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**The effect of diagnostic labels on attitudes toward the mentally
ill**

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The University of Arizona, 1987

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THE EFFECT OF DIAGNOSTIC LABELS ON
ATTITUDES TOWARD THE MENTALLY ILL

by

Jeffrey Victor Dozoretz

A Thesis submitted to the Faculty of the
DEPARTMENT OF PSYCHOLOGY
In Partial Fulfillment of the Requirements
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ABSTRACT

In order to investigate the possible detrimental effects of psychiatric diagnostic labels, two related experiments were performed. Subjects rated case descriptions of persons who could be said to suffer from mental illness, under various label conditions. There was an expectation that the history of a diagnostic label would have an effect on the attitudes expressed toward a person who bore that label, with labels with more extensive histories leading to more stigma than those with shorter or no histories. The obtained results did not support the hypotheses forwarded concerning differential effects of psychiatric labels. This lack of support was discussed as a possible result of methodological problems with the design and subject characteristics of this investigation.

CHAPTER 1

INTRODUCTION

The public image of mental illness has been studied extensively (e.g., Cumming & Cumming, 1957; Nunnally, 1961). Typical results of such studies have indicated that the public lacks accurate knowledge about mental disorders. Furthermore, studies have repeatedly demonstrated that, "...the mentally ill are regarded with fear, distrust, and dislike by the general public" (Nunnally, 1961: p.46). In general, there is a stereotype of mental illness which is grossly exaggerated and inaccurate, and the behavior of most persons who are mentally ill does not correspond to that stereotype (Gove, 1973). Gussow and Tracy (1968) found that in "a fantasy of total maximal illness," people feel that the two darkest fates one can suffer are to lose one's body with leprosy, or to lose one's mind with mental illness. In fact, attitudes towards lepers have been shown to be better than those towards the mentally ill (Nunnally, 1961). Other research has indicated that the mentally ill suffer losses of social esteem in a wide range of social roles. For instance, the highly negative role of ex-convict is viewed as more desirable than the role of ex-mental patient (Lamy, 1966).

These attitudes may seem medieval, which may be because they carry with them many of the same biases about mental illness held in the past. Furthermore, many of the terms now used to describe the mentally ill, both popular and diagnostic, have their origins in days long gone by. The aim of this paper is to examine the possibility that our attitudes towards the mentally ill come from the ancient world, with the biases being transmitted through the surviving terminology. The suggestion has been made that there may be some value to knowledge of past events that concern mental illness, as the disagreeable events of the past could very well influence contemporary opinions of mental illness (Farina, 1982).

Historical Background

Primitive and Ancient Societies

Deviant behavior has been recognized in every society throughout recorded history. Even before this, there is reason and evidence which would lead one to believe that deviant behavior was recognized in primitive societies. A look at the history of attitudes toward, and conceptions of, mental illness indicates that the mentally ill have long been misunderstood, feared, or despised. Long before scientific explanations were employed, magic and superstition were used to explain that which was not understood. The deviant behavior of the mentally ill is not an exception to this rule.

Primitive people are usually considered to have been animistic and superstitious. Skulls, which have survived from the stone age, have been found in Peru with small holes, or trephines, cut through the forehead. Based upon what is thought about primitive beliefs, these trephines are assumed to have been cut in order to allow evil spirits to escape from inside the skull. The assumption is, of course, that the evil spirits were responsible for the deviant behavior. Although purely conjectural, the evidence suggests that, even before recorded history, people attributed the cause of mental illness and deviant behavior to evil.

From these early beginnings, there grew a strong doctrine of demonology. That is, the belief that an autonomous evil being could reside within an individual and control his or her mind and body. Throughout the times of primitive societies, and well into early Egyptian, Roman, and Greek civilizations, psychological problems were thought to be the result of spirits and demonic possessions (Zilboorg & Henry, 1941).

At this point in history, however, there was a break with the intellectual orientation of the times. The ancient Greeks became the first group of people to incorporate man's behavior within the natural sciences. Hippocrates was the first, and most important, to question the prevailing belief that the gods controlled the state of man's mind. In an attempt to remove mental illness from the hands of the priests, Hippocrates insisted that mental disorders had the same causes as other diseases. His basic

premise was that human behavior was directly controlled by bodily structures or substances. Hippocrates' writings may be seen as a forerunner of many aspects of modern thought. However, despite Hippocrates' influence on other educated Greeks and Romans of the time, the evidence suggests that his writings were not generally accepted, but rather, were what became the point of view of a few brilliant and unique individuals who had little influence on their society (Ullmann & Krasner, 1969).

Middle Ages and European Societies

Near the end of the fifth century A.D., the civilization built primarily by the Greek and Roman societies collapsed. The great progress they had made in philosophy, medicine, and science was abandoned. In the uncertainty of the times, people, once again, turned to religion to supply the answers. Christianity began to find new strength throughout Europe. Meanwhile, backed by theology, the approach toward abnormal behavior again favored demonology. At first, theology recognized that the mentally ill may have been unwillingly seized by the devil as punishment for sins. In fact, until the thirteenth century, the church officially held that the mentally ill were simply innocent victims of the devil (Rotenberg, 1978). Given this, treatment procedures of the time were largely humane. The mentally ill could find refuge in monasteries. There, mild treatment techniques such as prayer, exorcism, or the use of herbs and holy water, were practiced.

