Approaches to Treatment of Schizophrenia as a Function of Evolving Stigma

Jacqueline Webster

Psychology Major

Thesis Advisor: Dr. Jan Gillespie, Associate Professor, Psychology

The College at Brockport

State University of New York

May 15, 2020

Schizophrenia's Definition and Hallmarks

In the early twentieth century, Eugen Bleuler coined the term Schizophrenia for a mental disturbance which he noted as being characterized by a separation of emotion and thought (Pridmore, 2016). Bleuler believed the defining feature of Schizophrenia to be a disorganized change in thought (Pridmore, 2016). Today, the *Diagnostic and Statistical Manual for Mental Disorders* (DSM; American Psychiatric Association, 2013) states that Schizophrenia is a complex mental disorder that is typically severe and often long lasting, characterized by both disturbed thought and behavior.

The diagnosis known as schizophrenia can be displayed through a variety of hallmark symptoms including, but not limited to, hallucinations, delusions, disorganized speech, catatonic behavior, and/or diminished emotional expression (DSM, 2013). Hallucinations are the experience of falsely perceiving in one's environment a stimulus which does not actually exist. Visual, auditory, or olfactory hallucinations are most common (Goldsworthy & Whitaker, 2015). Hallucinations are involuntary; an individual typically is not aware that the perceived stimuli are not real, although it is possible for one to be aware that they are hallucinating (Goldsworthy & Whitaker, 2015). The content of hallucinations can be anything that the human mind may come up with, often with very disturbing and frightening content including seeing figures or hearing voices. The content of auditory hallucinations may even encourage one to commit acts such as suicide or aggression toward others (Pratt, Gill, Barrett, & Roberts, 2014). Delusions are false beliefs that individuals continue to adhere to even if the delusions are disproven with fact (Stevens & Rodin, 2011). Stevens and Rodin (2011) note that it is important to look at the context of these beliefs because certain examples would not be considered delusional, such as belief in God(s) or religious stories in which miracles are performed. Thus, organized religion's

tenets or concepts --- where groups of people hold the same beliefs that cannot be proven – are not delusional. In contrast, one person's false belief in their own omnipotence could be considered a delusion. Common schizophrenic delusions include a belief that one is being hunted or watched, that one is particularly special (almost in a supernatural way), or that one is responsible for things far outside of their control (Stevens & Rodin, 2011). Finally, Will (1972) describes *catatonic behavior* as moving and speaking very little or not at all, being nonresponsive, showing muscle rigidity, and possibly including lack of eye movement or drooling.

Schizophrenic symptoms also can be classified on a dimension of "positive" versus "negative", with these adjectives implying not adaptive versus nonadaptive qualities, but rather symptoms reflecting either an increase (i.e., additive, "positive") or a decrease (subtractive, lessening) from levels of behavior that is a normal baseline. Accordingly, the positive symptoms in Schizophrenia can include hallucinations, which could be considered a much higher than average level of normal sensory experience; and delusions, a much higher than average level of imagination or fantasy (Pridmore, 2016). Negative symptoms in contrast often involve the reduction in a behavior or trait an individual once possessed, such as decreased emotional expression, lack of interest in socializing, loss of experiencing pleasure, and loss of organized speech and/or movement (Pridmore, 2016). Finally, one common consequence of having a severe mental illness is that people often stop caring about things that formerly were important to them, including grooming and personal hygiene, and/or maintaining a healthy diet and exercising (Pridmore, 2016).

The age of onset for symptoms of Schizophrenia typically varies in a range beginning in mid- to late adolescence through one's mid-thirties, with men typically showing symptoms

earlier than women (DSM, 2013). Schizophrenia is usually life-altering and disruptive, and can cause lack of productivity in all aspects of an individual's life (Pridmore, 2016). Schizophrenia is present in only about one percent of the population, but it can affect not only those with the disorder, but also their friends and family members, as well as the psychologists and psychiatrists who study the disorder and treat clients suffering from it (Pridmore, 2016).

Schizophrenia's Etiology

There have been many theories of possible factors that may play a role in causing Schizophrenia. In the 1950s, the disease was thought by professionals to be a reaction to severe anxiety, with lifelong symptoms that included withdrawing from society, relationships, and even one's own thoughts and feelings (Arieti, 1955). More recently, some researchers believe that an imbalance of certain neurotransmitters in the brain may have to do with the causation of Schizophrenia, such as an excess of dopamine (Torrey, 1983). This was believed to be true because certain antipsychotic drugs suppress dopaminergic activity in the brain. If lower levels lead to a reduction in symptoms, it was reasoned, higher levels of dopamine must be linked to the appearance of symptoms (Torrey, 1983). However, it has also been demonstrated that higher levels of dopamine are not the sole cause of Schizophrenia because other antipsychotics that do not suppress dopamine can still work to eliminate schizophrenic symptoms (Torrey, 1983).

