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Institutional Labels: A Language-Based Approach to Decreasing Stigma Associated with Schizophrenia and Psychiatric Hospitalization

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INSTITUTIONAL LABELS: A LANGUAGE-BASED APPROACH TO
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ABSTRACT

INSTITUTIONAL LABELS: A LANGUAGE-BASED APPROACH TO
DECREASING STIGMA ASSOCIATED WITH SCHIZOPHRENIA AND
PSYCHIATRIC HOSPITALIZATION

Jaime Grabow

Individuals with schizophrenia that have experienced psychiatric hospitalization are one of the most stigmatized populations of the mental health field. The language that is utilized to describe this population is linked with the perpetuation of stigmatizing attitudes associated with schizophrenia and psychiatric hospitalization. Altering the type of language that is used to describe these individuals can decrease stigma. Participants (N=79) were asked to read a description of a character where the language used reflected either a strength-based approach or a deficit-based approach to schizophrenia and psychiatric hospitalization. The characters are individuals diagnosed with schizophrenia that have recently been discharged from an inpatient unit at a psychiatric hospital. The characters were also described as currently living outside the hospital with outpatient treatment. Participants indicated the degree to which they were willing to interact and engage in social activities with them through a social distance scale. Participants were also asked to fill out a questionnaire regarding their beliefs about schizophrenia and psychiatric hospitalization. The questionnaires were written in either strength-based or deficit-based language depending on condition. There was no significant difference found between the strength-based language (SBL) condition and the deficit-based language (DBL) condition in willingness to engage in social activities with the characters. There was also no significant difference found between the strength-based language (SBL)

condition and the deficit-based language (DBL) condition in stigmatizing attitudes expressed on the belief questionnaire.

DEDICATION

I would like to dedicate this work to my wonderful family and friends who support me in

my education. I would specifically like to thank my parents for their undying love and

support. I would also like to dedicate this work to the many amazing patients that I have

had the pleasure of working with over the years. They are a major source of inspiration

for this study. Their perseverance has inspired me to continue my journey in the mental

health field.

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INTRODUCTION

Mental health stigma is defined by the American Psychological Association (APA) through several different forms. The APA identifies that overall mental health stigma is composed of public stigma, and self-stigma. Public stigma is defined as "the negative or discriminatory attitudes that others have about mental illness" (American Psychiatric Association, 2020, pg 1). Discriminatory attitudes include prejudices, stereotypes and behaviors towards the stigmatized person (Wood et al., 2014). Self-stigma is defined as "internalized shame and negativity that people with mental illness have about their own condition" as well as apprehension of being exposed to stigma (American Psychiatric Association, 2020, pg. 1; Valery & Prouteau, 2020).

In a study conducted by Cechnicki and Angermeyer (2011), the most common experiences of stigma manifest in interpersonal issues that include feelings of rejection and having contact broken off. Experiencing rejection from others is associated with lower education status and more psychiatric hospitalizations, while an overall negative public perception of people with mental illness is associated with unemployment and more psychiatric hospitalizations (Cechnicki & Angermeyer, 2011). It was found that unemployed older, single, females with lower education levels and a family history of mental illness were significantly more likely to become the victims of stigmatizing attitudes (Kinson et al., 2018; Cechnicki & Angermeyer, 2011).

The media is a known player in the stigmatization of people with mental illness, with shows, movies, and news providers often conveying the message that people with mental illness are dangerous (Black & Downie, 2010). The criminal justice system and the courts are also a major source of stigmatization for people with mental illness since

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the decisions made in courtrooms have a strong impact on societal views (Black & Downie, 2010). Surprisingly, people who work directly with people diagnosed with a mental illness also are a source of stigma and discrimination (Kinson et al., 2018). The attitudes of mental health professionals are influenced by their own background, personal experiences and often burnout from their work with clients (Kinson et al., 2018). Negative public attitudes associated with mental illness have also been found to stem from viewpoints that incorporate biological and genetic causes to psychiatric disorders (Wood et al., 2014).

