MENTAL PATIENT STATUS, WORK, AND INCOME: AN EXAMINATION OF THE EFFECTS OF A PSYCHIATRIC LABEL*

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Much controversy has focused on the effect of a label in bringing about the types of behavior the label connotes. This emphasis may have led some to ignore the possibility that a label can effect an individual in other ways. In the study "treated cases," individuals who have been treated, are compared to "untreated cases," individuals found to be similar in severity of psychiatric condition but who have not received an official label. Analyses controlling for psychiatric condition and other important variables show that a psychiatric label has a negative impact on income and work status. These results suggest that while a label may or may not directly affect the form of behavior for which it is affixed, it almost certainly has an impact on other areas. Finally, given these pejorative effects, there may be a partial role for labeling theory in understanding the stabilization of psychological disorder if a label increases environmental stress and decreases one's ability to cope with it.

During the 1960's "labeling" or "societal reaction theory" emerged as a dominant concern in the field of the sociology of deviant behavior (Cole, 1975). The work of Erickson (1962), Becker (1963), and Kitsuse (1962) began a series of inquiries which eventually led to a number of heated debates. One debate centered on Scheff's (1966) development of labeling theory into a social model of the etiology of mental illness.

The debate surrounding Scheff's social model focused on the ironic notion in labeling theory (Schneider, 1975) that societal efforts to control deviance lead not to its reduction but to its increase. It is when rule breakers are labeled, and constrained to adopt the societal view of themselves as deviant, that they begin to act in accordance with the stereotype associated with the label. It is this kind of thinking that led to Scheff's ninth proposition, which states that, "among residual rule breakers (those displaying initial symptoms), labeling is the single most important cause of careers of residual deviance (stabilized mental illness)." (Scheff, 1966:92-93). As Cockerham (1979) points out, however, it is precisely this etiological claim that has drawn the most attention from critics (Gove, 1970, 1975, 1979; Chauncey, 1975; Murphy, 1976). Gove's evaluation of the labeling hypothesis leads him to conclude that "the available evidence indicates that deviant labels are primarily a consequence of deviant behavior and that deviant labels are not a prime cause of deviant careers" (1975:296).

However, labeling can have effects other than direct etiological ones. In this regard the possible consequences of labeling can be conceptualized as involving three domains: 1) the creation of deviant behavior, 2) the stabilization or maintenance of deviant behavior, and 3) the consequences of a label for other areas of a person's life such as jobs, friendships, family relations, and mate selection. Critics of labeling theory have addressed the first and to a lesser extent the second domain. Underemphasized is the third domain, the extent to which a label has pejorative effects in other areas of a person's life. This third domain is my point of departure in a new look at the issues in labeling theory as they apply to mental illness.

SUPPORT FOR AN INQUIRY INTO THE EFFECTS OF A PSYCHIATRIC LABEL ON DIVERSE ASPECTS OF A PERSON'S LIFE

If the etiological claims of labeling theory are temporarily put aside and the consequences of a label on areas of a person's life other than his or her disorder are considered, we can con-
tinue to employ the insights of the labeling framework. Consider, for example, Lemert’s classic definition of “secondary deviance”:

Secondary deviation is deviant behavior, or social roles based upon it, which becomes means of defense, attack, or adaptation to the overt and covert problems created by the societal reaction to primary deviation. (1967:17)

The breadth of the notion of secondary deviance is implied by the words “defense, attack, or adaptation” indicating that reaction to a label can take many forms and therefore may affect many areas of an individual’s life. Similarly, concepts like Becker’s (1963) “master status,” Schur’s (1971) “role engulfment,” and Lofland’s (1966) “pivotal identity” suggest consequences for aspects of a person’s life other than his or her participation in deviant behavior.

Further support for an inquiry into the effects of a label on diverse aspects of a person’s life are available if one closely examines some of the empirical evidence on how labels are applied and perceived. Phillips (1966) demonstrated the effect a label can have on attitudinal social distance, a measure of rejection. The questions forming the social distance scale ranged from whether respondents would discourage their children from marrying an individual to whether they would have the individual as a neighbor. Between these two endpoints Phillips included questions concerning renting a room, working on the same job, and admitting the person to a favorite club or organization. Using five “Star Vignettes” (Star, 1955) and an additional vignette of a “normal” man, Phillips established a baseline of social response to each described behavior. A psychiatric hospitalization was included as identifying information in some of the descriptions, allowing Phillips to generate an assessment of the amount of rejection engendered by the label. The effect was substantial, particularly when reactions to the “normal” vignette with a label, and the “normal” vignette without a label formed the comparison.

In another study, involving unacquainted male college students, Farina et al. (1968) demonstrate the effect a label can have even when the assigned label has no basis in fact. One member of a pair of students was led to believe that the other had been told the former was either homosexual or mentally ill. In fact the other subject in the pair always received the same neutral information. The results showed that merely believing that one is viewed as stigmatized can influence a subject’s behavior, leading in turn to rejection by the other person in the pair. This study was subsequently replicated with a sample of mental patients (Farina et al., 1971).

