

How Previously Detained Youths Perceive “Mental Health” and “Counseling”

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Abstract

This study explored previously detained youths' perceptions of the term "mental health" and related stigma. The study also examined how the youth see and compare "mental health" to "counseling" services. Qualitative interviews were conducted with a diverse, purposeful sample of 19 youth aged 11-17 who scored high on the Massachusetts Youth Screening Instrument (MAYSI-2) for mental health disorders. Our findings suggest that participants often found it difficult to disclose that they were receiving mental health services to non-primary friends. Overall, there were negative and inaccurate perceptions of mental health. Furthermore, this terminology was not easily understood and was associated with mental health stigma. Given these negative association with "mental health," our results suggest that this term may be, in and of itself, a significant barrier to accessing treatment that requires further investigation. These findings should prompt researchers, policy makers, and mental health professionals to evaluate alternative names or descriptions of mental health services to reduce both internal and external stigma.

1.0 Introduction

On any given day in the U.S., about 61,000 youth will be placed in custody (Sickmund, Sladky, Kang, & Puzanchera, 2013). Youth involved in the justice system (i.e., justice-involved youth) are at higher risk of having a mental health disorder than their non-involved peers (Abram et al., 2013; Underwood & Washington, 2016; Lambie & Randell, 2013); in one study, 60% of male and 70% of female juvenile detainees met diagnostic criteria for a psychiatric disorder other than conduct disorder (Teplin, Abram, McClelland, Dulcan, & Mericle, 2002). Despite evidence of significantly higher rates of mental health problems among justice-involved youth, evidence suggests that they access mental health services at a lower rate than their non-involved peers (Merikangas et al., 2010; Liebenberg & Ungar, 2014). Low rates of service access for justice-involved youth are due to myriad barriers (Abram, Paskar, Washburn, & Temlin (2008); Hoagwood, Horwitz, Leaf, Poduska, Kellam, & Ialongo, (2002). Such barriers can be structural, whereby parents/caregivers experience significant bureaucratic challenges in pursuing mental health services for their child; conversely, youth may not believe they are in need of services, either because they do not have a mental health problem or they expect that their symptoms will improve on their own (Abram et al., 2008; Owens et al., 2002). Further, Saporito, Ryan, and Teachman (2011) posited that a youth's perception regarding mental health services can influence initial access to mental health services. Given this concern of how justice-involved youth attribute meaning to symbols representing mental health services, the purpose of this study was to investigate how previously detained youths who screened positive for mental health symptoms made meaning of the terms "mental health" and "counseling."

1.1. Unseen Mental Health Needs

Abram, Paskar, Washburn & Teplin (2008) conducted a study that examined perceived barriers to mental health services for 1,829 detained youth in Chicago, IL. Many youth participants stated that they did not have a mental health problem even though they met diagnostic criteria (Abram et al., 2008). The authors concluded that, “[d]espite the pervasive need for mental health services, detained youths do not perceive the mental health system as an important or accessible resource” while over half of participants believed their problems would simply go away without mental health services (Abram et al., 2008, p. 302). These findings suggest that detained youth may lack insight into their own mental health symptoms or may not be aware of their symptoms until they are discovered upon entry to detention (Aalsma, Brown, Holloway (2014). As such, they may perceive treatment as unnecessary or prohibitively difficult to access (Abram et al., 2015). Similarly, Watson, Kelly, and Vidalon (2009) found that nine justice-involved youth who had been diagnosed with psychotic or affective disorders denied the presence of a mental health diagnosis; instead, they attributed their difficulties to family problems or behavioral difficulties. Such denial of mental health diagnoses led participants to describe receipt of counseling rather than mental health services.

1.2. Mental Health and Stigma

If receipt of mental health services may be stigmatizing, then it is necessary to understand how different types of stigma serve as barriers to service access. Mental health stigma for youth who are diagnosed with mental health is complex (Clement et al., 2015) and remains a significant concern in the field (O’Reilly, & Lester, 2017). Goffman’s (1963) seminal research viewed stigma as a social construction of identity in which the stigmatized person internalizes his or her compromised social status into one’s self-concept; Goffman emphasized both psychological and social causes of stigma. Other scholars have emphasized two different

