

11-29-2018

Keep your distance: People sit farther away from a man with schizophrenia versus diabetes

Ryan Thibodeau

St. John Fisher College, rthibodeau@sjfc.edu

Heather M. Principino

St. John Fisher College, hmp01028@sjfc.edu

[How has open access to Fisher Digital Publications benefited you?](#)

Follow this and additional works at: https://fisherpub.sjfc.edu/psychology_facpub

 Part of the [Psychology Commons](#)

Publication Information

Thibodeau, Ryan and Principino, Heather M. (2018). "Keep your distance: People sit farther away from a man with schizophrenia versus diabetes." *Stigma and Health* Advance online publication..

Please note that the Publication Information provides general citation information and may not be appropriate for your discipline. To receive help in creating a citation based on your discipline, please visit <http://libguides.sjfc.edu/citations>.

This document is posted at https://fisherpub.sjfc.edu/psychology_facpub/21 and is brought to you for free and open access by Fisher Digital Publications at St. John Fisher College. For more information, please contact fisherpub@sjfc.edu.

Keep your distance: People sit farther away from a man with schizophrenia versus diabetes

Abstract

Although concrete behavior—such as avoidance, discrimination, rejection—is foundational to most definitions of stigma, knowledge of psychiatric stigma has been constructed mostly on the basis of measurement of self-reported attitudes, beliefs, and feelings. To help fill this gap, the current study examined avoidance behavior in psychiatric stigma. That is, we predicted that people would seek more physical distance from a man with a psychiatric problem than a man with a medical problem. One hundred fourteen undergraduates expected to meet a man with either Type II diabetes or schizophrenia. After completing several measures of self-reported stigma, participants eventually moved to an adjacent room and sat in one of several seats that systematically varied in their proximity to a seat ostensibly occupied by the target man. Results indicated that the expectation of meeting a man with schizophrenia, compared with diabetes, led to greater desired social distance, greater self-reported fear, and higher appraisals of the man's dangerousness and unpredictability. More importantly, participants elected to sit farther away from the ostensible man with schizophrenia. This pattern of findings offers behavioral evidence of the psychiatric stigma phenomenon that has mostly been documented via measurement of self-reported attitudes and impressions. We hope that these results stimulate renewed interest in measuring stigma-relevant behavior in the laboratory setting. (PsycINFO Database Record (c) 2018 APA, all rights reserved)

Disciplines

Psychology

Comments

©American Psychological Association, 2018. This paper is not the copy of record and may not exactly replicate the authoritative document published in the APA journal. Please do not copy or cite without author's permission. The final article is available, upon publication, at: <http://dx.doi.org/10.1037/sah0000156>

Keep Your Distance: People Sit Farther Away from a Man

with Schizophrenia versus Diabetes

Ryan Thibodeau and Heather M. Principino

St. John Fisher College

Ryan Thibodeau and Heather M. Principino, Psychology Department, St. John Fisher College.

Correspondence concerning this article should be addressed to Ryan Thibodeau, Psychology Department, St. John Fisher College, Rochester, NY 14618. E-mail: rthibodeau@sjfc.edu

Abstract

Although concrete behavior – avoidance, discrimination, rejection – is foundational to most definitions of stigma, knowledge of psychiatric stigma has been constructed mostly on the basis of measurement of self-reported attitudes, beliefs, and feelings. To help fill this gap, the current study examined avoidance behavior in psychiatric stigma. That is, we predicted that people would seek more physical distance from a man with a psychiatric problem than a man with a medical problem. One-hundred fourteen undergraduates expected to meet a man with either type-II diabetes or schizophrenia. After completing several measures of self-reported stigma, participants eventually moved to an adjacent room and sat in one of several seats that systematically varied in their proximity to a seat ostensibly occupied by the target man. Results indicated that the expectation of meeting a man with schizophrenia, compared to diabetes, led to greater desired social distance, greater self-reported fear, and higher appraisals of the man's dangerousness and unpredictability. More importantly, participants elected to sit farther away from the ostensible man with schizophrenia. This pattern of findings offers behavioral evidence of the psychiatric stigma phenomenon that has mostly been documented via measurement of self-reported attitudes and impressions. We hope that these results stimulate renewed interest in measuring stigma-relevant behavior in the laboratory setting.

