of any inductive codes or emerging themes from the raw data. Several inductive codes were developed and added to the coding template. Examples of inductive codes include contagion (justifying exclusion as fair because of beliefs that others will ‘get’ a mental health disorders if they include the target character) or symptom related (drawing on symptoms to explain how the target character has violated
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social conventions to justify exclusion as fair). An account of the summaries of the group interviews, the researchers initial impressions of the data, and a revised coding framework were presented to the research supervisor and discussed.

**Stage 3: Testing the reliability of the codes**

As in all psychological research the measures employed to collect and analysis data should be reliable. In an effort to establish the reliability of the coding method proposed for this study, the suitability of the coding framework to capture themes in the raw data were explored prior to beginning the data analysis. The transcripts of one group interview from each age and gender cohort were selected as pilot texts for the coding template. The transcripts were coded using the revised a priori template that consisted of deductive and inductive codes. The applicability of the codes to represent the data were discussed between the researcher and her supervisor before applying the template to the whole data set.

**Stage 4: Applying template codes and additional coding**

The coding manual was applied to the raw data. To permit multiple interpretations of ambiguous data and to ensure that codes and themes were grounded in the data; a broad and inclusive coding approach was applied (St. John & Johnson, 2000). The data were read and meaningful units of text that mapped onto the specific codes were categorised. Coding the data was an iterative process, with specific codes evolving into sub-codes or merging into other codes until the data was cohesively represented. QSR NVivo.9 was used to code and organise the themes relating to participants evaluation and justifications of the exclusion encounters and their beliefs about why the exclusion occurred.
**Stage 5. Connecting the codes and identifying themes**

During the coding phase, distinct patterns of codes were organised into potential themes. According to Crabtree and Miller (1999) connecting codes is the process of discovering such themes and patterns. Systematic comparisons across age, gender, mental health disorder, and scenario were conducted to explore any similarities and differences across these variables.

**Stage 6. Corroborating and legitimating coded themes.**

While the legitimacy of the codes and evolving themes were scrutinised throughout the analysis, in the write-up phase the research supervisor critiqued and challenged the interpretations and conclusions to ensure a coherent understanding and representation of the data had been achieved. Cross comparison of themes was performed to ensure that there were operational distinctions between the themes. The themes were then corroborated or cross-referenced with the raw data to certify that the data analysis and codes were reflected in the final themes. This process ensured that the final themes were data driven and not entirely influenced by the researcher’s expectation or desired findings.

**11.10 Establishing Transparency & Rigour in Qualitative Research**

Specific steps for ensuring rigour and assessing quality are advised (Elliot et al, 1999; Long & Godfrey, 2004; Meyrick, 2006), which were adhered to in this study as follows:

- The sample should be clearly described, with details of specific sampling techniques provided. This allows others to infer whether the findings derived the study could be generalised to other groups or individuals (see section 11.5.3).
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- Details provided pertaining to the collection of data should include the technique that was employed, who collected the data and any changes to the focus of the research or methods and justifications for such changes (see sections 11.5.3 and 11.8).

- During the analysis, Meyrick (2006) stresses the importance of presenting a fair representation of responses. This includes the views of respondents whose views differed to the general consensus of the sample, to ensure that data presented does not only rely on responses that support conclusions (Silverman, 1993). Meyrick (2006) argues that incorporating deviant viewpoints and interpretation of why such viewpoints occur can strengthen theory building. This was adhered to throughout the write up of the results presented in Chapter 12.

- Details about the processes through which the credibility of codes, themes, and interpretations was established should be provided (See Appendix N for a priori and final coding frameworks).

- Credibility was assessed through the input of the research supervisor (CH) who acted as an ‘analytical auditor’ throughout the coding and interpretation phase of the data analysis. The validity of the codes was enhanced through rigorously critiquing and debating the efficacy of codes and theme to represent the data.

- The conclusions offered by qualitative researchers should be grounded in data (Elliot et al., 1999; Meyrick, 2006), with explicit links between them, as supported by extracts from the data. Grounding conclusions in examples not only allows other readers to fully comprehend conclusions but also permits them to conceptualise other interpretations of the data. Elliot and colleagues recommend presenting general findings in a conceptual map that illustrates links between themes. These recommendations were adhered to in the present study. Throughout the next chapter
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themes and interpretation will be supported with extracts from the group interviews. In addition, conceptual maps are presented to represent the findings.
Chapter 12: Results of Study Two

12.1 Aim of Chapter

The findings of Study Two are presented in this chapter. Firstly, a description of children and adolescents’ evaluations of exclusion of the peers with mental health problems will be provided. Following on from this, insights into young people’s justifications for their evaluations of exclusion of peers with mental health problems are presented. In the final section, participants’ beliefs about why peers with disorders are excluded will be explored.

12.2 Social Reasoning about the Exclusion of Peers with ADHD and Depression

The findings of the present study provide an insight into children and adolescents’ perceptions of exclusion of peers with ADHD and depression in dyadic and group contexts. The results highlight the complexity involved in peer exclusion decisions. In most contexts, the majority of children and adolescents believed that exclusion of peers with ADHD and depression is wrong, yet when asked to explain why exclusion occurs, young people provided multiple reasons for exclusion. Thus a paradox emerges, which calls one to question whether, when faced with exclusion decisions involving peers with disorders in real-life situations, would young people perceive rejection as wrong and include the target peer, or become swamped in the plethora of reasons about why the peer should be rejected, and act accordingly.

What determines whether exclusion of peers with mental disorder is fair or not? Within the current database, exclusion is perceived as fair when (a) inclusion of the target peer violates reciprocal friendship expectations; (b) inclusion posses a risk or threat to one’s well-being; (c) young people believe that the target peer is personally responsible for his or her behaviour; (d) young people do not have a sense of duty or obligations towards the target
peer. Furthermore, exclusion is an issue of personal choice, thus beliefs about friendship autonomy come into play when evaluating exclusion scenarios (see Figure 13.1).

Throughout this chapter, the term friendship will be used to refer to relationships in either dyadic or group contexts, unless otherwise specified. The findings are presented under general themes that can be applied to both the peer with ADHD and the peer with depression in dyadic and group exclusion contexts. In doing so, the chapter provides a coherent overview of the findings and the unique and shared patterns in participants’ responses to exclusion of the target peers across dyadic and group contexts.

12.2.1 Evaluations: Is it Fair to Exclude a Peer with ADHD or Depression?

When asked to evaluate the legitimacy of dyadic and group exclusion of the peer with depression most perceived it as either unfair or provided mixed views. Only a minority of participants evaluated group and dyadic exclusion of the peer with depression as legitimate. While the same trend emerged in response to dyadic exclusion of the peer with ADHD, a different pattern was observed in relation to group exclusion of this peer. In the group exclusion context, most participants believed that it was legitimate to exclude a peer with ADHD. These findings highlight the importance of the target of exclusion and the context in which exclusion occurs in determining legitimacy. To explore these evaluations in greater detail, the findings pertaining to justifications for participants’ evaluations will now be explored (see Figure 12.1).
Figure 12.1. Evaluations of the legitimacy of exclusion model: Factors that determine evaluations of exclusion of the target peers in both group and dyadic exclusion contexts.
12.2.2. Justifications: Explaining Participants’ Evaluations of Exclusion

12.2.2.1 Friendship Expectations

It is important to reiterate that most participants did not exclusively condone exclusion of the target peers, except in response to group exclusion of the peer with ADHD, thus the justifications for most exclusion contexts presented here are the view of the minority. Most participants who evaluated exclusion of the peers with depression and ADHD as fair largely did so by referring to adverse emotional and social consequences associated with befriending the target peers. In addition, specific to the peer with depression, many young people also reflected on this peer’s withdrawn behaviour, criticising the peer’s failure to engage in reciprocal interaction to justify their evaluation. Young people’s justifications for exclusion tapped into the expectations they have for their friendships: reciprocity and risk. Those who perceived exclusion as fair believed that the target peers violated these friendship expectations. As will be shown below (section 12.2.3), the majority of participants referred to friendship expectations to explain why others would not want to befriend a peer with depression or ADHD in dyadic or group contexts. However, as most believed exclusion was not exclusively fair, only a vague insight into how these peers violate expectations can be deduced from the findings here. A more in-depth insight into how peers with disorders violate friendship expectations was revealed when participants’ beliefs about why exclusion occurred were assessed, the results of which are provided below (section 12.2.3).

In the group context, the majority of participants justified exclusion of the peer with ADHD because of the threat of adverse social consequences that he or she posed. While used to justify exclusion of this peer in the group context only, most participants questioned this peer’s ability to engage in appropriate conduct and believed he or she would disrupt the normative functioning of the group. For example, Reece (15 ADHD, group exclusion) said

“If you have known him for a long time and he has always been like that you might
not want to try and be friends because of how he acts … so you might think it is justified not to invite him because he might ruin it [the film] for everyone else”.

Brian (10, ADHD, group exclusion) endorsed a similar justification for exclusion, “It’s Ok, because he butts into everyone and annoys people. He talks when the movie is on and that gets seriously annoying so they might not want him coming in case he ruins it”. Furthermore, Alana (10, ADHD, group exclusion) justified exclusion of this peer by reflecting on the consequence of inclusion for others outside of the group.

“it wouldn’t be that fair on the other people because if they did invite her because as you were saying in the thing, the story that she was like talking during class and wasn’t listening to anyone, like she would probably be doing that in the movie so I don’t think it would be ok to invite her”.

In the dyadic context, most young people who believed exclusion was legitimate rationalised their evaluations by explaining that the target behaviours would impinge on the successful functioning of the dyad. Saoirse (16, ADHD, dyad exclusion) stated, “I think it’s ok if she doesn’t want to be friends with her because I’d probably find Jane annoying, the way she just like butts in and stuff”. Similarly, Olly (10, ADHD, dyad exclusion) believed exclusion was legitimate by reflecting on the peer’s externalising behaviour. He said, “it seems that he wants to be in everything, like wants to have everything and like listening to what everyone is saying like maybe like Peter would like his own business like not Jake butting in the whole time”. Together these findings suggest that children and adolescents believed that normative group and dyadic contexts are not compatible with this peer’s externalising behaviour.

In the group context, participants who condoned exclusion of the peer with depression predominantly rationalised their evaluations by reflecting on this peer’s reclusive behaviour. Young people believed that to maintain group membership one must contribute to the group
and failure to do so warranted exclusion. For example, Gary (16, depression, group exclusion) commented, “Well if he’s not hanging out with them anymore then it is not really [unfair]. Like he can’t really be expected to be invited if he’s not friends with them anymore.” Similarly, Maggie (10, depression, group exclusion) justified the exclusion stating, “I think it’s fair because she hasn’t been playing with them for long and it’s fair because they’re not really her friends anymore”. Amber (16, depression, group exclusion) reinforced this notion suggesting, “Maybe like her friends think that she’s not interested because maybe she’s been saying no to them before and then they think well what's the point of asking her if she’s just going to say no”. These findings suggest that reciprocal interaction is an important expectation of friendships; particularly within friendship groups and some believe that failure to meet this expectation is worthy of rejection.

While observed in response to dyadic and group exclusion, only very few participants drew on the belief that the peer’s depressive mood would put others at risk of depression to condone exclusion. For example, Molly (10, depression, dyad exclusion) explained why exclusion of this peer was fair, “Lauren, she’s being like all sad and everything and you don’t really want to be around a person who is all sad … because she’d just like bring you down”. Similarly, Joe (16, depression, group exclusion) justified the exclusion stating that the peer with depression “brings everyone down because he is so sad all the time”. Interestingly, while beliefs about contagion of low mood were only suggested by a few to justify exclusion, most participants referred to this belief when asked to explain why the peer with depression was rejected (see section 12.5).

The fact that majority of participants justified group exclusion of the peer with ADHD on the grounds that he or she would disrupt group functioning highlights that the externalising behaviour exhibited by the peer with ADHD is perceived as highly deviant in group situations. While the behaviour exhibited by the peer with ADHD was ‘too-
externalising’, responses indicated that the peer with depression was perceived as ‘too-withdrawn’ within group situations. Justifying exclusion by reflecting on the failure of the peer with depression to engage in reciprocal interaction indicates that for some participants fulfilling this expectation is important to maintain group membership.

12.2.2 Responsibility Attributes & Causal Factors

Participants who justified exclusion as legitimate also suggested that the target peers were personally responsible for their behaviour, while those who believed the target peers’ were not personally responsible for their behaviour evaluated exclusion as unfair. These findings support an Attribution approach to stigma. In response to both the peer with ADHD and depression, many young people suggested that exclusion was not legitimate if the target peer was not responsible for his or her actions. For example, Brendan (10, dyad, depression) perceived the rejection as wrong stating, “it mightn’t be his [target peer’s] fault that he’s tired, like it could be someone else’s [fault] or he might be sick or something”. Similarly, those who interpreted the behaviour exhibited by the peer with ADHD as unintentional used these beliefs to reject the legitimacy of exclusion: “just because she’s clumsy and whatever doesn’t mean like she won’t be a good friend” (Aine, 16, ADHD, dyad exclusion) and “she sounds like a bit of a chatter-box and chatter-boxes can be really annoying … without realising … it’s not their [people like the peer with ADHD] fault that they’re chatter-boxes” (Lucy, 10, ADHD, dyad exclusion). Even when exclusion was perceived as fair, the importance of concession if one was not personally responsible for their behaviour was observed. For example, Louise (16, ADHD, dyad exclusion) said, “I think it’s like her choice who she wants to be friends with but it’s not Jane’s fault that like she forgets things and she shouldn’t judge her so much, she should maybe see if they could be friends”.

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Many young people also highlighted the importance of finding out the root cause of the target peer’s behaviour before making exclusion decisions. For example, Aisling (10 ADHD, dyad exclusion) suggested, “But like if Paula doesn’t know her [peer with ADHD] properly, like she might have something going on at home that like she doesn’t like or having a hard time like you cant just judge her.” Daniel (16, depression, dyad exclusion) clearly highlighted the importance of constructing a rationale for the peer’s behaviour:

“you wouldn’t do that [exclude target peer]. You would find out what is wrong with him first and then if it is a serious reason then you would stick by him but if it is not [a serious reason] then you wouldn’t”.

Eoin (10, depression, dyad exclusion) endorsed a similar opinion:

“What I would do kind of is, you’d kind of, you’d see what's wrong, you’d see what's bugging him and if it’s just nothing then it’s your decision but you should, I wouldn’t just dump him like that, I’d see what's happening to him, what's wrong, it might be anything, it might not be anything but it might be like really something like really big, as Brian [another participant] said like a divorce or his Dad or Mam both got fired and like they’re not able to afford anything”.

Similarly, John (16, depression, dyad exclusion) said, “ if something actually happened like somebody died or something, because you’ll get over that, but if he is just depressed for no reason, getting down and all, he’ll probably make you feel bad as well”. Implicit in these comments was the belief that a definable cause for the peer’s depression was necessary for exclusion to be deemed unfair; otherwise, the behaviour was perceived as wilful and rejection was legitimate.

Discussions about perceived responsibility in the context of exclusion legitimacy were more common in response to the peer with ADHD. Aoife (10, ADHD, dyad exclusion), suggested that the peer with ADHD could be described as either forgetful or lazy and
believed that forgetfulness was an accidental trait that warranted concession, but laziness was an act of wilful behaviour that validated rejection:

“That would be kind of annoying [being friends with the peer with ADHD], if like, you know how you said that she’s always like forgetting stuff and all, you know if she’s just forgetting it that’s ok but say if she’s just being lazy and you know, then that would be kind of annoying so you’d have like a bit of a reason to be annoyed with her”.

John (15, ADHD, dyad exclusion) endorsed a similar belief. He evaluated exclusion as legitimate and supported his view by saying “he sounds like a bit annoying, if he is doing it purposely”. However, not all young people believed that controllability was a contingency factor upon which to evaluate exclusion. Jamie (16, ADHD, group exclusion) thought personal responsibility was irrelevant, validating the exclusion as fair by stating that “whether your man [peer with ADHD] means to or not he’s coming across as arrogant”. Despite this, for most participants the target peer’s personal control over the expression of his or her behaviour featured as a key determinant in whether exclusion was legitimate or not. The importance of controllability as a key determinant in the legitimacy of the exclusion may be explained by the finding that participants believed that depression was caused by external factors, such as a stressful life event like parental marital breakdown. While ADHD was mostly conceptualised as either wilful behaviour or as a result one’s upbringing.

Contact with and knowledge of an individual with a diagnosis of ADHD appeared to positively influence perceptions of the peer with ADHD. While only two individuals reporting having contact with a peer with ADHD, knowledge about ADHD emerged as important in many discussions. One adolescent female spoke of how her brother has ADHD and passionately evaluated the group exclusion scenario as wrong. She explained how exclusion from group activities affects him: “I’m completely against it because it’s really
mean and I’ve seen that it does affect him” (Aisling, 16, ADHD, group exclusion). Another adolescent spoke of having a friend like the peer with ADHD and stressed the challenges he experiences as his friend and the importance supporting him. Aaron (15, ADHD, group exclusion) said:

“you kind of have to go through it and cope to be honest because I’m really one of his best friends and he has a load of problems and you have to listen to him. It’s irritating but like you have to drive through it though”.

While contact with a person with ADHD emerged as important for these two participants, no participants spoke of or alluded to having contact with a person with depression.

In most adolescent group interviews, at least one participant labelled the target peers with the correct diagnostic terms, suggesting that they had greater knowledge about the disorders compared to younger participants. Concurrently, adolescents who inferred a mental disorder also tended to evaluate exclusion as unfair. For example, Mary (15, depression, dyad exclusion) condemned exclusion “you cant just leave her on her own … I kind of feel like she is depressed”. Connor (16, ADHD, dyad exclusion) explained how a diagnosis might be important in facilitating acceptance of this peer:

“Well if he has something wrong with him like ADHD you might think because it’s not his fault, than it [the rejection] might be wrong but it depends like … If it’s not his fault that he is acting that way or if he is just doing it because of his personality or whatever … If he does have ADHD then his friend will understand, if it is his personality then it kind of changes the situation”.

Daniel (15, ADHD, group exclusion) advocated that others should be more understanding of this peer:

“Well it sounds like he has ADD or ADHD…. Like don’t just exclude him and let him hear that at the same time that would be a bit harsh. Like if he has
something feel sorry for him. Well don’t feel sorry for him but like respect that.” Similarly, Phil, (15 ADHD, group exclusion) said, “He sounds like he has ADHD so if he does you have to cut him a bit of slack because it’s not his fault”. Although most who attributed the peer’s behaviour to ADHD condemned the exclusion, one boy highlighted that a diagnosis would not override the importance of other factors, such as personal choice. Matt (15, ADHD, dyad exclusion) shed light on the complexity of exclusion by suggesting that uniform evaluations of exclusion are difficult:

“If it is something like that then [ADHD] it’s not ... like I might not really be his fault. You know. And it would be unfair unfriending him or whatever but ... in the end it is kind of up the person who they want to be friends with”.

Beliefs about the prognosis or timeline of the disorders were not frequently discussed, nor did they inform legitimacy evaluations. Only two girls mentioned that the disorders were temporary. For example, Emer (10, ADHD, dyad exclusion) said “I don’t think it [exclusion] is ok that she doesn’t want to be friends with her because she may change her personality over the years and she could like pick up on her work”. While Caitlin (15, depression, dyad exclusion) evaluated the exclusion as wrong stating “it’s [the depression] probably only a phase and she’ll get out of it when she’s older”.

In general, participants who believed that the peers with ADHD and depression were not responsible for their target behaviours were more accepting of these individuals as inferred by their perception of exclusion as unfair. Particularly, participants who had personal contact with a peer or family member with ADHD or who attributed the peer’s behaviour to a diagnosis of ADHD advocated tolerance and acceptance of this peer. The examples provided above, demonstrated that these young people believed the peer with ADHD was not responsible for his behaviours, thus suggesting important links between contact and knowledge with attribution beliefs and acceptance.
12.2.2.3 Relationship Responsibility & Obligations

The type of relationship one has with another is also important in determining exclusion evaluations. Depending on the closeness of the relationship, young people have varying levels of inclusion obligations. Mainly young people discussed feeling obliged to support peers who are distressed or perceived as vulnerable. Many participants believed that they are important sources of support for these peers. Furthermore, both children and adolescents were acutely aware of the adverse consequences of peer exclusion on the well-being of the target peer. Drawing on this sense of duty, rejection of a peer from a longstanding dyadic relationship tended to be more unjust than excluding a peer from a group. The group context ensured that individual responsibility to fulfil the duty of a supportive friend was diluted among group members.

In the group context obligations hinged on whether the excluded peer was a member of the group. Laura (16, depression, group exclusion) explained that “the class is usually split up into different groups of friends and like it depends if it’s like her friends that are going to the cinema or the other group of friends”. She explained that exclusion would be unfair if one was actively excluded by his or her group, however, if an out-group excluded a member of another group the exclusion would be legitimate. Aisling (16, ADHD, group exclusion) also endorsed a similar belief:

“As much as a hyper person annoys me, I’d still feel obliged to ask them … the fact that it’s a class thing and then I think she should definitely be invited, if it was like just a group of friends, like I’m best friends with Jennifer, we kind of have our own cliques, I wouldn't expect her to come out and personally ask me to go with that clique because its, you're not obliged”.

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Niall (16, ADHD, group exclusion) also noted that the type of activity is important in evaluating the fairness of the exclusion scenario by differentiating between the fairness of exclusion scenarios from school based social activities and external social activities:

“If it is just something they are doing like on the weekend ... with friends ... then it’s grand like. If they are going with like part of the school and everyone from the school is going then he probably should be invited. Like they don’t have to invite him if it is kinda nothing to do with school and it is just a personal kind of thing”.

These comments indicated that in more exclusive groups, exclusion is legitimate. This guideline about inclusion was summarised by Adam (11, depression, group exclusion): “if you are going to invite everybody else you might as well invite everybody”.

Participants also frequently suggested that they had a responsibility to support peers when distressed. This was observed in response to peer with depression only. Isabel (16, depression, group exclusion) “if they’re her friends they should try and see what’s up and try and make it better and try and help anyway”. There was a general agreement that rejection was unfair if the peer was rejected after the onset of the depressive episode. Shannon (15, depression, dyad exclusion) explained, “if she’s been friends with her a long time ... she should really get, see if there’s some way she could help her ... instead of just like leaving her alone altogether”. Participants also believed they were important sources of support and had the skills to help their peers through inclusion and making the peer feel wanted. Maeve (16, depression, dyad exclusion) said:

“Lauren is in like a bad place and maybe she just needs a friend ... Its like I mean if I was feeling like depressed or something, like Lauren is feeling. I’d certainly want my friends by my side like, I wouldn’t want them to say well I don’t want to be your friend anymore because of the way your acting”.
In fulfilling this obligation young people believed that the support provided would help alleviate some of depressive symptoms. Specifically, they commented on their ability to increase their peer’s “confidence and, maybe she’d be better” (Andrea, 15, depression group exclusion), “cheer him up” (Jack, 10, depression dyad exclusion) and “make her like more herself again” (Marie, 15, depression group exclusion).

While most participants believed that inclusion would have a positive effect on the psychological well-being of the peer with depression, many young people were also aware of the adverse psychological consequence of being excluded. In response to both the peer with depression and ADHD they acknowledged that failing to accept such peers would induce adverse mental health consequences: “It just make him worse if you just tell him you won’t want to be his friend anymore because he is acting differently” (Daragh, 16, depression dyad exclusion). Clara (15, depression, group exclusion) suggested exclusion “might make her more depressed and she might take extreme measures.” Caitlin (15, ADHD, group exclusion) suggested, “She’ll feel like nobody likes her or she has no friends. Then like she’ll probably, you know the way she’s really talkative, she mightn’t be as talkative anymore, she might lose her personality”. Ciaran endorsed a similar concern (10, depression, dyad exclusion) “it will lower his self esteem so he’ll never feel any better”. Similarly, Maeve (15, ADHD, group exclusion) suggested that “Her self esteem and her confidence might go down because of what happened, she might feel like she isn’t wanted.” Concern for the mental health of both peers was particularly evident among adolescent girls across numerous group interviews. Notably, adolescent males did not consider the well-being of the peer with ADHD. This may tap into perceptions that the peer with ADHD is resilient or that such emotional consequences are not typical across all males.

As shown, the type of relationship one has with another is important in determining evaluations of exclusion; generally young people assess the legitimacy of exclusion by
evaluating the type of relationship with the target peer and reflecting on associated obligations to this individual. A greater sense of duty and obligation was attached to relationships within a dyadic context whereas there was evidence that individual responsibility was not as salient within larger peer group contexts.

12.2.2.4 The Voluntary Nature of Friendship

The expectancy that friendships are voluntary contracts was discussed in all group interviews. Young people who evaluated dyadic exclusion as fair frequently employed psychological reasoning to explain their assessment by referring to the importance of personal choice. That said, however, participants who believed exclusion was unfair often qualified their evaluations by highlighting the power of personal autonomy in friendship decisions. For example, Daniel (10, ADHD, dyad exclusion) said, “It’s Peter’s choice if he wants to be friends with him or not in all fairness because he gets to decide who wants to be friends with him because it is his life and he gets to choose”. Young people were clear that friendships were exclusive voluntary contracts that could not necessarily be applied to all peers. For example, both Jack (16, ADHD, dyad exclusion) and Lee (11, depression, dyad exclusion) condoned the exclusion stating, “you can’t be friends with everyone”. While Eimear (15, depression, dyad exclusion) said, “you can’t force someone to be friends someone that they don’t want to be friends with”. Joe (11, ADHD, dyad exclusion) explained that there is often an expectancy placed on young people to be friends with all their peers but he inferred that this expectation is not realistic because of personal preference for specific traits and qualities in others. He stated:

“the teacher is going yeah ‘everyone has to be friends’ but they don’t know what they are like, you know what they are like and say if they were annoying or that, like you'd know so you have your own friends”.
While personal choice was deemed as one of the most important factors in legitimising dyadic rejection, young people did not frequently use this reason to condone group rejection. Only one participant spoke of personal choice to justify group exclusion: Conor (16, depression, group exclusion) “Well it’s their choice if they do not want to invite him so it’s alright”. However, a further small minority highlighted the power of personal choice in decisions about peer group inclusion despite evaluating exclusion as wrong. For example, Rita (15, depression, group exclusion) explained, “In a way it is their choice whether they want to invite her or not but it’s not a good choice but they can still decide whether they want to or not”. Similar conclusions were also expressed by Jack (11, depression, group exclusion): “it is your decision but it’s kind of scab if you don’t [invite him]” and Sean (10, ADHD, group exclusion) “it’s kind of mean that they don’t invite him but again it’s their life”. Thus, the voluntary nature of friendships was more salient in dyadic than group contexts, which is most likely due to the more intimate nature of dyadic contexts. However, the minority view that decisions about inclusion within the peer group rests in the hands of the majority highlights that underlying power of personal choice to infiltrate all contexts.

Common interests were not frequently suggested as reasons for the legitimacy of exclusion. Only six group interviews reflected on these issues to qualify the importance of personal choice. For example, Aine (15, ADHD, dyad exclusion) suggested, “she might not have one thing in common with her”, while Peter (16, ADHD, dyad exclusion) suggested, “they might not be into the same stuff”. These factors appeared to be more important in the dyadic compared to the group context. Only two primary school aged boys, in the ADHD condition, suggested that the peer with ADHD was excluded from the group because he did not share the same interests as other members. The apparent unimportance of common interest and similarity in determining acceptance relative to the other fore-mentioned factors
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shows that young people infrequently drew on reasons that were independent to the peer’s mental health condition to justify exclusion. This suggests that the deviance of the disordered behaviour exhibited by the target peer was very salient, such that most justifications for exclusion focused on this and not other factors.

