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Review

Opening doors or building cages? The adverse consequences of psychiatric diagnostic labels

Lars Veldmeijer[1,2], Gijs Terlouw[1,2], Nynke Boonstra[1,2] and Jim van Os[1]

Psychiatric diagnostic labels can no longer be considered mere neutral descriptors for mental distress; the weight of evidence indicates that they shape reality, often in problematic ways. Providing accurate information about the scientific status of diagnostic labels helps minimize many of these problems. Academic psychiatry and psychology must therefore learn to resist the temptation to reduce human complexity to fixed labels, provide accurate information when labels are applied, consider to separate diagnoses from experienced distress, recognize patients' experiences as legitimate perspectives, and, most importantly, develop the conceptual competence to design and integrate alternative human-centered approaches that go beyond diagnosis-centric practices.

Addresses
[1] Department of Psychiatry, Utrecht University Medical Center, Heidelberglaan 100, Utrecht, 3584 CX, The Netherlands
[2] Research Group Health and Wellbeing, NHL Stenden University of Applied Sciences, Rengerslaan 8-10, Leeuwarden, 8917 DD, The Netherlands

Corresponding author: van Os, Jim (J.J.vanOs-2@umcutrecht.nl)

Introduction

A legend was born when The Inverness Courier published an article about the sighting of a 'whale-like fish' in Scotland's Loch Ness. The sighting, described as a massive unknown being rolling in the water, quickly earned the label monster and instigated many future observations. Years of research, however, found no scientific proof that any monster inhabits the lake. Nonetheless, beliefs about a prehistoric monster still lingered, unknowingly shaping people's perceptions. As it speaks to the imagination, people insist to this very day that they have seen the Loch Ness monster. Naming a phenomenon influences what human beings perceive as reality. Thus, it is not unreasonable to assume that the power of the label monster — the term to categorize and identify, in this case, a whale-like fish — contributed to the reification of ambiguous evidence into something seemingly concrete that aligned with people's expectations.

Similar to the categorization of a whale-like fish as the Loch Ness Monster, psychiatric classifications, such as in the DSM, describe and standardize poorly understood human experiences of distress and suffering. However, these constructs, describing manifestations of mental distress and suffering, lack an empirical foundation [1–4]. Moreover, while the DSM uses a binary framework, research increasingly shows mental distress is a far more gradual, dynamic, and multidimensional experience [5,6]. As Plato might put it, current diagnostic categories of mental distress do not "carve nature at its joints." Without a clear empirical definition of mental distress, any attempt to carve nature at its joints inevitably fails, risking stagnation in the development of psychiatric diagnostics [7–12]. To prevent a static state, numerous scholars have developed and proposed alternative frameworks and perspectives [13,15,16]; others have suggested removing labels that fail to alleviate individual suffering [17] or abolishing diagnostic systems such as the ICD and DSM altogether [18]. These approaches aim to foster a nuanced understanding of mental health conditions, shifting the focus away from rigid categories toward more flexible, dimensional perspectives [17–22]. While these perspectives create avenues of opportunity, the persistence of diagnostic labels is still a source of unease and can have certain adverse effects on people. Although classifications do not appear to exist in the natural world as they are conceptualized, they occupy a dominant position within the mental health landscape, shaping treatment guidelines, informing public attitudes, and serving as 'passports' that facilitate access to care [21,23]. This paper presents and discusses evidence that describes how diagnostic labels shape and are shaped by reality.

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Research into the potential adverse consequences of psychiatric diagnostic labels

