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# The conceptual development of mental health and illness in preschool children

Rosanna Bell  
*Ryerson University*

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THE CONCEPTUAL DEVELOPMENT OF MENTAL HEALTH AND ILLNESS  
IN PRESCHOOL CHILDREN

by

Rosanna Bell, BA, University of Toronto, 2005

A Major Research Paper  
presented to Ryerson University

in partial fulfillment of the requirements for the degree of

Master of Arts  
in the Program of  
Early Childhood Studies

Toronto, Ontario, Canada, 2007

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# THE CONCEPTUAL DEVELOPMENT OF MENTAL HEALTH AND ILLNESS IN PRESCHOOL CHILDREN

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Master of Arts  
Early Childhood Studies  
Ryerson University

## ABSTRACT

Children with a mental illness may be at significant risk of suffering from negative social evaluations and the exclusion of their peers. This paper examined healthy preschool children's earliest conceptual constructions of mental health and illness through two elected representations – the term *crazy* and depictions of emotionally and behaviourally deviant peers. Interviews with eleven preschool children reveal the concept of mental illness has yet to be constructed from a psychological standpoint. However, preschool children are highly sensitive to social-conventional as well as higher moral codes and discriminate against peers' who violate these codes, particularly those who display anti-social tendencies. Findings suggest that preschool is a formative period for establishing negative attitudes towards social and moral code violating behaviours that are often the symptoms of psychiatric conditions and which may represent the onset of more complex and enduring patterns of inter-group intolerance and discrimination. Implications for education are provided.

### Key words:

(mental health and illness, conceptual development, *crazy*, peer deviant behaviour, attitudes)

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## **I. Introduction**

*“The greatest omission in the work that I see is that it fails to stress the reality that most of the mental health disorders affecting Canadians today begin in childhood and adolescence.”*

*- Dr. Diane Sacks  
“Out of the Shadows at Last”*

### **1.1 Statement of the Problem**

In the last two decades, Ontario’s educational system has adopted more inclusive attitudes and practices to support its exceptional children (Reiser, 2006; Underwood, 2006). One group that appears to be on the bottom rung of the “inclusion” ladder is children with mental illness. Currently, a reported 20% of Canadian children under the age of 18 struggles with mental health issues and only approximately half of these cases are being identified and treated (Kirby & Keon, 2006; West, 1997). The overwhelming prevalence of this problem implies that most children will have had direct exposure to a mentally ill peer and will have encountered the dominant cultural attitudes and prejudices related to such conditions. Children’s interpretations of their troubled peers’ behaviour will invariably have direct implications on the social and emotional adjustment of these individuals.

The focus of the current study is thus the exploration healthy children’s conceptions of mental health and illness. Identifying their perspectives may be a critical step towards promoting the social acceptance and support of mentally ill children in our classrooms, communities and ultimately, in a broader cultural context. More specifically, this knowledge may help inform mental health and stigma-prevention education directed to our youngest students. Exploring their understandings may also help determine if this age group is intellectually and emotionally prepared to benefit from education of this

nature. Undoubtedly, the earlier children are educated, the better their chances of developing inclusive and empathetic perspectives of such persons.

Educating our youngest students about this issue may also have a significant impact on the 20% of children who suffer from mental illness (Kirby & Keon, 2006; West, 1997). Mental health and stigma-prevention education may encourage young sufferers to seek help from educators and practitioners. According to the Kirby Report: *Out of the Shadows at Last*, the school setting is the optimal, yet currently most underdeveloped, site for identifying and providing services to children who are at risk or who suffer from mental illness (Kirby & Keon, 2006). Ultimately, early detection and therapeutic interventions will increase the likelihood of positive long-term health implications for the child, their family and the efficiency of our health-care system.

A second objective of this study is to explore how children perceive peers who exhibit aggressive or anti-social behaviours. Bullying and peer victimization has become a central issue in our schools due to the potentially profound and long-lasting emotional impact it can have on children and their families. Research reveals that peer aggression can begin as early as the preschool years (Crick, Casas & Chin, 1999). Children's perspectives on bullies may help contribute to the effective design of education that promotes awareness and discussion of this issue in our schools and homes.

Children who are mentally ill are profoundly stigmatized and marginalized in our society. This research is guided by a social justice and inclusion philosophy that aims to highlight the importance of grappling with children's mental health issues, particularly within our educational system. The current study also takes a qualitative approach that is intended to provide critical insight into a broader scope of issues requiring in-depth

analysis. Thus, the focus of this qualitative inquiry is to explore, in healthy children, the knowledge and attitudes that comprise their earliest understandings of mental health and illness. The topic under study will be examined in children via two elected representations of mental illness, that is, the term *crazy* and narrative depictions of peer deviant behaviour.

## **1.2 The Pervasive Cultural Discourse of Mental Illness**

Research indicates that preschool children are privy to the dominant cultural discourse of mental illness through portrayals in popular culture. TV media (Diefenbach, 1997) and programming geared toward children under the age of ten (Wilson, Nairn & Coverdale, 2000) convey powerful and stigmatizing messages about mental illness. Often these messages manifest in the representation of characters who act in socially deviant ways and through the use of denigrating labels (e.g., “crazy”, “mad”, “losing your mind”).

Diefenbach (1997) examined the nature of portrayals of mentally ill individuals in American prime-time television. Over one third of these individuals on the television program were the perpetrators of violent crimes or exhibited violent behaviour compared to the 1.5-3.6% of mentally ill people who are reportedly violent in current American statistics. In addition, the quality of life of mentally ill persons and the impact of mentally ill persons on society were portrayed as overwhelmingly negative compared to the general population.

A discourse analysis of children’s TV programming reveals that negative depictions of characters with mental illness are quite common. Wilson et al. (2000) examined fifty seven hours of young children’s shows and found that almost half of the

shows made reference to or depicted a mentally ill individual. The characters were all portrayed as objects of amusement, derision or fear with typically unattractive physical attributes, i.e., rotting teeth, small eyes, as well as behaviours that indicated a loss of self-control or good judgment. Many children are exposed to television from birth, absorbing the lexicon and social perceptions of individuals with socially deviant behaviour. As a result, these children may be learning to separate and alienate other children or adults who suffer from a mental illness or who reflect similar characteristics. While the direct impact of such programming remains unexplored, it is clear that children prior to school age are being exposed to the social stigma that surrounds and isolates victims of mental illness in our culture.

### **1.3 Developing a Conceptual Understanding of Mental Illness**

Over the last thirty years, quantitative methods have dominated the limited collection of studies focused on examining children's conceptions of mental illness. Qualitative investigations which use more child-centered methods remain to be a strong presence in literature of this kind - particularly where preschool children are involved. Typical methodologies have consisted of school age children rating individuals who are labeled with an emotionally deviant health condition. Within this literature, a small subset of these studies has focused on the developmental aspect of children's perceptions (Coie & Pennington, 1976; Novak, 1975; Spitzer & Cameron, 1995; Weiss, 1986).

Children appear to develop the ability to distinguish between various mental health conditions from as early as 4 years of age. Weiss (1986) used a social distancing measure to compare the perceptions of children in kindergarten (age 4-6), grade 2, grade 4 and grade 8. All children were asked to draw a stick-figure, which was to represent

themselves, in relation to a symbol representing someone from the following categories: *crazy, mentally ill, emotionally disturbed, handicapped* and *normal*. Children's attitudes were judged based on the degree of distance between the two representations for each category. Children of kindergarten age seemed to perceive some distinctions between these labels because they preferred to have the greatest social distance from the *crazy, mentally disturbed* or *mentally ill* persons. While it remains unclear how these children interpreted each label, the results suggest that preschoolers may be capable of discerning some categorical differences in these groups which may represent the onset of more generalized in-group/out-group prejudicial attitudes.

According to Adler and Wahl (1998), school age children have very poor behavioural expectations of adults labeled mentally ill compared to "normal" adults. This study used a two part, quantitative approach. In part one, researchers asked third-grade children to create three separate stories about a person in a picture labeled *normal, physically ill* and *mentally ill*. In the second part of the study, children were questioned about their perceptions of various forms of behaviour associated with a mentally ill person. Some questions included: would he be likely to dress nicely?...have a job?...cry a lot? etc. Results showed that mentally ill adults were associated with the highest number of negative physical and behavioural characteristics suggesting that these particular labels negatively impact children's expectancies. It was also found that physically and mentally ill adults were considered equally helpless. However, children lacked the ability to clearly distinguish these two health conditions and virtually no children could accurately explain the term *mental illness*.

In contrast, research examining the effect of mental health labels applied to peer figures revealed a minimal effect on school age children's perceptions (Novak, 1975). A group of fourth-, fifth- and sixth- grade public school children were asked to evaluate two imaginary peers, one in a labeled condition and one in an unlabeled condition. The following labels were randomly assigned: *normal*, *depressed*, *aggressive*, *phobic*, *schizoid*, and *immature* and each child received two different types of imaginary peer conditions. The labels were not defined for the children. Three dependent variables were measured: attractiveness, preferred social distance and perceived similarity. Novak reported that, only for the *schizoid* imaginary peer labeled condition, did boys and girls prefer a greater social distance compared to the non-labeled condition. Interestingly, both boys and girls evaluated peers of the opposite sex, labeled as *disturbed*, as less attractive compared to peers of the same sex. Overall, aggressive behaviour was most negatively sanctioned by all children, in the label and non-label conditions. From this pattern of results, it appears that labels minimally impact children's perceptions of their peers' behaviour. This suggests that school age children may only associate mental health labels with adult behaviour but not to children's behaviour.

Children's difficulty with applying mental health labels to their peers may be related to their understanding (or lack thereof) of the underlying psychopathological origin of mental illness. In a study by Coie and Pennington (1976), first-, fourth-, seventh- and eleventh grade boys and girls were read two stories that depicted characters who were described with aggressive tendencies or psychotic and paranoid social tendencies and were asked to rate the characters' degree of deviance. Most first grade children normalized peer deviant behaviour and made no reference to a psychological



origin. The behaviours were perceived as a natural response to threats in their environment such as peer provocation. Middle school and high school children made some reference to a psychological etiology or were capable of fully recognizing the psychopathological origin of this behaviour. This suggests a strong developmental pattern in children's understandings of the relationship between deviance and mental disorder. Thus, peer behaviour may not be framed by particular mental health labels until children have grasped the underlying psychological origins of these conditions.

Spitzer and Cameron's (1995) mixed methods study similarly found that school age children struggle to define the phrase *mental illness* and its related formal terms. However, this age group has been exposed to more informal, referential terms for *mental illness* demonstrated by their understandings of the word *crazy*. Ninety first-, fourth- and seventh graders were interviewed on their beliefs about the definition, characteristics, causality and treatment associated with the terms *mental illness* and *crazy*. Children struggled with the meaning of *mental*, often attributing it to a physical aspect of illness. On the other hand, first graders were able to identify and discuss the meanings of *crazy*. In definitions of *crazy*, children would often make implicit references to mental states which were typically personified by individuals with an anti-social behaviour disorder. For example, they claimed that *crazy* people were "weird", "strange", and "different" and their behaviour consisted of "hitting" and "pushing people". It seems that, by school age, children have begun to develop behavioural expectancies of individuals who are labeled by certain, lexical representations of mental illness.

Children's attitudes about mental illness appear to remain relatively stable throughout their elementary school development. Weiss (1994) conducted a longitudinal

study, working with the same set of children during kindergarten and in their eighth grade. Results showed that children's preferred social distance measures were consistent at both stages of their development. In addition, research has found that children of varying ages tend to share similar behavioural expectancies of mentally ill persons. Spitzer and Cameron's (1995) study showed parallel results between first, fourth and seventh graders' classification of a *crazy* individual as "weird", "deviant" and "violent". Both studies indicate that young children's exposure to the cultural knowledge and attitudes regarding mental illness may have a profound and lasting impact throughout development and possibly into adulthood.

#### **1.4 Preschool Children's Conceptual Capacities**

To date, the literature has sparsely investigated children's conceptual understanding of mental health and illness, particularly with populations under the age of 6. It is suspected that preschool children's cognitive capacities are generally perceived as insufficiently developed to deal with this subject matter. However, the current research holds that preschoolers possess some extraordinary conceptual facilities that may support an understanding of mental health and illness.

