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Reducing Stigma Associated with Schizophrenia

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Reducing Stigma Associated with Schizophrenia.

by

James Reling

An undergraduate honors thesis submitted in partial fulfillment of the
requirements for the degree of

Bachelor of Science

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Thesis Advisers

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Todd Bodner

Q : “What would you call yourself then? What sort of label would best characterize your position?”

A: “I hesitate with my answer because such a label may affect the perception and appreciation of what I am saying in a negative way; if you are labelled you are not seen.”

- **Maturana, H. (2004) *From Being to Doing: The Origins of the Biology of Cognition*, pg. 34.**

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ABSTRACT

I examine stigma associated with schizophrenia and how psychiatric diagnosis, mental health professionals, the criminal justice system, and society ostracize and contribute to the suffering of approximately three million Americans. I doubt schizophrenia's conceptualization as a progressively deteriorating biological disease and present the social conditions that accumulate stress for the individual and lead to psychotic episodes. I argue that schizophrenia cannot be understood as a "thing," but as a complex system of numerous variables contributing to a system of disorder resulting from prejudiced attitudes, discriminatory social-structural conditions, and unjust treatment of human beings needing extra resources to thrive. Ultimately, I present discrimination of people with psychological disorder as a human rights issue, parallel to the *neurodiversity* movement to normalize autism as existing in the greater variation of human neurodevelopment. People with psychotic symptoms do not need to be "cured;" they do need acceptance, assistance, and resources to thrive alongside their family, friends, and the greater society. I infer necessary radical structural change to diagnostics, treatment, and the criminal justice system to unravel structural discrimination. I hypothesize reducing stigma by an intermediate practical suggestion of eradicating the label "schizophrenia" from our language as stigmatizing. I will draw upon 15 years of promising evidence of moderate reduction in social attitudes following Japan's renaming of schizophrenia ("mind-split disease") to "integration disorder."

I wish to dedicate my thesis to my professor, Dennis Swiercinsky, for his ongoing support, conversation, suggested resources, and inspiration for this project. More than anyone, Dr. Swiercinsky shaped my approach to understanding psychological disorder and cognitive neuroscience. He introduced me to many of the problems discussed in this paper, as well as to the field of systems science. His retirement from teaching is a profound loss for Portland State University. I hope it gives him the time to play piano and the mental space to finish writing his opus on psychological disorder.

Also, to Srini: My heart breaks knowing I could have been a compassionate friend.

WHAT IS SCHIZOPHRENIA?

The short answer is *nobody knows*. A remarkable statement when illuminated by the fact that schizophrenia (SCZ) has the longest history of any formal classification of psychological disorder and became the foundation on which all psychiatric diagnoses are conceptualized. Described by Crow (2008) as “the disease¹ of humanity” since SCZ may have evolved with language, is largely associated with socio-cultural and interpersonal stress, and is difficult to research with animal models. A search for “schizophrenia” in the Academic Search Premiere database brings up nearly 62,000 results since 1956. Indeed, there are many more pages of words since SCZ was first systematically described in the 1890s by Emil Kraepelin as “dementia praecox” before being renamed “schizophrenia” by Eugen Bleuler in 1908. Hypotheses of SCZ’s cause(s), refinement of symptom descriptions, and lists of associations from neuroimaging and genetic research have been further catalogued over the last century.

However, identifying symptoms and giving something a name only provides the *illusion* that SCZ is understood. It is not known what causes approximately 1% of the world’s population to experience the symptoms associated with SCZ. Manifestations of the condition are so heterogeneous (highly variable) that most researchers doubt all cases of SCZ result from the same underlying neurobiological process; Tandon, Nasrallah, and Keshavan (2011) believe it likely that SCZ is a “meta-syndrome” with no one cause to account for the extreme diversity.

¹ The term “disease” is often used by the public, media, and in the literature to describe SCZ. However, this term is defined in Hyman (2010) as: “Disease: generally used to describe a medical condition or abnormality conferring harm or risk of harm in which etiology or pathologic processes (pathophysiology) are known.” They differentiate “disorder” as the term to describe when these variables are unknown. Therefore, “disease” is not an accurate description of SCZ.

They claim that this heterogeneity should not be considered a sign of failed research, but as the key question to focus future research.

Though it is common for people to not exhibit obvious behaviors—to have their first psychotic episode—until early adulthood, evidence suggests underlying neurobiological processes contributing to a susceptibility of psychotic symptoms begin prenatally (Catts et al., 2013). There is no “cure” for SCZ, only a long history of coerced or forced treatment with unpleasant “antipsychotic” medication to quell some symptoms and control patients through heavy sedation. Unfortunately, there have been no major advancements in medication for SCZ since the 1950s, apart from some lessening of side-effects.

Kraepelin first described SCZ as an unrelenting progressive deterioration of cognition, which he differentiated from the better outcomes of bipolar disorder (Harding & Zahniser, 1994). Later in his life, Kraepelin changed his mind about SCZ being necessarily progressive as most people show some remission and leveling of symptoms over time. However, this sense of prognostic hopelessness has prevailed to this day. Receiving a diagnosis of SCZ remains a social death sentence, which probably explains why suicide rates are higher than any other diagnosis and SCZ is considered one of the top ten leading causes of disease-related disability in the world (Tandon, Keshavan, & Nasrallah, 2008).

The historical account of how people diagnosed with SCZ have been treated is a human rights nightmare—horrifying, shameful, and largely existing under the radar of most people’s awareness. At different times, patients have been isolated and/or rejected from their families, tortured, restrained, sterilized, lobotomized, shocked with strong electric currents, and even put on display for gawkers in zoo-like settings (Frances, 2013; Harman, 2003). Most often, this population has been left to rot in deplorable conditions, which continues today manifesting as

below poverty living conditions, homelessness, or imprisonment. Unlike abundant media portrayals over the last couple decades of quirky and endearing people or fictional characters with autism, OCD, or depression, there are very few positive media portrayals of people with symptoms of SCZ.² Most often they are represented as dangerous and unpredictable and require restraint for the good of society (Wahl, 1995). No other psychiatric diagnosis shares the level of persistent negative stigma as SCZ (Corrigan & Bink, 2016).

How is schizophrenia classified and diagnosed?

The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) was released in 2013 with only minor changes from the previous edition, *DSM-IV-TR* (2000). Both editions list five characteristic symptoms of SCZ. The previous edition required observation of two out of the five symptoms for a duration of one-month. The updated *DSM-5* groups three of the five symptoms as core *positive symptoms* diagnosed with high reliability: 1) delusions; 2) hallucinations; 3) disorganized speech. *DSM-5* requires at least one of the two observed symptoms required for diagnosis to be among these three positive symptoms. The other two characteristic symptoms are: 4) grossly disorganized or catatonic behavior; 5) *negative symptoms* (i.e., diminished emotional expression or avolition). To receive a diagnosis of SCZ, the person must exhibit continuous signs of disturbance for at least six months, including social and/or occupational dysfunction (American Psychiatric Association, 2013).

The *DSM-5* absorbed SCZ as one of a spectrum of psychotic disorders along with catatonia, schizotypal disorder, and schizophreniform disorder. Previous editions of the *DSM* attempted to explain the heterogeneity of SCZ with five subtypes, but as Tandon et al. (2013)

² The portrayal of mathematician John Nash in *A Beautiful Mind* (Grazer, 2001) is a rare exception.

explain, these subtypes were recognized as having poor reliability, low stability over time, and negligible prognostic value well before the *DSM-IV* was authored. The *DSM* task force found these subtypes to explain little and were rarely used by clinicians in actual diagnosis, and claim these subtypes were only retained in *DSM-IV* “because of the substantial clinical tradition” (p.6).

What is the harm of categorical approaches to classifying psychiatric diagnoses?

Among the great debates of the field of psychology is the validity of diagnosing disorder based on the categorical approach of counting behaviors and the persistence of reported symptoms over a certain amount of time to determine the presence of one of the hundreds of disorders listed in the *DSM* (Paris, 2013). *DSM* categorization describes the *typicality* of a disorder to which clinicians are expected to compare to their patient to determine a diagnosis. By definition, categories have boundaries which can appear distinct on paper, but are fuzzy and open to interpretation. If SCZ requires two of five typical symptoms for a duration of one month, does that mean a client does not require treatment if they show multiple symptoms for only 29 days? Also, if one person has all five symptoms and another has only two, is it valid to claim they have the same disorder?

As Paris (2013) explains based on research in cognitive psychology, people prefer to think in categories and are uncomfortable with ambiguity because it is demanding on cognitive energy. The creators of the *DSM* valued *interrater reliability*—the likelihood that separate clinicians will identify the same category based on observing the same set of symptoms—which allowed the validity of disorders to take a back seat to reliability. As a result, *DSM* categorization

is useful for research and clinician communication. However, the *DSM*³ has become the bridge between psychiatry and the legal system, health insurance, treatment, and other systems critical to each person's "*life, liberty, and pursuit of happiness*" (U.S., 1776). Therefore, the *DSM*'s lack of validity has dire consequences which are simply unacceptable in a society that espouses the value of universal equality.

It does make sense to classify medical conditions with known causes and pathology into categories. As Marecek and Hare-Mustin (2009) explain, biomedical diagnoses are based on their underlying cause, not subjectively reported symptoms. This is largely because in many cases, separate biological maladies can present similar symptoms. Therefore, diagnosing a disease based on symptoms can lead to false positive identification and misdirected treatment.

As there are no known biological tests for psychological disorder, classifying it in the same way as medical diseases only obscures their causes and leads to *reification*⁴ (Hyman, 2010). Colignon (1989) defines reification as "the error of regarding an abstraction as a real phenomenon" (p.83). They explain that psychological disorder consists of a highly complex interaction of biological, psychological, and socio-cultural factors and its mechanisms and biological development are not clearly understood. To classify disorder in a clinically useful way and communicate to a wide audience, it is deemed necessary to simplify the complex phenomenon into constructs with names and lists of behaviors. Reification is the result of these reductions of complex phenomenon leading people to believe diagnostic classification is an accurate and complete understanding of the construct when they were intended to be *heuristics*

³ Introductory psychology students are often presented the *DSM* as the "*Bible of psychiatry*" which is misleading and indoctrinating for a book better described as the "*Bible of insurance and pharmaceutical companies*."

⁴ John Stuart Mill wrote, "The tendency has always been strong to believe that whatever received a name must be an entity or being, having an independent existence of its own." (qtd. in Hyman, 2010)

(practical and efficient short cut placeholders to communicate about complex phenomenon). The reification of diagnostic classification leads to overconfidence that diagnoses such as SCZ clearly describe well-understood diseases. As Tandon et al. (2013) explain, the *DSM-5* task force originally intended to incorporate neurobiological measures and genomic information into the *DSM* to support diagnoses. However, this aspiration failed as results from neuroscience and genetics research have only generated interesting hypotheses and correlations. Ultimately, the *DSM-5* task force found insufficient evidence to incorporate biological and genetic evidence beyond noting speculative findings.

Marecek and Hare-Mustin (2009) point to 1980 as a turning point in psychiatric diagnosis with the creation of *DSM-III*. They claim that mental health professionals made a deliberate political choice of adopting the “language of medicine” to understand psychological disorder (e.g., disease, relapse, prognosis, etc.) (p.80). Psychiatry wanted to be taken seriously as a medical specialty and began focusing more on discovering the biological causes of disorders, perhaps because this framework is more compatible with pharmaceutical treatments. Unfortunately, this move to medicalize psychological disorder resulted in less emphasis on the unique individual’s personal history and social and cultural contexts. In other words, psychiatrists deliberately deemphasized the psychosocial contributions to disorder. This change was not due to scientific evidence, nor has it led to important scientific discoveries about the etiology of psychological disorder. In addition to reification, Frances (2013) explains this approach has led to “diagnostic inflation,” over diagnosis and over treatment.

Could dimensional approaches to diagnosis replace categorical?

Categories are dichotomous, which in the case of diagnosis means someone either has or doesn't have the disorder. Since categories are predetermined, they fail to account for the variability between unique individuals or how experiences with the same diagnosis could significantly differ between people. Particularly in the case of SCZ, categorical classification does not account for the wide heterogeneity where any number of those diagnosed could have widely different symptom profiles. According to Paris (2013), classifying phenomena along a continuum is far preferable for *quantifying the degree to which traits exist*. Dimensional approaches to classification dissolve the boundary between disorder and normality rather than placing someone in an either/or category. As Heckers et al. (2013) clarify, categorical diagnosis contributes to the lack of progress in finding the *mechanism* (biological cause) of SCZ. Particularly since it's likely that SCZ does not have a single cause or is a single disease (Paris, 2013; Tandon et al., 2013).

Both dimensional and categorical approaches to diagnosis are inadequate as they do not account for the complexity of mental processes. As Paris (2013) explains, "mind is an *emergent* property of the brain and cannot be fully explained on a cellular or molecular level" (p.75). Trying to medicalize and reduce disorder as "brain diseases" misses many levels of analysis, such as psychological, social/cultural, and other contexts that help explain the individual's experience and how best to help them. Paris (2013) concludes that a valid dimensional scale cannot be added to the current system; a new system would have to be recreated around this goal, which clearly isn't happening any time soon.