These studies show that a psychiatric label can have an effect both on members of the general public and psychiatric patients. In this respect they are consistent with the literature on the public’s stereotypes and rejection of the mentally ill (Nunnally, 1961; Whatley, 1958; Tringo, 1970; Bord, 1971; Cumming and Cumming, 1957). However, if one takes a close look at the kind of influence the label has in these studies, it is apparent that the demonstrated effect is not on the symptoms of the “illness” or “disorder” but on other areas of the individual’s life. In the Phillips study, the questions forming the social distance scale suggest that a person with a label is likely to have more difficulty finding a job, a place to live, a group of friends, and a marriage partner. In Farina’s studies, the consequences of the label are social psychological in nature, with the labeled individual becoming tentative, less effective, and less likeable.

There is, therefore, ample support in the theoretical and empirical literature for an inquiry into the adverse effects of a label on areas other than a person’s psychiatric condition. How might these negative consequences manifest themselves? What are the processes involved?

MECHANISMS WHICH MAY PRODUCE PEJORATIVE LABELING EFFECTS IN THE WORLD OF WORK

A label and the social reactions that come with it can have a negative effect in a number of ways, each of which may be more or less important for a particular person. As a result, one useful way to think about this process is as a series of steps in which social and social psychological factors induce and/or reinforce, in varying ways and to varying extents, the inability to function in social roles.2 In what follows I draw attention to two sets of contributing factors—discrimination by others, and mechanisms which operate through the labeled person’s expectation of rejection.

Discrimination by Others

One way in which former patients can be harmed in the world of work is by the direct discrimination of employers. Not only will em-

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2 I am grateful to an anonymous reviewer for pointing out that the effects of a label are produced incrementally and are most likely accomplished through, and most usefully conceptualized as, a series of reinforcing conditions.
ployers openly admit that they would prefer not to hire expatriates (Olshtansky et al., 1958), they will also be less friendly in an interview situation and rate an applicant's chances of getting a job significantly lower when he/she reveals a history of mental illness (Farina and Felner, 1973). Furthermore, in many states such occupations as policeman, fireman, and teacher categorically exclude persons with a history of mental hospitalization (Ennis and Siegal, 1973). In addition to direct discrimination, a label can indirectly affect one's ability to obtain a job. For example, former mental patients can be denied a driver's license, thereby excluding them from jobs that require driving. In these ways, having a label increases one's chances of being unemployed and decreases one's chances of obtaining a job that pays well.

Mechanisms That Operate Through the Individual's Expectation of Rejection

In addition to discrimination by others, a label can impair the ability of patients to obtain jobs and earn income by influencing their sense of what others think of them. This process begins even before a treatment source is contacted. As Elinson and his colleagues (1967) found, even when the public reports that they personally would not be "repelled" by a former mental patient (only 17 percent reported that they would), a full 75 percent believe that most people would be. Thus, newly admitted patients are likely to fear rejection from others simply as a consequence of beliefs they held before they entered treatment.

After the patient enters treatment, this initial fear can be reinforced and made concrete by the kinds of "mortifying" processes Goffman (1961) has identified. This can occur even when treatment efforts are well intentioned and free of the most blatant abuses. Since patients must live with social control mechanisms designed to manage their most bizarre and dangerous fellows, most are subjected to restrictions they, as individuals, do not need. Given an initial tentativeness about what becoming a mental patient might mean, newly admitted patients may come to believe that they do need the restrictions they endure, and are, therefore, justifiable objects of the negative opinions they fear.

The fear of rejection, once it is embedded in the individual, can then become a reality, as Farina's studies have shown (Farina et al., 1968; Farina et al., 1971). Expecting and fearing rejection, patients may act less confidently, more defensively, or they may simply avoid a threatening contact altogether. The result is likely to be a poorer performance, less imbeded with the self-confidence employers want to see.

Finally, given the process outlined above, patients may begin to internalize a negative view of their abilities, viewing themselves as "ineffective," "hopeless," or "unworthy." The occurrence of this sort of internalization has been suggested by a number of labeling theorists (Scheff, 1966; Lofland, 1966; Schur, 1971) but also has parallels in social psychology. For example, although Bem's (1978) "self-perception" theory has focused on the awareness of physical and emotional states, he also suggests that his theory may be applicable to broader self-conceptions such as "good boy" or "bad boy." According to Bem (1978), individuals infer what they are feeling from the way they are behaving, as evidenced, for example, by the after dinner comment, "Oh, I must have been hungrier than I thought." Bem states the core of self-perception theory as follows:

Individuals come to "know" their own attitudes, emotions and other internal states partially by inferring them from observations of their own overt behavior and/or the circumstances in which this behavior occurs. Thus, to the extent that internal cues are weak, ambiguous, or uninterpretable, the individual is functionally in the same position as an outside observer, an observer who must necessarily rely on the same external cues to infer the individual's inner states. (1978:222)

If this line of thinking is applied to the situation of the former mental patient, one can begin to see how patients may come to develop low self-esteem and to believe that they really are ineffective. The situational cues they experience as patients tend to be unfavorable. As they watch their own behavior in such situations and see that it is tentative and ineffective, they are likely to draw unfavorable conclusions about themselves. When such conclusions become internalized they place the former patient at a disadvantage in future situations.

