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Review Article

Mental Health: Stigma, Language and Nosology

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Abstract

Fundamentals: Medical care in the scope of mental health is still facing important barriers. The aim of the present work is the critical study on specialised quality literature on this field, considering that mental health is a priority problem in public health. This work aims to provide a topical, narrative, analytical and exhaustive reflection on the obstacles that stigma, language and nosology entail.

Methods: Secondary research consisting of critical examination of other related works which are mainly theoretical and clinical but rarely empirical studies.

Results: A new use of language is being postulated; however, this may not entail traditional operational syndromic criteria being downgraded. On the other hand, the media's approach to mental health is currently being highly questioned since there are countless erroneous ideas, frivolities and myths that are constantly repeated. Likewise, certain sensationalist speeches reinforce stigma. Language must be understood as a linguistic behaviour that will also require a relevant philosophical and analytical approach, taking into account that the conversation on health and disease does not operate the same way in different contexts. We will critically and superficially deal with diagnosis, discrimination and prejudices surrounding mental disorders.

Conclusions: The tendency towards stigmatisation of mental disease occurs in almost all spheres and this signifies important communicative and cultural challenges. The scientific deliberations and controversies presented in this work on the use of language in diagnosis and the current and potential taxonomic systems on mental disease are highly topical.

Keywords: Language; Mental Health; Nosology; Prejudice; Stigma

Introduction

Patient care in the broad sphere of mental health still faces barriers in terms of features, education and costs. In the last decade a plethora of research has been verified concerning stigma in mental health [1]. Likewise, numerous are the theoretical assumptions on which the multifaceted concept of "mental disorder" is based, depending to a large extent on the empirical framework used.

Significant diversity exists in certified health education of psychiatrists and clinical psychologists [2]. Research into mental health, in general, is in quite a critical state. In this field there are moreover many confluences between the natural and human sciences. It is now time for European psychiatry and clinical psychology to develop suitable language in which to study the mind, psychopathology and nosology, which are quite heterogeneous contexts. In this direction, projects such as the *Roadmap for Mental Health Research in Europe* have been encouraged with the aim of developing a comprehensive, coordinated research agenda [3, 4].

We will presently examine stigma and knowledge in mental health, the stereotypes, ideological prejudices and discrimination, as well as some aspects of the modern taxonomy and certain international recommendations. To better contextualise the text, readers are referred to, among other documents: *Mental Health Promotion and Mental Disorder Prevention: A Policy for Europe* (2005), *European Framework for Action on Mental Health and Wellbeing* (2016) and *European Programme of Work, 2020–2025 – "United Action for Better Health in Europe",* all published by the World Health Organisation. The goal of our research is to help understand important basic aspects related to mental health that widely concern health professionals and society.

Material and Method

The basis for the research has been the compilation selected by the authors for this study of the highest-quality, albeit disperse and scarce, related scientific bibliography. A concise epistemological, cultural and philosophical analysis will be conducted concerning psychosocial health as well as concerning use of technical language in health and mental pathology. The amount of literature of any type published on

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the subject is extensive, but generally incidental and of very uneven qualification.

Methodologically, the present contribution is a brief "metasynthetic" review of a relevant, topical issue, which will be presented as a critical examination of other works, mainly theoretical and clinical approaches. We use the concept of metasynthesis to refer to ways of integrating findings from qualitative research [5]. The methodology has been chosen primarily because of the highly subjective nature of the information sources, which in turn constitutes the main limitation of both the excellence of these sources and of this research.

Results and Discussion

- **Culture, Language and Stigma**

Modern anthropology understands culture as a diverse and different, fluid and flexible set of systems elaborated by different societies. The social stigma of mental disorders, deemed a condition or "brand" that triggers exclusion, varies according to language and culture. It has been suggested that it may be higher in Spanish-language media compared to English-language media [6]. In fact, the media's approach to mental health is nowadays being heavily challenged. So promoting and disseminating specific pedagogical interventions on mental health has been proposed, aimed at the world of journalism [7] while carrying out timely anti-stigma actions [8], including self-stigma.

