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Sociolinguistics of Naming in Mental Health: Ethics, Identity, and the Politics of Labelling

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Abnstract

This article examines the ethical, sociological, and linguistic dimensions of naming practices within mental health discourse, explicitly addressing the tension between person-first language (PFL) and identity-first language (IFL). Person-first language (e.g., "person with schizophrenia") is predominantly advocated within clinical and institutional contexts as a means to mitigate stigma and affirm individual dignity. Conversely, identity-first language (e.g., "autistic person," "Deaf person") is increasingly adopted by different communities to assert identity, autonomy, and cultural solidarity. This divergence illuminates an underlying conflict between prescriptive ethical norms imposed by institutions and emergent claims of personal and collective identity.

Employing interdisciplinary theoretical frameworks - including labelling theory (Scheff, 1966; Goffman, 1963), discourse theory (Foucault, 1972; Butler, 1997), affective psychology (Lewis, 1971; Nathanson, 1992), and philosophy of language (Fricker, 2007; Shotter, 1993) - this research argues that psychiatric naming is inherently normative rather than neutral. Diagnostic labels operate beyond mere categorisation, actively shaping individual subjectivities, legitimising institutional practices, and delineating boundaries of inclusion and exclusion. Consequently, the naming process can perpetuate social stigma, induce internalised shame, or foster collective empowerment, contingent upon the specific socio-cultural context and conditions of participatory involvement.

Utilising cultural case studies, including the recent controversies surrounding Disney’s rebranding of the Seven Dwarfs in Snow White and the institutional promotion of Latinx, the article underscores how language reforms enacted without community consultation risk resulting in "inclusion without participation." Such instances illustrate the phenomenon of euphemistic erasure, wherein sanitised terminology inadvertently marginalises the communities it intends to represent. This research proposes an ethical framework for medical linguistics predicated upon reflexivity, community agency, and contextual sensitivity to address these pitfalls. Rather than imposing uniform terminological standards, the article advocates for a dialogical approach: clinicians, researchers, and policymakers must foreground the linguistic preferences of affected communities and treat language as inherently relational, rather than prescriptive.

The article concludes by advocating increased participatory, mixed-methods research into the influence of linguistic framing on clinical practice, self-perception, and social integration. Ultimately, it reconceptualises medical language not merely as an instrument of clarification but as an arena for ethical negotiation and epistemic justice. Naming practices, therefore, must not serve as definitive verdicts imposed externally but as open-ended questions posed relationally, with humility, attentiveness, and profound respect for lived experiences.

Keywords: Medical Linguistics, Psychiatric Labelling, Identity-First Language, Person-First Language, Epistemic Injustice

Introduction

Language is never a neutral medium[1]. In the field of mental health, the ways in which individuals are named, categorised, and described carry not only semantic weight but profound ethical and social consequences. Psychiatric labels - such as *schizophrenic*, *mentally ill*, or *autistic* - do not simply refer to clinical entities; they participate in the construction of subjectivities, social hierarchies, and, in many cases, enduring stigma (Goffman, 1963; Szasz, 1961).

In recent decades, there has been a growing institutional focus on the ethical implications of medical language. Most major health organisations and style guides, including the American Psychological Association (2020), recommend person-first language (PFL) to mitigate stigma and affirm individual dignity. According to this model, one should say *“a person with schizophrenia”* rather than *“a schizophrenic”*, to place the person before the condition.

However, this linguistic norm has been increasingly challenged, particularly by communities such as autistic and Deaf individuals, who often prefer identity-first language (IFL), e.g., *“autistic person”* or *“Deaf person”* (Sinclair, 2013; Kapp et al., 2013). For these groups, the diagnosis or condition is not viewed as an affliction to be linguistically distanced from, but as an integral part of identity, culture, and lived experience.

The tension between PFL and IFL is not merely semantic; it reveals a deeper conflict between prescriptive institutional ethics and grassroots linguistic agency. Bottema-Beutel et al. (2021) argue that top-down linguistic reforms risk perpetuating ableist assumptions, even in language that is respectful. Furthermore, such reforms often disregard the fundamental linguistic principle that language is descriptive by nature — reflecting usage, community norms and evolving meanings — rather than prescriptive.

