



Self-labeling and its effects among adolescents diagnosed with mental disorders[☆]

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ABSTRACT

While youths are increasingly diagnosed with serious psychiatric disorders, little is known about how they conceptualize their own problems or the impact of mental illness labels on their psychological well-being. These are matters of great concern because of the potential vulnerability of young people to stigma as well as the fact that fear of labels or anticipation of stigma are common barriers to adolescents' ongoing mental health service utilization. This study uses mixed-method interviews with 54 US adolescents receiving integrated mental health services in a mid-sized mid-Western city to examine: (1) the extent to which they use psychiatric terms to refer to their problems ("self-label"), and (2) the relationships between adolescents' self-labeling and indicators of psychological well-being (self-esteem, mastery, depression and self-stigma). Associations between self-labeling and perceived negative treatment by others (public-stigma), clinical and demographic factors are explored to identify which adolescents are more likely to self-label. Based on Modified Labeling Theory [Link, B., Cullen, F., & Struening, E. (1989). A modified labeling theory approach to mental disorders: An empirical assessment. *American Sociological Review*, 54(3), 400–423.] and Thoits's [(1985). Self-labeling processes in mental illness: The role of emotional deviance. *American Journal of Sociology*, 91(2), 221–249.] work on self-labeling, it was expected that many youth would not self-label and that self-labelers would demonstrate poorer psychological well-being. As expected, the findings indicated that only a minority of adolescents 'self-labeled'. Most conceptualized their problems in non-pathological terms or demonstrated uncertainty or confusion about the nature of their problems. Adolescent who self-labeled reported higher ratings on self-stigma and depression, and a trend toward a lower sense of mastery, but there was no association with self-esteem. Certain characteristics and experiences were correlated with a greater propensity to self-label including: more perceived public-stigma, younger age at initiation of treatment, and higher socio-economic status. This work contributes to knowledge about the variation of adolescents' experiences with stigmatizing labels and their impacts.

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Introduction

While youth in the United States are increasingly diagnosed with serious psychiatric disorders (e.g., Moreno, Laje, & Blanco, 2007), little is known about their own interpretation of their problems and the stigmatization they experience (Hinshaw, 2005; Wahl, 2002). Understanding youths' experiences with mental illness (MI) labeling and stigma is important due to the established association between stigma and treatment avoidance, under-utilization, and poor adherence (Sirey, Bruce, & Alexopoulos, 2001; Vogel, Wade, & Hackler, 2007). Fear of labels or anticipation of stigma is a common barrier to adolescents' help-seeking and

mental health (MH) service utilization (Boldero & Fallon, 1995; Yeh, McCabe, & Hough, 2003). These barriers are of great concern because most youth who show evidence of mental health problems, especially minorities, do not receive any type of mental health care (e.g., Cauce, Domenech-Rodríguez, & Paradise, 2002; Katakoka, Zhang, & Wells, 2002). Moreover, an understanding of the perspectives of these young consumers is critical because of the links between labeling, stigma, and lowered self-concept found among adult patients (Corrigan, 1998; Link, 1987; Markowitz, 2001). Adolescents maybe especially vulnerable to stigmatizing labels because adolescence is a period of identity consolidation characterized by a powerful need for a sense of competence, social acceptance, and autonomy (Leavey, 2005; Wisdom, Clarke, & Green, 2006).

This study uses qualitative and quantitative data from face-to-face interviews with adolescents receiving integrated services to examine: (1) the extent to which adolescents refer to their problems using psychiatric terms ("self-label"); (2) the relationship

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between self-labeling and indicators of psychological well-being (self-esteem, mastery, depression and self-stigma); and (3) the associations between self-labeling and public-stigma as well as clinical and demographic factors.

Labeling, self-labeling and impact on adult mental health consumers

It is widely assumed that being diagnosed and treated for a mental illness can have unintended, harmful effects for individuals. If the label is acknowledged and accepted by an individual, it can generate a sense of powerlessness and “enduring vulnerability” (Hayne, 2003). The label can activate stereotypes and negative behaviors toward individuals assumed to be part of a uniform, undesirable group; this devaluation and discrimination is termed public-stigma (Corrigan & Watson, 2002; Link & Phelan, 2001). A psychiatric label can also generate self-stigma referring to the shame and self-directed prejudice experienced by the ‘marked’ individual, who applies negative stereotypes toward her/himself (Corrigan, 2007). Self-stigma, in turn, has been associated with a host of negative outcomes including depression, lowered self-esteem, social isolation, and reluctance to seek help (e.g., Corrigan, Watson, & Barr, 2006; Link & Phelan, 2001).

