

Toxic Boomerang: The Effect of Psychiatric Diagnostic Labeling Upon the Labeler

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Abstract

Labeling theory highlights the negative implications of psychiatric diagnoses upon the labeled but not the labeler. Diagnostic labels erode clinician empathy; in addition, they alienate the clinician from the client, and the client from the clinician. We discuss the relationship of diagnosis to professional legitimacy and authority, and suggest alternatives to labeling that promote clinician empathy and professional meaning.

Keywords: labeling, psychiatric diagnosis, empathy, meaning, professional authority

Introduction

Labeling theory has long highlighted the negative implications of psychiatric diagnostic

labels upon those whom the label is placed. A prominent identified effect is that of the individual internalizing deviant characteristics associated with the diagnostic label (Lemert, 1967; Link, 1987). However, there are two parties to consider in the diagnostic relationship: those who are labeled (diagnosed) and the labeler (those who diagnose). Interestingly, little has been written about the costs of psychiatric labeling upon the labeler, i.e., the mental health clinician. Just as there are consequences attributed to one being labeled, there may also be definable after-effects for the labeler. The purpose of this paper is to present our construct, the “toxic boomerang” (Figure 1). It is defined as an effect of modern mental health diagnosis-based practice where clinicians over-emphasize diagnostic labels which impact their

