



## special articles

Psychiatric Bulletin (2004), 28, 213–215

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### Changing minds at the earliest opportunity

Stigmatising attitudes towards mental illness are reinforced by lack of knowledge, and it would seem logical to tackle this from the earliest possible age. A series of talks about mental illness to primary school children were enthusiastically received by the pupils, and revealed that negative attitudes were already present among the older children. The mixed responses of teaching staff supported the idea that increasing awareness of mental illness may have a place in primary education.

Among the achievements of the Royal College of Psychiatrists' anti-stigma campaign (Royal College of Psychiatrists, 1998) was the stimulus for me – as a parent and as a psychiatrist – to make a personal contribution, in the form of an offer to my children's primary school to discuss mental illness with the pupils. Most primary schools encourage parental involvement, yet my offer was met with hesitation. There is little in the formal curriculum about mental health, and the poverty of medical literature examining the impact of education on attitudes of young children suggested that stigma was at play.

Wolff & Pathare (1996) showed that negative attitudes to people with mental illness are fuelled by lack of knowledge, and that the main determinant of goodwill was at the educational level. Wilson *et al* (2000) suggested that young people are socialised into stigmatising conceptions of mental illness through children's television programmes. Projects with secondary school-age children might reduce negative stereotypes of people with schizophrenia (Schulze *et al*, 2003). Conceivably, attempts to counteract stigma at primary school level could also be of value. This article describes a small observational, qualitative study to test the feasibility of more formal research, and generate clear research questions.

#### Practical issues

Rightly, there are many constraints on attempts to influence the beliefs of children. Most of these can be addressed by a good relationship with the head teacher. There is an understandable reluctance among busy teachers to participate in any venture that might increase their workload. In this case, it was easy to justify the benefits of talking to children about the

existence of mental illness and the importance of tolerating difference within any community. I circulated written information about my talks to the teachers in advance, noting that their aim coincided with government policy towards social inclusion. Having obtained permission, the next step was to plan the events and to source useful material. The format, developed in collaboration with a colleague with teaching experience, consisted of reading a story aloud, followed by playing games, and role play for the older children. Giving eight separate talks on one day was a mistake! Unsurprisingly, my performance deteriorated as the day wore on, as did the concentration of the children. Personal commitments necessitated this gruelling timetable; few of us would find it easy to spare more than a day for such a voluntary enterprise.

#### Content of the talks

Three different talks were planned, their length and content tailored to the age group of the children (Box 1). I spent about 20 minutes with the youngest children, and 30 minutes with the older groups. I introduced myself both as a mother of children at their school, and as a 'special sort of doctor'.

##### Box 1. Content of talks

###### Years 1 and 2

Story: *Something Else* by Kathryn Cave, illustrated by Chris Riddell

Games: choosing to stand in a corner of room representing a particular condition (tummy ache, broken arm, sadness or 'madness'); 'Simon says': being caught out, creating feelings of exclusion

###### Years 3 and 4

Story: excerpt from *The Illustrated Mum* by Jacqueline Wilson

Games: drawing a 'mad' person; 'Hangman'; 'Simon says'

###### Years 5 and 6

Story: excerpt from *The Illustrated Mum* (less funny, more disturbing than the excerpt chosen above)

Games: drawing a 'mad' person; listing rude names for physically and mentally unwell people; 'Hangman'

Role play of case vignettes

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### Years 1 and 2 (age 5–7)

The book I chose for this age group, *Something Else*, by Kathryn Cave (1995), describes individual exclusion on the basis of appearance, and the feelings that this engenders. We discussed the feelings experienced by the main character. Next, playing a game in which the children chose to stand in a corner of the room representing a particular type of illness provided an opportunity to discuss their choices, and introduced the idea of visible and invisible illness, suffering due to both, and treatment. Lollipops were awarded for participation!

### Years 3 and 4 (age 7–9)

The reading for this and for the oldest group came from a novel that skilfully deals with the issue of living with a parent suffering from bipolar disorder: *The Illustrated Mum* (Wilson, 2000). It includes entertaining but disturbing passages about a mother's unusual behaviour. The children were then asked to draw a picture of a 'mad person'; we all compared our pictures (mine was an attempt to draw someone who looked sad), which led to class discussion of what mental illness might be, comparison with physical illness, and the effects of other people's attitudes. The game 'Hangman' used words such as 'mental' and 'psychiatrist' and the concept of treatment was introduced. Playing 'Simon says' illustrates the emotional consequences of exclusion, and before starting, I pretended to exclude certain children on the basis of personal attributes such as their initials or their hair colour.

### Years 5 and 6 (age 9–11)

Children in these age groups were read a more disturbing excerpt from *The Illustrated Mum*, in which the children in the story take their mother to hospital. Following the exercise of 'drawing a mad person', I used discussion of the children's drawings to help define behaviour, emotion and thinking as separate mental functions that can be altered by illness. The oldest group was asked to name illnesses, both mental and physical, and we talked about why fewer types of mental illness were familiar. Finally, the children divided into groups of four or five. Each group rehearsed and performed a case vignette: one involved taking a depressed mother to hospital (as in the novel extract that they had heard); another was an exploration of what happens when someone is observed to be behaving bizarrely in public (in my example, standing in the street, stopping traffic and shouting); the third asked the children to pretend that a sister with anorexia was attending her general practitioner because of her mother's concern; and the fourth explored issues around visiting a grandparent who could see and hear things that were not really there. During discussion of the role plays, therapeutic concepts were introduced.

