The Rumpelstiltskin effect: therapeutic repercussions of clinical diagnosis

Alan Levinovitz,[1] Awais Aftab[2]

BJPsych Bulletin (2025) Page 1 of 5, doi:10.1192/bjb.2025.10137

[1]Professor of Philosophy and Religion, James Madison University, Harrisonburg, VA, USA; [2]Clinical Assistant Professor of Psychiatry, Case Western Reserve University, Cleveland, OH, USA

Correspondence to Awais Aftab (awaisaftab@gmail.com)

First received 22 Apr 2025, final revision 3 Jul 2025, accepted 14 Jul 2025

Summary Clinicians across medical disciplines are intimately familiar with an unusual feature of descriptive diagnoses. The diagnostic terms, despite their non-aetiological nature, seem to offer an explanatory lens to many patients, at times with profound effects. These experiences highlight a striking, neglected and unchristened medical phenomenon: the therapeutic effect of a clinical diagnosis, independent of any other intervention, where clinical diagnosis refers to situating the person's experiences into a clinical category by either a clinician or the patient. We call this the Rumpelstiltskin effect. This article describes this phenomenon and highlights its importance as a topic of empirical investigation.

Keywords Classification; sick role; medical ritual; hermeneutics; placebo.

Consider the following clinical scenario: a 42-year-old history professor seeks a psychiatric evaluation for dealing with low mood, anxiety and poor self-esteem. Despite a successful academic career, she feels that she has not lived up to her potential and her efforts have been plagued by a persistent inability to focus, a tendency to procrastinate and difficulty completing tasks without last-minute pressure. These struggles have been present since childhood but were dismissed by her parents and teachers as laziness, to be remedied via rigorous self-discipline. Over the years she internalised these judgements, developing a harsh and critical attitude towards herself.

During the initial psychiatric assessment, her psychiatrist identifies characteristic signs of attention-deficit/hyperactivity disorder (ADHD), a diagnosis that is subsequently supported by neuropsychological testing. When informed of the results, she expresses a sense of tremendous relief at finally having an explanation. The official diagnostic term, despite its merely descriptive nature, seems to offer an explanatory lens that she had previously lacked. The new lens, in turn, had a profound therapeutic effect with improvements in mood, anxiety and sleep.

This clinical anecdote is a composite one for illustration, but it captures a real and widespread effect of diagnosis. In a *New York Times* story about ADHD diagnoses in older adults, a woman diagnosed at age 53 described her reaction as follows: 'I cried with joy,' she said. 'I knew that I wasn't crazy. I knew that I wasn't broken. I wasn't a failure. I wasn't lazy like I had been told for most of my life. I wasn't stupid.'[1]

Clinicians in a variety of disciplines and settings see this dynamic play out in diverse diagnoses: tension headache, tinnitus, chronic fatigue syndrome, restless leg syndrome, insomnia disorder, irritable bowel syndrome, functional dyspepsia, chronic idiopathic urticaria and autism spectrum, to name but a few.

Their experiences highlight a striking, neglected and unchristened medical phenomenon:

The therapeutic effect of a clinical diagnosis, independent of any other intervention, where clinical diagnosis refers to situating the person's experiences into a clinical category by a clinician or the patient.

We call this the Rumpelstiltskin effect. In what follows, we show how this effect is predicted by a variety of cross-cultural tropes; lay out evidence for the effect, along with probable mechanisms of action; and suggest how clinical practice and research should address its existence.

The Rumpelstiltskin effect

In the classic Grimms' folk tale, *Rumpelstiltskin*, a young woman promises her first-born child to a little man in exchange for the ability to spin straw into gold. When he comes to collect, she begs for mercy and he offers her a way out. She must guess his name.

Now a queen, the woman runs through every name in the German language, as well as every colloquial nickname she can think of. None work. Finally, her servant discovers the little man's highly esoteric name – Rumpelstiltskin – and she is released from her obligation.

Crucially, the source of the queen's severe distress does not have a familiar name. Nor can she substitute a layperson's description such as 'funny little man'. Esoteric knowledge of an official name is required to gain control over what ails her. As soon as she knows the name, the problem takes care of itself.

