

The Effects of the Patient's Diagnosis on Professionals and Students in a Psychiatric Setting: A Labeling Perspective

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Health professionals in the psychiatric field have begun to ask to what extent the patient's diagnosis influences their perceptions of his behaviour and prognosis. The proponents of the societal reaction perspective (or labeling theory) no doubt have sensitized professionals to the impact of diagnostic labels in particular and psychiatric labels in general. Theorists such as Becker (1973: 179) have pointed out that labeling places a person in circumstances which make it harder for him to continue the normal routine of everyday life and thus provoke him to abnormal actions. "Deviance is not a quality of the act the person commits, but rather a consequence of the application by others of rules and sanctions to an 'offender'. The deviant is one to whom that label has successfully been applied; deviant behaviour is behaviour that people so label" (Becker: 9). Labeling is not necessarily a function of the individual's acts or symptoms, but of societal reactions to certain behaviours which violate social norms and rules of conduct (Erickson, 1962).

This approach gives more emphasis than traditional psychiatric theory to social processes, yet does not entirely neglect individual aspects (Scheff, 1966: 17). The purpose of this theory, then, is not to reject psychiatric and psychological formulations in their totality, but to develop a model which will complement the individual system models by providing a complete and explicit contrast (Scheff, 1966: 285-56).

Cogent questions for health professionals at this time are: does the patient's diagnosis provoke a stereotyped image, thereby altering the expectations of care givers, and if it does, is this attitude transmitted to the patient, consequently altering his self-image? Scheff has alluded to the suggestibility of the psychiatric patient. Social-psychological principles indicate that persons under strain are highly suggestible, particularly to suggestions from prestigious people such

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as physicians (Scheff, 1966: 118-119). This raises the question, might the patient conform to the expectations, whether positive or negative, of health professionals?

Empirical research findings in the area have been thought-provoking. Rosenhan (1973) has described an experiment in which eight sane people gained secret admission to twelve different hospitals. He found that diagnoses were in no way affected by the relative health or the circumstances of the pseudo-patients' lives. Rather, the reverse occurred; the perceptions of their circumstances were shaped entirely by their diagnoses. Having once been labeled as schizophrenic, despite their show of sanity there was nothing the pseudo-patients could do to overcome the label. The label profoundly coloured others' perceptions of them and their behaviours and was so powerful that many of the pseudo-patients' normal behaviours were overlooked or seriously misinterpreted.

Denzin and Spitzer (1966) found that knowledge of a psychiatric patient's legal entry status and the source of the decision to enter treatment influenced staff members' predictions of the patient's self-presentation and conformity. These studies suggest that health professionals are greatly influenced by the psychiatric diagnosis, yet psychiatric categories have been found to be unreliable. Different psychiatrists have been found to classify the same person into different categories (Beck, 1962). Moreover, the same behaviour may be considered evidence of mental illness in one social class and idiosyncrasy in another (Hollingshead and Redlich, 1958).

Temerlin (1968) found that suggestions greatly influenced the perceptions of psychiatrists in arriving at the label of mental illness in normal subjects. Those who were told that the subjects were mentally ill perceived them as such, whereas those who did not have these instructions arrived at different conclusions. This poses a certain dilemma: there are inaccuracies in arriving at the diagnosis, yet when a diagnosis is given it carries with it certain behavioural expectations from health care workers.

In response to the societal reaction perspective, Gove and Fain (Gove, 1970; Gove and Fain, 1973) have raised some pertinent and provocative questions. They have argued that the labeling perspective views stabilized deviant behaviour on the part of the individual as being primarily due to the actions of others. Relatively little importance is attached to the behaviour which caused the labeling in the first place. They referred to this behaviour as primary deviance, as opposed to secondary deviance which is the behaviour produced by being placed in a deviant role.

According to the societal reaction perspective, the most crucial step in the development of stable deviant behaviour is the experience of being caught and publicly labeled a deviant. Whether or not this happens to an individual is believed to be largely dependent on his position in the social structure. The societal reaction theorists argue that persons who have passed through such a ceremony and have been forced to become members of a deviant group (e.g., by being placed in an institution) have undergone a profound and generally irreversible process. It is argued that they are likely to accept the ascribed deviant role, developing a deviant self-image and world view. Perhaps more important, it is believed that their deviance, having been publicly established, will act as a master status which will override other social attributes and they will no longer have the opportunity to behave normally. (Gove and Fain, 1973: 494.)

