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International Journal of Social Psychiatry 2007; 53; 526
DOI: 10.1177/0020764007078359

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HOW CHILDREN STIGMATIZE PEOPLE WITH MENTAL ILLNESS

PATRICK W. CORRIGAN & AMY C. WATSON

ABSTRACT

Many advocates have called for more anti-stigma programs targeting the attitudes of children towards people with mental illness as a way to forestall subsequent prejudice and discrimination as they age and develop. In order to better understand how children stigmatize people with mental illness, we reviewed the substantial literature on social cognitive development and ethnic prejudice. This literature suggests a curvilinear relationship. Children as young as three show some endorsement of stereotypes about people of color, which slowly increases and seems to peak around age five to six. Older children, interestingly, show lower rates of ethnic prejudice. Differences between mental illness and ethnicity-related stigma may influence the form of this relationship and we provide some hypotheses representing this difference. We then summarize the literature on stigma change, focusing on how specific strategies interact with what is known about social cognitive development and prejudice. Strategies that are reviewed include education, contact, social cognitive skills training, role play for empathy, peer interaction, protest and consequences. Implications for continued research in this area are highlighted throughout the article.

Key words: stigma, children

Research completed during the past two decades has begun to describe the problems wrought by mental illness stigma and ways to diminish it. This work has distinguished between public stigma (what the general population does to people with mental illness when endorsing the prejudice and acting in a discriminatory manner) and self-stigma (what people with mental illness do to themselves when they internalize stigma) (Corrigan & Watson, 2002). In partnership with advocacy groups, this research has also begun to lay out a program to erase the stigma in order to increase the opportunities of people with mental illness. Children are often identified as an important target population for stigma change (Hinshaw, 2005; Wahl et al., 2002); perhaps the cognitive processes of preschool and primary grade children could be influenced so that prejudice about and discrimination towards people with mental illness never develops or is muted. Ideally, we could foster future generations of adults where the stigma of mental illness is neither so prevalent nor egregious. These kinds of programs require better understanding of how stigma develops and is maintained in children.
Theory and research on mental illness stigma has been significantly advanced through a translational research agenda; i.e. enhancing theoretical and methodological approaches to mental health issues by extrapolating related ideas from basic behavioral research (Corrigan et al., 2003a). Research on mental illness stigma has borrowed heavily from basic social psychological research that explains the prejudice and discrimination experienced by minority groups. The translational research agenda has thus far largely been applied to understanding how adults stigmatize people with mental illness and ways to diminish it. The purpose of this paper is to apply a similar translational approach to increasing comprehension of how children stigmatize people with mental illness and how child-age stigma might be reduced. Bridging existing research on child development with the priorities of mental illness stigma will inform the research agenda meant to explain how children acquire mental illness stigma. Recently, anti-stigma programs have begun to target children as an effort to forestall the prejudice and discrimination of mental illness before young people can begin to act on it. Our review is meant to inform these kinds of programs.

CHILDHOOD DEVELOPMENT OF PREJUDICE AND DISCRIMINATION

We contrast two cognitive models that explain how children develop prejudice and stereotypes: an incremental learning model and a cognitive stage model. Almost all the research on these models examined the prejudice related to ethnicity or, to a lesser extent, gender. We extrapolate the significance of research on what are relatively manifest stigmas to mental illness, which is frequently a hidden stigma.

Figure 1 summarizes the research on childhood cognitive development relevant to understanding stigma and its impact. Research in this area has largely focused on ages three to seven years as the key developmental period with regard to the development of prejudice and discrimination, with this period divided into three important epochs roughly circumscribing three, five and seven years of age. The caveat extended to much of developmental psychology applies to Figure 1. Namely, three, five and seven are average ages for developmental milestones; the population is likely to be described by a fair-sized range on either side of the means, reflecting the standard error of the corresponding construct. Figure 1 also includes the two dominant models that try to explain these empirical findings: the incremental learning model and the cognitive stage model. We first review the overall research findings and then examine the explanations and predictions provided by these models.

As a general summary, the middle timeline of Figure 1 has a dashed line meant to represent level of prejudice by age. Two points marked on the dashed line are worth noting and seem to challenge naive ideas about prejudice in children. First, relatively young children are not innocents in terms of prejudice. White children as young as two and a half endorse the idea that their group is good and blacks are bad (Aboud, 1988; Clark & Clark, 1947). Second, the relationship between prejudice and age in children is not described by a monotonic increasing function. Somewhere between age five and seven seems to be a watershed age where prejudice actually declines from earlier years. Evidence for these two conclusions is summarized below.

What the evidence suggests

Research on ethnic stigma suggests that children as young as three years old are sensitive to cues that signal group differences. Children at this age are able to discriminate between blacks and
Figure 1. Summary of research on how elements of prejudice and discrimination develop. The middle of the three time lines summarizes the evidence on when perception of stigmatizing cues, knowledge of stereotypes, and endorsement of stereotypes is evident in 3 to 7 year olds.

The dashed line is meant to summarize what seems to be counterintuitive evidence; namely, level of prejudice may diminish after age five. Arrow A on the dashed line suggests that young children actually show some prejudice. Arrow B suggests that older children endorse prejudice at a lower rate than younger children.

The top of the three time lines represents the learning process as a continuous incremental event. The bottom focuses on qualitatively distinct cognitive stages which influences the development of cues, stereotypes and prejudice.