Other theories of Schizophrenia's etiology include developmental and environmental possibilities. These theories focus upon negative factors that could impact pregnancy, such as trauma or stress on the mother, disease, the influence of drugs or alcohol, or improper nutrition (Torrey, 1983). While these factors could have a negative effect on a developing fetus, there is no way to determine absolute cause of Schizophrenia as being due to these factors (Torrey,

1983). Instead, Schizophrenia is most likely due to a combination of causes including both genetics and also environmental conditions.

In the mid-twentieth century, researchers believed that Schizophrenia had primarily genetic causes, ranging from the notion that Schizophrenia was caused by one single, heritable gene, to the idea that a number of these genes worked together to bring about the condition (Torrey, 1983). Numerous studies examining co-occurrence of schizophrenia in identical twins have been conducted in an attempt to determine how large a role genetics may play (Torrey, 1983). Taken together, findings indicate that a sibling diagnosis of Schizophrenia generally means only a thirty percent chance that the other identical twin would also develop the disease (Torrey, 1983). These results led researchers to believe that the etiology of Schizophrenia had to include other causes in addition to genetics, such as environmental factors (Torrey, 1983). Most researchers agree that there are genes which cause susceptibility to developing Schizophrenia, but that environmental factors also play a large role in whether or not symptoms of the disease begin to show (Torrey, 1983). This theory of Schizophrenia's dual origins is known as the *diathesis-stress* theory of schizophrenia. The diathesis-stress perspective holds that some individuals possess an inborn genetic predisposition which makes them more susceptible to a diagnosis of schizophrenia if, and when, they experience trauma or severe stressors in their lives (Rosenthal, 1970; Gottesman, 1991).

Historical Notions of Schizophrenia

Schizophrenia may be considered a "misunderstood" mental illness. Most people have heard of the disorder, but there are common misconceptions about the causes, symptoms, and treatments of it. Since the disorder was discovered, there have been many different attitudes and beliefs that have evolved over time as new knowledge arose. During the time of the Renaissance,

Schizophrenia was thought of as ridiculous and humorous, and Schizophrenic patients were laughed at when describing their symptoms (Schleiner, 1985). Today, Schizophrenia is known by mental health professionals as a serious disorder with multiple debilitating symptoms.

During the Middle Ages and the Renaissance, many people in Western Europe believed that those with psychotic illnesses were possessed by demons or involved in witchcraft (Evans, 1966). Due to these beliefs, there were few attempts to treat the mentally ill in positive or productive ways, but rather many of them were persecuted or "exorcised" to rid them of their so-called demons (Evans, 1966). Interestingly enough, the ancient Greeks and Romans believed that mental illnesses were just as legitimate as physical illnesses and they were one of the only societies before modern times to study and accept mental illness (Evans, 1966).

In the early twentieth century, one common misconception about Schizophrenia was that poor parenting could cause a child to one day develop the disorder (Torrey, 1983). In particular, children with "bad mothers" were thought to be most at risk (Torrey, 1983). "Bad mothers" could include mothers who were overbearing, controlling, highly anxious, or rejecting (Harrington, 2016). These incorrect beliefs had their roots in Sigmund Freud's theories about so-called "infantile sexuality" and his hypothetical "Oedipal conflict" pertaining to children's sexual wishes about parents (Torrey, 1983). Torrey states that Freud actually knew little about Schizophrenia and was not particularly interested in educating himself further about it because he did not care to see Schizophrenic patients. The faulty reasoning behind this notion was that there were many people with Schizophrenia, and also a lot of people with "bad mothers", therefore these things must be correlated (Torrey, 1983). However, little to no scientific evidence has ever supported a "bad parenting" theory of schizophrenia's cause.

In the mid- twentieth century, the "bad mother" theory grew to include other family members. Studies of this beginning in the early twentieth century were deeply flawed because these studies had no control groups, and showed a confirmation bias towards Freud's theory. By the mid-twentieth century, more valid studies were published on these topics, demonstrating that parental qualities did not cause children to develop Schizophrenia (Torrey, 1983).

Schizophrenia and Stigma

The Oxford *Dictionary of Psychology* defines stigma as "a mark of disgrace associated with a particular circumstance, quality, or person" (Colman, 2008). Byrne (2000) states that stigma can occur due to any experience or condition that is different from that which is considered mainstream. Stigma surrounding mental illness is still a prominent issue in the present day (Byrne, 2000), and it can have significant detrimental effects. Many people with mental illness experience shame and isolation due to stigma, and people often suffer great losses of relationships with friends, family, and romantic partners upon becoming ill (Baker & Procter, 2015). Also, people with mental illness may internalize stigma and criticism and start to believe negative things about themselves, including that they are incompetent, violent, irrational, or unworthy of love or appreciation (Dingfelder, 2009).