categories of stigma: public stigma and self-stigma (Corrigan, Rüsch, & Scior, 2018). According to Corrigan and colleagues (2012), public stigma results from widely perpetuated negative stereotypes, prejudices, and discriminatory behavior toward people with a given characteristic deemed abnormal, such as mental illness. Self-stigma occurs when a person who lives with such a characteristic internalizes a combination of such stereotypes, prejudices, and discriminatory behaviors (e.g., someone with impaired mental health is not behaviorally assertive in pursuing work or housing opportunities, at least partially due to self-stigma). Ahmedani (2011) posited health professional stigma as an additional type of stigma, and explained that the personal bias of mental health providers can act as a barrier to providing services. Furthermore, Liggins & Hatcher (2005) reported that some of their participants felt marginalized and labeled by their health providers. In one Swiss study, there was evidence that mental health providers, such as psychiatrists, psychologists, and nurses, sought social distance from those with severe mental illness (Nordt, Rossler & Lauber, 2006).

Regardless of the specific type of stigma, Corrigan and colleagues (2017) maintained that stigma causes shame, which could undermine self-worth for people living with psychiatric disorders via self-stigma. Lannin, Vogel, Brenner, Abraham, & Heath, (2016) posited that self-stigma may also interrupt the initial decision of people with mental health problems to seek information about treatment; therefore, reduction of self-stigma may help address one barrier to treatment.

1.3. Making Meaning of “Mental”

Chisholm and colleagues (2018) explored the construction of mental illness among adolescents between 11-18 years and its implication for treatment. Their findings revealed a dual perception of mental illness. The participants mentioned stereotypes and extreme examples

of mental illness, which centered on “craziness” (p. 7). Conversely, participants were also able to share insightful understanding of mental distress and identified the importance of emotional well-being and ill-health (i.e., mental illness). These themes are consistent with other findings that adolescents have stigmatized attitudes towards people with mental illness. For example, Maclean, Hunt and Sweeting (2013) found that British students aged 11-18 viewed symptoms of mental illness as “rare,” “weird,” and taboo (p. 6). The participants for this study maintained that they would not seek mental health treatment due to stigma associated with the symptoms of mental illness.

Overall, a review of the literature on adolescent mental health and associated stigma highlights that youth often do not seek necessary help even though many mental health problems first present during adolescence (Kessler et al., 2007). Although there are a variety of barriers that may deter youth from pursuing mental health services, stigma has been a fairly consistent theme within the literature (Watson, Kelly, & Vidalon, 2009; Gulliver, Griffiths, & Christensen, 2010; Lannin, Vogel, Brenner, Abraham, & Heath, 2016; Chisholm, Patterson, Greenfield, Turner and Birchwood, 2018). One specific barrier to treatment engagement for maybe be how adolescents, including justice-involved youth (McCormick, Peterson-Badali, & Skilling, 2017; Swank, & Gagnon, 2017), understand the term “mental health,” especially those who have screened positive for mental health symptoms and, therefore, likely are in need of mental health services. Such an investigation is important particularly if these youth perceive the term as stigmatizing.

Therefore, the primary aim of the current study was to examine how previously detained youth who screened positive on a mental health screening instrument perceived mental health terminology as a barrier to service engagement.

2. Methods and Materials

2.1. Procedures

Given the research team's intent to understand participants' meaning making of the terms mental health and counseling, qualitative methodology was appropriate in that depth over breadth of understanding was the goal. Three doctoral-level social science researchers that were trained at the graduate level in conducting qualitative research conducted semi-structured interviews, one of whom was well-versed in interpretive phenomenological qualitative analysis. Each researcher discussed potential biases and preconceptions prior to data analysis in order to be aware of them and to mitigate their impact.

Data collection occurred in four counties within one Midwestern state in the U.S. The length of interviews ranged from 6 to 39 minutes ($M = 21.74$); the one six-minute interview was an outlier in that the participant wanted two gift cards instead of one and, therefore, provided minimally descriptive responses. The broader purpose of the study was to understand how youth and their parents/caregivers sought mental health services while detained and shortly after release from juvenile detention. A semi-structured interview guide of 21 questions were designed to examine how youth and their parents/caregivers accessed physical and mental health services. However, three questions were specific to the data presented in this manuscript (see below).

Table 1. Abbreviated Semi-Structured Interview Guide

1) How do your friends affect your getting counseling services?
2) What do you think of when you hear the word, "Mental Health?"
3) For you, is there a difference in getting counseling services compared to getting mental health services?