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**Incremental Learning Model**

- Absence of stereotypes and prejudice
- Vicariously learns stereotypes from parents and other key models and adopts them as personal beliefs
- Vicariously learns social undesirability of some stereotypes and suppresses reporting them as personal beliefs

**What the evidence suggests**

- 3 yo: Relative prejudice level
- 5 yo: B
- 7 yo

- Perceives cues that differentiate groups and identifies with ingroup
- Has knowledge of stereotypes and endorses some as personal beliefs
- Seems to suppress endorsing some stereotypes as personal beliefs

**Cognitive Stage Model**

- End of sensorimotor stage; child able to apply perceptual skills to social groups
- Cognitive limitations of pre-operational children; labels similar groups as good, dissimilar as bad
- Conservation and other transformational skills help child to see that different is not bad
whites, to assign racial labels and to identify to which groups they belong (Aboud, 1988; Augoustinos & Rosewarne, 2001; Clark & Clark, 1947; Goodman, 1964; Katz, 1973; Vaughan, 1964; Williams et al., 1975a,b). Interestingly, children are able to perform these perceptual tasks without being aware of the racial concepts, classifications or stereotypes that accompany them (Aboud, 1988; Clark & Clark, 1947; Goodman, 1964).

By five years of age, research suggests that children are knowledgeable about outgroup stereotypes (Aboud, 2003; Bar-Tal, 1996; Katz & Kofkin, 1997; Teichmann, 2001). In a classic paper, Devine (1989) said that knowledge of stereotypes is not equivalent to endorsement of them (prejudice). Her work has distinguished low-prejudice groups from high-prejudice groups in terms of whether adults who are knowledgeable about stereotypes personally believe them. Research on children has shown that most children around five years of age have knowledge of stereotypes and report that they personally believe them (Aboud, 2003; Augoustinos & Rosewarne, 2001; Augoustinos & Walker, 1995).

Interestingly, seven-year-olds show the same level of stereotype knowledge but much lower levels of prejudice, i.e. agreeing with the stereotype. In particular, a marked decrease in prejudice towards people of color is noted as children aged from five to seven. This is a particularly robust finding that has emerged in studies using a variety of measures (Aboud & Skerry, 1984; Asher & Allen, 1969; Augoustinos & Rosewarne, 2001; Black-Gutman & Hickson, 1996; Clark et al., 1980; Doyle et al., 1988; Katz, 1979; Katz et al., 1975; Rice et al., 1974; Williams et al., 1975a,b; Zinser et al., 1981). The improvement in seven-year-olds seems to represent fewer prejudicial beliefs about the outgroup rather than less favoritism towards the ingroup (Epstein et al., 1976; Fox & Jordan, 1973; George & Hoppe, 1979).

Incremental learning versus cognitive stage models

Do learning stereotypes, yielding to prejudice and behaving in a discriminatory manner develop in a continuous incremental fashion or in qualitative leaps signifying discrete cognitive developmental stages? Classic social psychological theory supported the former model; namely, that children are born with no stereotypes, prejudice and/or discrimination and slowly acquire them through incremental learning processes during interactions with parents, peers and other key people in their lives (Adorno et al., 1950; Allport, 1954; Brand et al., 1974; Rosenfield & Stephan, 1981; Schofield, 1986; Stephan, 1999). This assumption has important implications for stigma change strategies; parents and other important models need to be incorporated into anti-stigma programs that are meant to stop children from endorsing the stereotypes. However, the incremental learning model yields two hypotheses that have not been supported by research:

1. Because children learn prejudice and discrimination through interactions with mother and father, a significant association between parent and child attitudes should be found. It has not been found (Aboud & Doyle, 1996; Branch & Newcombe, 1986; Kofkin et al., 1995).
2. Because prejudice and discrimination is acquired incrementally, younger children should typically show lower scores on measures of the constructs than older children.

As described earlier, research has fairly consistently shown that children a few years younger than seven frequently endorse negative statements about outgroups at a higher rate than older children. Proponents of the incremental learning model have an answer for this finding. As children age from five to seven, they learn social desirability rules that teach them to constrain their prejudicial beliefs.
For example, parents teach their children to suppress prejudicial statements in order to avoid social opprobrium. Alternatively, the change from high to low prejudice as a child ages from five to seven is often used as evidence that supports the cognitive stage model of prejudice development.

The cognitive stage model represents the classic developmental theory of Piaget (1985) and its more contemporary manifestations (Flavell, 1999; Flavell & Miller, 1998). According to these models, children cognitively develop through a series of stages during which qualitatively distinct abilities emerge. Piaget, for example, grouped three- to seven-year-olds into the sensorimotor (with children of three years of age at the end of this stage), preoperational (in which three- to five-year-olds would find themselves) and concrete operational stages (characteristic of children older than seven). Children towards the end of the sensorimotor stage have developed a fairly reliable ability to perceive their world, although they have limited skills for putting these perceptions to language. The perceptions and cognitions of preoperational children are largely egocentric and limited to one aspect of a situation at a time. The concrete operational child shows the ability to cognitively conserve concepts, classify information and adopt the viewpoint of others. Presence or absence of these stages can be demonstrated by a child's ability to complete various perceptual and cognitive tasks that have been shown to be benchmarks of the abilities learned at that stage. Although various social and developmental psychologists have used these theories to explain the evidence summarized in Figure 1, research by Aboud and colleagues has been particularly germane to this translation (Aboud, 1988, 2003; Aboud & Amato, 2001).

