

## Labeling Theory

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In 1966, Thomas Scheff published a landmark book entitled *Being mentally ill: A sociological theory* (Scheff, 1966). Scheff introduced a labeling theory of mental illness grounded in a distinction between primary and secondary deviance. In contrast to the violation of explicit rules, which Scheff attributes to the actions of criminals or delinquents, psychopathology or aberrant behaviors that violate implicit rules are referred to as primary deviance. This primary deviance can lead an individual to be diagnosed with a mental disorder. Society members' reactions to the diagnostic label produce what Scheff called secondary deviance, the additional pathology or behavioral disturbance that can cause or worsen mental illness. The novelty of labeling theory lies in its emphasis on the importance of secondary deviance, and this has sparked considerable debate and empirical research.

### Influential Labeling Studies

Three studies continue to exert a disproportionate impact on the contemporary understanding and assessment of the merits of labeling theory: Temerlin's (1968) study of suggestion effects in diagnosis, Langer and Abelson's (1974) study of labeling bias, and the Rosenhan (1973) pseudopatient study. Temerlin (1968) had psychiatrists, clinical psychologists, and clinical psychology graduate students watch a videotape of an actor portraying a mentally healthy physical scientist and mathematician who had read a book about psychotherapy and wanted to discuss it with a psychologist. Before they watched this, participants were informed by an esteemed colleague with many professional

honors that the individual on the tape was "a very interesting man because he looked neurotic, but actually was quite psychotic." The clear implication was that the expert had access to more information about this man than participants would view on the tape. After they watched it, participants chose a diagnosis from a list of 30 choices that included 10 psychotic disorders, 10 neurotic disorders, and 10 miscellaneous personality types. "Normal or healthy personality" was an option in the latter category, and Temerlin believed this was the correct choice on the grounds that the actor portrayed a mentally healthy person. A majority (60%) of the psychiatrists, along with 28% of the clinical psychologists and 11% of the graduate students, chose a diagnosis from the psychotic disorders. By comparison, none of the participants in the four control groups (e.g., no suggestion, suggestion of mental health) diagnosed this individual as psychotic.

Temerlin (1968) concluded that suggestions influenced clinicians' diagnostic judgments, and this seems indisputable. Others interpret this finding as support for labeling theory on the grounds that the suggested label of psychosis affected participants' judgments. It is not clear how this interpretation relates to the theory, however, as there is no indication of any role played by secondary deviance in this study. The man on the tape was instructed to portray a mentally healthy person, and there was no opportunity for participants to react to the label in ways that might affect his behavior. Another problem is that the observed suggestion effect itself is arguably a reasonable response to a situation in which participants had to combine two sources of information, one of some validity and one of little or none, to reach a judgment. First, participants were told by a qualified expert that although the man on the tape would not appear to be so, he was in fact "quite psychotic." Next, they were shown a tape that contained largely irrelevant

behavior. Seeking to discuss a book with someone knowledgeable on the subject is not a context in which one might expect to observe evidence strongly indicative of the presence vs. absence of any mental disorder. Participants had no reason to discount the expert's opinion, particularly given that they were led to believe this expert possessed more valid information than what was shown on the tape. Therefore, it seems unreasonable to expect participants to completely override the expert's judgment and select "normal or healthy personality" as their best guess diagnosis. Taking the expert's input into account is arguably the more sensible response to a highly ambiguous situation.

In the second influential study of labeling, Langer and Abelson (1974) had clinicians watch a videotape of a job interview with the sound removed. Half the participants were told in advance that the interviewee was a patient, the other half that he was a job applicant. After watching the tape, participants responded to a series of open-ended questions about the interviewee that blind raters later scored along a 10-point scale of psychological adjustment. Among psychoanalytically oriented participants, ratings were more negative for patients than for job applicants, whereas among behaviorally oriented participants, ratings were comparable across experimental conditions.

Langer and Abelson (1974) concluded that whereas behavioral therapists were immune to the influence of a "mere label," psychoanalytic therapists were biased by this label. This interpretation of the results once again contains a problematic assumption. Referring to "mere labels," Langer and Abelson presumed that patients and job applicants experience equivalent levels of adjustment and therefore that the label was in fact irrelevant. In the absence of data on the actual adjustment of patients and job applicants, which Langer and Abelson did not provide, there is no defensible criterion against which to evaluate participants' judgments. Unfortunately, the challenge of how best to integrate multiple sources of

information that vary in their validity is often ignored in labeling research. Most investigators appear to presume that a diagnostic label does not denote any empirically relevant behavioral information. This assumption seems inconsistent with Scheff's original conception of labeling theory, in which he maintained that primary deviance leads to a diagnostic label. Given this foundation, one can reasonably infer some level of primary deviance from the existence of a diagnostic label. The key question, unaddressed by Temerlin or Langer and Abelson, is whether a label leads to secondary deviance that in turn causes or worsens mental illness. Receiving a suggestion, watching a videotape, and making diagnoses or ratings of a target does not constitute a paradigm capable of testing the labeling theory of mental illness.