Link and Phelan (2006) enumerated five steps for conceptualizing stigma. These steps include labeling differences, attaching stereotypes to differences, separating oneself from those with differences, discriminating against the group that is different, and finally exercising power over said group. For example, conceptualizing stigma against Schizophrenia could include: labeling individuals as Schizophrenic and attaching stereotypes to those with Schizophrenia, such as their being "dangerous, stupid, crazy, etc." (Link & Phelan, 2006). The outcome of this can be separation from those labelled as Schizophrenic ("us vs. them"), and discriminating

against Schizophrenic individuals, such as being verbally disrespectful towards them. Finally, exerting power over Schizophrenic individuals, such as using forceful treatment, may also result.

Stigma separates people from each other because of fear or ignorance. If the origin and causation of stigma are studied, attempts to alter or eliminate it can be made. Decreasing stigma could result in more people being accepting of Schizophrenic persons, and help create a climate where individuals could better focus on their treatment and symptom reduction. Unfortunately, stigma against the mentally ill can even be a factor in non-improvement of symptoms regardless of treatment (López-Ibor, 2002). Therefore, the main research question of the current review is "How have treatment practices for Schizophrenia developed as attitudes of the disease have evolved throughout the twentieth and twenty-first centuries?" The basis for this research question is that new knowledge has changed attitudes and stigma surrounding Schizophrenia, which has then had an impact on the treatment practices of the disease.

Early Treatment Practices in Schizophrenia

One of the earliest "treatment" practices was relocating those suffering with mental illness to quiet, peaceful locations such as the countryside in hopes that they would be able to rest and get better. A historically accurate short story by Charlotte Perkins Gilman (2013) titled "The Yellow Wallpaper", depicts the journal entries of a woman experiencing psychosis in 1892. The journal entries describe how the woman's husband, a physician and a very logical man, rents a home in the country for the summer and confines his wife to the upstairs room to heal (Gilman, 2013). He had diagnosed his wife as having "temporary nervous depression with a slight hysterical tendency", which was a common diagnosis for women at that time (Gilman, 2013). The journal entries bring to light the negative attitudes toward mental illness and the lack of understanding/desire to treat those affected (Gilman, 2013).

One of the most famous, even infamous, early-mid twentieth century treatments of Schizophrenia was lobotomy. Lobotomies were introduced in the United States in 1936, and are best described as invasive brain surgeries that alter brain function and inflict neurological damage (Johnson, 2014). One major effect of a lobotomy is the difference in emotional expression before and after the surgery, as typically, lobotomized patients express little to no emotion afterwards (Johnson, 2014). There were different types of lobotomies, but one of the most common was prefrontal lobotomy, in which the area between the thalamus and the frontal lobes of the brain was surgically destroyed (Johnson, 2014). Lobotomies would now be considered barbaric and outdated, but the procedure was once thought to be innovative and successful in treating maladaptive psychological symptoms and even improving psychotic symptoms. Tens of thousands of patients received them (Johnson, 2014). Freeman is thought responsible for the use of lobotomies accomplished with ice picks, which were forced through the eye sockets of patients to damage the frontal lobes; he was even given awards for his work. While perhaps a more accepted procedure in the early-mid twentieth century, lobotomies now are historically acknowledged as cruel and inhumane (Johnson, 2014).

Johnson (2014) recounts the story of client Howard Dully, who was lobotomized as a boy in 1960. His memoir as an adult described his experiences and life, and clearly convey the stigma linked to everything associated with serious mental illness. Before Dully opened up about his experiences, he had told very few people about his lobotomy, explaining that he was certain that people would think he was a freak, and treat him like a “drooling Frankenstein monster”. Dully kept his secret out of fear of stigmatization.

Institutionalization as Treatment

In the 19th and early 20th centuries, lack of knowledge and discrimination due to stigma also led to many mentally ill people being institutionalized in state hospitals, less formally known as asylums (Chow & Priebe, 2013). There were multiple reasons why mental institutions were built, including the attempt to create a facility where mentally ill clients could have a high level of care away from the stress of their normal life (Fakhoury & Priebe, 2007). Institutions were typically built away from urban areas because it was thought that urban areas created more stress that could harm recovery, and so most institutions were built in comfortable, less busy areas (Fakhoury & Priebe, 2007). Dorothea Dix was an American activist who played a particular role in the rise of state hospitals. She campaigned for better living and treatment conditions for patients, many of whom were put in prisons before her efforts (Paulson, 2012). While Dix and others held hope that the mentally ill would be more sympathetically protected and cared for in state hospitals, others favored the idea because it would separate the mentally ill from the rest of polite society in state-controlled institutions. Thus, the stigmatization of the mentally ill as disgraceful or unfit for interaction with others persisted (Paulson, 2012).