Gove and Fain (1973) stated that with regard to mental illness, the evidence indicates the societal reaction theorists are wrong in minimizing the importance of primary deviance, for the bulk of the evidence indicates that persons who are hospitalized are seriously disturbed and the hospitalization is initiated as a last resort after the situation has become untenable in the community.

This study is not intended to settle the debate between the two schools of thought. Rather, it attempts to glean information about the extent to which professionals and students are influenced by the patient's diagnosis. Such information may be useful in enhancing the quality of care offered to patients who seek professional help.

RESEARCH PROBLEM AND METHODOLOGY

In an attempt to determine whether the diagnostic label influences the perceptions of health professionals and students in arriving at a patient's prognosis, a study was undertaken in a psychiatric facility in British Columbia.

The study was conducted by presenting a case history and a set of questions to three separate groups of health professionals and students in the psychiatric field. Each group was given the same case history with a difference diagnostic category. The history was a brief account of an actual person's behaviour while in an inpatient setting. An effort was made to describe the patient's behaviour in simple terms, avoiding psychiatric terminology.

From this information, participants were expected to respond to an eleven-item questionnaire. The purpose of the questionnaire was to survey the opinions of the respondents regarding different aspects of the patient's performance in the future: education, employment, contact with the health care system, relationship with family and friends, and pattern of social interactions. The participants rated their responses on a five-point scale.

THE POPULATION

The sample was one of convenience. Thirty-five people responded to the questionnaire, nineteen of whom were registered nurses who were on duty in the psychiatric unit at the time the study was conducted, and sixteen of whom were senior students* in the health professions, and completing an experience in an inpatient psychiatric setting. The respondents were grouped according to the diagnostic category on the patient's case history presented to them.

Group 1: Included six students and six health professionals. The case history given to them had the diagnosis of simple schizophrenia on the patient's profile.

Group 2: Included five students and six health professionals. They were given a history which suggested that there was a diagnosis, but which was concealed under tape.

Group 3: Included five students and seven health professionals. The diagnosis was omitted from the information given to them.

The researcher explained that the results of the study would be shared with the participants. They were assured that the data would be grouped, so that their individual contributions would not be identifiable.

The rationale for selecting both qualified professionals and students for participation in the study was to identify any differences in the responses between the two groups. The major practical differences between the two groups are the socialization of professionals into the health care system, and the experience that professionals have in working with patients who have been given a diagnosis. One could assume that experienced health professionals have the capacity to arrive at conclusions by directly observing a patient's behaviour. However, because they are socialized into a profession which reinforces the use of diagnostic labels, they may tend to rely upon these labels when they are available, in a way which reduces their own observations of the patient's behaviour to a secondary source of information in arriving at a prognosis. It can be assumed that students, on the other hand, lack both the socialization and the work experience; most of their knowledge may be theoretical. Therefore, they may not exhibit a consistent stereotype of patients assigned to different diagnostic categories, but may, instead, base their conclusions on the stereotype of the psychiatric patient.

* The sixteen students included nursing students from a university programme and one student in psychology.

THE PROCEDURE

The participants were given the questionnaire in small groups in a conference room with the researcher present. They were given twenty minutes to complete the questionnaire. They were requested not to discuss it among themselves. Care was taken to ensure that respondents did not notice that there were three different diagnostic categories associated with the same patient history. Although the three groups were in the same room, the questionnaires were distributed in such a way that those getting a certain diagnostic category were in the same area. This reduced the chance of observing a different diagnostic category on another person's questionnaire.

About one week after the questionnaires were completed, the results were shared with the participants, and their reactions and comments to these results were taped. These were treated as additional data.

ANALYSIS OF THE DATA

Descriptive analyses of the data were presented, utilizing percentages and means. Two sets of comparisons were made: between students and professionals, and among the different diagnostic categories.

To facilitate analysis of the data, the five-point scale was collapsed into three categories based on a continuum from a positive perception of the patient's capabilities to a negative perception. Some questions were reversed to ensure the positive-negative directionality. An item analysis was done for students and professionals in each diagnostic category, by calculating the percentage responses of each group in each category (Table 1). Because the sample size was small, statistical tests of significance were not used.

Questionnaire responses focussed on eleven areas described under Table 1.

DISCUSSION OF FINDINGS

The findings of this study were delineated by grouping the data into the separate diagnostic categories and comparing the responses of students and health professionals in these categories. Comparisons were made between the professional and student groups in a given category, within each group across the categories, and between the two groups across the categories. As the sample size was small, emphasis was placed on the more sharply-delineated findings. Table 1 gives the percentage breakdown of responses in each category.

