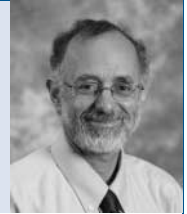


Editorial

The power of language:
use in psychiatry

Rif S. El-Mallakh and Sabine Doenninghaus

**Summary**

Language dictates how individuals process and understand concepts. This phenomenon is examined for the terms ‘antipsychotic’ and ‘antidepressant’. When the use of medications is extended in new directions (for example when an antipsychotic is used as an antidepressant), the name not only loses its utility, but may become an obstacle to treatment. Clinicians need to be aware of these issues.

Declaration of interest

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Background

Users of language generally believe that they are controlling the language and rarely are aware of the power of language to constitute their meanings, beliefs and attitudes. Language is a complex tool, and its use in healthcare makes it more complex because of the intricate and somewhat foreign concepts that medical language communicates. This reaches its extreme in the field of psychiatry where concepts are abstract, ephemeral and sometimes far removed from daily experience. In medicine, diagnostic labels that are attached to conditions regarded as deviations from the fuzzy concept ‘health’, result from the cognitively based desire for, and processes of, classification.¹ Although this serves the purpose of organisation and communication, classification schemes can give rise to a wide range of unintended consequences of language use. The effect of language on the field of psychiatry and on patients can best be understood when we examine medications.

**Problems with
existing drug nomenclature**

Medications names usually comprise the brand name, the generic name and the drug class (for example Seroquel, quetiapine, antipsychotic medicine). Whereas the brand name is chosen for marketing reasons (it sounds fine and is easy to memorise), the generic name is based on the classification of the drug and gives information about the drug’s chemical composition, which is informative for the medically or pharmacologically trained, but not for the layperson. Patients usually do not know or remember a medication’s generic name. What they do remember, though, is the drug class the medication belongs to, because the class names the reason for why they are taking the medication. This classification is where the actual power of names comes into play.

A drug classified and labelled as an ‘antipsychotic medication’ tells the patient that they are taking it because they are psychotic. Likewise, a medication classified and labelled as an ‘antidepressant’ tells the patient that they are depressed. From a semiotic and cognitive sciences perspective, a name or label (as a linguistic sign) activates not only a certain mental concept in the language user’s mind, but also its opposite or reverse, because both language use and thinking function on the basis of comparing and contrasting. Both terms (the sign and its opposite) seem to signify the underlying illness (psychosis and depression, respectively); thus, they serve to communicate not just the purpose of the medication but the more undesired message of ‘you need this drug because you are crazy or lazy’. As such, these labels may contribute to the stigma of psychiatric problems. The use of the current scheme of medication classification is further complicated by the extension of use of antipsychotics or antidepressants in conditions in which people are not psychotic or depressed (such as antipsychotics as antidepressants or antidepressants as anxiolytics). Additionally, the terms may inflate the efficacy of the agents in the minds of the lay public. In other words, the label ‘antidepressant’ communicates known efficacy of the agent as an antidepressant. For this reason, headlines in lay press discussing the suboptimal efficacy of these agents attract attention – because the label of ‘antidepressant’ creates expectations beyond the science of what these drugs do. In other words, the choice of the classification system tells the patient something about his or her illness and implies efficacy of the treatment choice, sometimes misleadingly. This may backfire when the drug is used to treat people for an illness not described in the drug’s name, but nearly always contributes to a subtle form of stigma in patients’ minds.

Although these issues can themselves create problems, it is important to understand that the drug classes of medications are artificial. It is interesting to note that the classification of an agent is frequently determined by its first use. For example, if quetiapine or aripiprazole had been initially examined in major depression rather than psychosis and initially introduced for that condition, they would have been called ‘antidepressants’. An example of this is the ‘antidepressant’ amoxapine, which is known as the antidepressant that can cause tardive dyskinesia,^{2,3} and which is also an effective antipsychotic.⁴ Similarly, if an antipsychotic, had initially been studied in acute mania and initially introduced for that condition, it might have been called a ‘mood stabiliser’. In these instances, one may have been puzzled when it

would be later discovered that these ‘antidepressants’ or ‘mood stabilisers’ are also effective antipsychotic agents. For these reasons, 71.7% of psychopharmacology conference attendees that participated in a survey agreed that the current terminology was inadequate or confusing.⁵

