The Consequences of Labeling Mental Illnesses on the Self-concept: A Review of the Literature and Future Directions

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Abstract

Diagnosis of mental illness has become increasingly reified. People are being labeled; they are seen as *being* mentally ill instead of *having* a mental illness. Unfortunately, negative stereotypes are associated with mental illness. According to labeling theory, the stigma of being labeled mentally ill actually *causes* one to be mentally ill as a result of effects described as self-fulfilling prophecy. According to a modified version of the theory, assumptions about causation are omitted, and only the negative impact on self-concept is addressed. This impact is described in later research about stigma and self-stigma. Stigma can have negative consequences for self-concept by lowering self-efficacy, which fosters dysfunctional coping styles and ultimately reduces quality of self-concept. Also, stigma can be internalized and create self-stigma, in which the label predominates self-concept and reduces self-esteem. Thus, eventually, the reification of diagnosis leads to lowered self-concept through stigmatization effects. In spite of these negative effects, it is reasonable to believe that positive effects also exist. A label could foster self-acceptance, causing one to seek treatment, and can also foster interpersonal understanding. It is argued that these effects should be investigated. On the basis of outcomes, it should be decided whether diagnosis should or should not be reported to the patient.

Introduction

Mental illnesses have been diagnosed more and more frequently since the introduction of the first version of the Diagnostic and Statistical Manual of Mental Disorders (DSM, American Psychiatric Association, 1952) and other diagnostic classification systems during the latter half of the twentieth century. These tools were developed for creating a shared language, thus facilitating communication about mental illnesses. Critics argue, however, that the result of classification has been much more than a common language. Mirowsky and Ross (1989), for example, claim that diagnoses are being seen as entities, - as non-overlapping categories in which all characteristics of a dysfunction are covered. They postulate that imposing a diagnosis obscures rather than provides information, and that it impedes rather than facilitates understanding. Diagnoses are being made into something absolute with an almost physical reality, instead of functioning as a general, simplified description of a cluster of problems. This "reification" dominates thinking about mental illness in society, clinical practice, research and law (Hyman, 2010). People are seen as *being* mentally ill instead of *having* a mental illness. Societal institutions such as health insurance uphold this practice (Mirowsky & Ross, 1989). The diagnosis thus has become more of a label, which is a reified and stereotypical version of the diagnostic description. It appears that the label is often associated with stigma (for example, Corrigan, 2007).

The consequences of this label for the self-concept of those who receive it will be the focus in this article. In the literature it is argued that labeling has a negative impact on self-concept. Self-concept is defined as everything one knows and thinks about oneself (Gazzaniga, Heatherton & Halpern, 2010). Two components of self-concept are especially important for the purposes of this article: self-esteem is the evaluative aspect of self-concept (Shavelson & Bolus, 1982) and self-efficacy is one's subjective feeling of competence: it is the idea that one is capable of exerting control over his environment (Bandura, 1997). Labeling theory describes the negative impact of labeling on self-esteem and self-efficacy. More modern theories focus specifically on the negative impact of societal stigma and self-stigma. In this article, the development of labeling theory and stigmatization theories will be discussed. After that, an important point of criticism will be discussed: labeling theory and stigmatization theories overlook the fact that diagnosis could also have positive effects. A number of positive effects will be proposed. A conclusion will be drawn on the basis of the balance between positive and negative consequences of being diagnosed with mental illness and future directions for research will be suggested.

Labeling theory

Original labeling theory

Labeling theory originated in the book "Being Mentally Ill" by the sociologist T. J. Scheff (1966). Scheff introduced the idea that being labeled mentally ill causes one to be mentally ill. Individuals learn cultural stereotypes through jokes, cartoons and media. People internalize these stereotypes. Once they become mentally ill, these internalized ideas become relevant: they come to dominate one's self-concept. One realizes what others expect of him as a mentally ill person. According to Scheff, one has no choice other than to act out these role expectations: he becomes mentally ill. In a review (1974) he describes thirteen studies in which social factors that predispose people to be easily stigmatized appeared to be significantly related to institutionalization rates. He considers these findings to be evidence for his labeling theory.