Participants who justified exclusion on the grounds of personal choice also stipulated a number of contingency rules attached to this expectation. The most frequently expressed rule was that it is essential to be mannerly and courteous to all peers. For example, if you chose not be friends with someone you still should “just talk to him and be friendly” (Daragh 11, depression, dyad exclusion) and not “be mean” (James, 16, depression, dyad exclusion). Similarly, Aoife (10, ADHD, dyad exclusion) advocated a similar opinion, “I think it is okay for her not to be friends because everyone has their own opinion but there’s no need to be rude and like they don’t need to be the best of friends, she just needs to be polite”. Jack (16, ADHD, dyad exclusion) also evaluated the rejection as legitimate as long as he was not a victim of harassment from the perpetrator: “As long as he doesn’t bully him it’s alright”. Emer (10, ADHD, dyad exclusion) explained how to be courteous to the peer by differentiating between the type of activities one should engage in with friends and acquaintances:

“she can spend time with her in school and talk to her and maybe help her when she asks her a question but she doesn’t have to go to the cinema with her or she doesn’t have to invite her to her party she just has to be like polite”.

Another contingency rule attached to voluntary expectations was that inclusion decisions should not be based on first impressions. Young people stated that you should not “judge a book by its cover” (Mia, 10, ADHD, dyad exclusion) and “you should give everyone a chance like” (Aileen, 15, depression, dyad exclusion). Tiernan (10, depression,
dyad exclusion) commented, “if he doesn’t like him he should get to know him and then he
might actually be friends with him in the end”. Although young people stressed the
importance of getting to know a peer, the decision to include him or her is an individual’s
personal choice. Rona (15, ADHD, dyad exclusion) explained, “it is going to be her choice if
she wants to be her friend or not but maybe she should give her a chance and then like take it
from there”. The issue of prejudgement was specific to the friendship rejection context,
which suggests that there is less personal responsibility for individuals to validate potential
friends within the group context, instead a collective responsibility assumes.

It was generally agreed by all that it is one’s personal choice who they befriend. The
freedom and control young people have over their relationships ensures that one’s partner in
the dyad or group have the final say on who is accepted or rejected. However, as friendships
are voluntary all parties must want and choose to accept the other. Thus, while young people
are very powerful regulators of their social world, individual’s personal success within the
peer environment is a two-way process that hinges on being accepted by others.

12.2.2.5 The Complexity of Peer Exclusion

The complexity of peer exclusion was highlighted in the themes above where
evaluations were contingent upon aetiological and responsibility attributes, peer obligations,
and friendship expectations. Furthermore, young people frequently endorsed bi-dimensional
exclusion evaluations, whereby exclusion was both fair and unfair. Ciara (11, ADHD, dyad
exclusion) highlights the tension between voluntary expectations and friendship obligations:
“is not ok because she should be friends with everyone because it will just be mean to leave
each other out ... But in the same way she doesn’t have to be friends with everyone in the
world.” Similarly, Brona (15, ADHD, group exclusion) explains how assessing obligations
and risk expectations can cause difficulty in determining fairness:
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“Well I think it’s kind of both ways because it’s kind of mean of them not to invite her; I don’t think it’s fair on her but at the same time if she, at home if she talks through the whole, when they’re watching TV, if she talks the whole time, she’s going to do the same thing at the cinema so I kind of understand why they wouldn’t invite her.”

Comparable responses were seen in response to the peer with depression. For example, Lisa (16, depression, group exclusion) demonstrated an interaction between reciprocity expectations and obligations. She perceived rejection as unfair because “if she’s like always down and stuff then they should be inviting her places to make her like more herself again” but subsequently said “and it kind of is ok for them not to invite her in some way though because if she doesn’t talk to them there’s no point in making an effort when she’s so grumpy”. The difficulty young people experienced in evaluating the situation was summed up by Alana (10, ADHD, group exclusion) “Well it’s kind of difficult because like they’re both really, they’re both not fair, so it’s kind of hard to tell the difference”.

12.2.3 Why are Children and Adolescents with Mental Health Disorders Excluded?

Friendship Expectations & Violations

In most exclusion contexts, with the exception of group exclusion of the peer with ADHD, majority of participants viewed exclusion as either (a) unfair, justifying it on the grounds that it was harmful to recipients; (b) both unfair and fair, by drawing on personal choice factors, the harmful effects of exclusion on the victim, and the potentially harmful group or personal consequences of including the target peers. However, regardless of whether participants felt exclusion was fair or unfair, all participants were asked why the target peer was excluded (as depicted in the exclusion scenario). Participants provided multiple reasons to explain the encounter. The discussions provided an insight into young people’s attitudes towards peers
with mental disorders, and the social, personal, and group factors that cause these peers to be excluded. Overall, the findings presented in this section provide an additional insight into the social conventional reasons young people use to explain why majority peers feel uneasy interacting with classmates with mental disorders and thus exclude them.

The findings suggested that within dyadic and group contexts children and adolescents endorse clear friendship goals as follows: (a) a friend should sustain, or enhance, one’s subjective well-being and happiness; (b) acceptance of a peer should maintain or contribute to cohesive dyadic and group dynamics. Ultimately, young people choose friends who, they believe, will be good companions and who will facilitate the attainment of these goals. But what constitutes a good companion? Crudely, a good companion is someone who adheres to the norms of young people’s friendship expectations. The findings showed that young people endorsed two friendship expectations: reciprocity and risk. The former taps into expectations that one’s friends will engage in reciprocal social and emotional support as well as interaction. The latter refers to expectations that there is an element of risk attached to relationships. Friends can have an adverse influence on our psychological well-being or by association implicate us in negative social consequences of their actions. When choosing friends and group members, children and adolescents evaluate their peers, assessing whether they have the ability to meet these expectations (see Figure 12.2 below). Attitudes towards these peers and beliefs about whether peers meet or violate friendship expectations largely explain why children and adolescents with mental disorders are excluded. The findings presented in this chapter exclusively focuses on social reasoning about exclusion, however, by doing this one can reasonably infer why and when peers are included. Thus while the model (see Figure 12.2) provides an explanatory framework for peer exclusion and inclusion, the findings will primarily attend to reasoning about exclusion.
Figure 12.2. Friendship Expectations Model: Explaining why peers with mental health disorders are excluded in dyadic and group contexts
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1.2.3.1 Reciprocity

The importance of reciprocity was evident in all aspects of friendship. Friends are expected to share one and others confidences, joys, and failures as well as contribute equally to the maintenance of the friendship through joint participation in social activities and events. In doing so, empathy, support, and enjoyment between peers are fostered. Encompassed in reciprocity is the belief that friends will be reliable and loyal participants in dyadic or group contexts. Significant weight was applied to the expectation of reciprocity such that young people believed that the target peers’ failure to engage in reciprocal interaction or provide social and emotional support was the reason that they were excluded. The results showed that all group interviews were apprehensive that the symptomatic behaviour exhibited by the peers with ADHD or depression would prevent fulfilment of these expectations in both dyadic and group contexts.

Most young people were critical of the withdrawn behaviour exhibited by the peer with depression, expressing concern that by virtue of being behaviourally reticent he or she would not engage in friendship reciprocity. In most groups, participants spoke about the need to “put an effort into” friendships (Maura 16, depression, dyad exclusion) and acknowledged that friendships are not “one sided” (Maura, 16, depression, dyad exclusion). Gavin (16, depression, group exclusion) explained, “You can’t just sit back and expect to be asked to go places with people. You have to put yourself out there”. Ryan (15, depression, dyad exclusion) highlighted how the peer with depression failed to meet the expectation of reciprocity explaining that the other peer:

“feels like he [the peer with depression] is barely hanging around with him anymore so he decides to call it off ... He’s not participating in anything. He’s not involving himself with friends so he feels that it is rather pointless being with him.”
This was further rationalised by Amber (16, depression, group exclusion): “Maybe like her friends think that she’s not interested because maybe she’s been saying no to them before and then they think well what’s the point of asking her if she’s just going to say no”. Others suggested that by failing to contribute to the relationship the group simply “forgot about” (Lisa, 10, depression, group exclusion) this peer, highlighting the potential for such peers to become invisible. This was emphasised by Jack (16, depression, group exclusion) “because he is so quiet and down he could have become invisible”. Amy (11, depression, group exclusion) summarised the pertinence of reciprocity: “what’s the point in like bringing her out, if she hasn’t been letting us participate with her in what she wants to do, so why should we let her participate in things we want to do”.

Inclusion of a peer who does not engage in reciprocal interaction would impinge on the ability of others to enjoy their company. For example, Niall (16, depression, group exclusion) imagined being at a party with the peer with depression: “he [peer with depression] would just be sitting in the corner ... and not doing anything like being real boring and real depressing too”. While Aoife (10, depression, dyad exclusion) said “if she wants to play a game and then Lauren [girl with depression] is just like ‘ah no I don’t want to’ and then they’ll just be sitting there and doing nothing and then that just is really boring”. Ultimately, the peer with depression violated the reciprocal norm that friends contribute to the successful functioning of activities through joint participation and thus “they didn’t think it would be worthwhile him coming” (Matthew, 15, depression, group exclusion).

The expectation of reciprocity was so ingrained in young people that they often interpreted violations of this norm as an indicator of others’ evaluations of them. For example, Eimear (10, depression, group exclusion) explained that the group would think that the peer with depression “doesn’t want to be friends with them anymore”. In addition, others “might think he doesn’t like being around them” (Joe, 10, depression, dyad exclusion) or
believe “she doesn’t care about us” Katy (16, depression, group exclusion). Overall, withdrawn behaviour is frequently interpreted an indicator that an individual is not invested in the relationship. The expectation that peers contribute socially to both dyadic and group relationships was summarised by John’s (16, depression, group exclusion) interpretation that the depressed peer is “excluding himself”.

All young people also referred to the symptomatic behaviour exhibited by the peer with ADHD to explain why exclusion occurred. They believed this peer was excluded because he or she “never calms down” (Jennifer, 16, ADHD group exclusion), “butts in a lot” (Seana, 10, ADHD, dyad exclusion), “talks all the time” (Jack, 16, ADHD, group exclusion), “always fidgets” (Maurice, 10, ADHD, dyad exclusion) and “doesn’t pay attention to anyone” (Alana, 10, ADHD, group exclusion). Participants interpreted these externalising behaviours as deviant and thus believed that inclusion of this peer would not be conducive to the successful attainment of friendship goals. For example, adolescents, in particular girls, believed that the peer with ADHD did not have the capacity to “care about anyone else” (Laura, 15, ADHD, group exclusion). He or she would not provide reciprocal emotional and social support: “she seems like she wouldn’t ask like if you’re ok … just kind of like wouldn’t notice” (Dee, 16, ADHD dyad exclusion). Similarly, Jack (16, ADHD, dyad exclusion) noted, “It seems like he only thinks about himself. He doesn’t think about others”. They not only expressed concern about this peer’s ability to support them but also to support others within the peer group. Sinead (16, ADHD, group exclusion) described a situation in which a group of girls were comforting a peer who “was down” and commented that the peer with ADHD would interrupt and make the girl think: “my problems don’t matter”.

Females, and in particular female adolescents, criticised the social deficits that were exhibited by the target peers, thus suggesting that they were acutely aware of the reciprocal expectations of their friends. Some girls emphasised the importance of confiding in peers,
and suggested that the peer with depression was excluded as she failed to share her troubles. For example, Joyce (10, depression, group exclusion) questioned, “why would they be friends with her if she’s not sharing anything with them?” while Catilin (16, depression, group exclusion) said, “they might have thought oh well if we were her friends she should have told us what’s going on with her”. Aisling (15, depression, group exclusion) suggested that this peer was excluded because the group “mightn’t know anything about her” as a result of her silence.

In response to the peer with ADHD, they highlighted the value of listening to one another and were apprehensive of this peer’s friendship potential due to her externalising behaviour. For example, Lorraine (16, ADHD, dyad exclusion) suggested, “Paula would like prefer somebody who would listen to it [her issues] and respond to it or listen”. While Sally (10, ADHD, dyad exclusion) also reflected on potential unreciprocated support that one would experience if they befriended this peer: “if she won’t listen to you and she thinks that you have to listen to her all the time, it wouldn’t be fair”. Furthermore, Louise (16, ADHD, group exclusion) explained that this peer was excluded because “she [peer with ADHD] won’t be able to help them [her peers] if there is something wrong with them”. These comments indicate that reciprocal support within friendships is important for girls. However, to provide or receive such support, confiding with and listening to friends are essential expectations that all parties must fulfil. The importance of reciprocal expectations was much less obvious in discussions with males, suggesting that reciprocity is more significant for girls.

Young people expect their friends to engage in reciprocal emotional support and behaviour and believe that the social deficits associated with ADHD and depression, albeit different, impinged on the target peers’ ability to engage in reciprocal interaction and support. Such is the importance of reciprocity that the potential of the target peers with ADHD and
depression to violate this expectation was always discussed when explaining exclusion in both dyadic and group contexts. As can be seen in Figure 12.2 below, the pungency of reciprocity was such that it also influenced risk expectations, which will be described next.

**12.2.3.2 Risk:**

All group interviews discussed that there is an element of risk attached to befriending a peer with a mental health problem, thus demonstrating an awareness of the influence that peers have on them. Expectations of friendship risks and a desire for happiness and to maintain normative group or dyadic function ensures that both children and adolescents are cautious about accepting peers whom they perceive as deviant or problematic. Thus, young people engage in a cost-benefit analysis of existing and potential friendships, carefully assessing the severity of the target peer’s deviant behaviour and the personal risks of including him or her. One would be motivated to exclude a peer if befriending him or her would incur substantial personal or group risks. There were distinct types of risk associated with accepting the target peers. In response to the peer with depression, participants were concerned about the negative effect he or she would have on their own mental health, whereas in response to the peer with ADHD, they were concerned with the social and disciplinary consequences of this peer’s behaviour.

In both the dyad and group exclusion context, many young people believed that including the peer with depression would cause them to also experience low mood. For example, they suggested that being friends with this peer “might drag her down as well, make her think about things ... that she mightn’t want to think about” (Laura, 16, depression, dyad exclusion) or “make everyone else sad” (Emma, 16, depression, group exclusion) and “bring the mood down” (Brian, 15, depression, group exclusion). Occasionally, young people explicitly endorsed the belief that depression is contagious. For example, “Paula would
probably just get depressed” (Aoife 15, depression, dyad exclusion) and “she might make her depressed” (Chloe, 16, depression, dyad exclusion). Victor, (16, depression, group exclusion) suggested that the peer with depression should be aware of the risk he inflicts on the group commenting that would be “selfish” of the peer with depression to decide go to the cinema.

While young people were concerned that including the peer with depression could cause them to become depressed, only one participant suggested, that inclusion of the peer with ADHD would increase the externalising behaviour in others. Aoife (10, ADHD, group exclusion): “if you hang around with her a lot maybe you’d start acting like that at home”. Instead, for most young people the risks associated with including a peer with ADHD were conceptualised as negative social and disciplinary consequences. In particular, 10 to 11-year-olds believed that by association the peer with ADHD would incur negative disciplinary consequences on them in both dyad and group contexts. Ellie (10, ADHD, dyad exclusion) suggested, “if like she sits beside Jane [peer with ADHD] and probably she thinks that Jane will keep on talking to her and she’ll get in trouble”. Similarly, Isobel (10, ADHD, group exclusion) suggested that exclusion occurred because “they don’t want to get kicked out because of her talking”. Children in one particular group discussed how the peer with ADHD would impact on their learning. For example, Carl (10, ADHD, dyad exclusion) said, “Peter might want to learn stuff in school but he’s always disturbing the teacher”. Thus, they were not only concerned that including this peer would have disciplinary repercussions but that he or she could prevent them obtaining academic goals. Concerns about the risks associated with befriending a peer with ADHD were summed up by Cian (11) who rhetorically stated, “do you want to be friends with someone who is always getting in trouble? They might get you in trouble and you don’t want to be getting in trouble all the time if it’s someone else’s fault”.

These findings suggest that, compared to adolescents, younger children were more concerned
with ‘doing good’ and thus when evaluating this peer they were acutely aware of the disciplinary risks associated with befriending him or her.

While 10 to 11-year-olds were concerned about the disciplinary consequence of including the peer with ADHD in dyadic and group contexts, all age and gender groups referred to the social consequences of inclusion. Emphasis was placed on the social consequences of including this peer in the group context only. Including a peer with ADHD risked disrupting normative group functioning. Most participants suggested that the group were motivated to exclude the target peers because they could not behave as per the norm of the target social context. Reflecting on the context of the group exclusion scenario, young people questioned whether this peer had the necessary skills to engage in appropriate behaviour at the cinema: “if she can’t sit still in a classroom they probably think she won’t be able to sit still in a cinema either and she’ll ruin the movie for them” (Julie, 16, ADHD, group exclusion). Eileen (10, ADHD, group exclusion) empathised with the actions of the group “Well like I could understand why they don’t want her going because she’d just like ruin it and talk through the whole thing”. Some adolescents believed that including this peer was so controversial that it would ignite conflict within the group: “if we do invite her it’s going to cause arguments, it’s going to cause fights” (Jennifer, 16, ADHD, group exclusion). Likewise, Niall (16, ADHD, group exclusion) thought that this peer had the potential to “get on someone’s nerves and end up causing a big hassle or maybe a fight”. However, it is important to note that perceptions that the peer was exceptionally deviant and that inclusion could escalate into conflict and breakdown group cohesion was a minority view. Instead, most participants, and in particular adolescents, believed that the peer with ADHD would generally disrupt group functioning, implying that unity and sameness across group members is paramount, especially in adolescence.
In both dyadic and group contexts, some suggested that befriending a peer with ADHD also posed a threat to their social reputation. For example, Emma (10, ADHD, dyad exclusion) explained, “you kind of want to be with people who are good so you don’t get like a bad name”. Her comment not only suggested that our peers’ influence other’s perceptions of us but also implicitly suggested that the peer with ADHD was ‘not good’. Molly (11, ADHD, dyad exclusion) also endorsed a similar opinion suggesting “she doesn’t want to be her friend in case she [peer with ADHD] does something wrong and then the whole class will hate her and everyone will hate her”. Caoimhe (16, ADHD, dyad exclusion) highlighted the personal consequences associated with befriending this peer, suggesting that she “could get upset for what other people are saying for hanging around with her”.

As suggested by Caoimhe, above, there were adverse emotional consequences of befriending a peer with ADHD. Possible adverse emotional consequences emerged more frequently than suggestions that this peer would spoil one’s social reputation. The most common affective responses towards this peer were shame, anger, and frustration. Eoin (11, ADHD, dyad exclusion) admitted, “it’s kind of embarrassing if you’re the friend of the person who is always getting in trouble”. This was reinforced by Niall (16, ADHD, group exclusion) who suggested that one “might be embarrassed to be seen” with the peer with ADHD. Sinead (16, ADHD, group exclusion) suggested that this peer was unpredictable and so others would not only “embarrassed at what she might do” but also “afraid of like the reaction they might get from other people”. While some participants spoke about being embarrassed of the peer with ADHD, shame was not explicitly discussed in response to the peer with depression. Only one adolescent boy indirectly implied that others might be ashamed of this peer, suggesting he was excluded because “they might not want to be seen with him” (Matthew, 15, depression, group exclusion). Frequently, participants reflected on how the impulsive behaviour exhibited by the peer with ADHD would evoke anger and
frustration. For example, Ruth (16, ADHD, dyad exclusion) described that the peer with ADHD as loud and annoying and commented, “I myself, I don’t like people like that, I’d get annoyed myself like if people are always like shouting out in class”. Similarly, Daniel (15, ADHD, group exclusion) said, “if you’re trying to talk and he keeps butting in on you. It would be frustrating”. When considered in the context of the goals of friendship, experiencing shame, frustration or anger are likely to prevent goal attainment. While a plethora of affective responses emerged in response to the peer with ADHD, the primary affective consequence of accepting the peer with depression was a decrease in one’s mood (discussed above).

Acknowledging a range of adverse emotional, social and disciplinary risks attached to forming a relationship with a peer with ADHD or depression, suggests that young people perceived that befriending peers with disorders is a risky venture. Furthermore, drawing on such risks to explain exclusion highlights that young people exclude peers with ADHD and depression as a form of social regulation to maintain and protect normative functioning.

Young people’s beliefs about why a peer with ADHD or depression would be excluded from a dyad or group were assessed to explore attitudes towards peers with mental health problems. Notably, beliefs that peers with ADHD are bold or annoying, and beliefs that peers with depression are boring or are contagious, were the most common attitudes to arise in the discussions. This question could therefore be considered as successful at eliciting information about why in general peers with disorders are excluded. Thus, responses went beyond attitudes towards the target peers to include in-depth information on social, personal and group factors that initiate exclusion.
12.3 Summary & Conclusion

Overall, the results suggested that while exclusion is largely perceived as unfair, justifications highlight that exclusion is not straightforward and legitimacy is often contingent upon a multitude of factors. The fact that some participants evaluated exclusion as neither exclusively right nor wrong ultimately highlights the complexity involved in reasoning about peer exclusion. Participants who perceived exclusion as fair did so by reflecting on the social deficits exhibited by the target peers and risks they imposed. Furthermore, the type of relationship one has with the peer prior to exclusion, along with perceptions of responsibility appeared to play a role in determining exclusion. Participants also justified exclusion by drawing on the voluntary nature of friendships, which appeared to be more pertinent in dyadic compared to group contexts. Furthermore, the findings suggested that children and adolescents exclude peers with mental disorders because they challenge the expectations young people attach to their friendships. While the means by which the respective peers failed to meet these friendship expectations differed, a common thread was observed; befriending a peer with a mental health problem limits the extent of reciprocity that occurs and poses emotional and social risks to other individuals in dyadic and group contexts. The findings also suggest that more risks were attached to including a peer with ADHD compared to depression. However, the peer with depression violated more reciprocal expectations than the peer with ADHD.

In conclusion, the findings suggest that exclusion is complex. Young people have sophisticated expectations of friendships such that they are cautious about including a peer who may prevent them from obtaining their friendship goals. By discussing legitimacy of and justifications for exclusion and why peers with ADHD or depression might be excluded, young people provided a valuable insight into why peers with disorders experience difficulty gaining acceptance from their peers.


Chapter 13: Discussion (Study Two)

Chapter 13: Discussion for Study Two

13.1 Aim of Chapter

This chapter will discuss the findings of Study Two of this research programme. The findings will be discussed by reflecting on the results of the published research on social reasoning about exclusion. Drawing on the findings, young people’s perceptions of the exclusion of peers with ADHD and depression will be discussed. In doing so, participants’ evaluations of exclusion, justifications for such evaluations, and beliefs about why a peer with ADHD or depression would be excluded will be discussed. Furthermore, possible explanations for the findings will be provided. Finally, limitations of this study and suggestions for future research will be discussed.

13.2 The Aims & Objectives of the Current Study

The purpose of Study Two was to expand our understanding of discrimination towards peers with ADHD and depression, by exploring why children and adolescents might be reluctant to befriend peers with mental health disorders. The current study did this by adopting a Social Domain perspective on exclusion, that exclusion is not always intended to hurt or harm the victim, but instead may be used to protect one-self or others or to maintain social conventions (Killen et al., in press). As no studies have explored children and adolescents’ reasoning about exclusion of peers with mental disorders, a specific aim of this study was to explore young people’s evaluations of exclusion scenarios involving these peers and assess justifications for their evaluations. Acknowledging that young people’s justifications for the legitimacy of exclusion may not shed light on exactly why peers with disorders are excluded, beliefs about why the exclusion occurred were also assessed. During the analysis, gender, age, and disorder specific patterns in responses were explored, where possible.
13.3 Evaluations of the Legitimacy of Exclusion: Interpreting the Findings

The results of this study indicated that most children and adolescents view exclusion of peers with ADHD and depression as unfair; however, one exception to this trend was found. In group contexts, most evaluated exclusion of the peer with ADHD as legitimate. While this is the first study, to the researcher’s knowledge, to explore social reasoning about peers with mental health disorders, this finding appears to deviate from the trend found in other SDT research. Previous research has found that dyadic exclusion is perceived as more legitimate than group exclusion (Nucci, 2001), even when evaluating exclusion of aggressive or socially withdrawn peers (Park & Killen, 2010). The divergent pattern found in the present study suggests that externalising behaviour is fundamentally incompatible with normative peer functioning within the group context, and thus children and adolescents use this behaviour as a criterion for exclusion. Indeed, this finding may explain why many young people with ADHD are not accepted by their peer group (Blachman & Hinshaw, 2002; Hoza et al., 2005).

While the aforementioned findings represented majority views of exclusion, a notable portion of participants either believed that exclusion of the peer with depression, and dyadic exclusion of the peer with ADHD, was legitimate or could not arrive at a uniform evaluation, and thus concluded that exclusion was both fair and unfair. Similarly, group exclusion of the peer with ADHD was not always perceived as fair. The findings demonstrated that exclusion decisions are not exclusively moral issues. Instead, participants’ understanding of exclusion is complex. Assessing young people’s justifications for their exclusion evaluations (asking why they thought exclusion was fair/unfair?) provided some coherency to this complex issue. The information provided informed the design of the Evaluations of the Legitimacy of Exclusion Model (see Figure 12.1, Chapter 12 section 12.2.1), the features of which will be subsequently discussed. However, it is important to note here that, while the types of reasoning participants used to evaluate exclusion differed when the target peer had ADHD or
depression, the thematic structure of the explanations were generally comparable. In addition, the type of reasoning participants used did not notably change across the context of exclusion (dyadic or group), nor did strong age or gender differences emerge.

13.3.1. Responsibility & Causal Beliefs: The Role of Attributions

A core theme that arose in the context of justifying exclusion was that beliefs about whether the target peers were personal responsibility for their conditions, influenced fairness evaluations of the exclusion. This finding supports Attribution research on stigma (e.g. Weiner 1988, Corrigan et al., 2007), that shows that beliefs about how personally responsible people with mental disorders are for their conditions, results in disparate emotions of anger and sympathy, which in turn influence behaviour. The present study, however, highlights the importance of responsibility attributions in influencing social reasoning about exclusion. Throughout the discussions, participants who explicitly thought that the peers were not to blame for their behaviour tended to evaluate exclusion as wrong. Thus, there were strong links between moral beliefs about exclusion and beliefs about responsibility for the target peers behaviour. While previous research, from a Social Domain perspective, has shown that beliefs about responsibility are often used to provide context to evaluations that exclusion is immoral, the relationships between these cognitions are typically observed in response to gender or racial exclusion (e.g. Killen & Stangor, 2001). For example, in the context of gender-based exclusion, a child might evaluate exclusion stating, “It is not ok to exclude him from playing Barbies, because it is not his fault he was born a boy”. What makes the present findings different is that race and gender are unanimously perceived as uncontrollable, while the same cannot be stated about mental health disorders. Many people do believe that deviant behaviours associated with mental disorders are intentional and the individual is personally responsible for his or her behaviour. Thus, disparate exclusion evaluations were observed
when the target was perceived as responsible for his or her behaviour, which stresses the importance of tackling responsibility attributions in anti-stigma interventions.

In addition, the findings provide an insight into the complex relationship between beliefs about causes and responsibility attributions and social acceptance or exclusion. For example, participants discussed that if there was not a concrete, or in some instances ‘good enough’ reason for depression, then exclusion was legitimate. Furthermore, participants placed stronger emphasis on the relationship between perceived responsibility and evaluations of exclusion in response to the peer with ADHD compared to depression. This suggests that responsibility stereotypes play a more influential role in determining unfavourable responses towards peers with ADHD. The findings provide a novel insight into role of perceived responsibility in determining exclusion, and thus extend our knowledge on the importance of attributions in the stigma process.