TABLE 1. SUMMARY OF QUESTIONS
AND SUBJECTS' RESPONSES BY CATEGORY
EXPRESSED IN PERCENTAGES

	No Diagnosis		Concealed Diagnosis		Diagnosis Given	
	Students	Professionals	Students	Professionals	Students	Professionals
1. <i>Client's return to the studies pursued before his illness.</i>						
Yes	20	86	40	0	67	33
Somewhat probable	80	14	60	17	33	17
No	0	0	0	83	0	50
2. <i>Graduation from college.</i>						
Yes	0	71	50	0	50	40
Somewhat probable	60	29	25	20	33	0
No	40	0	25	80	17	60
3. <i>Grade average if he graduated.</i>						
A	0	0	0	0	0	0
B	20	60	50	25	100	50
C + P	80	40	50	75	0	50
4. <i>Employability of client.</i>						
Yes	100	100	80	67	83	100
Somewhat probable	0	0	20	33	0	0
No	0	0	0	0	17	0
5. <i>Client able to hold a steady job.</i>						
Yes	20	57	40	17	0	33
Somewhat probable	40	43	20	67	33	33
No	40	0	40	17	67	33
6. <i>Client an outpatient after hospitalization.*</i>						
No	0	0	0	0	17	0
Yes — short period	20	29	20	50	17	83
Yes — extended period	80	71	80	50	67	17
7. <i>Client re-hospitalized.*</i>						
No	0	0	0	0	17	0
Somewhat probable	20	29	40	50	17	83
Yes	80	71	60	50	67	17
8. <i>Time interval between present hospitalization and future re-hospitalization.*</i>						
3 years and over	40	0	25	0	0	33
2 years	0	57	0	50	40	0
6 mos. - 1 year	60	43	75	50	60	67
9. <i>Future social behaviour recognizable to his friends as somewhat abnormal.</i>						
No	20	29	40	17	17	33
Somewhat probable	40	43	0	67	33	67
Yes	40	29	60	17	50	0
10. <i>Level of dependence on family: Live with family.**</i>						
No	40	29	60	33	17	17
Somewhat probable	0	14	20	17	50	50
Yes	60	57	20	50	33	33
11. <i>Able to have close friends.</i>						
Yes	0	29	40	17	17	17
Somewhat probable	80	57	40	33	33	50
No	20	14	20	50	50	33
Numbers (N=35)	5	7	5	6	6	6

*These items were referred to as "illness role" in the discussion of the findings.

**This category was deleted after the data were analyzed as it proved to be an ambiguous item with both groups. Living away from home does not necessarily imply independence.

DIAGNOSIS GIVEN OF SIMPLE SCHIZOPHRENIA

The most outstanding differences in the responses given by students and professionals when a diagnostic label was given were seen in the items that focussed on education, employment, and "illness role" of the patient.

Education. The students were more optimistic than the professionals about the patient's future college career in terms of resuming studies, maintaining grade average, and graduating from college.

Employment. However, the optimism of students waned when asked about the patient's employment capabilities. Although the majority predicted he would be employable, they were not so sure that he would be able to keep a steady job. None was willing to venture the opinion that the patient would be able to hold down a steady job for an extended period.

Unlike the students, the health professionals were more optimistic about the patient's future as an employee than they were about his future as a student. All responded that he would be employable, and there was an even spread in their responses in relation to whether or not he would be able to keep a steady job (33 per cent, Yes; 33 per cent, Somewhat Probable; 33 per cent, No).

Illness Role. The students were also more pessimistic than the professionals in the way they viewed the future "illness role" of the patient. The majority saw him as needing prolonged outpatient contact, and rehospitalization within a short period of time, whereas the professionals tended to see him as needing short-term outpatient contact with possible rehospitalization.

In relation to future social conduct, more students than professionals perceived that he would be recognized as abnormal by friends and associates in later years, and that he would be unable to maintain close friendships in the future.

In summary, these data reflect the pessimistic outlook of students on items concerning employment, contact with the health care system and future social conduct, no doubt their perception of the degree of impairment associated with a schizophrenic illness. Granted, they viewed the patient as being able to succeed in the college system. However, their familiarity with the student role may have coloured their perception of another person's ability to succeed in this role. The responses of the professionals may reflect their experiences with persons labeled as schizophrenic, that is, persons who can hold some form of employment, with some support from the health care system, but who would be unable to maintain a high standard of performance

in a situation which they may have perceived as demanding, that is, the college situation.

It could be argued that health professionals have all been capable students. However, not all health professionals have been educated in the college system, so their experience in this area may be limited. Students who are familiar with the student role may perceive it as less demanding and more tolerant of "abnormal" behaviour than the employee role, which requires sustained high quality performance and the ability to work cooperatively with others.

