Persons diagnosed with severe mental illness are frequently stigmatized as dangerous and unpredictable. Historically, these attitudes have perpetuated years of cruel, inhumane treatment of persons diagnosed with severe mental illness. Stigma research continues to show a link between a belief in the biological/genetic origins of mental illness and higher levels of stigmatization and prejudice. Despite this fact, the most visible anti-stigma programs portray mental illness as “an illness like any other,” such as diabetes or cancer, with the belief that a reduction in blame will result in a reduction in stigma. Several explanations have been provided about why the biological explanation of mental illness is not correlated with decreases in stigma. However, no study thus far has gone beyond conjecture. In the present study, I used a qualitative approach to seek out the underlying attitudes that may contribute to increased stigmatization with a biogenetic conceptualization of mental illness.
EXAMINING CAUSAL BELIEFS AND STIGMATIZING ATTITUDES TOWARD PERSONS DIAGNOSED WITH SEVERE MENTAL ILLNESS

A Thesis

Submitted to the faculty of Miami University in partial fulfillment of the requirements for the degree of Master of Arts Department of Psychology by Emily K. Reese Miami University Oxford, Ohio 2010

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Examining Causal Beliefs and Stigmatizing Attitudes Toward Persons Diagnosed with Severe Mental Illness

Persons diagnosed with severe mental illness frequently are stigmatized as dangerous and unpredictable (Angermeyer & Matschinger, 2003; Page, 1995; Page & Day, 1990; Rahav, 1987; Skinner, Berry, Griffith, & Byers, 1995). Such attitudes can lead persons diagnosed with severe mental illness to avoid seeking services, as well as erect barriers to finding housing, securing financial assistance, finding employment, and building interpersonal relationships (Farina & Felner, 1973; Page, 1995; Page & Day, 1990; Wahl, 1999). Stigmatization is pervasive in Western society, stemming not only from the general public, but also from well-educated professionals and persons diagnosed with severe mental illness themselves (self-stigmatization). Historically, these attitudes have perpetuated years of cruel, inhumane treatment of persons diagnosed with severe mental illness, sometimes in the name of finding a “cure” (e.g., bleeding, use of emetics, electroshock, insulin coma, freezing and scalding baths, simulated drowning) and other times with the aim of protecting the rest of society (e.g., involuntary confinement, sterilization, sedation) (Whitaker, 2002). Stigma research continues to show a link between a belief in the biological origins of mental illness and higher levels of stigmatization and prejudice (Dietrich, Beck, Bujantugs, Kenzine, Matschinger, & Angermeyer, 2004; Fisher & Farina, 1979; Read, 2007; Read & Harré, 2001; Read, Haslam, Sayce, & Davies, 2006; Walker & Read, 2002). Despite this fact, the most visible anti-stigma programs portray mental illness as “an illness like any other,” such as diabetes or cancer, with the belief that a reduction in blame will result in a reduction in stigma.

Several researchers have provided possible explanations as to why the biological explanation of mental illness is not correlated with decreased stigma. The first explanation is avoidance of threat, and is based on the premise that because “they” (i.e., persons diagnosed with severe mental illness) are biologically different, “normal” people do not have to fear going crazy themselves. The second involves evolutionary drives, or the need to protect the gene pool from undesirable weakness. The third is patronization. From this perspective, persons diagnosed with severe mental illness are like children who need strict discipline. However, no study thus far has gone beyond conjecture.

For the present study, I utilized a qualitative approach to seek out the underlying attitudes in the lay population that may contribute to increased stigmatization with a biogenetic
conceptualization of mental illness. By exploring some of the possible reasons as to why the biological perspective does not reduce stigma, mental health professionals and antistigma programs will be better equipped to discover strategies that may work better to reduce stigma. In order to fully grasp the importance of this issue, I will review the relevant extant literature in support of the following premises: (a) Stigmatization is a chronic and distressing problem for persons diagnosed with severe mental illness; (b) biological explanations for the causation of mental illness have led to inhumane treatment of persons diagnosed with severe mental illness; (c) stigmatization in particular increases with belief in biological causation of mental illness; and (d) current antistigma programs continue to explain mental illness in terms of biological causation only, and the general public’s beliefs are beginning to shift accordingly. I then will present some possible explanations for the link between stigma and belief in biological causation of mental illness.

**Stigmatization of Persons Diagnosed with Severe Mental Illness**

**Society-level stigmatization.** The stigmatization of those diagnosed with severe mental illness, especially schizophrenia, has been well documented in empirical research (e.g., Angermeyer & Matschinger, 2003; Page, 1995; Page & Day, 1990; Rahav, 1987; Skinner et al., 1995). Individuals diagnosed with severe mental illness are routinely perceived by the public to be dangerous, irresponsible, and unpredictable (Crisp, Gelder, Rix, Meltzer, & Rowlands, 2000; Link, Phelan, Bresnahan, Stueve, & Pescosolido, 1999; Socall & Holtgraves, 1992). For example, in one general public survey ($n = 1737$), $70\%$ of respondents perceived persons labeled schizophrenic as dangerous, and $80\%$ viewed them as unpredictable (Crisp et al., 2000). Over half of respondents indicated that persons with schizophrenia could never recover (Crisp et al., 2000). In another study, researchers provided participants with a vignette describing a man who felt others were plotting against him and could read his mind, heard voices when all alone, and secluded himself socially; $61\%$ of respondents indicated that this individual was somewhat or very likely to be violent (Link et al., 1999). Socall and Holtgraves found not only that persons diagnosed with severe mental illness were perceived as unpredictable by their respondents, but also that this belief led to a greater desire for social distance (1992).

As a result of negative public perceptions, persons with severe mental illness face discrimination when seeking housing, applying for jobs or financial assistance, and cultivating social relationships (Farina & Felner, 1973; Page, 1995; Wahl, 1999). One study investigated
how persons would be treated differently in job interviews if the prospective employers were told that the individual had spent time in a mental hospital, in comparison with persons having no known history of mental illness. When prospective employers believed the applicant had spent time in a mental hospital, the applicant received half as many job offers as the non-mentally ill applicant (Farina & Felner, 1973). In addition, prospective employers were significantly less friendly to the ex-mental patient (Farina & Felner, 1973). Page found that admission of inpatient mental health treatment to prospective landlords significantly decreased the probability that the landlord would disclose housing availabilities (1995).

Skinner and associates (1995) conducted a study to examine how mental illness stigma differs from other types of social stigma. Participants were presented with a choice between an ex-mental patient (who had spent time in a mental hospital for severe mental illness), an ex-convict (who had been incarcerated for a serious criminal offense) and an ex-drug addict (who had spent time in a residential drug treatment center). Respondents then were asked to respond with one of the above three persons to forced-choice items such as, “A young lady about to be married would be more upset to learn that her fiancé is…,” and, “The man whom most people would place more confidence in, in an emergency, is…” (Skinner et al., 1995, p. 8). Participants endorsed negative attitudes toward the ex-mental patient across more contexts than they did toward the other roles, especially in terms of social functioning, romantic relationships, work, and child-rearing (Skinner et al., 1995).

Another study used a self-report measure to allow those diagnosed mentally ill to report on their experiences (Wahl, 1999). In this study, 70% of respondents indicated having been treated as less competent because of their diagnosis of mental illness, with many of these persons being advised by others to lower their expectations in terms of career prospects (Wahl, 1999). Sixty percent reported being shunned by others, and less than half (47%) indicated that friends were supportive when learning of their mental illness (Wahl, 1999).

Based on the literature reviewed above, it is clear that the lay public’s stigmatization of persons diagnosed with severe mental illness is pervasive across context and time. This highlights the importance of mental health professionals and antistigma programs acquiring a better understanding of where these attitudes originate. Unfortunately, the literature indicates that mental health professionals themselves endorse stigmatizing attitudes toward persons diagnosed with severe mental illness.
**Professional-level stigmatization.** Well-trained professionals, including those in the mental health field, also harbor stereotypes and discriminating attitudes toward persons diagnosed with severe mental illness (Lauber, Anthony, Ajdacic-Gross, & Rössler, 2004; Mirabi, Weinman, Magnetti, & Keppler, 1985; Nordt, Rössler, & Lauber, 2006). For example, one study found that psychiatrists were no different than the general public with regards to desire for social distance from a person meeting criteria for a diagnosis of schizophrenia from the *Diagnostic and statistical manual of mental disorders* (DSM-III-R) (Lauber et al., 2004). In another study, psychiatrists expressed reluctance to rent a room to someone diagnosed schizophrenic, to recommend someone diagnosed schizophrenic for a job, and to approve someone diagnosed schizophrenic marrying into their family (Lauber et al., 2004). In addition, yet another study found that psychiatrists endorsed more negative stereotypes about persons diagnosed with schizophrenia than both the general public and non-psychiatrist psychotherapists (Nordt et al., 2006). Specifically, psychiatrists were more willing to identify words such as “dangerous,” “unpredictable,” “stupid,” “bedraggled,” and “weird” (to name a few) as applying to persons diagnosed with schizophrenia (Nordt et al., 2006, p. 710). One survey revealed that a majority of mental health professionals (including psychiatrists, psychologists, social workers, caseworkers, and psychiatric nurses) preferred to avoid contact with the chronic mentally ill by referring them to other mental health professionals (Mirabi et al., 1985). The same survey found that 63% of respondents found work with this population to be unrewarding and unsatisfying (Mirabi et al., 1985).

**Individual-level stigmatization.** Due to the pervasiveness of psychiatric stigma, persons diagnosed as mentally ill often will self-stigmatize, contributing to feelings of powerlessness (Corrigan & Watson, 2002). Corrigan and Watson explain that self-stigma can result in overwhelming pessimism, low self-esteem, and low confidence (2002). Estroff (1989) describes severe mental illness as “more than an illness that one has; it is something a person is or may become” (p. 189). The individual then may perceive the self as less human and unworthy of respect or happiness. In a first-person narrative, one woman eloquently describes her struggles with self-stigmatization thus: “Enjoying life is not possible if you do not believe that you even have a right to exist, let alone consider improving your self-esteem” (Gallo, 1994, p. 409). Gallo goes on to explain how self-stigmatization affected how she was treated by others. Because she viewed herself as worthless, she tended to isolate herself socially. Because she isolated herself
socially, others viewed her as standoffish and rejected her, increasing her social isolation (Gallo, 1994). Internalized stigma, paired with the fear of stigma from others, can prevent distressed persons from seeking help for their problems and from reaching out to build social relationships (Gallo, 1994).

**Stigma and Beliefs about Causation**

Psychiatric stigma has been shown to be moderated by beliefs regarding the cause of mental illness. Specifically, stigmatization increases with greater belief in biological causation of mental illness as opposed to psychosocial causation (Dietrich et al., 2004; Fisher & Farina, 1979; Read, 2007; Read & Harré, 2001; Read et al., 2006; Walker & Read, 2002). Beliefs in biological causation can include such factors as biochemical imbalances, abnormal genes, and/or abnormal brain structure. Beliefs in psychosocial causation can include factors such as past traumas, a troubled home life, and/or situational distress (e.g., the recent death of a loved one or sudden job loss). I will return to the link between stigma and belief in biological causation of severe mental illness later on, but first it is important to review the history of biological perspectives on mental illness, as well as current biological perspectives on mental illness, for background on this issue. Because of the dominance that biological perspectives on mental illness currently enjoy in Western society, it is important to understand them if they are a source of stigmatizing attitudes.

**History of biological perspectives.** Whitaker (2002) has summarized many of the biological theories of the origins of mental illness that have been proposed over the years. These include speculation as to possible causes like “distempers” (p. 9), “circulatory imbalances” (p. 14) and “defective germ plasm” (p. 41). Based upon such explanations, physicians have inflicted questionable and horrifically cruel “treatments” such as bleeding, emetics, starvation, beatings, drowning, straitjackets and other physical restraints, insulin coma, removal of teeth and organs, sterilization, clitoridectomy, confinement, electroshock, and prefrontal lobotomy, to name a few (Whitaker, 2002). In the early days of treatment for those deemed mad, many physicians felt that torture was the best way to restore the mad to sanity. In the words of 17th century physician Thomas Willis, “Truly nothing is more necessary and more effective for the recovery of these people than forcing them to respect and fear intimidation. By this method, the mind, held back by restraint, is induced to give up its arrogance and wild ideas and it soon becomes meek and orderly” (as cited in Whitaker, 2002, p. 6). Willis goes on to extol the benefits of “tortures and
torments” in helping “maniacs” to recover more quickly (as cited in Whitaker, 2002, p. 6). Persons deemed as mad were no longer treated as fellow humans. Rather, they were thought of as similar to wild animals, needing to have terror, shame, and pain inflicted upon them in order to break their spirits, and showing excessive compassion toward them was viewed as cruelty (Whitaker, 2002). Thus, stigmatization of those deemed mad was part and parcel of the accepted standard of treatment.

By the early 20th century, the cost of caring for those diagnosed mentally ill seemed to become one of the main motivating factors behind such methods as electroshock, insulin coma, and lobotomy, as they were more cost-effective than psychoanalysis (Miller, 2003). This trend continued with the introduction of the first pharmaceuticals intended to treat severe mental illness, which were less expensive and less labor intensive than performing lobotomies, but produced the same results (Miller, 2003; Whitaker, 2002). It is possible that stigma may have played, and may still play, a role in viewing such “treatments” as acceptable. Peter Breggin, a psychiatrist and well-known critic of the psychopharmaceutical industry, elaborates on this possibility:

Biopsychiatry lives by the principle that its patients are so different from other humans that almost anything can be done to them, including surgical, electrical, and chemical lobotomy. By contrast, the ethical helping person assumes that those seeking help possess the same human sensitivities as anyone else. (1991, p. 61)

The biological perspective can have the effect of making persons diagnosed with severe mental illness seem less human, and thus less deserving of civil rights and compassion. This, in turn, can lead to approval of treatments that one would not even consider inflicting on a “normal” person. This is in contrast to a person with a physical disability, for “a heart patient has just one thing wrong with him, while a mentally ill person is completely different from other patients” (Cohen & Struening, 1962, p. 351).

Contemporary biological perspectives and associated concerns. In more recent decades, mainstream scientific thought has continued to champion biological theories of mental illness, such as genetic predispositions and chemical imbalances. I will briefly describe these two perspectives and their associated treatments, as well as some related concerns with these approaches.
Genetic predispositions. Proponents of the concept of genetic predispositions for severe mental illness frequently cite twin studies as evidence. Some studies show that identical, or monozygotic (MZ), twins are more likely to be concordant in terms of schizophrenia diagnosis than are fraternal, or dizygotic (DZ), twins (Pinel, 2003). Adoption studies also are popular in the defense of the genetic predisposition explanation, as some studies appear to indicate that, in terms of schizophrenia diagnosis, children are more concordant with biological family members than with adoptive family members (Pinel, 2003). Many studies also have attempted to identify more specific genes or genetic mutations whose presence can help predict schizophrenia diagnosis (Pinel, 2003).

Chemical imbalances. The genetic predisposition explanation and the chemical imbalance explanation are not mutually exclusive, as it is thought that a genetic predisposition can be the cause of a chemical imbalance (Pinel, 2003). With regards to severe mental illness, most of the evidence used in support of the chemical imbalance explanation is indirect in nature. In other words, researchers observed that administering drugs which affected dopamine levels in the brain led to changes in symptoms; increased levels of dopamine were correlated with an increase in positive psychotic symptoms, and decreased levels of dopamine were correlated with a decrease in positive psychotic symptoms (Pinel, 2003). Thus, from this correlation, many researchers have arrived at the conclusion that disruption in the dopaminergic system causes schizophrenia (Pinel, 2003).

Concerns with contemporary biological perspectives. Many prominent psychiatrists and researchers have voiced concerns over the shortcomings of genetic predisposition and chemical imbalance causal explanations for the symptoms of those diagnosed severely mentally ill. Kenneth Kendler, a psychiatrist, prominent psychiatric researcher for NIMH, and co-editor-in-chief of Psychological Medicine, recently noted that, despite myriad research studies, there are no simple neuropathological, neurochemical, or genetic explanations for psychiatric disorders (Kendler, 2005). The authors of a recent text on neuropharmacology, including Steven Hyman (Professor of Neurobiology at Harvard Medical School and former director of the NIMH), explain, “The hypothesis that dopamine is a direct contributor to the pathogenesis of psychotic disorders has significant weaknesses…. Although pharmacologic manipulation of neurotransmitter systems may exacerbate or ameliorate psychotic symptoms, aberrations in these systems do not necessarily underlie psychotic disorders” (Nestler, Hyman, & Malenka, 2008, pp.
To put it another way, the fact that Tylenol relieves headaches does not mean headaches are caused by a lack of Tylenol. John Haracz, a researcher at the UCLA Brain Research Institute, expresses his concern that what little direct evidence there is for the dopamine hypothesis “is either uncompelling or has not been widely replicated” (Haracz, 1982, p. 455). Yet it is still common to find modern psychology textbooks describing the dopamine hypothesis as “the most widely recognized theory of the neural basis of schizophrenia” (Pinel, 2003, p. 465).

