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Can a less pejorative Chinese translation for schizophrenia reduce stigma? A study of adolescents' attitudes toward people with schizophrenia

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Abstract The term *jing-shen-fen-lie-zheng* (mind-split-disease) has been used to denote schizophrenia in Chinese societies. Many Asian countries, where the Chinese writing system is used, adopt a similar translation. This study examined whether a less pejorative name s*i-jue-shi-diao* (dys-regulation of thought and perception) as a diagnostic label for symptoms of schizophrenia could reduce stigma. Secondary school students (n = 313) were randomly assigned to read a vignette with one of four labels: s*i-jue-shi-diao*, *jing-shen-fen-lie-zheng*, *jing-shen-bin* (mental illness), and no label. Students expressed their social distance, stereotypes held, and attributions toward a young adult who met the Diagnostic and Statistical Manual-IV of Mental Health Disorders criteria for schizophrenia. It was found that psychiatric labeling did not have a statistically significant main effect on attitude measures. However, students with religious beliefs were more accepting toward the target individual associated with diagnostic label than one with no labeling. The results cast doubts that less pejorative labels can reduce the social stigma of schizophrenia. Some potential drawbacks in using politically correct terms to describe schizophrenia are highlighted.

Key words attitudes, Chinese, labeling, mental illness, schizophrenia, stigma.

INTRODUCTION

Stigmatization remains a significant problem for individuals with mental illness. Previous studies found that a label of mental illness could lead to biases in interpreting behavior, discrimination in job application, negative emotional response, rejection, and a damaged sense of self.[1] Thus, eliminating the stigma associated with mental illness is an important goal. To reduce stigma, promotion of contact between the public and individuals with mental illness and education to dispel misconceptions about people with mental illness, have shown positive results.[2]

One indirect method for reducing stigma is the use of politically correct labels to describe mental illness. If negative stereotypes are associated with a label currently in use, replacing the term with a more appropriate, less pejorative name may reduce prejudice and discrimination. The use of politically correct labels is often preferred by people with mental illness. Mueser *et al*. found that users of mental health services preferred the term 'client' than 'patient' and 'consumer' but one-fifth indicated that it did not matter which term was used.[3] A study in Japan found that subjects had less feeling of stigma and negative self-image when they attended a clinic named 'Mental Clinic' (in English) than one using the Japanese name for 'Department of Psychiatry and Neurology'.[4] However, there have been debates among professionals about the 'correct' terms to describe people with mental distress. Baker and Menken proposed that the term mental illness could be abandoned[5] but many held opposing views.[6] A similar controversy happened in Japan about renaming the term schizophrenia.[7–9]

In a review of antistigma strategies, Corrigan and Penn pointed out that people with schizophrenia rep-

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resent individuals with both a discredited (i.e. they may manifest psychotic symptoms in public) and discreditable stigma (i.e. if in remission, they may be able to hide their mental illness from others).[10] Researchers need to consider the discredited–discreditable dimension when developing specific interventions to reduce stigmatization toward people with schizophrenia. The use of politically correct labels may help to reduce the discreditable stigma. However, previous studies showed that behaviors and symptoms of psychiatric disorders were the most crucial variables in determining public attitudes toward people with mental illness. Lehmann *et al*. found that social reaction was influenced by behaviors such as anxiety, agitation, depression, and withdrawal and much less by a label of mental illness.[11] Penn *et al*. found similar reactions toward a vignette describing symptoms of schizophrenia and the same vignette associated with the label 'schizophrenia'.[12] Cormack and Furnham showed that social reaction was determined by the type of behavior portrayed in four vignettes (paranoid schizophrenia, depression, alcoholism, and agoraphobia).[13] Psychiatric labeling was not significantly associated with social distance, anticipation of prognosis, and beliefs about etiology but resulted in beliefs that the disorders were more serious.

