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Why Language Matters: A Qualitative Inquiry Into the Implications of Language Used During Provider-Patient Interactions on University Students' Perceptions and Understandings of Their Own Mental Health

Language surrounding mental health has been utilised to mechanise and normalise stigma. Associated connotations of prejudice can deter individuals from accessing critical support. There are few studies investigating use of language within clinical contexts. This paper investigates implications of language used during provider-patient interactions in shaping patients' understandings of their mental health. Semi-structured, online interviews were conducted with ten university students with previously obtained mental health diagnoses or treatment. Interpretative phenomenological analysis identified three core themes: impact of navigating complex language and services on diagnostic experiences; a lack of person centred care as dehumanising; existing prejudices of the individual and others impact experiences of ill mental health. Results suggested clinical language can be emotive, acting as either a barrier or enabler to sense making of mental health diagnoses. This research can translate to operational language use guidelines in clinical settings, ultimately contributing to patient well-being.

Key words: stigma, communication, language, mental health literacy, provider-patient

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Evidence demonstrates ever-increasing rates of young people aged 17-19 experiencing mental illness, from 1 in 10 in 2017, to 1 in 4 in 2022 (Newlove-Delgado et al., 2022; Thorley, 2017). Furthermore, university students are suggested to be at an increased risk of developing ill mental health through exposure to contextually unique stressors, such as moving away from familiar support and surroundings, increasing pressures to succeed and find independence, and meet assessment deadlines (Farrer et al., 2019). Evidence shows that 27% of UK university students indicate psychological distress, compared to just 3-11% of age-matched non-students (Aronin & Smith, 2016; Leahy et al., 2010). This prevalence increases to 30-50% when considering international student populations alone (Auerbach et al., 2018; Stallman, 2010).

Despite moves towards a more tolerant and accepting society in terms of mental health recognition (Janmaat & Keating, 2017), elements of stigmatised attitudes continue to pervade mental health discourse. Stigma exists as a divisive mechanism between the *norm* and *other*, promoting a hierarchy of normality (Goffman, 1963), and is often maintained through mainstream media misrepresentations of those with mental health difficulties. Language has been noted to contribute to the conceptualisation of mental health, including through the endurance of derogatory language and internalisation of associated stigma (Kousoulis, 2019).

Impact of Linguistics on Experiences of Ill Mental Health

Much of the language used within everyday lexicon is so integrated into our vocabulary that they are deemed acceptable and are often rooted in outdated and now inappropriate ideology. For example, the term to *commit* suicide is a commonly used term when stating that an individual has taken their own life. However, the term's original purpose was to refer to the criminal act of taking one's own life, framing it as an act of deviance rather than of serious mental ill-health (Sommer-Rotenberg, 1998). This was only decriminalised in the UK in 1961 (Beaton et al., 2013). Similarly, the term *special needs* was originally coined as a positive alternative to acknowledging a person with a disability. The rationale was to offer a substitute for the *dis*- vernacular, and to move away from stigmatised attitudes surrounding disability. However, the evolution of this term to the present day means that it can now be witnessed in attempts to derogate and belittle individuals, demonstrating the amalgamation of stigma and language and its ability to evolve into unacceptable labelling (Morton et. al., 2016). As such, what constitutes acceptable language evolves over time. This use of derogatory language can be upsetting to individuals and have an impact upon their experiences of living with a mental health condition.

Over recent years, mass media coverage and social media has added another dimension to how individuals experience their mental health, and the negative impact language can have upon these experiences by fuelling harmful stigma. There are however reports of the media guidance making efforts to avoid derogatory language around stigmatised mental health such as *schizo* and *psycho* in relation to conditions such as schizophrenia (Bowen et al., 2019). Despite these efforts, a linguistic analysis of UK popular press highlights a persistent and significant *othering* of those with severe mental health difficulties, such as schizophrenia and personality disorders (Bowen et al., 2019; Bowen, 2019). A further linguistic analysis also found evidence of othering of those with depression via derogatory and stigmatising language use via the social media site, Weibo (Li et al., 2018). In 2014, a survey investigated over 2000 adults' attitudes towards ill mental health in England (Mind, 2015). Findings revealed that over a third of participants believed people with mental ill-health to be violent, with 12% of people claiming they would be frightened to live near someone with these difficulties.

Therefore, there is clear evidence that language can fuel misconceptions of mental health and contribute to harmful stigma, often exacerbated by the media. This can have detrimental impacts on individual experiences of living with ill mental health (Thornicroft et al., 2022) and reduce their quality of life (Atanasova et al., 2019; Corrigan & Watson, 2002; Corrigan et al., 2013).