Scheff's work has generated criticism and heated debate (for example: Gibbs, 1972 in: Scheff, 1974; Gove, 1982 in Link, Struening, Cullen, Shrout & Dohrenwend, 1989). One criticism concerns the very foundation of original labeling theory research. The methods of these early studies consisted of comparing hospitalization rates in groups of high socioeconomic status with those of groups of low socioeconomic status. It was assumed that people of lower status would be less resistant to labeling effects and thus would be hospitalized more often than people of higher status. It was repeatedly confirmed that low-status groups were indeed overrepresented in hospitals (Scheff, 1974). Critics argued, however, that the differences in hospitalization rates would be related in a different way to social status and would not necessarily be susceptible to labeling effects. Thus, Scheff's theory never came to constitute hard evidence that diagnosing (labeling) mental illness had a negative effect on self-concept and well-being.

Modified labeling theory

Two decades later, a modified version of labeling theory was developed by Link et al. (1989). The most important difference between the updated version and Scheff's theory was the removal of connotations regarding causation. Thus, the new theory did not make any claim to the effect that labeling *caused* mental illness. Link modified Scheff's model and tested it. In Link's model, the negative consequences of labeling are mediated by non-adaptive coping responses. People's self-efficacy is impaired by a mental illness label: they start to fear uncontrollable negative reactions. A person can react by secrecy, withdrawal or preventively educating others about his mental illness. The first and second kinds of reaction in particular can have negative consequences for self-concept. Because those diagnosed with a mental illness expect rejection, Link and his colleagues argued that they act in a way that fosters rejection, and this rejection impairs self-esteem. This in turn can lead to either the persistence of an existing disorder or the development of a different one (Link et al., 1989).

Note that the modified perspective makes no assumptions about the relative susceptibility of different groups. The new operationalizations make it unnecessary to compare groups of high and low

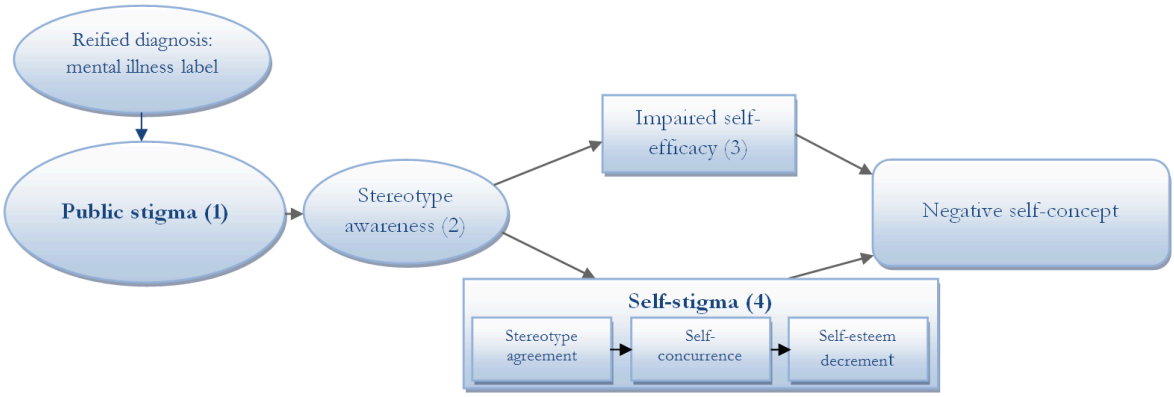

Figure 1: *Two pathways from stigmatization to lowered self-esteem: the self-fulfilling prophecy pathway in which stereotype awareness leads to impaired self-efficacy and the self-stigma pathway in which stereotype awareness leads to self-esteem decrement.*

social status, so that evidence for the theory can be found without making these assumptions.

Stigma and self-stigma

In modified labeling theory, it is assumed that diagnosis has a negative influence on self-concept through stigma and stigma expectations. Recently, research has focused more on how exactly these factors affect self-concept.