This article explores the sociological and ethical implications of linguistic labelling in the context of mental health. Drawing on critical theories of labelling (Goffman and Scheff), power and discourse (Foucault and Butler), and the psychodynamics of shame (Lewis and Nathanson), this examination explores how naming can either reinforce marginalisation or serve as a tool of resistance and identity formation. Through a discussion of identity politics in neurodivergent and Deaf communities, contrasted with the linguistic vulnerability experienced by individuals with severe psychiatric diagnoses, the article concludes that ethical language must be contextualised, participatory and reflexive.

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[1] As first articulated by Ferdinand de Saussure, language functions not as a transparent vehicle for thought but as a system of differences without positive terms. The relationship between *signifier* (sound-image) and *signified* (concept) is arbitrary and socially determined, making language a constitutive medium rather than a neutral conduit. Jacques Derrida further destabilised the notion of fixed meaning, arguing that signification is always deferred and mediated - a process he termed *différance* (Derrida, 1967/1976). Thus, far from being transparent, language is structurally indeterminate and politically charged.

The article concludes by proposing a model of dialogical medical linguistics that centres community agency in naming practices, treating language as a relationship to cultivate rather than a standard to enforce.

By integrating sociological, philosophical, and clinical frameworks, this article contributes to ongoing debates in medical sociolinguistics, proposing an ethical naming model rooted in dialogical praxis rather than normative standardisation.

Historical Genealogy of Psychiatric Labels

From its earliest formulations, psychiatric language has reflected - and reinforced - cultural assumptions about normality, deviance, and human value. A historical examination of psychiatric labelling reveals that diagnoses are not fixed ontological realities, but rather historically contingent categories shaped by institutional interests, social anxieties, and linguistic conventions (Shorter, 1997; Rose, 1998).

The Origins of Degenerative Labelling

In the early 20th century, terms such as *idiot*, *imbecile*, and *moron* were not insults, but clinical classifications. Edmund Burke Huey (1912) offered one of the most precise hierarchical formulations:

> “Idiots - those so defective that their mental development never exceeds that of a normal child of about two years. Imbeciles - those whose development is higher than that of an idiot, but does not exceed that of a normal child of about seven years. Morons - those whose mental development is above that of an imbecile, but does not exceed that of a normal child of about twelve years.” ((Huey, 1912, as cited in Merriam-Webster, n.d.)

These categories reflected a deterministic view of intelligence and human value, often used to justify institutionalisation, eugenics, and exclusion from civil rights. Over time, the terms were abandoned—not because the underlying attitudes disappeared, but because their connotations became socially and politically unacceptable.

From *Dementia Praecox* to Schizophrenia

Emil Kraepelin, often regarded as the founder of modern psychiatric nosology, introduced the term *dementia praecox* in the late 19th century to describe a chronic, deteriorating form of psychosis that he believed was distinct from manic-depressive illness. His model emphasised early onset and irreversible cognitive decline—a view that pathologised early adulthood and cemented a biologically deterministic framework (Kraepelin, 1919/1971).

Eugen Bleuler later replaced *dementia praecox* with *schizophrenia*, a term meant to reflect the splitting of psychic functions rather than a progressive dementia. However, even this “reformulation” was fraught with conceptual ambiguity and stigma. As Wong et al. (2003) argue, schizophrenia has functioned less as a precise diagnosis than as a floating signifier -

flexible enough to absorb a wide range of deviant behaviours, yet rigid enough to deny patients' narrative agency.

The Normalisation of Diagnostic Language

With the publication of the DSM-III in 1980, American psychiatry attempted to move towards a more standardised, atheoretical approach to diagnosis, focusing on symptom clusters rather than aetiology. While this shift aimed to improve reliability, it also led to the institutional normalisation of diagnostic labels such as *borderline personality disorder*, *bipolar disorder*, and *obsessive-compulsive disorder*. These terms soon migrated into public discourse, appearing in media, educational settings, and casual conversation.

Today, to say “I am a bit OCD” or “She is totally bipolar” is not uncommon. This discursive shift reveals how clinical labels have become identity markers, often disconnected from their medical definitions. As Rose (2003) points out, modern psychiatry no longer operates solely within the clinic; it shapes subjectivity across culture, law, and everyday interactions.

Language and Social Control

Historically, psychiatric nomenclature has served as a tool of social control as much as of diagnosis. Szasz (1961) famously argued that the very concept of “mental illness” is a metaphor - a linguistic mechanism used to delegitimise dissent and enforce normative behaviour. In this view, labelling is not simply clinical; it is normative, disciplinary, and political. The Hungarian psychiatrist has also criticised the act of labelling as a form of social control rather than a scientific description.

