

Psychiatric Diagnosis: Friend or Foe to Stigma?

Labeling and classifying phenomena in the world have been inherent within human nature from the beginning of recorded history. Aristotle (384-322 BC), a Greek philosopher who lived from 384-322 B.C., was the first known person to categorize all life and assign labels to various species of plants and animals. Centuries later, this categorization spread into medicine, where pioneers like Emil Kraepelin developed formal taxonomies of mental illness. These diagnostic systems exist still today with the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (DSM-5; American Psychiatric Association, 2013), where a clinician identifies a patient's behavior and labels the behavioral pattern.

Anyone who has played the “label game” will know how unsettling labels can be. The game involves getting a partner to find a label on or around you (e.g., on a clothing tag, shoe, purse) and actively reading them aloud. This process of having someone see the labels on you can be uncomfortable and vulnerable. Thus, how do these prototypical psychiatric labels affect the individual being labeled?

I first want to qualify what I mean by mental illness “labels.” There is a distinction between scientific, psychiatric terminology (e.g., “Schizophrenia”) used to diagnose an individual with a mental illness and colloquial terms often used by laypeople (e.g., “psycho”) to describe psychopathology. In this paper, I aim to uncover how both psychiatric and colloquial labels impact the affected individual regarding self-stigma or stigma from others directed at the person. My central question asks whether these labels promote or reduce mental health stigma.

This paper focuses on two forms of mental illness stigma: a) public stigma and b) self-stigma. Public stigma refers to the negative attitudes (e.g., stereotypes, prejudices) held by a culture or society about certain groups of people. This type of stigma can present through hiring

practices at jobs, where employers avoid hiring individuals who disclosed being diagnosed with a severe mental illness. Alternatively, self-stigma involves an individual taking those stigmatizing beliefs from their society or culture and internalizing them toward oneself. Put differently, self-stigma is when individuals *believe* what is being said about them from their culture (Michaels et al., 2012).

To further illustrate an example of public versus self-stigma, I will use a well-known study in the social psychology literature. A known stereotype is that Asian men are better at mathematics than White men. An experimental study conducted by Aronson and colleagues (1999) demonstrated that when White men learned their math test scores would be compared to Asian men, the White men performed drastically worse than when they learned it was not being compared to any other. The public stigma (i.e., Asian men are better at math) was internalized by the White individuals (i.e., self-stigma), causing them to perform worse on the test afterward.

Patients are diagnosed with a mental illness in the DSM-5 when they meet several criteria: a) the patient's behavior is deviant from the individual's cultural expectations, societal norms, and developmental trajectory; b) the individual must experience emotional distress or daily functional impairment because of their behavior (Beidel et al., 2016). As you might guess, if someone falls slightly below the criteria threshold, they will not receive a diagnosis. The DSM-5 was designed to have cutoffs, although these thresholds are arbitrary and based on no scientific evidence. However, this medical model of psychopathology helps clinicians and researchers decisively determine what is normal and abnormal, with clear, categorical boundaries. Diagnostic labels were designed to condense complex information down into a single term, with the intent to facilitate communication among clinicians and researchers about a

patient. This form of labeling also has secondary advantages, like treatment research and insurance billing and coding.

Research findings suggest that accurate psychiatric labels—ones that are specific and not general—may be more helpful than harmful when reducing stigma. This assertion sounds counterintuitive, but in a sample of Australian youth, researchers found that accurate diagnoses promoted greater help-seeking behavior and reduced self-stigma (Wright et al., 2011). Furthermore, participants rated people with accurate diagnoses as “sick” rather than “weak.” This distinction may imply that formal diagnoses send a message to laypeople that one’s ‘odd’ behavior is justified since its cause is something outside the individual’s control. Cheung and colleagues (2018) report similar findings, where respondents rated an individual with a label of “schizophrenia” as having more control and intentionality, opposed to an individual labeled with “perceptual dysregulation;” the differences were further pronounced between genders, where women were rated lower regardless of which label described them. I will cover the issue of women and psychiatric diagnoses later in the paper.