Each of the 19 youth interviews were digitally recorded and then transcribed by an outside contractor that specialized in transcription of qualitative data. After each interview, two members of the research team (i.e., the interviewer and another) would meet to debrief the experience of the interview.

2.2. Participants

Participant recruitment was based on a purposeful, criterion-based sample (Patton, 2002). Inclusion criteria were previously-detained youth who: (a) scored above the cutoff threshold on the Massachusetts Youth Screening Instrument (MAYSI-2), a mental health screening tool administered at detention intake, (b) were released back to their home for a minimum of 30 days, (c) were between 11 and 17 years of age, and (d) had at least one caregiver (i.e., parent or legal guardian) who agreed to be simultaneously interviewed. As long as the youth could communicate and was not a risk to self or a member of the research team, they were not be excluded from participating (e.g., severe mental illness).

To clarify, the MAYSI-2 is a 52-item, dichotomously scored (i.e., yes/no response) mental health screening instrument used to identify youth who warrant further mental health assessment. A positive screen for these youth consisted of a score in the caution or warning range (2 or higher) on the 5-item suicide ideation scale, or a warning range score (3 or higher) on two or more of the remaining six subscales (alcohol/drug use, angry/irritable, depressed/anxious, somatic complaints, thought disturbance, traumatic experiences (Grisso, Barnum, Fletcher, Cauffman, & Peuschold, 2001).

Youth ages ranged from 11 to 17 years of age with a median age of 15.5 for males and 16 for females; all had previously been detained in their county's juvenile justice system. Seven males were Black, four were White, and one was Hispanic for a total of 12 male youth. Three of

the females were Black, four were White, and none were Hispanic for a total of seven female youth. A total of twelve youth had received outpatient care; eleven were taking prescribed psychiatric medications; and eleven of the youth had recently begun or were continuing mental health services upon their reentry to the community.

2.3. Recruitment

Upon approval from Institutional Review Board (IRB), detention center staff completed training with the IRB learning modules on ethics, coercion, and the importance of self-determination during the recruiting process. After successful completion of the training, detention center staff phoned parents/caregivers of potential participants who met inclusion criteria and read an IRB-approved script describing the study. Next, parents were asked if they would be interested in receiving a call from a member of the research team for additional information. During this call, the research team was available to answer questions about participation and informed potential participants' parents/caregivers of the \$20 gift card incentive.

2.4. Interviews

Semi-structured interviews were conducted with 19 youth. Parents/caregivers were also interviewed separately; however, only data from youth interviews were examined in this manuscript. Interviews took place in locations that were most convenient for participants (e.g., homes, libraries, private rooms at juvenile detention centers); the majority of interviews occurred in participants' homes. After interviews concluded, two researchers would meet to process the interview, the interviewer's notes, and feelings that emerged. Biases were identified through discussions and personal notes by the research team to minimize reactivity.

2.5. Data Analysis

Interview transcriptions were read and analyzed via open coding. Open coding is defined as “the part of analysis that pertains specifically to the naming and categorizing of data by breaking down data into discrete parts, closely examining them, comparing for similarities and differences, and asking questions about the phenomena...” (Rubin & Babbie, 2011, p. 483). The purpose of employing open coding was to find common themes within the youth’s responses then to subsequently organize, analyze, and illustrate these themes using exemplars from the data. Researchers then identified data that corresponded to distinct sub categories and came to consensus on labeling them according to emergent themes.

The data collection and analysis was performed using a grounded theory approach, focusing on youth’s perceptions while also being careful not to impose one’s preconceived ideas or theories on the study. The grounded theory method (Creswell, 2017) is an inductive approach that avoids analysis of having a “preconceived theory or hypothesis” in mind but instead, “seeks to discover patterns and develop theories from the ground up, with no preconceptions (Rubin & Babbie, 2011, p. 479). The grounded theory approach allowed the interviews to speak for themselves; given that this approach allows for any and all responses that may emerge. Therefore, grounded theory allowed for richer and more compelling insights into the phenomenon of interest. Specifically, these researchers analyzed the qualitative data set consisting of transcripts of interviews with participants. Participants’ responses related to mental health stigma, meaning, and the perception of mental health services and counseling. The researchers met weekly throughout the analytic process. Before reading the transcripts, each researcher created categories they believed would emerge in order to identify and acknowledge preconceived biases. Each researcher individually read the same three transcripts and used open coding. Researchers met to discuss codes that were being used and categories that were