The arguments outlined above concern why a psychiatric label is likely to have pejorative consequences for social functioning. However, an alternative explanation must be considered. J. K. Wing, a prominent British psychiatrist, recognizes the possible effects of labeling processes, calling them "secondary reactions," but he also emphasizes aspects associated with the underlying disorder which consist of "the biological or psychological abnormalities of the illness itself, or the primary residual impairments caused by the illness" (Wing, 1973:5). Clearly then, a possible explanation of work-related difficulties in patients is the nature and
effects of the underlying disorder. Stated in its strongest form, a perspective which emphasizes the effects of the disorder would predict that a label is achieved because of one’s psychiatric condition and has little or no independent effect on functioning in social roles. Since it is possible to explain the role functioning of patients and former patients either by their psychiatric condition or by their exposure to the effects of labeling, a strategy is required that will allow an assessment of the importance of each factor independent of the other.

THE STRATEGY

Any strategy for investigating the effects of labeling by contrast with psychiatric condition must come to terms with the problem that the two characteristics coincide in studies focused solely on patients. In order to claim that either one or both factors are causally implicated, one must find a method of unconfounding them.

As Scheff (1966:199) has pointed out, an ideal method would be to interview a large random sample of the population, carefully assessing the “true” severity of their disorders, and then randomly assigning severely impaired persons of like diagnosis to one of two groups. The first group would be identified as mentally ill, sent to a mental hospital, and exposed to the types of social relations that the status of mental patient carries with it. The second group would simply be left alone, unidentified, to carry on their lives uninterrupted. At some appropriate second point in time, the income and social functioning levels of these two groups would be assessed. Clearly this kind of investigation of the problem is impossible to conduct for both practical and ethical reasons.

Short of this sort of experimentation, the problem must be approached using naturally occurring groups. Fortunate for this purpose, a large body of evidence culled from epidemiological studies of the true prevalence of psychiatric disorders suggests that significant numbers of individuals who suffer from these disorders have never been treated for them (Link and Dohrenwend, 1980). In this study, “treated cases”—persons who have entered psychiatric treatment—will be compared to “untreated cases”—individuals found to be psychiatrically impaired, but who have never received treatment. This sets up the intriguing possibility of comparing individuals who are similar in terms of psychiatric condition but distinctly different in terms of whether they have a psychiatric label. In this manner, an assessment of the effects of a psychiatric label, independent of the level of psychiatric impairment, can be obtained.

THE SAMPLE

The data used in this study were collected by Dohrenwend and his associates in the Washington Heights section of New York City during 1965–1967. Comparable information was collected on a number of groups including a sample of community residents and a sample of psychiatric clinic outpatients.

The community sample is a probability sample, stratified on educational level, within the ethnic groups of White Protestant, Irish, Black, Jewish, and Puerto Rican. The subjects were drawn from two larger probability samples of the Washington Heights area, conducted by the Community Population Laboratory of Columbia Presbyterian Medical Center. Of the 391 subjects selected from these samples for inclusion in the Washington Heights study, complete interviews were obtained from 65.5 percent (257) individuals.

The patients were selected with the help of the therapists in the clinic, to approximate six “behavior types” following descriptions of the “Star Vignettes” (Star, 1955). These vignettes, which have been widely used in attitude studies, were employed in order to ensure a wide range of pathology. Of the interviews sought, 75.7 percent were completed, yielding a sample of 112 outpatients. The patients were from the Washington Heights area and generally paralleled the ethnic and class diversity of the community.

The strength of this sample is that the data contains information on the psychiatric status of both patient and community populations. All of the interviews were conducted by experienced psychiatrists trained in the use of the two survey instruments, the Structured Interview Schedule (SIS) (Dohrenwend and Crandell, 1970), and the Psychiatric Status Schedule (PSS) (Dohrenwend et al., 1970; Spitzer et al., 1970). Respondents were randomly assigned to the interviewing psychiatrist with the constraint that Spanish-speaking respondents could only be assigned to Spanish-speaking psychiatrists. In addition, respondents were randomly assigned to one of the two instruments. The SIS is a standardized interview schedule and relies on fixed alternative responses to questions. The PSS relies more on open-ended questions, followed by probes. These responses are then coded into fixed categories which are based on the clinical judgment of the interviewer. The psychiatrists, who interviewed the subjects in their homes, were not informed of their status as “patient” or “community resident” at the outset. In order to maximize the “blindness” of the psychiatrists, respondents were asked not to reveal information concerning their treatment history.
However, some respondents did reveal their history, and others were easily identified by comments they made about the medication they were receiving.

