Politically Correct Labels and Schizophrenia: A Rose by Any Other Name?

by David L. Penn and Amy Nowlin-Drummond

Abstract

This study investigated the role of politically correct labels in emotional reactions, attributions regarding illness, behavioral intentions, and knowledge of schizophrenia symptoms. Two samples, undergraduate students and community members, were asked to rate a target individual on various scales using one of four labels varying in "political correctness": consumer of mental health services, person with severe mental illness, person with schizophrenia, and schizophrenic. Results showed that the label "consumer of mental health services" was associated with less negative reactions and was considered to be reflective of a condition more likely to change relative to the other, less politically correct labels. However, this label did not result in greater behavioral intention to interact with persons with a psychiatric disorder. Furthermore, participants receiving this label identified fewer symptoms associated with *DSM–IV* criteria of schizophrenia and were more likely to attribute responsibility for the condition to the target person, relative to the other labels.

Keywords: Stigma, schizophrenia, politically correct, labeling, severe mental illness

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Stigmatization remains a significant problem for individuals with schizophrenia. In particular, persons with schizophrenia are viewed negatively by the general public (Farina 1998), with such views likely impacting the person with schizophrenia's self-esteem, social network, and reintegration into the community (see Wahl and Harman 1989 for a discussion of related issues). Thus, eliminating the stigma associated with schizophrenia has emerged as an important goal in the treatment of this disorder, in addition to reducing symptomatology and improving psychosocial functioning.

To reduce stigma, a number of direct interventions have emerged. These include promotion of contact between persons with schizophrenia and those in the community, and education to address misinformation about severe mental illnesses such as schizophrenia (e.g., that all persons with schizophrenia are extremely violent) (Corrigan and Penn 1999). In general, promotion of contact between community members and persons with schizophrenia has a favorable impact on negative attitudes (Kolodziej and Johnson 1996; Mayville and Penn 1998), while education to disabuse individuals of false impressions regarding schizophrenia tends to have positive, albeit short-lived, effects (Corrigan and Penn 1999). Thus, there is evidence that stigma may be reduced by directly changing individuals' attitudes toward persons with schizophrenia.

Indirect methods for reducing stigma have also been employed via the use of less pejorative, more "politically correct" labels to describe persons with schizophrenia (e.g., "consumer"). These labels are intended to counteract descriptors that are noun based (e.g., "schizophrenic") or outdated (e.g., "mental patient") (Kailes 1985), descriptors that by themselves can induce stigma in the absence of aberrant behavior (Link et al. 1987; Socall and Holtgraves 1992). However, despite the intuitive appeal of using benign labels to reduce stigma, there is no empirical evidence that politically correct labels affect attitudes toward persons with schizophrenia or other severe mental illnesses. In the area of physical disabilities, it was found that "nondisabling" descriptors (i.e., "person with a physical disability") did not improve attitudes relative to more "disabling" descriptors (i.e., "a disabled person") (Patterson and Witten 1987; Millington and Leirer 1996; Gouvier et al. 1997). Therefore, it is possible that mental health professionals and community members are adopting labels to describe persons with schizophrenia that may not reduce stigma.

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In this study, we compared the effects of labels, varying in political correctness, on participants' attitudes and behavioral intentions toward persons with schizophrenia, as well as their knowledge of the disorder. The attitudes that were measured included participants' emotional reactions and attributions regarding the disorder, attitudes often used to measure psychiatric stigma (Weiner et al. 1988; Penn et al. 1994; Penn et al. 1999; Corrigan 2000). It was hypothesized that more politically correct labels would result in less negative attitudes toward persons with schizophrenia. However, we also predicted that these labels would be associated with more ambiguity concerning their definition compared to less politically correct labels. Finally, to assess generalization of the findings, the study was investigated across two samples of research participants: undergraduate students and persons recruited from the community.