Consistent with a Piagetian framework, three-year-old children who have completed the sensorimotor stage of cognitive development are perceptually able to distinguish cues that distinguish ingroups from outgroups and identify with their ingroup. Language abilities are limited, however, so that knowledge of stereotypes that correspond with the ingroup–outgroup distinctions is relatively low. Preoperational five-year-olds have acquired sufficient language abilities to recount the stereotypes that correspond with ingroup–outgroup distinctions. Hence, knowledge of stereotypes markedly increases. Their inability to avail complex cognitive processes (e.g. conserve concepts and classify information) and overall egocentrism prevent them from separating knowledge of stereotypes from personally believing them. Dominated by one dimension of appraisal, the unsophisticated preoperational child may be constrained to conclude that the ingroup is good and the outgroup is bad (Aboud, 2003). Hence, they appear to endorse prejudicial statements about stigmatized groups.

Expanded conceptual abilities of individuals in the concrete operational stage explain the noticeable reduction in prejudice from age five to seven. The later development of processes associated with multiple classification and conservation are credited with the frequently noted rise in middle childhood of positive outgroup attitudes (Aboud, 2003; Bigler & Liben, 1993). For example, research has shown that white children with higher test scores on measures of conservation and multiple classification were less likely to endorse racial prejudice regardless of age (Aboud, 2003). This pattern explains the dip in prejudice as children age beyond five years.

COGNITIVE DEVELOPMENT AND MENTAL ILLNESS STIGMA

The necessary first step in translating social psychological theory about childhood development of prejudice and discrimination to mental illness is reviewing existing research on mental illness
Corrigan & Watson: Children and Stigma

Wahl et al. (2002) recently summarized research conducted on children regarding their perceptions and cognitions about people with mental illness. Their review distinguished children’s knowledge about and attitudes towards people with mental illness, which dovetails nicely with the review of cognitive development earlier in this paper. Unfortunately, most of the studies in Wahl et al.’s paper examined samples of children who rarely fell in the three to seven developmental range reviewed in Figure 1.

Only one of six studies in the Wahl review examined knowledge of mental illness and mental illness stereotypes in children under seven. Spitzer and Cameron (1995) found that seven-year-olds were unfamiliar with terms like mental illness and psychiatry but could correctly define weird and crazy, especially as applied to adults in vignettes manifesting psychiatric symptoms. Weiss (1985, 1986, 1994) completed a series of studies on personal beliefs (a proxy of prejudice) about people with mental illness on kindergartners to third graders. His results largely mirrored the general pattern outlined in Figure 1. Namely, that younger children (age five in kindergarten) were more likely to verbally endorse prejudice about people with mental illness than older children. The combined evidence provides preliminary support for the model representing the relationship between age and prejudice about mental illness in young children outlined in Figure 1.

Some differences in mental illness stigma

There are some interesting differences between ethnic and psychiatric outgroups that need to be considered in future research on children’s views of people with mental illness. Two issues are especially provocative and are considered more fully here: (1) the cues that signal stigmatizing reactions to people of color are relatively manifest while those leading to prejudice against people with mental illness are somewhat hidden; and (2) the nature of outgroup identity and status for people with mental illness is qualitatively distinct from people of color, women, and other outgroups. Our goal is to generate some testable and important hypotheses based on this review as well as discuss some of the methodological conundrums that may arise to challenge the valid testing of these hypotheses.

Hidden cues

Goffman (1963) maintained that cues suggesting stigma in people of color and gender are relatively obvious (skin color and body features) while those for mental illness are much less so. This distinction has important implications for understanding the development of prejudice in children. What conditions are sufficient for a child to perceive a set of cues as signaling a specific ingroup or outgroup? What are these cues vis-à-vis mental illness?

What are the cues that suggest mental illness groupness? Research on adult samples show that the general public infers mental illness from four signals: psychiatric symptoms, social skills deficits, physical appearance and labels (Corrigan, 2000; Penn & Martin, 1998). Many of the symptoms of severe mental illness – inappropriate affect, bizarre behavior, language irregularities and talking to self aloud – are manifest indicators of psychiatric illness that frighten the public. Research has shown that symptoms like these tend to produce stigmatizing reactions (Link et al., 1987; Penn et al., 1994; Schumacher et al., in press; Socall & Holtgraves, 1992). Moreover, poor social skills that are a function of psychiatric illness also lead to stigmatizing reactions. Deficits in eye contact, body language and choice of discussion topics (Bellack et al., 1990; Mueser et al., 1991) potentially mark a person as mentally ill and lead to stigmatizing attitudes. Finally, research suggests that personal appearance may lead to stigmatizing attitudes (Eagly et al., 1991;
Penn et al., 1997; Schumacher et al., in press). In particular, physical attractiveness and personal hygiene may be manifest indicators of mental illness leading to stereotypic responses from one’s community; e.g., ‘that unkempt person on the park bench must be a mental patient’.

Note, however, the potential for misattributing someone as mentally ill based on these three signals. What might be eccentric behavior that is not pathognomonic of a psychiatric disorder could be misunderstood as mental illness. Social skills vary on a continuum such that low skills may represent a shy person rather than mental illness. Physical appearance may also lead to false positives about judging someone as mentally ill. Many street people with slovenly appearance are believed to be mentally ill when, in actuality, they are poor and homeless (Koegel, 1992; Mowbray, 1985). Just as the presence of these three signs may yield false positives, the absence of these signs will often lead to false negatives.