Therefore, to remain practical for clinical use, *DSM-5* maintained the categorical approach with an added attempt to account for variability and flexibility by recognizing

dimensional aspects. They emphasized the *domains of psychopathology*—hallucinations, delusions, disorganized thought, disorganized or abnormal motor behavior (including catatonia), and negative symptoms—as well as *dimensions* and *gradients of psychosis*. In other words, disorder severity can be defined by the level, number, and duration of the signs and symptoms (Heckers et al., 2013). However, without any formal way to quantify these dimensions and gradients, it remains to be seen whether this addition has practical utility.

What are the behaviors and symptoms associated with schizophrenia?

In a series of papers providing “just the facts” of SCZ (Tandon et al., 2008, 2009, 2010, 2011; Keshavan et al., 2008a, 2008b) give an overview of the major research findings of SCZ including nosology, neuroscience, genetics, treatment, as well as to speculate on future directions of inquiry. SCZ includes a wide range of behavior considered abnormal divided into categories (or “domains”), each of which has a great deal of variability from person to person. Positive, negative, and cognitive symptoms characterize the disorder, and each symptom can range from absent to present, slight to severe, and intermittent to chronic. To complicate matters, there is considerable overlap of symptoms with other conditions—particularly bipolar disorder. Mood and cognitive difficulties are also common as is comorbid depression, anxiety, and substance abuse disorders.

Positive symptoms are behaviors not typically present or pervasive in the rest of the population. These symptoms are often described as “impaired reality testing” or “losing touch” with some aspect of reality (National Institute of Mental Health, n.d.; Tandon et al., 2009) Positive symptoms can range from benign and subtle to fantastical and incoherent to other people. The client must exhibit at least one of the positive symptom domains to be diagnosed

with SCZ: **Delusions** are defined as “fixed beliefs that are not amendable to change in light of conflicting evidence” (APA, 2013). There are many different themes of delusion and the most common in SCZ are of a persecutory nature, such as believing that other individuals, organizations, or groups intend to harm or harass the believer. Delusions are considered “bizarre” when they express a loss of control over one’s mind or body, such as believing one’s thoughts have been *removed* or *inserted* by an outside force (thought withdrawal/thought insertion), or that one’s body or behavior is being externally manipulated (delusions of control). **Hallucinations** are perceptual experiences without external stimulus which can occur in any of the senses, though auditory hallucinations are most common to SCZ (Tandon et al., 2009). A person may hear one or even many voices—there is a great deal of variability—but the voice(s) may comment on, or make commands on the person’s behavior. **Disorganized thinking** is usually inferred through unusual speech such as jumping from topic to topic (tangentiality), using language and syntax in a way incoherent to others (“word salad”), or answering questions in a manner unrelated or only loosely related to the questions (loose associations). Antipsychotic drugs block dopamine receptors and help quell many people’s positive symptoms and so it is generally believed, but unproven, that excess dopamine causes delusions and hallucinations.

Negative symptoms relate to an absence or blunting of behavior that is typically present in most people. Particularly prominent in SCZ is diminished emotional expression and avolition—a loss of motivation/initiative. Many of the negative symptoms overlap with major depression and autism. The underlying neurobiological mechanisms of negative symptoms are not well understood, are difficult to treat, and are considered the most debilitating component of SCZ (Tandon et al., 2009).

One issue with how positive and negative symptoms interact is that a person may be treated with antipsychotics and show a remission of positive symptoms while concurrently becoming increasingly socially isolated and unmotivated (negative symptoms). Positive symptom abatement combined with loss of motivation can in turn effect drug adherence and resource seeking which can result in a relapse of psychotic symptoms. This cycle generates a pattern that contributes to the belief that SCZ is necessarily an enduring, progressive, and hopelessly debilitating “disease.”

Mood symptoms typically appear years ahead of the onset of psychotic symptoms, but are often missed as an early warning sign. These symptoms usually appear in late adolescence and early adulthood when it’s not unusual for a person to be moody. Depression is very common in SCZ and more severe in those who struggle with alcohol or drug use. Overall, mood symptoms take a large toll on this community and contribute to withdrawal and social isolation (Tandon et al., 2009).

Though neither *motor* nor *cognition symptoms* are universally present in this population, these symptoms are highly associated with SCZ. A reduction of psychomotor activity is common, though paradoxically, excessive motor activity often accompanies a florid phase of positive symptoms. Catatonia, or motor and/or behavior immobility, is usually associated with more severe illness (Tandon et al., 2009). Catatonia and motor symptoms can also be induced by the original antipsychotics such as chlorpromazine widely prescribed in the 1950s–1970s, which were used largely to quell hallucinations and delusions and to pacify patients in state hospitals. Cognitive impairment tends to be generalized but specific common impairments include episodic memory, processing speed, verbal fluency, attention, executive function, and working memory (Tandon et al., 2009). Cognitive impairment is also a strong predictor of poor social and

vocational outcome, particularly with impairments of social cognition. There is a great deal of overlap of cognitive symptoms seen in SCZ with many affective disorders.

Tandon, Keshavan, and Nasrallah (2008) also list the many co-occurring factors that contribute to high mortality and the “disease burden” of SCZ. Among this population is a higher occurrence of obesity and cardiovascular disease. Alcohol, nicotine, and cannabis abuse are very common and contribute to heightened impairment, worsening of psychotic symptoms, and blunting of antipsychotic effectiveness. People with symptoms of SCZ are five times more likely to smoke cigarettes than the general population and smoking greatly contributes to health problems. Over the last ten years, there has been a great deal of research focused on cannabis use as a risk factor as it seems to be associated with an earlier onset of disorder. Another common factor that contributes to disease burden listed in Tandon, Keshavan, and Nasrallah’s (2009) review is the prevalence of anxiety disorders in the early phases of illness. Comorbid substance use disorders are frequent and correlated with the more violent and unpredictable behavior that stereotype SCZ. Many people experiencing psychotic symptoms lack insight that they have a disorder, which means they believe treatment is unnecessary for them. Others may acknowledge their symptoms, but misattribute them to other causes. As would be expected, lack of insight, anxiety, and substance use have a large effect on seeking resources and adhering to treatment.

Tandon et al. (2009) explain how mortality among those diagnosed with SCZ is considerably different than the typical population and has *worsened* since the 1990s. A third of this population attempt suicide at least once and 5% of individuals with symptoms of SCZ terminate their own lives. Suicide completion rates are responsible for the larger excess deaths among males with schizophrenic symptoms. Family support and social connectedness seem to protect against suicide, whereas coexisting mood and motor symptoms, substance abuse, poor

treatment adherence, akathisia (severe restlessness), and impulsivity are the main factors associated with greater suicide risk. Overall, cardiovascular disease (from smoking, obesity, and other lifestyle factors) is responsible for the largest number of excess deaths, and takes a larger toll on women diagnosed with SCZ. There is also a 10% higher risk of accidents among people exhibiting psychotic symptoms. Overall, lifespan among this population is approximately 15–20 years less than the general population.

A vast majority of people with schizophrenic symptoms are not violent, though violent behavior is highly associated with the *stereotype* of SCZ. As Tandon et al. (2009) report, people with symptoms of SCZ are far more likely to be victims of violence. When violent behavior does occur, it is usually in conjunction with severe positive symptoms (e.g. paranoid delusions), comorbid substance use, impulsivity, or comorbid psychopathy or other personality disorders.

What is the epidemiology of schizophrenia?

Tandon et al. (2009) report SCZ as one of the most disabling of all psychiatric disorders. SCZ is estimated to affect approximately 4.5 people per population of 1000, or around .7% of all people at some point during their lifetime. The incidence is consistent worldwide, however several demographic factors appear to increase risk. These factors may be connected to the person's degree of social stress and social connectedness, including urban birth and upbringing. Migration, a factor connected to social adversity, also seems to increase risk of developing psychotic symptoms, particularly when the person migrated from a country with a predominately Black population to one that is predominately White. Unsurprisingly, a higher prevalence of SCZ is found among people of lower socio-economic classes. Other environmental factors associated with higher risk are being born in the winter/spring, prenatal infection and famine, and cannabis

abuse during adolescence. Older paternal age seems to double the risk. In the U.S., males are about 1.4 times more likely to develop SCZ than women. Interestingly, this male to female difference is not found in developing countries.

Tandon et al. (2009) depict how quality of life is greatly diminished in SCZ and a diagnosis significantly increases the likelihood of unemployment and homelessness. Less than one-fifth of people with symptoms of SCZ are fully employed. Two-thirds have never been married and most suffer from reduced contact with family and have few friends. Families of those with psychotic symptoms report a higher burden than other psychiatric disorders, along with lower support from their social network and professionals. There is also a substantial societal cost to SCZ by way of reduced productivity, homelessness, skyrocketing incarceration rates and high comorbid medical and substance abuse problems.

Tandon et al. (2009) describe the onset of course in SCZ. Just as categorical boundaries are fuzzy, so are the boundaries between the *phases*, or stages, of SCZ. During early development, before the condition would be recognized, is considered the **premorbid phase**. Delays can occur in motor development and deficits in attention and academic achievement are common, as are social isolation and emotional detachment. These premorbid phase behaviors often go unnoticed, or are only associated with SCZ in retrospect.

The **prodromal phase** is the period leading to the first onset of a psychotic episode (Tandon et al., 2009). This stage can last anywhere from months to years, though the mean is approximately five years. This phase is characterized by the beginning swell of cognitive, negative, and depressive symptoms and ends with approximately a year of early accumulation of positive symptoms until entering a full psychotic phase.

The **psychotic phase** is not inevitable as only about 1/6–1/2 of people who seek treatment during the prodromal phase go on to develop SCZ (Tandon et al., 2009). Substance abuse and life stressors are believed to precipitate the first episode, though determining specific triggers is difficult in most cases. The first psychotic episode is characterized by florid delusions and hallucinations as well as a worsening of the other symptoms. Onset age has a large range of 15- to 45-years-old with a peak during 18–30 years-old. For unknown reasons, first psychotic episodes tend to occur in males on average of 5–7 years earlier than females. Women also tend to have better premorbid functioning, lower completed suicide rates, respond better to treatment, and have a better overall prognosis than men. Whether these variances are due to neurobiological differences between gender or social-cultural reasons is unclear and is likely a complex interaction of all of these factors.

The **stable phase** follows the psychotic phase, though the name is highly misleading as this stage is grossly variable for different individuals (Tandon et al., 2009). SCZ is classically characterized as a chronic series of exacerbations and remissions of psychotic symptoms. However, psychotic outbreaks seem to usually be triggered by stress, nonadherence to treatment, or substance abuse. Over the long term, positive symptoms tend to lessen and negative symptoms tend to increase in severity. Overall, around a quarter of people diagnosed with SCZ show full psychopathological remission and half show social remission. Deterioration beyond the psychotic phase seems to be associated with the duration of untreated psychotic symptoms. Therefore, people with adequate resources to begin treatment early have a higher likelihood to reach a plateau and stabilize, or even resolve completely.

What has neuroscience and genetics research contributed to the understanding of schizophrenia?

Tandon et al. (2008) explain that though two-thirds of cases occur sporadically, SCZ is understood to have a strong heritable genetic component. Having a family member that experiences psychotic symptoms does increase risk. However, genetics research has identified approximately 4000 genes linked to SCZ—approximately 20% of the 19-20 thousand genes in the human genome. There does not appear to be a major gene locus that could explain heritability or predict who will develop SCZ and many promising initial findings have not replicated in subsequent studies.

Like genetics research, many correlations have been discovered in neuroscience research, all of which overlap with other disorders and it is hard to know which findings are worth pursuing to specifically elucidate differences in neural development between people who experience psychotic symptoms. A few of the twenty(!) most robust findings listed in Keshavan et al. (2008b) follow: Less overall brain volume; an increased volume of the ventricles; a reduction of neurons in the hippocampus; a reduction (and sometimes a reversal) of the usual cerebral asymmetry; structural alterations in white matter tracts which are essential to “communication” between neurons. Other findings, such as an increase in basal ganglia volume, may be directly related to taking antipsychotics.

It is difficult to discern direction of causality when it comes to findings from neuroimaging. Does a lesser brain volume contribute to *causing* the behaviors associated with SCZ... or do the behaviors somehow *cause* a shrink in volume... or is the person simply born with an atypical ratio of gray matter to ventricle space? Chronic stress, as evidenced by raised cortisol levels, is known to affect gray matter volumes in the hippocampus and cortisol has been shown to be elevated immediately preceding psychotic episodes (Keshavan et al., 2008b).

Overall, attempting to study SCZ based on neurobiological and genetics findings seem to be dead-ends that may or may not resolve with advancements in future technology. However, since the medical model dominates, a large majority of research funding is directed toward this type of research rather than investing in psychosocial interventions to help people cope with symptoms (Frances, 2013).

What are the treatments for schizophrenia?

Tandon, Nasrallah, and Keshavan (2010) review treatments and outcomes of people with symptoms of SCZ. Prior to the accidental discovery of what became known as antipsychotic medication in the 1950s, treatment mostly consisted of isolating the patients in mental hospitals to protect themselves and society. Other treatments offer fodder for horror films such as submerging all but the head of the patient in a freezing cold bathtub, sensory deprivation, electroconvulsive therapy, insulin coma therapy, and prefrontal leucotomy. Interestingly, the outcome of SCZ is better in non-Western countries. Since the 1950s, over 60 antipsychotics have been developed, all of which block the dopamine D-2 receptor, only reduce positive symptoms, and are only moderately effective. Antipsychotics have a great deal of unpleasant and variable side-effects such as sedation, hypotension, irregular heartbeat, sexual dysfunction, and disrupting acetylcholine transmission which can have a wide range of effects on the central and peripheral nervous system.