Recent studies, however, have begun to document the variable and complex way in which adults react to being labeled by professionals. Many psychiatric patients do not accept the psychiatric diagnoses ascribed to them, often preferring alternative, less pathological explanations for problems (Camp, Finlay, & Lyons, 2002; Kravetz, Faust, & David, 2000; Ritsher & Lucksted, 2000; Van Voorhees, Fogel, & Houston, 2005; Warner, Taylor, & Powers, 1989). In other words, many patients who are labeled do not *self-label* or attribute their problems to mental illness/disorder. For many, recognizing and accepting a mental health problem is a dynamic, drawn-out process that does not neatly correspond to the process of receiving a formal diagnosis (e.g., Aneshensel, 1999; Karp, 1996). Often people will endure a lengthy period of distress, multiple episodes of acute symptoms, and multiple encounters with mental health (hereafter simply “health”) services before adopting any mental illness labels (hereafter simply “labels”). Some will continue to vigorously resist labels or involvement with services, while others adopt an “illness identity” (Aneshensel, 1999).

Stigmatizing labels seem to engender self-stigma and a negative self-concept for some individuals and not others (Crocker, 1999; Crocker & Garcia, 2006; Major, 2006). Even when individuals recognize the negativity attached to labels, being labeled does not lead to consistently negative effects (Kravetz et al., 2000; Warner et al., 1989). Some do not accept as valid the negative stereotypes associated with mental illness or do not accept their application to themselves (Camp et al., 2002; Doherty, 1975; Khang & Mowbray, 2005). For example, O’Mahony (1982) found that adult psychiatric inpatients agreed with negative stereotypes concerning mentally ill people in general, but denied that these stereotypes represented them. Furthermore, it is important to note that labels can also have positive effects that partially offset the stigmatizing and demoralizing impact of the label. Some psychiatric patients describe relief in having a label that can explain psychological symptoms, validate their experiences and guide them in knowing what to expect and how to cope (Hayne, 2003; Karp, 1996).

Adolescents’ conceptualization of their problems and the potential impact of self-labeling

Similar to adults, youth labeled with psychiatric diagnoses likely interpret and respond to the labels ascribed to them in multiple and dynamic ways. Youths’ process of coming to terms with having mental disorder can be lengthy and fraught with ambiguity, which

over time, comes into sharper focus with the intensification of symptoms and distress (Leavey, 2005; Wisdom & Green, 2004). Youth report that some barriers to identifying with the label include: difficulty in getting a ‘correct’ diagnosis (implying diagnoses are fluctuating and unreliable), “connecting” with mental health providers, and the undesirable implications of the diagnosis for their sense of normalcy, identity, and independence (Wisdom & Green, 2004).

Youth identified as emotionally disturbed often do not apply the psychiatric/illness labels to themselves and put little stock in formal diagnostic labels (Barese, 2003; Draucker, 2005). For instance, Mowbray, Megivern, and Strauss (2002) asked college students who had been diagnosed with serious psychological disorders in high school to reflect back on those experiences. The researchers found that while the students acknowledged having “problems”, most reported that they never conceived of these problems as a *mental illness*. According to these students, peers who labeled themselves as having a mental illness were socially ostracized, denigrated, or pitied. These findings highlight the distinction between individuals’ recognition of problems and their conceptualization of these problems as mental disorder. They also suggest that for youth, defining self as disordered maybe an undesirable process associated with a poorer capacity to integrate socially. These studies have begun to map out youths’ experiences, but they have been limited by very small and non-diverse samples, as well as reliance on retrospection.

Research is also sparse regarding the impact of labeling or self-labeling on youths’ psychological well-being, and the findings are mixed. Several earlier studies found that youth labeled cognitively disabled or delinquent reported lower self-esteem if they perceived this label as accurate, personally relevant, were in agreement with society’s negative evaluation of the label, and placed a lot of value on others’ opinions (Chassin & Stager, 1984; Stager, Chassin, Laurie, & Young, 1983). More recently, Wisdom and Green (2004) found that some adolescents diagnosed with depression experience their label as useful and a source of relief. For others, however, the label was judged as having a negative effect on youths’ sense of self and view of their future, contributing to “...an illness identity that impedes recovery” (p. 1236). Certainly, the need exists for continued exploration of youths’ responses to labels.

Theoretical framework

In this study, Modified Labeling Theory (MLT) (Link, Cullen, & Struening, 1989; Link & Phelan, 2001) is used to guide questions on labeling and its impact on adolescents. MLT is heavily influenced by the theory of symbolic interactionism (e.g., Mead, Cooley) in terms of the focus on the self as constructed by others through communication and interaction. It hypothesizes that an individual labeled with mental illness is susceptible to a negative self-concept if s/he internalizes stereotypes that s/he was socialized to accept long before being labeled. The theory surmises that both internalized conceptions, as well as others’ rejection based on the label or on (deviant) behavior, contribute to coping strategies used by individuals with mental illness that are intended to be self-protective but are often self-defeating. Coping strategies such as withdrawal and secrecy tend to further isolate individuals and generate self-fulfilling expectancy effects that reinforce a negative self-concept in the form of low self-esteem, demoralization and vulnerability to repeat episodes. Generally, studies confirm the relationship between being labeled, perceived stigma, self-esteem, self-mastery, and depression (e.g., Link, Mirotnik, & Cullen, 1991; Wright, Gronfein, & Owens, 2000).

