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On the Tyranny of Professional Labelling

JAMES HORLEY, University of Alberta

ABSTRACT *The psychodiagnostic labels that mental health professionals apply to their clients can have significant, negative impacts. Clients can suffer serious harm not just through internalization of the construct but through social reaction to the label. The specific construct of psychopathy is used to demonstrate some of the unpleasant albeit unintended effects of professional labelling. A few recommendations to avoid damaging diagnostic labels are provided. Copyright © 2011 John Wiley & Sons, Ltd.*

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> True or false, that which is said of men often occupies as important a place in their lives, and above all in their destinies, as that which they do. (Hugo, 1887, 1)

INTRODUCTION

Labels matter. Labels or names affect all of us throughout our waking lives as we attempt to determine what we can or cannot do, feel or do not feel, think or do not think. As much as we might tell ourselves and others that names cannot hurt us, they can hurt and hinder as much as heal and help.

It seems to matter little whether the process of labelling occurs in the schoolyard, on the factory floor, or at home. There are, however, certain social actors who are able to label others with particular potency. Significant others, particularly friends and family, as well as numerous individuals we know and respect, can be responsible for powerful labels, good and bad. One source of personal labels includes professionals, especially physicians and mental health workers, who we turn to in times of need. Psychologists, psychometrists, psychotherapists, psychiatrists, counsellors, and social workers are in a position of social power with respect to vulnerable clients who are often in search of psychosocial predicates to understand better their personal conditions. Unfortunately, despite the best of intentions, mental health workers can employ predicates in a damaging fashion.

Social scientists have described and documented labelling effects from various perspectives. Becker (1963) presented a social response theory of deviance, where the social labelling of an anomalous/non-normative specific behaviour or course of action can and does allow an individual to be described as deviant. Becker's focus was on 'minor deviants' such as marijuana smokers but Sarbin (1967), following a similar line of thinking, argued that those individuals

Correspondence: James Horley, Department of Social Sciences, Program in Crime and Community, Augustana Faculty, University of Alberta, Camrose, Alberta, Canada T4V 2R3.
E-mail: jhorley@ualberta.ca

who behave in very strange, chronic manners are likely to be described as 'crazy' or 'mentally ill'. For Sarbin, this does not mean that craziness or mental illness exists except insofar as some people are placed into such a category and treated differently, often stigmatized and discriminated against. Indeed, Szasz has argued for years that use of various terms under the heading 'mental illness' is nothing more than an attempt by social authorities to ostracize those plagued by problems in living (e.g. see Szasz, 1974). Scheff, too, saw the imposition of a 'sick role' on those described as psychiatrically disabled through various social means, including court decisions and psychiatric ward placement (Scheff, 1964), as key to subsequent psychological symptoms. More recently, a number of researchers and psychotherapists have argued along similar lines, although frequently from rather different theoretical positions, against the use of terms like mental illness or related labels (e.g. Raskin and Epting, 1993).

The impact of a more limited set of labels, the psychodiagnostic terms of the *Diagnostic and Statistical Manual* (DSM; see American Psychiatric Association, 2000), has been considered by a number of writers. Caplan (1995) has condemned the entire effort of the American Psychiatric Association (APA) since the first appearance of the manual (American Psychiatric Association, 1952). She cites, among other problems, the rather limited perspective of the DSM organizing committee that leads to certain groups (e.g. women, the poor) being over-pathologized. Verhaeghe (2004), too, has criticized the direction of the DSM in terms of pursuing only observable symptoms. For Verhaeghe, the approach of the APA promotes conformity in patients via negative labelling of the expressions of their underlying psychological disturbances, and no linkages to therapies are provided by the approach. Indeed, there is some evidence that DSM labelling has a negative impact on the psychotherapeutic process (Honos-Webb and Leitner, 2001).

Like Verhaeghe (2004) although for somewhat different reasons, the personal and social impact of certain psychodiagnostic labels worry me. Self-acceptance of some constructs – those from the first two axes of the current DSM (American Psychiatric Association, 2000) are a prime example – can have a bearing upon subsequent behaviour, generally for the worse. Even if such labels are rejected the mere use of the terms to describe a person can have significant social consequences. Consideration will be limited here to a single construct – psychopathy – in order to focus the discussion. Psychopathy is a concern to me as a forensic psychologist not only because it is 'alive and well' (Patrick, 2003, 605) but because it seems poised to become a foundation of contemporary forensic research, despite the objections of some forensic psychologists who see problems with the label on a number of fronts (e.g. see Werlinder, 1978; Arrigo and Shipley, 2001; Gendreau et al., 2002; Walters, 2004; Horley, 2008).

