Mind your language!

A guide to language about mental health and psychological wellbeing in the media and creative arts

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& Anne Cooke

Mind your language

Many of us experience mental health problems, but it's sometimes difficult to know what language to use to describe them.

It's a delicate topic and it's easy to cause offence or to imply something you didn't mean, even if you use 'official' psychiatric terms.

'Adjust your medication'

One problem is that psychiatric diagnoses carry particular associations in the public mind.
For example, there is a widespread assumption that people who have been given the diagnosis of schizophrenia are dangerous. Perhaps because of these associations, people who use mental health services experience a lot of prejudice and discrimination.

We wouldn't, now, use language that pokes fun at people on the grounds of their sexuality, gender or ethnicity, but some people still use mental health terms as insults.

A classic example was when UK politician Eric Pickles told a survivor of alleged abuse to '*adjust her medication*'.

‘Psycho killer’

Despite the ‘*psycho-killer*’ and ‘*mad axe-man*’ headlines, in reality very few crimes are committed by people with mental health problems.

Even when an offender has a history of mental health problems, there are nearly always other issues that are more relevant in explaining their crimes. However, people with mental health problems are much more likely than others to be *victims* of crime.

‘She’s a schizophrenic’

A second problem is that diagnostic labels are sometimes used as if they represent the person’s whole identity.

This is particularly the case for diagnoses such as ‘*schizophrenia*’ or ‘*personality disorder*’.

People can never be summed up with a single word.

And diagnoses are not life sentences: problems often get better.

So, for journalists and programme-makers, it’s important to avoid language that wrongly implies either, for example referring to someone as ‘*a schizophrenic*’ or saying he or she ‘*is bipolar*’.

‘Ill, diseased, disordered and dysfunctional’

Psychiatric diagnoses are ways of categorising and labelling experiences but - despite what people sometimes think - they tell us nothing about what might have caused them. They are defined in a circular way:

Q. *Why does my son hear voices?*
A. *Because he has schizophrenia.*
Q. *How do you know?*
A. *Because he hears voices.*

People often assume that a psychiatric diagnosis means that someone’s difficulties are caused by an underlying brain problem. However, there is no direct evidence to support this idea.

The experiences that we think of as ‘*mental health problems*’ are very real and can be very distressing, but not everyone finds it helpful to think of them as illnesses.

Using the term ‘illness’ can be useful in acknowledging the immense difficulty that these experiences can cause, and in accessing much needed help and support.

However, it also has significant downsides. For example, it risks perpetuating the frightening but unproven idea that they are caused by brain diseases, and obscuring the fact that psychological distress, however it manifests, is often an understandable reaction to the events and circumstances of our lives.

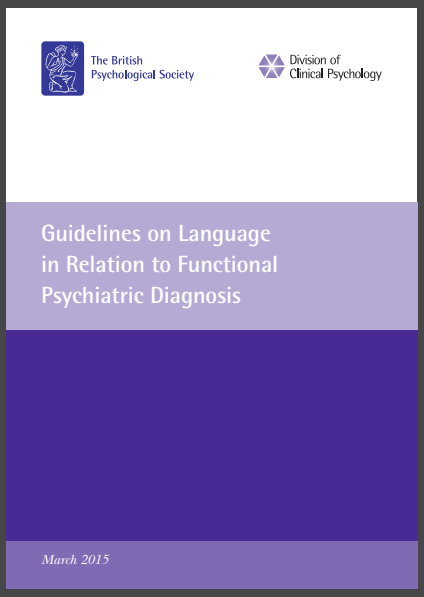
Sometimes the distress comes, not from the experience itself, but from other people’s reactions to it. For example, in some societies, and in some subcultures of our own, hearing voices is seen as a gift rather than a problem.

So, rather than saying that someone ‘suffers from schizophrenia’ (or ‘bipolar disorder’ or ‘personality disorder’), it is more accurate to say that she or he ‘has been given a diagnosis of...’.

Instead…

Wherever possible, it is preferable to describe problems in everyday language, ideally in the person's own words. Ordinary language is not only more informative, but avoids the problems described above. So, instead of referring to '*schizophrenia*', it's better to say what someone is actually experiencing, for example hearing voices or believing things that others find strange.

This is the approach advocated by the British Psychological Society, which has questioned the scientific basis and the usefulness of psychiatric diagnosis.



Rather than saying someone is '*suffering from clinical depression*' we could describe them as experiencing low mood or simply as being depressed and feeling hopeless. When a professional uses the term, it really only means that that they believe someone's problems are serious enough to require professional help.