THE MEASUREMENT OF THE VARIABLES

The Labeling Variable

Not all labeling is "official labeling." Informal labeling occurs in family, work, and friendship groups long before officials become involved (Turk, 1973; Hawkins and Tiedeman, 1975; Cockerham, 1979). Davis and Schmidt (1977) suggest that a series of events occurs in informal groups that lead first to the identification of the "typical" behavior of an individual by an associate, then to a consideration of the individual as a "type" of person, and finally to agreement on the part of a social group that the person is such a "type." In this view the labeling process is a continuum rather than a dichotomy, with the all-encompassing official label as an end point.

Unfortunately, the study of the complex process of labeling is such a difficult undertaking that researchers usually rely on the presence or absence of "official labels" in their investigations. However, where psychiatric disorder is concerned, such oversimplification may not be as limiting as with other types of deviant behavior. Evidence from the study of families of mental patients shows that there is a tendency to go to extremes to avoid labeling a family member mentally ill (Yarrow et al., 1955). Moreover, there is evidence that official labeling and hospitalization entail an immediate and severe impact in their own right, as suggested by Goffman's (1961) notion of a "betrayal funnel." In many cases, therefore, the dichotomy of labeled/not labeled may be almost as effective as a measure of the more complete labeling process since the official label marks such an important turning point that it may be discontinuous in effect with what has gone before.

Psychiatric Disorder

Three measures of psychiatric disorder are employed in this analysis: the Midtown Mental Health Rating of impairment (Srole et al., 1962), the Stirling County Caseness Rating (Leighton et al., 1963), and a psychiatric diagnosis. The Midtown Mental Health Rating is a measure intended to reflect the degree of impairment in functioning due to psychopathology. Respondents range on a six point scale from "well" to "incapacitated" with intermediate categories of mild, moderate, marked, and severe. The Stirling County Caseness Rating was developed by the Leightons and their colleagues in their study of the prevalence of psychiatric disorder in Stirling County (Leighton et al., 1963). The purpose of this rating is to assess the probability that the individual under question is a psychiatric case. Four levels of probability are used, ranging from "almost certainly a psychiatric case" to "almost certainly not a psychiatric case." The diagnostic distinctions used in the present analysis are psychotic, neurotic, personality disorder, and no diagnosis. They are introduced into the analysis as well because the ratings mentioned above ignore qualitative differences in the mental disorders which might be important in obtaining work and earning income.

The reliability of these measures was determined by assessing the agreement between two psychiatrists, the actual interviewer and a second person who rated the data using a tape recording of the initial interview. The reliabilities of the Midtown Mental Health Rating and the Stirling County Caseness Rating were estimated using an intraclass correlation coefficient and were .84 and .68 respectively. The reliability of the diagnostic distinctions was assessed using Cohen's (1960) Kappa and was .58.

Income

The measurement of income is not as straightforward as one might expect. In the Washington Heights data set, the only available assessment is of annual family income measured in nine intervals from 1 (less than $2,000) to 9 (greater than $15,000). Since the proposed test refers to the disability of patients, family income by itself is not the ideal measure to test the hypothesis. It should be pointed out, however, that Myers and Bean (1968:172) investigated the issue of the earnings of former psychiatric patients by class level and obtained similar results whether they used individual or family income. Also, from another point of view family income is a better measure. Part of the interest here is in the consequences of the possibly debilitating effects of the social treatment of psychiatric patients, and a measure such as family income which more effectively assesses the monetary resources available to the family is more desirable for that purpose.

Work Status

In addition to family income, information was collected on individual work status for a random half of the sample (those interviewed with the SIS). Two questions form the basis of this measure. The first assesses current employment status with a "2" being assigned those who are unemployed, a "1" to those partly em-
employed, and "0" to those fully employed. The second question asks how many weeks during the past year the individual was without work as a result of being unemployed or laid off. Those who answered between 24 and 52 weeks were assigned a "2"; those answering between 1 and 23 a "1"; and finally those who answered that they had not been without work at all were assigned a "0." In this manner, a two item measure was constructed, following the work of Barbara Dohrenwend and her colleagues (1973). Scores on the measure varied from a low of "0" to a high of "4," with a high score representing a disadvantaged work status. The reliability of this scale is .92.

