Dispelling the Stigma of Schizophrenia: What Sort of Information Is Best?

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Abstract

This study investigated what type of information reduces stigmatization of schizophrenia. Subjects were presented with one of six varying descriptions of a hypothetical case in which a target individual had recovered from a mental disorder. Subjects were asked if they knew someone with a mental illness. Those individuals who had no previous contact perceived the mentally ill as dangerous and chose to maintain a greater social distance from them. In general, knowledge of the symptoms associated with the acute phase of schizophrenia created more stigma than the label of schizophrenia alone. In contrast, more information about the target individuals post-treatment living arrangements (i.e., supervised care) reduced negative judgments. Implications for public education and future research are discussed.

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Individuals who suffer from a chronic mental illness carry the additional burden of being labeled as "different" by the general population. Reviews of the literature on community attitudes suggest that individuals with a mental illness are viewed by others with distaste and fear (Johannsen 1969; Rabkin 1974; Link et al. 1987). Such negative perceptions have a number of implications. Specifically, family members of individuals with a chronic mental illness report that stigmatization lowers the identified patient's self-esteem, contributes to disrupted family relationships (Wahl and Harman 1989), and adversely affects employability (Olshansky et al. 1958; Farina and Felner 1973; Link 1982) as well as opportunities for Federal and other financial support. This point was recently made by Braff (1992) in his discussion of psychosocial treatment: "Unfortunately, this cost-effectiveness analysis is necessary because psychiatric patients in general, and psychotic patients in particular, are terribly stigmatized, and their care is underfunded in our society" (p. 37).

Labeling can produce stigmatization in the absence of aberrant behavior (Farina and Ring 1965; Farina et al. 1968; Piner and Kahle 1984). This finding has important implications for individuals whose mental illness is in remission. For example, such individuals may be shunned and looked upon with derision, even if their behavior is "normal." Might similar reactions occur if previous symptomatology (i.e., acute symptoms) is known about individuals presenting with appropriate behavior? If this is the case, then awareness of past symptoms may, in fact, increase the social barriers between the recovered individual and his or her community.

The foregoing suggests that the consequences of having the label "mentally ill" can culminate in making the environment an adverse one for the recovering individual. As noted by Link (1982) "...a negative label, through a series of reinforcing conditions, seems likely to increase environmental stresses such as job loss or rejection of would-be marriage

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partners, reduce access to social supports, and generate tentativeness and lack of confidence that undermines an individual's usual means of coping" (p. 213). Thus, consistent with the diathesis-stress model of schizophrenia (i.e., Nuechterlein and Dawson 1984), the increase in environmental stressors associated with being stigmatized might contribute to relapse rate.

An important component of aftercare may then involve the use of methods to dispel the negative label of mental illness. A starting point may be the dissemination of basic knowledge about mental illness to the general population. Research suggests that individuals who possess more information about mental illness are less prejudicial toward the mentally ill (Roman and Floyd 1981; Link and Cullen 1986; Brockington et al. 1993). For example, Barrowclough et al. (1987) reported that those relatives of schizophrenia probands who are more knowledgeable about the disorder tend to be less critical of the patient. It has not yet been determined whether previous contact with the mentally ill will reduce stigmatization toward a stranger with a mental disorder.

Stigmatization may also be reduced by increasing individuals' familiarity with the current life context of recovered patients (e.g., providing information that the discharged individual lives in a group home). Such information may disabuse individuals of the notion that most discharged patients are living under unsupervised conditions. Finally, one might expect the label of "mental illness" to be less demeaning if information is omitted regarding behavior during the acute phase of the illness. The description of acute symptomatology may reinforce the stereotype of the recovered mentally ill as bizarre and unstable. Neither of these informational components (i.e., life context and admission of previous symptoms) have been investigated in former research on stigma and mental illness. Thus, they represent potential sources for changing the perceptions people have of the mentally ill.