Method

Participants. The participants were 113 undergraduates from Louisiana State University and 77 nonundergraduate adults from the surrounding area. The demographic characteristics of these samples are summarized in table 1. One-way analyses of variance (ANOVAs) and chi-square tests revealed that the community sample was older ($F = 693.5$, $df = 1, 186$, $p < 0.01$) and had more years of education than the undergraduate sample ($F = 51.7$, $df = 1, 187$, $p < 0.01$). Finally, there were more participants of Asian background in the undergraduate sample ($\chi^2 = 12.25$, $p < 0.01$).

Labels. To find labels that varied in political correctness, a computerized review of the literature over the past 2 years (i.e., PsychLit, Medline, and major journals from the American Psychiatric Association and the American Psychological Association [APA]) was conducted, and 16 commonly used labels were selected (these labels are available from the first author). These 16 labels were then sent to persons who were either members of the Schizophrenia and Other Serious Mental Disorders (SOSMD) special interest group from the Association for the Advancement of Behavior Therapy or on the SOSMD membership mailing list. These individuals were either mental health professionals currently working with persons with severe mental illness or academicians with research experience in the area. The labels were rated on a seven-point Likert scale anchored by 1 (not at all politically correct) and 7 (very politically correct). Thirty-two individuals responded to the mailing.[1] Labels were then selected that were rated as "high" (i.e., "consumer of mental health services," $M = 6.59$[2]), "relatively moderate" (i.e., "person with schizophrenia" [$M = 5.56$], "person with a severe mental illness" [$M = 5.31$]), and "low" in political correctness ("schizophrenic," [$M = 1.53$]). Although the labels "person with schizophrenia" and "person with a severe mental illness" were rated comparably in political correctness, they were both selected because they are consistent with the APA's recommendation to use terms that do *not* equate the person with the disorder (APA 1994). Furthermore, including them both in the study provided an opportunity to determine whether the terms "schizophrenia" and "severe mental illness" have a differential impact on stigma.

Table 1. Sample descriptive statistics

Variable	Sample	
	Undergraduate	Community
Mean age (SD)	19.8 (2.4)	42.9 (8.8)*
Mean yrs of education (SD)	13.2 (1.1)	15.2 (2.6)*
Gender		
Males	53	37
Females	60	40
Ethnicity[1]		
Caucasian	81	68
African-American	12	6
Asian	15	0
Other	5	2

Note.—SD = standard deviation.
[1] One person from the community sample did not identify an ethnicity.
* $p < 0.05$

Two strategies were utilized for determining the reliability of the label ratings. First, we conducted intraclass correlation coefficients (ICCs) for the 32 respondents across the 16 labels. Using a two-way random model with absolute agreement as a criterion, the average ICC was high (0.98). Second, a one-way within-subjects ANOVA was conducted on the four labels selected for the study. The result of this analysis was significant ($F = 218.3$, $df = 3, 29$, $p < 0.01$), with post hoc tests showing that all labels significantly differed from one another with the exception of the labels "person with schizophrenia" and "person with a severe mental illness," which did not differ from one another. Therefore, the raters were able to reliably distinguish among labels high, moderate, and low in political correctness.

Dependent Measures. The following dependent measures were used in the current study: social distance, affective reaction, and dangerousness scales; attributions

[1] Approximately 100 label questionnaires were sent out.

[2] The label "consumer" was expanded to read "consumer of mental health services" to lend a bit more specificity to this term.

regarding mental illness; a symptom knowledge measure; and behavioral intentions. These measures were selected because they have been used in previous work on stigma and schizophrenia (Link et al. 1987; Penn et al. 1994; Penn et al. 1999) and they represent a range of potential reactions to someone with a mental illness (e.g., emotional, attributional). It should be noted that for each of the scales described below, participants were asked to rate a target individual according to one of the four psychiatric labels described above. For example, participants randomly assigned to the "schizophrenic" label were asked to rate a "schizophrenic" with respect to desired social distance, affective reaction, and other factors.

