REFLECTIONS

Reframing language in mental health discourses: Towards a more humane approach

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Abstract

This is a reflection on the nature of language used by psychologists in the contexts of referrals and assessments. Through an example of a brief referral, I attempt to unpack the "clinical" language that may dehumanise and pathologise individuals. Further, I attempt to reframe it through a language, that is not just a shift from "deficits" to "strengths", rather a discourse respecting personhood. With a brief emphasis on neurodiversity and feminism, I reflect on the importance of incorporating affirmative language whether it is neuro-affirmative, queer-affirmative, age- or caste-affirmative, within and outside mental health practice.

Keywords: *Language, mental health, critical psychology, neurodiversity, clinical psychology*

There was a recent, typically brief referral by a psychologist, on a social media group of mental health professionals in India, that read:

> *Looking for a psychologist who deals with children to treat problem behaviors in a 12-year-old child arising after mother committed suicide 3 months ago. Mother was schizophrenic and father is an alcoholic. The child is also suffering from anxiety and has social skills deficits. Any leads will be helpful.*

Whether you are a psychologist or not, you may have witnessed such discourses around mental health by professionals on various platforms. This article discusses questions based on the above example of a referral, and the ways in which it could have been framed with more compassion.

To begin with, how did you feel when you read the above referral? What are your thoughts about the language used? Would you have written it any differently? If so, how? Reflecting on these questions stimulates one to be cautious about the choice of words, and attempts to arouse a sense of empathy for an individual's personhood. As a mental health professional, I would probably have used similar language had I not been exposed to the concepts of neurodiversity, feminist theory, intersectionality, and power structures. Often, these concepts are seldom discussed or taught in clinical training in India. With the seventh edition of the *Publication Manual of the American Psychological Association* (APA) [1] focusing on inclusive and bias-free language in research, there has been a shift to some extent in the use of language around gender, race, social class and age, at least when mandated by editors of reputed journals. However, everyday discourses in the clinical context are still dominated by language that implicitly denotes a certain power or position of the discipline and, sometimes, the therapist. Further, an increasing awareness of queer-affirmative psychotherapeutic practice has helped many mental health professionals to be more sensitive to gender diversity and inclusive language. However, the irony lies in that mental health professionals who are exposed to the "humanistic school of thought'" continue to use such descriptions that dehumanise and pathologise an individual.

When I discussed this concern with a senior clinical psychologist, the argument presented was that "clinical psychology is about psychopathology, psychodiagnostics and psychotherapy, so why not use pathological terms?" A counter-argument can be drawn from a critical psychological framework and social model of disability [2, 3], around the questions of whether psychopathology is always located within an individual or within the contexts in which these mental health difficulties occur and how one understands the unique subjective experiences involved. Can't one reimagine clinical psychology beyond textbook definitions and the fitting of a person's experiences into diagnostic categories, and be more inclusive?

In the disability sector, activists have strongly resisted the medical model that attributes disability solely to bodily dys/functions, and insist on understanding disability in the context of social, capabilities and contextual models, where the social model attributes disablement to society and its failure to provide adequate support [4]. If the mental health sector adopts a similar view on contextual, social and

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cultural origins, it would be possible to understand the person behind the symptoms requiring a particular 'fix' or solution. Consequently, the term "strength-based approach" has been widely used in positive psychology theory, as a way to deconstruct pathology. This approach uses aspects such as helpful factors, hobbies and interests, and skills a person can develop, usually without considering the context of the individual.

Going back to the initial example of the referral, let us reflect some more on its phrasing. Why would anyone want to "deal" with a person or "treat a problem"? Is it not possible to "work with" a person or a difficulty? What does "problem behaviour" mean here? Why is it not looked at as a "response" to a difficult situation? Why is the word "commit" used with suicide? There have been many writings around the decriminalisation of suicide and on the use of terms such as "dying by suicide", despite which "commit" is still used [5]. What does "schizophrenic" mean here? Is the person's identity only defined by a mental health difficulty? Why can't it be "a person who has schizophrenia" or "a person experiencing schizophrenia"[a]? Similarly, why would one want to use the label "alcoholic"? The US National Institute on Drug Abuse has provided guidelines for language use to reduce negative bias, and suggests the broad term "substance-use" for all substances [6]. Next, what does "suffering" mean? Why can't it be "experiencing" or "going through"? Is it considered as suffering by the person concerned or are we assuming it is suffering? And finally, why use the term "deficits"? Why not "challenges" or "difficulties"? If these changes were incorporated into its language, the referral may have read:

> *Looking for a psychologist who works with children, for a 12-year-old child with behavioral challenges whose mother died by suicide three months ago. The mother had schizophrenia and the father has difficulty in managing substance-use. The child is also experiencing anxiety and has social skills challenges. Any leads will be helpful."*

How did you reframe this referral? How did you feel during the process of doing so? To me, it felt liberating, as if I was being kinder and more compassionate to myself.

Besides referrals, such language is also used in psychological assessment reports, especially in the assessment of learning disabilities, autism spectrum, attention deficit hyperactivity disorder (ADHD), among others, where the focus is on "deficits" in various domains. However, these "deficits" can instead be viewed as "challenges", and can incorporate what one "can do" besides living with the challenge in question. Many people, including some professionals, still continue to use the term "mental retardation" [7]. The implications of such practices may be that the person needs to be "fixed", rather than the person's environment can be made more supportive.

The lens of neurodiversity facilitates our understanding of human experiences as "variations" rather than as "deviations" or "abnormal" [8]. Similarly, a feminist understanding of power structures and gender diversity enables us to be aware of rights, privileges, and other oppressive factors [9] and this awareness may lead to a greater capacity to empathise and view people with greater fairness and respect. While it is important to use clinical terms based on the context, and not all clinical terms may incorporate a deficit-based language, it is still essential to reflect on how the patient/client/person using the mental health service would like to represent themselves. When mental health professionals use affirmative language, whether it is neuro-affirmative, queer-affirmative, age- or caste-affirmative, it can potentially encourage everyone to use a language that is more humane and respectful in everyday discourse. If mental health professionals can model healthy emotional experiences within the psychotherapeutic context, then surely, appropriate and respectful language can be modelled as well, both within and outside psychotherapy?

[a]***Note:*** There is an ongoing debate in the disability community on "disability-first" versus "person-first" language. For instance, autistic individuals prefer the term "autistic" rather than "person with autism."

References

1. American Psychological Association (APA). *The Publication Manual of the American Psychological Association*. APA; 2020. 7th ed. Chapter 5. pp. 131-149.
2. Oliver M, Sapey B. *Social work with disabled people*. Palgrave Macmillan; 2006.
3. Seidmann S, Di Iorio. Abnormal psychology: A Psychology of Disorders. In: Parker, Ed. *Handbook of Critical Psychology*. Routledge; 2015. 1st ed. Chapter 9. pp. 88-95.
4. Ghosh N. Introduction: Interrogating Disability in India: Theory and Practice. In: Ghosh N, ed. *Interrogating Disability in India: Dynamics of Asian Development*. New Delhi: Springer; 2016. https://doi.org/10.1007/978-81-322 3595-8_1
5. Padmanathan P, Biddle L, Hall K, Scowcroft E, Nielsen E, Knipe D. Language use and suicide: An online cross-sectional survey. *PloS One*. 2019 Jun 13;14(6), e0217473. https://doi.org/10.1371/journal.pone.0217473
6. National Institute on Drug Abuse. Words Matter - Terms to Use and Avoid When Talking About Addiction. 2023 Mar 8[Cited 2023 Oct 10]. Available from: https://nida.nih.gov/nidamed-medical-health-professionals/health-professions-education/words-matter-terms-to-use-avoid-when-talking-about-addiction
7. Albert AB, Jacobs HE, Siperstein GN. Sticks, stones, and stigma: Student bystander behavior in response to hearing the word "retard." *Intellect Dev Disabil*. 2016 Dec; 54(6):391–401. http://dx.doi.org/10.1352/1934-9556-54.6.391
8. Armstrong T. *The power of neurodiversity: unleashing the advantages of your differently wired brain*. Da Capo Press; 2011.
9. The Listeners' Collective. Indian Wheel of Power and Powerlessness. The Listeners Collective; 2023 Jan 11[Cited 2023 Oct 10]. https://thelistenerscollective.org/indian-wheel-of-power-powerlessness/