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The Institutionalized Cruelty of Biased Language: From Grand Illusion to Delusion of Normalcy

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Abstract

Mental health professionals can find themselves in a precarious balancing act. On one hand they are attempting to demonstrate unconditional positive regard for clients while on the other, they are walking clients through the process of conforming to the expectations of treatment. Clinicians encountering reactance or 'sustain talk' and 'discord' may then vent their frustrations in staff meetings and within the context of treatment. In this paper, counselors are urged to forgo biased stereotypical negative language (indeed, even their thoughts) in ways that frame clients as a 'problem' and 'difficult' in addition to other labeling descriptors. Use of such language is a form of harm, analyzed in terms of Mill's (1869) 'harm principle' according to which one ought to refrain from actions, including use of language, which are damaging to another person's rights. Ordinarily the effects of language do not rise to the level of physical harm that Mill was concerned to limit, but seen through the lens of Hallie's (1981) 'institutionalized cruelty', labeling is a sort of language that undermines the dignity of clients, obviates the avowed commitments of mental health counseling professionals, and scars the reputation of 'helping' and 'caring' in the profession as a whole. The idea of normalcy against which these judgments are often made is an illusion, and in any case irrelevant to the knowledge necessary to treat the person on which the harmful label has been fixed.

Keywords: ethics, labeling theory, terminology, institutional cruelty, mental health, counseling

In clinical rounds, at a weekly meeting in which client cases are sorted and treatment plans are hashed out by staff members, the supervisor queries one of the counselors to talk about how the new client is adjusting to the program. The counselor hastily responds, "*He's a difficult one and uncooperative, too"*. The supervisor concurs with the counselor's assessment, "*I know that type. I think all of us in this room know all too well how frustrating it is when a client isn't cooperating with the treatment process"* [The treatment team is observed enjoining; nodding their heads in agreement].

The social processes in clinical rounds and general staff meetings and behind closed-door debriefings are a dynamic external feedback loop built into the practice environment, conveying normative standards via informal conversations and interactions (between administrators, supervisors, practicum students, and clinicians) imprinting a 'hidden curriculum' (Martin, 1998) on professional practice. There are a few things troubling about the 'hidden curriculum' in this staff meeting. For one, the counselor does not explain in what way the client is difficult or uncooperative. At the same time, the counselor does not provide a clear example of these characteristics or an explanation of what is behind the problematic behavior; typically, no one questions the statement. The supervisor affirms the counselor's appraisal before following up with questions about why the client is said to be difficult (intoning a 'problem client') or how the counselor intends to usher in cooperation from the client.

Perhaps the supervisor is only trying to help make the counselor feel heard—empathized with or understood in the company of colleagues who have experienced the same frustration—before getting to the bottom of this quick initial appraisal. Nevertheless, this exchange should not have happened at all. The counselor's use of these labels and the supervisor's acceptance of them is harmful to the client, the counselor, and the profession.

This paper is focused on the practice of assigning pseudo-diagnostic constructs or labels to clients. Research indicates that labeling has the effect of reification (Rosenhan, 1973): bringing clients and others into compliance with a vague and negative assessment (Frances, 2013). This practice is harmful to the client, for it is a form of "institutionalized cruelty" in the sense that as a toxic norm—i.e., a persistent pattern of client-humiliation—it undermines the client's right to positive regard and appropriate treatment with respect to the underlying causal factors of the behavior in question. As such, this kind of language is also detrimental to the

profession and the 'claims-maker' (counselor), for it undermines the claimant's commitment to principled professionalism and competency, which compounds the ill effects for clients.

The crux of the problem lies in the idea of normalcy, whereby arbitrary classification schema encourages knowledge-claims about clients that serve the self-interest of counselors. In turn, such 'normalcy' carries implications in treatment including iatrogenic effects, ones that stem from the act of examination or treatment. Finally, suggestions are broadly sketched on how counselors can be more circumspect about using language with no apparent clinical utility and therapeutic value.

Labeling and Name-Calling: AKA Unprofessional 'BS'

For the sake of clarity, labeling in-and-of-itself is not necessarily problematic. Indeed, ascribing characteristics to clients is necessary in determining how best to proceed, with a course a treatment. Van Hoose and Kottler (1985) observed both the advantages and the value of the act labeling (or naming) adds to the therapeutic process, stating, "In the process of *functional behavioral labeling*, a client's specific behaviors are described in meaningful, illustrative, individualized language, not only so that the counselor can understand clearly which concerns are to be addressed but so that the client can understand how, when, where, and with whom the self-defeating patterns are exhibited" (p. 132). Similarly, the term 'difficult' can be a metacategory or metaconstruct featured in so-called denial, manipulative, or resistant patterns in clients with psychiatric diagnoses such as antisocial personality disorder and borderline personality disorder (Hahn et al., 1996). But descriptors of this sort might also be used off the cuff to refer to clients perceived as difficult but not formally diagnosed with a DSM-5 personality disorder. The scope of labeling referred to in this paper is focused on the latter—specifically when counselors and treatment staff ascribe stable and global attributes that are variants of 'difficult' (disruptive, willful, unacceptable, uncooperative, challenging, etc.) in place of definitive clinical indicators of behavioral variables relevant to treatment.

