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Language Preferences Surrounding the Diagnostic Labels for Anxiety and Depression

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Fall 2022

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Abstract

The contention between whether to use person-first language (i.e., “person with X”) or identity-first language (i.e., “X person”) to describe individuals with disabilities has been primarily investigated within the field of special education, but it has not been well explored in relation to mental health. Subsequently, there is a limited amount of information about what terms are preferred to describe mental disorders by individuals who are living with those conditions. This exploratory quantitative study employed an online survey to explore levels of preference for and offensiveness of terms used to describe anxiety, depression, and mental health between 125 participants with varying relationships to these conditions (i.e., have a diagnosis themselves or are a friend, family member, or clinician to someone with a mental disorder). Findings indicate that the most preferred diagnostic labels amongst both individuals with and without anxiety/depression were “Anxiety,” “Depression,” and “Mental Health Condition” while the most offensive diagnostic labels were “Neurotic Disorder,” “Sad, Empty, or Irritable Mood,” and “Emotional Disturbance.” Additionally, the most preferred labelling structure amongst both individuals with and without anxiety/depression was person-first language while the most offensive labelling structure was identity-first language. Considering that diagnostic terminology and labelling structures can have implications on how an individual perceives themselves and is perceived by others, it is important to utilize language that reflects community preferences. The data collected from this study can help inform guidelines for how to describe individuals with anxiety and depression within spoken and written discourse in a sensitive and respectful manner.

CHAPTER 1: INTRODUCTION

Background of the Study

The Americans with Disabilities Act (ADA) became a legal standard in 1990 and serves to prevent discriminatory actions from occurring against individuals with disabilities (Berger, 2013; U.S. Department of Justice, 2020). This law was a monumental triumph of the disability rights movement and enforces the absence of discrimination most notably in the workplace (Berger, 2013; U.S. Department of Justice, 2020). “Disability” is a broad term, however, the ADA delineates this human condition as follows: “An individual with a disability is defined by the ADA as a person who has a physical or mental impairment that substantially limits one or more major life activities, a person who has a history or record of such an impairment, or a person who is perceived by others as having such an impairment” (U.S. Department of Justice, *Americans with Disabilities Act (ADA)*, 2020, para. 3). This specific legal definition of “disability” encompasses both physical and mental conditions which therefore suggests that mental illness can be characterized as a disability so long as it “limits one or more major life activities” (U.S. Department of Justice, *ADA*, 2020, para. 3).

In addition to the inclusion of mental illness within the ADA’s conceptualization of disability, the history of individuals with mental illness parallels the history of individuals with physical and intellectual disabilities. Throughout history, individuals categorized as having any disability were subjected to inhumane treatment, blatant discrimination, and deliberate separation as displayed through institutionalization and forced sterilization (Berger, 2013; Farreras, 2022). Institutions isolated individuals with disabilities from their family, friends, and society at large in an effort to alleviate the perceived burden of their differences (Berger, 2013; Farreras, 2022). This intolerance towards individuals with disabilities subsequently fueled the eugenics

movement which sought to eradicate the possibility of disability within future generations through practices such as forced sterilization (Berger, 2013; Farreras, 2022). Historically harmful societal attitudes and behaviors also spurred the genesis and utilization of derogatory labels to speak and write about individuals with disabilities such as “feeble-minded,” “lame,” “mad,” and “lunatic” (Clark & Marsh, 2002). As a community, individuals with disabilities have advocated to rightfully earn societal autonomy and dignity after years of unjust treatment and a history plagued by misunderstanding (Berger, 2013). Efforts to amend disability language and labels in a manner that reflects the current preferences of individuals with disabilities is one avenue through which this goal has been pursued.

Language preferences have been explored within numerous disability communities and the findings demonstrate that preferences can differ depending on the condition and the relationship that an individual has with the condition (Ashford et al., 2019; Bury et al., 2020; Dunn & Andrews, 2015; Granello & Gibbs, 2016; Granello & Gorby, 2021; Kenny et al., 2016; Pivovarova & Stein, 2019; Rottenstein, 2014). Within the preexisting literature, there is no known study to date on language preferences in relation to anxiety and depression despite these mental health conditions being extremely prevalent within society. In 2019, “an estimated 19.4 million adults in the United States had at least one major depressive episode. This number represented 7.8% of all U.S. adults” (National Institute of Mental Health [NIMH], *Prevalence of Major Depressive Episode*, 2019, para.1). Likewise, “anxiety disorders are the most common mental illness in the U.S., affecting 40 million adults in the United States age 18 and older, or 18.1% of the population every year” (Anxiety & Depression Association of America [ADAA], *Did You Know*, n.d., para. 1).