It seems that familiarity with a given role decreases the mystique associated with the expectations of that role.

DIAGNOSIS OMITTED

When the responses in this category were compared with the responses elicited in the previous diagnostic category, differences were found in items concerning education, employment, and "illness role".

Education. Interestingly enough, the professionals changed to being optimistic about the patient's career as a student in terms of his ability to return to college, whereas the students tended to be more uncertain about the patient's ability to meet the expectations of the student role. This, of course, is in contrast to the responses of professionals and students when given a diagnostic label. The professionals obviously saw the patient with the schizophrenic label as less able to pursue a college career than the patient who was given no label. It seems that, when given a label, they were more influenced by the label than they were by the actual case presentation.

The uncertainty created by no fixed diagnosis may have affected the students' responses, as there were no parameters to assist in predicting the degree of incapacity of the client. The experienced professionals may have relied on the patient's reported behaviour, whereas this may have had little significance for the students. However, when a label was given, it seemed that professionals tailored their expectations to fit the label, and became more pessimistic about the patient's abilities.

Employment. All professionals and students in the "diagnosis omitted" category predicted that the patient would be employable. However, the professionals were more optimistic than the students that he would be able to keep a steady job. In comparing these responses of the professionals to those elicited when a diagnosis was given, the degree of optimism was higher when the diagnostic label was removed.

Illness Role. The majority of students and professionals in the "diagnosis omitted" category perceived that the patient would need prolonged outpatient contact, and that he would be rehospitalized. The pattern of responses among professionals was different when given a diagnosis, with a higher number predicting short-term outpatient contact and the possibility of rehospitalization. However, they tended to view the patient as needing more rapid rehospitalization, that is, within six months to one year after discharge from hospital. Unlike the professionals' responses, those of the students tended to be similar when given case histories with the two different diagnostic categories. They seemed to be uniformly pessimistic, and viewed the patient as spending much time in hospital, either on an inpatient or outpatient basis.

These data suggest that both groups perceived a need for greater social control through contact with the health care system when they were uncertain of what they were dealing with. Although the professionals perceived the patient as more capable of managing college work and keeping a steady job when his diagnosis was omitted, they seemed reluctant to release him from the controls that can be imposed by the health care system, if they could not fit him into a diagnostic category.

In summary, the data reflect a higher level of optimism among professionals about the patient's future performance when no diagnostic label accompanied the case history, although there were areas in which this pattern was not sustained, particularly in his future contact with the health care system. It seems that professionals, when given a case history with a diagnostic label, based their expectations of the patient's performance on the label rather than on the description of the patient's behaviour, as reflected in the differences in their responses in the two diagnostic categories. The same cannot be said for the students, who seemed more pessimistic when the diagnostic label was removed.

The question can be raised as to why the diagnostic label did not have the same overall effect on students. Two reasons could be suggested. One is that the diagnostic label provided some parameters for predictions to the inexperienced students. Without this, they tended to be more conservative in their outlook. The other is that the label may have been a negative stimulus to students, who tended to compensate for this by viewing the patient's future behaviour with a greater degree of optimism.

DIAGNOSIS CONCEALED

The suggestion that a diagnosis was present but was not available to the respondents triggered the most negative responses in the three categories among professionals. This was not so among the students, whose responses did not reflect the same degree of pessimism.

Education. The majority of the professionals did not see the patient as either resuming his college studies or graduating from college, whereas all of the students thought he might return to college, and 50 per cent predicted that he would graduate. Not only were the professionals more pessimistic than the students, but, when compared to professionals in the "diagnosis omitted" category, the level of optimism of the latter was in striking contrast. Note that the students were most optimistic when the case history presented to them had a diagnosis, and they were most pessimistic when this was omitted.

Employment. Although a majority of the professionals predicted the patient would be employable, they seemed unsure about his ability to hold down a steady job, with the majority seeing this only as a possibility. The students were more optimistic about the patient's future employment capabilities.

It is obvious that professionals had higher expectations of the patient's performance when no diagnosis was given. These expectations decreased when the diagnosis was concealed. The pattern among students was not as clearly delineated. Although the students on the whole tended to be optimistic that the man would be employable, in making predictions about a steady job, they were most optimistic when presented with a concealed diagnosis, and least optimistic with a diagnostic label. However, in general, professionals were more positive than students that the patient would be able to hold a steady job.

Illness Role. In the "concealed diagnosis" category, more students than professionals saw the patient as having a need for extended outpatient contact for a prolonged period, and for rehospitalization within a short period of time after discharge (six months to one year).