The uses of 'difficult' and its variants are, to use a commonplace expression, BS. Adapting the so-called questioning yardstick from Carl Sagan (1996), Taleff (2006) produced a verbiage classification system he aptly named 'the bullshit [BS] detection kit' for counseling professionals, an offshoot of Carl Sagan's (1996) famous 'baloney detection kit' offering a list of valuable principles for spotting 'baloney', as Sagan put it. BS here refers to ascriptions made with indifference to evidence, solid reasoning, and ultimately the search for truth, in both process

and end product (Frankfurt, 2010; Law, 2011; Penny, 2010). This kind of BS is connected to overly generalized critical thinking issues insofar as good critical thinking habits fundamentally involve a concern for the truth and demand clarity and precision in thought and language. Indeed, well-honed critical thinking skills are imperative for combating BS in all its forms (Taleff, 2006).

So, why use BS? In short, it serves to vent frustrations and mask ignorance; it places the blame of stalled treatment on the client, and it is easier than looking for an explanation for problematic behavior. Thus, unprofessional BS is deliberately intended to do the same thing; specifically, employ an evaluative descriptor to discuss the perils of using evaluative descriptors. Like numerous other critical thinking fallacies involving biases, labeling is a form of 'biased language' that serves the counselor in the short term but results in actions that oppose the stated and noble objectives of the counselor and the profession.

Biases are errors in judgment and can be ubiquitous in some treatment environments. Errors in judgment can include seeking out evidence for what we already believe, neglecting evidence that counts against what we already believe, interpreting evidence in light of what we already believe, ignoring or oversimplifying evidence, and in general finding explanations outside of evidence (Gambrill, 2012). Using biased language to describe clients is similarly misleading in the sense that its use and acceptance circumvents the discovery of evidence relevant to the client's condition, attitudes, and potential for recovery, while at the same time providing cover for a counselor that may be ill-equipped to decipher the clues, in part because biased language is related to critical thinking errors and promotes cognitive biases (e.g., for a sampling see Table 1).

Table 1. Critical Thinking Errors Related to and Promoted by Biased Language.

Concept	Meaning	Self-serving interest of biased language
Biased assimilation	Interpreting ambiguous events in light of power of expectation, i.e. what we already believe (Taleff, 2006). Also kicks in when faced with complex, conflicting evidence about some topic on which we have an existing opinion (Taleff, 2006).	• Obscures the space between the problem and what is needed (human capital, resources, more fully developed set of techniques, and clinical repertoire) to solve primary problems. Also, shifts focus to the clinician's skills with problems of secondary interest to clients. • Allows for speedy ('midbrain', primal, *evolutionarily wired*) and pain free cognitive closure. • Enables the appearance of competence to mask ignorance. • Circumvents critical thinking processes—the path of least (disagreeable) cognitive resistance taken. • Assuages anxieties around uncertainty. • Facilitates appearance of being right in maintaining sense of stability in belief structure, e.g., around asserting control over the client and retaining expert status so as not to feel defeated, unsure, confused, ignorant, etc. • Discounts importance of a holistic-centered approach by overlooking environmental influences and situational forces obscuring broader aspects of the
Positive test strategy	We seek what we expect to find (Brotherton, 2015).	
The backfire effect	In the face of evidence against a belief we become even more confident about the misguided belief (Brotherton, 2015).	
Availability error	Judging something or someone by what is most freshly available or the most predominate thing that comes to mind first (Taleff, 2006). Also, what is most vivid or recent tends to grab our attention and hold our interest, rendering it more memorable, and, therefore, more mentally accessible to factoring judgment (Gambrill, 2005; Taleff, 2006).	
Confirmation bias	Predisposed to look for evidence that supports biases, prejudices, and belief system while neglecting information, and simply ignoring facts and evidence that disagrees with pet theory, claim, belief, or idea (Taleff, 2006).	

Fundamental attribution error	Tendency to overlook circumstances and the situation and ascribe explanation to personality traits and characteristics (Taleff, 2006).	client's clinical and treatment profile. • Generates answers in short amount of time, especially when under pressure to solve and resolve problem (Sharpe et al., 1994).
Generalization fallacy (inclusive, hasty, exclusive)	Propensity to inclusively lump everyone together, thereby making a quick and easy assessment. Hastily jump to conclusion before facts and evidence warrant such conclusion (Taleff, 2006). Glossing over the messy details of complex information to an exclusive, simple, or singular-factor explanation that lacks nuance (Taleff, 2006).	• Disinvites constant hunt for real measurable evidence of steady client improvement. • Limitations of knowledge and effectiveness not accurately perceived. • Overestimate treatment and counseling intervention potency and efficacy, thereby avoiding the imposter syndrome.
False dichotomy/false dilemma	Presume only 'either/or' possibilities exist (for a certain condition) when in fact there are 'and/both' options (Taleff, 2006). False dilemmas corner one into unreasonable thinking or serve to advance an agenda (Taleff, 2006).	• Onus of responsibility for change falls on the client and accountability is shifted away from the provider. • Enables and reinforces dogmatic allegiance to a particular philosophy (e.g. 'tough love' expressed in such sentiment as, *I love you enough to 'tell it how it is, call you names, yell and scream at you, and kick you square in the rear end'*).
Bandwagon effect/ad Populum	Certain 'popularly accepted' modes of thought are adopted and 'normal' standards of conduct increasingly conformed to due to the appeal of seeing peers do it (often reason enough for accepting it) and/or encouragement of peers getting rewarded for it in some form or fashion (Taleff, 2006).	• The feeling of knowing, being certain, and seeming right feel good due to dopaminergic surges and neural network activity (Burton, 2008). • Facilitates personal beliefs to stay locked into the particular view one is wedded to.
Incorrect classification fallacy	Reliance on ambiguous terms distorts information leading to faulty classifications (Taleff, 2006).	• Allows personal experience and opinion to outweigh academics, literature, and empirically derived truths. • Emotional investment in righteous moralizing (e.g., junkie scumbag, meth head) and tribal identity (it's us [good] staff or them [bad] clients) is saved.

