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Guest Editorial

All psychiatric disorders are equal, but some are more equal than others! An unconscious bias that calls for precision terminology

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Summary

We address the unconsciously biased perception of psychiatric disorders, highlighting a hierarchical perspective that favours certain diagnoses over others. We aim to uncover reasons for these inequities, emphasising the need for a shift toward pathophysiology-based nomenclature that can promote equal support for each disorder, enhance treatment adherence and encourage open discussions.

Keywords

Psychosocial interventions; education and training; history of psychiatry; mental health services; philosophy.

Pathologies can broadly be categorised into two groups: somatic disorders and psychiatric disorders. The distinguishing characteristic determining which category a pathology falls into is whether the core problem is primarily viewed as an aberrant bodily process, such as the destructive growth of a tumour, or as a distressing phenomenological or behavioural process, such as depression or antisocial personality. Although the two kinds of pathology share substantial similarities in that they both have a biological, and often an environmental, causal factor, they are viewed radically differently. In general, somatic disorders are perceived to be an unfortunate event that causes a person bodily distress, whereas psychiatric disorders are perceived to be a defect of the person her- or himself.

This fact has been thoroughly investigated and demonstrated by the French philosopher and historian Michel Foucault (1926–1984) in *Madness and Civilization: A History of Insanity in the Age of Reason* (1961). In this work, he traces the stigmatising cultural heritage faced by people with psychiatric disorders. In the Middle Ages and Renaissance, most conditions we today would term psychiatric disorders were regarded as a sinful state of madness and deviation from reason. In the 17th century, across Europe people considered insane were incarcerated in institutions, along with other citizens deemed morally defective, such as criminals, dissenters and vagrants, illustrating the perception that insanity was a fundamentally moral deviation. This was later replaced by a view of insanity adopting a softer, but no less invasive and controlling, form of power in which the psychiatrist acted as a paternalistic disciplinarian reshaping the morally corrupt insane. Although our current understanding of the underpinnings of psychiatric disorders has improved substantially, some traces of such centuries-old conceptualisation of psychiatric disorders still pollute the field and continue to influence how mental illness is perceived and approached.

Although it cannot be dismissed that some negative perceptions may stem in part from actual behaviour, and that entirely erasing such negative perceptions may be challenging, it is important to be mindful that stigmatising labels and negative stereotypes lead to overestimations and exaggerated assessments of such behaviours. One of the consequences of these negative stereotypes of people with psychiatric disorders is self-stigmatisation, which refers to the internalisation of these stereotypes by people with psychiatric disorders not only explicitly but also implicitly, outside of conscious awareness. Self-stigmatisation can be considered a particular case of a more general tendency to identify a person with a disorder rather than recognising that the disorder is just one aspect of the person as a whole. This identification process is facilitated by using terminologies such as 'I *am* bipolar' when people wish to communicate that they *have* bipolar disorder, since it tends to equate the whole person with their disorder.[1] It is essential to oppose this trend by recognising in our terminology that every individual with a psychiatric disorder is a whole person who is primarily comprised of aspects that are often not determined by that disorder, such as overall personality, interests, opinions, intellectual ability, creativity and so on.

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Although all psychiatric disorders are subject to some degree of negative stereotyping, there is considerable inequity between the different psychiatric diagnoses regarding the content and extent of negative stereotypes. For instance, substance use disorder tends to be perceived as a moral defect, whereas schizophrenia has connotations of being a deviation from rationality, implying potential unreliability and threat. On the other hand, people with disorders such as major depressive disorder and generalised anxiety disorder are typically viewed as the unfortunate victims of neurochemical imbalances or environmental insults such as childhood maltreatment. Thus, some psychiatric disorders are regarded as pathological processes that people are victims of, whereas others are viewed as defects in the moral or rational character of the patient. One of the potential consequences of this inequity in prejudice is the risk of inequality in societal support as well as an undesirable impact on treatment outcomes. Therefore, the problem to address is twofold. First, we must find ways of reducing or eliminating the negative stereotypes causing excess distress to people with psychiatric disorders, and second, we must formulate solutions to the inequity in the perception of different psychiatric disorders.