Control Variables

Many of the control variables are sociodemographic variables such as marital status, education, age, and occupation. The reliability of these assessments has typically been found to be quite high (Jencks, 1972; Siegel and Hodge, 1968). Marital status is measured by a dummy variable with "1" equal to married and "0" equal to not married. Education is a four-point scale ranging from "1," less than grade school to "4" indicating college education or more. Occupation is an 11-point scale with "0" equal to low prestige and "10" equal to high prestige. The scale used to measure occupation is one developed by Dohrenwend and his associates which closely corresponds to the Duncan index (Duncan, 1961). The question concerning occupation refers to "usual occupation" so that current status is not as effectively measured by this variable as it is by income. It is employed, therefore, as a control variable rather than a dependent variable in the analysis assessing the effect of patient status.

RESULTS

The results presented below are from several different subsamples of individuals taken from the larger Washington Heights study. Since an ideal randomized experiment is not possible for practical and ethical reasons, the aim of the analyses is to provide a number of tests of the hypothesis with these different subsamples. This permits an assessment of whether there is sufficient convergence in the results to warrant confidence in them.

Result Set #1: The Effect of a Psychiatric Label on Income as Assessed in the Community Sample

The first assessment of the effects of a psychiatric label is conducted on a sample which includes only those individuals who were interviewed as a part of the community study. In this sample of 257 individuals, 26 reported that they had been in treatment in a mental hospital or a public clinic. Three of these 26 were excluded because they were in treatment in a hospital during the year before the interview and could not be expected to earn income as a result. In addition, a number of persons failed to report their income, leaving 229 individuals—20 patients and 209 nonpatients—with complete information on all of the variables in the model.

This test of the hypothesis that a psychiatric label has pejorative consequences is an important one for two reasons. First, the individuals who reported that they had been in treatment were not selected because of their participation in any particular clinic or hospital. Instead they represent a sampling of individuals found in the community and are therefore more representative of the population of patients than a group selected from a particular treatment setting. Second, the individuals had all been out of treatment for at least a year. This makes it less likely that the individual's current psychiatric condition is confounded with the effects of a label. Indeed the current impairment levels of these former patients were not significantly higher than the rest of the population, as evidenced by a correlation of only .09 between impairment and patient status.

The model for Table 1 was developed by including variables that have been shown to be important to the attainment of income (Blau and Duncan, 1967; Coleman and Rainwater, 1978; Duncan, 1968; Jencks, 1972). Also, given that the dependent variable is family income, marital status is entered to control for the effects of having more than one breadwinner. Two variables of possible importance to the model, age and sex, were excluded because their effects were not significant. The final model, therefore, contains measures for education, occupation, marital status, and the variables of theoretical importance, psychiatric impairment and patient status.

As Table 1 shows, when important social variables are controlled, the effect of patient status is in the expected direction and is stronger in its effect than psychiatric impair-
ment. The assessment of diagnosis was excluded because its effects were not significant either additively or in interaction with the patient status variable. This finding is important because it shows that the effect of the labeling variable holds, is of a relatively constant magnitude within diagnoses, and is, therefore, not specific to just one type of disorder. This may, of course, be due to the fact that there were too few former patients in the community sample and their diagnoses too widely spread to provide a powerful test. Of the twenty, 10 were neurotic, 4 had personality disorder, 1 was psychotic, and 5 had no diagnosis. For this reason it will be necessary to reassess the influence of diagnosis in subsequent analyses.

Even though the effect of patient status is significant at the .05 level for a one-tailed test (.10, two-tailed), this demonstration of its effect should not stand alone since there are very few patients (20) in the community sample, and therefore little variability on the patient status variable. In order to generate more confidence in the results, some means of increasing the number of patients in the analysis is necessary.

Given that the Washington Heights study includes a sample of clinic outpatients, it is possible to increase the number of individuals with the status of mental patient by combining the community and outpatient sample. The two samples are similar in terms of their diversity on important sociodemographic variables such as education, ethnicity, sex, and age, and in addition the clinics from which the patients were selected are located in the same general area as the one from which the community sample was drawn. They are, nevertheless, different samples drawn from different populations and thus pose problems when they are combined.

Result Set #2: The Effect of a Psychiatric Label on Income Using the Combined Community-Outpatient Sample

The results presented in this section are based on the same 229 individuals used in result set #1, plus all those individuals from the outpatient sample who were not in a psychiatric hospital during the year in which income was assessed and who had complete information on the income variable. This left 84 outpatients yielding a total sample of 313. It is important to note that joining these two samples not only accomplishes the desired increase in the variability of the patient status variable but also generates a problem by increasing the possibility of a "regression artifacts" bias. Regression artifacts refer to observed effects that are due to the phenomenon of regression to different group means (Campbell and Erlebacher, 1975; Cook and Campbell, 1979). Given this possible bias, two separate analyses are conducted using individuals from the combined sample.