This type of folk tale (Aarne–Thompson Tale Type 500) appears in numerous cultures. The details vary, but the theme is identical. Discover the esoteric name, control and destroy the source of suffering. Traditional exorcism works according to a similar principle. Ordinary terms exist for the afflictions attributed to demons: sloth, mendacity, gluttony and so on. However, when normal efforts to overcome sloth are inadequate, an exorcist is brought in. Discovering the demon's name is crucial to controlling it – not merely sloth, but Belphegor, the demon of sloth – which is why demonological treatises and exorcists spend so much time on names, from ancient China to modern England (see, for example – [2,3]). Other examples abound, from cultural practices of keeping true names secret to contemporary literature such as Ursula Le Guin's classic Earthsea book series, in which mages can control only what they correctly name.

This principle is also at work in modern medicine. If a clinical diagnosis can have a therapeutic effect, then, at least in some instances, diagnoses are medical interventions in themselves and ought to be treated and researched as such, with an eye to both positive effects and potential iatrogenic harms. Likewise, self-diagnosis should be understood as an attempt to secure the therapeutic effect of a medical intervention to which patients do not have official access. In what follows, we lay out evidence for the existence of the Rumpelstiltskin effect, along with hypotheses about the mechanisms responsible for it.

Evidence for the Rumpelstiltskin effect

While research directly investigating this phenomenon remains limited, multiple studies have examined the impact of medical diagnoses, revealing consistent themes that are in accordance with the Rumpelstiltskin effect as we have described it. A systematic scoping review by Sims et al[4] developed a thematic framework for understanding the effects of diagnostic labels, and identified five primary themes: psychosocial impact, support, future planning, behaviour and treatment expectations. The review found that diagnostic labels often provided individuals with feelings of relief, validation and empowerment. These labels helped remove uncertainty, facilitate communication and enhance self-understanding. Furthermore, the diagnoses frequently led to beneficial social connections through mentorship and support groups. Similarly, O'Connor et al[5] conducted a systematic review and thematic synthesis examining how psychiatric diagnoses affect young people. They found that the scientific authority inherent in the diagnostic label validated the authenticity of young people's struggles and recast them as legitimate medical conditions. This validation reduced self-blame, facilitated the formation of meaningful social identities and often led to improved social acceptance.

Other relevant research concerns the impact of how healthcare providers communicate with patients. In a notable randomised controlled trial, Thomas[6] studied patients with medically unexplained symptoms. The study revealed that patients showed greater improvement when their GP provided a firm diagnosis with a positive prognosis, compared with those who received neither. This improvement occurred regardless of whether patients received actual treatment. Savage and Armstrong[7] found that patients expressed higher satisfaction when doctors made definitive statements about diagnosis and treatment, rather than soliciting patient input in a more collaborative approach.

Evidence for the existence of a Rumpelstiltskin effect also comes from other lines of research. Clinicians are reporting higher rates of self-diagnosis, in part due to social media and the internet (see, for example, [8]). Since self-diagnosis does not typically provide access to medical interventions, one of the primary motivations for it is likely to be access to the therapeutic effect of the diagnosis itself.

We also have robust evidence demonstrating the power of the mind to affect psychological and somatic symptoms through the placebo and nocebo effects. If a purely psychological intervention – the placebo treatment – can produce changes in psychological and somatic symptoms, then it makes sense that another such intervention, namely the diagnosis, could also produce changes in psychological and somatic symptoms.

Possible mechanisms of effect

Clinical lens and hermeneutical breakthrough

Fundamentally, a clinical diagnosis invites patients to see their experiences through a medical lens. The medical interpretive framework recognises suffering in ways that everyday language often can not, because the latter tends to characterise problems as personal inadequacies. Clinical language is also more standardised than everyday language, which offers at least the appearance of a cohesive explanatory framework for a person's impairment.

The philosopher Miranda Fricker uses the example of postpartum depression to illustrate how the act of naming a phenomenon can serve as a transformative moment of understanding.[9] As anecdotal evidence, she quotes a woman describing her first encounter with postpartum depression as a medical diagnosis:

'In my group people started talking about postpartum depression. In that one forty-five-minute period I realised that what I'd been blaming myself for, and what my husband had blamed me for, wasn't my personal deficiency. It was a combination of physiological things and a real societal thing,

https://doi.org/10.1192/bjb.2025.10137 Published online by Cambridge University Press

isolation. That realisation was one of those moments that makes you a feminist forever.' (p. 149)[9]

Fricker reflects on this moment as an instance of what she terms hermeneutical injustice – a wrong done to someone in their capacity as a knower, due to a collective lack of conceptual resources necessary to make sense of their experiences. The lack of a recognised concept for postpartum depression created a 'hermeneutical darkness', a gap in collective understanding that deprived individuals of the ability to fully comprehend their experiences.