Juxtaposing concerns about false positives that many signals provoke with the idea that the stigma of mental illness may be hidden begs the question, what, then, is the mark that leads to stigmatizing responses? Several carefully constructed studies suggest labeling as a key variable (Jones et al., 1984; Link, 1987; Scheff, 1974; Schumacher et al., in press). People who are known as ‘mentally ill’ will likely be the victim of mental illness stigma. Labels can be obtained in various ways: others can tag people with a label (a psychiatrist can inform someone that Ms X is mentally ill), individuals can label themselves (a person can decide to introduce himself as a psychiatric patient) or labels can be obtained by association (a person observed coming out of a psychologist’s office may be assumed to be mentally ill).

The combination of the subtlety of mental illness stigma and the greater inferential demand needed to perceive groupness in a collection of people with mental illness, compared with an ethnic minority, suggests that the relationship between age and prejudice outlined in Figure 1 may differ for mental illness stigma. The prejudice related to ethnicity seen at a young age in children (three to five years) is attributed to perception of difference in skin color and the relatively unsophisticated attribution that emerges from preoperational children: that different is bad (Aboud, 1988). We would hypothesize that young children will be unable to perceive the cues that distinguish people with mental illness from the ‘normal’ population; as a result, they will be less likely to endorse prejudicial statements about this group at age 5 (unlike the pattern found for ethnic prejudice). This hypothesis is somewhat supported by data that show that seven-year-olds were unfamiliar and/or confused by terms like mental illness and psychiatry (Spitzer & Cameron, 1995). Data from a recently completed dissertation upheld this hypothesis (Aldridge, 2003); preschoolers and kindergartners were essentially unable to distinguish the groupness of pictures of children who were ‘normal’ or ‘mentally ill’. Of course, we need to be cautious about findings that fundamentally support a null hypothesis. Future research needs to manipulate various cues for mental illness stigma in different age groups to determine when children correctly distinguish the group of people with mental illness.

If subsequent studies support our hypothesis about later age for identifying mental illness stigma and endorsing the prejudice of mental illness, then we hypothesize a second change in a child’s development of mental illness prejudice from the model representing ethnic prejudice. In Figure 1, data suggested that a marked reduction in prejudice is evident as children move from five to seven years of age. This reduction was explained as the result of more mature concrete operational cognitive abilities as the child ages (Aboud, 2003; Bigler & Liben, 1993). If children are only able to perceive outgroup differences in people with mental illness after the child exhibits concrete operational skills, then the dip in prejudice outlined in Figure 1 should not manifest itself.
Outgroup identity

As discussed earlier in this paper, there are assumptions about intergroup differences in ethnicity that may not hold for mental illness. In terms of ethnicity, we assume that a variety of seemingly separate cultural groups exist and that ingroup versus outgroup perception depends on the ethnic group to which the perceiver belongs. Hence, African American children view blacks as the ingroup and whites as the outgroup. The unique characteristics of different ethnic groups are essential for intergroup perceptions (Brewer, 1999). This kind of assumption does not seem to explain groupness in mental illness. The ‘normal’ group exists only in juxtaposition to the group of people with psychiatric symptoms. Consider the point conversely; the concept of normal groupness makes no sense without a prior group of people labeled as abnormal.

Research on ethnic prejudice suggests that as children move from age five to age seven, prejudice decreases because attributions about outgroups moderate (Aboud, 1988). Namely, seven-year-olds tend to manifest fewer negative statements and more positive statements about an outgroup. How might this moderation appear in mental illness given that the traditional differentiation of ingroups and outgroups used to describe ethnic groups may not apply? Put another way, are there any positive attributes about the mental illness group which can be perceived as children cognitively mature? In order to answer similar questions, Corrigan and Garman (1997) compared the positive and negative group-related beliefs and experiences of African Americans with those of people with mental illness. Positive beliefs/experiences about African Americans included highly supportive extended family, strong religious orientation, and acceptance of gender equity. Negative beliefs/experiences included stereotypes about dangerousness, lack of ambition and intelligence. People with mental illness identified a similar slew of negative experiences: stereotypes about dangerousness, incompetence, unpredictability and childishness come to mind. However, there seemed to be no positive experiences or beliefs about mental illness. This leads to the hypothesis that as children age, they may report fewer negative attributes about people with mental illness, but show no change in positive attributes about the group per se.

One would think that this means that mental illness is a group to which no one strives to be identified. However, the consumer movement of the past 30 years has shown that there is an organized collection of people alternatively calling themselves consumers, survivors or ex-patients who identify with the group known publicly as mentally ill (Deegan, 1990; Fisher, 1994). In large part, these people have come together for mutual support to battle a frequently hostile mental health system and public. Authors from this movement have written about closer connections to such values as the artistic, spiritual and communal as a result of their roots in the mental illness group (Ralph, 2000; Van Tosh et al., 2000). Their conclusions beg for future research that addresses a variety of questions and hypotheses. Are experiences related to the artistic, spiritual and communal core characteristics by which people with mental illness describe and know their group? Does the public readily understand the group positively in terms of these descriptors? Do children learn these descriptors as they cognitively mature?

