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Culture is Central to Recovery

Alexis Hamill, Ph.D.

The mental health field in the United States is strongly influenced by a Western perspective and has begun to acknowledge the importance of incorporating diversity and of understanding mental health from non-western perspectives. The principles of psychosocial rehabilitation are inline with this progress. By embracing the PSR model we recognize the necessity of personalized care. This recognition extends to the cultural identities of the people we serve.

The value of culture is highlighted in the second of the 12 Core Principles and Values of psychiatric rehabilitation as outlined by the Psychiatric Rehabilitation Association. That second principle states, "Psychiatric rehabilitation practitioners recognize that culture is central to recovery, and strive to ensure that all services are culturally relevant to individuals receiving services."

The phrase, "culture is central to recovery" is worth further exploration. To me, it means several things. When we recognize that culture is prevention, we can draw on the strengths of a person (including their connection to culture or interest in connecting with their culture) to help them overcome obstacles.

This phrase also reminds me that to provide the best care we must know evidence-based practices as well as the approaches that are backed by community-based evidence. True community integration often involves more than supporting someone in their journey to reach goals of returning to school or work. Community integration for a person may be about learning the language or spiritual practices of their heritage, becoming a mentor to a member of their community, attending events, ceremonies, and cultural groups, or giving back.

Recognizing the lenses through which we each see the world and being open to new views is a practice we as mental health workers strive to implement from the moment we begin working with another person. For example, my work as a psychologist at a safety net clinic serving diverse members has taught me that it is perfectly appropriate for people to be motivated to improve their condition for others (e.g. friends, family, ancestors, community) or for themselves. The concept that people need to be doing mental health work for themselves is a Eurocentric perspective that is reinforced by the United State's individualistic mainstream culture.

The principles of PSR are crucial when working with people who have been disproportionately impacted by discrimination. Marginalized groups are likely to have experienced trauma, whether through discrimination, community or interpersonal violence, or historical trauma, all of which can reduce feelings of hope even in very resilient people. Conveying hope and respect is key in order for a provider to be of help; in fact, conveying hope and respect is the very first PSR principle.

In addition to the stigma of mental illness, minority clients are more likely to have faced oppression and thus are both more in need of a PSR approach and may need more patience and support from providers in order to make use of a PSR approach. For example, people with a history of disenfranchisement may not at first trust a provider to be a partner or to really engage in a shared decision-making approach, and may doubt that they have any agency to improve their own life.

The 12th and final PSR principle is also vital for work with underserved populations. It reminds us to integrate behavioral health, medical, and holistic treatments. Given the disproportionate impact of chronic physical conditions for minority communities, this principle can literally be the difference between life and death for the people we serve.

When we are serving those who are most in need, it behooves us to draw on the PSR model. It is with these individuals that we often experience the most external pressure to take a less recovery-oriented stance and to focus on medication and reduction of symptoms. We must not lose sight of that person in the context of their culture and their values and support them in finding their voice, rather than projecting our culture and values onto their silence.

Recovery Update

is a collaboration by providers within the Veterans Health Administration, as well as mental health providers and recovery resources in the community. This periodic newsletter is intended to disseminate Psychosocial Recovery (PSR) information, news and developments. If you would like to contribute to Recovery Update or have questions regarding this publication, please contact:

Ross Melter, Psy.D. (ross.melter2@va.gov)
PRRC Psychologist
VA Puget Sound HCS
American Lake Division



About the Author:

Dr. Alexis Hamill is the Site Clinical Lead and Training Program Manager for the Native American Health Center in the Fruitvale neighborhood of Oakland, California. She completed her postdoctoral fellowship in psychosocial rehabilitation at the San Francisco Veterans Affairs Medical Center. She received her doctorate in clinical psychology from Bowling Green State University. She has experience working in a variety of Psychosocial rehabilitation settings where she has provided direct care and recovery-oriented program development.

Provider Panel on Community Institutionalization (CI):

How we can foster greater community inclusion of individuals in recovery from SMI

“Community Institutionalization” (CI) is a term used by the recovery community to describe the experience of individuals who are alienated from community activities and instead are solely reliant on treatment settings to meet psychosocial needs such as socialization, pursuing recreational interests, and having an outlet for creative expression. For instance, an individual who attends a day treatment program four times a week may still experience CI if they spend their evenings and weekends restricted to their home.