This historical trajectory - from taxonomies of idiocy to contemporary DSM categories - reminds us that every psychiatric label is a sedimented linguistic artefact, shaped by specific historical conditions. Analysing naming in mental health without acknowledging this genealogy ignores the layered violence and exclusion embedded in the structure of psychiatric language itself.

Theoretical Framework

The intersection of language, identity and psychiatric diagnosis necessitates a multidisciplinary theoretical approach. This section combines four key areas: labelling theory, power and discourse; shame and internalisation; and the fundamental distinction between descriptive and prescriptive linguistics. These perspectives provide the conceptual basis for critically re-evaluating medical language in mental health contexts.

Labelling and Stigma

First articulated in the sociology of deviance, labelling theory suggests that social identities are constructed through the act of naming (Scheff, 1999). In the context of psychiatry, labels such as *schizophrenic* or *mentally ill* function not merely as descriptors but as social markers that carry normative assumptions and institutional consequences. Goffman (1963) famously conceptualised stigma as the process by which a discrediting attribute becomes central to a person’s identity in the eyes of others, and ultimately in their self-conception.

Although labelling may be unavoidable in clinical settings, how labels are formulated and used can mitigate or exacerbate the social isolation and internalised shame experienced by individuals with mental health conditions.

Naming as Power: Foucault and Butler

In psychiatric and medical discourse, naming is not a neutral descriptive act; it is a power dynamic that creates the very categories it seems to describe[2]. Michel Foucault’s genealogical method reveals that the classification systems used in medicine and psychiatry do not merely reflect disorders, but actually create them through discursive and institutional practices. In *The Archaeology of Knowledge* (1972) and, more specifically, in *Madness and Civilisation* (1961), Foucault demonstrates that the diagnosis of 'madness' did not emerge from empirical observation but from systems of confinement, surveillance and moral judgement. In this context, language is not passive; it is an instrument of normalisation that draws boundaries between the sane and the insane, the treatable and the deviant[3] [4].

Building on this legacy, Judith Butler (1997) extends the analysis of power to encompass subjectivity. Through the lens of performativity, she argues that speech acts do not merely describe identities; they enact them. When individuals are labelled, particularly within institutional contexts, they are simultaneously assigned to subject positions that carry normative expectations. Being labelled 'mentally ill' means more than just receiving a

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[2] The act of naming is not ideologically neutral, because it constitutes a performative exercise of power that frames what is sayable, knowable, and governable. Drawing on Judith Butler’s theory of performativity and Michel Foucault’s genealogy of discourse, naming can be seen as a mode of subjectivation that binds individuals to social categories through regimes of knowledge and control. In this sense, to name is not merely to describe, but to delimit - and thereby to include, exclude, or subordinate.

[3] Michel Foucault’s *Madness and Civilization* (1961/2006) offers a genealogical account of how “madness” became constituted as an object of medical and moral knowledge in Western culture. He traces the discursive and institutional mechanisms - particularly from the classical age onward - by which reason defined itself in opposition to unreason, establishing psychiatry as a technology of exclusion and control. For Foucault, psychiatry operates less as a neutral science and more as a technology of power - a system that disciplines bodies and silences deviance under the guise of therapeutic care. His genealogical critique parallels, albeit from a different standpoint, the radical scepticism of Thomas Szasz (1961), who maintained that psychiatric diagnoses are moral judgements masquerading as medicine. While Foucault deconstructs psychiatry as a socio-historical apparatus, Szasz denounces it as a pseudoscientific violation of personal liberty.

[4] The radical critiques of psychiatry articulated by Thomas Szasz and Michel Foucault must be understood not only as theoretical positions, but as responses to concrete historical abuses within institutional psychiatry. In the mid-20th century, invasive procedures such as lobotomy, electroconvulsive therapy (ECT), and insulin coma therapy were not uncommonly employed as instruments of social or political control. In state hospitals, particularly in the United States and the Soviet bloc, lobotomy was often administered not for therapeutic benefit but to render "difficult" individuals more manageable or institutionally convenient (Persaud, 2005; van Voren, 2010). In totalitarian regimes, psychiatry was at times weaponised against dissidents: ECT and forced hospitalisation were applied in the USSR to silence opposition under diagnoses like "sluggish schizophrenia" (van Voren, 2010). It is within this context of biopolitical misuse that the scepticism of Szasz and Foucault toward psychiatric authority must be interpreted - not as abstract hostility, but as responses to real histories of coercion disguised as care.

diagnosis; it means being situated within a matrix of social intelligibility that defines who you are, what you can say and how you will be heard.