Mental health should be considered a priority public health issue [9]. See, among other documents: a) former Recommendation 818 within *Situation of the Mentally Ill* (1977) of the Parliamentary Assembly of the Council of Europe; b) *Monitoring the Convention on the Rights of Persons with Disabilities* (2010) of the United Nations (UN); and c) Royal Spanish Decree 1030/2006, updated in 2019, which established the portfolio of common services in Spain's National Health System.

There are a multitude of misconceptions, frivolities and myths about mental health that are repeated. When this occurs in ordinary language and especially on social media, it inevitably generates stigma. Language is the form in which thought is built and expressed, so for the vast field of mental health, those involved must set out to find that which is ideal or most appropriate and free of sophistry for each occasion. It should be noted there is currently a growing interest in electronic natural language processing strategies [10], but they may have uncertain consequences and outcomes in this sphere.

Certain sensationalist discourses on mental disorders reinforce stigma, when what would be ideal is to favour intersubjectivity, defined as mutual understanding, so as to improve human interaction. A psychiatric framework based on tolerance [11] and large doses of empathic behaviour are recommended for the mental health field. Empathy is known to be vital in pro-social, interpersonal relationships and is closely correlated with therapeutic success, more so for cognitive than for emotional empathy. This means that, where appropriate, the subject will have to modify his or her own discriminatory styles of which he or she is aware and mitigate or suppress the resulting aversive events.

One of the premises of developmental psycholinguistics is that each individual experiences his or her own life according to certain narratives that are learned through language and media. Some authors call this implicit subjective quality "narrative identity" [12], a narrative that commonly recalls episodic or autobiographical memories and is more interesting to the listener when there is coherence in the narrative [13]. Functional magnetic resonance imaging suggests that structures in the cerebral cortex are dynamically reactivated to support vivid verbal recall [14].

The first-person narrative of the patient or client may not be linear and reject coherence, but it will be relevant to recovery from a mental disorder. It will often incorporate social, political and legal aspects [15]. Taking into account the complexity of the identification process, narrative psychology has been dealing in particular with the difficulties of identity formation in adolescence [16].

It should be considered that for the so-called "philosophy of mind" the so-called "neutral monism", as opposed to the traditional mind-body dualistic abstraction, neither prioritises mind nor matter and seems compatible with the hypothesis of the "psychoneural identity" of materialism. That is, it is assumed that mental activity resides in the brain and is the province of neural configurations [17]. Logically, such an assumption would have to be properly inferred from the narrative language used by health workers.

It is true that discourses on health and illness function differently in different contexts, mainly insofar as they usually carry ideological implications. In the field of mental health in particular, language, verbal or not, has to be understood as applied interdisciplinary linguistic behaviour that will require the appropriate analytical philosophical approach. Leaving aside the clinical approach chosen by the specialist, analytical philosophy is understood here to mean that which is particularly interested in the study of language and its logical analysis.

From the clinical perspective, the relevant professional will have to bring about a real updating of his or her epistemological attitude to deal with the origin, revision and legitimisation or validity of the corresponding applied knowledge. It should be borne in mind that before interacting professionally with a person, the characteristics of the linguistic approach to that person should be chosen correctly. In addition, the patient or client should be encouraged to maintain the internal self-directed discourse or language that is most conducive to him or her, as it will enhance cognitive processes such as working memory, perception and categorisation, as well as executive functions [18].

The importance of language and the quality of communication in the context of the early home environment for favourable shaping of children's neurocognitive trajectories should be underlined [19]. Similarly, older people will experience changes in their mental skill set or cognitive functioning, which may include both language and the ability to communicate more broadly. In this respect, the *Estudio*

Longitudinal Envejecer en España ("Longitudinal Study on Ageing in Spain", 2011), partly promoted by the Centre for Human and Social Sciences of the Spanish National Research Council (CSIC) is worth consulting.

