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THE DEPRESSION AND BIPOLAR DISORDER (DBSA)- GREATER HOUSTON LANGUAGE TASK FORCE REPORT

A. INTRODUCTION

Language matters. Language makes a difference. Not only what we say, but how we say it can change the impact of our message on the listener. Speech can comfort and support or hurt and discriminate. Words, depending on their usage, can contribute to clarity and understanding or confusion and misinterpretation. With the importance of effective communication in mind, Depression and Bipolar Support Alliance of Greater Houston (DBSA Greater Houston) commissioned a Language Task Force to undertake a study of the language used in the field of mental health. The major goals of the Task Force are to reduce discrimination and to promote an environment of respect and understanding for people diagnosed with a mental disorder.

The Task Force reviewed existing literature on the subject and engaged in a dialogue with people who have varied backgrounds in mental health. Individuals with mental illness, caregivers, mental health professionals, and members of the general public were consulted. The Task Force also considered the *DSM-5*, the newly released edition of the *Diagnostic and Statistical Manual of Mental Disorders* published by the American Psychiatric Association. The hope is that this report will reduce the mystery surrounding the topic of mental illness, result in a better understanding of mental health issues, and help to eliminate the discrimination that people all too often show toward individuals who have been diagnosed with a mental disorder.

B. DEFINING AND DESCRIBING THE ILLNESSES

The language used to define and describe mental disorders is crucially important. While change in terminology may be unlikely in the foreseeable future, the basic descriptive term used to describe this group of diagnoses, “mental illness,” is confusing because it is typically used in contrast to other types of diagnoses, which are described as “physical illness.” This false distinction between mental illness and physical illness serves to promote discrimination by suggesting that mental illness denotes a separate category of illnesses that are mysterious and threatening. In reality, mental illnesses result from different types of brain dysfunctions, but the brain is no less physical than any other organ in the body, such as the heart, lungs, or liver.

Within the Task Force deliberations and during other conversations, there was much discussion about the terms “illness,” “disorder,” and “mental.” People have different emotional reactions to and understandings of the terms. It was agreed, however, that there is a need to be consistent with language use. In an effort to be aligned with the terminology used in research and in the *DSM-5*, DBSA Greater Houston will use the

term, “mental disorder,” to refer to these diagnostic categories of illnesses. The Language Task Force spent considerable time discussing the challenges related to labeling the diagnoses in the field of mental health. Our hope is that continued discussion of appropriate and helpful terminology will lead to better understanding of these illnesses and help fight discrimination against people who have received such diagnoses.

With respect to specific disorders, the word “depression” is indelibly imprinted in the history of the mental health field. Any discussion of language in this field, however, needs to make note of the confusion frequently associated with the use of the word “depression.” On the one hand, a lay person might use “depression” to describe a mild, temporary form of sadness that people sometimes loosely refer to as “the blues.” This feeling will normally resolve itself in a few days with no medical attention required. On the other hand, as described in DSM-5, Major Depressive Disorder and Persistent Depressive Disorder (previously known as Dysthymia), refer to disabling illnesses that can impair life and functioning, either partially or totally, because of biochemical changes in the brain (American Psychiatric Association, 2013). Individuals diagnosed with Major Depressive Disorder and Persistent Depressive Disorder experience symptoms ranging from mild to very severe, but no matter the magnitude of the symptoms, all can cause major interference with daily life.

Like depressive disorders, Bipolar Disorders have also been misunderstood. Due to lack of education, the general public tends to fear or mistrust individuals diagnosed with Bipolar Disorder. As the name suggests, Bipolar Disorder involves the existence of two poles comprised of multiple symptoms. The two poles consist of the high end, which is described as “mania,” and the low end, which is described as “depression.” Between these two poles, individuals experience a range of manic and depressive symptoms along a continuum. Most individuals diagnosed with Bipolar Disorder experience bouts of depressive episodes that are longer in duration than manic or hypomanic episodes. (American Psychiatric Association, 2013) Because Bipolar Disorder includes episodes of depression, individuals diagnosed with depressive disorders and Bipolar Disorder often find they have shared experiences.