Innocuous Remarks and Claims-Making

The result of biases is clearly the problem of overlooking factors relevant to a complete causal explanation of the event in question (Gambrill, 2012). When the cause is missed, the solution similarly obscured (Gambrill, 2005). This is no less true of using biased language to describe a client. Even when spoken "innocently" or without ill intent at a staff meeting the words are at best misleading and self-serving; worse, they are instrumental in the reification of issues at more than one level. As Gambrill (2005) put it: “The words clinicians use not only shape their own experience and actions but those of their clients as well” (p. 123).

When clinicians employ evaluative descriptors as a vehicle to express frustration (classic cacophemism), they tend to distort, exaggerate, or sloppily misconstrue a client's behavior, making it sound worse than it actually is (Howard & Korver, 2008). Labels employed in this manner are “typically imprecise” (Gambrill, 2005, p. 169). “They say too little about positive attributes, potential for change, and things that do positively occur as new or different and instead say too much about presumed negative characteristics and limits to change” (Gambrill, 2005, p. 169). More precisely, labels dropped off the cuff by other program staff can negatively misrepresent a clinician's feelings about the client prior to examining evidence and even before meeting the client (Browne & Keeley, 2010).

Labels of this sort nevertheless look like explanations, which interferes with the counselor's ability to assess clients fairly (Rosenhan, 1973). As Browne & Keeley (2010) put the problem, we shorthand our way to a kind of blindfold about what might be going on underneath the label:

> To explain requires an analysis of why a behavior occurred. Explaining is demanding work that often tests the boundaries of what we know...When asked to explain why a certain behavior has occurred, it is frequently tempting to hide our ignorance of a complex sequence of cause by labeling or naming the behavior. Then we falsely assume that because we know the name, we know the cause. We do so because the naming tricks us into believing we have identified something the person has or is that makes her act accordingly. For example, instead of specifying the complex set of internal and external factors that lead a person to manifest an angry emotion, such as problems with relationships, parental reinforcement practices, feelings of helplessness, lack of sleep,

> and life stressors, we say the person has a 'bad temper' or that the person is hostile. Such explanations oversimplify and prevent us from seeking more insightful understanding (p. 79).

This use of language does not aim to identify and change specific behavior. Thus, these distortions are not likely to help clients succeed, be beneficial to overall treatment, or improve the effectiveness of interventions.

Unfortunately, it is not merely that such language does not help. Given that biased language tends to emphasize deficits and negatives, it can be misconstrued as evidence that the odds are not on the client's side. The effect is that counselors buy into the label and its associated meaning and expectations. This effect drains counselor motivation to help the client, consequently failing to instill hope and foster a mindset of success in clients. Indeed, after having been misled by the label, the counselor adopts a counterproductive mindset about the client's likelihood of failure, and even the client's likely contribution to an expectancy of failure (Jussim, 2012; Sibicky & Dovidio, 1986). In effect, labels that seem merely vague or misleading can nevertheless deny a client access to program resources or methods, warp clinical decisions, and lead to ineffective intervention. Clinicians swayed by labels might decide to intervene without sufficient reason or conversely overlook a client for treatment intervention because the behavior is considered normal (or abnormal for that matter).

Because it masquerades as knowledge, the use of biased language is a kind of 'claims-making' (Gambrill, 2012). Claims-making is an activity that in effect lays the groundwork for structuring discourse about a topic or issue. An issue is identified in the content of a claim made in some public way. Once the issue has been identified as such, a framework has been laid, intentionally or not, which constrains in various ways the solutions that might be considered in response. The upshot is that the way we present and talk about an issue has bearing on what we might be able to do about it. In this sense, labeling works as a "filter to produce a biased image of the client [that effectively] excludes other possibilities and becomes reality" (Dorre & Kinnier, 2006, p. 70). For example, when biased language affixed to clients is pathologizing and stigmatizing, it encourages continuation and exacerbation of the very behavior observed which garnered the label in the first place (Jussim, 2012).

Biased language essentially ends up becoming a knowledge claim about the client within a master narrative affecting how the counselor thinks about the client and interprets the client's behavior, framing the client in a way that affects judgments about the need for treatment—its frequency, duration, intensity, and choice of method. Because biased language draws undue attention and emphasis to what is perceived as wrong with the client, a distorted depiction emerges that creates undue pessimism about the possibility of change and degrades treatment care (Schwartz & Sharpe, 2010), which in turn decreases the chances of positive outcomes and diminishes the prospect of achieving treatment goals.

In short, the mere venting of frustration through biased language means that the causes of behavior are obscured, decisions about what sorts of interventions are appropriate are skewed, and focus is placed on the search for deficiencies (Taleff, 2010).