The income of the most impaired community residents compared to the least impaired patients. Given a possible regression artifacts bias, one straightforward and convincing method of analysis is to deal separately with two carefully selected subsamples rather than with the entire combined sample. First, all patients who score three or lower on the impairment scale are selected and form one group. Then the most impaired community members, those who score three or higher, are selected to form a second group. The 33 patients selected in this manner have a mean impairment level of 2.33 and the 58 community members a mean of 3.44. This comparison of highly impaired community cases with less impaired patients has a bias against finding that patient status leads to lower income. Even if the individuals in the two subsamples regress toward their group mean, this selection of cases helps insure that any regression effects are corrected. This strategy is strengthened by the reliability of the impairment rating scale which is .84, indicating that regression effects due to unreliable measurement are not likely to be substantial.

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4 The possible influence of regression effects on the results of this study can be more adequately understood using the following diagram provided to me by one of the reviewers of an earlier draft of this paper.
The following analysis of covariance shows the results of the comparison of these two groups with education, occupation, and marital status entered as covariates. The comparison requires that the effects of the covariates on income do not differ between groups (i.e., patient versus nonpatient). This assumption was tested and found to hold. As Table 2 indicates, patient status has a significant effect on income. The adjusted means show that the labeling effect is a negative one even when the least impaired patients are compared to the most impaired community members.

The effect of a psychiatric label on income assessed by using LISREL. Another approach is based on the methodological innovations of Karl Joreskog and his colleagues which have recently been usefully applied within sociology (Long, 1976; Kohn and Schooler, 1978; Wheaton, 1978). These innovations are important for this analysis because they allow one to build measurement models of abstract concepts using observed "indicator variables." The latent variable measuring the abstract concept is shorn of the unreliable portion of the variability in each of the indicators since only that portion of the variance within each indicator that is consistent with another indicator is employed. The latent variable is therefore highly reliable. Since one of the most important reasons that regression effects emerge is the unreliability of measurement, the techniques developed by Joreskog and Sorbom (1978) are particularly attractive as approaches to the problem at hand.

In order to deal with problems of unreliability of measurement in the present assessment, a second indicator of psychiatric status is employed and a latent variable incorporated into the model. Two ratings, the Midtown Mental Health Rating which has been used thus far, and the Stirling County Caseness Rating are used. Diagnosis was also entered into the model but was subsequently dropped when its effects did not reach statistical significance. In this instance, with the addition of the outpatients, far greater variability on diagnosis was involved. Thus the finding, reported in Result set #1, which showed that a label has a relatively constant effect within diagnoses, is supported by this set of results as well. Table 3 presents the maximum likelihood solution obtaining when the parameters specified by the model are estimated.

The model employed in Table 3 fits the data well; the chi-square is .799 with 10 degrees of freedom yielding a probability level of .999 which is not significant. Given this result, it is possible to proceed to an examination of the hypothesis concerning the effect of a psychiatric label.

As Table 3 indicates, patient status has a significant independent effect on income, when psychiatric status and other important variables have been held constant. Furthermore, this model incorporates only the reliable portion of the two indicators of psychiatric status, thereby testing the hypothesis within the context of a model which reduces the chances of regression effect bias.

Result Set #3: The Effect of a Psychiatric Label on Work Status Using a Random Half of the Combined Community-Outpatient Sample

The analysis involving work status is important for two reasons. First, the finding that a psychiatric label has a negative impact on certain domains of a person's life will be strengthened if it can be replicated with a second dependent variable. Second, the measure of income is a measure of family resources and though marital status was entered to control for the effects of having two breadwinners, the argument will be stronger if a measure of individual functioning is employed as well.

The model explaining work status is developed using the 182 individuals randomly assigned to be interviewed using the Structured Interview Schedule (SIS), which contains questions concerning recent work history. The sample excludes community residents and clinic outpatients who had been hospitalized.

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5 This means that the model as postulated fits the data well. It is important to note that "fitting the data" does not guarantee the accuracy of the model. Indeed as Duncan (1972) and others (Costner and Schoenberg, 1973) point out, more than one model can fit the data. Nevertheless, when the model tends to fit the data, the investigator knows that no gross misspecifications have occurred and that he/she need not engage in corrective procedures aimed at increasing the fit of the model.
during the year immediately preceding the interview. Also excluded are respondents who had no record of ever being employed and therefore could not be expected to have their careers affected by either patient status or psychiatric condition. This left 126 cases for the analysis.

In developing the model, two independent variables, psychiatric condition and education, are included because of their theoretical importance. The inclusion of other variables was determined by their contribution to the explanation of variance in the work status variable. (Work status, it will be recalled, is a reliable composite measure of current employment status and recent work history.) Variables included in the analysis are sex, age, marital status, education, patient status, and psychiatric condition, while those excluded are ethnicity and diagnosis.

Once again the possible influence of "regression artifacts" must be considered. Therefore the analysis is conducted using Joreskog and Sorbom's techniques, and a latent reliable measure of psychiatric condition is employed using both Impairment and Caseness ratings. As Table 4 shows, the effect of patient status is significant in the expected direction. Other things equal, including psychiatric condition, the acquisition of the status of mental patient appears to have a negative impact on a person's chances of getting and keeping a job.