We asked a panel of VA providers about community institutionalization – these were their responses:

1. How can Community Institutionalization get in the way of an individual’s recovery goals?

As Veterans become reliant on the VA to meet their needs, they often lose the initiative to move forward in pursuit of their recovery goals. Our program areas should be encouraging, empowering and challenging them to identify and pursue areas of interest. We, as providers, must demonstrate that we have expectations of them, or it is unlikely that they will have expectations of themselves. – **Anthony Hedges; Peer Specialist at Chillicothe, Ohio VAMC**

The term “Institutionalization” has a long history. It refers to the misinformed social policy of removing individuals with SMI from their homes and communities and housing them (most often) in large hospitals where personal freedoms were highly restricted. As we all know, the doors to these hospitals were locked and the grounds (often) surrounded by fences. In the best case it was counter-therapeutic, in the worst cases it was violent and inhumane. Also, as we all know, “Institutionalization” was followed by “De-Institutionalization.” This movement was characterized by assisting individuals with moving out of the large hospitals and into smaller group homes, residential care facilities, apartments and sometimes back with family. Individuals now lived in the community, in the sense that they lived in buildings (apartment buildings, homes) that were in neighborhoods. No more locked doors and fences. During the day individuals were (and are) provided with physical and mental healthcare in a variety of settings including psychiatrists offices, community mental health centers, Fountain House model programs, Day-hospitals, Intensive Outpatient programs, drop-in centers, NAMI support groups, Assertive Community Treatment programs (MHICM), PRRCs, and others. So, progress has been made. However, with this progress a new reality has emerged. Some individuals with SMI spend time attending programs and services related to physical and mental health care, but are not connecting with non-service providers. They wake up, get ready for the day, hop on the bus or get in a car, get to the psychiatrist’s office, the treatment center or day-program, spend time there, and then go home. They don’t have connections with the community, other than to receive services. This phenomenon is termed “Community Institutionalization.” One error we sometimes make at this point in the history of mental health services is to provide everything an individual might need within our programs (physical health care, social support, financial aid, leisure activities, volunteer opportunities, faith and spiritual support, etc.) and forget to assist, support, encourage and link individuals with people, places and organizations “in the community” (i.e. non-service providers) who can better serve the individual and promote our ultimate goal, namely, to promote full integration of individuals with SMI into the daily life of our communities (work, live and play as any other individual within the community). “Community Institutionalization” can get in the way of recovery if we create a sub-culture that is separate and apart. If we assume that individuals will always need every possible service we provide, and if we create a separate world of activity that is not linked with our neighborhoods and communities-at-large. – **David Rowan, Ph.D., Recovery Programs Manager, St. Louis VAMC**

Individuals who attend psychosocial programming designed to assist with the building of knowledge and life skills miss taking an active role in their own recovery if the information learned is not applied in their natural, community settings outside of their treatment facilities. Residual fears about increased autonomy and internalized stigma can often interfere with individuals’ progress around community integration and the consistent utilization of community resources available to them. Despite continuous and collaborative efforts by providers, some individuals remain reluctant to engage in non-hospital activities, even when able to verbalize interest and the value in doing so. These individuals, in particular, tend to have the most difficult time disengaging from the program through graduation or transition to lower level of care despite being involved in full aspects of the program for some time. – **Marilyn Garcia, Ph.D.; PRRC Program Manager, Hines VA**



About the Author:

Members of our national provider panel on CI include:

- David Rowan, Ph.D.
(Recovery Programs Manager, St. Louis VAMC)
- Ryan Gardner, LCSW
(Program Coordinator; Veteran’s Recovery Center (PRRC); Palo Alto VAMC)
- Anthony Hedges
(Peer Specialist at Chillicothe, Ohio VAMC)
- Roslyn Lopez, MS, CRC
(Supervisory Vocational Rehabilitation Specialist at VA Northern California HCS)
 - Arminia Alcorn
(Occupational Therapist, North Texas VAMC)
 - Randy Hamman
(Vocational Rehab Specialist and Volunteer Coordinator at Topeka VAMC)
- Marilyn Garcia, Ph.D.
(PRRC Program Manager; Hines VA)



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2. What are some ways that we as providers can encourage participation in community activities and reduce Community Institutionalization”?