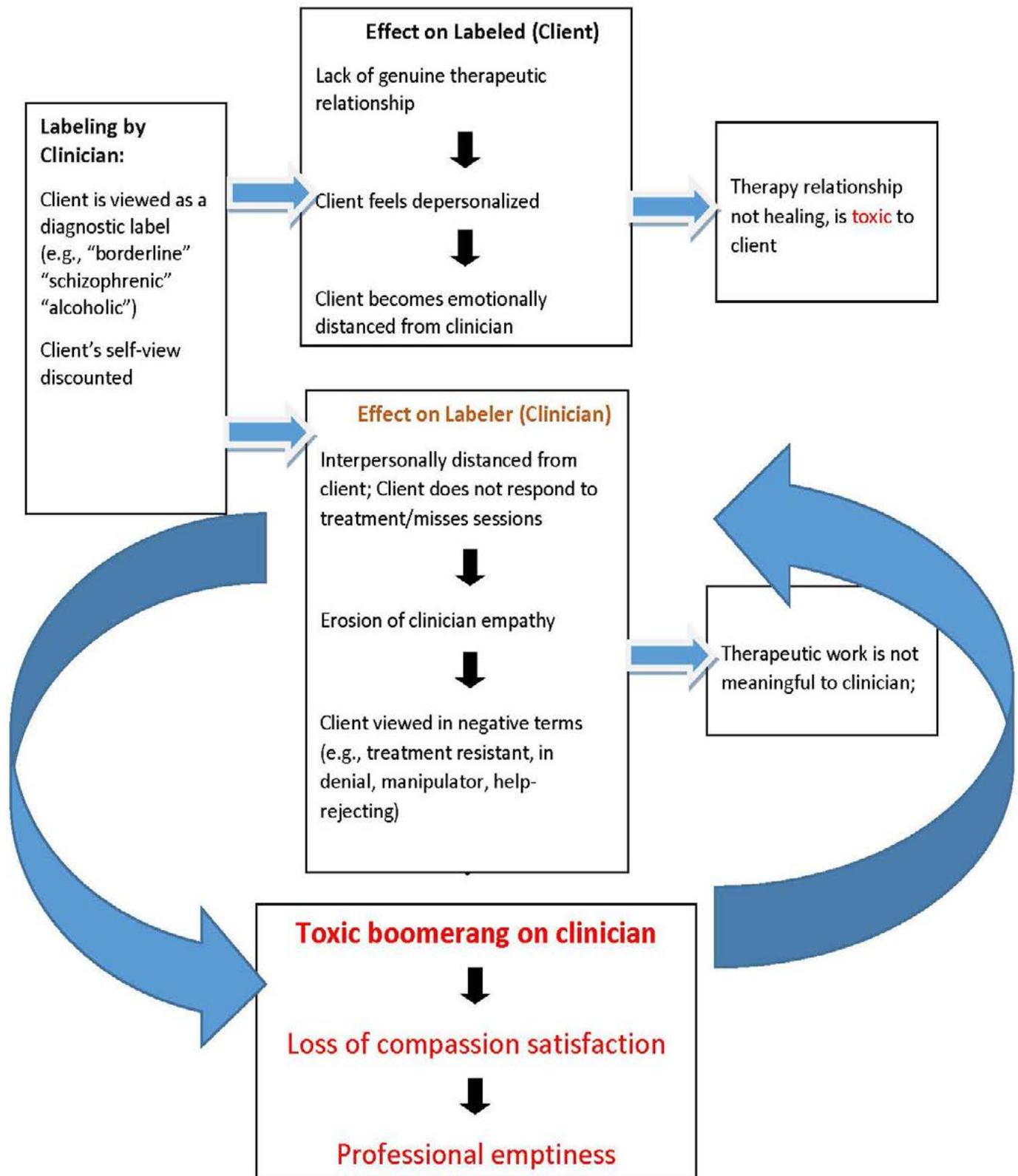


Figure 1. Toxic boomerang.

ability to be empathic and therapeutic; thus leading to client alienation, a sense of lack of professional efficacy, and resultant loss of meaning in work. In this paper we explore the relationship of the toxic boomerang and (1) loss of professional meaning, and (2) the “sage complex,” and its association with professional legitimacy and authority. The paper concludes with alternatives to labeling that promote clinician empathy and professional meaning.

What Is the Toxic Boomerang?

We suggest that the toxic boomerang is the outcome of clinical practice that overemphasizes diagnoses and underemphasizes empathic understanding of human distress in favor of classifying clients. Our construct that labeling affects the labeler is paradoxical: why should there be a negative impact upon the holder of power, the labeler? The theoretical basis may be found in Bandura’s (1978) reciprocal determinism. Bandura theorized that an individual’s behavior is influenced by personal factors and the social environment, and reciprocally, their behavior impacts the environment. At the interpersonal level, Bandura (1978) observed that “people reciprocally determine each other’s actions” p. 356. Reciprocal determinism in the toxic boomerang context may emerge as follows. The therapist influences the client’s behavior through the power differential inherent to labeling (“I have the answers, and my clients do not”). In turn, the client’s reaction to being labeled impacts the therapeutic environment (“I don’t feel helped and reject your advice”). The therapist’s professional competency may initially be driven by the authority derived from diagnosing others. However, a diagnostic code-driven practice may foster a barrier between the clinician and the individual seeking help through reducing the likelihood of genuine interactions (Austrian, 2005; Wakefield, 2010; Fish, 2012), attempts to understand the other from their perspective, and provision of unconditional regard (Rogers, 1961) important to the development of therapeutic alliance and treatment

efficacy (Burns & Nolen-Hoeksema, 1992; Castonguay, Costantino, Holtforth, & Grouse, 2006). It may promote a distanced or disconnected style. Lack of connectedness or detachment has been shown to impact negatively on the formation of a therapeutic alliance (Moyers, Miller, Hendrickson, & Stacey, 2005; Ackerman & Hilsenroth, 2001; Ackerman & Hilsenroth, 2003; Kim, Wampold, & Bolt, 2006) as well as therapist effectiveness (Lafferty, Beutler, & Crago, 1989; Hersoug, Hoglend, Havik, von der Lippe, & Monsen, 2009).

The client’s environmental reaction to the diagnostic label may be to feel a lack of being understood and involved in the therapeutic process (i.e., distancing). Bandura (1982) described human behavior as regulated in part by a self-evaluative component leading either to satisfaction or dissatisfaction. Power and control derived from diagnosing others may be superficial markers of therapist self-competence that may be eroded by client rejection. The clinician’s reaction to the client’s lack of connectivity in treatment may be a negative self-review as to professional efficacy. Thus, a negative self-evaluation, e.g., the therapist’s lack of self-efficacy or the belief in one’s capacity to accomplish a task, may in turn fuel dissatisfaction.

