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Championing Person-First Language: A Call to Psychiatric Mental Health Nurses

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Abstract

At the heart of recovery-oriented psychiatric mental health care are the dignity and respect of each person and the ways in which helping professionals convey a person's uniqueness, strengths, abilities, and needs. "Person-first language" is a form of linguistic expression relying on words that reflect awareness, a sense of dignity, and positive attitudes about people with disabilities. As such, person-first language places emphasis on the person first rather than the disability (e.g., "person with schizophrenia" rather than "a schizophrenic"). This article champions the use of person-first language as a foundation for recovery-oriented practice and enhanced collaborative treatment environments that foster respect, human dignity, and hope.

Keywords

person-first language, inclusive language, stigmatizing language, disability language, recovery-oriented practice

Since 2010, the Substance Abuse and Mental Health Services Administration (SAMHSA) strongly supports a national agenda of mental health recovery-oriented values and principles among psychiatric mental health professionals. The agenda builds on the National Consensus Statement on Mental Health Recovery (SAMHSA, 2006), the President's New Freedom Commission Report on Mental Health (2003), and the Surgeon General's Mental Health Report (U.S. Department of Health and Human Services [DHHS], 1999) and its supplement, Mental Health: Culture, Race and Ethnicity (DHHS, 2001). The first lays out 10 fundamental components of mental health recovery, whereas the latter three reports provide a rich context for understanding the national and local evolution of mental health services toward a recovery orientation.

At the heart of recovery-oriented psychiatric mental health care are the dignity and respect of each person and the ways in which helping professionals convey a person's uniqueness, strengths, abilities, and needs. "Person-first language" serves as an essential starting point for conveying respect and for addressing the social exclusion and discrimination experienced by people with mental illnesses (SAMHSA, n.d.).

What is "person-first language"? It is a form of linguistic expression relying on words that reflect awareness, a sense

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of dignity, and positive attitudes about people with disabilities (Washington State Developmental Disabilities Council, 2009). As such, person-first language places emphasis on the person first rather than the disability (e.g., "person with schizophrenia" rather than "a schizophrenic").

The purposes of this article are twofold: (a) to explore the importance of person-first language for the successful provision of recovery-oriented care and (b) to set the stage for a call to action of psychiatric mental health nurses to have person-first language become integral to their practice and serve as a foundation for promoting recovery for the individuals they serve. These purposes are particularly important in light of the long tradition that nurses have played as experts in psychiatric care (Videbeck, 2011).

Table 1. Examples of Person-First Language.

Write or say . . .	Instead of . . .
People with schizophrenia	Schizophrenics
Person with a mental illness	Mentally ill person
People receiving mental health services	Service recipients
People diagnosed with psychotic depression	Psychotically depressed people
Child identified as having an emotional disturbance	Emotionally disturbed child
Person who has Alzheimer's disease	Victim of Alzheimer's disease
Individuals coping with addictions	Addicts who are suffering
Healthy teens	Nondisabled teens

Literature Review

Language is a distinctive characteristic of human beings (Edelman, 1974). It allows us to communicate, inform, and alter thinking and attitudes. It can be used to describe and enhance and, conversely, it can be used as a weapon to distort, devalue, and stigmatize (Snow, 2007). Words are powerful (Wahl, 2003). When used indiscriminately, words can create barriers, misperceptions, stereotypes, and labels that are difficult to overcome. Labels can promote separateness and isolation while promoting hierarchical power differentials (Vojak, 2009), a condition incongruent with the goal of recovery.

In health care, words are used to communicate, categorize, reference, and describe. The use of derogatory descriptors (e.g., the manipulator), the custom of using a diagnosis as an identifier (e.g., the borderline), or the use of outdated terms (e.g., handicapped, cripple) can perpetuate negative stereotypes (United Spinal Association, 2011) and reinforce what Snow (2007) refers to as "a powerful attitudinal barrier" (p. 1). These "attitudinal barriers," created in part by the utilization of disability-focused language, can produce obstacles more disabling than the diagnosis itself (Snow, 2007) and in turn shape thinking and affect behavior in a negative manner.