From admission, providers should convey this expected outcome to the client; bearing in mind the client might be resistive to discussing leaving the program before starting. To promote participation in the community the expectation is not only verbally (use of recovery terms/language) conveyed but also visually (job announcement and posters with recovery statements displayed in the group rooms or on inpatient units) and physically e.g., outings planned by clients with staff oversight, but not program resources, educational groups created with client input addressing barriers to community integration, etc. – **Armintia Alcorn; Occupational Therapist, North Texas VAMC**

Providers, programs and systems can do a great deal to encourage full participation and integration with community activities. We start by talking openly with individuals with SMI about the goal of full community participation and integration. We talk about the benefits of full integration, and create an expectation that all individuals belong in the larger community and that all individuals can find, get and keep connections in the larger community. Next, we assist each veteran with building the skills they need to feel confident and comfortable going out into the community. This might mean assisting with self-care skills (sleep hygiene, general hygiene, wellness management skills, etc.), social skills (how to be assertive, how to carry on a casual conversation, etc.), financial management (how to budget so that you have money for a monthly bus pass), symptom management (how to manage your anxiety when going into a new situation), and so on. When veterans are ready, we can travel with them or meet them in the community to practice these skills. We can talk with them about what meaningful activities they want to be involved with. We can build relationships with community organizations and link veterans to these organizations. For example, in St. Louis we have a group called “Veterans Volunteer.” The leader of the group has developed relationships with community based non-profit agencies who need volunteers. Veterans start by volunteering with a group, where they have the support of the VA staff and other VA peers. After getting comfortable with this and learning the skills needed to be successful, veterans volunteer on their own at these and other agencies around the city. Using this progressive model, veterans move from receiving services, to VA supported groups, to independent volunteerism at non-mental health organizations. – **David Rowan, Ph.D., Recovery Programs Manager, St. Louis VAMC**

Connecting them with community resources and encouraging participation in community support groups and activities of interest. Assists Veterans with engaging in new activities, if that present challenges for them. We should teaching them the skills to become self-sufficient and to live independently. MHICM and CRC homes should have opportunities for them to learn the skills of self-care (laundry, cooking, cleaning, etc.). PRRCs should also have skills building groups and hand on opportunities to practice the necessary skills for independent living, and there should be measurable goals directed toward that end. – **Anthony Hedges; Peer Specialist at Chillicothe, Ohio VAMC**

At the PRRC in Martinez we have developed a volunteer group that involves scheduling volunteer events at local agencies during our group meeting times. We have already gone to such places as: animal shelters, soup kitchens, local hospitals. We then meet at the agency as a group and participate in either a volunteer activity there or receive a tour of the agency and learn the steps one needs to take in order to volunteer. We just started it about 7 weeks ago and we have already been successful in that two of the Veterans in the group have already started volunteering at one of the agencies we visited. It appears that going together as a group helped them make the connection and then they were able to then make the decision to continue on their own. – **Roslyn Lopez, MS, CRC; Vocational Rehabilitation Specialist at VA Northern California HCS**

Providers can continue to dedicate time and efforts to identifying barriers and promoting the importance of community involvement for achieving and maintaining recovery—from early on in the program education/enrollment process, through the stages of treatment, and post-graduation/discharge. By promoting hope and displaying confidence in an individual’s ability to take on new, growth-inspiring challenges, providers model behavior that the individual can learn from and adopt for building self-esteem and small successes. Providers can also contribute positively by offering opportunities for family education and supportive involvement in treatment by others to help reduce the individual’s alienation, increase loved ones’ understanding and acceptance of mental illness, and teach practical skills for greater, improved interactions through utilization and expansion of a network of support. — **Marilyn Garcia, Ph.D.; PRRC Program Manager, Hines VA**



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(PRRC Program Manager; Hines VA)



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3. Are there ways in which we as providers can contribute to Community Institutionalization? How can we be mindful of avoiding such practices?

Yes, unfortunately, we can and sometimes do contribute to “Community Institutionalization.” When we design programs that do not have an expectation of graduation, we are contributing to “Community Institutionalization.” When we only provide mental health services and do not link veterans to non-mental health people, organizations and places, we are contributing to “Community Institutionalization.” When we fail to talk to veterans about things they would like to do in the community, we are contributing to “Community Institutionalization.” We can be mindful by writing and regularly reviewing mission and vision statements to remind us that our goal is full community integration. We can review and discuss the 10 Elements of Recovery in staff meetings, groups and individually with veterans. We can link up with other groups and organizations that have similar goals and aspirations (NAMI, Psychiatric Rehabilitation Association, Mental Health America, Clubhouse model programs). And, we can make a personal commitment to assist and support each veteran to live a life that is fully connected with the larger community. – **David Rowan, Ph.D., Recovery Programs Manager, St. Louis VAMC**