Stigmatizing attitudes and perceptions experienced by people with mental illness can be impairing and have negative effects on the stigmatized individual, their families, the mental healthcare system and society (Cuttler & Ryckman, 2019; Valery & Prouteau, 2020). Mental health stigma is a major contributor to the prolonging of untreated illness (Kinson et al., 2018). High burden related to stigma and discrimination is associated with a poorer clinical state and poorer self-esteem (Zäske et al., 2019). Patients that have a larger social circle, may feel more threatened about losing interpersonal relationships due to mental health stigma (Zäske et al., 2019). Stigma also negatively affects employment opportunities, income level, as well as public views surrounding social benefits and healthcare costs (Valery & Prouteau, 2020). In addition, stigmatization may also lead to discrimination through loss of housing opportunities and denial of societal rights (e.g., inability to hold public office) (Black & Downie, 2010).

Stigmatizing attitudes has been found to differ significantly across psychiatric categories (Valery & Prouteau, 2020). Schizophrenia, a major psychiatric disorder, is especially vulnerable to stigma and discrimination (Kinson et al., 2018). Multiple studies

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demonstrate that schizophrenia is one of the most stigmatized psychiatric disorders by the public, with the highest beliefs of dangerousness, unpredictability, incompetency, poor prognosis, and desire for social distance (Valery & Prouteau, 2020; Wood et al., 2014). People with schizophrenia are more likely than people with any other psychiatric disorder to report experiences of stigma and discrimination, such as verbal abuse and physical abuse (Wood et al., 2014). People diagnosed with schizophrenia usually experience two types of issues related to their illness: the symptoms associated with the disorder, as well as prejudice and discrimination from the public that can be experienced as a "second illness" (Fresán et al., 2018; Valery & Prouteau, 2020). Schizophrenia is associated with the most negative stereotypes, are the least blamed for their illness and are seen as having a very poor prognosis in comparison to anxiety and depression (Wood et al., 2014). People with schizophrenia that are diagnosed with comorbid depression experience higher levels of stigma in contrast to individuals who are diagnosed with their first episode of psychosis or depression alone (Kinson et al., 2018). Among the public, schizophrenia also generates the most negative attitudes and desire for social distance in comparison with autism spectrum disorder or bipolar disorder (Valery & Prouteau, 2020). Stigma and discrimination is frequent for individuals with first episode psychosis and is associated with symptom burden as well as depression severity and level of functioning (Kinson et al., 2018).

A study conducted by Mestdagh and Hansen (2014) found that the mental health care system as well as mental health professionals are a considerable source of stigmatization towards people with schizophrenia. It was found that nurses were more likely to view people with schizophrenia as having a poorer prognosis than people

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diagnosed with borderline personality disorder (Valery & Prouteau, 2020). In addition, it was found that psychologists were more likely to believe that people with schizophrenia were more ineffective and incomprehensible than people diagnosed with borderline personality disorder (Valery & Prouteau, 2020).

There is also a considerable amount of stigma surrounding psychiatric hospitalization. In a study conducted by Xu et al. (2019), people who had experienced psychiatric hospitalization felt more shame, self-contempt and stigma stress and experienced increased self-stigma and reduced empowerment after 1 year since their first hospitalization. There was also more stigma stress associated with poor recovery after 2 years since their first hospitalization (Xu et al., 2019). In an additional study, prior psychiatric hospitalization, longer duration of untreated schizophrenia and higher symptom severity predicted higher rates of self-stigma at the end of a 3 year period (Kinson et al., 2018). Interestingly, people receiving inpatient services in a psychiatric hospital have reported greater perceived stigma as compared to those receiving services in a general hospital or in primary care (Kinson et al., 2018).

Involuntary admissions in particular may have more intense consequences for people with schizophrenia (Xu et al., 2019). Involuntary hospitalization may increase the likelihood that people with schizophrenia feel stigmatized, as it is associated with power exertion and may lead to a decrease in social status (Xu et al., 2019). These individuals may experience shame and embarrassment as a response to having diverged from societal norms, which can affect quality of life (Xu et al., 2019). Being hospitalized could also affect social discrimination as well as the individual's self-stigma, which in turn affects their service use and likelihood of recovery (Fresán et al., 2018). Individuals are more

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likely to experience lowered self-esteem if they have no input into their treatment which can lead to feeling unable to function independently (Xu et al., 2019). Stigma-associated reactions to hospitalization can continue to affect the individual, even after their discharge from an inpatient unit and may have a lasting negative effect on recovery (Xu et al., 2019).