"Disability language"—the act of identifying the disability before the individual—has been cited as a contributing factor to the perpetuation of stigma and negative attitudes toward people with disabilities (Lynch, Thuli, & Groombridge, 1994). The use of person-first language (or "nondisabling language") has been advanced as a solution and the preferred terminology when referring to people with disabilities (Research and Training Center for Independent Living, 2008). As illustrated in Table 1, person-first language "puts the person before the disability and describes what a person *has*, not what a person *is*" (Snow, 2007, p. 3). It asserts that individuals are first and foremost people, not a diagnosis or label (Ashcroft & Anthony, 2006), and it stresses strengths and abilities rather than limitations and disabilities (Russell, 2008).

Origins of Person-First Language

In reviewing the literature, the emergence of person-first language as the preferred lexicon appears to owe its origins to the disability movement (Ashcroft & Anthony, 2006) and the establishment of organizations and legislation across the nation dedicated to addressing the needs of individuals with disabilities. Serving as a catalyst for this change was passage in 1975 of the Education for All Handicapped Act, which enacted free, appropriate, public education for individuals from 3 to 21 years of age. Opportunities for education in mainstream classrooms called attention to the capabilities of persons identified as having disabilities (Blaska, 1993). A number of forces converged to challenge attitudes and create change, including strong advocacy for removing barriers to full community participation (Mayerson, 1992) and enactment of the Americans with Disabilities Act (ADA) in 1990. The law served to legally end discrimination, reduce barriers to employment, and ensure access to education for individuals with disabilities (U.S. Department of Justice, 2002).

The natural evolution of person-first language serves to carry on the goal of ending discrimination by altering the way we refer to and talk about people with disabilities verbally and in writing. Just one year after the passage of the ADA, for example, the Association for Persons with Severe Handicaps is credited with taking the lead in endorsing the formal use of person-first language in its journal guidelines for authors (Back, 2010; Blaska, 1993). Before that, in 1987, the Research and Training Center on Independent Living (2008) created guidelines for reporting and writing about people with disabilities. The *Guidelines*, now in its 7th edition, addresses the need

for accurate terminology to describe people with disabilities. Using the input of more than 100 national disability organizations, the publication urges journalists, clinicians, and scholars to consider specific portrayal issues (e.g., taking care not to sensationalize a disability by using such terms as "crippling," "afflicted by") while using appropriate and clearly defined terminology when referring to people with disabilities. The *Guidelines* calls for putting the person first, not the disability, because "labeling the person as the disability (for example, a *quad*) dehumanizes the individual and equates the condition with the person" (Research and Training Center on Independent Living, 2008, p. 2). There are currently more than one million copies of the *Guidelines* in print, indicating widespread usage within the rehabilitation and education communities.

In addition to finding its way into the ADA (civil law), person-first language has found its way into other important legislation, including the Individuals with Disabilities Education Act (a federal special education law). Journals, including several special education and rehabilitation periodicals, have started requiring person-first language writing in documents submitted for publication (Russell, 2008). Correspondingly, a search on Google.com of the key words "person-first language" produced 89,300,000 hits, an increase of 64,000,000 in 4 years. It appears that person-first language has become a standard of practice in numerous disciplines.

Person-First Language and Mental Health Recovery

Following publication of the seminal New Freedom Commission Report on Mental Health as well as the Surgeon General's report on mental health and its supplement on culture, race, and ethnicity, person-first language has become closely linked to the recovery movement and psychiatric rehabilitation model of care. The vision of the New Freedom Commission on Mental Health (2003) included the transformation of existing mental health care into "a coordinated, consumer-centered, recovery-oriented mental health system" (p. 86). It boldly declared that the goal of a transformed system of care is recovery.

In this context, recovery has most recently come to be defined as "the process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential" (SAMHSA, 2011a). Razi (2012) asserts that language can be used to "guide people with mental health issues to recovery" (p. 1). She urges individuals to be intentional and responsible about the words they choose. Ashcroft and Anthony (2006), moreover, believe that person-first language sets a tone of inclusion and community rather than one of exclusion and isolation. Language is one method of altering consciousness for people in the recovery movement as well as a way to change attitudes and beliefs of those in the community (White, 2001).