What Promotes the Toxic Boomerang?

At the practice contextual level, the prominence of psychiatric diagnosis has accelerated over the recent decades as a consequence of modern mental health practice that requires codes for billing (Austrian, 2005; Wakefield, 2010). Pressure is exerted on clinicians to focus on relegating clients to diagnostic codes. In describing the historical arch of American psychiatry, Fish (2012) noted that earlier psychodynamic psychiatry focused on the individual’s distress in the context of their life history in order to develop an understanding of the underlying problem. By the 1970s, the move away from the psychoanalytically centered DSM II to the DSM-III classification system based on discrete diagnostic categories (Pierre, 2010) coincided with the burgeoning demands for

categorization driven by insurers. In addition to insurance companies, managed care medical centers and mental health licensing agencies promote a culture of diagnosis (Austrian, 2005). The forces of reimbursement and professional licensing demands discourage clinicians from practicing outside a diagnostic sphere.

How Is Loss of Meaning Related to the Toxic Boomerang?

Professional identity, for many, represents a prominent aspect of their sense of selves as well as sense of meaning (Littman-Ovadia & Steger, 2010). At the interpersonal level, social learning theory and reciprocal determinism offer this observation: one's perceptions are altered by the effects "of their actions and the observed consequences to others." (Bandura, 1978, p.356) Paradoxically, diagnosing others may ultimately erode a therapist's sense of self-efficacy and lead to dissatisfaction. That is, while the diagnostic endeavor may initially enhance the therapist's sense of mastery, it may also promote client distancing (due to labeling) and the loss of an ability to be influential in the therapeutic context. Sussman (2007) explored the literature related to why individuals choose psychotherapy as a profession and found that the desire to help may be a primary drive for a large percentage of psychotherapists. However, Sussman cautioned that the motivation to help may be much more complex than an altruistic need to relieve others of their emotional pain. Sussman's review of studies of psychotherapists over multiple decades suggests that helping others is multi-layered; i.e., driven by a desire to feel needed, to experience vicariously the relief of emotional distress, power needs, the need to express compassion, or a sense of moral duty. Sussman noted that a still deeper motive for helping others may be a desire to master or understand one's own inner conflicts or even perhaps, as a method of reparation of personal guilt for having hurt others.

Frankl's (1984) concept of an existential vacuum (emptiness in place of meaning and purpose in life) may offer a related underlying

mechanism of the toxic boomerang. What draws many mental health clinicians to the field is a sense of meaning derived from their work, be it driven by a compassion for others and a genuine desire to ease emotional pain, or other motives as noted by Sussman (2007). Stripping meaning away from work leads to emptiness and a loss of sense of purpose, creating the existential vacuum. The consequences of a lack of meaning in one's life are profound. Research in the area of meaning, defined as a sense of purpose and of significance, suggests substantial negative effects (depression, lack of social connectivity, social alienation) when individuals believe their lives to be meaningless (Heintzelmann & King, 2014). Meaning in one's work is associated with occupational satisfaction and interpersonal effectiveness (Littman-Ovadia & Steger, 2010; Stillman, Lambert, Fincham, & Baumeister, 2011). Indeed, it can be even more critical than that; as Frankl (1984) observed in the Nazi concentration camps when he was interred, he found that meaning in one's life was essential to survival.

Toxic interactions emerging from reduced clinician empathy is not a new concept. Twenty years ago Breggin (1991) coined the phrase "toxic psychiatry," referring to medical training and psychiatry residency that produced psychiatrists whose authoritarian rigidity reduced their empathy and made them ineffective therapists, which ultimately led to professional dissatisfaction. Additionally, that clinicians derive meaning from their interactions with clients was noted a decade ago by Stamm (2002) who coined the term "compassion satisfaction," referring to therapeutic work that was empathic and therefore meaningful. When compassion satisfaction diminishes, compassion fatigue (the inability to experience a sense of professional efficacy) increases (Stamm, 2002).

Why Is Labeling Toxic to Therapists?