Rather than describing someone as a '*patient*' with '*symptoms*' which require '*treatment*' (clinical, medicalising, language), we could say simply that someone needs or has sought help from a professional.

The issues are similar when describing anxiety. We all experience anxiety, and those of us for whom it is severe enough to prompt us to seek professional help might be given a label of '*anxiety disorder*'. '*Generalised anxiety disorder*' means that the person is anxious much of the time. It is better just to describe the person's problems ('*extreme anxiety*' or '*frequent panic attacks*' for example) than to use clinical sounding terms that can be misleading and that risk perpetuating the myth that a specific underlying problem has been identified which only experts can understand.

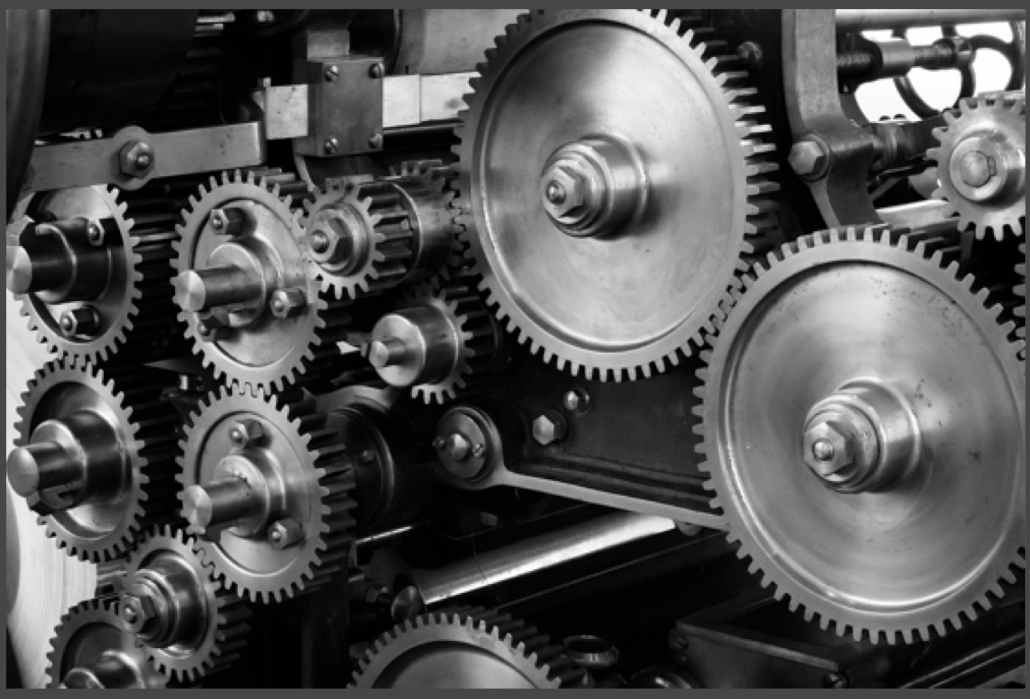
Another common diagnosis is '*Obsessive Compulsive Disorder (OCD)*'. This term means that someone experiences anxious, intrusive thoughts (for example worrying about contamination or danger) and tries to manage them by, for instance, repeatedly cleaning or checking things. Sometimes this can get out of control, take up a lot of time and be very disabling and distressing. Whilst some people find the term '*OCD*' useful, it's often better just to say what the person does or is anxious about.

Often, the clinical terms are just somewhat opaque labels for particular habits or traits. For example, '*trichotillomania*' means that someone has an anxious habit of pulling their hair out, and it's often better just to say that.

The term '*personality disorder*' is sometimes used to refer to a wide range of personal problems, including such things as; self-harm, very low self-esteem, or problems in close relationships. Often, though not always, these difficulties are related to things that have happened to people, perhaps in our early lives, for example neglect or abuse. Feminist scholars in particular have been very critical of the term on the basis that it is invalidating and victim-blaming.

When writing about these issues, the best option is usually to use the words that the person him or herself uses.

… because…



One of the reasons that language matters so much is that using medical terms can get in the way of understanding the reasons that someone's problems might have developed.

Terms like '*schizophrenia*' and the other terms we're discussing here are labels – short-hand descriptions – for patterns of thoughts, emotions and ways of acting that can be problematic for people.

There are obviously reasons why the problems themselves have developed, but the labels used to describe them aren't explanations.