### 13.3.2 Friendship Responsibility & Obligations

An important theme to emerge among participants who condemned exclusion was the belief that one has an obligation or duty to support one’s peers in time of need. While participants did not discuss the possibility that inclusion would improve the behaviour of the peer with ADHD, many explicitly thought that accepting the peer with depression would alleviate his or her low mood, and thus evaluated exclusion of this peer as unfair. Specifically, most participants who condemned exclusion of the peer with depression believed that they had the ability and duty to help the target peer overcome his or her disorder. Previous research that has explored social reasoning about the exclusion of aggressive or shy peers (Park & Killen, 2010) did not report that participants spoke of a responsibility to provide support to the target peers as a reason to condemn exclusion. Thus, this finding is novel to the present research, and is likely to be explained by the fact that this
study focused on emotional and behavioural disorders. Help-seeking research shows that peers are important sources of support for young people when distressed (Schoner-Reichl & Miller, 1996). The findings from the present study also informs this literature, demonstrating that young people are willing sources of support and believe that they have the skills to help distressed peers. A possible explanation for why the provision of support was offered to the peer with depression and not ADHD is that young people view internalising symptoms as transient while externalising symptoms are perceived as fixed.

### 13.3.3 Age & Gender Differences

Quantitative research that explores social reasoning about gender and racial exclusion consistently shows that girls perceive exclusion as more wrong than boys (Killen & Stangor, 2001; Park & Killen, 2010). In addition, a consistent finding from the existing literature is that, with age, exclusion is often perceived as more legitimate, especially when social conventions are violated (Horn, 2003; Nucci, 2001; Park & Killen, 2010). Furthermore, existing research shows that identity and group norms become more important to children with age (Abrams, Rutland, Pelletier, & Ferrell, 2009; Nesdale, Durkin, Maass, & Griffiths, 2005a; Rutland et al., 2005). However, few subtle gender and age differences emerged in participants’ evaluations and justifications about exclusion. Specifically, an age difference was found in participants’ ability to accurately label the disorders. Adolescents suggested that the target peers had ADHD or depression more frequently than younger children, and such adolescents simultaneously evaluated exclusion as unfair on the basis of the diagnosis. This findings supports previous research that shows that knowledge about mental health disorders becomes more sophisticated with age (Fox et al., 2010; Hennessy, Swords, & Heary, 2008). However, it also builds on this, by tentatively demonstrating that knowledge can influence how young people reason about exclusion of peers with disorders. In relation to gender
differences, female adolescents placed greater emphasis on the adverse consequences of exclusion on the well-being of both peers when evaluating exclusion as unfair. This finding supports previous research that suggests that girls are more concerned about inclusivity (Killen & Stangor, 2001; Park & Killen, 2010).

13.3.4 The Importance of Cohesive Dyadic & Group Functioning

The present study indicated that those who evaluated exclusion as legitimate frequently justified their viewpoint by reflecting on the potential of these peers to disrupt normative friendship functioning in both dyadic and group contexts. Specifically, this study revealed that participants believed that inclusion of the target peers would violate the expectation that friends should engage in reciprocal interaction and support; albeit different, the behavioural excesses and deficits exhibited by these peers would prevent them from fulfilling such expectations. Furthermore, participants who evaluated exclusion as fair believed that believing that befriending a peer with a mental health problem was a risky endeavour that could incur many personal and social sacrifices on their part. Together, violations of reciprocal expectations and imposing personal and social risk, ensures that inclusion of these peers would disruption normative friendship dynamics (see section 13.3.2 below for a discussion on these themes). Similarly, research consistently shows that when young people believe that inclusion of a target peer would threaten cohesive peer dynamics, they evaluate exclusion of the target peer as legitimate (Malti et al., 2012; Park & Killen, 2010; Verkuyten & Steenhuis, 2005). While most of the published research explores evaluations of gender or racial outgroup peers, Park and Killen (2010) noted that participants used similar reasons to support the exclusion of aggressive and socially withdrawn peers. These authors also noted that participants discussed group functioning issues more often in response to exclusion of aggressive and withdrawn peers compared to exclusion of peers.
based on group membership, such as gender or nationality. While the present study focused on exclusion of peers with ADHD and depression, drawing on Park and Killen’s findings, it is reasonable to suggest that inclusion of peers with disorders may be more disruptive to normative group and dyadic functioning than acceptance of outgroup gender or racial peers.

13.3.5 Autonomy in Dyadic & Group Inclusion Decisions

The present study revealed that participants’ autonomy to choose whom they include was a core theme to emerge among participants who evaluated exclusion as fair. Similarly, personal choice in friendship decisions consistently emerges as important for children and adolescents in other Social Domain research (Horn, 2003; Killen & Stangor, 2001; Nucci, 2001). While the voluntary nature of friendship was discussed in response to the peer with ADHD and depression, the finding that this issue was more commonly discussed in dyadic, compared to group contexts supports previous research (Park & Killen, 2010; Malti et al., 2012). The contingency rules or obligations associated with personal choice, such as, ‘you should always be mannerly’, and ‘get to know potential friends before disregarding them’, suggests that reasoning about exclusion decisions are not straightforward. Personal choice explanations featured less frequently than discussions about reciprocal expectations young people attach to their friendship or beliefs that there are risks associated with including a peers with a mental disorder. This finding suggests that the deviance of the target peers behaviour was particularly salient, so that participants focused on this over other non-mental health factors to justify exclusion. It also stresses the importance of the behavioural norms and expectations that guide young people’s friendship decisions.
13.3.6 Contact with Peers Similar to the Vignette Characters

In line with previous research, contact with peers similar to those described in the vignettes appeared to influence reasoning about exclusion (Killen et al., 2010; McGlothlin & Killen, 2010; McGlothlin & Killen, 2006). Specifically, those with contact (a sibling and friend) with an individual with ADHD, perceived exclusion as unfair and drew on moral reasons to justify their beliefs. However, it is important to note that only two people reported having contact with an individual with ADHD, thus only tentative generalisations can be made. A more reliable finding was that those who correctly identified the disorder perceived exclusion as unfair. The influence of knowledge was most evident in response to the peer with ADHD. In response to the peer with depression, fewer participants explicitly acknowledged that the peer had depression, instead they described him or her as depressed, implying that the target peer’s behaviour was not perceived as a clinical disorder. The use of the word ‘depressed’ as an adjective in everyday language calls us to question whether participants were aware that the target peer had a mental health disorder. It is possible that young people have difficulties discerning between mood states and those of a clinical nature. To support this query further, no participants discussed having contact with a peer with depression. While it is possible that participants did not know anyone with depression, it is estimated that about 30% of adolescents have some varying degree of depression (Headstrong, 2012), which suggests that not knowing anyone with depression is unlikely. This raises questions about young people’s ability to recognise depression as a psychiatric disorder. However, in general the results pertaining to knowledge and contact with peers with disorders supports others who suggest that contact and education interventions may be a useful way of reducing stigma (Pinfold et al., 2003; Watson et al., 2005).
13.4 Why Peers with ADHD & Depression are Excluded

Asking participants why the target peers were excluded provided an insight into why children and adolescents may not want to befriend a peer with a mental health disorder, and consequently exclude them. The subsequent information obtained helped inform the design of the Friendship Expectations Model (Figure 12.2, Chapter 12 section 12.2.3). Specifically, the findings showed that young people attach reciprocity expectations to their friendships in both dyadic and group contexts that, they believe, are likely to be violated if a peer with ADHD or depression is accepted. For example, while participants reflected on the internalising behaviour exhibited by the peer with depression to explain exclusion, they were also concerned that social support and friendship duties would not be reciprocated in a relationship with this peer. Similarly, they expressed concern that the peer with ADHD would dominate interactions and not have the ability to provide them with reciprocal support.

Participants’ well-defined expectations of their friends is supported by a large body of research that shows that by middle childhood children expect their friends to help them when needed, to provide emotional support, to be trustworthy, and to share their experiences (Bigelow, 1977; MacEvoy & Asher, 2012; Zarbatany, Ghesquiere, & Mohr, 1992). Specifically, reciprocity has been acknowledged as essential element of friendships (Rubin, Bukowski, & Parker, 2006).

The present study also suggests that young people perceive an element of risk attached to friendship when the peer in question has an emotional or behavioural disorder. Specifically, young people were concerned about the potential negative influence such peers may have on them. For example, participants justified and explained exclusion of the peer with depression by referring to concerns that one would become depressed in his or her company. Previous research has not identified this as a cause for discrimination towards peers with depression in childhood or adolescence. Similarly, young people were concerned
about the ability of the peer with ADHD to engage in acceptable behaviour and reflected on the adverse consequences of this to explain exclusion. Young people spoke of social conventional expectations that peers should behave in ways that are compatible with expected group behaviour, notably being able to regulate one’s emotions and impulse is paramount. The peer with ADHD violated such expectancies, such that including this peer would disrupt group cohesion, inflict unwanted disciplinary consequences on others, and spoil social reputations. This novel finding, that young people perceive an element of risk attached to friendship, may be explained by the fact that previous research has only explored children and adolescents’ expectations and understanding of friendship with peers without disorders. Thus, while it is possible that young people perceive a level of risk in all friendships, this expectation was only unveiled as they were required to discuss friendships with deviant peers.

Peer relations researchers largely adopt an interpersonal approach to the exclusion of children and adolescents with mental disorders. They conceptualise that children with depression are rejected because they spoil social interactions by initiating little social contact, exhibiting poor energy and motivation and moan (Caldwell et al., 2004; Peterson et al., 1985). Children with ADHD, on the other hand, are rejected because of the challenges imposed on social interactions as a result of their poor attention skills and resistance to controlled behaviour (Coplan et al., 2003; Patterson & Sanson, 2001). The present body of research also demonstrated that the symptoms of depression and ADHD are important in determining exclusion, but it enhanced our understanding of why young people with disorders are excluded by highlighting the means by which symptoms violate the conventions associated with friendships (e.g. reciprocal expectations and assessing potential risks or threats). Thus, these findings expand our understanding of why peers with disorders are excluded. Unlike traditional approaches adopted in mental health stigma research, these do
not simply show that such peers fare worse than others within the peer context, but instead shed light on the issues that are important to young people when selecting friends.

13.4.1 Adverse Consequences of Including the Target Peers

Concerns about the risks associated with the target peers, warrants further discussion. The belief that the peer with depression would cause others to become depressed taps into a stereotype that mental disorders are contagious which, from an evolutionary perspective, is posited as a primary cause of mental disorder stigma in adults (see Kurzban & Leary, 2001). Similarly, research shows that children sometimes believe that mental disorders in their peers are caused by contamination or contagion (Fox, Buchanan-Barrow, & Barrett, 2010). However, this is the first study to show qualitative evidence of the contagion effect of low mood, which may be a factor in determining exclusion of peers with depression. The potential of qualitative approaches to unveil novel or unexplored aspects of children’s cognitions is an undeniable strength of the methodology employed in this study.

Participants’ apprehension about the social and disciplinary consequences of including the peer with ADHD can be explained by research that shows that from about 7 years of age children develop a sense of responsibility for the actions of their friends (Bennett, Yuill, Banerjee, & Thomson, 1998). As the youngest participants in this study were 10 years of age it is likely that this sense of responsibility was well established, thus explaining their concern about possible disciplinary and social consequences of this peer’s behaviour. Furthermore, participants’ concern that inclusion of the peer with ADHD would ruin their own or group’s social reputation may be explained by other research from Social Identity perspectives, that shows that maintaining group identity is important to young people (Nesdale et al., 2005b). For example, if the behaviour exhibited by a peer with ADHD or depression does not conform to that of another individual or group, including this peer may
cause members or individuals to believe that the factors (e.g. impulse control and regulated behaviour) that were important in bringing the group together, or essential to one’s self-concept, are weakened. Furthermore, including this peer may challenge the ways in which others perceive those who are friends with this peer. Awareness that others may perceive you or your group differently may also give rise to feelings that one’s identity is being threatened. Research that has explored the relationship between prejudice and perceived threat posed by outgroup members, shows that when the threat of another group is manipulated, in competitive situations, negative perceptions of the outgroup increase (Nesdale et al., 2005b). While the threat posed by peers with disorders is different to the concept of threat manipulated in Nesdale’s research, a common trend is observed; if a group or individual poses a risk to the successful functioning of one’s group, or social world, negative perceptions of target group or the individual are likely.

13.4.2 Developmental & Gender Issues

Compared to boys, when asked to explain why the target peers were excluded, girls were more concerned that if they befriended a peer with depression or ADHD, she would fail to provide them with support and empathy. While drawing on these reasons to explain exclusion, they also emphasised the importance of providing support to one’s friends. This contradiction can be explained by research that shows that girls expect more empathy and support from their friends (Clarke & Ayers, 1993), but they also report being much more affected by transgressions of core friendship expectancies compared to boys (MacEvoy & Asher, 2012). Thus, decisions about whether to include or exclude a peer with a mental health problem may be more difficult for girls as they potentially would be more affected by the social deficits that accompany disorders.
Overall, the findings revealed only subtle gender and age differences in young people’s social reasoning about exclusion of peers with disorders. This stands in stark contrast with other SDT research (e.g. Horn, 2003; Killen & Stangor, 2001; Malti et al., 2012; Park & Killen, 2010). The nature of qualitative research may provide a possible explanation for this finding. While qualitative research, and in particular thematic analysis, allows the researcher to uncover unique patterns of responses and infer the strength of such responses, this approach does not have the ability to reveal differences to the level of precision that quantitative methods can. In addition, as no previous research has explored exclusion of peers with mental health disorders, it is also possible that the absence of such age and gender differences may be specific to this research context.

13.5 Applying the Findings from the Present Study to Social Domain Theory

As the findings of this study were analysed differently to the way in which SDT research is usually analysed, the themes that emerged were not explicitly described in terms of moral, social convention, and psychology domains. This can largely be attributed to the influence of inductive coding of the data and the novel findings that emerged. However, the nature of the core themes that emerged can be fundamentally categorised as moral, psychological, and social conventional (see Table 13.1 below). For example, participants who evaluated exclusion as unfair reflected on moral reasons to support their claim. They advocated that including the peer with depression would help alleviate his or her low mood; this willingness to help the target peer is an expression of moral behaviour. Furthermore, the themes of Risk and Reciprocity are socially conventional in nature. For example, the expectations that one’s friends will engage in reciprocal interaction, provide necessary social support, and meaningfully contribute to successful functioning of the relationship are all social conventions that we attach to our friendships. Consistent with other research that explores
social reasoning on the exclusion of racial or gender outgroup peers, or peers with aggressive or shy behavioural dispositions, young people reason about the exclusion of peers with mental disorders by reflecting on these three core domains. Thus, the findings show that SDT provides a meaningful contribution to understanding reasons for the exclusion of children with emotional and behavioural disorders. It is important to note, however, that often a blanket categorisation of the themes fails to capture their complexity, as occasionally the themes spanned multiple domains. For example, the theme Responsibility Attributions & Causal Factors incorporated moral and social conventional beliefs. Participants who accurately labelled the target peers’ disorders or believed that they were not personally responsible for their disorder evaluated exclusion as wrong, advocating equal treatment of these peers. Such responses can be categorised as moral. Whereas, participants who believed the target peers were personally to blame for their disorder, evaluated exclusion as legitimate by drawing on stereotypes pertaining to the disorders. Thus, from the methodological approach used in the present study, fixing the themes within one domain or another failed to capture the complexity of issues that were involved when reasoning about the exclusion of peers with mental health disorders.
Table 13.1

Categorisation of the Themes to Emerge from this Study Under Social Reasoning Domains

<table>
<thead>
<tr>
<th>Moral Justifications: References to helping and caring for other by including them. Reference to equal treatment or access.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Relationship Responsibility &amp; Obligations</strong></td>
</tr>
<tr>
<td>“If they’re her friends they should try and see what’s up and try and make it better and try and help anyway” (depression, group exclusion).</td>
</tr>
<tr>
<td>“The fact that it’s a class thing then I think she should definitely be invite” (ADHD, group exclusion).</td>
</tr>
<tr>
<td><strong>Responsibility Attributions &amp; Causal Factors</strong></td>
</tr>
<tr>
<td>“It sounds like he has ADD or ADHD … Like don’t just exclude him” (ADHD, group exclusion).</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Social Conventional: references to social expectations, appeals to normative group or dyad functioning, as well as beliefs or stereotypes about the target individual. Influences of others such as peers or authority figure.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Friendship Expectations</strong></td>
</tr>
<tr>
<td><strong>Reciprocity</strong></td>
</tr>
<tr>
<td>“What’s the point in like bringing her out, if she hasn’t been letting us participate with her in what she wants to do” (depression, group exclusion).</td>
</tr>
<tr>
<td>“It seems like he only thinks about himself. He doesn’t think about others” (ADHD, dyadic exclusion).</td>
</tr>
<tr>
<td><strong>Risk</strong></td>
</tr>
<tr>
<td>“She might make her depressed” (depression, dyadic exclusion).</td>
</tr>
<tr>
<td>“They don’t want to get kicked out because of her talking” (ADHD, group exclusion).</td>
</tr>
<tr>
<td><strong>Responsibility Attributions &amp; Causal Factors</strong></td>
</tr>
<tr>
<td>“He sounds like a bit annoying, if he is doing it purposely” (ADHD, dyad exclusion).</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Psychological Justifications: references to individual preferences.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Voluntary Nature of Friendship</strong></td>
</tr>
<tr>
<td>“Well it’s their choice if they do not want to invite him so it’s alright”.</td>
</tr>
</tbody>
</table>

*Note.* The themes pertaining to this study are italicised.
13.6 Limitations & Recommendations

13.6.1 Methodological Issues

While the present research has provided valuable insight into opinions about excluding a peer with ADHD or depression and enhanced our knowledge on discrimination, this study is not without limitations. Firstly, as mentioned in relation to Study One, this study assessed responses towards hypothetical peers; thus, caution must be heeded in generalising the findings towards actual peers with disorders.

As data on participants’ behavioural and emotional profiles were not collected, the sample employed in this study was potentially a mixed pool of participants, whereby some participants may have had personal experience of mental health issues. It is possible that young people with a mental disorder have different views on this topic compared to those without disorders. Thus, future research should employ a more homogenous sample or conduct this research on more defined target groups (i.e. those with personal experiences, those with experience in their social circle and those with limited experience). In addition, research shows that experiences with exclusion can, in certain conditions, lead to greater empathy (Killen et al., 2010). While young people did not discuss personal experiences of exclusion, future research should explore whether such experiences affect young people’s views of exclusion of peers with disorders.

As mentioned in Chapter 10 section 10.6.2.1, group interviews were employed because of the advantages they have in yielding data from young people about their social experiences. Given that the present study was the first study, to the researchers knowledge, to explore social reasoning about exclusion of peers with mental disorders, a qualitative analysis was deemed appropriate to obtain foundational data on this topic (see Chapter 10 section 10.6.2). However, group interviews are not without limitations, the group context ensures that one cannot entirely assume that participants expressed their own individual view.
While friendship groups were created to attempt to provide a sense of ease and security within the group, it is possible that participants’ responses were influenced, or curbed, by the responses of others. Thus, future research should use individual interviews as a method of data collection, and explore whether similar or divergent patterns of responses are found across the two methodologies.

13.6.2 Theoretical Issues

Previous research has demonstrated that stereotypes about personal responsibility and dangerousness predict stigmatising behaviour towards peers with depression (Corrigan et al., 2007; Swords et al., 2011a). Stereotypes about the contagion of low mood, along with social and disciplinary consequences of befriending a peer with ADHD were found to be important in justifying exclusion in the present study. Future research should statistically test whether these cognitions predict stigmatising behaviour. In particular, the finding that contagion was a concern in response to the peer with depression and not ADHD is worthy of future research, especially as (a) depression is a risk factor in predicting self-harm and suicide; (b) young people are the greatest at risk group of self-harm and suicide (Agency for Health Care Policy and Research, 1999); (c) and young people report peers as valuable sources of support when distressed (Hennessy & Heary, 2009; Headstrong, 2012; Sullivan, Arensman, Keeley, Corcoran, & Perry, 2004).

As mentioned earlier, only subtle gender and age differences emerged in the findings of this study, which may be a function of the qualitative approach employed. Given that the SDT research, that is analysed quantitatively, consistently reveals age and gender related patterns in young people’s social reasoning about exclusion, future research should quantitatively explore reasoning about exclusion involving peers with disorders. Cross-sectional research using similar age and gender groups to those used in the present study
would shed light on whether the findings observed were a function of the method used or specific to the exclusion of peers with mental health disorders. Research should also explore the statistical strength of differences in young people’s evaluations of the legitimacy of exclusion of peers with mental health disorders across both the context of exclusion (dyad and group) and disorder (ADHD and depression). Furthermore, it is important to note that ADHD and depression are not the only mental health conditions that persist in childhood and adolescence, this research could be modified to explore social reasoning about the exclusion of peers with other common mental health problems, such as conduct disorder, anxiety, or phobic disorders.

Conceptual models on participants’ evaluations of exclusion of peers with mental health disorders and participants’ beliefs about why such peers are excluded were developed. Through further development and empirical testing both have potential to advance our understanding of peer stigma towards children and adolescents with mental disorders. Given the comprehensive detail involved in the Evaluations of the Legitimacy of Exclusion Model, and the overlap between this model and the Friendships Expectations Model, it is reasonable to hypothesise that the former model might provide a good model for predicting acceptance of peers with disorders. Thus, to obtain an inclusive understanding about the factors involved in determining social acceptance of peers with mental health disorders, the utility of the Evaluations of the Legitimacy of Exclusion Model should be quantitatively explored using Structural Equation Modelling techniques. Given that much research suggests that the degree of stigma projected against people with mental health problems hinges on the age and gender of the perceiver, beliefs about friendship expectations, attribution beliefs and personal duties to help and care for one’s peers may be useful mediating variables in a model of acceptance. To date, research has only explored Attribution models of acceptance of peers with ADHD and depression in childhood and adolescence (e.g. Corrigan et al., 2007; Swords et al.,
Chapter 13: Discussion (Study Two)

2011a). Perceived responsibility for the target peer’s disorders were key latent variables in both studies. While both studies found that beliefs about responsibility were important in predicting acceptance, these authors recommend that the models should be expanded or compared against other competing or novel models. It is possible that the Evaluations of the Legitimacy of Exclusion Model may be a useful alternative, or complementary, model to attribution accounts of acceptance. In addition, researchers should systematically compare the effectiveness of both Attribution Models and the Evaluations of the Legitimacy of Exclusion Model. Finally as mentioned above, the stereotypes about peers with disorders should be incorporated into scales that specifically assess attitudes towards peers with ADHD and depression. Research that draw on the findings of this study will offer a novel perspective on mental disorder stigma in childhood and in adolescence.

13.7 Summary & Conclusion

This is the first study to provide an insight into why children and adolescents with ADHD and depression are excluded, from the perspectives of their peers. The results suggested that befriending a peer with a mental health problem is challenging, as the symptoms of mental disorders potentially transgress expectations that young people have of their friends. While children and adolescents can provide a variety of reasons for why a peer with ADHD or depression might be excluded, in both a dyadic and group contexts, participants did not unanimously condone exclusion. Assessing perceptions of fairness of exclusion showed that exclusion decisions are not straightforward. The complexity of exclusion calls one into question the complex relationship between self-reported responses and actual behaviour. In a real-life context, when faced with an inclusion decision regarding a peer with a mental health disorder, would beliefs about fairness and inclusion offered by those who condemned exclusion be over-rided by the many reasons they provided to explain why exclusion
occurred? The present study has advanced our knowledge on discrimination towards peers with mental disorders in childhood and adolescence; however, more comprehensive research on this topic is warranted.
Chapter 14: General Discussion

14.1 Aim of Chapter

The aim of this chapter is to reflect on the overall findings of Study One and Study Two of this body of research. A general discussion on how this research has advanced knowledge on stigma towards peers with mental disorders in childhood and adolescence will be presented. In addition, the implications of the findings to inform theory and suggestions for interventions to improve acceptance of peers with mental health disorders will be discussed.

14.2 The Contribution of this Body of Research to the Literature

Young people’s perceptions of peers with mental health problems have become a prime research agenda for many stigma researchers (e.g. Hennessy, Heary, Swords, Hinshaw, Jorm and colleagues). The rationale for this growing body of research is that, understanding majority youths’ cognitive, emotional, and behavioural responses towards peers with disorders, as well as their understanding of mental illness will provide valuable knowledge on the processes involved in stigma and how to tackle it. In line with this rationale, the present body of research makes an original contribution to the literature in a number of ways.

Overall, this body of research aimed to enhance our general understanding of stigma towards peers with ADHD and depression in childhood and adolescence. By incorporating qualitative and quantitative approaches this body of research embraced the value of both methodologies as independent and complementary approaches for enhancing knowledge on stigma. While under the umbrella of stigma, both studies were designed and conducted as two separate pieces of research. Furthermore, the contrasting types of measures: an implicit attitude task, self-report questionnaire, and group interviews produced three very different types of data, each telling a unique story about peer stigma. However, general comparisons
and conclusions can be made by exploring trends in disorder, age, and gender related findings.

The findings provided an insight into the unique and shared ways in which children and adolescents with externalising and internalising disorders are stigmatised by their peers. Firstly, Study One showed that peers with ADHD and depression are consistently perceived more negatively than peers without disorders. The findings from Study Two, relating to participants’ reasoning about exclusion provides contextual information about young people’s understanding of these peers’ symptoms and what type of symptomatic behaviour is as acceptable or objectionable. For example, the potential for a peer with depression to bring down the mood of others and his or her apparent lack of input into group and dyads may explain why such peers are viewed unfavourably compared to a peer without a disorder. While the peer with ADHD may be perceived more negatively than a peer without a disorder because of the social and disciplinary consequences he or she imposes on others. Thus, young people’s beliefs about the target peers provide valuable information for explaining why these individuals have a difficult time within the peer group.

Another robust finding was that the peer with ADHD was explicitly evaluated more negatively than the peer with depression on most measures. While main effects were observed for the type of mental health disorder across most explicit variables in Study One, of note, however, was the absence of a main effect for mental health disorder on implicit attitudes. Peers with ADHD were not implicitly perceived more negatively than peers with depression. The findings from Study Two suggested that peer approval might be more difficult for young people with ADHD. Specifically, most participants viewed exclusion of the peer with ADHD from a group activity as fair, while a similar trend was not found in response to exclusion of a peer with depression. When pitted against the implicit results, the self-reported data suggest that participants, except adolescent girls, engage in more controlled
responses when evaluating a peer with depression and are less inhibited to provide socially desirable responses about peers with ADHD. Gawronski and deHouwer (in press) suggest that implicit attitudes are better predictors of spontaneous behaviour. Thus, in ‘real’ peer environments young people may be more cruel to peers with ADHD, however, in contexts where exclusion decisions or evaluations of peers with depression are made spontaneously or under time pressurized conditions, this peer may experience similarly negative peer interactions. Overall, these findings suggest that children and adolescents with ADHD are likely to face more resistance gaining acceptance from their peers and concurrently experience more negative peer experiences than those with depression or without disorders.

A common thread emerged between the two studies in relation to responsibility stereotypes. Study One found that, compared to the peer with depression, the peer with ADHD was perceived as significantly more personally responsible for his or her behaviour. Study Two noted that participants discussed responsibility attributions when evaluating the exclusion of the peer with ADHD more than when evaluating exclusion of the peer with depression. Specifically, participants highlighted that fairness of exclusion hinged on whether the peer’s behaviour was intentional or not. Overall, these findings suggest that responsibility stereotypes may be more important in determining stigma towards peers with ADHD compared to depression.

Study One highlighted the value of utilising explicit measures and an implicit measure to assess perceptions of peers with mental disorders. Specifically, the unique gender and mental health disorder interaction, whereby adolescent males exhibited a strong negative implicit attitude towards the peer with depression, is noteworthy. A similar trend was not observed on the explicit measure, thus, indicating that the data resulting from both implicit and explicit measures depicted a divergent story about how young males react to peers with depression. These findings suggest that adolescent males are motivated to control actual
explicit perceptions of peers with depression and provide more socially desirable perceptions instead. The absence of obvious gender differences, particularly in relation to males’ perceptions of depression, in the data from Study Two, provides further strength to the claim that adolescents’ males are perhaps motivated to control evaluations of such peers.

