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# Reinforce, reframe or remove? What should psychologists do with diagnostic labels?

**Klair Norman**

Over the past 50 years, the range of diagnostic labels has relentlessly expanded, through iterations of psychiatric diagnostic systems like DSM and ICD, underpinned by a massive medicalisation engine, criticised for overpowering alternative interpretations and discourses (Solvag, 2007). As a result, there has been a startling increase in the number of individuals labelled as having a disorder or disability (Frances & Batstra, 2013). This has led to much debate over the utility and validity of diagnostic labels. For some, labels are seen as desirable commodities, enabling more timely and effective services. Others argue that labels work against the inclusion agenda by positioning the problem 'within-person', stigmatising diversity and further marginalising those with difficulties. Surrounded by this controversy, psychologists are faced with the dilemma of deciding how to shape their own professional choices and actions. This article considers arguments for three possible options.

## Option 1: Reinforce

An often-cited benefit of the current classificatory system is that labels may help individuals and their families to feel that their difficulties are real, acknowledged and less mysterious or scary (Avdi, Griffin & Brough, 2000). Many labelled individuals and their families feel that their diagnosis has led to a more empathetic understanding from others, e.g. by defusing charges of low motivation, lack of effort, stupidity, naughtiness or poor parenting. Qualitative research has suggested that diagnostic labels can increase self-esteem and help individuals and their families to feel like they are not alone (Solvag, 2007). Amid pressures from service-users to provide a formal label for their difficulties, and in light of evidence that some people view their label as a productive part of their lives, Macdonald and Kearney (2013) argue that individuals themselves should retain the 'right to be labelled'. This highlights the need for thinking about ownership of labels and who has the right to suggest their usage (Riddick, 2000).

A number of practical benefits have been identified to support the retention of traditional labels. Terms generated through diagnostic labelling are pooled to produce epidemiological and statistical data, allowing for identification of trends and helping stakeholders prepare and advocate for appropriate provision of resources (Cranshaw, MacFadyen & Dodd, 1992). Diagnostic labels are also useful in research, where grouping of participants is necessary. Indeed, the shared understanding that arises from using labels means that both academics and practitioners can effectively communicate generalised ideas with each other. Finally, it is suggested that the current system of classification arose because the human mind requires mental hooks to think about problems and even if the present categorical labels were abolished, a new set of descriptors would evolve to take their place (Henley, Ramsey & Algozzine, 2009).

## Option 2: Reframe

Some academics and practitioners suggest a 'middle ground' which reframes the perceptions and conventions of diagnostic labelling, rather than colluding with or rejecting them (Hodge, 2016). This may involve challenging the negative connotations of labels, improving issues regarding public and private stigma and rejecting the assumption that deficit equals deficiency. Supported by the neurodiversity movement, there is a body of literature that suggests labelled groups can develop a sense of minority pride and belonging (Jones, Gallus, Viering & Oseland, 2015). From this perspective, diagnostic labelling could eventually become dispensed with but only "when it has served (at best) certain awareness raising and educative functions and is no longer seen as a productive part of the lives of disabled people" (Riddick, 2000, p.665).

Hodge (2016) suggests that labels should only be used in necessity and with care and certainty that it serves an empowering purpose for the individual and is critical to their developing identity. The careful use of language in acknowledging the fallibility and contextual influences of diagnostic labelling is also suggested as language sets a tone and reflects values (Davis, 2004). For example, practitioners might report that 'according to (a specific source) an individual currently meets the criteria for a diagnosis of XYZ' rather than simply stating that 'an individual has XYZ'.

A reframing stance may argue for provision of services based solely on need regardless of any clinical diagnosis, stepping up with training, observation and normalisation first (Frances & Bastra, 2013). Professionals could also invest conscious efforts towards critical analysis and monitoring of the value, function and impact of diagnostic labels, highlighting to others the fact that diagnostic labels are merely human constructs rather than real entities. Furthermore, resources could be directed towards increased systematic investigation and wider understanding of the personal consequences of a diagnostic label for those concerned, since there is currently a paucity of high quality evidence in this area.

## Option 3: Remove

Challenges have been made regarding the inconsistencies associated with both psychiatric diagnoses and educational diagnoses such as dyslexia (Elliott & Grigorenko, 2014). Questions have also been raised over their lack of explanatory or predictive power, hence their lack of utility as scientific concepts (Haslam, 2014). From a social oppression perspective, diagnostic labels are seen as detrimental to personhood, through diminishing individuals' potential for change or growth, rendering them as 'other 'to their non-labelled peers and exerting social control or pressure to conform to a narrowing concept of 'normal'

(Latif, 2016). Reviews of current literature point to harmful effects of labeling such as diminished self-esteem, peer rejection, reduced aspiration, reduced interest by parents, negative stereotyping by teachers, learned helplessness and poor adult adjustment (Batstra et al., 2012). Furthermore, it has been argued that a diagnostic label can unhelpfully become the primary adjective or dominant story for individuals, drowning out all the other stories that could be told about them (Runswick-Cole, 2016).

It is important to recognise that the current system of diagnostic labelling is situated and maintained within political, economic, historical and cultural forces (Hodge, 2016) and there may be a resistance to surrendering conventional practice. Consequently, rejection of the current system must be supported by clear propositions of how things could be otherwise. Conceptions in the current literature advocate a system that expects, is receptive to and aims to effectively include a wealth of non-dominant behaviours, heterogeneity and differing phenotypes; a system where appropriate support can be sought without having to resort to a label of a 'disorder' (Davis, 2004). Within this system, observed struggles or differences are seen as relative extremes of normal variability and nobody seeks to stratify individuals into distinct, deficit-based category groups. Nevertheless, this does not entail romanticising all diversity as beneficial, nor ignoring the challenges faced by those experiencing difficulties and needs. Responses to needs should be timely because undue resources are not wasted in asking 'what is wrong' with individuals but invested in efforts towards identifying (through a response to intervention approach) what necessary resources or environmental conditions might be needed for their diverse nature to thrive. Where individuals experience significant difficulties with access or adjustment, it is their conditions, lack of support or marginalisation that are problematised, rather than the individual.

## Summary and Reflections

The three options presented above are neither exhaustive nor mutually exclusive. It is anticipated that the paper will inspire discussions about the pros and cons of continuing to use diagnostic labels. In this way, practitioners can work together to decide or reimagine how they might make sense of diverse developmental trajectories and common human problems, conduct helpful research and support more positive outcomes for those who would benefit from their assistance.

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