Both thinkers agree that language is regulatory: it shapes the possibilities within which subjects can be recognised. In mental health contexts, however well-intentioned, the prescriptive imposition of terms may thus function as a form of discursive containment. When institutional actors enforce person-first language without engaging those directly affected, they risk transforming care into control and respect into *epistemic domestication*. Language here is no longer a bridge to recognition but a gatekeeping mechanism. Consequently, to examine naming in psychiatry is not to ask merely *what* we call people, but *who has the authority to call*, and *under what conditions such naming becomes intelligible, legitimate, or oppressive*. Recognition, in this view, is not a neutral act of inclusion but a discursive negotiation of power.

Shame, Identity, and the Self

While naming operates at the level of social classification, it also penetrates the intimate structure of subjectivity. Being named can profoundly shape how individuals perceive themselves, especially in stigmatising or pathologising terms. Drawing on the work of Helen Block Lewis (1971) and Donald L. Nathanson (1992), this section emphasises the pivotal role of *shame* in identity formation, both as a psychological mechanism and a social construct.

Lewis did not view shame as merely an emotion, but rather as a self-evaluative feeling that arises when the individual internalises perceived discredit or failure to meet normative expectations. Nathanson built on this idea with the concept of the shame spiral: a process in which external judgement triggers internalised shame, resulting in withdrawal and self-silencing and the reinforcement of a stigmatised self-image. In mental health contexts, labels such as “schizophrenic”, “disordered”, or “noncompliant” do not merely denote a diagnosis; they become mirrors through which individuals view themselves.

The interplay between language, emotion and identity is particularly pronounced in psychiatric settings, where the language used by institutions often carries both epistemic authority and emotional weight. The absence of opportunities to contest or redefine one's label exacerbates this dynamic. When language is imposed from outside and resistant to dialogue, shame becomes a structural position — a way of being in the world shaped by discursive subordination, rather than a fleeting reaction. Furthermore, the internalisation of labels reflects broader power dynamics: if a person is consistently referred to in terms that reduce them to their diagnosis — however euphemistically framed — they may begin to see themselves through the lens of that label.

In this way, what began as a *clinical descriptor* becomes an *ontological enclosure*. The individual is not simply named but fixed, defined through a category that appears objective yet functions as a social verdict.

An ethical approach to language in mental health must therefore recognise not only the cognitive but also the affective and existential dimensions of naming. To name without listening is to risk producing not just misrecognition, but a *crippling self-concept* that is haunted by unspoken shame. In this light, naming must be reimagined not as an authoritative act of definition, but as a relational gesture, capable of reinforcing marginalisation or restoring dignity.

Linguistics: Descriptive vs Prescriptive Norms

Ultimately, linguistic philosophy offers valuable insights into how language operates in medical contexts. Traditionally, linguistic scholarship has emphasised the descriptive nature of language, reflecting actual usage patterns, evolving community norms and negotiated meanings. In contrast, medical and bureaucratic institutions often adopt a prescriptive approach, establishing strict guidelines for the use of terminology.

While these norms are ethically motivated, they frequently overlook individuals' preferences and linguistic self-identifications, resulting in a 'rhetoric of imposed politeness', where the appearance of sensitivity replaces genuine engagement and dialogue. Therefore, ethical linguistic practice in mental health contexts requires a shift from prescriptive standards to descriptive, dialogical and participatory approaches that recognise and respect community-driven language preferences.

Discussion: PFL vs IFL

Person-First Language: Origins and Ethical Intentions

Person-first language (PFL), such as *"person with autism"* or *"individual with schizophrenia"*, was introduced during the 1970s in the context of the disability rights movement. It was intended to decentre the diagnosis and emphasise the individual's humanity, resisting dehumanising institutional discourse (Brown, 2011). In clinical and academic literature, PFL has become standardised to reduce stigma and respect dignity (American Psychological Association, 2020). The underlying ethical assumption is that the diagnosis is an external and undesirable condition, and should not linguistically define the subject.

While this intention remains valid in many clinical settings, particularly in acute care or severe psychiatric conditions, it has also provoked criticism for its implicit pathologisation of identity. By linguistically separating the person from the diagnosis, PFL may imply that the condition is inherently harmful and should be distanced from selfhood.