beginning to emerge. Over weekly meetings, the research team agreed on initial categories and then used a combination of open and axial coding called microanalysis, where the coder took notes line by line and generated any additional codes as they read (Patton, 2002). In addition, authors verbally compared the similarities and differences of the 19 cases. This method allowed us to identify themes for each of the interviews. Finally, codes that represented categories, and themes were inputted into NVivo 8 software (QSR, 2008), where coders scored each of the 19 participant transcripts. Individual annotations were made with each transcript during analysis to be discussed in the next research team meeting.

3. Results

The results are discussed in three different sections categorized by theme. Broad emergent themes included (a) public peer stigma, (b) mental health meaning, (c) and the perception of seeing a treatment provider for “mental health” versus “counseling.”

3.1. Public Peer Stigma

Participants discussed different aspects of disclosure to their peers that they received mental health services. When asked, “How do your friends affect you getting counseling services?” three themes emerged: reasons for non-disclosure to peers, non-supportive peers, and supportive peers.

3.1.1. Non-disclosure to Peers

Results indicated that youth felt uncomfortable telling their friends that they attended counseling either because they expected to be judged or because it did not come up. Despite divergent individual responses regarding peer stigma, most participants ($n = 12, 63.1\%$) in this study did not disclose information about receiving counseling services to their friends. For example, a 16-year-old Black female elaborated: “Well, my friends, they really don’t even know

that I've had counseling. I don't talk about it to them... we talk about anger management, but not as far as like real, real counseling and stuff." She made a distinction between feeling comfortable disclosing a more normative treatment experience such as "anger management" and not wanting to disclose, "real counseling," to friends.

3.1.2. Non-supportive Peers

About one quarter of the participants ($n = 5$, 26.3%), revealed that their peers were not supportive of attending counseling and felt as though they would be ridiculed. For example, a 14-year-old Black male explained he did not talk to his friends about his family problems because he feared they may have thought differently of him:

Interviewer: So can you tell me, what is their attitude about you getting counseling, like, going to counseling?

Youth: I don't really tell them what goes on in my house because I don't think—if somebody thinks that I'm getting counseling, oh, I'm not cool anymore. They'll say I'm a mental retard and stuff like that.

In this case, the youth inferred that his friends would react negatively if they found out about his family problems and that, as a result, he was in counseling. Specifically, he was focused on the perception that receiving counseling was associated with "mental retard[ation]."

A 16-year-old White male also highlighted his perception of peer stigma and how he expected his friends would react:

Interviewer: What would you say is the biggest obstacle, the biggest thing that has ever gotten in the way of you getting counseling services?

Youth: Probably my friends thinking different about me... like all my friends that I hang out, they'd probably think that I'm weird for going to counseling or saying that I'm stupid or something like that and that I just, I wouldn't feel right around my friends if I went to counseling services, if I needed it.

Interviewer: What might they say? What would you imagine them saying if they found out you were going to counseling?

Youth: They'd probably be all weird around me and probably won't talk to me at all...If they were like real good friends, like I have a couple of real good friends that would probably accept it, that me going to counseling but most of them, they wouldn't probably talk to me since then at all.

This individual contemplated how his friends might respond and distinguished his peers as belonging to two groups: close friends and other peers. He believed that some "real good friends" may be accepting, however, he speculated that most of them would no longer associate with him if he disclosed that he received counseling.

3.1.3 Supportive Peers

In contrast to the majority of participants feeling criticism from their peers, some youth ($n = 2$, 10.5%) felt that their friends were receptive to counseling. A 17-year-old White male who received wraparound mental health services shared the encouragement he had received from friends: "[They're] with me 100% all the way...all my friends are actually supportive. They want me to go through it and that way it'll help me."

A 17-year-old White female revealed how counseling was highly sought after within her peer group:

Interviewer: How do your friends affect your getting counseling services?

Youth: I don't know. They don't.

Interviewer: No attitude about it or no thoughts that they have about it?

Youth: No, a lot of my friends wish they could get counseling services. It's been like that, or they do. Like now it just seems like it's cool to go up and say 'oh yeah, yesterday my therapist said.' It's kind of like a trend to have issues I guess. I don't know, it's like it makes them seem like they're cool.