Implications of the Presence of Stigma in Mental Health Care Services

Hamilton et al. (2016) found that mental health care settings can be common contexts for the presence of mental health discrimination. One explanation for this is ingrained societal stigma that pervades through to critical services, including mental health provision (Carlisle et al., 2001). For example, Rao et al. (2009) reported data from 108 mental health professionals' responses to the Attitude to Mental Illness Questionnaire (Luty et al., 2006). This data revealed highly stigmatised attitudes towards those with *active* ill mental health difficulties, such as continued substance use, which lessened when patients were in remission. Further, Browne (2010) found that the longer mental health professionals work in mental health settings, the more their authoritarianism lessons, and benevolence improves. This is also demonstrated in educational settings, where the importance of experience and mental health education has been found to reduce teachers' stigmatised views towards obsessive-compulsive disorder when coupled with a brief educational intervention (Chaves et al., 2021). This supports the argument that prejudice exists within support services and that mental health education and personal experience working with mental ill-health may be crucial in reducing prejudice and stigmatised views.

Diagnostic Labelling and Clinical Language

Under the current medical model of diagnostics and healthcare delivery, diagnostic labels are impossible for clinicians to avoid as they are vital to classify individuals for treatment and relevant support (Garand et al., 2009). Diagnostic labels allow clinicians to assume homogeneity of the nature and aetiology of the specific issue, and arguably enable an efficient process to refer individuals to relevant treatment and/or support (American Psychiatric Association [APA], 2000). This efficiency, however, poses flaws by offering an assumed uniformity of mental health issues that often ignores the individual contexts that can influence symptoms, onset, triggers and related symptoms of the illness (Garand et al., 2009). The reductionist nature of diagnostic labels can lead to clinical blind spots, which can impact accessibility of services. Such blind spots may lead to a lack of much needed individualised care (Lipinski et al., 2021; O'Dowd et al., 2022). For example, lack of clinical knowledge around neurodivergence is widely reported to contribute towards misdiagnosis and lack of suitable support (Hanley, 2016; Kelly et. al., 2022; Werling & Geschwind, 2013). Therefore, where the language adopted that represents these clinical labels can be useful in identifying treatment and support, the reductionist nature can be to the detriment of the patient.

Evidence denotes the importance of dialogue and language used during the initial patient-provider exchange when a mental health diagnosis is made. This may be as it is often the first time an individual internalises the meanings associated with mental health related terminology, in relating this to themselves (Jorm, 2000). Language use prior to and during a mental health diagnosis can act as a catalyst for the internalisation of prejudiced concepts and provide the confirmatory basis for which stigma and stereotyping are able to exist (Link et al., 1989). For example, diagnostic labels such as schizophrenic and psychotic are still common practice, despite being commonly used as degrading and offensive slurs (Richards, 2018). Similarly, supporting evidence from focus groups explored experiences of receiving a diagnosis of Alzheimer's and/or mild cognitive impairment (Frank et al., 2006). Findings indicated how language and interactions during the clinical diagnosis can influence preconceived negative ideas to surface and shape the way an individual perceives their mental health in the present and the future. Although this work was not conducted in the context of mental ill-health, it may be reasonable to suggest that similar experiences may exist in communities that have received a mental health diagnosis. Therefore, it may add value to explore this within these communities (Lingler et al., 2006), including those who are at a disproportionately higher risk of ill mental health, such as university student populations (Campbell et al., 2022).

To the authors' knowledge, there are no current empirical studies investigating the role of language use when seeking help for a mental health condition or symptoms. In particular, there is a lack of focus on the lived experiences of university students during this crucial time. This research will address this knowledge gap and explore ways language can impact an individuals' understanding of their own mental health. It is therefore hoped that this work will translate into operational language use guidelines in clinical settings, ultimately contributing to patient well-being and healing.

Therefore, this study aims to address the following research question: *What are university students' experiences of language use when receiving a mental health condition diagnosis?*

Interpretive Phenomenological Analysis (IPA) will be used to analyse data for the present study. IPA is beneficial for research that explores mental health topics as it enables in-depth exploration of subjective experiences of mental health and the language used by participants to convey meaning assigned to those experiences (Eatough & Smith, 2017; Shinebourne, 2011; Smith et al., 2021).

Methods

Methodological Approach

This study adopted qualitative semi-structured interviews using Interpretive Phenomenological Analysis (IPA). This involves an ideographic and double-hermeneutic approach through a critical realist lens. Ideography concerns an in-depth focus on the subjective experiences of an individual before moving to broader generalisations, something that is considered integral for understanding individual experiences within a broader context (Love et al., 2020; Smith, 2004). Double hermeneutics firstly involves the participant making sense of their experiences during the interview, and secondly the researcher interpreting this during data analysis (Smith & Nizza, 2022). Critical realism assumes that there is one single reality, which can be experienced by people differently (Archer, 1998). This is appropriate for this work as it recognises that experiences are open to interpretation in recognition that there is no single correct interpretation of this data.

Participant Identification and Recruitment

Participants were approached through an email sent to a UK University's volunteer list in the South Yorkshire area, outlining the scope of the research and inclusion criteria. Inclusion criteria were those 18 years or above, currently studying in higher education, and had received a mental health diagnosis from 2015. The latter timeframe was deemed appropriate as this is when the most recent DSM was published in efforts to ensure participant responses were more likely to reflect language use under the current diagnostic guidance.