The Social Distance Scale comprises seven questions that refer to interaction with an individual with mental illness. Each question was rated by the subject on a four-point Likert scale anchored by 0 (definitely willing) and 3 (definitely unwilling). Performance on the Social Distance Scale is indexed by summing the seven items. The reliability for this scale was good (Cronbach's $\alpha = 0.81$).

The Affective Reaction Scale required that participants rate their emotional responses to a target individual with mental illness on ten bipolar adjective pairs (e.g., apprehensive–comfortable). The participant was instructed to rate each item on a seven-point scale with neutral being the midpoint. The internal consistency for this scale was 0.84.

The Dangerousness Scale comprised 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. Each item is rated on a seven-point Likert scale, with 1 being "strongly agree" and 7 being "strongly disagree." The internal consistency of this scale was 0.75.

To measure attributions regarding mental illness (Weiner et al. 1988; Corrigan 2000), participants responded to three questions asking them to rate a target individual's degree of blame and responsibility for his or her illness, as well as how likely the condition was to change. Each question was rated on seven-point Likert scales. The items and anchors were: Blame (not at all to blame–entirely to blame), Responsibility (not at all responsible–entirely responsible), and Changeability (likely to change–not likely to change).

Knowledge of symptoms associated with schizophrenia was measured by administering to participants a list of 11 common psychiatric symptoms (this symptom list is available from the first author). The symptoms were selected to represent a range of psychiatric disorders (e.g., obsessive-compulsive disorder, bulimia). Participants were instructed to circle the three symptoms associated with one of the four labels (i.e., consumer of mental health services, person with schizophrenia, person with a severe mental illness, or schizophrenic). A "symptom" score was computed based on the number of symptoms identified that were most consistent with *DSM–IV* criteria for schizophrenia (i.e., hallucinations, delusions, and bizarre behavior). Thus, the range of performance on this measure was 0–3.

Behavioral intention was measured with two items. The first item asked if participants were interested in attending a meeting at the university with persons with mental illness (i.e., using one of the four labels) from the community to discuss issues related to stigma. Participants were asked to indicate their interest in attending the meeting by circling either "yes" or "no" on the answer sheet. The second item asked participants to record their phone number so that they could be contacted regarding this meeting. Because responses on these two items were highly intercorrelated ($r = 0.98$), they were combined into a single behavioral intention variable. It should be noted that data on behavioral intention were included for only the undergraduate sample, as some members of the community sample lived outside the city limits, which likely influenced their responses to these items.

Procedure. Undergraduate participants were tested in a classroom of 20–30 persons per session. Community participants comprised staff-level employees at the university, who were sent packets via intercampus mail, and persons working in local businesses, who were contacted via research assistants.[3] Participants were randomly assigned to receive one of the four psychiatric labels. The order of the dependent variables was randomly determined for each participant, with the exception of the behavioral intention measure, which was always administered last.

Results

Preliminary Analyses. Prior to conducting the primary analyses, we examined whether there were differences in the demographic characteristics in the participants randomly assigned to the four labeling groups. The results of one-way ANOVAs and chi-square tests revealed that the four groups differed only in years of education ($F = 3.44$, $df = 3, 185$, $p < 0.05$); participants who received the label "person with schizophrenia" had significantly more years of education ($M = 14.9$) than participants who received the labels "person with severe mental illness" ($M = 13.7$) and "consumer of mental health services" ($M = 13.6$).

Because participants in the four labeling groups differed in years of education, we conducted a series of Pearson correlations between years of education and the

[3] Data on the response rate (i.e., the number of packets completed relative to those sent) for the community participants were not available.

dependent measures in the study. In general, years of education was weakly associated with the measures of stigma (i.e., average correlation = 0.05), with the only significant association being between years of education and ratings of perceived dangerousness ($r = -0.15$, $p < 0.05$). Therefore, any significant main or interactive effects involving the Label variable for ratings of dangerousness were repeated with education as a covariate.