Identity-First Language: Affirmation and Belonging

In contrast, identity-first language (IFL), such as *"autistic person"*, is actively embraced by members of neurodivergent and Deaf communities. For these groups, the condition is not seen as an affliction but as an integral part of personal and communal identity. As Kapp et al. (2013) argue, neurodiversity frames autism as a difference in cognitive functioning, not a disorder to be fixed. IFL, therefore, becomes a declaration of pride, solidarity, and resistance to the deficit model of disability.

This linguistic preference is supported by empirical evidence: Taboas et al. (2023) found that 87% of autistic adults ($N = 728$) in a U.S. sample preferred IFL, whereas 728professionals (N

= 728professionals (*N*=207) remained aligned with PFL. This divergence reflects a broader sociolinguistic phenomenon: those with direct lived experience of a condition are more likely to seek ownership over its naming. At the same time, professionals may adhere to institutional norms shaped by abstract ethical principles.

The case of Deaf culture further illustrates this. The capital-D “Deaf” community defines itself through shared language (sign), history, and values, not through a lack of hearing. For Deaf individuals, being labelled as “a person with hearing loss” is reductive, even offensive. The IFL model sociologically affirms collective identity, whereas the PFL model implies deficiency and assimilation.

Schizophrenia and the Limits of Self-Definition

However, not all diagnostic categories are experienced in this way. Individuals with diagnoses such as schizophrenia or bipolar disorder often lack a cohesive activist identity. They may experience their condition as intrusive, episodic, or unwanted, treated as external to the "true self"[5]. As such, person-first language may be preferred not because it is imposed, but because it provides a linguistic shield - a way to preserve personhood in the face of pervasive stigma (Granello & Gibbs, 2016)[6].

Where PFL is chosen voluntarily, it functions ethically. However, when applied prescriptively, regardless of the linguistic preferences of those it describes, it reinforces a hierarchical structure of voice, where institutional actors determine the legitimate form of expression. The Mad Pride[7] movement offers a critical exception: by reclaiming terms such as “mad” or “schizophrenic” - including, for instance, distributing T-shirts emblazoned with slogans like “I am bipolar. What is your superpower?” - it demonstrates how identity-first language can be employed even in the context of traditionally stigmatised diagnoses, functioning as a political act of reappropriation and identity formation. Rather than advocating

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[5] The notion of the “true self” refers to a philosophical and psychological construct denoting an inner, authentic core of identity - perceived as stable, coherent, and morally salient. In Western psychological discourse, it is often associated with essentialist views of personhood, where deviations due to illness or external influences are seen as distortions rather than integral aspects of the self (see Strohminger & Nichols, 2014). This idea is frequently invoked, implicitly or explicitly, when individuals lingistically —distance themselves from psychiatric diagnoses, framing them as alien to the self’s presumed essence.

[6] The ontological status of a condition plays a crucial role in shaping how individuals linguistically and existentially relate to it. Conditions such as autism and Deafness are increasingly conceptualised not as pathologies, but as stable, lifelong traits that fundamentally structure one’s perceptual and cognitive orientation to the world. In contrast, psychiatric diagnoses such as schizophrenia are frequently experienced - and socially constructed - as invasive, episodic, and disruptive. These conditions are often regarded as external to the “true self,” leading to linguistic formulations such as “I have bipolar disorder” or “I live with schizophrenia,” which imply a subject–condition duality rather than an identity claim. This distinction underscores the differential use of person-first and identity-first language: where the former preserves ontological separation from the condition, the latter embraces it as constitutive of identity and community.

[7] The Mad Pride movement emerged in the late 1990s as a form of psychiatric survivor activism challenging biomedical authority and reclaiming psychiatric labels such as “mad”, “lunatic” and “schizophrenic” as sources of identity and pride. Influenced by earlier anti-psychiatry thinkers (e.g., Laing, Szasz) and disability justice movements, Mad Pride contests the framing of madness as pathology and advocates for alternative understandings rooted in lived experience, creativity, and resistance. See LeFrançois, Menzies, and Reaume (2013), and contributions in Asylum: The Radical Mental Health Magazine.

linguistic sanitisation, the movement insists that reclamation, not replacement, is the path to empowerment.