With time, however, the innocence of the mentally ill was questioned. Any connection with the devil was suspect, in that there must have been something about the victim which attracted the devil. By the fourteenth and fifteenth centuries, public sentiment, as well as official church doctrine, began to hold that mental illness was the direct result of possession, which followed a deliberate pact with the devil. The tolerance and humane treatment afforded the "innocent victims of the devil" was no longer seen as appropriate for those who voluntarily entered a pact with Satan. Because these "witches" did the devil's work, they were seen as a physical and moral threat to their communities. The result of this was extreme intolerance for these deviants.

On December 9, 1484, Pope Innocent VIII issued a papal bull in which he encouraged the clergy of Europe to search for and drive out all witches from the frontiers of the faithful (Zilboorg & Henry, 1941). This decree began a religious mission, which was not only supported by the church, but was upheld by the science and politics of the times. Furthermore, the bull ushered in a period, which would last through three centuries, during which the treatment of the mentally ill was tragic and brutal.

Throughout the centuries which followed Pope Innocent VIII's pronouncement, the mentally ill were hunted and accused as witches, tortured to obtain confessions, and put to death. The logic was simple. Once an individual was diagnosed as a witch, the

body had to be made into an uncomfortable home for the devil. This could be accomplished through whipping, beating, stoning, or, even best, by burning. Those who were not put to death were subjected to terrible tortures and inhumane conditions, much of this under the authority of the medical experts of the time.

Large numbers of the mentally ill were housed in dungeons and jails. There they were confined to small spaces, and were often shackled to the walls. This represented the "enlightened" treatment procedures used throughout Europe in the sixteenth through eighteenth centuries. The use of fright, bloodletting, and purgatives were also common treatment techniques. Even those whom history has depicted as humane and enlightened were not always above such procedures. Phillippe Pinel, famous for the removal of the chains from the people imprisoned in a large asylum in Paris in the late 1700's, argued that the mentally ill should be treated as sick human beings, rather than as animals. However, sections of his classic, A Treatise on Insanity (1801) indicate that he advocated the use of force and fraud, and relied on terror and coercion in his treatment of the mentally ill (Pinel, 1973).

American Society

From this European backdrop, the early colonists came to the New World. Along with their physical possessions, these settlers brought the culture and attitudes of their lands with them. One of the European customs which found widespread acceptance in the New

World was witch hunting. Two well defined periods of witch hunting swept across the colonies. The first of these in the period from 1647-1663, and the second from 1688-1693 (Deutsch, 1949). In the most famous of these colonial witch hunts, hundreds of people were arrested in Salem, Massachusetts within a few months, in 1692. Nineteen died. Meanwhile, back in Europe, the last witch was killed in England in 1722, in Germany in 1775, and in Switzerland in 1782 (Ullmann & Krasner, 1969).

The official medical position on mental disorder was no more enlightened in the colonies than in the lands that fathered them. In fact, as there was no real incentive for the more skilled European physicians to travel to America, the medical profession in the colonies probably represented a less enlightened position than its European counterpart. Benjamin Rush is considered by many to be the father of American psychiatry. Depleting agents, such as bloodletting, purgatives, and emetics, held a primary place among his remedies. Furthermore, Rush accepted the necessity of coercion by restraint and certain forms of corporal punishment, such as whippings, in his treatment of the mentally ill (Deutsch, 1949; Rush, 1973).

Modern Attitudes

With the rise of moral treatment in the late 1700's, medical and scientific views of mental illness began to approach more modern outlooks. The question still exists, however, if our attitudes

towards the mentally ill have really changed much over the years since the Middle Ages. Some recent research would suggest that the modern public is more enlightened in their approach to mental illness. That is, that the public has come a considerable distance toward the rejection of old beliefs and superstitions about mental illness, and toward the adoption of more modern scientific viewpoints (Woodward, 1951). Lemkau and Crocetti (1962; Crocetti & Lemkau, 1965) have been among the more vocal supporters of this position. On the basis of data from a large urban sample, they were able to conclude that attitudes have changed in favor of the mentally ill, and that the time has come to discount the theory that the mentally ill are subjected to rejection. This position, however, appears to receive support only from a small minority of investigators.

Most modern research seems to indicate that little progress has been made to improve the public image of the mentally ill. While many of the studies in this area were done a long time ago, often with questionable methodologies, they have continued to indicate that attitudes toward the mentally ill may lead to rejection and stigmatization (Cumming & Cumming, 1957; Nunnally, 1961). Even children's attitudes toward the mentally ill lead them to rate the mentally ill more negatively than normals, cripples, or retardates (Wilkins & Velicer, 1980). Surely, however, both sides can not be correct. Farina (1982) suggests that the failure to distinguish between attitudes toward patients, and information

about the nature of mental disorders, may account for some of the inconsistencies in the literature. Certainly, the research would support the notion that the public is better educated in regards to mental illness. The fact that the public is better informed about mental illness does not imply that they harbor more positive attitudes. In fact, additional information has been shown to be ineffective in the promotion of attitude change in regards to mental illness (Altrocchi & Eisdorfer, 1961). Thus, the more favorable results of some recent studies may reflect that people know more about mental illness, but not that they feel differently.