Initially, this youth stated her friends *did not* (emphasis added) influence her receiving counseling services. However, when the interviewer rephrased the question, she explained her friend's perceptions. These two individuals' experiences contrasted considerably with all other participants in this sample by having friends that were supportive of counseling. However, the terminology used to describe mental health services impacted some participants' perceptions of receiving services.

3.2. "Mental Health" Meaning

Youth participants in this study had an overwhelmingly negative perception of the term "mental health." The most common words used to describe this term were "retarded" and "crazy"; this finding illustrated participant's tendency to focus on the word "mental" and associate it with either mental retardation or being psychotic. When asked, "What do you think of when you hear the words, mental health?" participants' responses were consistent with four main themes: confusion, retardation, psycho, and shame.

3.2.1. Confusion

A number of youth's responses were consistent with confusion regarding the meaning of mental health. For instance, a 15-year-old Black female revealed her ambiguity toward the term:

“I wouldn’t really know because I don’t know if counseling is mental health but if it is mental health then I know mental health. But I don’t really know what mental health is, for real.”

Her response indicated that she was unclear whether or not there was a difference between counseling and mental health. However, she had a clearer understanding of counseling but was less certain when she attempted to define mental health.

A 14-year-old Black male also demonstrated confusion with the meaning of mental health: “Mental—...I know it’s not mental retarded, but it’s, like, how you act help, something like that. I don’t know, but I know it’s not mental retarded.” This participant knew that mental health and “mental retarded” did not have the same meaning. However, he continued to use this highly derogatory, stigmatized word, despite his awareness that mental health does not mean mentally retarded. Thus, this stigmatized term was inextricably linked to mental health and confused him. In contrast, other youth explicitly discussed their tendency to connect mental health to “retarded.”

3.2.2. “Retarded”

The following examples illustrate how youth can attribute the word “mental” and, therefore, mental health, with having an intellectual/cognitive disability. “Retard,” “retarded,” and “slow people” were frequently used. A 16-year-old White female admitted her propensity to associate mental health with mental retardation saying: “Mental health. I don’t know. The first thing that pops into my head is like honestly a slow person... like a retard. That is what I think of, like mental health.”

Another 16-year-old White male responded similarly when he heard “mental health”: “Retarded. Like having mental health—like saying you have something wrong with your head like something’s wrong with you or you have a problem or just something in that category.”

Both youth illustrate how having a mental health issue can suggest being “retarded” in that “something’s wrong with your head.” In contrast to the prior participant’s perspective that mental health was a need for a “slow person,” this male participant’s understanding was more descriptive of a psychological state than one’s cognitive abilities.

3.2.3. “Psycho”

The third theme that emerged was “psycho,” from various participants who used phrases such as psychotic, killer, or crazy people. A 17-year-old White male’s response elaborates on his meaning making of mental health: “Psycho. When people say mental health you automatically jump to the conclusion that they are psychotic and they have a lot of mental problems.” A 16-year-old White female shared similar thoughts: “I think of crazy people. I only think of schizophrenic people. Those people... it mainly makes me think of people that are in a mental health institute.” For these participants, mental health was associated with being crazy and poor mental functioning. A 15-year-old Hispanic male also described his thoughts on mental health meaning:

Interviewer: What do you think of when you hear the word mental health?

Participant: As a kid, for me, a teenager, when you first hear the word mental health you think of someone crazy. You think of a mental hospital. You don't think of actually the well being of someone. You just think that it's something you used to describe someone as crazy, a mental person.

This participant contextualized his viewpoint by stating, “[as] a kid,” which indicated that individuals from his age group may have different views from adults. He explained how mental health seems to depict someone who is “crazy” that may require hospitalization. He also indicated that “the well-being of someone” was not associated with mental health services. The

loss of control in one's mental functioning seemed to frighten several participants in this sample, as they mentioned long-term psychiatric hospitalization.

3.3. Shame (Self-Stigma)

A 16-year-old Black male expressed shame about how others viewed his mental health problems:

Sometimes it can make you feel like you're a bad person how people say that, 'he has mental health issues and he can't control himself.' That's how people were referring to me when they say 'He has anger problems' and all this stuff. 'He needs to be put on meds.'