Purpose of the Study

The purpose of this exploratory analysis is to elucidate the language preferences of individuals with anxiety and depression to address the dearth of literature concerning this growing and populous community. Through comparisons between individuals with and individuals without anxiety/depression, the identified language preferences could help inform which diagnostic terms and labelling structures to use when describing this community within spoken and written discourse.

Definition of Key Terms

Anxiety: An overarching categorization for more specific mental disorders (i.e., generalized anxiety disorder, panic disorder, agoraphobia, etc.) that can be generally characterized by persistent and disproportionate feelings of fear and worry (American Psychological Association [APA], 2013; World Health Organization [WHO], 2016).

Depression: An overarching categorization for more specific mental disorders (i.e., major depressive disorder, persistent depressive disorder, etc.) that can be generally characterized by an overwhelming feeling of sadness and a loss of pleasure (APA, 2013; WHO, 2016).

Identity-First Language: A labelling structure that refers to an individual by their condition first and mimics “X person” (Dunn & Andrews, 2015; Kenny et al., 2016). For example, “disabled person;” “anxious person;” “depressed person.”

Mental Health Condition: A term that encompasses a breadth of disorders (i.e., anxiety disorders, depressive disorders, schizophrenia, etc.) and delineates a condition that can alter an individual’s thoughts, feelings, and behaviors to the extent that their daily functioning is impaired (APA, 2013; WHO, 2016).

Person-First Language: A labelling structure that mimics “person with X” to emphasize that an individual is not defined by their disability (Bury et al., 2020; Dunn & Andrews, 2015; Granello & Gibbs, 2016; Granello & Gorby, 2021; Kenny et al., 2016). For example, “person with a disability;” “person with anxiety;” “person with depression.”

CHAPTER 2: LITERATURE REVIEW

The person-first language movement is a recent effort towards destigmatizing disability discourse by advocating for a labelling structure that mimics “person with X.” The reasoning behind this structural change is that it emphasizes that a person’s identity and value are not dependent on their disability (Bury et al., 2020; Dunn & Andrews, 2015; Granello & Gibbs, 2016; Granello & Gorby, 2021; Kenny et al., 2016). Person-first language is aligned with the social model of disability which suggests that disabilities exist due to societal barriers that are intolerant of individuals who diverge from what is considered “normal” (Dunn & Andrews, 2015; Haegele & Hodge, 2016; Kenny et al., 2016; Retief & Lešosa, 2018). This conceptualization along with person-first language accentuates the individual and diminishes some of the barriers that being defined by a disability can pose (Dunn & Andrews, 2015). The social model is only one framework for understanding the construct of disability and directly opposes the prevailing medical model that conceptualizes disability as the result of dysfunctional bodily processes (Dunn & Andrews, 2015; Haegele & Hodge, 2016; Retief & Lešosa, 2018). Within the medical model, disability is viewed as a disease/illness/condition with the aim of treatment being to eradicate the presenting problems (Dunn & Andrews, 2015; Haegele & Hodge, 2016; Retief & Lešosa, 2018). The social model and enforcement of person-first language is an effort to acknowledge the need for structural changes and accommodations rather than treatments that target the individual, which are characteristic of the medical model (Dunn & Andrews, 2015; Haegele & Hodge, 2016; Retief & Lešosa, 2018). However, despite the progressive intentions of the social model and person-first language, these beliefs can be construed to suggest that the individual should not want the condition to be a part of their identity due to the accompanying negative connotations (Kenny et al., 2016). A third model of

disability is referred to as the minority model which postulates that disability is a difference that contributes to the diversity of humanity and should be an internalized aspect of one's identity (Dunn & Andrews, 2015). This framework is compatible with the reasoning behind identity-first language which advocates for a labelling structure that mimics "X person" (Dunn & Andrews, 2015; Kenny et al., 2016). There are speculations that preferences for this phrasing are related to the degree to which an individual associates their identity with the disability (Dunn & Andrews, 2015).