Due to the impacts, it is important to understand how stigma-related responses to hospitalization affect this population (Xu et al., 2019). People with schizophrenia experience stigma differently depending on the phases of illness and treatment type; including inpatient and outpatient treatment (Kinson et al., 2018). Since people with schizophrenia experience more stigma and discrimination than other disorders, they are more likely to be afflicted by stigma if they had been psychiatrically hospitalized (Xu et al., 2019). The areas where these individuals receive the highest amount of reported discrimination includes being shunned by people who knew about their mental health issue, making and keeping friends, discrimination from family, and discrimination from mental health staff (Kinson et al., 2018). In people with schizophrenia that have experienced psychiatric hospitalization, higher levels of stigma are linked to depressive illnesses and lower levels of functioning (Kinson et al., 2018). Multiple inpatient hospitalizations are associated with higher levels of stigma and discrimination, which impacts symptom burden functioning (Kinson et al., 2018). Higher symptom burden is related to increased unfair treatment and decreased ability to overcome stigma (Kinson et al., 2018). Age of illness onset and length of hospitalization can predict perceived stigma and discrimination, with longer length of hospitalization being the strongest predictor (Fresán et al., 2018).

To measure stigma, studies tend to incorporate vignettes or provide measures that ask about "mental illness" (Yanos & DeLuca, 2020). Studies that utilize vignettes have demonstrated the public stigma that is associated with mental illness (Wood et al., 2014). Studies have demonstrated that perceptions of dangerousness for a hypothetical person diagnosed with schizophrenia have increased from 1996 to 2018 (Yanos & DeLuca, 2020). Schizophrenia elicited more negative attitudes, more social distance, and less willingness to help compared to other psychiatric diagnoses (Wood et al., 2014). In addition, there has been an increase in support for the use of hospitalization, for people with mental illness when using a vignette (Yanos & DeLuca, 2020).

Previous anti-stigma interventions have been implemented with minimal positive results. For example, contact involving people with mental illness is a method that has been used to decrease stigma through debunking myths surrounding mental illness (Yanos & DeLuca, 2020). Unfortunately, this approach is not widely accessible to the public and requires one-on-one contact. Many anti-stigma interventions have not been a perfect fit to the mission of decreasing stigma effectively on a wide scale. Investigating stigmatizing attitudes from the public are crucial to developing solutions to decrease discriminatory behaviors (Wood et al., 2014). Anti-stigma interventions that reduce stigma burden and enhance individual empowerment can improve recovery in people with mental illness (Xu et al., 2019). Empowerment towards recovery from serious mental illness should be an objective that involves the increase of social functioning and self-concept (Xu et al., 2019). The right stigma intervention needs to have a sustained commitment and must be implemented on a systematic level (Yanos & DeLuca, 2020).

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By examining the public, it has been shown that perceptions associated with psychiatric disorders are influenced by the words used to describe them and can lead to stigmatizing attitudes (Ashford et al., 2019). According to previous studies, the use of strength-based language is very likely to reduce negative perspectives towards people with mental illness (Gernsbacher, 2017). Strength-based views indicate that recovery from psychosis is possible and attainable (Wood et al., 2014). This could counteract the stigma created by the biological perspective of schizophrenia (which creates a viewpoint of permanent illness), without dismissing the biological etiology of schizophrenia. Many agencies, including the American Psychological Association, endorse the use of strength-based language (also known as person-centered language) in conversations and in documentation (Kinson et al., 2018).