INTRAPERSONAL CONSEQUENCES OF LABELLING

Psychopathy is a term that may well date to the early 19th century, but it is one that has become popular only during the late 20th century, and not in any clear and consistent fashion (Werlinder, 1978; Arrigo and Shipley, 2001). Long gone are the days when psychopathy was a term used synonymously with psychopathology. The meanings of the term now are complex and depend on the specific profession, professional training, and perhaps politics of the user. Psychopathy, however, is never used in a positive fashion. Psychopaths are evil, deadly monsters who lack a conscience and prey on humans, and they suffer from either an immature neurological nature or at least some form of biogenetic anomaly (Cleckley, 1941;

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Hare, 1970, 1993; Lalumiere et al., 2001). It is a term that tends to be used interchangeably with antisocial personality disorder (APD; American Psychiatric Association, 2000) and sociopathy despite some acknowledged differences – differences that a few clinicians and researchers are working hard to eliminate (see Hare et al., 1991).

The extremely pejorative meanings of *psychopathy* are well known to the general public through popular writings, including the popular writings of forensic psychologists (e.g. Hare, 1993). Forensic clients who are diagnosed or labelled as APD or psychopathic appear to me well aware of the negative aspects of such terms. From my interviews over 25 years with thousands of clients, the most common views of their so-called psychopathic characteristics include 'born bad', 'damaged', 'dangerous', 'rotten bastard', 'emotionless', 'pathological liar', 'don't care for others', and 'completely fucked up'. Generally, they see their prospects as bleak because 'there's no cure' in part due to 'it's in the genes'. Some, to be sure, are not so grim in their personal assessment, and they seem to embrace the label of psychopath – they 'knew' that there was something different or 'wrong' with them and such a diagnosis confirmed their suspicions. It also allowed them to pursue their lives of murder and mayhem because 'this is who I am, I can't change'. Much of my effort in psychotherapy with such an individual involves challenging such a notion or, at the very least, that it describes the client in any meaningful manner. My first question is often 'So what does "psychopath" mean to you?' and the answer is often a quizzical look or a return question such as 'Don't you know?' or perhaps 'You're the shrink, right? You tell me!' The quandary that I face, and other therapists who attempt to defeat the impact of such labels must deal with as well, is that it is our profession which is providing these labels, this self-knowledge. We must argue against ourselves, our own colleagues, to say in effect 'Forget what these other respected individuals have told you, perhaps over years'. It appears that such labels or self-constructions (Kelly, 1955) – information about the self which is very powerful and reassuring, hence positive (see Horley, 2008) – can become self-fulfilling for many individuals. Many resist with good reason my attempts, no doubt construed as daft by many clients, to claim that they are not truly what they have been told they are. After all, they can argue, the diagnosis is confirmed by their life of crime and causing pain to all those around them for many years, despite my attempts to suggest that the terms are only applied after considering their personal criminal and antisocial histories. Very few of my clients come into therapy with me questioning their psychodiagnoses, but the ones who do wonder, however timidly and tentatively, are often the individuals who I see turn their lives around, not only for a few weeks or months but over the long term. Their rejection of limiting and negative self-definition allows them to construct a more successful self-identity – one that is not doomed by the constraints of such notions as 'psychopath'.

Given the possible, harsh personal consequences of such labels as 'APD' or 'psychopath', why would any clinician employ such terminology? I would not accuse any of my colleagues of being deliberately nasty or simply sadistic, although some forensic clinicians no doubt are less then effective therapeutically from years of working with less than ideal clients in working conditions that can only generously be described as less than ideal. There are likely many reasons for the use of harmful labels. Unquestionably some forensic mental health workers believe in psychiatric nosologies like the DSM, despite the lack of precision and reliability that almost all established systems demonstrate, because they believe in a variety of perceived benefits. Parsimony is one perceived benefit: busy clinicians overloaded with

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overwhelming caseloads need to be able to assess clients quickly and impart the results briefly. With unclear meanings associated with many diagnoses like APD and psychopathy, however, this benefit seems more illusory than real. Many of us deal regularly with dangerous individuals who deceive and who appear to lack any remorse or concern for their victims; but can we expect a single label to convey precisely how dangerous we truly feel they are and in what manner? How much of a sentence do we feel a judge or jury should impose on a convicted felon? By the time the details of any assessment are spelled out for a court, an agency, or another clinician, the addition of a diagnostic label is likely unnecessary unless another purpose is to be addressed.