One group that has exemplified the intersection between language, identity, and models of disability is the Deaf community. Society perpetuates the narrative that disability is synonymous with deficit, however, the Deaf community has discredited this notion through intentional language and group identification (De Clerck, 2007; Hamill & Stein, 2011; Jones, 2002). Treatments for deaf people are aligned with the medical model of disability and suggest that hearing is and should be desired (Hamill & Stein, 2011; Jones, 2002). However, the Deaf community does not subscribe to the belief that being deaf is a disability and suggest that this categorization is an imposed social construct (De Clerck, 2007; Hamill & Stein, 2011). Instead, deaf people identify as belonging to a minority group with shared experiences and language (i.e., sign language) which holistically constitutes Deaf culture (De Clerck, 2007; Hamill & Stein, 2011; Jones, 2002). Deaf culture is delineated with a capital 'D' as opposed to a lowercase 'd' which instead characterizes the pathological condition of deafness (Dunn & Andrews, 2015; Hamill & Stein, 2011). Deaf culture was achieved by disassociating deafness from the medical model and reclaiming this condition as an integral and prideful component of one's identity (De Clerck, 2007; Hamill & Stein, 2011; Jones, 2002). As such, people within the Deaf community

prefer the use of identity-first language as opposed to person-first language (Dunn & Andrews, 2015).

While there is no universally agreed upon labelling structure due to variations in personal preference, what may appear to be a slight grammatical change has implications on the inward and outward perceptions of the individual with the label (Ashford et al., 2019; Bury et al., 2020; Granello & Gibbs, 2016; Granello & Gorby, 2021; Kenny et al., 2016; Pivovarov & Stein, 2019). Language preferences surrounding disability rhetoric have been studied in disciplines such as special education, and recently, researchers have specifically investigated the contention between person-first (i.e. “person with X”) and identity-first language (i.e. “X person”) with regards to autism (Kenny et al., 2016). Kenny et al. (2016) conducted a large-scale survey in the United Kingdom to assess language preferences for communicating about autism. More than three thousand respondents with varying relationships to autism indicated their preferences for terms used to label and describe autism by answering a series of closed-ended questions followed by a final open-ended question. Findings from autistic adults, professionals, and family members/friends demonstrated that the main discrepancy amongst groups was the use of person-first versus identity-first language. While autistic adult respondents more frequently endorsed identity-first language, professionals commonly utilized person-first language, and family members/friends were divided regarding their preferences.

Similarly, Dunn and Andrews (2015) cite raw unpublished data from Rottenstein (2014) that assessed language preferences within a sample of individuals with a broad range of disabilities in the United States. Findings demonstrated that a vast majority of the participants indicated a preference for person-first language (Dunn & Andrews, 2015; Rottenstein, 2014). This discrepancy between the preferences of autistic adults in the United Kingdom and

individuals with a range of disabilities in the United States illuminates how person-first and identity-first language are context specific and an amalgamation of personal preference and social influences (Dunn & Andrews, 2015; Kenny et al., 2016; Rottenstein, 2014).

Researcher Simon Bury and colleagues drew inspiration from Kenny et al. (2016) and collected data on the preference for and perceived offensiveness of terms used to describe adults on the autism spectrum within Australia (Bury et al., 2020). Unlike Kenny et al. (2016), this study only included individuals with a self-reported diagnosis of autism. The quantitative portion of this study found that none of the terms presented on the survey were perceived as offensive since mean ratings from Likert-scale questions were below a neutral response of three and a half. With this being said, “Autistic,” “Person on the Autism Spectrum,” and “Autistic Person” all produced high mean preference ratings from Likert-scale questions with no statistically significant differences between terms. The lowest mean preference ratings were associated with person-first phrasings that included either the word “condition” or “disorder” demonstrating that the negative connotations of specific terms may transcend any preference for labeling structures.

The survey from Bury et al. (2020) also included rank ordering questions which demonstrated that while “Autistic” was the most preferred term according to rank orderings, a large portion of participants also delineated this term as being their least preferred. On the contrary, “Person on the Autism Spectrum” was the second most preferred term according to rank orderings, but endorsement of this term was more centralized around the top three ranks (as opposed to the first and last ranks). These quantitative data from Bury et al. (2020) demonstrates that a divide still exists amongst the autism community in Australia with regards to preferences for either person-first or identity-first language. The qualitative data compounded this quantitative divide with one theme expressing autism as being an integral component of an

individual's identity while another theme demonstrated that an individual is not defined by autism as it is only one aspect of their sense of self (Bury et al., 2020). This study provides another example as to how language preferences are subject to individual differences, influenced by the surrounding context, and reflective of inward perceptions.

