National Association of State Mental Health Program Directors
Older Persons Division (NASMHPD OPD)
Language Guidelines

Approved by the Executive Committee of NASMHPD Older Persons Division on March 24, 2014.
Approved by the members of the NASMHPD OPD on May 7, 2014.

The NASMHPD Older Persons Division has produced these language guidelines for its membership and the field of aging and mental health to promote the respectful use of language in our field. The guidelines are not to be considered requirements, but intended to provide leadership and guidance to members of the OPD in the respectful use of language in our field. These guidelines are based on the fundamental values of the aging and mental health communities and are strongly influenced by the psychiatric rehabilitation field: respecting the worth and dignity of all persons and groups, as well as honoring and advocating for individual rights and interests, and opposing discrimination in aging, services and in society.
The Guidelines for the use of language are governed by the principles of the OPD. The examples are offered to be illustrative and are not intended to be prescriptive.

Person-First
The overriding philosophy of the work of OPD members in aging and mental health is to see people as people first. By interacting with people as people first and, through our actions and our words, by using "person-first" language, we educate the public that the people who are assisted through all types of aging and mental health services are people first. While, as individuals, we retain the right to use the words we prefer, as OPD members, the principle of "person first" should guide all our actions, including our written and spoken language.

Expressing a person-first philosophy and adhering to it are two separate matters. In order to make this philosophy come alive, we must each become acutely aware of the words we commit to paper or to conversation, and equally aware of the manner in which we represent ourselves, both in public and in private interactions.

It is the intent of NASMHPD OPD that print and online documents and publications will use person-first language, which refers to people in a way that emphasizes or focuses attention on the fact of their humanity and personhood, rather than on the existence of a disability, illness, condition, or characteristic. Groups and individuals are to be designated by their roles and personal achievements, rather than their diagnoses or labels.
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Person First Language Examples
• Person: Use "person" alone when the person's role (e.g., psychiatrist) or diagnosis is irrelevant. For example: The sentence, "People succeed at work when they have adequate skills and supports," is true whether we are talking about someone who is returning to work after receiving behavioral health, aging, or other human services, or about someone who has landed a new job after retirement.
Persons or People: Similarly use persons plural when you wish to identify a group of people with something in common, rather than "the" in front of various terms that might describe them in a manner that creates an Us/them sort of perception. The sentence, "Older persons (or adults over the age of 60) represent the fastest growing segment of the US population," is an example of language to use whenever referring to a group of older adults, (people over the age of 60), rather than "the elderly."
• Person with a psychiatric disability. Someone with a history of depression, not "suffering from depression" - suffering is a self-descriptive concept, to be used only by the person who is experiencing the "suffering."
• Person who uses services at this agency, not "my client," which implies possession or a controlling attitude.
• An individual diagnosed with schizophrenia, not "a schizophrenic."
• Practitioner of behavioral health or health services, or behavioral health practitioner.

A person in recovery, not a “mentally ill person.”
• Practitioner in recovery, to signify someone who is recovering from a mental illness and is providing services, not “consumer-provider.”

Examples for Rehabilitation and Recovery
• The overarching message of recovery is hope: it is possible for a person who has a severe and persistent psychiatric disability to have a rich and meaningful life.
• If a person has a disabling condition, “recovery” means gaining a sense of meaning, a positive identity, fulfilling relationships, the role of citizen and community member, the capacity to cope with adversity, and recognition of the gifts and lessons learned through the recovery struggle.
• Rehabilitation refers to the development of skills and supports needed to achieve one’s goals, given a condition (physical and/or mental) that creates difficulties in daily functioning. The rehabilitation perspective focuses on increasing ability, and builds on a person’s strengths to facilitate success in meeting the person’s own goals.
• Treatment focuses on symptom reduction and, while often an important service to coordinate with rehabilitation, is distinct. The treatment perspective looks at pathology and limitations, since its focus is on decreasing discomfort.
• Use terms like “service/resource coordination” rather than “case management,” since people are not “cases,” and should not be “managed.”
• Use terms such as “individual example” rather than “case study,” and “research participant” rather than “subject,” so as to keep the focus on the person and to avoid dehumanization.
• Rehabilitation promotes a partnership, which means that terms such as “compliance” (a metaphor of force), are to be avoided, since “compliance” suggests mindless conformity. Terms like “involvement,” “adherence,” “partnership,” and “cooperation” are less passive, and more suggestive of someone taking responsibility for his or her own recovery.