When we do not challenge them to do as much on their own as they are capable of, we are failing them. Loading Veterans onto buses for community outings is not really community integration, especially if these Veterans have transportation of their own, or public transportation is a viable option. Have them meet you there in the community. If they are not comfortable with using public transportation (P.T.), have skills building sessions – actually practice utilizing P.T. with the assistance of a staff member until they are comfortable. – **Anthony Hedges; Peer Specialist at Chillicothe, Ohio VAMC**

Providers can help Veterans by encouraging self-efficacy, use of strength-based language and greater utilization of Peer Support Specialists as models for recovery. – **Armintia Alcorn; Occupational Therapist, North Texas VAMC**

Providers can inadvertently contribute to Community Institutionalization by having low expectations for individuals with SMI and engaging in behaviors that foster dependency on the mental health system and treatment providers (e.g., imposing one’s own vision of recovery onto an individual; displaying reluctance to graduate or discharge an individual due to fear of a relapse; implicitly or explicitly conveying message that an individual is too sick to recover or that provider knows best). Psychosocial programs that facilitate ongoing and long-term involvement in facility activities to meet all social, recreational, emotional, physical, and spiritual needs impede individuals’ growth and their utilization of natural supports and community resources for continual learning. Providers can be mindful of avoiding these practices by remaining grounded in the overarching psychiatric rehabilitation principles and values and mental health recovery components, ensuring Person-centered care by honoring personal choice and taking more collaborative, motivational approach for meeting individuals where they are currently, and creating an environment that encourages informed and supported risk-taking for achieving one’s goals. — **Marilyn Garcia, Ph.D.; PRRC Program Manager, Hines VA**

Yes, there are a few ways that provider contribute to “Community Institutionalization,” including underestimating an individual’s skills, resiliency, and support system. Too often providers are concerned about an individual not succeeding, and, as a result, limit their self-determination by restricting important learning opportunities. In addition, staffing and productivity concerns can also keep individuals accessing care beyond the achievement of maximum gains. To counteract “Community Institutionalization,” it’s imperative for the program (and its providers) to meet frequently and mutually develop recovery-oriented treatment plans with timeframes, identify and implement opportunities for community reintegration activities, share stories of recovery role models, connect consumers to Peer Specialists, educate the community about the importance of using person-centered language, practicing shared decision-making and risk-taking, and strengthening our relationships with community resources such as “Stamp Out Stigma,” Depression Bipolar Support Alliance (DBSA) and the National Alliance on Mental Illness (NAMI). — **Ryan Gardner, LCSW ; Program Coordinator, Veteran’s Recovery Center (PRRC); Palo Alto VAMC**



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(PRRC Program Manager; Hines VA)



NAMI Homefront: Program Overview

Suzanne Robinson, MSW

NAMI Homefront was developed to meet the unique needs of families of Service Members and Veterans who live with mental health conditions. It is a six-session adaptation of the evidence-based NAMI Family-to-Family program which is taught by family members who have a relative living with mental illness, also referred to as a brain disorder. NAMI began offering NAMI Family-to-Family in Department of Veterans Affairs (VA) facilities around the country in 2000, to address the emotional toll of loving a Service Member or Veteran with a mental health condition and the impact symptoms can have on everyone around them. NAMI Homefront was developed to meet the specific needs of military and Veteran families. NAMI Homefront is designed for spouses/partners, parents, siblings, adult children and others who love a Service Member or Veteran who's dealing with the complex challenges of a mental health condition. NAMI Homefront is taught by families of Service Members and Veterans who know what participants are experiencing.

The curriculum includes the following components:

- Six 2.5 hour sessions of instructional material, discussions and interactive exercises which may be delivered as a series of consecutive weekly classes, or twice per week on consecutive weeks (e.g., twice on Saturday with a break for lunch or Tuesday and Thursday for three consecutive weeks, etc.) to accommodate busy schedules
- Information on how to access programs, benefits and resources for Service Members and Veterans are included in a General Resources section of the NAMI Homefront program manual
- An online version of the NAMI Homefront program is taught live by two instructors enabling those with caregiving responsibilities to participate from home no matter their location
- An evaluation process to both build an evidence base on the effectiveness of the program and ensure that the program continually delivers best practices and current information most needed by the families of Service Members and Veterans



About the Author:

Suzanne Robinson, MSW is the Senior Education Program Manager for the NAMI Family-to-Family & NAMI Homefront programs, as well as the NAMI Education, Training and Peer Support Center. For more information on NAMI Homefront, please visit: www.nami.org/homefront