Much of the research supposedly linking schizophrenia diagnosis with genetic factors is fraught with methodological problems (Boyle, 2002). One issue involves researchers using psychiatric hospital populations to sample from. Researchers have noted that MZ pairs concordant for schizophrenia diagnosis are statistically more likely to be admitted to a psychiatric hospital together than are DZ twins concordant for schizophrenia diagnosis (Boyle, 2002; Leonhard, 1980). Thus, when researchers study psychiatric hospital populations, MZ twin concordance rates are likely to be inflated. In addition, no researcher has yet conducted a study in which investigators responsible for interviewing participants were blind to participants’ zygosity (Boyle, 2002). It is not unreasonable to assume that foreknowledge about zygosity would influence findings. This is particularly true when researchers utilize a “schizophrenia spectrum” approach to diagnosis (Boyle, 2002, p. 164). Using this system, researchers can classify twins as concordant for schizophrenia even when both have not received schizophrenia diagnoses. For example, one study included diagnoses of paranoid personality disorder and narcissistic personality disorder, along with many variants of schizophrenia diagnoses, as all belonging to the schizophrenia spectrum (Tienari et al., 1994). Using this system, one twin could be diagnosed with schizophrenia and the other with narcissistic personality disorder, and the pair would be classified as concordant.

Contemporary biological treatments. The biological perspectives, particularly the chemical imbalance explanation, have ushered in a new era of “treatments” for persons diagnosed with severe mental illness, frequently in the form of pharmaceuticals. Those receiving a diagnosis of schizophrenia routinely receive prescriptions for either neuroleptics or atypicals. While the manufacturers of these pharmaceuticals laud their products as the panaceas for psychotic disorders, actual consumers of these drugs use descriptions such as “sheer torture,” “Thorazine fog,” and “drug prison” to characterize their experiences (Breggin, 1991, p. 47). Although the original neuroleptic drugs were hailed as an easier and less costly method of
performing a lobotomy (Whitaker, 2002), the same drugs are marketed today as antipsychotic medications that can help a psychotic patient to “lead a more normal and fulfilling life” (NIMH, 2009, para. 4). However, “the mechanism of action of the neuroleptics is no mystery: clinically the drugs produce a lobotomy and neurologically the drugs produce a lobotomy” (Breggin, 1991, p. 56, emphasis in original).

Many of the accepted modern neuroleptic and atypical medications for severe mental illness diagnoses carry with them severely disabling side effects, including (but not limited to) diabetes, acute dystonia, akathisia, pseudoparkinsonism, and tardive dyskinesia (Morrison, 2008). The prospect of tardive dyskinesia is especially troubling in that “it has no specific treatment. Unless the antipsychotic [neuroleptic] drug is discontinued quickly, tardive dyskinesia can become permanent, persisting even after the medication is eventually stopped” (Morrison, 2008, pp. 82-83). Alternatively, despite encouraging empirical evidence, safe and effective treatments like psychotherapy continue to be either largely ignored (see Karon, 2008a, 2008b; VandenBos, 2008) or seen merely “as an add-on to medication” (NIMH, 2009, “CBT for schizophrenia,” para. 1).

**Link between stigma and biological causal beliefs.** As I have explained both the problem of psychiatric stigma as well as the biological perspective on mental illness, I now will turn to a discussion of how belief in biological causation of mental illness specifically relates to psychiatric stigma. As early as the 1970s, mental illness stigma research had correlated beliefs in biological causation with increased prejudice, perceived dangerousness, and desire for social distance (Dietrich et al., 2004; Fisher & Farina, 1979; Read, 2007; Read & Harré, 2001; Read et al., 2006; Walker & Read, 2002). In one study, undergraduates were enrolled in one of two abnormal psychology classes, one of which was taught by a professor who endorsed biosocial causes of mental illness, and the other of which was taught by a professor who endorsed social-learning causes of mental illness (Fisher & Farina, 1979). According to the results of a subsequent questionnaire, undergraduates’ exposure to a biosocial (versus social-learning) model of mental illness was correlated not only with increased stigma toward persons diagnosed with mental illness, but also with greater use of drugs and alcohol (among the participants themselves) to cope with emotional problems (Fisher & Farina, 1979). In addition, the same participants expressed greater reluctance to seek help for emotional problems from counseling services (Fisher & Farina, 1979). In other words, biological explanation of emotional distress appears to
lead to behaviors aimed at escaping distress through substance use rather than seeking problem resolution.

Read and Harré (2001) found that belief in biogenetic causes of mental illness among undergraduates is correlated with decreased willingness to become romantically involved with a mental patient, or even to live next door to one. The link between biological causal beliefs and desire for social distance also was demonstrated by Dietrich and colleagues (2004), who found, from a general public survey, that participants believing in biological causal factors for schizophrenia (brain disease or heredity) were more likely to express desire to avoid social relationships (e.g., co-worker, childcare provider, neighbor) with persons diagnosed schizophrenic than were participants believing in environmental causal factors (lack of parental affection or broken home). In particular, perceptions of dangerousness and unpredictability of persons diagnosed with severe mental illness are significantly higher among those who adhere to a biological model of causation (Walker & Read, 2002). In a recent general public survey, genetic attribution of mental illness even has been correlated with increased stigma (i.e., greater desire for social distance) toward families of persons diagnosed with severe mental illness, who are viewed as biologically tainted by association (Phelan, 2005). In this study, participants listened to vignettes describing a person who felt others were plotting against him and could read his mind, heard voices when all alone, and secluded himself socially. When the person’s difficulties were described in terms of a genetic problem, participants endorsed a significantly greater desire for social distance from the person’s siblings than if the difficulties were described as non-genetic in nature (Phelan, 2005).

One study demonstrated a correlation between biological causal beliefs of mental illness and harsh physical treatment (Mehta & Farina, 1997). In this study, undergraduates were told they would be completing a learning task with a partner. Participants were divided into three groups: one-third of the participants were made to believe that their partner had a mental disease, one-third were made to believe their partner had past psychosocial problems, and the remaining third believed their partner was “normal”. Specifically, the “mental disease” condition involved describing past nervous breakdowns as “a disease like any other,” affecting “biochemistry” and requiring “taking some medicine” (p. 410). Part of the “learning task” involved administering mild electric shocks to partners who gave incorrect responses. Participants administered more severe electric shocks to their partners in the learning task if told the partner had a mental disease.
as opposed to traumatic psychosocial experiences. The self-report measures in this study indicated that participants were less likely to blame their partners if the partner’s problem was explained in disease terms, but this reduction in blame did not translate better treatment—just the opposite. The researchers succinctly encapsulate this finding: “People evidently do feel they must be kind to those whose illnesses are conspicuous. Yet, the results of the current study suggest that we may actually treat people more harshly when their problem is described in disease terms!” (Mehta & Farina, 1997, p. 415, emphasis in original).

As mentioned previously, a recent study found that psychiatrists endorsed more negative stereotypes about persons diagnosed with schizophrenia than both the general public and non-psychiatrist psychotherapists (Nordt et al., 2006). Specifically, psychiatrists were more willing to use identify words such as “dangerous,” “unpredictable,” “stupid,” “bedraggled,” and “weird” (to name a few) as applying to persons diagnosed with schizophrenia (Nordt et al., 2006, p. 710). This finding is consistent with the link between belief in biological causation of severe mental illness and stigma, as psychiatrists tend be more likely to favor biological treatments for mental illness.

**Current antistigma approaches.** Numerous organizations, including (but not limited to) Mental Health America (MHA), the National Alliance on Mental Illness (NAMI), and the World Psychiatric Association (WPA) are active in efforts to fight stigmatization of persons diagnosed with severe mental illness. The current efforts are clearly helpful in some ways, but appear to be harmful in other ways. I now will describe some of the key strengths and limitations of the current antistigma initiatives, as they are important in terms of implications for the present study.

**Strengths.** Two main strengths of current antistigma initiatives include combating negative stereotypes and increasing contact between the general public and persons diagnosed with severe mental illness. Antistigma programs currently are quite active in combating negative stereotypes concerning persons diagnosed with severe mental illness in the media. For example, both MHA and NAMI recently called for the discontinuation of a Burger King advertisement in which the King mascot was shown being tackled and restrained by mental health workers, who described him as “insane” for offering such low prices on his food products (Hesse, 2010, para. 2). The efforts of these organizations were supported by members of the general public, who were called on my MHA and NAMI to voice their opposition to the advertisement, and the
advertisement was quickly discontinued (Hesse, 2010). NAMI details many similar battles against stigma in the media on the websites Stigma Alerts Archive (NAMI, 2010). The efforts of these groups and their supporters have been effective in promoting the notion that perpetuation of offensive stereotypes will not be tolerated.

Research has shown that contact between members of the general public and persons diagnosed with severe mental illness can be quite effective in reducing stigma, and many programs have chosen to capitalize on this finding (Rosen, Walter, Casey, & Hocking, 2000; Vaughan & Hansen, 2004). This strategy is particularly effective when persons diagnosed with severe mental illness are willing to share their personal narratives regarding their struggles and recovery (Vaughan & Hansen, 2004), which is the basis for NAMI’s In Our Own Voice program (NAMI, 2010b). This program focuses on offering presentations free of charge to various groups, including students, law enforcement officers, and faith communities, from persons diagnosed with severe mental illness. The presentations allow for audience members to ask questions and interact with the speaker to gain a better understanding of the individual as a person (NAMI, 2010b).

**Limitations.** Many researchers and antistigma programs (see MHA, 2009b; NAMI, 2009; Rosen et al., 2000; Vaughan & Hansen, 2004) persist in the belief that encouraging the public to view mental illness as biological in origin (i.e., “an illness like any other”) will decrease stigmatization. It is important to emphasize, as previously stated, that the biological perspective does appear to be effective in reducing blame; unfortunately, the absence of blame is not tantamount to the absence of stigma (Crisp et al., 2000; Lincoln, Arens, Berger, & Rief, 2008; Mehta & Farina, 1997). For example, the same survey that found only 7% of participants believing that persons with schizophrenia were to blame for their disorder also found 70% of participants perceiving persons with schizophrenia as dangerous, and 80% perceiving them as unpredictable (Crisp et al., 2000). When blame is reduced, persons diagnosed with severe mental illness are not seen as responsible for their actions and thus cannot be held morally accountable for them; the problem is seen as physical in nature, as opposed to a weakness in character. However, a biological causal explanation also can have the effect of portraying persons diagnosed with severe mental illness as hopeless and having a poor prognosis, as they have no control over their own well-being (Lincoln et al., 2008).
Empirical evidence continues to show that belief in biological causation does not reduce stigma (see Read, 2007, for a review of this literature); despite this, it is still posited that the biological perspective constitutes “a supportive orientation toward the mentally ill” (Rahav, 1987, p. 67). Mental Health America (MHA), lists possible causes of schizophrenia as “genetics (heredity), biology (the imbalance in the brain’s chemistry); and/or possible viral infections and immune disorders” (MHA, 2009a, para. 3) while also stating that “accurate facts and information” are a necessary component of fighting stigma (MHA, 2009b, “How you can combat stigma,” para. 1). According to this view, spreading the “truth” about schizophrenia has become synonymous with spreading the biological perspective, and the emphasis on biological explanations for severe mental illness has gradually begun to change public beliefs.

Worldwide, the lay public has historically adhered to a belief in psychosocial origins of mental illness. A 1970 review revealed widespread resistance toward belief in biological causation of mental disorder (Sarbin & Mancuso, 1970). However, perhaps due to the efforts of antistigma programs, the proliferation of pharmaceutical advertisements, and the teaching of biologically-based theories in the classroom, the lay beliefs in Western countries are beginning to shift toward the biomedical perspective (Angermeyer & Matschinger, 2003; Dietrich et al., 2004; Jorm, Christensen, & Griffiths, 2005). A 1999 survey showed about 85% of respondents believing in “chemical imbalance in the brain” as a cause for schizophrenia, as well as nearly 70% viewing schizophrenia as a “genetic or inherited problem” (Link et al., 1999, p. 1330).

While it is important to note that stigma toward persons diagnosed with severe mental illness always has existed, the current approach to reduce stigma has actually been shown to exacerbate it. As the biomedical mindset continues to permeate society, it is possible that this will also include increased prejudice, stigmatization, and perceived dangerous of those diagnosed as mentally ill. Thus, harsh treatment and dangerous “remedies” may continue to be allowed to proliferate.

**Possible Explanations for the Link between Stigma and Biological Causal Beliefs**

Despite evidence to the contrary, the biomedical causal explanation of mental illness has been assumed by many to be less stigmatizing because, if mental illness is beyond a person’s control, the person cannot be blamed for it or held accountable for her or his actions (Angermeyer & Matschinger, 2005). There are many explanations that have been offered as to why this perspective is not in fact associated with decreases in stigmatization. For example,
Read (2007) suggests the possibility that people stigmatize persons diagnosed with severe mental illness as a way to avoid threat, or a need “to deny our own fear of ‘going crazy’” (p. 123). Thus, if “the brains of people with schizophrenia are different from the brains of people without the illness” (NAMI, 2009, “What are the causes,” para. 1), the average person with a “normal” brain does not need to fear the possibility of getting the illness. This explanation may be related to the fact that people tend to see “brain disease” as qualitatively different from any other biological disease. As Mullen (1997) points out, “it is rare to see newspaper headlines indicating that an ex-surgical patient or ex-obstetric patient has perpetrated some heinous deed, however headlines involving ex-psychiatric (mental) patients are commonplace” (p. 6). In addition, viewing human distress in terms of biological disorders allows us to distance ourselves from some of the more horrific details of the lives of persons diagnosed with severe mental illness. For example, psychology students often are taught to view the case of the Genain quadruplets as conclusive evidence of schizophrenia’s genetic origins, due to the fact that all four received the diagnosis of schizophrenia. It is less common to hear about the environment these women experienced as children (e.g., complete isolation from other children, physical abuse from their father, constant public scrutiny, etc.) as a possible causative factor (Sarason & Sarason, 2005).

Haghighat (2000) offers another explanation in espousing an evolutionary approach in which persons diagnosed with severe mental illness are stigmatized for purposes of self-preservation, perpetuating survival of the fittest. According to this proposition, humans are driven to discriminate and stigmatize against others in order to ensure greater access to resources for themselves, as well as to protect the gene pool from illness and other undesirable traits (Haghighat, 2000). Consequently, if mental illness is perceived as a biological abnormality, stigmatization is bound to occur. As mentioned previously, genetic attribution of mental illness has been linked with increased stigma toward families of persons diagnosed with severe mental illness, whom people seem to view as biologically tainted by association (Phelan, 2005). Consistent with this theory, persons with certain physical illnesses (e.g., leprosy, cholera, AIDS) also are victims of stigmatization, particularly with regards to social distance (Brakel, 2003; Herek, 1990).

Mehta and Farina (1997) suggest that stigma may result from people viewing the biologically “mentally diseased” as in need of firm guidance and discipline (like children), therefore justifying harsh treatment. As mentioned previously, their study found a willingness
among participants to administer more severe electric shocks to a partner in a learning task if told the partner had a history of mental disease as opposed to traumatic psychosocial experiences. Interestingly, even though more severe shocks were administered to those designated as diseased, participants tended to rate the shocks as more painful when they were administering them to participants designated as psychosocially distressed. Thus, participants were more sensitive to inflicting pain if they viewed distress in psychosocial terms as opposed to disease terms.