Psychiatric Disability
In general, the term “psychiatric disability” is preferred to both the phrase “mental illness,” and the use of specific diagnoses. For OPD, the concept of disability implies the possibility of regeneration of ability through rehabilitation. Terms focusing on “illness,” “disorder,” and “diagnosis” reflect a medical model rather than a strengths based or rehabilitation perspective. We recognize the right of individuals to refer to themselves as they choose - for example, a person might not believe that his/her psychiatric condition is disabling, and might prefer a term other than “disability.” However, we also recognize that OPD has a responsibility to educate. For example, while effective communication with the medical community might, at times, make medical terminology useful, in representing the OPD organization, members are urged to avoid the most medically oriented terms, such as “patient” or “illness,” and to assist the medical community in changing itself from a system that “does to” into a system that encourages partnerships between the people who use services and the people who provide them.

When necessary, specific diagnoses are preferred to more global terms, and are to be used in a person-first format, as in “a person with schizophrenia.” Since many forms of psychiatric disorder exist, the terms “mental illness” and “psychiatric disability” should be specified as clearly singular (e.g., a person diagnosed with a mental illness or a person diagnosed with a psychiatric disability) or plural (e.g., people who have been diagnosed with a variety of disorders). Emphasizing the existence of a variety of psychiatric disorders corrects the description of “mental illness” as a single entity.
Acceptable terms are: person with a psychiatric disability, people with psychiatric disabilities, psychiatric illnesses, emotional or mental disorders - stressing the personhood of people with disabilities.
Unacceptable language includes dehumanizing or pejorative words or phrases, such as “the mentally ill,” “schizophrenics,” or “chronic.”

Examples for Psychiatric Disability
• “Psychiatric disability” implies something a person has (not “is”), while emphasizing ability, and is analogous to “physical disability.”
• A “mental illness” implies a medical perspective, with an emphasis on diagnosis and symptoms, and is analogous to a “physical illness.”
• “Mental health” implies wellness and successful cognitive and interpersonal behaviors, and is analogous

to “physical health,” in the sense that someone can be basically healthy while still experiencing occasional periods of “illness” or symptoms.
• Terms like “serious,” “significant,” “severe,” and “persistent” provide an image of a long-term (potentially life-long) difficulty, and are better than “chronic,” which implies hopelessness. Even for the most severe and long-term psychiatric disorders, however, we believe in the possibility of recovery.
• A description of specific strengths and weaknesses in relation to a desired goal is preferable to an overly general and pejorative term such as “low functioning.”

People in Recovery
While the term “consumer” appears to have wide acceptance as a description of individuals who use behavioral health services, some individuals argue that “consumer” implies choice from a variety of service options, a choice that often does not exist in fact. While recognizing that individuals and groups have the right to select the terms they prefer to use to describe themselves, OPD has chosen, in official documents and events, to use the terms “person in recovery” or “people in recovery” to refer to people who use or have used psychosocial rehabilitation services.
Any term, can come to be used in a demeaning manner. For example, “consumer” has been used in some instances to indicate a role that is of low social status, suggesting a “consumer” is subservient to a “provider,” who is in a position of authority. Because any “shorthand” terms tend to diminish the personhood of an individual, OPD recommends that they not be used in official documents and events.