The implicit findings showed that adolescent females had a positive implicit attitude towards the peer with depression. In contrast, the qualitative findings suggested that compared to males, females, and in particular adolescent girls, criticised the social deficits exhibited by the peer with depression, and discussed how she would fail to meet reciprocal expectations. Furthermore, when evaluating exclusion, adolescent girls emphasised the wrongfulness of exclusion because of the potential negative mental health consequences with might incur on the victim. Analysing these findings provides a notably disjointed picture of how females perceive peers with depression. However, one interpretation to settle these findings is that while girls openly acknowledge that the quality of friendship with peers with depression might be hampered by the peer’s symptoms, they believe that such peers should be supported, and thus do not evaluate them negatively. Thus, because adolescent girls are not socially motivated to control their attitudes towards peers with depression, in open discussions, they do not self-censor their responses. One possible consequence of this is that, in open discussions, they speak about the negative aspects of peers with depression, which might be censored by individuals who are motivated to control responses.

A possible reconciliation of the findings that gender differences emerged as important in the quantitative, but not in the qualitative study, might be attributed to fundamental differences between the two approaches. For example, qualitative research by MacLean and colleagues (2010) found only very subtle gender differences in the meaning or consequences children and adolescents attributed to psychological symptoms or the act of symptom reporting. The authors noted that these findings stood in sharp contrast to the plethora of
quantitative research that indicates that females report more psychological symptoms than males. MacLean and colleagues thus concluded, that the public environment created within group interviews compared to the private setting in which questionnaire research is conducted, and differences in the degree to which male and females self-censor, may explain this finding. Specifically, they suggested that participants’ willingness to engage in gender specific responses may depend on how public or intimate the context is. Thus, the differences in intimacy of the environments created within the group interviews, questionnaire, and implicit settings may account for the divergence in gender patterns across the two studies.

In Study Two, differences in responses across the two age groups were less clear than disparities in views about the target peers or between the gender groups. Again, this may be a function of the qualitative approach. However, a notable difference to emerge was the finding that younger children appeared to be more concerned with the adverse disciplinary consequences of including the peer with ADHD, while adolescents focused on the social consequences of accepting this peer. In a similar vein, the findings from Study One showed that, compared to younger children, adolescents wanted less social interaction with both peers, however, felt more relaxed working at a closer proximity to these peers in a school context. While the findings from Study One were not disorder specific, a similar thread prevailed through both studies. In adolescence, individuals with disorders are excluded because of the social implications of acceptance; he or she might disrupt normative peer functioning. While in childhood, peers with disorders are rejected because of the threat they pose to others in academic contexts; he or she might cause them to get in trouble. Together, these findings support previous research that highlights that normative peer group functioning is paramount in adolescence (e.g. Horn, 2003).

While only tentative comparisons can be made between the two studies, as the research questions relating to the studies were fundamentally different, the findings showed
that different research settings (implicit, private explicit, and group explicit) produce different accounts of stigma. Indeed, this is not to argue, for example, that the findings from the implicit measure are more, or less, true than the questionnaire or group interviews. Nor, are the collective quantitative results more, or less, valid that the qualitative findings. Instead, the empirical worth of the information obtained from both studies is equally valued. Study One provided a systematic insight into the shared and unique ways in which boy and girls explicitly and implicitly perceive peers with ADHD and depression in childhood and adolescence. Specifically, this study bridged important methodological limitations of the existing literature and highlights the importance of assessing both implicit and explicit evaluations of peers with mental disorders to gain a comprehensive perspective of stigma. Study Two highlighted the ways in which children collectively and interactively negotiate about social exclusion involving peers with mental disorders. In doing so, it provided a novel insight into mental disorder stigma, as it exists in childhood and adolescence, which has not been offered by previous research. This information provides educators and researchers an insight into why peers with mental disorders are excluded, and thus can inform practical initiatives to help facilitate acceptance of these peers.

14.2.1 Theoretical & Empirical Implications of the Current Findings

The present body of research makes a number of theoretical contributions to the mental disorder stigma literature. The primary conceptual advance of Study One was that it is the first study to comprehensively assess all known explicit and implicit aspects of stigma and explore differences across demographic variables and internalising versus externalising disorders. In doing so, the findings showed that perceptions of peers with disorders varied depending on the aspect of stigma assessed. These findings support theoretical claims (Hinshaw, 2007; Link & Phelan, 2001) and other empirical evidence for a multi-dimensional
conceptualisation of stigma (Corrigan et al., 2007; Jorm & Wright, 2008; Reavley & Jorm, 2011a, b; Watson et al., 2005; Wolf, et al., 1996). Furthermore, the findings showed different patterns of explicit and implicit responses towards peers with depression and ADHD, highlighting that findings pertaining to the stigmatisation of particular mental health disorders cannot be generalised to other disorders. Thus, it is important to develop an understanding of stigma towards specific disorders.

The finding that the nature and extent of stigma also varies depending on demographic variables adds to our understanding that age and gender differences do exist in perceptions of peers with disorders. However, the differences between demographic groups are not straightforward and generally depend on interplay between the target disorder and the aspect of stigma being studied. Overall, Study One highlighted the complexity of stigma and need for comprehensive assessments to advance knowledge of this phenomenon in childhood and adolescence.

The findings from Study One also add to our theoretical understanding of the development of implicit attitudes. The differences in patterns of explicit and implicit responses support the dual-process theory of social cognition (Fazio, 1990; Fazio & Towles-Schwen, 1999; Schuette & Fazio, 1995; Chapter 3 section 4.3.2). However, the pattern of responses found on the implicit measure did not conform to the general trend found in the developmental literature on implicit attitudes towards racial outgroup peers. Research on implicit attitudes towards racial outgroups tends to show stability in the strength of attitudes from 6 to 10 years of age and into adulthood (Baron & Banaji, 2006; Dunham, et al., 2006). While implicit attitudes in Study One remained relatively stable across the two age groups, the finding that implicit attitudes towards peers with depression changed as a function of gender from childhood to adolescence, proposes that the development of implicit attitudes towards peers with mental health problems is unique, compared to the development of
implicit evaluations towards racial outgroups. Indeed, as this was the first study to explore implicit attitudes towards peers described as having ADHD or depression, further research is needed to substantiate these findings.

In Study One, no significant differences emerged in perceived dangerousness of the target peers with mental health disorders or between groups. Also, scores on this measure indicated that participants mostly disagreed with the statement that the peers with disorders were dangerous. Furthermore, in Study Two beliefs about dangerousness did not emerge in the discussions about why the target peers were excluded. Together, these suggest that dangerousness attributions may not be relevant cognitions in stigma towards peers with ADHD or depression in childhood or adolescence. While other research has found that this attribution predicts avoidance of peers with depression (Corrigan et al., 2007) and the strength of such beliefs varies upon age and demographic variables (Reavley & Jorm 2008); such research typically targeted older adolescents or adults and used mental disorders, such as schizophrenia or personality disorder (Angermeyer & Matschinger, 2003; Corrigan et al., 2001; Jorm & Wright, 2008). To ensure that all potentially important stigma constructs are assessed, Jorm and Wright (2008) stress the need to systematically develop quantitative stigma items from the findings of qualitative research. The findings from Study Two highlight numerous cognitions, such as beliefs that depression is contagious, peers with depression are boring, peers with ADHD are bold, and befriending a peer with ADHD will ruin one’s social reputation, that should be incorporated into quantitative stigma research. These findings also demonstrate the importance of investigating social cognition in childhood and not assuming that stigma cognitions that exist in adulthood can be reliably applied to younger cohorts.

The findings of Study Two contribute to both the mental disorder stigma and intergroup literature by providing an insight into why children and adolescents may not want
to befriend a peer with a mental health disorder and consequently exclude them. This study highlighted the value of applying developmental theory, such as SDT to mental disorder stigma research. This study demonstrated that when evaluating exclusion, children and adolescents employ moral reasoning to condemn exclusion, but social conventional reasons and psychological reasons to condone exclusion of these peers. Tentatively, these findings demonstrate that young people reason about exclusion of peers with disorders in a similar manner to how they reason about other outgroup peers (Killen & Stangor, 2001; Horn, 2006; Park & Killen, 2010). Furthermore, when discussing why exclusion occurred, participants largely spoke about the social conventions or expectations that they construct for their friendships. However, they not only spoke about the importance of symptoms of depression and ADHD in determining exclusion, but also the consequences of symptoms in the context of young people’s friendship expectations to explain exclusion. In addition, findings that attribution beliefs about responsibility were important in shaping evaluations on the legitimacy of exclusion highlight that mental disorder stigma theory and developmental stigma theories can complement and inform one another. Thus, it is important for mental health stigma researchers and developmental and social psychologists to adopt theories and methods used within one another’s research area and engage in active collaboration. Specifically, the novel findings that emerged in this research may be particularly fruitful in influencing the development of anti-stigma interventions (see section 14.2.2 below).

While the attribution of responsibility appeared to be important in both Study One and Study Two, one has to question whether beliefs about responsibility and subsequent acceptance are uni-dimensional or whether children who are disliked are perceived as being more responsible for their behaviour? It is possible that beliefs about responsibility may be more important as mediating factors in determining stigma. The rationale for this is influenced by work by Hymel (1986) that investigated children’s perceptions of disliked and
popular peers in a variety of positive and negative hypothetical scenarios. The findings showed that, compared to peers who were popular, disliked peers were evaluated as more responsible for their behaviour. In their review of the literature, Juvonen and Weiner (1993, pp.330-331) conclude,

“It seems that once a classmate is considered unpopular, the actions of the peer are interpreted in ways that further promote negative reactions and maintain negative expectations, particularly because of views that the action was carried out intentionally”.

The findings of this body of research have made numerous theoretical contributions to the literature. However, the original design and methodological approaches adopted in both studies ensures that subsequent research to improve the measures (e.g. the IAT) and replicate the findings is essential.

14.2.2 Practical Implications

Stigma researchers unanimously agree that anti-stigma interventions in childhood and adolescence are necessary to not only facilitate acceptance of people with disorders and improve their outcomes, but also to improve attitudes towards mental health in general and educate the public about mental illness, so that people will seek early and appropriate mental intervention upon experiencing a mental health difficulty. This section will provide an overview of the applicability of the findings from the present research programme to the development of anti-stigma interventions. General recommendations about how the present findings can inform stigma interventions, regardless of the intervention strategy employed, will be presented. In addition, a discussion on the applicability of the current findings to a selection of education, contact, and media based interventions are considered. It is important to note, however, that the following discussion is not an exhaustive account of possible
strategies that should be investigated when designing anti-stigma interventions. For example, notably absent here are interventions that aim to address stigmatising messages that may be communicated to children and adolescents from significant adults through direct and indirect communication, as well as through discourse and teachings about mental health (e.g. Aboud, 2002). Furthermore, interventions based on bystander principles that empower young people to challenge discrimination in the classroom and playground so that social norms of intolerance of discrimination and inequality are created (e.g. see Aboud & Joong, 2007), as well as community based participatory interventions that aim to address stigma from a grass-root approach (e.g. see Corrigan & Shapiro, 2010 for a discussion) are also worthy of consideration.

The results of the present study provide some valuable information for the development of interventions. Firstly, the findings from Study One suggest that while children do not report overly negative explicit attitudes and behaviour towards peers with ADHD or depression, when compared to a peer without a mental health disorder, they are perceived more negatively. Furthermore, the implicit measure also showed that most participant groups implicitly evaluated such peers more negatively than the peer without a disorder. These findings imply that young people with mental health disorders may experience more negative interactions with their peers. While Study Two did not compare responses towards a peer with a disorder and a peer without a disorder, the findings highlighted may concerns that young people have about befriending peers with ADHD or depression. Overall, the findings suggest that implementing anti-stigma interventions with children and adolescents is advisable.

While designing anti-stigma interventions is recommended, the findings from this research also raise pertinent issues that need to be considered when developing and implementing such interventions. Study One, and to a lesser extent Study Two, demonstrated
that responses to and perceptions of the target peers varied as per participants’ age and gender. Thus, when developing interventions for young people, children and adolescents, and boys and girls, should not be perceived as homogeneous groups. It is possible that generic programmes for young people may not work in the same manner across age and gender groups. Given the differences found in responses across participants groups in the present study, the effectiveness of anti-stigma interventions should be monitored within age and gender groups.

In addition, the findings from both studies highlight that, as mental health disorders, ADHD and depression are not perceived as a homogenous entity. Instead, clear differences were consistently observed in how young people responded to the target peers when either externalising or internalising behaviour was the focus of the vignette. These findings suggest that disorder specific programmes may be necessary to reduce stigma, and thus should be considered when designing interventions. Generic interventions that target mental disorders as a homogenous entity are likely to fail to change unique stigmatising responses associated with ADHD and depression and only serve to limit our understanding on how to tackle stigma. It is also important to reiterate that the present research only explored responses towards same gender peers; thus, it is possible that other considerations may need to be adhered to when developing interventions towards different sex peers with mental disorders.

The findings also provide valuable information about issues that should be targeted or addressed in intervention research. Of particular concern is adolescent males’ negative implicit attitude towards the peer with depression. As stated earlier, adolescent males’ negative implicit evaluations of depression could possibly influence the type of support they provide to peers experiencing low mood, or prevent them from seeking appropriate help following the onset of depression. When these possibilities are considered in the context that young males are more likely to die by suicide than females, improving attitudes towards
depression among members of this group is a priority. Specifically, the notable difference between adolescent boys and girls' implicit attitudes towards the peer with depression suggests that interventions tailored to improve male attitudes towards depression may be necessary.

While tailored interventions that target specific age and gender groups and focus on particular disorders appear to be necessary, this is not always logistically or financially feasible. Although differences across the participant groups were observed in both studies, the findings from Study Two showed that many common misconceptions about ADHD and depression, and similar concerns about including peers with these conditions, prevailed across all age and gender groups. For example, while the reasons participants gave for excluding a peer with depression or ADHD were notably different, the common theme that peers with such disorders would fail to be a good companion was observed in response to both disorders. Furthermore, beliefs about responsibility appeared to influence the acceptability of exclusion of the target peer. Thus, where tailored interventions are not practicable, it reasonable to suggest that all young people may benefit, albeit to varying degrees, from generic anti-stigma interventions that strive to enhance acceptance of diversity and integration of peers with disorders.

When designing programmes, the type of intervention, for example, whether it is education focused or contact-based, should receive much consideration. The findings from this thesis suggest that educating young people about ADHD and depression might be a productive approach. For example, Study One showed that the peers with disorders were feared more than the comparative peer without a disorder. Also, the peer with ADHD was perceived to be more personally responsible for his or her behaviour than the peer with depression. Study Two highlighted misconceptions that the low mood exhibited by peer with depression was contagious, and that the peer with ADHD was bold. Furthermore, beliefs
about personal responsibility for the target peers’ disordered behaviour also appeared to be important in determining exclusion. These findings imply that educating children and adolescents about ADHD and depression might decrease fears about contagion and beliefs that peers with disorders are responsible for their conditions, which in turn might improve attitudes and behaviour towards them. However, education based interventions highlight that attitude and behaviour change is not that simplistic.

In general, education-based strategies find improvements in attitudes immediately post-intervention (Ng & Chan, 2002; Schulze et al., 2003; Watson et al., 2004; Williams & Pew, 2007), however, behaviour is most resistant to change (Economou et al., 2011; Pinfold et al., 2003; Schulze et al., 2003). It is now acknowledged that educational only interventions sometimes produce positive changes in stereotypes and prejudice, but do not reliably predict behaviour (Schachter et al., 2008). Thus, while the findings from the present body of research show that misconceptions about ADHD and depression are commonplace, it is unlikely that education alone is sufficient to induce lasting and meaningful decreases in stigma.

The findings showed that participants were less willing to engage in interactions with, or befriend, the peers with disorders compared to the peer without a mental health disorder (Study One). Concerns that accepting the target peer would induce unwelcome emotional or disciplinary consequences, or that he or she would fail to meet the reciprocal expectations that young people apply to their friendships, were also found to explain exclusion of these peers. These findings further complicate understanding of stigma and the development of concurrent interventions. While educating children and adolescents may bring about changes in specific attitudes about responsibility or contagion, it is reasonable to suggest that education alone is unlikely to induce more positive attitudes and behaviour towards such peers, especially when considered in the context of friendship expectations and consequences. Instead, as suggested by Schachter et al., (2007), contact-based interventions
may be more successful at facilitating acceptance of such peers. One possible means of inducing contact with peers with ADHD or depression is through video interventions, during which participants are shown a realistic depiction of a peer with a target disorder. Previous research has shown that educational programmes with a video-based contact element produced significant improvements in post treatment attitudes and behaviour towards target individuals with disorders among adolescents (Chan, Mak, & Law, 2009; Stuart, 2006). Drawing on the findings of the present research, depictions of the target characters interacting with peers in both social and academic contexts would be a useful strategy to introduce participants to potential positive aspects of befriending such peers. In particular, the target peer’s strengths and individual qualities, and not simply behavioural deficits or excesses, should be portrayed. Thus, adapting existing video-based interventions to depict peers with ADHD and depression might be a fruitful avenue of research.

Indirect contact interventions are another pragmatic means of reducing stigma, which could be adapted to improve perceptions of peers with ADHD or depression. These interventions are thought to be especially useful when the possibility of actual contact is low (e.g. Cameron & Rutland, 2006; Feddes, Noack, & Rutland, 2009), as they do not depend on personal experience of contact with the target individual or group. Instead, they hinge on either awareness that others, similar to them, have contact with the target individual or group, or stimulating hypothetical scenarios involving the participant and target individual or group. Research has shown that school-based extended contact (learning that a member of your own group is friends with a member of an outgroup) or imagined contact (imagining interactions with an outgroup member) interventions been successful in promoting positive attitudes and behaviour towards hypothetical peers with disabilities (Cameron & Rutland, 2006; Cameron, Rutland, & Brown, 2007; Cameron, Rutland, Turner, Holman-Nicolas, & Powell, 2011). For example, in an imagined contact intervention with 5 to 10-year-olds, Cameron and colleagues
(2011) found that asking children to imagine spending time playing and having fun with a disabled peer immediately improved friendship intentions, perceptions of warmth and competence, and general attitudes towards a physically disabled peer. The use of vignettes in this type of research ensures that the methodological approach adopted in the present research could be easily adapted to such interventions. One possible means of doing this is to expand the vignettes used in the present body of research, so that they do not primarily focus on the expression of the target disorders, but also depict the characters within positive interactions with peers without disorders, in social or academic contexts. Consistent with the approach adopted in Cameron and colleagues study, another potentially successful approach is to stimulate imagined contact between the participants and the target vignette characters with ADHD or depression.

While indirect contact interventions appear to be useful and can be readily modified to target peers with mental disorders, it is important to note that such interventions are more successful when participants do not have any contact with the target group (Cameron & Rutland, 2008; Feddes et al., 2009; Turner, Crisp, & Lambert, 2007; Cameron et al., 2011). Therefore, similar interventions may be more useful in early childhood where contact with peers with mental health disorders may be more unlikely. Comprehensive research on the effectiveness of contact-based interventions to reduce mental health stigma is a priority, especially as imagined or extended contact intervention could be designed to target beliefs about friendship expectations involving peers with mental health disorders.

The findings of Study One demonstrated the need to measure implicit and explicit attitudes to understand young people’s perceptions of peers with mental disorders. The differences found in patterns of responses across the measures stresses the need for intervention to assess changes in both explicit and implicit perceptions. Only one study has explored the utility of a video-based intervention to improve implicit attitudes. Saporito and
colleagues (2011) found that a video-contact education intervention, featuring a male peer with a dual diagnosis of ADHD and depression, improved explicit responses toward general mental illness, but not implicit attitudes. Thus, while video-based interventions may be effective in improving self-reported attitudes and behaviour towards peers with mental health disorders, negative implicit attitudes may be more difficult to change. However, it is reasonable to hypothesise that a contact-based intervention is still likely to be the most productive approach to tackle implicit attitudes. For example, research exploring the influence of contact on perceptions of racial outgroup peers has shown that children who reported having cross-race friends with South East Asian children exhibited more positive implicit attitudes towards these peers (Turner, Voci, & Hewstone, 2007). Thus, in-vivo contact, or perhaps indirect contact, may be necessary to observe improvements in implicit perceptions.

The findings of Study Two demonstrate the pivotal role different types of social reasoning have on perceptions of discrimination towards peers with mental health disorders. It is possible that contact-based interventions may also promote moral reasoning about exclusion of peers with disorders, which in turn may reduce stereotypes and facilitate inclusion. While specific interventions have not tested this hypothesis, research shows that children and adolescents who have contact with racial outgroup peers are more likely to view exclusion of these peers as wrong and use less racial stereotypes in their discussions about exclusion (Crystal, Killen, & Ruck, 2008; Killen et al., 2010). Thus, the effectiveness of anti-stigma interventions should not only be assessed by attitude and behaviour change, as measured by explicit and implicit stigma assessments, but also by exploring changes in social reasoning about exclusion of peers with disorders.

Mass media campaigns involving indirect contact and education elements are another strategy that can be employed to reduce mental disorder stigma. Such campaigns are
relatively cheap, compared to contact and education interventions, and reach wider audiences, so that they potentially induce population-level change, thus making them popular with governmental agencies. Campaigns with a focus on recovery or an emphasis on the person and not the diagnosis have been shown to be more effective (Clement, Jarrett, Henderson, & Thornicroft, 2010). However, few campaigns target children and adolescents, an exception to this in the Irish context is the ‘let someone know campaign’, which was specifically aimed at encouraging adolescent boys to seek help when distressed (Let Someone Know, 2009). An evaluation of this campaign was either not conducted or the data are not publically available, thus, limiting our knowledge on the effectiveness of adolescent mass media campaigns. Corrigan (2012) depicts a similar picture of mass media campaigns in the US, expressing concern that very few studies evaluating effectiveness have appeared in peer-reviewed journals. One of the few evaluations of a local UK media campaign aimed at adults showed improvements in mental health literacy, but not improvements in attitudes or behaviour (Evans-Lack, London, Little, Henderson, & Thornicroft, 2010). While mass media campaign may be useful, the present body of research highlighted that stigma is highly complex, thus, more interactive and sophisticated interventions may be successful at tackling this problem.

The present body of research suggests that misconceptions about mental health disorders prevail and that young people are not only concerned about the social consequences of befriending a peer with a disorder, but also the quality of the friendship they might have with this peer. Considering these findings and drawing on the evidence for the efficacy of education-contact based interventions, it is reasonable to hypothesise that education-contact based interventions will be effective at reducing stigma towards peers with ADHD and depression. However, only tentative inferences about such interventions can be suggested, as at present, limited efforts have been made within the scientific community to research the
effectiveness of child and adolescent focused anti-stigma interventions (see Sakellari, Leino-Kilpi, & Kalokerinou-Anagnostopoulou, 2011 for a review). Drawing on the finding of the present research, future research should consider the development of tailored interventions, for specific participant groups, that focus on target mental health disorders. When this is not possible, the efficacy of generic interventions should be assessed across age and gender groups.

14.3 Summary & Conclusions
Positive social experiences with peers are important to facilitate the attainment of many developmental outcomes in childhood and adolescence. Thus, to be accepted by one’s peers is a significant developmental goal for all children. Unfortunately, not all young people are accepted and, in particular, those with mental health problems often struggle to gain social approval. The efforts made throughout this body of research to advance knowledge on children and adolescents’ perceptions peers with of mental health disorders shows that while individuals with ADHD or depression are perceived more negatively than individuals without disorders, they are not unanimously devalued. Instead, the extent of negativity projected towards peers with mental health disorders depends on the type of condition they have, as well as the gender and age of the perceiver. From a methodological perspective, the nature of responses also hinges on how stigma is assessed. The findings pertaining to exclusion of these peers suggests that children and adolescents do not perceive all forms of exclusion as fair, instead exclusion depends on multiple factors, including attitudes and beliefs about the target condition, friendship obligations and expectations. The findings that young people believe exclusion of these peers occurs because of the risks the target peers pose to others, and the consequences of the social deficits associated with their disorder on friendship quality, provided an invaluable insight into this social phenomenon.
The present research has addressed some important empirical gaps in the mental disorder stigma literature and has provided foundational knowledge on social reasoning about discrimination towards peers with ADHD and depression. The findings from the explicit and implicit stigma measures highlighted the complexity of mental health disorder stigma and importance of using both explicit and implicit assessments. Deviating from traditional assessments of mental health disorder stigma, Study Two provided a novel insight into why these peers are victims of exclusion. It is hoped that the information obtained from both studies will be used to inform anti-stigma interventions, while the methods employed in Study One will be used in future exploratory and intervention research. However, our knowledge on mental health disorder stigma in childhood and adolescence is far from complete; thus, this thesis stresses the need for continuous efforts to be made to understand and facilitate the acceptance of children and adolescents with mental health disorders.
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Appendix A: Publication pertaining to this thesis.


The definitive version is available at [www.blackwell-synergy.com](http://www.blackwell-synergy.com)
Explicit and implicit stigma towards peers with mental health problems

Running Head: Explicit and implicit stigma towards peers with mental health problems

Explicit and implicit stigma towards peers with mental health problems in childhood and adolescence

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Explicit and implicit stigma towards peers with mental health problems

**Background:** Children and adolescents with mental health problems are widely reported to have problems with peer relationships, however, few studies have explored the way in which these children are regarded by their peers. For example, little is known about the nature of peer stigmatization and no published research has investigated implicit attitudes thus ensuring that stigma is not well understood. In order to address this issue the current study explored patterns of explicit and implicit stigmatization of peers with depression and attention deficit hyperactivity disorder (ADHD). **Methods:** The sample was 385 children ($M = 10.21$ years) and adolescents ($M = 15.36$ years). Participants completed a questionnaire assessing explicit stigma towards an age and gender matched peer with ADHD or depression and another peer with ‘normal issues’ who were described in vignettes. They also completed a modified version of the Implicit Association Test (IAT) that explored implicit attitudes towards the target peers. **Results:** Questionnaire data indicated that the peer with ADHD was perceived more negatively than the peer with depression on all dimensions of stigma, except perceived dangerousness and fear. In contrast, the IAT findings suggest that some participants had more negative views of the peer with depression than the peer with ADHD. Specifically, the findings demonstrate that adolescent males demonstrated significantly stronger negative implicit evaluations of depression compared to younger males and adolescent females. **Conclusions:** Children and adolescents demonstrate stigmatising responses to peers with common mental health problems. The nature and extent of these responses depends on the type of problem and the type of measurement used. The findings highlight the importance of using both explicit and implicit measures of stigma. **Key words:** Stigma, mental health problems, implicit attitudes, ADHD, depression. **Acronyms:** Implicit Association Test (IAT), Name-behaviour training (NB)
Understanding stigmatization is imperative if people with mental health problems are to enjoy an acceptable quality of life (WHO, 2003). Although few studies have explored peer stigma in childhood and adolescence, the research that exists shows that peer stigmatization is a widespread problem (Walker, Coleman, Lee, Squire, & Friesen, 2008). Research shows that rejected children with emotional and behavioural problems are at risk of experiencing adverse developmental outcomes from educational underachievement and unemployment (Woodward & Fergusson, 2000) to delinquency and problem behaviour (Ladd & Burgess, 2001; Wentzel, 2003), even after controlling for other risk factors and baseline levels of externalising behaviour. As mental health problems persist over time (Kim-Cohen, et al., 2003), people are susceptible to potential lifelong stigmatization, which may have originated in childhood. Consequently, it is imperative that the nature of peer stigma is thoroughly examined.