The Present Study

The prevalence and dangers of psychiatric stigmatization are well documented, and the finding that the biomedical perspective on the origins of mental illness is associated with higher levels of stigmatization of persons diagnosed with severe mental illness is robust. However, although plausible explanations abound as to why this association may exist, none of the supposed explanations has been investigated. The present study is a qualitative investigation of beliefs, assumptions, and values that accompany the biological viewpoint of the origins of mental illness in an effort to uncover new ways to combat stigmatization of persons diagnosed with severe mental illness. Specifically, I have made an effort to explore what support may exist (if any) for the three possible explanations previously mentioned: avoidance of threat (those diagnosed with severe mental illness are so different from myself that I do not need to fear becoming severely mentally ill myself), evolutionary drives (the gene pool needs to be protected from undesirable traits like severe mental illness), and paternalism (the severely mentally ill, like children, are not fully able to care for their own needs and make their own choices). The aim here is not to generalize findings to the population, but rather to explore what may be true, which can inform future research.

The Researcher’s Perspective

As is likely clear at this point, I am not a proponent of the biological perspective. With regard to persons diagnosed with severe mental illness, I tend to view their difficulties in terms of creative ways of coping with distress. For example, if a person is diagnosed with paranoid schizophrenia, I begin with the assumption that the person has experienced profound interpersonal injury. It follows from this conceptualization that the paranoia serves a protective function in that it creates distance between the person and others, minimizing the potential for further interpersonal injury. When viewed this way, the person’s paranoia seems quite logical.
Thus, I object to the use of terms such as “symptom”, “illness”, and “disorder”, as they denote dysfunction inherent to the person as opposed to dysfunction in the person’s environment that the person is trying her or his best to respond to.

Based on the extant literature, as well as my own observations of the growing popularity and consumption of psychopharmaceuticals and the growing tendency for people to view their distress and the distress of others in terms of illness, I expected to find considerable support for the avoidance of threat explanation for stigmatization. To me, the biological conceptualization of severe mental illness is a convenient way to collectively deny the extent and impact of abuse and suffering that exist in society. It is less frightening to think in terms of genes.

I did not expect much support for the paternalism explanation because paternalism involves caring as a component. I really did not expect my participants to care much. After all, caring can be a form of threat as well; if you care about someone who has been diagnosed with a severe mental illness, you are more likely to feel the pain of knowing that person is suffering. By not caring, one can distance oneself from that pain.

Likewise, I did not expect much support for the evolutionary explanation. It felt unlikely to me that survival of the fittest would be particularly salient for my participants, even at a subconscious level. I felt confident that, because their basic survival needs were being consistently met, they would not be pulled by internal drives to desire for resources to be allocated only to the genetically superior. Also, as I knew my participants would be college freshman, I did not expect childbearing to be a particularly salient issue either. This aspect could reduce the possibility of subconscious concerns about protecting the gene pool.

Method

Participants

A total of 307 Miami University undergraduates (mean age = 18.6) completed a screening questionnaire (Appendix A) in partial fulfillment of a research participation requirement. The screening questionnaire included the Opinions about Mental Illness (OMI) questionnaire (Cohen & Struening, 1962) in order to assess the presence of stigma. Participants responded to the OMI items on a six-point Likert scale, which consisted of “strongly disagree”, “disagree”, “somewhat disagree”, “somewhat agree”, “agree”, and “strongly agree”. In addition, two questions were added to the end that asked whether or not participants agreed with a
biological conceptualization of mental illness, and one question asked if participants would be willing to participate in a follow-up interview for additional course credit.

When deciding which participants I would ask to interview, I excluded participants who did not answer every question asked on the OMI. Also, I excluded non-freshmen, participants who indicated they would not be available for an interview, and participants who did not leave contact information. I selected from participants who endorsed biological beliefs of causation of mental illness, meaning that they responded either “agree” or “strongly agree” to the two items concerning biological causation of mental illness. Also, I only selected from participants who scored over 100 on the OMI items. As there is no universal scoring method for the OMI, the selection of 100 as the cutoff point was somewhat arbitrary. Although it is a low score overall (one that could be achieved by answering “disagree” for every item), choosing this cutoff allowed for including participants who may have scored high on one of the subscales, but low on the others. (As I will explain later on, the OMI subscores appear to be more revealing than the global scores.)

I contacted 10 of the remaining 40 participants to invite them to take part in an interview, allowing one week to respond. For each participant that did not respond, I invited another from the list until I had ten participants to interview. After completing the interviews, I selected four for data analysis based on the richness of their content. Several of the interviews not chosen were rather impoverished, as some of the participants did not elaborate much on their responses to the interview questions.

There are two reasons why I selected an undergraduate population. First, I had a large pool of participants responding to the screening questionnaire. This facilitated the process of acquiring enough persons to participate in the interview phase. Second, although I knew I would not be able to acquire a group of respondents which would be perfectly representative of the general public, I wanted to approximate the general public’s lack of formal knowledge about schizophrenia. Therefore, I recruited freshmen who had had very little, if any, formal instruction about schizophrenia. I wanted to learn about implicit attitudes, not explicit instruction.

**Opinions about Mental Illness Questionnaire**

The OMI was originally developed through multiple factor analysis from a pool of 200 items concerning opinions of mental illness (Cohen & Struening, 1962). Three factors emerged with especially high Pearson correlations. These factors were named Authoritarianism (.86),
Benevolence (.73), and Social Restrictiveness (.60) (Cohen & Struening, 1962). Holmes and colleagues (1999) succinctly describe these three factors, with a variation in the name of the third, as follows:

1. **Authoritarianism**—people with severe mental illness are irresponsible, so their life decisions should be made by others;
2. **Benevolence**—people with severe mental illness are childlike and need to be cared for; and
3. **Fear and exclusion**—people with severe mental illness should be feared and therefore segregated from the community. (p. 447)

While these three factors do not directly correspond with the present study’s three possible explanations of stigma, there are some relevant similarities. The fear and exclusion factor bears some resemblance to both the avoidance of threat explanation and the evolutionary explanation. If one were attempting to deny the possibility of developing a severe mental illness (avoidance of threat), it would make sense that one would want to segregate oneself from persons diagnosed with severe mental illness. Likewise, if evolution drives humans to ally only with the genetically superior, segregation seems a likely outcome. Thus, the outward appearance of stigma in these cases may be the same, but the underlying causes are quite different. The patronization hypothesis seems highly analogous to the benevolence factor at first glance. However, the patronization hypothesis also incorporates some degree of authoritarianism. From this perspective, persons diagnosed with severe mental illness do need to be cared for like children, but also require strict rules and discipline to correct behavior.

Although the OMI was presented in its entirety to participants, only the items which load onto these three factors were included in the analysis (40 items total). Thus, total scores for the OMI had a possible range of 40 to 240. Listings of factors and their constituent items can be found in Appendix B.

There is no universal scoring method in place for the OMI. For the present study, I have provided OMI results in terms of percentages to reflect degree of agreement with stigmatizing statements. For example, based on a six-point Likert scale, the maximum score for the Social Restrictiveness subscale would be 66. The participant would need to respond “strongly agree” (or “strongly disagree” for reverse-scored items) for all 11 items on this subscale to achieve this.
score. If the respondent’s raw score is 19, the corresponding percentage of the maximum possible score figures to approximately 29 percent.

**Interviews**

The interviews consisted of questions concerning attitudes toward persons diagnosed with schizophrenia. Schizophrenia was selected for convenience as a representative of the larger concept of severe mental illness. Schizophrenia also has been shown to elicit higher levels of stigma compared to other mental illnesses (Lincoln et al., 2008).

I aimed the interview questions toward exploring whether or not participants’ beliefs and values were consistent with one or more of the previously discussed explanations for stigmatization. To review, these explanations include avoidance of threat (the severely mentally ill are so different from myself that I do not need to fear becoming severely mentally ill myself), evolutionary drives (the gene pool needs to be protected from undesirable traits like severe mental illness), and paternalism (the severely mentally ill, like children, are not fully able to care for their own needs and make their own choices).

The following questions are representative of topic areas explored in the interviews; I did not necessarily ask them verbatim, and I included additional prompts at times in order to understand the participant’s response or to encourage the participant to say more. Full transcripts of the interviews used for analysis are included in Appendix C.

1. **What comes to mind when I mention the word “schizophrenia”?** What are your first thoughts when I mention schizophrenia? What is a person with schizophrenia “like”? What kinds of behaviors would you expect from such a person?

2. **Have you ever known someone who was diagnosed with schizophrenia or any other mental illness?**

3. **What do you think causes schizophrenia?**

4. **Would you ever date someone with schizophrenia? Live next door? Be friends with?** Why or why not? How would you feel if you found out one of your friends had schizophrenia?

5. **Can a person with schizophrenia lead a fulfilling life? A “normal” life? How would such a person be limited, if at all?**

6. **What is the best treatment for schizophrenia?**

7. **Where did you learn what you know about schizophrenia?**
I intended for the first question to elicit the participants’ automatic, unprocessed reactions toward schizophrenia. I felt the second was important for examining any possible differences in attitudes between persons who are acquainted with someone diagnosed with schizophrenia and persons who are not. For the third, I intended to elicit causal beliefs of the origin of schizophrenia. I used the fourth and fifth sets to seek out the presence or absence of stigmatizing attitudes toward schizophrenia in general, as well as to attempt to explore the underlying reasoning for these attitudes. For example, a belief that a person diagnosed schizophrenic is unlikely to be married could be indicative of an evolutionary perspective (that such a person is unfit to marry) or a patronizing perspective (that such a person is too childlike to make such a commitment). For the sixth, I intended to elicit either stigmatizing or prosocial attitudes, as well as confirmation of causal beliefs (i.e., the participant could claim to endorse a biopsychosocial perspective, but if she or he suggests medication as the best treatment, it could be indicative of a stronger pull towards biological origins). For the seventh, I intended to explore whether participants’ viewpoints were formulated in a deliberate way (e.g., from a previous course with explicit education of a particular viewpoint) or a more implicit way. For example, if the participant responded with “I don’t know” or “I can’t remember”, this could be an indication that the participant’s attitudes were developed based on influences from the media and advertisements on a subconscious level.

I kept the initial questions open-ended and non-directive, so as to attempt to not lead participants to answer in a certain way. Part of my aim here was to see what participants mentioned spontaneously. I asked more specific questions in the second half of the interview to encourage elaboration and explanation subsequent to the initial responses. I asked various follow-up questions depending on individual participant responses and therefore the questions were slightly different for each interview. The chief questions I asked in the second half included the following:

8. Do you think it’s at all possible that you could have a severe mental illness like schizophrenia one day? How would you feel about yourself if you did?
9. How are people with schizophrenia different from people who don’t have schizophrenia?
10. Should a person with schizophrenia ever be a parent? How likely would it be for the child to develop schizophrenia as well? Should people with schizophrenia be sterilized?
11. What are some ways that would help a person with schizophrenia? Can they be reasoned with, or would they respond better to firm rules and discipline?

12. Are people with schizophrenia to blame for their problems? Could they get better if they had enough will power?

I intended to use these remaining questions to probe more closely for evidence of one of the proposed explanations. In terms of the eighth question, for example, overemphatic denial of the possibility could be evidence for the avoidance of threat explanation. If the participant mentioned being helpless and highly dependent on others, the paternalism explanation could be indicated. If the participant described feeling like a burden on society, it could be evidence for the evolutionary explanation. In terms of the ninth question, a participant’s response strongly emphasizing differentness or strangeness could indicate avoidance of threat. For paternalism, I would expect use of terms such as “childlike”, “irrational”, or “naïve”. A response supportive of the evolutionary explanation might include words such as “defective” or “unfit”.

For the tenth question, a paternalistic response might include the reasoning that a person diagnosed schizophrenic would not be able to handle the responsibility of being a parent, while an evolutionary response would likely be more directly focused on passing along defective genes. For the eleventh question, a participant who emphasized firm rules and discipline would give support to the paternalism explanation, while a participant who emphasized separation of the person diagnosed schizophrenic from the rest of society would give support to the avoidance of threat or evolutionary explanations. I felt the twelfth question was important for assessing participants’ thoughts on blame, as this seems to be the one positive outcome of the biological conceptualization that is consistently supported by the literature.

I conducted the interviews in the Psychology Building at Miami University. I selected a room with a couch and several comfortable chairs, as I felt a more casual environment might help participants feel comfortable and non-defensive. The interviews were audio recorded and were transcribed by research assistants.

Data Analysis

After transcription was completed, I read through each of the ten interviews to refamiliarize myself with their content. As mentioned previously, the four interviews I selected for analysis were the ones I judged to be more rich and detailed. The six interviews not selected
did not differ greatly from the four selected in terms of content, but rather in terms of eloquence and elaboration.

After I had chosen four, I examined each transcript for the presence of evidence for any of the stigmatization explanations described in the literature. These proposed explanations served as a framework for my analysis, and I did not look specifically for any possible alternative explanations. I have represented each interview separately with respect to these stigmatization explanations. All participant names have been changed to protect confidentiality. I have included direct quotations from the interviews in each instance. By presenting the words of the participants verbatim, the reader will be able to judge for herself or himself whether or not my interpretations are warranted by the data.

**Ethical Considerations**

I provided participants with a phone number for on-campus student counseling services in the event that participation in this study were to cause any concerns, anxiety, or distress. None of the interview participants showed any signs of emotional distress, although most, to some degree, expressed that they didn’t feel they knew enough about schizophrenia to be able to answer the questions I was asking. I reassured them that I was interested in their initial impressions as opposed to testing their knowledge, and that if they didn’t know an answer, it was perfectly acceptable for them to guess. This encouragement appeared to put them at ease.

From my review of the psychiatric stigma literature, the link between stigma and the belief in biological causation of mental illness was salient to me at the time of the interviews. This fact introduced two ethical issues to my interactions with interviewees. First, how would my background knowledge affect our interaction? Would it be clear to my participants how I felt about these issues, and would that in turn influence their answers? I dealt with this issue by embracing a credulous approach for the interviews. For me, this meant formulating my interview questions in such a way as would convey my curiosity without causing the interviewee to feel defensive. I was vigilant throughout the process to probe in such a way that would invoke participants to explain their position without feeling the need to defend or rationalize their position. I feel that a warm demeanor, as well as occasional encouragement (e.g., “You’re doing great,” “I really appreciate this,” etc.), were quite helpful in this regard.

My second ethical concern had to do with whether or not I should attempt to influence my participants’ perspectives. If I were aware that my participants held viewpoints that could be
potentially harmful toward persons diagnosed with severe mental illness, did I have any obligation to try to educate them on viewpoints less likely to be harmful? Would such an obligation be part of my role as a researcher, or was my role only to observe without overtly attempting to change anything? Before beginning the interviews, had I decided that the latter choice seemed more appropriate, as well as more consistent with my choice of taking a credulous approach. My role was to collect information, not to intervene. However, this position shifted slightly when my participants expressed to me how eager they were to learn more about schizophrenia as a result of our conversation. Based on my own experiences of noticing psychology textbooks and other common resources tending to lean heavily toward biological explanations of schizophrenia diagnosis, I wondered whether or not my participants would even have a chance of exposure to a more psychosocial perspective.

I made the decision to send a few resources by email to my participants. One link was for the International Society for the Psychological Treatments of the Schizophrenias and other Psychoses (ISPS, 2009). The other was for MindFreedom International, an organization which promotes activism for the rights of persons diagnosed with mental illness, and advocates for humane treatment alternatives (MindFreedom, 2009). I also included reference information for two books: *Brain-disabling treatments in psychiatry: Drugs, electroshock, and the psychopharmaceutical complex* (Breggin, 2008) and *Mad in America: Bad science, bad medicine, and the enduring mistreatment of the mentally ill* (Whitaker, 2002). I explained in the email that many resources (e.g., textbooks, websites, pharmaceutical advertisements, etc.) tend to emphasize a medical understanding of schizophrenia and mental illness in general, and that I thought they might be interested in seeing the other side of the debate. I did not state explicitly which side of the debate I adhered to. Although I personally adhere strongly to the psychosocial perspective, my main motivation for distributing these resources was not in the interest of persuading participants to accept my perspective. Rather, I wanted to provide my participants with enough information for them to understand that an alternate perspective exists, and to let them decide for themselves what makes sense to them. Participants were free to choose whether or not to agree with the resources I sent, or indeed, whether or not to read them at all. Because I had completed data collection at the time I distributed these resources, I could be assured that my doing so would not have any impact on my results. In addition, because I had already awarded
research participation credit to my interview participants, I felt confident that they would not feel unduly pressured into accepting my views.

**Results**

Overall scores for all OMI respondents were not particularly high ($\bar{X} = 52\%, \ SD = 7\%$). However, there was some variation in the subscale scores. Participants tended to endorse a higher percentage of items on the Benevolence subscale ($\bar{X} = 70\%, \ SD = 6\%$) than for the Social Restrictiveness subscale ($\bar{X} = 48\%, \ SD = 9\%$) or Authoritarianism subscale ($\bar{X} = 47\%, \ SD = 8\%$).