As Tandon et al. (2010) further explain, pharmacotherapy alone has little impact on negative symptoms, cognitive and social functioning, quality of life, and does not reduce the likelihood of suicide and risk of relapse. However, psychosocial therapies do help all these problems. Therefore, those who receive and adhere to antipsychotic medication *and* psychosocial

therapy fare the best in the long run. Particularly helpful interventions include family members to reduce high *expressed emotion*—critical, hostile, and emotionally over-involved attitudes among relatives. The effect sizes of **cognitive behavior therapy** (CBT) have been inconsistent across studies, yet seem to confirm that CBT can be effective in coping with positive symptoms. CBT does require a necessary degree of insight, as it works by reframing delusions and hallucinations as misinterpretations and irrational attributions. **Cognitive remediation** approaches can compensate for impaired cognition by using aids such as reminders and prompts to enhance executive and social functioning. More research is needed, but **social skills training** has shown promise for improving day-to-day living skills such as self-care, basic conversation, vocational skills, and recreation. **Assertive community treatment** (ACT) consists of outreach by mental health professionals to help patients in the community with low avolition. ACT has been found to reduce hospitalizations and improve housing stability. **Supported employment** helps place people in jobs that meet their abilities and offer ongoing assistance and seems effective in helping patients find and maintain employment, though more long-term studies are needed. Unfortunately, all these methods are under-utilized.

What is the evidence that CBT benefits people with psychotic symptoms?

Psychiatrists are generally pessimistic about using psychotherapy for treating psychotic symptoms and emphasis is placed on using antipsychotic medications, which only address positive symptoms. Largely, antipsychotic medications pacify patients rather than empower and teach skills to cope with their cognitive challenges. However, this pessimism does not reflect the otherwise optimistic research literature on CBT for psychotic disorders.

Corrigan and Calabrese (2005) explain CBT assists the client to identify distressing cognitions (such as auditory hallucinations and delusions) and reframe them as beliefs and to seek less distressing interpretations. Drury, Birchwood, Cochrane, and Macmillian (1996) found a marked decline in positive symptoms in their study of CBT for psychosis—only five percent of their sample showed residual symptoms nine-months after therapy, as compared to the persistent symptoms of greater than half their control group. A 2001 meta-analysis by Gould, Mueser, Bolton, Mays, and Goff (as cited in Corrigan & Calabrese, 2005, p.248) found CBT to be a promising strategy for decreasing severity of psychotic symptoms with an effect size of 0.65 across seven controlled studies.

Kingdon and Turkington (1991, 1994) describe a form of CBT that incorporates research by Strauss (1969) showing that delusions and hallucinations are not discrete events but exist on a continuum from minor to grand. These continua can be expanded further, for example to include hallucinations from typical human states such as sleep deprivation or ingesting psychedelic drugs. This spectra assumption allows more accurate assessment of magnitude and degree of symptoms. It also normalizes troubling perceptions and beliefs for those in therapy by understanding their psychotic experiences are not alien to the spectra of human experiences. Examples of this reframing include appreciation that hallucinations can occur naturally during sensory deprivation states and delusional beliefs can include astrology, as well as religious beliefs. In CBT distressing symptoms are framed as protective behavioral responses to stress on the individual rather than as manifestations of a “brain disease.” Their series of studies show significant reductions in positive and negative symptoms and depression at a nine-month follow-up compared to a control group that was treated with a non-directive technique called “befriending.” The cognitive therapy group also had shorter periods of hospitalization during the

follow-up and no suicides or homicides over a 7-year period (Kingdon & Turkington, 1991; Turkington & Kingdon, 2000).

What are the barriers to treatment for schizophrenia?

According to Tandon et al. (2010), a large majority of patients do not currently receive evidence-based treatments that could improve their quality of life and reduce their disability. There might simply be too much reductionist research on SCZ without enough interdisciplinary analysis of the big picture. Neuroscientists and geneticists tend to specialize on a small target of examination with great intensity. A neuroscientist could easily spend their entire career studying a single module or network of the brain. This level of detail is important to scientific discovery, especially as there are so many mysteries to be uncovered in the brain. Neuroimaging techniques are evolving rapidly. However, they are currently coarse and crude.

Critical psychologists Fox, Prilleltensky, and Austin (2009) also point to psychology's focus on the individual, rather than considering a person's behavior in its cultural and societal contexts. This individualistic perspective has many faults. First, this perspective makes it too easy to ignore the roles of structural inequality and oppression in contributing to the stress that makes people vulnerable to psychological disorder. Focusing on the individual overemphasizes individualistic values such as autonomy and self-actualization. Sloan (2009) adds that this perspective diverts attention from seeking collective solutions. Their view is that the dichotomy between "individual" and "social" is an illusion and imply that both should be understood as indistinguishably intertwined. Furthermore, the individualistic perspective tends to blame the individual for their shortcomings rather than focusing on the role of social inequality.⁵

⁵ See p.36 for discussion of the just world hypothesis.

Furthermore, they critique psychology's "fragmentation and overspecialization⁶" (Fox, Prilleltensky, & Austin, 2009, p.4). Professionals are expected to narrow their research to reductionist questions with limited variables that can be operationalized and examined with statistics. Certainly, specialists are important to all fields of inquiry, however these researchers warn that rampant hyper-focus reduces exposure to adjacent fields that critique the status quo, such as political theory, sociology, and anthropology.

What is sorely needed are more *translational neuroscientists*, PhD level scholars that build bridges between medical discovery and clinical application (The University of Chicago, 2017). Ideally, these professionals should not supplement their income with gifts and grants from the pharmaceutical industry to remain as ethically neutral as possible. Translational neuroscientists should work with mental health professionals—psychologists, counselors, social workers, and psychiatrists—applying existing knowledge of the brain to enhance non-pharmacological treatment modalities that are relatively easy to apply at all phases of SCZ,⁷ from early prevention of psychotic episodes to later symptom coping skills.

There also needs to be a shift away from one-size-fits-all treatment approaches to personalized therapy that honors the unique individual's needs (Tandon et al., 2010). Those struggling with mental illness should not be treated as if they have a localized brain disease, but rather as a complex bio-psycho-social system embedded within an exponentially complex political-social-cultural system. Individualized treatment may require multiple modalities to address many levels of disability. Attention should be paid particularly to the client's social systems, coping skills, and stress levels as these seem to be the triggers of psychotic episodes.

⁶ See also: *reductionism*: The assumption that a complex idea can be understood in terms of its simpler parts or components.

⁷ Referred to in Tandon et al. (2010) as "phase-specific treatment strategies."

Another major barrier to improving treatment for SCZ are the conceptual blinders around the eyes of pharmaceutical researchers as they continue to focus on dopamine D-2 antagonism. Excess dopamine, also known as the “dopamine hypothesis,” is one of the oldest proposed theories of SCZ primarily because dopamine is the target of antipsychotic medication. Though the dopamine hypothesis is prominent in the popular understanding of SCZ, researchers conclude that evidence is sparse for a dopamine imbalance *causing* SCZ. Deacon (2013) refer to the current research development approach as looking for a pharmacological “magic bullet” – a pill targeting D-2 that will “cure” SCZ. This stubborn approach, nearly 70 years since the first antipsychotics were accidentally discovered, continues despite very little advancement. Meanwhile, there is little evidence that adjusting dopamine levels will help more than the positive symptoms associated with SCZ. However, since D-2 targets have been shown to reduce positive symptoms, it is much easier and profitable to make slight adjustments in the formula of existing drugs and rebrand them as having less unpleasant side effects than the previous drug.

The pharmaceutical focus on dopamine antagonists is emblematic of a deeper problem, which is the influence and power that drug companies have been handed in the mental health industry. Marecek and Hare-Mustin (2009) explain how the U.S. is one of two countries that allow direct-to-consumer advertising of prescription drugs. Commercials during popular television shows and full-page advertisements in magazines have accelerated the public’s belief that psychological disorders are primarily biologically based and can be easily remedied with a pill. They reinforce the unproven construct that depression, anxiety, and psychotic behaviors are due to neurochemical imbalances.⁸ Pharmaceutical companies have been embraced by the APA,

⁸ The idea of “chemical imbalances” is essentially the modern version of ancient Greek physician Hippocrates’s theory that medical and psychological disorders are rooted in an imbalance of bodily fluids, called “humors.” This belief dominated Western thinking from approximately 400 B.C. until the 17th century.

allowed to sponsor events at psychiatric conferences, and grant a large amount of medical research. This has an impact on what conditions are prioritized for pharmaceutical research, which is in turn impacted by which drugs are the most marketable to the public (e.g., drugs to improve the sex drives of men and antidepressants). The medicalization of psychological disorder has obscured the field by treating people as biological machines needing their neurotransmitters recalibrated instead of looking at the social and environmental stressors that contribute to an individual's suffering or their inability to cope in an oppressive system.

Dead-ends in scientific research, inadequate pharmacological treatments, nuance-free categorical approaches to diagnosis, and lack of interdisciplinary analysis are specific problems under the larger umbrella of structural discrimination.⁹ Slapping a fresh coat of paint on a fundamentally broken system will not improve people's lives in a significant way. The system would need to be discarded and built fresh, which is not realistic to suggest in a system so entrenched in a hierarchy that keeps its metaphorical boots firmly on the throat of the mentally ill. The power structures are not motivated to help these people, especially when those most affected are stereotyped as dangerous criminals and of lower socio-economic status, minorities, and immigrants. Without support, these people fill the spaces underneath urban bridges like first-world refugee camps, or rot in our growing private prison populations to benefit CEOs and stockholders.

⁹ See p.46 for discussion of structural discrimination.

Should the concept of schizophrenia be dumped as invalid or re-conceptualized to fit updated scientific discovery?

There are many hypotheses about what should be done to improve our understanding of the concept currently known as SCZ. Some researchers believe the existing construct impedes scientific research due to its lack of a cohesive and integrated model that incorporates the known facts of SCZ (Keshavan, Nasrallah, & Tandon, 2011). SCZ contains extreme heterogeneity in clinical expression, modest treatment effectiveness, and overlap of symptoms with numerous other disorders; labeling all of these people as having the same disorder seems to impede narrowing in on underlying causes or effective treatments. On the other hand, as Tandon et al. (2009) also explain, a diagnosis of SCZ does characterize a clinical profile with typical patterns, research supporting associated symptoms, neurobiological abnormalities, and responsiveness to antipsychotic medication. Also, the concept of SCZ is similar worldwide with one of the highest inter-rater diagnostic reliabilities of any psychiatric diagnoses.

One proposal to be further explored in this paper is to keep the general concept, but to simply replace the label. The focus of this proposition is to disassociate the word “schizophrenia” from its pervasive negative stereotypes. However, as Tandon et al. (2009) caution, many researchers are skeptical of this proposal, believing research should stay focused on discovering the underlying genetic and neurobiological underpinnings of SCZ rather than getting caught up in “political correctness” and terminology. There is a reasonable concern that changing the name could be interpreted by the public as signaling a substantial discovery of a fundamental truth about SCZ requiring a corresponding paradigm shifting name. However, evidence from a 2002 name change in Japan supports a reduction in stigma and prejudiced

attitudes, particularly by young people toward those with what is now labeled as “integration disorder”¹⁰ (Sato, 2017).

An even more radical perspective could favorably compare SCZ to autism spectrum disorder in several important ways. Though both have distinctly different courses and manifestations, there is also a healthy degree of conceptual, neurodevelopmental, and genetic overlap (Crespi, Stead, & Elliot, 2010; Konstantareas & Hewitt, 2001). It seems the underlying neurobiology of both begins prenatally. Therefore, capacity for both appear to exist from birth though present on different timelines. Clinical manifestations of autism usually become obvious at a very young age. Symptoms associated with SCZ might not be debilitating, or even obvious, until early adulthood, but that doesn’t mean the onset is as sudden as it appears. Both are highly heterogeneous regarding symptoms. Neither appears to be necessarily progressive, particularly with adequate resources and social support.

A growing disability rights movement called *Neurodiversity* stresses the idea that conditions such as autism, ADHD, and SCZ are not disorders, but fit along the long tail of human development variability (Baron-Cohen, 2017)—essentially a “spectrum” within a spectrum. People vary in height, intelligence, and the so-called big five personality traits; neurodiversity proposes that people also naturally vary in sensory sensitivity and social cognition. The movement calls for abandoning the idea that people with autism can be “cured” with a yet to be discovered pharmaceutical. Instead, people with autism should be appreciated as having strengths and challenges worth supporting, not only in the name of equality, but for their potential to contribute to society in meaningful ways. Stigma toward those with autism hasn’t been erased, but support for autism does appear to have taken center stage in ways that SCZ has

¹⁰ See p.64 for discussion of the name change to “integration disorder” in Japan.

not. There has been a large movement to develop educational programs, technological aides, and products to assist people with autism meet their challenges.

Just as autism might be best placed on the long tail of the normalized distribution of human variability instead of pathologized, people with the vulnerability to exhibit psychotic symptoms might be best conceptualized on the opposite end of that long tail. If this is the case, seeking a “cure” for SCZ might be redirected toward increasing social support. Recognizing that all people have the capacity to hallucinate or subscribe to delusional beliefs from time to time, research and interventions could focus on harm reduction, CBT, and other psychosocial interventions that include families to cope with and manage symptoms. People prone to psychotic symptoms should not be left to fall through the cracks and suffer from social and structural discrimination. People that experience hallucinations and delusions could be considered “the dreamers” in our culture and valued for their perspective and insights. Our society does a great disservice by not considering them worthy of human rights.