Keywords: psychiatric stigma; approach and avoidance behavior; schizophrenia

Keep Your Distance: People Sit Farther Away from a Man
with Schizophrenia versus Diabetes

Knowledge of psychiatric stigma has been constructed mostly on the basis of measurement of self-reported attitudes, beliefs, and feelings. Surprisingly little is known about whether this self-reported public stigma manifests in measurable behavior (but see Corrigan et al., 1999; Mehta & Farina, 1997; Penn & Nowlin-Drummond, 2001). This represents a critical gap in knowledge, since numerous influential definitions of stigma underscore the behavioral dimensions (e.g., discrimination) of the phenomenon (e.g., Link & Phelan, 2001).

Although some manifestations of psychiatric stigma (e.g., lack of insurance parity between medical and psychiatric conditions) reflect group-level behavior and decision-making, our focus here is on individual-level behavior that is observable and measurable in the laboratory. The current study executed a laboratory-based procedure for the measurement of approach-avoidance behavior, specifically, which has received very little attention with respect to psychiatric stigma. Approach-avoidance is a basic building block of complex social behavior, and it figures prominently in conceptualizations of stigma. Indeed, following Corrigan & Watson's (2002) definition, we assume that stigma involves the unfolding of interrelated processes including stereotyping, prejudice, and most notably, behavioral avoidance. Approach-avoidance is intrinsically important insofar as it reflects the public's willingness to engage with individuals with mental illness, a prerequisite for social exchange that could ameliorate the isolation that commonly accompanies psychiatric stigma (Sayce, 2000). Examination of the public's physical approach-avoidance of individuals with mental illness is likely to valuably inform scholarship on psychiatric stigma.

Using a procedure adapted from the social psychology literature (Macrae, Bodenhausen,

Milne, & Jetten, 1994), Thibodeau, Shanks, and Smith (2018) found that the physical closeness of the chair in which participants elected to sit vis-à-vis a man who they thought had schizophrenia correlated with both self-reported social distance and fear. This pattern of findings offers modest correlational evidence in favor of the procedure's validity (see also Norman, Gawronski, Hampson, Sorrentino, Szeto, & Ye, 2010; Penn & Corrigan, 2002). This correlational evidence is valuable, but the question of the measure's suitability to experimental research remains open. Indeed, in two experimental studies, a continuum belief intervention (Thibodeau et al., 2018) and a stereotype rebound manipulation (Penn & Corrigan, 2002) did not affect seat selection. A clear demonstration of the measure's laboratory utility would require evidence – heretofore lacking – that it is sensitive to the kinds of experimental manipulations that psychiatric stigma scholars commonly carry out. For example, would the public seek more physical distance from an individual with a psychiatric problem compared to a medical problem?

The current study had two aims. First, it tested the hypothesis that participants in a laboratory setting would seek more physical distance from a man with a psychiatric problem (schizophrenia) than a man with a medical problem (type-II diabetes). Second, it aimed to offer experimental validation of the seat selection procedure to extend the strictly correlational evidence heretofore gathered (Norman et al., 2010; Thibodeau et al., 2018).

Method

Participants

Undergraduate students ($n = 114$, 83.3% female, 80.7% White, 100.0% single, M age = 18.4) participated in exchange for course credit. Most participants ($n = 81$) indicated that they had a friend and/or family member with mental illness. Participants were randomly assigned to the diabetes ($n = 57$) or schizophrenia condition ($n = 57$).

Materials

Self-reported stigma was indexed using three tools. The Social Distance Scale (SDS; Link, Cullen, Frank, & Wozniak, 1987) includes seven items that measured participants' willingness to engage, at varying degrees of closeness, with the target person with schizophrenia or diabetes (described below). Responses were recorded on four-point scales (1 = definitely willing, 4 = definitely unwilling).