In fact, avoiding a label and using politically correct labels can have negative effects. Angermeyer and Matschinger compared the public attitudes toward a vignette describing symptoms of schizophrenia in conjunction with the label 'schizophrenia' and one with no labeling. Subjects rated the vignette without a label as having a more favorable prognosis but attributing greater responsibility to the target individual for his/her illness.[14] Penn and Nowlin-Drummond examined the attitudes toward four labels: consumer of mental health services, person with schizophrenia, person with a severe mental illness, and schizophrenic.[15] The respondents were not given any information regarding what the label represented. The study found that the label 'consumer of mental health services' was associated with less negative emotional reactions but greater attribution for responsibility.

The term 'schizophrenia' comes from the Greek words *schizein and phren*, which means to split and mind in English. In countries where the Chinese writing system is used, the term 'schizophrenia' is translated as 'mind-split-disease'. A recent study in Japan found that university students were more stigmatizating toward a person presenting with thought broadcasting in conjunction with the label *seishin-bunretsu-byou* (mind-split-disease) than one without the label.[16] The authors argued for relabeling the Japanese translation for schizophrenia and hypothesized that a more appropriate and less stigmatizating term to be useful for public education and diagnostic communication.

A new program was launched in Hong Kong in 2001 for early assessment and intervention for young people with psychosis. One major task is to make the service more accessible to clients and improve readiness for help-seeking. A new Chinese name s*i-jue-shi-diao* is designed to denote psychosis; *Si* refers to thought, *jue* refers to perception, and *shi-diao* refers to dys-regulation. The new term is used instead of *jing-shen-bing* (mental illness), *zhong-xing-jing-shen-bing* (psychosis or severe mental illness), and *jing-shen-fen-lie-zheng* (schizophrenia). *Shi-diao* (dys-regulation) can give a less negative impression than *bing* and *fen-lie* (illness and split). In addition, the new name avoids the term *jing-shen*, which is associated with the stereotype of insanity in Chinese societies. The program has been advertised in mass media using the new Chinese term s*i-jue-shi-diao*. Educational material for the program includes advice to seek early medical attention for hallucination, delusion and disturbed thinking.

Our study aimed to provide empiric data to help the discussion about renaming the term schizophrenia in Asian countries, where the term schizophrenia is translated as 'mind-split-disease'. We compared labeling effects of s*i-jue-shi-diao* (dys-regulation of thought and perception) and the Chinese label currently used to denote schizophrenia, *jing-shen-fen-lie-zheng*. We included two controls for comparison, one with no diagnostic label and the other with the label *jing-shen-bin* (mental illness). We examined the attitudes of a group of adolescents toward a vignette describing acute symptoms of schizophrenia in conjunction with one of the four labeling conditions. Our hypothesis was, when associated with symptoms of schizophrenia, the effects of politically correct labels would be limited. We selected adolescents as our study population. First, there has been limited data on adolescents' attitudes toward people with mental illness. Second, adolescence and young adulthood mark the onset of a number of mental illnesses including schizophrenia. Third, the new early psychosis program in Hong Kong is targeted at young people. It will be useful to know whether a less pejorative label can improve adolescents' acceptance of people with schizophrenia. Our findings will be discussed in light of the use of politically correct labels to reduce the stigma of mental illness.

METHODS

Subjects

We conducted our study in June 2003 at a secondary school in Hong Kong. The school was selected by con-

Table 1. Sample description (total, $n = 313$)

Variable	Mean ± SD (range)
Age (year) ($n = 306$)†	15.2 ± 0.9 (13–18)
Gender (% female) ($n = 313$)	49.5
Ethnicity (% Chinese) ($n = 313$)	100
Religion (%) ($n = 312$)	
No religious belief	71.5
Christian	22.1
Catholic	3.2
Buddhism and others	3.2
Father's education (years) ($n = 220$)	9.5 ± 3.0 (3–20)
Mother's education (years) ($n = 226$)	8.8 ± 3.1 (0–16)
Father's occupation (%) ($n = 313$)	
Professional	10.2
Associate professional	9.3
Skilled worker	41.5
Semi-skilled worker	4.2
Unskilled worker	13.1
Retired	4.2
Unemployed/housework	17.6
Mother's occupation (%) ($n = 313$)	
Professional	3.2
Associate professional	5.4
Skilled worker	14.4
Semi-skilled worker	2.2
Unskilled worker	10.5
Retired	0.6
Unemployed/housework	63.6
Had previous contact with a person with mental illness (%) ($n = 313$)	13.7
Relationship with the person with mental illness (%) ($n = 43$)	
Respondents themselves have a mental illness	4.7
Family member	7.0
Friend of the family	14.0
Relative	23.3
School friend/classmate	11.6
Client of voluntary work	20.9
Neighbor	18.6