The present study sought to address the hypothesis that various levels of information about a recovered person with a mental illness would lead to different emotional and social reactions to that individual. Subjects were given one of six vignettes describing a hypothetical individual, based on those used by Link et al. (1987).[1] These vignettes differed with respect to the label of the disorder provided and whether information was included on the individual's previous symptomatology and the aftercare setting. To address the issue of whether previous contact with mental illness leads to less negative impressions (e.g., Roman and Floyd 1981), subjects were classified into two groups based on their response to the question "Do you know someone with a mental illness?"

The following hypotheses were formulated: (1) Individuals who report having had previous contact with the mentally ill will be less stigmatizing toward a newly encountered individual than those without previous contact. (2) Reports on previous symptomatology in the acute phase will be more stigmatizing than if this information is omitted (i.e., if only a label is provided). (3) Inclusion of information about the aftercare setting will help allay negative responses toward the target individual.

[1]The vignettes were modified to better represent the functioning of a discharged outpatient. The Link et al. (1987) vignettes described the target individual as working full-time in a local business and earning $20,000 per year. In the present study, the target individual is described as doing part-time janitorial work and earning $4,000 per year.

Methods

Subjects. Three hundred and twenty-nine undergraduates from the University of Nebraska–Lincoln participated in the study in partial fulfillment of course requirements. Subjects were tested in groups of 15 to 20.

Measures.

Vignettes. Subjects were given one of six vignettes to read. The first vignette, entitled "Depression," was included to determine whether stigmatization is associated with mental illness in general or schizophrenia in particular. Vignette No. 1 thus states that "Jim Johnson" was previously hospitalized because of depression. Vignette No. 2 provides the label of "schizophrenia" and is entitled "Label." Vignette No. 3, known as "Label/Symptoms," provides the label of schizophrenia in conjunction with a description of the target individual's symptoms at the time of hospitalization. Symptoms were based on how a "prototypical patient" would appear before hospitalization.[2] Vignette No. 4

[2]The symptom profile was developed by the first three authors and reviewed by a clinical psychologist and Program Director at a State hospital, each of whom has over 10 years' experience in working with individuals with chronic mental disorders.

provides the label of schizophrenia with a description of the aftercare setting and is entitled "Label/Home." A description of the aftercare setting was based on consultation with a case manager at a community mental health center and the coordinator of a local aftercare facility. Vignette No. 5 includes information about the label and symptoms associated with schizophrenia, as well as the aftercare setting. This description is entitled "Label/Symptoms/Home." Vignette No. 6, entitled "Symptoms," provides information only about the symptoms associated with schizophrenia. Appendix I lists Label, Label/Symptoms, and Label/Home vignettes.

Dependent measures. Five dependent measures were used in the current study: social distance and dangerousness scales (see Link et al. 1987), measures of the target individual's characteristics and skills, and a measure of affective reactions to the target individual.

The Social Distance Scale comprises seven questions that refer to interaction with the target individual (see appendix II for description of all measures). Each question is rated by the subject on a 4-point Likert scale (0 = definitely unwilling to 3 = definitely willing). A composite measure of social distance is derived by totaling the sum of all items. The internal consistency (Cronbach's alpha) of this measure was 0.75.

The Characteristics Scale contains 20 items that assess impressions of the target individual's personality and behavioral attributes. Based on the vignette they read, subjects were asked to rate on a 7-point semantic differential scale whether the target individual possessed certain characteristics. The items consisted of 20 bipolar adjective pairs. The scale was adopted from Oberlander (1990) and was found to have an internal consistency of 0.87.

The Affective Reaction Scale required that subjects rate their emotional responses to the target individual. The scale consists of 10 bipolar adjective pairs having emotional content (e.g., calm–nervous). The subject was instructed to rate each item on a 7-point scale with neutral being the midpoint. The internal consistency of this scale was 0.86.

The Skill Assessment Scale has eight items describing various abilities that were *not* overtly stated in the vignette. Thus, the subject had to go beyond the information given to make a judgment of the target individual's skill level. Each item was rated on a 7-point Likert scale from strongly agree to strongly disagree with neutral being the midpoint. The internal consistency of this scale was 0.81.