Stigma is an umbrella term that collectively refers to stereotypes, prejudice and discriminatory behaviour towards people with mental illness (Hinshaw & Stier, 2008). Stereotypes are cognitive schemas or beliefs about members of a social group (Hamilton, Stroessner, & Driscoll, 1994). While stereotypes are cognitive labels, prejudice involves affective laden negative attitudes that influence behaviour towards the stigmatized person or group (Weiner, Perry, & Magnusson, 1988). In the social cognitive literature, prejudice is used as an alternative term for stigma, collectively describing any negative orientation towards an individual or outgroups along the dimensions of negative attitudes, attributions and discriminatory behaviour (see Raabe & Beelmann, 2011). However, acknowledging these concepts as separate entities is essential for researchers to understand the associations between social cognition, emotion and behaviour (Hinshaw, 2007) and how they independently operate in the stigma process. Discrimination involves the differential treatment of one group or individual relative to another, which in childhood is salient in the
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form of peer exclusion (Brown & Bigler, 2005). Stigma also transcends this, with the stigmatized individual internalising this degradation, resulting in self-stigma (Hinshaw, 2005). However, this paper focuses on public stigma; how the affected individual is regarded by others. Stigma is a complex construct that is a challenge to assess empirically, as reflected in the literature where most studies focus on subaspects thus providing an incomplete understanding of the construct.

To overcome the limitations imposed by self-presentation biases implicit measures have been employed in research with adults (e.g. Teachman, Wilson, & Komarvoskaya, 2006; Rüsch, Corrigan, Todd, & Bodenhausen, 2011). Although research with children suggests that implicit attitudes form quickly (Dunham, Baron, & Carey, 2011), are independent of explicit attitudes (Dunham, Baron, & Banaji, 2006) and are predictors of behaviour (Cvencek, Greenwald, Meltzoff, 2011) no published studies have used implicit measures to assess stigmatization of psychological problems in childhood. The absence of such research is probably due to implicit measures reliance on visual representations of the target attitude object. Developing a method to assess implicit mental health attitudes is a challenge as there is no obvious way to provide a visual image to depict a specific disorder and using psychiatric labels is problematic with children who may not be familiar with them. However, the advantages of implicit measures and their potential to further our understanding of stigma warrant efforts to create a developmentally appropriate implicit stigma measure that can be used for mental health problems (Hinshaw, 2005).

Research suggests that age and gender are important factors in determining patterns of stigma. Wahl (2002) noted a developmental increase in negative attitudes and social distance towards mental illness. Recently, research showed that children become more accepting of peers with ADHD and depression with increasing age (Swords, Heary, & Hennessy 2011). However, there was an exception to this trend for boys with depression. Other research
suggests that developmental differences hinge on the assessed dimension of stigma (Jorm & Wright, 2008). Some research shows that females report more positive behavioural and cognitive responses towards peers with disorders (Jorm & Wright, 2008; Williams & Pow, 2007). However, others do not recognise gender as an important factor (Law, Sinclair, & Fraser; 2007; Walker, et al., 2008).

The present study investigates how children and adolescents stigmatize peers with ADHD and depression. These conditions are the most prevalent externalising and internalising disorders in childhood (Lynch, Mills, Daly, & Fitzpatrick, 2006) and therefore most socially relevant to young people. The two developmental cohorts represented in this study were chosen as evidence suggests changes in attitudes and prevalence of disorders from childhood to adolescence (Swords et al., 2011; Lynch et al., 2006). This paper explores the multiple dimensions of explicit stigma: stereotypes, prejudice, and discrimination. Firstly, it examines the hypothesis that the nature and extent of stigma varies across the age and gender of the perceiver and type of mental health problem of the target peer. It then assesses implicit attitudes towards the target peers and tests the hypothesis that implicit attitudes are contingent on the aforementioned participant variables and the target peer’s mental health disorder.

Method

Participants

Participants were 203 children (96 boys and 107 girls) and 182 adolescents (86 boys and 96 girls) in year 7 and 12 of education in primary and post-primary public schools in the Connaught region of the Republic of Ireland ($N=385$). Ages ranged from 10-11 years ($M = 10.21, SD = .72$) and 15-16 years ($M = 15.36, SD = .50$). A proxy measure of participants’ socio-economic status (SES) was calculated from the highest level of education achieved by
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their consenting parent/guardian. Breakdown of SES among participants was approximately 50% low, 30% middle, and 20% high.

(INsert Table 1)

Materials

Strengths & Difficulties Questionnaire (SDQ; Goodman, 1997): All participants completed the self-report SDQ. The SDQ is a 25-item scale comprising of one Prosocial Scale and four problem-specific subscales (Conduct Problems, Peer Problems, Hyperactivity, and Emotional Problems), which can be summed to produce a Total Difficulties Score. This score was dichotomised using recommended cut off scores for ‘normal/borderline’ (≤ 19) versus ‘abnormal’ (≥ 20). Internal reliability for this study was .71. Participants with an ‘abnormal’ score on the SDQ were removed from the analysis to ensure that responses obtained were limited to participants without emotional or behavioural difficulties.

Vignettes: The vignettes described peers with ADHD, depression and a peer with ‘normal issues’ (Appendix A). Psychiatric labels did not accompany the clinical vignettes.

Stereotypes: ‘Responsibility’ and ‘Dangerousness’ were assessed using single items from the revised Attribution Questionnaire (r-AQ; Corrigan et al., 2007). ‘Responsibility’: ‘It is not [Target child’s] fault that he/she acts like this’. ‘Dangerousness’: [Target child] is not dangerous’. Scores ranged from 1-7 and items were coded so that higher scores indicated stronger stereotypes.

Prejudice: Emotional responses to the peers were also assessed using modified r-AQ single items. ‘Anger’: ‘[Target child] would make me angry’. ‘Fear’: ‘I would be scared of [Target Child]’. Score ranged from 1-7 with higher scores indicated more prejudice.
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**Discrimination:** The Shared Activity Questionnaire (SAQ; Morgan, Walker, Bieberich, & Bell, 1996) was used to assess participants’ behavioural intentions to engage in social, academic and recreational activities with the target peer. The SAQ consists of 24 items, and scores range from 24-72. Higher scores indicating greater behavioural intentions to include the target peer activities across the three domains. The SAQ has good internal consistency reliability ($\alpha = .95$). Two indices of social distance were explored: relationship social distance and physical social distance. Relationship social distance was assessed with the Classroom Social Distance Scale (Horace Mann-Lincoln Institute of School Experimentation, 1957). Participants indicated the type of relationship he/she wanted with the peer. Responses ranged from ‘I would like to have [target child] as my best friend’ to ‘I wouldn’t want [target child] in my class’ on a scale of 1-5. Higher scores reflected greater relationship social distance. Physical social distance was assessed with a modified version of Weiss’s (1986) paper-and-pencil projective figure placement test. Participants were presented with a stick image of the peer sitting at a desk and selected a seat where they would feel relaxed working with him/her. Scores ranged from 1 to 7 with higher scores indicating more physical social distance.

**Implicit Attitudes:** A modified Implicit Association Test (IAT; Greenwald, McGhee, & Schwartz, 1998), using the recommendations by Baron and Banaji’s (2006) to use a developmentally appropriate version with children, was used to assess participants’ implicit attitudes. This computer response latency measure is a dichotomous categorisation task that requires participants to sort four types of stimuli into two response buttons. The stimuli are exemplars of two target categories (e.g. mental health condition versus no mental health condition) and two contrasting attribute categories (e.g. good versus bad). The task rests on the assumption that it is easier to sort stimuli from two categories that are associated with one another compared to categories that are not associated. In a typical IAT the stimuli are
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presented as images or labels. To avoid using psychiatric labels and overcome the impossibility of capturing ADHD and depression in an image, the names of the vignette peers were the target stimuli and presented in four different colours. Consistent with the condition that participants were assigned to, participants responded to the names of one of the following combinations of vignettes: ADHD and ‘normal issues’ or depression and ‘normal issues’. The attribute stimuli were chosen to reflect dimensions of stigma: bad (dangerous, scary, guilty, weak) and good (safe, friendly, innocent, strong). All stimuli were presented simultaneously as written and auditory words. Prior to completing the IAT participants were required to sort the attribute stimuli as either good or bad to ensure that valence of the words was understood.

First participants practiced target categorisation (the disordered peer versus the peer with normal issues) with a blue and yellow response button (20 trials). In the second block they practiced attribute categorisation (good versus bad words, 20 trials) using the fore-mentioned response buttons. After this, they completed two combined discrimination blocks during which participants mapped specific combinations of target and attribute stimuli onto the same response button. For example, if Jake (ADHD) or bad words were presented participants pressed the blue response button and when David (normal issues) and good words were presented the yellow response button was pressed (20 practice trials: 40 test trials). Next participants practiced matching names of the peers with the opposite response buttons (20 trials). If Jake (ADHD) was previously paired with the blue response button, the yellow button was pressed when presented with this name. Finally they completed two more combined discrimination blocks whereby the previous pairing of the combined blocks was reversed; for example, David and bad words shared the blue response button and Jake and good words shared the yellow response button (20 practice trials; 40 test trials). A correct response was required before progressing to the next presentation and response latencies
were recorded from the presentation of the stimulus to the correct response. The initial pairing of the names of vignette peers and good/bad words was counterbalanced across participants. The inter-stimulus interval was 300ms. IAT D-scores were calculated using the improved scoring algorithm recommended by Greenwald, Nosek and Banaji (2003). A score of zero indicated a neutral attitude towards both peers, while positive scores indicated a negative evaluation of the peer with the mental health condition.

**Name-Behaviour Training (NBT):** To ensure assessed implicit attitudes were towards the vignette peers and not name preference, a NBT procedure similar to Ranganath & Nosek’s (2008) attitude induction procedure was used. Participants read the vignettes and fourteen named behavioural descriptions on a laptop. They then identified the peers by matching the names and unnamed behavioural descriptions. Ten correct responses were required before completing the IAT.

**Procedure**

Participants were randomly assigned an ADHD or depression condition and provided with one of eight versions of the questionnaire booklet that comprised of the SDQ, two vignettes and a stigma questionnaire. The content of the vignettes differed across the booklet depending on the age and gender of the participant and the condition they were assigned. Specifically, participants read about an age and gender matched peer with ‘normal issues’ and a peer with a mental health disorder, either ADHD or depression. After the questionnaire, participants read the vignettes again and individually completed the NBT and the IAT in a quiet empty room on a laptop. The presentation order of implicit and explicit measures does not affect explicit and implicit mean scores (Nosek, Greenwald, & Banaji, 2005). Participants had written parental consent and verbally assented to take part. Ethical approval was granted for this study by the National University of Ireland, Galway Research Ethics Committee.
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Data analysis

The data were analysed using PASW (SPSS) for Windows version 18. IAT D-scores were analysed using one sample t tests. All measures were analysed with 2x2x2 between subjects factorial ANOVAs with participants’ gender and age and the disorder of the vignette peer as the between group factors while implicit attitudes, explicit stereotypes, prejudice and discrimination were the independent factors. Effect sizes were calculated using partial η² (pη²). Interactions were explored with simple effect F tests.

Results

Preliminary analysis

There were no significant differences between participants’ gender, age or SES across the two experimental conditions (see Table 1). Ten participants obtained ‘abnormal’ Total Difficulties SDQ scores and were subsequently removed from the analysis (n = 375). Paired sample t tests revealed that participants exhibited significantly more positive responses toward the peer with ‘normal issues’ compared to the peers with disorders across all the dependent variables, except perceived responsibility (see Table 2). Explicit findings pertaining to the peer with ‘normal issues’ were excluded from subsequent analysis.

Explicit Stigma

For prejudicial anger, the ANOVA revealed main effects for the disorder described in the vignette [F(1, 367) = 24.60, p < .0001, pη² = .06] and participants’ age [F(1, 367) =17.15, p < 0.001, pη² = .05], which were qualified by a significant disorder by age interaction [F(1, 367) = 5.37, p < 0.05, pη² = .01]. As shown in Table 3 adolescents reported significantly stronger feelings of anger towards the peer with ADHD compared to the peer with depression.
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$[F(1, 371) = 24.06, p < 0.001]$. In comparison to children, adolescents reported more anger towards the peer with ADHD $[F(1, 371) = 21.06 p < 0.001]$.

For relationship social distance, the ANOVA revealed main effects for the vignette disorder $[F(1, 367) = 11.97, p < .001, \eta^2 = .03]$ and participants’ age $[F(1, 367) = 9.00, p < .01, \eta^2 = .03]$, which were superseded by a significant disorder by age by gender interaction $[F(1, 367) = 4.57, p < 0.05, \eta^2 = .01]$. As depicted in Figure 1 greater relationship social distance from the peer with ADHD compared to the peer with depression was reported among adolescent males $[F(1, 367) = 6.06, p < 0.05]$ and adolescent females $[F(1, 367) = 4.78, p < 0.05]$ and 10-11 year old females $[F(1, 367) = 10.11, p < 0.001]$. Among 10-11 year olds, boys reported significantly greater relationship social distance from the peer with depression $[F(1, 367) = 5.18, p < 0.05]$ compared to girls. Furthermore, among males in the ADHD condition, adolescents wanted more relationship social distance compared to children $[F(1, 367) = 12.56, p < 0.001]$. Descriptive statistics for responses on the stigma variables across the participants’ age and gender and the type of disorder depicted in the vignettes are presented in Table 3.

(INsert Figure 1)

(INsert TABLE 2 & 3)

No significant interactions emerged on the other explicit stigma variables ($p > 0.05$). Significant effects for the disorder described in the vignettes were found for physical social distance $[F(1, 367) = 8.90, p < .01, \eta^2 = .03]$, perceived responsibility $[F(1, 367) = 14.1, p < .01, \eta^2 = .04]$ and behavioural intentions $[F(1, 367) = 10.64, p < .01, \eta^2 = .03]$, such that the peer with ADHD was perceived as being more personally responsible for his/her condition and discriminated more than the depressed peer. Significant age effects emerged for physical social distance $[F(1, 367) = 4.97, p < .05 \eta^2 = .01]$ and behavioural intentions
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$[F(1, 367) = 14.14, p < .001, \eta^2 = .04]$ and perceived fear $[F(1, 367) = 7.60, p < .05, \eta^2 = .01]$. Adolescents wanted less physical social distance from the peers but excluded them from activities more. Adolescents also reported being more afraid of the peers compared to younger participants. Significant main effects for gender were found for behavioural intentions $[F(1, 367) = 15.95, p < .001, \eta^2 = .04]$ and perceived responsibility $[F(1, 367) = 6.20, p < .05, \eta^2 = .01]$, such that males were less inclusive of the peers and perceived them as being more responsible for their disorders. All descriptive statistics for the between subject variables on the dimensions of stigma are described in Table 2 above.

Implicit Attitudes

Four participants were excluded from the analysis as more than 10% of response latencies were less than 300ms (Greenwald et al., 2003). A further five did not complete this phase due to other school commitments ($n = 376$). A one way t test revealed that IAT scores significantly differed from zero, indicating that participants displayed negative implicit evaluations of the peers with disorders [$D = .23, SD = 61, t(323) = 6.89, p < 0.001$]. The ANOVA revealed a main effect for participants’ gender $[F(1, 366) = 12.25, p < 0.01, \eta^2 = .03]$ which was qualified by a disorder by age by gender interaction $[F(1, 366) = 4.25, p < 0.05, \eta^2 = .01, \text{Figure 2}]$. Male adolescents’ implicit attitudes towards depression were significantly more negative than comparative implicit responses towards ADHD $[F(1, 358) = 5.62, p < 0.05]$, younger males’ $[F(1, 358) = 8.37, p < 0.01]$ and female adolescents’ implicit attitudes towards the depression $[F(1, 358) = 23.32, p < 0.001]$.

Discussion
This study investigated how children and adolescents stigmatize peers with mental health problems. In doing so, it examined whether the nature of implicit and explicit stigma are contingent upon the type of mental health condition experienced by the target peer and the age and gender of the perceiver.

The explicit results suggest that youth are not as negative towards the peers with disorders as expected. Other research notes similar findings (Watson et al., 2004; Schulze, Richter-Werling, Matschinger, & Angermeyer, 2003), however, in the present study when compared to ‘typical’ peers responses are significantly more negative. This study found that ADHD is more explicitly stigmatized than depression. However, the extent of stigmatization is often dependent on the perceivers’ age and gender or the measure of stigma. Compared to children, adolescents were less accepting and more prejudiced towards both disorders, especially ADHD. This could be explained by adolescents’ preference for social order within the peer group and their tendency to advocate exclusion of peers who might impinge on successful group functioning (Horn, 2003). However, adolescents also reported less physical social distance from the target peers, highlighting that they acutely differentiate between the social consequences of interacting with peers across contexts. The differences noted across the discrimination measures emphasize the importance of assessing multiple dimensions of stigma.

In contrast to previous research, dangerousness stereotypes were not dependent on socio-demographic variables or the type of mental health disorder (Reavley & Jorm, 2011). Differences did emerge for responsibility stereotypes, such that the peer with ADHD was viewed as being more responsible for his/her condition compared to the depressed peer. Consistent with previous research, males believed that the peers were more responsible for their illness (Williams & Pow, 2007). Males were also less accepting of the peers with
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disorders which could be explained by gender norms as boys tend to perceive peer rejection as more acceptable than girls (Killen & Stangor, 2001; Park & Killen, 2010).

This study demonstrated that implicit mental health stereotypes that are free from potentially contaminating labeling effects (Haris, Milich, Corbitt, Hoover, & Brady, 1992) and confounding effect of mental health literacy (Wahl, 2002) can be measured by incorporating a NBT procedure into the IAT. Specifically, this study created a novel way of assessing implicit stereotypes towards peers who are not explicitly labeled as outgroup members but who by nature of their behaviour are perceived as socially deviant. This method is potentially useful for research on implicit cognition towards other ostracised groups such as aggressive peers, or peers with developmental disabilities.

The findings that children, particularly boys, were more positive towards peers with ADHD could be explained by the fact that ADHD is more prevalent among boys in childhood (Agency for Health Care Policy and Research, 1999) and some of the symptoms associated with this condition such as hyperactivity may be more characteristic of the child male gender role. Thus the symptoms associated with ADHD may be perceived as normative behaviours among young boys. Likewise, depression is more prevalent among adolescent girls than adolescent boys or children of either sex (Twenge & Nolen-Hoeksema, 2002) and some symptoms of depression may be more normative behaviours of the female gender role. These factors might explain adolescent females’ neutral implicit evaluation of depression. The implicit results suggest that children and male adolescents are motivated to inhibit their explicit negative evaluations of depression. The difference in negative implicit attitudes towards depression between younger and older males is worthy of consideration as it indicates changes in the acceptability of emotional symptoms from childhood to adolescence. Suicide is the second leading cause of death among male adolescents and depression is a major risk factor (Centre for Disease Control, 2009). In addition, young people report peers
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as vital sources of social support when distressed (Swords, Hennessy, & Heary, 2010). It is possible that negative implicit evaluations of depression could influence the quality of support young male provided to such peers. Research should investigate possible relationships between implicit mental health attitudes and behaviour.

Although this research has addressed important gaps in the stigma literature, the results are in response to hypothetical peers and thus caution must be exercised when generalising the findings. Another limitation of this study is the use of single item measures. While practical, the psychometric properties of these measures may be questionable as they are vulnerable to random measurement error. The discrimination measures utilised in this study were self-report and not actual behaviour. While capturing incidents of peer discrimination in real-life situations is challenging, experimental behavioural techniques that attempt to capture proxy measures of actual behaviour (e.g. Cyberball; Williams, Cheung, & Choi, 2000) should be utilised. Although this study highlighted the important role of gender in the stigma process, this research would be enhanced by exploring implicit and explicit responses towards different sex peers. Future research should also investigate the reasons children provide for excluding peers with mental health problems. This work may expose the cognitive processes involved in discrimination and further our knowledge on the nature of stigma. Finally, an understanding of stigma is incomplete without addressing the internalisation of stigma in affected individuals. Research has explored explicit self stigma in childhood, however, no published studies have assessed implicit self stigma among this group.

Conclusions

This study showed how children and adolescents implicitly and explicitly stigmatize peers with ADHD and depression. Stigma is contingent upon the disorder in question and gender
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and age of the perceiver. The unique patterns of stigma demonstrated by the implicit findings highlights the importance of utilising both implicit and explicit measures. When designing educational and anti-stigma interventions, researchers and practitioners should employ implicit measures and attempt to promote positive implicit and explicit cognitions and associated behaviour.

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Key points

- Few studies have explored the nature of peer stigma and no published research has investigated implicit attitudes.

- This study suggests that children stigmatize peers with ADHD more than depressed peers. The nature of stigma is influenced by the age and gender of the perceiver with older youth and males displaying more explicit stigma. Both disorders are implicitly perceived negatively. However, the negative implicit attitudes towards peers with depression are stronger among older than younger males.

- The results further understanding of explicit stigma and lay foundations for our knowledge of implicit attitudes. Findings provide important information for the development of anti-stigma interventions.
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Table 1 Characteristics of participants in each condition

<table>
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<th></th>
<th>Depression</th>
<th>ADHD</th>
<th>$\chi^2$</th>
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<tr>
<td>Gender</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>88</td>
<td>94</td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>106</td>
<td>97</td>
<td>.57</td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10-11 years</td>
<td>102</td>
<td>101</td>
<td></td>
</tr>
<tr>
<td>15-16 years</td>
<td>92</td>
<td>90</td>
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<td>SES</td>
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<tr>
<td>Low (second level completion only)</td>
<td>75</td>
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</tr>
<tr>
<td>Middle (post-second level diploma or certificate)</td>
<td>52</td>
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<tr>
<td>High (degree or higher)</td>
<td>38</td>
<td>29</td>
<td>3.22</td>
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*Note. A proxy measure of SES is calculated by the highest level of education achieved by the consenting parent*
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<table>
<thead>
<tr>
<th>Table 2</th>
<th>Overall means (standard deviations) for comparative vignettes in both experimental conditions</th>
</tr>
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</table>

<table>
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<tr>
<th>Experimental Condition</th>
<th>Depression</th>
<th>ADHD</th>
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<tbody>
<tr>
<td></td>
<td>Vignette: Depression</td>
<td>Vignette: Normal issues</td>
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<tr>
<td>Stereotypes</td>
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<tr>
<td>Dangerousness</td>
<td>3.28 (2.26)</td>
<td>2.84 (2.30)</td>
</tr>
<tr>
<td>Responsibility</td>
<td>3.67 (2.00)</td>
<td>3.84 (2.00)</td>
</tr>
<tr>
<td>Prejudice</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fear</td>
<td>1.74 (1.10)</td>
<td>1.51 (1.00)</td>
</tr>
<tr>
<td>Anger</td>
<td>2.50 (1.40)</td>
<td>2.17 (1.58)</td>
</tr>
<tr>
<td>Discrimination</td>
<td></td>
<td></td>
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<tr>
<td>Behavioural intentions</td>
<td>52.20 (12.5)</td>
<td>59.66 (10.70)**</td>
</tr>
<tr>
<td>Relationship social distance</td>
<td>2.31 (1.07)</td>
<td>1.56 (0.81)**</td>
</tr>
<tr>
<td>Physical social distance</td>
<td>2.55 (1.77)</td>
<td>1.67 (1.32)**</td>
</tr>
<tr>
<td>Implicit attitudes</td>
<td>0.24 (0.61)</td>
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</table>

*p < 0.05, **p < 0.001
## Table 3

Means (standard deviations) on each stigma variable by mental health condition, age and gender of participants

<table>
<thead>
<tr>
<th></th>
<th>Depression</th>
<th>ADHD</th>
<th>Depression &amp; ADHD</th>
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<tbody>
<tr>
<td></td>
<td>10-11 years</td>
<td>15-16 years</td>
<td>Overall</td>
</tr>
<tr>
<td>Stereotypes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dangerousness</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>2.96 (2.34)</td>
<td>3.72 (2.19)</td>
<td>3.31 (2.28)</td>
</tr>
<tr>
<td>Female</td>
<td>3.00 (2.32)</td>
<td>3.54 (2.16)</td>
<td>3.62 (2.16)</td>
</tr>
<tr>
<td>Overall</td>
<td>2.98 (2.32)</td>
<td>3.62 (2.16)</td>
<td>3.28 (2.26)</td>
</tr>
<tr>
<td>Responsibility</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>3.97 (1.88)</td>
<td>4.00 (1.81)</td>
<td>3.99 (1.83)</td>
</tr>
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### Explicit and implicit stigma towards peers with mental health problems

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Explicit and implicit stigma towards peers with mental health problems

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</table>
Figure 1 Vignette mental health disorder by participants’ age and gender interaction for relationship social distance

Figure 2 Vignette mental health disorder by participants’ age and gender interaction for implicit attitudes.
Appendix C: Vignette Validation Information Letter

Dear _____,

A research team from the School of Psychology, at the National University of Ireland and University College Dublin are currently undertaking research exploring child and adolescents, aged 10-11 and 15-16 years, attitudes and reactions to peers who behave in ways that are associated with ADHD and depression.

We hope to present participants with vignettes describing children with ADHD and depression. The participants will then be asked to answer questions on how they would react to the child, how the child makes them feel and their attitudes towards the child. They will also be asked to complete a computer based implicit attitude measure. As our research hinges on the depiction of ADHD and depression through the written medium of a vignette it is imperative that the vignettes employed in this study provide a realistic portrayal of the behaviours associated with these conditions. We would like you to facilitate us in achieving our research goal by allowing us to get some feedback on the proposed vignettes. If you would like to help us, we would appreciate if you could read the vignettes provided below, rate the accuracy of the vignettes to depict the target condition and provide any feedback you feel necessary to improve the vignettes. The process should take no longer than ten minutes.

Your validation and feedback will ensure that this study will provide valuable knowledge on children’s perceptions, attitudes and reactions to children who behave in ways that are associated with ADHD and depression. It is hoped that this research will provide valuable information for the development of educational programs to promote more positive attitudes towards children who display such behaviours.

Thank you in advance for your assistance.

Yours faithfully

___________________________

on behalf of the research team:

Claire O’Driscoll MSc
National University of Ireland
Galway

Caroline Heary M.Psych.Sc., Ph.D
National University of Ireland
Galway

Eilis Hennessy Ph.D., C.Psychol
University College Dublin


Appendix C: Vignette Validation Questionnaire

Peer Stigmatization of Childhood Mental Health Disorders.

This questionnaire describes the behaviour of fictional children based on classifications of disordered behaviour from DSM-IV. The aim of the research is to find good descriptions of depression and ADHD as it exists in childhood and adolescence. Based on your validation and feedback these vignettes will be employed to explore children’s attitudes towards peers with these conditions. Please read each vignette and then rate it on how well it describes the behaviour of a child with the named disorder. Please provide feedback on anything that strikes you about the vignettes and ways it can be improved. For simplicity I have alternated the disorders between boys and girls. When the vignettes are presented to children they will be presented as behaviour of a child of the same sex.

ADHD Combined Subtype

Jane is in the same year as you. In her spare time Jane likes running with her athletics club and has won many medals in competitive races. In school she seems to be more interested in other people’s work than her own work. Sometimes she forgets what her teacher has told her to do and needs to be reminded. She often finds it difficult to work on group activities. When the teacher asks the class a question, Jane often blurts out the answer before the teacher has a chance to finish. Jane also finds it hard to stay sitting down when she is supposed to and gets up or fidgets a lot. If the teacher asks her to return to her seat she sometimes doesn’t seem to hear her. Often she has trouble waiting her turn in games, shouts loudly during P.E. class and interrupts when people are doing things. She regularly loses her books and pencils.

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<tr>
<td>2</td>
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</table>

Feedback:

Depression

Larry is in the same year as you. He used to love playing sports and hanging out with his friends after school. Last year he was the captain of his football team, however, recently he has stopped going to training and the coach made another player captain. He hasn’t been interested in anything lately. He doesn’t smile or laugh as much anymore. Larry’s results in school have also deteriorated. When Larry’s teacher asked him about this, Larry explained that he is feeling tired all the time and was finding it difficult to sleep at night. He wants to do
better but thinks that he is not good at anything. Larry spends a lot of time thinking about all the things that he is not able to do and other sad thoughts.