Strength-based language includes the structural framing of language that refers to the person before the disability (e.g. person with schizophrenia) (Gernsbacher, 2017). This contrasts with deficit-based language (also known as identity-first language), which refers to the disability before the person (e.g. "schizophrenic", "autistic", "alcoholic") (Gernsbacher, 2017). Using deficit-based language, as opposed to strength-based language has been found to influence greater stigmatizing attitudes and perceptions towards people with psychiatric disorders (Cuttler & Ryckman, 2019). In previous studies examining public perceptions of substance use disorder, terms such as addict, alcoholic, abuser and junkie can induce stigma (Ashford et al., 2019). Using deficit-based language to describe a person with schizophrenia endorses the perception that these individuals are dangerous and unpredictable and increases the perceived permanence of psychiatric disorders (Cuttler & Ryckman, 2019). Strength-based language is not only

used to refer to an individual's diagnosis, but also used to discuss situations involving their experiences or treatment. For example, the strength-based alternative to "symptomatic" would be "experiencing symptoms." In addition, the strength-based alternative to the phrase "reliant on medication" would be "uses medication as a recovery tool." In a study conducted by Cuttler and Ryckman (2019), it was found that characters with psychiatric disorders that were identified with deficit-based disorder labels were rated worse than those given no label on various trait ratings. Moreover, characters that were labeled using deficit-based language were rated significantly worse on many trait ratings in comparison to characters labeled using strength-based language. These results indicate using strength-based language to describe an individual with a psychiatric disorder may be helpful in reducing stigmatizing attitudes and perceptions (Cuttler & Ryckman, 2019).

The effects of language on stigmatizing attitudes for individuals with various psychiatric conditions can be seen from the study conducted by Cuttler and Ryckman (2019). This same language could also be used to decrease stigmatizing attitudes associated with schizophrenia and psychiatric hospitalization. The current study investigated how utilizing strength-based language in a vignette of a person with schizophrenia that has been psychiatrically hospitalized can influence stigmatizing attitudes. This study also investigated how utilizing strength-based language would decrease stigmatizing beliefs expressed in a beliefs questionnaire that measures attitudes towards schizophrenia and psychiatric hospitalization. It was hypothesized that using strength-based language to describe a person with schizophrenia that has been psychiatrically hospitalized would decrease stigmatizing attitudes measured by social

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distance items. It was also hypothesized that utilizing strength-based language in a belief questionnaire about attitudes towards schizophrenia and psychiatric hospitalization would decrease stigmatizing beliefs expressed in the questionnaire.

METHOD

Design

In this study, there was a manipulation of language used in the vignettes of characters diagnosed with schizophrenia that have experienced psychiatric hospitalization. There was also a manipulation of language used in a belief questionnaire asking about attitudes towards schizophrenia and psychiatric hospitalization. One condition utilized strength-based (SB) language in the character vignettes and belief questionnaire. A second condition utilized deficit-based (DB) language in the character vignettes and belief questionnaire. The participants were randomly assigned to one of the two conditions. Each participant was asked to read one vignette describing a character diagnosed with schizophrenia that was recently discharged from inpatient treatment and is currently involved in outpatient treatment.

Participants

Participants (N=79) were recruited using the undergraduate research SONA pool at St. John's University and were compensated 0.25 SONA credits for completing the survey. The age range of the sample was 17 to 35 years of age with an average age of 19.6. A majority of the sample identified as White (40.5%), with the rest identifying as Hispanic (19.0%), African American/Black (13.9%), Asian (13.9%), or Other (10.1%). Two participants choose not to disclose their race (2.5%). There were two conditions in total, with 35 participants in the strength-based language condition and 44 participants in the deficit-based language condition. Participants that failed the attention checks (n=3) were not included in the final analyses. The final sample consisted of 79 participants (65 females and 14 males).

Materials

Character Descriptions. Each of the target descriptions consisted of a short paragraph describing a person with schizophrenia who was recently discharged from inpatient treatment and is currently receiving outpatient treatment. The character name for each vignette was gender-neutral to avoid any gender-bias. Depending on the condition, the vignette described the person and their experiences using strength-based or deficit-based language (see the Appendix for examples).

Social Distance Items. There are six social distance items that reflect varying degrees of willingness to engage in social activities with the character. Each character was rated on these social distance items in the format of a 6-point scale anchored by definitely unwilling (1) and definitely willing (6). The social distance questionnaire included items such as "work at your job with this person," "move next door to this person" and "trust this person to take care of your child." See appendix for a complete list of items. All the scores on the social distance items were averaged to create each participant's social distance composite score.