†Difference from total *n* reflects omission on questionnaires, except the item on relationship with the person with mental illness.

venience and was a Band Three secondary school according to the Hong Kong Education Department. Students of a Band Three school have on average lower academic results than Band One and Two students. All Third and Fourth Form students of the school ($n = 314$) (equivalent to academic grade Ten and Eleven of the American Education System) agreed to participate and signed an informed consent form. One subject omitted one page of the questionnaire and hence data from 313 students were used for further analysis. The students were mostly from working class families (Table 1). Only 13.7% of the sample had previous contact with someone with a mental illness.

Procedures

The study was conducted with the help of teachers but it was made clear that participation was voluntary and anonymous. The students had no prior formal teaching on mental health. We explained the purpose of this study as an investigation of attitudes toward psychiatric terms and symptoms with no mention of stigmatization. The teachers responsible allowed adequate time for the students to complete the questionnaire.

The students were tested in a classroom of about 40 persons and randomly assigned to receive a vignette with one of the four labeling conditions: *jing-shen-fen-*

lie-zheng, s*i-jue-shi-diao, jing-shen-bin,* and no label. They were instructed to read the case vignette carefully before answering the questions regarding attitudes toward the target individual. Then the students filled out their gender, age, religion, ethnicity, parents' education and occupation, and if they had previous contact with someone with a mental illness. The students who had previous contact with mentally-ill individuals filled out whether the person was their family member, friend of the family, relative, friend, school friend, classmate, voluntary work's client, neighbor, or other and if they had a mental illness. The information sheet, vignette and questionnaire were presented in Chinese.

Vignettes

The vignette described a Seventh Form student (equivalent to University Year One of the American Education System) who met the Diagnostic and Statistical Manual-IV of Mental Health Disorders criteria for schizophrenia. The content was based on one previously used in the 1996 General Social Survey in the United States.[17] We randomly varied the sex of the character described in the vignette (Ka-hung for male and Ka-yan for female). The label was presented as title of the case vignette and also described at the end of the vignette, which read: 'Ka-hung/Ka-yan saw a doctor who diagnosed him/her as suffering *jing-shen-fen-lie-zheng*/s*i-jue-shi-diao/jing-shen-bin*). He/She requires hospital treatment and medication'. The vignette with no label read as: 'Ka-hung/Ka-yan requires hospital treatment and medication'.

Dependent measures

The following dependent measures were used in the current study: social distance, stereotypes of schizophrenia, and attributions regarding mental illness. The students used a 4-point Likert scale, with 1 being 'strongly disagree' and 4 being 'strongly agree', to indicate their attitudes toward the target individual. The social distance scale has previously been used in adolescent populations to measure respondents' readiness to enter different types of social relationships with the person described in the case vignette (Table 2).[18] The internal consistency (Cronbach's alpha) for the social distance scale was 0.83. The questionnaire on stereotypes assessed positive and negative stereotypes of schizophrenia (Table 3).[18–20] We calculated a negative stereotype score by averaging the scores of all items, except one that assessed creativity. The negative stereotypes scale had an internal consistency of 0.68. The students responded to three items on attributions (blame, responsibility and prognosis) regarding the

Table 2. Social distance of secondary school students in Hong Kong towards a person with symptoms of schizophrenia ($n = 313$)[†]

