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EDITORIAL

Words matter

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"A rose by any other name would smell as sweet"
– William Shakespeare,
Romeo and Juliet, Act 2, Scene 2

"Don't you see that the whole aim of Newspeak is to narrow the range of thought? In the end we shall make thoughtcrime literally impossible, because there will be no words in which to express it"
– George Orwell, *1984*

In this issue of *Annals of Clinical Psychiatry*, North and Pfefferbaum[1] describe the impact of changing terminology in psychiatry, highlighting the use of the term "mental" instead of "psychiatric." As they point out, use of the word mental was largely influenced by persons and organizations that were not psychiatric, possibly (we think) motivated by gaining their cooperation.

Perhaps the best example of its use is in the full title of DSM-5, *Diagnostic and Statistical Manual of Mental Disorders, 5th ed*. Mental has since been watered down to mental health, while the term behavioral health has gained popularity. The terms mental health and behavioral health lack semantic clarity; we are unable to clearly define what mental health or behavioral health are, or exactly what those terms mean. The newer terms may have had the laudable goal of reducing stigma, but some experts conclude the opposite occurred by pushing psychiatric disorders further from the rest of the medical field.[2] The example from North and Pfefferbaum of the substitution of mental for psychiatric is instructive, but is only 1 example in a field rich with substitutions (eg, the name of the National Institute of Mental Health, 1 of only a few institutes not using the name of disease[s] or organs for the research it conducts).

One must consider that language is always evolving. This is true in psychiatry, just as in the world. Terms we now find unacceptable (eg, insane asylum) were once commonplace, only to be replaced by more

neutral and perhaps less pejorative terms (eg, psychiatric hospital, mental hospital). But have we gone too far? Have we lost perspective by discarding perfectly useful terms because they offended someone? And if a person, or group, was offended, why? Over time, replacement terms accumulate their own baggage and are then discarded.

Psychiatry has a long history of discarding arguably useful terms, only to replace them with terms, words, or phrases that are imperfect, less descriptive, and ultimately less meaningful. We all lose when we water down language such that the new terms lack meaning. We often replace terms that may offend someone, but the target keeps moving. One person's psychiatric illness becomes another's mental health disorder, or now, a behavioral issue. Issue is perhaps the most overused and hackneyed term, but it has rapidly gained a foothold in our profession. It conveys nothing, yet daily we hear colleagues refer to the patient's issues, not their psychiatric disorder. In the race to avoid making someone uncomfortable, are we losing our ability to communicate?

Take diagnoses. As psychiatrists, we diagnose and treat mental disorders and there is no way to sugarcoat a diagnosis, even if some psychiatrists and patients reject it. For example, a diagnosis of borderline personality disorder (BPD) is often considered stigmatizing, and for that reason many clinicians are reluctant to make it.[3] Many patients with BPD are not even told their diagnosis. Why? Probably stigma, and even many psychiatrists don't like the diagnosis. On the other hand, certain diagnoses (such as bipolar disorder, posttraumatic stress disorder [PTSD], and attention-deficit/hyperactivity disorder) seem to be in vogue, and patients appear to like these diagnoses. Sometimes psychiatrists enable patients by conveying their own discomfort with a diagnosis. Patients have the mistaken belief that these disorders are better (ie, less stigmatizing), more treatable, more biologic, or better yet, more neurological. These notions are often incorrect.

We have seen this in particular with veterans and PTSD. We have had patients who attribute all manner of behavioral symptoms to PTSD, rather than to a less acceptable personality disorder diagnosis. In our view, the need to develop more palatable diagnostic terms is often driven by stigma.[4] Don't like BPD? How about emotional dysregulation disorder? Don't like dementia? How about neurocognitive disorder? Don't like mental retardation? How about intellectual disability? Changing the term doesn't make the patients go away.

We expect that in another 20 years we will develop substitute terms for all these conditions that are considered more politically correct. Yet, in another 20 to 30 years, these new terms may become stigmatizing and politically incorrect, too. Realize the common lay language term "going mental" is becoming pejorative these days.

Other terms have served to diminish the role of physicians, who are now often known as "providers."[5,6] The term provider suggests we are one of many coequal clinicians and differ little from psychologists, nurse practitioners, physician assistants, or social workers. Mangione et al[5] wrote "To characterize doctors as mere providers is a linguistic debasement that further reduces our professional identity. It downgrades physicians to practitioners who provide services that others could render." While the word was first recognized in United States federal law in the 1970s, it has a darker history due to its use by the Third Reich to debase Jewish physicians.[5]

Our own observation is that the use of provider accelerated under managed care in the 1990s, perhaps as a cynical ploy by insurers to make us all appear interchangeable. If all are equal, why should reimbursement differ? And with other "me, too" disciplines chipping away at our boundaries, perhaps we will all eventually be equivalent. Psychologists want prescribing authority, which nurse practitioners and physician assistants already have. The latest trend is physician assistants rebranding themselves as physician associates. And, of course, our patients are now consumers, clients, or users, terms that only serve to further monetize the doctor-patient interaction. The commercial roots of the terms consumer, customer, and client, and the fact patients themselves do not prefer to be labeled this way, have been reported long ago. Probert et al[7] asked 100 patients whether they preferred to be called consumers, customers, clients, or patients. Most (N = 96) preferred to be called patients. In a scoping review of 33 articles examining generic "preferred terms for labelling individuals who access health care across settings," 27 reported a preference for patient, and 4 for client.[8] Those who preferred client were typically based in mental health settings and from studies conducted in the USA. As Andreasen[9] pointed out, "patient" is derived from the Greek word pathos (suffering), and literally means "one who suffers." This is a descriptive, not demeaning term. In her discourse on the commercial connotation of the word consumer, Andreasen[9] wrote about the pernicious devaluation of the doctor-patient relationship when using this

term: "If doctors perceive themselves as 'selling services' they might as well join the world's oldest profession."

We could go on. "Evidence-based" is another overused and overstated term used to reassure us that what we do is scientifically founded, as if prior generations never followed data or considered evidence. In truth, much of what we do is not evidence-based, though we wish it were. For example, there are no FDA-approved medications for most DSM-5 disorders. For that reason, many of our patients cannot truly be said to be prescribed evidence-based treatment. The same is true for psychotherapy. Most patients who engage in psychotherapy are probably not receiving an evidence-based therapy (eg, cognitive-behavioral therapy, dialectical behavior therapy) and instead receive generic supportive therapy. For these reasons, psychiatric treatment will remain an art long into the future.

Language is constantly evolving, but psychiatry should resist and possibly prohibit[10] changes that further erode and confuse public perceptions of our education, training, or expertise. The language used by others—namely business administrators, insurance companies, and members of other professions attending to the needs of patients—is part of a subversive effort to demedicalize, commodify, commercialize, and industrialize medicine, especially psychiatry. The Newspeak used by these entities is incompatible with and contrary to our core values.

As Nasrallah[11] wrote, "We are physicians, not providers, and we treat patients, not clients!" As physicians, we have a rich tradition. Let's uphold that. ■

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