Belief Questionnaire Items. There are thirteen Belief questionnaire items that discuss beliefs related to schizophrenia and psychiatric hospitalization. This questionnaire has been derived from elements of the Community Attitudes Towards the Mentally Ill Scale (Taylor & Dear, 1960). The scores on the belief questionnaire were averaged into an overall belief score that represents each participant's stigmatizing attitudes. The scoring of the questions were also organized into several dimensions: Dangerousness Beliefs, Societal Beliefs, and Treatment Availability Beliefs. The participants were also

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asked to provide some information on demographics, current or intended career path, as well as their experience with schizophrenia and psychiatric hospitalization.

Procedure

The entire study was performed on the program Qualtrics. All participants read a consent form and affirmed their willingness to participate in this study. Participants were randomly assigned to the strength-based language condition or the deficit-based language condition. Participants were then asked to read one character vignette and fill out a social distance questionnaire asking them to express their willingness to engage in different activities with the character. The vignettes were written in strength-based or deficit-based language depending on condition. Participants were then asked to answer questions about their beliefs associated with schizophrenia and psychiatric hospitalization. The beliefs questionnaire was written in either strength-based or deficit-based language depending on the condition. The participants were also asked to provide some demographic information and information on their experience with schizophrenia and psychiatric hospitalization. They were also asked to provide information on school major, and intended career path. After the participants had completed the survey, they were debriefed on the purpose of the study.

The social distance composite scores and the belief composite scores served as the main dependent measures. An alpha level of .05 was used for all statistical tests.

Social Distance Items

The ratings on the social distance items were averaged to create a social distance composite score. Examples of social distance items were "work at your job with this person," "move next door to this person," and "trust this person to take care of your child." A t-test assuming equal variances was conducted on the social distance composite score means to compare the two conditions. The t-test revealed that there was no significant difference between the strength-based language condition (M=3.96, SD=1.10) and the deficit-based language condition (M=3.81, SD=0.95), in willingness to engage in social activities with the characters, $t(77)= 0.68$, $p =0.50$. The means are listed in Table 1. Further investigation revealed that participants who had a friend and/or family member diagnosed with schizophrenia had significantly more favorable social distance composite scores than participants who did not have a friend and/or family member diagnosed with schizophrenia (p=.045).

Stigmatizing Belief Questionnaire

The ratings on the belief questionnaire were combined to create a stigmatizing belief composite score. The scores for questions (1,3,4,5,6,&11) were reverse coded. A t-test revealed that there was no significant difference between the strength-based language condition (M=2.23, SD=0.59) and the deficit-based language condition (M=2.42, SD=0.32), in expressing stigmatizing beliefs on the belief questionnaire, $t(77)= -1.27$, $p =0.21$. The means are listed in Table 1. The ratings on the belief questionnaire were also

organized into several dimensions: Dangerousness Beliefs, Societal Beliefs, and Treatment Availability Beliefs. A t-test was performed for the subcategories of dangerousness beliefs, societal beliefs, and treatment availability beliefs, between conditions. The difference between the strength-based language condition (M=2.52, SD=0.58) and the deficit-based language condition (M=2.81, SD=0.39) for dangerousness beliefs was approaching significance but had not reached statistical significance, t(77)= -1.89, p =0.06. There was no significant difference between the strength-based language condition (M=1.96, SD=0.58) and the deficit-based language condition (M=1.93, SD=0.31) for societal beliefs, t(77)= 0.26, p =0.80. There was no significant difference between the strength-based language condition (M=2.14, SD=1.23) and the deficit-based language condition (M=2.43, SD=0.86) for treatment availability beliefs, t(77)= -1.26, p =0.21. These means are listed on Table 2.

Further investigation revealed that males expressed significantly more stigmatizing beliefs on the beliefs questionnaire then females (p=.001). Participants who are psychology majors or minors expressed significantly less stigmatizing beliefs than non-majors or minors (p=.001). Participants who had been psychiatrically hospitalized in the past expressed significantly less stigmatizing beliefs that those who had not been psychiatrically hospitalized (p=.007). Participants who plan to work in the mental health field expressed significantly less stigmatizing beliefs than participants who do not plan to work in the mental health field (p=.003).