The Dangerousness Scale comprises eight items that tap individual beliefs about whether a person who is, or has been, mentally ill is likely to be a danger to others. The questions pertain to the mentally ill in general, rather than the target individual described in the vignette. Each item is rated by the subject on a 7-point Likert scale from strongly agree to strongly disagree with midpoint being no opinion. The internal consistency of the scale was 0.78.

To assess degree of overlap among dependent measures, Pearson correlational analyses were conducted. All dependent measures were significantly correlated with one another (table 1), a finding likely associated with both shared variance and large sample size. Shared variance averaged 15 percent, and ranged from 5.7 percent (Characteristics–Dangerousness) to 26 percent (Characteristics–Skill) suggesting that the measures were tapping into relatively independent domains.

On completion of the dependent measures, subjects filled out a brief demographic questionnaire in which they were asked if they knew someone with a mental illness. Forty-four percent of the sample answered "yes" to this question. Of this group, they identified the following disorders as those with which they had had contact: schizophrenia (24%), depression (22%), manic depression (16%), mental retardation/Down's

Table 1. Intercorrelations between dependent measures

Dependent measures	2	3	4	5
1. SOCDIS	0.46[1]	0.38[1]	0.42[1]	0.30[1]
2. DANGER	—	0.24[1]	0.35[1]	0.28[1]
3. CHARAC		—	0.43[1]	0.51[1]
4. AFFECT			—	0.39[1]
5. SKILL				—

Note.—SOCDIS = Social Distance; DANGER = Dangerousness; CHARAC = Characteristics; AFFECT = Affective reaction; SKILL = Skill rating.

[1] $p < 0.01$.

syndrome (9%), anxiety (3%), nervous breakdown (3%), eating disorders (3%), Alzheimer's disease (2%), and alcoholism (1%). Interestingly, 17 percent of the sample stated that they knew someone with a mental illness, but were unable to specifically identify the disorder.

Procedure. Subjects were randomly assigned to one of the six vignettes' conditions. They began by reading the vignette. The vignette was then removed and the subject was administered the five dependent measures in the following order, which was based on random selection: social distance, characteristics, affective reaction, skill assessment, and dangerousness. Subjects then completed the demographic questionnaire and were debriefed.