Principled Professionalism and the Ideal Counselor

Biased language adversely affects the counselor and the profession as well, simply by breaking with the practices embodied by 'principled professionalism' (Goodson, 2000). Principled professionalism is a multifaceted concept. At its core, principled professionalism in mental health and addiction treatment is a creed that reflects a value system honoring the client in a nurturing therapeutic relationship (Taleff, 2005). Principled professionalism obligates clinicians to adopt for themselves a professional etiquette and uphold professional standards; it is a commitment to broadening and honing one's overall clinical skillset to provide the highest quality recovery services possible; it is a felt duty to the standards by which one achieves personal and professional growth and ethical maturity (Carroll & Shaw, 2013). Principled professionalism requires practitioners to demonstrate their commitment and fulfill their obligations in everyday practice while keeping pace with patient advocacy (Goodson, 2000). In the face of enduring challenges to clinicians and irrespective of client deeds, principled professionals maintain fair-mindedness, adhering to professional values and principles in supporting client interests without mistreatment or clinical abandonment (Roberts & Dyer, 2004b).

Professional standards embody the notion of the 'ideal' counselor. In humanistic psychology, the ideal counselor is impartial enough to accept and support clients irrespective of the client's

deeds. That is, ideal counselors have *unconditional positive regard* for their clients, which is essential for effective therapy. As Malone and Workman (1998) point out, "caring for patients…requires that [clients], but not their manipulative or self-destructive actions, be unconditionally accepted (p. 4). Johnson and Ridley (2008) note the elements of unconditional positive regard take form in a virtue of care emanating respect that attunes the counselor's behavior to: 1) viewing a client as someone with intrinsic value and worth, b) prizing the client's strengths and recognizing their potential, c) refusing to assign pejorative labels, d) radical acceptance: clients are human beings—imperfect and infallible—being responsive to client preferences, needs, and interest even if client errors or opinions, behavior, and choices are in disagreement with that of the counselor, e) listening attentively to understand and communicate understanding, f) offering warmth in the form of genuine interest and sincere concern (p. 125).

Unconditional positive regard is a noble idea, something to be strived for, the mark of exceptional counseling (Van Hoose & Kottler, 1985). Yet, contrary to this unconditional Rogerian (1961) regard, counselors *conditionally* demonstrate positive regard. Van Hoose and Kottler (1985) note, for instance, that clinicians, "selectively and conditionally give positive regard…when clients do their homework, share their feelings, make progress; in contrast, we give clients the cold shoulder (which we call neutrality) when they play games, act destructively or aggressively, and sabotage or resist our best efforts to be helpful" (p. 126).

What does it mean to demonstrate unconditional positive regard for the client when the client's deeds run counter to successful treatment? This is especially thorny since the goal of counseling is to assimilate clients into the values and goals structure of the treatment model in congruence with the agency's goals, objective, mission statement, and overarching treatment philosophy. So, for example, a client may be expected to comply with an abstinence-only approach to achieving remission from habituated substance use, which might be exceedingly difficult for the client to endure in the short-term and successfully sustain in the long run. There is a burden then on counselors to balance the competing expectations of objectivity, professional integrity, agency commitments, and client needs.

Nevertheless, it is possible to psychologically and emotionally distance oneself from the tendency to use language that merely labels clients as, for example, difficult, obstinate, resistant, in denial, manipulative, incorrigible, co-dependent, or uncooperative (Eron & Lund, 1995). The defining feature of unconditional positive regard is not that the counselor never feels

a tinge of frustration or ounce of negative emotion; rather, the counselor consciously avoids stirring a stew of unrefined emotions and thoughts, and consciously eschews blaming their clients, and consciously rebuffs the seductive dodge of biased language that brands clients with shorthand terms (taxonomy, clinical language of truncation) including metaphors that have distorting effects and virtually no clinical utility, diagnostic function, or therapeutic treatment value.

Since biased language embodies unsupportive, negative, and even adversarial attitudes, it marks regression from the expectation of unconditional positive regard for clients. Especially when biased language is in favor of short-term counselor self-interest, it is thereby counterproductive to the counselor's longer-term interests—that is, professional development and growth that fosters attitudes and actions in line with the 'principle of caring' which promotes a therapeutic alliance and supports the objectives and goal of treatment (Lauver, Holiman, & Kazama, 1982).

The breakdown in professionalism is part and parcel of the same. The breakdown occurs because claims-making has a biasing effect that, over time, deepens its impression in the mind of counselors until the ascription is believed with conviction. The belief set channels itself in covert expression (laughing behind the client's back) and subtle or nonverbal ways through body language (body posture, facial expression, eye rolling) and inflection of tone and speaking volume in accord with the so-called difficult client. These subtle expressions of belief convey a lack of respect for the client and a hesitation to involve the client as an informed participant, together impeding holistic caregiving. Once the bias is fully reified, clinicians may verbally, in tone of voice, direct communication, or inaction, trivialize or malign the feelings, concerns, interests, values, and thoughts of the client (Chen & Noosbond, 1997).

Thus, while it may be believed that thoughts are not ethical issues until they manifest in harmful behavior (Johnson & Ridley, 2008), private thoughts and assumptions about a client inevitably bleed into the public sphere and unconsciously seep into all manner of social exchanges and adulterate clinician-client transactions (Fiester, 2012). Prejudicial influences pave the way for wider inroads of negativity affecting reasoning, processing, and judgments, and ultimately treatment of clients. Fiester's (2012) review of the literature led to his conclusion that such labels invite the provider to behaviors that range from raising one's voice or shouting, to using foul language, making accusatory remarks or insulting comments, all the way up to

spewing racial or ethnic slurs, or using sexist, homophobic, racist, or anti-Semitic epithets (p. 3). This bears itself out in psychological studies on implicit bias and stereotype effect—phenomena with some similarity to biased language and labeling effects— suggesting that language patterns and actions of practitioners are subject to latent effects and unconscious priming (R. Sommers-Flanagan & J. Sommers-Flanagan, 2015).