Unfortunately, I fear that a label like 'psychopath' serves a number of other purposes. For some therapists, it may allow for hedging of bets, as in 'I think this individual responded to my efforts over the past several months (years), but I'm not sure so I'd better point out that he is a psychopath after all, and we all know that they respond poorly to treatment.' It may also be the case, especially when a simple assessment with no treatment is conducted, that use of the term is a way, via the self-fulfilling nature of the label, that a client called a psychopath and given a very poor prognosis actually demonstrates the anticipated outcome. No doubt such a reason for employing such labels is less than conscious.

Naturally, a simple explanation for using such labels is that it reflects the reality that some individuals are simply 'born bad' and remain bad until the day they die, and the label simply reflects this innate badness. This is certainly what theorists like Eysenck (1964) concerned with criminal conduct across the lifespan with a heavy biological emphasis would have us accept. The evidence, however, appears to suggest that such a simple view of human nature is untenable. Even prominent researchers within the field of psychopathy point out that there is not consistency across the lifespan because there is a marked decrease in criminal activity between the ages of 35 and 45, the so-called 'psychopathic burn-out' (Hare, 1970, 1993). Why apply a static designation to an individual who can or perhaps will alter his/her behaviour? Once applied, it is very difficult to obliterate the name. Far too many people, professional and public, accept the saw 'Once a psychopath always a psychopath'.

SOCIAL IMPACT OF LABELS

Even if clients resist labels like 'psychopath', there are still the social consequences of being called a psychopath. These consequences remain less than clear, but they appear to be profound from the little research that has been done to date.

There is more than anecdotal evidence that the diagnosis of psychopathy has a clear impact on triers-of-fact in criminal cases. Some research conducted in Texas (e.g. Edens *et al.*, 2005) has assessed the impact of a psychopathy diagnosis on jurors considering capital punishment. When a defendant convicted of a capital crime is described as an 'incurable psychopath', jury members are much more likely to recommend the death penalty (Edens et al., 2005), even when the individual is a juvenile (Edens et al., 2003). Jurors also appear to recommend harsh penalties in 'sexually violent predator' cases when the defendant is described as psychopathic (Guy and Edens, 2003, 2006). The research conducted to date, however, is not only limited by being based in Texas, but the methodology has been limited to simulation research. Further research also needs to examine the impact on triers-of-fact in non-capital offences, including offences involving assault.

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One rather sad episode involving the effects of psychopathy remains clearly in mind for me. A mother of one of my clients, a teenager who was incarcerated for an inappropriate sexual relationship with a younger sister, contacted me and asked if I had found her son to be a psychopath. I explained that her son, a heavy drug user who displayed a very tenuous grip on consensus reality, displayed none of the behaviours typically ascribed to psychopathy. She insisted on me testing him – indeed, she even told me what test to use – and she was very disappointed when I held my ground and denied her demand. As I was informed later by a community-based therapist who treated her son on release, the mother had pursued him with the same request and even became very belligerent when he declined to assess for psychopathy. I wondered why a mother would insist that her son – her only son in this case – was a psychopath so I investigated further. It turned out that he had threatened her life with a kitchen knife just prior to his incarceration and, while she declined to press charges, she was now afraid for her life. Despite her concern for her son, or perhaps because of it, she wanted him labelled a psychopath by officialdom probably because she expected a much longer sentence, or perhaps just closer police protection, with such a label. A psychopathy diagnosis provided her with a means of protecting herself and her family.