Items	Strongly disagree[‡]	Disagree	Agree	Strongly agree	Mean score[§]
I would be afraid to talk to Ka-hung[¶]	37 (12)	172 (55)	98 (31)	6 (2)	2.23
I would not be upset or disturbed to be in the same class with Ka-hung[††]	18 (6)	112 (36)	155 (50)	28 (9)	2.38
I could imagine making friends with Ka-hung[††]	7 (2)	107 (34)	186 (59)	13 (4)	2.34
I would feel embarrassed or ashamed if my friends knew that Ka-hung is my family member	61 (20)	183 (59)	61 (20)	8 (3)	2.05
If Ka-hung sits next to me in class, I would rather sit somewhere else	59 (19)	190 (61)	56 (18)	8 (3)	2.04
If Ka-hung is my friend and is at the hospital, I would go and visit hime	4 (1)	29 (9)	219 (70)	61 (20)	1.92
I would not invite Ka-hung to my birthday party	41 (13)	198 (63)	68 (22)	6 (2)	2.12
I would not bring along Ka-hung when I meet my friends	30 (10)	175 (56)	101 (32)	7 (2)	2.27
When going on a class outing, Ka-hung should rather stay at home	67 (21)	204 (65)	38 (12)	4 (1)	1.93
I would never fall in love with someone like Ka-hung	26 (8)	118 (38)	124 (40)	45 (14)	2.60
Ka-hung should not work in jobs that involve taking care of children or young people	20 (6)	175 (55)	103 (33)	17 (5)	2.37
Ka-hung should not go to regular school	68 (22)	195 (62)	43 (14)	7 (2)	1.96

[†]Data are presented as No. (% of sample); [‡]1 = strongly disagree, 2 = disagree, 3 = agree, and 4 = strongly agree; [§]higher scores indicate greater social distance; [¶]Ka-yan for vignettes of female character; [††]items that are scored in reverse direction.

Table 3. Stereotypes held by secondary school students in Hong Kong towards a person with symptoms of schizophrenia ($n = 313$)[†]

Items	Strongly disagree[‡]	Disagree	Agree	Strongly agree	Mean score[§]
Ka-hung cannot cope with stress before exams[¶]	17 (5)	141 (45)	138 (44)	17 (5)	2.50
Ka-hung comes from a family with little money	51 (16)	225 (72)	33 (11)	4 (1)	1.97
Ka-hung cannot be helped by doctors	135 (43)	167 (53)	9 (3)	2 (1)	1.61
There is not much chance that Ka-hung will succeed in career	77 (25)	200 (64)	32 (10)	4 (1)	1.88
When meeting Ka-hung, one should better watch out	28 (9)	160 (51)	113 (36)	12 (4)	2.35
Ka-hung can be good at school[††]	1 (0)	37 (12)	230 (74)	45 (14)	1.98
Ka-hung is difficult to talk to	18 (6)	166 (53)	113 (36)	16 (5)	2.41
Ka-hung blows his top for the slightest reason	17 (5)	136 (44)	136 (44)	24 (8)	2.53
Ka-hung is particularly good at music or art[‡‡]	20 (6)	175 (56)	108 (35)	10 (3)	2.35

[†]Data are presented as No. (% of sample); [‡]1 = strongly disagree, 2 = disagree, 3 = agree, and 4 = strongly agree; [§]Higher scores indicate stronger endorsement of negative stereotypes, except the item on creativity; [¶]Ka-yan for vignettes using female character; [††]items that are scored in reverse direction; [‡‡]this item is excluded in the calculation of negative stereotypes score.