THE NATURE OF STIGMA

Stigma is a consensus-derived identifier of membership to a specific group as “morally polluted” (“Stigma,” 2003). The word stigma comes from ancient Greek and was adopted into Latin, before being reborn in English during the late sixteenth century. The word originally described a “mark” made from either a pointed instrument or heated brand; therefore stigma is equivalent to a tattoo left by a puncture in the skin or a brand on the skin from heated iron. The term was associated with the branding of slaves, criminals, or traitors to signify that they are to be shunned or avoided. During the middle ages, the term came back in vogue with a strong association to the wounds left on Christ’s body from crucifixion. Sociologist Erving Goffman (1963) applied the term “social stigma” to denote disapproval of a person or group that differs from the cultural norms. Goffman identified three forms of social stigma: obvious physical deformations such as physical disability; “tribal stigmas” such as being from a non-dominant ethnicity or religion; and deviations in personal traits such as being unemployed, having an addiction, being a single parent, or experiencing psychological disorder. Therefore, the meaning of stigma was expanded by Goffman from physical to also *figurative marks* which deeply discredit a person for their deviance from what is considered “normal” in our culture. What is considered normal is dictated by the dominant group holding the most power in society.

Patrick Corrigan, a psychologist at the Illinois Institute of Technology, appears to be the leading researcher of stigma’s effects on people with mental illness. His name is attached to hundreds of articles and chapters since the 1980s. Corrigan has written with a passionate pursuit to unravel the complexities and nuances of stigmatization and how to change it. He frames

stigma an issue of *social injustice* deeply embedded in all levels of societal structure (Corrigan, 2005b; Corrigan & Bink, 2016).

What is the boundary between mental illness and “normal”?

Corrigan (2005a) lists reasons why the boundary between *mental illness* and *normal* remains “fuzzy.” He cites a 20% prevalence rate for psychological disorder considered “serious mental illnesses.”¹¹ This proportion of one-fifth is of a large enough magnitude that mental illness should not be considered rare or as distressing only a small minority of the population. Also, many of the characteristic symptoms of these illnesses such as depression and anxiety are common to most people, though to a lesser degree. Specific to psychosis, Strauss (1969) found hallucinations and delusions to exist on continua; van Os, Hannssen, Bijl, and Ravelii (2000) found these experiences also exist (albeit to a much lesser extent) in the general population. It is well known that sleep deprivation can lead to hallucinations and religious beliefs can be considered delusional to people outside that religious group. Both hallucinations and delusions can be temporarily induced through LSD and psilocybin mushrooms. In many cultures, hearing dead relatives’ voices is considered normal (Marecek & Hare-Mustin, 2009).

A behavioral symptom of a poor person’s *disorder* might look a lot like a rich person’s *eccentricity*. Marecek and Hare-Mustin (2009) point out that psychiatric diagnoses are unavoidably influenced by cultural mores and societal values. One glaring example is the fact that homosexuality was only excluded as a mental disorder in the *DSM-III* (APA, 1980) due to the tireless fight by gay activists to normalize homosexuality in the eyes of society. Nothing

¹¹ In the literature, such as Corrigan (2002), “major mental illness” and “serious mental illness” tend to be synonymous and include schizophrenia, bipolar disorder, and major depression.

about the nature of homosexuality changed; it was society's slow shift in acceptance of homosexuality that privileged a move from the category of *abnormal* to *normal*. Currently, transgender people rage a similar battle to be considered "normal" and free of pathology.

Mental illness and the concept of normal versus abnormal are best understood as *social constructions*. These concepts are not descriptions of objective reality. Rather, they are defined by social consensus. As Marecek and Hare-Mustin (2009) explain, language highlights certain features of objects, situations, and relationships, thereby constraining and influencing our experience of reality. Therefore, normal and abnormal are not based on objective measure. They are used in a way that suggests a spectrum, yet the boundary between them is arbitrarily open to shifts in societal beliefs.

Frances (2013) wrote a book length rant, *Saving Normal*, about *DSM*-based diagnosis from his perspective as a former member and lead of the *DSM-III-DSM-IV-TR* task forces. He believes that mental disorders should be diagnosed only when the presentation is clear, severe, and not likely to resolve with time or from a change in lifestyle. He describes how the *DSM* began with a goal of cataloging disorders to enhance research and as a guide for professionals. It was not intended for the *DSM* to become the arbiter of who is considered normal, who is eligible for insurance benefits, and who is considered a criminal in our society. Frances refers to "diagnostic inflation" as a major concern, as the quantity of disorders have swollen from 106 in the *DSM-I* (APA, 1956) to 300. This inflation has led to the stunning realization that nearly half of all Americans will have a diagnosable mental illness during their lifetime (Rosenberg, 2013). By trying to be more in-line with the medical model, the *DSM* has pathologized conditions of living in a stressful society; pharmaceutical companies advertise quick and easy solutions to these problems rather than lifestyle changes or learning coping and emotional regulation skills.

What is the process of stigmatization of people diagnosed with schizophrenia?

Research into the process of stigmatization has largely occurred within the disciplines of social psychology and sociology. All minority groups are stigmatized to some extent and there is a deep historical catalog examining the effects of stigma on people of color, nontraditional sexual and gender orientation, women, immigrants, refugees, the poor, and people with mental illness.¹² Stigma can be divided into several types. *Public stigma* is applied by society toward the stigmatized group. *Self-stigma* is the stigmatized individual's belief that they fit the stereotype of the label (Corrigan & Bink, 2016).

Stereotypes are socially constructed categorical descriptions, or commonly held beliefs, or consensus “facts,” about a package of traits shared by a group of people. To make quick decisions and conserve cognitive energy, humans rely on efficient patterns of mental processing reinforced by prior experience. If they do not have much direct positive experience with people outside their ingroup, they come to rely on the more familiar ingrained stereotypes transmitted through media, society, and culture. Though some stereotype traits can be positive (e.g., the stereotype that Asian-American students are good at math), negative evaluations are more common. Since stereotypes apply to groups, nuance of the individual is lost to the category. Stereotypes are usually understood to be inherent to all members of the group with exceptions viewed as rare; if someone is perceived as failing to fit the stereotype of their group, they are often considered of a different category called “exceptional.”

¹² The terms “mental illness,” “mental disorder,” and “psychological disorder” are used interchangeably in the literature. These terms should be considered stigmatizing as they connote “abnormality” and in turn infer a judgement of value on people with variable traits. They also tend to be pluralized as “psychological disorders” but this contributes to reification (see p.5 for discussion of *reification*).

To put it bluntly, most people have a deep fear of *losing their mind* – to lose control of their own thoughts and behaviors. SCZ represents this fear in its very name, which translates to “a mind that is torn asunder” (Lavretsky, 2008). SCZ is poorly understood by most people and popular understanding tends to come from media examples (Wahl, 1995) dominated by real and fictional people that have *lost control of their minds* and behaved in inexplicable and terrifying ways (e.g., serial and spree killers, paranoid conspiracy theorists, and lone men arguing with themselves as they wander the city streets). Therefore, commonly held stereotype traits about SCZ include dangerousness, unpredictability, incompetence, inability to care for themselves, childlike, immoral, and responsible for their condition (Corrigan & Bink, 2016; Corrigan & Kleinlein, 2005).

Stereotypes of social groups are deeply embedded in our social structure, yet are not necessarily endorsed by everyone. **Prejudice** is the belief that stereotypes accurately reflect a social group; holding prejudice tends to generate negative emotional reactions toward members of the outgroup such as fear and anger (Corrigan & Kleinlein, 2005). These beliefs ultimately lead to a denial of life opportunities such as access to mental health resources (Link & Phelan, 2001). In the case of SCZ, fears of unpredictability and dangerousness often lead to avoidance by others, or a desire for greater *social distance* (Martin, Pescosolido, & Tuch, 2000; Markowitz, 2005).

Discrimination is the behavioral reaction to prejudiced beliefs and can take many forms from overtly aggressive and hostile behavior by individuals to subtle and insidious systemic social and political policy. For example, employers may fail to hire a person with a history of psychological disorder (Link, 1987) and landlords may refuse to rent an apartment to a person with psychological disorder (Page, 1995). There is as a long shameful history of segregation of

patients in mental hospitals, which has shifted since the 1970s to modern urban *mental health ghettos*: low-income housing, homelessness, and prisons. Also, discrimination may lead to public endorsement of coercive treatment and forced medication (Corrigan & Bink, 2016; Pescosolido, Monahan, Link, Steuve, & Kikuzawa, 1999). Having a serious mental illness in the U.S. essentially means to be a criminal guilty of moral failure, worthless to contributing toward a capitalist system outside of consuming expensive pharmaceuticals or generating revenue in privately held prisons.

How does labeling and ambiguous behavior contribute to stigma?

Corrigan and Kleinlein (2005) identify four “signals” that induce stigmatizing attitudes toward people with psychological disorder: psychiatric symptoms, social skills deficits, physical appearance, and labels. The first three signals have a high potential for “false positives” or misattributing someone as mentally ill when they may be eccentric, shy, from another culture, or of different socio-economic conditions. Meanwhile, many people struggling with symptoms of psychological disorder can conceal their condition, leading to “false negatives.” Therefore, the first three signals are unreliable signals of mental illness and **labeling** is the key variable leading to stigma (Link, 1987).

However, it is an oversimplification to say labeling leads to stigmatizing attitudes without including the role of behavior considered to be “abnormal” (Gove, 1982). In response to criticism about not including the role of behavior on stigma, Link, Cullen, Frank, and Wozniak (1989) proposed a “modified labeling theory” to account for the interaction effect of a person labelled as having a psychological disorder acting in ways that are considered unusual or ambiguous to others. This compromise accounts for the roles of labeling *and* behavior in stigma;

however, stigma is often induced by the label alone and so unusual behavior should be considered sufficient, but not necessary for stigma.

Otatti, Bodenhausen, and Newman (2005) equate clinical diagnosis as a form of stereotyping. By assigning a client to a diagnostic category, the client's unique qualities are lost to focus on their resemblance to the typical set of symptoms that characterize their membership in the group (e.g., "schizophrenics hear voices and have bizarre beliefs"). Once a diagnosis has been assigned, the clinician may become insensitive to the client's unique set of symptoms, strengths, and goals. Treatment strategies may be based on generalizations about the group rather than the specific individual qualities of the client (e.g., "schizophrenics need antipsychotics to suppress their symptoms"). Therefore, these researchers warn that diagnostic categories can lead to biased preconceptions, default assumptions, and group-based expectations.

A few classic studies illustrate how labeling biases mental health professionals' assessments of client behavior, particularly when the behavior is ambiguous. An often-cited study of Rosenhan (1973) described a group of his undercover colleagues intentionally landing themselves in psychiatric wards based on presenting a single ambiguous symptom—reporting an internal voice repeating "empty," "hollow," or "thud." Most of the actors were immediately diagnosed with SCZ and hospitalized. Once hospitalized, the actors claimed to no longer hear a voice and showed no further signs of disordered behavior. Upon their release, the actors were still considered "schizophrenic," but *in remission*. Langer and Abelson (1974) had psychotherapists rate the *psychological adjustment* of a video-taped young man being interviewed; half were told the young man was a "job applicant," the rest were told he was a "patient." Despite having watched the same video, therapists who believed the man was a patient viewed his behavior as more "disturbed" than those who were told he was a job candidate. A

study by Sagar and Schofield (1980) looked at how people generally judge ambiguous behavior by a stigmatized group. White participants watched a video of either a Black or White actor poking another person with a pencil. This same ambiguous action was determined “hostile” by the Black actor and “playful” when performed by the White actor. Ottati et al. (2005) conclude from these studies that categorical labels influence what the perceiver believes regardless of the data presented. Humans tend to interpret behavior with unclear intentions in biased ways that are consistent with stereotypic generalizations.

Some people can conceal obvious signs of experiencing psychotic symptoms, but others behave in ways that are considered *bizarre* because they range outside social norms. Ambiguous behavior is often misconstrued as it makes other people feel uncomfortable. More importantly, because a dominant stereotype of people labeled with SCZ is *dangerousness*, they risk trivial actions interpreted by others as personally threatening. To complicate matters, the stereotype of *unpredictability* amplifies other’s desire for greater social distance.

Is there evidence to support stereotypes about schizophrenia?

Ottati et al. (2005) clarify that stereotypes of mental illness are often inaccurate and exaggerated. A nationwide survey found close to 75% of the public view people with mental illness as “dangerous” (Link, Phelan, Bresnahan, Stueve, & Pescosolido, 1999b). However, research by Steadman, Morris, and Dennis (1998) found no association of violence and mental illness when focused on individuals *free of substance abuse*. As Link et al. (1999a) conclude, the risk of violence by people with psychological disorder is comparable to the risk of violence by young males in general. As Watson, Ottati, Lurigio, and Heyrman (2005) re-state, “Individuals with mental illness are commonly no more dangerous than the typical teenager” (p.202).