STIGMA CHANGE IN CHILDREN

Two large bodies of work are relevant for understanding methods for reducing a child’s prejudice and discrimination of people with mental illness; see Table 1. The first is the research on specifically changing adult attitudes and behaviors towards people with mental illness; this research is largely
completed on adults. The second is studies on ways to change child attitudes towards minority groups in general. We attempt to integrate these two literatures in order to outline the breadth of approaches for improving children’s attitudes towards mental illness. The point of our paper is to explain how social cognitive development of children is a principal factor in their acquisition of prejudice and discrimination. Much of the research on stigma change was not directly relevant to child development. However, the relationship between social cognitive development and stigma change is highlighted where evidence is available.

**Education**

Educational approaches to stigma contrast the myths of mental illness with facts. Educational strategies aimed at reducing mental illness stigma have used public service announcements, books, flyers, movies, videos and other audiovisual aids to dispel myths about mental illness (Bookbinder, 1978; National Mental Health Campaign, 2002; Pate, 1988; Smith, 1990). Evidence from education studies suggests that people with a better understanding of mental illness are less likely to endorse stigma and discrimination (Brockington et al., 1993; Link & Cullen, 1986; Link et al., 1987; Roman & Floyd, 1981) and that education programs produce short-term improvements in attitudes about people with mental illness (Corrigan et al., 2001, 2002; Holmes et al., 1999; Keane, 1991; Morrison & Teta, 1980; Penn et al., 1994, 1999). Although education can be a useful strategy, the magnitude and duration of improvement in attitudes and behavior towards people with mental illness may be limited (Corrigan et al., 2001, 2002). Further research is needed to determine its long-term effects and to examine the impact of different delivery (public service announcements, classroom lecture, movies, and so on) and content strategies.

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**Table 1**

A summary of anti-stigma strategies; the first column represents strategies that have been shown to affect mental illness prejudice and discrimination in adults (Corrigan & Penn, 1999; Watson & Corrigan, 2005). The second column represents strategies that have been used to generally decrease prejudice and discrimination in children (Aboud & Fenwick, 1999; Aboud & Levy, 2000). The second column is limited to strategies that are also putatively relevant to mental illness stigma (e.g. we excluded bilingual education).

<table>
<thead>
<tr>
<th>Strategies used to change mental illness prejudice and discrimination in adults</th>
<th>Strategies used to change any prejudice or discrimination in children</th>
</tr>
</thead>
<tbody>
<tr>
<td>Education: contrast the myths and facts of mental illness</td>
<td>Anti-prejudice education: diminish prejudice about outgroups by providing knowledge and modeling positive attitudes about the groups</td>
</tr>
<tr>
<td>Contact: provide regular and equal interaction among people with mental illness and the public</td>
<td>Integrated schooling: diminish prejudice by mixing ingroups and outgroups in school</td>
</tr>
<tr>
<td>Protest: point out the injustice of prejudice and ask groups to suppress stigmatizing attitudes</td>
<td>Role playing and empathy: have ingroup members role play a person from an outgroup</td>
</tr>
<tr>
<td>Consequences: economically punish people like media outlets for perpetuating stigmatizing images about mental illness</td>
<td>Training social cognitive skills: teach younger children more cognitively advanced skills such as differentiation</td>
</tr>
<tr>
<td>Peer pressure: pair a high-prejudice student with a low prejudice student to discuss attitudes about outgroups with the idea that the low-prejudice student will model and change the high-prejudice student.</td>
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</tr>
</tbody>
</table>
Much of the research on mental illness stigma and education was done on high school and college students or adults. Research on anti-prejudice education to decrease racial biases has sought to document the reduction in prejudice and discrimination by providing children with information about selected cultural outgroups (Banks, 1995; Sleeter & Grant, 1994). This kind of approach has become fairly popular in the educational system; one review found that 46% of schools have some kind of multicultural education program in place (Washburn, 1996). Proponents of this approach provide knowledge about the historical and cultural contributions of ethnic groups; educators assume that prejudice will diminish as children acquire a more complex picture of the group (Aboud & Levy, 2000). Like education for mental illness, research on this approach has been mixed with occasional positive findings (Litcher & Johnson, 1969) and frequent non-significant results (Litcher et al., 1973; Weigel et al., 1975; Yawkey, 1973).

Realizing that knowledge is not enough – that relaying objective facts without a sense of importance or empathy will not affect prejudice – researchers have sought to augment education programs by influencing children’s norms about social groups. One common way to influence norms within education programs is for authorities (e.g. children’s teachers) to endorse the anti-bias message implicit within an education program. These authorities would explicitly state that integrated and free interactions among children of all groups are the ideal. Summaries of the research using this kind of anti-bias program suggest a minor reduction in the prejudicial attitudes of children who participated (Derman-Sparks & Phillips, 1997; McGregor, 1993). Applying this approach to mental illness stigma, children would be educated about peers with mental illness and teachers would endorse the need for free and fully integrated interactions among children with and without mental illness.