Martinez and colleagues (2011) found that when referring to an individual with a general diagnostic label (e.g., a psychotic disorder), others viewed the person as less human and more dangerous. But when a patient was described with a specific mental illness (e.g., schizoaffective disorder), they were described as more human and less dangerous. Interestingly, this interaction only occurred when discussing mental illnesses, not physical illnesses. On a similar note to physical illness, do you notice that nobody says “[person] is physically ill” when someone is diagnosed with cancer? This only occurs with mental illnesses, and some studies show that this has unintended consequences. By simply using the term “mentally ill” to describe a behavioral depiction vignette, participants were more likely to perceive the individual as dangerous

(Angermeyer & Matschinger, 2003). These findings should cause us to question our diction and reshape how we refer to psychiatric labels.

What if psychiatrists or psychologists misdiagnose a patient? How does this impact internal and external stigma? Robert Bjorklund (1998) recounts his experience with being misdiagnosed with schizophrenia at age 14. Bjorklund was no longer himself after the avalanche of antipsychotics and neuroleptics he was given and their hideous side effects; he was “the schizophrenic.” Despite having no acute symptoms of schizophrenia, like hallucinations or delusions, this diagnosis was now his identity. Only years later was he diagnosed with an accurate label: bipolar disorder. However, in the 90s, schizophrenia was more stigmatized than today, and this took years for Bjorklund to detach from his identity.

Misdiagnoses also remain on one’s permanent medical record, raising difficulties in the long term. The case of “Mr. A” evidences how easy it was to receive a schizophrenia diagnosis after a psychiatrist’s erroneous interpretation of the Rorschach Inkblot Test—even though he had no characteristic symptoms of the disorder. Mr. A had difficulty getting employment and lowered his military rating, limiting the number of military assignments he could pursue (Witztum et al., 1995). If such life-altering consequences are possible, this implores the need for thorough assessment methods to increase certainty about assigning a diagnosis. Today, psychiatrists are required to diagnose a patient—even after a 10-minute visit—to receive payment from the insurance company (Frances, 2013). The incentive to receive a paycheck outweighs the need for accurate diagnoses in some instances. This inaccuracy ultimately contributes to increased hardship for the patient—some of which result from stigma.

Regarding race and ethnicity, some groups receive greater backlash from a label than others. Black Americans who present to clinics with symptoms of anxiety and depression are more

likely to be misdiagnosed with psychosis-related disorders like schizophrenia. This tends to happen because of discrepancies between clinician and patient cultures, racial biases, or simply misinterpreting the patient's description of their symptoms (Paradis et al., 1992). I view this as 'stigma embedded within stigma, because of the tendency for White clinicians to disparately pathologize ethnic minority patients with unwarranted serious mental illness diagnoses.

Gender biases in diagnosis also reflect public stigmas. Women are more likely to be diagnosed with borderline personality disorder, depression, anxiety, psychotic disorders, and eating disorders, despite having roughly equal prevalence in both genders (American Psychiatric Association, 2013). Some research suggests that this may be due to how the conditions present themselves in each gender, but nevertheless, women disproportionately receive these diagnoses. Women also have an exclusive label set aside for them, premenstrual dysphoric disorder (PMDD), which was introduced in DSM-5. This label is meant to capture a cyclic pattern of depression, anxiety, and irritability symptoms two weeks before her menstrual period. Despite no empirical evidence for this cyclical pattern, PMDD is still in the new revision of the DSM.

If being more intentional about using precise diagnostic terms is preferable, rather than lay mental health terms, are there any precautions we must take? Lately, there has been a movement within the mental health arena to implement more person-first language in our speech. Person-first language involves just that: putting the *person* first. For example, instead of saying "Mark is a schizophrenic," person-first language would rephrase it as "Mark has schizophrenia." Research supports this idea, too, where Cuttler and Ryckman (2018) found that fictitious characters were rated far worse when the character was labeled 'is bipolar' instead of *having* bipolar disorder. Thus, while using diagnostic terms is a step in the right direction, we need to be cognizant of how we refer to the label in our speech by using person-first, possessive language.