Procedure

Ethical approval was obtained from the University of Sheffield ethics committee (Reference: 038291). Those who expressed interest were sent an information document at least one week prior to data collection. Semi-structured interviews were arranged online at participants' convenience. Informed consent was obtained via an online form prior to interviews.

Interview questions aimed to encompass potential topics that could be discussed, and provide space for the participants to guide the research in line with their nuanced experiences. Questions included: "If you are comfortable, would you mind telling me about your experiences with your mental health?", "How would you have described your experiences of your mental health prior to your diagnosis?", "What were your experiences of language around mental health prior to your diagnosis?" and "What were your experiences, if any, of language use during your mental health diagnostic appointment?”. Each interview was audio recorded, transcribed verbatim and interpretive notes were made by interviewer EC (Ryan & Bernard, 2003).

Data Analysis

IPA was undertaken to understand participant experiences of language use when receiving a mental health condition diagnosis. Author EC conducted the IPA alongside discussions with author LP to support deepening of ECs interpretation of the data. The IPA involved the following process (Smith & Nizza, 2022):

1. Reading and rereading of transcripts and listening to audio recordings playing close attention to the context of each participant.
2. A semantic and a latent approach was taken to interpreting and noting the main points of each individual transcript in relation to the research question, paying attention to pauses, hesitancies, use of language and any emotions conveyed. These notes were linked to supporting quotations.
3. Personal Experiential Statements (PESs) were then constructed for each transcript by conceptually pulling together the notes from the previous step. The PETs aimed to represent each individual participant’s story.
4. For each transcript, Personal Experiential Themes (PETs) were constructed by grouping the PESs.

The above four steps were repeated for each participant. Author EC then looked for patterns across all PETs for all participants to develop Group Experiential Themes (GETs) that aimed to represent the consensus among participants.

Researcher Reflexivity

For transparency, the authors deem it important to disclose the positionality of author EC, who conducted the data collection and analysis for this study. EC has lived experiences of navigating access to mental health support. Her interpretation of her diagnostic process was littered with complex and medicalised language which impacted on ECs sense of self. In addition, EC has personally experienced the impact of how stigma can still pervade conversations and attitudes of society, which she views as challenging the way mental health is perceived and navigated. The current study thus aims to explore this issue, through seeking to understand the experiences of individuals who have also received a mental health diagnosis. Throughout data collection and analysis, continuous reflections will be recorded in a diary by EC to support the process of interpreting the shared experiences of participants on an individual and group level.

Ensuring Rigour in the Research Process

To ensure rigour in qualitative research, four key pillars have been identified: credibility, transferability, dependability and confirmability (Lincoln and Guba, 1986). Definitions of these terms in this work are based upon definitions identified by Lincoln and Guba (1986). Credibility requires results to be true from the viewpoint of participants themselves. This was ensured by regular checking of researcher interpretation of the data during the interviews. This involved repeating interpretations back to participants and asking for further detail or clarification where required. Dependability refers to the extent the study is repeatable. This was ensured through a detailed description of study methods, and excellent record keeping when collecting and analysing data to ensure a clear audit trail. Confirmability is defined as ensuring results can be agreed by other researchers. This was achieved through continuous reflection and discussion between co-authors to deepen understanding of the data. Transferability refers to the extent that fundings can be transferred to other contexts. This was addressed by ensuring that both convenience and snowball sampling were adopted so participants reflected those including and beyond the authors' networks.

It must however be noted that due to the unique position of the researcher, these findings may be interpreted differently by different researchers. Further, due to the varied and distinct experiences of individuals, a different participant sample may also yield slightly different results. Therefore, where efforts have been made to ensure the rigour of this work, due to its nature, there is no single way to ensure complete dependability, confirmability and transferability.

Results and Discussion

Ten university students took part in the study and characteristics of this sample can be found in Table 1. See Table 2 for how GETs and subthemes were generated from PETs. Three GETs and two sub themes were identified from the data.

Theme 1: Impact of Navigating Complex Language and Services on Diagnostic Experiences

Emotive Language: A Significant Contribution to Diagnostic Experiences.

The Royal College of Psychiatrists (2009) emphasises the importance of how a strong therapeutic relationship depends on the strength of communication, thus cultivating a constructive clinical interaction which actively involves the individual in their mental health treatment. In contrast, when sharing experiences of navigating mental health services and receiving mental health diagnoses, participants in the present study revealed that challenges were posed by clinicians' language use that caused emotive feelings of belittlement, dismissal, and confusion. Further, the complex nature of navigating services, comprehension of the complexities and volume of clinical language and information provided was also found to be overwhelming and a cause of significant anxiety. In contrast, some participants shared how once they were able to navigate these challenges, they found empowerment and accepted their diagnostic label.

Gabrielle reported feeling invalidated and belittled during an interaction with a diagnostician, which drastically changed her experiences of, and faith in, her mental health service. Gabrielle explained how her diagnostician referred to her mental health difficulties as “normal teenage experiences” and claimed that “they tried to present it to me and sell it to me as such a normal thing”. Gabrielle shared that numerous clinical diagnoses were recorded in the report later provided that resulted from this appointment. This evoked confusion and distress for Gabrielle, and a loss of trust in her clinicians, who she felt deterred her from accessing critical support, and in the end she “gave up on the NHS” .