The four interviewees presented here were 18 year old Caucasian freshmen at the time of the interviews (3 women, 1 man). All four endorsed agreement with the two questionnaire statements concerning biological causation of schizophrenia, in terms of biochemical imbalance as well as genetics. Like the other respondents, all four endorsed a high percentage of items on the Benevolence subscale of the OMI (62% to 77%) and relatively lower percentages on the Social Restrictiveness subscale (30% to 52%) and Authoritarianism subscale (35% to 59%).

**Relevant Themes**

The paternalism explanation was supported by the data across all four interviews, consistent with participants’ relatively high scores on the Benevolence subscale of the OMI. (Because I did not calculate OMI subscores until after completing my thematic analysis of the interviews, I was not predisposed by the OMI results to seek out support for the paternalism explanation.) Participants were reluctant to agree with the idea of explicitly limiting the rights of a person with schizophrenia (in terms of forced sterilization or strict rules and disciplinary actions). Even so, it is evident that they question the ability of person with schizophrenia to care for herself or himself (Beth: “They can’t really be responsible for what they do”) and to live independently (Dawn: “They’d probably need other people there to help them”).

None of the participants believed that a person with schizophrenia should be blamed for their mental illness, which is not inconsistent with previous research findings that attitudes of blame are reduced with individuals who believe in biological causation of mental illness (Lincoln et al., 2008; Mehta & Farina, 1997). What appears to be the case here is that when blame for mental illness is reduced, so is a belief in the individual’s personal agency. Therefore, reduction in blame could very well lead to the belief that a person with severe mental illness is “helpless” (as stated by Beth).
The avoidance of threat explanation received some support from the data as well. Support for the avoidance of threat explanation often related to the participant’s belief in her or his own personal agency as what separated her or him from someone who has been diagnosed schizophrenic. For example, Beth expressed her belief that she was different from a person with schizophrenia because “I don’t have a problem with really getting too overwhelmed inside. I’m pretty big with just making lists and charging through them.” She insinuates here that that a person with schizophrenia would be different because such a person would not have the ability to do these things for herself or himself because of her or his disorder.

The evolutionary explanation was not supported by the data. Participants tended to speak in terms of biological predispositions to schizophrenia. Therefore, they did not express fears about defective genes being passed along, as a predisposition could only be activated by certain environmental circumstances.

I now will describe each interview in more detail. As mentioned previously, I have included verbatim quotations, as well as the complete transcriptions of the interviews (Appendix C) so that the reader may judge the plausibility of my conclusions.

Ann

Ann’s subscale scores on the OMI were 35% for Authoritarianism, 77% for Benevolence, and 36% for Social Restrictiveness. Ann’s interview responses indicated support for the paternalism hypothesis, which asserts that persons with severe mental illness are in need of guidance, structure, and discipline, much like children who don’t know any better. Responding to my query of “What comes to mind when I mention the word schizophrenia?” Ann replied that many people with schizophrenia “walk away from help, and they don’t like to take criticism because they think that people are out to get them.” Ann seemed to imply in this response the notion that people diagnosed schizophrenic are obviously in need of help and criticism, as well as the notion that their feelings of paranoia are unfounded. Additionally, “walk away from help” carries with it the implication that a person diagnosed schizophrenic does not know what is good for her or him, that the person is unable to understand her or his best interests. When I asked if persons with schizophrenia could lead normal lives, Ann indicated that taking “medicines” was necessary: “So if they do that, I think they can…. To lead a normal life, they’re dependent on medication, which is never a good thing.” This indicates the belief that a person diagnosed schizophrenic is unable to be normal without help, this time in the form of pharmaceuticals.
In discussing what life would be like for Ann if she were to develop schizophrenia, she commented that “a lot of people have issues with mental disorders and they don’t understand them a lot of times,” suggesting the attitude that the severely mentally ill do not have insight into their own problems. Despite the fact that Ann would “hate being dependent on medications and things,” she adds, “I would seek help, I hope,” suggesting a belief that a diagnosis of schizophrenia carries with it a high probability of being dependent on others for help, as well as not being able to act in one’s own best interest. As we discussed whether or not a person with schizophrenia could be reasoned with, Ann said, “I think that they can be reasoned with if you try hard enough.” Although she did not advocate for structure and discipline for people with schizophrenia, her response is suggestive of the idea that people with schizophrenia need help from people who will “have a lot of patience” with them”, comparable to the way one would need patience when dealing with a child.

Ann’s responses provided some support for the avoidance of threat hypothesis, which asserts that persons diagnosed with schizophrenia are so biologically different from one that one does not need to be afraid of developing schizophrenia. The theme of differentness was brought into sharp relief as Ann described how people with schizophrenia are different from other people: “It’s just different genes, and I guess in the way that they think and the way that they act.” In other words, due to being biologically different, a person with schizophrenia thinks and acts differently from Ann. Ann clarified her response by differentiating schizophrenia from being physically disabled: “If I couldn’t walk, I could still lead a relatively normal life, because basically your brain functions normally and all of those different things.” In this response, Ann appears to suggest that physical disability is less threatening than schizophrenia would be, and would not prevent her from living a “normal” life. I asked Ann what she thought the best treatment for schizophrenia would be, and she responded, “I guess the only one that I know of is medication, so I guess I’d answer that.” This response implies that the person diagnosed schizophrenic is biologically different from Ann to the point that a biological intervention is the only treatment option that comes to mind. The theme of differentness arose again when I asked Ann if she could possibly develop schizophrenia: “I don’t think so. I mean, I don’t have anyone in my family that I know of that has ever had it…so I don’t think that I could.” As we talked further, the threat being avoided was made apparent: “I’d want to lead a normal life, because I have huge goals that I would want to continue, and I wouldn’t want anything to inhibit that.”
Ann is safe from schizophrenia by virtue of her non-schizophrenic genes, and is therefore safe from the threat of not being able to accomplish her goals in life. Despite Ann’s emphatic assertion that people diagnosed schizophrenic are “still people”, her other responses seem to indicate how threatening she would find the diagnosis for herself.

The evolutionary theory, which suggests that psychiatric stigma stems from a desire to promote survival of the fittest and to protect the gene pool, was not supported. After stating that she would probably not want to date someone diagnosed schizophrenic, Ann added, “I wouldn’t want to be around someone who doesn’t trust me.” Thus, Ann’s aversion seems to be on a more interpersonal level. The evolutionary theory would anticipate a response perhaps indicating a desire to avoid passing on undesirable genes; no such response was given. However, a proponent of the evolutionary explanation may argue that Ann’s aversion is a visceral, survival-oriented response to a person who may be genetically inferior. In response to this rebuttal, I note that Ann did not endorse any aversion to the idea of persons with schizophrenia becoming parents: “If they’re responsible enough to take care of a baby, and to know when to seek help when they need it and different things like that, I don’t see why not.” In addition, Ann was opposed to sterilization of persons with schizophrenia, stating, “That’s just discriminating. That’s like racial or gender discrimination…. They’re still people!” I would argue that these responses are contrary to the evolutionary explanation.

Beth

Beth’s subscale scores on the OMI were 43% for Authoritarianism, 62% for Benevolence, and 47% for Social Restrictiveness. Beth’s interview responses supported the paternalism hypothesis. When asked what a person with schizophrenia would act like, she mentioned “helpless” as one of her responses, adding, “It’s not them controlling what they do, it’s their thoughts. So they can’t really be responsible for what they do.” Her comments are suggestive of the belief that a person with schizophrenia does not have the power to act against the “chaos” inherent in schizophrenia, and thus a person with schizophrenia is not to be held responsible for inappropriate actions. Beth supposed that, if she lived next door to someone with schizophrenia, she would be “concerned with their well-being,” possibly indicating a belief that someone with schizophrenia may not be capable of taking care of his own needs. Deflection of responsibility appears once more as Beth adds, “I hope they would make me aware of [their diagnosis] and if something weird were to happen, I would understand that it’s because of their
schizophrenia...I wouldn’t have to worry what it is because I would know and be able to help them.” Again, inappropriate behavior was excused and there was a desire on Beth’s part to help someone she believes is in need. This theme continued as we discussed the limitations a person with schizophrenia might have in life: “If they lash out at me because of their schizophrenia or something I didn’t do, that would be fine.” When I asked whether strict rules or reasoning would work better in treating someone with schizophrenia, Beth answered, “You can’t really reason with someone if they’re convinced that something they’re hearing is right when it’s not, but at the same time, you can’t just dismiss everything they say that you don’t agree with.” Here, Beth demonstrated her belief that it would not be helpful, for purposes of rapport, to simply dismiss every odd thing a person with schizophrenia says; however, her response indicates the underlying notion that the perceptions of a person with schizophrenia are not “right”, and perhaps the idea that attempting to reason with such a person would be analogous to attempting to reason with a stubborn child.

Beth’s responses suggested inconsistent support for the avoidance of threat hypothesis as well. For example, when asked if she could ever develop schizophrenia, Beth responded, “I don’t really think so…. I don’t have a problem with really getting too overwhelmed inside. I’m pretty big with just making lists and charging through them,” insinuating that a person diagnosed with schizophrenia would be different; she or he would not have the ability to do these things for herself or himself. However, when asked how persons with schizophrenia were different from persons without it, Beth answered, “I don’t think you’d be able to tell unless it was really severe,” signifying a belief that a person diagnosed with schizophrenia is not so completely different from Beth that another person could immediately be able to see a difference between them.

The evolutionary hypothesis was not supported by Beth’s responses. She did not indicate any discomfort with the idea of a person with schizophrenia becoming a parent (“I don’t think just being raised by a parent with schizophrenia would just automatically make a kid have it”), nor did she believe a person with schizophrenia ought to be sterilized to prevent spreading defective genes (“It’s not something you can just catch”). Also, Beth indicated that she would not be in favor of separating people with schizophrenia from the rest of society as she asserted, “You can’t just give up on people and put them in a mental institution.” These responses are not consistent with the evolutionary drives explanation.
Chad’s subscale scores on the OMI were 41% for Authoritarianism, 68% for Benevolence, and 30% for Social Restrictiveness. Chad’s interview responses demonstrated some support for the paternalism hypothesis. His thoughts on what a person with schizophrenia would be like, although not explicitly paternalistic in nature, seem similar to the way in which someone might describe a rambunctious toddler: “I think they would maybe not think about things too much, maybe their initial reaction to act on instinct would be kind of jittery, not being able to sit still.” A hint of paternalism can be seen later on in the interview as we discussed living next door to a person with schizophrenia. Chad envisioned being able to “get used to things happening, too, and you might just start to overlook actions.” There is the hint that inappropriate or odd behaviors could be overlooked because the person with schizophrenia simply doesn’t know any better. Chad did not agree with the idea of sterilizing people with schizophrenia, saying, “I don’t think their right to choose whether or not they want to have children should be taken away from them”; however, he follows up this thought by adding, “In really severe cases of any type of mental illness, your judgment isn’t really clear, but I don’t know, I can’t say that I would want to be responsible for telling someone they’re not allowed to have children just because of something like that.” From Chad’s follow-up response, it seems that he has some doubts about whether a person with schizophrenia is capable of exercising the proper judgment necessary for parenting. Furthermore, it is interesting that he phrases his objection in terms of the fact that he would not want to be “responsible for telling someone they’re not allowed to have children”. Chad seems to not want to make the decision (or deliver the news of it) himself, but it is unclear as to how much he would object to the decision being made by someone else. As we talked about treating a person with schizophrenia, Chad acknowledged feeling unsure as to “how well reasoning would work, but it would be worth a try, I guess. … Maybe you can try and show them other ways of reacting or, I’m not sure. I mean, maybe in more severe cases you would need more structure and stricter rules.” Again, Chad’s words could easily be applied to the behavior of a misbehaving child: reasoning may or may not work, they need to be shown how to act, and strict rules are sometimes necessary. Chad returns to the notion that a person with schizophrenia needs to be shown how to behave appropriately later on in the interview: “If you isolate them, they’ll just continue to act the only way they know
how to.” People with schizophrenia, like children, tend to act on instinct and need guidance in order to act appropriately.

Chad’s responses provided marginal support for the avoidance of threat hypothesis. When asked if it would be possible for him to develop schizophrenia, Chad responded, “It’s not entirely genetics, but it increases your chance maybe. As far as I know, there is no schizophrenia in our family, so I have a much smaller chance of developing something like that, but it is possible, I guess. I hope not.” Although it is clear that Chad would not welcome the prospect of developing schizophrenia (“I hope not”), the thought of it is not threatening enough to lead him to deny the possibility that he could develop schizophrenia. As we discussed ways of helping people with schizophrenia, Chad stated his belief that “somebody who specializes in schizophrenia would probably be able to do more for that person than just anyone,” indicating the possible underlying assumption that people with schizophrenia are so different from normal people that they can only be understood by specialists. However, he adds to his response by saying, “I think anyone wants to be treated like a person, so in some cases treating someone like they have a mental illness could possibly make it worse, or at least make them feel worse.” This statement seems to acknowledge a belief in sharing a common humanity with persons who have schizophrenia, implying that they are not so different after all.

Chad’s responses did not provide much support the evolutionary hypothesis. When asked if a person who has schizophrenia should ever have children, Chad responded, “I don’t think it would be fair to say, ‘No, they can’t,’” and also indicated that having children was a “choice” that should not be taken away from someone who has schizophrenia. In a similar vein, he later added, “Just because the parent has it doesn’t mean the child will have it.” Thus, although he believes it would be possible to pass on a predisposition, the children would by no means be certain to develop schizophrenia. Still, there seemed to be a hint of ambivalence and hesitation as Chad talked about how it would be unfair to tell a person with schizophrenia that she or he could not have children. This hesitation seemed reminiscent of his earlier comments about not wanting to be the one to make the decision to deprive someone of their rights.

Dawn’s subscale scores on the OMI were 59% for Authoritarianism, 77% for Benevolence, and 52% for Social Restrictiveness. Dawn’s interview responses demonstrated some support for the paternalism hypothesis. When asked if a person with a severe case of
schizophrenia could lead a normal life, Dawn answered, “They’d probably need other people there to help them. They’d probably need more people to rely on and they’d probably be less independent.” This response indicates a belief in the inability of a person with schizophrenia to cope independently with his or her struggles. Dawn also believes that a person with schizophrenia may have a lack of understanding of social mores: “They might be limited in socially working with others and understanding things.” Dawn’s mention of “understanding” indicates the attitude that people with schizophrenia don’t know any better. After Dawn expressed that she thought either therapy or medications could be useful in treating schizophrenia, I asked her which might be more effective: “Well, I think it’d be a personal choice.” This implies a belief that a person with schizophrenia has the ability, as well as the right, to make autonomous decisions; however, she also adds, “It depends on the severity of the case…. I would think meds might be easier because if you had a severe case it might be harder to interact with a therapist or someone,” implying that, the more severe the schizophrenia, the less autonomy. Dawn had an ambivalent opinion on whether or not someone who has schizophrenia should ever have children, saying, “Now would be a good time to know if it’s a genetic thing…. I’m not going to say no because I feel if they want to have children they should be able to, but they should think about that if they’re going to have kids….. They should really not take it lightly.” She was hesitant to say “no” outright, but her responses show some clear reservations, especially as she wonders “if they’d be able to raise their kids themselves, like if they were capable of it” with more severe cases. The question of whether or not a person diagnosed schizophrenic could be a fit parent comes into play. Dawn indicated that she would be opposed to forced sterilization, saying, “I don’t think anyone should have to be sterilized unless there is a legit reason, which I don’t even know what would be a legit reason.” She indicated that this procedure also should be a “choice” for the individual to decide. As we talked about ways in which persons with schizophrenia could be helped, Dawn indicated that “people who are going to work with them should really know what [schizophrenia] is so they know different ways to handle it and stuff.” She implies that a person without explicit knowledge of schizophrenia, like herself, would not be able to be helpful; rather, people with schizophrenia need to be “handled” by professionals who know what they’re doing.

Dawn’s responses did not seem to support the avoidance of threat hypothesis. When asked how a person with schizophrenia might act, Dawn answered that a person who did not
know the diagnosed individual well “might not realize that they’re schizophrenic.” Therefore, if it is possible to not even be able to tell when a person is schizophrenic, the person can’t be all that different from you and me. Dawn’s response to the question of whether or not she could develop schizophrenia was mixed. She felt that neither her genetics nor her environment would lead her to develop it, but she did acknowledge the possibility of having schizophrenia “if by chance I got in a severe car accident and had brain damage or something that might…impair my mental stability.” Thus, she believes it is unlikely, but possible.