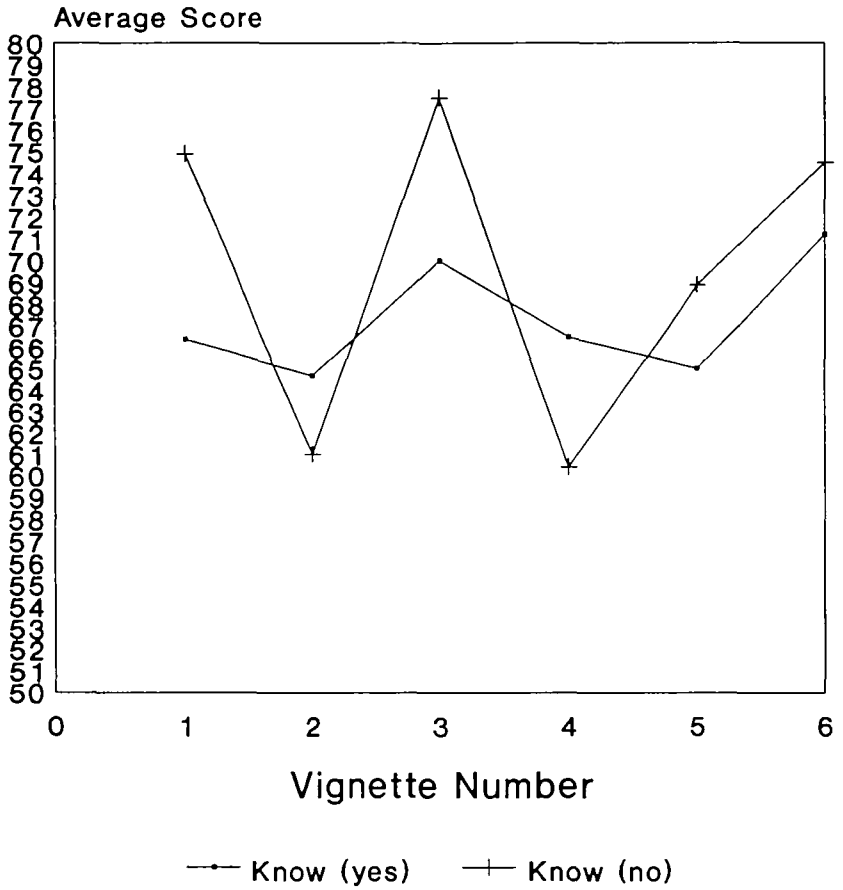
Results

The scores for the five dependent measures were entered into a 2 (Previous Contact; Yes–No) × 6 (Vignette Type) between-groups multivariate analysis of variance (MANOVA) to control for family-wise error. Following a significant Previous Contact × Vignette Type interaction (F = 1.66, df = 5,1041, $p < 0.05$), a series of 2 × 6 (Previous Contact × Vignette Type) analysis of variances were conducted on each Impression measure. A significant interaction was found only for the rating of the target individual's characteristics (F = 2.91, df = 5,316, $p < 0.02$) and is depicted in figure 1.

Further examination of the interaction revealed that for subjects who knew someone with a mental illness, no differences in ratings occurred as a function of Vignette Type (F = 1.17, df = 5,138, not significant [NS]). However, Vignette Type did affect ratings for those subjects who did *not* know someone with a mental illness (F = 9.71, df = 5,167, $p < 0.01$). This finding supports our hypothesis that less stigmatizing responses are found among individuals who have had previous contact with the mentally ill. Post-hoc analyses using Tukey Honestly Significant Difference revealed that vignette No. 4 (Label/Home) and No. 2 (Label) were significantly less stigmatizing than vignette No. 6 (Symptoms), No. 1 (Depression), and No. 3 (Label/Symptoms). This finding is consistent with another of our hypotheses that the reporting of previous symptomatology is more stigmatizing than omission of such information.

Main effects for the Previous

Figure 1. Mean ratings of target individual's characteristics based on subjects' previous contact with a mentally ill person as a function of vignette type



(interaction)

Contact and Vignette Type variables are summarized in tables 2 and 3 (higher scores = more negative ratings). Because of the interaction involving the target individual's characteristics, this variable is excluded from tables of main effects. Table 2 illustrates that the lack of previous contact with someone who has a mental illness was associated with a desire to maintain greater social distance from the target individual and a perception of the mentally ill as more dangerous. This finding supports the hypothesis that less stigmatizing responses occur among individuals who have had previous contact with the mentally ill.

As shown in table 3, greater negative affective reactions about the target individual were elicited when subjects were provided with a label of schizophrenia and the symptoms (Label/Symptoms) or symptoms alone (Symptoms), rather than with a label of depression (Depression). Subjects inferred that the target individual had more skills when provided with the label of schizophrenia (Label) versus the label and symptoms of schizophrenia (Label/Symptoms), symptoms alone (Symptoms), or a label of depression (Depression). When information was provided about the aftercare setting in conjunction with the label of schizophrenia (Label/Home), it was less stigmatizing than a description of schizophrenia symptoms alone (Symptoms).

These findings, in conjunction with those reported from the Characteristics Scale, support the hypothesis that including information about previous symptomatology is more stigmatizing than merely labeling the disorder.

To investigate our final hypothesis that information about aftercare helps lower stigmatization, we planned comparisons on the vignettes Label/Symptoms versus Label/Symptoms/Home, and Label versus Label/Home across all dependent measures (for Characteristics, this analysis was conducted across Previous Contact). A significant difference was found only for the Characteristics dependent measure (no previous contact condition); subjects rated the target individual's characteristics as less negative in the Label/Symptoms/Home condition compared to the Label/Symptoms condition $t(167) = 2.56$, $p < 0.02$, thereby giving partial support to this hypothesis.