Further, four participants (Chloe, Gabrielle, Amina and Matthew) reported how language led to feelings of dismissal when receiving a mental health diagnosis both during and after their appointments. They shared their increased sense of hopelessness following the use of suggestive phrasing by their diagnostician, as well as Amina, who recalled being branded “too complex” for support by a student mental health service. This experience of dismissal left Amina with the feeling that services “don’t really fancy it”. Here, “it” refers to providing support for her mental health challenges, and could represent her perception of services placement of insignificance on these challenges. This left Amina questioning “at what point do you expect me to keep trying?”, “do you want me to seriously try and hurt myself?”. Amina shared that the connotations of describing an individual as “not enough” within a clinical context incurred feelings of misplacement and confusion when navigating her treatment process, adding stress to her experience. This also appeared to cause internalised rejection and the perception of this as a personal downfall; “it’s your fault, they just don’t wanna see you and they’re coming up with…excuses” (Amina).

These challenges are reflected in the literature whereby there is recognition of a more recent transition to the perceptions that mental health lies upon a continuous spectrum. Therefore, there are calls for more precise language use in clinical settings to prevent ambiguous, idiosyncratic dialogue (Pierre & Frances, 2016) and associated feelings of anxiety.

Amina shared her experiences of navigating complex services and being “ping-ponged” from service to service without an explanation or diagnostic descriptor, in that clinicians were unable to agree on a diagnosis due to conflicting understandings of what constituted certain mental health issues. Here, the implications of a lack of clarity within the service provider’s dialogue caused great upset for Amina and offered little support in understanding their own mental health at a challenging time when they were seeking support. The contrasting perspectives bring to question the individual differences at play which may impact on the perceived use of diagnostic specificity over ambiguity. This could be argued to represent a missed opportunity for the service to provide clarity through more lay language to avoid confusion and distress.

Further, Sophie reported she found the amount of information disclosed during appointments had a negative impact on her experiences of mental health services. She found the volume of this information overwhelming and difficult to

Table 1. Participant Demographic Information

Demographics	**Participant (pseudonymised)**									
	Amina	**Dorothy**	**Emma**	**Matthew**	**Xena**	**Chloe**	**Rebecca**	**Gabrielle**	**Katrina**	**Sophie**
Gender*	F	F	F	M	F	F	F	F	F	F
Age (years)	19	Not disclosed	18	48	Not disclosed	22	27	18	19	31
Diagnosis**	Complex PTSD***	Anxiety disorder	PTSD; anxiety; depression	Depression	Anxiety disorder	Depression	Depressive disorder; undefined eating disorder	Anxiety disorder; PTSD; OCD****	Bipolar disorder	Depression; anxiety; agoraphobia
Diagnosis obtained in (country)	UK	Hungary; Greece	UK	UK	China	UK	UK	UK	UK	UK
Professional delivering diagnosis	Unspecified CAMHS***** team member	Psychiatrist	Psychologist	GP	Psychiatrist	Unspecified CAMHS team member	GP	Unspecified CAMHS team member	GP	GP

Note. *M = male, F = female; ** formal diagnosis or received treatment for; ***post-traumatic stress disorder; ****obsessive-compulsive disorder.

Table 2. Generation of GETs and subthemes from PETs

GETs*	**Subthemes**	**PETs****	**Amina**	**Dorothy**	**Emma**	**Matthew**	**Xena**
Impact of navigating complex language and services on diagnostic experiences	Emotive language: a significant contribution to diagnostic experiences	Impersonal, generalised language		X	X		X
		Belittling the issue	X			X	
		Dismissive and or discriminatory language	X	X	X	X	X
	The role of emotive language in identity sense making	Overwhelming amount of information available difficult to navigate	X	X	X		
		Feelings of relief	X	X	X	X	
The lack of person-centred care as dehumanising		Importance of label fitting with the person	X	X	X	X	X
		Importance of validation of feelings	X	X	X	X	X
		Labels helping understand own MH symptoms		X	X	X	X
		Importance of communication with clinician	X	X	X	X	X
		Clinical fatigue	X				
		Importance of thorough explanation	X	X	X	X	X
		Need for compassion		X	X	X	X
		Inappropriate interactions between clinician and individual	X	X			
		Desire for active role in treatment		X	X	X	
		Feeling lost within process	X	X	X		
		Medicalised model		X	X		X
		Passed from service to service	X	X	X	X	
		Frustration and desperation	X			X	
Existing prejudices of the individual and others impact experiences of ill mental health		Lack of prior understanding of mental health system	X	X	X	X	
		Impacts of stigma/taboo on access to support or support seeking	X	X		X	
		Importance of supportive peers	X	X	X	X	
		Media representation	X	X			
		Cultural and/or generational prejudices		X			

Note. *GETs = Group Experiential Theme, **PETs = Personal Experiential Them

Table 2. Generation of GETs and subthemes from PETs (Continued)