Primary Analyses. To determine the effects of psychiatric label and sample on emotional reactions to the target individual, a 4 × 2 (Label × Sample) multivariate analysis of variance (MANOVA) was conducted on the Social Distance, Dangerousness, and Affective Reaction scales. The only significant multivariate effect was for Label ($F = 2.72$, $df = 9, 522$, $p < 0.005$). The effects of Sample ($F = 2.44$, $df = 3, 172$) and the Label × Sample interaction ($F = 0.93$, $df = 9, 522$) were both nonsignificant.

Following the significant MANOVA, a series of one-way (Label) ANOVAs was conducted separately on the Social Distance, Dangerousness, and Affective Reaction scales. All ANOVAs were significant (all p's < 0.01). Probing of the main effects with Tukey Honestly Significant Difference (HSD) post hoc tests revealed that the label "consumer of mental health services" resulted in less negative affective reactions and lower perceived dangerousness relative to the label "schizophrenic," and less desired social distance relative to the labels "person with severe mental illness," and "schizophrenic" (table 2, all p's < 0.05). It should also be noted that the difference in mean ratings of perceived dangerousness based on the labels "consumer of mental health services" and "person with schizophrenia" (with the latter being rated as more dangerous) approached statistical significance ($p < 0.055$).

The significant main effect of Label for the dangerousness scores was repeated including years of education as a covariate. The results were virtually unchanged, and in fact, the above trend of a difference between the labels "consumer of mental health services" and "person with schizophrenia" was now significant ($p < 0.05$).

Because only two of the three attribution measures were correlated with one another (i.e., Blame and Responsibility, $r = 0.62$, $p < 0.01$), a 4 × 2 (Label × Sample) MANOVA was conducted on the Blame and Responsibility variables, and a separate 4 × 2 ANOVA was conducted on the Changeability attribution measure. With respect to the MANOVA, the only significant effect was for Label ($F = 2.39$, $df = 6, 360$, $p < 0.05$). The effects of Sample and the Sample × Label interaction were both nonsignificant (p's > 0.20).

A series of one-way ANOVAs conducted on the Blame and Responsibility attribution measures revealed

Table 2. Stigma measures as a function of label (means and standard deviations)[1]

	Label			
Dependent variable	**Consumer of mental health services**	**Person with schizophrenia**	**Person with a severe mental illness**	**Schizophrenic**
Emotional reaction[2]				
Affective reaction	32.5[a] (9.3)	37.3 (9.2)	34.3 (8.7)	38.6[b] (8.3)
Dangerousness	27.7[a] (8.5)	32.3 (7.8)	31.5 (8.5)	33.1[b] (9.0)
Social distance	11.2[a] (3.6)	13.1 (3.9)	13.3[b] (3.2)	13.5[b] (4.2)
Attributions				
Blame[3]	2.9 (1.2)	2.3 (1.0)	2.9 (1.3)	2.8 (1.5)
Responsibility[4]	3.3[a] (1.3)	2.6[b] (1.1)	3.2 (1.3)	2.7 (1.4)
Changeability[5]	3.5[a] (1.2)	4.1 (1.1)	4.0 (1.2)	4.2[b] (1.3)
Behavioral intention (*n*)				
No	12	12	18	15
Yes	17	11	12	14
Knowledge of symptoms				
No. of symptoms identified[6]	0.93[a] (0.8)	1.5[b] (0.7)	1.2 (0.8)	1.5[b] (0.8)

[1] Means with different subscripts significantly differ from one another ($p < 0.05$).
[2] Higher numbers connote greater negative reactions.
[3] Higher numbers connote greater blame.
[4] Higher numbers connote greater responsibility.
[5] Higher numbers connote lower likelihood of changing.
[6] Higher numbers connote greater accuracy.

an effect for Label only on the Responsibility variable ($F = 3.25$, $df = 3, 184$, $p < 0.023$); participants rated the person with the label of "consumer of mental health services" as more responsible for his or her condition relative to the target individual with the label "person with schizophrenia" (Tukey HSD, $p < 0.05$, table 2). The effect of Label on ratings of blame attributed to the target person was not significant ($F = 2.10$, $df = 3, 184$, $p > 0.10$).