Beyond the surface

One of the pivotal elements contributing to such a discriminatory stance on various psychiatric disorders is the terminology used to describe them, which potentially can carry certain connotations or

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stigmas. Terminology is one of the most important means of communication about a disorder; hence, how a disorder is named and framed can greatly shape perceptions of the disorder and attitudes and behaviours towards it. It can also have a significant impact on treatment outcomes. The nomenclature of psychiatric disorders has always been dynamic.[2] To keep the momentum going, we need to move towards informative and inclusive terminologies to reflect an accurate picture of a disorder rather than being derogatory. Framing a disorder should strike a balance between providing accurate diagnostic information and avoiding harmful stereotypes. Schizophrenic (split-minded), antisocial, borderline, bipolar, abuser, autistic, psychotic, etc. are labels that may lead to prejudiced attitudes, social exclusion, self-stigmatisation and even discrimination between different psychiatric diagnoses, and unconscious bias among not only the public but also patients and even healthcare providers.

Ergo, terminologies for all psychiatric conditions should promote a more holistic view, abolish the tendency to define and marginalise individuals solely based on a condition, and try to convey that a disorder is merely one facet of a patient's life and not a defining characteristic.[3] Psychiatric disorders are brain disorders, and the observed phenotype can be traced back to the brain. Therefore, terminologies framing any psychiatric disorder as a medical condition rooted in biological, psychological and social factors eliminate the notion of moral failings and improve the understanding of the ramifications associated with the condition. Additionally, when a disorder is seen as primarily a pathological condition embedded in the brain rather than a character flaw, it enhances patients' willingness to actively engage in their path to (symptomatic/functional) recovery and adhere to a treatment strategy, significantly affecting treatment outcomes. It also makes it more likely for an individual to open up and seek help, which gives rise to receiving a higher quality of assistance and treatment.

This approach must also be expanded to the nomenclature of different medication categories used to manage psychiatric disorders. For instance, the terms 'antipsychotics' and 'mood stabilisers' are hardly explanatory, as the indication of medications in these categories has extended far beyond amelioration of psychosis and stabilisation of mood. Besides, we do not yet have a solid definition of these terms.[4] This picture also holds true for other categories, including but not limited to antidepressants, anxiolytics and so forth. Consequently, some medications are regarded as superior to others; for instance, stimulants are viewed differently from antipsychotics, mood stabilisers or even medications utilised to treat substance use disorders. Therefore, novel taxonomy is needed, which could be based on medications' pharmacological mode of action[5] or their chemical structure rather than having a reductionist approach that labels drugs as having specific indications. In reality, they are used for a much broader spectrum of disorders. Furthermore, indication-based labelling may risk perpetuating current stereotypes regarding psychiatric disorders and medications associated with them.

Fortunately, approaches are already emerging, as exemplified by the Neuroscience-based Nomenclature project (NbN), along with more biologically grounded suggestions for personality disorders and schizophrenia.[2] However, a more earnest commitment and accelerated progress are imperative. Meanwhile, mental health practitioners should be conscious of their own possible biases that might influence their rapport with patients who have particular psychiatric diagnoses. Unconscious biases can lead to unequal treatment and affect how patients perceive their disorders and adhere to their treatments. By acknowledging and addressing the possible presence of biases, providers can ensure that all patients will receive equitable care. Healthcare providers are perfectly suited to educate patients, their families and the public about the biological underpinnings of different psychiatric disorders. We encourage all mental health practitioners to use terminologies grounded in aetiology, pathophysiology or mechanisms of action (both for psychiatric disorders and the medications associated with them) not only to refer to the complex genetic, neurobiological and environmental factors contributing to such disorders, but also to help reduce the stigma, empower individuals to seek help and enhance their engagement in treatment.

Of course, these paradigm shifts are just one side of the coin that are to be complemented by actionable strides through collective endeavours.[2] Needless to say, having neutral, scientifically based holistic nomenclature can – among many other things – usher in an era in which every psychiatric disorder is truly and equally valued and supported, devoid of any discriminatory hierarchy, while mirroring the intricate fabric of the human brain.

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Author contributions

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