**Further Examination of Alternative Hypotheses**

The three sets of results reported above converge in indicating that a psychiatric label has a negative impact on the work-related aspects of an individual's life. This holds, even when psychiatric condition is held constant. While each set of results has weaknesses, they are different weaknesses in each case. Result set #1 is based on a small number of patient cases (20) but is less susceptible to the confounding of patient status with psychiatric condition as evidenced by the low (.09) correlation between them. Result set #2 contains more variability on the patient status variable and thus provides a stronger test of the hypothesis but is

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<table>
<thead>
<tr>
<th>Latent Variable</th>
<th>Standardized Direct Effect</th>
<th>Unstandardized Direct Effect</th>
<th>t-value</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measuring Psychiatric Condition</td>
<td>.101</td>
<td>.113</td>
<td>1.12</td>
<td>n.s.</td>
</tr>
<tr>
<td>Patient Status</td>
<td>.225</td>
<td>.815</td>
<td>2.38</td>
<td>.05</td>
</tr>
<tr>
<td>Sex (1=male, 0=female)</td>
<td>-.283</td>
<td>-.965</td>
<td>-3.38</td>
<td>.001</td>
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<tr>
<td>Education</td>
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<td>-.148</td>
<td>-1.01</td>
<td>n.s.</td>
</tr>
<tr>
<td>Age (in years)</td>
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<td>.020</td>
<td>1.55</td>
<td>n.s.</td>
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<tr>
<td>Marital Status</td>
<td>.204</td>
<td>.701</td>
<td>2.45</td>
<td>.05</td>
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</tbody>
</table>

* A high score indicates a disadvantaged work status.
Weakened because it deals with the only available income measure, family income. Result set #3 concerns a smaller sample than Result set #2 but uses an assessment of individual functioning, the work status measure. The fact that each set of results has different weaknesses and still shows that a label has pejorative consequences generates confidence in the validity of the results.

Despite the convergence of these results, however, there are still two interpretive issues to be considered. First, it is possible that unmeasured variables may account for the direct effect of patient status. One such variable is previous income. If people with low income are more likely to be labeled, as some labeling theorists might argue, and earlier income is strongly related to income as measured, it is possible that the direct effect of patient status would disappear upon entering earlier income into the model. Although this possibility cannot be definitely ruled out because earlier income has not been measured, it is weakened by the pattern of findings in Result set #1. While earlier income has not been measured, educational level has, and it is generally obtained before current income. In Result set #1, it is the more highly educated who are slightly more likely to have obtained the status of patient, as evidenced by a positive correlation of .150 between the two variables. If income and education are highly correlated, as they usually are, we would expect the same positive (or at least not a strong negative) relation between earlier income and patient status. If this reasoning is correct, it would be unlikely for earlier income to have the negative association with patient status that would be necessary to reduce the direct effect of patient status to near zero. While an alternative explanation involving earlier income is weakened by this reasoning, it is nevertheless possible. Also, it is possible that other unmeasured variables may affect the results in unknown ways, either weakening or strengthening the direct effect of patient status. As it stands, patient status has been shown to have a direct negative effect within the context of a number of the most important determinants of social position.

The second interpretive issue focuses on whether a label might be conceived as an outcome of psychiatric condition. In the analyses presented in this paper, psychiatric condition and patient status are considered simultaneously and the correlation between them is not analyzed causally. This particular strategy was adopted because such a wide variety of factors as public attitudes, the referral practices of "gatekeepers," and the availability of services all determine who enters treatment (Dohrenwend and Dohrenwend, 1969: 5–7).

Since it was not possible to specify these relationships in this analysis, it seemed wiser to consider both psychiatric condition and patient status as exogenous variables. However, one might argue that psychiatric condition is the cause of patient status, thereby postulating a different pattern of causal pathways and thus an altered interpretation of the results (see Figure 1).

Figure 1 proposes a different modeling and thus a somewhat different way of interpreting the results by postulating that psychiatric impairment causes a person to be labeled. If this is assumed to be true, it is possible to take the results a bit further by "decomposing" the effects (Alwin and Hauser, 1975) of impairment on income. If this is done for Result set #2, impairment has a direct negative effect on income of −.054 and an indirect effect through patient status of −.085, for a total effect of −.139. Patient status has only a direct effect of −.162, which incorporates the indirect effect of psychiatric condition. Given this modeling of relationships, the magnitude of the total effect of psychiatric condition is stronger because of the addition of its indirect effect through the variable of patient status. This interpretation is consistent with Gove's (1975) assertion that deviant labels result from deviant behavior. Labeling can then be thought of as an amplifier of the effect of psychiatric condition explaining how psychiatric condition comes to have an impact on work status and income. It is important to remember, however, that the effect of psychiatric condition must operate through patient status in order to have its effects on income. If individuals are not labeled, there is only a modest impact (the direct effect) of psychiatric condition on income. Also, if the effects of all of the variables in the model, including psychiatric condition, are removed from both patient status and income (or work status), a significant, unique association between the two remains.\(^6\) Both components, the

\(^6\) The concern is the variance in income and work status that is uniquely accounted for by patient status. The partial correlation between patient status and income, controlling for psychiatric condition, occupation, education, and marital status, is .157
effect of psychiatric condition through patient status and the unique effect of patient status, suggest the importance of labeling in producing negative consequences for those who are processed by the mental health system.