Another relevant theory for understanding the variability inherent in self-labeling is Thoits’s (1985) theory on self-labeling processes in mental illness. Thoits claims that there are three

conditions facilitating the process of self-labeling: (1) the individual who self-labels is well-socialized (i.e., shares the cultural perspective of others); (2) there are clear and known norms about acceptable behavior that can be applied to oneself or by others; and (3) the individual who self-labels is motivated to conform to social expectations (p. 223).

Extending these ideas to adolescent mental health consumers, the expectation is that many, perhaps most, would likely not meet one or more of these assumptions. In particular, behavioral and emotional norms are less clearly defined in adolescence. The range of acceptable behavior for youth is vast and largely dependent on context.

The present study

The primary purpose of this study is to examine the extent to which adolescents diagnosed with psychiatric disorders indicate they self-label as mentally or psychologically disordered, and the impact of self-labeling on their psychological well-being. It is expected that (1) adolescents will demonstrate variability in their inclination to self-label; and (2) adolescents who self-label will report poorer psychological well-being, defined as low self-esteem and sense of mastery, as well as higher depression and self-stigma. In addition, this work also explores who, among adolescents, is more likely to self-label. This study focuses on three domains expected to correlate with adolescents' self-labeling: (a) public-stigma, (b) clinical characteristics, and (c) demographic factors.

Public-stigma

Drawing from the theory of symbolic interactionism, messages received from significant others help shape adolescents' conceptions of their problems. This maybe particularly true when problems are ambiguous and the individual lacks an appropriate explanation for them (Mechanic, 1972). Youths' perception of devaluation and rejection by others on account of their problems may reinforce the idea of having a serious illness or condition.

Clinical factors

Illness characteristics maybe associated with the propensity to self-label. The nature of symptoms, level of distress or impairment, and chronicity of problems may serve as signals that fuel the process of self-labeling. For instance, certain disorders maybe perceived as "worse" in terms of prognosis or more reflective of bona fide mental illness (Phelan, Yang, & Cruz-Rojas, 2006). Mood disorders, comorbid disorders, problems associated with poor role functioning are typically associated with greater perceived need and treatment help-seeking (e.g., Rizzo et al., 2007; Thompson & May, 2006); these may also be associated with greater likelihood for self-labeling. On the other hand, individuals diagnosed with disruptive behavior disorders are more likely to externalize attributions of problems (Hill, 2002), therefore one might expect a lower inclination to self-label. Finally, youth with comorbid diagnoses maybe more likely to self-label relative to those with one diagnosis, if multiple labels generate more recognition or awareness.

Demographic factors

Demographic factors have been associated with adolescent problem identification and help-seeking, and maybe related to self-labeling. Males, racial/cultural minorities, and younger youth are less inclined to trust or seek services and are more apt to feel stigmatized by receiving services (Cauce et al., 2002; Lindsey, Korr,

& Broitman, 2006; Rizzo et al., 2007). SES shapes attitudes and relationship to human service institutions (e.g., Liu, Ali, & Soleck, 2004; Maher & Kroska, 2002), and maybe related to how youth conceptualize their problems.

Methods

The findings are based on a cross-sectional, mixed-method study of adolescents receiving integrated mental health services in a mid-sized, mid-western city. The program serves youth diagnosed with at least one mental disorder; many are markedly or severely impaired in various functional domains and receiving services in multiple human service systems. Integrated services provide intensive case coordination using a strength-based, team model approach that seeks to avoid more restrictive placements by building youths' and families' coping capacities using community resources and supports.

Procedure

Between February 2006 and August 2007, youths' case coordinators introduced the study and provided invitations in team meetings to legal guardians and clients who met the inclusion criteria: (a) age 12–18 years; (b) enrolled in the program 8 or more weeks; and (c) has an available parent or legal guardian who could provide consent. Adolescents with significant cognitive deficits/delays or pervasive developmental disorders were excluded. If parents/guardians and adolescents expressed interest to the case coordinator, their phone number was provided to the investigator, who contacted the parents/guardians to schedule an interview. After completing the face-to-face parent interview, investigator obtained informed consent from the parents/guardians to interview the adolescents separately. Adolescent interviews typically lasted 75–90 min; these were audio-taped and professionally transcribed. Participants received \$20 in compensation.

The interview schedule

Youth interviews were semi-structured and included qualitative questions embedded among rating scales used to elicit personal experiences related to treatment, perceptions of problems and reactions to labels and treatment. Qualitative questions provide an opportunity for individuals to express their thoughts and emotions without imposing limits (Padgett, 1998). Data utilized for this paper comes primarily from adolescent interviews; clinical data were drawn from agency charts and parent interviews.

Measures

Qualitative measure (self-labeling)

To assess self-labeling, adolescents were asked: "How do you think about the problems/issues that you've had?" or "What do you think is the nature of the problems or issues for which you are getting treatment?" It was emphasized that what is of interest is *their* thoughts and opinions rather than what others have said. Some probes included: (a) "What do you call the problems that you are dealing with?" (b) "What are the words you use?" If participants used general terms such as 'disability' or 'special needs' they were asked to clarify what type. If participants made no mention of psychiatric disorder or condition, the follow-up question was: "Do you think of yourself as having a mental health problem?" The three main categories of youths' labeling detailed in the results section include: (1) Avoidance of mental illness labels; (2) Uncertainty about labels; and (3) Use of labels.