A diagnosis functions not only as a medical label but also as a social tool for making comprehensible previously unarticulated suffering. Feeling understood, by oneself and others, is a psychological good that could contribute to the Rumpelstiltskin effect. The official name serves as a bridge between individual experiences and generalised patterns. In other words, it allows for a transition from an idiographic approach to an individual's contingent and contextual difficulties to a nomothetic approach offering the best fit to a clinical prototype.[10,11] Additionally, diagnoses provide patients with a shared language that facilitates communication with healthcare providers and connects them to supportive communities of individuals facing similar challenges. These communities facilitate a strong sense of shared identity, which can relieve stigma and empower members through participation in shared advocacy goals, as seen within the neurodiversity movement.

Learned associations, the power of rituals and the sick role

The act of diagnosis is, in most cases, a prelude to medical care and treatment. Another mechanism at play in the Rumpelstiltskin effect may be an acquired association between the naming of a condition in a medical context and the promise of relief and access to the 'sick role'.[12] When a patient receives a diagnosis, it offers hope and reassurance. The association can continue to play out even in situations where a diagnosis is made but treatment is not sought or none is available.

This process is further amplified by the power of culturally sanctioned rituals. Diagnostic terms are ritualised constructs imbued with institutional authority. When a condition is officially named by a specialist, it acts as a conditioned stimulus, evoking an expectation of care and recovery that has deep roots in human societies. The anticipatory relief would be particularly effective within cultural contexts that position medical diagnoses as authoritative and transformative.

However, it is important to note that the anticipatory benefits of diagnosis are not universal. For some patients, a diagnosis can evoke fear or stigma, especially if the condition is chronic, poorly understood or socially marginalised. In other cases, the initial therapeutic impact may diminish if the anticipated benefits – such as effective treatment or social support – fail to materialise. The effects of a medical diagnosis are not universally good or benign. Seeking it or relying on it can lead to undesirable consequences that are typically associated with overmedicalisation. Of particular concern for descriptive diagnoses are worries around patients' misunderstanding of the clinical label as referring to a distinct aetiological process or a permanent identity.

Relief from cognitive ambiguity

Receiving a diagnosis resolves the cognitive ambiguity that attends unexplained suffering. Patients with undiagnosed problems frequently struggle with confusion and have difficulty communicating their experiences to others, and even to themselves. A descriptive diagnosis provides a prototypical explanation that alleviates these difficulties. Although it does not offer an aetiological answer, descriptive diagnosis functions as a framework that organises disparate symptoms into a legible and standardised pattern: a recognised problem shared by people across the world with core symptoms that have been described in textbooks and studied by experts.

A diagnosis alleviates uncertainty by introducing a categorical label around which a narrative can be built. Human beings are narrative creatures; we understand ourselves and our world through the stories we tell. A diagnosis gives patients the tools to construct a story that explains their suffering and renders it comprehensible. Relief of uncertainty and distress may also be related to the phenomenon of affect labelling. Putting feelings into words can help manage negative emotional experiences, and it has been hypothesised that affect labelling does so by diminishing emotional reactivity.[13]

Interestingly, we see this potential mechanism in the origins of the Rumpelstiltskin story. The etymology of the little man's strange name is typically traced to a German household imp, 'little rattle stilt', who was blamed for unexplained noises and mysterious movement of objects. This esoteric name is actually an explanation of the otherwise inexplicable.

Diagnosis and iatrogenic harm

While the focus of the Rumpelstiltskin effect, and hence our discussion, is the positive effects of a clinical diagnosis, we do want to acknowledge the potential harms of diagnosis. The systematic reviews by both Sim et al[4] and O'Connor et al[5] report the risks, along with the benefits, of diagnosis. A diagnosis can threaten and devalue a person's self-identity and can lead to social alienation, invalidation, stigmatisation and detrimental behavioural modifications. Patients can interpret their moods, thoughts and actions through the lens of a diagnostic category in a manner that is expansive and unwarranted. A diagnosis also makes one vulnerable to iatrogenic harm from clinical treatments. We previously speculated that the Rumpelstiltskin effect may have a relationship with the placebo effect in medicine. Similarly, many of the harms described above may also be conceptualised as being related to the nocebo effect.