Linguistic asymmetry

A particularly illustrative example of discursive asymmetry appears in the terminology used to describe behavioural traits associated with autism. In clinical literature, repetitive behaviours and interests (RRBIs) are often pathologised through deficit-oriented labels. Bodfish (2007), for instance, defines restricted and RRBIs as "abnormal behaviours characterised by repetition, rigidity, inappropriateness, and lack of adaptability." Similarly, Ravizza et al. (2013) refer to stereotypic movements, such as hand flapping or body rocking, as "purposeless" and "produced repeatedly in a similar manner," thereby reinforcing a biomedical narrative of dysfunction. However, when described by autistic individuals themselves or by advocacy organisations such as the National Autistic Society, these same behaviours are reframed as stimming - short for self-stimulatory behaviour - or as self-regulatory practices that support emotional balance, focus, and well-being (National Autistic Society, n.d.[8]). What clinical discourse labels as "restricted interests" are often reclaimed by autistic persons as "intense interests," representing not a cognitive limitation but a source of passion, depth, and expertise. This terminological divergence is not merely semantic: it reflects a profound ontological contest over the meaning of behaviour, the nature of difference, and the right to define one's experience.

Case Studies: Inclusion Without Participation

Efforts to reform language used in discussions about mental health and disability are often motivated by good intentions, such as reducing stigma, promoting dignity and fostering inclusion. However, when such reforms are imposed unilaterally by institutions, corporations or governing bodies, paradoxical outcomes can arise, such as symbolic inclusion coupled with material or cultural exclusion. This tension is particularly evident when communities are **spoken for** rather than **spoken with**. The following cases illustrate how language intended to promote inclusivity can be experienced as alienating or erasing by the communities it aims to support.

Disney and the "Magical Creatures"

The implications of imposed naming extend beyond clinical contexts. For example, in 2023, Disney's decision to replace the term (and actors) *"dwarves"* from its live-action remake of *Snow White* with unspecified "*magical creatures*" was met with backlash from the dwarfism community. Although the intention was to avoid stereotyping, the result was a form of symbolic erasure: the community in question was neither consulted nor represented.

This episode highlights the risks of 'inclusion without participation'. The outcome can be disempowering when naming is reformed on behalf of marginalised groups without their involvement. The lesson is clear: ethical language must be dialogical. Even well-meaning

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[8] See the National Autistic Society's guidance on behaviour and obsessions, retrieved from https://www.autism.org.uk/advice-and-guidance/topics/behaviour/obsessions/all-audiences on 1 May 2025.

euphemisms can perpetuate exclusion if they silence the people they are intended to support: this situation is an example of what Miranda Fricker (2007) has termed 'epistemic injustice'[9] - the harm inflicted when individuals are deprived of the ability to contribute to shared social knowledge or to define their place within it. In mental health, such injustice emerges when naming is performed for, rather than with, those named.

“Latinx” and Linguistic Resistance

Another widely discussed example is the institutional adoption of the term *Latinx*—a gender-neutral alternative to Latino/Latina—promoted across academic, corporate, and governmental spaces in the United States. Despite its inclusive intent, surveys indicate that only a tiny percentage (3–5%) of Hispanic or Latino individuals in the U.S. use or recognise the term (Pew Research Center, 2020). Many view it as an anglicised imposition incompatible with the structure of the Spanish language and lacking grassroots legitimacy. This example illustrates the dangers of prescriptive inclusion. When language becomes a site of ideological performance, there is a risk of alienating the people it claims to represent. As Medina (2021) argues, identity terms should emerge through dialogue, based on community self-definition rather than being imposed by elites.

Euphemism as Erasure

Various institutional guidelines have shown a trend towards euphemistic language, such as replacing 'disabled' with 'differently abled', 'mental illness' with 'mental health condition', and 'dwarf' with 'short person'. While these shifts are often intended to soften negative connotations, they can also serve to avoid addressing discomfort, effectively erasing lived experience in favour of rhetorical hygiene. While this linguistic sanitisation is often well-intentioned, it may ultimately displace structural critique by framing difference as an individual trait rather than a collective design failure.[10].

Prescriptive Guidelines and Linguistic Ratification

The above cases raise a fundamental question: can inclusion be authentic if it is engineered from above through linguistic policy rather than emerging from within a community through its practices? When language becomes a set of codified prescriptions determined by public relations strategies, institutional guidelines or medical ethics boards, there is a risk that it will become a system of ratification rather than comprehension. In other words, people may adopt the language without truly understanding it, agreeing with it, or undergoing a genuine

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[9] Miranda Fricker distinguishes between *testimonial injustice*, where individuals are disbelieved due to prejudice, and *hermeneutical injustice*, where they lack the interpretive tools to articulate their experience. Both are common in mental health contexts, where prescriptive language sustains institutional power by marginalising lived perspectives and silencing community-defined vocabularies.