A common framework and set of terminology to refer to stigma are lacking. Nor is there a substantial body of robust, quality research on the stigma associated with mental disorders, although there are many related publications of all kinds [1]. Cross-stigma is a common reality that most likely holds back the clinical and personal recovery of people with mental disorders, but remains poorly understood [20, 21].

Among other instruments, Spanish versions of the following have recently been validated: *Discrimination and Stigma Scale* for people with schizophrenia [22] and the *Peer Mental Health Stigmatization Scale* [23] for adolescents. Within Spain, Royal Legislative Decree 1/2013, which approved the *Texto Refundido de la Ley General de Derechos de las Personas con Discapacidad y de su Inclusión Social* ("Consolidated Text of the General Law on the Rights of Persons with Disabilities and their Social Inclusion"), updated in 2017, can be consulted.

Studies on micro-aggressions against stigmatised people are emerging, albeit heterogeneously, almost everywhere [24]. To conclude this section, we will only mention here that one should be aware how varied are the possible tolerance responses of the stigmatised subject, or that subject who feels that he/she may be stigmatised, since that expectation can significantly alter his/her behaviour [25].

- **Mental Health Prejudices and Stereotypes**

Suffering stigmatisation is a common experience among mental health service users, although this is not always the case [26]. Stigmatising agents may be the professionals involved themselves [27] and even trainees, such as medical students [28]. Widespread and popular negative labels, unfair prejudices and the easy tendency to scaremongering and generalisation are important issues in stigmatisation processes. This is the case with the often supposed or alleged automatic association with lasting psychosocial disability, which in the employment context signifies a considerable, complex problem. In this regard, see the UN's *Guide for Business on the Rights of Persons with Disabilities* (2017).

As a general rule, in everyday clinical practice gender-stereotypical beliefs and consequent prejudicial attitudes exist [29] which, though unintentional, can lead to epistemic injustices, such as discrediting based on biases.[1] Stereotyping is, in essence, the simplified set of cognitive constructs or schemas and expectations that are usually by-products of socialisation.

Stigma and discrimination of all kinds, including those applied to racial or ethnic minorities occur in multiple health care settings and undermine diagnosis, treatment and successful health outcomes. Internalised cognitive and other biases have the potential to seriously affect the quality, consistency and accuracy of decision-making in professional clinical practice [30]. Usually the individual who is stigmatised is also stereotyped and stereotyping is often resistant to change. In addition, mental disorders in any age group, particularly in children and adolescents, are undoubtedly one of the major health challenges of our century, including the consequences of bullying behaviour resulting from stigma.

- **Discrimination and Diagnosis**

The difficulties of advancing in taxonomy of mental disorders that could be useful to research have hampered the results of many published clinical studies. Insofar as the language of so-called "functional diagnoses" is concerned, it is worth consulting the statement of principles of the Clinical Psychology Division at the British Psychological Society, compiled in *Classification of Behaviour and Experience in Relation to the Use of Functional Psychiatric Diagnoses* (2013). This classification aimed somewhat speculatively that psychopathological diagnoses should be understood more as a response to psychosocial factors than as an expression of true disorders or illnesses. Clearly, if this latest nosological understanding continues to prevail, it will also continue to be associated with the dominant biomedical model,[2] a model that is considered reductionist by many authors.

To combat the biomedical model that some question, a new use of language has been postulated within the ambitious, aforementioned British Psychological Society's classification system, but it is left to individual criteria as to which each professional prefers. So consequently, it would be almost inevitable to depart from traditional operational and differentiating nosological criteria to make mental health diagnoses. These would probably likewise encourage terminological, clinical, descriptive and therapeutic confusions. And it is reasonable to assume populism; even unqualified practice might be stimulated.

In a singular fashion, it has been proposed to increase the role of phenomenology in psychopathological diagnosis [31], the historical background and roots of which remain as relevant as ever [32]. There is a fairly widespread demand to take into account the individuality, subjectivity and phenomenology of patients with mental symptoms. Such a demand is routinely made in conjunction with the futuristic vision of an analysis increasingly packed with biological and other individual data in the name of an ambitious yet unclear, personalised therapy [33].