Comparisons among students in the three categories revealed a higher degree of pessimism in regard to the items referring to contact with the health care system, both when the diagnosis was missing, and when it was concealed. A higher number predicted rehospitalization when the diagnosis was omitted, and more rapid rehospitalization was predicted (within six months) when the diagnosis was concealed.

A difference of opinion among professionals in the three diagnostic categories was also evident with regard to the items about future

hospital contact. Most professionals anticipated that the patient would maintain contact with the health care system, but there was a diversity of opinions regarding the intensity of such contact. However, the diagnostic label clearly had some impact on the professionals' perception of the patient's need for early hospitalization, whereas this was not so among the students.

In summary, professionals in the "concealed diagnosis" category were more pessimistic than students on the items pertaining to education and employment. The students, however, saw the patient as needing prolonged contact with the health care system.

SUMMATION OF RESPONSES IN THE THREE DIAGNOSTIC CATEGORIES

As another method of viewing the data, the eleven items were combined to determine the overall responses of professionals and students in each diagnostic category. When the items were combined within the diagnostic categories, the most positive responses among the professionals were elicited when the diagnosis was omitted, and the most negative when the diagnosis was concealed (Table 2).

To quantify the responses to each question, positive, neutral and negative responses were given the numerical values $X = +1$, $X = 0$, $X = -1$, respectively. These were computed for both professionals and students.

When the responses of all professionals to all questions were averaged, the following means ($\bar{X}$) were obtained:

No Diagnosis	$\bar{X} = +.08$
Diagnosis Concealed	$\bar{X} = -.32$
Diagnosis Given	$\bar{X} = 0$

(Note that, if all responses were positive, we would get $X = +1.0$; if all were negative, $X = -1$.)

One may postulate some probable causal factors to explain this phenomenon. First of all, it can be stated from the item analysis that the label of schizophrenia evoked more negative responses than the omission of the diagnosis. One could argue that when the diagnosis was given professionals responded to stereotypes of the schizophrenic person, rather than to the behaviour that was presented in the case history. As Denzin and Spitzer (265-271) and Rosenhan (250-258) have pointed out, once given a diagnosis, predictions are made on the basis of the label, rather than on the circumstances of the person's life. The findings in this study support this viewpoint. When no statement of a diagnosis was made, interpretation of the person's behaviour produced more positive predictions.

TABLE 2. COMBINED ITEMS WITHIN THE
DIAGNOSTIC CATEGORIES — RESPONSES EXPRESSED
IN PERCENTAGES

Combined response to questions 1-11.	No Diagnosis		Concealed Diagnosis		Diagnosis Given	
	Students	Professionals	Students	Professionals	Students	Professionals
Positive	22	37	35	14	26	30
Neutral	33	33	27	40	35	40
Negative	45	29	38	46	38	30

However, the most relevant finding pertains to the high degree of negative responses when the diagnosis was concealed. It seems that, when the professionals were made aware that indeed there was a diagnosis, but were unable to find out what it was, they tended to predict a morbid prognosis. The schizophrenic label gave some parameters for making predictions, but the concealed label gave a greater scope for predicting morbid outcome. This is analogous to the suggestion effects in psychiatric diagnosis: "when in doubt, diagnose illness" (Temerlin). When an insufficient diagnosis is given, professionals may lean toward illness and pessimism, rather than toward health and optimism. This seems to illustrate the labeling effect among professionals attuned to the label.

The responses of students were different from those of professionals. On the whole, the students were more pessimistic. When the items were combined within the diagnostic categories, the pessimistic responses were highest among those students not presented with a diagnosis, and similar for those presented with a concealed diagnosis and the schizophrenic label (Table 2).

To quantify the responses to each question, positive, neutral and negative responses were given the numerical value $X = +1$, $X = 0$, $X = -1$, respectively. When the responses of all students to all questions were averaged, the following means ($\bar{X}$) were obtained:

No Diagnosis	$\bar{X} = -.24$
Diagnosis Concealed	$\bar{X} = -.04$
Diagnosis Given	$\bar{X} = -.12$

A possible explanation for these findings is that the inexperienced students relied on the diagnosis of schizophrenia and the suggestion of a diagnosis for a framework from which to make predictions, whereas when no diagnosis was given, they tended to overemphasize

the sick label, and may have used the "psychiatric patient" label from which to make predictions.