A common expression in the Netherlands is that it is better to have a broken leg than a depression. Generally, it is thought that people find it hard to understand mental disorders and to talk openly about them. Those diagnosed with a mental illness often feel ashamed because of their disorder. As mentioned before, mental illnesses are being more and more thought of as non-overlapping categories since the introduction of the DSM's. According to Corrigan (2007), this categorization leads to a sense of "groupness" and "differentness". It creates a sense of "us," normal people, and "them," the mentally ill. The out-group is perceived as homogeneous and stable. This would not be a problem if the perceptions of the out-group were positive. However, society holds negative stereotypes of people with mental disorders. Discrimination by, for example employers or insurance companies, appears to be prevalent (Noe, 1997). This is the public stigma element of the model in figure 1 (1).

Stigmatization appears to have a negative impact on self-concept through the processes described in figure 1 (for example, Markowitz, 1998; Link et al., 2001). People become aware of the societal stigma. This is the "stereotype awareness" component of the model (2). Because of negative experiences with discrimination and stigmatization people come to fear rejection. The self-efficacy component of self-concept (3) is thus impaired (Rosenfield, 1997). This may act as a self-fulfilling prophecy: people could act more defensively or less confidently, or could even avoid social interaction. This would then lead to less satisfying social interactions and thereby lower self-esteem (Link et al., 2001). Note that this is the same as the process described above in modified labeling theory.

In self-stigma, people internalize the negative stereotypes that others hold about them (Corrigan, Watson & Barr, 2006). This is not the same as the "self-efficacy" pathway described above. In this pathway, one feels one is stigmatized and acts in a way consistent with the stigmatization. In self-stigmatization, one agrees with the stereotype and adopts it as one's own. In addition, one comes to embrace the belief that the internalized stereotypes apply to him or her, a phenomenon known as self-concurrence. This leads to "self-esteem decrement," in which self-esteem declines because of the individual's negative beliefs about him- or herself. These components can be found in the lower right half of the model depicted above (4).

Self-stigma is a very common phenomenon in the mentally ill. At least a quarter of depressive patients suffer from high self-stigma, and the higher the self-stigma, the more intense the depression (Yen, Chen, Lee, Tang, Yen & Ko, 2005). In schizophrenia, self-stigma is high, especially for young patients in a less severe stage of the disease. This group might be more aware of their own impairment and the associated stereotypes (Werner, Aviv & Barak, 2007). In borderline personality disorder self-stigma is particularly high, maybe because individuals with this disorder are shame-prone (Rüsch et al., 2006).

Self-stigma has a far reaching effect on self-concept. One internalizes highly negative stereotypes about one's own diagnostic group, and doing this colors every perception about oneself. Research (e.g., Corrigan et al., 2006) has shown that particularly the self-concurrence and self-esteem decrement aspects of self-stigma have a negative effect on self-concept and, ultimately, on general well-being. Rüsch et al. (2006) found that the relationship between self-stigma and self-concept remains significant after controlling for depression and shame-proneness. Thus, these latter variables are not included in the model.

As can be seen in this model, labeling theory is supported and explained by research about stigma and self-stigma.

Positive psychological effects of labeling

Recent literature agrees that reified diagnosis (labeling) leads to stigma and that stigma leads to lowered self-esteem. However, there seems to be a gap in the literature when it comes to the positive psychological impact of diagnosis, although this hardly implies that this impact does not exist.

Searching internet forums and popular magazines, it seems that many patients and people around them are relieved when they receive a diagnosis. People seem to be relieved that the dysfunction that they have, has a name, at least initially (Murphey, 1995 in: Young, Bramham, Gray

& Rose, 2007). It is reasonable to believe that people feel acknowledged in their struggle. In Young et al. (2007) eight adults who received a diagnosis of ADHD described initial feelings of relief and even joy. One participant said: "In one part of me I felt elated. It was almost like, 'Oh, there's an actual reason why I acted like that.'"(p. 496). One could argue that this effect has implications for self-concept. A label could function as a justification of socially unacceptable behavior, making it possible for an individual to blame his disorder, rather than his character flaws, for his behavior. From literature about self-serving bias, it is known that blaming outside factors for our negative behavior and taking personal credit for our positive behavior is associated with higher self-esteem (Gazzaniga et al., 2010). Thus, it would be expected that blaming a mental illness label for deviant behavior is good for self-esteem.