<table>
<thead>
<tr>
<th>Very accurate description</th>
<th>Very inaccurate description</th>
</tr>
</thead>
<tbody>
<tr>
<td>6</td>
<td>5</td>
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</tbody>
</table>

Feedback:

Thank you for taking the time to complete this questionnaire. Your feedback is much appreciated and will be used to improve research in the area of Child & Adolescent Mental Health.
Appendix C: Details of the Pilot Study for Study One

Study One Pilot Study

The primary objectives of the pilot study were to explore the utility of the clinical vignettes, the IAT, and the questionnaire to assess stigma towards peers with mental health problems among 10 to 11-year-olds and 15 to 16-year-olds. Specifically, the aims of the pilot are outlined below:

Aims & Objectives

Overall Aim:

1. To assess participants’ experience of taking part in this study, by exploring their responses towards the explicit questionnaire and implicit measure.

Vignettes:

1. To ensure that the vignettes were age appropriate and easily comprehended by the target cohorts.

2. To ensure that the vignettes provided a realistic insight into the lives of children within the target cohorts.

Wording of Questions:

1. To ensure that all questions were developmentally appropriate.

2. To ensure that there was no ambiguity surrounding the meaning or interpretation of questions or words.

IAT:

1. To explore whether the target attribute words were distinctively good or bad by asking participants to group attribute words according to these two categories.

2. To test that the proposed attribute words were developmentally appropriate.

Study Length:
Appendix C

1. To establish the estimated time it takes to complete the whole study.

2. To explore how best to ensure that the administration of the study would be as least disruptive as possible to class activities.

Participants

The participants consisted of 21 primary school students (8 male, 11 female) and 17 secondary school students (7 male, 10 female) enrolled in year 7 and 12 of education in primary and post-primary public schools in the in Galway City and county, respectively (N = 38). Ages ranged from 10-11 years (M = 10.35 years, SD = .32) and 15-16 years (M = 15.45, SD = .65).

6.5.3 Materials

The measures included in the pilot study are presented in the Table 1 below. A full description of all the measures used in the pilot and main study are presented in Chapter 7 section 7.4.
### Appendix C

Table 1:

*The Explicit and Implicit Measures Employed in the Pilot Study*

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<td>Strengths &amp; Difficulties Questionnaire (SDQ)</td>
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<td><strong>Target Stimuli</strong></td>
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<td>Vignettes (ADHD/depression &amp; ‘normal’ issues)</td>
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<td>Experience with peers with disorders</td>
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<td>Contact &amp; Similarity Items</td>
<td>Maieron, Roberts, &amp; Prentice-Dunn, 1996; Magiati, Dockrell, &amp; Logotheti, 2002</td>
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<td>Lease, Musgrove &amp; Axelrod, 2002</td>
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<td><strong>Prejudice &amp; Stereotypes</strong></td>
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<td>Corrigan et al., 2007</td>
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<td>Morgan, Walker, Bieberich, &amp; Bell, 1996</td>
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<td>Horace Mann-Lincoln Institute of School Experimentation, 1957</td>
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<td>Weiss, 1986</td>
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<td>Implicit Association Test (IAT)</td>
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</tbody>
</table>
Appendix C

Procedure

Letters requesting permission to recruit participants for the pilot were sent to the principals of the two schools. The letter outlined the aims and objectives of the study and provided details of study procedure (See Appendix D). A week later, the researcher contacted the schools by phone to answer any questions about the project. The principals of both schools agreed to permit the pilot to take place. Two teachers were nominated to facilitate the administration of the pilot. The teachers received copies of the questionnaire, consent forms, and information packages for parents and students (See Appendix E and F). They distributed these to students in class and informed them of the date they were to be returned.

In the primary school, one 5th class was randomly selected to be invited to take part and 30 consent forms and information packages were given to all students. Twenty-six consent forms were returned (86.6% response rate), 21 of which were signed to permit participation in the study (80.8% consent rate for those who returned the forms). Following a verbal description of the study, all students with parental consent assented to take part.

Twenty students from one randomly selected transition year class in the post-primary school were invited to take part in the pilot study and were provided with information packages and consent forms. Seventeen students returned signed consent forms, all permitting them to take part (85% consent rate for those who returned the forms). All seventeen students also provided verbal assent following a description of the study.

The procedure differed slightly between the primary and post-primary school groups. Participants from the primary school group were brought in groups of four into a quiet room to complete the study. Whereas, participants from the post-primary school group were all given the explicit questionnaire in their classroom and then brought in pairs to a quiet room to complete the IAT. These two administration procedures were employed to explore which
procedure would be most suitable for the school environment and most time efficient for both the participant and the researcher.

The instructions that both the primary and post-primary group received were consistent across the two groups. Participants were told that the researcher was from the School of Psychology in NUI, Galway and that psychologists are interested in finding out why it is we act and think in certain ways. The researcher explained that she was specifically interested in knowing why we become friends with some people and not others. They were told that they would be given a questionnaire that asks them questions about themselves. They would then read about two peers that are the same age and gender as them. They were assured that the young people described in the stories do not go to the same school as them and are not people they know. They were asked to read about the young people described in the stories and answer the questions about them as honestly as they could. They were assured that it was not a test and that there were no right or wrong answers. They were also encouraged to put up their hands if there were any words or questions that they did not understand. Participants were then assigned to either an ADHD or depression condition and provided with a questionnaire. Depending on the condition they were assigned to, they read about and responded to one peer with a mental health disorder (ADHD or depression) and a peer with ‘normal issues’. Once participants had completed the questionnaire they were asked to form groups of 3 or 4 to discuss the questionnaire. They were instructed to discuss the stories and take note of any aspects of the questionnaire that were liked or found confusing and, if necessary, make a list of areas that needed to be improved. They were given 10 minutes to do this, after which they were required to elect a spokesperson to inform the researcher of their findings. The researcher took note of feedback from each group and clarification, where necessary, was obtained. Students were thanked for their ideas and told that they would now be required to complete a pairing task on the researcher’s laptop.
Appendix C

Prior to completing the IAT participants were required to categorise the target attribute words that featured in the IAT as either good or bad. They were reminded that this was not a test and that they should ask the researcher if there were any words they did not understand or were confused about. Consistent with the condition that they had been assigned to, participants read the two vignettes again. Once participants had done this, they sat at the computer and the researcher provided them with instructions on how to complete the name-behaviour induction training and the IAT. They were instructed to complete the task as quickly and as accurately as possible. After they had completed the IAT, participants were asked for individual feedback on the difficulty of the task.

Results
Primary school participants were able to complete the questionnaire independently. It was also noted that they appeared to be confident to ask the researcher about questions that they did not understand. In general, they thought that the questionnaire was easy to understand. The only question that many participants did not understand featured in the r-AQ that assessed prejudice towards that vignette characters. The original question was ‘I would feel at ease with [target peer]’. It was decided that this item would be changed to ‘I would feel relaxed with [target peer]’. All students understood the term relaxed. On the SDQ, participants also had difficulty with the word ‘squirming’, in the statement ‘I am constantly fidgeting or squirming’, but understood it when it was explained to them. It was decided that for the main study the word squirming would be omitted and the statement ‘I am constantly fidgeting’ would be used.

When asked what they thought about the children in the story, participants stated that the children in the stories were reflective of children their own age. Most children reported that they found the questionnaire easy and not too long. One participant (age 10) didn’t want
to finish the questionnaire. She said it was too long and she did not like questions. Prior to completing the IAT, participants had to categorise the attribute category stimuli exemplars as either good or bad. Most children had no problem doing this and categorised them successfully. Three children did not understand the words ‘innocent’ and ‘guilty’. The researcher explained the meaning of these words and gave examples of when they are used. When completing the IAT, all participants fully understood which words belonged to each category. To ensure that all participants correctly understood the dimensions along which the attribute words should be categorised it was decided that, in the main study, participants would categorise the words prior to completing the IAT. The name-behaviour training appeared useful in teaching the children about the behaviours displayed by the target children, as all but one student got 80%+ correct on the name-behaviour pair test. Completion of the questionnaire took between 25-30 minutes, with one student taking 40 minutes to complete. Most students took between 15-19 minutes to complete the name-behaviour training and IAT task.

Some general comments are presented below:

• “They are like real children”.
• “There are children like that in our school”.
• “I know children like them”.
• “They do things like other children my age”.
• “It (the questionnaire) looks long but it’s not that bad”.
• “It (the IAT) was confusing at first when the responses changed, but then it was fine”.

Post-primary school participants completed the questionnaire entirely independently and did not report any problems understanding the questions or words used. Their comments
were considered overall to be positive. Students acknowledged that although there were some problems about making decisions on the target characters, based on the limited information they were provided with, they thought that the vignettes created a vivid depiction of what they might be like if they were to encounter the target characters. It took participants approximately 25 minutes to complete the explicit questionnaire. On average, the computer task took about 15 minutes to complete. All but two students were able to categorise the IAT attribute words correctly. The two students that experienced some difficulty were confused about the words *weak* and *strong*, they commented that in some situations being strong could be a bad thing. The researcher acknowledged this and explained that in this task weak was to be considered *bad* and strong *good*. These participants had no difficulty categorising these words as *good* versus *bad* in the IAT task. The name-behaviour training was successful in teaching participants about the behaviours typical of the target individuals. All students were successful in achieving over 80% correct responses on the name-behaviour test prior to completing the IAT. Mistakes among this group were minimal. The IAT was also well received; participants understood what was asked of them and all participants kept up the required speed needed on the IAT to be included in the analysis. Some representative comments included:

- “Although we know these girls are not in our school, they could be girls my age”.
- “It’s hard to know what they are really like all the time but we think the stories give a glimpse into what they are like most of time, so we think we could answer the questions on what we know from the stories”.
- “It obvious that the two teenagers in the stories are very different, but teenagers like them exist”.
- “We think the questions were easy to understand and were fine for people our
Appendix C

age”.

- “The computer task was interesting, as at times we thought it was getting really long and then the instructions changed so you had something different to do, so you didn’t get bored”.

The pilot study revealed that, overall, the proposed measures were developmentally appropriate for the target cohorts. No changes were made to the language used in the vignettes and participants believed that the vignettes adequately described actual peers. Based on participants’ feedback, minor changes were made to the wording of two items only. While most participants understood the meaning of the IAT attribute words and could independently categorise the words as good or bad, it was decided that for the main procedure participants would be required to practice categorising the words prior to completing the IAT. Participants were able to complete the explicit and implicit phases independently without notable fatigue. The procedure employed in the post-primary school, whereby participants completed the questionnaire in their class group and were brought in pairs to complete the IAT, was deemed more time efficient for both the students and the researcher, compared to administering the explicit and implicit measures in groups of 4 participants. Thus, this procedure was employed in the main study (see Chapter 6 section 6.5).

Debriefing

Participants were thanked for their participation and an informal debriefing was carried out following both the implicit and explicit assessments. During this time, the researcher was available to answer any questions they had.
Appendix D: School Recruitment Letter (Study One)

School of Psychology,
Cois Abhainn,
National University of Ireland, Galway.

Dear Principal,

A research team from the School of Psychology, at the National University of Ireland and University College Dublin are currently undertaking research exploring children and adolescents, aged 10-11 and 15-16 years, attitudes and reactions to peers who behave in ways that are associated with concentration difficulties, strengths and difficulties and low mood.

We would like to invite your school to take part in this research. In order to complete this research, we hope to present students with stories describing two imaginary children. Students will then be asked to answer questions on how they would react to the child, how the child makes them feel and their attitudes towards the child. They will also be asked to complete a brief computer task on the researcher’s laptop. In the computer task they will be asked to match the children described in the stories to words that they think best describes the child.

Children will also be asked to complete a questionnaire on their own behaviour. This information can tell us if any children engage in behaviours or experience feelings similar to the children in the stories. If children’s responses on this questionnaire indicate that they may be having some emotional or behavioural difficulties, we will inform parents about this, and provide contact details for services, if they wish to speak with a health professional.

This study will provide valuable knowledge on children’s perceptions, attitudes and reactions to children who behave in ways that are associated with concentration difficulties, academic ability and depression. It is hoped that this research will provide valuable information for the development of educational programs to promote more positive attitudes towards children who display such behaviours.

This research is taking place under the supervision of Dr. Caroline Heary who is developmental psychology lecturer at the School of Psychology, NUI Galway and Dr Eilis Hennessy, who is a child psychology lecturer at the Department of Psychology, University College, Dublin. Participant recruitment and data collection will be carried out by Ms Claire O’ Driscoll, who is a PhD student at the School of Psychology at the National University of Ireland, Galway. If you would like to help us with the recruitment of participants for this study please contact Claire at the information below. Additionally, if you would like any further information about this study, please do not hesitate to contact us (Ms. Claire O’ Driscoll at 091-493264, email: c.odrisoll1@nuigalway.ie or contact Dr. Caroline Heary at 091 495059).

Thank you in advance for your assistance.

Yours faithfully

___________________________
on behalf of the research team:

Claire O’Driscoll MSc. Caroline Heary M.Psych.Sc., Ph.D Eilis Hennessy Ph.D., C.Psychol
National University of Ireland Galway National University of Ireland, Galway University College Dublin

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Appendix E

Appendix E: Parental/Guardian Information Letter For Schools (Study One)

Dear Parent/Guardian(s)

We are involved in a joint research project at the National University of Ireland, Galway and University College Dublin on children’s reactions to their peers’ behaviour. In particular, we are interested in how children develop an understanding of others who behave in ways that are associated with attention and concentration difficulties, strengths and difficulties and low mood. As part of this project we are asking children and young people between the ages of 10-11 and 15-16 years to read short stories about imaginary children and then fill out a questionnaire asking them questions about the stories. These questions will ask how they might interact with these children in a variety of situations. They will also be asked if they have ever met anyone who displays similar behaviours and skills. They will also be asked to complete a brief computer pairing task that asks them to match the children to words that they think best describe them. The entire procedure should take no more than forty five minutes to complete.

Your child will also be asked to complete a questionnaire on their own behaviour and feelings. This information can tell us if your child may engage in behaviours or experience feelings similar to the children in the stories. If children’s responses on this questionnaire indicate that they may be having some emotional or behavioural difficulties, we will inform parents about this, and provide contact details for services, if they wish to speak with a health professional.

We will be very grateful if you will permit us to ask your child if he/she would like to take part in this project. If you are willing to do so, we ask that you complete and sign the short questionnaire on the back of this letter where we request that parents give us some background details on their family. This information can tell us whether the children who take part in our study are representative of children in Ireland and whether there are differences in the views of children from different backgrounds. All information given by parents and children will be treated in complete confidence and will remain anonymous. The only information which we cannot keep confidential, is if a child were to disclose information relating to a child protection issue such as abuse or neglect. If this were to occur, we are required to notify the authorities of such matters.

We will send a summary of our findings to all the schools that take part when the data has been analysed. The results will eventually be published in an academic journal but the publication will make no reference to specific individuals or schools. When completed, it is hoped that this study will provide important information on the attitudes and reactions of children towards peers with different behaviours. It will also represent an important foundation for the development of educational programmes to promote positive attitudes towards such children.

An information sheet is included with this letter, but if you would like further details about any aspect of the research please contact Claire O Driscoll by telephone at 091-493264 or by e-mail c.odriscoll1@nuigalway.ie

Yours faithfully

_________________________________________

on behalf of the research team:

Claire O Driscoll MSc.    Caroline Heary M.Psych.Sc., Ph.D    Eilis Hennessy Ph.D., C.Psychol
National University of Ireland    Galway    National University of Ireland Galway    University College Dublin
Appendix E

Appendix E: Parental/Guardian Information Letter (Study One)

Research Information Sheet
Children’s Understanding of their Peers’ Behaviour

Introduction
Your child is being invited to take part in a research study. Before you decide to allow your child to participate, it is important for you to understand why the research is being done and what it will involve. This Information Sheet will tell you about the purpose, risks and benefits of this research study. If you agree to allow your child to take part, we will ask you to sign a Consent Form. If there is anything that you are not clear about, we will be happy to explain it to you. Please take as much time as you need to read it. You should only consent for your child to participate in this research study when you feel that you understand what is being asked of your child and you have had enough time to think about your decision.

Thank you for reading this.

Who is doing the research?
Three people are involved in this research: Dr Caroline Heary, who is a lecturer in developmental psychology at the National University of Ireland in Galway, Dr Eilis Hennessy, who is a lecturer in child psychology at University College Dublin, and Claire O Driscoll who is completing a PhD in the School of Psychology at the National University of Ireland, Galway.

What is the purpose of the study?
The purpose of the study is to improve our understanding of children's attitudes and reactions to other children who display behaviours such as those associated with concentration difficulties, strengths and difficulties and low mood. We hope that the findings of our study will help us to understand more about the way in which children feel about one another. It will help us answer questions such as - why some children are liked and accepted and other children have difficulties being accepted. In this way, we hope that our findings will be of benefit to all children.

Does my child have to take part?
It is your choice and your child’s choice if you would like your child to take part in the study. Children can only take part once parents have given permission for their child to do so. If you do decide to allow your child to take part you will be asked to sign a consent form and will be given this information sheet to keep. Your child is still free to withdraw at any time throughout this study and without giving a reason. This will not affect your child's rights in any way.

What will happen to my child?
The child will be presented within their classroom with stories that describe two imaginary children and asked to complete questionnaires asking them how they might interact with the child, how comfortable they would feel being with the child in the story and how they would describe the child to their friends. They will also be asked to
complete a computer task in which they will be asked to match the child with words that they think best describe him/her.

Children will also complete a questionnaire on their own behaviour and feelings. This is to identify children that display similar behaviours or feelings to the children in the stories and who may be sensitive to the questions being asked. Parents/Guardians of children identified as displaying a number of the behaviours and emotions on this questionnaire will be notified and the contact details of services will be made available to them.

We are also asking parents to give us some background details on their family. This is so we can tell whether the children who take part in our study are representative of children in Ireland and whether there are differences in the views of children from different backgrounds.

**How long will my child’s part in the study last?**
Your child’s total participation time will be no longer than 45 minutes. The questionnaires will take approximately 20 minutes to complete. The computer task will take approximately 25 minutes.

**What are the benefits to your child in taking part?**
There are no personal benefits to taking part in this research, although sometimes children can enjoy taking part in the questionnaires and computer activities, and it also provides them with an opportunity to learn about research. The results of the research will however, help us understand children’s reactions and attitudes to peers and provide us with a greater understanding of peer relationships. The information your child provides can help researchers and educational professionals develop more effective educational programs to promote more positive attitudes towards all children.

**What are the potential risks of taking part?**
There are no risks to taking part in this study, although it will take up some time if your child decides to take part. It is not expected that this research will be difficult or upsetting for the child, however, the child always has the right to withdraw at any time from the study.

The researcher will reassure all children that there are no right or wrong answers and will be available to answer any questions that may arise from the study. While most of the questions in this study are about imaginary children described in stories, there is one questionnaire that involves asking children about their own feelings and behaviour. This questionnaire will allow us to identify whether any of the children taking part in the study, show any similar feelings or behaviours to the children in the stories. If a child’s responses indicates that they may be experiencing some difficulties, parents will be notified and the contact details of relevant services will be provided to the parents of that child.

**What will happen at the end of the study?**
The information all the children provide will be transferred onto a computer in such a way that it cannot be linked to named individuals and the names will be destroyed when the study is finished. The information collected in this study will also answer
Appendix E

questions such as how children think, feel and may act towards other children with different behaviours. It will also allow us to explore differences in the responses of younger and older teenagers and differences between boys and girls.

After the results are analysed a summary of the findings will be sent to all participating schools. The results will eventually be published in an academic journal but the publication will make no reference to specific individuals or schools.

The information gathered in this study will be compared to a related study which is being carried out in the University College Dublin by Dr. Eilis Hennessy, which looks at the experiences of young people who themselves have emotional or behavioural difficulties. Both studies are important for understanding how young people react to other children.

Voluntary Participation/Withdrawal
If you decide to allow your child to participate, your child is free to discontinue participation at any time. Your child will be told that they may skip any questions they do not want to answer. Your child may also withdraw from the study at any time and without giving a reason. This will not affect you or your child’s rights in any way.

What if I have a complaint during my participation in the study?
The research team will be available for you to contact if you have any complaints during your participation in the study. See contact information below.

Will my child’s results from this study be kept confidential?
All information that is collected about your child during the course of the research will be kept strictly confidential and will not be shared with anyone else. The information collected in this research study will be stored in a way that protects your child’s identity. Results from the study will be reported as group data and will not identify your child in any way. The only exception to confidentiality is if a child were to disclose information indicating they were at risk of abuse or neglect. In such circumstances parents or school/club authorities may have to be informed.

Further Information
If you have any questions, please do not hesitate to contact Claire O Driscoll at 091-493264 or email c.odriscoll1@nuigalway.ie. You can also contact Dr. Caroline Heary who is supervising this project (091-495059).

Thank you very much for allowing your child to take part in this study, your cooperation is much appreciated.

If you have any concerns about this study and wish to contact someone independent and in confidence, you may contact *The Chairperson of the NUI Galway Research Ethics Committee, c/o Office of the Vice-President for Research, NUI Galway, ethics@nuigalway.ie*
Appendix E: Consent Form (Study One)

Children’s Understanding of their Peers’ Behaviour

Please return this form before ....
Please tick the required boxes below to indicate whether or not you agree to allow your child to take part in the study and sign the form at the end.

I confirm that I have read the information sheet for the above study.  
I am satisfied that I understand the information provided and have had enough time to consider the information.  

☐

I understand that all my child’s information will remain confidential (with the exception of a child protection issues arising), my child will not be named in the study report and my child can withdraw at any time from the study.

☐

I am aware of what the study is about and agree to allow my child to take part.

☐

I ______________________ (name of parent/guardian) consent to allow my child to take part in this study.

Child’s Name:  ____________  Child’s Date of Birth:  ____________

Parent’s Name:  ____________

Signature of Parent/Guardian:  ____________

Contact Number  ____________

Date:  ____________

Or

I DO NOT consent to allow my child to take part in this study:  ☐

Child’s Name:  ____________

Parent’s Name:  ____________

Signature of Parent/Guardian:  ____________

Date:  ____________
Appendix E: Parent/Guardian Demographic Information (Study One)

Family Information

1. Are you the child's:  Mother  □  Father  □

2. Your age:  
   - under 20  □
   - 31 - 40  □
   - 51 - 60  □
   - 21 – 30  □
   - 41 - 50  □
   - over 60  □

3. Number of children in your family:  _____

4. Your educational experience: (please tick the box that applies)
   - Intermediate/Group Certificate  □
   - Bachelor's Degree  □
   - Leaving Certificate  □
   - Higher Degree  □
   - Diploma/City & Guilds  □
   - Other (please give title)  ____________

5. Do you have a paid job?  Yes  □  No  □

   If 'Yes', please give your job title:  __________________________

IF YOU ARE LIVING WITH A SPOUSE/PARTNER

6. Your partner's age:  
   - under 20  □
   - 31 - 40  □
   - 51 - 60  □
   - 21 – 30  □
   - 41 - 50  □
   - over 60  □

7. Educational experience of your spouse/partner: (please tick the box that applies)
   - Intermediate/Group Certificate  □
   - Bachelor's Degree  □
   - Leaving Certificate  □
   - Higher Degree  □
   - Diploma/City & Guilds  □
   - Other (please give title)  ____________

8. Does your spouse/partner have a paid job?  Yes  □  No  □

   If 'Yes', please give his/her job title:  __________________________
Appendix F

Appendix F: Participant Information Sheet (Study One)

We are carrying out a study on what young people in Ireland think of other people their own age and we would be interested in hearing your views!

A team of people from the National University of Ireland, Galway & University College Dublin are carrying out this research. Research is just a fancy word for finding out about something. It is important for us to learn more about the way in which children think and feel about one another - why some children are liked and others are disliked. Taking part in this research will help us to do this.

We are visiting schools in the West of Ireland, and are looking for children / young people between the ages of 10 and 15 to read short stories about imaginary children and fill out our survey. This survey will ask questions on things like:

• Would you like to get to know the child?
• What kind of things you might like to do with the child?
• How would you describe the young people in the stories?

After you do this, we would like you to play a short computer game. In the game you will have to match the child described in the stories with words that best describe them.

After this, we will ask about your experience completing the questionnaire in groups with other students.

We would also like you to complete a short questionnaire asking you questions about your own feelings and how you behave. If we find that some children have feelings or behaviours that they might need help with, we may need to talk to your parents about this.

Remember - This is not a test. There are no right or wrong answers. We are just interested in hearing about your ideas and feelings. Claire, the researcher will be visiting your school next week to see if you would like to take part in this survey.

In the meantime, if you would like any further information, please do not hesitate to contact Claire at 087-6386723 or by e-mail: c.odriscoll1@nuigalway.ie

Thank you for reading about this study!
Appendix G: Depression Condition Female Primary School

Please fill out the following information:

Participant number: ....................

Your age: ..............

We are interested in how YOU feel and act. Please try to answer all questions as truthfully as possible.
How much do you agree with the following statements?

Read each question and tick the box you most agree with!

<table>
<thead>
<tr>
<th>Question</th>
<th>Not True</th>
<th>A little bit True</th>
<th>Certainly True</th>
</tr>
</thead>
<tbody>
<tr>
<td>a</td>
<td>I try to be nice to other people. I care about their feelings</td>
<td>![Not True]</td>
<td>![A little bit True]</td>
</tr>
<tr>
<td>b</td>
<td>I am restless, I cannot stay still for long</td>
<td>![Not True]</td>
<td>![A little bit True]</td>
</tr>
<tr>
<td>c</td>
<td>I get a lot of headaches, stomach-aches or sickness</td>
<td>![Not True]</td>
<td>![A little bit True]</td>
</tr>
<tr>
<td>d</td>
<td>I usually share with others (food, games, pens etc.)</td>
<td>![Not True]</td>
<td>![A little bit True]</td>
</tr>
<tr>
<td>e</td>
<td>I get very angry and often lose my temper</td>
<td>![Not True]</td>
<td>![A little bit True]</td>
</tr>
<tr>
<td>f</td>
<td>I am usually on my own. I generally play alone or keep to myself</td>
<td>![Not True]</td>
<td>![A little bit True]</td>
</tr>
<tr>
<td>g</td>
<td>I usually do as I am told</td>
<td>![Not True]</td>
<td>![A little bit True]</td>
</tr>
<tr>
<td>h</td>
<td>I worry a lot</td>
<td>![Not True]</td>
<td>![A little bit True]</td>
</tr>
<tr>
<td>i</td>
<td>I am helpful if someone is hurt, upset or feeling ill</td>
<td>![Not True]</td>
<td>![A little bit True]</td>
</tr>
<tr>
<td>j</td>
<td>I am constantly fidgeting</td>
<td>![Not True]</td>
<td>![A little bit True]</td>
</tr>
<tr>
<td>k</td>
<td>I have one good friend or more</td>
<td>![Not True]</td>
<td>![A little bit True]</td>
</tr>
<tr>
<td>l</td>
<td>I fight a lot. I can make other people do what I want</td>
<td>![Not True]</td>
<td>![A little bit True]</td>
</tr>
<tr>
<td>m</td>
<td>I am often unhappy, down-hearted or tearful</td>
<td>![Not True]</td>
<td>![A little bit True]</td>
</tr>
<tr>
<td>n</td>
<td>Other people my age generally like me</td>
<td>![Not True]</td>
<td>![A little bit True]</td>
</tr>
<tr>
<td>o</td>
<td>I am easily distracted, I find it difficult to concentrate</td>
<td>![Not True]</td>
<td>![A little bit True]</td>
</tr>
<tr>
<td>p</td>
<td>I am nervous in new situations. I easily lose confidence</td>
<td>![Not True]</td>
<td>![A little bit True]</td>
</tr>
<tr>
<td>q</td>
<td>I am kind to younger children</td>
<td>![Not True]</td>
<td>![A little bit True]</td>
</tr>
<tr>
<td>s</td>
<td>Other children or young people pick on me or bully me</td>
<td></td>
<td></td>
</tr>
<tr>
<td>t</td>
<td>I often volunteer to help others (parents, teachers, children)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>u</td>
<td>I think before I do things</td>
<td></td>
<td></td>
</tr>
<tr>
<td>v</td>
<td>I take things that are not mine from home, school or elsewhere</td>
<td></td>
<td></td>
</tr>
<tr>
<td>w</td>
<td>I get on better with adults than with people my own age</td>
<td></td>
<td></td>
</tr>
<tr>
<td>x</td>
<td>I have many fears, I am easily scared</td>
<td></td>
<td></td>
</tr>
<tr>
<td>y</td>
<td>I finish the work I’m doing. My attention is good</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Imagine the ladder is a way of picturing your school.
At the top of the ladder are the people who are liked the most.
At the bottom of the ladder are the people who no one listens to and no one wants to play with.