Unfortunately, many state hospitals never evolved to have the quality of care that Dix had dreamed of (Paulson, 2012). Many hospitals also accepted the elderly or physically ill members of society who had nowhere else to go (Paulson, 2012). Institutions were built with a good intent, but became very overcrowded and lacked adequate funding (Fakhoury & Priebe, 2007). Many clients living in institutions experienced poor health and unhygienic conditions, and there were many cases of staff in these facilities treating the patients unethically and abusively (Fakhoury & Priebe, 2007).

Deinstitutionalization

In the mid-1950s, there were almost 560,000 patients with mental illness in state hospitals, compared to approximately 110,000 today (Mechanic & Rochefort, 1990). Deinstitutionalization, a movement to reduce and close state hospitals, began in the 1970's (Paulson, 2012). Many mentally ill patients who had been living in institutions (spending varying amounts of time there) were sent back into the community to live and continue treatment, hopefully with more personal freedom. This freedom proved beneficial for some but it made life more difficult for others due to individuals' widely varying support systems and access to treatment (Paulson, 2012). Also, deinstitutionalization occurred during a time of social and political reform in America. Society was changing; values of independence, freedom to make life choices, and self-determination became highly important (Bachrach, 1975). Moreover, deinstitutionalization coincided with the community mental health movement, which saw a shift to more community-based treatment programs and a focus on prevention of institutionalization (Bachrach, 1975). There was societal and political pressure to close mental hospitals due to some institutions' poor living conditions, questionable treatment practices, and lack of preparation of clients for independent living (Bachrach, 1975). Some patients stayed institutionalized due to the severity of their illness and need for a high level of care, but many patients were able to again live in the community and function with outpatient programs and community support (Bachrach, 1975).

Not surprisingly, there were different opinions among Americans about mentally ill individuals leaving the institution to be integrated back into the community, and not all reactions were positive (Bachrach, 1975). Some people preferred it when mentally ill persons were separated from the rest of society; those same people did not welcome those with mental illnesses back for community-based treatment (Bachrach, 1975). Paulson (2012) claims that

given this, the seriously disturbed may deny their illnesses. They may be held responsible for the diagnosis, instead of being taken care of, a phenomenon noted in community psychology as "blaming the victim" (Rappaport, 1977). Though there are many outpatient programs that provide wonderful treatment options, many individuals may not seek or keep up with their own treatment. Evidence of this is that there are now more mentally ill persons in jail than in mental hospitals (Paulson, 2012).

Schizophrenia in the mid-late 20th Century

In the 1950's, most Americans were uneducated about mental illness, particularly Schizophrenia (Phelan, Link, Stueve, & Pescosolido, 2000). Many citizens narrowly defined mental illness as psychosis; it was believed among the public that if you were mentally ill, you must have psychotic symptoms, which is not always true (Phelan et al., 2000). Generally, the American people's attitudes toward mental illness were those of fear and rejection (Phelan et al., 2000). The mid-20th century was a time of rapid growth in American society and medicine, and attitudes toward mental illness were slowly evolving as deinstitutionalization and treatment advances occurred.

One huge evolution in the treatment of Schizophrenia was the discovery of successful antipsychotic drugs which controlled the more dramatic and debilitating symptoms. Discovery of the successful antipsychotic medication was serendipitous; a French surgeon studying treatments for surgical shock in 1952 observed that the drug Thorazine (brand name Chlorpromazine) affected patients' mental states for the better (Kane & Correll, 2010). A French psychiatrist then used Chlorpromazine on Schizophrenic patients and found that the drug calmed their severe symptoms (Kane & Correll, 2010). Chlorpromazine was approved for widespread use in the

United States by the Food and Drug Administration in 1954; by ten years later, it had been used to successfully treat almost 50 million cases of schizophrenia (Kane & Correll, 2010.)

Baloush-Kleinman, Levine, Roe, Shnitt, Weizman, & Poyurovsky (2011) conducted a study into adherence to one's medical regimen in patients with Schizophrenia and Schizoaffective disorder who were taking antipsychotics. The researchers found that the individuals who took antipsychotics as instructed to had an abundance of positive outcomes including: more awareness of their illness and their need for treatment, a better relationship with their doctor, more perceived social support, and fewer overall negative events (Baloush et al., 2011). Thus, adhering to medical instructions as prescribed with antipsychotics can greatly improve symptoms and overall functioning in these clients.