Meanwhile, people struggling with symptoms of SCZ are at great risk of victimization, particularly by criminals and the police.¹³

Labels of psychological disorder such as SCZ are automatically and unfairly linked to ingrained beliefs associated with violence induced by ubiquitous stereotypes. High profile media examples abound of people labeled with SCZ acting inexplicably and committing horrific acts as opposed to stories highlighting remission, resilience, and coping. *Availability bias* is a heuristic where people make rapid judgments based on how effortlessly an example comes to mind (Tversky and Kahneman, 1974). In the case of hearing the word “schizophrenia,” popular examples are overwhelmingly antisocial and so associations are largely negative. Meanwhile, each new instance of media portrayal of SCZ associated with violence provides corroborating evidence to support and reinforce the belief, which is another heuristic referred to as *confirmation bias* (Wason, 1968).

It would be naïve to claim that people experiencing cognitive symptoms associated with SCZ have no capacity for acting in violent ways, but rather the potential for dangerousness is grossly over exaggerated, assumed to be inherent, and too readily misattributed as *caused by* SCZ. There are certain patterns of paranoid delusion that are more associated with violent behavior, but when violence happens, the cause is better attributed to a complex interaction of persecutory delusions, substance abuse, inadequate treatment, and systemic oppression. Therefore, societal concern about dangerous behaviors associated with SCZ should invest in unraveling the underlying factors that do contribute to violence and suffering.

¹³ See p.48 for discussion of the criminalization of mental illness and discrimination by the police.

How have public reactions to mental illness changed over time?

People tend to believe prejudice and discrimination are historical problems which have improved with education and public knowledge (Corrigan & Kleinlein, 2005). Dreadfully, the public's perceptions of persons with psychological disorder have *worsened* over the last century. Toward the conclusion of the 1990s, Phelan, Link, Stueve, and Pescosolido (2000) followed up a survey of public beliefs about persons with psychological disorder originally conducted by Star (1952). Phelan and colleagues found the proportion of people who associated psychological disorder with violence had nearly *doubled* since the 1950s. The association with violence was particularly robust when those surveyed quickly thought of psychotic behavior as an example of "mental illness." Furthermore, those surveyed expressed a desire for greater *social distance* from those with psychological disorder: They were less willing to live near, socialize with, or work alongside people with psychiatric disorders; they did not want a group home for the "mentally ill" nearby; nor did they want a person with psychological disorder to marry into their family. In a separate study, Pescosolido et al. (1999) found more than 40% of respondents believed persons with signs of psychotic symptoms should be forced into treatment. Discussing this research, Markowitz (2005) declares it a paradox that "public understanding of mental illness has apparently increased, yet the perception of persons with psychotic disorders as being dangerous has also increased" (p.136). Apparently, education is not enough to reduce prejudiced beliefs toward those with stigmatized psychological disorder.

What other factors contribute to stigma toward those considered “schizophrenic”?

Phelan et al. (2000) conclude that more people empathize with conditions such as depression, yet devalue SCZ as something that happens to people outside their ingroup. This double standard may ascend from the relatability of depression, as despair and lack of motivation affects most people from time to time. However, behaviors associated with SCZ appear alien and terrifying to those who don't recognize that all people also have the capacity to experience minor delusional beliefs and perceptual hallucinations from time to time (van Os et al., 2000).

Ottati et al. (2005) also explain the role of the *just world hypothesis*, a phenomenon originally described by Lerner (1980). Each person orients their perspective to the world in relation to their self, and tend to believe their ability to cope is due to their own personal strength. Believing in one's own resiliency is healthy. However, there is an accompanying assumption¹⁴ that “the world is a fair place” and therefore “people tend to get what they deserve.” This argument is an extension of deep-seated puritanical religious beliefs ingrained in our culture. In other words, those who work hard, resist temptation, deny impulsive behavior, and act morally obtain positive outcomes; bad things happen as punishment for the sin of moral failure. An experiment to specifically test the effects of perceiving a “just world” found a strong correlation of endorsing this belief with an increased tendency to blame victims for having contracted a sexually transmitted disease and they chose to withhold help and support for these people (DePalma, Madey, Tillman, & Wheeler, 1999). From the just world perspective, a homeless person might be judged as having chosen to live on the street, or because of their own

¹⁴ Ironic, as people with psychotic symptoms may lack the insight to understand their beliefs as delusions, Lerner (1980) referred to the common assumption of a just world as “the fundamental *delusion*.”

moral failings (e.g., laziness). Conversely, people with delusional beliefs could be discounted as too stubborn to seek or stick to treatment, or due to character flaws or inadequate parenting.

What impact does public stigma have on people with psychological disorder?

Generally, those with psychological disorder have the same life goals as those free of cognitive and/or physical disabilities. Corrigan and Kleinlein (2005) list these goals as obtaining competitive employment and living independently in a safe and comfortable home.

Unfortunately, these researchers report less than 15% of people with serious mental illness are employed. Sturm, Gresenz, Pacula, and Wells (1999) declare unemployment rates among persons with psychological disorder to be three to five times higher than the rest of the population. Willis, Willis, Male, Henderson, and Manderscheid (1998) examined data from the Substance Abuse and Mental Health Services Administration (SAMHSA) to find more than 60% of people with mental or emotional problems are unemployed and nearly a quarter of this group live below the poverty level. They found most Americans considered “long-term mentally ill” reside in inadequate housing, lack needed support, or are homeless. One significant challenge is that those with psychological disorder must often compete for housing with other low-income groups considered to be more suitable tenants (Carling, 1990).

Rössler, Salize, van Os, and Reicher-Rössler (2005) review reasons SCZ is considered one of the top-ten most burdensome and costly disabling illnesses worldwide. Life expectancy is reduced by approximately 15–20 years, and not because SCZ itself is lethal. The high mortality is primarily due to suicide. Reduced health is common in this population, whether from chain-smoking cigarettes, high rates of obesity and diabetes, poor sleep, lack of exercise, accidents,

and/or comorbid substance abuse and depression disorder. In addition to health problems, there are substantial financial costs by way of treatment, hospitalization, and incarceration.

What are the effects of stigma on families of people with psychological disorder?

Family and friends of those considered to have psychological disorder often suffer from *associative stigma* (Mehta & Farina, 1988). As Angell, Cooke, and Novac (2005) explain, the psychoanalytic approach has a long tradition in the U.S., which assumes mental illness is caused by “problematic family dynamics.” This theory is particularly toxic because it leaves parents feeling responsible for causing their child’s psychological disorder. In fact, only recently has psychiatry turned away from the dominating theory that SCZ arises from the person’s mother withholding affection. Even as formal theories of psychological disorder have been medicalized and shifted away from blaming parents, this creed may be so deeply entrenched in our culture that parents remain held at fault. Unfortunately, parents can be blamed even within a family, leading fathers and mothers to blame each other. Friends of the family may also implicitly or explicitly imply family dynamics to blame. When most vulnerable to the stressors of supporting a struggling family member, parents and siblings often feel the weight of guilt, shame, and alienation from friends and extended family. Conversely, many may deny, or fail to acknowledge the symptomatic behaviors of their loved one. Wahl and Harman (1989) found self-esteem and relationships among family members of those with psychological disorder tend to suffer. Phelan, Bromet, and Link (1998) report associative stigma had worsened since the 1970s.

Castle and Morgan (2008) explain the role of “expressed emotion,” within the family environment for the outcome of a person suffering psychotic symptoms. High levels of expressed emotion include critical comments, hostility, and/or over-involved attitudes of family members.

As can be expected, lower levels of expressed emotion are associated with better outcomes for the person (Butzlaff & Hooley, 1998). As Rössler et al. (2005) further review, relapse directly correlates with the person's social and emotional environment within the household and so the family's love, patience, and support is crucial to reaching and maintaining functional recovery. Adherence to medication, family education, and family support can reduce rate of relapses from 50% to less than 10%.

What is the media's contribution to stigma?

A person identified as having schizophrenic symptoms reports their media-based associations prior to being diagnosed:

“All I knew were the stereotypes I had seen on television or in the movies. To me, mental illness meant Dr. Jekyll and Mr. Hyde, psychopathic serial killers, loony bins, morons, schizos, fruitcakes, nuts, straight jackets, and raving lunatics. They were all I knew about mental illness, and what terrified me was that professionals were saying I was one of them” (Deegan, 1997, p. 371).

Echoing this sentiment with extensive analysis of popular television and movies, Wahl (1995) found media uncritically depicts persons with serious psychological disorder as fitting stereotypes of dangerousness, unpredictability, and incompetence. This means audiences are selectively exposed to a biased sample of terrifying characters with psychological disorder. As mentioned earlier, this selective exposure nurtures an availability-bias heuristic—a default association of mental illness with fear. Consequently, a person primarily exposed to representations of people with mental illness as “crazed killers,” “incompetent children,” or “rebellious spirits” (Wahl, 1995; Hyler, Gabbard, & Schneider, 1991) can be expected to feel apprehensive about interacting with people labeled “schizophrenic.”

Major news sources are the primary way the public learns about mental illness and these media largely reinforce the stereotype of dangerousness associated with SCZ. Vahabzadeh, Wittenauer, and Carr (2011) compare stigmatizing descriptions of SCZ in U.S. newspapers from the year 2000 to 2010. Despite finding a significant decrease in reporting on crime committed by people with symptoms of SCZ, there was no change in rates of stereotyping people with schizophrenic symptoms as dangerous criminals. Though journalists generally endorse the goal to be fair and unbiased in their reporting, capturing readers' attention with sensational headlines tends to trump nuanced descriptions of people with psychological disorder (e.g., "Knife-Wielding Woman Suffered From Schizophrenia") (p.444). They found 60% of human interest articles in 2010 about SCZ focused on crimes committed by people exhibiting psychotic symptoms; nearly 75% of those articles were about murders by people believed to have SCZ. Even though people with indicators of SCZ are far more likely to be victims of crimes, only 1.6% of the articles reported on their victimization. They found no change over the decade in using the terms "schizophrenia" and "schizophrenic" as metaphors for illogical behavior or "split personality" (e.g., "Audiences are really schizophrenic...") (p.444).

What role do mental health professionals play in stigma?

Angell et al. (2005) reveal the surprising tragedy that mental health professionals often hold pejorative attitudes toward people with psychological disorder. Psychiatry has a long history of coercive treatment approaches that infantilize their patients and assume low expectations for recovery, which has contributed to the deep structural stigma persisting today.

Mental health professionals have their own type of availability bias, or *clinician's illusion*¹⁵ (Harding and Zahniser, 1994), where pessimism about recovery arises from more frequent exposure to statistically less common chronic disorders and/or cases of less functional than average people with psychological disorder. This skewed bias of extreme cases results in prejudiced attitudes and discrimination by way of paternalistic and coercive treatment strategies (Angell et al., 2005). Mental health professionals too often communicate to their patient, or to that person's family, a pessimistic belief that chances of functional recovery are unlikely. Since mental health professionals are the people that are turned to for explanations of psychological disorder and available treatments, their prejudice has significant impact.

What are consumer experiences of interacting with mental health professionals?

Angell et al. (2005) inspect first-hand consumer reports of their experiences with the mental health industry. Many report “lacking a voice” in their own treatment and recovery. Some feel burdened over the implicit hopelessness of being referred to as “chronically mentally ill.” Other patients express feeling “dehumanized” by professionals’ ignorance of the basic needs and desires of people with psychological disadvantages as the same needs and desires as other human beings. Another common occurrence is belittlement and/or being maligned as if childlike and helpless. Some complain of a risk that asserting themselves can lead to being labeled “resistant” or “non-compliant.” Numerous consumers report feeling presumed accountable for their condition not improving; their inability to control their symptoms can be implicitly inferred as evidence of their moral failure.

¹⁵ See p.47 for discussion of a similar unnamed phenomenon that effects police attitudes toward people with psychological disorder.

What is the process of people with psychological disorder internalizing stigma?

Corrigan (1998) explains how most people living in our culture steeped in stigmatizing beliefs are aware of the stereotypes and prejudice surrounding people with psychological disorder.¹⁶ The degree to which a person diagnosed with a psychiatric disorder accepts these stereotypes as true has a significant impact on their self-esteem, self-efficacy, and confidence in their own future (see also: Corrigan & Calabrese, 2005; Holmes & River, 1998). Inconveniently, many people soon develop self-prejudice when formally labeled with SCZ—a process referred to as *self-stigmatization* (Gallo, 1994). The diagnosed person is usually acquainted with the negative stereotypes associated with SCZ, and/or swiftly becomes aware the extent to which people are prejudiced against the outgroup to which they've been assigned. Upon diagnosis, they anticipate being devalued and rejected (Angell et al., 2005). As a type of *self-fulfilling prophecy*, many people diagnosed with SCZ distance themselves from other people, pass on opportunities, behave defensively, and experience a loss of self-esteem. Avoidance behaviors result in being perceived as socially awkward and to social distancing by others (Link et al., 1987; Angell et al., 2005).

Corrigan and Kleinlein (2005) explain the connection of self-prejudice leading to negative emotional reactions including low *self-esteem* (personal worth) and low *self-efficacy* (expectation that one can successfully cope with life demands). Self-prejudice, low self-efficacy, and feeling demoralized strip motivation to pursue work or independent living opportunities (Link, 1987), which Corrigan, Bink, Schmidt, Jones, and Rusch (2016) call the “why try” effect.

¹⁶ Some people with serious cognitive impairment are exceptions.

Is internalized self-stigma inevitable?