GETs*	Subthemes	PETs**	Chloe	Rebecca	Gabrielle	Katrina	Sophie
Impact of navigating complex language and services on diagnostic experiences	Emotive language: a significant contribution to diagnostic experiences	Impersonal, generalised language	X	X	X	X	X
		Belittling the issue	X	X	X	X	
		Dismissive and or discriminatory language	X	X	X	X	X
	The role of emotive language in identity sense making	Overwhelming amount of information available difficult to navigate					X
		Feelings of relief				X	
The lack of person-centred care as dehumanising		Importance of label fitting with the person	X	X	X	X	X
		Importance of validation of feelings	X	X	X	X	X
		Labels helping understand own MH symptoms	X	X	X	X	
		Importance of communication with clinician	X	X	X	X	X
		Clinical fatigue					
		Importance of thorough explanation	X	X	X		X
		Need for compassion	X	X	X	X	X
		Inappropriate interactions between clinician and individual			X		X
		Desire for active role in treatment	X			X	X
		Feeling lost within process	X		X		X
		Medicalised model	X	X	X	X	X
		Passed from service to service	X	X		X	X
		Frustration and desperation	X	X	X		
Existing prejudices of the individual and others impact experiences of ill mental health		Lack of prior understanding of mental health system	X	X	X	X	X
		Impacts of stigma/taboo on access to support or support seeking	X	X	X		X
		Importance of supportive peers	X	X	X	X	X
		Media representation		X		X	
		Cultural and/or generational prejudices		X	X		

Note. *GETs = Group Experiential Theme, **PETs = Personal Experiential Them comprehend, stating, “it can be quite intense, like information overload”, often meaning “you don’t really remember things or conversations that well”. Gabrielle and Xena’s responses demonstrate language may both contribute to the daunting nature of approaching support through the use of overly clinical descriptors, but also that the sheer volume of information given by the practitioner can further cloud an individuals’ understanding of their own mental health, risking a negative impact on their experiences of their ill mental health following the appointment.

The Role of Emotive Language in Identity Sense Making

Evidence reports the human need for generating an identity for individual suffering to help sense making of these experiences (Chen, 2009). In Every Patient Tells a Story, Sanders (2010) notes the crucial role of clinicians curating a narrative for the patient which is perceived to fit their experience allowing progression in understanding their own mental health. In support of this, participants in the present study shared experiences of how navigating the complexities of clinical language impacted upon making sense of their identity as an individual and their mental health diagnosis. Conversely, one participant shared how clinical interactions made them feel empowered and understood.

Six participants (Amina, Chloe, Emma, Gabrielle, Sophie and Xena) shared a lack of clarity during communication with clinicians. Gabrielle described the language use as “scientific mumbo-jumbo” that she was required to “translate” to her family. The term “translate” here emphasises how the sheer complexity of language use here could be akin to translating and understanding a foreign language. This was reflected by Xena, who recalled it taking a long time for her to truly understand language used by her clinicians and in the numerous questionnaires she was asked to complete. Xena shared that she perceived this as an over-complication, in that individuals’ personal experience is in fact “more complicated than the books”, indicating a “gap between the real life and the serious”. This could be interpreted as Xena struggling to feel that her experience is individual to her, by attempting to categorise and make sense of her mental health condition through questionnaires and medicalised language.

Conversely, three participants found the diagnostic label to be a source of comfort and clarity once they were able to identify themselves within its parameters (Katrina, Amina, Chloe). Chloe recalled feelings of empowerment as she “got more involved as it went on”, taking back ownership and actively participating in her own mental health journey while acknowledging her role within her diagnostic process. Following the navigation of service and language complexities, Amina evoked feelings of relief and clarity – “I was like, oh! That’s me! Everything they said was like, oh yeah, yeah, I do have that, oh yeah, I do- I do experience that thing”. In this way, Amina’s experiences of finding a label which they related to appeared to reconstruct their understanding of her own mental health and identity, evolving from desperate pleas such as, “at what point do you expect me to keep trying?”, to a cathartic sense of transparency through the use of a powerful simile: "like being seen for the first time".

Eight participants expressed a wish to have a diagnostic label to help make sense of their mental health. For example, Katrina reflected this idea, stating "it's good to actually… know what you're dealing with", and that she had finally found something which "fit". Similarly, Gabrielle described gaining a label as putting "a name to a face", personifying their mental health and framing it as something tangible.

Further, Matthew explained how his clinical interactions contributed to his feelings of empowerment and making sense of his mental health - "being able to sort of go into a situation and not have to go through everything again…it was really nice… it felt very personal and safe going there". This demonstrated the ability of practitioners to curate a safe and understanding space in which full disclosure is enabled, allowing individuals to feel at ease. Matthew discusses the criticality of empathy within the patient-provider relationship:

If that empathy is there… yeah, it's a set of symptoms I need to diagnose, but, what's important for you in that moment is that you're able to say something and somebody will believe you about how you're feeling… (Matthew).