One of the social consequences of a diagnosis of psychopathy, and to some extent APD, is diminished access to treatment resources, and it may well spell no treatment for some individuals. Clinical lore at present tends to suggest that treatment is ineffective for antisocial individuals. Some researchers have reported that treatment is ineffective for psychopathy, even making them more likely to reoffend criminally (Rice et al., 1992), although more recent reviews tend to be a little less pessimistic, but only a little (see Harris and Rice, 2003). Certainly my training involved a healthy dose of fear of psychopathic clients. One forensic psychiatrist, a family friend who had all but retired from private practice, sat me down one night to fill me in on the perils of working with offenders, the police, and the courts. When I asked about a private civil suit that he had mentioned only briefly, he told me that he was being sued for malpractice by a former client but that it was entirely his own fault because he knew the man was 'an extreme psychopath' before entering into therapy with him. The message that he gave me loud and clear was to avoid psychopathic clients like the plague unless I wanted to waste time, energy, and money, likely ending up in court or a public inquiry. Trouble awaits any clinician foolish enough to attempt to treat a psychopath!

CONCLUSIONS AND RECOMMENDATIONS

We need to stop calling our clients names. It can be iatrogenic. However well intended, labels such as 'psychopath' place limits to change and to improvement on clients to the extent that they internalize our professional constructs. Even if they reject our terms, they might still have to live with the consequences of the labelling process through social reaction to publication of the particular name. The social impact of labelling an individual psychopathic seems to be ignored by many specialists, including Hare (1993), who claim to be concerned with the ethics of labels. Their concern about labelling, however, is limited to accurate labelling, although some (e.g. Edens and Petrila, 2003) thankfully do go beyond a concern with accuracy to a concern with, for example, the immediate impact of labels on juveniles and pre-pubescent individuals. Ethical issues surrounding labels should not concern accuracy, whatever that might refer to in the case of such a contentious and ephemeral notion

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as psychopathy, but it should concern harm or potential harm to clients. The potential damage of labels like 'psychopath' appears to outweigh any possible benefits.

Is it possible to avoid labels while performing our assessment or diagnostic duties? The short answer is 'Naturally!' but the solutions may not be as straightforward as the response. First and foremost, we can reject completely certain systems, such as the DSM, that employ particularly pernicious constructs. Some students when presented with this option react in horror. How could they possibly obtain or retain employment adopting this strategy? My response, only partially facetious, is that there is often a cost to defending personal principles, but I do suggest strongly that the potential benefits more than compensate for any costs. Assessment or treatment reports of non-labellers may be longer than those of labellers, but the clarity purchased at the cost of a longer report should be worth the additional verbiage. If nothing else, the client should be left in a much better position of knowing what issues need to be addressed, and much more likely to have hope that the change necessary can occur.

Kelly (1955, 1969) had a novel and useful approach to clinical assessment. He suggested using 'transitive diagnosis … [to avoid any] nosological pigeonhole' (Kelly, 1955, 775). A transitive diagnosis is a dynamic statement of the important issues at hand in therapy in order to help a client look for 'bridges between the client's present and his future' (Kelly, 1955, 775). A diagnosis that changes constantly, as the client changes, avoids the trap of being pre-emptive by trying to place an active, struggling client into a box formed by a traditional nosological category. Of course, such an approach requires a dynamic theory, such as the one proposed by Kelly (1955, 1963, 1970) who viewed all individuals as personal scientists. As Bannister (1979) noted of Kelly's theory and model, it is one of the few that attempts to set aside the social power of therapists by proposing that clients, like their therapists, are on an equal footing, both functioning like scientists. An egalitarian theory, avoiding distinctions between we-as-psychotherapists and them-as-patients, is perhaps a good starting point to ending harmful labelling effects.

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REFERENCES

American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders. Washington, DC: American Psychiatric Association, 1952.

American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders: Text Revision (4th edn). Washington, DC: American Psychiatric Association, 2000.

Arrigo BA, Shipley S. The confusion over psychopathy: historical considerations. International Journal of Offender Therapy and Comparative Criminology 2001; 45: 325–44.

Bannister D. Personal construct theory and politics. In I Stringer and D Bannister D (eds) Constructs of Sociality and Individuality. London: Academic Press, 1979; 21–34.

Becker HS. Outsiders: Studies in the Sociology of Deviance. New York: Free Press, 1963.

Caplan P. They Say You're Crazy: How the World's Most Powerful Psychiatrists Decide Who's Normal. New York: Addison-Wesley Longman, 1995.

Cleckley H. The Mask of Sanity: An Attempt to Clarify some Issues about the So-Called Psychopathic Personality. St Louis, MO: Mosby, 1941.