“Don’t ask what’s wrong with me, ask what’s happened to me!”

We all deal with many stressful events in our lives – divorce, rejection, redundancy, bitter disappointments, bereavement and various kinds of failure. Even positive events – winning the lottery, for example – can be stressful. Some of us have more than most to deal with, in the shape of poverty, domestic violence, racism, bullying, family problems, loneliness, abuse or trauma.

For many people, the distress that leads them to seek professional help has roots in social disadvantage: poverty, poor housing, insecure and low-paid jobs, missing out on formal qualifications, living in stressful environments or having to move home frequently. Some young people who grow up in poverty end up in secure training centres or in care, and this also increases their risk of experiencing mental health problems. Former prisoners are also at increased risk.

Even problems that may be difficult for others to understand, such as hearing voices, and those that have traditionally been seen as ‘*symptoms of severe mental illness*’ are often related to stressful events and life circumstances, particularly abuse or other forms of trauma. Between half and three-quarters of people receiving mental health care report having been either physically or sexually abused as children.

As Jacqui Dillon, a writer and campaigner on mental health issues, says: “*Don’t ask what’s wrong with me, ask what’s happened to me...*”

‘No shit, Sherlock !’

Psychologists often become frustrated with the way mental health problems are portrayed: the use of medical language and the idea of ‘*illnesses*’ tends to minimise these connections.

Journalists, people working in the media, film-makers and programme-makers have a responsibility to ensure that the public are aware of these important factors shaping our psychological wellbeing – and the fact that we can do things to change them.

Difficult but worthwhile...

It takes effort to change the language we use.

But avoiding the traps outlined here will avoid unwittingly misleading people and make for better, more accurate, journalism.

We would like to thank the many people who gave us feedback on an earlier version of this leaflet. We plan to review it periodically, and welcome comments and suggestions.

Peter Kinderman is Professor of Clinical Psychology at the University of Liverpool. His research interests are in psychological processes underpinning wellbeing and mental health. He has published widely on the role of psychological factors as mediators between biological, social and circumstantial factors in mental health and wellbeing, and has received significant research grant funding – most recently from the Economic and Social Research Council (ESRC), to lead a three-year evidence synthesis programme for the 'What Works Centre for Wellbeing', exploring the effectiveness of policies aimed at improving community wellbeing and from the National Institute for Health Research to investigate the effectiveness of human rights training in dementia care. His most recent book, 'A Prescription for Psychiatry', presents his vision for the future of mental health services.
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Anne Cooke is a Consultant Clinical Psychologist and Principal Lecturer at Canterbury Christ Church University where she trains clinical psychologists for the UK's National Health Service. She writes regularly for the Centre's blog Discursive of Tunbridge Wells. Anne worked in NHS mental health services for many years. She is interested in the power of ideas, particularly the idea of mental illness which she frequently debates on Twitter and elsewhere. She recently edited the British Psychological Society's influential public information report *Understanding Psychosis and Schizophrenia: Why people sometimes hear voices, believe things that others find strange, or appear out of touch with reality, and what can help* (www.understandingpsychosis.net). She delivers mental health awareness training based on the approach outlined here: www.academia.edu/20006242/Educating_the_Community_for_Social_Inclusion
Anne is the British Psychological Society's Practitioner of the Year 2016-17.
You can follower on Twitter as @annecooke14.

Citations, credits and image sources:

Further reading:

https://www.bps.org.uk/system/files/user-files/Division%20of%20Clinical%20Psychology/public/Guidelines%20on%20Language%20web.pdf
The British Psychological Society's Division of Clinical Psychology guidelines on writing about mental health.

https://blogs.scientificamerican.com/mind-guest-blog/why-we-need-to-abandon-the-disease-model-of-mental-health-care/
Psychological perspectives on mental health by Peter Kinderman

www.understandingpsychosis.net
An overview of the current state of knowledge in the field, concluding that psychosis can be understood and treated in the same way as other psychological problems such as anxiety or shyness. Edited by Anne Cooke.

1. https://pixabay.com/en/crowd-of-people-crowd-people-blur-1209630/
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3. https://www.thesun.co.uk/archives/news/569779/psycho-killer/ and http://nypost.com/2017/03/07/schizophrenic-who-stabbed-his-mom-to-death-to-inherit-3-2m/
4. https://twitter.com/OnlyUsCampaign
5. https://www.bps.org.uk/system/files/user-files/Division%20of%20Clinical%20Psychology/public/Guidelines%20on%20Language%20web.pdf
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