A 10-item measure of emotional reactions (Schomerus, Matschinger, & Angermeyer, 2013) was administered. Items were grouped into fear (e.g., "I feel insecure"), anger (e.g., "I feel annoyed"), and prosocial (e.g., "I feel the need to help") categories. Responses were recorded on five-point scales (1 = strongly disagree, 5 = strongly agree).

A 12-item semantic differential tool (Olmsted & Durham, 1976) was administered to measure stereotyped attitudes. Participants rated both the target person and the "Average Man" on seven-point scales anchored by bipolar adjectives (e.g., strong-weak). Difference scores were computed by subtracting ratings for "Average Man" from ratings for the target person. Two items, safe-dangerous and predictable-unpredictable, were analyzed given their special relevance to schizophrenia stigma.

Procedure

All study procedures were approved by the local institutional review board. The experimenters' script is available as an online supplement. Upon arrival at the laboratory, participants were asked to retrieve a chair in the corner of the room, situate it to face the experimenter's chair, and sit down. After participants' departure, the experimenter measured the distance between the two chairs; this measurement served as an index of baseline physical distance. Participants were told that the study – which aimed to measure "knowledge of health

conditions” – was conceived via a partnership between the college’s psychology department and a local health advocacy group. Participants were then told that they would meet a volunteer from the group, who was waiting in a room across the hall. Participants were told that the volunteer would deliver a short presentation and then administer scales that measure participants’ knowledge of health conditions.

Next, participants read a letter that they were told the volunteer wrote to describe his organization and to “say a little about his background.” In the letter, which was printed on bogus letterhead stationary, the volunteer disclosed that he was diagnosed with either type-II diabetes or schizophrenia. Diabetes group participants read about the volunteer’s struggles with common symptoms of the condition, including frequent urination, physical exhaustion, and weight fluctuations. Schizophrenia group participants read about the volunteer’s struggles with paranoid delusions, auditory hallucinations, and disorganized speech. Upon completion of participants’ reading, they completed a form that evaluated their attentiveness to letter content.

Next, participants completed the three self-report stigma measures in a fixed order. To explain why participants were being asked to share impressions of a person with whom they were still unacquainted, the experimenter explained that the scales capture participants’ *predictions* of what the volunteer *would be* like.

Participants were then invited to accompany the experimenter to the room across the hall where the volunteer was ostensibly waiting. During the short walk, the experimenter stated: “I’m pretty sure the volunteer stepped out for a few minutes, and I don’t think he has returned.” The experimenter and participant then entered the room, at which point the experimenter confirmed the volunteer’s absence. Six identical chairs, all equidistant from one another, lined a wall. These chairs varied systematically in their proximity to an opposing chair in the corner of the room.

Pointing to the opposing chair, the experimenter stated: “The volunteer is sitting there. You’re welcome to grab another seat – any seat is fine – and he’ll get started with you when he returns in a moment.” The volunteer’s personal effects – a jacket, a carrying case, and a notebook on an adjacent table – reinforced the salience of his position in the room. The experimenter observed the participant sit, exited the room, and recorded the seat selection measurement.

After thirty seconds, the experimenter re-entered and informed the participant that the study had concluded. The experimenter then administered a funneled debriefing instrument that probed participants’ suspicions about the study deception. After debriefing, participants were thanked and dismissed.

Results and Discussion

Responses to the funneled debriefing instrument indicated that the study’s cover story was believable. Specifically, 106 participants indicated that they believed the story about the upcoming encounter with the volunteer. The eight participants who suspected that no such encounter would happen were excluded from the analyses reported below. However, results are identical when the full sample is analyzed.