DOI: 10.1002/ppi

Edens JF, Petrila J. Legal and ethical issues in the assessment and treatment of psychopathy. In CJ Patrick (ed.) Handbook of Psychopathy. New York: Guilford, 2003; 573–88.
Edens JF, Guy LS, Fernandez K. Psychopathic traits predict attitudes toward a juvenile capital murderer. Behavioral Sciences and the Law 2003; 21: 807–28.
Edens JF, Colwell LH, Desforges DM, Fernandez K. The impact of mental health evidence on support for capital punishment: are defendants labelled psychopathic considered more deserving of death? Behavioral Sciences and the Law 2005; 23: 603–25.
Eysenck HJ. Crime and Personality. London: Routledge & Kegan Paul, 1964.
Gendreau P, Coggin C, Smith P. Is the PCL-R really "unparalleled" measure of offender risk? A lesson in knowledge accumulation. Criminal Justice and Behavior 2002; 29: 397–426.
Guy LS, Edens JF. Juror decision-making in a mock sexually violent predator trial: gender differences in the impact of divergent types of expert testimony. Behavioral Sciences and the Law 2003; 21: 215–27.
Guy LS, Edens JF. Gender differences in attitudes toward psychopathic sexual offenders. Behavioral Sciences and the Law 2006; 24: 65–85.
Hare RD. Psychopathy: Theory and Research. New York: Wiley, 1970.
Hare RD. Without Conscience: The Disturbing World of the Psychopaths among Us. New York: Guilford, 1993.
Hare RD, Hart SD, Harpur TJ. Psychopathy and the DSM-IV criteria for antisocial personality disorder. Journal of Abnormal Psychology 1991; 100: 391–8.
Harris GT, Rice ME. Treatment of psychopathy: a review of empirical findings. In CJ Patrick (ed.) Handbook of Psychopathy. New York: Guilford, 2003; 555–572.
Honos-Webb L, Leitner LM. How using the DSM causes damage: a client's report. Journal of Humanistic Psychology 2001; 41: 36–56.
Horley J. Sexual Offenders: Personal Construct Theory and Deviant Sexual Behaviour. Hove, UK: Routledge, 2008.
Hugo V. Les Miserables. New York: Thomas Y. Crowell, 1887.
Kelly GA. The Psychology of Personal Constructs (2 vols). New York: Norton, 1955.
Kelly GA. A Theory of Personality: The Psychology of Personal Constructs. New York: Norton, 1963.
Kelly GA. The role of classification in personality theory. In B Maher B (ed.) Clinical Psychology and Personality: The Selected Papers of George Kelly. New York: Wiley, 1969; 289–300.
Kelly GA. A brief introduction to personal construct theory. In D Bannister (ed.) Perspectives in Personal Construct Theory. London: Academic Press, 1970; 1–29.
Lalumiere ML, Harris GT, Rice ME. Psychopathy and developmental instability. Evolution and Human Behavior 2001; 22: 75–92.
Patrick CJ. Back to the future: Cleckley as a guide to the next generation of psychopathy research. In CJ Patrick (ed.) Handbook of Psychopathy. New York: Guilford, 2003; 605–12.
Raskin JD, Epting FR. Personal construct theory and the argument against mental illness. International Journal of Personal Construct Psychology 1993; 6: 351–69.
Rice ME, Harris GT, Cormier C. An evaluation of a maximum security therapeutic community for psychopaths and other mentally disordered offenders. Law and Human Behavior 1992; 16: 399–412.
Sarbin TR. On the futility of the proposition that some people be labeled 'mentally ill'. Journal of Consulting Psychology 1967; 31: 447–53.
Scheff TJ. Social conditions for rationality: how urban and rural courts deal with the mentally ill. American Behavioral Scientist 1964; 7: 21–7.
Szasz TS. The Myth of Mental Illness: Foundations for a Theory of Personal Conduct (rev. edn). New York: HarperCollins, 1974.
Verhaeghe P. On Being Normal and Other Disorders: A Manual for Clinical Psychodiagnostics. New York: Other Press, 2004.
Walters GD. The trouble with psychopathy as a general theory of crime. International Journal of Offender Therapy and Comparative Criminology 2004; 48: 133–148.
Werlinder H. Psychopathy: A History of the Concepts. Philadelphia, PA: Coronet, 1978.

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