The discussion surrounding person-first and identity-first language has permeated the realm of mental health as Granello and Gibbs (2016) examined the influence of person-first and identity-first language on levels of expressed tolerance. In this study, participants were given the same survey with the only difference being whether the question utilized the phrasing of "the mentally ill" or "people with mental illness." In this scenario, "the mentally ill" and "people with mental illness" exemplify identity-first and person-first language respectively. This variation in language structure had significant implications as participants who completed the survey that incorporated "people with mental illness" exhibited higher levels of expressed tolerance. While this study does not measure the preferences of individuals with a diagnosable mental illness, it does illuminate the relationship between language and personal attitudes and beliefs.

Within the field of mental health, schizophrenia has been identified as one of the most stigmatized disorders amongst professionals (Valery & Prouteau, 2020). In 2021, researchers Granello and Gorby examined levels of expressed tolerance amongst professional counselors and counselors in-training for the terms "schizophrenic" (i.e., identity-first) and "person with schizophrenia" (i.e., person-first). Similarly to Granello and Gibbs (2016), participants within this study were administered identical surveys aside from the phrasing used to express a schizophrenia diagnosis. Participants that were administered a survey with the identity-first term demonstrated lower levels of expressed tolerance compared to participants with the person-first term. Specifically, the term "schizophrenic" was associated with perceptions of inferiority and

dangerousness while the term “person with schizophrenia” was more closely related to a sympathetic attitude (Granello & Gorby, 2021). These findings coincide with the results from Granello and Gibbs (2016) but also demonstrate that language can have either positive or negative implications for individuals with a specific diagnosis, not just a mental health disorder in general.

The diagnostic labels and terminology for substance use disorder (SUD) have also been subject to criticism in recent years as this mental health condition is highly stigmatized (Valery & Prouteau, 2020). While the diagnostic label of “substance abuse” was included within the DSM-IV, this term was eliminated from the DSM-5 and replaced with “substance use disorder” (Ashford et al., 2019). Language shapes our conceptualizations of others and words including “substance abuse” and “substance abuser” contribute to the maintenance of stigma surrounding individuals with SUD (Ashford et al., 2019; National Institute on Drug Abuse [NIDA], 2021). A study conducted by Ashford et al. (2019) utilized an implicit bias test known as the “Go/No-Go Association Task” to measure attitudes elicited by the terms “substance abuser” and “person with substance use disorder.” This study demonstrated that while both terms were more readily associated with negative adjectives, the strength of this association was greater for the identity-first phrasing of “substance abuser.” The findings from Ashford et al. (2019) support the recommendation published by the NIDA (2021) which is to utilize person-first language in reference to SUD. However, as demonstrated by Kenny et al. (2016), the diagnostic labels used by individuals with a specific diagnosis may differ from the terminology used by those with a more distant relationship to the condition (i.e., friends, family, and clinicians). With regards to SUD, researchers Pivovarova and Stein (2019) asked individuals who use heroin which language they prefer to use when describing themselves, and what language they prefer others use. While

individuals who use heroin reported using the word “addict” to describe themselves, they preferred that others use the person-first term of “person who uses drugs” when referencing them. This finding is reflected within the NIDA’s recommendation but also demonstrates how a person’s view of themselves may differ from how they want to be viewed by others and that this phenomenon can be implicated through language (Pivovarova & Stein, 2019). While these references recognize that person-first language alone will not eradicate the stigma surrounding SUD, they do suggest that person-first language can help alleviate the strength of negative associations and attitudes held by the public (Ashford et al., 2019; NIDA, 2021; Pivovarova & Stein, 2019).

Aside from the debate between identity-first and person-first language, the everyday vernacular and clinical rhetoric surrounding mental health is riddled with derogatory and stigmatizing labels. A study conducted by Rose et al. (2007) compiled a list of the most common words used to describe people with mental health disorders within a population of school-age children from England. A sample of the words reported include “disturbed, nuts, confused, psycho, and crazy” (Rose et al., 2007, p. 3). Additionally, mental health diagnoses are being reconsidered on the basis that they may perpetuate stigma and inflate publicly held misconceptions (Beltrán, Sit, & Ginsburg, 2021). For example, it is argued that the terms “oppositional” and “defiant” independent of a diagnostic label have negative connotations and thus, when used to characterize an individual, generate negative perceptions of the self (Beltrán, Sit, & Ginsburg, 2021).