On the one hand, the reader will notice that diagnostic labels appear to help reduce stigma when used correctly. However, modified labeling theory posits that these tags of psychopathology give individuals a sense that they are broken and damage their self-esteem (Link, 1987). Over time, patients meld with their diagnosis to where it becomes a facet of their identity. Researchers like Widiger & Mullins-Sweatt (2010) claim that these labels hinder scientific progress because they *promote* stigma, especially in one diagnostic category: personality disorders. When disorders are conceptualized as qualitatively distinct departures from ‘normality,’ this, according to Widiger and Mullins-Sweatt, implies a global sense of being flawed. There is an assumption that a ‘normal personality’ exists, and labels indicate when an individual’s personality is *not* normal.

Personality disorder diagnoses are especially prone to this problem because personality is a central component of one’s identity. “Borderline personality: The disorder that doctors fear most.” This 2009 *Time Magazine* cover title provides some insight into the stigma around BPD—even among mental health professionals. BPD is a condition marked by a persistent and pervasive pattern of unstable interpersonal relationships, affect, self-image, and impulsivity (American Psychiatric Association [APA], 2013). The *Time Magazine* cover only reflects the sentiment at the time surrounding BPD. It was classified as an Axis II disorder (along with developmental disorders) in the DSM-IV, meaning that it was lifelong and untreatable. The Axis system no longer exists in the current edition of the DSM partly because of breakthroughs in treatment research indicating that BPD was the *most* treatable personality disorder. However, the BPD stigma continues to linger because of its name. To receive the “borderline” label, a patient must only meet five of the nine diagnostic criteria outlined in the DSM-5. This minimum threshold means that there are 256 different variations of how a patient can present with BPD,

which demonstrates how unreliable and uninformative the diagnostic system is. Since the diagnostic label fails to capture the breadth of a ‘disorder,’ the stigma affects people who may not even exhibit all aspects of BPD but still receive the label.

Historically, homosexuality was included in the DSM as a mental disorder and was not removed until 1973 after the civil rights movement. As anyone would imagine, this label amplified anti-gay sentiments throughout the nation. Today, many ideologies continue trying to separate the idea of homosexuality being a mental illness—effects still felt by its days in the DSM. However, a new DSM label is being leveraged against LGBTQ+ individuals: gender dysphoria. This disorder refers to the psychological distress experienced when one’s sex assigned at birth is incongruent with their gender identity (APA, 2013). Not every transgender individual will experience gender dysphoria. This disorder is only diagnosed when *distress* is involved—when these individuals find ways to align their biological sex and gender expectations, distress typically subsides. They would no longer qualify for the gender dysphoria diagnosis. Despite this, many current anti-LGBTQ+ people erroneously use the diagnostic label to leverage their arguments. As if they are paying homage to the days of homosexuality in the DSM, these fallacious gender dysphoria arguments claim that being transgender is a mental illness since it is in the DSM.

It is often ironic that there is no ‘yes’ or ‘no’ answer to whether labels promote or reduce mental illness. Like any complicated issue, the answer is nuanced and depends on various factors. Research suggests that in most instances, accurate diagnostic labels help reduce stigma when used appropriately but can be harmful when distorted by society. One byproduct of mental health stigma is label avoidance, where people choose not to seek services because of the stigma associated with a diagnosis (Ben-Zeev et al., 2010). Label avoidance ties back in with the idea of

Link's (1987) modified labeling theory, where the person and diagnosis become synonymous—the fear of prejudice and discrimination against someone with a mental illness is enough to ward people away from treatment.

I want to expand to a broader view where I highlight how our culture can implement this now. Our culture often takes diagnostic labels and morphs them into colloquial slurs, which refer to the derogatory words used by laypeople when speaking about mental illness. Words like “retard,” “psycho,” and “crazy” are only three of the 250 derogatory words for mental illness used frequently (Rose et al., 2007). Applying the previous recommendations about using psychiatric labels correctly, how do we move forward? First, it is imperative that we each quit using the term ‘mental illness’ and instead shift to descriptive terms like major depressive disorder or panic disorder. Once this is done, we need to use the labels in a possessive format, not noun format (i.e., saying “someone with major depressive disorder” and not “he is depressed”). Until our diagnostic systems change, we cannot do otherwise.