So, though seemingly innocuous, the term ‘difficult’ and its variant substitutes and meanings are anything but. These words by way of claims-making frame clients in a way that misguidedly constrains treatment options while framing the counselor in a way that undermines competence, stymieing professional growth, generating conflicts between professional values and personal self-interest, and circumventing the hard mental work of thinking deeply, critically, and carefully to sound rational explanations of client behavior. And if this is the norm of the profession, it suffers the scourge of its own culture.

The Philosophical Basis of 'Speak No Evil'

There is little doubt counselors can find themselves in a precarious balancing act, attempting to demonstrate unconditional positive regard for clients while at the same time walking them through the process of conforming their behavior to the sociological values and methodology of treatment. Counselors encountering discord or reactance in their interaction with clients, given the upshot of the foregoing argument, still must not bias their language (indeed, even their thoughts) in ways that frame clients as difficult or its variant forms. This sort of language is *harmful*; on various levels, injurious to clients, mental health professionals, and the reputation of the profession as ‘helping’ or ‘caring’ as a whole. ‘Harm’ however, is a vexing concept, especially as it pertains to words. Yes, one might concede, it's not ideal to peg a client as difficult, but it's not as if the client is forcefully terminated or administratively discharged from treatment. Indeed, professionals are bound to overcome whatever obstacle a client puts their way. So, is there any *real* harm in counselors expressing their client-related frustrations only in the company of fellow treatment professionals at a staff meeting? Doesn't the benefit of airing these feelings and the camaraderie of similar shared experience outweigh the worry that counselors will be self-brainwashed into thinking that there is no hope? Is there any harm to clients, real or otherwise?

This challenge hints that perhaps the bar is set to low on 'harm' and thus demands an account of what constitutes 'real' harm in light of the undeniable benefits of freedom of thought and expression. In response, it is useful to consider philosophical arguments that focus on that problem, beginning with the question of what basis there is to socially constrain expressions of individuality, and in particular opinions. John Stuart Mill (1869) articulated what has come to be known as the Harm Principle (HP): roughly, no one can legitimately constrain another person's actions unless those actions are both other-regarding and likely to cause harm to others. HP is generally understood to, in effect, place a principled limit on so-called paternalistic measures aimed at preventing citizens from engaging in activities that might be harmful to themselves, or simply distasteful to others (Stanford Encyclopedia of Philosophy, 2014). Paternalistic overreach is a violation of the rights accorded to citizens in a free and civilized society. That is, each is free to live according to her own conception of the good, as long as and up to the point at which so living crosses the boundaries of someone else's right to the same.

While Mill's (1869) use of HP was aimed at societal interference of individual liberties, it is also a useful ethical principle for self-regulating actions that are bound to affect others. Applying the principle in any sphere of action (i.e. social, professional, personal), however, requires a precise understanding of what is means to 'harm' others. The paradigm case of harm of course is physical violence, but other possibilities present themselves. In the context of language, for instance, it is not hard to think of examples (like extremely offensive hate speech) that might cause so much psychological damage to the hearer that its mere verbal expression ought to be a violation of HP.

But from Mill's (1869) social-justice perspective, restricting offensive speech fast becomes a slippery slope since nearly any speech can be offensive to someone and thus by extension of HP, warrant suppression of offensive claims. Mill (1869) was thus careful to make a distinction between harm and the lesser psychological toll of being subjected to even deeply offensive hate speech. To be a genuine harm to others, "an action must be injurious or set back important interests of particular people, interests in which they have rights" (citing Brink, 2013, p. 174). A pilot having a few alcoholic drinks right before piloting the plane others have just boarded can be justifiably prohibited, for example, since the pilot has a duty (in virtue of the rights of others) to safely transport passengers to their destination to the best of the pilot's ability, which is likely to be adversely (and potentially catastrophically) affected by inebriation. At

the same time, HP cannot protect one from seeing two men holding hands in the terminal or hearing the xenophobic rhetoric of a group of Trump supporters that gathers outside the airport to tell foreigners to go back home.

So, committed was Mill to free speech that the only exceptions Mill countenanced to its free expression were in contexts that threaten physical violence or were likely to incite such violence—exceptions based on HP. As a society, Mill argued, we are 'greater gainers' to tolerate each other's differences than be forced to live per one of many possible and equally arbitrary conceptions of the good (Stanford Encyclopedia of Philosophy, 2014). We are thus not obligated to share opinions but we are obligated to preserve the right of all to have and express their own opinions.

So, while words can certainly hurt, they do not typically cause harm given Mill's view. On its face then HP is a principle by which the relatively temperate though biased language of concern here can be philosophically reproached only if there is a bridge between their contexts of utterance (generally between colleagues or in private notes) to the client who likely experiences physical harm as a result, which is a fairly difficult argument to make.

There is, however, precedent for making such an argument. Waldron (2012), for example, argued that certain kinds of speech—again, his concern was hate speech—were such that, beyond being offensive, their very utterance undermines the target group's guarantee of safety and freedom in society by overtly attacking the dignity and equal worth of members of the target group. The harm done under these circumstances, even when the speech comes from small and socially-reviled fringe groups, is not negligible, since history shows that the long-term consequences of verbal assaults can result in the most heinous forms of violence and death—Nazi anti-Semitism being one obvious example.

