Use of the Term 'Mental Illness'

by Charles Weinberg, LICSW, BCD

How do we feel about use of the term "mental illness"? The phrase is prevalent in mental health and may continue to be broadly used for quite some time. To the extent that its use destigmatizes (because it can mean "I am not crazy" and "I am not bad"), it is a good thing. To the extent that it validates the uniqueness of someone's experience and helps providers be empathetic, it is a good thing. To the extent that it helps find statistically valid and empirically confirmed biochemical or genetic aspects of mental health problems to create a wider range of effective treatment tools, it is a good thing.

But the New Freedom Commission and Uniformed Services Package say mental health care must be transformed to reflect the principles of the Recovery Model. We know there are several key aspects of the Recovery Model:

- Stigma is a prominent concept in the Recovery Model, but it is also a major cause of non-adherence. Individuals who have a full range of mental health challenges say they want to be seen as people—not as a problem and not as an illness. They do not want to be labeled.

- Rehabilitation is another fundamental concept. Our job as providers is to encourage, educate, and empower veterans and others with mental health difficulties to do the work necessary day after day—for as long as needed—to maximize their potential for recovery.

- The Recovery Model is intended to be strengths based.

- A need to empower the client in the treatment process and seek client feedback, because a client's perception of the therapeutic relationship is a strong predictor of treatment outcomes.

We know that **language matters**. The term mental illness derives clearly from a neurobiological approach, which often deemphasizes psychosocial issues—the very issues that drive and affect the valued life goals of those we serve. When treating a "mental illness," rehabilitation can be marginalized by care providers (focusing more on medicine than the therapeutic relationship) and care receivers (showing up only for a script, or with a fixed narrative of "being sick," which can lead to the "why try" syndrome). Use of the term mental illness can contribute to a clouded view, where care providers and receivers see most things through the lens

of a dysfunctional label. It tends to create a false mutually exclusive dichotomy of "normal" and "mentally ill," as opposed to the reality of a continuum of mental health functioning, where all people struggle to some degree, but with a varying range of impairment. Use of the term mental illness emphasizes the need for treatment that identifies and then ameliorates negative symptoms, as opposed to the teaching of coping skills and facilitation of wellness in a more holistic, recovery-oriented, and strengths-based approach.

Use of the term mental Illness is consistent with the reality and problems/benefits of psychiatric diagnosis. Diagnosis is supposed to stem from an objective nosology that tells us how to treat and help people with mental health problems. But diagnosis also labels and contributes to stigma. Diagnosis can be laden with values (homosexuality used to be represented in the Diagnostic and Statistical Manual of Mental Disorders [DSM]). It can be subjective, as there are problems with inter-rater reliability (schizoaffective disorder will not be in DSM–5, but how can a true "mental illness" disappear?).

Treatment outcomes are determined by three sets of variables—yes, variables within clients, but also variables in systems, providers, and relationships. Do we spend equal time on these issues, or disproportionate time dwelling on diagnostic reasons and labels—issues that are beyond our control? Perhaps we should spend more time on the issues we can control, such as those involving providers and relationships. If we want to be evidence based, don't we have to look at all of the evidence (even the hard part of looking in the mirror)? Although clients make their own decisions (and the idea is not to take ownership for their actions or set unrealistic expectations for ourselves as providers), in the parallel process of self-improvement, we as providers have to model what we are encouraging and teaching.

Now I have a confession to make. Just a few short years ago, I was the guy who would confront the client like heck and try to bust through his resistance. When he would eventually drop out, I'd claim he didn't want my help anyway. Today I understand the need to meet people where they are at, in addition to being direct and specific with my best clinical recommendations. It also helps if I roll with resistance, validate clients' right to make choices I do not agree with, and model acceptance of what cannot be controlled, regardless of diagnosis or severity of the presenting problem.

So, more often than not I find myself using the term "mental health problems" and not "mental illness," because in my opinion it better represents reality and is likelier to lead to better outcomes.

Regardless, I believe it is a good thing that we are asking ourselves these questions. We question not to paralyze, but to be empathetic to those we serve, to be aware that we can always learn new and better approaches, and to be true to ourselves.

Charles Weinberg is the Local Recovery Coordinator for Huntington Veterans Affairs Mental Health Clinic in West Virginia. Contact him at Charles.Weinberg@va.gov .