The goals of NAMI Homefront are to:

- Provide the fundamental information necessary for the family to understand what the Service Member or Veteran is experiencing including topics related to trauma, combat stress, TBI, substance use disorders, PTSD and other mental health conditions
- Help participants cope with the impact that mental health conditions have on the individual and their family
- Provide tools for the family to use even after completing the program that will assist them in responding as effectively as possible to challenging situations and crises
- Help the family learn to take care of their own needs in addition to those of their Service Member or Veteran



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Program Curriculum

Class 1: Introduction to Family Education

Special features of the course; learning about the normative stages of our emotional reactions to the challenges presented by mental health conditions in the family; the belief system and principles on which NAMI are programs are based; recognizing that mental health conditions are fundamentally biological disorders; addressing the challenges presented by the stigma around symptoms, specifically in military and Veteran culture.

Class 2: The Biology of Mental Health Conditions and Getting a Diagnosis

Overview of development and functions of key brain areas; research on functional and structural brain changes related to mental health conditions and brain injury; overview of the diagnostic process; critical periods in developing a brain disorder and symptom management; strategies in development of a Crisis File and sharing participant personal stories.

Class 3: Understanding Trauma and Overview of Diagnoses

Discussion of trauma from the perspective of the general public, then specifically about various types of trauma experienced by military personnel and their families; emphasize a picture of normal reactions to abnormal events and normalizing the fact that there is always some level of residue associated with exposure to trauma; overview of the types and subtypes of some of the major mental health conditions including mood episodes and mood disorders, post-traumatic stress disorder, anxiety disorders, obsessive compulsive disorder, schizophrenia, borderline personality disorder, co-occurring brain disorder and addictive disorders.

Class 4: Treatment Systems and Services

Overview of the systems that may be involved in the Service Member's treatment including the U.S. Department of Defense Military Health System, the VA's Veterans Health Administration and the civilian mental healthcare systems; overview of different types of mental health service providers; overview of different types of therapy and treatment, including medications; emphasis on the importance of working collaboratively (the Service Member or Veteran, the healthcare provider and the family) to achieve the best outcomes; suggestions and tips for communicating with the healthcare provider and the importance of advocating for the needs of the Service Member or Veteran and the family.



About the Author:

Suzanne Robinson, MSW is the Senior Education Program Manager for the NAMI Family-to-Family & NAMI Homefront programs, as well as the NAMI Education, Training and Peer Support Center. For more information on NAMI Homefront, please visit: www.nami.org/homefront

Class 5: Crisis Preparation and Communication Skills

Acknowledge the impact of mental health conditions on each family member and the Service Member; learning to separate the symptoms and behavior from the individual; loving the person behind the disorder; learning various skills that can be used to improve day to day communications within the family as well as during episodes of crisis; communication skills, problem solving skills, tips for handling challenging behavior, crisis preparation and response, developing a relapse plan.

Class 6: Family Roles, Recovery and Self-Care

The unique challenges of various family roles (spouse/partner vs. parent vs. sibling, etc.); the importance of self-care in being an effective family caregiver; discussion of any unresolved needs of participants; emphasize building an advocacy team for the Service Member; invitation to join NAMI in the fight to end discrimination and ensure access to appropriate treatment services; evaluations and certificates.



Recovery Reminders

Tim Smith, Ph.D., Peggy Henderson, Psy.D., Dan O'Brien-Mazza & Jeffrey Burk, Ph.D.

- Recovery is a journey, typically with lots of twists and turns. Recovery happens, but it doesn't happen on our timeline. Be encouraging, and let the process unfold in its own way.
- It takes a while to change old habits, but being mindful of the words we choose is crucial. Language matters!
- Recovery plans should reflect the Veteran's personal goals and be based on their strengths, needs, abilities, and preferences (SNAP)
- All people, without exception, have the capacity to learn and grow
- Before meeting a new client/Veteran patient, I remind myself that I am meeting another person who has similar needs, wants and goals as I do. We aren't very different from one another.
- Whenever I am asked to "help" someone, I ask myself, "how would I want to be helped?"
- Try to be present as a person in session. The Veteran should have a sense of you as an individual.
- As I look at the Veteran sitting across from me, I ask myself "What is this person's hidden talent? What is this person's strength?" Sometimes the Veteran may not be able to identify talents or strengths—it becomes my job to help the Veteran find his strengths.
- When I write my chart notes, I want the next person reading that note to really be able to "see" the Veteran. More than her gender, her age, her race, her military service area or symptoms. The note should relay the Veteran's individuality and personhood.