To further argue against the position that attitudes toward the mentally ill have changed, Bord (1971) points out that the effort to reeducate the public in regards to mental illness has acquainted them with psychiatric symptomatology, and has made favorable responses to direct questions about mental illness normative. He goes on to conclude that publically displayed attitudes will continue to be favorable, while reactions to the mentally ill will continue to be characterized by rejection. In other words, the trend toward greater knowledge and sophistication in regards to mental illness may have given the public a "verbal smokescreen" which permits them to hide their true feelings (Rootman & Lafave, 1969).

In an attempt to study whether this is true, Neff and Husaini (1985) examined both the medical and moral models of mental

illness. As has been shown, for most of the history of the world, mental illness has been conceptualized morally. That is, mental illness was seen to be the result of sin or demonic possession, and was to be dealt with by punishment, exclusion, or execution. This view was contrasted with a more modern, medical model. This point of view holds that patients are not morally responsible for their illnesses, and, thus, should not be punished or looked down upon for them. Those who would endorse the medical model should, therefore, be more tolerant of the mentally ill. What was found, however, was the tendency for the endorsement of the medical model to be associated with less tolerance. This would seem to suggest lip service to the medical model, while people actually retain a moralistic image of mental illness. When examined, then, one might suspect that poor attitudes toward the mentally ill may be firmly anchored in our cultural belief system, and are not very susceptible to modification (Olmsted & Durham, 1976).

Psychiatric Labels

The question of how these attitudes are transmitted still remains. As has been suggested, the answer to this question may be found in the terminology used to describe mental illness. Much of the diagnostic and popular terminology used today has roots in the demonology and prejudice of the ancient world. Just as the mentally ill were once seen as creatures in the grip of the devil, we now ask, "What possessed him?". Furthermore, the phrase that one is

"beside himself," or "has lost his senses," is simply a survival of the ancient belief that the soul could leave the body (Neaman, 1975). The term "lunatic" implies that a person may be affected with intermittent insanity which can be attributed to changes in the moon (Hare, 1981). Despite the fact that most people, no doubt, use these terms with no conscious awareness of their original meanings, one must be careful not to overlook the possible unconscious influence these terms might have.

Popular descriptions of mental illness are not the only place in modern psychology where the influence of the past can be seen. Much of the diagnostic classification system has roots in ancient times. Mania and melancholia appear in most classification systems from the time of Hippocrates on (Hare, 1981; Sprock & Blashfield, 1983). Through the years, the classification system has been revised many times. Pinel simplified the diagnostic system to four fundamental types, mania, melancholia, dementia, and idiotism, that resembled Hippocratic categories. In 1885, the Congress of Mental Medicine derived a single system in which eleven categories were agreed upon. These included mania, melancholia, dementia, periodical insanity, progressive systematic insanity, organic and senile dementia, general paralysis, insane neurosis, toxic insanity, moral and impulsive insanity, and idiocy (Sprock & Blashfield, 1983). Of note is the fact that most of these terms are still recognizable today.

There is reason to believe that, through the years, many of these terms used to describe mental illness have taken on connotations based upon the poor image of mental illness of the times. Osgood, Suci, and Tannenbaum (1957) demonstrated that words have more than simply their denotative meaning. Words, or concepts, come to take on additional, or connotative meanings. Furthermore, affect may become associated with words. If this is so, the terminology which is used to describe mental illness might have taken on some surplus, connotative meaning. Given the negative image of mental illness throughout history, and the bias of popular terminology used to describe mental illness, modern diagnostic labels might serve to bias the public toward the rejection of the mentally ill.

The notion that people might be perceived differently when a label is attached to their behavior is not a new one. Research on mental retardation has consistently found a significant differential effect on people's judgements of cases under different labelled conditions (Budoff & Siperstein, 1978; Elam & Sigelman, 1983; Foley, 1979). When psychiatric labels are considered, Rosenhan (1973) is perhaps the most noted of those who maintain that they have an influence on the perception of those who bear them. In his now famous study, Rosenhan sent pseudopatients to gain admission into psychiatric hospitals. Each complained of a single psychiatric symptom, but behaved as usual in all other respects. Upon admission to the hospitals, each was given a psychiatric diagnosis. From that

point on, Rosenhan reports, each pseudopatient was seen in terms of their psychiatric label. All behaviors were interpreted in such a way as to remain consonant with the diagnosis. In fact, once so labelled, the pseudopatients were never detected as malingerers.

Rosenhan's study does not stand alone. Many studies exist which suggest that the process of labelling the mentally ill has a detrimental effect on how they are perceived. At various times, slides (Leimkuhler & Ziegler, 1978), audio tapes (Temerlin, 1968; 1970), and video tapes (Gjerde, Sand, & Kleiven, 1979) of unfamiliar individuals have all been rated while under various labelled conditions. In each case, subjects were influenced to see psychopathology in cases where there was none, or to ignore existant psychopathology, simply by the manipulation of how the condition was labelled. These labels were also shown to affect evaluations of the actors' pasts. In another study (Rothaus & Morton, 1962), job applicants involved in role play exercises were rated considerably more favorably when they described themselves, and their hospitalization, in problem centered, as opposed to mental illness terms. The authors suggest that mental illness terms are overloaded with meanings and connotations that stand in the way of attitude change. When given the chance to rate the mental illness terminology, patients themselves rated popular descriptions less well than diagnostic labels. Both, however, were rated more negatively than problem oriented terminology (Crompton & Groot,

1966). Again, while much of this work may be outdated, the findings seem consistent, and important enough to look at.