Community language preferences have been explored in topics such as disability, autism, mental illness, schizophrenia, and SUD (Ashford et al., 2019; Bury et al., 2020; Dunn & Andrews, 2015; Granello & Gibbs, 2016; Granello & Gorby, 2021; Kenny et al., 2016;

Pivovarova & Stein, 2019; Rottenstein, 2014), however, there is no known literature to date on language preferences in relation to anxiety and depression even despite their prevalence (ADAA, n.d.; NIMH, 2019). Both the American Psychological Association (APA, 2015) and Jensen et al. (2013) advocate for making person-first language a customary practice within the contexts of therapeutic relationships and clinical treatment settings, however, the studies cited above demonstrate how language preferences are dependent on the individual, context, and condition making it difficult to make blanket statement recommendations. Considering the power of language in its ability to elicit emotional reactions both within the individual being labeled and by those who hear and use the verbiage (Ashford et al., 2019; Bury et al., 2020; Granello & Gibbs, 2016; Granello & Gorby, 2021; Kenny et al., 2016; Pivovarova & Stein, 2019), it is imperative that the language surrounding anxiety, depression, and mental health in general is amended in a manner that reflects the preferences of the community.

CHAPTER 3: METHODS

Purpose

The present study was guided by the research question: What are the public's language preferences surrounding terms related to mental health for individuals with anxiety/depression and their communities of support (e.g., family members, friends, clinicians, etc.)? The purpose of this study was to identify language preferences surrounding anxiety, depression, and mental health with the intention of informing spoken and written discourse in a manner that reflects these preferences and diminishes levels of experienced stigma.

Research Design

This quantitative study utilized a design that was adapted from a research paper by Simon Bury, Rachel Jellett, Jennifer Spoor, and Darren Hedley (2020) with permission from Simon Bury obtained via email. While the designs of both the present study and Simon Bury's study are similar, the topics of interest are different. In the present study, quantitative data were collected through an online survey that consisted of closed-ended questions and asked participants to indicate both how much they prefer and how offensive they find terms related to anxiety, depression, and mental health in general. These closed-ended questions were formatted using both a 5-point Likert scale and a rank ordering system.

This study was theoretically guided by the medical, social, and minority models of disability (Dunn & Andrews, 2015; Haegele & Hodge, 2016; Kenny et al., 2016; Retief & Lešosa, 2018). Within the medical model, disabilities are conceptualized as a disease/illness/condition that can and should be cured with effective treatment (Dunn & Andrews, 2015; Haegele & Hodge, 2016; Retief & Lešosa, 2018). Meanwhile, the social model postulates that disability results from societal barriers and therefore, the focus should be on

amending the surrounding environment (Dunn & Andrews, 2015; Haegele & Hodge, 2016; Kenny et al., 2016; Retief & Lešosa, 2018). Contrary to both the medical and social models, the minority model suggests that disability is a natural variation inherent within the human race and should be a prideful component of an individual's identity (Dunn & Andrews, 2015). Items in the present study were designed to evaluate how participants responded to terms representative of each of these models. For example, the medical model was reflected in terms from the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed., DSM-5, APA, 2013) and *International Classification of Diseases, Tenth Revision* (ICD-10, WHO, 2016), the social model was reflected in use of person-first language, and the minority model was reflected in use of identity-first language.

Sample and Setting

The target sample size of this study was 100-300 participants to allow for a robust between groups comparison between participants with and without anxiety/depression (at least 50 participants with anxiety/depression and 50 without). Anyone 18 years or older was eligible to participate, regardless of mental health status and geographic location. In other words, this study *did not* require participants to have a professionally diagnosed mental health disorder and *was not* restricted to only those who reside in the United States. In addition to the age requirement, participants needed to have access to a computer and the internet to complete the online survey. The broad eligibility criteria made this study available to a large population allowing for the collection of diverse perspectives on the topic of interest.

Procedure

This study was officially approved by the University of Vermont Institutional Review Board (IRB) on February 28th, 2022. This study qualified as “exemption category 2” since the information was collected through a survey and the participants’ identities remained anonymous.