First, knowledge of general health and illness seems to be a critical conceptual building block for understanding mental illness. Siegal (1988) reported that preschool children exhibit a basic understanding of the nature of contagion and contamination. Several methods addressed these two health concepts. For contagion, preschoolers were asked to watch video segments that showed a puppet either suffering from a cold or a toothache. Children were much more likely to indicate that colds, rather than toothaches, are caught by proximity to an agent. Researchers then read preschoolers a narrative

about a boy whose knee was scraped and who claimed that he got it from sitting next to another boy. They found that children were very likely to report that this child was “pretending”, suggesting their belief that accidents are not contagious. For the concept of contamination, children heard three stories about different objects (cockroach, comb, spoon) falling into a glass of milk and were asked to identify whether or not a child could get sick from drinking the milk. Most preschoolers were unwilling to drink the milk even after the foreign object had been removed, suggesting their awareness of contamination. Thus, this age group appears to have a general conceptual framework for illness and its causes.

Second, children as young as three years of age possess the remarkably intuitive ability to distinguish between animate and inanimate objects through the selective attention to relevant features of that object (Subrahmanyam, Gelman & Lafosse, 2002). Three- and four-year-olds and a group of adults were asked to sort twenty photographs that depicted a three dimensional object into two piles on the basis of a specific property (e.g., “can move by itself”, “needs to eat”, “can talk”, “can feel happy and sad”). These photographs showed animates (person, dog, bug) and simple artifacts (chair, spoon, keys). Virtually all children sorted the objects into the same two piles that the adult group had. Thus, preschool children’s animate-inanimate discrimination ability may be largely governed by intuitive, conceptual principles.

In terms of social-conceptual capacities, research has demonstrated that 4- and 5-year-olds can identify other individuals’ false perceptions and beliefs (Sabbagh & Callanan, 1998; Szarkowicz, 1997) and differing emotional states (Harwood & Farrar, 2006). Undoubtedly, the conceptualization of psychological states is a principal capacity

for understanding the origin mental illness. Sabbagh and Callanan (1998) examined children's use of meta-representational language, or language that describes their own and others' mental states, in conversations with their parents. Researchers found that 4- and 5-year-olds consistently used terms that explicitly referenced false beliefs or delusions, recognizing the discrepancy between perception and reality. For example, one child claimed: "the parents don't know that they're up there. They think he's still in bed." (p.495) Children's ease of fluency with meta-representational terms indicates their cognitive shift from a self-centered toward a belief-centered social orientation.

Research examining children's theory of mind reveals that 4- and 5-year-olds were capable of taking the perspective of others (Szarkowicz, 1997). In one study, theory of mind was defined by three capacities which develop in a linear fashion: 1) understanding that perception can be knowledge, 2) understanding that perceptions are based on interpretations of knowledge from the environment, and 3) understanding that the mind can misrepresent reality. Using variations on the false-belief task, researchers found that most 4- and all 5-year-olds had a capacity in all three domains. In contrast, 3-year-olds remained at stage one understanding. Interestingly, verbal ability was not found to be a predictor of perspective-taking abilities. Thus, children's understanding of the interpretive nature of mental states seems to begin to emerge at preschool age.

Harwood and Farrar (2006) found that affective perspective taking, the ability to recognize the emotional state of another, is significantly correlated to theory of mind. Both abilities require the interpretation of a subjective reality, whether the information from this subjective mental state is emotion-based or belief-based. It is suggested that social-emotional understanding may be a prerequisite for the ability to identify the

characteristics and behaviour of mental illness – as emotional functioning is a major determinant of mental health.

By preschool age (between 4-6 years old), a basis for social-emotional understanding has been established. Harwood and Farrar (2006) found a significant correlation between outcomes on physically- and socially-based false belief tasks and the ability to predict the emotions of a friend - particularly in scenarios where the emotions of the child and the friend were contrasting (e.g., happy child and sad friend). The developmental congruency between theory of mind and affective perspective taking indicates that the latter may emerge at roughly the ages of 4 and 5.

Given the presence of these seemingly sophisticated social and conceptual capacities, one could speculate that preschool children may possess the intuitive underpinnings to understand and discuss some fundamental characteristics of mental health and illness.

### **1.5 Theoretical Framework**

The purpose of this study is to help identify how preschoolers think, feel, classify and talk about mental health and illness. Consistent with the paradigm assumptions within the social constructivist tradition, the study incorporates a grounded theory approach and a context-dependent inquiry (Bryman & Teevan, 2005). The qualitative design is used to obtain a rich and multi-faceted view of children's perspectives on this topic, particularly given the current partiality towards quantitative methods in the literature. The methods consist of open-ended questioning and are flexibly implemented in two out of the three tasks. This approach may be conducive to a free exchange and negotiation of ideas directed towards mutual understandings on the subject matter.

Analysis is guided by the assumption that children are active interpreters of their environment and experiences and are architects of a personal view of reality. As a result, the onus is on the researcher to explore how the participants may have construed and responded to the methodologies. Grounding oneself in the research findings may help capture a more genuine representation of children's constructions of the meaning of *crazy* and their perceptions of peer deviant behaviour.

On a more personal note, it is also recognized that the methodological design, implementation and interpretations of this study are driven by my assumptions about children. I subscribe to the view that culturally determined beliefs and expectations about what children *should* be becomes the norm for children in our society. This set of values affects children's perceptions of their own reality and thus, their interactions with adults and peers. My analysis and interpretation of the findings reflect this orientation, (i.e., is the child responding according to what they perceive the researcher wants or expects of them?)

A second assumption relates to the developmental theory that is endorsed. Rooted in my psychology background and pervasive in this research approach, is the Piagetian "ages and stages" theory which stipulates that human cognition has a biologically pre-determined trajectory based on four stages of development (Piaget, 1954). In the current study, the sample was designed to represent all three age groups (4s, 5s and 6s) to provide conditions for developmental comparisons. The findings are partially organized based on age group and analysis is strongly driven to find developmental patterns within the data.

Two aspects of this study represent novel research terrain. First, the literature has given minimal attention to the perspectives of children under the age of 6. A significant body of research reveals that 4- and 5-year-olds have fairly sophisticated conceptual capacities which may underlie the ability to conceptualize mental health and illness. Preschoolers also appear to be linguistically equipped to navigate within this topic depending on the lexical framework of the methods. Second, a review of literature indicates a clear bias towards quantitative methods for this subject matter. The qualitative focus of this study may tease out aspects of children's knowledge that quantitative research alone has overlooked.

Ultimately, this study intends to illustrate a snapshot of one group of preschool children's current conceptualizations of mental health and illness. It does not intend to seek or provide explanations for *how* these children have developed these conceptual models.

The following research questions will be the focus of investigation:

- 1) How do children conceptualize the term *crazy* and a *crazy* person?
- 2) How do children interpret and classify peer deviant behaviour?
- 3) What is the relationship between their understanding of *crazy* and peer deviant behaviour?
- 4) How do children's theory of mind and social-emotional perspective-taking ability relate to their conceptual model of mental health and illness (as defined by these two elected representations)?

## II. Method

### 2.1 Definition of Terms:

The study will provide operational definitions for the following two terms: *mental illness* and *crazy*. *Mental illness* or a psychiatric disorder is considered an abnormal mental condition, whereby one exhibits symptoms that cause significant distress or dysfunction, whether the impairments are cognitive, behavioural, emotional or social (Corrigan, 2004). This definition is considered to be culture-specific.

The formal definition of *crazy* is mental illness or insanity with a loss good judgment and self-control. A *crazy* person likely exhibits behaviour which blatantly deviates from accepted social codes. The stipulated definitions of *mental illness* and *crazy* are intended to bear no impact on the responses of the participants due to the qualitative nature of the investigation.

### 2.2 Sample and Site:

The study was conducted in two kindergarten classes in a public primary school in the Toronto District School Board (TDSB). The school is located in one of Toronto's upper-middle class neighbourhoods. Both classes benefited from consistent parental involvement and participation and a number of classroom resources, i.e., an Assistant Teacher and an Educational Assistant in the morning class, parent volunteers, an abundance of books and numerous classroom activity areas.

Eleven preschool children participated in the study. The sample consisted of three 4-year-olds, five 5-year-olds, and three 6-years-olds all from English-speaking backgrounds. Five participants were female and six were male.



Participants were selected on a “first-come-first-serve” basis. A brief information letter was sent home with all of the kindergarten students in both classes. The letter provided the option for parents to indicate interest in having their child participate. Upon receipt of this letter, parents were contacted and notified that a consent form would be sent home with their child. Those children whose parents returned the signed consent form were included in the study. Two children, who had met the aforementioned criteria, did not participate because these children did not give their personal consent.

### 2.3 Procedures:

Following ethics approval, contact was made with the school officials to gain access to the kindergarten classrooms and make the necessary arrangements. From my first day of attendance in the class, it took four days to receive the first signed parental consent form. During this time period, I attended both classes every day and attempted to build a rapport with all of the children by assisting them with their activities and participating in their games.

I began session #1 with the first child on the same day that I received their signed parental consent form. All of the first sessions with the eleven participants followed this pattern. The first session with every participant began by reading to them the child consent form. Follow-up questions were asked to ensure their full understanding of the agreement. The child was assured that they did not have to participate and that if he/she did consent, he/she could terminate the session at any time without any consequences to themselves. It was also plainly stated that their identity and data would be kept confidential. If and when the child agreed to participate, I immediately proceeded with the tasks.

For all participants, the tasks were conducted during class time on a one-on-one basis in one of two locations: the hallway outside the classroom or in the health office down the hallway from the classroom. In the first eight research sessions, the participants were given the choice between these two locations. However, the hallway option was withdrawn after those first eight sessions because it was too noisy and distracting for the children. In session #1, the first four participants chose to sit in the hallway for the tasks. The remaining seven participants had session #1 in the health office. For session #2, all children completed the tasks in the health office. Most participants appeared to be comfortable with this arrangement despite the fact that none had been in that location before. Nevertheless, each child was encouraged to explore and discuss their new surroundings before the tasks began. During task administration, the teacher continued to conduct their classroom as usual with the non-participating students.

From a social constructivist standpoint, the researcher-participant relationship is a critical factor in research with children. Though I did not have a formal title like other school officials, children likely perceived me as an authority figure, similar to their teacher and principal, due to the school context and my “adult” status. I made efforts to establish conditions that developed the researcher-participant relationship by: a) nurturing a casual and comfortable exchange and, b) attempting to neutralize the inherent power dynamic that exists in adult-child and researcher-participant interactions.

The following strategies were used to achieve these goals. As previously stated, I was present in both classes for four days prior to beginning data collection and made a point of interacting with each child during this time. Children knew me as Rosie, rather than a formal title such as “Ms. Bell”. I attempted to assume a “friendship” role by

avoiding any didactic or authoritative tones. During my explanation of the consent form, it was emphasized that I was a student, just like them, working on a project about children their age. Immediately prior to commencing data collection, each child had the opportunity to explore the research materials and experiment with the tape machine. Efforts were made to maintain my “friendship” role during the research exchange by encouraging casual discussion throughout and between the tasks. Finally, the child consent agreement allowed the child to authorize their own participation in the study and to take part in a traditionally “adult” practice.

The participants were not asked to avoid disclosing the research activities to their classmates because this approach was considered too restricting. Asking children to keep it a “secret” from their friends, may not be an effective approach anyway. Therefore, it was possible that previous participants may have discussed the tasks with future participants, perhaps influencing their peer’s responses.

#### 2.4 Data Collection Methods:

The study employed three tasks: a vignette (story) activity, an interview and a drawing activity. The vignettes were designed to identify children’s perceptions of peer deviant behaviour while the interview and drawing activity were both designed to stimulate discussion about the meanings they associate with the term *crazy*. Research was divided into two sessions. Session #1 consisted of the vignette activity; session #2 consisted of the interview and drawing activity.

Vignettes are a well established approach to broach the topic of mental health and illness with children and youth (Novak, 1975; Marsden & Kalter, 1976; Spitzer & Cameron, 1995). They provide significant experimental control by allowing subjects to

react to concrete situational behaviour in a comparable design. The three vignettes used for this study were developed by psychiatrists for the Marsden and Kalter (1976) study and were also used by Spitzer and Cameron (1995) to examine children's ability to classify various forms of peer deviant behaviour. Ultimately, vignettes allow researchers to explore children's perceptions of deviant behaviours and deviant personalities without the bias of an external label.

In the vignette activity, participants heard three different depictions of peer aged, male characters. Vignette #1 depicted a well-adapted child, vignette #2 depicted a child with an anti-social behaviour disorder, and vignette #3 depicted a psychotic/borderline psychotic child. The vignettes were presented in the same order for each child. Following each vignette, the child was asked a set of five questions addressing their perception and attitude towards that character. Children were also assessed based on their ability to classify peer deviant behaviour according to psychological diagnostic standards determined by the Diagnostic and Statistical Manual IV, that is, labeling the peer in vignette #1 as *normal*, and labeling the peers in vignette #2 and #3 as *crazy* (American Psychiatric Association, 2000). Results of their classification of the three peers in the vignettes were validated by their descriptions of *crazy* in session #2. The task was conducted with strict adherence to the script and probing questions only consisted of "why?" Task time was approximately 20 minutes.