The third influential study of labeling is described in Rosenhan's (1973) classic paper "On being sane in insane places." Eight mentally healthy individuals, including Rosenhan himself, requested admission at mental hospitals based on a complaint of distressing auditory hallucinations. Specifically, they reported hearing the words "empty," "hollow," or "thud." Some of the participants visited more than one hospital, for a total of 12 "pseudopatient" experiences. In each instance, the pseudopatient was admitted to the hospital and diagnosed with a mental disorder. Schizophrenia was diagnosed 11 times and manic depression once. Once admitted, each pseudopatient stopped faking any symptoms. Though they took extensive notes to record their observations, pseudopatients were instructed to act in an otherwise normal fashion and to respond honestly to questions so that the research team could determine whether hospital staff would discover their "sanity" and release them. After an average stay of 19 days, each pseudopatient was discharged with his or her original diagnosis reclassified as "in remission."

Selecting from the observations recorded by the pseudopatients, Rosenhan (1973) asserted that "psychiatric diagnoses . . . carry with them

personal, legal, and social stigmas” (p. 252). He wrote that “the data speak to the massive role of labeling in psychiatric assessment. Having once been labeled schizophrenic, there is nothing the pseudopatient can do to overcome the tag. The tag profoundly colors others’ perceptions of him and his behavior” (pp. 252–253). Rosenhan surmised that “the label sticks, a mask of inadequacy forever” (p. 257). The final sentence unifies the paper by implying that diagnostic labels led to the abusive practices observed by the pseudopatients: “In a more benign environment, one that was less attached to global diagnosis, [the staff’s] behaviors and judgments might have been more benign and effective” (p. 257).

Many commentators have argued that Rosenhan had used faulty methodology, ignored pertinent data, and reached erroneous conclusions. For example, Rosenhan based assertions on anecdotes drawn from a wealth of observational data rather than making more appropriate comparative judgments (e.g., he concluded that bias alone led one staff member to perceive one patient as having a history of emotional ambivalence in close relationships); relied on speculations or presumed consensus of expert opinion to support strong empirical claims (e.g., “the view has grown that psychological categorization of mental illness is useless at best and downright harmful, misleading, and pejorative at worst”; Rosenhan, 1973, p. 251, no citations provided); made questionable inferences about others’ perceptions without independent corroboration (e.g., discussed nurses’ ostensibly label-biased perception of psychopathology solely on the grounds of their factual observation that “patient engaged in writing behavior”); and appealed to hypothetical counterfactuals without supplying or citing supportive evidence (e.g., in the case of emotional ambivalence noted above, stating that “an entirely different meaning would have been ascribed if it were known that the man was ‘normal’”; Rosenhan, 1973, p. 253).

Spitzer (1976) emphasized that the pseudopatients’ discharge diagnoses posed a

serious threat to Rosenhan’s (1973) central conclusions. Spitzer collected data suggesting that an “in remission” classification was used only rarely when patients were discharged from psychiatric hospitals. Given this contextual information, the uniform application of such an unusual diagnostic qualifier demonstrates how attentive professionals were to the pseudopatients’ behaviors. To the extent that this study addresses labeling theory at all, it provides little support for it. The initial diagnoses of psychosis appear not to have unduly clouded diagnosticians’ subsequent judgments, for in every case the staff correctly observed the absence of signs or symptoms of psychopathology prior to discharge. Though the primary deviance responsible for their initial diagnoses was faked, the staff do not appear to have responded to the initial diagnoses in ways that elicited secondary deviance.

### **Empirically Evaluating Labeling Theory**

Most often, labeling has been studied by examining people’s perceptions—or, sometimes, the personal experiences—of differently labeled groups of patients. However, alternative explanations for any observed differences may be as or more compelling. Ruscio (2004) stresses a point taken from Scheff’s original theory: Diagnostic labels denote abnormal behaviors. Naturally, they do so imperfectly, but to completely discount a label would be foolish, especially in the absence of more valid information that is inconsistent with the label. At least as important, as noted earlier, it is not clear how secondary deviance is implicated in studies that compare differently labeled individuals. These are only some of the ways in which proponents have been vague in deriving predictions from labeling theory and loose in interpreting results as supportive.

In an early review of this literature, Scheff (1974) identified a total of 18 relevant studies, judged 13 of these to be consistent with labeling theory and five to be inconsistent, and concluded that this provided good support. In

addition to the well-known limitations of such a “box-score” approach to reviewing empirical literature (e.g., because of the “file drawer problem” an unknown number of null results may be unpublished, disconfirmations should carry more epistemic weight than confirmations), much of the research cited in support of labeling theory is methodologically flawed. For example, Scheff singled out Rosenhan (1973) and Temerlin (1968) as the strongest sources of support. As noted earlier, these studies bear on the role of secondary deviance that is key to labeling theory only weakly, if at all. Even from Scheff’s sympathetic perspective, other studies were judged still less informative.