Siegel (2007), a psychiatrist and therapist, in his work relative to the mindful brain, remarked that human connections shape our neural

connections. As such, the newly emerging field of interpersonal neurobiology (Badenoch, 2008; Cozolino, 2010) may offer one theoretical model useful to understanding the precipitants of the toxic boomerang. Interpersonal neurobiology describes the neural interaction between the therapist and client in psychotherapy. Admittedly, neurobiologic explanations may be viewed as too simplistic and mechanistic toward explaining the deeply philosophical experience of an existential vacuum that may accompany loss of meaning in work (Frankl, 1984). It offers one explanation for the corrosive nature of labeling, i.e., the toxic boomerang to the therapist.

Interactional neurobiology theory describes how therapy stimulates right-hemisphere to right-hemisphere interactions of warmth and empathy from therapist to client which are indispensable to the healing relationship (Cozolino, 2014; Hojat, 2007). Clinicians who interact with their clients as a diagnostic label (“borderline,” “dependent,” “chronically depressed”) rather than respond to their pain may be perceived as robotic and distant, and not empathic. The client feels disconnected from the therapist. In turn, the client’s lack of connectivity is perceived by the therapist. Consequently, the right-hemisphere to right-hemisphere empathic interaction between therapist and client is not triggered, and the client does not experience relief from emotional distress. At the neurobiological level, when the therapist is perceived as distant and authoritarian by the client, there is a lack of perceived pleasure in the therapist-client interaction by both the therapist and the client. The client does not experience healing and the therapist does not experience the pleasure of healing another. The underlying brain processes related to pleasure (i.e., the dopaminergic nucleus accumbens circuitry) triggered by empathy and altruistic actions do not occur in the therapist (Hojat, 2007; Cozolino, 2010; Decety, 2011). The emotions triggered by such relationships (anxiety on the part of the client, and dissatisfaction and irritation on part of the therapist) are negative and toxic to healing. As the effects of diagnosing others (loss of meaning,

loss of pleasure) are profound, why do clinicians continue to remain fixated on this method of interacting with their clients?

The Sage Complex, Power, Authority, and Legitimacy

In the early 1900s, anthropologist Franz Boas (1989) noted astutely that people in power are slow in developing sympathy for people out of power. Mental health professionals’ need to remain in authority may explain why the profession has eagerly embraced diagnostic reductionism over client-centered conceptualization of an individual (Rogers, 1961). The clinician as “labeler” may have a sense of empowerment, i.e., “I am wiser than you as I know you better than yourself.” We call this the “sage complex.” The current mental health professional culture as well as the DSM-5 (American Psychiatric Association, 2013) and its predecessors offer mental health clinicians a powerful identity through legitimizing their role as the arbiters of psychological normality. Austrian (2005) described an additional lure and flaw of diagnostic labeling; it fosters a “magical” security for inexperienced clinicians that can lead to a false understanding of the person. Diagnosis may also offer mental health clinicians a sense of professional legitimacy, or equivalence, when interacting with non-mental health physicians whose work is structured around diagnosis. DSM labeling short circuits knowing a person based on the assumption that any individual can be reduced to a cluster of symptoms through jargon-based observations.

Fish (2012) described the expansion of the diagnostic categories in each DSM iteration as the reckless medicalization of normal human behavior; an endeavor that results in additional millions meeting diagnostic criteria for a mental illness, although they are not disordered. Wakefield (2010), a leading critic of the DSM, echoed this view by noting that mental health professionals adhering to this system have to reconcile that their diagnoses encroach into every aspect of normal human reaction. There is little divide between psychological normality and abnormality. Consequently, such

a classification system leads to increased vulnerability to misidentify cultural and context driven reactions as mental illness (Wakefield, 1992; Horowitz & Wakefield, 2007). In addition, the medicalization of normal reactions also has the effect of augmenting the “sageism” of the mental health professional. This is not to imply that a categorical classification system which promotes reliability in clinician understanding and treatment of the symptoms of mental disorder is of no value. Rather, the process has trumped its underlying purpose, and encouraged an institutional professional legitimacy (e.g., in a medical setting, outpatient setting, forensic setting) that is tethered to diagnostic competence. The modern clinician has, in effect, succumbed to the sage complex.

