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Labeling of mental disorders and stigma in young people

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ABSTRACT

Mental disorders are common in young people, yet many do not seek help. The use of psychiatric labels to describe mental disorders is associated with effective help-seeking choices, and is promoted in community awareness initiatives designed to improve help-seeking. However these labels may also be coupled with stigmatizing beliefs and therefore inhibit help-seeking: lay mental health or non-specific labels may be less harmful. We examined the association between labeling of mental disorders and stigma in youth using data from a national telephone survey of 2802 Australians aged 12–25 years conducted from June 2006 to August 2006. Label use and stigmatizing beliefs were assessed in response to vignettes of a young person experiencing depression, psychosis or social phobia. Logistic regressions examined the association between a range of labels commonly used, including psychiatric labels, and a range of stigma components. There were no significant associations between label use and the stigma components of "stigma perceived in others", "reluctance to disclose" and for the most part "social distance". Most mental health labels were associated with seeing the person as "sick" rather than "weak" and accurate psychiatric labels had the strongest effect sizes. However, for the psychosis vignette, the "dangerous/unpredictable" component was predicted by the labels "schizophrenia/psychosis", "mental illness" and "psychological problem", and the accurate psychiatric label showed the strongest association. For all vignettes, generic lay labels were not associated with stigma, but also rarely had a counter stigma effect. These findings suggest that the use of accurate psychiatric labels by young people is seldom associated with stigma and may assist young people by reducing perceptions of weakness. However, community education that promotes accurate labeling of psychosis should proceed with caution and address beliefs about dangerousness and unpredictability.

Introduction

Mental disorders are prevalent in young people, affecting at least 1 in every 4 to 5 each year (Patel, Flisher, Hetrick, & McGorry, 2007), yet many do not seek help (Slade, Johnston, Oakley Browne Andrews, & Whiteford, 2009). Recognizing and labeling a mental health problem as it emerges is considered to be a natural part of the help-seeking process (Angel & Thoits, 1987; Biddle, Donovan, Sharp, & Gunnell, 2007; Vogel, Wester, Larson, & Wade, 2006). Indeed, the identification and labeling of mental disorders is a focus of mental health community awareness initiatives designed to facilitate help-seeking and entry into treatment (Dumesnil & Verger, 2009; Kelly, Jorm, & Wright, 2007). However, the use of labels in the field of mental health has been contentious. There have been decades of debate about their potential for harm, particularly in relation to fueling stigmatizing attitudes (Gove, 1975; Jorm & Griffiths, 2008; Link, Cullen, Struening, Shrout, & et al, 1989; Pescosolido et al., 2010; Scheff, 1966).

Labeling and stigma

Studies examining Labeling Theory (Scheff, 1966) and Modified Labeling Theory (Link et al., 1989) have been at the forefront of research examining the association between labeling and stigma related to mental disorders. They have reported on the negative and stigmatizing impact of a person being labeled as mentally ill or as a consumer of mental health services. Consistent with this view, there is other research showing that the use of psychiatric terms by the public to label mental health problems (as opposed to people) can also be stigmatizing (Angermeyer & Matschinger, 2005; Penn & Nowlin-Drummond, 2001). Although recently this has been the subject of debate (Jorm & Griffiths, 2008; Read, Haslam, & Davies, 2009; Read, Haslam, Sayce, & Davies, 2006).

However, Link and Phelan (2010) have argued that labeling has both positive and negative aspects and needs to be considered as a "package deal". They suggest that whilst there is evidence that labeling a person who has received psychiatric treatment as "mentally ill" is stigmatizing, labeling the problem—the illness itself—can be beneficial, as it facilitates treatment and ultimately amelioration of symptoms. Therefore

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a critical distinction needs to be made between labeling the person and labeling the problem, that is, the label that stems from being a person who has participated in psychiatric services (Rüsch, Angermeyer, & Corrigan, 2005) versus labeling a mental health problem as it emerges in the process of recognition and help-seeking.

Research into the labeling of mental health problems by the public and its association with stigma has used a variety of methods. The most common have been to examine reactions to the label itself (Mann & Himelein, 2004; Penn & Nowlin-Drummond, 2001), to present a vignette and ask whether the person is mentally ill (prompted identification) (Link, Phelan, Bresnahan, Stueve, & Pescosolido, 1999; Martin, Pescosolido, & Tuch, 2000; Perry, Pescosolido, Martin, McLeod, & Jensen, 2007; Pescosolido et al., 2010; Phillips, 1967), or to ask the participant to label a vignette and then pool all labels involving mental illness (Angermeyer & Matschinger, 2003; Angermeyer & Matschinger, 2005). However, the distinct labels used to describe a mental disorder that have been elicited without prompting are more likely to reflect the experience of recognizing and labeling a mental disorder as it occurs in the real-life process of help-seeking (Angel & Thoits, 1987; Biddle et al., 2007; Vogel et al., 2006). Indeed prompted labeling or pooling results may mask the real effect of how different labels are associated with stigma, as they do not take into account the different effects of the various labels a person may use. For example, prompting with the label "mental illness" or "mentally ill" may be more of an indicator to a respondent of the person having participated in psychiatric services (Rüsch et al., 2005) rather than a description of a mental health problem itself.