Contact

Interpersonal contact between the public and members of the stigmatized group yields significant decrements in prejudice (Allport, 1954; Pettigrew & Tropp, 2000). Optimal contact entails five elements (Cook, 1985; Gaertner et al., 1996; Pettigrew & Tropp, 2000): (1) Equal status between groups: In the contact situation, neither minority nor majority group members occupy a higher status. Neither group is in charge. (2) Common goals: Both groups should be working toward the same ends. Some studies of optimal contact have used joint tasks such as completing a puzzle (Desforges et al., 1991); this might work well in a school setting. (3) No competition: The tone of the contact should be a joint effort, not a competitive one. (4) Authority sanction for the contact: This might mean that the contact intervention is sponsored or endorsed by the head of the school. (5) Moderate disconfirmation: The contact’s benefits are enhanced when it is with a person that moderately disconfirms the stereotypes about his or her group (Johnston & Hewstone, 1992; Reinke et al., 2004; Weber & Crocker, 1983). Individuals that highly disconfirm prevailing stereotypes – e.g. a film star who once suffered from schizophrenia – may be considered ‘special exceptions’ such that the anti-prejudice effect they engender fails to generalize to all people with mental illness. Conversely, contact with persons that behave in ways consistent with the stereotypes – e.g. meeting an obviously psychotic homeless person – may reinforce stigmatizing attitudes or make them worse.

A recent meta-analysis (Pettigrew & Tropp, 2000) of more than 200 studies of intergroup contact supports its effectiveness for reducing prejudice. The 44 studies in the meta-analysis that consisted of a structured program that maximized the five conditions listed above yielded consistently larger reductions in prejudice than comparison groups. Additionally, contact interventions
were most effective if they involved face-to-face interactions and if they occurred in work or organizational settings. Several studies specifically focusing on contact’s effect on mental illness stigma have produced promising findings. Corrigan and colleagues found that contact with a person with mental illness produced greater improvements in attitudes than protest, education and control conditions (Corrigan et al., 2001, 2002; Reinke et al., 2004).

School integration provided a natural laboratory for the assumptions of the contact hypothesis. Social psychologists hypothesized that Black and White children regularly interacting within integrated schools will show marked reductions in prejudice and discrimination compared with peers in segregated education systems. Daily interaction in classrooms seem to naturally facilitate several of the factors necessary for contact to diminish prejudice (Allport, 1954). Unfortunately, the promise of integrated education in terms of prejudice is not mirrored by the data. Studies frequently show mixed findings or no differences (Schofield, 1995). A recent comprehensive review of the outcome literature related to integrated schooling suggests that some positive gains are seen in Black children whereas White children may actually show more negative responses to people of color (Stephan, 1999).

Friendship seems to be the key mediator in the contact effect in school. Research has shown that children who report a cross-race friendship at a young age are less likely to endorse stereotypes about that racial group (Ellison & Powers, 1994; Jackman & Crane, 1986; Patchen, 1983). Unfortunately, survey research has found that cross-race friendships may be the exception rather than the norm (Hallinan, 1982; Hallinan & Texiera, 1987; Patchen, 1983), although other studies suggest that this trend has significantly improved in the past decade (Aboud & Mendelson, 1999; DuBois & Hirsch, 1990). Some educators have enhanced contact effects by building in specially created opportunities for individualized, positive interaction in the early grades (Miller, 1983; Patchen, 1983; Schofield, 1995).

These findings suggest that contact effects are most likely to remediate prejudice towards people with mental illness when the teachers opt to facilitate positive, friendship-building interactions among children with and without mental illness. The threat of ‘coming out of the closet’ once again becomes a key factor in realizing this kind of contact. Decisions need to be made whether children with mental illness will disclose their outgroup status in order to facilitate contact effects. This means that some parents of children with mental illness, who are rightfully concerned about their child’s socialization and education, must risk their child being stigmatized to attempt this kind of friendship building. Moreover, the mother and father must risk experiencing family stigma that suggests, for example, that bad parenting produced their child’s mental illness (Corrigan & Miller, 2003).

Training social cognitive skills
According to the social cognitive developmental model, a young child’s manifestation of prejudice and discrimination is a product of limited cognitive abilities commensurate with their stage of development. Developmental psychologists have used social cognitive skills to teach children these abilities in order to decrease prejudice. These skills training programs have focused on ages four to seven years, given that these are key ages for manifesting prejudice. Children at this age have relatively simple conceptual notions of social outgroups; for example, they perceive outgroup members unidimensionally and as all alike. Strengthening a child’s ability to differentiate among members of an outgroup can reduce prejudice (Aboud & Levy, 2000; Katz et al., 1999). Katz and Zalk (1978) used a perceptual differentiation task to facilitate this goal; children were trained to
give pictures of several outgroup members distinct names, thereby increasing the differentiation of the group. Pre-post tests of prejudice for this intervention yielded greater change than for a contact condition. Similar benefits were found during an education program using a curriculum that taught students a variety of attributes about 30 pictured peers from a multi-racial class (Aboud & Fenwick, 1999). The key element of these tasks is instruction on ‘variety’, which helps the child better perceive differentiation.

Using a similar approach, research participants have been trained to view human nature as dynamic rather than static. A series of studies showed that children who learned that human experience is malleable, rather than fixed, were less likely to endorse stereotypes (Dweck, 1998; Levy et al., 1998). Dweck et al.’s earlier research on teaching malleability has been limited to providing college students information about the dynamic quality of most human traits; a recent study, however, was able to yield positive effects for sixth graders (Levy & Dweck, 1999). We do not yet know of any attempt to adapt this approach for the limited cognitive abilities of much younger children.