Ideally, it has been proposed to introduce the so-called contextual or personalised "precision diagnosis" into professional practice [34–36] as a promising emerging therapeutic approach, but the reality is that the very foundations of the concept of precision in psychiatry and clinical psychology are not secure [37]. A provocative taxonomy of psychopa-

1 At least in the domain of mental health, stereotypes linked to the socio-cultural construct of "gender" often lead to overcompensation.

2 Descriptive scientific psychopathology is the semiological basis of clinical practice. It should clarify what proportion of psychosocial and biological elements, where applicable, occur in each symptom described. Naturally, it would have to agree on an updated common narrative that must be subject to continuous changes of many different kinds.

thology composed of continuous dimensions rather than the usual discrete categories is also being encouraged [38]. If effective, this project would bring about a major change in clinical assessment and diagnosis, which is supported by more authors, especially those who are emphatically against diagnostic promiscuity or belong to the field of psychology [39, 40].

The so-called "transdiagnostic approach" to mental disorders seeks to identify as many factors as are common to different pathologies. It also aims to be the most humanistic, innovative, up-to-date and promising alternative to conventional nosology. Recent proposals in this regard are the "Research Domain Criteria" (RDoC) by the USA's National Institute of Mental Health. RDoCs have emerged as an open, integrative framework to provide empirically based theories on the pathogenic mechanisms of mental disorders [34, 41, 42]. Indeed, it is true that many of the neurobiological dysfunctions currently identified are transdiagnostic. What is certain, however, is that no credible nosological paradigm shift has materialised so far [43], which applies to RDoCs and Bakker's aforementioned proposal [39], which would thus be relegated to remaining basically illusory projects.

Particularly relevant and critical are the issues of suicide and violence. Violence, understood as an attack on free will, breaks the quintessence of Kantian pragmatic ethics, as does suicide when it betrays a duty. Both actions will affect, where applicable, the obligation for appropriate limitations of the required informed consent of the actor subject [44]. They will also compromise the value of deontological and confidentiality requirements for the technical practice in the field of mental health and, therefore, of any psychotherapy [45]. But specifically, the use of violence need not imply mental pathology. The default narrative that emphasises the link between severe mental disorder and violence increases stigma and discrimination.

To conclude, it is not a matter of overestimating modern "neurotechnologies", understood as new proposals to diagnose and intervene in various mental disorders. They include so-called biofeedback therapy and Internet-based digital therapies [10, 46] or those using mobile phones [47]. Neurotechnologies often attempt to offer hypothetical alternatives to well-established health care options such as psychiatry and clinical psychology in an undiscriminating way. Or they aspire to become accessory modes of communication for both specialities. In fact, it is common for them to be advised by or involve non-health, non-medical or non-mental health staff [48]. These types of neurotechnical language are promoted with a great deal of autonomy, even knowing the risks involved and that the two specialities mentioned coincide in their usual praxis in the best scientific study on mental health, as well as being acceptably rigorous and aware of their limitations.

Conclusions

In practice, the tendency to stigmatise mental pathology occurs in all areas: health, social, educational, communicative, occupational, and domestic and others. Often multiple stigmatised identities also converge within one person or group. It is of great importance for those involved that pertinent, well-advised self-discipline, responsible for fostering language and attitude, with special emphasis on media interventions, occurs normally. This is a challenge for all concerned, be they individuals, professional organisations, associations, scientific societies, the media or institutions.

We can say that it is a current, common challenge to be aware of the stigmas that are almost immediately assigned to people who have any mental pathology, without excluding other pathologies and circumstances that are equally stigmatising. It would therefore be highly appropriate to contextualise the cultural environment and language used about any psychological diversity on any occasion, including the prejudices and stereotypes attached to it.

Related and equally topical issues are the scientific deliberations and controversies concerning present and future diagnostic and taxonomic systems of mental pathology, as well as the relevant applied language. It is up to the staff concerned not to turn atypical coping with ordinary life problems necessarily into disorders. Many of the issues raised here continue to be hotly debated today, sometimes even controversially.

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