The use of the language "believe you" places importance on the need for feelings to be validated and the relief that results from this. The importance of a clinician who can accept, without judgement, an individuals' lived reality and empathise with that truth is critical for a constructive and positive clinical interaction. The sheer importance of this clinical interaction is demonstrated by Rebecca, who claims "I would've died if I hadn't spoken to my doctor". To further, Matthew notes "had those first two [doctors] been not that good, I don't know where I'd be really". This sentiment of desperation displays the degree of power which clinicians hold in facilitating change in patients' experience within the mental health system. Therefore, it could be concluded that practitioners who use clearly defined and articulated labels can help individuals make sense of themselves and their mental health, showing that this language is not always to the detriment of the individual patient.

In terms of developing an optimal patient-provider relationship, relational interactions appear to offer a more supportive and in-depth alternative to a more medicalised clinical approach as described by participants in this study and can reduce recurrent medical visits, medicine prescriptions and referrals (Pereira Gray et al., 2018). Therefore, it may be deduced that medicalised language alongside a more person-centred, relational approach may increase the likelihood of more positive experiences of mental health diagnostics and subsequent service provision. To make this possible more consistently across services, increases on the mental health workforce are required due to the increased uptake of mental health services in the UK since 2016 and a decline in the workforce since 2009 (British Medical Association [BMA], 2021).

Theme 2: The Lack of Person-Centred Care as Dehumanising

Transactional care refers to an interaction whereby the patient approaches the health care professional with a specific need, which is then diagnosed and treated or referred for further support (Salisbury, 2020). Within these interactions, the success and quality of care is based upon efficiency, ticking boxes, and following designated guidelines. Participants in the present study provide evidence that this can be at the detriment to patient care. Participants shared reports of language surrounding diagnostic labels placing additional burdens on them, as well as how clinical interactions through both spoken and formally recorded language use in reports left them feeling dehumanised due to a lack of person-centred care. This was often reported to have a detrimental impact on the patient-provider relationship.

All but one participant noted their feelings of burden or rejection in receiving a diagnostic label to represent their ill mental health. For example, in obtaining the diagnostic label of post-traumatic stress disorder (PTSD), Emma shared how the linguistic composition of this label negatively impacted her feelings around her mental health which was viewed as placing an additional burden on her. Emma referred to PTSD as a “heavy title”. Similarly, Rebecca described a label she received that included the term “disability” as “a heavy weight on my shoulders”. Emma and Rebecca’s references to a physical weight (““heavy” and “heavy weight”) place emphasis on this burden and associated efforts required to navigate their mental health and support services.

Rebecca further shared the impact of this on her experiences of her mental health by saying that the language used and delivery of her label caused her anxiety. In relation to her diagnoses, she explained “it did take me aback”, as she had “not considered it [her mental health challenges] to be something long term”. Her initial reaction to this was “woah, I’m not disabled!” Rebecca's expectations were not consistent with the outcome.

As a result, Rebecca continued to share her feelings of conflict around reaching out to services for support and rejecting her label as being disabled. She shared that this experience was followed by personal reflections where she questioned “why was I so averse to that diagnosis or that word when used towards me?”. Rebecca did not identify as disabled, therefore her categorisation that involved use of *dis* language (“disorder”) caused her to question her own identity to which she shared her response to her diagnostician: “you’ve just made me feel so uncomfortable… that’s not the lens I was using to look at myself”. Unfortunately, the delivery and management of delivering Rebecca’s diagnosis appears to be an example of a lack of patient centred and individualised care.

Rebecca and Emma’s experiences of label burden and rejection, and Rebecca potentially withdrawing from service provision may be explained by the Modified Labelling Theory (MLT) (Link et al., 1989). The MLT assumes that labels have a negative effect on an individual and lead to societal withdrawal, at the detriment to the individual. This further evidences the importance of carefully considered language use in clinical settings to ensure person-centred care and increasing the likelihood that patients feel they can approach services for support.

In support of this argument, Katrina described her experience with a senior clinician as lacking in comfort and empathy, claiming it “felt like he didn’t particularly care about the person or the story or whatever, he just wanted facts”. The use of the term *the person* in Katrina’s explanation here further emphasises her feelings of dehumanisation. She felt that the clinician’s inflexible approach wanted her to provide a reductionist or “boxy” version of her challenges and that they were not interested in her as an individual – “I could just get the story down to ‘this is what happened’, not how I felt about it… this is how I got to telling people”. This approach left little room for human nature or considerations of individual difference. This was further supported by Dorothy who described a “very unsupportive” experience whereby her clinician used the term “client” when referring to her and “she never called me by my name”. Dorothy stated feeling as if she was “talking to a robot that was just paid to listen… then moves on to the next person”. This use of language appears to set structured and divisive boundaries between the individual and professional, while also suggesting a consumerist view of mental health support.