Particularly worrisome is when patients internalise the idea that their diagnosis identifies a chronic, intrinsic

https://doi.org/10.1192/bjb.2025.10137 Published online by Cambridge University Press

deficiency, which can foreclose on agency and turn diagnosis into a self-fulfilling prophecy. For instance, a diagnosis of an anxiety disorder could lead a person to engage in more avoidance behaviours, mistakenly believing that they will be overwhelmed, with the avoidance creating a vicious cycle of persisting anxiety.[8]

Diagnostic categories, especially in psychiatry, carry a fraught cultural heritage. Stigma is well documented and reflected in patterns of discrimination in employment, healthcare, housing and beyond.[14] Friends, family and acquaintances can shift their expectations, inadvertently creating alienation. 'Looping effects', described by the philosopher Ian Hacking, are also relevant to these concerns.[15] A psychiatric diagnosis can alter a person's behaviours, self-understanding and how they describe and report their symptoms. Individuals and institutions may in turn respond to them differently, reinforcing those changes. In addition, insidious harm often comes from internalised stigma. Despite providing short-term relief, a diagnosis can become a long-term source of shame, curtailing self-worth and relational openness. In some cases, it can lead to clinical disengagement precisely at the moments when a therapeutic connection is most needed.

Disagreement about the implications of an official diagnostic name can also lead to problems. Typically, clinicians approach suffering through a negative model in which suffering is seen as having little intrinsic value and requires alleviation. But suffering can also be viewed positively, as having the capacity to play a redemptive role or produce unexpected gains.[16] Given the tendency to understand diagnoses in terms of dysfunction and deficit, those who prefer to view their experiences as dangerous gifts or spiritual transformations may find that these authoritative names impose an undesired and unhelpful narrative on their lives – an especially important consideration with psychiatric diagnoses.[17]

Implications for clinical practice and suggestions for future research

If the Rumpelstiltskin effect is indeed a clinically significant feature of some diagnoses, clinicians should be mindful of its role in a number of ways. After diagnosing a patient and beginning a treatment plan, it is important to consider that the treatments may account for only part of the patient's improvement, because the mere fact of being diagnosed might also be a factor. When patients exhibit a desire for a particular diagnosis during a clinical interaction, clinicians should be sure to make space to explore the role that diagnosis would play for the patient, potentially touching on the mechanisms we lay out here to determine whether they apply to the patient's interest in diagnosis.

However, responsible clinical practice must be informed by a robust evidence base. Since the Rumpelstiltskin effect has never been officially identified, there is a striking lack of both qualitative and quantitative research directly examining the phenomenon. Such research is essential, and we see a number of promising areas in which to address this. First, qualitative research should investigate patient perspectives on the meaning of official diagnosis, clarifying how they understand the shift from ordinary descriptive language to a descriptive diagnosis, as well as whether and how they perceive the diagnosis affecting their symptoms. Likewise, there should be qualitative investigation into the perspectives of medical professionals on the efficacy and ethics of diagnosis as intervention, as well as their perceptions of the mechanisms of effect.

Quantitative research would help to clarify how clinician and patient perspectives align with effect sizes in various populations and clinical contexts. Parallels between the placebo effect and the Rumpelstiltskin effect are likely, which means that a promising area of research would be the relationship between the two, as well as salient similarities and differences between how they work.[18,19] Some of the mechanisms we have previously discussed for the Rumpelstiltskin effect, such as learned associations, expectations and power of rituals, are also implicated in the placebo effect. Existing research on the magnitude of placebo response may also have relevance for the magnitude of the Rumpelstiltskin effect.[20,21] Finally, both quantitative and qualitative research is essential for illuminating the extent to which rising rates of self-diagnosis can be explained by the effect.

This research programme will surely yield many surprises, requiring adjustments on the part of clinicians and patients alike. And, if the Rumpelstiltskin effect is as important and widespread as we believe, both the research and the adjustments will improve the welfare of patients and point us in promising new directions for clinical practice.

Acknowledgements

We thank the two anonymous peer-reviewers of our article for their comments and contributions. One of the reviewers suggested the example of Ursula Le Guin's Earthsea books, which we ended up including in the paper. We also thank Dr Lawrence Haber for pointing out relevant non-psychiatric diagnoses that exhibit this effect.

About the authors

Alan Levinovitz, PhD, is Professor of Philosophy and Religion at James Madison University, Harrisonburg, VA, USA. **Awais Aftab**, MD, is Clinical Assistant Professor of Psychiatry in the School of Medicine at Case Western Reserve University, Cleveland, OH, USA.