Note too that the equal guarantee of safety and freedom in society is an important interest in which people have rights. As such, anything that truly undermines that guarantee is a lot more like a drunk pilot than two men holding hands. The latter might be quite offensive to some but the former can cause real harm. But Waldron's (2012) argument moves the speech of the group telling foreigners to go back home into the camp of drunk pilots too, since it is just the sort of action that undermines the equal guarantee of safety and freedom in society.

Waldron's (2012) argument stresses the genuine (Millean) harm that occurs when (and because) certain kinds of speech plant seeds of suspicion that germinate in social stratification,

and, in time, culminate in violence. Time, therefore is only one piece of the bridge between the actions of one person to its harm on another. The imbalance of power is another crucial component of the bridge. Philip Hallie (1981) argued that persistent patterns of humiliation made possible in unequal power dynamics produce what he deemed 'the subtlest kind of cruelty': institutionalized cruelty.

Institutionalized cruelty refers to the almost invisible comportment of the majority to assault the dignity and humanity of the minority subjected to it. In its most egregious and obvious form it is exemplified by slavery and Nazi anti-Semitism, but it persists in class distinctions as well. In each of these examples, power is distributed inequitably; a condition that is reinforced over time in such a way all parties are, habituated to the injustice. As Hallie (1981) put it:

> In episodic cruelty the victim knows he is being hurt, and his victimizer knows it too. But in a persistent pattern of humiliation that endures for years in a community, both the victim and the victimizer find ways of obscuring the harm that is being done. Blacks…and Jews come to think of themselves as inferior…so that the way they are being treated is justified by their "actual" inferiority, by the inferiority they themselves feel. A similar process happens in the minds of the victimizers...They feel that since they are superior…they deserve to do what they wish, deserve to have these lower creatures under their control (p. 24).

How does this sort of cruelty become institutionalized—how, for example, did whites come to believe that they were superior and that their enslavement of blacks was justified? Hallie (1981) suggested that over and above the economic and political hegemony of the white majority, language was a powerful tool in perpetuating the conditions and the consequences of the power imbalance:

> Just as important as these "physical" powers was the power that words like "nigger" and "slave" gave the white majority. … They utilized the language to convince not only the whites but the blacks themselves that blacks were weak in mind, in will power, and in worth. These words…diminished both the respect the victimizers might have for their victims and the respect the victims might have for themselves (Hallie, 1981, p 25).

The effect of institutionalized cruelty—its temporal culmination in violence—is not necessarily what makes it harmful. The normalization of attitudes that start from and perpetuate unjust power imbalances is harmful, and language plays a crucial role in its institutionalization. In the case of class distinctions, for example, it is persistent attitudes that regard 'the poor' as 'lazy freeloaders', which keeps poor people in a state of entrapment. In the first place, fewer opportunities and resources are available to bring people out of this condition, and making matters worse, an underlying disrespect for the humanity of people in this condition maintains the status quo.

Something very much like this occurs when counselors regard their clients as difficult, even behind their backs with colleagues, at staff meetings, or in private notes. The label serves to normalize a power differential that strips the client of her inherent right to respectful acknowledgment in the form of unconditional positive regard. In a very real sense, the client becomes the label, to the counselor and to herself. That labeling, while still possibly short of a violation of Mill's (1869) harm principle, is nevertheless a gross injustice to the client, and gravely injurious to a profession that exists to serve them.

Delusions of Normalcy

It is here that there is a crux of the tendency to label clients as difficult—a delusion of normalcy. There is something quite perplexing about the ubiquitous, systemic use of biased language in the treatment realm. How is it that a client expressing symptoms idiosyncratic to a mental disorder and seeking out help from a program designed to provide specialty treatment to address such symptoms of disorder, ends up construed by treating staff as if against some mystical norm of effortless recovery, *abnormally* difficult? What baseline is there for compliance under these circumstances? Moreover, how is compliance operationalized? (for detailed analysis on the use and implications of compliance terminology, see Williams & Mee-Lee, 2017).

There are different ways to make judgments about what is normal or outside the parameters of normalcy. Clinical psychologist, Paula Caplan (1995) delineates five standard assumptions underlying decisions about what it means to be "normal". The first is known as the 'infrequency model' (Caplan, 1995), which looks to the statistical regularity of a behavior as defining 'normal' and whatever is outside this range as defining 'abnormal'. Accordingly, this standard of normalcy is implicitly invoked when staff make judgments about clients being

difficult, which is an umbrella shorthand term applied to clients on the fringe of average, or a few standard deviations from the mean. If most clients are perceived as 'compliant'—the defined or expected norm based on what is seemingly most common— the minority of clients perceived as non-compliant are thought of as 'abnormal' or 'deviant'. One issue with this model is that the range that constitutes normalcy is somewhat arbitrary, which means that in borderline cases the underlying cause of 'barely-compliant' is an important discovery that may be missed in virtue of a decision to call that behavior normal.

The second way to assess normalcy looks to what seems to be 'absent' in the client, with respect to what is deemed 'normally' not absent (Caplan, 1995). This is just a variation of the infrequency model, except that a behavior is either present or not rather than within or outside a range. The absence of compliance, for example, implies that the client is difficult. Of course, since compliance, difficulty, cooperation, etc. are nebulous in meaning and highly subjective descriptions not universally understood or objectively assessed, the lack of certainty and absoluteness is problematic as a client may be judged as difficult to one staff member but not to another.