The sanguine news about self-stigma is that it is not universal among all people in stigmatized groups. Drawing from the sociology literature on how different stigmatized groups (women, gay, Black, etc.) internalize prejudice, Corrigan and Watson (2002) recognize the *fundamental paradox of self-stigma*, or fact that a substantial minority of persons respond to stigma with *psychological reactance* (Brehm, 1966), where they explicitly oppose negative evaluations. They may experience *righteous anger* (Chamberlin, 1978) over discrimination by the public and mental health system. Positive self-impressions can emerge as they feel more connected to a stigmatized community (Corrigan & Kleinlien, 2005). Rejecting self-stigma leads some to affirming actions such as mutual empowerment and activism (Wright, 1997) and to becoming more active participants in their treatment plan (Corrigan, 2002). *Empowerment* is understood as the polar-opposite of self-stigma and therefore is associated with higher self-esteem, higher self-efficacy, and positive identity (Corrigan & Watson, 2002). This elevated self-image can lead to advocating for better services and opportunities (Watson & River, 2005).

A less common, but not insignificant response to stigma is *indifference* (Hayward & Bright, 1997). Whether a stigmatized person reacts with indifference or righteous anger seems hinged on how comfortably that person identifies as a member of the stigmatized group (Corrigan and Kleinlein, 2005). Those who highly identify as members of the group tend toward righteous anger, positive identity, and positive self-perception (Watson & Corrigan, 2005; Watson & River, 2005). These positive outcomes are good reason to disclose one's status and become actively involved with a community of people stigmatized for similar reasons.

One thing that is confusingly clear from the literature outlining stigma is that reactions to becoming a member of a stigmatized group are complex and difficult to predict. Whereas one

person may feel alienated and despondent over receiving a diagnosis, others may feel inspired by their membership in a group, outraged by discrimination, and energized to advocate for social change. Yet others can roam in and out of these states depending on their motivation and the status of their interpersonal relationships. The application of stigma is socially determined, therefore labile and flexible enough to be reduced, if not eliminated, through social change.

What role does context play in how people with psychological disorder respond behaviorally?

Other researchers emphasize that self-esteem is domain-specific and can fluctuate based on social context (Crocker & Wolfe, 2001). *Stereotype threat* (Steele, 1997) is a well-established phenomenon in which a member of a stigmatized group struggles to perform in a situation where a specific negative stereotype applies (e.g., the stereotype that women are incompetent at math can result in emotional distress or disengagement when women are asked to demonstrate math skills). Corrigan and colleagues (2001, 2003) suggest a similar style of stereotype threat disengagement may account for some of the poor social functioning of persons labeled with a psychological disorder (Corrigan & Calabrese, 2003; Corrigan & Holzman, 2001). Knowing the public believes a stereotype such as, “schizophrenics are out of touch with reality” may lead people labeled as such to not value “careful cognition” and appear disoriented or confused in social interactions (Watson & River, 2005). This disengagement feeds into the cycle of self-fulfilling prophecy by confirming the expectation by others that the person is incoherent or disoriented.

How does the interaction of psychological disorder and substance abuse contribute to stigma?

Unfortunately, approximately half of people that qualify for a serious psychiatric diagnosis such as SCZ also suffer from substance dependence (Mueser, Bennett, & Shner, 2016). Substance use itself is considered a psychiatric disorder that is also highly associated with a stereotype of violent behavior. Rasinski, Woll, and Cooke (2005) describe the “dual stigmatization” of comorbid psychiatric disorders and substance dependence interaction, which magnifies the potential for opportunity loss. Link, Struening, Rahav, Phelan, and Nuttbrock (1997) found 70% of the men they studied with co-occurring psychiatric and substance use disorders reported four or more types of rejection; 65% assumed most people would look down on them. Recovery does not seem to lessen stigma, as these researchers also report stigma toward these men had not changed a year following successful treatment for both conditions. Even seeking recovery from substance use can be stigmatizing as a survey found 39% reported experiencing shame or embarrassment about being in recovery and 37% reported concern that others would find out they were seeking help for substance use (Rasinski, Woll et al., 2005).

What role does self-stigma have in accessing mental health services?

Corrigan and Kleinlein (2005) explain how many people with symptoms of psychological disorder choose to not pursue mental health services to *avoid* being labeled out of fear of discrimination. According to one large study, only 60% of people that qualify for the *DSM*-based definition of SCZ participate in treatment (Regier, Narrow, Rae, & Manderscheid, 1993). Another study found severity of symptoms has no impact on how likely a person is to participate in treatment (Narrow, Regier, Norquist, Rae, Kennedy, & Arons, 2000; Kessler, Berglund,

Bruce, Koch, Laska, & Leaf, 2001). Sirey, Bruce, Alexopoulos, Perlick, Friedman, and Meyers (2001) establish a direct relationship between stigma and adherence to treatment; the more people feel the effects of stigma, the less likely they are to stick to treatment. These studies indicate that many people who would be likely to improve from treatment either avoid or drop-out of treatment specifically because of stigma. To counter-balance, one important factor that does correlate with pursuing treatment is positive attitudes of family members (Greenley, Mechanic, & Clearly, 1987).

How does a historical accumulation of stigmatizing attitudes lead to structural stigma?

Corrigan and Kleinlein (2005) explain how stigma at individual levels (public and self-stigma) are only the tip of the iceberg and perhaps the more benign forms of social stigma. Sociologists have documented how the historical accretion of U.S. economic and political injustices based on discrimination have coalesced in abysmal *structural stigma* (Link & Phelan, 2001). Institutional policies arise from the explicit or implicit prejudice of people in positions of power; structural stigma is the accumulation outcome of keeping stigmatized groups in a subordinate position (Pincus, 1996). Pincus explains structural discrimination as being “race and gender neutral in intent,” but having a negative impact on women and/or minorities. An example of structural stigma toward people with psychological disorder include lack of parity between mental health and general medical coverage (Feldman, Bachman, & Bayer, 2002). Benefits for “physical” illnesses have substantially outweighed those for “mental” illness for as long as the existence of medical insurance companies.¹⁷ This precedent has led to the unfounded assumption

¹⁷ Even more perplexing, this lack of parity is out-of-sync with the widely accepted modern medical model of psychiatric disorder as a biologically-based brain disease.

that increasing benefits for mental illness would somehow diminish benefits for ailments considered “physical.” Another example of structural stigma is the lower rate of federal money allocated to mental health research (Link & Phelan, 2001).

Pincus (1996) points out the insidious nature of structural discrimination, as in many cases it may not be illegal, nor explicitly intended to be discriminatory, rather it is “carrying on business as usual” (p.192). Therefore, they emphasize a need to reexamine our fundamental cultural assumptions and values to disentangle discrimination embedded in our social organization. Obviously, this is no easy task, particularly in the case of SCZ’s century of coercive and clearly abusive treatment modalities.

Critical psychologists discuss the blind-spot of the field of psychology focusing on the experience of individuals without enough emphasis on the group within larger society (Fox et al., 2009). It is straight-forward enough to identify ways for an individual to resist the effects of stigma. However, many stigmatized people do not have the luxury or freedom to become involved with social activism because of systemic oppression. As Marecek and Hare-Mustin (2009) point out, social and political conservatism has practically decimated resources for federal and state funds for mental health care. These reforms disproportionately harm racial and ethnic minority groups, as well as those from impoverished backgrounds.

“Indeed, in the USA today, there are more mentally ill people in prisons than in mental hospitals. Needless to say, as prisoners, they receive little or no mental health care; moreover, prison conditions frequently exacerbate their difficulties” (Marecek & Hare-Mustin, 2009, p.90)

What role do police and the criminal justice system play in stigma?

As previously mentioned, the *clinician’s illusion* describes how pessimistic and negative attitudes can develop from frequent exposure to persons with more chronic than average

syndromes. A similar bias applies to police officers, who are selectively exposed to a sample of people in crisis or who have committed crimes. It is easy to appreciate how many factors, including exposure to this selective sample, inadequate training, information overload, time pressure, and being highly motivated to arrive at quick decisions in ambiguous situations exhaust limitations in cognitive capacity and lead to *category-based information processing* (Fiske, 2000). As Watson et al. (2005) explain, police officers are likely to rely on group stereotypes when judging or responding to a specific person with mental illness.

The long-term effect of structural discrimination has been the *criminalization of mental illness* (Teplin, 1983). As Markowitz (2011) explains, prior to the deinstitutionalization movement beginning in the 1970s, many people suspected of struggling with psychotic symptoms would have been diverted to mental health programs such as psychiatric hospitals. Widespread criticism of inhumane treatment by hospitals was supposed to push reform into creating an infrastructure to treat people with chronic psychological disorder in the community. However, the 1980s were ushered in by an obliteration of social resources by Ronald Reagan and the Republicans, who declared a “war on drugs” and enforced “zero tolerance” crime policies that continue to target stigmatized groups. Hospitals were essentially emptied to urban centers followed by jails and prisons became increasingly the warehouse centers of people with serious mental illness. As things currently stand in the U.S., people with serious mental illness are three times more likely to be found in the criminal justice system than in hospitals¹⁸.

Lurigio and Harris (2007) claim that tougher drug laws are particularly responsible for increased criminalization of mental illness due to the high rate of comorbid substance abuse. Psychiatric treatment facilities have a notoriously horrifying history of coercive treatment,

¹⁸ See <http://www.treatmentadvocacycenter.org>

neglect, and outright abuse (Harman, 2003). Outrage against this history has led to increased rights for people to refuse treatment and to challenge the practice of mandated treatment (Lamb, Weinberger, & Gross, 1999). On one hand, coercive treatment imposes on the autonomy of individuals. On the other hand, lacking insight under certain themes of delusional psychotic symptoms such as extreme paranoia and feelings of hopelessness make it difficult for some people to make informed decisions about pursuing treatment. Concurrently, public hospital beds have been reduced dramatically and access to community mental health services is limited (Lamb et al., 1999). This complex interaction of increased criminality and decreased services have resulted in many people remaining untreated even if they would prefer treatment.

Watson et al. (2005) refer to police as “the gatekeepers of both the criminal justice and mental health systems” (p.197). Police are typically the first point of contact with the criminal justice system for people with psychological disorder. Police are in the position to decide whether a person will be referred to community services (if this option even exists in their community) or arrested. People showing signs of serious psychological disorder are more likely to be arrested (Teplin, 1984) and to spend more time in jail than people without signs of psychological disorder (Steadman et al., 1995). People with serious mental illness represent 16% of the U.S. prison and jail population (Ditton, 1999), many are untreated (Markowitz, 2011).

Furthermore, Watson et al. (2005) show how difficult it is for police to overcome stereotype biases, as it requires the perceiver to possess *all* the following conditions: an awareness that their initial judgment is biased; a motivation to correct for the bias; a capacity to correct for the bias; and a correct estimation of the direction and amount of the initial bias. These researchers referred to meeting these conditions as a “formidable challenge” for police officers.

Arrigo and Fox (2009) point toward the “conflicting group values” of police as the root of social problems such as mistreatment of people with psychological disorder. Watson et al. (2005) explain how “police culture” was found (in Manning, 1995) to be characterized by conservatism, cynicism, authoritarianism, emotional detachment, secrecy, suspiciousness, social isolation, group loyalty, an “us” versus “them” orientation toward citizens, and aggressive policing style. They point out that it was once believed these traits were associated with a distinct “police personality” of people attracted to the occupation, but these traits may result as a reaction to occupational stress and/or are not generalizable among police officers. Ultimately, police are people and so are varied and too complex to be generalized.

Regardless of how common authoritarian and social dominance personality traits are among police, they are often in high-pressure situations that demand rapid life-or-death judgments. Fearing for their own safety leaves little motivation to err on the side of cautious compassion. Watson et al. (2005) explain how ambiguous behavior by those with psychological disorder can easily be mistaken by police officers as aggressive. Police also tend to view people with psychological disorder as untrustworthy, lacking integrity, incompetent, and unable to provide reliable information. In addition to dangerousness and unpredictability, these stereotypes result in police being more likely to arrest a person with mental illness rather than refer them to mental health services. When people with psychological disorder report being victims of crimes, they are often treated dismissively. Police also may feel unrewarded for the extra effort required to refer or transfer people to mental health services rather than arresting and holding them in jail. Complications with health insurance and the bureaucracy of medical facilities prohibits officers from easily referring people to treatment centers. And finally, police typically receive inadequate

training for identifying distinct types of disorder and in methods to deescalate psychological crises.

A rare attempt to offer direct primary responder support to police interaction with people experiencing mental health crises is Portland, Oregon's Behavioral Health Response Team ("Behavioral Health Unit," n.d.). The Behavioral Health Response Team pairs professional mental health professionals with police as they contact people in the community. This program began in 2013 after an investigation of the Portland Police Bureau (PPB) by the Department of Justice (DOJ) found, "reasonable cause to believe that PPB engages in a pattern or practice of unnecessary or unreasonable force during interactions with people who have or are perceived to have mental illness" (DOJ, 2012). The PPB have a particularly heinous history of abusing and killing people with mental illness, including the high-profile incident of three officers beating James Chasse, a young man diagnosed with SCZ, to death in 2006 ("United States v. City of Portland," 2017). However, even since 2013, members of the PPB have killed at least ten other people with serious psychological disorder including a homeless man in his fifties and a Black teenager in February of this year (Brown, 2017). There has yet to be a thorough analysis of whether the Behavioral Health Response Team has been overall effective in reducing mistreatment by the PPB.