An alternative strategy for improving social cognitive skills of this age group (4 to 7) has used multiple classification tasks (Hohn, 1973). In one series of studies meant to diminish gender-related prejudice, children were instructed to sort objects by type and color (nonsocial training) or a set of pictures of men and women by gender (social training) (Bigler & Liben, 1992, 1993). The social training, multi-classification task was enhanced by teaching children about the interaction among gender roles and occupations. Results showed that those children trained in multiple methods of social classification were better able to recall counter-stereotypes.

**Role playing and empathy**

Aboud and Levy (2000) argue that role-playing strategies that facilitate empathy for outgroup members have much in common with social cognitive skills training. First, role playing focuses on capabilities that are considered relevant for diminishing the prejudice that impedes all intergroup relations. Second, role-playing strategies focus on skills that vary developmentally and can be potentially enhanced by situational exercises. The success of role playing rests on the theoretical assumption that preschoolers and kindergarteners are egocentric (unable to assume the perspective of someone different from themselves) and/or sociocentric (cannot assume the perspective of someone from a different group) (Piaget & Weil, 1951). Hence, role-playing strategies put children in the other’s shoes by instructing them to play the role of outgroup peer. Through this kind of acting, children gain the perspective of and empathy for the outgroup.

Perhaps the best-known example of this kind of role playing is Jane Elliot’s exercise with her third-grade class in Iowa (Peters, 1971). In order to teach the class empathy for peers of different groups, Elliot spent one day treating blue-eyed children as superior and giving them special favors. The next day, she switched to brown-eyed students, making them the preferred children, and treating blue-eyed peers in a more inferior manner. She wanted to show that something as arbitrary as eye color can lead to unfair consequences. Research on high school and college students have shown that blue-eyed/brown-eyed role playing leads to diminished prejudice (Breckheimer & Nelson, 1976; Byrnes & Kiger, 1992); we are aware of only one study that has tested this approach on younger children. Weiner and Wright (1973) used an armband version of Elliot’s approach (randomly assigned to wearing green or orange armbands) and found that White third graders in the role-play group were significantly more likely to attend a picnic with peers than those in a control group. Note that these effects seem to be non-specific; children diminished their prejudice towards African American peers after participating in the role play even though the exercise...
did not specifically address ethnic issues. Research has yet to determine whether the benefits of brown-eyed/blue-eyed role playing diminish other prejudices experienced by people of color or to other outgroup stigmas. Of particular relevance to this paper, research would need to determine whether this kind of role playing would diminish the prejudice related to such latent stigmas as mental illness.

Additional research has qualified the findings of role playing. One study suggested that role playing may increase anger toward the discriminator rather than empathy for the targeted outgroup (Finlay & Stephan, 2000). Alternatively, Aboud and Levy (2000) have hypothesized that young children may cope with the painful empathy that results from role-playing discrimination by distancing themselves from outgroup peers rather than perceiving them as similar. Future research must dismantle the impact of role-playing exercises on the various possible responses to inter-group relations.

**Peer interaction**

Because of apparent differences (children do not see parents as being similar), research suggests that parents and other key adults are not role models for anti-stigma attitudes and behaviors. Social scientists have sought explanations for this counterintuitive finding. One reason may be that adults are typically unwilling to explicitly discuss their views on ethnicity and other minority groups with their children (Kofkin et al., 1995). In the rare times that they do talk about race, parents do not tailor the discussion to the developmental level of the child (Aboud, 1988; Katz, 1976). Aboud and colleagues (1996, 1999) hypothesized that peers might be better resources for stigma change because they are less likely to censor opinions about a topic and because the cognitive style of communication is automatically at the level of a same-age peer. A typical format for this kind of strategy is to pair a low-prejudice child with a same-age, familiar, high-prejudice child. The dyad is then presented with a stimulus picture (e.g. for racial prejudice, separate pictures of a Black and White child), and asked to rate the person in the picture across a series of positive (the child is neat, honest, a nice person) and negative (the child is a bully, lazy, and dirty) values. Of more importance, the dyad are asked to discuss their rationale for each rating.

Interestingly, observers of these dyads note that neither the high- nor low-prejudice child attempts to dissuade their partner in terms of rating or rationale. Of further note, although it is clear at the beginning of these discussions who is the high- and low-prejudice child, the dyad appeared quite similar in response by the end of the discussion (Aboud & Doyle, 1995; Aboud & Fenwick, 1999). More balanced evaluation of ingroups and outgroups corresponded with descriptions of Whites that included more negative attributes and of Blacks with more positive features. This finding might represent a methodological confound of the studies: regression to the mean. Namely, subsequent testing of children selected for low and high prejudice would result in similar post-test scores. Future research needs to attempt similar dyadic prejudice change by not selecting pairs based on extremes in pre-test prejudice scores.

Other research on peer collaboration shows that solutions generated by participants are more mature than their initial positions (Chapman & MacBride, 1992). Specific qualities of the interaction seem to facilitate positive gains. For example, expression of contradictory positions along with an explanation is better than agreement and better than no explanation (Nelson & Aboud, 1985). Interpretive statements that exceed mere description are instrumental in helping dyads achieve more balanced statements (Teasley, 1995; Ticao & Aboud, 1998).
Protest and consequences

Protest strategies highlight the injustice of specific stigmas and lead to a moral appeal for people to stop thinking that way: ‘shame on you for holding such disrespectful ideas about people with mental illness!’ Ironically, this kind of attitude suppression may have a rebound effect so that prejudices about a group remain unchanged or actually become worse (Corrigan et al., 2001; Macrae et al., 1994; Penn & Corrigan, 2002). Although there are both cognitive and social explanations of this kind of rebound, perhaps the simplest is the construct of psychological reactance (Brehm & Jones, 1970): ‘don’t tell me what to think!’ Hence, protest may have limited impact for changing public attitudes about people with mental illness.