Implications

Clinicians and researchers must be aware of the power of names and how they use these words. Clinicians should particularly be aware of the power of these labels to their patients. We must be aware that using these words creates expectations and consequences that go beyond the communication of one of the properties of a specific chemical. To this end, the initiative of the Taskforce on Nomenclature, established in a collaborative effort of four major colleges of neuropsychopharmacology (American College of Neuropsychopharmacology (ACNP), European College of Neuropsychopharmacology (ECNP), Asian College of Neuropsychopharmacology and International College of Neuropsychopharmacology (CINP)) to create a new multi-axial pharmacologically driven nomenclature, is beginning to address and resolve the problem.⁵

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References

- 1 Dönninghaus, S. *Die Vagheit der Sprache: Begriffsgeschichte und Funktionsbeschreibung anhand der tschechischen Wissenschaftssprache [The Vagueness of Language: History of a Concept and Description of its Functions based on Czech Academic Discourse]*. Harrassowitz Verlag: 2005.
- 2 Huang CC. Persistent tardive dyskinesia associated with amoxapine therapy – two case reports. *Hillside J Clin Psychiatry* 1986; **8**: 209–13.
- 3 Singh GP. Amoxapine-induced tardive dyskinesia. *Indian J Psychiatry* 2009; **51**: 327.
- 4 Apiquian R, Fresan A, Ulloa R, Ede la Fuente-Sandoval C, Herrera-Estrella M, Vazquez A, et al. Amoxapine as an atypical antipsychotic: a comparative study vs risperidone. *Neuropsychopharmacology* 2005; **30**: 2236–44.
- 5 Zohar J, Nutt DJ, Kupfer DJ, Moller H-J, Yamawaki S, Spedding M, et al. A proposal for an updated neuropsychopharmacological nomenclature. *Eur Neuropsychopharmacology* 2014; **24**: 1005–14.

extra

‘Hat on, hat off!’ A memorable clinical encounter

Reza Kiani

On my first day to review patients at a day centre for people with intellectual disabilities, the parents of one of the patients proudly introduced their son to me: ‘This is Gary, who has defied medical opinion for 50 years. He is a fighter, doc!’ Gary was a non-verbal wheelchair user with a profound intellectual disability and treatment-resistant epilepsy. But he was also a happy soul and a joy to be with.

Soon after he was born his parents were warned that he would not survive to see his first birthday but he proved everyone wrong; his parents were preparing to celebrate his birthday soon by taking him on holiday.

I reviewed Gary’s seizure diary, meticulously kept by his mother. Frustratingly, it was full of multiple types of epileptic attacks ranging from partial seizures and myoclonic jerks to tonic-clonic attacks. These occurred relentlessly on a daily basis in spite of him being on various anti-epileptics. He had already been seen and discharged from a tertiary epilepsy centre and the local epilepsy clinic, as ‘nothing else could be done to [treat] his complex epilepsy’.

On one of the pages of the diary, I noted a strange entry: ‘hat on, hat off!’ This was written in the antecedent column, where other triggers such as respiratory infections were also recorded. Surely, I asked myself, I had misread his mother’s handwriting? But no, this was correct. Apparently, years ago when Gary was under the care of a senior colleague (who had retired well before I joined as a senior registrar), his parents were told to pull the flat cap that he used to wear down over his eyes to help prevent clusters of partial seizures getting worse or evolving into severe tonic-clonic attacks. To my amazement, his mother said that this did the trick and still does sometimes, even when nothing else can help. She was adamant that this simple measure had helped reduce the use of rescue medications and emergency admissions for prolonged seizures. Her explanation, which seemed plausible, was that Gary was more relaxed and less anxious, as the visual stimuli including bright lights, known triggers in some types of epilepsy, were eliminated by pulling the hat over his eyes for a few minutes until he settled down again.

The mother talked about my colleague who had given them that advice: ‘Not all the professionals were pessimistic. She used to look at the books and reassure us that if a medication did not work, there would be something else that could be tried. She even came to our house to do blood tests early in the morning (. . .) if needed. Something that nobody else would do, she was a wonderful doctor, like a family member, she was!’

On my way back to hospital that day, I was full of admiration for my retired colleague. I also thought of how simple acts of kindness, practical optimism and empathetic gestures by a professional who was there for the family were remembered after such a long time.

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