### Children's responses

Throughout the day, I was impressed by the children's interest and participation in the issues raised. The youngest groups seemed to use words such as 'mad' and 'crazy' to mean unboundaried, wild behaviour and this was regarded positively by the significant proportion (about a third) who chose the 'mad' corner of the room. The next age group were fascinated by what I meant by words such as 'mental' or 'mad', and although one child was very clear that mental illness did not equate with intellectual impairment (her mother had epilepsy), there was much group discussion about whether the September 11 hijackers were 'mad'. This age group was also particularly vociferous about the immorality of exclusion: I was chastised for pretending to leave anyone out of our games!

There seemed to be more evidence of stigma towards people with mental illness in the oldest children, not only in what was said but also in their reluctance to discuss certain issues. The children were clearly trying their hardest not to cause offence. For example, when listing rude names for people with mental illness, I had to generate a few to get them going, but once started, they were able to think of many. The most informative item performed in the role plays involved a group of children pretending to have walked past someone shouting and gesticulating in the middle of the road, putting himself and others at risk of injury; the children's role-play of this situation developed into a scene about being followed and running away. There was another good example of the influence of stigma in a comment by one of the class teachers that she thought my explanation of an eating disorder for another of the role plays (as an illness in which people can think they are fat when they are not, and therefore do not eat enough to be healthy) might 'give them ideas'. I felt this concern was adequately dealt with when one of the girls in the class volunteered the extra information that people with anorexia also make themselves vomit.

The pictures drawn by the children depicted a wide variety of perceptions of mental distress. A large proportion showed people with abnormal physical attributes (such as an extra nose or a strange hairstyle); many also depicted frightening teeth or angry expressions. Another group of pictures depicted non-human forms, such as arms on springs. Some drawings demonstrated bizarre behaviours, such as wearing ripped clothing or eating inedible objects. A very small proportion showed otherwise normal people with expressions of sadness or other extreme emotion.

### Feedback from teaching staff

In an attempt to evaluate the talks, I devised a brief questionnaire (three questions) for the teachers of the various age groups. This asked if they considered the children better informed as a result of the talk, whether the presentation was age-appropriate and whether the session should be repeated in the future (each teacher had only observed one talk). Despite my handing the



questionnaire to each teacher personally and requesting its return at a feedback meeting I had arranged for the following week, only four out of the eight questionnaires were returned. The responses were mixed. One did not reply to any of my questions, but instead gave some helpful and thoughtful comments ('A series of talks (say six) might be needed, warm-down and plenary sessions are essential'). Of the other three respondents, two wanted the talk repeated in the future, two felt the children were better informed and one thought that the presentation was age-appropriate.

## Discussion

Primary school might be the ideal place to begin the discussion of attitudes to mental illness, as children participated in the talks enthusiastically. Some of the older children had already developed stigmatised opinions, as has been previously described (Weiss, 1994). Attitudes of children to mental illness have been shown to be associated with race, religion, past experience, parental opinion and socio-economic status, and many of these attitudes are stable with age (Weiss, 1986; Spitzer & Cameron, 1995). Other authors have shown developmental trends, with older children more able to conceptualise psychological problems as 'internal' to the person (Dollinger *et al*, 1980). Increased benevolence towards those with learning disabilities may develop because of exposure to positive images and experiences of these people (Weiss, 1994).

The impact of education on attitudes is less well studied. Medical education was shown to improve attitudes towards and acceptance of people with mental illness in medical students (Mino *et al*, 2000), and two recent educational interventions in London and in Germany have been demonstrated to have a positive impact on older children's attitudes towards mental illness (Pinfold *et al*, 2003; Schulze *et al*, 2003).

It is necessary to assess the form of education that might be of use to those either suffering from mentally distressing symptoms themselves, or in contact with someone who does (e.g. parent or sibling). Providing a forum for open discussion of an often taboo subject might in itself be considered valuable, and Bailey (1999) suggested that early education in the hows and whys of mental illness would increase children's understanding. To this end, the College anti-stigma campaign Changing Minds have produced children's books, pamphlets and a CD-ROM for older children. The issues are sensitive, so the experience of a mental health worker is useful, and may be valued by teaching staff – who may themselves have stigmatising attitudes. Many of us are parents, which may provide useful experience when attempting to devise a series of age-appropriate talks; my own children

### Box 2. Research questions generated

- How do the attitudes to mental illness of primary school children vary with age?
- What is the impact of an educational package on these attitudes?
- What form should the educational package take?
- How should parents be incorporated?
- How do teachers rate such interventions?

have definitely helped! More research is clearly needed; some topics generated by this study are listed in Box 2. Finally, increasing awareness of mental health and illness in young children is unlikely to cause harm, and could be argued to be an important component of all primary education.

## Declaration of interest

None.

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