Another model goes by the name 'delay' or 'fixation' model (Caplan, 1995). A client that does not act his age, for example, or is considered too old to behave a certain way, functionally qualifies as abnormal. The evidence for this label is a demonstrated deficit or difficulty in fitting in socially with peers and staff, a perceived lack of coping skills, or inability to adapt to the prescribed role as a client by violating program rules or staff expectations and attracting negative attention. The myth of so-called co-dependency is a quintessential example of how a client that cares deeply about a relationship and values it over personal autonomy and independence is thought of as immature, fixated, and underdeveloped (i.e. co-dependent).

The fourth model is 'reality-testing' (Caplan, 1995). By this approach, clients who sign up for treatment, follow staff recommendations, and progress to the expectations of staff are in touch with reality, whereas a client who 'bites the hand that feeds them', fails to adhere to a treatment plan, does not complete homework assignments, or present himself in group therapy in some way is not in touch with the reality of addiction and treatment and the hard work necessary to 'beat' drug addiction. This model is similarly arbitrary in its characterization of reality, since group facilitators at different programs have different standards of what is required to overcome drug dependency. One facilitator might, for example, think assigning homework is

'out of touch with reality' and not necessary to help clients overcome drug addiction whereas from the theoretical orientation of a different treatment modality emphasis is placed on helping patients succeed at homework since homework completion correlates with success in cognitive behavioral therapy (Sokol, Fox, Becker-Weidman, 2013). Yet, another treatment program may operate on a different view of reality and treatment philosophy by eschewing excessive rulemaking—especially 'Thou shall not' rules—in the interest of avoiding needless power struggles over control, autonomy, and authority between staff and clients out of which clients are deemed difficult, non-cooperative, etc.

The fifth normality model is the 'disproportion model' (Caplan, 1995). Thus, clients who have too much or too little emotion, thought, feeling, self-control, intelligence, need, want, or some other attitude, action, psychological disposition, or character trait are described as abnormal. The problem with this model is again the arbitrariness of 'too much' and 'too little'. A client is marked as abnormal, for example, by a) being too different or too similar to the counselor, b) being too smart, too fat, too clean, or too anxiety-provoking, c) complaining too much, d) not talking enough or sharing too much in group, e) insisting too much on referrals for medical appointments and specialty referrals, e) being too reliant on medications, f) obtaining too much help through urgent care, g) having too many problems, h) not seeking enough help, support, or feedback from staff, i) having too few days of being 'clean and sober', j) being too slow to get better, k) being too dependent on the program, l) having too many psychological defenses (reaction formation, projection, denial), j) breaking too many rules, k) having too little motivation, m) being too negative, n) not interested enough in treatment or getting better, etc. (Koekkoek, van Meijel, & Hutschemaekers, 2006).

Even if there were a non-arbitrary way to measure 'normalcy', demonstrating normalcy or not would be irrelevant to treatment. Difficulty or non-cooperation from clients may be a clinical sign attributable to core psychological issues (Miller & Rollnick, 2012). For instance, suppose a client violates the non-fraternization policy while in residential treatment by having sex with another client three days after program admission. Possibly, the client's behavior is an expression of being sexually exploited in the past and not a genuine or authentic expression of emotion and feeling for the other client—that is, it may be a clinical sign warranting interpretation consistent with therapeutic help (Roberts & Dyer, 2004a). Similarly, a client's self-defeating behavior in treatment may be related to neurochemical correlates of active addiction or from

brain reward and craving states (Bogenschutz, 2004). But instead of considering the deeper picture, focus is on difference based on value judgments, with their attendant measurement and assessment issues, in determining the proper amount of proportionality which already varies across context, culture, and social-historical forces (Caplan, 1995).

Aside from calculating what is average and therefore normal or abnormal, treatment agencies have built in normative standards for judging behavior and arbitrating labels. These standards are imbued with moral judgments about what sort of client behavior is appropriate and inappropriate, good and bad, proper and improper, healthy and unhealthy, normal and abnormal, right and wrong. Assessment and measurement are sorted by 'objective' rules, treatment protocols, and de facto policy and practices which set the stage for violations that in turn reinforce how agencies have defined themselves, their values, and their treatment protocols and policies. This is a vicious circle. At the heart of biased language are institutionally incubated stereotypes that give birth to ideas of normalcy. Normalcy, however, is an illusion and the agency's focus on 'normalizing' client behavior is a delusion.

Imposition of a label affronts a client's individuality and saddles the client with the negative connotation of that label, and the experience that the connotation has the power to shape (Radcliffe & Stevens, 2008). The reality is that any client may be difficult at one time or another, and that a difficult client can be perceived as such to one staff member but not to another. Similarly, clients perceive staff as more or less caring, accepting, understanding, trustworthy, and, thus, may unconsciously project underlying anxiety to a particular staff member (Miller & Rollnick, 2012). Variations in experience and temperament mean that staff members have different levels of tolerance for different kinds of client behavior. Some staff may lack critical information about the client or client's world, lack the skills to reach client, lack the confidence to apply the strategies and skills needed for the client, or have become so personally invested that they have lost professional objectivity or perspective in the situation.

Conclusion

Treatment staff and counselors cannot possibly scrub the whole counseling context clean of bias or realistically expect a totally bias-free treatment environment—there are too many human factors at play in the terrain to make it humanly possible. However, that does not mean that counselors should not take a full and honest inventory of personality factors, practice

methods, cultural issues, and service delivery standards to work toward reducing the amount of biased language that is endemic in the treatment setting culture of their profession.

