Mind your language!

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

Peter Kinderman
& Anne Cooke
“Adjust your medication”

Many of us struggle with mental health problems. So it’s important to choose our words carefully and avoid unnecessary offence. We wouldn’t, now, use language that pokes fun at people on the grounds of their sexuality, gender or ethnicity. It is equally unacceptable to insult people because of their mental health status.

We do not want, for instance, to tell someone who has survived childhood sexual abuse to “adjust your medication”.

Many of us sometimes do irrational, bizarre or self-destructive things. Politicians are particularly good at it. Both satire and robust political journalism rely on accurate and honest description. But it’s very easy for the language of ‘crazy’ and ‘nutters’ to drift towards insults.

We need to be able to report the news, including tragic events and irrational behaviour, without either causing unnecessary offence, or more importantly, without unwittingly perpetuating inaccurate and unhelpful ideas about mental health.
One alternative is to use medical language such as psychiatric diagnoses, but even these can be problematic.

One problem is that psychiatric diagnoses carry particular associations in the public mind, for example the widespread assumption that people who have been given the diagnosis of schizophrenia are dangerous.

This is most likely a result of negative and stereotyped media reporting.

Homicide and crime are the most frequent themes in coverage of mental health, and films and television dramas tend to depict people with mental health problems as violent and unpredictable.
“Psycho killer”

In fact, 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.

People with serious mental health problems are much more likely than others to be victims of crime.

But the idea of the ‘psycho-killer’, the ‘mad axe-man’, remains popular, especially in the tabloids.
“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 people experiencing psychosis – “schizophrenics”.

Labels are for things, not people.

People cannot and should not 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.

We should never say that someone “... is a schizophrenic...” or “...is bipolar...” or “...is schizophrenic...”. Labelling the person is simply wrong. It is scientifically inaccurate and insulting.
Psychiatric diagnoses are shorthand descriptions of people’s experiences. So, even when used technically correctly, there are a number of problems with their use in the media.

They tell us little about the nature or causes of someone’s problems. Rather than being ‘diagnostic’ in the traditional sense of pinpointing a cause, they are circular: “he’s committed an irrational act because he’s irrational”.

They also risk implying that the problems are qualitatively different from ‘normal’ distress or confusion and result from an underlying brain problem or disease. For example many people assume that “clinical depression” is fundamentally different to the low mood that many of us experience from time to time. However in practice the term usually indicates not a different type of depression, but rather that he person’s mood has been so low that they have sought professional help.
Mental health is a contested area: there are no blood tests or other independent tests for, say, depression or schizophrenia. There is no direct evidence that psychological distress and confusion are necessarily symptoms of an underlying illness or brain problem. Describing them as ‘mental illnesses’ (in other words, attributing the person’s problems to a hypothetical disease) is just one way of conceptualising them, and not everyone agrees that it is the most helpful one. There is a debate about whether quasi-medical diagnostic labels such as ‘schizophrenia’ are ever helpful.

One reason is that they risk implying that a cause has been identified; that people have unusual beliefs or hear voices “because they have schizophrenia”. So, rather than saying that a person “... suffers from schizophrenia...” (or bipolar disorder or personality disorder...), it is better to say that she “… has been given a diagnosis of...”.

That’s more accurate, but even better would be to describe the person’s problems in ordinary language.

As well as being less misleading, and less likely to be used as an insult, descriptions in ordinary language are far more informative. So, instead of referring to “schizophrenia”, it’s better to talk about someone “hearing voices”, or whatever their particular experience is. Instead of referring to “paranoid schizophrenia” or “paranoia”, we could say “… she was terrified that people were plotting to kill her...”.

This is the approach advocated by the British Psychological Society, which has been sharply critical of psychiatric diagnoses for the reasons outlined here.
In order to avoid these problems, it’s better to use ordinary terms that describe what the person actually experiences. For example rather than ‘suffering from clinical depression’ we could describe someone as experiencing “low mood”, “depressed mood” or simply as being depressed and feeling hopeless. 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.

When describing anxiety, similar care is needed. We all experience anxiety and those of us whose anxiety is severe enough to prompt us to seek professional help might be given a label of “anxiety disorder”. Similarly, ‘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”, “fear”, or “worry” for example) than to use clinical sounding terms that can be misleading and that risk perpetuating the myth that a specific problem has been identified and there is something wrong with the person or their brain.

Instead of “personality disorder”, it is better to talk about “self-harm” or “difficulties in intimate relationships” or “mood swings” (depending, of course, on the nature of the person’s problems)... and we should remember and recognise that such difficulties nearly always signal that the person has survived abuse or victimisation in childhood. The best option is often to use the words that the person him or herself uses to describe the difficulties.

Another common diagnosis is “obsessive compulsive disorder”. But again what that term means is that someone experiences anxious, intrusive, thoughts (for example worries about contamination or danger) and tries to manage them by repeatedly cleaning or checking things. Sometimes these can get a bit out of hand and take up a lot of time (and they don’t offer long-term solutions, of course). It’s often better just to say what the person does and worries about. Similarly, using strange sounding words like “trichotillomania” might give us a frisson of thrill, but if someone has an unfortunate habit of anxiously pulling their hair out... it’s better just to say that.

… instead…
One of the reasons that language matters so much is that using clinical terms can get in the way of the very important issue of understanding other 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 complex patterns of thoughts, emotions and behaviours. The problems themselves – hearing voices, holding unusual beliefs, etc. – clearly have developed for reasons.

But the label used to describe them isn’t an explanation.
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.

There is a clear link between the kinds of distress that lead people to seek professional help and social disadvantage: poverty, poor housing, insecure and low-paid jobs, missing out on formal qualifications, living in crowded city areas, 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 very serious problems such as hearing voices can be reactions 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...”
For journalists, broadcasters and writers, it’s particularly important to make the connection between the events and circumstances of our lives - trauma, abuse, poverty, unemployment, bullying, social disadvantage, inequality -, and our psychological wellbeing.

Psychologists often become frustrated with the way mental health problems are portrayed. The importance of the events and circumstances of our lives in the origins of mental health problems has been demonstrated over and over again.

And yet... probably because of the incessant use of medical language and the idea of ‘illnesses’ ... they are routinely overlooked and minimised.

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.
“Yes, you know, you’re right, it’s hard… … most worthwhile things are.”

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, more elegant, journalism.

Here... We’re asking for a bit more work, a bit more thought. But that will ultimately lead ultimately to better writing and broadcasting.
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.
You can follow him on Twitter as @peterkinderman

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). Anne is the British Psychological Society’s Practitioner of the Year 2016-17. You can follow her on Twitter as @annecooke14.
Further reading:


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

6. https://twitter.com/OnlyUsCampaign
8. 
13. © Peter Kinderman and © Anne Cooke