The discovery of the first antipsychotics was very important in the treatment history of Schizophrenia, and early antipsychotics are still used today (Miyamoto, Duncan, Goff, & Lieberman, 2002). These "first generation" antipsychotics controlled the positive symptoms of Schizophrenia, such as hallucinations and delusions, but they did not improve negative symptoms, such as loss of pleasure, speech/movement, and changes in sociability (Miyamoto et al., 2002). In addition, these antipsychotics were not effective for all clients who tried them (Miyamoto et al., 2002). Between twenty five and sixty percent of Schizophrenic clients either did not experience an improvement in symptoms or only experienced partial improvement (Miyamoto et al., 2002). There were also a number of side effects that were often experienced by clients, including tardive dyskinesia, which causes repetitive and uncontrollable movements that may be displayed in the face or limbs and can persist over the long term (Jeste & Caligiuri, 1993). These issues have been addressed, and newer, "second generation" antipsychotics with fewer side effects are more commonly used today (Miyamoto et al., 2002).

The development of second-generation antipsychotics allowed improvements in the side effects shown by older antipsychotic drugs, including interference with movement and motor skills (Jeste, Rockwell, Harris, Lohr, & Lacro, 1999). Newer antipsychotics can improve both positive and negative symptoms of Schizophrenia whereas the older antipsychotics improved positive symptoms only (Jeste et al., 1999). Unfortunately, however, the newer antipsychotic drugs came with a new set of side effects, including weight gain and obesity, hyperglycemia (a sign of diabetes), and hyperlipidemia (high cholesterol). Hudepohl and Nasrallah (2012) note that newer antipsychotics have begun to be used not only with psychotic disorders, but also for other mental disorders such as bipolar disorder and major depressive disorder.

Along with antipsychotics, Schizophrenic individuals may choose to accompany this treatment with psychotherapy for a combination treatment which has been linked to better treatment outcomes particularly when there is a strong therapeutic relationship (Hewitt & Coffey, 2005). Though psychotherapy may help Schizophrenic clients, medication is typically the most popular and effective treatment method (Hewitt & Coffey, 2005). Medication has helped many clients, but there are critics of the modern psychiatry system as well. Bentall (2009) argues that modern psychiatry is too heavily focused in the biological aspect of mental illness and states that medication may be overprescribed. Haddad, Brian, and Scott (2014) noted the dilemma of nonadherence in taking one's medications as a key issue as well. Schizophrenic individuals may forget to keep up with their medication or refuse to take it due to many reasons, including believing they are better and no longer need them, or suspicion of the medication's effectiveness. The result is often a relapse in symptoms (Haddad, Brain, & Scott, 2014). Despite the pros and cons of psychiatry, medical professionals are continually working to improve medications and other treatment options for all mental illnesses.

Modern Attitudes and Evolving Stigma

Nordt, Rössler, and Lauber, (2006) examined attitudes towards Schizophrenia in the general public and among mental health professionals. Results demonstrated that the average American lacks knowledge about Schizophrenia and favors minimal contact with Schizophrenic persons. Mental health professionals report more receptivity to persons with Schizophrenia, but don't necessarily want contact with Schizophrenic clients (Nordt, Rössler, & Lauber, 2006). It has also been found that both the general public and mental health professionals would rather spend time with an individual diagnosed with major depression than an individual with Schizophrenia (Nordt, Rössler, & Lauber, 2006). During psychotic outbreaks, few Schizophrenic clients understand or grasp that they are mentally ill, and few of them understand that they are in need of treatment (McEvoy, Aland, Wilson, Guy, & Hawkins, 2006). These obstacles can also cause a wide gap in Schizophrenic and non-Schizophrenic individuals' social contact.

Stigma surrounding Schizophrenia has evolved throughout time, which has also changed treatment. During the middle ages, Schizophrenia was not taken seriously (Schleiner, 1985). Medical professionals, communities, and even family members did not understand the disorder and Schizophrenic individuals were ridiculed and dismissed by most; therefore treatment consisted of demonic exorcisms or being put to death (Schleiner, 1985). During the late 19th and early 20th centuries, institutionalization began as a form of treatment for the severely mentally ill (Chow & Priebe, 2013). Some professionals, such as Dorothea Dix, took mental illness seriously and tried to create institutions as nurturing environments to take care of patients, although not all professionals were as caring towards mentally ill persons (Paulson, 2012). Many families, communities, and even some professionals, welcomed this segregation of the mentally ill from the rest of society (Bachrach, 1975).