Some, however, would still suggest that diagnostic labels do not contribute to the rejection of the mentally ill. Dr. Robert Spitzer, who is in large part responsible for the current diagnostic classification system, has indicated that he does not believe "...that labels by themselves, have very much to do with the way people perceive patients with mental disorders" (R.L. Spitzer, personal communication, March 26, 1985). Yet, in this very same communication, he admits that, "In developing D.S.M. III we did try to avoid terms that were likely to be stigmatizing." Still, Spitzer maintains that patients with mental illness generally exhibit all sort of undesirable behaviors, and that these behaviors are the basis for societal rejection.

A number of studies would, however, suggest that Spitzer may not be correct when he assumes that societal rejection of the mentally ill is based only on the undesirable behaviors patients might exhibit. When people have been presented with descriptions of persons with various types of mental disorders, very often attempts are made to dismiss the descriptions as normal. Only the most extreme forms of mentally ill behavior are recognized as such by most people (Cumming & Cumming, 1957; Star, 1961; Yarrow, et.al., 1955). That is, only when the behaviors described deviate a great deal from what is considered normal will people define these behaviors as mental illness. Only when this behavior is recognized

as that which might be labelled mental illness, do we find rejection (Phillips, 1967). Among those who seek help, rejection is much more evident when the source of help defines the problem as one of mental illness. For instance, Phillips (1963) found that individuals described with identical behavior are increasingly rejected as they are described as utilizing no help, the clergy, a physician, a psychiatrist, or a mental hospital. Further, a normal case description leads to more rejection when the person described is said to be utilizing a psychiatrist than does a description of a schizophrenic who seeks no help. Nunnally (1961) approached the problem more directly, and found that words and communications connected with mental illness usually create a fairly high level of anxiety. Although these studies were done a long time ago, they seem to indicate that the rejection of the mentally ill may not result solely or primarily from the undesirable behaviors they might exhibit, but also from the labels which are imposed on them.

Some, who have recognized the possible detrimental effects of psychiatric labels, have proposed the elimination of the classification system. Among the most famous of the proponents of this position is Thomas Szasz. Szasz argues that mental illness is no more a real explanation for man's problems in social living than was witchcraft or demonology (Szasz, 1960). He suggests the replacement of psychiatric diagnosis with a purely descriptive system that focuses on behaviors. While this might solve the

problem of how to remove the stigma of diagnostic labels, the elimination of the diagnostic classification system does not seem reasonable.

Despite the pitfalls, there are purposes to psychiatric diagnosis. Diagnostic labels help mental health professionals to communicate with each other, enable them to better conceptualize the processes involved in psychiatric illness, and help them to control these disorders. This control involves the ability to predict course and outcome of a particular illness, and yields valuable treatment information (Spitzer, 1975). Thus, despite the negative connotations, some form of diagnostic classification system seems indicated.

Although, for the above stated reasons, the total elimination of the diagnostic nosology does not seem viable, this does not imply that there is nothing that can be done to remove the negative connotations of the diagnostic labels. Szasz (1961) makes the point that when the term "mentally ill" replaced the term "malingering," the image of those who were thought to be malingerers improved considerably. The Group for the Advancement of Psychiatry (1966) urged the replacement of much of the mental illness terminology in any statutes which dealt with the mentally ill. These included such terms as "commitment," "insanity," and "lunacy". The substitution of more benign terms, such as "hospitalization" and "mental illness," was sought to improve the image of the mentally ill. Although these words reflect more of the

popular terminology associated with mental illness, there is reason to believe that the image of the mentally ill might be improved by the replacement, not the elimination, of many of the diagnostic labels.

To summarize, then, the possible detrimental effects of psychiatric diagnostic labels have been documented. However, the benefits of a standardized classification system can not be overlooked. Given that mental illness labels are probably necessary, the labels to be used should be chosen carefully. While it is true that changes have been made, of note is the fact that many of the labels that are now in use originated at a time when mental illness was poorly understood. Further, changes that have been instituted have not been empirically studied to determine what, if any, differential effect these changes may have had on the perception of the mentally ill. If misconceptions have become associated with the labels, then diagnostic labels may lead to the rejection of the mentally ill not only because they are labels, but also as a result of the surplus, incorrect connotations associated with the labels.

To address this issue, two experiments, in which subjects rated case descriptions of persons who could be said to suffer from mental illness under various label conditions, were performed. There was an expectation that the history of a diagnostic label would have an effect on the attitudes expressed toward a person who bore that

label. Labels with an extensive history were expected to be more stigmatizing than those with a shorter history, which, in turn, were expected to lead to more rejection than no label at all. In addition, medical sounding labels were included to examine the possibility that these might be viewed more favorably than psychological diagnostic labels. The following studies were designed in order to attempt to directly test these hypotheses.