Upon completion of the vignette questions, the researcher asked the child several follow-up questions to encourage reflection upon the activity and their responses. This strategy helped to validate the children's previous responses. The questions were as follows:

- 1) Were you able to follow the stories ok?
- 2) Were the stories too long for you?
- 3) Which story was your favourite? Why?

### **Session #1: Vignettes**

#### **1) "Normal" Personality - Mike**

*When the school year started Mike was in Miss Barry's 1<sup>st</sup> grade room. All the kids knew that he wanted to be in the other 1<sup>st</sup> grade room, where his two best friends were. When Miss Barry asked questions, Mike never raised his hand. At recess he always went to play football with his friends from the other room. A few weeks later in gym class the boys began playing basketball and Mike's team was the best in the school. The kids noticed that Mike wasn't talking about wanting to be in the other class anymore. Miss Barry heard Mike talking to his friends saying "we have the best team in the school." The next day in science Mike had a great idea for a project for his class.*

#### **2) Anti-social Personality – Paul**

*Paul is a 2<sup>nd</sup> grader. One morning the children were working on writing a paper. When the bell rang they went outside for recess. But Paul didn't go outside. When the kids came back and sat down at their desks, one of the girls jumped up and yelled. There was a thumbtack on her chair. Most of the kids laughed and laughed. Sometimes Paul hits other children on the playground. When his teacher tells him to stop he says, "I don't want to." One time he even tried to kick the teacher. He often gets sent down to the principal's office. At recess most of the boys say that they have a lot of fun playing with Paul and he can hit the baseball really far.*

#### **3) Psychotic/Borderline Psychotic Personality – Scott**

*Scott is a 1<sup>st</sup> grader. When it was his turn to give his report in class he told us about the planet Venus. Right in the middle he jumped up, ran to the window and yelled, "Here they come; the Venus space ships are coming to school." The teacher went over to Scott and said she had heard a truck in the street outside and maybe Scott did too. Sometimes Scott cries in class and once he said it was because of the monsters from space. When one of the other kids says something about the planets, Scott says that they are all wrong. He says he's been there and he knows what its like. Sometimes at recess Scott pretends to be a Martian and all the other kids around him laugh because he does it so well.*

#### **Questions:**

- 1) What do you think about this boy?
- 2) Why do you think he acts this way? (theory of mind/perspective taking)
- 3) How similar are you to this boy? (similarity)
- 4) Would you like to be this boy's friend? (likeability/social distance)
- 5) Do you think this boy is crazy or normal? (classification of deviant behaviour)

The interview focused on exploring the meanings children assign to the term *crazy*. This term may be the most accurate lexical access point to young children's conceptions of mental illness. Studies indicate that the term *mental illness* is not understood until junior high school (Poster, Betz, McKenna & Mossar, 1986; Spitzer & Cameron, 1995). Spitzer and Cameron (1995) showed that first grade children were familiar with *crazy* as an indication of illness and classified certain deviant behaviour relating to anti-social behaviour disorders using this term.

As previously stated, *crazy* formally denotes insanity or mental illness and implies a loss good judgment and control over one's behaviour. However, informal definitions for *crazy* include: being "distracted or temporarily out of control as a result of some violent emotion", "very foolish and wild", or "very enthusiastic" (Gage Dictionary, 1998). Therefore, analysis is geared towards exploring the meanings preschool children have constructed in the context of these common cultural understandings.

The interview consists of two parts. In part one, the child was shown ten cards, each illustrating a different word (i.e., crazy, happy, sad, smart, mean, surprised, angry, shy, nice, scared). The child flipped over and read each card in random order with the help of the researcher. After each card the researcher asked the child two questions: 1) do you know this word? 2) what does (crazy) mean? This task was intended to introduce the word "crazy" to the child and to obtain their personal definition. The remaining nine words were intended to: 1) help divert the child's attention away from *crazy* in order to avoid bias and, 2) help contextualize the meaning of *crazy* as a word that "describes people".

In part two, the child was asked a list of between eleven and thirteen questions. Using the same cards, the child chose one card from the researcher's hand, such as "happy". The researcher then asked the child the first four interview questions using the word "happy" (e.g., what does a (happy) person look like?). Next, all cards were turned over and the researcher took a turn to choose a card. The *crazy* card was selected and used as the subject of the seven interview questions. The questions were intended to address children's definition, characteristics (psychological, physical or behavioural), causality, possible treatment and attitudes they associate with a *crazy* person.

The interview questions were independently devised for the sake of this study. To establish validity, questions #1-5 were previously pilot tested with one 5-year-old kindergarten student. Results of the pilot suggest that 5-year-olds are verbally and linguistically equipped to negotiate within this topic and capable of providing remarkably insightful and extensive responses. She was familiar with *crazy*, providing a definition, multiple behavioural characteristics and personal anecdotes which related to this concept.

Due to the young age of the participants, the interview was administered in a semi-structured fashion. This approach helped maintain the child's focus on the topic while allowing for some flexibility and digression within the discussion. For example, in several different interview sessions, myself and the child participated in a game created by that child using the research materials. The flexibility of this task was intended to encourage children to assert control during our interaction and to develop a sense of security with me. Task time was approximately 25 minutes.

## ***Session #2: Interview***

- 1) What do you think a \_\_\_\_\_ person looks like?*
  - 2 ) What do you think a \_\_\_\_\_ person acts like?*
  - 3) What do you think causes a person to become \_\_\_\_\_?*
  - 4) Would you like to be a \_\_\_\_\_ person's friend?*
  - 5) Do you think being \_\_\_\_\_ is a good thing or a bad thing? Why?*
  - 6) Do you think a child could be \_\_\_\_\_?*
  - 7) Do you think that a \_\_\_\_\_ person is healthy or sick?*
- If the response to question #7 is "sick", ask questions #8 and # 9.*
- 8) How would you help a \_\_\_\_\_ person?*
  - 9) Do you think someone can become crazy in the same way as catching a cold? Why?*

The drawing component of this study had three functions. First, the visual data was intended to compliment the vignette and interview data by obtaining a multidimensional view of children's knowledge and attitudes. Children were provided with a means of visually expressing the subject matter previously discussed in the interview. Moreover, the expression of our ideas onto paper was meant to help organize children's thoughts and to clarify and enhance their verbal explanations. Second, the drawing activity gave the researcher an opportunity to work side-by-side with the child on a common task. This strategy may have enhanced researcher-participant camaraderie and thus, mutual understanding on the themes discussed. Third, the art activity was



considered an intrinsically enjoyable task and a welcome change of pace from the cognitively demanding interview task.

Using the two cards that were discussed in the interview (e.g., happy and crazy), the child was asked to draw something or someone that reminded them of *crazy*. The researcher also drew a picture using the same instructions with the other selected word. Typically, I allowed the child to draw quietly so that he or she could focus on the task. However, if the child raised an idea related to their drawing, I would probe for further information. The researcher and participant informally negotiated towards an understanding of the underlying meanings of both drawings during and after task completion. This activity was conducted in an unstructured and flexible manner. Following our discussion, I requested ownership of the child's drawing. Task time was approximately 10-15 minutes.

In the interest of exploring the developmental relationship between children's theory of mind and social-emotional perspective taking ability in relation to their conceptual understanding of mental illness, the following strategies were adopted. Question #2 ("Why do you think he acts that way?") of the vignettes was designed to examine children's theory of mind by asking children to identify the origin of another individual's behaviour. However, this question is not considered an authentic measure of theory of mind based on psychological research standards. The results are considered only suggestive of the existence or absence of this cognitive capacity. In addition to the results from question #2, any responses that hinted at children's ability to identify another individual's mental or emotional state, particularly where this state was different from

their own, was considered an indication of theory of mind and socio-emotional awareness.

The tasks were designed to be short, engaging and age appropriate. Session #1 and session #2 were conducted at least two days apart for each participant, though the average interval was typically three to four days. The tasks were broken into two sessions for the following reasons: 1) to maintain children's interest and attention throughout the tasks, 2) to avoid having the child associate peer deviant behaviour, depicted in the vignettes, with the term *crazy*, discussed in the interview and drawing activity.

The following chart illustrates the demographic profile of the participants and the data collection methods they participated in.

**Table 1: Data Collection Matrix**

Participant	Age	Gender	Vignettes	Interview	Drawing
SS	4	Male	Yes	Yes	Yes
JH	4	Male	Yes	Yes	Yes
BN	4	Male	Yes	Yes	Yes
JK	5	Male	Yes	Yes	Yes
MY	5	Female	Yes	Yes	Yes
BK	5	Male	Yes	Yes	No
JE	5	Female	Yes	Yes	Yes
KE	5	Female	Yes	Yes	Yes
OR	6	Female	Yes	Yes	Yes
LL	6	Female	Yes	Yes	Yes
JP	6	Male	Yes	Yes	No

### 2.5 Data Analysis Approach:

All tasks were transcribed from the audiotape recording into a text document. In accordance with the interpretivist research tradition, the current study used a content analysis approach, identifying several emergent themes and sub-themes which are

connected by broader core categories imposed by the methodological design. The findings are reported in a narrative discussion and several thematic tables.

There were several pre-conceived codes which were grounded in the task questions which acted as a guide during data analysis (i.e., *theory of mind, crazy behaviour, lexicon, origins, health, attitudes and gender*). It was a conscious process of gathering information that related to these codes throughout the analysis procedure. As the process continued, several additionally related and diverging codes also emerged from the data.

Initially, the data was reviewed for general ideas and insights related to the phenomenon in question. With additional readings new codes emerged, codes were renamed, or they were discarded. A comparison method was used to recognize similarities, differences and consistencies in meanings across the data. Larger chunks of meaning began to emerge and were grouped into the major themes.

The collection of emergent themes easily collapsed into three main categories. Two of the three categories were based on the two elected representations of mental illness in this study (i.e., *crazy* and peer deviant behaviour). The third category was based upon a mixture of pre-conceived and emergent codes in the data that provided explanations related to cognitive-development for the findings in categories one and two.

### III. Findings

All eleven children seemed engaged in the study tasks and provided rich, detailed descriptions of the various meanings they have assigned to the term *crazy* and the attributes of a *crazy* person as well as their perceptions of peers who exhibit deviant behaviours. Inquiry using these two representations (*crazy* and peer deviance) offered unique insight into children's earliest conceptual constructions related to mental health and illness. The findings are organized and reported primarily based on preschool children's conceptualizations as a unified group and, secondarily based on observed developmental patterns in the three age groups (4-, 5- and 6-year-olds). The findings are broken into three major categories:

- i. Children's perceptions of peer deviant behaviour (largely based on results from the vignette activity)
- ii. Children's conceptualizations of *crazy* (based on results from all three tasks)
- iii. Children's social-conceptual capacities (based on the results of all three tasks)

All categories are explicated in a narrative format and in several thematic tables with excerpts and quotes from the interactions with the children.

#### 3.1 Children's Perceptions of Peer Deviant Behaviour

The vignettes were designed to determine if this group is capable of classifying peer deviant behaviour according to psychological diagnostic standards determined by the Diagnostic and Statistical Manual IV (American Psychiatric Association, 2000). In this case, the term *crazy* was to be matched with the peer figures with mental health conditions in vignette #2 and #3. Generally, children's responses in all three age groups did not demonstrate a consistent understanding of the association between *crazy* and

these two psychological conditions (anti-social behaviour disorder and psychosis). Only one 6-year-old provided an accurate classification for all three vignettes. Clearly, preschool children do not consistently associate *crazy* with mental health conditions. Similarly, children did not exempt “normal” individuals, those who do not have a clinical mental illness, from this classification. According to these results, the meanings children have assigned to *crazy* do not consistently include the characteristics related to mental illness as defined by these two psychological conditions. See Table 2. Children’s responses to questions #3 and #4 of the vignettes were used to determine general peer appraisals. See Figure 1.

#### ***Vignette #1: Mike – “Normal” Personality***

Children’s evaluations of Mike were extremely divided – about half perceived this character in positive ways and the other half in negative ways. Approximately half of the children wanted to be his friend and believed themselves to be similar to him while the other half did not or were unsure. An overwhelming number (9 out of 11) of children classified Mike as *crazy*. The rationale for this classification varied significantly for each participant. For example, one child claimed that Mike is *crazy* because “he doesn’t realize that he can make friends in another class.” Another child stated that “I think he’s *crazy* because he wants to be going to another grade one class.” One 6-year-old indicated he was *crazy* because “he doesn’t raise up his hand” in class.