Quantitative measures

Psychological well-being measures.

- *Self-esteem* was measured using the Rosenberg Self-Esteem Scale (Rosenberg, 1965) on a 4-point Likert scale (1-strongly disagree, 4-strongly agree) ($\alpha = .81$).
- *Mastery* was measured using the Pearlin Mastery Scale (Pearlin, Menaghan, & Lieberman, 1981) on a 4-point Likert scale ($\alpha = .70$).
- *Depression* was measured using CES-D (Radloff, 1977), on a 4-point scale ranging from 0 = none of time or rarely to 3 = most or all of the time ($\alpha = .90$).
- *Self-stigma* was measured using 5 items adapted from Austin, MacLeod, and Dunn (2004) Self-Stigma Scale (in relation to epilepsy) which assesses youths' sense of shame, embarrassment, and worry about others' responses to their problems, e.g., "How often do you feel embarrassed about your emotional or behavior issues?", rated on a 4-point frequency scale ($\alpha = .81$).

Public-Stigma. It measured youths' perception of rejection and devaluation by peers or significant adults on account of problems or treatment. The scale includes 6 items (rated yes/no), 3 items were adapted from Link, Struening, and Rahav's (1997) Rejection Experiences scale, e.g., "Do you feel disrespected by others because of your emotional/behavior issues?"

Clinical/illness measures.

- *Child and Adolescent Functional Assessment Scale (CAFAS)* is a broad clinical assessment of children's functioning in different life domains (Hodges, 1994). The score is the sum total of 5 subscales, each ranging between 10–140 (higher indicates more functional impairment): Role Performance, Behavior toward Others, Mood/Self Harm, Substance Abuse and Thinking. Each youth was to be rated every 3 months, but CAFAS scores within the past 3 months were available for only 43 of 54 youths.
- *Disorder type*, was a diagnosis elicited from agency records, were analyzed individually and also by the following classification (yes/no): (a) disruptive behavior disorders: ADD/ADHD, Conduct Disorder, Oppositional Defiance Disorder (ODD), (b) affective disorders: Depression or Anxiety, Bipolar Disorder NOS, Mood Disorder NOS, (c) substance dependence or abuse (AODA), and (d) Post-traumatic stress disorder (PTSD). Several diagnostic labels were not individually analyzed because of small numbers: Reactive Attachment Disorder (11.3%), Obsessive Compulsive Disorder (3.8%) and Schizophrenia (1.9%).
- *Comorbidity* referred to being diagnosed with more than one diagnosis (yes/no).
- *Age at first mental health treatment* (medication or counseling) (from parent interview).

Demographic measures. These include adolescents' age, gender and race (white vs. others). SES measures included parent's education level (dichotomized by college graduate vs. others to assess the effect of higher education) and receipt of state medical assistance (yes/no).

Analysis

Qualitative analysis

Content analysis involved first carefully reading the transcripts in their entirety and then sorting all data pertaining to a question/

area (e.g., description of own problems). Subsequently, salient themes in each content area were identified and noted with example excerpts. This process was repeated for all 54 interviews, maintaining openness toward the development of new themes and sub-themes ("analyst constructed typologies") in the manner recommended by Patton (1990). This process was undertaken separately by the investigator and a research assistant for reliability purposes. A random selection of 25 adolescents was subjected to analysis of inter-coder agreement on labeling classification using the Kappa coefficient; findings indicated "substantial" agreement (Landis & Koch, 1977): $K = .68$. Discrepancies were resolved by reviews of the transcripts and reflective discussions.

Quantitative analysis

Non-parametric (Chi-square) and parametric tests of association (ANOVA) were utilized to explore bivariate relationships between adolescents' inclination to self-label (3 categories) and potential correlates.

Results

Sample

Characteristics of the adolescent sample are shown in Table 1. This was a racially and economically diverse sample of adolescents who have been involved in mental health services for 6.5 years on average prior to interview. A majority (83%) was diagnosed with more than one disorder; 45.3% were diagnosed with an affective and disruptive type of disorder (not shown). The typical CAFAS score of 66.7 indicates a need for multiple sources of supportive care (Hodges, 1994).

Conceptualization and labeling of problems

When adolescents were asked how they think about and the language they used to describe the problems/issues they have experienced, many appeared to have difficulty in articulating an answer as evidenced by common hesitation, blank looks, and initial responses of "I don't know". It seemed they are not accustomed to being asked to reflect on the nature of their problems, at least not in this manner. Following some prompts, all adolescents responded and their ideas fell into three categories: (1) no use of psychiatric labels, (2) uncertainty about labels, and (3) use of psychiatric labels.