Complexity of the stigma construct

A further complexity in this area is that stigma is a multidimensional construct that has been variably described and measured, potentially leading to inconsistency in the evidence. Various facets of stigma have been examined from the perspective from which they are experienced. These include personal stigma – the stigmatizing attitudes a person has regarding others (Griffiths, Christensen, Jorm, Evans, & Groves, 2004); self-stigma – the stigmatizing views individuals have in regard to themselves (Corrigan & Watson, 2002); perceived stigma- beliefs regarding the stigmatizing views that others hold (Griffiths et al., 2004); interpersonal stigma – the stigma that occurs within interpersonal communication and lived engagements (Yang et al., 2007); discriminatory behavior (Corrigan, Markowitz, Watson, Rowan, & Kubiak, 2003); the experience of being stigmatized (Wahl, 1999); and structural discrimination – the policies of private and governmental institutions that restrict the opportunities of people with mental illness (Corrigan, Markowitz, & Watson, 2004). Furthermore, these different facets of stigma are themselves multidimensional. For example, personal stigma has various components, including desire for social distance, perception of mental disorders as due to weakness, belief in dangerousness, reluctance to disclose to others, desire for social control and goodwill (Jorm & Oh, 2009).

Unprompted labels and stigma

Social distance and a range of other personal stigma components have been the focus of a small number of studies that have examined the association between unprompted labeling of mental disorders and stigma. All of these studies have used the vignette method to examine labels applied to vignettes of schizophrenia/psychosis or depression (see Table 1). Social distance has been the most frequently examined aspect of stigma. In regard to schizophrenia, use of the accurate label has been found in one study to be associated with social distance items (Angermeyer, Holzinger, & Matschinger, 2009), however the association was non-significant in the other study examining the accurate label (Jorm & Griffiths, 2008). By contrast, social distance was associated with other labels for this vignette such as psychological/mental/emotional problem (Jorm & Griffiths, 2008) and brain/mind problem (Kermode, Bowen, Arole, Pathare, & Jorm, 2009). However, generally associations between other mental health labels and social distance tended to be negative or non-significant. For depression, only one study showed an association between the accurate label and a social distance item (Angermeyer et al., 2009), but in general most findings were non-significant (Angermeyer et al., 2009; Jorm & Griffiths, 2008; Kermode et al., 2009).

In regard to personal stigma, one study used a schizophrenia vignette and an association was found between belief in dangerousness and the accurate label for schizophrenia (Jorm & Griffiths, 2008). However, for studies examining depression, most associations with the accurate label were either non-significant or showed a negative association (Jorm & Griffiths, 2008; Wang & Lai, 2008).

In summary there seems to be more association between accurate and non-specific labels and stigma for schizophrenia/psychosis vignettes than for depression vignettes, confirming findings that schizophrenia is generally more stigmatized (Angermeyer & Dietrich, 2006). However it is difficult to draw definite conclusions, as the studies vary according to the aspect of stigma measured, the vignettes and stigma scales used, and cultural differences between the countries studied.

Labeling as a facilitator of help-seeking

Labeling also plays a key role in the help-seeking process (Angel & Thoits, 1987; Biddle et al., 2007; Vogel et al., 2006). This is of particular importance for adolescence and young adulthood, as this is when mental disorders commonly first occur (Kessler et al., 2007) and is therefore when help is likely to be sought for the first time. Help-seeking evolves during this time as young people move from relying on their parents during adolescence to external sources of help as they progress into young adulthood (Jorm, Wright, & Morgan, 2007b; Rickwood, Deane, Wilson, & Ciarrochi, 2005).

One study that examined the association between unprompted label use and help-seeking amongst young people (Wright, Jorm, Harris, & McGorry, 2007) reported that accurate labels were more consistently associated with preference for recommended forms of treatment, relative to all other mental health and non-mental health labels. A more recent study examined the unprompted labels most commonly used by young people to describe a range of mental disorders and explored their association with help-seeking intentions and preferences (Wright, Jorm, & Mackinnon, 2011). Even when important factors such as age and gender were controlled for, findings suggest that accurate psychiatric labeling of a range of mental disorders in vignettes predicted a preference for professionally recommended sources of help with greater consistency than any other labels commonly used. Inaccurate or imprecise mental health labels such as "mental illness" had weaker associations, while broad, non-specific labels such as "stress", "paranoid" and "shy" predicted less intention to seek any help at all if the respondent experienced the problem described in the vignette. Adult studies have reported similar findings (Angermeyer et al., 2009; Goldney, Dunn, Dal Grande, Crabb, & Taylor, 2009).

Labeling as an inhibitor of help-seeking (through stigma)

Whilst effectively labeling a mental disorder may facilitate help-seeking amongst the young, it may also be coupled with