#### ***Vignette #2: Paul – Anti-social Personality***

Most children typically perceived Paul as a rule breaker who is “bad” or “not nice”. Paul was described in negative ways by the greatest number of children of all three vignettes. Nine of the children were not interested in being Paul’s friend and did

not believe they had similarities to this character. The 4-year-olds consistently used the word “mean” as a descriptor while the 5- and 6-year-olds were more explicit about their rationalizations for avoiding his friendship. For example, “he hits people on the playground”, “I think he would try to kick me or hit me” and “he might hit me”. The latter two quotes were unique self-references that were clearly not retrieved from the vignette. Seven children classified Paul as *crazy*. When asked why, one 4-year-old explained “because he goes down to the principal’s office.” A 5-year-old believed he was “very crazy” because “maybe he doesn’t like people.” One 6-year-old explained that “he puts thumbtacks on people’s chair and he didn’t go outside.”

The two exceptions, who had neutral evaluations of Paul, empathized with this character. One 5-year-old believed that she was similar to him and wanted to be his friend. She claimed that she has unintentionally demonstrated similar behaviours herself, stating “I hit people by mistake and other people and you don’t really notice or do it on purpose. Sometimes I do it by accident and you don’t really know.” The second child, who is also 5 years old, believed that Paul was a “bad boy”, however when asked if he wanted to be Paul’s friend, he said “I’ll have to think about that one.” He provided a personal anecdote about a real-life peer in his class which helped explain the ambiguity of his responses.

“I’m going to ask that used-to-be-friend Mark why he smacked the teacher in the face...Sometimes when somebody smacks me...guess what? I smack people in the face. I smacked two people in the face. A different Mark and somebody whose 7. I’m only a 5-year-old but I’m smacking someone older than me in the face.” (JK)

This child seemed to have mixed emotions about Paul’s behaviour possibly because he exhibits similar behaviours himself.

### ***Vignette #3: Scott – Psychotic/Borderline Psychotic Personality***

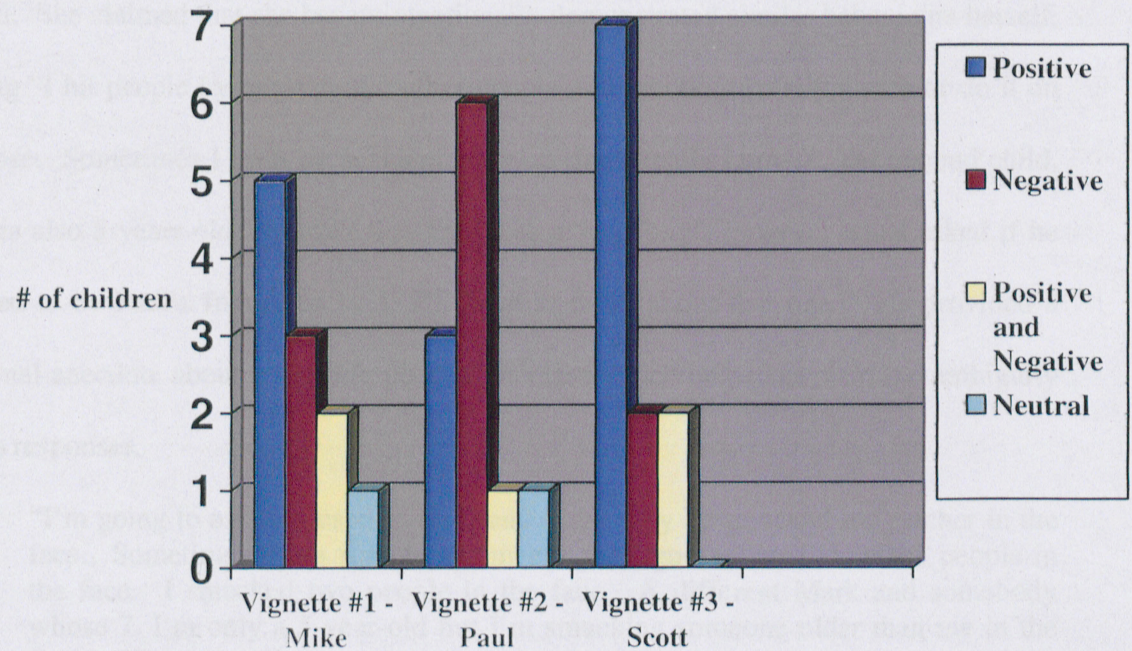
Overall, Scott received the highest number of positive appraisals from the participants of all three vignettes. He was classified as *crazy* by six children and by seven as “normal”, taking into account the children who used both classifications. One 5-year-old claimed he was normal because “he likes space a lot.” A 6-year-old explained that he was normal because “he doesn’t say inappropriate words, he says nice kind of words. He doesn’t act silly and stuff like that.” The children who classified Scott as *crazy* explained that it was either because he was a “liar” or because he could not differentiate reality from his own imagination. Interestingly, most children either did not want to be Scott’s friend or were uncertain about the possibility.



**Table 2:** Children's Classifications of Peer Deviant Behaviour

Participant	Age	V1: Normal	V2: Crazy	V3: Crazy
SS	4	N & C	Bad	N
JH	4	C	C	N
BN	4	N	N	C
JK	5	C	(No answer)	Really C
MY	5	C	N & C	N & C
BK	5	C	C	N
JE	5	C	Very C	Very C
KE	5	N	N	a little C, a lot N
OR	6	C	C	N
LL	6	C	C	C
JP	6	N & C	C	C

N – Normal, C - Crazy

**Figure 1.** Children's Appraisals of Peer Figures in the Vignettes



## 3.2 Children's Conceptualizations of *Crazy*

### 3.2.1 The Semantic Foundations of *Crazy*

Within preschoolers descriptions of the term *crazy* emerged six sub-themes that specify the most prevalent meanings of this term: i. Behaviour/Lexicon, ii. Physical Characteristics, iii. Intentional vs. Unintentional Behaviour, iv. Origins, v. Being Normal and *Crazy*, vi. The Ambiguity of *Crazy*.

#### 3.2.1.1 Behaviour/Lexicon

All of the children's understandings of *crazy* were predominantly characterized by specific externalizing behaviours. This is consistent with research that has explored young children's meanings of the term (Spitzer & Cameron, 1995). Three categories emerged from children's behavioural descriptions: **unusual**, **socially unacceptable** and **morally dubious**. Developmental patterns in children's descriptions seemed to emerge across the three years. Four-year-olds appear to relate *crazy* to behaviour that is described in neutral and positive terms, while the 5- and 6-year-olds described, in mostly negative terms, more severe forms of behaviour which, in their explanations, were preceded by negative social consequences.

Four-years-olds commonly referred to unusual or socially unacceptable types of behaviours that were considered either "**funny**" or "**silly**". One 4-year-old referred to the notion of **unpredictability**, stating "nobody knows what he (Mike) is going to do next." **Risky** behaviour was also considered *crazy* (e.g., "a crazy driver" or the act of "going on an airplane by yourself"). These children also associated *crazy* with **unusual** types of behaviour such as "sticking my tongue out" and pretending to be like a Martian.

Children who were 5 and 6 described unusual, socially unacceptable and morally dubious behaviours. “Silly”, “bad”, “not nice”, “not funny”, and less commonly “mean”, “wild”, “hyper”, “weird” and “sad”, were descriptors of *crazy* behaviours. Both ages provided similar accounts of *crazy*, alluding to severe forms of socially unacceptable behaviours. These included **unusual** and **animal-like behaviour**, **delusional/psychotic behaviour** and **anti-social tendencies including aggression and violence** against the self and others.

Unusual behaviour was a common thread cited in all of 5- and 6-year-olds’ responses. These behaviours consisted of shaking one’s head, making strange noises, screaming, scaring people, becoming dizzy, running around and yelling, “going wild and messing up the cards and stuff”, being hyper and “tickling and fooling around.” Several children made reference to animal-like behaviour including a chicken and a monkey. “Acting like a monkey, pushing chairs around and standing and jumping on chairs.”

Four children associated *crazy* with delusional thoughts about reality and personal identity. This idea was mainly evoked by Scott of vignette #3. For example, two children classified Scott as *crazy* because he believed that Martians come to town and that he had been into outer space. One child claimed, “He’s just going in his imagination.” I responded, “Do you think that Scott thinks it’s real?” The child replied, “Yes, but it’s not real.” Another child discussed a fictional character in his drawing who had delusions about being Superman and that he was capable of flying. “He’s not Superman but he really thinks he is. So that’s why I made him fly.” One child associated delusional behaviour with Paul of vignette #2. She claimed that he believes that the baseball is

actually a peer who is laughing at him and that's why he hits the ball so hard. "He's thinking other children are laughing at him but it's really a baseball."

Many children referred to anti-social tendencies such as lying, disliking people and criminal and violent behaviour. Two children made reference to lying and one child referred to disliking others: "...maybe he doesn't like people because they are always laughing at kids (others)." Another child believed that stealing is *crazy*. They explained, it is "taking stuff from people and going crazy with them saying 'I got a toy...ahhh!'" Finally, aggression and violent behaviour emerged repeatedly throughout children's narratives, particularly during discussions about Paul. These behaviours included putting thumbtacks on peoples' chairs, hitting people on the playground, throwing mud at someone, making fun of someone and "banging your head on the wall on purpose." When children were asked if they would like to be a *crazy* person's friend, one child responded, "No. They might push me down and strangle me." Another claimed, "No. I wouldn't like him to sit on me, like being a horsey. Crush me."

### *3.2.1.2 Physical Characteristics*

Physical or perceptually dominant characteristics played a minor role in children's constructions of *crazy*. It seems that preschool children have yet to develop stereotypic attitudes about the appearance of a *crazy* person. None of the participants explicitly mentioned gender, race or age in response to the question: "What does a crazy person look like?" Two 5-year-olds made references to an individual's hair. One child described her younger sister's hair: "her hair is like crazy". Another child discussed a character in a movie she had watched, "here's her crazy hair that the stick made her hair go into and she dyed it with lots and lots of colours. See? Hair? So crazy."

### 3.2.1.3. Origins

Within the confines of this small sample, an age related pattern emerged in terms of children's ability to identify an origin or causal condition of acting *crazy*. In response to the interview question, "What do you think causes a person to become crazy?", all three 4-year-olds did not provide a causal explanation. Two children stated that they did not know the answer and the third child claimed that "nothing makes them crazy - they just are crazy."

Five-year-olds seemed to grasp the concept of causal conditions, predominantly referencing external, social factors. For example, *crazy* behaviour could be triggered by "someone yelling at them", "when somebody says something funny", "if you saw a pretend ghost", or if others "weren't listening to you." Two of these four children also made reference to an internal causal factor. For example, one child claimed that one becomes *crazy* "from all the fun they were (are) having". The most overt, though puzzling, reference to a psychological cause of *crazy* behaviour was: "I have a little thing in my head where there are pictures on it and each day it moves but sometimes it moves in the day so sometimes it moves together and creates a crazy face."

Six-year-olds referred exclusively to psychological causal factors. Related to Scott's false belief that he had visited outer space, one child claimed, "...maybe he imagined he was in outer space but he was dreaming but maybe he didn't realize it." Another child explained, in great detail, the physiological processes that produce externalizing behaviours. This child showed considerable insight into the principal role of the brain and the implications of having the brain lose control over the body.

"So the body sometimes doesn't listen to the brain and it does things like, they think they're crazy. So if the body, so if the skeleton body makes the skin go like

then it just makes it go like that.” I asked, “So what’s the brain doing?” He replied, “So the brain is the boss and it tells the whole everything in this body what to do but sometimes it doesn’t listen so the hearts what makes the arms and legs move so the heart just wants the person to act crazy so it makes them act crazy.” (JP)

#### 3.2.1.4 *Intentional vs. Unintentional*

*Crazy* behaviour was either perceived as intentional or unintentional and was rarely categorized as both. Half of all children made reference to behaviour that was goal-directed and purposeful. For example, “crazy driving” and “pretending to be like a Martian”, stated by two 4-year-olds. Two 5-years-olds claimed that lying and “banging your head on purpose” was *crazy* behaviour. These actions seem to imply a sense of control and agency.

A significant number of children believed that acting *crazy* is unintentional. A 4-year-old mentioned that “falling down” is *crazy*. The 5-year-olds explicitly referred to a lack of control, that is, “bonk(ing) my head but I don’t want to” and more generally, “when people do something that they don’t want to do but they do it” and “someone out of control.” Children also indicated that there are unintended consequences related to *crazy* behaviour. For example, they act “silly” and, as a result, hurt other people. Only one child, who was 6 years of age, described a broader set of *crazy* behaviours that could be considered intentional *and* unintentional, i.e., intentional - kicking the teacher, throwing glasses and breaking them, and unintentional – having a delusional thought that Martians truly exist.