The argument could be made that the Dangerousness Scale differs from the other dependent measures because it requires an evaluation of the mentally ill in general rather than the specific target individual. Therefore, data were reanalyzed after omitting the

Table 2. Means for each impression measure as a function of previous contact with a mentally ill individual

	Previous contact	
Impression measure	Yes mean	No mean
Social distance	7.9	8.6[1]
Affective reaction	30.2	31.4
Skill assessment	20.7	21.6
Dangerousness	24.4	27.1[1]

[1] $p < 0.05$ between Yes and No.

Table 3. Means for each impression measure as a function of vignette type

	Vignette type					
Measure	Depression	Label	Label/ Symptoms	Label/ Home	Label/ Symptoms/ Home	Symptoms
Social distance	7.74	8.30	8.10	7.98	8.76	8.66
Affective reaction[1]	28.00a	29.40	32.87b	31.52	30.48	33.25b
Skill assessment[1]	22.64b	18.29a	22.00b	19.81a	20.96	23.50b
Dangerousness	25.54	24.93	25.31	25.71	25.96	27.94

[1] Different letters indicate significantly different groups.

information from the Dangerousness Scale. The 2 (Previous Contact) × 6 (Vignette Type) between-groups MANOVA approached significance ($F = 1.02$, $df = 5,1130$, $p < 0.10$). Followup analyses revealed the exact pattern as reported above except that the main effect of Previous Contact on Social Distance was significant at the uncorrected alpha level (0.05), but not for the more conservative Bonferroni-corrected alpha level (0.0125).

Discussion

The results of this study suggest the presence of conditions that may reduce the stigmatization of individuals with schizophrenia. The most salient factor appears to be whether the respondent has had previous contact with the mentally ill. Specifically, those subjects who reported having known someone with a mental illness were less likely to be influenced by the type of information presented in the vignette. Further, those with previous contact perceived the mentally ill as less dangerous. This finding replicates previous work with community subjects (Link and Cullen 1986). Subjects who reported *not* knowing someone with a mental illness tended to rate the mentally ill as more dangerous and believed that more social distance should be kept from the target individual.

These findings suggest that stigmatization may be reduced by promoting direct contact between the public and individuals with a mental illness (Trute and Loewen 1978; Link and Cullen 1986). For example, visits with ex-patients in group homes may free individuals of negative perceptions. Such contacts may help individuals be less influenced by negative information about mental illness, such as that typically portrayed in the media (Gerbner et al. 1981).

Among individuals who reported knowing someone with a mental illness, there were vast differences in what was considered to be a mental illness (e.g., Down's syndrome). Perhaps most striking is that 17 percent of these respondents were unable to identify the particular disorder. This underscores the need to educate the public about mental illness. Given that the current sample was composed of undergraduate students, it appears that education about mental illness is not adequate at the high-school level. Just as many of our youth take sex education classes they also should be educated about the realities and myths of mental illness.

Description of previous symptomatology in the acute phase of schizophrenia was more stigmatizing than a label alone. A former patient who cannot deter the spread of such information may, therefore, face rejection, even if presenting with nonaberrant behavior. Description of acute symptomatology may be tapping into subjects' fears regarding the dangerousness of individuals with a mental disorder (Link and Cullen 1986; Link et al. 1987). Thus, reducing the impact of previous symptomatology may be achieved by sharing facts about the relationship between violent behavior with acute and remitted functioning. Recent findings by Link et al. (1992) suggest that the key factor in determining the likelihood of violence among individuals who have had a mental illness is the presence of current psychotic symptoms. Consequently, individuals who are no longer delusional or experiencing hallucinations are no more likely to be violent than community residents.

The findings lend partial support to the hypothesis that information about the aftercare setting reduces stigmatization. Less negative ratings of the target individual's characteristics were elicited when information about current living context was provided. However, since the effect was limited to one dependent measure, the finding must be replicated and perhaps a more comprehensive description of aftercare facilities is recommended before confident conclusions can be drawn.