CHAPTER 2

EXPERIMENT 1

Method

Subjects

Sixty subjects (30 male, 30 female) were recruited from the undergraduate population at a large southwestern university. Students participated in order to partially fulfill the requirements of an introductory psychology course. Subjects self selected into the study.

Procedure

Case descriptions were written to represent persons suffering from Schizophrenia, Dementia, and Mania (See Appendix). In order to determine how reliably and validly these descriptions represented the disorders they were intended to, mental health professionals were asked to read each, and to assign what they felt would be the most appropriate diagnosis from the Diagnostic and Statistical Manual, Third Edition (D.S.M. III) (American Psychiatric Association, 1980). Twenty clinical psychologists were randomly selected from a local telephone directory, and sent the unlabelled case descriptions along with an explanation. Five of the twenty returned the descriptions with their diagnostic impressions. Of the five returned, all five

identified the case description of the person suffering from mania within the diagnostic category intended, four identified the case description of the person suffering from dementia within the diagnostic category intended (one was returned undiagnosed), but only two correctly identified the case description that was intended to represent schizophrenia. As such, this case description was revised, and the above procedure was repeated with different psychologists. Again, five were returned. Of those returned, for each of the case descriptions, all of the mental health professionals assigned a diagnosis within the diagnostic category intended. This was taken as evidence of the reliability and validity of the case descriptions.

Subjects were recruited and randomly assigned to four conditions. The unlabelled case descriptions served as a control condition. Three experimental conditions differed only in one respect. In the experimental groups, the first sentence of each case description was followed by a sentence which stated: "(Name) suffers from what psychologists would call (diagnostic label)". Cases were labelled with either the current D.S.M. III diagnoses, fictional psychological sounding diagnoses, or fictional medical sounding diagnoses. In order, these were: Schizophrenia, Dysocia, or Acortica; Dementia, Acognia, or Myelinia; and Mania, Affectia, or Limbicalis. These case descriptions represented disorders which bear diagnostic labels which have not been changed in recent years, as opposed to those in Experiment 2, which have. Labels were consistent across case descriptions within each condition.

Subjects were told that this research was intended to examine how people react to various types of other people. They were told that each person described was very different from the others, with very different personality characteristics. Subjects were asked to read each case description, form an impression of the person described, and fill out the short measures which followed each. Subjects completed the study and were debriefed as to the exact nature of the investigation.

Two measures followed each case description. The first was a semantic differential scale (Osgood, et al., 1957) (See Appendix). This consisted of twelve adjective pairs, Four for each of the three identified factors of this measure; Evaluative, Potency, and Activity. The Evaluative factor was made up of the following adjective pairs: good - bad, successful - unsuccessful, beautiful - ugly, and reputable - disreputable. The Potency factor was made up of the following adjective pairs: hard - soft, strong - weak, heavy - light, and severe - lenient. The Activity factor was made up of the following adjective pairs: active - passive, excitable - calm, hot - cold, and rash - cautious. These adjective pairs were selected as a function of their having been identified as loading very strongly on their respective factors (Osgood, et al., 1957). Subjects were asked to circle the number which most closely described how they felt about the person they had read about. The score for each adjective pair was scaled from one, for the most positive extreme, to seven, for the

most negative extreme. A score of four indicated a completely neutral response on an item. Positive and negative responses were counterbalanced, and adjective pairs for each factor were evenly mixed throughout the measure.

The semantic differential was followed by the Interpersonal Judgement Scale (I.J.S.) (Byrne, 1971) (See Appendix). This served as an interpersonal attraction measure. This measure is composed of six questions which cover various topics related to the person in question. These include intelligence, knowledge of current events, morality, adjustment, subject's personal feelings toward, and subject's desire to work together in an experiment. Each question is scaled from an extremely positive to an extremely negative response. This is a seven point scale, counterbalanced across questions. Subjects completed these scales for each of the case descriptions. Responses were scored, and the results were analyzed.

Results

Responses on both measures were scored from one, for the most positive extreme, to seven, for the most negative. Total scores were calculated for each measure. Repeated Measures Analysis of Variance (ANOVA) was performed in order to determine if there were significant differences among reactions to the case descriptions under the various label conditions. Analysis of total scores revealed no significant differences. The Semantic Differential was then divided into the three described factors. Again, no significant differences

were found with the Repeated Measures ANOVA. Finally, the individual items of each measure were examined, again with no significant differences found.

As a second level analysis, One-way Analysis of Variance was performed for each case study. Analysis of total scores revealed no significant differences. The semantic differential was then divided into the three described factors. One-way ANOVA was again performed to see if significant differences existed across label conditions on these factors. The only significant finding occurred on the Potency factor for the Mania case description ($F = 2.978, p = 0.0391$). Means were as follows: Control, 11.2667; Current D.S.M. III label, 13.5333; Fictional psychological sounding label, 14.0667; and Fictional medical sounding label, 14.7333. The Newman-Keuls method of multiple comparisons was used to determine that the significant difference was the result of the control condition being judged more positively than the other conditions, among which there were no differences.