STIGMA REDUCTION

Why and how to foster personal empowerment?

Rappaport (1987) explains that in a therapeutic context, being empowered means having control over one's treatment and life. Corrigan and Calabrese (2005) define personal empowerment as the *opposite of self-stigma*. They claim empowered persons can be expected to have high self-efficacy and self-esteem, to not feel overwhelmed by their symptoms or psychiatric label, to have a positive outlook, and to take an active role in their recovery. One challenge for approaches to empowerment is that they require active involvement of the client. However, empowerment can be nurtured by granting the consumer greater control over their treatment. Collaborative approaches to therapy emphasize strengths and the potential of the consumer; research has found programs that include the client in all facets of treatment show better outcomes to vocational and independent living goals (Corrigan, Faber, Rashid, & Leary, 1999; Corrigan & Garman, 1997).

Assertive Community Treatment (ACT) (Stein & Test, 1980), brings services to the consumer's home or workplace with moderate to good effects found on reducing hospitalizations, increasing housing stability, shrinking symptoms, and improving quality of life (Mueser, Bond, Drake, & Resnick, 1998). Supported employment and education approaches empower clients through *ongoing support*, rather than merely *preparing* the client for school or work (Corrigan & Calabrese, 2005). Other approaches that foster empowerment are volunteer clubhouse community centers where participants are considered "members" rather than "patients" and take an active and equal role as the supporting staff and vote on clubhouse decisions (Fountain House, 1999).

What role does personal disclosure of psychological disorder have for lessening stigma?

Compared to other stigmatized groups such as those based on race and gender, distinct features of SCZ may not be noticeable to others. Corrigan (2005a) wrote a chapter to explain the complicated benefits and drawbacks of a person with psychological disorder disclosing their status to others publicly and privately. Since the definition of “disclosure” and comparative costs and benefits remains unclear in relation to psychological disorder stigma, Corrigan looks to parallel experiences of disclosure in the gay and lesbian community¹⁹ (Corrigan, 2005a). The process of “identity development” for people with psychological disorder can be like the experience of many gay and lesbians in their coming to terms with their status leads to sensing the risk of being alienated from the “normal” population for disclosing their status. Revealing one’s status as gay or lesbian or having psychological disorder carry risks of being discriminated against, though in many different and some similar ways. Benefits to disclosure include abatement of stress from keeping their status secret and hence more satisfying interpersonal relationships. Coming out can lead to greater support from friends, family, and their respective communities. However, whereas evidence clearly supports the overwhelming benefits of coming out as gay or lesbian, much more research is needed to determine the full cost benefit analysis of disclosing one’s status as experiencing symptoms of SCZ.

¹⁹ Comparing stigma associated with psychological disorder to stigma associated with the gay and lesbian community is somewhat delicate as homosexuality was considered a mental disorder until 1980. Corrigan (2005a) lists the differences and similarities of these groups to make the central point that both differ from stigma associated with race or gender in that status can often be concealed until the individual chooses to disclose. Also, people with psychological disorder frequently are not aware of their status until adolescence/emerging adulthood, which is the case for many people coming to terms with their identity as including being gay or lesbian. Both groups have a great deal of variability and in many other ways they cannot be meaningfully compared.

What are the effects of reappropriation of stigmatizing labels?

Refusing to use stigmatizing labels is just one approach to lessening stigma. Corrigan (2005a) describes a more aggressive action taken by some charismatic individuals to reappropriate stigmatizing labels as a source of pride (e.g., the term “queer” was once considered pejorative but is now widely accepted as an umbrella term to include all non-heterosexual groups). Those who reclaim labels may be empowered by *righteous anger* to reject stigma and openly identify with the label to signal their pride as members of the stigmatized group. There are several benefits for label reappropriation, including enhanced self-esteem and disarming the power of the term being used against the group. Expressing pride in membership implies the belief that being outside the “norm” is not bad or necessary to hide. Reappropriation also shifts the ostracizing aspects of the term away from harming an individual to acknowledging their community’s shared experience and mutual support. An example of reappropriation among people with psychological disorder is a social justice and human rights in mental health advocacy group, MadNation. Naturally, reappropriation is not something that can be prescribed by a mental health researcher, but must be instigated and chosen collectively by the group members.

Recently, there have been people considered to have autism expressing a preference to be referred to as “autistic,” using identity-first language, which directly counters professional emphasis on person-first language (Brown, 2011). People expressing this perspective claim to be proud to identify as members of a group with similar perceptual experiences. Others have lamented the dropping of the label “Asperger’s syndrome” from *DSM-5* as they feel there is considerably less stigma associated with being a member of this sub-group rather than as members of the general umbrella of ASD (Giles, 2014; Lutz, 2013). Others express concern that lumping Asperger’s into the ASD implies homogeneity when high-functioning and low-

functioning syndromes require much different resources for support (Ben-Zeeve, Young, & Corrigan, 2010). However, Ohan, Ellefson, and Corrigan (2015) conducted a study that implies dropping the name has not impacted stigma.

Many people report feeling relief when initially diagnosed with a disorder for the primary reasons that they now have a word to describe their experiences and the knowledge that they are not alone in having these experiences (Mental Health America, n.d.). However, reappropriation of stigmatizing labels is a complex issue. There does not appear to be evidence to support strong benefits for people with psychological disorder to self-identify with a pejorative label, such as referring to themselves as “schitzo,” “crazy,” or “mad.”

What are strategies to challenge and change public stigma?

Corrigan and his colleagues have listed three strategies for changing stigma: *Protest*, *education*, and *contact* (Corrigan & Bink, 2016; Watson & Corrigan, 2005; Corrigan, River, Lundin, Penn, Uphoff-Wasowski, Campion et al., 2001; Corrigan & Penn, 1999). Each has strengths, weaknesses and limited effects, though contact has the most robust support for reducing stigma.

Protest strategies highlight the injustice of specific behaviors and take action by shaming, boycotting, or appealing to the morality of prejudice and discrimination. Protest has severe limitations in reducing stigma because shaming a person for their attitude can lead to a rebound effect and inadvertently worsen prejudice (Macrae, Bodenhausen, Milne, & Jetten, 1994), perhaps due to psychological reactance (Brehm, 1966). However, protest can change specific behaviors, particularly if the protest has a financial impact (e.g., the National Alliance for the Mentally Ill contributed to cancellation of a television show by publicly shaming its

sponsors for advertising on a show reinforcing ignorance and stigma toward mental illness) (Watson & Corrigan, 2005). Protest by way of public shaming and boycotting has become very easy in the age of social networking websites, though positive outcomes are few and far between.

Educational strategies attempt to replace stereotypes and misinformation with “factual information” about mental illness. There is some evidence that people with better understandings of mental illness are less likely to endorse stigma and discrimination (Brockington, Hall, Levings, & Murphy, 1993), and that education programs can produce short-term improvement in attitudes (Corrigan et al., 2001). However, effects of educational strategies are limited. People are not likely to change their beliefs over the long-run without significant motivation to consistently inhibit default stereotypes with explicit cognitively controlled personal beliefs (Devine, 1995). Stereotypes provide an energy conserving cognitive template heavily reinforced by confirming “evidence,” and require a great deal of mindful awareness of counter evidence to consistently reject the stereotype. Therefore, if a person has endorsed a stereotype that people labeled with SCZ are dangerous from watching decades of stigmatizing movies and television shows, they may be only temporarily influenced by learning a fact such as: *individuals with mental illness are no more dangerous than the general population* (Watson and Corrigan, 2005). Subsequent information, such as a sensationalized news story about a person with mental illness committing a violent crime, is likely to reactivate and reinforce the original dangerousness stereotype. This belief has been deeply ingrained and becomes easily reactivated with the newly confirming evidence provided by the stigmatizing news report (Fyock & Stangor, 1994).

Contact strategies are the most effective, yet most challenging to facilitate. They consist of interpersonal contact between the public and members of the stigmatized group (Corrigan et al., 2001). Contact interventions are more complicated than originally conceptualized by Allport

(1954/1979), who suggested that interacting with members of an outgroup reduced prejudice. To reduce stigma effectively, it is preferable that the meeting occurs face-to-face in a formal work or organizational setting (Pettigrew & Tropp, 2000). The stigmatized group member(s) should present themselves and their story in a way that gently disconfirms the stereotype and focuses on their successes and optimism for recovery (Watson & Corrigan, 2005). However, the presenter should not come across as so atypical of prevailing stereotypes that they risk being judged as special exceptions and disassociated from the stigmatized group (Watson & Corrigan, 2005).

Based on a meta-analysis of 44 studies, Pettigrew and Tropp (2000) found “optimal” contact interventions *require* four elements to be most effective at reducing prejudice:

1. *Equal status between groups.*²⁰ Neither group should be in charge or occupy a higher status, as opposed to typical contact between power groups (e.g., doctor-patient, landlord-resident, employer-employee).
2. *Common goals.* Both groups should work toward the same objective (e.g., solving a neighborhood problem or collaborating on a community project).
3. *No competition.* The nature of the contact should be a mutual effort and not for one group to out-perform the other.
4. *Authority sanction for the contact.* The contact intervention should be sponsored or endorsed by management of an employment organization, or by community organizations (e.g., the Board of Education, Better Business Bureau).

²⁰ Here “group” is used in the social psychology context of ingroup (non-stigmatized persons) and outgroup (stigmatized persons).

How does the content of the message matter in anti-stigma campaigns?

Some researchers warn that biologically based *disease explanations* for mental illness may reduce blame, while also provoking coercive and harsh treatment toward the person with psychological disorder (Corrigan, Rowan, Green, Lundin, River, Uphoff-Wasowski et al., 2002; Mehta and Farina, 1997). Many modern anti-stigma campaigns focus on biological explanations for mental illness, such as NAMI's "Mental Illness is a Brain Disease" campaign. Attributing SCZ as a brain disease may make others more *sympathetic* toward the person's suffering and less likely to blame them for moral failure. However, putative biological explanations evoke pity (sympathy), which activates *benevolence stigma*, or stereotypes of the person as childlike (Brockington et al., 1993). As a result, the person is assumed to lack control of their behavior which can reinforce the stereotype of unpredictability and potential for violence (Read & Law, 1999).

In contrast, *psychosocial explanations* reframe symptoms as inferred reactions to life events by focusing on environmental stressors and trauma such as childhood abuse, poverty, and job stress. These types of explanations appear effective for reducing beliefs of dangerousness and unpredictability (Read & Law, 1999), and increasing positive images and reducing fear (Watson & Corrigan, 2005). Psychosocial explanations are not perfect; some research suggests they ignore important genetic and biological factors and increase blame toward the person with psychological disorder or their family (Corrigan & Watson, 2004). The combined research on the effects of *biological explanations reducing blame but increasing fear* and *psychosocial explanations reducing fear but increasing blame* is a thorny problem requiring further research and careful consideration on how to manage successful anti-stigma campaigns.

A preliminary study by Corrigan, Schmidt, Bink, Niweglowski, Al-Khouja, Qin, & Discount (2016) tests how the public responds to messages that include descriptions of positive symptoms along a continuum of experience. Participants were exposed to various written testimonials by people with symptoms of SCZ describing their condition either by listing their symptoms like the *DSM* categorical approach, or by quantifying their symptoms. Statements included: “I don’t always have symptoms, but when I do, I hear voices and sometimes believe the CIA is investigating me;” “Most people get nervous in their daily lives;” and “Hallucinations and delusions can happen to anyone when they are stressed.” (p.8). They found some effect on reducing stigma in the readers, but the bigger effect was increased optimism for recovery. In a recent editorial, Corrigan (2016) warns that more research is needed on whether messages that promote the “normalcy” of mental illness symptoms is valuable to reducing stigma.

The public education approach, as introduced above, specifically contrasts stereotypes with facts (e.g., violence prevalence rates) and shows mixed results. Corrigan et al. (2002) conducted a study comparing educational approaches. One condition focused on dangerousness by providing accurate information about violence prevalence rates. The other condition focused on explaining causes and treatments of mental illness. Both conditions reduced perceptions of dangerousness and decreased a desire for greater social distance. Yet the dangerousness condition increased blame, whereas the causal treatment decreased blame. Thus, Watson and Corrigan (2005) caution, “The goal of improving attitudes about mental illness in general is laudable, yet too amorphous to achieve” (p.290). They recommend a *targeted approach* that focuses on educating specific groups (e.g., employers, landlords, police officers, legislators, and media executives) with a message crafted to tackle *specific stereotypes* with the “causal”

explanation that would be most compelling for that group (e.g., addressing an employer's concern about incompetence).

Could a systems science approach to conceptualizing psychological disorder help account for complexity?

A systems science approach to accounting for the multiple and interacting *causes* of psychological disorder could overcome the limitations of reductionism, and of the unsatisfying dichotomy between stigmatizing biological and psychosocial explanations. Hieronymi (2013) explains that competence in systems thinking could be the key to understanding problems that are “highly interlinked, complex and multidisciplinary” (p.580). As the approach suggests, systems science is a field that is useful to examining complex structures with many interacting variables to understand and potentially manipulate the behavior of the system as a whole. Classic examples of complex systems include the weather, the brain, the economy, cities, and social networks. As Mitchell (2011) explains in her book introducing systems science and complexity theory, as more variables of the system are identified, operationalized, and quantified, the better models can be designed to predict the emergent behavior of the system. Predicting the behavior of dynamical systems (adaptive and constantly changing) is *dependent on the initial condition*. Initial conditions of complex systems must account for all variables and are notoriously difficult to measure precisely.