A 4 × 2 (Label × Sample) ANOVA conducted on the Changeability variable resulted in a main effect for Label that approached significance ($F = 2.60$, $df = 3, 180$, $p < 0.053$). Probing of this marginally significant effect revealed that participants rated the target person with the label "consumer of mental health services" as more likely to change relative to the person with the label "schizophrenic" (Tukey HSD, $p < 0.05$, table 2).

With respect to participants' intention to attend a meeting on campus with a group of persons with mental illness, a chi-square analysis conducted on the Behavioral Intention variable (i.e., "Yes" or "No" with respect to attending a meeting) as a function of label was not significant ($\chi^2 = 2.06$, *ns*) (for the undergraduate sample only).

Finally, a 4 × 2 (Label × Sample) ANOVA was conducted on the Symptom scores to determine whether the labels conveyed differential information regarding *DSM–IV* criteria for schizophrenia. The ANOVA resulted in a significant main effect for Label ($F = 5.1$, $df = 3, 182$, $p < 0.005$) and Sample ($F = 9.8$, $df = 1, 182$, $p < 0.005$), although the Label × Sample interaction was not significant ($F = 1.09$, $df = 3, 182$, *ns*). Probing of the Label main effect (Tukey HSD) revealed that participants administered the label "consumer of mental health services" identified fewer symptoms associated with schizophrenia, according to *DSM–IV* criteria, relative to participants who received the labels "person with schizophrenia" and "schizophrenic" (all p's < 0.05).

The significant main effect for Sample was due to the undergraduate group identifying more *DSM–IV* schizophrenia symptoms ($M = 1.44$) relative to the community participants ($M = 1.06$). Because undergraduate and community samples differed in age and years of education, this analysis was repeated including each of these variables separately as covariates.[4] Although the results were unchanged with years of education as a covariate, the significant difference between the groups was eliminated after age was included in the analyses ($F = 0.001$, $df = 1, 185$, *ns*).

[4] The undergraduate and community samples also differed in the percentage of participants of Asian descent. To determine the effect of ethnicity on the Symptom Knowledge variable, we conducted a one-way ANOVA on Symptom Knowledge as a function of ethnicity for only the undergraduate sample (i.e., to determine whether participants of Asian descent performed differently on this task relative to participants of other ethnic backgrounds). This ANOVA was not significant ($F = 0.93$, $df = 3, 109$, *ns*). Therefore, participant ethnicity was not included in the covariate analyses.

Discussion

This study investigated two issues relevant to the stigma associated with schizophrenia. The first issue concerned whether labels varying in political correctness have a differential effect on various indexes of stigma, including emotional reactions, attributions regarding mental illness, and behavioral intentions. Second, we sought to determine whether the study results were consistent across two samples of participants, namely undergraduate students and persons recruited from the community. These issues are discussed below.

The findings indicate that the label "consumer of mental health services," relative to less politically correct labels, was associated with less negative emotional reactions to a target individual. Furthermore, participants who received this label were more likely to indicate that the target person's condition could change over time relative to those participants who received the label "schizophrenic." However, use of this label may come at a price. For example, it was also associated with attributing greater responsibility to the target person for his or her illness. While this could potentially empower the individual in recovery, it could also have a negative impact (Corrigan 2000); research on expressed emotion suggests that symptoms that are viewed as under one's control, or intentional, may be especially likely to elicit critical comments (Weisman et al. 1998). Thus, encountering a "consumer of mental health services" may result in more benign reactions (i.e., relative to other psychiatric labels), but may also result in expectations that the person can, and should, change—an expectation that could produce frustration if the changes do not occur.