A number of caveats should be noted about the present findings. First, on two of the five dependent measures (i.e., Characteristics and Skill assessment), the label of *depression* was more stigmatizing than schizophrenia. Two factors may account for this finding: (1) Undergraduate subjects may not know what is meant by the term "schizophrenia" (this may account for the finding that subjects unfamiliar with mental illness rated the label of depression as more stigmatizing than the label of schizophrenia). Furthermore, the misuse of this term in daily jargon (e.g., "it has been somewhat schizophrenic around here") may contribute to the confusion regarding the definition of this disorder. (2) It is plausible that the subjects viewed depression as a disorder that is more under the control of the individual than schizophrenia. Thus, the individual with depression might be "blamed" for his or her disorder. This finding may relate to subject belief systems concerning whether a disorder is more biologically or psychosocially determined. Testing this hypothesis, however, is beyond the scope

of the present analysis.

Second, the subjects in the study were drawn from a population that does not typically come into contact with the recovered mentally ill (although the classroom setting does afford better control over presentation of material compared to mail or telephone interviews with community members). Further, this subject group does not influence the lives of ex-patients in the community to the extent of the general public, who face issues such as employing ex-patients and aftercare facilities moving into their neighborhoods. Thus, future research should replicate and extend these findings with a community sample. Finally, the present study made use of written vignettes about a hypothetical individual. Ecological validity may be enhanced by using videotapes of patients, actors depicting patients, or clinical case histories.

The present study represents an attempt to determine what type of information reduces stigmatization of individuals with schizophrenia. The major findings were twofold: Knowledge of previous symptomatology led to more negative reactions about the target individual (i.e., affective, characteristic, and skill ratings), and previous contact with the mentally ill abates negative judgments that might arise in encounters with an unfamiliar person who has a mental disorder. It is painfully apparent that even if inpatient and outpatient treatments are successful, gains will be minimal if the patient returns to a hostile and uninformed community. Therefore, efforts to reduce the stigmatization of individuals with schizophrenia should be given the priority that other treatment modalities demand.

References

Barrowclough, C.; Tarrier, N.; Watts, S.; Vaughn, C.; Bamrah, J.S.; and Freeman, H.L. Assessing the functional value of relatives knowledge about schizophrenia: A preliminary report. *British Journal of Psychiatry*, 151:1–8, 1987.

Braff, D.L. Reply to cognitive therapy and schizophrenia. *Schizophrenia Bulletin*, 18(1):37–38, 1992.

Brockington, I.F.; Hall, P.; Levings, J.; and Murphy, C. The community's tolerance of the mentally ill. *British Journal of Psychiatry*, 162:93–99, 1993.

Farina, A.; Allen, J.; and Saul, B. The role of the stigmatized person in affecting social relationships. *Journal of Personality*, 36:169–182, 1968.

Farina, A., and Felner, R.D. Employment interviewer reactions to former mental patients. *Journal of Abnormal Psychology*, 82:268–272, 1973.

Farina, A., and Ring, K. The influence of perceived mental illness on interpersonal relationships. *Journal of Abnormal and Social Psychology*, 70:47–51, 1965.

Gerbner, G.; Gross, L.; Morgan, M.; and Signorielli, N. Health and medicine on television. *New England Journal of Medicine*, 305:901–904, 1981.

Johannsen, W. Attitudes towards mental patients: A review of empirical research. *Mental Hygiene*, 53:218–227, 1969.

Link, B.G. Mental patient status, work, and income: An examination of the effects of a psychiatric label. *American Sociological Review*, 47:202–215, 1982.

Link, B.G.; Andrews, H.; and Cullen, F. The violent and illegal behavior of mental patients reconsidered. *American Sociological Review*, 57:275–292, 1992.

Link, B.G., and Cullen, F.T. Contact with the mentally ill and perceptions of how dangerous they are. *Journal of Health and Social Behavior*, 27:289–303, 1986.

Link, B.G.; Cullen, F.T.; Frank, J.; and Wozniak, J.F. The social rejection of former mental patients: Understanding why labels matter. *American Journal of Sociology*, 92:1461–1500, 1987.