Finally, the individual items of each measure were examined with One-way ANOVA. Only the successful - unsuccessful adjective pair on the Evaluative factor of the semantic differential yielded a significant result ($F = 3.335, p = 0.0257$), and that only for the Dementia case description. Means were as follows: Control, 1.9333; Fictional psychological sounding label, 2.0667; Current D.S.M. III label, 2.7333; and Fictional medical sounding label, 3.0000. The Newman-Keuls method of multiple comparisons was used to determine that the significant difference was the result of the control and

fictional psychological sounding labels being judged more positively than the other conditions. No I.J.S. questions yielded significant differences.

CHAPTER 3

EXPERIMENT 2

Method

Subjects

Seventy five subjects (40 male, 35 female) were recruited from the undergraduate population at a large southwestern university. Students participated in order to partially fulfill the requirements of an introductory psychology course. Subjects self selected into the study.

Procedure

Case descriptions were written to represent persons suffering from Histrionic Personality Disorder, Anti-social Personality Disorder, and Anxiety Disorder (See Appendix). In order to determine how reliably and validly these descriptions represented the disorders they were intended to, mental health professionals were asked to read each, and to assign what they felt would be the most appropriate diagnosis from the Diagnostic and Statistical Manual, Third Edition (D.S.M. III) (American Psychiatric Association, 1980). Twenty clinical psychologists were randomly selected from a local telephone directory, and sent the unlabelled case descriptions along with an

explanation. Five of the twenty returned the descriptions with their diagnostic impressions. Of the five returned, for each of the case descriptions, all of the mental health professionals assigned a diagnosis within the diagnostic category intended. A second mailing, to different psychologists, again yielded five returns which confirmed the original findings. This was taken as evidence of the reliability and validity of the case descriptions.

Subjects were recruited and randomly assigned to five conditions. The extra condition in this experiment reflects the fact that the mental disorders represented here bear diagnostic labels which actually have been changed in recent years, as compared to those in Experiment 1, which have not. Again, the unlabelled case descriptions served as a control. The four experimental conditions differed only in one respect. In the experimental groups, the first sentence of each case description was followed by a sentence which stated: "(Name) suffers from what psychologists would call (diagnostic label)". Cases were labelled with either the current D.S.M. III diagnoses, the appropriate diagnoses from previous editions of the Diagnostic and Statistical Manual, fictional psychological sounding diagnoses, or fictional medical sounding diagnoses. In order, these were: Histrionic Personality Disorder, Hysterical Personality Disorder, Accentic Personality Disorder, or Neurotropic Disinhibition; Anti-social Personality Disorder, Sociopathic Personality Disorder, Externalized Personality, or Frontal Diaschisis; and Anxiety Disorder, Anxiety Neurosis,

Apprehension Disorder, or Parahippocampal Metabolis. Labels were consistent across case descriptions within each condition.

Subjects were told that this research was intended to examine how people react to various types of other people. They were told that each person described was very different from the others, with very different personality characteristics. Subjects were asked to read each case description, form an impression of the person described, and fill out the short measures which followed each. The measures used were identical to those described in Experiment 1. Subjects completed the study and were debriefed as to the exact nature of the investigation. Responses were scored, and the results were analyzed.

Results

Responses on both measures were scored from one, for the most positive extreme, to seven, for the most negative. Total scores were calculated for each measure. Repeated Measures Analysis of Variance (ANOVA) was performed in order to determine if there were significant differences among reactions to the case descriptions under the various label conditions. Analysis of total scores revealed no significant differences. The Semantic Differential was then divided into the three described factors. Again, no significant differences were found with the Repeated Measures ANOVA. Finally, the individual items of each measure were examined, again with no significant differences found.

As a second level analysis, One-way Analysis of Variance was performed for each case study. Analysis of total scores revealed a significant finding on the I.J.S. for the Anti-social Personality Disorder case description ($F = 2.572$, $p = 0.0452$). Means were as follows: Previous D.S.M. label, 28.9333; Current D.S.M. III label, 32.3333; Fictional psychological sounding label, 32.6667; Control, 33.0000; and Fictional medical sounding label, 33.6667. The Newman-Keuls method of multiple comparisons was used to determine that the significant difference was the result of the Previous D.S.M. label condition being judged more positively than the other conditions, among which there were no differences. No other total score was found to be significant.

The semantic differential was then divided into the three described factors. One-way ANOVA was again performed to see if significant differences existed across label conditions on these factors. No significant differences were found. Finally, the individual items of each measure were examined with One-way ANOVA. For the Anti-social Personality Disorder case description, the I.J.S. Adjustment item demonstrated a significant difference among the label conditions ($F = 2.523$, $p = 0.0486$). Means were as follows: Previous D.S.M. label, 5.0667; Current D.S.M. III label, 5.2667; Control, 5.6667; Fictional medical sounding label, 5.8000; and Fictional psychological sounding label, 6.0000. The Newman-Keuls method of multiple comparisons was used to determine that the significant difference was the result of the Previous D.S.M. and the Current

D.S.M. III labels being judged more positively than the other conditions. The I.J.S. item tapping subjects' personal feelings toward the person described showed significant differences among the label conditions, again for the Anti-social Personality Disorder case description ($F = 2.610$, $p = 0.0427$). Means were as follows: Previous D.S.M. label, 4.2000; Control, 5.1333; Fictional psychological sounding label, 5.3333; Fictional medical sounding label, 5.4000; and Current D.S.M. III label, 5.6000. The Newman-Keuls method of multiple comparisons was used to determine that the significant difference was the result of the Previous D.S.M. label being judged more positively than the other conditions, among which there were no differences. No other individual item showed significant differences on either measure for any of the case descriptions.