No use of psychiatric labels or other terms of disorder/disability/illness

Over a third of participants (37.0% or 20) did not view themselves as emotionally or mentally disordered: "not like crazy or psycho or anything like that" (female, White, age 16). Instead, problems were defined in a myriad of ways such as "(lack of) honesty", "not caring", "family problems", "teenage problems", "anger", and "outbursts". In several cases, participants indicated that the behaviors or problems that others had diagnosed were simply "normal", a manifestation of who they were, and were not experienced as a sign of abnormality. A 13-year-old White girl said, "I feel like myself. I'm me. Nobody can change—no medicine or nobody can change who I am".

Participants often described a *behavioral* problem (e.g., getting into fights, getting frustrated easily, running away from home) but, when asked, denied thinking of themselves as having mental health problems. In the minds of many participants, there seemed to be a fundamental distinction between a mental health problem and a behavior problem. Participants who reported not seeing themselves as having problems tended to normalize or minimize the gravity of their behavior problems by comparing their troubled

Table 1
Adolescent characteristics and correlates of labeling.

| Demographic factors | Total % or M (SD) | No use of labels, N = 20 M (SD) or N | Uncertain re: labels, N = 23 M (SD) or N | Use of labels, N = 11 M (SD) or N | Sig. |
|---|-------------------|--------------------------------------|--|-----------------------------------|-------------------------------|
| Age | 14.9 (1.6) | 14.8 (1.4) | 15.1 (1.5) | 14.7 (1.9) | $F = .36, p = .70$ |
| Gender (Male) | 63% | 16 | 11 | 7 | $\chi^2_{(2)} = 4.0, p = .13$ |
| Race/ethnicity (Caucasian) | 59.3% | 12 | 5 | 5 | $\chi^2_{(2)} = 5.6, p = .06$ |
| Medical assistance | 53.7% | 15 | 11 | 3 | $\chi^2_{(2)} = 7.1, p = .03$ |
| Parent education (<college grad) | 79.6% | 16 | 21 | 6 | $\chi^2_{(2)} = 6.2, p = .04$ |
| Clinical characteristics^a | | | | | |
| Age at 1st treatment | 8.4 (3.4) | 10.2 (3.8) | 7.7 (3.1) | 7.3 (2.5) | $F = 3.6, p = .03$ |
| Disruptive behavior D/O | 70.4% | 15 | 14 | 9 | $\chi^2_{(2)} = 2.4, p = .31$ |
| Affective D/O | 70.4% | 12 | 18 | 8 | $\chi^2_{(2)} = 1.2, p = .55$ |
| AODA | 20.4% | 5 | 5 | 1 | $\chi^2_{(2)} = 1.3, p = .53$ |
| PTSD | 22.2% | 3 | 5 | 4 | $\chi^2_{(2)} = 1.7, p = .43$ |
| Comorbidity | 83% | 15 | 20 | 9 | $\chi^2_{(2)} = 4.8, p = .78$ |
| CAFAS ^b | 66.7 (24.1) | 63.5 (20.6) | 72.8 (31.4) | 64.5 (11.3) | $F = .69, p = .51$ |
| Stigma | | | | | |
| Perceived public-stigma | 2.7 (2.0) | 1.5 (1.6) | 3.1 (2.0) | 3.9 (1.8) | $F = 7.2, p = .002$ |
| Psychological well-being | | | | | |
| Self-stigma | 2.1 (.75) | 1.7 (.49) | 2.2 (.77) | 2.5 (.79) | $F = 5.9, p = .005$ |
| Self-esteem | 3.0 (.48) | 3.2 (.25) | 3.0 (.54) | 2.9 (.64) | $F = 1.3, p = .28$ |
| Mastery | 3.0 (.47) | 3.1 (.36) | 3.0 (.51) | 2.7 (.53) | $F = 2.8, p = .07$ |
| Depression | 20.4 (12.1) | 15.2 (10.0) | 23.6 (13.3) | 23.5 (10.7) | $F = 3.3, p = .04$ |

^a Some diagnoses that were not individually analyzed because of small numbers included: Reactive Attachment Disorder (11.3%), Obsessive Compulsive Disorder (3.8%) and Schizophrenia (1.9%).

^b CAFAS scores were available for only 43 youths.

behaviors and feelings to general ideas of what normal teens do (or do not do).

Others referred to certain standards or a threshold beyond which problems are “serious” and can be considered mental health problems (i.e., severe enough to require psychotropic medication, lead to legal trouble, necessitate leaving home). A 14-year-old African American male said:

I have problems I need to work through, but other than that, I'm fine...just regular family problems and daily personal problems...I don't consider those big issues where I need to take medication for it. Other people see that for me, but I think the medication is just making it worse.

The tone and language of many youth classified as non-labelers were relatively non-defensive and matter-of-fact. However, in some cases, there was a defiant attitude accompanying the comments, as if to say ‘I know what others have said and I reject it’.