Biased language in the form of labeling is unprofessional BS. Labeling clients with descriptors such as 'difficult' (or worse) misconstrues client status and is merely self-serving. It may reflect therapist frustrations, but as categorization it is misleading, often overly negative, and cannot advance the therapeutic process or help clients address their own condition. Labels divert attention from the ineffectiveness of the program, the treatment, or the counselor, and place the responsibility for failures onto the client. Negative labeling prohibits the deeper enquiry necessary to understand and treat the underlying cause of the client's 'difficult' behavior. It represses the true perspective of the client by imposing a narrowly constructed, deficit-based diagnostic, which overshadows the shared decision-making that is essential to the counseling relationship.

Colombo (2008) raised questions that concern how labeling may promulgate power conflicts and antagonistic postures. If the effect of employing unprofessional language is to marginalize client participation, is it not fundamentally unethical for client encounters with their counselor to take place within the boundaries of deficit-based language and labels, if this is inherently disadvantageous to the client?

Labels not only are not beneficial, they are also harmful. Their prevalence is a form of client pigeonholing (i.e., "claims-making") that creates a restrictive narrative and leads to denial of services and top-notch effort that may have been helpful to the client. Language frames perspective, and how clinicians think of clients shapes the language components they use while interfacing with clients, which, in turn, impacts the client's psychosocial functioning and the degree of efficacy of the clinician (Kelly, Saitz, & Wakeman, 2016; Kelly, & Westerhoff, 2010; Miller & Rollnick, 2012). This type of harm is analyzed in the 'harm principle' conceived by Mill (1869), which requires refraining from actions, including use of language, which are damaging to another person's rights. Ordinarily, the effects of language do not rise to the level of physical harm that Mill was concerned to limit. However, seen through the lens of Hallie's (1981) 'institutionalized cruelty', it is evident that the routine of imposing labels on clients *is* a form of persistent humiliation, which serves to normalize a power differential that strips the client of their inherent right to respect. Like all forms of institutionalized cruelty, this indignity fosters a hierarchical, self-perpetuating mindset on both sides of the imbalance, which is harm enough.

Furthermore, all such harmful labeling occurs against a backdrop of assumed 'normalcy', yet such normalcy seems an entirely arbitrary and imposed construct, regardless of how 'normal' is defined. Such labeling is irrelevant to the task of treating people that wish to be helped. Counselors and treatment staff can recommit to the ideals of principled professionalism and unconditional positive regard for clients by eschewing the tendency to use labels, which negatively harm their clients and their client relationships. If a client seems difficult or uncooperative, it is not unreasonable for counselors to engage in self-examination by asking what is being expected from the client, in what aspect of these expectations is the client seen as 'difficult', and why? The counselor in such a scenario might extend such self-analysis by raising many further pertinent questions:

- Am I in a state of denial about being resistant, manipulative, uncooperative, and generally difficult with this client?
- At what point do I seek assistance from colleagues or find sources of support in the literature for how best to address the alleged difficulty?
- Have all expectations been articulated and have I given the client every chance to express his or her reservations?
- What sort of vices does my supposedly consummate professional way of thinking conceal and what sort of virtues does the client's 'difficult' behavior reveal? (Potter, 2016).
- For how long must arguments continue with bickering staff about the difficulty of engaging with this client before sensible professionalism warrants client referral to a different provider for competent and appropriate care?
- And what does the belief that it is acceptable to harmfully name-call clients say to so-called specialists and professionals about the lack of training to ensure we engage with the concept of unconditional positive regard throughout treatment? [e.g. training in good empathic skills are associated with better client outcomes (Kaplan, Keeley, Engel, Emsermann, Brody, 2013), and low empathy counselors can have worse outcomes than no treatment at all (Moyers & Miller, 2013)].

Such questioning aims to advance the therapeutic process and achieve principled professionalism.

Principled professionalism also speaks to treatment staff who no longer believe that the labeling descriptors used in everyday counseling are normal or acceptable. This averting and

correcting of value judgments can be achieved by following the genealogical method proposed by Givens (2015), which entails both linguistic and historical stages. The linguistic stage is intended to investigate the hidden beliefs behind such value-laden jargon and shed light on the rationale for using such biased language. Some questions that might arise out of this stage are the following:

- By what authority or counseling theory is support given to our practice of labeling clients as unmotivated, difficult, or otherwise?
- What is the purpose of frequently calling clients manipulative or conning?
- Whose interest is being served in asserting that the client is in denial?
- What does the client's resistance tell us they are rejecting, especially in terms of the clinic staff and the services provided in the name of treatment? (Mitchell, 2007; Taleff, 1997).
- What alternative language can we use that both reflects our aspirational values and ideals as treatment professionals and fosters change, human flourishing, and growth in our clients?

Next is the historical stage. This is where staff members engage in historical inquiry by searching for the reasons why certain language exists in the counseling context and tracing the history of its deployment. Here, staff critically appraise how such language functions in shaping client and staff identities and their modes of interaction. Engaging in such analysis will hopefully unravel cognitive biases while elevating 'awareness (i.e., 'consciousness raising') that staff will be able to disabuse themselves of faulty assumptions and perceive the requirement for affirmative new standards for conceptualizing client concerns and needs (Given, 2015). As Given (2015) notes: "With a critical eye toward evaluative jargon, counselors may use the genealogical method to clear the ground for new opportunities for clients to engage in the counseling process, achieve preferred goals, and exist as new identities" (p. 20). Thus, the vice of unprofessional deficit-based expression is avoided and the language habits of staff members are redirected to the virtue of solutions.

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