#### 3.2.1.5 *Being Normal and Crazy*

Typically, *crazy* and *normal* are considered to be semantically opposed or, at minimum, mutually exclusive terms (Spitzer & Cameron, 1995). Several 4- and 5-year-

olds challenged this notion, indicating that one could simultaneously have both qualities. During the vignette activity, a 4-year-old claimed that “some are normal and crazy and some people are just normal.” This child used both adjectives to describe Mike, stating that he is normal because “he acts like a regular boy” and crazy “because nobody knows what he’s going to do next.” One 5-year-old claimed that Paul was “a bit normal, a bit crazy because he can play the baseball and all those kinds of things. Why I think he’s crazy is because he puts thumbtacks on people’s chairs.” A second 5-year-old described Scott as “a little crazy and a lot normal.” The 6-year-olds did not use normal and crazy to describe the same individual.

#### *3.2.1.6 The ambiguity of crazy*

The younger children indicated some confusion or unfamiliarity with *crazy*. Two of the 4-year-olds created abstract visual depictions that they claimed were associated with *crazy*. One child drew squiggly lines and dots. When asked why he made dots, he replied, “I don’t know about that yet.” Another child drew a boy who was sticking his tongue out. Next to him was a set of squiggly lines in a circular shape. He named this structure a “doy yoy yoy.” I asked him about it and he replied, “It’s something that I don’t know about yet.” However he claimed that the boy in the drawing did know about the “doy yoy yoy.”

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**Table 3a. The Semantic Foundations of *Crazy***

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Age	Behaviour	Physical Characteristics	Origin
4	Nobody knows what he's going to do next (SS)		Nothing makes them crazy...they just are (SS)
	Stick my tongue out (BN)		
	He's a crazy driver (JH)		
5	When people do something they don't want to do (MY)		Someone yelling at them (MY)
	Maybe he doesn't like people because they are always laughing at kids (him) (JE)	Her hair is like crazy (JE)	If you saw a pretend ghost (JE)
	They would hurt me (KE)	Here's her hair that the stick made her hair go into and she dyed it with lots and lots of colour. See? Hair? So crazy (KE)	
	He tells lies (JK)		Somebody says something funny (JK)
	Shakes their head and makes noises (BN)		They just weren't listening to her (KE)
6	He was throwing mud at her and making fun of her (OR)		Maybe he imagined he was in outer space but he was dreaming but maybe he didn't realize it (OR)
	You're hyper and running everywhere and tickling and fooling around (LL)		
	He hits other people on the playground, he tries to kick the teacher and I think he's the one who put the thumbtack on the chair (JP)		So the brain is the boss and it tells the whole everything in the body what to do...(JP)

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**Table 3b. The Semantic Foundations of *Crazy***

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Age	Being Normal and Crazy	The Ambiguity of Crazy
4	Some are normal and crazy And some people are just normal (SS)	I don't know about that yet (SS)  It's something that I don't know about (BN)
5	A bit normal, a bit crazy. Because he can play baseball and all those kinds of things. Why I think he's crazy is because he puts thumbtacks on other people's chairs (MY)  A little crazy, a lot normal (KE)	

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### 3.2.2 The Personification of *Crazy*

Children clearly understood *crazy* to be a human attribute based on their extensive references to specific individuals who personify this trait. Children's personifications of *crazy* are based on the following four sub-themes: i. Who can be *crazy*?, ii. The Self and *Crazy*, iii. Gender, iv. Health.

#### 3.2.2.1 *Who can be crazy?*

Most participants (9 of 11) in the study believed that children were capable of being *crazy*. The most prominent real-life references were made to their younger and older siblings. "I remember the craziest thing she (younger sister) ever did. Once she was pretending to be asleep when I was really sleeping and then (\*screams\*) and then she woke me up..." The questions were not specifically designed to address children's attitudes towards adults in this context. However, three of the eleven children referred to *crazy* adult behaviour throughout the course of the two sessions. One of these children claimed that his dad acts *crazy*: "he (dad) drives crazy."

#### 3.2.2.2 *The Self and Crazy*

A considerable proportion (4 out of 8) of the children who believed that children could be *crazy* also classified themselves accordingly. All were 4- and 5-year-olds. One 4-year-old claimed, "I'm sometimes crazy". Two 5-year-olds who referenced themselves as *crazy* stated, "I've been crazy" and "...I'd be crazy at home sometimes." All three 6-year-olds did not make such a reference.

#### 3.2.2.3 *Gender*

Children's gender classification of *crazy* people reflected a same-sex bias across all participants. Gender references in session #1, the vignette activity, were disregarded

because all three characters were male which may have biased children's responses. The focus was on *crazy* characters that children discussed in session #2. Virtually every participant personified a *crazy* person in terms of their own gender (i.e., boys referred to boys and girls referred to girls). Their consistent depiction of same-sex peers appears to be more a reflection of the salience of gender rather than an indication of the characteristics they associate with a *crazy* person.

#### 3.2.2.4 Health

It appears that *crazy* is not a health-related descriptor for preschool children. Ten out of eleven children classified a *crazy* person as healthy though none provided a rationale for this response. Two children claimed that a *crazy* person could be sick. One child explained that one becomes sick *and* crazy "from all the fun they (are) were having", indicating that these conditions are mutually exclusive. The 6-year-old explained that a *crazy* person is sick "because if they're sick they make us sad." During the drawing activity, when asked to draw someone or something that's *crazy*, this child depicted a person who was sick in bed. She claimed "you're sick because you were acting too crazy." Thus, sickness is the *outcome* of *crazy* behaviour, not vice versa.

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**Table 4. The Personification of *Crazy***

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Age	Who can be crazy?
4	<b>myself, my younger brother</b> (SS)  my dad, <i>not</i> children (JH)  <b>myself</b> (children) (BN)
5	<b>myself</b> (children), adults (MY)  <b>myself</b> (BK)  my younger brother, my teenage friend (JK)  my younger sister, <i>not</i> adults (JE)  children, adults (KE)
6	a little boy (OR)  children, adults, Rosie (the researcher) (LL)  <i>not</i> children (JP)

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### 3.2.3 Attitudinal Development

Children's meanings of *crazy* typically conveyed an attitudinal undercurrent which was generally positive or negative, but rarely neutral. A potent developmental pattern emerged over the preschool years in their general attitudes towards being *crazy*. The language that 4-year-olds used to describe *crazy* was consistently positive. This age group all believed being *crazy* is a "good thing" or a "funny thing", often describing it as "silly". They did not, however, provide discernible rationalizations for these perspectives.

The 5-year-old children, in particular, often held ambivalent attitudes towards *crazy* (i.e., it was considered a good and bad thing depending on the context). In responses to the interview question, "Do you think being crazy is a good thing or a bad thing?", one 5-year-old replied,

P: "Goodish-badish."

R: "How come goodish?"

P: "Because I've been crazy."

R: "You have?"

P: "A lot of times."

R: "Really? What did you do when you were?"

P: "Well I bonk my head, bonk my head, bonk my head."

R: "Oh ok. So why is it badish?"

P: "Well because I have a little thing in my head where there are pictures on it and each day it moves but sometimes it moves in the day so sometimes it moves together and creates a crazy face."

The same child was also very emphatic when claiming that she would not like to be a *crazy* person's friend "because crazy people are...crazy." In response to interview question #5, another 5-year-old claimed that being *crazy* is "medium" because "sometimes we can act crazy anytime we want." He stated that he did not know if he wanted to be a *crazy* person's friend because "sometimes they're not crazy and

sometimes I am crazy.” Interestingly, these two participants also classified themselves as *crazy* in certain situations.

All 6-year-olds had consistently negative attitudes towards *crazy*. In response to the aforementioned question, this age group all stated that being *crazy* is a “bad thing.” These children provided more in-depth rationales for their response focused on the possible negative social consequences of such behaviour. One child claimed that “if you do it at school then you might get in trouble for doing it” while another child believed that “it could hurt someone if they’re spinning and they hit someone.”

### **3.3 Children’s Social Conceptual Capacities**

Theory of mind and social-emotional perspective-taking are considered cognitive capacities which may facilitate children’s conceptual understanding of mental health and illness. Thus, a second aim was to explore how their impressions of mental illness, represented by *crazy* and depictions of deviant peers, are related to these underlying social conceptual capacities. In addition, children’s social-conventional and moral knowledge also emerged as a potentially critical factor affecting their perceptions of these two representations of mental illness (*crazy*, peer deviance).

#### ***3.3.1 Theory of mind/Social-emotional Perspective-taking***

Based on this approach, there was a significant discrepancy between the 4-year-olds versus the 5- and 6-year-olds. All 4-year-old children seemed to struggle with the designated theory of mind question. One child claimed they did not know the answer for this question. The second child provided answers which indicated their perspective-taking ability, stating “...because he just wants to play with his friends and he doesn’t want to go outside.” The third child’s response also had implications for theory of mind

and their social-emotional perspective-taking ability. He stated: "...because he's upset about everything." None of these children made strong references to other individual's differing mental states or false beliefs.

Four of the 5-year-olds responses' strongly implied the presence of theory of mind. Each child made reference to delusional beliefs defined as one's subjective perspective misrepresenting objective reality. For example, one child implied that Scott is *crazy* because "he thinks that Martians come to town." Another child discussed a fictional child who believed he was superman and could fly. "He thinks he can fly but he can't." One child even noted her own tendency to misconstrue reality at times: "sometimes I (hit people) by accident and you (I) don't really know."

Emotional considerations seemed to be equally important for 5-year-old children's rationalizations of others' behaviour. One child indicated that his brother felt scared when "there was a lion chasing him in his dreams." Another child made a strong empathetic statement, claiming that she would like to be a sad person's friend because "when you have friends its not as bad." One child communicated her mature understanding of human emotions, explaining that "sometimes people feel sad and scared" and that being scared is "normal."

Two of the three 6-year-olds expressed a firm knowledge of false beliefs and a strong capacity for empathy. One child discussed Scott's behaviour, "...he imagined he was in outer space but he was dreaming but maybe he didn't realize it...Maybe he thinks about it and it's a little scary." A second child also claimed that Scott truly believed he went into outer space. "He's just going in his imagination". I asked, "Do you think that Scott thinks that that's real?" He replied, "Yes, but it's not real." He also provided

insight into the human emotional condition, “Some people say they’re not scared of anything because just want to be like they’re being cool but they are scared of something and that’s called lying.” The third 6-year-old made no discernible responses that demonstrated her theory of mind or a social emotional understanding.

### *3.3.2 Social-conventional and Moral Knowledge*

Children of all ages showed some knowledge of social conventions and higher moral principles. These two pieces of knowledge seemed to form a large basis for their decisions of social inclusion and exclusion (Killen, 2007). Social conventional knowledge is rule-based and context-dependent while moral principles guide judgments independently of higher authority (Cassidy, Chu & Dahlsgaard, 1997; Killen, 2007). Children seem to exhibit varying degrees of both sets of justice knowledge though it appears that, with age, children make increasing use of both sets of knowledge to guide their judgments of peer behaviours. Strong indicators of social conventional knowledge were based on their reference to rule violations while moral judgments were indicated by references to negative social consequences. Typically, children’s references were generated by vignette #2 and #3.

All three 4-year-olds employed their knowledge of social conventions to make judgments about peer behaviour. Paul was described as acting “mean” and “rude”, which are attributions that largely take into account the social context and norms in which they occur. The 4-year-olds did not provide explicit explanations for these social evaluations.

Three of the 5-year-olds tended to have more detailed responses in terms of the social consequences of behaviour which may have stronger moral implications. One child stated that Paul “is a bad boy because he hits people.” Another child explained the

social consequences of lying. She claimed that “if it’s a lie you shouldn’t laugh. It makes people cry.” A third child believed that “crazy is bad...sometimes when they’re acting silly they can sometimes hurt people.”

Two of the three 6-year-olds were also fairly explicit about the negative social consequences of anti-social behaviour. One child claimed that when Paul “puts the thumbtack on somebody else’s chair it wasn’t really fair.” The second child explained that a child cannot be crazy because, “It’ll get them in trouble like throwing glasses and breaking them. That wouldn’t be nice because then the school would kick you out. Or if you did that to your parents they would punish you.”