Table 4. Attributions held by secondary school students in Hong Kong regarding a person with symptoms of schizophrenia ($n = 313$)[†]

Items	Strongly disagree[‡]	Disagree	Agree	Strongly agree	Mean score[§]
Blame					
Ka-hung is to blame for his illness[¶]	140 (45)	151 (48)	17 (5)	5 (2)	1.64
Responsibility					
Ka-hung is responsible for the recovery of his illness	27 (9)	62 (20)	162 (52)	62 (20)	2.83
Prognosis					
Ka-hung is unlikely to recover	126 (40)	178 (57)	9 (3)	0 (0)	1.63

[†]Data are presented as No. (% of sample); [‡]1 = strongly disagree, 2 = disagree, 3 = agree, and 4 = strongly agree; [§]higher scores indicate greater blame and responsibility and lower likelihood of recovery; [¶]Ka-yan for vignettes using female character.

person described in the vignette (Table 4). We translated the scales into Chinese and reviewed the sentence structure to make sure they were clear and comprehensible. Higher scores indicate greater social distance, stronger endorsement of negative stereotypes, greater blame and responsibility, and lower likelihood of recovery.

Statistical methods

All statistical analysis was done by SPSS 10.0 for Windows (SPSS Japan, Tokyo, Japan).[21] We used one-way ANOVA and χ^2 test to examine any significant differences between the four labeling groups in sociodemographic variables, history of previous contact with mentally ill individuals, and attitude measures towards the person described in the vignette. There were about 75 subjects in each labeling condition. The sample size was able to detect a difference of 0.6 SD between two means at 5% significance level with power 90%.[22]

RESULTS

Social distance, negative stereotypes and attributions regarding schizophrenia

On the whole, the attitudes toward the person described in the vignette were positive. The mean social distance score was 2.2 (SD = 0.4; range = 1.0–3.8), indicating that the students tended to disagree keeping a distance from a person with symptoms of schizophrenia (Table 2) and for negative stereotypes, the mean score was 2.2 (SD = 0.4; range = 1.0–3.4) showing that many respondents disagreed with the negative stereotypes toward the target individual (Table 3). However, for items on ability to cope with

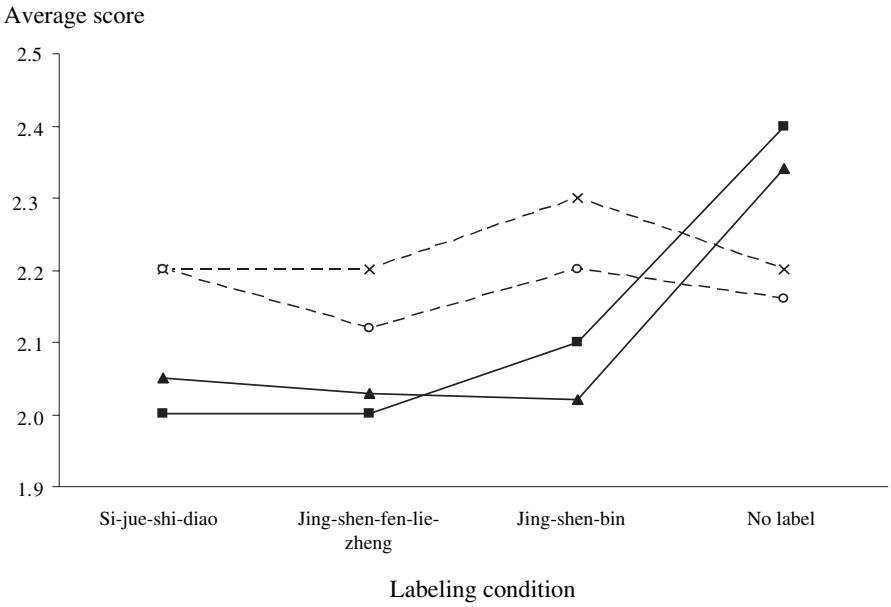

Figure 1. Mean ratings of social distance and negative stereotypes based on subjects' religion as a function of labeling condition (—■— social distance, religion [yes]; —▲— negative stereotypes, religion [yes]; --×-- social distance, religion [no]; --○-- negative stereotypes, religion [no]).

stress and unpredictability, about equal number of students agreed and disagreed with the stereotypes. The students were optimistic about the prognosis of schizophrenia and most subjects disagreed that the person described in the vignette was to blame for his/her illness (Table 4). However, 72% of the respondents strongly agreed or agreed that the target individual was responsible for the recovery for his/her illness.