CHAPTER 4

DISCUSSION

As discussed above, in each of these two experiments, there was an expectation that the history of a diagnostic label would have an effect on the attitudes expressed towards a person who bore that label. Labels with an extensive history were expected to be more stigmatizing than those with a shorter history, which, in turn, were expected to be more stigmatizing than new labels, with no history. Any label, of course, was expected to lead to more rejection than no label at all. Finally, medical sounding labels were included with the thought that these might be viewed more favorably than psychological diagnostic labels. As has been indicated, the results obtained did not support any of the above expectations. There may be many reasons for this outcome.

The first, and perhaps simplest, explanation for the obtained results would be the possibility that the basic premise of the hypotheses was wrong. That is, that negative conceptions of mental illness did not become associated with diagnostic labels, so did not result in their becoming a source of social stigma, or, at least, that that association has changed in recent years. While this might be the natural conclusion drawn given the results of the investigations, there still seems something curious about such a conclusion. While the results did not support a difference in

attitudes under various label conditions, there was also no evidence found to suggest a difference between the label conditions and the no label control. As reviewed earlier, the notion that abnormal behavior is rated more negatively when labelled is well documented and accepted. That no such difference was found in these investigations, while possibly a reflection of an actual change in people's reactions to the mentally ill, seems more likely to reflect some possible shortcoming in the design of these particular studies.

One possible explanation which may account for some of the lack of positive results in these studies is the failure to consider the social class and education level of those who participated. Observation of the social scene might suggest that the more educated, higher social class members of a community hold more liberal views toward mental illness. In general, college students tend to fall into this category. Thus, studies such as these, based on college students, should be less likely to find rejection of those defined as mentally ill than studies based on less educated or lower social class members of society. This very question has been looked at empirically (Clark & Binks, 1966; Dohrenwend & Chin-Shong, 1967; Hollingshead & Redlich, 1958). Although done long ago, the findings of these investigations seem to confirm that lower status groups are predisposed to greater intolerance of the kinds of deviance which is defined as mental illness.

In the present studies, the results might have been affected not only by the fact that the subjects were college students, but

students in a psychology course, as well. Research has indicated that courses in psychology effectively change students' attitudes toward mental illness and mentally ill people in a favorable direction (Costin & Kerr, 1962; Dixon, 1967; Graham, 1968). Thus, the use of college students, who also were enrolled in a psychology course, as subjects in these studies is likely to have influenced the results in the observed direction.

In addition to subject variables, there are some considerations about the research process itself which might have had some influence on the outcome of these studies. As psychology students, it is likely that the subjects has some familiarity with the process of psychological experimentation. Although there was no indication on debriefing that the subjects were suspicious of the true nature of the question, it is not unreasonable to wonder if some might have been suspicious, in general, and influenced to respond in a socially desirable direction. Furthermore, the research process itself was quite artificial. As pointed out by one of the clinicians who reviewed the case descriptions for the reliability and validity check, the descriptions were insufficient to really diagnose mental disorders, and were really only caricatures. Subjects' reactions to these short descriptions may not actually reflect how they might react to real people with real psychiatric disorders in real situations.

As with most research, then, these studies seem to raise more questions than they address. While possible that the outcome of this research indicates that attitudes toward those labelled as mentally ill have improved, issues concerning the subjects and design make difficult the interpretation of the obtained results. Thus, the lack of significant findings must be viewed as inconclusive, though, perhaps, not unimportant. The rejection of those identified as mentally ill remains an important open issue. Continued research into the question should be pursued with representative populations under real world conditions. As those presently at work on future editions of the Diagnostic and Statistical Manual of mental disorders consider the psychiatric labels of "Self-defeating Personality Disorder" and "Premenstrual Dysphoric Disorder" to describe masochistic behavior and premenstrual distress, larger portions of the population may become candidates for psychiatric labels. As long as there is a chance that the application of psychiatric labels may invite social stigma, the importance of continued study into this question should not be overlooked.

CHAPTER 5

APPENDIX

Case Descriptions

Schizophrenia

Mary White is a young woman in her twenties. She used to work as a store manager and was quite active. In the last six months, however, she has not worked and does not seem interested in looking for a job. Mary stays in her room much of the time, but when she does talk to other people, they often find it difficult to follow what she is saying. Things she says often don't seem to logically follow one another. Sometimes she confides in her family that she is afraid that other people know what she is thinking before she says it. It is odd beliefs like this which put other people off, so Mary spends much of her time alone.

Dementia

Mike Williams is a 62 year old retired police chief. Lately, people around him have noticed that his memory is not what it used to be, and, in fact, it seems that many of his intellectual skills have shown a steady decline. He has difficulty defining words, and, sometimes, can't even find the right word to express what he wants to say. He still enjoys painting and walking in the woods with his wife. He also takes great joy in his grandchildren.

Mania

Jon Brown is a university student and athlete. For the past few weeks he has felt restless and full of energy. He has felt little need for sleep, and seems to want to do and say things faster than his body will let him. He has recently become involved in some foolish investments, but he is not worried. He feels invulnerable. He has been taking a lot of risks on the playing field, and does not understand why his teammates are concerned. There just isn't enough time in the day for him to sit around worrying.