Although person-first language is important in setting a tone of inclusion, culturally responsive care may at times mean shying away from the use of such language. In 1993, for example, the National Federation of the Blind issued a resolution opposing use of person-first language. The Federation noted then and continues to reinforce today that straightforward language (e.g., blind person) is an important way to show respect for the blind. It urges direct language that does not "sugar coat" blindness or deny the actual disability (Streeter, 2010). While the Federation takes a strong stand, numerous disability guidelines indicate that using "person who is blind" is preferable. Nonetheless, some guides recognize respectful language to include "blind/visually impaired person" as well as "person who is blind/visually impaired" (e.g., Mobility International USA, 2006). When in doubt, the best course would be to ask which term a person prefers (Ward & Associates, 1994).

Relationship of Person-First Language to Stigma and Recovery

In addition to the recovery movement, person-first language is strongly affiliated with the concept of stigma in the literature and is primarily discussed in the context of stigma prevention (Horsfall, Cleary, & Hunt, 2010; Perese, 2007; Shattell, 2009; Vojak, 2009). Stigma continues to reflect on the negative and fearful attitudes toward persons with mental illnesses that are still prevalent in society today (Griffin, 2007), despite stigma reduction programs such as the National Alliance on Mental Illness's Stigma Busters. Corrigan (2007) argues that stigma robs people of their potential life opportunities. Reducing stigma one word at a time through the use of person-first language is a place to start in the march toward the integration of recovery-focused care into the vocabulary and professional practice of psychiatric mental health nurses.

Additionally, there has been a great deal of research and commentary of the role of stigma and the impact it has on people with mental illnesses and their families. Perese (2007) looked at the roadblocks to recovery and cited stigma as one of three potentially devastating barriers to recovery for people with mental illnesses. She called on psychiatric mental health nurses to stop using stigmatizing language and encouraged nurses to help their colleagues to do the same. Viewing language as a vehicle for change, Vojak (2009) cautions those in health care to reject stigmatizing language and adopt the

language of inclusion in the quest to develop the kind of communities in which we all wish to live.

The contribution of family members of people with disabilities should also be mentioned in a review of person-first language. Kathie Snow has made a career of championing person-first language as she witnessed firsthand through the eyes of a mother the stigmatization associated with the words "disability" and "handicap" (a word no longer used in state or federal legislation). Snow suggests a paradigm shift that encourages others to view disability as a "natural characteristic of being human," similar to gender, ethnicity, age, or sexual orientation (Snow, 2007, p. 3). This shift in focus, she argues, facilitates a reduction in the stigma associated with people with disabilities while placing the focus on the person rather than the disability (Snow, 2007).

This paradigm shift has slowly gained momentum and acceptance across a myriad of disciplines. Scholars in the field of rehabilitation, psychology, and education have written at length on the importance of placing people first through the intentional use of person-first language. Wahl (2003), for example, has examined the role of stigmatizing language and behaviors in relation to observed discrimination and prejudice. While acknowledging that words hold power, he urges us to also work together and rise above the lack of knowledge, misunderstanding, intolerance, discrimination, and self-stigma that undermine recovery for people with mental illnesses.

Ragins (n.d.) writes extensively on the value of moving from an illness-centered/symptom relief focus to a person-centered perspective of care as he assists individuals with mental illnesses to live meaningful lives. Illness-centered perspectives may inadvertently promote the use of stigmatizing language. Shifting to a person-centered recovery approach, on the other hand, endorses the use of person-first language as a mechanism of change.

Similarly, SAMHSA's Recovery Consensus Statement (2006) supports the use of person-first language, which undoubtedly supports essential components of recovery—respect for the individual and hope for the future. Indeed, it could be argued that the use of non-person-first language is antithetical to the SAMHSA Recovery Consensus Statement. Furthermore, non-person-first language reveals the speaker as guided by the 100+ year myth that mental illnesses are ultimately permanently disabling, deeply rooted from a time when people were "confined to institutions, often for the remainder of their adult lives" (SAMHSA, 2011b, Question 1).

Within mental health nursing, there seems to be a scarcity of scholarly discourse on the impact of language and on the presence of person-first language in the nursing literature. Given these circumstances, it seems prudent to make use of the work scholars and clinicians in other disciplines have made to the advancement of information supporting the use of person-first language. It also seems prudent to encourage psychiatric mental health nurses to adopt the use of person-first language when collaborating in the care and recovery of people with mental illnesses. Person-centered language is a method of conveying hope, promoting respect, and working with people to establish a meaningful life.