DISCUSSION

The results of this study are not completely consistent with some of the previous research that demonstrates the benefits of strength-based language in decreasing stigma; although there are studies that suggest there are minimal or no benefits to using strength-based language. As mentioned by Cuttler and Ryckman (2019) studies have not yet determined conclusively that deficit-based language is more deleterious than strength-based language because the scenarios vary across disorders. Strength-based language is used widely among different agencies and endorsed by the American Psychological Association; however, there are several groups who object to the use of strength-based language and argue that it does not treat everyone as a person first (Gernsbacher, 2017). Some scholars argue that strength-based language may actually promote stigma by "overcorrecting" the language to the extent of further stigmatization (Cuttler & Ryckman, 2019; Gernsbacher, 2017). Interestingly, strength-based language is used considerably more frequently to refer to people with disabilities than to refer to people without disabilities, which may contribute to the promotion of further stigma (Gernsbacher, 2017). As suggested by the American Speech Hearing-Language Association, referring to all persons, both those with and without disabilities with strength-based language may correct this issue (Gernsbacher, 2017). In contrast, many authors, editors, organizations, patient advocacy groups, and scholarly journals suggest embracing deficit-based language (also referred to as identity-first language) for both people with and without disabilities (Cuttler & Ryckman, 2019; Gernsbacher, 2017). It has been found that identifying with a disability is associated with an increase in well-being, self-esteem, and quality of life for many different disability groups, which contributes to why identify-first

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language is often preferred (Gernsbacher, 2017). Therefore, it is important that individuals with psychiatric disorders be asked about their preferences for labels, so the use of these preferred labels can be respected (Cuttler & Ryckman, 2019).

It is also important in the pursuit of finding an effective anti-stigma intervention to recognize that stigma involves more than labeling and stereotypes (Cuttler & Ryckman, 2019). There are many factors that contribute to the formation and maintenance of stigmatizing attitudes; however, language may only play a small part in that stigma or interact with other major components of stigma. For example, the perspective that psychiatric disorders are primarily caused by a biological or genetic factor contributes to attitudes that exaggerate the seriousness, persistence, and differentness of a disorder (Cuttler & Ryckman, 2019). Therefore, it may be beneficial to create an intervention that balances these viewpoints but does not take away from the biological etiology of some of these disorders. Similarly, the use of a dimensional model for psychiatric disorders (ranging from low to high severity and/or few to many symptoms) may reduce stigma in comparison to the categorical model that is used by the DSM (Corrigan et al., 2017). Research regarding the implementation of the dimensional model and its effectiveness at decreasing stigma may be helpful in forming an effective anti-stigma intervention.

A possible limitation of the current research includes that the subject pool consisted of participants from the undergraduate research SONA pool at St. John's University. Some of these participants likely rushed through the survey or were working on multiple tasks at once. Thus, the manipulation in the study may have been less impactful with some of these subjects. This study incorporated one attention check in the

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beliefs questionnaire, but did not incorporate any for the social distance items. More attention checks may have been helpful in recognizing these participants. In addition to this limitation, reacting to brief descriptions of the characters may have not been effective in demonstrating the language framing. Instead of a brief one paragraph vignette, the description could have included a more extensive description of the characters (perhaps a page long). Participants may have also been hesitant to give extreme ratings on the basis of a paragraph of information (Cuttler & Ryckman, 2019). It is important to note that the small number of male participants in this study may also have affected the results since males typically hold more stigmatizing attitudes. Future researchers could also conduct a similar study with an in-person administration employing live confederates who are introduced by their name and a strength-based or deficit-based label only to assess implicit biases or body language (Cuttler & Ryckman, 2019). Lastly, this study was conducted during the COVID-19 pandemic; therefore, items related to social distance may have been affected.

Future studies should also investigate if there are the effects of strength-based language on stigma from staff and services providers in community mental health clinics and hospitals. Considering that these providers are a major source of stigmatization for people with mental illness and that they are using strength-based language in their practice, it would be helpful to see if the language change is effective in altering the perspectives of service providers. Investigating if there are effects of strength-based language on self-stigma for people with mental illness should also be examined, as it was revealed that participants who had been psychiatrically hospitalized in the past expressed significantly less stigmatizing beliefs that those who had not been psychiatrically

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hospitalized. Perhaps this population is more affected by the language type than groups who have no prior experience with psychiatric hospitalization. The expansion of this study is necessary to understand the full impact of strength-based language since it is so widely used in the mental health field. If the results of future endeavors demonstrate that there is no effect, then the discontinuation of strength-based language should be investigated and considered.