Examples for Person in Recovery
• Whenever possible, use “person” to refer to a person, and qualify that word only when essential to the issue under discussion. Qualifiers provide additional information, such as “a person from Portugal,” or “the person with the red eyeglass frames,” or “a person who has been diagnosed with post-traumatic stress disorder (PTSD),” or “a person who has tested HIV-positive.”
• “Consumer” means a person who buys goods or services, yet many people who use mental health and aging services do not purchase those services themselves, and often are assigned to a local service provider. Choice has been rarely, if ever, built into the mental health service system.
• “Patient” implies a medical setting, and is typically a passive role in relation to “doctor,” or “nurse,” and is not to be employed outside of the context of that role.
• “Client” implies a customer who purchases professional services, such as the services of a lawyer or a psychotherapist, and should not be employed outside of the context of that role.
• “Member” indicates that a person belongs to a particular group, and can be used acceptably in reference to someone who participates in a specific program, provided it is given and received with respect.

Inclusion and Diversity
Consistent with the principles of cultural sensitivity and awareness and the intent to deliver ethical multicultural and age appropriate services, OPD members recognize that differences, discrimination, and isolation continue to create unique situations in which culture may emerge. The cultures of sexual orientation, gender identity, age, and/or disability also create a sense of belonging and identity, similar to the cultures of ethnic heritage.
OPD members recognize that discrimination and oppression exist within our society, and take many forms. We all have a role and responsibility in eliminating the discrimination and oppression that arise from disrespectful and insensitive language. Conditions of negative attitudes, bias, rejection, ageism, and discrimination are addressed as rights violations, as well as barriers to the attainment of health.
Language often is used to assign people to categories, emphasizing difference and separation. It is the recommendation of OPD that print and online documents and publications will use inclusive language, which refers to people in a way that emphasizes or focuses the reader’s attention on similarities, equality, and respect. The underlying principle is one of balance and parity in language, avoiding the condescension that can arise from “us-them” and “either-or” categories.
Language used should impart the sense and sentiment that the people described are equals who have strengths, skills, talents, and uniqueness as a whole person. Language that detracts from the sense of value of the whole person is to be avoided, along with terms that exclude, marginalize, diminish, or lower the status of any individual or group. Additionally, stereotypes and words that derive from negative assumptions should be avoided.

A group should be described using the term(s) preferred by that group, following the principle that "respectful" is defined by the person or group being respected. We need to become aware of (and avoid) any "hot-button" phrases or derogatory code words in our language that excite or inflict shame. We need to recognize that when a person is a member of an oppressed group, any term describing that group can become tainted. The language used is eventually colored by the attitudes expressed when a word or phrase is used. By changing our use of language, we are hoping to create attitude change, not to cover-up negative attitudes by using previously unspoiled terms.
The preparation of official OPD documents, and the composition of NASMHPD - OPD membership, should attend to including and representing diverse perspectives, including people of different ages as well as cultural/ethnic backgrounds, and people in recovery.

Examples for Inclusion and Diversity
• Standard inclusive language includes such phrases as "people of all ages, cultural, ethnic, and linguistic backgrounds, national origins, languages, religions, colors, sizes, gender identities, and sexual orientations," or "including people of diverse histories, backgrounds, and personal characteristics." The principle behind these lists of items is to respect diversity, and to include all people.
• Words and phrases derived from derogatory names or stereotypes of a certain group are to be avoided. For example: "gypped," which is derived from the disparaging term "gypsy," and implies that all Romani people are cheats and swindlers. While we may not be aware of all possible derivatives, we are always sensitive to the possibility of insult, and open to changing the language we use.
• By consciously and respectfully recognizing diversity in gender identities and sexual orientations, we promote openness and trust. As with all aspects of similarity and difference, gender identity issues, sexual orientation, and relationship status influence our perceptions and experiences.
• As with other terms used to describe aspects of diversity, terms such as "lesbian, gay, bi-sexual, and transgendered" belong in a person-first format, are used as specifically as possible, and are based on the preferences of the individual or group being described. For example, say "provides services to people who self-define as gay or lesbian," rather than "gays."
• Recognition of diversity in gender identity and sexual orientation should include acknowledgement of individuals who are asexual, intersex, and currently questioning their sexual and/or gender identities.
• Inclusion extends to people of diverse sexual orientations, and sensitive language avoids unintentional heterosexual bias. For example, asking about marital status ignores long-term committed same-sex relationships that are not recognized by law as "marriages." Language that recognizes the possibility of differences is accepting. For example, a neutral term such as "partner" is preferable to "spouse."