Future Directions

This paper has examined how, at the individual level, someone can eliminate stigmatizing language when using psychiatric labels in their language. Now I want to overview the systemic changes that need to occur for further change. Radical efforts have been underway to eliminate diagnostic labels for personality disorders. Among the many reasons for this shift, stigmatization is near the forefront. An alternative to identifying personality pathology are diagnostic systems built upon the five-factor model (FFM; Costa & McCrae, 1992). The FFM reduces personality into five broad domains consisting of variable levels of agreeableness, conscientiousness, extraversion, neuroticism, and openness to experience. Instead of diagnosing someone with the classic “borderline personality disorder (BPD),” a clinician using a FFM approach might say a

patient scores very high on neuroticism scales and very low on agreeableness scales. This alternative is much more informative of the *individual* and reduces the stigma associated with loaded terms like “borderline.” Once receiving a diagnosis, many patients will research their condition for more psychoeducation. Since the word “borderline” is associated with immense stigmatization, patients may doubt a bright prognosis. However, with the FFM, patients are not put into a box but along a continuum.

Unlike physical illness, where diseases have a traceable origin and location in most cases, mental disorders manifest in various hidden ways. Psychiatric diagnoses tend to be dispensed based upon observed symptoms of some underlying, unobservable cause. However, the National Institute of Mental Health has been constructing a new method of organizing and labeling mental disorders, assuming that all observable behaviors have some neurobiological basis. The Research Domain Criteria (RDoC; Insel et al., 2010) encompasses this new approach to labeling mental disorders, and it may facilitate an era of decreased stigma surrounding classic labels. RDoC should not be confused with the FFM, which only solves the personality labeling problem mentioned previously; RDoC is a total revamp of *all* psychiatric disorder labels. By examining neural circuitry, physiology, behavior, and self-reports, RDoC conceptualizes a ‘problem’ behavior into multiple units of analysis. Scientists argue that this method of framing mental illness across these multi-dimensional paradigms will make mental ‘illness’ less susceptible to pathologized and stigmatizing language—as is the case with the medical model of the DSM-5 (Weine et al., 2018).

Aside from diagnostic system overhauls, how else can our culture reduce the stigma with labels? I propose we also invest in bringing more minority communities into the mental health arena. Minority communities can include those in underrepresented racial and ethnic groups,

sexuality, mental health diagnoses, gender, and sex. As shown previously, many labels (e.g., sexual orientation disorder in DSM-II) were developed more from ideologies and not science. These ideologies and perspectives tended to originate from middle-aged, upper-class White men. With scientists and clinicians who are more representative of minority distributions, I posit that we can achieve less stigmatizing labels from one group inflicted upon another. In other words, when everyone has equal input in a labeling system, there is an expansive representation and less stigma.

In sum, this paper attempted to briefly review how our diagnostic systems originated and their role in influencing mental health labels in colloquial language. These systems are responsible for pathologizing normal human behavior like sexuality and contribute to an array of stigma around mental illness. However, I have also highlighted how these labels can benefit those with a mental disorder and reduce internal and external stigma. Pathways for ultimately improving the stigma around labels is to rid them simply. New systems of mental health taxonomy, like the FFM and RDoC, try to do this, but research is still ongoing on how to implement them in clinical practice. Until this can be achieved, the burden is upon every individual to use mental health labels responsibly. Avoid the blanket term ‘mental illness’ when describing someone’s diagnosis and use person-first language when disclosing their diagnosis.

I see a future where individuals can freely visit mental health professionals without the fear of receiving a label looming over their heads. I see a world where clinical science treats people without using a label. Labels convey quick and accessible information about how a patient *might* be, but they do not portray this individual's entire portrait. The human mind is far too complex to be equated with a single word; therefore, we should start treating diagnosis as such.

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