The consequences of diagnostic labeling are not exclusive to the context of mental health. A systematic scoping review [24] revealed that receiving a diagnosis is not always beneficial in a psychosocial sense. This holds true not just for mental problems, but also for many physical illnesses. The results also indicated that diagnostic labeling often alters the patient-provider dynamic, a finding corroborated by professionals. Generally, the effects of diagnostic labels might offer relief, yet provoke anxiety and potentially lead to unnecessary treatment or harm [17]. Documented potential adverse effects of psychiatric diagnostic labels include, among others, stigma, reification, the perpetuation of 'disorderism', diagnostic overshadowing, identity foreclosure, and discrimination [2,25–28]. Only one systematic review was conducted in the past decade that explicitly focused on synthesizing the experience of the mental health diagnostic process [29]. This review examined the perspectives of different stakeholders, revealing, among others, a fundamental ambivalence towards diagnostic labels. While some individuals felt empowered and validated in receiving a diagnosis, for other people it had detrimental effects. A meta-synthesis [30] on autism spectrum diagnosis reached a similar conclusion: diagnosis can bring clarity and relief but also more confusion, self-stigma, and feelings of hopelessness. For most people, whether perceived as a positive or negative consequence, the assigned label had an impact on their self-conception. This is not entirely surprising, as it is known that despite changing across time and cultures, labels are often treated as if they reveal and hold a lasting, intrinsic truth [31].

The adverse consequences of labels on self-conception

Scholars have investigated the impact of diagnostic labels on individuals' self-conception. For example, it has been hypothesized that the very act of categorizing people creates new ways of being by offering new identities. This is known as the "looping effect" [32]. Recently, researchers found that young people indeed frequently reinterpret psychiatric labels like anxiety and depression [33]. The participants transformed these labels from strictly medical terms into more nuanced and broader cultural categories. It is not uncommon for people to internalize the labels they bear, aligning their lived experiences with the expectations imposed by these categories, making the label central to their identity. This is not without consequences. When people internalize their place within the diagnostic framework, the label can become an integral part of who they are and how they explain their struggles, potentially influencing their understanding of the possibility of recovery and change. Accordingly, when people report such internalized meanings, clinicians or researchers risk misinterpreting these personal meanings as manifestations of mental health conditions rather than as reflections of the label's psychological impact. Such misinterpretations can lead to distortions in the way psychiatric labels are described or understood by those who develop and apply them, but also by those to whom they are assigned.

Regarding the lived experience of diagnostic labeling and self-perception, there seem to be positive and negative perceptions [34]. In a recent study, individuals with lived experience reported positive perceptions, including the externalization of the problem and hope for an external 'cure', while negative perceptions were characterized by stigma and powerlessness. Notably, participants' sense of powerlessness as a negative perception was intricately linked to the externalization of the problem, initially a positive theme, as they experienced that their diagnoses located the problem outside their sphere of control. Externalization of the problems influences people's agency and can negatively affect personal recovery, eventually risking hopelessness and pessimistic beliefs about getting better.

Given the fluid nature of mental distress and personal change, symptom dimensions in DSM classifications suffer from poor temporal and inter-rater reliability. Therefore, mental health service users find themselves moving between different categories over time. While this may sound harmless at first glance, research shows shifting diagnoses can lead to disorienting and harmful impacts [35]. Frequently changing diagnostic labels can leave individuals feeling invalidated and uncertain. Evidence from longitudinal studies shows individuals are not seldom forced to embark on a journey of frequently shifting classifications [36], and thus risk redefining themselves multiple times through the lens of different heuristic constructs. For those who are frequently relabeled, it may take many years to realize that the reliability of these categories, in fact, is weak. For example, a Dutch expert by experience documented in detail how he was assigned more than twenty diagnostic labels in twenty years of psychiatric care and how shapeshifting in diagnostic identity had negatively impacted his self-conception [37].

The adverse consequences of labels on public perception and social behavior

The influence of diagnostic labels extends beyond individuals' self-conception. Labels not only influence how people see themselves but can also shape how others perceive and evaluate those who hold them. A meta-analysis demonstrates the real-world consequences of diagnostic labeling in educational settings [38]. Children who received diagnostic labels often faced biased evaluations from teachers, who assessed their behavior, personality, and overall capabilities

through the lens of their diagnosis. This Pygmalion-effect has, in fact, been known since the 1960s. As a result, children so labeled must cope not only with the challenges associated with their human variation but also with the stigma attached to their label. Hence, children may come to see themselves and may be seen by others through the prism of a discrete mental disease entity rather than through a lens that sees humans as complex beings with varied and unique experiences in context. Additionally, the impact of diagnostic labels on children may have a potential adverse long-term effect. In an Irish cohort study, researchers found that children labeled with ADHD at age 9 exhibited more emotional difficulties, poorer peer relationships, and weaker self-concept by age 13 compared to their undiagnosed peers [39]. Correspondingly, another study compared two groups: children formally diagnosed with ADHD and a similar group exhibiting comparable levels of hyperactivity and inattention but without a diagnostic label [40]. Over an average period of seven years, children with a diagnostic label showed poorer outcomes across several measures, including higher rates of self-harm, lower confidence in their academic abilities, diminished self-efficacy, and more frequent displays of negative social behaviors.

