Barry Goldwater and the power of labels

Several decades ago, I attended a travelogue presentation with my parents at a local church. The speaker was a well-known politician who had recently traveled through the Grand Canyon and was now presenting the many pictures he took via a slideshow (this was long before PowerPoint presentations and digital photography). He shared his plans concerning his legislative agenda to protect Grand Canyon National Park and the surrounding areas.

I remember this event because after the show, I stood in a long line to get the speaker's autograph on a paper napkin as a keepsake of the occasion. Sen. Barry Goldwater of Arizona signed my napkin with a mechanical pencil. He would later run for the office of president of the United States and suffer one of the most lopsided losses in presidential election history.

Goldwater's loss was the result of many things, including a now-famous television commercial involving the image of an atomic bomb exploding and a little girl plucking a daisy. It is known as the "Daisy" ad. Another factor in Goldwater's loss was an article published in 1964 in *Fact* magazine titled "The Unconscious of a Conservative: A Special Issue on the Mind of Barry Goldwater." The magazine surveyed psychiatrists about the mental fitness of Goldwater to be president. None of the psychiatrists surveyed had ever examined or even met Goldwater, but they still felt they could make assumptions about him by reviewing his public actions and comments. Goldwater eventually sued *Fact* magazine for libel and won punitive damages of $75,000. The senator probably would rather have won the White House.

In 1973, the American Psychiatric Association bestowed an informal name — the Goldwater rule — on Section 7 of its *Principles of Medical Ethics*. Section 7 prohibits a psychiatrist from offering a professional opinion on someone's capacity unless the psychiatrist has conducted an appropriate examination of that person and has received permission to share that information or diagnosis.

The determination and use of mental health diagnoses have a long and difficult history. From the days of Hippocrates, the ancient Greek physician who held that mental illnesses (mania, paranoia, phobias and melancholia) were caused by an imbalance of the four humors of the body, to the development of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*) and *International Classification of Diseases* (*ICD*), we have attempted to label behaviors that we find abnormal or that interfere with the tasks of daily living. Over time, our ability to differentiate between those suffering with various mental health maladies and those struggling with normal developmental travails and reactions to societal expectations has improved.

For example, the first two editions of the *DSM* offered more along the lines of glossary descriptions of the diagnostic categories rather than the comprehensive and concise overviews of the myriad disorders contained in the *DSM-5*. The *DSM-III* attempted to be neutral with respect to the causes of mental disorders, and it was even more noteworthy for removing homosexuality as a mental disorder and replacing it with the category of sexual orientation disturbance. This represented a more nuanced (for its time) understanding of sexuality and sexual expression.

Regardless, through the years, these descriptions, labels and categories have held (and still hold) a great deal of power. They have been used to oppress certain individuals and classes of people, while offering access to services for others. For some people, these labels have offered a description and an explanation for their behaviors; for others, these labels have relieved them of the responsibility for their crimes. Diagnostic labels have also been used as a weapon to degrade and disgrace certain individuals, as in the case of Barry Goldwater.

This is why the specific subsection on diagnosis of mental disorders (E.5.) in the *ACA Code of Ethics* begins with these words: "Counselors take special care to provide proper diagnosis of mental disorders."

What is 'special care'?

Diagnosis holds an interesting place in the profession of counseling. We are the profession that historically has sought to engage the whole person, without judgment, accepting the client in the moment as a person to be valued, not labeled. We eschew the idea of tagging someone with a diagnosis that is essentially a list of behaviors and characteristics and not a true

representation of the whole person. Previous editions of the *DSM* have been accused of being ethnocentric (Caucasian-oriented) and difficult to apply to other cultures and contexts. Meanwhile, other stakeholders (e.g., pharmaceutical companies) welcome the growing number of diagnosable disorders and have pushed for more clinical indicators that can be treated (both on and off label) by their many products.

At the same time, professional counselors work in the real world. A counselor might fail to make a living without being able to offer some kind of diagnosis and treatment plan to the insurance companies that are paying the therapy bills. We also understand that an accurate diagnosis, when required, can be a benefit to clients. It can offer them a better understanding of complex issues and emotions that may otherwise have caused confusion, fear or even thoughts of suicide. In some cases, educational benefits (e.g., an individualized educational program) and disability resources cannot be accessed without a diagnosis. Therefore, as counselors, we take special care to ensure that any diagnosis is made using the most appropriate assessment techniques, including a well-planned clinical interview, and the most relevant instruments and tests.

Part of that special care is taking into account the impact of culture on the client's life. A client can live in multiple cultures. There is the culture of the dominant society with its expectations, traditions and norms. If the client is not from the dominant culture, constant adjustments (hourly, daily and weekly) may have to be made that cause their own stress in the continuing existence of the client. There is also the client's own culture, which may or may not closely resemble the culture of the dominant society. What may be a normal custom or behavior in the client's culture may be seen as part of a cluster of behaviors that indicate something far different in the dominant society.

Added to the cultural considerations are the impact of socioeconomic status and access to medical and mental health resources. Poverty, food insecurity and fear of losing one's housing all have an impact on people's behaviors. Interestingly, the adage that money can't buy happiness is also true. Although wealth has its benefits, it also has its own set of expectations and stresses that impact people's lives. Part of the counseling profession's cultural sensitivity includes a requirement to be aware of the misuse of labeling and diagnosis with certain individuals and populations.

These issues, along with others, are why the *ACA Code of Ethics* offers counselors the option to "refrain from making and/or reporting a diagnosis if they believe that it would cause harm to the client or others" (Standard E.5.d.). This is an important consideration. It requires counselors, when necessary, to use an ethical decision-making model to work through the positive and negative consequences on the client of making and reporting an accurate diagnosis. This is not a decision to be made without the client's participation or full knowledge of the risks and benefits of being diagnosed.

For example, when given a diagnosis of major depression, what are the potential consequences for clients on their ability to purchase life insurance, receive a military promotion, obtain a security clearance or run for the office of president of the United States? The counseling profession does not allow for or condone committing fraud by underdiagnosing or withholding required information to other stakeholders concerning a client's condition (when the client allows that information to be shared). It does, however, require counselors to think through what is in the best interest of the client in the given situation and to disclose and discuss that with the client prior to any release of information.

This portion of the *ACA Code of Ethics* also has a societal side to it. Most counselors can tell stories about being asked to posit a diagnosis based on the behaviors of a public official or, more personally, an acquaintance, relative or local celebrity. We might even feel a sense of personal power when asked to provide our professional opinions. It can be construed as a compliment that others think highly of our diagnostic prowess. However, our professional obligation to society and to the person in question is to refrain from offering such opinions, especially in public venues, unless we have met the obligation of taking special care in making such an assessment and have the explicit permission of that person to make such a personal disclosure public.

The American Counseling Association has released a statement concerning publicly diagnosing the mental state of an individual. It states, in part:

"When publicly discussing public figures and others, professional counselors should avoid *DSM*- and *ICD*-related terms, especially *diagnosis* and *disorder*. Counselors should not attach a specific *DSM* or *ICD* diagnosis to any individual through messaging or statements in media outlets or social media. ...

"Avoiding public statements that label an individual with a mental disorder is in the best interest of the public. This approach aligns with one of the counseling profession's core professional values, as stated in the preamble of the *ACA Code of Ethics*: Practicing in a competent and ethical manner."

Barry Goldwater would be proud of us. ❖

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