Nuechterlein, K.H., and Dawson, M.E. A heuristic vulnerability/stress model of schizophrenic episodes. *Schizophrenia Bulletin*, 10(2):300–312, 1984.

Oberlander, L.B. "*The Impact of Stereotypes on Clinical Decision Making Patterns Among Mental Health Professionals: An Empirical Demonstration.*" Unpublished doctoral dissertation, University of Nebraska–Lincoln, 1990.

Olshansky, S.; Grob, S.; and Malmud, I.T. Employer's attitudes and practices in the hiring of ex-mental patients. *Mental Hygiene*, 42:391–401, 1958.

Piner, K.E., and Kahle, L.R. Adapting to the stigmatizing label of mental illness: Foregone but not forgotten. *Journal of Personality and Social Psychology*, 47:805–811, 1984.

Rabkin, J. Public attitudes towards mental illness: A review of the literature. *Schizophrenia Bulletin*, 1(Experimental Issue No. 10):9–33, 1974.

Roman, P.M., and Floyd, H.H. Social acceptance of psychiatric illness and psychiatric treatment. *Social Psychiatry*, 16:21–29, 1981.

Trute, B., and Loewen, A. Public attitude toward the mentally ill as a function of prior personal expe-

rience. *Social Psychiatry*, 13:79–84, 1978.

Wahl, O.F., and Harman, C.R. Family views of stigma. *Schizophrenia Bulletin*, 15(1):131–139, 1989.

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Appendix I: Vignettes

Label

A description of a 27-year-old man, Jim Johnson, follows. About 2 years ago, Jim was hospitalized after being diagnosed with schizophrenia. After receiving treatment, he now appears to have recovered and is doing fairly well.

Jim is clean and well-groomed. He has a part-time janitorial job, which pays $4,000 a year before taxes. He gets along well with his coworkers, takes the usual coffee and lunch breaks, and tends to his job the remainder of the workday. Jim checks his work carefully and completes each task before moving on to another. This might slow Jim down a little, but he is never criticized for the quality of his work.

Socially, Jim is interested in meeting and dating young women in the community, and he is considering joining a local church group to become acquainted with them. Jim also has an ambition to get a more responsible and better paying job.

Label/Symptoms

This vignette includes all of the above-mentioned information in addition to the following description of pretreatment symptoms.

Before admission to the hospital, Jim was experiencing problems in perceiving the world around him. He would sometimes hear voices, which were hallucinations. His process of thinking was confused and tangential; he would often shift from one idea to another. At times he was difficult to understand.

Jim demonstrated little emotional expression. He rarely smiled or got angry. In general, he appeared apathetic to others. In fact, Jim had gradually withdrawn from his family and friends so that any type of social contact was minimal. This apathy also related to how Jim seemed to feel about himself, because his skills in grooming and hygiene deteriorated.

Label/Home

This vignette includes all of the information in the Label vignette in addition to the following description of aftercare.

Currently, Jim lives in the community and shares a house with other individuals who have suffered from similar problems. The house has a 24-hour staff who assist the residents in contacting their social worker/case manager and psychiatrist for consultation. In addition, the staff is there to help the residents monitor their medications (if necessary), organize group activities, and provide guidance if the residents encounter any challenging problems in the community (e.g., dealing with the department of social services). Jim also meets every 2 weeks with a counselor to talk about what is going on in his life.

Appendix II: Dependent Measures

Social Distance Scale

Based on the description of Jim Johnson, rate the following statements on the following scale: 0 = definitely willing; 1 = probably willing; 2 = probably unwilling; 3 = definitely unwilling.

1. How would you feel about renting a room in your home to someone like Jim Johnson?
2. How about as a worker on the same job as someone like Jim Johnson?
3. How would you feel having someone like Jim Johnson as a neighbor?
4. How about as the caretaker of your children for a couple of hours?
5. How about having your children marry someone like Jim Johnson?
6. How would you feel about introducing Jim Johnson to a young woman you are friendly with?
7. How would you feel about recommending someone like Jim Johnson for a job working for a friend of yours?