It seems plausible to assume that the experience of students and professionals played some part in determining their responses to the individual items. The students on the whole were more optimistic than the professionals about the patient's ability to return to college and graduate with grades that were similar to those he had achieved prior to his illness. The professionals, on the other hand, were more optimistic about the patient's ability to hold down a steady job. It may be that the professionals saw the patient as having difficulties, with later stabilization, therefore he would be unable to finish his studies, but would be able to hold a job at a later time, whereas the students were not as attuned to the temporal features of the problem, but had the notion that, in the end, the illness would prevent the patient from holding a job.

The striking feature in this study is the degree to which the professionals' perceptions were altered when given the same case history with different diagnostic categories. The professionals' expectations of the patient were higher when they were left to interpret his behaviour when no diagnosis was given. The reverse was true for the students, who seemed most pessimistic when they were left without the diagnosis.

DATA ELICITED FROM TAPE RECORDINGS

Further data were gleaned from tape-recorded discussions held with the students and health professionals on separate occasions. The raw data were used to stimulate the discussions, which lasted about half an hour. These discussions were used to clarify and reinforce interpretations made from the questionnaire responses.

The students stated that their response to the label was that "the patient would be able to do more than the diagnosis would indicate". Their initial sympathy for the patient prompted them to respond positively to the items on education. They also felt they lacked experience with diagnostic labels. This implied that the diagnosis in itself would not guide the students to make predictions about the patient's prognosis. It seems that the students who were not presented with a diagnosis did not have the initial stimulus to react to. Therefore, their predictions were made on the stereotype of the psychiatric patient, which tended to be more negative.

In explaining their positive responses to the patient's future education prospects and their negative responses to employment possibilities, they stated that the patient had learned to cope with university, therefore he would be able to cope with the old situation better than

with a new job, which would require him to learn new skills. They also perceived the university milieu as requiring fewer social skills. One could suggest that their perceptions were based on their familiarity with the student role, and their anxieties in a work situation. They therefore saw the patient as being able to readjust more readily to a familiar situation (university), than to a new situation (job).

Students attributed their negative outlook to their lack of experience in working with psychiatric patients; they expected the worst and saw hospitalization as the only way of coping with stress. However, one has to explain the reason for the shift from being optimistic to being pessimistic when they were presented with a diagnostic label. The students themselves admitted that, initially the label made them want to defend the patient. This way of responding declined as the original stimulus (label) became more remote; then the students as a whole were more inclined to respond according to their stereotype of the psychiatric patient.

They summarized three factors which affected their perceptions:

1. initial negative response to the diagnostic label, which led them to sympathize with the patient;
2. identification with the student role and their perception of this role;
3. their lack of experience in dealing with diagnostic labels, and therefore their inability to associate any particular predictions with the schizophrenic label; they therefore tended to use the stereotype of the psychiatric patient.

The professionals attributed the differences in their responses in the three diagnostic categories to their experience. When presented with a diagnosis, they based their predictions on the prognosis usually associated with the diagnostic label. Their optimism about future employability of the patient was based on their assumption that the patient would choose a job he could manage. From their experience; they found that different jobs required different levels of skills, and a person could always find a job congruent with his capabilities. Their lack of anxiety associated with the work situation was in marked contrast to the students.

Some points brought out by the professionals were:

1. Their positive responses about employment were related to their familiarity with this experience in contrast to the college situation which they saw as more difficult. (Some professionals had not gone through a university programme.)
2. When presented with a diagnosis they made predictions from the diagnosis; when no diagnosis was available, they made predictions from the information in the case history.

3. When the diagnosis was concealed, they tended to be more cautious, as they knew a diagnosis existed, but were not aware of the severity. According to the professionals, "when the diagnosis is concealed, one imagines the worst".

SUMMARY, CONCLUSIONS, AND IMPLICATIONS

SUMMARY AND CONCLUSIONS

This study was carried out in a psychiatric setting in British Columbia to determine whether the diagnostic label assigned to a patient influenced the perceptions of students and health professionals in arriving at the patient's prognosis. A case history, together with an eleven-item questionnaire, was given to a total of thirty-five registered nurses and students in the health care field. The questionnaire surveyed the opinions of respondents concerning the patient's future adjustment. The items related to education, employment, "illness role", and future social conduct. The respondents were grouped into three: each group was given a case history with a different diagnostic category (1. diagnosis of simple schizophrenia; 2. diagnosis concealed under tape; and 3. diagnosis omitted). The data were analyzed by using percentages and means. Two sets of comparisons were made: between students and professionals and among the different diagnostic categories.

The main findings in this study can be summarized as follows:

Professionals

1. Their responses were most positive when the patient's diagnosis was omitted.
2. The label of simple schizophrenia evoked more negative responses than the omission of the diagnosis.
3. The concealed diagnosis evoked the most negative responses of all three categories.