This participant believed that others saw his "mental health issues" as influencing others to perceive him as a person who was angry out of control, a bad person. Having a "mental health issue" was stigmatizing for this 16 year old because others viewed him as in need of psychiatric medication. Thus, this participant's experience exemplified how outsiders' perceptions can harm one's self-image via both self and public stigma.

3.4. Comparison of "Mental Health" and "Counseling"

Youth shared their perceptions of receiving MH compared to counseling services in response to the question: "For you, is there a difference in getting counseling services compared to getting mental health services?" Overall, responses indicated either uncertainty or the youth's negative perceptions of mental health. A 15-year-old Black female responded with her preference:

Participant: I'd rather go to counseling.

Interviewer: Can you tell me about that?

Participant: Because counselors don't put you on medication and label you as crazy or bipolar. They just talk to you and if you don't want to go back you don't have to go back, but the [mental health agency] wants to keep you there and they'll keep you.

This participant's perspective suggested that the implications of receiving MH resulted in negative consequences compared to counseling.

3.4.1. Peer Reactions

This 16-year-old White male explained why he expected his peers to view the terms "counseling" and "mental health" differently:

Interviewer: Would there be any different thoughts if they found out you were going to counseling or if you told them that you were going to mental health, do you think they'd respond differently?

Participant: Oh, yeah and they'd probably respond differently if I said I was going for mental health problems cause they'd probably think oh, he's like a killer or something, not like a killer but probably they'd think I'm just horrid or have something wrong with my head.

This youth believed that his peers would react negatively to him "going for mental health problems," which was different than his perception of his close friends' view towards counseling. In contrast, he expected them to associate the term with an extreme negative judgment, someone who was "a killer." However, one youth who was receiving intensive wraparound services believed his peers were supportive of him receiving mental health services. This 16-year-old White male provided an illustration of why youth tend to have a more optimistic outlook toward counseling compared to "mental health."

Interviewer: Is there a difference in getting counseling services compared to getting mental health services?

Youth: Counseling is helping your mental health. I don't see a difference. Counseling's just another word to say mental health.

Interviewer: Does any one of those words [counseling and mental health] seem more positive or more negative than that other?

Participant: Counseling seems more positive, just because you hear it more. You hear counseling more. But whenever you hear something that you're not used to, it's like mental health. You're like, 'Huh?' You get on edge. You're like, 'What is this you're talking about?' But when you say, 'Counseling,' you'll be like, "Oh, okay, I think I can do that."

Initially, this youth reported that he saw the two words synonymously. However, he articulated that he perceived counseling more “positive[ly]” than mental health because it was commonly used and, thus, was a more normalized term. As such, there were a number of youth in this study who found counseling to be a less stigmatizing term than mental health.

3.5. Uncertainty of Terms

Although many youth expressed negative attitudes toward the words mental health when directly compared to counseling, a number were unsure if there was a difference between the two terms. A 14-year-old Black female illustrated this uncertainty:

Interviewer: Are you getting counseling or mental health services, do you think?

Participant: I don't know the differences between therapists and counseling.

Interviewer: That's interesting. Is there a difference between mental health, getting mental health treatment and therapy in your mind?

Participant: Yeah.

Interviewer: Can you tell me what the difference would be?

Participant: I don't know because I don't know what the answers really mean.

Interviewer: Which one do you like better? Which one seems like it's more you?

Participant: Counseling and therapy.