DISCUSSION

Implications for the Income Determination Literature

While the focus of this paper has been on the merits of a perspective which emphasizes the effects of labeling, the issue of how people come to earn more or less income has been touched upon as well (Jencks et al., 1972; Duncan, 1968; Coleman and Rainwater, 1978; Jencks et al., 1979). The conclusion that a psychiatric label affects an individual's income, and the arguments of a social psychological nature that indicate that this may involve the individual's perceptions of what others think of the label, suggest a more general point that has implications for our understanding of the process that determines who earns how much. If the process works as indicated for former mental patients, it may well be that similar consequences exist for other groups that have to wonder what others think of them such as blacks, exconvicts, people with a hare lip, and women. On the opposite side, inclusion in categories that are viewed positively in the wider society may engender the belief that one will be favored, thereby increasing confidence, and therefore success. This line of reasoning has been well developed in the formulations of those adhering to expectations-states theory (Berger et al., 1972; Berger et al., 1977) but has not been widely applied in the income determination literature. One of the important points emerging from this perspective is that the consequences of being in one or another category can be present even in the absence of outright discrimination or favoritism. In this way, large differentials between various segments of society may be maintained without the widespread incidence of direct discrimination (Yuchtman-Yaar and Semyonov, 1979). Furthermore, since the mechanism operates through the individual and since no concrete evidence of discrimination need be present, the problem may be inappropriately attributed solely to the character of the individual not only by others but by the person himself/herself. Again, the findings reported above are only suggestive in this regard, but they do indicate that those interested in why certain groups achieve more or less than others should be sensitive to the possibility that injustice may be maintained without direct discrimination.

Implications for the Labeling Perspective

Finally and most important, the findings reported in this paper have implications for the labeling perspective. They show that if we temporarily set the etiological issue aside, as has been done in this paper, and focus on the consequences of a label for other areas of an individual's life, we see that a label can have important consequences. As a result, it would be inappropriate to abandon the labeling perspective. Instead we must begin to question how a label influences dimensions of behavior not directly associated with the reason the individual was labeled in the first place. This sort of investigation can and should employ the kinds of insights that have characterized the labeling tradition, except that the major portion of concern should be temporarily shifted away from the question of the direct etiological role of a label. This shift will be important for two reasons.

First, it offers the possibility of furthering the development of a body of findings surrounding the idea that a negative label can have important consequences, many of which are pejorative in nature. In addition to being important in their own right, such investigations will speak to the major issue of just how important labeling processes are. If further empirical evidence shows that labels do have negative effects on various aspects of a person's life as the evidence in this paper indicates, then labeling hypotheses should be elaborated and attempts to specify just how such negative effects emerge should be undertaken.

Second, the eventual results of such a program of research offer the genuine possibility of developing a theory which assigns a partial role to labeling in the etiology of disorder. At the outset of this paper, I suggested that the consequences of a label could be implicated in 1) the creation of deviance, 2) the stabilization or maintenance of deviance, and 3) in areas of a person's life other than his or her deviance such as jobs, friendships, family relations, and mate selection. To this point, the empirical inquiry and the interpretation of the findings have been limited to the third type of consequence mentioned above. However, the findings have implications which transcend this domain and extend in interesting ways to the second type of consequence, the stabilization or maintenance of disorder. The reason is that

(significant at the .01 level with 307 d.f.). The partial correlation between patient status and disadvantaged work status, controlling for psychiatric condition, sex, marital status and education, is .182 (significant at the .05 level with 120 d.f.)

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a negative label, through a series of reinforcing conditions, seems likely to increase environmental stresses such as job loss or rejection by would-be marriage partners, reduce access to social supports, and generate a tentativeness and lack of confidence that undermines an individual's usual means of coping. If this is demonstrated by further research, a link will have been established between social reaction theory and main currents of inquiry into the etiology of disorder that have concerned themselves with stressful life events, social support, and coping ability. If a label and the social reactions it engenders place individuals at higher risk with respect to these domains, then it has increased their exposure to the kinds of conditions that environmentally oriented researchers have found to be most important in the etiology of mental disorder (Dohrenwend and Dohrenwend, 1981). In this way it is entirely possible that a psychiatric label does play a partial role in the maintenance of disorder and that a social reaction perspective can contribute in a meaningful way to the understanding of the development of chronic mental disorder.

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