Students

On the whole, they were more negative than the professionals in their predictions about the patient's future performance.

1. Their responses were most positive when the diagnosis was concealed.
2. The label of simple schizophrenia evoked more positive responses than the omission of a diagnosis.
3. The omitted diagnosis evoked the most negative responses of all three categories.

The sample in this study was small, therefore the findings should be interpreted with caution. However, it is clear that the professionals were negatively influenced by the presence of the diagnostic label or the suggestion of a diagnosis. This finding is congruent with that of

other researchers concerning the power of the diagnostic label to influence our expectations of a patient's performance (Rosenhan).

The findings also support the viewpoint expressed earlier in this study. Socialization and experience can influence the perceptions of both students and professionals. Having been socialized into a profession which reinforces the use of labels, the professionals, given the same information about a patient, will interpret it in the light of the accompanying diagnostic label. Without a label, they will try to interpret the data; with a label, they tend to fall back on stereotypes.

In considering this particular finding, a crucial question is whether the diagnostic label influences clinical decision-making. Are health professionals bound by the label, or is it viewed as just another piece of information? From this study, it is not clear that the label of simple schizophrenia influences the type of care the patient receives. One could suggest, however, that if professionals expect patients with the label of simple schizophrenia to function less competently in the future than patients who are not so labeled, this could well influence the treatment goals and the treatment programme of the labeled patient. If this is so, the inference can be made that the diagnostic label influences clinical decision-making. This is an area that bears investigation.

In reviewing the responses of students, it seems that their lack of experience and socialization into the health professions influenced the way in which they perceived the patient's future performance. The diagnostic label did not have as negative an impact as it did on the health professionals; rather, one could suggest a different type of labeling among students: that of the psychiatric patient label. Whereas the professionals were negatively influenced by the diagnostic label, the inexperienced students seemed more influenced by the stereotype of the psychiatric patient. If indeed the students reflected the layman's view of mental illness, it becomes evident that limited knowledge about psychiatric illnesses and the label "psychiatric patient" conjure up more negative stereotypes than specific diagnostic labels. One is therefore led to question if the non-professional label of "psychiatric patient" has more devastating consequences for the patient than the diagnostic label given by health professionals. Research findings support the viewpoint that the public view of mental illness is negative (Cumming and Cumming, 1957; Philips, 1963).

Although the students seemed adversely affected by the stereotype of the psychiatric patient, this was not evident to the same degree

among professionals. On the whole, the professionals were quite optimistic that the patient would be able to function in a job. This brings up the question of stigmatization of the mentally ill. Gove (1973) pointed out that it is clear the public has a negative stereotype of mental illness. However, it is not that clear that the stigma of mental hospitalization has a major effect on the social situation of most former mental patients. His research findings indicated that most patients following their hospitalization, did not perceive that the stigma of being in a hospital posed a serious problem. Compared to their behaviour before hospitalization, many of the patients in his study showed marked improvement in their relationships with persons with whom they were living, and modest improvement in their instrumental performance and community activities.

The following statement of Gove must be taken into account. "The public stereotype of the mentally ill is highly negative and when the public is presented with abstract cases, the responses indicate that they will seriously discriminate against persons labeled as mentally ill. However, . . . when persons actually confront someone who has been labeled mentally ill they in fact do not seriously discriminate against them." (p. 500). The experienced health professionals may have found that patients were able to adjust to their various roles upon their return to the community. Therefore, when presented with a case history of an actual patient, the professionals did not see the patient as being chronically incapacitated, but as being able to participate in normal everyday activities. Granted, they expected the patient to keep in contact with the health care system. This expectation, no doubt, was derived from their experiences with their own patients. The students, on the other hand, may not have had experience with ex-hospitalized patients, and may have been familiar only with the lay stereotype of the psychiatric patient.

IMPLICATIONS

Although the sample was small, and one of convenience, which limits the generalizations from the study, the findings bear some similarity to previous research. Accepting this, there are certain implications.

1. *For education of health professionals.* This study suggests that reliance on diagnostic labels may preclude the use of observational data. If indeed labels interfere with observation, one should question the implication this has for the education of health professionals. It seems that there needs to be emphasis on observation of behaviour, and on arriving at conclusions from direct observations rather than from the diagnostic label alone. One thing that the study points out

is that professionals are not necessarily enslaved by diagnostic labels; if labels are removed, they base their interpretations on the patient's behaviour. If the label is present, however, they use that rather than the actual behaviour, having been socialized into a system where labels are relied upon. It should not be inferred that labels are "bad", and that all labels should be discarded. Possibly if there were no diagnostic labels, professionals would develop some other form of labeling. The crux of the matter is that health professionals should be taught how to develop their observational skills, and how to interpret their observations rather than relying upon a presented diagnosis.