There is a second drawback to the label "consumer of mental health services." Specifically, relative to less politically correct labels, it conveys less information relevant to the diagnosis of schizophrenia. This raises an interesting issue, namely, the purpose of psychiatric labels. If psychiatric labels are meant to convey information regarding a specific category or object, then the label "consumer of mental health services" fails in this purpose. However, if the purpose of psychiatric labels is to destigmatize, then the "consumer" label is somewhat of a success. In fact, one could argue that this label is able to destigmatize because of its very nonspecificity to schizophrenia; it may refer to a variety of disorders rather than one in particular. Alternatively, labels such as "consumer" may destigmatize because they allow one to avoid utilization of more pejorative, stigma-inducing labels (e.g., "schizophrenic"). Indirect support for this latter hypothesis is found in the results of post hoc correlational analyses conducted between performance on the Symptom Knowledge measure and the study's

dependent variables.[5] Most of the correlations were not significant, which suggests that labels, politically correct or not, are important above and beyond what they convey about the nature of mental illness. As such, it is likely that psychiatric labels have multiple purposes, many of which are context dependent, so that evaluation of politically correct labels may have to be done on a situation-by-situation basis, rather than in a global manner.

A few final points should be made regarding politically correct psychiatric labels. First, the labels did not have a differential impact on behavioral intentions. Although behavioral intent is *not* the same as actual behavior, it is considered by some to be an important precursor of behavior (e.g., Theory of Reasoned Action, Fishbein and Ajzen 1975). These results, therefore, indicate that label effects at the attitudinal level may not translate into effects at the behavioral intention level (Krauss 1995). However, the impact on actual behavior cannot be assessed at this time. Second, it should be noted that the three less politically correct labels did not significantly differ from one another on any of the stigma measures. This suggests that the labels "person with schizophrenia," "person with severe mental illness," and "schizophrenic" may have similar effects on stigma. However, because the latter term equates the person with the disorder, it should be avoided (APA 1994). It also suggests that the label "person with severe mental illness" is no less pejorative than the label "person with schizophrenia." Therefore, the terms "severe mental illness" and "schizophrenia" may have similar connotations. Finally, inspection of the mean ratings on the stigma measures indicates that most were in the neutral range. Therefore, it may be inaccurate to characterize participants' attitudes toward persons with mental illness as "negative"; attitudes may be more or less neutral. Thus, future research should look at absolute ratings as well as relative differences in scale ratings.

The present findings indicate that the results were fairly consistent irrespective of sample studied. This is an important issue, as undergraduates differ from persons in the community on a number of cognitive and attitudinal variables (e.g., attitude crystallization and formation, sensitivity to peer pressure; Sears 1986). The only significant difference that emerged was the undergraduate sample identifying more symptoms associated with schizophrenia relative to the community participants. This likely reflects the undergraduate students' more recent exposure to psychology courses. Indirect support for this assertion was found after the analyses were repeated including age as a covariate; the significant difference between the groups was eliminated. Thus, the difference between these groups in their knowledge of schizophrenia symptoms was accounted for by the community sample's greater age, which may reflect this sample's greater number of years away from school, relative to the undergraduate sample. Otherwise, the results suggest that undergraduates and community members are quite similar with respect to their emotional reactions and behavioral intentions toward mental illness.

In closing, the findings from the present study suggest that we should exercise caution when adopting new labels to describe persons with schizophrenia. Although the label "consumer of mental health services" was generally associated with more positive reactions relative to less politically correct labels (e.g., "schizophrenic"), such labels may convey less specific information about the disorder in question. This paucity of information may lead the recipient to "fill in the blanks," which could have the untoward effect of increasing stigma. Furthermore, even if a particular label is currently "politically correct," there is still the possibility that, if continually paired with a particular disorder, it may eventually take on stigmatizing properties itself. Finally, we should actively include persons with the disorder themselves in the labeling process (Mueser et al. 1996), as asking their preference for what they are called may be another way of empowering them.

[5] The only variable significantly associated with the Symptom Knowledge measure was changeability ($r = 0.16$, $p < 0.05$); identification of more symptoms associated with schizophrenia was related to perceptions of the disorder as being less likely to change.

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