C. PERSON-CENTERED LANGUAGE

In describing the challenges faced by individuals living with mental disorders, the Task Force recommends keeping the focus on person-centered, or person-first, language. Historically, people have been labeled individually or as a group based on their illness (“schizophrenics,” “manics,” “depressives,” “crazy”). This labeling does not help educate people, nor does it fight discrimination, and in fact, labeling may actually add to the fear that exists. The goal of a person-centered approach is to stress the intrinsic worth, dignity, and uniqueness of the individual rather than to focus on the illness or its symptoms. The person will be described as having the illness or a diagnosis of the illness rather than as being the illness (“he has been *diagnosed with* bipolar disorder,” or she *has a mental health condition*”). (Hogg Foundation for Mental Health, 2013) The emphasis will be placed on the individual’s abilities rather than on his or her disabilities. The strategy is to avoid defining people by their diagnosis (“disabled”), to avoid statements

that suggest blame (“she is so manipulative”), to avoid comments that involve judgment or evoke pity (“he is afflicted with depression,” or “she is lazy”), and to avoid statements that define people by their behavior (“she is a cutter”). (Washington State Department of Social and Health Services, 2010) It is particularly helpful to recognize people for the progress they have made. The ultimate goal is to acknowledge the person for his or her personal transformation rather than passing judgment on whether or not the individual is “treatment compliant” (for example, refraining from phrases such as “off his meds”). The Task Force recommends language that promotes acceptance, respect, and uniqueness, and that treats the individual with a mental disorder as greater than his or her diagnosis.

D. LANGUAGE TO AVOID

While using person-centered language is an active approach to creating a respectful and empowering environment, the avoidance of certain language also needs to be considered. Any words that identify the person as the illness are detrimental (“he is bipolar”). Instead, while acknowledging that the individual has a disorder with certain associated symptoms, emphasis should be placed on the fact that the individual is more than his diagnosis. While an individual with a mental disorder may describe herself as “suffering from” or “struggling with” the disease during a given period of time, others should avoid this type of language because it tends to dramatize the illness. (IARSPRS, 2003) Shocking or sensational words (“crazy” or “lunatic”) should definitely be avoided, even if used jokingly. (Washington State Department of Social and Health Services, 2010) Words suggesting that a person with a mental disorder is “disabled” undermine the positive and constructive attitudes that can help people improve their condition. (IARSPRS, 2003) Likewise, words that deprive people of their power to improve are detrimental (stating that someone is “stuck” might prevent them from moving forward, whereas the word “challenged” still allows for movement).

Finally, “stigma” is a word commonly associated with mental disorders, referring to the shame that people feel when they are dealing with a mental disorder. In fact, the major source of the “stigma” is the negative, discriminatory attitude that many people in society exhibit toward individuals who have a mental disorder. (IARSPRS, 2003) Thus, the Task Force recommends avoiding use of the word “stigma” as much as possible because it promotes a victim mentality. Use of the term “discrimination” is preferred since it suggests the ignorance that characterizes people who harbor a prejudicial attitude toward individuals with mental disorders.

E. LANGUAGE OF SUICIDE

Suicide can sometimes be the tragic outcome of a mental disorder. In the event of a suicide, the use of appropriate language can be critical in promoting a proper understanding of the event and in avoiding an unintended hurt to family and friends who are grieving. The term “committed suicide” should be avoided. (Ball, 2011) In its everyday usage, “commit” frequently has a negative connotation and is associated with criminality, such as “committing murder” or “committing adultery.” To say that the

person “died by suicide” represents an alternative, neutral description of what occurred and preserves the dignity of the person who died. This terminology is non-judgmental and consistent with the way we describe other causes of death (died of cancer or died in a car accident). In addition, the words “success” or “failure” should not be applied to an attempted suicide. A suicide attempt that does not result in death is not a failure, but rather an opportunity for the person to find help and hope (Ball, 2011). Every suicide is a tragedy, and certainly not a success.

F. CONCLUSION

Language affects the way people think about and relate to others. The goal of the DBSA Greater Houston Language Task Force is to help individuals become sensitive to language usage in print, online, in staff conversations, in presentations to groups in our community, among facilitators, and in all public and private conversations. To accomplish this goal, DBSA will examine and revise our mission statement as needed. In addition, the Task Force will make a presentation to the Board of Directors concerning the importance of using language properly when speaking of mental disorders. Finally, this document will be made available to the public in an effort to emphasize the need for careful use of language in the field of mental health.

References

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