An online supplementary table reports correlations between seat selection and baseline physical distance, demographic variables, and self-report stigma variables. The expectation of meeting a volunteer with schizophrenia, compared to diabetes, led to greater desired social distance, $F(1,104) = 38.59, p < .001, \eta_p^2 = .27$, greater self-reported fear, $F(1,104) = 22.49, p < .001, \eta_p^2 = .18$, and higher appraisals of the volunteer’s dangerousness, $F(1,104) = 27.25, p < .001, \eta_p^2 = .21$, and unpredictability, $F(1,104) = 49.90, p < .001, \eta_p^2 = .32$. It also led to greater self-reported prosocial emotion, $F(1,104) = 5.19, p < .03, \eta_p^2 = .05$ (see Table 1).

More importantly, controlling for baseline physical distance, participants elected to sit

farther away from the ostensible volunteer with schizophrenia compared to diabetes, $F(1,103) = 4.21, p < .05, \eta_p^2 = .04$ (see Table 1). Analyses of bootstrapped mediational models (Hayes, 2013), details of which are reported in online supplementary figures, indicated that none of the self-report variables affected by the experimental manipulation mediated the group effect on seat selection. Thus, self-reporting of explicit attitudes and feelings available to conscious awareness does not explain participants' tendency to seek more physical distance from the ostensible volunteer with schizophrenia. A key priority for future research is to interrogate mediational processes. Explicit attitudes and feelings that may more strongly predict distance-seeking behavior (e.g., appraisals of risk) merit attention. Implicit attitudes toward individuals with schizophrenia are also worth exploring.

The relatively modest size of the group effect merits discussion. First, individuals with diabetes are themselves subject to notable public stigma and they are commonly avoided (see Schabert, Browne, Mosley, & Speight, 2013, for a review). Thus, the stigmatized status of both conditions – diabetes and schizophrenia – likely compressed the size of the group effect that emerged. Second, the group difference emerged in spite of several factors that likely conspired to undermine it by inclining participants toward closer physical proximity. Schizophrenia group participants read a letter ostensibly from the volunteer that was expertly written. Participants may have thus concluded that, despite his past struggles, the volunteer was currently functioning normally. Moreover, participants probably deemed it unlikely that the college would permit an unstable individual to come into contact with students. This assumption would assuage some psychological pressure to maintain a comfortable distance. Finally, the expectation of a discussion with the volunteer likely engaged norms surrounding interpersonal interaction that compel close physical proximity.

Modification of the seat selection procedure to address these limitations should maximize variability in physical proximity, thus enhancing the measure's sensitivity to stigma-related processes. We should also note that study experimenters were privy to participants' group membership. Additional research should strive to secure experimenters' blindness or perhaps execute a computerized protocol that obviates the need for a human experimenter. Another important direction for future research is to evaluate the generalizability of our findings by examining medical problems apart from diabetes and psychiatric problems apart from schizophrenia. Finally, addition of a "normal" control group in future research could help rule out the possibility that our findings reflect physical approach of a person with diabetes rather than physical avoidance of a person with schizophrenia.

References

- Corrigan, P.W., River, P.L., Lundin, R.K., Wasowski, K.U., Campion, J., Mathisen, J., et al. (1999). Predictors of participation in campaigns against mental illness stigma. *Journal of Nervous and Mental Disease, 187*, 378-380. doi: 10.1097/00005053-199906000-00008
- Corrigan, P.W., & Watson, A.C. (2002). Understanding the impact of stigma on people with mental illness. *World Psychiatry, 1*, 16-20.
- Hayes, A.F. (2013). *Introduction to mediation, moderation, and conditional process analysis: A regression-based approach*. New York: Guilford Press.
- Link, B.G., Cullen, F.T., Frank, J., & Wozniak, J.F. (1987). The social rejection of former mental patients: Understanding why labels matter. *American Journal of Sociology, 92*, 1461–1500. doi: 10.1086/228672
- Link, B.G., & Phelan, J.C. (2001). Conceptualizing stigma. *Annual Review of Sociology, 27*, 363-385. doi: 10.1146/annurev.soc.27.1.363
- Macrae, C.N., Bodenhausen, G.V., Milne, A.B., & Jetten, J. (1994). Out of mind but back in sight: Stereotypes on the rebound. *Journal of Personality and Social Psychology, 67*, 808-817. doi: 10.1037/0022-3514.67.5.808
- Mehta, S., & Farina, A. (1997). Is being “sick” really better? Effect of the disease view of mental disorder on stigma. *Journal of Social and Clinical Psychology, 16*, 405-419. doi: 10.1521/jscp.1997.16.4.405
- Norman, R.M.G., Gawronski, B., Hampson, E., Sorrentino, R.M., Szeto, A., & Ye, Y. (2010). Physical proximity in anticipation of meeting someone with schizophrenia: The role of explicit evaluations, implicit evaluations and cortisol levels. *Schizophrenia Research, 124*, 74-80. doi: 10.1016/j.schres.2010.07.021