Similarly, Gabrielle noted that this medicalised, symptom-based approach to explaining her diagnosis influenced her to rationalise her own mental health in a more reductionist way rather than taking the time to reflect on her own individual needs and challenges - “changed the way I viewed my own mental health because I then put it into lists of symptoms and things, instead of actually thinking about myself as a person”. This was contrary to her preference:

…it takes it out of the emotional context which I feel like you want. You know, for someone just to say, ‘oh I know, that sucks, and you must feel really really bad’, instead of going ‘that’s just a compulsion, that’s a symptom of what you have mentally ill with you’, you know? That sort of differing in language… (Gabrielle).

Further, the reductionist language use was also reported to impact upon patient-provider relationships in all participants in the present study, which often deterred them from seeking further support. Chloe explained how they were unable to form a relationship with the clinician, claiming they “didn’t really get on”, as they felt “like she was just telling me everything I felt was wrong”. As a result of this invalidating interaction, Chloe reported being “put off” accessing support when offered further cognitive-behavioural therapy. In addition, Gabrielle discussed how they were discouraged from accessing support as the clinician failed to listen, noting “I just thought, you know what, if they’re not gonna listen then who is?”. Amina reflects this perceived frustration, exclaiming, “at what point have you not learnt to listen?!” when discussing the clinicians' inability to listen to their issues. This incapacity, coupled with the belittlement of their issues, not only deters those most in need from accessing appropriate support, but also appears to contribute towards the internalisation of their difficulties as a fault of their own, further contributing to more negative experiences of mental health. This is demonstrated through Amina's questioning, "have I done something wrong? Is there something more I could be doing?".

The role language plays in a lack of person-centred care could be explained by the language used in the DSM5, language that clinical practitioners are required to adopt when making decisions around mental health diagnoses. Kinderman et al.'s (2013) suggests the language in the DSM dehumanises individual experiences, and removes the emotional, person-centred aspect of accessing mental health support. This language filters down into clinical practice and demonstrates how lack of person-centred care can be rooted in institutional imperfections and do not solely lay with the individual clinicians when diagnosing mental health conditions. Further, Allen Frances in Phillips et al. (2012) argues that while the DSM is flawed, it remains good enough for clinical use, however this does not take away from the argument that this language may not be *good enough* to be transferred directly into patient-provider interactions.

A possible resolution could be the National Institute of Mental Health's Research Domain Criteria (RDoC) in which psychiatric terminology is free of theoretical influence and is simplified for use in research contexts (Pierre & Frances, 2016). While this presents caveats in terms of its primary use in research rather than clinical settings, the introduction of simplified language within the field demonstrates potential for the diffusion of more accessible and digestible terminology into other areas.

Theme 3: Existing Prejudices of the Individual and Others Impact Experiences of Ill Mental Health

One of the many challenges diagnosticians face in relation to communication with their patients is navigating existing prejudices or misconceptions patients may already have in relation to mental health. For example, in light of viewing her diagnostic report, Gabrielle notes "they made me seem like a freak on my medical record". Gabrielle also shared her preconceptions of mental health disclosed that she "was concerned about how people would then change their view on me as a person, and just sort of go "ah, she's a bit of a freak isn't she?". The repetition of "freak" suggests that upon acquiring a label, Gabrielle applied her existing negative preconceptions surrounding mental health to herself which contributed to her belief that others could also apply these negative preconceptions to her, something that caused great anxiety.

This suggests that existing prejudices are deep rooted in society and is often perpetuated by the desensitised use of derogatory terminology (Yanos et al., 2010). Supporting evidence argues that language contributes to the development of what is to be understood by mental health, coined by the amalgamation of "culture and biology" (O'Reilly & Lester, 2017, p. 4; Osteen, 2008). Therefore, language is argued to no longer be seen to accurately reflect reality; instead, interpretations of reality appear to be constructed and conceptualised through language based on misconceptions (O'Reilly & Lester, 2017). Theoretical assumptions of the MLT (Link et al.,1989) could also explain this phenomenon as this assumes that individuals exposed to lower levels of stigma are likely to perceive more control over their mental health, supporting their ability to find comfort within the diagnostic label. Further, Pybus (2018) reports that those in difficult socioeconomic circumstances experience heightened stigmatised attitudes surrounding their mental health, something that was beyond the scope of the present study.

Further, existing prejudices can also be responsible for the construction of negative narrative in individuals receiving a mental health diagnosis. For example, Rebecca continually referred to her mental health issues as something "wrong" with her, questioning whether she was "weak" for needing support. This sentiment was shared by Matthew, who was filled with "a sense of shame", and viewed his experiences of his mental health as a sign of "weakness". Matthew shared how societal and familial communications reinforced these feelings of negativity towards their mental health when sharing that his family had "no… understanding or empathy with it at all". Here, "it" refers to his mental health challenges. He shared that the influence of this "coloured the way I'd felt about it", and "probably contributed to me being reluctant to seeking help". Matthew explained, "it sort of made me feel that… it was more of a failure of me, than a condition that I needed to deal with".