Where would you be placed on the ladder? Fill in the circle where you think **YOU** would be on this ladder.
You are going to read about two girls called Davina and Lauren. These children are about the same age as you. You will then answer some questions about what you think about these children and what you would feel comfortable doing with them.

Davina is in the same year as you. She likes school because she has good friends in her class, but would like it better if her teachers didn't give her so much homework. She plays with her friends after school one or two times during the week and at weekends. She has several hobbies, including playing sports and listening to music. Davina usually gets on well with other kids, but sometimes they have arguments. However, she always makes up with them. Most of the time, Davina does well in school but has to work hard at some subjects especially Maths and Irish. She is well behaved in school and rarely gets in trouble from her teachers.

<table>
<thead>
<tr>
<th>YES</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you know somebody who is like Davina?</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Once every few months</th>
<th>Once every few weeks</th>
<th>Every week</th>
<th>Every day</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>![Star]</td>
<td>![Star]</td>
<td>![Star]</td>
</tr>
</tbody>
</table>

If you know somebody like Davina, how often do you see him/her?
If you had to describe DAVINA to your classmates, what kinds of words would you use? Below is a list of words to help you. Circle the words you would like to use. You can use as many or as few words as you want. Here is the list:

<table>
<thead>
<tr>
<th>Healthy</th>
<th>Clever</th>
<th>Crazy</th>
<th>Honest</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neat</td>
<td>Cruel</td>
<td>Bright</td>
<td>Dumb</td>
</tr>
<tr>
<td>Careful</td>
<td>Careless</td>
<td>Unhappy</td>
<td>Happy</td>
</tr>
<tr>
<td>Slow</td>
<td>Alert</td>
<td>Greedy</td>
<td>Ashamed</td>
</tr>
<tr>
<td>Lonely</td>
<td>Proud</td>
<td>Bored</td>
<td>Friendly</td>
</tr>
<tr>
<td>Glad</td>
<td>Dishonest</td>
<td>Mean</td>
<td>Kind</td>
</tr>
<tr>
<td>Sloppy</td>
<td>Alright</td>
<td>Cheerful</td>
<td>Sad</td>
</tr>
<tr>
<td>Pretty</td>
<td>Weak</td>
<td>Helpful</td>
<td>Stupid</td>
</tr>
<tr>
<td>Smart</td>
<td>Ugly</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**For example:**

I would describe DAVINA as kind and proud

Circle the words **Kind** and **Proud**
Appendix G

What do you think about Davina?

<table>
<thead>
<tr>
<th></th>
<th>Disagree a lot</th>
<th>Disagree a little</th>
<th>Don't know</th>
<th>Agree a little</th>
<th>Agree</th>
<th>Agree a lot</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 It is not Davina's fault that she acts like this</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 If Davina needed help I would help her</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 Davina should go to a different school to me</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4 Davina is not dangerous</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5 I would try to stay away from Davina</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7 Davina is good fun</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8 I would feel relaxed with Davina</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

How do you feel about Davina?

<table>
<thead>
<tr>
<th></th>
<th>Disagree a lot</th>
<th>Disagree a little</th>
<th>Don't know</th>
<th>Agree a little</th>
<th>Agree</th>
<th>Agree a lot</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 I would feel sorry for Davina</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 I would be scared of Davina</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 Davina would make me angry</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4 Davina would make me happy</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Imagine **DAVINA** moves to your school and is in your class, here is a list of things that you might do with her. Tick the answer that shows how you feel about doing each of these things with Davina.

For example:

I would not ask **DAVINA** to come to my house to watch TV

Tick the **NO** box beside this statement  

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Maybe</th>
</tr>
</thead>
<tbody>
<tr>
<td>a Ask Davina to come to my house to watch TV</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b Sit next to Davina in class</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c Work in the school library with Davina</td>
<td></td>
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<tr>
<td>d Share my games or books with Davina</td>
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<tr>
<td>e Work on a science project at school with Davina</td>
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<tr>
<td>f Be in the same reading group with Davina</td>
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<tr>
<td>g Study spelling words with Davina at school</td>
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<tr>
<td>h Invite Davina to my birthday party</td>
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<td>i Ask Davina to go swimming with me</td>
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<tr>
<td>j Ask Davina to go for a walk with me</td>
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<tr>
<td>k Eat lunch next to Davina at school</td>
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<tr>
<td>l Walk together with Davina in the hall at school</td>
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<tr>
<td>m Do art with Davina in class</td>
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<tr>
<td>n Pick Davina to be on my soccer team</td>
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<tr>
<td>o Work out maths problems in class with Davina</td>
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<tr>
<td>p Write a story or report for school with Davina</td>
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<tr>
<td>q Ask Davina to join my club</td>
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<tr>
<td>r Do homework with Davina at home after school</td>
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<tr>
<td>s Go to the cinema with Davina</td>
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<tr>
<td>t Play with Davina outside during lunch break</td>
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<tr>
<td>u Pick Davina as my partner in a game with other children</td>
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<tr>
<td>v Be good friends with Davina</td>
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<tr>
<td>w Go to a football match with Davina</td>
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<tr>
<td>x Ride bikes with Davina</td>
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</tbody>
</table>
Imagine the ladder is a way of picturing your school.
At the top of the ladder are the people who are liked the most.
At the bottom of the ladder are the people who no one listens to and no one wants to hang out with.

Where would you place Davina on the ladder?
Fill in the circle where you think Davina would be.

Imagine...

Your teacher has asked you to work at a desk with Davina.
Tick the seat where you would feel most relaxed working with her.
Please mark the statement that best describes how you feel about Davina.

For example:

I would like to have **DAVINA** in my group of friends

Tick the box beside this statement ✔

Only choose one statement

<table>
<thead>
<tr>
<th>Davina</th>
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<tbody>
<tr>
<td>I would like to have her as one of my best friends</td>
</tr>
<tr>
<td>I would like to have her in my group but not as a close friend.</td>
</tr>
<tr>
<td>I would like to be with her once in a while but not often or for a long time.</td>
</tr>
<tr>
<td>I wouldn’t mind her being in my classroom but I wouldn’t want to have anything to do with her.</td>
</tr>
<tr>
<td>I wouldn’t want her in my class</td>
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</tbody>
</table>
Lauren is in the same year as you. She used to love playing sports and hanging out with her friends after school. Last year, she was the captain of her school football team, however, recently she has stopped going to training. Her classmates have noticed that she isn’t interested in anything lately and doesn’t play with them anymore. She doesn’t smile or laugh as much as she used to. Lauren is falling behind in her school-work. When Lauren’s teacher asked her about this, Lauren explained that she is feeling tired all the time and is finding it difficult to sleep at night. She wants to do better but thinks that she is not good at anything. Lauren spends a lot of time thinking about all the things that she is not able to do and other sad thoughts.

<table>
<thead>
<tr>
<th>YES</th>
<th>No</th>
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<tbody>
<tr>
<td>Do you know somebody who is like Lauren?</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Once every few months</th>
<th>Once every few weeks</th>
<th>Every week</th>
<th>Every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>☀️</td>
<td>🌟</td>
<td>🌟</td>
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</tbody>
</table>

If you know somebody like Lauren, how often do you see him/her?

<table>
<thead>
<tr>
<th>Not at all</th>
<th>Not really</th>
<th>A little</th>
<th>A lot</th>
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<tbody>
<tr>
<td>☀️</td>
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</table>

Do you think you are like Lauren?
If you had to describe Lauren to your classmates, what kinds of words would you use? Below is a list of words to help you. Circle the words you would like to use. You can use as many or as few words as you want. Here is the list:

<table>
<thead>
<tr>
<th>Healthy</th>
<th>Clever</th>
<th>Crazy</th>
<th>Honest</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neat</td>
<td>Cruel</td>
<td>Bright</td>
<td>Dumb</td>
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<tr>
<td>Careful</td>
<td>Careless</td>
<td>Unhappy</td>
<td>Happy</td>
</tr>
<tr>
<td>Slow</td>
<td>Alert</td>
<td>Greedy</td>
<td>Ashamed</td>
</tr>
<tr>
<td>Lonely</td>
<td>Proud</td>
<td>Bored</td>
<td>Friendly</td>
</tr>
<tr>
<td>Glad</td>
<td>Dishonest</td>
<td>Mean</td>
<td>Kind</td>
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<tr>
<td>Sloppy</td>
<td>Alright</td>
<td>Cheerful</td>
<td>Sad</td>
</tr>
<tr>
<td>Pretty</td>
<td>Weak</td>
<td>Helpful</td>
<td>Stupid</td>
</tr>
</tbody>
</table>

For example: I would describe Lauren as kind and proud. Circle the words Kind and Proud.
### What do you think about Lauren?

<table>
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<tr>
<th></th>
<th>Disagree a lot</th>
<th>Disagree</th>
<th>Disagree a little</th>
<th>Don’t know</th>
<th>Agree a little</th>
<th>Agree</th>
<th>Agree a lot</th>
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### How do you feel about Lauren?

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1. It is not Lauren’s fault that she acts like this
2. If Lauren needed help I would help her
3. Lauren should go to a different school to me
4. Lauren is not dangerous
5. I would try to stay away from Lauren
6. Lauren is good fun
7. I would feel relaxed with Lauren
8. I would feel sorry for Lauren
9. Lauren would make me angry
10. Lauren would make me happy
Imagine LAUREN moves to your school and is in your class, here is a list of things that you might do with her. Tick the answer that shows how you feel about doing each of these things with Lauren.

I would not ask LAUREN to come to my house to watch TV
Tick the NO box beside this statement ✓

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Maybe</th>
</tr>
</thead>
<tbody>
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<td>a</td>
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</table>
Imagine the ladder is a way of picturing your school.
At the top of the ladder are the people who are liked the most.
At the bottom of the ladder are the people who no one listens to and no one wants to play with.

Where would you place **Lauren** on the ladder? Fill in the circle where you think Lauren would be on.

---

Your teacher has asked you to work at a desk with Lauren.
Tick the seat where you would feel most relaxed working with her.

---

**Lauren**
Appendix G

Please mark the statement that best describes how you feel about Lauren

For example:

I would like to have Lauren in my group of friends

Tick the box beside this statement

Only choose one statement

![Image](image1.png)

Lauren

<table>
<thead>
<tr>
<th>I would like to have her as one of my best friends</th>
</tr>
</thead>
<tbody>
<tr>
<td>I would like to have her in my group but not as a close friend.</td>
</tr>
<tr>
<td>I would like to be with her once in awhile but not often or for a long time.</td>
</tr>
<tr>
<td>I wouldn’t mind her being in my classroom but I wouldn’t want to have anything to do with her.</td>
</tr>
<tr>
<td>I wouldn’t want her in my class.</td>
</tr>
</tbody>
</table>

Some kids have influence and power over other kids—they get others to do what they want. Circle the child who you think has more influence and power over the other

For example:

I think Davina is more powerful than Lauren

Circle Davina

a Davina or Lauren

b Me or Davina

c Me or Lauren

Thank You For Taking Part!!
Appendix G: ADHD Condition Post Primary Male

Please fill out the following information:

Participant number: 

Your age: 

We are interested in how YOU feel and act. Please try to answer all questions as truthfully as possible.

How much do you agree with the following statements?

Read each question and tick the box you most agree with!

<table>
<thead>
<tr>
<th></th>
<th>Not True</th>
<th>A little bit True</th>
<th>Certainly True</th>
</tr>
</thead>
<tbody>
<tr>
<td>a</td>
<td>I try to be nice to other people. I care about their feelings</td>
<td><img src="image" alt="Not True" /></td>
<td><img src="image" alt="A little bit True" /></td>
</tr>
<tr>
<td>b</td>
<td>I am restless, I cannot stay still for long</td>
<td><img src="image" alt="Not True" /></td>
<td><img src="image" alt="A little bit True" /></td>
</tr>
<tr>
<td>c</td>
<td>I get a lot of headaches, stomach-aches or sickness</td>
<td><img src="image" alt="Not True" /></td>
<td><img src="image" alt="A little bit True" /></td>
</tr>
<tr>
<td>d</td>
<td>I usually share with others (food, games, pens etc.)</td>
<td><img src="image" alt="Not True" /></td>
<td><img src="image" alt="A little bit True" /></td>
</tr>
<tr>
<td>e</td>
<td>I get very angry and often lose my temper</td>
<td><img src="image" alt="Not True" /></td>
<td><img src="image" alt="A little bit True" /></td>
</tr>
<tr>
<td>f</td>
<td>I am usually on my own. I generally play alone or keep to myself</td>
<td><img src="image" alt="Not True" /></td>
<td><img src="image" alt="A little bit True" /></td>
</tr>
<tr>
<td>g</td>
<td>I usually do as I am told</td>
<td><img src="image" alt="Not True" /></td>
<td><img src="image" alt="A little bit True" /></td>
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<tr>
<td>h</td>
<td>I worry a lot</td>
<td><img src="image" alt="Not True" /></td>
<td><img src="image" alt="A little bit True" /></td>
</tr>
<tr>
<td>i</td>
<td>I am helpful if someone is hurt, upset or feeling ill</td>
<td><img src="image" alt="Not True" /></td>
<td><img src="image" alt="A little bit True" /></td>
</tr>
<tr>
<td>j</td>
<td>I am constantly fidgeting</td>
<td><img src="image" alt="Not True" /></td>
<td><img src="image" alt="A little bit True" /></td>
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<tr>
<td>k</td>
<td>I have one good friend or more</td>
<td><img src="image" alt="Not True" /></td>
<td><img src="image" alt="A little bit True" /></td>
</tr>
<tr>
<td>l</td>
<td>I fight a lot. I can make other people do what I want</td>
<td><img src="image" alt="Not True" /></td>
<td><img src="image" alt="A little bit True" /></td>
</tr>
<tr>
<td>m</td>
<td>I am often unhappy, down-hearted or tearful</td>
<td><img src="image" alt="Not True" /></td>
<td><img src="image" alt="A little bit True" /></td>
</tr>
<tr>
<td>n</td>
<td>Other people my age generally like me</td>
<td><img src="image" alt="Not True" /></td>
<td><img src="image" alt="A little bit True" /></td>
</tr>
<tr>
<td>o</td>
<td>I am easily distracted, I find it difficult to concentrate</td>
<td><img src="image" alt="Not True" /></td>
<td><img src="image" alt="A little bit True" /></td>
</tr>
<tr>
<td>p</td>
<td>I am nervous in new situations. I easily lose confidence</td>
<td><img src="image" alt="Not True" /></td>
<td><img src="image" alt="A little bit True" /></td>
</tr>
<tr>
<td>q</td>
<td>I am kind to younger children</td>
<td><img src="image" alt="Not True" /></td>
<td><img src="image" alt="A little bit True" /></td>
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</tbody>
</table>
Imagine the ladder is a way of picturing your school. At the top of the ladder are the people who are liked the most. At the bottom of the ladder are the people who no one listens to and no one wants to hang around with.

Where would you be placed on the ladder? Fill in the circle where you think YOU would be on this ladder.
You are going to read about two teenagers called Jake and David. They are about the same age as you. You will then answer some questions about what you think about these teenagers and what you would feel comfortable doing with them.

Jake is in the same year as you. In school he seems to pay more attention to things going on around him than his own work. Sometimes he forgets what his teacher has told him to do and needs to be reminded. When the teacher asks the class a question Jake often blurts out the answer before the teacher has a chance to finish. Jake often finds it hard to stay sitting down when he is supposed to and gets up or fidgets a lot. He has difficulty waiting his turn and butts into his classmates’ conversations. In his spare time, Jake likes to play his computer and train with his athletics club. When his parents ask him to help around the house he sometimes doesn’t seem to hear them. He often does not finish his homework or chores. Jake talks non-stop when his family is watching TV. He finds it hard to organise his bedroom and regularly loses his books, computer games and other things he needs.

<table>
<thead>
<tr>
<th>YES</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you know somebody who is like Jake?</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Once every few months</th>
<th>Once every few weeks</th>
<th>Every week</th>
<th>Every day</th>
</tr>
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<tbody>
<tr>
<td></td>
<td><img src="image1" alt="Star" /></td>
<td><img src="image2" alt="Star" /></td>
<td><img src="image3" alt="Star" /></td>
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</tbody>
</table>

If you know somebody like Jake, how often do you see him/her?
Appendix G

<table>
<thead>
<tr>
<th></th>
<th>Not at all</th>
<th>Not really</th>
<th>A little</th>
<th>A lot</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>⭐</td>
<td>⭐</td>
<td>⭐️</td>
<td>⭐️</td>
</tr>
</tbody>
</table>

Do you think you are like Jake?

---

**Describe Jake**

If you had to describe Jake to your classmates, what kinds of words would you use? Below is a list of words to help you. Circle the words you would like to use. You can use as many or as few words as you want. Here is the list:

- Healthy
- Clever
- Crazy
- Honest
- Neat
- Cruel
- Bright
- Dumb
- Careful
- Careless
- Unhappy
- Happy
- Slow
- Alert
- Greedy
- Ashamed
- Lonely
- Proud
- Bored
- Friendly
- Glad
- Dishonest
- Mean
- Kind
- Sloppy
- Alright
- Cheerful
- Sad
- Pretty
- Weak
- Helpful
- Stupid

For example:

I would describe Jake as kind and proud

Circle the words Kind and Proud
### What do you think about Jake?

<table>
<thead>
<tr>
<th>Disagree a lot</th>
<th>Disagree a little</th>
<th>Disagree a little</th>
<th>Don't know</th>
<th>Agree a little</th>
<th>Agree</th>
<th>Agree a lot</th>
</tr>
</thead>
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<tr>
<td><img src="image1" alt="Star" /></td>
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<td><img src="image7" alt="Star" /></td>
<td><img src="image8" alt="Star" /></td>
<td><img src="image9" alt="Star" /></td>
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<td></td>
<td></td>
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<tr>
<td><img src="image10" alt="Star" /></td>
<td><img src="image11" alt="Star" /></td>
<td><img src="image12" alt="Star" /></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1. It is not Jake’s fault that he acts like this
2. If Jake needed help, I would help him
3. Jake should go to a different school to me
4. Jake is not dangerous
5. I would try to stay away from Jake
6. Jake is good fun
7. I would feel relaxed with Jake

### How do you feel about Jake?

<table>
<thead>
<tr>
<th>Disagree a lot</th>
<th>Disagree a little</th>
<th>Disagree a little</th>
<th>Don’t know</th>
<th>Agree a little</th>
<th>Agree</th>
<th>Agree a lot</th>
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<td><img src="image19" alt="Star" /></td>
<td><img src="image20" alt="Star" /></td>
<td><img src="image21" alt="Star" /></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1. I would feel sorry for Jake
2. I would be scared of Jake
3. Jake would make me angry
4. Jake would make me happy
Imagine JAKE moves to your school and is in your class, here is a list of things that you might do with him. Tick the answer that shows how you feel about doing each of these things with Jake.

I would not ask JAKE to come to my house to watch TV
Tick the NO box beside this statement

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Maybe</th>
</tr>
</thead>
<tbody>
<tr>
<td>a.</td>
<td>Ask Jake to come to my house to watch TV</td>
<td></td>
</tr>
<tr>
<td>b.</td>
<td>Sit next to Jake in class</td>
<td></td>
</tr>
<tr>
<td>c.</td>
<td>Work in the school library with Jake</td>
<td></td>
</tr>
<tr>
<td>d.</td>
<td>Share my music or books with Jake</td>
<td></td>
</tr>
<tr>
<td>e.</td>
<td>Work on a school project with Jake</td>
<td></td>
</tr>
<tr>
<td>f.</td>
<td>Be in the same reading group with Jake</td>
<td></td>
</tr>
<tr>
<td>g.</td>
<td>Study for an exam with Jake at school</td>
<td></td>
</tr>
<tr>
<td>h.</td>
<td>Invite Jake to my party</td>
<td></td>
</tr>
<tr>
<td>i.</td>
<td>Ask Jake to go swimming with me</td>
<td></td>
</tr>
<tr>
<td>j.</td>
<td>Ask Jake to go for a walk with me</td>
<td></td>
</tr>
<tr>
<td>k.</td>
<td>Eat lunch next to Jake at school</td>
<td></td>
</tr>
<tr>
<td>l.</td>
<td>Walk together with Jake in the hall at school</td>
<td></td>
</tr>
<tr>
<td>m.</td>
<td>Do art with Jake in class</td>
<td></td>
</tr>
<tr>
<td>n.</td>
<td>Pick Jake to be on my soccer team</td>
<td></td>
</tr>
<tr>
<td>o.</td>
<td>Work out maths problems in class with Jake</td>
<td></td>
</tr>
<tr>
<td>p.</td>
<td>Write a story or report for school with Jake</td>
<td></td>
</tr>
<tr>
<td>q.</td>
<td>Ask Jake to join my club</td>
<td></td>
</tr>
<tr>
<td>r.</td>
<td>Do homework with Jake at home after school</td>
<td></td>
</tr>
<tr>
<td>s.</td>
<td>Go to the cinema with Jake</td>
<td></td>
</tr>
<tr>
<td>t.</td>
<td>Hang out with Jake outside during lunch break</td>
<td></td>
</tr>
<tr>
<td>u.</td>
<td>Pick Jake as my partner in a game with other teenagers</td>
<td></td>
</tr>
<tr>
<td>v.</td>
<td>Be good friends with Jake</td>
<td></td>
</tr>
<tr>
<td>w.</td>
<td>Go to a football match with Jake</td>
<td></td>
</tr>
<tr>
<td>x.</td>
<td>Go for a cycle with Jake</td>
<td></td>
</tr>
</tbody>
</table>
Imagine the ladder is a way of picturing your school. At the top of the ladder are the people who are liked the most. At the bottom of the ladder are the people who no one listens to and no one wants to hang around with.

Where would you place Jake on the ladder? Fill in the circle where you think Jake would be on.

Imagine……..

Your teacher has asked you to work at a desk with Jake. Tick the seat where you would feel most relaxed working with him.

Jake
Please mark the statement that best describes how you feel about Jake

For example:

I would like to have Jake in my group of friends
Tick the box beside this statement ✓

Only choose one statement

<table>
<thead>
<tr>
<th>Jake</th>
</tr>
</thead>
<tbody>
<tr>
<td>I would like to have him as one of my best friends</td>
</tr>
<tr>
<td>I would like to have him in my group but not as a close friend</td>
</tr>
<tr>
<td>I would like to be with him once in awhile but not often or for a long time.</td>
</tr>
<tr>
<td>I wouldn’t mind him being in my classroom but I wouldn’t want to have anything to do with him.</td>
</tr>
<tr>
<td>I wouldn’t want him in my class.</td>
</tr>
</tbody>
</table>
David is in the same year as you. He likes school because he has good friends in his class, but would like it better if his teachers didn’t give him so much homework. He hangs out with his friends after school one or two times during the week and at weekends. He has several hobbies, including playing sports and listening to music. David usually gets on well with other teenagers, but sometimes they have arguments. However, he always makes up with them. Most of the time, David does well in school but has to work hard at some subjects especially Maths and Irish. He is well behaved in school and rarely gets in trouble from his teachers.

<table>
<thead>
<tr>
<th>YES</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you know somebody who is like David?</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Once every few months</th>
<th>Once every few weeks</th>
<th>Every week</th>
<th>Every day</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If you know somebody like David, how often do you see him/her?

<table>
<thead>
<tr>
<th>Not at all</th>
<th>Not really</th>
<th>A little</th>
<th>A lot</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Do you think you are like David?
If you had to describe DAVID to your classmates, what kinds of words would you use? Below is a list of words to help you. Circle the words you would like to use. You can use as many or as few words as you want. Here is the list:

<table>
<thead>
<tr>
<th>Healthy</th>
<th>Clever</th>
<th>Crazy</th>
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</tr>
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<tbody>
<tr>
<td>Neat</td>
<td>Cruel</td>
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</tr>
<tr>
<td>Careful</td>
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<tr>
<td>Slow</td>
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<tr>
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<tr>
<td>Glad</td>
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<td>Pretty</td>
<td>Weak</td>
<td>Helpful</td>
<td>Stupid</td>
</tr>
<tr>
<td>Smart</td>
<td>Ugly</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### What do you think about David?

<table>
<thead>
<tr>
<th>Statement</th>
<th>Disagree a lot</th>
<th>Disagree</th>
<th>Disagree a little</th>
<th>Don't know</th>
<th>Agree a little</th>
<th>Agree</th>
<th>Agree a lot</th>
</tr>
</thead>
<tbody>
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<td>1</td>
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### How do you feel about David?

<table>
<thead>
<tr>
<th>Statement</th>
<th>Disagree a lot</th>
<th>Disagree</th>
<th>Disagree a little</th>
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Imagine **David** moves to your school and is in your class, here is a list of things that you might do with him. Tick the answer that shows how you feel about doing each of these things with David.

For example: I would not ask **David** to come to my house to watch TV

Tick the **No** box beside this statement ✓

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Imagine the ladder is a way of picturing your school.
At the top of the ladder are the people who are liked the most.
At the bottom of the ladder are the people who no one listens to and no one wants to hang around with.

Where would you place **DAVID** on the ladder?
Fill in the circle where you think David would be.

Imagine......

Your teacher has asked you to work at a desk with David.
Tick the seat where you would feel most relaxed working with him.
Please mark the statement that best describes how you feel about David.

For example:

I would like to have DAVID in my group of friends
Tick the box beside this statement ✓

Choose only one statement

<table>
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<th>David</th>
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<td>I would like to have him as one of my best friends</td>
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<tr>
<td>I would like to have him in my group but not as a close friend.</td>
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<tr>
<td>I would like to be with him once in awhile but not often or for a long time.</td>
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<td>I wouldn’t mind him being in my classroom but I wouldn’t want to have anything to do with him.</td>
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<tr>
<td>I wouldn’t want him in my class</td>
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Some teenagers have influence and power over other teenagers—they get others to do what they want. Circle the person who you think has more influence and power over the other.

For example:

I think David is more powerful than Jake
Circle David

a DAVID or JAKE

b ME or DAVID

c ME or JAKE

Thank You For Taking Part!!
Appendix H: Follow up Letter Re: Strengths & Difficulties Questionnaire (Study One)

School of Psychology,  
Cois Abhainn,  
National University of Ireland, Galway.

Dear Parent/Guardian(s)

I would like to thank you for allowing your child ______________ to take part in the recent Children’s understanding of Peers’ Behaviour study that took place in your child school. As part of the study each child was required to complete the Strengths and Difficulties Questionnaire (SDQ). The SDQ is a pre-screening tool that identifies children who may experience emotional or behavioural symptoms. Your child’s scores on this questionnaire were above the standard cut off point and thus suggest that he/she may be experiencing emotional or behavioural difficulties. The SDQ is not a diagnostic tool and therefore your child’s score does not necessarily mean that he or she has a emotional or behavioural disorder. We would however, recommend that you contact your local GP to discuss these issues. Your GP will be able to advise you on the best steps to take to ensure your child get all the support he/she may need. You can also contact the psychological services at the Galway HSE (see details below). However, we would advise that a visit to your GP is perhaps the most effective option.