Dawn’s responses did not indicate much support for the evolutionary hypothesis. She did indicate that persons with schizophrenia “should really not take it lightly” when considering whether or not to have children; however, she did not agree that this is any basis for forced sterilization, as mentioned previously.

Discussion

The Researcher’s Experience

At first, I was somewhat surprised that I did not find more support for the avoidance of threat explanation. Upon further reflection, it seemed possible that perhaps my participants were simply uninformed as to the kinds of traumatic life events that can precede a diagnosis of severe mental illness. After all, they are not mental health professionals and have not (knowingly) been acquainted with anyone receiving a schizophrenia diagnosis. If they were taught that biology is the cause, or, more likely, that a biological predisposition can be expressed upon exposure to some generic traumatic event, then they have not had the same exposure to the kinds of details that mental health professionals encounter that can lead one to recoil in terror. Because they are unaware of the enormity of the threat, they feel less of a need to distance themselves from it.

Furthermore, the participants may have responded differently if I asked them questions about “less severe” diagnoses such as anxiety or depression. Because these diagnoses are more widespread than schizophrenia, the participants may feel more threatened by the possibility that they could someday find themselves diagnosed with either. Thus, they may feel more inclined to avoid any implication of possible weakness of character on their part (blame) and adhere to an explanation that could absolve them of this (biology).

I was heartened to discover how much my participants seemed to care about the well-being of the hypothetical person diagnosed with schizophrenia. As a prime example, when I asked Beth what it would be like to live next door to a person with schizophrenia, her response
was quite touching: “Concerned with their well-being. I hope they would make me aware of it and if something weird were to happen, I would understand that it’s because of their schizophrenia, it’s not just, like, I wouldn’t have to worry what it is because I would know and be able to help them.” After an extensive review of the literature on psychiatric stigma, one almost cannot help but get a somewhat grim picture in one’s mind of these “stigmatizers.” Consequently, I came into this study holding stigmatizing beliefs about my participants, and I apologize for that. Ironically, the notion that benevolent stigma is not really stigma is one of the problems I seek to fight. But when one hears a person describing concern and care for another human being, it can be difficult to keep in mind that concern and caring can be problematic if they function to infantilize their target. Still, this does seem a more desirable problem to tackle. Our goal need not be to teach people to care if that part is already there. Rather, we need only teach people how to care.

Implications

Antistigma programs. The reader should not construe the findings of the present study as any indication that reduction in blame is not generally a good thing. However, it does seem that reducing blame has the unintended consequence of viewing persons diagnosed severely mentally ill as helpless victims. It may be helpful for antistigma programs to consider making a clearer distinction between blame and responsibility in their outreach efforts. For example, the MHA website does acknowledge that schizophrenia is not caused by a lack of willpower, which seems a good way to convey that persons with the diagnosis are not to blame for their troubles (MHA, 2009). However, the website also states that “no cure for schizophrenia exists” (MHA, 2009, “Recovery and Rehabilitation,” para. 1). This statement is somewhat misleading, for although there may be no empirically identifiable “cure” for the diagnosis of schizophrenia, many people can and do recover to the point that they are symptom-free for the remainder of their lives (Harding & Zahniser, 1994; Hopper & Wanderling, 2000; Karon, 2006; Mackler, 2008). Simply stating that no cure exists gives the false impression that schizophrenia is inevitably a lifelong diagnosis. The website also implies that a person with a schizophrenia diagnosis will inevitably require a variety of services “to live a productive and independent life in the community” (MHA, 2009, “Recovery and Rehabilitation,” para. 1). At this point, it could be helpful to mention that many people with schizophrenia diagnoses recover to the point where they no longer need such services, emphasizing personal agency instead of dependency.
As mentioned previously, antistigma groups seem to be quite adept at countering negative stereotypes in the media about persons diagnosed with severe mental illness. Part of the problem may be the dearth of information disseminated to general public about what persons diagnosed with severe mental illness actually are like. In other words, people are told what not to believe without being given any corresponding information on what to believe. People are told how not to act without being given any corresponding information on how to act. Mental illness antistigma campaigns may be helped by learning from physical disability antistigma campaigns. For example, the Judicial Council of California (JCC) has devised an informative pamphlet on disability etiquette which could be used as a model. This pamphlet includes tips such as, “Don’t automatically give assistance. Ask first if the person wants help,” as well as, “Don’t leave persons with disabilities out of a conversation of activity…. Include them as you would anyone else,” and, “They know what they can do and what they want to do” (JCC, 2009, paras. 3, 7). This particular pamphlet briefly mentions “mental disabilities” under the heading “Persons with Hidden Disabilities” (JCC, 2009). While it is encouraging that an effort was made to include persons diagnosed with mental illness in this antistigma effort, it would be an improvement to have pamphlets available which discuss persons diagnosed with severe mental illness as a focus instead of an afterthought.

Antistigma programs could emphasize that, even though a person diagnosed with a severe mental illness is not to blame for her or his struggles, she or he is not a helpless victim. These programs could temper caring attitudes with education about the capabilities of persons diagnosed with severe mental illness to make their own personal choices, and also to recover. It may be especially helpful to disseminate research that clearly demonstrates how many persons diagnosed with severe mental illness do go on to live normal, symptom-free lives without biological interventions (Harding & Zahniser, 1994; Hopper & Wanderling, 2000). Long-term studies on persons diagnosed schizophrenic have shown not only that a majority recover to the point of becoming self-sufficient, but also that those who recover fully are those who have stopped taking psychopharmaceuticals, usually against their physician’s orders (Harding & Zahniser, 1994; Karon, 2006; Mackler, 2008). This is further evidence that persons diagnosed with severe mental illness not only are able to make life decisions in their best interest, but also that they may make better decisions for themselves, in some instances, than “professionals” would make for them.
**Future research.** A replication of the present study with mental health professionals could be helpful in gaining further insight into professional-level stigmatization. It may be particularly revealing to examine how stigmatization may differ between therapists who favor biological causal explanations for severe mental illness and therapists who adhere to psychosocial causal beliefs. Such an investigation may provide additional clues as to how antistigma initiatives could intervene at the professional level. For example, based on the results of the present study, it is possible that therapists who favor biological causal explanations for severe mental illness are more likely to view their clients in a patronizing way. If this is so, the best intervention may simply be education. Like the general public, many mental health professionals and researchers remain unaware of the strong empirical support that exists for nonbiological treatments, and against biological treatments, for persons diagnosed with severe mental illness (Mackler, 2008). Twenty-five years ago, a survey of various mental health professionals revealed that “the respondents felt that the future direction of research in psychiatry lies overwhelmingly in neurochemistry, neurophysiology, and psychopharmacology, with 90 percent attesting to the importance of these areas” (Mirabi et al., 1985, p. 404). When considering the previously mentioned harmful side effects of biological interventions for severe mental illness, as well as the stigma inherent in viewing severe mental illness as biological in nature, it is somewhat surprising that researchers would continue to pursue such treatments so doggedly, especially in light of the promising results of research for psychotherapy with persons diagnosed with severe mental illness (Karon, 2006; VandenBos, 2008). Emphasizing nonbiological interventions for those diagnosed with severe mental illness could have the effect of greatly reducing professional-level stigmatization.

In addition, it could be interesting to explore whether the avoidance of threat explanation may have a greater bearing on professional-level stigmatization than society-level stigmatization. As mental health professionals are more likely to encounter the narratives of distress underlying their clients’ “symptoms” than the general public is, they may be more inclined to employ strategies to avoid their own distress upon hearing such stories. In this way, belief in biological causation could serve a protective function.

When considering the results of the interviews, it is important to consider that responses are in many ways contingent upon the types of questions asked. Future research could investigate rephrasing questions in an effort to glean additional insight into the participant’s
perspective. For example, instead of asking participants about their own beliefs, the researcher could ask participants how they think most people believe. This approach can be used to reduce defensiveness around sensitive issues and decrease the likelihood that the participant will respond based on social desirability issues and demand characteristics (Albrecht, Walker, & Levy, 1982).

Although the evolutionary explanation for stigma was not supported by the present study, the data are not sufficient to conclude that this explanation has no bearing on stigmatization. The questions I selected and the manner in which I asked them could have profoundly affected the answers provided. One aspect that was problematic was my asking the question, “Do you think a person who has schizophrenia should ever have children?” Chad’s response to this was quite ambiguous, especially as he said, “As long as there are treatments for it, at least to manage it, I wouldn’t see where it would be a problem.” It is unclear what Chad means by “treatments” or “manage” in this statement. Is he making a reference to using biological treatments for parent, child, or both, to manage the problems implicit in genetic transmission of schizophrenia? Or is he referring to utilizing psychotherapy as a way to manage the parent’s schizophrenia symptoms so that the parent is able to provide a more stable home environment for the child? More specific questions could be helpful in future investigations, as well as asking the same questions in different ways. Instead of asking whether persons with schizophrenia should ever have children, which is somewhat vague and open to more ambiguous responses, the researcher could ask whether or not it would be ideal for persons with schizophrenia to have children. In addition, the researcher could ask questions specifically around compulsory, society-sanctioned sterilization of those diagnosed schizophrenic as opposed to sterilization in general.

In the present study, I explored what may be true concerning public attitudes toward persons diagnosed with severe mental illness, with respect to etiological beliefs. Future research could explore how etiological beliefs may influence public attitudes toward persons diagnosed with non-psychotic disorders, such as mood or anxiety disorders. One study has indicated that viewing depression as biologically caused may decrease stigmatization toward the diagnosed individual (Angermeyer & Matschinger, 2003). Much more research needs to be done before we can conclude that this is universally true. If the finding continues to be supported, it may be interesting to explore why such a difference exists between depression and schizophrenia in terms of stigma correlates.
Conclusions

Despite the efforts of many to promote the biological conceptualization of severe mental illness as a way to fight stigma, it appears that stigma is likely inherent to the biological conceptualization. The lack of conclusive evidence for biological causation of severe mental illness does not prove that biology is completely unrelated to diagnosis of severe mental illness. However, a good deal of research does show the superiority of nonbiological conceptualizations as opposed to biological conceptualizations, both in terms of stigmatization and in terms of outcomes for persons diagnosed with severe mental illness. The idea of viewing the diagnosis of severe mental illness as “an illness like any other” as a way to reduce stigma is no longer credible. I am hopeful that we may begin to see a shift in the treatment of those diagnosed with severe mental illness from what is most profitable to what is most helpful.
References


Hopper, K., & Wanderling, J. (2000). Revisiting the developed versus developing country distinction in course and outcome in schizophrenia: Results from ISoS, the WHO Collaborative Followup Project. *Schizophrenia Bulletin, 26*, 835-846.


Appendix A

Screening questionnaire presented to all participants

Adapted from Cohen and Struening’s Opinions about Mental Illness (OMI) questionnaire (1962)

Instructions: Please rate your level of agreement with the following statements. Remember that there is no right or wrong answer; the statements are simply a matter of opinion.

1. If parents loved their children more, there would be less mental illness.

<table>
<thead>
<tr>
<th>Strongly disagree</th>
<th>Disagree</th>
<th>Somewhat disagree</th>
<th>Somewhat agree</th>
<th>Agree</th>
<th>Strongly agree</th>
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2. One of the main causes of mental illness is a lack of moral strength or will power.

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<thead>
<tr>
<th>Strongly disagree</th>
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<th>Somewhat disagree</th>
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3. Mental patients come from homes where the parents took little interest in their children.

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<thead>
<tr>
<th>Strongly disagree</th>
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<th>Somewhat agree</th>
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4. Although they usually aren’t aware of it, many people become mentally ill to avoid the difficult problems of everyday life.

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<tr>
<th>Strongly disagree</th>
<th>Disagree</th>
<th>Somewhat disagree</th>
<th>Somewhat agree</th>
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5. The mental illness of many people is caused by the separation or divorce of their parents during childhood.

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<th>Strongly disagree</th>
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6. People would not become mentally ill if they avoided bad thoughts.

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<th>Strongly disagree</th>
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7. People who are mentally ill let their emotions control them; normal people think things out.

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<tr>
<th>Strongly disagree</th>
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<th>Somewhat disagree</th>
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8. If the children of mentally ill parents were raised by normal parents, they would probably not become mentally ill.

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<th>Strongly disagree</th>
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<th>Somewhat agree</th>
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</table>
9. When a person has a problem or worry, it is best not to think about it, but keep busy with more pleasant things.

<table>
<thead>
<tr>
<th>Strongly disagree</th>
<th>Disagree</th>
<th>Somewhat disagree</th>
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</table>

10. Nervous breakdowns usually result when people work too hard.

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<tr>
<th>Strongly disagree</th>
<th>Disagree</th>
<th>Somewhat disagree</th>
<th>Somewhat agree</th>
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<th>Strongly agree</th>
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</table>

11. The patients of a mental hospital should have something to say about the way the hospital is run.

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<tr>
<th>Strongly disagree</th>
<th>Disagree</th>
<th>Somewhat disagree</th>
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<th>Strongly agree</th>
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</table>

12. Mental illness is usually caused by some disease of the nervous system.

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<tr>
<th>Strongly disagree</th>
<th>Disagree</th>
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<th>Strongly agree</th>
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</table>

13. All patients in mental hospitals should be prevented from having children by a painless operation.

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<tr>
<th>Strongly disagree</th>
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<th>Strongly agree</th>
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</table>

14. The small children of patients in mental hospitals should not be allowed to visit them.

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<thead>
<tr>
<th>Strongly disagree</th>
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<th>Somewhat disagree</th>
<th>Somewhat agree</th>
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<th>Strongly agree</th>
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</table>

15. Mental illness is an illness like any other.

<table>
<thead>
<tr>
<th>Strongly disagree</th>
<th>Disagree</th>
<th>Somewhat disagree</th>
<th>Somewhat agree</th>
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</table>

16. It is easy to recognize someone who once had a serious mental illness.

<table>
<thead>
<tr>
<th>Strongly disagree</th>
<th>Disagree</th>
<th>Somewhat disagree</th>
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17. Most mental patients are willing to work.

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<th>Strongly disagree</th>
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<th>Somewhat disagree</th>
<th>Somewhat agree</th>
<th>Agree</th>
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</thead>
</table>

18. Regardless of how you look at it, patients with severe mental illness are no longer really human.

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<thead>
<tr>
<th>Strongly disagree</th>
<th>Disagree</th>
<th>Somewhat disagree</th>
<th>Somewhat agree</th>
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</table>

44
19. Many people who have never been patients in a mental hospital are more mentally ill than many hospitalized mental patients.

<table>
<thead>
<tr>
<th>Strongly disagree</th>
<th>Disagree</th>
<th>Somewhat disagree</th>
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</table>

20. There is something about mental patients that makes it easy to tell them from normal people.

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<tr>
<th>Strongly disagree</th>
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<th>Somewhat disagree</th>
<th>Somewhat agree</th>
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<th>Strongly agree</th>
</tr>
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</table>

21. If people would talk less and work more, everybody would be better off.

<table>
<thead>
<tr>
<th>Strongly disagree</th>
<th>Disagree</th>
<th>Somewhat disagree</th>
<th>Somewhat agree</th>
<th>Agree</th>
<th>Strongly agree</th>
</tr>
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</table>

22. Even though patients in mental hospitals behave in funny ways, it is wrong to laugh about them.

<table>
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<th>Strongly disagree</th>
<th>Disagree</th>
<th>Somewhat disagree</th>
<th>Somewhat agree</th>
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</table>

23. People with mental illness should never be treated in the same hospital as people with physical illness.

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<tr>
<th>Strongly disagree</th>
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<th>Somewhat disagree</th>
<th>Somewhat agree</th>
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<th>Strongly agree</th>
</tr>
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</table>

24. A person who has bad manners, habits, and breeding can hardly expect to get along with decent people.

<table>
<thead>
<tr>
<th>Strongly disagree</th>
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<th>Somewhat disagree</th>
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</table>

25. If the children of normal parents were raised by mentally ill parents, they would probably become mentally ill.

<table>
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<th>Strongly disagree</th>
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<th>Somewhat disagree</th>
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</table>

26. A heart patient has just one thing wrong with him, while a mentally ill person is completely different from other patients.