In addition, Amina was aware of the prejudice which may pervade within the mental health system. When attempting to access support through disclosing her lived experiences to the clinician, she claims "I don't want them to, like, write me off as someone who's being really dramatic and is just a bit, you know, of an attention seeker". This suggests a constant awareness felt in order to navigate through individuals' stigmatised attitudes irrespective of the context. Sadly, evidence does indeed suggest that these negative stereotypes that individuals hold about their own mental health are positively correlated with poor self-esteem (Corrigan & Rao, 2012) and social isolation (Mowbray et al. 2002). This isn't something participants in this study offered reflections on; however, future research may wish to explore this more thoroughly to increase understandings of how to support those who experience this.

Limitations and Recommendations

A limitation of the current study is that two of the ten participants were international students, with one receiving their diagnoses in China, and the other in both Hungary and Greece. It is important to note that this may have impacted on the results due to the differences between health care provisions in different countries, and how these individuals may have experienced these contexts. Further, participants didn't offer reflections on their experiences as a university student. The results should therefore be interpreted with caution, especially when considering application specifically to student populations. However, it is also useful to observe that insights into the experiences of language use by diagnosticians at the point of mental health diagnosis to be in part consistent with the participants who gained their diagnoses in the UK. Therefore cautiously, with a limited sample size the present study, we could consider that although there are variations in clinical provision between counties, this may indicate a universal need to explore the importance of language in this context.

Additionally, some of the most stigmatised groups in mental health were not included in the study, such as those with a diagnosis of schizophrenia and borderline personality disorder (Mannarini et al., 2022; Hazzell et al., 2022). This was not an active decision from the researchers, however those who volunteered to take part were not from these arguably more highly stigmatised groups. This is perhaps unsurprising as participants with mental health difficulties such as schizophrenia are widely reported to be challenging to recruit to research (Allan et al., 2022). It is important to address this in future research as evidence indicates difficulties around clinical care and diagnostic experiences for these groups (Krauss, Bernard & Okusaga, 2022; Guvenek-Cokol & Ongur, 2023).

A further limitation is the lack of control over participant demographic composition such as age, gender and socioeconomic status that resulted from the convenience and snowball sampling strategy. The sample also only comprises one male out of ten participants, therefore, results may be heavily biased to a female viewpoint. This is consistent with the finding that male participants are more difficult to recruit in mental health research due to the prevalence of stigma associated with diagnoses, such as depression (Hinton et al., 2001).

This study also omits information around the specific extent of experiences participants had with mental health services. This is something that is recommended for future research to help contextualise findings further. In terms of research advancement, factors such as socio-economic status (SES) should be reported and exploring the potential influences of SES on language surrounding mental health and diagnostic experiences could be valuable. Lastly, future research should adopt participatory approaches to include the voices of those with lived experience of ill mental health, as only they can provide insights into their worlds and only then can society work to support these communities (Vaughn & Jacquex, 2020).

Lastly, future work in this arena may consider the use of IPA of data as this offers the opportunity to scrutinise language at a micro and macro level from semantic and latent perspectives. The assumptions that underpin IPA that are derived from a critical realist approach also allows researchers to engage in double hermeneutics, offering a transparency regarding the derivatives of the data and the interpretation of the data that is offered.

Conclusions

Within the current clinical context, it appears all too often that patients are left feeling invalidated, belittled and frustrated following interactions aimed to address mental health challenges. This paper provides insights into the potential impact of language use during mental health diagnostic journeys on the experience of university students. Such impacts include evoking strong emotions and acting as a barrier or enabler to sense making when adjusting to a new mental health diagnosis. Participants demonstrated how this language use can reduce an individual's capacity to access support and shape their understanding of their own mental health (Mental Health Foundation, 2019; Corrigan & Watson, 2002). Language can also empower and champion individuals, through framing their mental health in a constructive and progressive manner (Sanders, 2010). This demonstrates a need for future research to further explore and thus enable the understanding and betterment of consistent, service-wide clinical interactions in acting as a safe and supportive space for those with mental illness, with a careful focus on the importance of language use in these settings.

This study’s findings will contribute to understanding the importance of language used in clinical settings when a mental health condition is diagnosed, and will have significance in the ways in which language can impact an individuals’ understanding of their own mental health. This work can now translate into, and contribute towards, operational language use guidelines in clinical settings, ultimately contributing to patient well-being and healing. The current findings should therefore be viewed as a starting point for ground-level research concerning language use during clinical interactions in mental health services. Further, these results could indicate the need for greater interpersonal training for clinicians to ensure patients are met with understanding and empathetic patient-centred care.

Conflict of Interest Disclosure

The Authors report no conflicts of interest.

Research Ethics Statement

The study followed ethical guidelines of the University Research Ethics Policy at the University of Sheffield. Approval No: 038291. Informed consent has been obtained from the participants. The participants received a detailed information sheet outlining the aims and content of the research, before completing an online consent form to agree to participate in the study.

Data Availability Statement

Data associated with the current study will be made available upon reasonable request to the corresponding author.

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Authorship Details

Elizabeth Jane Colbert: research concept and design, collection and/or assembly of data, data analysis and interpretation, writing the article, critical revision of the article, final approval of the article. Lauren Powell: data analysis and interpretation, writing the article, critical revision of the article, final approval of the article

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