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**Table 5. Social and Conceptual Capacities**


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Age	Theory of Mind/ Socio-Emotional Understanding	Socio-Conventional Knowledge	Moral Knowledge
4	He's upset about everything (SS)	He's rude (SS)  He's mean because he got sent down to the principle's office (JH)	
5	He thinks Martians come to town. I would like to be a sad person's friend because when you have friends it's not as bad (MY)  He thinks he can fly but he can't. My brother thought there was a lion chasing him in his dream... he felt scared (JK)  He's thinking other children are laughing at him but it's really a baseball. Maybe he doesn't like people because they are always laughing at kids (others) (JE)	He talks about bathroom words like bum. Bad talk (JK)	He's crazy. I don't hit people on the playground (BK)  He's a bad boy because he hits people (JK)  Crazy is bad. Sometimes when they're acting silly they can hurt someone.(KE)  If it's a lie you shouldn't laugh. It makes people cry (JE)
6	He imagined he was in outer space but he was dreaming but maybe he didn't realize it. Maybe he thinks about it but it's a little bit scary (OR)  He's just going in his imagination...its not real. Some people say they're not scared of anything but they are scared of something and that's called lying (JP)	He was acting crazy...The school would kick you out or if you did that to your parents they would punish you (JP)	When he put the thumbtack on somebody's chair it wasn't really fair (OR)

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## IV. Discussion

This study set out to explore children's earliest understandings of mental health and illness. The pattern of results revealed that preschool children assign predominantly divergent meanings to *crazy* and to peer deviant behaviour, the study's two elected representations of mental illness. The constructed meanings, evoked by these two representations, will be discussed based on how they relate to and diverge from the clinical definition of mental illness.

### 4.1 Children's Conceptualizations of *Crazy*

At a fundamental level, children seem to represent *crazy* by **unusual**, **"rule-breaking"** or **morally dubious** behaviours. These three categories of behaviours are consistent with behaviours related to the established *informal* definitions of *crazy* which include: "temporarily out of control", "very wild or foolish" and "very enthusiastic" (Gage Dictionary, 1997). Do these meanings relate to the clinical definition of mental illness? The three categories encompass *some* of the externalizing behaviours that are caused by psychiatric conditions. This is consistent with literature that has examined school age children's perceptions of mental illness using the term *crazy* (Spitzer & Cameron, 1995). Thus, the externalizing behaviours symptomatic of mental illness comprise only *part* of preschoolers' larger conceptualizations of *crazy*, particularly at age 5 and 6.

Most children's conceptualizations of *crazy* do not include the *formal* definition which denotes the presence of a psychopathological origin. Research with school age children supports this finding (Coie & Pennington, 1976; Spitzer & Cameron, 1995). Not surprisingly, this group was unsuccessful at classifying peer deviant behaviour according

to psychological diagnostic standards, as stipulated by the DSM-IV (American Psychiatric Association, 2000). For most preschoolers, *crazy* is not a diagnosis but rather a characterization of an individual who exhibits a specific set of behaviours. In support of this notion, almost all participants classified a *crazy* person as “healthy” indicating that they do not relate it to an internal pathological process.

An overwhelming majority of the participants (9 out of 11) believed that children are capable of being *crazy*. This finding appears to contradict literature that reports that school age children typically have difficulty classifying peer externalizing behaviours with certain mental health labels. For example, some labels include *depressed*, *aggressive*, *phobic* (Coie & Pennington, 1976; Novak, 1975). However, most preschoolers conceptualize *crazy* as a broad set of overt behaviours without the added complexity of the covert psychological or illness components. Thus, children who label their peers accordingly, are not typically referring to a mental health condition.

From a developmental perspective, it was interesting to detect, through participants’ descriptions of *crazy*, their firm grasp on the concept of goal-directed behaviours. Approximately half of the children believed that *crazy* behaviours are intentional, controlled manipulations on behalf of the actor. The other half believed that *crazy* is largely defined by a lack of control or purpose in one’s behaviour. For the latter group, children often made explicit reference to the individual’s lack of control (e.g., “I bonk my head but I don’t want to...”). They seemed to imply that this is an abnormal or undesirable state of being and that typically, individuals’ behaviours are purposefully directed. Thus, most preschool children appear to have grasped the fundamental social-conceptual understanding that behaviour is typically goal-driven and directed. The

findings, however, did not indicate any age-related distinctions in this conceptual capacity.

#### **4.2 The Role of Children's Social-conventional and Moral Knowledge**

An analysis of children's evaluations of their peers' behaviour revealed that their knowledge of social-conventional norms and moral principles are both powerful guiding influences. This idea is supported by a well-established, contemporary view of moral development which argues that preschoolers' deal with moral dilemmas in everyday life and show an interest in the rights as well as the rules of social interactions (Johansson, 2001). Thus, it is reasonable to expect that this set of preschool children may be well-versed in addressing issues that require knowledge of social-conventional rules and moral principles.

According to the Social Domain Theory, preschool children use these two knowledge domains to assess a social situation and to help determine peer inclusion or exclusion (Cassidy, Chu & Dahlsgaard, 1997; Killen, 2007). Because *crazy* often implies "rule-breaking" or morally dubious behaviours, particularly for 5- and 6-year olds, preschoolers' who are categorized accordingly may experience harsher social judgment or exclusion. The following findings from the vignette task support this idea. Paul of vignette #2 hits the teacher and kicks children – two social and moral code violations. He also often gets sent to the principal's office which is a strong marker of a social norm violation. The findings showed that seven participants classified Paul as *crazy*, he received the highest number of negative evaluations of all three vignettes and a predominant number of children preferred to have social distance from him. Consistent with research on children's perceptions of peer deviance, peer aggression is the most

negatively sanctioned form of behaviour by school age children (Novak, 1975). On the other hand, Scott of vignette #3 was more often normalized, received the lowest number of negative evaluations of all three vignettes and the group was more evenly split in terms of this child's social acceptance. For most children, Scott's behaviour was imaginative, which seems to be considered a "normal" type of behaviour for children of this age. Thus, peer inclusion or exclusion may be at least partially determined by preschool children's knowledge of and use of social-conventional and moral principles in the assessment of their peers.

Also supported by the Social Domain Theory is the evident *increase* between the ages of 4 and 5 in these preschoolers' considerations of group welfare and moral principles in the formation of peer appraisals. Children who were 5 and 6 years old more often expressed the negative consequences of *crazy* and "bad" behaviours (e.g., "getting into trouble" - social-conventional, "hurting someone" - moral). Related to this developmental trend, these children represented *crazy* by increasingly apparent forms of social-conventional and moral code violations (e.g., hitting someone, stealing) versus 4-year-olds who often described unusual or "funny" behaviours or expressed uncertainty in their understanding of *crazy*. Accordingly, in the fifth and sixth years, a *crazy* person tends to be described with more negative character attributes and there is a clear developmental increase in negative attitudes towards being *crazy* (i.e., 4-year-olds all hold positive attitudes, 5-year-olds hold positive, negative and ambivalent attitudes, 6-year-olds all hold negative attitudes).

Children's attitudinal progression is reflected in the following patterns. First, older children had a stronger sense that *normal* and *crazy* are either diverging or

semantically opposing terms. With development, children were also less likely to identify the self as *crazy*, particularly by the age of 6. Interestingly, two children (5-year-olds) who used *crazy* as a self-referential term both had generally ambivalent attitudes towards the concept. This finding may be reflecting the tension between the negative properties they associate with the concept and the fact that they consider themselves to be *crazy* at times.

From a sociological perspective of mental illness, preschoolers are quickly becoming active participants in the social processes of identification and labeling of mental illness. This theoretical standpoint defines the symptoms of a mental illness as primarily rule-breaking or social norm violating behaviours. A “deviant” is the label that a group collectively assigns to an individual who repeatedly demonstrates such behaviours (Scheff, 1966). In this study, the developmentally related semantic shift in children’s understandings of *crazy* may be driven by a broader process of refinement of social-conventional and moral reasoning capacities, and thus the ability to assess and label such behaviours. Ultimately, the formation of consistently negative attitudes towards *crazy* and/or “bad” behaviours has major implications for the social inclusion or exclusion of a rule-breaking or “deviant” peer and may be indicative of the onset of more complex inter-group intolerance in young children.

#### **4.3 Moral Development and Children’s Social and Conceptual Capacities**

An analysis of social-emotional perspective-taking in children’s data also indicates a strong developmental shift in the fifth and sixth years, consistent with literature findings (Harwood & Farrar, 2006). Children seemed to personally identify

with other individuals' emotions in certain hypothetical situations and place increased importance on the role of emotions in their peers' self-management skills.

Hoffman's empathy theory of moral development may help explain how social-emotional perspective-taking relates to children's use of social-conventional and moral knowledge and, thus, the evaluation of their peers (Kristjansson, 2004). The guiding principle of this model states that empathy and justice become bonded when individuals empathize with victims of injustice and they become aware of both their empathic feelings and the activated justice principles. This process is known as 'empathic distress' which reportedly becomes apparent in children's justice assessments between the ages of five and eight. Thus, Hoffman's theory supports the findings of a developmental congruency between children's empathy and their moral and group-oriented judgments about their peers. Thus, children's evaluations of peer externalizing behaviours may be guided by the ability to take the emotional perspective of that child, particularly in the fifth and sixth years.

An exploration of children's 'theory of mind' also indicates a strong developmental shift in the fifth year. Almost all 5- and 6-year-olds understood the nature of subjective reality which was concluded from their explicit references to the false beliefs of others. Four-year-old participants did not make such references. Consistent with literature findings, theory of mind and socio-emotional perspective-taking seemed to arise at similar times in human development (Harwood & Farrar, 2006). This may be due to the fact that both social-conceptual capacities require the identification of the other's mental state, whether belief- or emotion-based. Thus, children's ability for social

perspective-taking may be an additional knowledge resource that informs children appraisals of peer behaviours.

The aforementioned developmental shifts, suggested by the data, are also undoubtedly facilitated by children's general language capacities. Research indicates that the preschool years represent a significant period for language development in terms of phonological awareness and oral language proficiency (Pullen & Justice, 2003; Dickinson, McCabe, Anastasopoulos, Peisner-Feinberg & Poe, 2003). Children's increased receptivity to and comprehension of language may assist in: 1) contextualizing and making sense of peer deviant behaviours – evident in children's increased ability to describe specific associated behaviours and to explain real-life experiences, 2) facilitating changes in their conceptualization of *crazy* - evident in children's increasingly complex and specific explanations of this lexical representation. Language development also has implications for children's attitudes towards mental illness – namely, children are becoming increasingly fluent in the types of language that promote the culturally dominant, negative views about individuals who exhibit deviant behaviours. In addition, the apparent advancement in verbal ability across ages most likely enhanced children's articulation of the meanings they assigned to *crazy* and their perspectives of peer deviant behaviours. Thus, increased language facilities may play a pivotal role in framing preschool children's conceptualizations of mental health and illness in more culturally-consistent, "adult" ways.

In order to cultivate an understanding of mental illness, children must also undoubtedly be exposed to the raw informational data that comprise our cultural understandings. These social-conceptual capacities may create the cognitive conditions to



conceptualize the various facets of mental illness. However, it is the social resources (i.e., parents, teachers, peers, etc.) that will stimulate these conceptual capacities through the transfer of knowledge. Conditions for optimal learning may depend on engaging these capacities with this social data as they are emerging in children.

#### **4.4 Methodological Assessment/Limitations**

##### ***4.4.1 General Issues***

It is necessary to reflect upon the efficacy of the methods as an essential part of genuinely representing these children's perspectives. The study will explore the general issues and specific, method-related issues related to research with young children.

It is clear that the current study's two elected representations of mental illness, *crazy* and peer deviant behaviours, cover diverging conceptual ground for these preschool children. Not surprisingly, children's descriptions of *crazy* represent a much broader scope of meanings (consistent with this term's multitude of dictionary definitions). The meanings that specifically relate to the stipulated definition of mental illness play a *partial* role in children's conceptual models of *crazy*. These meanings are predominantly represented in their descriptions of peer externalizing behaviours. By the same token, children do not consistently label peer deviant behaviour that is caused by a mental illness as *crazy*. For example, Scott's behaviour was largely considered "normal". Clearly, these two approaches delve into overlapping but mostly divergent subject areas.

It is speculated that once children have a clear conceptualization of the psychological domain, these two representations of mental illness will further converge in children's conceptual blueprint. Equipped with this conceptual tool, children may be able to grasp: 1) the cause and effect relationship between maladaptive psychological

processes and externalizing behaviours, 2) which externalizing behaviours are a result of these maladaptive mental states and, 3) that *crazy* can be a reference to maladaptive mental states.