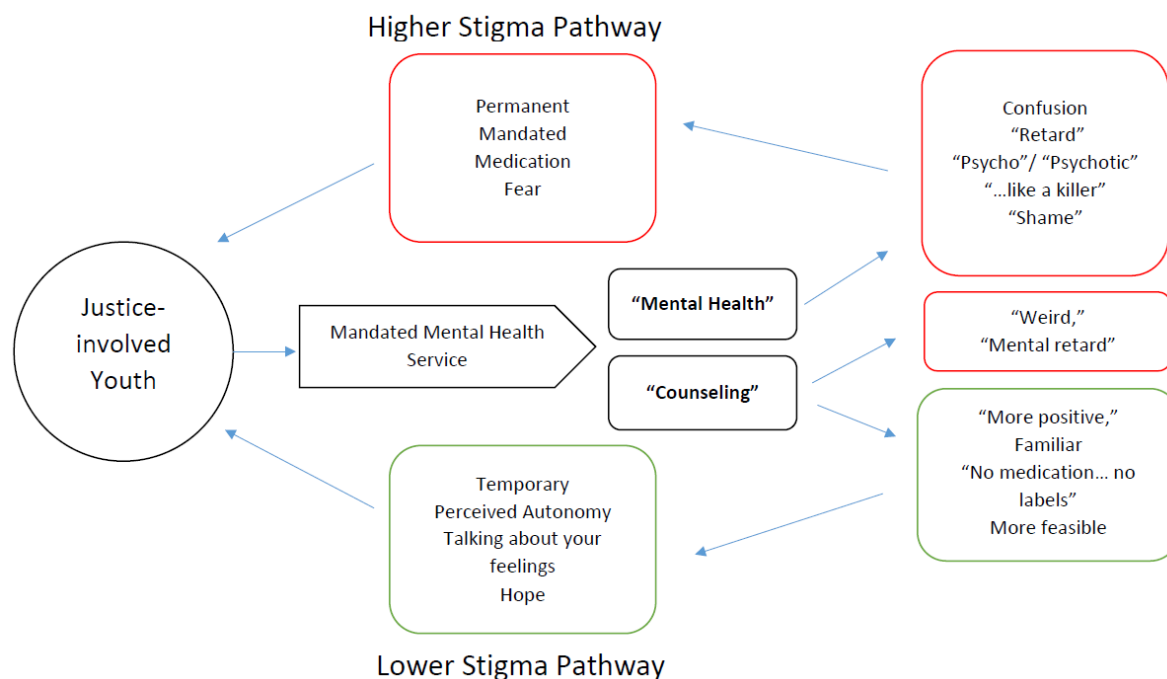
This youth originally stated she did *not* (emphasis added) know the difference, then later stated that she believed there *was* (emphasis added) a difference but was unable to discern it. When asked which term she personally preferred, she clearly identified her preference: Counseling and therapy.

In response to the question, "To you, is there a difference in getting counseling services compared to getting mental health services?" other participants were straight forward in sharing their uncertainty. A 16-year-old White female replied, "Honestly, I am not sure what mental health services really is." Similarly, a 12-year-old Black male said, "Kind of...I'd rather not answer that question, I can't think of anything."

Overall, the results suggest that the youth in this study had negative perceptions, reactions, and attributions to "mental health" compared to "counseling." Thus, a model from the data emerged (See Figure 1). No participants in this study described mental health favorably when asked to compare the two terms. At best, one participant saw them as synonymous. In addition, a few participants who did not report negative perceptions toward the term mental health expressed overall confusion or uncertainty about its meaning.

4. Discussion

These findings highlight some possible barriers for the low rates of mental health service use among justice-involved youth, which remains an area of interest for researchers (Hassett, & Lane, 2018; Liebenberg & Ungar, 2014). Our results revealed negative or at best, neutral perceptions and attitudes among participants toward the term “mental health.” While some found it confusing, others associated the term with words like killer, psycho, or retarded (see Pathway figure below). The term “mental health” led justice-involved youth who had been mandated to treatment to the higher stigma pathway, whereas the term “counseling” led them to the lower stigma pathway.



Thus, use of stigmatizing labels and terminology may be especially relevant for justice-involved youths' willingness to seek and participate in mental health services. If they were under the impression that those in need of mental health care were mentally retarded, crazy, psycho, or another stigmatizing term, it was no surprise that participants in this sample who screened high for mental health symptoms refrained from seeking treatment unless mandated by

the court. Thus, negative labels such as “crazy” and “psycho” likely increase stigma for youth who are identified with mental health needs.

These findings are in line with previous research that associated “psycho” with someone who was “crazy,” “retarded,” or a danger to themselves or others (Watson et al., 2009, p. 1094). However, unlike Watson and colleagues, this study offered youth an alternative label to compare meaning. As the Pathway model suggests, counseling subjectively increases the perception of autonomy while increasing some level of hope. Given participants’ negative association of “mental health,” our findings suggest that the term in and of itself may be a barrier to accessing treatment (Corrigan, 2007) and emphasize the need to examine the language used to describe mental health services. Changing terminology used to describe mental health services may mitigate justice-involved youths’ negative perceptions of mental health. Researchers and clinicians are encouraged to continue to examine less stigmatizing terminology to describe treatment for mental health conditions for this vulnerable population.