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<tr>
<th>Strongly disagree</th>
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<th>Somewhat disagree</th>
<th>Somewhat agree</th>
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<th>Strongly agree</th>
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</table>

27. To become a patient in a mental hospital is to become a failure in life.

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<thead>
<tr>
<th>Strongly disagree</th>
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<th>Somewhat disagree</th>
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<th>Strongly agree</th>
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</table>
28. Patients in mental hospitals are in many ways like children.

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<tr>
<th>Strongly disagree</th>
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29. More tax money should be spent in the care and treatment of people with severe mental illness.

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30. Although some mental patients seem all right, it is dangerous to forget for a moment that they are mentally ill.

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31. A woman would be foolish to marry a man who has had a severe mental illness, even though he seems fully recovered.

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32. Anyone who tries hard to better himself deserves the respect of others.

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33. Our mental hospitals seem more like prisons than like places where mentally ill people can be cared for.

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34. People who have been patients in a mental hospital will never be their old selves again.

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35. If our hospitals had enough well trained doctors, nurses, and aides, many of the patients would get well enough to live outside the hospital.

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36. The law should allow a woman to divorce her husband as soon as he has been confined in a mental hospital with a severe mental illness.

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37. The best way to handle patients in mental hospitals is to keep them behind locked doors.

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38. Many patients in mental hospitals make wholesome friendships with other patients.

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39. Although patients discharged from mental hospitals may seem all right, they should not be allowed to marry.

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40. Many mental patients are capable of skilled labor, even though in some ways they are very disturbed mentally.

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41. There is little that can be done for patients in a mental hospital except to see that they are comfortable and well fed.

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42. Many mental patients would remain in the hospital until they were well, even if the doors were unlocked.

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43. Anyone who is in a hospital for a mental illness should not be allowed to vote.

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44. Every mental hospital should be surrounded by a high fence and guards.

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45. Every person should make a strong attempt to raise his social position.

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46. Most women who were once patients in a mental hospital could be trusted as baby sitters.

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47. Most patients in mental hospitals don’t care how they look.

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48. Obedience and respect for authority are the most important virtues children should learn.

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49. College professors are more likely to become mentally ill than are business men.

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50. People who are successful in their work seldom become mentally ill.

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51. There is hardly anything lower than a person who does not feel a great love, gratitude, and respect for his parents.

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52. The death penalty is inhuman and should be abolished.

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53. Every person should have complete faith in some supernatural power whose decisions he obeys without question.

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**Additional questions**

54. Schizophrenia is caused by a biochemical imbalance in the brain.

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55. Schizophrenia is caused by defective genes.

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56. Have you ever been diagnosed with schizophrenia?

| Yes | No |
57. Would you be willing to participate in a follow-up interview to discuss your opinions about mental illness (for additional credit)?

| Yes | No |

58. Do you have any comments you would like to make?
Appendix B

Relevant factors from OMI measure

Authoritarianism

1. There is hardly anything lower than a person who does not feel a great love, gratitude, and respect for his parents.
2. Obedience and respect for authority are the most important virtues children should learn.
3. When a person has a problem or worry, it is best not to think about it, but keep busy with more pleasant things.
4. A heart patient has just one thing wrong with him, while a mentally ill person is completely different from other patients.
5. All patients in mental hospitals should be prevented from having children by a painless operation.
6. There is something about mental patients that makes it easy to tell them from normal people.
7. People with mental illness should never be treated in the same hospital as people with physical illness.
8. Mental illness is usually caused by some disease of the nervous system.
9. If people would talk less and work more, everybody would be better off.
10. Every person should make a strong attempt to raise his social position.
11. It is easy to recognize someone who once had a serious mental illness.
12. Nervous breakdowns usually result when people work too hard.
13. People who are mentally ill let their emotions control them; normal people think things out.
14. Although patients discharged from mental hospitals may seem all right, they should not be allowed to marry.
15. One of the main causes of mental illness is a lack of moral strength or will power.
16. Every mental hospital should be surrounded by a high fence and guards.
17. People would not become mentally ill if they avoided bad thoughts.
18. Every person should have complete faith in some supernatural power whose decisions he obeys without question.
19. A person who has bad manners, habits, and breeding can hardly expect to get along with decent people.
20. The best way to handle patients in mental hospitals is to keep them behind locked doors.
21. Although some mental patients seem all right, it is dangerous to forget for a moment that they are mentally ill.
22. College professors are more likely to become mentally ill than are business men.
23. Regardless of how you look at it, patients with severe mental illness are no longer really human.
24. The patients of a mental hospital should have something to say about the way the hospital is run.

**Benevolence**

1. Even though patients in mental hospitals behave in funny ways, it is wrong to laugh about them.
2. There is little that can be done for patients in a mental hospital except to see that they are comfortable and well fed.
3. Anyone who tries hard to better himself deserves the respect of others.
4. Patients in mental hospitals are in many ways like children.
5. To become a patient in a mental hospital is to become a failure in life.
6. Our mental hospitals seem more like prisons than like places where mentally ill people can be cared for.
7. Although they usually aren’t aware of it, many people become mentally ill to avoid the difficult problems of everyday life.
8. More tax money should be spent in the care and treatment of people with severe mental illness.
9. Although some mental patients seem all right, it is dangerous to forget for a moment that they are mentally ill.
10. Every person should make a strong attempt to raise his social position.

**Social Restrictiveness**

1. A woman would be foolish to marry a man who has had a severe mental illness, even though he seems fully recovered.
2. Although patients discharged from mental hospitals may seem all right, they should not be allowed to marry.
3. People who have been patients in a mental hospital will never be their old selves again.
4. There is little that can be done for patients in a mental hospital except to see that they are comfortable and well fed.
5. The law should allow a woman to divorce her husband as soon as he has been confined in a mental hospital with a severe mental illness.
6. Most women who were once patients in a mental hospital could be trusted as baby sitters.
7. The small children of patients in mental hospitals should not be allowed to visit them.
8. Most patients in mental hospitals don’t care how they look.
9. All patients in mental hospitals should be prevented from having children by a painless operation.
10. Many patients in mental hospitals make wholesome friendships with other patients.
11. Anyone who is in a hospital for a mental illness should not be allowed to vote.
Appendix C
Participant interviews

Ann
E: This is going to be really casual. A lot of these questions you might not know the answer to, but that’s okay. It’s basically just a matter of opinion. I’m not looking for the right answer. I just want to know how you’re thinking, what you think, what your opinion is, what your gut reaction is. So, don’t feel like you have to know any of the answers, okay? So what comes to mind when I mention the word schizophrenia?
A: I think of people who aren’t really in touch with the outside world, they’re kind of like…how do I…they don’t really like to be with people, they think that people are out to get them. Do you want to know what I know about?
E: Yeah, anything!
A: I think that something bad had to happen that they became that way. I think of a video I watched about schizophrenia where a lot of them are homeless and they don’t like to get help.
E: A lot are homeless and don’t like to get help?
A: Yeah, they walk away from help and they don’t like to take criticism because they think that people are out to get them.
E: You said this was a movie you saw?
A: Yeah, in my junior year in psychology class we had a little video thing on it.
E: So it was like kind of a documentary?
A: Yeah, kind of. It just followed people who were trying to help, I think testing for medicines and trying to help them or something.
E: Oh, okay, so was this like a home video that they did themselves?
A: I think…it wasn’t very professional.
E: Okay, so you took undergraduate psychology?
A: Well, I wouldn’t call it a psychology class but we didn’t really do anything in high school.
E: Oh, so this was high school? Ok. But it was a psychology class, but--
A: We didn’t really do much of it at all.
E: Okay. Now how would you expect a person with schizophrenia to act? What would their behaviors be?
A: I guess, I don’t really know if there is lesser cases or anything, but I think of extremes where they kind of annoy people and it takes a long time to trust someone. They’re kind of skeptical of everything. I know of the voices in their head type of thing.
E: Okay. Anything else come to mind?
A: Like how they act and stuff?
E: Yeah.
A: I think it’s just that people are out to get them and they’re always questioning you and that type of thing. I can’t think of anything else, sorry.
E: No, that’s fine, that’s completely fine. I appreciate this. Have you ever known anyone who was diagnosed with schizophrenia?
A: No.
E: How about any other kind of mental disorders?
A: Autism.
E: Okay.
A: At my high school they have the special needs kids with the regular kids, so they’re walking in the hallways and things like that. So I’ve been around them. I mean, I don’t really know any of them personally, but I’ve been around them.
E: Okay. What do you think causes schizophrenia?
A: I think it’s…like, you’re born with some gene or some, I guess it’d have to be a gene where you couldn’t get schizophrenia and then something has to…like some event in your life has to trigger it for you to become schizophrenic.
E: So what kind of event do you think?
A: I would guess something traumatic or something that would be life-changing. And then, I mean not just normal everyday things.
E: But you would have to have the gene first?
A: Yeah.
E: Would you ever date someone if you knew that he had schizophrenia?
A: I probably wouldn’t.
E: Any thoughts on why you would not want to?
A: I think that, like I said, I don’t know much about it, I just know the extreme cases. I wouldn’t want to be around someone who doesn’t trust me, like, that’s part of a relationship.
E: What if it were a next door neighbor? How would you feel about living next door?
A: I’d be fine living next door.
E: What if it were one of your friends?
A: I would probably be friends with them. Or I guess continue to be friends with them.
E: Do you think a person who has schizophrenia can lead a fulfilling life, or a normal life?
A: Yeah, I think they can. I think that there’s different medicines and different things like that that you can take to help you. So if they do that, I think they can.
E: How do you think someone with schizophrenia might be limited in their life?
A: To lead a normal life, they’re dependent on medication, which is never a good thing. I guess they’d have to, like if it’s triggered by something, then they…I guess any big life experience or any big change in their life could trigger it, so I think that that would be a problem.
E: So just the potential to have it triggered again and have it get worse, or…?
A: Well, just someone, if it’s in their genes, like in their family, they could potentially get it. I think different traumatic events, I mean I’m assuming being a doctor and losing someone in surgery or something like that. I’ve known that to trigger other things like depression in people, so I’m assuming that that could be a traumatic event in someone’s life. [inaudible] It depends on how emotionally attached or things like that you can get.
E: What do you think the best treatment for schizophrenia would be?
A: I guess the only one that I know of is medication, so I guess I’d answer that.
E: Okay. And you mentioned this high school class that wasn’t really that great apparently; where else did you learn what you know about schizophrenia, or what you think?
A: We did a little bit of it in PSY 111 here, it’s the class I’m in now.
E: What kinds of things did you go over?
A: One thing I remember is that, to get schizophrenia, the right gene combination has to happen at the right time—or the right person at the right time and the right gene combination. That’s really about it. We didn’t learn about any actions, just how you get it and gender and stuff, I guess.
E: Do you think it’s possible that you could maybe get schizophrenia one day?
A: I don’t think so. I mean, I don’t have anyone in my family that I know of that has ever had it…so I don’t think that I could.
E: If you were to somehow develop schizophrenia, how would that be for you? What would that feel like, how would you feel about yourself?
A: I don’t know. I mean, I’d want to lead a normal life, I guess, because I have huge goals and things like that that I would want to continue and I wouldn’t want anything to inhibit that. I think that, I know a lot of people have issues with mental disorders and they don’t understand them a lot of times, so I think that would be an issue…sort of dating and marrying and friendships and things like that. I think that would be an issue, and I would seek help, I hope, but I hate being dependent on medications and things. It’s just not me.
E: So you mentioned that, in the video, a lot of them didn’t want to take medication, either. Do you think that’s where you would be, where you wouldn’t want to take medication? Or would you have to?
A: I mean, I don’t know how I would act, but I would hope that if I knew that that would help me to lead a normal life, I would hope that I would take the medication.
E: But you wouldn’t like the idea of being dependent on it?
A: I don’t like the idea of being dependent on medication, no.
E: How do you think people who have schizophrenia are different from people who don’t?
A: I guess it’s just different genes, and I guess in the way that they think and the way that they act…I’m not really sure, I only know the extreme cases. I guess that they’re more skeptical and I feel like it would be really, really hard to lead a normal life, but if you had that…and I guess if you tried to get help, I think you could lead a normal life, it’d just be a lot harder to do and you’d have another obstacle to get over.
E: So it would just be more of a struggle?
A: Yeah, I guess like just with like any other disability.
E: So having schizophrenia, would you say, would be similar in some ways as being physically disabled?
A: Kind of. I think…I wouldn’t say physically disabled because I think being—like, if I couldn’t walk, I could still lead a relatively normal life, because basically your brain functions normally and all of those different things. Like, it wouldn’t affect your intelligence level, and different things like that. But I would compare it to if you had a learning disability or another mental disability.
E: Do you think a person with schizophrenia should ever be a parent?
A: Yeah, I think that is something that they’d have to talk to with their spouse or with their family and different things like that, and make sure that…I think it’s the same with any parents. If they’re responsible enough to take care of a baby, and to know when to seek help when they need it and different things like that, I don’t see why not. I think it’s the same as with a history of alcoholism or something like that, if they can control themselves with alcohol then [inaudible].

E: Do you think that there’s chance that the kids could also develop schizophrenia?
A: Yes.
E: Because of the genetic link?
A: Yes.
E: Should people with schizophrenia ever be sterilized in order to prevent spreading those genes?
A: No, I mean that’s just discriminating. That’s like racial or gender discrimination….

E: So, they’re still people like you and me?
A: Yeah, they’re still people! It’s not like….
E: …Okay. What are some of the ways that people with schizophrenia can be helped to live a better life?
A: Medication. I’m sure there’s some sort of counseling, or just depending on different…their family, too, can help them, I guess.
E: Do you think a person with schizophrenia can be reasoned with? Or would they need more rules or a lot of structure and discipline?
A: I think that they can be reasoned with if you try hard enough. Like I said in that video that I watched, they couldn’t talk to them when they had to have a lot of patience and build their trust before they could communicate with them.
E: So they had to be really patient with them and…
A: Yeah.
E: …develop a sense of trust. Why do you think someone with schizophrenia would not be trusting? Where do you think the skepticism comes from?
A: I really have no idea. I mean, that’s the only thing I know that I’ve seen. It’s just the nature of the disease or illness or whatever you call it.
E: Okay. Do you think that people who have schizophrenia, that it’s their fault that they have it, or that maybe it’s their parents’ fault, or…?
A: I don’t think so. I mean, there’s got to be some genetic mutation somewhere that caused that. That’s not always someone’s fault. And then to trigger it, that isn’t always their fault, either. So I’d say no.

E: Do you have anything else that you want to add at this time?

A: (inaudible)

E: Okay, that’s all I’ll need from you today. I’ve got a debriefing form to give to you with some contact information if you ever want to know more information. Thank you so much for participating! I really appreciate your coming in.

A: No problem!

E: I know it’s hard when you don’t know that much about it…

A: Yeah!

E: …but I appreciate you hanging in there! Have a good day!

A: You, too!

Beth

E: This is going to be really casual. Basically, a lot of the questions I’m going to ask are just a matter of opinion. I’m not expecting you to know any of the right answers. There really are no right answers. And a lot of the things I might ask, it’ll be like, “Well, I don’t really know about this at all,” but just give me your gut reaction, whatever your first impression is. No right or wrong answers. So what comes to mind when I mention the word schizophrenia?

B: That it’s inside your head and it’s about not being able to control what you think…just chaos within your mind.

E: Chaos…. Anything else?

B: Just, like, a mangled series of events in your head.

E: What do you think about a person with schizophrenia would act like?

B: Tense. I feel like they would be a bit irritable.

E: Irritable.

B: Helpless. I don’t know, my impression is that schizophrenia isn’t all the time, but you can have like fits of it. So, I just think they’re generally normal, but when they have them, like, it’s not them controlling what they do, it’s their thoughts. So they can’t really be responsible for what they do because their mind is going crazy inside.

E: So sometimes they’re normal, but they get into these episodes, kind of?
B: Yeah. I think schizophrenia is like the voices in your head, and I think once it gets too cluttered, you have to act upon it, or someone with schizophrenia acts upon it. Then they just deal with whatever is going on at that moment, regardless of the situation. Like, if they’re in a meeting and the voices are controlling their head too much, they’ll like lash out on what’s going on inside.

E: So, not really being aware of the situation, just kind of responding to what is going on inside?

B: Yeah.

E: Okay. Have you ever known someone who has been diagnosed with schizophrenia?

B: No

E: How about other kinds of mental illness?

B: I’m pretty sure that my grandma is bipolar. Everyone in my family thinks that she is crazy. And it’s like a personality disorder. She believes her own lies and tries to convince us that her lies are true, and we’re clearly sure that they’re false.