Labeling has another, more obvious positive effect: it helps a patient to get the right treatment. The patient can engage in therapy and receive medications developed specifically for his or her problems. Psychotherapy has positive consequences for self-concept (for example: Ashcraft & Fitts, 1964). In addition, during treatment itself, people can enter programs for financial, vocational and psychological support (Rosenfield, 1997). This also has important consequences for well-being. According to Rosenfield (1997) these particular effects of labeling are also mediated by self-concept. By providing people an opportunity to rehabilitate or to empower themselves against prejudice, they enhance their self-esteem and self-efficacy, which, as we have seen, increases well-being.

Also, diagnosis its intended effect: it creates a common language among professionals and lay people. When people know someone's label, they understand him better and might be more forgiving toward socially unacceptable behavior. In this way, a label might prevent rejection instead of causing it. As has long been known, being accepted by others is a very important determinant of self-esteem (Cooper-Smith, 1967 in: Crouch & Straub, 1983). Insofar as a label is associated with greater understanding and acceptance, it could thus be beneficial for self-esteem.

Other, more practical advantages of diagnosing can easily be imagined. Mental health monitoring has probably become a lot easier since a single diagnostic system has become generally accepted. The advantages in terms of health insurance and government policies are self-evident.

Conclusion and implications

The evidence generally indicates that (1) reified diagnosis leads to stigma and self-stigma, (2) experienced and expected stigma leads to non-adaptive coping responses, and (3) these responses lead to lowered self-efficacy, lowered self-esteem and therefore a more negative self-concept. Thus, the reification of diagnosis under the influence of the DSM diagnostic system ultimately leads to lowered self-concept among those who receive diagnoses.

However, one could imagine that labeling also has positive effects in that (1) it can provide relief and self-justification when one acts in ways that are socially unacceptable, (2) it helps one get access to the right treatment and support programs, (3) it engenders understanding and (4) it has practical advantages for policy. As we have seen, the first three effects might have positive consequences through their impact on self-esteem. However, virtually no studies have investigated these possible effects directly. In more indirect studies these effects might have been overlooked because they tend to manifest themselves earlier than the negative effects (Young et al., 2007) or might only be present in therapeutic situations. So, though it is reasonable to believe that these effects exist, nothing yet is certain.

Concluding, it can be said that although diagnosis has negative effects, eliminating it would be like throwing the baby away with the bathwater. First the positive psychological impact of labeling should be investigated. In general terms, the relative importance of positive and negative consequences should be considered. If the results indicate solely negative effects, it could be argued that diagnosis should not be communicated to patients at all. However, because of ethical and theoretical concerns such a course of action is highly impractical. Still, steps could be considered to reduce the negative effects of diagnosis. For example, stigma could be lessened by interpersonal contact with mental patients (Couture & Penn, 2003) or through education (Corrigan, 2007). Also, programs to eliminate self-stigma could be implemented in psychotherapy (Kroska & Harkness, 2006). Elimination of stigma and self-stigma would help prevent labeling from exerting a on self-concept. Further, many interventions could

be proposed to enhance self-concept directly (Crouch & Straub, 1983).

However, it is possible that individual differences influence the consequences of diagnosis. For example, we have seen that not every disorder has the same self-stigmatizing effect. Also, it might be the case that there is variability in stigma susceptibility, as suggested by Scheff (1966). Such factors should be identified. If research shows that individual factors are indeed important, it could be argued that communicating a diagnosis to a patient should be tailored to every individual case.

Summarizing, labeling appears to have both negative and positive consequences for self-concept. The possible positive consequences should be investigated, so that it can be decided if and how diagnoses should be communicated to patients.

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