Interestingly, twenty-five years ago, social theorist Thomas Carlton (1989) wondered whether the fight by social work (and by extension psychology) for diagnostic parity with psychiatry had been “fought on the right battleground” (p.84). Carlton argued that social workers were focused by design on enhancing a client’s ability to manage their lives in an effective manner when burdened by physical or mental illness. That process offered a different paradigm and professional practice model than the medical diagnostic model. Nonetheless, in the decades since Carlton’s comments, many social workers and psychologists have adopted wholesale the medical model. Moreover, they have been accorded, through their respective licenses, the authority to assign labels (i.e., DSM diagnoses); indeed, they must do so for professional legitimacy (license) and for psychotherapy reimbursement from insurance providers.

Despite cautions raised by social theorists related to diagnoses (Carlton, 1989; Wakefield, 1992; Austrian, 2005; Fish, 2012; Wakefield, 2015), a narrative understanding is often rejected as not being cost-effective. Moreover, clients who defy quick categorization or characterization may be viewed by clinicians as problematic, time consuming, and may be dismissed as malingerers. As such, some mental health institutions have opted for diagnostic templates to detect malingering

quickly (Lebougeois Lii, 2007). In forensic psychiatric settings, in particular, there may be the added effect of peer pressure to be able to quickly encapsulate an individual into a diagnosis, in order to demonstrate to others that you are savvy enough to spot a malingerer quickly, and can engage in an “instant diagnosis.” In such settings, not labeling others may be viewed as incompetence, naiveté, and reflective of poor training. Because of this, mental health clinicians working in forensic hospitals, prisons, jails, and other related facilities face a complex set of concerns surrounding empathy in the therapeutic process that make it difficult to provide effective treatment (Maschi & Killian, 2011). In some cases this approach has led to increased client suicides and assaults (Romney, 2006). Allegations that clinicians create safety hazards, due to suspicion of poor boundaries, may be made if they do not readily place a label, such as “psychopath,” on a client or articulate that they understand “criminal games” (Allen & Bosta, 1981). Clinicians may feel an intense pressure to label others due to a fear of being shunned and facing potential job loss. It may be that the new scarlet letter is “E” for Empathy.

Looking Toward the Future: Enhancing Meaning-Based Clinical Work

Given institutional and professional consequences for those who do not diagnose clients, why should clinicians be willing to approach their clients differently? A persuasive and ethical justification is that psychotherapy is substantially dependent upon the relationship between the provider and the client. More than five decades ago, both existential psychologist Rollo May (1958) and client-centered psychologist Carl Rogers (1961) underscored the importance of “being with” the client. Understanding people from their world rather than throwing techniques at them was identified then, and remains today, the core of the healing therapeutic process. Badenoch (2008) describes this as the mutuality of the therapeutic relationship toward creating empathic inner

communities. This is a construct supported by neurobiological research demonstrating interactive neural processes occurring between the therapist and the client that are critical to healing (Cozolino, 2010; Siegel, 2007). Badenoch describes the curative process in the therapist-client relationship as one where the therapist conveys hope that in turn becomes a wellspring of healing flowing from the therapist to the client. Badenoch suggests that the paradigmatic ground of empathy and hope is what sets the foundation of mutuality. As with all dyadic human interactions, the process is not one-sided. The therapist being for and present with another (or conversely being distant) impacts the healing process for the client as well as the meaningfulness of therapists' work for themselves.

Social work practice, perhaps more than psychology and psychiatry, offers a unique mental health service poised to move in the direction of meaning-based conceptualizations of clients. Social work ethics emphasize the intrinsic value of each person (National Association of Social Workers, 2008), which provides social work with a distinct professional paradigm: one that has historically encompassed social policy and individual advocacy; moved from the medical model toward a person-in-environment view of mental illness; and shifted toward a holistic approach (Zastrow, 2010). Within the last four decades, Austrian (2005) noted a theoretical shift in focus, in that social workers are moving away from a linear medico-psychiatric approach to the "person-in-environment" paradigm. This shift has highlighted the importance of the person, within a context, while developing a comprehensive psychosocial understanding of the individual. Of note, this framework has been useful in guiding treatment planning by highlighting self-determination, cultural diversity, religious practices, and the value of family and friends as integral members of a support team.