[10] The author argues that euphemistic terms such as *differently able* risk masking structural exclusions under the veneer of inclusivity. Rather than challenging disabling environments, such language may relocate the source of difficulty within the individual, thereby shifting attention away from collective responsibility. An alternative framing proposes the concept of *unpaired* rather than *disabled*, to highlight the mismatch between individual embodiment and the socio-technical world. In this view, disability emerges not from inherent incapacity but from a systemic failure of design, access, and recognition.

transformation. Inclusion without participation is not inclusion: it is linguistic gentrification[11] - the replacement of organic community language with polished, externally approved alternatives that look progressive but leave no room for dissent, complexity, or voice.

Towards an Ethical Model of Medical Linguistics

The preceding discussion reveals that linguistic choices in mental health and disability discourse are not merely stylistic: they are ethical statements embedded in asymmetrical relationships of power, knowledge and representation. Therefore, it is insufficient to resolve the tensions between person-first and identity-first language through universal prescriptions. Instead, what is needed is an ethical model of medical linguistics that is reflexive, participatory and responsive to sociocultural context.

From Linguistic Prescription to Dialogical Practice

In institutional and clinical settings, language is often regulated through top-down guidelines that prescribe the 'correct' terminology, favouring person-first formulations by default. While these guidelines are well-intentioned (based on the principles of nonmaleficence and respect for persons), they often lack a dialogue-based approach. The prescriptive approach assumes that ethical language can be determined in advance, outside context, and applied uniformly across diverse populations. An ethical model must reject this assumption. Instead, it should treat language as a dialogical act that unfolds between clinician and patient, researcher and community, and society and those affected. Ethical language is not found in handbooks but in situated negotiation — an exchange that demands active listening, humility and relational sensitivity (Shotter, 2008).

Principles of an Ethical Model

A responsive and pluralistic approach to medical linguistics should be structured around three interdependent principles:

(a) Reflexivity

Practitioners and researchers must continuously examine their positionality, institutional authority and the assumptions embedded in their speech. Reflexivity involves recognising that 'neutral' language often expresses dominant cultural norms. It also requires an awareness of how one's words may affect the interlocutor's self-perception, sense of agency, and dignity.

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[11] The term *gentrification* was coined by sociologist Ruth Glass in 1964 to describe the transformation of working-class London neighbourhoods through the influx of the middle class, leading to displacement and cultural homogenisation. Derived from *gentry* (of noble or landed class) and the suffix *-fication*, it denotes the process of becoming more socially elevated or refined. By analogy, linguistic gentrification refers to the imposition of institutional or euphemistic language that displaces organic, community-defined terms - often under the guise of inclusion, but with effects of erasure and epistemic domination. Linguistic gentrification mimics inclusion while silencing participation.

(b) Community Agency

Terms must emerge from **within** communities, rather than being imposed **upon** them. Medical institutions should consult directly with advocacy groups, patient organisations, and self-advocates when developing naming conventions. This mirrors the participatory approaches already employed in public health and disability justice frameworks (Charlton, 1998).

(c) Situated Appropriateness

There is no universally respectful or inclusive term. In acute psychiatric contexts, however, PFL can offer a sense of linguistic distance and psychological protection. In neurodivergent or Deaf cultures, IFL may be central to affirming identity. The ethical criterion is contextual appropriateness, which balances institutional responsibility with individual or communal preferences.

Practical Pathways Toward Implementation

Translating ethical principles into practice requires more than just adopting guidelines; it demands structural and dialogical changes across institutions, clinical settings and research cultures. One initial step is to formulate language policies in consultation with those most affected, rather than dictating them from above. Hospitals, academic journals and research institutions should engage with advocacy groups, community representatives and service users to ensure that naming conventions reflect a shared understanding, rather than an assumed correctness.

In clinical encounters, the act of naming should be personalised, just as informed consent governs medical interventions, linguistic self-definition should form part of the therapeutic alliance. Clinicians could start by asking how the individual wants to be addressed in conversation and documentation. This simple question recognises language as an essential component of relational respect.

Academic researchers also bear responsibility. Rather than adhering to editorial conventions or style manuals, authors should explain the rationale behind their linguistic choices. A brief statement explaining the rationale behind their linguistic choices, such as using identity-first language based on community preference, can transform language from a technical device into an ethical position.