Uncertainty about the application of labels to oneself

The majority of participants (42.6% or 23) indicated uncertainty and confusion about how to conceptualize their problems. In both direct and indirect ways, these adolescents communicated that they were unsure about the nature of their problems—whether these were a disorder or a manifestation of something more controllable. Direct expressions of uncertainty included words such as “maybe”, “not sure”, “probably”, “I don't know” and “I guess”. Uncertainty is exemplified in the words of a 16-year-old White girl:

...when [case coordinator] told me I was depressed, I mean I guess I was depressed, but I didn't really know if I was or not. I mean I can't just openly admit it because I don't really know what depressed means or something, and I mean I guess I have a mental illness but I don't really know – I mean I can't really prove to myself that I do have one.

Several youth reported “sometimes” perceiving themselves as having a disorder, but when their mood improves or things go well in their life, they cease believing that there are any problems:

P: Well when I get really angry and depressed and I have to go to the hospital. That's when I think well maybe, it's true (have bipolar disorder).

I: When does it not make sense? When do you not feel you have a disorder?

P: When I'm calm and I can get along with people I guess (White male, age 14, dx: Bipolar 1 d/o)

Indirect expression of uncertainty was reflected in contradictory statements made by participants. On the one hand they agreed that they had a disorder, but then (a) changed their mind during the interview; or (b) disagreed that they had any problem that was medical or not fully controllable. The latter type of response is exemplified by a 16-year-old, mixed-race male, who initially stated that he was aware of a mood disturbance: “*Yeah, I think I still have it... cause bipolar's mood swings. I have mood swings. That's been a problem*”. Several minutes later, however, this youth expressed the belief that his problems stemmed from bad choices and a negative attitude: *From my perspective, I think I can do anything I want to do as long as I put my head to it, and the reason I've had problems was just the way I looked at things. There's nothing more than that*. Often, youth classified in this category appeared somewhat defensive about this question or flustered in their responses.

Self-labeling: defining problems using mental health or illness/disability terms

One of five participants (20.3% or 11) made a reference to a diagnosis (e.g., “*bipolar problem*”, “*ADD or ADHD*”), condition (e.g., “*very emotionally depressed*”), or addiction (e.g., “*marijuana problems*”) as the nature of their problems. Youth in this group expressed no doubt, confusion or ambivalence about “having” a mental disorder. The tone and language used by self-labelers were matter-of-fact:

Um, well my anxiety, I know. Like, I get nauseous sometimes, just when I try to go to school...And I have panic attacks. So I definitely know the anxiety. And the depression...its just, like, I just get so down. And just so, like...beat up, like, ‘God, I just can't do it...’ (White female, age 16, dx: anxiety NOS, depression NOS, sensory integration disorder)

Youth classified as “self-labeling” peppered their discussion of problems and treatment with DSM-IV terms, often attaching the word “my” or “I have” (e.g., ‘*my depression*’ or ‘*my bipolar*’). This is demonstrated by a female aged 17 (dx: Bipolar I, ADD, Learning disorder NOS): “*I don't think my bipolar really affected my like school*

relationships with like teachers". Self-labeling also involved acknowledging that while many people have 'ups and downs' in their functioning or mood, their personal experiences are excessive in frequency or intensity:

... like I have really high mood swings between like being like really happy, kinda like on top of the world and then being like being depressed to the point of like suicidal and things...I feel like I have a lot more mental issues than most people... (White male, age 17, dx: dysthymia; ADHD, NOS; substance abuse; conduct disorder)

These participants often referred to their illness as an organic part of themselves. In several cases, they referenced their disorder as an additional part of their mind or their brain. For example, a White female (age 13, dx: Bipolar I, ODD) reported: "*Umm, it's like a mental illness in my brain that like you can bounce from being happy to sad, or angry to happy, kinda like mood swings*". In several cases, youths indicated that taking psychotropic medication facilitated or reinforced their conceptualization of their problems in terms of disorder. For instance, when asked if he considered himself someone that has mental health issues, a Hispanic male age 17 (dx: PTSD, ADHD, learning disorder) claimed: "*Yeah. I know that for a fact, because I experience myself, I took myself off the meds one time, and boy, was I off the wall*".

Is self-labeling correlated with psychological well-being?

The extent to which adolescents self-labeled was associated with several indicators of psychological well-being. As shown in Table 1, participants who avoided self-labeling also scored more favorably (lower) on measures of self-stigma ($p < .01$) and depression ($p < .05$). Also, there was a statistical trend indicating that youth classified as uncertain about or disinclined to self-label scored higher on self-mastery relative to those classified as self-labelers. Surprisingly, there were no differences between labeling groups in self-esteem scores.

Is self-labeling associated with public-stigma, clinical factors, and demographics?

Public-stigma

Adolescents' self-labeling corresponded with their reported exposure to negative messages from others: youth who self-labeled reported more exposure to rejection experiences relative to those who were less certain about labels or avoided them altogether.