E: Hmm.

B: I think because my grandpa died when he was in his fifties, and she was kind of really religious before that, and then she just became really attention-seeking, and now that she’s old she is attention-seeking, but doesn’t know how to do it like a normal grandma. So she’ll like, I don’t know, like I was just talking to my mom about it the other day. But it’s frustrating for us because she won’t admit it, so we just have to deal with her being crazy.

E: Yeah. Do you know anyone else with any kind of mental disorder?

B: Um, yeah I know other people with mental illness, but not schizophrenia.

E: That’s fine.

B: This one girl I worked with had seizures and I was really good friends with someone who was anorexic.

E: Anorexic. What do you think causes schizophrenia?

B: Um, my first instinct is like some kind of disorder where you can’t filter you thoughts. They just can pile up at once and you can’t deal with them.

E: So do you think it might be kind of like the person never learned how to filter their thoughts?

B: No, I don’t think it’s a learning thing, I think it’s a biological—like, a normal brain has this function that controls only thinking of so many things at once. Schizophrenia, like—oh yeah, now I’m thinking of people with ADD. Yeah, like, they can’t focus on one thing, people with
ADD, and they didn’t learn that way, it just kind of happened to their brain structurally, and I think that’s the same with schizophrenia. There is nothing that they could have done. It just kind of occurs and things can lead to it, maybe.

E: So it’s a problem with their brain?
B: Yeah.
E: Do you think it might be genetic or something they acquire over time like a disease?
B: I think its kind of…I think with a lot of mental diseases, including schizophrenia, you can have a predisposition to it from your genes, but some people might never get it, and some people, depending on how they grow up, might suppress what they think and they already have the predisposition.
E: So they already have the predisposition and something happens to bring it out?
B: Yeah, like their environment, kind of.
E: What in their environment do you think might bring it out?
B: Um…like the way they’re taught to deal with feelings and emotions. I think if you keep stuff in, it becomes too much to deal with and you have to let it out and tell somebody, if you always have that going on you’ll just…like, you can’t let out a thousand things to one person, you won’t know what to focus on.
E: Would you ever date someone with schizophrenia?
B: Um, probably if they were able to manage it.
E: How would you feel living next door to someone with schizophrenia?
B: Concerned with their well-being. I hope they would make me aware of it and if something weird were to happen, I would understand that it’s because of their schizophrenia, it’s not just, like, I wouldn’t have to worry what it is because I would know and be able to help them.
E: How would you feel if you found out that one of your friends had schizophrenia?
B: Um, it would probably just be something that, I don’t think it would change my being friends with them, it would just be something that I would learn about them, because if I was already friends with them I would probably already notice some of the symptoms of it.
E: Do you think a person who has schizophrenia can lead a normal or fulfilling life?
B: Yeah.
E: What kinds of limitations would a person like that have?
B: Well, I think depending on how severe it is, it might limit their relationships with other people and quite possibly their coworkers at their job if it’s really severe. You can’t do your work.
E: How do you think it would affect other relationships?
B: Well, like when you said “would you date someone with schizophrenia,” in my perception of it, if you can kind of get a hold on it, I don’t know if there is medication for it, but if it’s something that’s not going to affect me in a negative way, like if they lash out at me because of their schizophrenia or something I didn’t do, that would be fine. But if it’s so bad that you can’t control and if it affects how you treat someone negatively…
E: So the lashing out…
B: Yeah. I don’t really know how lashing out is in schizophrenia, that’s just what I think of. I just think, like, frustrated in the situation at times, but yeah….
E: Okay. What do you think the best treatment is for schizophrenia?
B: Um, I think it’s a mixture of medication and counseling—well, not counseling, but being able to…well, I guess it is counseling. Just, like, get your thoughts out if you’re really stressed so it doesn’t lead to a big episode.
E: So a combination of the two, medication and counseling?
B: Yeah, depending on…I think there are different levels of severity in it, so if it’s pretty minor, then maybe just one or the other, or a little bit of both.
E: Where did you learn what you know about schizophrenia? Do you remember taking any classes or seeing movies about it…?
B: Um, I think I saw something on TV about it when I was younger. Yeah, I used to watch…somebody important in history had it and then I asked my mom and she said it’s when you hear a bunch of voices. So I was exposed to it on TV and asking my mom.
E: So was it a movie on TV or was it a documentary?
B: It was a documentary, but I don’t remember who it was.
E: Okay. But it was a historical person, so do you remember if it was someone from a few years ago or…
B: It was someone from a long time ago, yeah. I just can’t remember…it was some kind of, like…historical thing where, they were definitely European and that’s all I can tell you.
E: That’s fine. Do you think its possible one day that you could ever develop schizophrenia?
B: Um, I don’t really think so.
E: Why don’t you think so?
B: I guess I never really…I don’t know, I don’t have a problem with really getting too overwhelmed inside. I’m pretty big with just making lists and charging through them and I don’t really like to let things linger for too long, and I think that’s what would develop the schizophrenia.
E: So you feel you’re very organized?
B: Yeah, although I can really procrastinate and I self-talk. It’s just that schizophrenia seems too severe to have a diagnosis for getting really stressed.
E: So you could see yourself getting really stressed, but you don’t think you would get to the same degree…
B: I mean, when I self-talk, it’s like I control it by my own mind. If I have a bunch of stuff to do, I’ll be like, okay I need to do this, this, and this, in my head, but I have never experienced thoughts out of control in my head or that kind of thing. That’s why I don’t think I could get schizophrenia.
E: So you feel like you’re really in control and you don’t have any thoughts that—or rather, you don’t let them control you?
B: I don’t really know how to answer, like, I don’t think that…I don’t control all thoughts that come into my head, but…
E: But you don’t feel out of control?…
B: I mean, at times I’m out of control…it’s kind of weird…it’s kind of confusing because I don’t really know what causes it or…but I don’t know.
E: How do you think people who have schizophrenia are different from people who don’t?
B: I don’t really think you’d be able to tell unless it was really severe and if it were severe…just, I imagine it being a lot more focused on trying to get past whatever episode they’re having. It kind of just takes you through your daily life.
E: Do you think that a person with schizophrenia should ever have children?
B: Yeah.
E: Do you think there’s any risk for the kids to develop schizophrenia?
B: No, I mean, I think it can be in their genetics. I don’t think just being raised by a parent with schizophrenia would just automatically make a kid have it. I mean, one parent could have it and
the other can’t, and being raised by both. And they’re not going to be exposed to the same things as the person with schizophrenia is. They would have to have the exact same… they would have to be raised the exact same way kind of thing. They’ll have different experiences, so they’re not going to develop it like their parent would just automatically being an offspring of someone with schizophrenia.

E: So they might inherit the genes, but unless they’ve got the environment that makes it come out, they’re going to be fine?

B: Yeah.

E: Do you think people with schizophrenia should ever be sterilized to prevent spreading the disease?

B: I don’t think it’s like that, I think it’s more mental. It’s not something you can just catch.

E: So is it something you can get without having the predisposition, or…

B: I mean, I think if something traumatic happened to you, but if no one in your family had schizophrenia, you could develop it. It has to come from somewhere, and if it’s not in your genes, it could be from something horrible that happened to you and you’re just dealing with it later by having a lot of voices in your head.

E: What do you think are some ways that other people can help those with schizophrenia? Do you think it would be better to reason with the person or do you think that someone with schizophrenia would do better with a lot of strict rules and discipline?

B: I think it goes both ways. You can’t really reason with someone if they’re convinced that something they’re hearing is right when it’s not, but at the same time, you can’t just dismiss everything they say that you don’t agree with, like, “Oh, you have schizophrenia, you don’t know where you’re getting that from, you’re wrong.” I guess that’s how people could kind of deal with people with schizophrenia. You have to understand that you can’t just dismiss what you want to if you disagree with them just because they have schizophrenia. You have to actually kind of take in what they’re saying as a person and come to conclusions.

E: Do you think that people with schizophrenia are in some way to blame for the mental problems that they’re having, or that somebody else might be to blame, or nobody? Or several people?

B: I think people might be able to influence. Like, if your mom was super abusive to you or something, like mentally, when you were growing up, she can be to blame, but I can’t really
think of where you could bring it upon yourself. But it would be not just being neglected, but
your mom being, like, really messing with your head and your thoughts.
E: Do you think if the person had enough will power that they could get better if they really
wanted to?
B: In certain situations.
E: Certain situations?
B: Yeah, like going back to severity, if it’s pretty minor, you can either let it progress or just try
and get a hold on it through whatever you need to do, like medication or counseling or just
treatment options versus just sitting and accepting that you have schizophrenia.
E: So do you think that if it’s more severe, there might be less they could do, or…?
B: I think you just have to do a more rigorous treatment. I’m kind of making a comparison to
depression sort of, it just depends. You can let it spiral and get worse, but just because you’re
severely depressed doesn’t mean you’ll never come out of it, like, you’re just going to be
depressed. With schizophrenia, I think you can’t just give up on people and put them in a mental
institution. Even if it’s little steps, you don’t have to be completely cured to be working on
bettering yourself. Just little steps can help in your life.
E: So you don’t have to be completely cured to live a fulfilling life?
B: Yeah.
E: Do you think someone could ever completely be a hundred percent cured?
B: Um, I’m not sure. Like, I know, with just people I know with other mental disorders, once it
affects you, it’s kind of once you got through and experienced it and you have to, like with
anorexia you have to keep in check. They might seem normal now, but they still have to deal
with conflicting thoughts in your head. Like depression, once you get medication and go into
counseling for awhile, you can’t just stop both and say, “I’m cured.” Its just like, I think a
mental disorder is like having a physical body disorder, like if you have diabetes, you can’t just
take insulin once and, “Alright, my diabetes is cured.” You have to continually work on it, it’s
just like a disadvantage some people have.
E: So is there anything else you would like to add, any reactions?
B: Well, when I get home, I’m going to look up what schizophrenia actually is!
E: (Laughs). Okay, well that’s all that I need to ask from you. I have more information here with some contact information if you have any more questions. Thank you for coming in today I really appreciate it.

B: Thank you. Have a good day.

E: You, too!

**Chad**

E: Basically, this isn’t a test. This is very casual. I’m not interested in finding out what you know in a certain area. I’m going to be asking a lot of questions about schizophrenia and mental illness, so this isn’t about what you know. In fact, I’m really more interested in how you feel and what you think, even if it is just a guess. That is completely fine. No right or wrong answers, just based on first impressions. Okay?

C: Alright.

E: The first question I have for you is, what comes to mind when I mention the word schizophrenia?

C: Um, maybe like jerky movements, being scared of things a lot, I guess. I’m really not sure, actually. Kind of always looking around, moving around. Maybe an attempt to know what is around you or what is going on around you, but being uncertain at the same time. I don’t know….

E: You’re doing great!

C: Okay.

E: So kind of trying to understand but not really…

C: Maybe, I don’t know, not being sure of what’s around you, what you’re doing, or why you’re there.

E: So a lot of confusion?

C: Yes.

E: What do you think a person who has schizophrenia would be like? What kind of behaviors would you see? I know you mentioned a few; does anything else come to mind?

C: Maybe, I don’t know, they react to things quickly. Um, I think probably I think they would maybe not think about things too much, maybe their initial reaction to act on instinct would be kind of jittery, not being able to sit still. I’m not sure, I guess that’s all.

E: Have you ever known anyone who has been diagnosed with schizophrenia?
C: I don’t think so. Um, I mean, you see things in movies, but—and that definitely influences opinions, but personally, I don’t think I know anyone. There is a boy at my school, and I’m not sure, he might be schizophrenic. He might be autistic. I’m not really sure what he has, but I don’t think I know anyone.
E: So you don’t know this boy well?
C: Um, in high school, he sat at our lunch table every day. He was in a special program and their lunch period was the same time as ours. I think he was maybe fifteen years old, but he didn’t look like it. He definitely acted much younger. He was really smart. You could teach him things and he would pick up on things really fast. Like, we taught him to count to ten in Spanish and colors, but he was really social. He would walk up to you or a stranger and put his arm around you and say, “Hi, how are you?” So I just knew him from passing him in the hallways, and he would come over and visit during lunch. He just went to everybody’s table and sat down and started talking, so that’s about the extent to which I knew him.
E: Okay. You mentioned also movies; can you think of any movies in particular?
C: Specific?
E: If you don’t have any that’s fine, just if anything comes to mind, like TV shows or movies.
C: I can’t think of anything off the top of my head.
E: Okay. So just in general?
C: In general, yeah.
E: Okay. Have you ever known anyone with any other kinds of mental illness that you can think of?
C: My dad has depression and that’s pretty much my…I mean, I don’t understand it…but that’s pretty much my experience with mental illness because being around him every day and what he’s like and things that affect him. I know people think about mental illness as being crazy and locked up in an insane asylum type of thing, or like mental retardation, but I couldn’t really tell you much about any of those. Just the depression thing is kind of closest to me, so that’s kind of my experience with mental illness.
E: Okay. What do you think causes schizophrenia, if you had to guess?
C: I don’t know. Maybe something in the brain not going right, maybe. I don’t know if it’s necessarily genetic, but it can be like a birth defect kind of thing, maybe something went wrong during development. I don’t think I’ve ever heard of, like, something happening. Most things
I’ve heard of are that you’re born with it or that you develop it at an early age. Though maybe not necessarily that something happens and then you become schizophrenic. I don’t think that’s how it works, but I’m not sure.

E: So not caused by an event, but you kind of have to be born with it?
C: Yeah, or like an event can trigger it, but you would have already had it to some degree.
E: But the predisposition has to be there already?
C: Yeah.

E: Okay. Would you ever want to live next door to someone with schizophrenia? How would you feel about that?
C: I don’t know. I mean, I don’t really think I know enough about it to fairly say, “No, I wouldn’t,” or, “Yes, I would.” I think it would be something that I’d definitely have to get used to, I suppose. I don’t know enough about how schizophrenic people act to say whether that would, I don’t know, necessarily have a harmful effect. I don’t think…I think that I would be willing to try it. Like, I wouldn’t just automatically move away if someone who lived next door was schizophrenic, but I think I would have to see how things worked.

E: What kinds of things would you be concerned about?
C: I don’t know. Um….

E: It’s a hard one, I know. For example, would you fear for your safety? Would you wonder if you would be kept awake at night by weird things?
C: It might be like a disruption kind of thing. I don’t think necessarily fear for my safety, just kind of, maybe weird things going on. I really do wish I knew more about this now.

E: That’s okay. You don’t have to know about it. I’m curious as to know, how would that feel? What would your first impression be? Like, “Oh, I don’t want this person to live here”?
C: It would be kind of weird at first, I think. It would be kind of like, maybe avoid them, but then maybe, not maybe, the more you got to know the person the better things would be. You would understand why they were acting that way, um, and you would be more maybe accepting, too. You might get used to things happening, too, and you might just start to overlook actions, or I’m not sure what.

E: So just kind of the unknown.
C: Yeah, just kind of never being in the experience before, and people in general tend to judge, and you look at somebody and they act different so they’re automatically bad to be around. I
would maybe avoid them just because I was unsure of how to act or how to take things, but I don’t think necessarily avoiding them because I was afraid of them or because they were bad or anything.

E: Okay. Now what about if you were asked out by someone that you knew had been diagnosed with schizophrenia. Would that affect your decision whether or not to go out with someone on a date?

C: I think that regardless of whether they had schizophrenia or not, it would have to be how well I knew the person and if I liked that person, I got along well with them, maybe if we were friends before. I think if something that they did was…I don’t know…I think that if I didn’t agree with…I’m not sure. I don’t think that would be a basis on whether I said yes or no. I mean, it would probably directly affect whether I said yes or not based on their actions, but just the fact that they were diagnosed with schizophrenia alone would not have an effect.

E: Okay, so really it would depend on context?

C: Yeah.

E: Okay. Do you think that a person who has schizophrenia can lead a fulfilling life, a normal life?

C: Like I said, I really don’t know how it affects people, but I think that it’s possible. I don’t know if they’re, well, I’m sure that there’s medication to help that, or therapy. I think it’s possible, given the chance, for anybody to do something with their life, if not lead a perfectly normal life, a somewhat normal life, have some sense of normalcy. Yeah, I think they could.

E: Do you think it would ever be possible for someone who has schizophrenia to recover completely and not have it anymore?