2. *For the treatment of patients.* This study reveals that professionals had a more optimistic outlook about the future of the psychiatric patient than the students did. One could argue that this was based on their experiences with patients who had been able to re-establish themselves successfully in the community after their hospitalization.

The professionals in the study worked in a setting where patients were hospitalized for an average of 24-28 days, with intensive therapy, which usually included the patient's significant others and plans for the post-discharge period. Most patients had good follow-up care through daycare facilities, hospital clinics, community care teams, or private psychiatrists. One could suggest that patients were not away from the community long enough to lose significant contacts; furthermore, the involvement of significant others in patients' treatment may have facilitated transition from hospital to community. The follow-up care after hospitalization may also have facilitated re-entry into the community.

Compared to the patient who is hospitalized for several months, and whose ties with significant others and the community may be severed, the patient who receives intensive short-term therapy, maintains ties with the community and has good follow-up care may have a much better chance of re-integrating into the community after hospitalization.

This implies that we need to examine the treatment modalities used with patients and attempt to identify types of treatment conducive to resumption of social roles and instrumental performance within the community. It seems plausible that intensive short-term treatment, involvement of significant others in treatment and follow-up care which aims at normalizing the patient (e.g. focus on getting back to work and resuming social roles) may be more beneficial to the patient than long-term treatment which isolates him from his

family and community for extended periods. This is an area that merits future study.

As health professionals, we must identify ways in which we can continue to change stereotypes associated with diagnostic labels in particular, and mental illness in general, so that psychiatric disorders can be viewed as problems which lend themselves to solutions, rather than as lifetime illnesses. This possibly can be done through enhancement of the education of mental health professionals, improved treatment programmes, and public education.

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LES EFFETS DU DIAGNOSTIC DU PATIENT SUR LES PROFESSIONNELS ET LES ETUDIANTS DANS UN SERVICE PSYCHIATRIQUE: UNE PERSPECTIVE DU CATALOGAGE

Une brève enquête a été effectuée dans un service psychiatrique de la Colombie-Britannique dans le but d'étudier dans quelle mesure l'énoncé d'un diagnostic peut influencer des professionnels de la santé et des étudiants dans leur perception d'un pronostic concernant

le client. Une histoire de cas avec un questionnaire comportant onze sections ont été présentés à trente-cinq infirmières* diplômées et étudiants en sciences de la santé. Le questionnaire portait sur l'opinion des répondants quant à l'adaptation future du client. Les questions se rapportaient à l'éducation, au travail, au "rôle de malade" et au comportement social futur. On a divisé les répondants en trois groupes: on a présenté à chacun des groupes la même histoire de cas avec un diagnostic catégorisé ainsi: (1. diagnostic de schizophrénie simple; 2. énoncé du diagnostic couvert avec du ruban gommé; et 3. absence de diagnostic). Les données furent analysées par méthode de pourcentages et moyennes. On a établi deux modes de comparaison: entre étudiants et professionnels d'une part et entre les différentes catégories d'énoncé de diagnostic d'autre part. Les principaux résultats de cette recherche sont les suivants:

Professionnels: les réponses étaient plus positives lorsque le diagnostic était omis. L'énoncé d'une schizophrénie simple invitait à des réponses plus négatives que l'absence de diagnostic. Les réponses les plus négatives correspondaient au diagnostic camouflé.

Etudiants: en général, leurs réponses furent plus négatives que celles des professionnels quant aux prévisions touchant la future adaptation du client. Leurs réponses étaient plus positives lorsque le diagnostic était caché. L'énoncé d'une schizophrénie simple a entraîné des réponses plus positives que l'omission du diagnostic. C'est à cette dernière catégorie que correspondaient les réponses les plus négatives des trois catégories.

L'auteur étudie quelques-uns des facteurs qui peuvent avoir contribué à la divergence des réponses entre les professionnels et les étudiants. La taille de l'échantillon étant restreinte, il souligne que les résultats doivent être interprétés avec une certaine réserve. Ils vont cependant dans le sens de ceux d'autres chercheurs quant à l'influence de l'énoncé du diagnostic sur nos attentes relatives à la réadaptation du client. Ceci étant admis, l'auteur dégage quelques implications pour l'enseignement et la pratique clinique.

*Dans ce texte, les termes infirmière et étudiant se réfèrent également aux termes infirmier et étudiante.