Diagnostic classification views the person through the narrow lens of diagnostic categories. Over-reliance upon formal diagnostic paradigms, such as the Diagnostic and Statistical Manual (DSM) system, may be antithetical

to understanding the person from a contextual person-in-environment perspective. Austrian (2005), in writing to social workers regarding their interface with the DSM system, warned that social workers (and we would say mental health professionals overall) should resist falling into what she calls the classification trap. The debate waged recently by prominent psychiatrists (Phillips, Frances, Cerullo, et al., 2012) as to whether the then-pending DSM 5 expansion of disorders represented abstractions rather than real conditions, as well as concerns regarding its reliability and validity (Gordon & Cosgrove, 2013), underscores Austrian's admonition to be wary of diagnostic classifications.

Diagnostic methodology remains a boundary based system that strives to fit a person into a category. It stands in contrast to an eco-system approach that represents an assessment of the person in his or her unique context. Such differences move beyond semantics. The eco-system approach does not objectify a person as may be the case with a diagnosis; for example, identifying Ms. M. as schizophrenic versus an eco-system identification describing her as Ms. M with X strengths and Y weaknesses. The eco-system approach can facilitate understanding the whole person.

Badenoch's interpersonal neurobiological approach offers a method for the clinician to be mindful and engaged. It involves *therapists* keeping a journal to help identify their inner vulnerabilities that may derail therapy. In addition, as clients share their histories, Badenoch suggests that therapists hold images of their inner community; i.e., the internalization of their inner life. This interactive process, in contrast to classification reductionism, engages therapists with their clients at a profoundly genuine level.

Conclusion

Most people do not want to be labeled, they want to be understood. There is a drive and hunger in the general public for self-understanding as evident in the movement of positive psychotherapy focused on enhancing resilience,

happiness, and success training (Seligman, 2007; Green, Oades, & Grant, 2007). This is evident in the burgeoning interest in life-enhancement and life coaching (Spence & Grant, 2007; Seligman, 2007; Redzic, Taylor, Chang, Trockel, et al., 2014). The Internet has empowered people by giving them access to technical information that was not previously accessible and comprehensible. One example is medicine, where one can conduct a search and readily find medical resources to understand a condition and its current treatments. This has contributed to non-mental health medical professionals moving away from an authoritarian (“doctor knows best”) focus with their clients to a collaborative motivational process that highlights expression of empathy and reflective listening (Rollnick, Miller, & Butler, 2008; Antiss, 2009; Emmons & Rollnick, 2001). Similarly, mental health clients have access to information regarding psychiatric diagnoses and treatment. There is no longer a closed club of clinicians as the sole holders of specialized knowledge. Consequently, a result of this may be a paradigmatic change in mental health training promoted by clients seeking something deeper and more meaningful than being labeled. It may augur a movement away from the prominence of diagnosis of psychopathology toward understanding the individual who is seeking help.

This movement can also affect clinicians’ response to their work. Clinicians want and need to be engaged in the empathic understanding of others, and to experience compassion satisfaction rather than compassion fatigue (Stamm, 2002). As we stated at the outset, the toxic boomerang leads to the suffering of clinicians by stripping away meaningful understanding of the people they treat, corroding their sense of self as healer, and ultimately leading to feelings of professional emptiness. The costs of such compassion dissatisfaction and professional burnout are serious in that poor judgments and errors can result in lowered efficacy (Rossi, Cetrano, Petrile, Rabbi et al., 2012; Figley, 2002; Adams, Figley, Boscarino, 2008; Kumar, 2011). The increased awareness by the general

public of mental health issues and their drive toward self-understanding offer a great opportunity for mental health to embrace a non-judgmental and collaborative process. Ultimately, this is the healing antidote to the toxic boomerang.

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