Clinical characteristics

Of clinical characteristics, the only one to be significantly related to youths' inclination to self-label was the age at first mental health treatment. On average, youth who avoided self-labeling were older when first initiated into medication or counseling services relative to peers who self-labeled or were uncertain (age 10 vs. 7.3 and 7.7, respectively). Surprisingly, there were no significant relationships between self-labeling and other clinical factors (type of disorder, comorbidity, number of disorders, CAFAS) or the receipt of specific treatments (medication prescription, number of medications, past hospitalization).

Demographic characteristics

Several clinical and demographic factors were significantly associated with adolescents' self-labeling classification. Youth of racial/ethnic minority status were less likely to be self-labelers relative to White youth (only 4 of 11 were ethnic minorities). At the same time, of the 20 youth classified as non-labelers, a disproportionate number (12) were minorities. Gender was not statistically

significantly related to self-labeling, but it is noteworthy that the majority of non-labelers were boys (16 of 20). There was no significant association between self-labeling and age.

Both proxies for family SES were significantly related to youths' self-labeling. Adolescents whose families received State Medical Assistance were less likely to definitively self-label themselves as disordered: only 3 of 29 self-labeled. Adolescents whose parent was not a college graduate were also less likely to be classified as self-labelers and more likely to be uncertain about their labels, relative to their peers whose parent was a college graduate.

Discussion

This study's primary aim was to examine the extent to which a sample of adolescents receiving services identify themselves with mental illness labels, factors related to self-labeling, and the associations between self-labeling and psychological well-being. The results indicate that adolescents vary tremendously in the extent to which they utilize psychiatric terms to conceptualize and communicate their problems. Similar to their adult counterparts, adolescents are not passive recipients of psychiatric labels. The majority of participants in this study (43%) were uncertain about their problems and the language with which to describe them. These participants, more so than their peers, evidenced ambiguity, ambivalence and defensiveness in responding to questions about their views of the problems for which they receive services. Among adults, it is not unusual for psychiatric patients to evidence inconsistent beliefs about their problems and to hold "apparently disparate beliefs simultaneously" (Kinderman, Setzu, & Lobban, 2006, p. 1904). This ambiguity maybe tied to the idea that mental illness, in contrast to physical illness, is harder to hold at arm's length and make sense because of the difficulty in extricating "self" from symptoms (Karp, 1996; Kinderman, 2005). Complex perceptions of illness may also be tied to adolescents' still-maturing psychological and cognitive development, their social context, or the ambiguous phenomenology of psychiatric disorder in adolescence that renders it hard to distinguish disorder from 'normality'.

The second largest group of participants (37%) indicated they do not label their problems in terms of disorders, preferring descriptions of behavior or states that reflect external circumstances (e.g., "family problems"), impermanence (e.g., "teenage problems") or controllability (e.g., "not caring"). A preference for non-pathological depiction of problems has been well documented in the adult literature (Ritsher & Lucksted, 2000). But while the adult literature often ties disavowal of illness to "poor insight" (e.g., Kravetz et al., 2000; Lysaker, Campbell, & Johannesen, 2005), disinclination to self-label among youth maybe tied to other reasons. Youths' optimism is expected (and perhaps desirable) given the sense of promise and hope that we attach to young people in our society. Developmentally, the egocentrism and sense of invincibility that adolescents demonstrate (Elkind, 1967) may lead them to avoid labels. At the same time, avoidance maybe tied to inexperience or lack of perspective at a relatively early stage of dealing with problems. Finally, considering Thoits's (1985) assumptions about the dynamics of self-labeling, many adolescents maybe disinclined to self-label because they have less clearly defined behavior norms, less motivation to conform to established norms, or do not yet share the broad cultural perspectives about mental illness.

A minority (20%) communicated viewing their problems as mental disorders or conditions, using terms that mirror modern medical or organic conceptualizations and indicating ownership: e.g., "have a chemical imbalance" or "my bipolar disorder". The tone and demeanor of self-labelers relative to their peers was often different in terms of unruffled acceptance (or resignation,

depending on point-of-view) of the validity of psychiatric labels and their relevance as descriptors of their internal states.

Is self-labeling correlated with adolescents' psychological well-being?

This study provides a preliminary analysis of the extent to which self-labeling is associated with psychological well-being for adolescents (Link et al., 1989). Adolescents who self-labeled also reported higher ratings on self-stigma and depression. Also, there was a non-significant relation between self-labeling and a lower sense of personal mastery. These results suggest that for adolescents, self-labeling maybe demoralizing, stigmatizing, and disempowering. Among adults, the association between labeling and self-stigma has been documented (Corrigan & Watson, 2002; Hayward & Bright, 1997). Knowing that label acceptance is associated with negative psychological outlook, some have raised concerns about the wisdom of practitioners encouraging people to accept their labels (Doherty, 1975; Warner et al., 1989). It has become clearer in recent years that helping individuals to acknowledge their mental illness is far less important than helping them overcome public and self-stigma and develop ways of coping and gaining mastery over their illness (Cooke et al., 2007). Our results suggest this principle might apply to adolescents as well.