The simple act of placing the noun before the adjective (e.g., replacing "mentally ill person" with "person with a mental illness") serves to strengthen therapeutic alliance and promote recovery. Furthermore, the strategic use of the plural (e.g., replacing "mentally ill people" with "persons with mental illnesses") directly challenges the fallacy of "one size fits all" thinking and the notion that there is one mental illness.

> Words have power. They have the power to teach, the power to wound, the power to shape the way people think, feel, and act toward one and another. When a stigmatized group of people, such as those with mental illnesses, is struggling for increased understanding and acceptance, attention to the language used in talking and writing about them is particularly important. (Wahl, 1998)

Why Heed the Call to Action?

The dehumanizing shame of the stigma of mental illnesses is deeply entrenched in our society and closely linked to the emergence of the person-first language movement. Whereas it is beyond the scope of this article to trace the evolution of stigma to see how little things have changed for people with mental illnesses (Goffman, 1963; Link, 1987; Link & Phelan, 2001), it is crucial that nurses increase awareness and use every tool available to counter attitudes and behaviors that contribute to stigma and discrimination experienced by individuals engaged in care.

Of note, health and mental health professionals—including physicians, nurses, and social workers—may possess some of the same stigmatizing attitudes held by the general public. They may communicate such attitudes through disability practices rather than person-first practices, with the unintended consequence of contributing to stigma (Heflinger & Hinshaw, 2010; Wahl, 1999) and feelings of isolation, hurt and shame, low-self-esteem, a sense of failure, and self-identification as a condition, not a person with life experiences, values, hopes, and dreams (Wahl, 1999).

Language that does not place the person first creates a barrier and sets distance between the nurse and the individuals engaged in care, reinforcing the outdated mentality of "us versus them" (Hamilton & Manias, 2006). Shattell (2009) postulates that the use of unintended stigmatizing meanings are "more insidious and dangerous" than overtly stigmatizing language; this is because of the very lack of awareness in perpetuation of unequal systems of power and discrimination.

A 2008 survey and qualitative study of stigma in England, moreover, found that people who use mental health services reported that their lives were damaged by stigma and their inability to be heard by professionals, or to even challenge professionals and make requests for treatment changes. In the same study, while participants rated their experiences with community mental health nurses and psychologists better than with general practitioners and psychiatrists, the study participants described that mental health professionals "see me as an illness, not a person" (Rethink Mental Illness, 2008, p. 10). They said health professionals "should listen to what I'm saying" and "see me, not the illness" (p. 10). In short, nurses who use non-person-first or dehumanizing language may be inadvertently blocking persons from seeking assistance that nurses can provide.

As psychiatric mental health nurses, we have the power to make a difference. Just as individuals with psychiatric disorders seek recovery and optimal functioning, nurses and other health professionals can take steps toward their own "recovery," by examining and deepening their understanding of how words and the communication of words and ideas shape expectations, connote a sense of dignity, help strengthen a person's ability to cope, boost confidence, or foster a sense of hope (Corrigan, 2007). Person-first language may be one potent means for helping to diminish the insidious effects of stigma and discrimination and to reduce the likelihood of lost opportunities for people who are coping with mental health conditions.

Summary and Conclusion

This article articulates the importance of person-first language as fundamental to promoting recovery for those individuals we serve. Words, language, and labels can create and maintain embedded stigma, prejudice, and disrespect, or conversely promote functionality, healing, compassion and caring, while assisting individuals to reach their full potential in a self-directed life. A paucity of scholarly discourse on the impact of person-first language drives us to rally our colleagues to the potentially profound impact this concept could have on all facets of practice.

We urge you to assess the degree to which person-first language is at the core of the work you do, contribute to an expanding base of knowledge on the value of person-first language to the discipline of psychiatric mental health nursing and recovery outcomes of individuals engaged in care, and help establish person-first language as a core competency for psychiatric mental health nursing practice. Ultimately, the hope is that person-first language will form the foundation for recovery-oriented practice and enhanced collaborative treatment environments that foster respect, human dignity, and hope.

Author Roles

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