4.1. Public and Self-Stigma

Both public and self-stigma were identified with mental health services among our participants, which made them wary of using mental health service. There was a clear consensus that not disclosing to friends, especially those outside one’s inner circle, was necessary to protect against negative perceptions of themselves. Participants reported variable levels of self-stigma related to receipt of mental health services. In contrast, there was no indication that health professional stigma acted as a barrier relating to stigma for participants in the current sample (Schulze, 2007).

Stigma is an important factor to examine when studying barriers to treatment for mental illness because all the three types of stigma (i.e., self, public, and professional) have the potential

to negatively impact individuals who struggle with mental health symptoms (Scheid & Wright, 2017; Corrigan, 2018; Lannin, Vogel, Brenner, Abraham, & Heath, 2016). Attempts to reduce both public and self-stigma while creating neutral or positive associations with treatment may mitigate the impact of stigma as a barrier to treatment engagement.

4.2. “Mental Health” vs. “Counseling”

Participants attributed different meanings to participation in counseling compared to mental health services. They had a more favorable description for “counseling” compared to “mental health.” Participants generally perceived counseling to mean discussing your emotions and feelings, whereas mental health was equated with more severe issues, medications, and problems that were innate. Notably, one youth stated that mental health had a connotation that clinicians would try to restrict one’s freedom, presumably in an inpatient or other locked setting. These participants generally associated counseling with talk therapy and mental health with psychiatry or mental hospitals. Researchers should examine the impact of such negative interpretations by justice-involved youth on mental health service use prospectively. A preference for counseling over mental health, and the concern of involuntary commitment associated with the latter, was consistent with prior research findings by Watson and colleagues (2010).

Overall, the term “mental health” evoked a much more punitive and fearful reaction from participants, presumably due to stigmatization and the negative or unclear comprehension of the term; these findings are in line with the extant literature (Rowe et al., 2014; Maclean, Hunt and Sweeting, 2013). Participants who are mandated to receive “mental health” services may believe that mental health problems are more severe, life-long, and based on personal traits in contrast to physical health issues, which are normalized (Chandra & Minkovitz, 2007).

4.3. Limitations

This study has a number of limitations. Since the research team employed one-time, in-depth interviews with previously detained youth, these findings are only generalizable to that population within the United States. In addition, participants did not have an opportunity to review their transcripts (member-checks are important in that participants have an opportunity to clarify and edit their original thoughts (Guba, 1981). Data regarding the family history of mental illness or prior complete mental health treatment were not collected. Furthermore, it is important to acknowledge that stigma is only one of several barriers that contribute to low rates of mental health service access among youth. There are also other structural (e.g., as financial restraints, lack of insurance) and personal barriers (e.g., cultural influences and negative experiences in treatment). Thus, stigma should be examined in conjunction with other identified barriers to service access.

4.4. Conclusions

The findings of this research highlight the need for future researchers to focus on interventions that can alter how young people think about help-seeking. Research shows that 75 to 80% of youth in the United States do not receive proper mental health services for their mental health condition (Underwood & Washington, 2016). Thus, clinicians and researchers should consider how system-involved youth view mental health service terminology as part of a broader discussion of how services are described, regardless of system involvement. Participants in this study frequently identified the term “mental health” as a barrier to their willingness to seek or accept mental health services/treatment. Furthermore, participants preferred the term “counseling” compared to mental health. Although not always seen in a positive light, especially when disclosing to other peers, counseling was generally seen as “talking about your feelings

and problems.” Thus, the term counseling could be viewed as a low stigma pathway to treatment. Future research could employ large-scale focus groups to identify better labels for mental health services. A more acceptable association could break down one of the identified barriers to accessing mental health services. The aim of revisiting and revising mental health care may lead to positive and renewed understanding of mental health care going forward.

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Highlights

- Justice-involved youth attributed different meanings to the terms “mental health” and “counseling,” whereby the former term was associated with higher levels of stigma and the latter was associated with lower levels.
- Individuals in need of “mental health” services were perceived as psychotic, at increased risk of institutionalization, and in need of psychotropic medications while “counseling” was perceived as more normative.
- The findings are consistent with prior research and support the need for practitioners to reconsider how referrals to behavioral health interventions should be presented to adolescents and their caregivers/parents.