The study's findings may also reflect a reverse causal relationship: adolescents' depression maybe an antecedent to self-labeling rather than a consequence. As depression manifests in cognitions bearing on personal limitation (negative attributions), being depressed may lead individuals to self-label for doing so generates a coherent narrative about oneself. The absence of significant association between participants' scores on self-esteem and self-labeling supports the idea that depressive states promote self-labeling. Otherwise, if self-labeling *causes* depression, presumably by way of generating a negative self-concept, why would it not also affect self-esteem? A longitudinal examination of the correspondence between symptoms, labeling and individuals' interpretations of their illness over time would address questions of directionality between self-labeling and depression.

Contrary to expectations, however, there was no appreciable association between self-labeling and global self-esteem. This latter finding is quite hopeful for it indicates that, as is true among adults (e.g., Camp et al., 2002; Kravetz et al., 2000; Warner et al., 1989), it is not inevitable that youth who label problems as disorder will be more likely to experience a diminished self-concept.

Who was more likely to self-label?

Understanding factors that promote or deter self-labeling is instructive for identifying the profile of youth who would benefit from attention to their self-concepts in relation to their problems. As expected, adolescents reporting more exposure to social discrimination and devaluation on account of mental health issues were more inclined to self-label. However, the cross-sectional nature of this study renders it impossible to decipher the directionality between self-labeling and public-stigma. Stigmatizing responses on the part of others can be conceptualized as facilitating self-labeling, as this would generate congruence between external messages and self-perception. On the other hand, self-labeling has also been reported by youth as generating social rejection in various ways (Mowbray et al., 2002).

Of note, participants who began receiving treatment at a younger age were more likely to self-label. Adolescents maybe more likely to view problems as disorders when they have experienced them for a long time and through multiple episodes of treatment. It is also possible that youth entering the treatment system older are less likely to self-label because they have had

more time to develop a stable sense of self that allows them to resist new labels and changes in self-concept.

Contrary to expectation, type of disorder, comorbidity, and rated levels of functional impairment (CAFAS) were not related to self-labeling. Particularly surprising was the non-significance of association between self-labeling and disorder type. Mood disorders, in particular, have been associated with negativistic cognitive attributions (e.g., Abramson, Metalsky, & Alloy, 1989), expected to contribute to a sense that labels reflect internal and stable characteristics. The fact that ratings of severity of functional impairment (CAFAS) were unrelated to self-labeling maybe due to limitations in measurement. CAFAS ratings were available only for 80% of the sample and anecdotally, the extent to which these scores were reliable is unknown.

As anticipated, there were some significant differences in adolescents' self-labeling by demographic characteristics, specifically SES differences. Youth from families of lower SES were less likely to self-label than their peers. Also, there was a non-significant trend indicating that ethnic/racial minority youth were less likely to self-label relative to White peers. These demographic differences are consistent with the treatment utilization literature that consistently points to White, middle class individuals' greater inclination to utilize services (e.g., Cauce et al., 2002; Kazdin, Holland, Crowley, & Breton, 1997). Perhaps differences in viewing problems as psychiatric help can explain treatment disparities. Contrary to expectation, however, age and gender were not related to self-labeling although previous work points to the association between older age, female gender and greater participation and more favorable attitudes regarding help-seeking (Lindsey et al., 2006; Rizzo et al., 2007). While gender was not statistically significantly related to self-labeling in this study, observed differences point to males as far more likely than females to avoid using labels (80% non-self-labelers were males).

The methodology of this study limits the conclusions that can be drawn. The cross-sectional design precludes identifying directional relationships between self-labeling and psychological well-being. As noted, this would require longitudinal work that follows youth over time to capture their process of interpreting and internalizing labels and changes in outcome measures. Also, due to the small sample size, this work was limited in deciphering differences in self-labeling across various sub-samples (e.g., disorder type by race) or the application of more reliable and robust multivariate analyses which would be helpful in identifying factors that moderate or mediate youths' inclination to self-label and its effects.

The use of a small, self-selected sample also limits the generalizability of findings. This sample maybe unique in various ways. Finally, although the youth in this study all had functional impairments, this study lacked an adequate measure for symptom severity, which raises questions about the extent to which relationships between self-labeling and psychological well-being would be mediated by symptom levels.

Implications and directions for future work

Understanding how youth labeled with a psychiatric disorder conceptualize their problems and how labeling impacts them is a critical step in the development of knowledge about the variation of early experiences with mental illness for youth and their longer-term psychological and social implications. Pragmatically, knowledge in this area would also shed light on adolescents' help-seeking and treatment utilization patterns. Indeed, a natural next step for research is to examine the relationship between self-labeling patterns and treatment engagement over time.

Developing ways to make treatment more developmentally appropriate, helpful, and relevant for youth at various stages of

their trajectory in services is a fundamental challenge facing our society which is witnessing a growing gap between identified problems in childhood and the provision of services. Awareness of the profile of adolescents who are more likely to react negatively to involvement in treatment can also help clinicians to communicate more effectively and perceptively with young clients and their families. Informed clinicians would be in a position to ask the right questions and address real or anticipated stigma and other negative subjective experiences which can lead adolescents to avoid needed services.

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