Characteristics Scale

Based on your impression of Jim Johnson, rate him on the following characteristics:

				Neutral				
1. Strong	1	2	3	4	5	6	7	Weak
2. Boring	7	6	5	4	3	2	1	Interesting
3. Insensitive	7	6	5	4	3	2	1	Sensitive
4. Sophisticated	1	2	3	4	5	6	7	Naive
5. Bold	1	2	3	4	5	6	7	Shy
6. Sociable	1	2	3	4	5	6	7	Unsociable
7. Emotional	7	6	5	4	3	2	1	Rational
8. Cruel	7	6	5	4	3	2	1	Kind
9. Poised	1	2	3	4	5	6	7	Awkward
10. Unintelligent	7	6	5	4	3	2	1	Intelligent
11. Sad	7	6	5	4	3	2	1	Happy
12. Unsuccessful	7	6	5	4	3	2	1	Successful
13. Enthusiastic	1	2	3	4	5	6	7	Unenthusiastic
14. Insecure	7	6	5	4	3	2	1	Secure
15. Open	1	2	3	4	5	6	7	Defensive
16. Cold	7	6	5	4	3	2	1	Warm
17. Untrustworthy	7	6	5	4	3	2	1	Trustworthy
18. Interesting	1	2	3	4	5	6	7	Boring
19. Secure	1	2	3	4	5	6	7	Insecure
20. Effective	1	2	3	4	5	6	7	Ineffective

Affective Reaction

If you were to interact with Jim Johnson, indicate how you would feel:

				Neutral				
1. Pessimistic	1	2	3	4	5	6	7	Optimistic
2. Tranquil	1	2	3	4	5	6	7	Anxious
3. Supportive	1	2	3	4	5	6	7	Resentful
4. Fearful	1	2	3	4	5	6	7	Confident
5. Empathic	1	2	3	4	5	6	7	Angry
6. Disgusted	1	2	3	4	5	6	7	Sympathetic
7. Apprehensive	1	2	3	4	5	6	7	Comfortable
8. Irritable	1	2	3	4	5	6	7	Patient

Affective Reaction—*continued*

9. Relaxed	1	2	3	4	5	6	7	Tense
10. Calm	1	2	3	4	5	6	7	Nervous

Skill Assessment Scale

Based on the description of Jim Johnson, rate him on the following skills:

	Mostly agree			Neutral			Mostly disagree
1. He is able to control his temper	1	2	3	4	5	6	7
2. He can hear and speak clearly	1	2	3	4	5	6	7
3. He can express positive emotions	1	2	3	4	5	6	7
4. He is able to solve everyday problems	1	2	3	4	5	6	7
5. He can maintain a job	1	2	3	4	5	6	7
6. He has good social skills	1	2	3	4	5	6	7
7. He behaves predictably	1	2	3	4	5	6	7
8. He demonstrates initiative	1	2	3	4	5	6	7

Dangerousness Scale

	Strongly agree			No opinion			Strongly disagree
1. If a group of former mental patients lived nearby, I would not allow my children to go to the movie theater alone.	1	2	3	4	5	6	7
2. If a former mental patient applied for a teaching position at a grade school and was qualified for the job, I would recommend hiring him/her.	1	2	3	4	5	6	7
3. One important thing about mental patients is that you cannot tell what they will do from one minute to the next.	1	2	3	4	5	6	7
4. If I know a person has been a mental patient, I will be less likely to trust him.	1	2	3	4	5	6	7
5. The main purpose of mental hospitals should be to protect the public from mentally ill people.	1	2	3	4	5	6	7
6. If a former mental patient lived nearby, I would not hesitate to allow young children under my care on the sidewalk.	1	2	3	4	5	6	7
7. Although some mental patients may seem all right, it is dangerous to forget for a moment that they are mentally ill.	1	2	3	4	5	6	7
8. There should be a law forbidding a former mental patient the right to obtain a hunting license.	1	2	3	4	5	6	7