Histrionic Personality

Ann Jones is a 25 year old secretary. She has always been kind of an excitable type of person. Others have thought of her as immature and attention seeking. She just feels helpless and seems to be constantly seeking reassurance from others. No matter what the situation is, Ann seems to react with an exaggerated expression of emotions. A couple of times she has even threatened suicide, just to get people to take notice of her.

Anti-social Personality Disorder

Dean Scott is a 20 year old gas station attendant. He is the kind of person who feels little respect for authority or societal institutions. Because of this, he has repeatedly found himself getting into trouble. When he was younger, he got into a lot of trouble at school, and was eventually kicked out. Since then, he has found it difficult to hold a steady job. He says that he is just

trying to have a good time. He drinks heavily and is currently involved with several women. He is very impulsive and has trouble making solid commitments.

Anxiety Disorder

Lynn Wood is a junior in college. For the last few months she has felt "on edge," and has been irritable and impatient. She has felt worried, although not about anything in specific. This has led to her inability to relax, and to her feeling fatigued a good deal of the time. Sometimes she feels like her heart is pounding or racing, and she breaks into a cold sweat. This mood has been fairly consistent, and is really beginning to affect her school performance.

Semantic Differential

Please circle the number which best describes how you feel about (Name). If you feel that one end of the scale or the other very strongly describes how you feel, please circle the number 1 closest to that end of the scale. If you feel that one end of the scale or the other strongly describes how you feel, please circle the number 2 on that end of the scale. Circle the number 3 if you feel like that end of the scale slightly describes how you feel, and the number 4 if you feel completely neutral on a scale. Please complete each of the 12 scales below, and circle only one number per scale.

		(Name)									
BAD	1	2	3	4	3	2	1		1	GOOD	
SOFT	1	2	3	4	3	2	1		1	HARD	
ACTIVE	1	2	3	4	3	2	1		1	PASSIVE	
SUCCESSFUL	1	2	3	4	3	2	1		1	UNSUCCESSFUL	
STRONG	1	2	3	4	3	2	1		1	WEAK	
CALM	1	2	3	4	3	2	1		1	EXCITABLE	
BEAUTIFUL	1	2	3	4	3	2	1		1	UGLY	
LIGHT	1	2	3	4	3	2	1		1	HEAVY	
COLD	1	2	3	4	3	2	1		1	HOT	
REPUTABLE	1	2	3	4	3	2	1		1	DISREPUTABLE	
SEVERE	1	2	3	4	3	2	1		1	LENIENT	
CAUTIOUS	1	2	3	4	3	2	1		1	RASH	

Interpersonal Judgement Scale

Please complete the following scales with (Name) in mind.

1. Intelligent (Check one)

- I believe that this person is very much above average in intelligence.
- I believe that this person is above average in intelligence.
- I believe that this person is slightly above average in intelligence.
- I believe that this person is average in intelligence.
- I believe that this person is slightly below average in intelligence.
- I believe that this person is below average in intelligence.
- I believe that this person is much below average in intelligence.

2. Knowledge of Current Events (Check one)

- I believe that this person is very much below average in his/her knowledge of current events.
- I believe that this person is below average in his/her knowledge of current events.
- I believe that this person is slightly below average in his/her knowledge of current events.
- I believe that this person is average in his/her knowledge of current events.
- I believe that this person is slightly above average in his/her knowledge of current events.
- I believe that this person is above average in his/her knowledge of current events.
- I believe that this person is very much above average in his/her knowledge of current events.

3. Morality (Check one)

- This person impresses me as being extremely moral.
- This person impresses me as being moral.
- This person impresses me as being moral to a slight degree.
- This person impresses me as being neither particularly moral nor particularly immoral.
- This person impresses me as being immoral to a slight degree.
- This person impresses me as being immoral.
- This person impresses me as being extremely immoral.

4. Adjustment (Check one)

- I believe that this person is extremely maladjusted.
- I believe that this person is maladjusted.
- I believe that this person is maladjusted to a slight degree.
- I believe that this person is neither particularly maladjusted nor particularly well adjusted.
- I believe that this person is well adjusted to a slight degree.
- I believe that this person is well adjusted.
- I believe that this person is extremely well adjusted.

5. Personal Feelings (Check one)

- I feel that I would probably like this person very much.
- I feel that I would probably like this person.
- I feel that I would probably like this person to a slight degree.
- I feel that I would probably neither particularly like nor particularly dislike this person.
- I feel that I would probably dislike this person to a slight degree.
- I feel that I would probably dislike this person.
- I feel that I would probably dislike this person very much.

6. Working Together in an Experiment (Check one).

- I believe that I would very much dislike working with this person in an experiment.
- I believe that I would dislike working with this person in an experiment.
- I believe that I would dislike working with this person in an experiment to a slight degree.
- I believe that I would neither particularly dislike nor particularly enjoy working with this person in an experiment.
- I believe that I would enjoy working with this person in an experiment to a slight degree.
- I believe that I would enjoy working with this person in an experiment.
- I believe that I would very much enjoy working with this person in an experiment.

CHAPTER 6

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