In terms of the general research experience, the strategies used to nurture the researcher-participant relationship seemed to positively impact the children's level of engagement. First, the children appeared to be secure in their interactions with the researcher (e.g., often children would act out their ideas in highly animated and uninhibited ways). One child drew a picture of herself taking care of the researcher who was sick in bed. Second, participants of all ages seemed comfortable negotiating the direction of the research activities. For example, during the drawing activity, one child stated in reference to the markers we were using: "I'll pick all my favourite colours and lay them out here. You guess mine and I'll guess yours alright?" Interestingly, children seemed most compelled to assert themselves during the drawing activity possibly because it was the least structured activity of the study. Often the participants would provide feedback on the activities which helped guide the direction of the research: "I like the stories" or "can we do a new game now?"

Not surprisingly, several children were shy and quiet in the first session and gave short responses to the vignettes questions. These participants seemed to gradually gain a sense of security and control as the research proceeded, particularly during the drawing activity. Thus, the various rapport-building and participant-empowerment strategies seemed to facilitate a relaxed and rewarding interaction for both participant and researcher. However, it must be recognized that each child has individual and unique cognitive and personality characteristics which undoubtedly had a differential impact on

their interpretation and response to these strategies. Therefore, the strategies may have encouraged more natural responding in certain children but may have been counterproductive with other children.

Qualitative research with young children is a very delicate balancing act between encouraging open-ended discussion and meeting protocol demands. Data collection was met with the challenge of completing all of the pre-determined protocol within a short time frame while still encouraging children to openly and at-length, discuss their experiences. The interview and drawing activity, in particular, were designed to encourage children to discuss any ideas evoked by my questions – even if they seemed irrelevant or unrelated. However, considering preschoolers’ typically short attention span, I avoided large digressions from the topic so that participants had enough “energy” to complete all of the tasks. Therefore, at times I had to re-route the conversations back to my questions, which may have been abrupt and perhaps jarring for the children. While the tasks were executed within a manageable amount of time for all participants, the protocol constraints may have hindered their ability to share a comprehensive account on the subject matter. As a result, children’s accounts were interpreted cautiously, taking into account the limited scope of their responses.

Similarly, there was a tension between adhering to the protocol and probing for clearer understanding, which was often necessary to clarify children’s initial responses. One of my main methodological objectives was to broach the topic of mental health and illness without imposing my preconceptions or biases upon the participants. When probing into children’s remarks, I did not want to lead the participants or inadvertently allude to my own beliefs about mental illness. Severe deviations from the protocol may

have lead to such an outcome. Therefore, probing predominantly consisted of the “why?” question. It was recognized that any additional questioning on my behalf may have heavily impacted the nature of their responses and responses to later questioning. Therefore, probing was used frequently but cautiously.

As discussed in the methods section, the participants were not asked to keep the activities confidential from other classmates. As it turns out, children discussed, in detail, the research activities with each other. After my first session with JP, I conducted a session with his classmate, BN. During vignette #1, I asked BN to substantiate his response to question #1 (why do you think that Mike is normal and crazy?) He claimed “because that’s what JP said.” It is clear that after JP’s first session, he discussed our session with another classmate. Because the participants had the opportunity to interact throughout the day, this was considered a potential influence on children’s responses. Thus, participant-to-participant interactions can be a potentially significant variable in research with young children.

#### *4.4.2 Vignettes*

A number of design issues arose in the vignette task. Research indicates that vignettes are a reliable and well-established methodological approach to the topic of mental health and illness with children, particularly during school age (Spitzer & Cameron, 1995). Clearly, this method is rooted in quantitative inquiry, intended to offer considerable experimental control for comparable results across participants. It is conceivable that the vignette questions may not have addressed, with equal effectiveness, each child’s perceptions of these three characters. For example, in question #1: what do you think about this child?, the 5- and 6-year-olds offered substantial responses, whereas

the 4-year-olds often struggled to or did not provide an answer. This task is built on the assumption that experimental control will elicit comparable results. However, the cognitive and intellectual developmental differences among children may have affected the way that each age group, and each individual, construed and effectively responded to these questions. Therefore, the results from these eleven children vary, not only as a function of their individual perceptions of peer deviant behaviour, but as a function of their capacity to navigate within the cognitive demands of this task. A task with such high experimental control applied to a group with a range of ages and variable cognitive capacities must acknowledge the possibility of this limitation.

This task required that children understand the concept of a hypothetical or pretend domain. A small portion of 4- and 5-year-olds seemed to have some *initial* difficulty with the concept of being someone's "hypothetical friend". However, research on pretend play and "imaginary friends" indicates that, by the beginning of the second year, children use pretend play to differentiate the world of 'what is' and the world of 'what if' (Engel, 2005). Therefore, children's initial difficulties may have simply been related to familiarizing themselves with the "pretend" aspect of the activity.

Question #5 in vignette #1 seemed to bias children's responses in favour of the term *crazy* (do you think the child is normal or *crazy*?). This research can conceive of two explanations for this bias. First, *crazy* may simply appeal to this group because of its entertaining, off-beat quality. Second, children may have classified *all* behaviours as *crazy* if they were not considered *normal*. Several children could not explain why they thought Mike was *crazy* but that "he just is." Therefore, *crazy* may have simply been a default classification.

This close-ended question imposed constraints on children's explanations of their understandings of *crazy*. Research should avoid using dichotomizing variables with young children because they place limitations on the scope of their responses and inadvertently convey the researcher's beliefs about the phenomenon under discussion. An alternative strategy to avoid this bias would have been to ask the children to indicate the characters' *degree of craziness*. Undoubtedly, children's responses clearly showed that some behaviour is *crazier* than others.

#### 4.4.3 Interview

The design of my interview questions conveyed my personal assumptions about the nature of mental health and illness. The following questions I will discuss have particular relevance to this idea.

Question #1 indicated that I believe that there are specific physical characteristics associated with a *crazy* person. Interestingly, children did not construe this question as relating to physical attributes. Virtually all children referred to overt behaviours (e.g., jumping up and down, shaking their head). This indicates one of two things: physical attributes do not fall into children's conceptual understanding of *crazy* or this question was ineffectively worded. With this age group, it is necessary to be very explicit in one's questioning. For example, it may have been more effective to ask: what does a *crazy* person's face and body look like?

Questions #5 and #7 were also problematic because they utilized dichotomizing variables. In question #5, the child was asked to indicate whether being *crazy* is a good thing or a bad thing. Children were not given a "neutral" option. Similarly, in question #7, children had to choose between "healthy" or "sick". Most children chose "healthy",

though their choices were mostly unsubstantiated. In the broader pattern of responses, being *crazy* does not seem to have health implications according to these children. It is again suggested that the use of dimensional models may be provide more clarity than dichotomizing variables.

#### *4.4.4 Drawing Task*

Children's drawings were interpreted at face value, using their verbal explanations to navigate within the meanings, without the use of any projective techniques. Drawing was an effective final task for the research exchange. Most children were very eager to participate in this activity and children's explanations of their depictions dealt with themes that characterized the entire research interaction. Often the drawings would help children expand the ideas that they had raised in the interview into a complex narrative structure. The visual aspect clearly facilitated children's explication of the multiple meanings layered within their depictions.

#### **4.5 Ethical Considerations**

Ethical integrity was a forefront objective of this study, particularly when working with such a vulnerable population as preschool children. Recognizing that the subject matter could have been disturbing or upsetting for the children, it was raised in a cautious and sensitive manner. All children appeared to be very comfortable discussing the topic under study. However, at times, participants showed signs of uncertainty or fatigue, at which point, I proceeded with added caution or moved onto a new task component.

The importance of sensitively approaching this topic is captured by a particular interaction with a 5-year-old-boy, JK. While I was reading the second vignette about Paul, JK interrupted me and began discussing a child in his class who had exhibited

similar tendencies. He became recognizably aggravated by discussing this boy's behaviour, claiming that he is a "bad boy" and that he is no longer his friend. JK also claimed to have participated in similar behaviours himself, such as "hitting other kids". He then requested to hear the remainder of the vignette and the questions. I avoided asking JK question #5 (do you think this boy is normal or crazy?) because I did not want him to identify his himself or his classmate as *crazy*.

Exposure to peer deviant behaviour is a common experience for most preschool age children. Naturally, children may reference real-life peers in their explications of this type of behaviour. It is the researcher's responsibility to avoid conveying their judgments of this behaviour, which may require altering the protocol or terminating the discussions completely. In this case, JK was satisfied with having the researcher listen and acknowledge his remarks.

Ownership of the drawings was also a key ethical issue in research with children. Upon completion of the task, I asked the child if I could keep their drawing. Some children agreed and surprisingly, some did not. In the few instances where the children wanted to keep their drawing, I requested a photocopy, which all children agreed to, and then I returned the original copy to them. These children were given the choice of ownership of their drawings because it was important that they did not feel exploited or manipulated during our research exchange.

#### **4.6 Future Research**

The limitations of this study create several new possible avenues of inquiry. First, the size of this sample, though adequate for a qualitative investigation, could be expanded upon in order to produce a larger illustration of preschool children's perspectives on this



topic. Due to the small number of participants and the qualitative research approach to this investigation, emerging developmental patterns across participants cannot be generalized to the broader population of preschool children.

Future research on this topic may also benefit from enlisting a more diverse group of participants to enhance our currently narrow understanding of children's conceptualizations of mental health and illness. First, the current sample of participants does not represent the multitude of ethnic and racial groups that characterize our diverse Canadian cultural landscape. Ethnic and racial identity as well as socioeconomic background may impact how this concept develops in children and should be explored in future studies of this nature. Second, children with a relative or parent who suffers from a mental health condition may have great insight into the different social and psychological facets of mental illness. Giving children the opportunity to discuss familial mental health issues is undoubtedly a powerful new direction in research which would inform more family centered approaches in the treatment of mental illness (Gladstone, Boydell & McKeever, 2006). Of course, the implementation of this approach would require great sensitivity and caution given the age of the participants. Finally, comparing the perspectives of children whose parents are mental health workers versus a general sample of preschool children may offer insight into the impact of parenting and social learning on children's conceptual development in this area.

This study did not explore the precipitating developmental or environmental factors that drive children's conceptual model of mental health and illness. It is necessary to isolate these internal and external processes that drive this understanding. For example, future research should explore the relationship between moral development

indicators and children's interpretations and discrimination of their peers' behaviours. Environmental factors may also help construct children's understanding and attitudes towards mental health and illness, such as familial relationships and certain forms of media such as the internet, television and children's books.

Future studies working with this age group should also explicitly compare children's perceptions of peer versus adult externalizing behaviours. Research reports that children are comfortable applying mental health labels to adults, but not necessarily to their peers though explanations for this difference remain unclear (Adler & Wahl, 1998; Novak, 1975). Using more child-centered approaches, research should further explore children's discourse of peer and adult deviant behaviours and the lexical framework children employ to support these understandings.

Research has sparsely studied the impact of mental health education on children's attitudes, particularly with preschool age children (Shah, 2004). Examining the currently available resources that broach this topic with young children such as story books or videos may help develop our knowledge of effective preventative approaches. Education for our youngest students about the "hows" and "whys" of mental illness may help increase basic understanding and compassion for such individuals.

Finally, the qualitative approach to this study has helped contextualize the multitude of issues related to children's conceptualizations of mental health and illness within a larger developmental and social-conceptual framework. Children's rich descriptions and assessments of deviant peer figures has led to an understanding of the significance of social-conventional and moral knowledge as a possibly driving force in peer acceptance and rejection outcomes and the development of intolerant attitudes. This

has particularly strong emotional implications for young children who are mentally ill who exhibit these socially or morally unacceptable behaviours. Capturing a broader, more detailed framework of the issues surrounding preschoolers' earliest semantic constructions of mental health and illness, helps pave the way for new *experimental* forms of inquiry that would systematically isolate and examine these distinct variables in a cross-sectional design and help clarify their role in children's conceptual understanding and development.

#### **4.7 Overall Significance**

Supported by a burgeoning of educational literature, preschool children seem to be exposed to bullies in the educational setting and may be enduring damaging emotional and physical effects from their anti-social peers (Crick, Casas & Chin, 1999; Farrell, Tayler, Tennent & Gahan, 2002; Hyndman & Thorsborne, 1994). Several children identified the term "bully" and expressed the social dynamic between a bully and their peers. One 6-year-old child gave considerable insight into a "bullying" scenario:

"If you're being bullied that means they're being mean. And on TV if you're being bullied you have to tell an adult and then the adult can probably tell the mom and then the mom of the bully could tell that if he keeps doing that she'll take away something that he would never do that he really likes to do. And then if you bully him back he would know what it would be like to bully somebody, bullied him and it's not very nice so he would stop." (JP)

Another child had described a peer in their classroom who exhibits these forms of behaviours and who was clearly a source of aggravation for this child. Clearly, a proportion of this preschool group has experienced first- or second-hand peer victimization and may have experienced the harmful emotional effects. Our discussions reveal that children are already beginning to consistently discriminate against such peers.