Finally, an ethical approach to medical linguistics necessitates education. Healthcare professionals and researchers should be trained in terminology and the sociolinguistic and philosophical dimensions of naming: this process should include an awareness of how language shapes perception, structures authority, and influences lived experience. By incorporating these discussions into professional development programmes, institutions can transition from enforcing correctness to fostering reflexivity.

Beyond Labels: Language as Relational Act

At its most fundamental level, language in the context of mental health should not merely be understood as labelling. Instead, it is an **ontological act-**a means of relating to others, oneself, and the structures of power that organise human experience. This view aligns with dialogical ethics and care-based frameworks in contemporary philosophy (Buber, 1937/2000; Tronto, 1993).

Therefore, ethical language in psychiatry should start with a question, not a label: *"How would you like to be named?"*

Conclusion and Future Directions

The language of mental health is never neutral; the terminology influences what can be thought, said and understood. As this article argues, naming has both ontological and linguistic implications. To name is to define reality, shape perception, and confer status: this concept is not a new insight, but an echo of ancient traditions in which naming constituted a sovereign act of world-ordering[12].

Throughout this analysis, it has been demonstrated that the naming of psychological differences involves more than just semantics; it implicates deeper ontological commitments, power dynamics, and social structures. From the historical evolution of psychiatric labelling to the tensions between 'person-first' and 'identity-first' formulations, naming practices reflect assumptions about existence, power relations and social hierarchies.

The imposition of person-first language, often in the name of institutional respect, can become a form of linguistic paternalism, particularly when it disregards the lived experiences and preferences of those it is intended to protect. Person-first language (PFL) has been widely promoted in institutional and clinical settings based on the idea that language reforms can reduce stigma by setting a standard. While these guidelines are ethically motivated, they are based on the belief that modifying terminology can reshape public attitudes and institutional behaviour, and ultimately the lived experience of psychiatric patients. However, this idea sits uneasily alongside the fundamental linguistic principle that language is descriptive, not prescriptive. Language reflects usage, not intention, and attempting to impose ethical meaning through top-down enforcement may result in superficial compliance rather than genuine shifts in understanding or a reduction in discrimination.

In contrast, identity-first language, employed by groups such as the neurodivergent and Deaf communities, is a form of self-definition and resistance. It enables these communities to reclaim narrative agency in the face of systemic marginalisation.

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[12] The foundational significance of naming as a form of power is already present in the Judeo-Christian tradition. In Genesis 2:19–20, Adam is entrusted by God with the task of naming all living creatures - an act that signifies not only classification, but dominion and relational positioning within creation. To name, in this context, is to participate in the ordering of the world. This symbolic gesture reflects an enduring logic: naming is not merely descriptive, but formative; it configures ontological status and affirms authority. The deep resonance of this act underlines how language, from its mythical origins, is bound to structures of power, identity, and recognition.

However, this is not an all-or-nothing situation. Ethical medical linguistics is not about choosing one model over the other but about embracing plurality, contextuality, and relational ethics. When language is treated as an open-ended dialogue rather than a fixed code, it becomes a medium through which care, dignity and recognition can be expressed.

Whilst the present article advocates a relational and participatory model of psychiatric naming, it is crucial to recognise that such ethical-linguistic considerations are best applied in cases involving subclinical or stable presentations.

In acute psychiatric crises, such as episodes of schizophrenia involving active delusions or hallucinations, the primary imperative is patient safety rather than philosophical coherence. In such cases, the ethical priority may temporarily shift from dialogic negotiation to containment and care, with the hope that reflective discourse can resume once stability is restored.

To develop a more comprehensive understanding of the impact of linguistic framing on public perception, clinical outcomes, self-concept, and therapeutic engagement, further empirical research is necessary. Mixed-methods studies, which combine discourse analysis, ethnographic observation, and participant interviews, have the potential to provide a more comprehensive understanding of how language choices influence experiences in various settings. Furthermore, participatory action research involving service users and advocacy groups could inform the development of more inclusive, reflexive, and context-specific linguistic practices.

On a broader level, medical linguistics must address the philosophical tension between language as a regulation and language as a means of forming relationships. Ultimately, medical linguistics must move not from one terminology to another, but from euphemism to empathy, replacing regulation with relation. When we name, we are not merely describing; we are affirming, delimiting, including, or excluding. Thus, naming must never be a closed act. It must always remain a question, not a label.

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