Physician Emil Kraepelin began characterizing symptoms of Schizophrenia in the early 20th century, feeling that it was a distinct disorder (Bhati, 2013). By 1952, the first edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) was published, which demonstrated that consistency in defining mental illness was beginning to be valued (Bhati, 2013). Also during the mid-20th century, the community mental health movement and deinstitutionalization occurred, leading to closing of institutions and the transitioning of many mentally ill individuals back into communities (Paulson, 2012). The first antipsychotics were also discovered during this time period, which had an important impact on Schizophrenic treatment (Kane & Correll, 2010).

There were many mixed attitudes toward mental illness during the mid-20th century. Many professionals had hope for Schizophrenic treatment upon the discovery of antipsychotics (Kane & Correll, 2010). Woodward (1951) collected data on community attitudes toward mental illness during this time period. Many people said that they would not be ashamed to discuss a friend or family member who was mentally ill (Woodward, 1951). Additionally, many people agreed that there were not enough mental health services in their community (Woodward, 1951). However, there were also communities and families that wanted mentally ill individuals to stay institutionalized (Bachrach, 1975).

Since the first edition of the DSM, there have been four updated versions, each with new disorders, more specific characteristics, and more information known about mental disorders (Bhati, 2013). Newer antipsychotics emerged which eliminated many side effects of earlier antipsychotics (Miyamoto et al., 2002). Therapy has been coupled with medication for the best outcomes (Hewitt & Coffey, 2005). Silton, Flannelly, Milstein, & Vaaler (2011) studied stigma among Americans toward the mentally ill in 1996 and 2006. At both time periods, randomly

selected participants were read vignettes about mentally ill individuals and were tested to see how much social distance participants would desire with these clients (Silton et al., 2011). Results showed that participants in 1996 desired more social distance from the mentally ill than the participants in 2006. In particular, the participants who were younger and more educated were less likely to desire greater social distance (Silton et al., 2011). These findings demonstrate that stigma had slightly evolved throughout the decade between trials. Although Schizophrenia is better understood now than in the past, especially by mental health professionals, there are still many people who remain largely uneducated about the disorder and continue to hold negative attitudes toward those with Schizophrenia.

Reducing Stigma

According to Byrne (2000), mental health professionals need to address issues surrounding stigma with their mentally ill clients. The clients are not likely to mention that they are feeling rejected, stigmatized or ashamed of their illness, so it is important for those in clinical or medical positions to broach the subject (Byrne, 2000). One way to ask about stigma-related experiences could be to ask about relationship or job losses, experiences where they felt they had a disadvantage due to their illness, or times they felt excluded or embarrassed by others (Byrne, 2000). Byrne even suggests that dealing with the repercussions of stigma should be included in treatment plans for all clients.

Crant (2018) examined the effects of media portrayal of Schizophrenia on the occurrence of stigma. In this study, one group of participants watched a video demonstrating a professor with Schizophrenia successfully teaching a class, while the control group watched a documentary about koala bears. Results showed that participants in the experimental group thought more positively about Schizophrenia and rated those diagnosed with it as less dangerous

than the participants in the control group (Crant, 2018). These results suggest that educating people and portraying Schizophrenia in a positive manner can effectively lead to a reduction in stigma.

It is important to note that there are communities in the world that do not condone stigma toward the mentally ill. One city in Belgium called Geel is the oldest therapeutic community in Europe and perhaps the world (van Bilsen, 2016). The citizens in Geel have practiced the family foster care model for centuries, in which mentally ill individuals live in community residences with foster families who care for them (van Bilsen, 2016). Mentally ill people are accepted into families and are treated as a member of the family; they are given normal expectations to help out around the house and in the community, and they are loved and cared for in nurturing environments (van Bilsen, 2016). Geel sets a great standard and is a model that other communities can take inspiration from in the reduction of stigma.

Conclusion

Erving Goffman believed that stigma against the mentally ill was some of the most damaging social stigma one could experience, due to mentally ill individuals being treated as indefinitely "ruined" people with minimal rights and relationships (Stuart, 2008). Stigma is a powerful force that is difficult and time consuming to change, and many important mental health organizations, such as the World Association for Social Psychiatry, consider stigma to be a serious public health challenge (Stuart, 2008). Throughout the world, many organizations in different countries have begun to create interventions and anti-stigma programs to combat this important issue (Stuart, 2008). More than ever, people are becoming aware of stigma and attempts are being made to improve negative attitudes. Looking at past attitudes and treatment

practices of mental illness, particularly Schizophrenia is vitally important, because it can help to ensure that progress continues toward the improvement of people's lives.