When labels are attached to the individual, they can also ripple outward, influencing and even molding public attitudes and social behavior. For instance, labels influence the perception of marginal cases of mental distress. Experimental studies consistently show that diagnostic classifications increase the likelihood that individuals with mild or ambiguous symptoms are perceived as requiring professional treatment [41]. Another study highlights how psychiatric diagnoses promoted social distancing [42]. Participants exposed to diagnostic classifications expressed significantly greater reluctance to engage with individuals labeled as having psychosis compared to those described through clinical formulations. The effects of diagnostic labels on public attitudes can linger even after they are removed. A study found that participants who learned of a patient's initial diagnosis continued to rely on the given classification in their judgments, even when the diagnosis was later retracted [43]. Stigma, both from society to the person, as well as internal and within the person, is then allowed to take hold as a self-directed negative view of oneself that can result in hopelessness, a sense of powerlessness, and pessimistic beliefs about one's recovery and future, stopping people with mental distress from searching for and engaging in opportunities for meaningful connection and support.

Opening doors or building cages?

Based on the findings in this overview, psychiatric diagnostic labels can no longer be considered as mere neutral descriptors. Instead, it is safe to say that diagnostic labels shape reality in problematic ways. The initial goal of designing and maintaining labels was to facilitate research and standardize communication in mental health care. In the article, we have also established that, given the highly complex nature of mental distress, psychiatric diagnoses instead have become rigid constructs that define and confine human experiences.

For instance, many still believe diagnostic labels explain mental distress. This misconception is fueled by authorities that commonly confuse descriptive diagnostic labels like depression with causal explanations [44]. Similarly, academic textbooks often depict children labeled with ADHD as having a different, malfunctioning brain that necessitates medical intervention [45]. At the same time, it is clearly stated in the DSM that its classifications lack explanatory power — they are developed as syndromes and are, by design, atheoretical clusters of symptoms [46]. When labels are presented without this context, people may see them as real things in their body or brain that explain their suffering [47]. The systematic interpretation and explanation of mental distress as individual fixable biological or psychological malfunctions make people with mental distress vulnerable to hermeneutical injustice; it downplays the importance of people's unique perspectives and sensemaking of their experiences, which very well may differ from dominant narratives in contemporary psychiatry [48,49]. As a result, patients may be viewed as passive sources of information, and their perspectives may be perceived as less relevant, eventually holding them back from co-producing their diagnosis as epistemic agents [50–52].

To minimize these adverse consequences, professionals should avoid delivering diagnostic labels as absolute truths; instead, it should be the standard that people with mental distress receive personalized and evidence-based information from professionals on what diagnostic labels are and what they are not, to ensure they have been informed in the best way possible [53]. If people are made aware of the current scientific status of psychiatric labels, it is less likely that they would interpret them as discrete biological or psychological causes. A recent ethnographic study supports this perspective: students who were aware of the problems of biomedical terms surrounding labels reappropriated medical knowledge in ways that stripped labels of most of their oppressive force [54]. Transparent, clear, and collaborative communication may empower people with mental distress to relate to labels in a critical way, reducing the risk of being constrained by them [23]. Moreover, in the case that current diagnostic systems are shown to be too ingrained in the current organization of mental health care, since they open doors to pathways of care in many countries in the West, separating diagnoses from experienced distress may help, for the time being, mitigate the harm that psychiatric diagnostic labels can cause [55].