Data availability

Data availability is not applicable to this article as no new data were created or analysed in this study.

Author contributions

A.L. conceived of the project, and A.L. and A.A. jointly researched, wrote and revised the article.

Funding

This research received no specific grant from any funding agency, commercial or not-for-profit sectors.

Declaration of interest

None.

https://doi.org/10.1192/bjb.2025.10137 Published online by Cambridge University Press

References

1 Caron C. A.D.H.D. *Diagnoses are Surging among Older Americans*. The New York Times, 2024 (https://www.nytimes.com/2024/12/11/well/mind/adhd-diagnosis-older-middle-age.html [cited 14 April 2025]).

2 Lai C-T. The 'Demon Statutes of Nüqing' and the problem of the bureaucratization of the netherworld in early Heavenly Master Daoism. *T'oung Pao* 2002; **88**: 251–81.

3 Rowan K. 'Who are you in this body?': identifying demons and the path to deliverance in a London Pentecostal church. *Lang Soc* 2016; **45**: 247–70.

4 Sims R, Michaleff ZA, Glasziou P, Thomas R. Consequences of a diagnostic label: a systematic scoping review and thematic framework. *Front Public Health* 2021; **9**: 725877.

5 O'Connor C, Kadianaki I, Maunder K, McNicholas F. How does psychiatric diagnosis affect young people's self-concept and social identity? A systematic review and synthesis of the qualitative literature. *Soc Sci Med* 2018; **212**: 94–119.

6 Thomas KB. General practice consultations: is there any point in being positive? *Br Med J (Clin Res Ed)* 1987; **294**: 1200–2.

7 Savage R, Armstrong D. Effect of a general practitioner's consulting style on patients' satisfaction: a controlled study. *BMJ* 1990; **301**: 968–70.

8 Foulkes L, Andrews J. Are mental health awareness efforts contributing to the rise in reported mental health problems? A call to test the prevalence inflation hypothesis. *New Ideas Psychol* 2023; **69**: 101010.

9 Fricker M. *Epistemic Injustice: Power and the Ethics of Knowing*. Oxford University Press, 2007.

10 Aftab A, Ryznar E. Conceptual and historical evolution of psychiatric nosology. *Int Rev Psychiatry* 2021; **33**: 486–99.

11 Aftab A, Banicki K, Ruffalo ML, Frances A. Psychiatric diagnosis: a clinical guide to navigating diagnostic pluralism. *J Nerv Ment Dis* 2024; **212**: 445–54.

12 Parsons T. The sick role and the role of the physician reconsidered. *Milbank Mem Fund Q Health Soc* 1975; **53**: 257–78.

13 Lieberman MD, Eisenberger NI, Crockett MJ, Tom SM, Pfeifer JH, Way BM. Putting feelings into words: affect labeling disrupts amygdala activity in response to affective stimuli. *Psychol Sci* 2007; **18**: 421–8.

14 Van Brakel WH. Measuring health-related stigma—a literature review. *Psychol Health Med* 2006; **11**: 307–34.

15 Hacking I. *The Social Construction of What?*. Harvard University Press, 1999.

16 Davies J. The rationalization of suffering: contrary narratives of emotional discontent interplay in complex ways. *Harvard Divin Bull* 2011; **39**: 48–56.

17 Huda AS. Positive models of suffering and psychiatry. *BJPsych Bull* 2025; **49**: 49–51.

18 Frisaldi E, Shaibani A, Benedetti F. Understanding the mechanisms of placebo and nocebo effects. *Swiss Med Wkly* 2020; **150**: w20340.

19 Petrie KJ, Rief W. Psychobiological mechanisms of placebo and nocebo effects: pathways to improve treatments and reduce side effects. *Ann Rev Psychol* 2019; **70**: 599–625.

20 Khan A, Kolts RL, Rapaport MH, Krishnan KR, Brodhead AE, Browns WA. Magnitude of placebo response and drug-placebo differences across psychiatric disorders. *Psychol Med* 2005; **35**: 743–9.

21 Bschor T, Nagel L, Unger J, Schwarzer G, Baethge C. Differential outcomes of placebo treatment across 9 psychiatric disorders: a systematic review and meta-analysis. *JAMA Psychiatry* 2024; **81**: 757–68.

https://doi.org/10.1192/bjb.2025.10137 Published online by Cambridge University Press