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**Mental Health Stigma: The Impact of Labels for Axis I versus Axis II Disorders in the
DSM-IV**

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A mental disorder is defined as a “psychological, biological, or behavioural dysfunction that produces alterations in thinking, mood, or behaviour associated with significant distress and impaired functioning” (Health Canada, 2002b, p. 7). It has been found that mental disorders affect one-quarter of people worldwide at some point in their lives (World Health Organization, 2001). Labeling an individual as having a mental illness has both positive and negative implications (Rosenfield, 1997; Rosenhan, 1973); unfortunately, the majority of the implications of labeling come in the form of stigma projected onto the disordered individual (Goffman, 1963). The severity of the stigma experienced by those with a mental illness often depends on the type of mental illness they possess (Read & Harre, 2001). The arbitrary separation of Axis I clinical disorders and Axis II personality disorders in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) by mental health experts has created the notion that they are fundamentally different disorders with differential treatment options, availabilities, and prognoses. Whether or not these differences are significant is arguable; however, the differential stigma experienced by such patients is undoubtedly real. Qualified medical specialists and psychiatrists belonging to the American Psychiatric Association (APA) use current psychological research to create the diagnostic categories in the DSM (American Psychiatric Association, 2001); although, the social construction of these mental health labels often incorporates a political element as well (Armstrong, 1993; Cosgrove, Krimsky, Vijayaraghavan & Schneider, 2006). The way in which the DSM is socially constructed contributes to the differential stigma associated with Axis I and Axis II disorders and has a significant impact on both patients and clinicians.

Mental illness affects the majority of people either directly or indirectly at some point in their lives. With approximately twenty percent of Canadian adults having a mental disorder and another eighty percent of Canadians knowing someone with one (Health Canada, 2002b), it is

clear that mental health impacts the lives of almost everyone. In some cases, seeking treatment and being labeled as having a distinct mental illness (e.g., generalized anxiety disorder) can have a positive effect on self efficacy and improve treatment outcomes. Rosenfield (1997) suggested that being labeled may improve a person's self concept and allow them to successfully move forward with coping strategies specific to their illness. On the other hand, having the label 'mentally ill' can easily become a person's 'master status', according to Becker (1963), and have some serious negative implications.

When a person's mental disorder becomes their 'master status' (Becker, 1963), it is usually recognized by others and activates a specific schema during social interactions. This was demonstrated when Rosenhan (1973) sent eight research assistants into psychiatric hospitals as 'pseudo-patients' to determine if mental health professionals could detect their sanity. Being in the hospital activated the schema of mentally ill and affected all subsequent interactions with the staff, in which the label became a self-fulfilling prophecy that the 'pseudo-patients' could not escape. Although they were cooperative and didn't display any symptoms of mental illness after the initial consultation, the pseudo-patients were still released with "schizophrenia in remission", implying that they could not avoid the label they were given after entering the hospital (Rosenhan, 1973). Aside from the negative effects of labeling, there is also a general stigma associated with mental illness in our society (Goffman, 1963). People who are 'mentally ill' often experience social rejection and discrimination (Read & Harre, 2001), and are seen as being deviant, unpredictable, violent, dangerous, and uncontrollable (Dobson, 1996). The level of stigma experienced by people with mental disorders through labeling and societal prejudice often depends on what kind of illness they are diagnosed with using the DSM-IV.

The Diagnostic and Statistical Manual of Mental Disorders (DSM-IV), as outlined by the American Psychiatric Association (2001), is the diagnostic tool most widely used by mental health professionals and follows a multi-axial system with five separate axes of diagnosis. Axis I disorders refer to clinical disorders and includes: anxiety, dissociative, eating, mood, sexual, sleep, psychotic, somatoform, and substance-related disorders. Axis II disorders refer to personality disorders such as antisocial personality disorder, borderline personality disorder, and paranoid personality disorder (American Psychiatric Association, 2001). The separation of Axis I and Axis II disorders has created the impression that they are fundamentally and biologically different disorders. This arbitrary separation has an impact on several factors including: life course, clinicians' willingness to treat, treatment options, and prognosis, all of which interact to influence the amount of deviance and stigma associated with each type of disorder.

Axis I disorders are generally seen as treatable and tend to have a shorter life course than Axis II disorders. The Axis II personality disorders are usually thought of as being chronic or lifelong; some of which may fade out at around age 40 (Barlow, Durand, & Stewart, 2009). Clinicians are usually open to treat a variety of patients with Axis I clinical disorders, such as depression, anxiety, schizophrenia, and specific phobias; however, they are fairly reluctant to treat patients with Axis II disorders due to the stigma of being deviant and very difficult to treat. Overton and Medina (2008) found that many mental health professionals often avoid taking patients with severe mental illnesses, especially when dealing with cases of borderline personality disorder, antisocial personality disorder, and narcissistic personality disorder (Barlow et al., 2009). Their reluctance to treat Axis II disorders can both "perpetuate stigma and create new barriers to receiving treatment" (Overton & Medina, 2008, p. 146). Not only is there more available access to treatment, there are also significantly more treatment options open to patients