Table 1
Composite Means by Condition

Condition	Composite Means	
	Social Distance Composite	Belief Questionnaire Composite
SBL	3.96	2.23
DBL	3.81	2.42

Note. A higher number for the social distance composite mean indicates less stigmatizing attitudes. A lower number for the belief questionnaire composite mean indicates a more positive rating. DBL = deficit-based language, SDL = strength-based language.

Table 2
Belief Questionnaire Sub-Categories by Condition

Condition	Subcategories		
	DB	SB	TAB
SBL	2.52	1.96	2.14
DBL	2.81	1.93	2.43

Note. A higher number indicates more stigmatizing attitudes. DBL = deficit-based language, SDL = strength-based language, DB= Dangerousness Beliefs, SB= Societal Beliefs, TAB= Treatment Availability Beliefs.

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Character Vignettes:

Strength-Based Language Description

Sam is a person with schizophrenia that has recently received psychiatric inpatient services for the first time. After Sam began experiencing symptoms, Sam was brought to the local hospital to receive more support on the inpatient unit. Sam has since returned home. Sam has chosen to work with the recovery team to find medications that would work best as a tool to promote and sustain wellness. Sam currently lives independently in a one-bedroom apartment and has been participating in individual counseling and wellness groups offered at the local outpatient clinic. When Sam is experiencing symptoms, Sam reaches out to others for support and companionship. Sam is working with the recovery team to find alternatives to hospitalization for the future.

Deficit-Based Language Description

Sam is a schizophrenic that has recently been hospitalized at a psychiatric unit for the first time. After Sam became symptomatic, Sam was brought to the local hospital and admitted into the inpatient unit. Sam has since been released and is now back at home. Sam has been compliant with the treatment team and is reliant on medication to stay stable. Sam currently lives alone in a one-bedroom apartment and attends individual and group therapy in outpatient treatment. When Sam is symptomatic, Sam talks to peers in order to manage any negative emotions. Sam is currently working with the treatment team to stay out of the hospital.

Social Distance Items:

Work at your job with this person?
Work on a project with this person?
Move next door to this person?
Make friends with this person?
Rent a room with this person?
Allow this person to take care of your pet?
Allow this person to take care of your child?

Strength-Based Language Statements:
1. We need to adopt a far more tolerant attitude toward people with schizophrenia in our society.
2. I would not want to live next door to a person with schizophrenia.
3. Residents should support the idea of mental healthcare facilities in their neighborhood to serve the needs of the local community.
4. People with schizophrenia should not be treated as outcasts of society.
5. People with schizophrenia should be excluded from taking public office.

6. People with schizophrenia should not be denied their individual rights.
7. Mental healthcare facilities should be kept out of residential neighborhoods.
8. Most people with a history of schizophrenia can't be trusted as babysitters.
9. As soon as a person shows symptoms of schizophrenia, they should be hospitalized.
10. People with schizophrenia should be isolated from the rest of the community.
11. People with schizophrenia are less of a danger than most people suppose.
12. Locating mental healthcare facilities in a residential area downgrades the neighborhood.
13. Locating mental healthcare facilities in residential neighborhoods endangers local residents.

Deficit-Based Language Statements:
1. We need to adopt a far more tolerant attitude toward schizophrenics in our society.
2. I would not want to live next door to a schizophrenic.
3. Residents should accept mental hospitals in their neighborhood to serve the needs of the local community.
4. Schizophrenics should not be treated as outcasts of society.
5. Schizophrenics should be excluded from taking public office.
6. Schizophrenics should not be denied their individual rights.
7. Mental hospitals should be kept out of residential neighborhoods.
8. Most schizophrenics can't be trusted as babysitters.
9. As soon as a schizophrenic becomes symptomatic, they should be hospitalized.
10. Schizophrenics should be isolated from the rest of the community.
11. Schizophrenics are less of a danger than most people suppose.
12. Locating mental hospitals in a residential area downgrades the neighborhood.
13. Locating mental hospitals in residential neighborhoods endangers local residents.

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