Hahn (2018) describes how biogenetic explanations for Schizophrenia can actually cause more stigma compared to societal and humanitarian explanations. When people are told that genetics and biology cause Schizophrenia, they often don't blame individuals for having Schizophrenia, but they perceive them as being more dangerous and desire more social distance from them (Hahn, 2018). In future research, it would seem important to investigate the reasons why biogenetic explanations of schizophrenia lead to greater stigma than environmental explanations. In addition, another suggestion for future research is to examine more deeply media portrayals of Schizophrenia and how these can play a part in reducing stigma. Because so many people throughout the world have access to a form of media, this could be accomplished on a large scale. Finally, it would be interesting to see other communities adopt the foster family care system of Geel, Belgium, and study the differences and success stories in different therapeutic communities.

References

American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.). (2013). Washington, DC: Author.

Arieti, S. (1955). *Interpretation of schizophrenia*. NY: Robert Brunner.

Bachrach, L. L. (1975). Deinstitutionalization- an Analytical Review and Sociological Perspective. *National Institute of Mental Health*.

Baker, A., & Procter, N. (2015). Relationship Loss and Mental Illness. *Archives of Psychiatric Nursing*, *29*(*2*), 96-101. doi: 10.1016/j.apnu.2014.11.007.

Baloush-Kleinman, V., Levine, S. Z., Roe, D., Shnitt, D., Weizman, A., Poyurovsky, M. (2011). Adherence to antipsychotic drug treatment in early-episode schizophrenia: A six-month naturalistic follow-up study. *Schizophrenia Research, 130(1–3),* 176-181. doi:10.1016/j.schres.2011.04.030.

Bentall, R. P. (2009). *Doctoring the mind*. NY: New York University Press.

Bhati, M. T. (2013). Defining Psychosis: The evolution of DSM-5 schizophrenia spectrum disorders. *Current Psychiatry Research, 15,* 409. doi:10.1007/s11920-013-0409-9

Byrne, P. (2000). Stigma of mental illness and ways of diminishing it. *Advances in Psychiatric Treatment*, *6*(*1*), 65-72. doi:10.1192/apt.6.1.65

Chow, W.S., & Priebe, S. (2013.) Understanding psychiatric institutionalization: a conceptual review. *BMC Psychiatry 13,* 169. doi:10.1186/1471-244X-13-169

Colman, A. M. (2008). Stigma. In *Oxford Dictionary of Psychology (3rd ed.)*

Crant, J. (2018). The relationship between media portrayal of schizophrenia and attitudes toward those with schizophrenia, *Journal of the Indiana Academy of the Social Sciences, 21(1),* 48.

Dingfelder, S. F. (2009). Stigma: Alive and well. *American Psychological Association*, *40*(*6*), 56.

Evans, J. L. (1966). Witchcraft, Demonology, and Renaissance Psychiatry. *The Medical Journal of Australia*, *2*(*1*), 34-39. doi: 10.5694/j.1326-5377.1966.tb73383.x

Fakhoury, W., & Priebe, S. (2007). Deinstitutionalization and reinstitutionalization: major changes in the provision of mental healthcare. *Psychiatry*, *6*(*8*), 313-316. doi:10.1016/j.mppsy.2007.05.008.

Gilman, C. P. (2013). *The Yellow Wallpaper*. Start Publishing LLC. ISBN: 9781627933957.

Goldsworthy, R., Whitaker, H. (2015). Neural basis of hallucinations. *International Encyclopedia of the Social & Behavioral Sciences*, *2*, 499-503. doi: 10.1016/B978-0-08-097086-8.54010-0.

Gottesman, I.I. (1991). *Schizophrenia genesis: The origins of madness*. NY: Freeman.

Haddad, P. M., Brain, C., & Scott, J. (2014). Nonadherence with antipsychotic medication in schizophrenia: challenges and management strategies. *Patient related outcome measures, 5*, 43–62. doi:10.2147/PROM.S42735

Hahn, P. D. (2018). Hyping biological nature of mental illness worsens stigma. *Baltimore Sun*.

Harrington, A. (2016). "Mother Love and Mental Illness: An Emotional History." *Osiris, 31*, 94-115. doi:10.1086/687559

Hewitt, J., & Coffey, M. (2005). Therapeutic working relationships with people with schizophrenia: Literature review. *Journal of Advanced Nursing, 52*: 561-570. doi:10.1111/j.1365-2648.2005.03623.x

Hudepohl, N. S., Nasrallah, H. A. (2012). Antipsychotic drugs, *Handbook of Clinical Neurology, 106*, 657-667. doi:10.1016/B978-0-444-52002-9.00039-5.