Recovery Reminders is a recurring section in Recovery Update, in which providers suggest considerations or questions that clinicians may wish to ask themselves when working with consumers to ensure recovery-oriented care.

Contributors to this edition of Recovery Reminders include members of the Psychosocial Rehabilitation and Recovery Section (PRRS) in Mental Health Services, VA Central Office :

- **Tim Smith, Ph.D.**
National Director, Inpatient and Outpatient Psychosocial Rehabilitation & Recovery Services
- **Dan O'Brien-Mazza**
National Director, Peer Support Services
- **Peggy Henderson, Psy.D.**
National Director, Consumer & Liaison Services
- **Jeffrey Burk, Ph.D.**
National Mental Health Director; PRRS



Misuse of the Word “Schizophrenia”

Ross Melter, Psy.D.

Note: underlined text below represents clickable hyperlinks

A study conducted in [2003](#) found that, in a stratified random sample of U.S. newspapers, roughly 1% of all references to Cancer were metaphorical. The same study found that **28.1%** of all references to Schizophrenia were metaphorical.

This is alarming for a number of reasons. The widespread and indiscriminate use of the word schizophrenia increases stigma surrounding the illness and promotes public misunderstanding. A [1996 public report](#) on the perception of mental illness in America found that 61% percent of Americans believed that individuals suffering from schizophrenia were more likely to engage in violent behavior than the average population (this figure is similarly high at [present](#)). Studies have repeatedly debunked this notion, and instead demonstrated that individuals with serious mental illness are more likely to be *victims* of violent crimes (NAMI released a useful [infographic](#) on this subject). Further, because metaphorical use of the word schizophrenia is so disproportionately frequent, similar misunderstanding does not exist with other psychiatric and medical illnesses.

Perhaps most alarming – the metaphorical use of “schizophrenia” is often *wrong* (Patrick House does an excellent job of describing this in [Schizophrenic is the New Retarded](#)). In popular media, “schizophrenia” almost always refers to one of two things: **1)** holding two contrasting opinions simultaneously (for instance, a legislator’s policies are “[schizophrenic](#)” when they are viewed as contradictory) or **2)** being volatile and unpredictable (for instance, the economy is “[schizophrenic](#)” when it fluctuates). It is important to note that neither of these two characteristics are associated with the actual psychiatric diagnosis of schizophrenia.

The inaccurate and disproportionately frequent metaphorical use of “schizophrenia” has also been observed in social media. A [2015 study](#) comparing the use of hashtags containing the words “schizophrenia” and “diabetes” on Twitter found that hashtags related to schizophrenia were more likely to be medically inappropriate, sarcastic in tone and used non-medically. Similar findings have been reproduced in a [study of children’s television shows](#). Medically inaccurate uses of “schizophrenia” have even been found in scientific journals – for instance a [2007 article](#) published in *nature* referred to electrons as being “schizophrenic” for behaving erratically in high-temperature superconductors.

The authors of [Use of Schizophrenia as a Metaphor in U.S. Newspapers \(2003\)](#) provide a stark summary of the misuse of the word schizophrenia and its impact on stigma. They write, “Mark Twain once said that the difference between getting a word right and almost right is like the difference between lightning and a lightning bug. Getting the word ‘schizophrenia’ almost right facilitates social unacceptability, contributing to a reluctance on the part of persons with schizophrenia to seek help for the condition. We look forward to the day when prevention and education—not metaphor and demonization—are the dominant messages carried to the public by the news media. The random sampling of America’s newspapers suggests that we have a long way to go.” One of our most important tasks as recovery-oriented clinicians is to empower consumers and encourage them to advocate for themselves. They should know what’s being said about schizophrenia in our media, and they should know that much of it is wrong.

About the Author:



Ross Melter, Psy.D. is a PRRC Psychologist at the VA Puget Sound Health Care System; American Lake Division. He received his Psy.D. in clinical psychology from the Wright Institute in Berkeley, CA. Dr. Melter completed his predoctoral internship at the San Bernardino County Department of Behavioral Health (DBH) and postdoctoral fellowship at the VA Palo Alto Health Care System with emphasis in Psychosocial Rehabilitation (PSR). Dr. Melter’s professional interests include stigma reduction, recovery from serious mental illness, community integration, self-advocacy and concealable disabilities.