If you would like further details about any aspect of the research or the SDQ please contact Claire O Driscoll by telephone at 091-493264 or by e-mail c.odriscoll1@nuigalway.ie

Yours faithfully

___________________________________
on behalf of the research team:

Claire O Driscoll MSc.  
C.Psychol  
National University of Ireland

Caroline Heary M.Psych.Sc., Ph.D  
Galway National University of Ireland Galway

Eilis Hennessy Ph.D.,  
University College Dublin
Useful Information

Galway HSE Child & Family Support Services:
St. Anne’s Centre, Taylor’s Hill, Galway, Tel: (091) 521 755 or (091) 521 974
Lyradoon Family Centre, Salthill, Galway, Tel: (091) 521 059 or (091) 523 308
Ballard House, Westside, Galway, Tel: (091) 580 100

http://www.hse.ie/eng/services/Find_a_Service/lho/Galway/Children_and_Family_Services/

GPs in Galway
For a list of GPs in Galway call (091) 523 122 or log onto
http://www.galway.net/galwayguide/service/health/doc/all/

Support Services:
Parentline 1890 927 277
Mental Health Ireland: http://www.mentalhealthireland.ie
Appendix I: Interview Schedule (Study Two)

ADHD Dyad Exclusion

Jake is in the same class as you. In school he seems to pay more attention to things going on around him than his own work. Sometimes he forgets what his teacher has told him to do and needs to be reminded. When the teacher asks the class a question Jake often blurts out the answer before the teacher has a chance to finish. Jake often finds it hard to stay sitting down when he is supposed to and gets up or fidgets a lot. He has difficulty waiting his turn and butts into his classmates’ conversations. In his spare time, Jake likes to play his computer and train with his athletic club. When his parents ask him to help around the house he sometimes doesn’t seem to hear them. He often does not finish his homework or chores. Jake talks non-stop when his family is watching TV. He finds it hard to organise his bedroom and regularly loses his books, computer games and other things he needs.

Peter another boy is Jakes class doesn’t want to be his friends

Legitimacy of the exclusion

Is ok or not ok for Peter to decide that he does not want to be friends with Jake?

Reasons used to Justify/reject the exclusion encounter:

Why is it ok/not ok that Peter does not want to be friends with Jake?

Reasons for exclusion specific to the vignette character:

What is it about Jake that makes Peter not want to be friends with him?

Beliefs about causes of the mental health problem:

Why do you think Jake acts the way he does?

Beliefs about rights

Do we have a right to decide who we want to be friends with?
Depression Group Exclusion

Larry is in the same year as you. He used to love playing sports and playing with his friends after school. Last year, he was the captain of his football team, however, recently he has stopped going to training. His classmates have noticed that he isn't interested in anything lately and doesn't play/hang-out with them anymore. He doesn’t smile or laugh as much as he used to. Larry is falling behind in his school-work. When Larry’s teacher asked him about this, Larry explained that he is feeling tired all the time and is finding it difficult to sleep at night. He wants to do better but thinks that he is not good at anything. Larry spends a lot of time thinking about all the things that he is not able to do and other sad thoughts.

Larry hears his classmates planning a trip to the cinema on Saturday, but they don’t invite him.

Legitimacy of the exclusion

Is ok or not ok for his classmates to decide not to invite Larry?

Reasons used to Justify/reject the exclusion encounter:

Why is it ok/not ok that the classmates do not invite Larry?

Reasons for exclusion specific to the vignette character:

What is it about Larry that makes the classmates no invite him?

Beliefs about causes of the mental health problem:

Why do you think Larry acts the way he does?

Beliefs about rights

When we are in a group, does the group have a right to decide who they want to invite to activities such as going to the cinema?
Appendix J: Principal Recruitment Letter (Study Two)

Dear Principal,

A research team from the School of Psychology, at the National University of Ireland and University College Dublin are currently undertaking research exploring young people’s views on peer exclusion. We would like to invite your school to take part in the pilot phase of this study. The specific aim of the research is to examine the reasons children use to exclude peers who engage in behaviours associated with concentration difficulties and low mood. As part of this project we are asking twenty children and young people between the ages of 10-11 and 15-16 years to read short stories about imaginary children and then asking them their opinions on the stories in groups with other children. For example, in one story a boy/girl doesn’t want to be friends with another boy/girl who is described as having problems concentrating in class. Children will then be asked why they think the fore-mentioned boy/girl doesn’t want to be his/her friend. The group discussions will be audio recorded. This is to ensure that all the participants’ views are accurately recorded. Children’s names will not be linked to any of their comments and the content of the recording will be used solely for the purpose of this research.

This study will improve our understanding of young people’s opinions of situations in which their peers are excluded. It is hoped that this research will provide valuable information for the development of educational programs to promote more positive attitudes towards children who display such behaviours.

This research is taking place under the supervision of Dr. Caroline Heary who is a developmental psychology lecturer at the School of Psychology, NUI Galway and Dr Eilis Hennessy, who is a child psychology lecturer at the Department of Psychology, University College, Dublin. Participant recruitment and data collection will be carried out by Ms Claire O Driscoll, who is a PhD student at the School of Psychology at the National University of Ireland, Galway. If you would like to help us with the recruitment of participants for this study please contact Claire at the information below. Additionally, if you would like any further information about this study, please do not hesitate to contact us (Ms. Claire O Driscoll at 091-493264 or email: c.odrisoll1@nuigalway.ie or contact Dr. Caroline Heary at 091-495059).

Thank you in advance for your assistance.
Yours faithfully

___________________________
on behalf of the research team:

Claire O’Driscoll MSc. Caroline Heary M.Psych.Sc., Ph.D Eilis Hennessy Ph.D., C.Psychol
National University of Ireland Galway National University of Ireland Galway University College Dublin
Dear Parent/Guardian(s)

Sometimes children and young people exclude others from activities and events and we would like to understand why this happens. In particular, we are interested in the reasons children use to exclude peers who engage in behaviours associated with concentration difficulties and low mood.

As part of this project we are asking children and young people between the ages of 10-11 and 15-16 years to read short stories about imaginary children and then asking them their opinions on the stories in groups with other children. For example, in one story a boy doesn’t want to be friends with another boy who is described as having problems concentrating in class. Children will then be asked why they think the fore-mentioned boy doesn’t want to be his friend. The group discussions will be audio recorded. This is to ensure that all the participants’ views are accurately recorded. Your child’s name will not be linked to any of their comments and the content of the recording will be used solely for the purpose of this research.

We will be very grateful if you will permit us to ask your child if he/she would like to take part in this project. If you are willing to do so, we ask that you complete and sign the short questionnaire on the back of this letter where we request that parents give us some background details on their family. This information can tell us whether the children who take part in our study are representative of children in Ireland and whether there are differences in the views of children from different backgrounds. All information given by parents and children will be treated in complete confidence and will remain anonymous. We will send a summary of our findings to all the schools that take part when the data has been analysed. The results will eventually be published in an academic journal but the publication will make no reference to specific individuals or schools.

Permitting your child to take part in this study will provide us with a greater understanding of why some peers are excluded and others included. It is hoped that this study will provide important information on young people’s views on situations in which their peers are excluded. It will also represent an important foundation for the development of educational programmes to promote positive attitudes towards all children.

An information sheet is included with this letter, but if you would like further details about any aspect of the research please contact Claire O Driscoll by telephone at 091-493264, or by e-mail c.odriscoll1@nuigalway.ie

Yours faithfully

______________________________
on behalf of the research team:

Claire O Driscoll MSc.   Caroline Heary M.Psych.Sc., Ph.D   Eilis Hennessy Ph.D.,
National University of Ireland Galway   National University of Ireland Galway   University College Dublin
Appendix K

Appendix K: Parent/Guardian Information Leaflet (Study 2)

Introduction
Your child is being invited to take part in a research study. Before you decide to allow your child to participate, it is important for you to understand why the research is being done and what it will involve. This Information Sheet will tell you about the purpose, risks and benefits of this research study. If you agree to allow your child to take part, we will ask you to sign a Consent Form. We also ask that you complete the short demographic questionnaire included in this envelope. If there is anything that you are not clear about, we will be happy to explain it to you. Please take as much time as you need to read it. You should only consent for your child to participate in this research study when you feel that you understand what is being asked of your child and you have had enough time to think about your decision.

Thank you for reading this.

Who is doing the research?
Three people are involved in this research: Dr Caroline Heary, who is a lecturer in developmental psychology at the National University of Ireland in Galway, Dr Eilis Hennessy, who is a lecturer in child psychology at University College Dublin, and Claire O Driscoll who is completing a PhD in the School of Psychology at the National University of Ireland, Galway.

What is the purpose of the study?
The purpose of the study is to improve our understanding of young people’s opinions of situations in which their peers who display a range of behaviours from concentration difficulties to low mood, are excluded. We hope that the findings of our study will help us to understand more about the way in which young people think about one another. In this way, we hope that our findings will be of benefit to all children.

Why do I have to provide information about my family?
If you wish to allow your child to take part in this research we ask that you complete the short demographic questionnaire that is enclosed in this envelope. The questionnaire asks you for some brief details about your family. We are collecting this information to explore whether the children who take part in this research are representative of children in Ireland. It will also allow us to investigate whether there are differences in views of children from different backgrounds. All information given by parents and children will be treated in complete confidence and will remain anonymous. Names linking families to their information will be stored separately from the data in a locked cabinet and accessed by the researcher only. Please return this questionnaire with the signed consent form before the date stated at the top of the consent form.
Appendix K

Does my child have to take part?
It is your choice and your child’s choice if you would like your child to take part in the study. Children can only take part once parents have given permission for their child to do so. If you do decide to allow your child to take part you will be asked to sign a consent form and will be given this information sheet to keep. Your child is still free to withdraw at any time throughout this study and without giving a reason. This will not affect your child’s rights in any way.

What will happen to my child?
In groups with three other children, your child will be presented within their classroom with stories that describe imaginary children, who display a range of behaviours from concentration difficulties to low mood, and asked on their opinions about what happened in the stories. The discussion will be audio recorded by the researcher so that the views are heard.

We are also asking parents to give us some background details on their family. Thus us so parents to give us some background details on their family. This is so we can tell whether the children who take part in our study are representative of children in Ireland and whether there are differences in the views of children from different background.

How long will my child’s part in the study last?
Your child’s total participation time will be no longer than 30 minutes.

What are the benefits to your child in taking part?
We think your child will benefit indirectly and potentially directly from the research. The results of the research will help us understand children’s reactions and attitudes to peers and provide us with a greater understanding of peer relationships. The information your child provide will help develop a questionnaire that will be used in future research on this topic.

What are the potential risks of taking part?
An individual child may be anxious about talking in groups. The researcher will reassure all children that there are no right or wrong answers and will be available to answer any questions that may arise from the study. They will also be reassured that every child’s personal views and opinions are important and should be listened to. The researcher will facilitate the discussion within the group to ensure that all children have the opportunity to voice their opinions. It is not expected that this research will be difficult or upsetting for the child, however, the child always has the right to withdraw at any time from the study.

What will happen at the end of the study?
The information that the children provide will be transferred from the audio recordings onto a computer file in such a way that it cannot be linked to named individuals and the names will be destroyed when the study is finished. A summary of the findings will be sent to all participating schools. The results will eventually be published in an academic journal but the publication will make no reference to specific individuals or schools.

Voluntary Participation/Withdrawal
If you decide to allow your child to participate, your child is free to discontinue participation at any time. Your child will be told that they may skip any questions they do not want to answer. Your child may also withdraw from the study at any time and without giving a reason. This will not affect your child’s rights in anyway.
What if I have a complaint during my participation in the study?
The research team will be available for you to contact if you have any complaints during your participation in the study. See contact information below.

Will my child’s results from this study be kept confidential?
All information that is collected about your child during the course of the research will be kept strictly confidential and will not be shared with anyone else. The information collected in this research study will be stored in a way that protects your child’s identity. Results from the study will be reported as group data and will not identify your child in any way. The only exception to confidentiality is if a child were to disclose information indicating they were at risk of abuse or neglect. In such circumstances parents or school authorities may have to be informed.

Further Information
If you have any questions, please do not hesitate to contact Claire O Driscoll at 087-6386723 or email c.odriscoll1@nuigalway.ie. You can also contact Dr. Caroline Heary who is supervising this project (091-495059).

Thank you very much for allowing your child to take part in this study, your co-operation is much appreciated.

If you have any concerns about this study and wish to contact someone independent and in confidence, you may contact The Chairperson of the NUI Galway Research Ethics Committee, c/o Office of the Vice-President for Research, NUI Galway, ethics@nuigalway.ie
Appendix K: Demographic Questionnaire (Study 2)

Family Information

1. **Are you the child's:** Mother ☐ Father ☐ Guardian ☐

2. **Your age:**
   - under 20 ☐ 31 - 40 ☐ 51 - 60 ☐
   - 21 - 30 ☐ 41 - 50 ☐ over 60 ☐

3. **Number of children in your family:** _____

4. **Your educational experience:** (please tick the box that applies)
   - Intermediate/Junior Certificate ☐ Bachelor's Degree ☐
   - Leaving Certificate ☐ Higher Degree ☐
   - Diploma/City & Guilds ☐ Other _____________

**IF YOU ARE LIVING WITH A SPOUSE/PARTNER**

6. **Your partner’s age:**
   - under 20 ☐ 31 - 40 ☐ 51 - 60 ☐
   - 21 - 30 ☐ 41 - 50 ☐ over 60 ☐

7. **Educational experience of your spouse/partner:** (please tick the box that applies)
   - Intermediate/Junior Certificate ☐ Bachelor's Degree ☐
   - Leaving Certificate ☐ Higher Degree ☐
   - Diploma/City & Guilds ☐ Other _____________

8. **Your Address:** (for follow up correspondence, if necessary) _____________________________

   _____________________________________

   _____________________________________

   _____________________________________

   _____________________________________
Appendix K: Consent Form (Study 2)

Please return this form before ....
Please tick the required boxes below to indicate whether or not you agree to allow your child to take part in the study and sign the form at the end.

I confirm that I have read the information sheet for the above study. I am satisfied that I understand the information provided and have had enough time to consider the information.

I understand that all my child’s information will remain confidential, my child will not be named in the study report and my child can withdraw at any time from the study.

I am aware of what the study is about and agree to allow my child to take part.

I __________________________ (name of parent/guardian) consent to allow my child to take part in this study.

Child’s Name: ___________ Date of Birth: ___________

Parent’s Name: ___________

Signature of Parent/Guardian: ___________

Date: ___________

I DO NOT consent to allow my child to take part in this study.

Child’s Name: ___________

Parent’s Name: ___________

Signature of Parent/Guardian: ___________

Date: ___________
Appendix L: Participant Information Sheet (Study 2)

We are carrying out a study on what young people in Ireland think of other people their own age and we would be interested in hearing your views!

A team of people from the National University of Ireland, Galway & University College Dublin are carrying out this research. Research is just a fancy word for finding out about something. It is important for us to learn more about the way in which children think and feel about one another. Taking part in this research will help us to do this.

We are visiting schools in the West of Ireland, and are looking for children/young people between the ages of 10-11 and 15-16 to read short stories about imaginary young people and discuss the stories in groups with other children. You will be asked questions on things like:

• What do you think about what happened in the story?
• Why do you think the person in the story acts the way he/she does?

Remember - This is not a test. There are no right or wrong answers. We are just interested in hearing about your ideas and feelings. Claire, the researcher will be visiting your school next week to see if you would like to take part in this study. She will give you more details about the study then, and you will have an opportunity to ask her some questions.

In the meantime, if you would like any further information, please do not hesitate to contact Claire at 091- 493264 or by e-mail: c.odriscoll1@nuigalway.ie
Appendix M: Verbal Instructions for Study Two

Hi and welcome to our group. Thanks for coming and agreeing to talk to us today. My name is Claire. I am a researcher from in the School of Psychology in NUI Galway. Does anybody know what psychologists do? Psychologists are interested in finding out why we act and think the way we do. But we are interested in finding out about friendships, why some people are liked and others are not. We want to find out about your views on why one person might be invited to a party and another person is not invited. During this session we are going to read you stories about boys and girls who act in different ways. In these stories the boy or girl is excluded from playing with other children, for example in one story a girl is not invited to play a game of basketball. From what you have heard about the girl we want to know why you think the other children don’t want to her to play with them. Your thoughts and ideas will be used to develop a questionnaire that will be used in future research with other boys and girls.

The boys and girls you will hear about are the same age as you and might be similar to other children that you know. However, these children do not go to the same school as you and are not from your neighbourhood.

I also want you to know that there are no right or wrong answers. You ideas and thoughts are very important to us so I want you to answer our questions as honestly as possible. It is ok if you have different ideas to the other children in the group. If you disagree with something another kid has said it is ok to say so. So no matter what you think please feel you can tell us.

Does everyone know what trust means?. It is really important that we trust each other as a group. As we all might all have different opinions and ideas on the what happens in the stories we ask that you don’t tell other children about individual comments made in the group. It is ok to tell them that you had to listen to stories about talk about them but please do not slag/tease or tell others outside the group about what one particular person said. Can everyone agree on this?

Ca you all see this tape recorder? We are going to tape the discussion because we don’t want to miss or forget any of your important ideas and comments. We are going to call each other by our first names during the discussion but when your thoughts and ideas are being used to help me develop the questionnaire I won’t be using any names. This means that all your comments about the stories are confidential. Confidential means that they are private. The only time that I can’t keep your ideas private is if somebody told me that they were in danger or harm. If this happened I would have to tell a teacher or another person who can help you.

Because it is really important that we hear all your comments I want you to put up your hand before you speak. This will make sure that two people are not talking at the same time and that the tape-recorder picks up what you want to say. Putting up your hand will make sure that everyone has time to speak and also that you all listen to one another.
**Appendix N: Coding Frameworks**

Table 1.

*A priori coding categories for evaluations of & justifications for exclusion based on coding used by Killen, Pisacane, Lee-Kim & Ardila-Rey, 2001; Tisak 2005; Golstein & Tisak, 2010 & codes from initial reading of the data*

Moral: Reference to rights of the target individual, perceived fairness, physical or psychological well being of the target individual

<table>
<thead>
<tr>
<th>Code</th>
<th>Explanation</th>
<th>Depression Example</th>
<th>ADHD Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prosocial</td>
<td>Evaluating exclusion as wrong as it denies the target character from gaining access to support/help that he/she might benefit from.</td>
<td>“It is unfair because if Paula is friends with Lauren she could help her with the problems she is going through”.</td>
<td>“Jane probably doesn’t know she acts like this. If the group invited Jane to the cinema, they could tell her and she would change”</td>
</tr>
<tr>
<td>Empathy</td>
<td>Drawing on possible negative affective and cognitive reactions of target characters as a result of the exclusion</td>
<td>“It might make Lauren feel even worse about her”.</td>
<td>“It is unfair because it would make Jane upset”.</td>
</tr>
<tr>
<td>Equal access</td>
<td>Advocating that the target characters should be allowed access to group activities, friends etc.</td>
<td>“It’s not fair. Paula should give Lauren a chance. Maybe they could be friends when she gets to know her better”.</td>
<td>“ If the whole group is going on a trip they should invite everyone. It’s not fair to leave someone out”.</td>
</tr>
<tr>
<td>Discrimination/Bulling</td>
<td>Evaluating the exclusion as wrong by defining it as bullying</td>
<td>“Leaving people out is bullying. It is wrong”.</td>
<td></td>
</tr>
</tbody>
</table>
## Table 2.

_A priori Coding Categories for Justification of Exclusion Continued_

<table>
<thead>
<tr>
<th>Code</th>
<th>Explanation</th>
<th>Depression Example</th>
<th>ADHD Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Symptoms related</td>
<td>Drawing on symptoms to explain how the target character has violated social conventions to justify exclusion</td>
<td>Paula probably doesn’t want to be Lauren’s friend because she (Lauren) doesn’t want to do anything anymore so Paula probably thinks that Lauren doesn’t want to be her (Paula’s) friend”.</td>
<td>The group doesn’t want to invite Jane because she is unorganised, she might lose her ticket. Or she might talk throughout the film and ruin it on everyone else”.</td>
</tr>
<tr>
<td>Contagion</td>
<td>Beliefs that others will ‘get’ a mental illness if they include the target character</td>
<td>“If Paula is friends with Lauren, she (Paula) might start feeling sad all the time and become bad at school”</td>
<td>If the group invite Jane, some of the others in the group might think that it is ok to act like her and start shouting out”</td>
</tr>
<tr>
<td>Stereotypes</td>
<td>Justifying exclusion by drawing on negative adjectives to describe of the target individual</td>
<td>“It’s ok for the group to decide not to invite Lauren because she is rude”</td>
<td>“Jane is crazy. I wouldn’t want to be her friend”</td>
</tr>
<tr>
<td>Group Functioning</td>
<td>Justifying exclusion on the basis that including the target character would disrupt group cohesion.</td>
<td>“It’s ok (not to invite Lauren) because if Lauren was invited she would bring the mood of the group down. It would be awkward”.</td>
<td>“It’s ok that the group don’t invite her because someone would have to look after her and that would be unfair on that person”.</td>
</tr>
<tr>
<td>Social Norms</td>
<td>Drawing on normative social rules either established group peer groups, school, family, and culture.</td>
<td>“It’s ok not to invite Lauren because you can’t invite everyone all the time”.</td>
<td>“There might have only been a few tickets left for the film so not everyone could be invited”</td>
</tr>
</tbody>
</table>
### Table 3.

*A priori Coding Categories for Justification of Exclusion Continued.*

<table>
<thead>
<tr>
<th>Social Conventional</th>
<th>Code</th>
<th>Explanation</th>
<th>Depression Example</th>
<th>ADHD Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reference to social norms &amp; beliefs, maintenance of group functioning, group identity, obeying rules, cultural norms, conventions</td>
<td>Reciprocity</td>
<td>Justification based on previous exclusion by the target character (not symptom related).</td>
<td>“If Lauren didn’t invite you to a cinema trip that she was organising it would be ok not to invite her.”</td>
<td>“Maybe they always invite Paula but she doesn’t ever come”</td>
</tr>
<tr>
<td></td>
<td>Retaliation</td>
<td>Justification for exclusion in response to hypothetical adverse behaviour (bullying/relational aggression etc.) exhibited by the target character (not symptom related)</td>
<td>“Maybe the group don’t invite her because she has been mean or bullied them in the past”</td>
<td>“Maybe Paula doesn’t want to be Jane’s friend because she (Jane) borrowed something from her and lost it”</td>
</tr>
<tr>
<td></td>
<td>Influence from others</td>
<td>Pressure or demands from others to exclude the target individual</td>
<td>“Maybe Lauren has a bad reputation and Paula’s parents said she wasn’t allowed to be her friend”.</td>
<td>“Maybe nobody in the group invites her because all the other girls would be angry if anyone did”</td>
</tr>
<tr>
<td></td>
<td>Conflict with authority</td>
<td>Desire to obey rules. Justification for exclusion for fear the target character would violate proper conduct, causing upset to the group.</td>
<td>“If the group invited her to the cinema she might talk during the film and they would get kicked out”</td>
<td></td>
</tr>
</tbody>
</table>
## Table 4.

*A priori Coding Categories for Justification of Exclusion Continued.*

<table>
<thead>
<tr>
<th>Code</th>
<th>Explanation</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal Choice</td>
<td>Justification because of personal rights to decide</td>
<td>“We have a right to decide who we are friends with. It our own choice”</td>
</tr>
<tr>
<td>Common interests</td>
<td>Drawing on lack of common interests to justify exclusion</td>
<td>“You are not going to be friends with somebody who doesn’t like any of the same things as you”</td>
</tr>
<tr>
<td>Excluded child’s personal choice*</td>
<td>Referring to the target characters personal choice to decide if he/she wants to be included/excluded.</td>
<td>“Maybe Lauren doesn’t want to be friends with Paula and Paula knows this. You wouldn’t want to be friends with someone who doesn’t like you”.</td>
</tr>
<tr>
<td>Undifferentiated/Other</td>
<td>Unelaborated responses, responses with no explanations</td>
<td>“I don’t know”, “It’s ok”</td>
</tr>
</tbody>
</table>
Table 5.

*Final codes for justifications for evaluations of exclusion*

<table>
<thead>
<tr>
<th>Code</th>
<th>Explanation</th>
<th>Depression Example</th>
<th>ADHD Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Duty</td>
<td>References to obligations to include others based on the status of the relationship</td>
<td>“It is unfair to exclude her if she is already apart of the group”.</td>
<td>“If the whole class is going then he should be invited”</td>
</tr>
<tr>
<td>Helping</td>
<td>References to the ability of friends to change the peers behaviour</td>
<td>“Inviting her could make her feel better and she won’t be so sad anymore”.</td>
<td></td>
</tr>
</tbody>
</table>

Table 6.

*Final codes for justifications for evaluations of exclusion*

<table>
<thead>
<tr>
<th>Responsibility &amp; Causal Beliefs</th>
<th>Explanation</th>
<th>Depression Example</th>
<th>ADHD Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Responsibility Attribution</td>
<td>References to the cause of the target peers disorders to justify evaluations</td>
<td>“It is unfair to exclude him if he is sad because something big happened, like his parents are getting a divorce”.</td>
<td>“It sounds like he is doing it intentionally, so it is fair to leave him behind”.</td>
</tr>
<tr>
<td>Aetiological Beliefs</td>
<td>References to the cause of the target peers disorders to justify evaluations</td>
<td>“It is unfair to exclude him if he is sad because something big happened, like his parents are getting a divorce”.</td>
<td>“It is not ok to exclude her because she has ADHD”.</td>
</tr>
</tbody>
</table>
Table 7.

*Final Codes for Justifications for evaluations of exclusion continued*

<table>
<thead>
<tr>
<th>Voluntary Nature of Friendships</th>
<th>Code</th>
<th>Explanation</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Personal Choice</td>
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<td></td>
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</tr>
<tr>
<td></td>
<td>Excluded child’s personal choice*</td>
<td>References to the target characters personal choice to decide if he/she wants to be included/excluded.</td>
<td>“Maybe Lauren doesn’t want to be friends with Paula and Paula knows this. You wouldn’t want to be friends with someone who doesn’t like you”.</td>
</tr>
<tr>
<td></td>
<td>Manners</td>
<td>References to the importance of being civil to all regardless of friendship status</td>
<td>‘Even if you’re not his friend you still have to be nice.”</td>
</tr>
<tr>
<td></td>
<td>First Impressions</td>
<td>Reference to the importance of giving all children a chance before deciding to exclude them</td>
<td>“You have to give everyone a chance and then decide you don’t want to be friends with them”</td>
</tr>
</tbody>
</table>
Table 8.

*Final Codes for justifications for evaluations and reasons used to explain why children and adolescents with mental illness are excluded*

<table>
<thead>
<tr>
<th>Code</th>
<th>Explanation</th>
<th>Depression Example</th>
<th>ADHD Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reciprocity</td>
<td>References to unreciprocated action of emotional support</td>
<td>“She hasn’t been putting any effort into the relationship”.</td>
<td></td>
</tr>
<tr>
<td>Non-participation</td>
<td>References to lack of input provided by target peer into the relationship</td>
<td>“She hasn’t shared her problems with the group”.</td>
<td>“She wouldn’t even notice if you were upset”.</td>
</tr>
<tr>
<td>Support</td>
<td>References to the target peers inability to provide emotional or social support to others</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Risk</td>
<td>References to adverse consequences of befriending the target peers</td>
<td>“He will become depressed”.</td>
<td></td>
</tr>
<tr>
<td>Contagion</td>
<td>Reference to others becoming like the target peer in his or her company</td>
<td>“They won’t have fun with her”</td>
<td>“She will get them in trouble because she is so loud”.</td>
</tr>
<tr>
<td>Social &amp; Disciplinary Consequences</td>
<td>References to adverse social or disciplinary consequences of befriending the target peers</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>