Jeste, D. V., Caligiuri, M. P. (1993). Tardive dyskinesia. *Schizophrenia Bulletin, 19(2),* 303–315. doi:10.1093/schbul/19.2.303

Jeste, D. V., Rockwell, E., Harris, M. J., Lohr, J. B., Lacro, J. (1999). Conventional vs. newer antipsychotics in elderly patients. *The American Journal of Geriatric Psychiatry, 7(1),* 70-76. doi:10.1097/00019442-199902000-00010.

Johnson, J. (2014). *American lobotomy: A rhetorical history*. Ann Arbor, MI: University of Michigan Press.

Kane, J. M., & Correll, C. U. (2010). Past and present progress in the pharmacologic treatment of schizophrenia. *The Journal of Clinical Psychiatry*, *71*(*9*), 1115–1124. doi:10.4088/JCP.10r06264yel

Link, B. G., Phelan, J. C. (2006). Stigma and its public health implications. *The Lancet, 367*(*9509*), 528-529. doi:10.1016/S0140-6736(06)68184-1.

López-Ibor J. J. (2002). The power of stigma. *World psychiatry: Official Journal of the World Psychiatric Association* (*WPA*), *1*(*1*), 23–24.

McEvoy, J. P., Aland, J., Wilson, H. W., Guy, W., Hawkins, L. (2006). Measuring chronic Schizophrenic patients' attitudes toward their illness and treatment. *American Psychiatric Association*. doi:10.1176/ps.32.12.856.

Mechanic, D., Rochefort, D. A. (1990). Deinstitutionalization: An appraisal of reform. *Annual Review of Sociology, 16*(*1*), 301-327. doi: 10.1146/annurev.so.16.080190.001505

Miyamoto, S., Duncan, G. A., Goff, D. C., Lieberman, J. A. (2002). Therapeutics of schizophrenia. *Neuropsychopharmacology: The Fifth Generation of Progress, 56*.

Nordt, C., Rössler, W., Lauber, C. (2006). Attitudes of mental health professionals toward people with schizophrenia and major depression. *Schizophrenia Bulletin*, *32*(*4*), 709–714. doi:10.1093/schbul/sbj065

Paulson, G. (2012). *Closing the asylums: Causes and consequences of the deinstitutionalization movement*. Jefferson, NC: McFarland & Co.

Phelan, J., Link, B., Stueve, A., & Pescosolido, B. (2000). Public conceptions of mental illness in 1950 and 1996: What Is mental illness and is It to be feared? *Journal of Health and Social Behavior, 41(2),* 188-207.

Pratt, C., Gill, K., Barrett, N., Roberts, M. (2014). Symptoms and etiology of serious mental illness. *Psychiatric Rehabilitation, 3*, 33-74. doi: 10.1016/B978-0-12-387002-5.00002-0.

Pridmore, S. (2016). Schizophrenia. *Download of Psychiatry*, 7.

Rappaport, J. (1977). *Community psychology: Values, research, and action*. NY: Holt, Rinehart, & Winston.

Rosenthal, D. (1970). *Genetic theory and abnormal behavior*. NY: McGraw-Hill.

Schleiner, W. (1985). Renaissance exempla of schizophrenia: The cure by charity in Luther and Cervantes. *Renaissance and Reformation*, 9(3), 157-176.

Silton, N. R., Flannelly, K. J., Milstein, G., Vaaler, M. L. (2011). Stigma in America: Has anything changed?: Impact of perceptions of mental illness and dangerousness on the desire for social distance: 1996 and 2006. *The Journal of Nervous and Mental Disease, 199(6),* 361-366. doi: 10.1097/NMD.0b013e31821cd112

Stevens, L., Rodin, I. (2011). Mental state examination. *Psychiatry*, *2*, 10-11. doi: 10.1016/B978-0-7020-3396-4.00009-3.

Stuart, H. (2008). Fighting the stigma caused by mental disorders: Past perspectives, present activities, and future directions. *World Psychiatry*, 7: 185-188. doi:10.1002/j.2051-5545.2008.tb00194.x

Torrey, E. F. (1983). Surviving schizophrenia: A manual for families, patients, and providers (5th ed.). NY: HarperCollins.

van Bilsen H. P. (2016). Lessons to be learned from the oldest community psychiatric service in the world: Geel in Belgium. *BJPsych bulletin, 40(4),* 207–211. doi:10.1192/pb.bp.115.051631

Will, O. A. (1972). Catatonic behavior in schizophrenia. *Contemporary Psychoanalysis*, *9*(*1*), 29-58. doi: 10.1080/00107530.1972.10745252

Woodward, J. (1951). Changing ideas on mental Illness and its treatment. *American Sociological Review, 16(4),* 443-454.