The central point of using systems science to conceptualize psychological disorder is that it would honor the complex interaction of *systems of variables contributing to disorder*. Rather than looking at the heterogeneity of a disorder like what we call SCZ as a problem, the heterogeneity could be the inspiration for organizing the inquiry. Human behavior is especially complex, as it emerges from the interaction of many complex systems, including a person's

brain, body, environment, family, culture, and social systems. These systems are dynamic and behavior is also subject to moment-by-moment context. Systems science provides the template for examining the variables of these systems in a way that is open to quantifying and using mathematical modeling to manipulate variables to predict their effects on the system.

Could changing the diagnostic label of “schizophrenia” reduce stigma?

After a century of accumulated stigma associated with the name “schizophrenia,” the question arises, could merely replacing the label to something different reduce stigma?

J. van Os (2009; 2013) is one of the leading U.S. proponents of changing the name of SCZ. His reasons steer around changing societal stigma to aim at the parallel problem of “iatrogenic stigma;” he explains that SCZ is a reified and misleading term based on century old belief that SCZ is a disease. Furthermore, this “disease” has been characterized by the idea of having *a mind split from reality* which is confusing, inaccurate, and not relatable to the public. Most people can understand the nature of feeling depressed or anxious, or even what it means to experience a hallucination or a belief not connected firmly to reality. He explains that SCZ is a syndrome, or collection of symptoms, with dimensions that cluster together. He suggests the label “salience syndrome²¹” to replace SCZ because of conceptual similarities to “metabolic syndrome.” Considered a medical condition, metabolic syndrome is also a cluster of dimensional symptoms that when aggravated in aggregate to certain levels, a threshold can be reached that requires treatment for hypertension. Therefore, people with metabolic syndrome treat the condition by minding a handful of physiological symptoms—blood pressure, blood sugar, excess

²¹ He explains, “salience is about how internal or external stimuli can become attention-grabbing and how this, if it is not willed, can lead to perplexing experiences that result in a search for an explanation that are subsequently recognized as delusions” (van Os, 2009, p.370).

body fat, etc. Similarly, salience syndrome would describe a cluster of symptoms with varying gradients that collectively push the threshold until the person has a psychotic episode.

One patient activist diagnosed with SCZ expresses distaste of “salience syndrome” as George (2009) claims “salience” is “unfamiliar medical jargon” (p.467). He co-authors a follow-up article to explain the results of a competition to suggest a better name among his consumer-advocacy association members (George & Klijn, 2013). Out of 320 results, “dysfunctional perception syndrome” was the winner, but quickly become contentiously criticized among some members. They ended up choosing “psychosis susceptibility syndrome” as it appears sufficiently descriptive and contains the idea that people with the syndrome are susceptible but not guaranteed to experience a psychotic state. As people with direct experience of this syndrome, they believe the name would reduce self-stigma.

Corrigan (2014) believes proposals to change the name of SCZ are missing the point and he demands caution from seeking simple solutions. He states, “diagnostic relabeling as an approach to stigma change entangles the issue in the medical perspective rather than freeing it from psychiatry” (p.1263). Corrigan believes the people who suffer the stigma of the label should lead the social change against the stigma, drawing parallels to Black empowerment during the civil rights movement. All stigmatized groups have something in common, as Corrigan suggests, it is not the *label* itself that stigmatizes people, but the fact that they are considered *other* by the dominant group. The stigma arises from the shame associated with being judged as different. His solution is empowerment because it replaces shame with righteous anger and pride (self-worth) and is highly motivating for self-efficacy rather than succumbing to the “why try” effect. Corrigan also warns that relabeling could be construed as an act of “political

correctness” that would encourage virtue-signaling “word police” rather than diminishing stigma.

However, what sort of alternative is there to amassing so much evidence of the harmful effects of stigma, only to conclude that we must sit and wait for this group to revolt against our shared power structures and demand their equal rights? Disability is not a problem of an “other” group. Anyone can be physically disabled from an accident leading to paralysis, or an environmental toxin leading to a cancer, or dementia in advanced age, or a concussion damaging cognition and changing someone’s personality, or overwhelming depression from the accumulation of hard luck and poverty.... Mental illness is something that happens to us,²² *across our entire species*, whether through atypical neurodevelopment or accumulation of stress or traumatic childhoods. Some conditions, like symptoms associated with autism, arise early in life, whereas conditions like dementia tend to arise later in life. For yet to be understood reasons, SCZ tends to arise in the adolescence/middle of life. Stigma reduction should be a prominent goal to all members of our society.

So yes, Corrigan’s (2014) editorial is aptly titled, “Erasing stigma is much more than changing words.” He and his colleagues in psychology, sociology, and critical psychology all agree that stigma is a deeply entrenched systemic problem requiring radical societal change. The power structures are not motivated to change and will not do so at their own behest. Change will require anyone willing and able to challenge the supremacy of the professional organizations of psychiatry to demand equal rights and effective treatments. Pressure should be applied to cut off pharmaceutical companies from rewarding mental health professionals for endorsing their products, as well as the elimination of direct-to-consumer advertising and political lobbying

²² If serious mental illness affects approximately 23% of the population (Mueser et al., 2016) that’s no small minority.

influence. Police need to be trained on methods to deescalate mental health crisis situations. The *DSM* should be shelved for its stigmatizing effect. If the *DSM* serves as the *bible* of psychiatry, insurance companies, and the legal system, then rational blasphemy is necessary to disarm its authority. Essentially, the entire system needs radical overhaul to make a significant difference for human rights.

Changing the label of “schizophrenia” may be insufficient for immediate and total elimination of stigma. However, as throwing out the baby with the bathwater is ill-advised, disassociating the term from a condition defined a century ago could have small benefits that accumulate over time. It might be naïve to assume that this action would have a large effect on structural stigma, however it seems a baby step in a better direction.

What is the precedent for changing the label of “schizophrenia”?

Luckily, one does not have to merely speculate on the effects of changing the label of “schizophrenia.” Japan changed the label in 2002 from *Seishin-Bunretsu-Byo* (mind-split-disease) to *Togo-Shitcho-Sho* (integration disorder) and research is beginning to support its effect on reducing stigma. As Sato (2017) explains, the intention of changing the name in Japan was specifically to reduce stigma and to shift from the Kraepelinian tradition of assuming progressive deteriorating illness with little chance of recovery. Japan moved to re-conceptualize SCZ based on a biologically informed psychosocial vulnerability-stress model.

Japan has a different history than the U.S. with stigma of mental illness. The U.S. had its heyday with eugenics informed policy in the early 1900s,²³ which became a cultural taboo after

²³ It is estimated that in the U.S., 64,000 people considered “genetically inferior” were sterilized in the first several decades of the 1900s (Bouche & Rivard, 2014).

the Nazis adapted the American idea to justify Germany's state-sponsored genocide of Jews, homosexuals, and people with physical or mental disabilities. Japan openly embraced a less horrific, but still troubling version of eugenics until recently. A Japanese health education textbook from 1970 is quoted in Koike, Yamaguchi, Ohta, Ojio, Watanabe, and Ando (2016):

In order to prevent inheriting especially malignant genetic disorders, mothers who have genetic disorders such as schizophrenia and bipolar disorder can abort the pregnancy by Eugenic Protection Act. (p.7).

Whereas the U.S. was experiencing a period of deinstitutionalization (and subsequent lessening of mental health resources) in the 1980s, Japan moved in an opposite direction and increased available psychiatric beds nearly 3-fold with the belief that people with schizophrenic indications should be detained in the hospital long-term (Koike et al., 2016).

There is much evidence for optimism in Japan as Sato (2017) briefly reviews what has been learned in the fifteen years since the name change. The new name has been widely accepted by Japanese mass media, administration, and mental health professionals, as well as the people diagnosed with the new title and their families. Prior to the name change, only 37% of patients were informed of their diagnosis out of clinician concern over the impact of stigma—this proportion rapidly doubled within two years, demonstrating *reduced anticipation of rejection*. Patients have become more open about revealing their diagnosis to others and the anti-stigma movement has rapidly grown and been promoted by persons in recovery. Clinical goals have also shifted from a focus on *remission* to *functional remission* and *recovery*.

Koike, Yamaguchi, Yasutaka, Shimada, Watanabe, and Ando (2015) also examine the long-term effects of the name change on reducing stigma in Japan. They found the university students who filled out their survey knew more about, and had less negative stereotypes associated with the new name—only 42% of the students were familiar with the old name,

whereas 58% knew the new name. Those who reported personal experience with mental health problems held even less negative stereotypes than the students who had no experience. Which is another way to say both *public- and self-stigma has been diminished*.

Another study by Koike et al. (2016) surveys Japanese college students and their parents to compare how stigma toward SCZ had changed between generations. As expected, their results found parents were far more likely to recognize the old and new names as being the same condition. Parents that did not recognize the names as the same condition associated fewer negative stereotypes toward the new name. Overall, parents expressed greater stigma and desire for social distance from people with schizophrenic symptoms than their children. The researchers point out potentially confounding variables, such as substantial changes to educational curriculum on mental illness and increased support in schools for mental health. From this study, the researchers suggest a name change can reduce stigma in the long-run partially because younger people grow up unaware of the previous label and stigma associated with the old name.

Aoki, Aoki, Kasai, Thornicroft, and Henderson (2016) examine how newspaper portrayals of SCZ transformed from a decade before until a decade after the name change, specifically in terms of the dangerousness stereotype. They discovered an upward trend of articles associated with danger leading up to the name change, followed by a significant decrease in the more recent decade. They used newspaper coverage of bipolar disorder as their control variable, which had steadily increased in association with danger over this same 20-year period. They believe newspaper coverage can be an index of wider public opinion. Therefore, it seems reasonable to conclude that stigma and association of dangerousness with psychotic symptoms had significantly decreased since the name change.

Based on the short-term success of the name change, South Korea followed suit in 2012 (Lee, Kim, & Kwon, 2013) and Taiwan in 2014 (Sartorius, Chiu, Heok, Lee, Ouyang, Sato, Yang, & Yu, 2014). Japan also changed the name of dementia from *Chiho* (idiocy and stupidity) to *Ninchi-sho* (cognition disorder) in 2004 (Koike et al., 2015), suggesting the beginning of a positive trend in helping people with psychological disorder lead more fulfilling lives with less shame.

CONCLUSION

Stigma associated with psychological disorder is a complex problem requiring a sensitivity to complexity to resolve. Diagnostic labeling based on *DSM* categorization best serves the pharmaceutical and insurance companies, not the people who struggle with disability. SCZ was conceptualized a century ago as a progressive disease blamed on bad parenting and has never recovered despite ample scientific evidence that functional recovery is likely through evidence-based treatments for the individual and their family. Meanwhile, neuroscience and genetics research have only reinforced how little is known about psychological disorder as there are still no known mechanisms or biological markers for any psychiatric diagnosis. Despite lacking answers, psychiatry made the conscious choice to re-conceptualize psychological disorder based on a medical model to gain legitimacy as a science. This has only obfuscated the problem through reification of disorder constructs as understood and solvable through pharmaceutical interventions. Meanwhile, there has been no significant progress in antipsychotic drugs used to treat SCZ for approximately 70 years and CBT for psychosis is largely underutilized despite evidence to support its efficacy.

The term “schizophrenia” is a relic from an era when scientists largely made guesses at underlying biological problems based on observation of behavior and self-reported symptoms. Unlike depression, which is relatable to the public, SCZ fills people with fear over the anxiety of losing one’s mind or of being a victim of someone with unpredictable behavior. SCZ has been maligned by the media as synonymous with raving lunatics and dangerous criminals. In addition to the media, stigma of SCZ is reinforced by mental health professionals’ pessimistic attitudes and the “mental illness is a brain disease” messages of most anti-stigma campaigns. The horrific

conditions of psychiatric hospitals and asylums have been replaced by jails, prisons, poverty, and homelessness. Portland, Oregon, may have more progressive programs to help people experiencing mental health crises than many U.S. cities, but also has a police department found by the U.S. Department of Justice to regularly use unnecessary and unreasonable force against people with psychological disorder.

Social stigma is a significant obstacle that many people with disability are not able to overcome. This partially explains why SCZ has an excessive mortality rate, including the highest incidence of suicide of any disorder, even though SCZ itself is not lethal. Public stigma clearly arises from the negative stereotypes of dangerousness and unpredictability associated with the word SCZ. Structural stigma and discrimination are complex problems that would require a restructuring of our entire system to eradicate. However, there are little changes that can be enacted to reduce stigma and move toward a more equal and just society. One small change that could have some effect is simply changing the label to a term that is not associated with a century of stigmatizing associations and is more descriptive of psychotic experiences that are relatable to others. Japan chose “integration disorder” and has found success at reducing public and self-stigma.

Changing the name is a step in the right direction along the way to integrating people with psychological disorder as normal people with typical goals to live fulfilling lives with meaningful employment, interpersonal relationships, to not have to writhe in poverty, or be sequestered within the criminal justice system. Just as an industry has arisen to support the needs of people considered to have autism, people considered to have SCZ should be given similar opportunities to manage and soothe their troubling symptoms and not be ostracized as “other.”

No one is handing out human rights and so we must demand them.

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