Critics contend that the role of secondary deviance is overstated and have assembled several kinds of evidence that refute labeling theory. Gove (1982) notes that mental hospitals have a rigorous screening process to admit patients, most often on a voluntary basis, who need professional help:

The vast majority of persons labeled mentally ill are seriously impaired and their impairment is the major reason for labeling. . . labeling is not a major factor in a chronic career of mental illness but, in fact, labeling tends to initiate processes that minimize the length and severity of a person’s disorder. (p. 291)

Unless a clinician will offer the same treatment to all patients, some method of classification is required to connect patients with appropriate treatments. Gove also reviews evidence on the temporal ordering of former patients’ symptom manifestations and family members’ expectations. The data contradict the predictions of labeling theory that expectations stemming from diagnostic labels will elicit, or at least shape, patients’ deviant behaviors.

Gove and Howell (1974) found that, after controlling for severity of disorder, married and upper-class individuals were more likely to receive treatment than unmarried or lower-class individuals. This finding contradicts the expectation under labeling theory that individuals most capable of avoiding treatment

for mental illness should do so to prevent the secondary deviance caused by labeling.

Gove and Fain’s (1973) intensive interviews with 429 former mental patients revealed improvement in social relationships, positive evaluations of hospital experiences, improved assessments of personal situations, and increased capacity to deal with problems. Though some of these positive comments may be the result of biases in retrospective reporting, a small minority of the former patients (19) reported exclusively negative outcomes. As correlational data cannot establish causal relationships, these findings are difficult to reconcile with labeling theory. Gove and Fain (1973) also note that disparaging mentally ill individuals in an abstract, impersonal way (e.g., reading a vignette and circling a response on a social rejection rating scale) is very different from perpetrating discrimination against a mentally ill person. Attitudes do not always predict behaviors well, even with reliable measurements of attitudes and aggregate measures of behavior. Prejudice against the mentally ill may not result in significant secondary deviance if relatively few people act on their prejudice.

Gove (1982) concluded that “a careful review of the evidence demonstrates that the labeling theory of mental illness is substantially invalid” (p. 295). Reviewing studies in which diagnostic labels and deviant behaviors varied independently of one another, Link, Cullen, Frank, and Wozniak (1987) found that most failed to support labeling theory because behaviors were more important determinants of social reactions than labels.

### Further Difficulties for Labeling Theory

In addition to the weak empirical support summarized above, Ruscio (2004) noted a number of conceptual difficulties with labeling theory. First, research has demonstrated the cross-cultural generality of some important diagnostic constructs, which is inconsistent with the marked divergence that one would

expect under labeling theory. Second, the stigma of mental illness predates formal classifications of psychopathology. Throughout recorded history, treating mental illness in increasingly humane and effective ways has probably done more to reduce the associated stigma than creating, revising, or eliminating diagnostic labels. Third, clinician–patient confidentiality raises the question of just how a diagnosis itself could be responsible for stigmatization among family, friends, or coworkers. Fourth, diagnostic labels often exert a positive influence in the causal attribution process. The discounting principle of causal inference holds that knowledge of one plausible explanation for a behavior will serve to diminish the perceived influence of other causes. Thus, a diagnostic label may prompt the discounting of dispositional characteristics such as personality traits as causes of aberrant behaviors, and therefore attenuate blame and social rejection.

### Reducing the Stigma of Mental Illness

There is no compelling evidence for the alleged stigmatizing effect of diagnostic labels, and an empirically supported consensus that emerged early remains valid: “It seems likely that any rejection directed towards psychiatric patients comes from their aberrant behavior rather than from the label that has been applied to them” (Lehmann, Joy, Kreisman, & Simmens, 1976, p. 332). Some of the data reviewed above might be consistent—or at least less inconsistent—with a weaker version of labeling theory formulated to allow for stigmatizing effects of general labels such as “mentally ill.” On the other hand, such a weak version of labeling theory would fail to support a call for abandoning or revising specific diagnoses because such a general label can be inferred from any evidence of treatment-seeking or referral to a mental health professional.

Clinicians and clients are not naive, and labels are not necessarily the blunt instruments they are often depicted to be. By studying

interactions between professionals and the parents of disabled children, Gill and Maynard (1995) showed that diagnostic information can be elicited, and eventual diagnoses conveyed, in compassionate and meaningful ways. Like any other tools utilized by mental health professionals, diagnostic labels are imperfect and leave much room for improvement. Constructive criticism continues to spur the evolution and refinement of diagnoses. Focusing on other means of alleviating the stigma of mental illness, however, may achieve greater success than an undifferentiated assault on the enterprise of using diagnostic labels.

**SEE ALSO:** Errors/Biases in Clinical Decision Making; Rosenhan Pseudopatient Study; Spitzer, Robert (b. 1932); Syndrome, Disorder, and Disease

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