C: I think maybe it would always be there, there could always be something that could happen that could trigger it. I don’t think it could go away completely, maybe, but I think that with treatment you could kind of, I don’t want to say cover it up. I’m not sure how to put it. I don’t know, I think it could kind of be pushed to the side, maybe and not a central part of the person’s life, and not maybe affecting everything that they do, but I think there’s always that chance that it could reoccur in some instances.

E: Okay, so they could manage it to the extent that it wouldn’t affect their every day life.

C: Right.
E: What do you think the best treatment would be for a schizophrenic? I know you mentioned medications and you mentioned therapy.

C: I don’t know. It’s probably different for different people for different degrees of schizophrenia, or I don’t know if there are different types of schizophrenia. I don’t know. I think, I mean that some people respond well to medication and some people don’t. Some people respond well to therapy and some people don’t. Some people, it takes a combination of both. So I think it would depend on the case as to which one would be more effective.

E: Do you have any impressions on which might be more effective more of the time, or do you think they’re both about equal?

C: In general, it seems that medication is more common at least, if not more effective. So I guess I would probably have to say medication over therapy, but I don’t necessarily think it’s better. Maybe it works faster than therapy, therefore it seems to be more effective. But then maybe therapy would be more effective long term because if you’re on medication, as soon as you stop taking it, it will kind of come back.

E: Okay. Now you mentioned that you knew this person in high school, and you mentioned that you’ve seen movies and stuff and TV that kind of would give you impressions about schizophrenia. Can you think of any other ways in which you think have influenced you and the way you think about schizophrenia or other severe mental illness?

C: I think, I know all mental illnesses are different, but I think that a lot of what I think is based off of things that I know about other mental illnesses. For example, what I know about my dad and depression and how things work for depression maybe influences what I think about schizophrenia. I mean, I know different situations and they are different symptoms of different mental illnesses, they affect life in different ways, but I just think that personal experience with depression I’ve kind of maybe generalized it to, if not all mental illness, most mental illness just because I know that can be treated, and that for the most part he can lead a normal life with depression, but tendencies for certain days, like, he has good days and bad days, and just different things upset him and whatever. That kind of makes me think that it is manageable, but it’s still there. It could happen and I know, like I said about the medication, if you’re on it and then off of it, it comes back and just if he forgets to take medicine one day, then the next day is absolutely horrible for him.
E: Did you ever take any classes in high school? I mean, I guess you’re taking 111 right now; have you talked about schizophrenia yet?

C: No, we are just doing basic stuff still right now, like memory and neuro systems, just basic learning and behavior, so we haven’t really gotten into any of that yet.

E: Okay.

C: But it will be interesting when we do. Then I’ll know about schizophrenia!

E: Yeah, a lot of participants have said, “Now I’m going to go look it up.”

C: Yeah, I’m really curious to know about it now.

E: Do you think that it is at all possible that you could develop a severe mental illness like schizophrenia one day?

C: I guess anything is possible. When you have something so complex as your mind, you don’t ever know what’s going to happen. I think that I might be more likely to develop depression instead of something, it’s the things, like I said, the genetic part of it, what runs in the family, and it’s not entirely genetics, but it increases your chance maybe. As far as I know, there is no schizophrenia in our family, so I have a much smaller chance of developing something like that, but it is possible, I guess. I hope not.

E: Do you think a person who has schizophrenia should ever have children?

C: I don’t think it would be fair to say, “No, they can’t.” There are drawbacks to it, but I suppose now they have ways of testing to see if your children are more likely to develop it. As long as there are treatments for it, at least to manage it, I wouldn’t see where it would be a problem.

E: So do you think that there is a possibly that the kids will develop it, or it’s pretty certain that the kids will develop it? What are the chances?

C: I think there is a possibility. I mean, just because the parent has it doesn’t mean the child will have it. Like we talked about, before maybe you have it, but something sets it off, so there’s nothing to say that the child would be in a situation where that would develop. So it is definitely not a certainty that they would have it.

E: Okay. Do you think that people with schizophrenia should ever be sterilized and prevented from having kids?

C: No. I think that is a choice and I don’t think that just because they’re diagnosed with a mental illness, I mean, I don’t think their right to choose whether or not they want to have
children should be taken away from them. Maybe in some cases, in really severe cases of any type of mental illness, your judgment isn’t really clear, but I don’t know, I can’t say that I would want to be responsible for telling someone they’re not allowed to have children just because of something like that.

E: Okay. What do you think are some ways that someone with schizophrenia can be helped to behave better? Do you think it would be better to reason with someone with schizophrenia, or maybe they would do better with really strict rules and a lot of structure? What do you think would be best?

C: I’m not sure. Um, maybe, well, I don’t know how well reasoning would work, but it would be worth a try, I guess. I mean, if you know someone that has schizophrenia, maybe just being around them and figuring out to whatever extent that you can why they act certain ways or what causes certain things to happen, maybe you can’t necessarily prevent that, but you can understand why it happens. Maybe you can try and show them other ways of reacting or, I’m not sure. I mean, maybe in more severe cases you would need more structure and stricter rules and…I’m not sure.

E: That’s fine, you’re doing great.

C: I really do wish I knew more about this. Definitely looking it up.

E: So the more severe it gets, maybe the more structure you’ll need, but try reasoning and really try seeing it from their perspective, try to understand?

C: Yeah, I mean in order to help them in any way, you would have to first of all understand schizophrenia and understand them and then, I mean, the more severe the case, I think the more knowledge you would have to have. I don’t know, I know somebody who understands psychology, somebody who specializes in schizophrenia would probably be able to do more for that person than just anyone, but they just, I think anyone wants to be treated like a person, so in some cases treating someone like they have a mental illness could possibly make it worse or at least make them feel worse. But if you treat them just like another person, it could help them, you could help them and maybe they would feel more normal, so maybe they would act more normal. But if you isolate them, they’ll just continue to act the only way they know how to.

E: So isolation would be bad for someone who had this problem?

C: I think.
E: Do you think people who have schizophrenia are kind of to blame for having schizophrenia, or do you think it’s the parents’ fault, or society’s fault, or the gene’s fault?

C: I don’t think you can necessarily blame a person for being mentally ill. I don’t think that you can put blame on any one person or any one thing. I think it is a combination of things. So maybe they have it, which would be the gene’s fault, and then if your parents treat you differently for it, and like, a bad differently, like there’s something wrong with you, and then that could make it worse and that could be the parents’ fault. And society isolating you…the less they accept you, the more they’re at fault. That doesn’t necessarily mean they have to accept your actions if your actions are not reasonable, or if you could possibly hurt someone in some way, then you can’t just be like, “Well, that’s okay, you’re mentally ill, we’ll overlook that.” There have to be consequences to that, but you don’t necessarily have to assume that just because you’re mentally ill, you can get away with something or you can’t get away with something. I’m not really sure where I was going with that. I don’t think you can place the blame on any one specific thing.

E: Okay.

C: But especially not the person who has it. I don’t think they necessarily said, “Hey, I think I want to be schizophrenic.”

E: Do you think if they really wanted to and had enough will power that they could get better?

C: Maybe not completely, but to some degree, yes. As long as they’re, if their mind allows them to try to get better and they really want to get better, I think that it’s possible. I think some people use it as an excuse. They say they want to get better, but maybe they like being able to say, “Well, I can do this because I have a disorder.” So even though maybe part of them wants to get better, maybe part of them doesn’t because then they won’t have the excuse anymore, but I think maybe if they really work at it and put effort into it, I think they could help themselves to some degree.

E: Do you have anything else that you want to add about anything that we talked about?

C: I don’t think so.

E: Okay. Well that’s all the questions that I have for you. I have the debriefing form here with a little bit of extra information and I’m thinking about putting together a reference list for participants because a lot of people have expressed interest in wanting to know more.

C: Yeah that would be great.
E: That would be okay if I send you resources?
C: Yeah, definitely I think after my math class I’ll go look up schizophrenia in my psychology book. Yeah, that would be wonderful.
E: Well, thank you for coming and being so enthusiastic. This has been really great.
C: Thank you. I don’t know, I like this better than computer surveys.
E: Yeah?
C: You learn something, too, about yourself as well and what you think. I mean, I never really thought too much about schizophrenia before, so…
E: So it was more thought-provoking?
C: Yeah!
E: I’m glad this was enjoyable!
C: Thank you.
E: Have a good day!
C: Yeah, you, too!

Dawn

E: This is going to be really casual, this isn’t a test at all. You might not know the answers to a lot of these questions, and there really aren’t any right or wrong answers. So really what I’m looking for are your opinions, first impressions, initial thoughts. Even if you have to guess, guessing is completely fine and actually encouraged. So no right or wrong answers, no pressure.
D: Okay.
E: So, first of all, what comes to mind when I mention the word schizophrenia?
D: Double personality.
E: Double personality?
D: Yeah, or multiple. Well, the first thing that comes to mind, I always think of the movie Donny Darko.
E: Anything specific about the movie or the behavior?
D: He takes schizophrenia meds in it and he has really weird behavior when he comes out and stuff.
E: What would you expect a person who has schizophrenia to act like?
D: I don’t know, like, they act normal some of the time and then they might just act differently than they usually do some of the time.
E: So normal sometimes, but…
D: Like, normal for themselves sometimes, but different from their normal other times, maybe. Does that make sense?
E: So, when they act different, what kinds of things do you think of?
D: Well, I’d have to know them to know if they were acting different, because I would think they were just acting different from their normal, so it’d be odd for them to act that way.
E: So someone who didn’t know them…
D: Might not realize that they’re schizophrenic.
E: Okay. Have you ever known someone that’s been diagnosed with schizophrenia?
D: No.
E: What about other forms of mental illness?
D: Well, does ADD and stuff count?
E: Whatever you consider a mental illness…
D: Well, people I know have had ADD and ADHD, but other mental illness, I don’t personally know really.
E: Okay, that’s fine. What do you think causes schizophrenia?
D: I guess something with the wiring of their brain or their genes.
E: So it’s something they’re born with, or something they could develop later?
D: Well, I think you could kind of be either one, probably. I don’t know, I’ve never studied schizophrenia or anything, I’m just guessing.
E: That’s fine, guessing is great. How would you feel living next door to someone who has schizophrenia?
D: Well, I feel like, kind of uncomfortable if they had a severe case and did crazy stuff. Otherwise, it wouldn’t really be a big deal, I don’t think.
E: Would you fear for your safety at all?
D: I mean, if they did legit crazy stuff, like, were violent or anything like that, but that’s with anyone. But otherwise, no, not really.
E: Would you ever consider dating someone who had schizophrenia?
D: I mean, maybe, I’ve never known anyone with it, so I don’t know.
E: Do you think that a person who has schizophrenia can lead a normal life?
D: Yeah, if it’s not a super severe case, I would think that they probably could. It might be a little bit harder.

E: How would it be harder?

D: Well, just socially and stuff like that, it may be a little harder for them to work with others.

E: Now what if it’s a really severe case?

D: Then it’d probably harder. They might (inaudible), but they’d probably need other people there to help them. They’d probably need more people to rely on and they’d probably be less independent.

E: Less independent?

D: Yeah.

E: Can you think of any other ways they might be limited?

D: I don’t know. What comes to mind is they might be limited in socially working with others and understanding things, maybe.

E: Do you think they can lead a happy life?

D: Yeah, I don’t think just because you’re schizophrenic means you have to go around angry for your whole life or anything.

E: What do you think the best treatment is for schizophrenia?

D: I don’t even know what the treatments are…like meds, or maybe therapy and stuff.

E: Do you think one might be more effective than the other, or should you always have both?

D: Well, I think it’d be a personal choice. For some people meds might work better, and for others therapy and stuff might work better, so it depends on the severity of the case, I guess.

E: Do you think one treatment might be better for severe cases than another?

D: Well, just guessing, I would think meds might be easier because if you had a severe case it might be harder to interact with a therapist or someone.

E: Do you think that a person that has schizophrenia could ever recover completely and not have schizophrenia anymore?

D: I really have no idea, I mean, I don’t know how exactly you have schizophrenia.

E: Oh, that’s okay. If you had to guess though…

D: To completely recover? I think I want to say no, but it could probably be a lot easier or get a lot better.

E: So it could improve a lot?
D: Yeah, but I don’t know if they could recover because I don’t know a lot about schizophrenia.
E: You’re doing great, I appreciate this. Now, did you take any classes or anything in high school where you learned anything about schizophrenia?
D: I took psychology and we learned about some mental illnesses, but I don’t think we specifically focused on schizophrenia or anything.
E: Do you remember anything that you picked up?
D: Not about schizophrenia, no.
E: You’re in 111 right now—have you talked about schizophrenia at all?
D: We haven’t talked about it.
E: You mentioned Donny Darko. Are there any other movies or things you can think of?
D: Not that come to mind. I’ve seen some, but not that pop up in my mind. I just know Donny Darko because I have it.
E: Can you think of any other sources where you may have learned something about it?
D: I don’t know where I learned about this, maybe just talking, or class discussions, or TV maybe. Because I know it’s multiple personality disorder and stuff like that, but I don’t know….
E: That’s fine. Do you think it’s possible that you could ever have a severe mental illness like schizophrenia one day?
D: I don’t really think so.
E: How come?
D: I don’t know, there’s never been any mental illness in my family on either side, and I have a pretty normal life. I don’t do anything really bad, either. I don’t know, I don’t see anything that would cause it, because my lifestyle wouldn’t, and my genetics probably wouldn’t. So I would guess no, unless I got in an accident I suppose.
E: An accident?
D: If by chance I got in a severe car accident and had brain damage or something that might...impair my mental stability.
E: How would you feel about having schizophrenia, if you found out that you had it?
D: I don’t know because I feel if I had it I’d know something was wrong, possibly, I don’t even know…. I probably wouldn’t be too happy about it because I’m sure things would be harder, and I’d always be labeled (inaudible) schizophrenia, so I’d have a label of having that.
E: Do you think that someone who has schizophrenia should ever have children?
D: Now would be a good time to know if it’s a genetic thing…. I mean, maybe, I don’t know if it runs in families or genes…. I’m not going to say no because I feel if they want to have children they should be able to, but they should think about that if they’re going to have kids. I don’t know if it’s genetic or hereditary, but if it is, then they might want to consider that because their kids could have it or have a higher possibility of having it.

E: So they should consider it if it’s genetic?

D: Yeah, I’m not going to say that they shouldn’t have kids because I feel like they should be allowed to if they want to, but they should really not take it lightly, they should consider like, “Okay, the probability of my kids having it are this, and their lives might be affected by this and,”…that kind of thing.

E: So if it were not genetic at all, what do you think?

D: Then I think it depends on the severity of the case, like if they’d be able to raise their kids themselves, like if they were capable of it.

E: And you mentioned that there’s a chance that the kids could get schizophrenia?

D: I mean, I don’t know if it’s hereditary, but they shouldn’t have kids if their case is so severe that they might not be capable to raise kids, then they should consider that, and if it is genetic, then they should consider the probability of their kids getting it and how that would affect their kids’ lives and probably theirs.

E: Do you think people who have schizophrenia should ever be sterilized?

D: I think that should be a choice.

E: So if they choose to, that’s okay?

D: Yeah, I don’t think anyone should have to be sterilized unless there is a legit reason, which I don’t even know what would be a legit reason.

E: What are some of the ways that people can help persons with schizophrenia? Do you think it’d be better to reason with them, or would it be better if they had more structure and rules to work with?

D: I don’t know that much about the disease, but I think it would definitely help if people were educated about it, and people who wanted to work with them fully understood what it is. So I don’t really know about rules or anything because I don’t know exactly what it is.

E: So people who work with them should know about…
D: Yeah, people who are going to work with them should really know what it is so they know different ways to handle it and stuff.

E: Do you think someone who has schizophrenia is kind of to blame for having schizophrenia, or no?

D: Unless they can get it from somehow doing drugs or something, but I don’t know how it’s caused. But otherwise no, I don’t think anyone should be to blame for mental illness.

E: What about their parents or society?

D: No, I don’t think. I don’t want to say their parents would be blamed for it, but it’d kind of have an impact, like if both parents knew that their kid would have mental illness, maybe they should have considered it, but I don’t think anyone’s at fault because I guess you never know if your kid is going to have a mental illness.

E: But the person themselves is definitely not to blame?

D: No, unless the person did major drugs or something that caused them to get it, because then that’s kind of their fault for that.

E: Okay, is there anything else that you want to add?

D: No.

E: Here’s a debriefing, also some participants have expressed a desire to learn more about schizophrenia. Would you want me to send you some resources?

D: Sure, that’d be great.