Effects of labeling

Prior to conducting analysis on labeling effects, we examined whether sociodemographic variables and history of previous contact with the mentally ill influenced the respondents' attitudes toward the target individual. We found that subjects having history of previous contact with the mentally ill were more accepting towards the person described in the vignette than those without contact history (social distance scores; mean ± SD, 2.1 ± 0.3 vs. 2.2 ± 0.4, respectively; unpaired $t = 2.1$; d.f. = 311; $P = 0.04$). The former group had less endorsement of negative stereotypes (negative stereotypes scores; mean ± SD, 2.0 ± 0.4 vs. 2.2 ± 0.3, respectively; unpaired $t = 2.1$; d.f. = 311; $P = 0.04$) and were more optimistic about recovery (prognosis scores; mean ± SD, 1.5 ± 0.5 vs. 1.7 ± 0.5, respectively; unpaired $t = 2.1$; d.f. = 311; $P = 0.04$). Subjects with religious beliefs were also more optimistic about recovery than those with no religious beliefs (prognosis scores; mean ± SD, 1.5 ± 0.6 vs. 1.7 ± 0.5, respectively; unpaired $t = 2.6$; d.f. = 311; $P = 0.009$).

There were no significant differences in sociodemographic characteristics and history of previous contact with the mentally ill between the participants randomly assigned to the four labeling groups. Analysis using ANOVA found that there were no statistically significant differences between the four labeling groups in social distance, negative stereotypes and attributions regarding schizophrenia.

Because history of previous contact with the mentally ill and religion were related to the attitudes measures, a series of 2 × 4 (Previous Contact/Religion × Label) ANOVA were conducted on each attitude measure. Significant interactions were found for religion and labeling conditions on ratings of social distance ($F = 5.1$; d.f. = 3, 305; $P = 0.002$) and negative stereotypes ($F = 3.8$; d.f. = 3. 305; $P = 0.01$) (Fig. 1). For subjects who did not have religious beliefs, no significant differences in ratings were found as a function of labeling condition. However, labeling condition did affect ratings of social distance and negative stereotypes for those with religious beliefs ($F = 4.5$; d.f. = 3; $P = 0.006$ and F = 3.6; d.f. = 3; $P = 0.02$, respectively). Post-hoc analyses using Tukey Honestly Significant Difference revealed that subjects with religious beliefs were more willing to interact with the person labeled as *si-jue-shi-diao* and *jing-shen-fen-lie-zheng* and had less endorsement of negative stereotypes about the vignette with a label of *jing-shen-bin* than one with no labeling.

DISCUSSION

This study investigated the effect of diagnostic labeling on attitudes toward symptoms of schizophrenia among 313 secondary school students aged 13–18 years. We

observed that most adolescents disagreed with keeping a distance from a person with symptoms of schizophrenia and the negative stereotypes about schizophrenia. The students having previous contact with the mentally ill held less stigmatizating views. Diagnostic labeling did not have a statistically significant main effect on the attitudes but the students with religious beliefs were more accepting toward a person with symptoms of schizophrenia in conjunction with label than one with no labeling. The adolescents with religious beliefs were also more optimistic about the prognosis of schizophrenia.

There have been limited studies on the public attitudes towards people with mental illness in Hong Kong. None has been conducted on specific psychiatric disorders. Previous studies suggested that Hong Kong people were quite negative towards the mentally ill and mental health facilities.[23,24] In contrast, a survey found that secondary school students in Hong Kong showed benevolence towards the sufferers and did not subscribe to stigmatizing and rejecting attitudes towards the mentally ill.[25] This survey and a study in Germany[18] were consistent with our finding that most adolescents did not endorse negative views about people with mental illness. We found that history of previous contact with people with mental illness was associated with greater acceptance of the mentally ill. This finding has been reported in many previous studies.[12,26–28]

