

The importance of language in mental health care



Lancet Psychiatry 2018

Published Online

February 23, 2018

[http://dx.doi.org/10.1016/](http://dx.doi.org/10.1016/S2215-0366(18)30042-7)

[S2215-0366\(18\)30042-7](http://dx.doi.org/10.1016/S2215-0366(18)30042-7)

Used in a constructive manner, language can have a substantial impact on people's lives. In the context of mental illness, mental health, and wellbeing, negative words can be experienced as condescending, isolating, and stigmatising, whereas positive words can convey dignity, empathy, and hope. Colleen Vojak comments, "When used indiscriminately, words can create barriers, misconceptions, stereotypes and labels that are difficult to overcome. Labels can promote separateness and isolation while promoting hierarchical power differentials."¹ Examples of this language use in the context of psychiatry are shown in the panel.

At a 2017 conference, an NHS Clinical Director commented that "as we know, some children with mental health problems don't survive". Using the phrase "mental health problems" for what is in some cases a serious illness or an acute crisis is not appropriate. Mental illnesses, disorders, and issues exist on a spectrum from mild to acute. We should remain alert to over-medicalising experiences and challenges that would be better understood as a response to social or economic factors and normal human experiences: however, some current terminology should be adjusted if parity is to be achieved within the language used in health care.⁶ There are signs that this is happening: for example, at the 2015 New York Mental Health Research Symposium the tone and language used by the speakers when referring to patients with a mental illness or disorder was encouraging; patient and people were the preferred terms, with a total absence of phrases such as mental health problem, service user, and consumer.

In a 2017 publication,⁷ The Royal College of Psychiatrists outlined eight core values: communication, dignity, empathy, fairness, honesty, humility, respect, and trust. It reinforces a stronger, values-based climate which should influence the principles that shape the language and terminology used in person-centred mental health care. For example, the principle of first-person language acknowledges the person first, and then the condition or disability, assisting the shift from deficit-based to strength and resilience-based language. In addition, the Royal College's *Good Psychiatric Practice*⁸ suggests that a therapeutic relationship between a psychiatrist and a patient depends on respect, openness, trust, and good communication. The quality of communication can

facilitate a "doing with, not doing to" clinical approach, enabling effective therapeutic engagement between the patient and the clinician. Enhanced communication skills training should be a requirement for medical students, with the competency being assessed in clinical practice. This point is emphasised in the 2015 UK Supreme Court judgement—*Montgomery v Lanarkshire Health Board*⁹—which sets out a new legal standard for consent to medical treatment. It raises the status of shared decision making from guidance to a legal requirement and concludes that all doctors need the communication skills required to support this process.

The language that people use is based on choice. Uniformity is not always an achievable or realistic aim in complex and diverse environments. Individual terms should be considered in a wider context, focusing on developing a consensus and shared currency of values and principles which underpin the language people choose to use, ensuring consistency and best practice. Culture can change when it is addressed.

It would enhance the quality of care, at no extra financial cost, if everyone engaged in mental health

Panel: Use of language in psychiatry

- A submission by the Royal College of Psychiatrists in Wales to *The Parliamentary Review Panel on the Integration between Health and Social Care in Wales* stated that, "There are many examples of good practice. The Review must take a bottom-up as well as a top-down approach".² These are phrases commonly used by organisations but their use does not suggest that the two approaches are of equal value and importance.
- Parashar Ramanuj comments in the *BMJ*, "I am a psychiatrist who works in A and E. A person I see with panic disorder who is having an asthma attack is a 'patient'. The person in the cubicle next door who is acutely suicidal is a 'service user'. Beyond the perpetuating of stigma and disparity, I fail to see how being a 'user' of anything can be a positive thing. The worst form of projective identification."³
- In DSM-III, the term manic depression was officially changed to bipolar disorder.⁴ Consideration and similar adjustment could also apply to the terms schizophrenia and schizoaffective disorder; the word schizo is often used as a derogatory and offensive term. Altering language can noticeably contribute to reducing stigma.
- The Royal College of Psychiatrists recently launched an excellent and timely UK recruitment campaign known as Choose Psychiatry. However, the accompanying press release, Severe mental illness still misunderstood, contains the following which illustrates the negative impact of chosen language, "What can be better than making a depressed person happy or bring a psychotic one back to reality?"⁵ This statement is inappropriate since psychiatrists cannot make a depressed person happy. Perhaps what the text is wanting to convey is, what can be better than seeing a patient with depression receive the relevant treatment and make a good recovery? Also "or bringing a psychotic one back to reality" should read, or bringing a person with psychosis back to reality.

policy and service delivery were to commit to shaping and influencing a culture and standard of communication which diminishes stigma and promotes language that is appropriate, respectful, and empowering.

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I declare no competing interests

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