This does not mean that protest has no role in affecting stigma. There is largely anecdotal evidence that protest can change some behaviors significantly (Wahl, 1995). For example, NAMI StigmaBusters is an email alert system that notifies members about stigmatizing representations of persons with mental illness in the media and provides instructions on how to contact the offending organization and its sponsors (NAMI StigmaBusters, 2002). In 2000, StigmaBusters played a prominent role in getting ABC to cancel the program ‘Wonderland’, which portrayed persons with mental illness as dangerous and unpredictable. In the first 10 minutes of the series, a person with mental illness shot several police officers and stabbed a pregnant psychiatrist in the abdomen with a hypodermic needle. StigmaBusters’ efforts not only targeted the show’s producers and several management levels of ABC, they encouraged communication with commercial sponsors including the CEOs of Mitsubishi, Sears and the Scott Company. This suggests that organized protest can be a useful tool for convincing television networks and other media outlets to stop running stigmatizing programs, advertisements and articles rather than alienate an important advertising demographic.

Research might show protest to be effective as a punishing consequence to discriminatory behavior that decreases the likelihood that people will repeat this behavior. Research might also consider other types of punishing consequences such as legal penalties prescribed by the Americans with Disabilities Act and the Fair Housing Act. For example, what is the effect of judgments ordering that punitive damages be paid by employers who discriminate in hiring or communities that design zoning laws to keep persons with mental illness out of group homes (Stefan, 2001)? Do such penalties prevent future discrimination? Clearly, these questions are framed to reduce discrimination in adults. An important question for children would be the impact of punishment from authority figures like parents and teachers when the child obviously acts in a discriminatory manner.

Generally, punishing contingencies for children (or, for that matter, adults) may have unintended consequences. As a result, research should also identify reinforcers to affirmative actions that undermine stigma and encourage more public opportunities for people with mental illness. Examples include government tax credits for employers who hire and provide reasonable accommodations to people with psychiatric disabilities. For children, this might include some privilege from the teacher for participating in an anti-stigma program.

SUMMARY

Research attempting to model the relationship between prejudice and age has yielded a curvilinear association. Research on prejudice related to ethnicity shows that children at three years of age manifest some prejudice towards outgroups. Prejudice seems to steadily increase until about five years
and then fall off. This research has largely been demonstrated on manifest stigmas related to people of color or to gender. We conjectured that the relatively abstract operational skills needed to identify people with mental illness as part of a latent stigmatized group may occur at an older age when sufficient cognitive development has occurred. As a result, the hypothesized later onset of mental illness stigma may obviate a curvilinear relationship between age and prejudice. Future research needs to test this hypothesis by designing manipulations and independent variables that are sensitive to the subtleties of mental illness stigma. We also argued that the outgroup status of mental illness differs from ethnic groups; i.e. generally there are few positive characteristics of the mental illness outgroup which undermines any attempts to challenge mental illness stigma by referring to the assets of identifying with that group. This difference also needs to be integrated into future research.

The second half of this paper reviewed various anti-stigma programs and their relevance to children. A key part of this review dovetailed specific anti-stigma programs with the research on social cognitive development. The summary was useful in showing how specific social cognitive constructs can be addressed to diminish prejudice. However, most of the research in this area, like the earlier discussion, was done in terms of ethnic prejudice. Future research needs to address the challenges of changing children’s view about a less obvious outgroup.

By virtue of being social cognitive models, much of the research on public prejudice and discrimination has focused on cognitive elements and its corresponding affective evaluation. Studies have largely ignored theoretical development of how discriminatory behavior develops in children other than as the consequence of prejudicial cognitions. A few studies have used social distance as a proxy of discriminatory behavior (Aboud, 1988). We have argued that avoidance at work, in housing and in one’s community are all significant manifestations of the stigma of mental illness (Corrigan et al., 2003b). Future research on discrimination needs to examine how social avoidance manifests in children. Likely candidate behaviors include withholding friend-related behavior and being helpful as a co-student.

Our paper began by differentiating public stigma from self-stigma (loss in self-esteem and self-efficacy that results from internalizing prejudice and discrimination about a stigmatized group). Our discussion on stigma and children was mostly limited to the public stigma side of the picture. An equally important avenue for future research is self-stigma in children. How does the development of social cognitive processes influence the internalization of stereotypes by children with mental illness? Research on adults suggests that some people who are labeled mentally ill experience diminished self-esteem and self-efficacy because of the label (Corrigan & Watson, 2002). Diminished self-esteem and self-efficacy lead some people with mental illness into not pursuing life goals; e.g. ‘why try; I am unable to because I am a person with mental illness!’ Other people decide to not fully participate in psychiatric services in order to avoid the stigma caused by the label. Future research needs to determine whether and how children show similar patterns in self-stigma. Parents’ attitudes about mental illness and psychiatric services are highly relevant for developing child treatment plans. Hence, research needs to also determine how the family’s struggle with stigma affects the child.

ACKNOWLEDGEMENTS

This paper was made possible in part by grants from SAMHSA (SM-52363), NIMH (MH62198–01 & MH66059–01), and NIAAA & the Fogarty Center (AA014842–01).
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