with Axis I disorders versus those with Axis II personality disorders. There have been a variety of therapies designed for clinical disorders such as: Cognitive-Behavioural Therapy, Psychotherapy, Exposure Therapy, Behavioural Therapy, Interpersonal Therapy, and Exposure-and-Response Prevention Therapy, as well as countless drugs that can be prescribed such as: SSRI's, benzodiazepines, and antipsychotics. On the other hand, reliable therapies that have been designed and validated for Axis II personality disorders are limited to Dialectical Behaviour Therapy (for borderline personality disorder), Interpersonal Therapy, and psychoeducation (Barlow et al., 2009). Finally, the prognosis is usually much better for Axis I than Axis II disorders. For example, Hermens et al. (2004) found that the majority of people with depression have a relatively favourable outcome, whereas several studies looking at borderline personality disorder have determined that both short-term and long-term prognosis is poor, especially in cases with a history of childhood trauma (Gunderson et al., 2006; Winograd, Cohen, & Chen, 2008). It is important to note that these differences between Axis I and Axis II disorders are based on research trends, and that there are always exceptions to the rule. For example, Skodol (2007) found that positive experiences and relationships during childhood were associated with better prognosis and remission from avoidant and schizotypal personality disorders. It is possible that the poorer prognosis associated with Axis II personality disorders is due to the limited treatment options available. Whether these differences in course and prognosis are significant or simply reflect a bias in research publication is arguable; however, the differential stigma experienced by patients with an Axis II disorder in the form of less treatment variety and availability is undeniable.

It is necessary to examine the issues of research bias and stigma within a power-reflexive framework which highlights the interaction of knowledge and power and how claims of

knowledge come to be legitimized and perceived as truth in our society (Foucault, 1980). The categories used in the DSM to make diagnoses and label individuals are socially constructed by qualified medical specialists and psychiatrists belonging to the American Psychiatric Association. On the surface, it may appear as though the diagnostic categories created are valid and reliable since authors of the DSM are qualified and use the most up-to-date psychological research to create such labels (American Psychiatric Association, 2001); however, the social construction of these diagnostic labels and the amount of research dedicated to them often includes a political component (Armstrong, 1993; Cosgrove et al., 2006). For example, Cosgrove et al. (2006) found that fifty-six percent of the panel of authors of the DSM-IV had financial ties to pharmaceutical companies. This finding was especially pronounced for members of the 'mood disorder' and 'schizophrenia' panels (Cosgrove et al., 2006). It has also been recognized that more than half of the new authors of the DSM-V (the next edition) have financial associations with the drug industry (Dr. Shock, 2008). The increased role that money and power has been playing in determining what research is included in the DSM and how certain mental illnesses are perceived as being related to each other has given Armstrong (1993) reason to suggest that "the DSM is just as much a political document as a medical document" (Bereska, 2011, p. 229).

Political and financial ties create biases in research funding and publication, thereby shaping what mental health research is deemed legitimate or significant in the psychological community and ultimately influences the creation of the diagnostic labels that so many psychologists, psychiatrists, and mental health professionals rely on. It is possible that the longer course and poorer prognosis associated with Axis II personality disorders may be due to the limited variety of treatment options available. This limited variety of treatment may, in turn, stem from a lack of research on people with personality disorders because companies funding the

research do not want to work with patients stigmatized as being deviant and difficult. The lack of research and available treatment also influences clinicians' perceptions of and willingness to treat certain patients which further perpetuates the stigma. The social construction of the DSM by the American Psychiatric Association has created an apparent distinction between Axis I and Axis II disorders which is reflected in the differential stigma experienced by people with each class of disorder.

It is important that factors such as stigma be taken into consideration when critical medical documents, such as the DSM, are being created since mental health is an issue that so many people face, and having to manage a stigma (Goffman, 1963) could further the development of any illness. In certain cases, labeling someone with a specific mental illness can have a positive effect on self concept, self efficacy, and improve treatment outcomes (Rosenfield, 1997). In most cases, however, people with mental illnesses are seen as unpredictable, dangerous, and out of control (Dobson, 1996), and are stigmatized in the forms of social rejection and discrimination (Read & Harre, 2001). A person's mental illness can become their 'master status' (Becker, 1963) and activate a schema in others during social interactions, affecting all subsequent interactions, in which their deviant label becomes a self-fulfilling prophecy they can not escape (Rosenhan, 1973). The amount of stigma experienced by an individual is often based on what kind of disorder they have (Read & Harre, 2001). The arbitrary separation of Axis I clinical disorders and Axis II personality disorders in the DSM-IV by mental health experts has created the notion that they are fundamentally different disorders with differential treatment options, availabilities, and prognoses. Whether these differences are real and significant, or based on political factors affecting the creation of the DSM is questionable. Qualified medical specialists and psychiatrists of the APA use up-to-date research to

collaboratively design diagnostic labels (American Psychiatric Association, 2001); however, many of the members of the DSM panel have financial ties to pharmaceutical companies (Cosgrove et al., 2006), which affects research funding and publication. The politics associated with psychological research used in clinical practice must be examined at this power-reflexive level (Foucault, 1980) since important documents like the DSM affect both patients and the clinicians using them. The social construction of the DSM by the American Psychiatric Association has created the distinction between Axis I clinical and Axis II personality disorders which can be seen in the differential stigma associated with each class of disorder.

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