Discrimination
In discussions of prejudice, bias, and discrimination, the focus is to be on the person who holds and expresses the bias, and/or who acts in a discriminatory way. Discrimination is making a distinction in favor of or against a person, based on the group or category to which that person belongs.
"Stigma" refers to a mark or evidence of shame that is intrinsic to a person, and which often is used as justification for discrimination. In addition, the term "stigma" appears to perpetuate negative biases towards an individual and the consequent shame imposed upon individuals.
By using terms such as discrimination, prejudice, bias, or negative stereotype, the emphasis is, correctly, on the person who holds the negative attitude. OPD therefore recommends that terms such as discrimination, prejudice, bias, or negative stereotype be employed.

Examples for Discrimination
• Stigma refers to a mark or token of infamy, disgrace, or reproach. There is nothing inherent in people who have psychiatric disabilities or mental illnesses that deserves to be remotely associated with infamy, disgrace, or reproach; nor is "stigma" inherent in people who are older, people with diverse sexual orientations, gender identities, ethnicities, cultures, colors, or sizes. Therefore, the word "stigma" is considered unacceptable, and is not used.
• Some individuals have internalized negative attitudes, and experience a sense of shame, but any descriptions of this personal experience need to make clear that this internalized experience does not imply that there is reason for disgrace.
• Discrimination refers to a prejudiced act. Unfortunately, many people do engage in prejudicial acts towards people with psychiatric disabilities, and towards older people and people of certain cultural,

ethnic, and linguistic backgrounds, national origins, languages, religions, colors, sizes, gender identities, and sexual orientations. Many people, including anyone who has been diagnosed with a mental illness, have experienced acts of discrimination and prejudice. By using the term “discrimination,” we redirect attention to the person acting in a disrespectful and prejudicial manner. OPD believes that the focus should be on the person behaving in a prejudicial manner, and not on persons against whom such prejudice is levied. Therefore, “discrimination” is the preferred term in describing such acts of prejudice.
• An examination of “negative attitudes towards people with mental illness” is preferable to studying “the stigma of mental illness.” Similarly, a “campaign to increase respect and understanding” is a more positive description than an “anti-stigma” campaign.
• Discrimination based on race, color, national origin, religion, sex, age, employment opportunities or disability (physical or mental) is prohibited as specified in the following federal regulations: Title VI of Civil rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, The Age Discrimination Act of 1975, The Age Discrimination in Employment ACT (ADEA), and the Americans with disabilities Act (ADA) of 1990. All states also have various regulations prohibiting discrimination. OPD will actively promote improving education, and increasing recognition and non-discrimination in all of these areas.

Use of Titles

It is the recommendation of OPD that we do not use the honorific titles for people in our membership, or during meetings (in minutes or other notes). We do this in order to maintain our goal of recognizing the value of all individuals who belong to the organization.
In OPD electronic and print publications, which serve as our interface with the larger aging, behavioral health, health, educational and governmental communities, we will use all the titles to which individuals are entitled, by educational attainment, election, or birth. We also will be sure to reflect certification as a peer support specialist or other practitioner. We do this in order to maintain our recognition that people are to be treated with the respect that they are due, and that as a group, we value recognition of ones titles.

Conclusion

This is an “organic” document that will change as OPD and our societies grow and change. However, as changes occur, the philosophy of OPD shall remain steady: to interact with all people as persons first. That interaction shall be represented in each of our official publications and events through person-first language.
As OPD documents and publications are prepared (e.g., ethics, research, multicultural committee materials), edits will be made that will implement these guidelines. In addition, this document will be regularly updated. All OPD members, and interested others, are invited to submit comments regarding this document, and to participate in subsequent revisions.

*The OPD thanks PRA (Psychiatric Rehabilitation Association) for development of Language Guidelines upon which these OPD guidelines were based.