- Olmsted, D.W., & Durham, K. (1976). Stability of mental health attitudes: A semantic differential study. *Journal of Health and Social Behavior*, *17*, 35-44. doi: 10.2307/2136465
- Penn, D.L., & Corrigan, P.W. (2002). The effects of stereotype suppression on psychiatric stigma. *Schizophrenia Research*, *55*, 269-276. doi: 10.1016/S0920-9964(01)00207-9
- Penn, D.L., & Nowlin-Drummond, A. (2001). Politically correct labels and schizophrenia: A rose by any other name? *Schizophrenia Bulletin*, *27*, 197-203. doi: 10.1093/oxfordjournals.schbul.a006866
- Sayce, L. (2000). *From psychiatric patient to citizen: Overcoming discrimination and social exclusion*. New York: St. Martin's Press.
- Schabert, J., Browne, J.L., Mosley, K., & Speight, J. (2013). Social stigma in diabetes: A framework to understand a growing problem for an increasing epidemic. *Patient*, *6*, 1-10. doi: 10.1007/s40271-012-0001-0.
- Schomerus, G., Matschinger, H., & Angermeyer, M.C. (2013). Continuum beliefs and stigmatizing attitudes towards persons with schizophrenia, depression and alcohol dependence. *Psychiatry Research*, *209*, 665-669. doi: 10.1016/j.psychres.2013.02.006
- Thibodeau, R., Shanks, L.N., & Smith, B.P. (2018). Do continuum beliefs reduce schizophrenia stigma? Effects of a laboratory intervention on behavioral and self-reported stigma. *Journal of Behavior Therapy and Experimental Psychiatry*, *58*, 29-35. doi: 10.1016/j.jbtep.2017.08.002

Table 1

Effects of the Experimental Manipulation (Diabetes vs. Schizophrenia) on Seat Selection and Self-Reported Stigma (Social Distance, Self-Reported Emotion, and Stereotyped Attitudes)

	Diabetes	Schizophrenia
Social Distance***	1.6 (0.5)	2.2 (0.5)
Self-Reported Emotion		
Fear***	1.6 (0.7)	2.3 (0.8)
Anger	1.6 (0.7)	1.7 (0.5)
Prosocial*	3.1 (0.8)	3.4 (0.7)
Stereotyped Attitudes		
Dangerousness***	-0.2 (0.9)	0.9 (1.2)
Unpredictability***	0.3 (1.0)	1.9 (1.3)
Seat Selection*	2.8 (0.7)	3.1 (0.9)

Note. Means (SDs) reflect the original measurement scales. Social distance (1 = definitely willing, 4 = definitely unwilling). Fear, anger, and prosocial emotion (1 = strongly disagree, 5 = strongly agree). Stereotyped attitudes (-6 = maximum stereotyped attitudes for “Average Man” versus the volunteer, +6 = maximum stereotyped attitudes for the volunteer versus “Average Man”). Seat selection (1 = closest seat, 6 = farthest seat).

* $p < .05$, ** $p < .01$, *** $p < .001$