Thus, a strategic approach towards inclusion of such children would be two-fold – one, counseling the “bully” and explicitly explaining the negative social and emotional ramifications of such behaviours and two, discussing the reasons that “bullying” occurs to support more empathic and inclusive attitudes in all preschool children.

*Crazy* and peer deviant behaviours do not have health-related implications for these preschool children. Children of this age appear to understand some basic principles of health and sickness, that is, contagion and contamination. However, this general concept does not contribute to children’s conceptual understanding of these two representations of mental illness (Siegal, 1988). This understanding may be echoing the common cultural perception that mental health and illness is separate from general health issues, as they are often addressed accordingly in our policy and our health care practices. It is necessary to unite the cultural discourses of mental health and general health, as they are inseparable matters, and begin by conveying this perspective to our youngest children.

The current study has been motivated by a preventative philosophy of addressing children’s mental health issues at the earliest possible stages. The sooner children are educated about ‘exceptional others’, the greater likelihood that they will develop empathic understandings towards these individuals. Understanding how children interpret and react to peers who exhibit externalizing behaviours resulting from psychological conditions, is a fundamental building block in constructing an approach to support empathic attitudes towards these children. It is clear that preschool children are beginning to cultivate discriminatory attitudes towards “different” kinds of peers who violate social norms and moral principles. Undoubtedly, the social exclusion of such

children would increase the likelihood of perpetuating or even exacerbating these children's emotional issues. A preventative approach to eliminating intolerant attitudes towards and exclusion of children with mental illness would be to address these attitudes in their formative years.

This study underscores the importance of parents', early childhood educators' and practitioners' awareness of preschoolers' sensitivity to their peers' behaviour. Children's seemingly sophisticated use of social-conventional and moral knowledge may determine how children will interpret peers who exhibit deviant behaviour. These attitudes may have implications for the latter's acceptance into social groups and thus drives the construction of complex social structures within preschool circles. Undoubtedly, the 5- and 6-year old groups have demonstrated a capacity for social-emotional perspective-taking in their peers. Therefore, adults can play a pivotal role in guiding children's construction of their social and moral reality by stimulating children's empathetic and sympathetic reactions to these 'exceptional' peers.

It has been observed in this group of preschoolers that a conceptual understanding of the *psychological* may be beginning to emerge closer to 6 years of age. Once children are equipped with this complex conceptual tool, they may be intellectually prepared for more explicit, formal education about mental health and illness in the classroom. Educators may then scaffold children's understandings of mental illness by explaining the connection between the latent psychological processes and the manifest behaviours.

Finally, this study has also demonstrated that children are competent informants on their own experiences. Given the utilization of developmentally appropriate and engaging methodologies, children are often capable of providing considerable insight into

and of contributing to knowledge about their own conceptual and cognitive development. Discussions with these participants have also clearly demonstrated that, at the preschool age, children are actively interpreting their social reality. Not only do they construct their own meanings out the context of the specific social environments, but they also use this information to guide their own behaviour and the assessment of others.

#### **4.8 Conclusion**

Children who are mentally ill are at a double disadvantage in our society – not only do they suffer from their mental affliction but also the profound social stigma associated with their health condition (Levesque & Schacter, 2006). Our culture's discriminatory attitudes towards children's mental health issues are manifest in a multitude of ways, including the pervasive and negative portrayals of mentally ill persons in popular culture and the media, the under-representation of this area in the research literature, and the inadequacy of our education system to properly address these issues. It appears that children, as young as preschool age, are gradually detecting these insidious social attitudes. Further exploration of children's perceptions of their mentally ill peers may help develop new understandings about the way healthy children perceive and treat these peers. Preventative approaches, informed by children's perspectives, may better promote accepting and tolerant attitudes in our youngest children that endure into adulthood. This will encourage positive social and emotional outcomes for mentally ill children and their families and the evolution of more positive attitudes within our communities and society at large.

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## Appendix A: Letter to Parents

Dear Parent,

I am a graduate student in the Early Childhood Studies program at Ryerson University. I am writing to you to request your child's participation in a short research study as a part of my Major Research Paper. This study has been approved by the Toronto District School Board's External Research Review Committee (ERRC).

This investigation will explore the early concept formation of mental health and illness in preschool children, ages 4-6. Your child would participate in three activities over two 30 minutes sessions which would be administered one week apart. In session one, I will read three vignettes that depict a peer with "normal" behaviour and two forms of deviant behaviour associated with mental illness. After each vignette your child will be asked several questions that address their attitude towards this character. In the second session, your child will participate in a short interview and drawing activity that explore their understanding and attitude towards the term "crazy".

It is hoped that your child will benefit by having her/his opinions and ideas validated in the context of a research study with respect to the phenomenon in question. Accessing children's knowledge and attitudes about this concept may be a critical step towards future stigma prevention efforts and the development of mental health and illness education in schools for this age group.

If you are interested in having your child participate, I will contact you through the number you have provided in order to arrange a meeting time. If you agree to your child's participation after our meeting, I will then obtain your informed consent. Presently, the study looks to recruit a maximum of ten participants. Therefore, depending on the response, your child may or may not be chosen to participate.

Thank you for taking the time to consider my request and I look forward to hearing from you and answering any further questions you may have.

Sincerely,

Rosie Bell, B.A.  
rosanna.bell@ryerson.ca  
(416) 545-7139

Please check one of the following:

☐ I am interested in having my child participate and would like to be contacted for more information.

\_\_\_\_\_  
Name

\_\_\_\_\_  
Child's Name

\_\_\_\_\_  
Telephone #

☐ I am not interested in having my child participate.

## Appendix B: Parental Consent Agreement

### Ryerson University Consent Agreement

#### *Master of Arts in Early Childhood Studies, Major Research Paper (MRP)*

Your child is being asked to participate in a research study. Before you give your consent for your child to be a volunteer, it is important that you read the following information and ask as many questions as necessary to be sure you understand what your child will be asked to do.

**Investigators:** Rosie Bell, B.A., Graduate Student, [rosanna.bell@ryerson.ca](mailto:rosanna.bell@ryerson.ca)  
Dr. Jean-Paul Boudreau, PhD, Psychology Chair, Ryerson University.  
[chair@psych.ryerson.ca](mailto:chair@psych.ryerson.ca), 416-979-5000 ext.7047

**Purpose of the Study:** This study will explore a preschools children's (age 4-6) knowledge and feelings about the concept of mental health and illness. The child will be read and will discuss three short vignettes that show various types of peer behaviour and asking him/her open-ended questions about the term "crazy". Very few studies on mental health and illness have examined the perspectives of this age group. Accessing children's knowledge and attitudes about this concept may be a critical step towards future stigma prevention efforts and mental health education for this age group.

#### **Description of the Study:**

The child will be asked to participate in three tasks over two sessions which will be audiotaped.

##### **Session 1:**

- 1) **Vignette Task** - three short vignettes that depict a male, child character will be read to the child. Vignette #1 depicts a normal, well-adapted child, vignette #2 depicts a child with anti-social tendencies, i.e. hitting other children on the playground, vignette #3 depicts a child who is borderline psychotic, i.e., believes that he has been into outer space. After each vignette the child will be asked five questions about their attitude towards this character, i.e., what do you think about this boy? Would you like to be this boy's friend? Do you think this boy is crazy or normal? (30 minutes)

##### **Session 2:**

- 2) **Interview/Card Task** – Ten cards will each have a different word on it, i.e. happy, sad, smart, mean, crazy, nice, scared, shy, surprised, and angry. The child will be asked about their definition of each word. Then the child will be asked open-ended questions about a person who is described with two of these characteristics, i.e. happy person and crazy person. The questions are designed to understand their knowledge and beliefs about the term "crazy". (20-25 minutes)

- 3) **Drawing Task** – the researcher and child will draw together. The child will be asked to draw something or someone that reminds them of the word “crazy”. The researcher will use to other card discussed in the interview for their drawing. Drawings will be briefly discussed. (10 minutes)

**SOME SAMPLE INTERVIEW QUESTIONS INCLUDE:**

- What do you think a “crazy” person looks like?
- What do you think a “crazy” person acts like?
- Do you think a “crazy” person is healthy or sick?

**LOCATION:** the school classroom during school time

**TIME:** two sessions, each 30 minutes in length, one week apart

**What is Experimental in this Study:** The vignette activity is considered experimental because it is an established method used in psychological research to understand children’s attitudes towards and ability to classify deviant behaviour. This study will gather information for the purpose of data analysis which is also considered an experimental procedure. The interview and drawing task are not considered experimental because they are open-ended methods for collecting data.

**Risks or Discomforts:** It is possible that your child may be uncomfortable or wish to stop, but may be unsure of how to say no to the researcher. Therefore, prior to commencing the study, the child will be reminded that she/he can say “no” or “stop now” or “next question.” Additionally, the researcher will be alert to non-verbal signs of discomfort and/or fatigue on the part of the child. If the researcher sees that the child is significantly ill at ease, research will be terminated. If the researcher feels that the child’s safety is at risk, they will immediately notify a school official or someone responsible.

**Benefits of the Study:** This study will allow me to gain experience in conducting research with children, which will be of use to me in my present and future work with children. It is hoped that your child will benefit by having her/his opinions and ideas validated in the context of a research study. I cannot guarantee, however, that your child will receive any benefits from participating in this study. It is also hoped that accessing children’s knowledge and attitudes about this topic will be an important step towards the development of mental health and illness education and stigma reduction in schools for this age group.

**Confidentiality:** The data from this study will only be viewed by myself, Rosie Bell, and my master's supervisor, Dr. Jean-Paul Boudreau. This includes the audiotapes, transcribed records and field notes taken by the researcher. After data analysis is completed, the records and audio-tapes will be locked in a filing cabinet for one year at which time they will be destroyed and disposed. In the reporting of this data, your child's identity will not be used. If your child requests their drawing, they will be returned at the completion of the study (June 8, 2007). Otherwise, Dr. Boudreau will store them in a confidential manner, in a locked filing cabinet, for one year after which time they will be disposed.

**Incentives to Participate:** With your permission, your child will receive a small token of appreciation whether or not she or he completes the study (e.g. a small toy from the dollar store).

**Voluntary Nature of Participation:** Participation in this study is voluntary. Your choice of whether or not to have your child participate will not influence your future relations with Ryerson University or your child's school. If you decide that your child may participate, know that you are free to withdraw your consent and to stop your child's participation at any time without penalty or loss of benefits to which you are allowed.

At any particular point in the study, your child may refuse to answer any particular question or stop participation altogether. Your child may communicate refusal verbally and/or non-verbally (signs of fatigue).

**Questions about the Study:** If you have any questions about the research now, please ask. If you have questions later about the research, you may contact.

Principal Investigator/Study Coordinator: Rosie Bell  
Telephone Number: 416-545-7139

If you have questions regarding your child's rights as a human subject and participant in this study, you may contact the Ryerson University Research Ethics Board for information.

Research Ethics Board  
c/o Office of the Vice President, Research and Innovation  
Ryerson University  
350 Victoria Street  
Toronto, ON M5B 2K3  
416-979-5042

**Agreement:**

Your signature below indicates that you have read the information in this agreement and have had a chance to ask any questions you have about the study. Your signature also indicates that you agree that your child may participate in the study and have been told that both you and/or your child can change your or her/his mind and withdraw consent to participate at any time. Your second signature indicates that you agree to have your child audio-taped throughout the two research sessions.

You have been given a copy of this agreement to keep.

You have been told that by signing this consent agreement you are not giving up any of your legal rights.

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name of Child (please print)

\_\_\_\_\_  
Signature of Investigator

\_\_\_\_\_  
Date

Consent for your child to be audio-taped:

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date



## Appendix C: Child Consent Agreement

### **Ryerson University Child's Consent agreement**

*Master of Arts in Early Childhood Studies, Major Research Paper (MRP)*

**TITLE OF PROJECT:** Stories and words that describe people

I am willing to listen to and talk about stories that describe different characters with Rosie. I am also willing to talk about words that describe people with Rosie. We will do these activities together: a story activity, a word game and drawing a picture.

Its OK by me that:

1. Our conversations will not name or identify me
2. Our conversations will be tape recorded
3. Only Rosie and her teacher, Jean-Paul, will listen to the tapes. The teacher will protect the tapes by keeping them in a locked filing cabinet for one year and then will make sure if they aren't needed anymore to erase them.
4. I can stop the study at any time. One way I can do this is by saying "stop now" or I can say "next question."
5. I can end being part of the study at anytime without any questions being asked.
6. Rosie might talk to someone responsible if they are worried about my safety.

My name

\_\_\_\_\_

My signature or special mark \_\_\_\_\_

Today's date \_\_\_\_\_