We showed that psychiatric labeling did not have a major influence on attitudes towards people with schizophrenia when the symptoms of schizophrenia were presented. The finding was consistent with our hypothesis and agreed with studies on people with physical disabilities, which showed that politically correct descriptors such as 'person with a physical disability' did not improve attitudes relative to less 'correct' terms such as 'a disabled person'.[29,30] We have no data regarding the impact of the new program that uses the term s*i-jue-shi-diao* for publicity on attitudes towards mental illness and schizophrenia among Hong Kong Chinese. Our findings suggested that the adolescents in Hong Kong did not have negative stereotypes associated with the Chinese translation currently used to denote schizophrenia and the mass media advertisement using the new term *si-jue-shi-diao* had not resulted in better understanding and acceptance of people with schizophrenia.

An unexpected finding was that among students with religious beliefs, the reaction towards a person with symptoms of schizophrenia was more negative if the symptoms were not associated with a diagnostic label. We also found that students with religious beliefs were more optimistic about the prognosis of schizophrenia. One early study showed that church-goers tended to be less sympathetic and more authoritarian and socially restrictive towards people with mental illness, however, religious denomination had a significant influence on the attitudes.[31] We are not sure that the finding can be extrapolated to the adolescents in Hong Kong who have different backgrounds when compared with the adults in Toronto in the 1970s. The adolescents with religious beliefs might be sympathetic and benevolent toward sick people and diagnosing the symptoms of schizophrenia as mental illness delivered a message that the person was sick. Researches have shown that religion has a positive effect on physical and mental health. One explanation is that religious beliefs may foster optimism by claiming the existence of God that inspires hope.[32,33] This may explain the more optimistic views about the prognosis of schizophrenia among students with religious beliefs.

A few limitations should be noted in our study. We only studied secondary school students' attitudes toward people with schizophrenia. Our findings may not be applicable to members of the general public. Researches on psychiatric stigma in people of different age groups and sociocultural backgrounds are necessary. Students' self-reported attitudes toward people with schizophrenia did not necessarily correlate with actual behavior. One has to be careful when extrapolating our findings in real-life situations. Lastly, some may argue that describing an individual with acute psychotic features might lead the students to suspect a diagnosis of severe mental illness whether a label was mentioned or not. This raises an interesting issue about the use of politically correct labels. If labels are used alone with no mentioning of the symptoms of a psychiatric condition, a less pejorative term may serve to reduce stigma.[15] However, strategies to reduce stigma associated with schizophrenia should aim at the discredited and discreditable dimensions of stigma. Penn *et al*. showed that more information about post-treatment living arrangement could reduce negative judgments of an individual with symptoms of schizophrenia and a label 'schizophrenia'.[12] Our finding that students with religious beliefs were more accepting towards a person with symptoms of schizophrenia in conjunction with a diagnostic label indicated that labeling did not always have negative consequences.

CONCLUSION

We could not detect any attitude change towards people with schizophrenia by using a new, less pejorative diagnostic label among secondary school students in Hong Kong. Although there are many reasons for renaming the term schizophrenia in countries where

the Chinese writing system is used,[34] our finding does not support that renaming can improve the public attitudes towards people with symptoms of schizophrenia. We agree that mental health consumers prefer less pejorative terms to denote their illness but the cost of such practice is unclear. A non-specific or politically correct term for schizophrenia may convey an impression to consumers and their relatives that the condition is mild and self-limiting, hence influencing compliance to treatment. Members of the general public may attribute greater responsibility toward people with schizophrenia if a politically correct label is used to describe the illness.[15] In real life, mental health consumers may find it difficult to avoid other self-stigmatizating situations, such as consulting a psychiatrist and adherence to psychiatric medication. A name change for schizophrenia can also give rise to confusion about mental illness in the public. There may be disagreement among professionals with the new term used to describe schizophrenia, which can result in more confusion during diagnostic communication. Development of antistigma strategies should take into consideration the sociodemographic and cultural differences in attitudes toward people with mental illness. Emphasis should be given to programs that have proven effects. Public education and diagnostic communication can include an explanation that 'splitting-of-mind' is not an appropriate representation of people with schizophrenia.

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