The classification of the Loch Ness Monster was eventually recognized as a social construct through public dialogue and critical scrutiny. This overview shows that psychiatric diagnostic labels have attained a similar status, as in recent times, these constructs resonate as popular belief and a shared narrative that extends beyond their original intent and design. It is evident that people with and without mental distress reinterpret these classifications, imbuing them with excessive personal meaning, sometimes providing clarity and relief, other times confining people to their experiences and building cages around their identities. Not only in clinical settings but perhaps even more so in popular culture [56], where labels tend to have a mythical state. To improve psychiatric care, frameworks that allow a focus on individual narratives and the contexts in which they arise need to be designed, tested, and implemented [18,19,23,57–60]. After all, practice must evolve towards a framework where multiple perspectives coexist [23,61]: a practice where a diagnostic label is neither a definitive explanation nor a fixed entity but at most a flexible provisional tool for a temporary entry point on a path to collaborative understanding and recovery wherein the patient is recognized as an legitimate epistemic agent.

Conclusion

This overview indicates that tweaking diagnostic labels will not be enough to address the problems associated with psychiatric diagnosis. While diagnostic labels can open doors to care and, for some people, offer validation for their distress, the harmful consequences of labels may outweigh their pragmatic use, as diagnostic labels can confine identity and pathologize human experiences. Clear information on diagnostic labels can prevent people from perceiving labels as causal explanations for mental distress. Academic psychiatry and psychology, therefore, must learn to resist reducing human complexity to fixed labels and to develop the conceptual competence to design and integrate alternative human-centered frameworks that allow a focus on individual narratives and the contexts in which they arise. Attention from clinical practice and education toward recognizing that diagnostic labels are not passive tools is imperative. Acknowledging that labels, which are all too easy to construct but far less easy to dismantle, tend to shape reality, is the first step in doing better.

Author's contributions

LV, GT, NB, and JVO contributed equally to conceptualization, formal analysis, investigation, writing — original draft, and writing — review and editing.

Declaration of competing interest

None.

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Data availability

No data was used for the research described in the article.

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Further information on references of particular interest

21. * This publication critiques the progress of psychiatric diagnosis and explores emerging transdiagnostic frameworks that aim to move beyond categorical diagnoses. Though still heuristic and not clinically sufficient, these frameworks may function synergistically to improve diagnostic validity, research utility, and treatment guidance. The authors argue that building such a conceptual ecosystem is essential for advancing psychiatric science and better addressing the needs of stakeholders.

44. * This article reports on whether leading mental health organizations inaccurately present depression as a causal explanation rather than a descriptive label. A content analysis of widely accessed websites revealed that most used misleading causal language, reinforcing a common public misconception. The authors argue that such portrayals promote circular reasoning and scientific misunderstanding and call for clearer psychoeducation that accurately communicates the descriptive nature of psychiatric diagnoses.

48. * This paper, drawing on narrative theory, argues that disruptions of individuals' self-narratives may result in epistemic injustice, particularly hermeneutical injustice, where individuals struggle to make sense of their experiences due to the dominance of medicalized interpretations. The author highlights the ethical and psychological implications of imposing diagnostic narratives that conflict with personal meaning-making.

49. * This publication explores overdiagnosis in psychiatry as a form of hermeneutical injustice. Unlike under- or misdiagnosis, overdiagnosis wrongly frames non-pathological distress as illness and can potentially lead to adverse effects such as misunderstanding, self-alienation, and marginalization. The author argues for a mental health care that relies less on diagnosis-centric practices.

52. * This paper analyzes the dominant conception of objectivity in psychiatry as a structural contributor to epistemic injustice. The author argues that by privileging standardized tools over patients' subjective perspectives, psychiatry risks reducing individuals to mere data sources. While recent efforts to integrate patient perspectives into diagnostic frameworks like the DSM mark progress, they fall short due to the persistent constraints of standardization.

58. * This hypothesis and theory article introduces the concept of a 'problem-sustaining pattern' as an alternative to the traditional notion of mental disorder. While retaining key clinical functions, such as acknowledging clients' mental distress and guiding interventions, it challenges the assumptions of standard psychiatric models. By emphasizing dynamic interaction patterns and client agency, the proposed framework aims to reduce stigmatization and align more closely with complexity science.