Data were collected via an anonymous online survey that was developed and made accessible through Qualtrics, a secure survey platform. In total, this survey took approximately 10-15 minutes to complete. The survey for this study was distributed on social media platforms and through word of mouth without the use of any paid ads. On social media platforms such as Facebook and Reddit, there exists both public and private group pages that serve as online gathering spaces for individuals with anxiety, depression, and/or other mental health disorders. For example, Reddit group pages including “/r/Anxiety” and “/r/mentalhealth” with 530,000 and 312,000 members respectively were utilized throughout the recruitment process. These group pages allowed the study to reach diverse populations with a pre-existing expressed interest in the topics of anxiety, depression, and mental health. Specifically for private group pages, group moderators were contacted and provided with a short description of the study. It was only upon the approval and permission of a group moderator that the survey was posted on private group pages. In addition to group pages, the survey was also distributed to personal networks (i.e. Instagram), to members of clubs at the University of Vermont (e.g. Active Minds at UVM and UVM Neuroscience Club), and through word of mouth. The approved study notice and advertisement are included within Appendix B and C respectively.

Instrument

The first question of the survey screened for inclusion criteria by asking participants to identify whether or not they were age 18 year or older, with the survey only accessible to those who indicated that they were 18 years or older.

The survey began with standard demographic questions that assessed the participants' age, sex assigned at birth, gender identity, ethnicity, country of residence, highest level of education completed, and current employment status. Additionally, the demographic portion of the survey assessed the relationship that the participant had with anxiety and/or depression to discern if they have personally experienced these conditions or are familiar with them through association. Participants were asked to identify whether they had been clinically diagnosed with a mental disorder, or suspected that they have a mental disorder (e.g. anxiety, depression), or neither. For this study, a diagnosis of anxiety/depression was operationalized as either a clinical or suspected diagnosis since a primary interest of the study was how personal identities (i.e., a person who does or does not identify as part of the anxiety/depression/mental health community) translate into expressed language preferences. This survey question allowed participants to select more than one answer, for example, a participant could indicate that they have received an official diagnosis of anxiety from a provider *and* suspect that they have depressive disorder. An image of this survey question is provided in Figure 1 below:

Figure 1:

Do you currently have any of the following diagnoses or suspect you may have any of the following diagnoses? (please check all that apply):

	Received diagnosis from a provider	Suspected diagnosis
Anxiety Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Depressive Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Other clinical or psychiatric condition. Please specify: <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>

If participants indicated that they did not have a suspected or clinically diagnosed mental disorder, they were asked a follow-up question to assess how or if the participant was associated with anxiety, depression, or mental health in general, such as being a family member of someone with a mental disorder, friend of someone with a mental disorder, clinician for patients with a mental disorder, other (which they were asked to specify), or none of the above. An image of this survey question is provided in Figure 2 below:

Figure 2:

How are you associated with anxiety, depression, or mental health in general? (please select all that apply):

- I am a family member of someone with a mental disorder.
- I am a friend of someone with a mental disorder.
- I am a clinician for patients with mental disorders.
- Other
- None of the above

Following the demographic portion of the survey was a quantitative section which consisted of closed-ended questions that asked participants to indicate their preference for terms related to anxiety, depression, and mental health in general. The terms that were evaluated on the survey were extracted from prominent texts within the field of Psychology (including the DSM-5 and ICD-10), as well as the media more generally (e.g. Instagram, blogs, articles from *Verywell*

Mind, etc.). These resources served as a point of reference for how language surrounding anxiety/depression is used within scientific, clinical, and ordinary discourse. These terms were presented to participants using either person-first language, identity-first language, or no particular language structure. For example, preferences were independently measured for the diagnostic labels of “individual with anxiety,” “anxious individual,” and “anxiety.” This allowed for an exploration of both the preferred terms and the preferred language structures.

The closed-ended questions from this quantitative survey employed both Likert-scales and rank ordering. In total there were 12 questions that utilized a Likert-scale and 12 questions that utilized rank ordering. This portion of the survey was organized into six sections of related terms: terms for anxiety, person vs. identity-first language structure for anxiety, terms for depression, person vs. identity-first language structure for depression, terms for mental health in general, and person vs. identity-first language structure for mental health in general. Each section followed the same formatting of questions: two Likert-scale questions (one for preference and one for offensiveness) and two rank ordering questions (one for preference and one for offensiveness).

To evaluate preference for each term, participants were asked if they prefer a term related to either anxiety, depression, or mental health in general by selecting an option that ranged from “strongly disagree” to “strongly agree” on a 5-point Likert scale. Participants were then asked to rank order the same set of terms related to either anxiety, depression, or mental health in general from most to least preferred.

To evaluate offensiveness of each term, these Likert-scale and rank ordering questions were then replicated to measure offensiveness in order to discern between general preferences and harmful language. For example, participants were asked to indicate if they are offended by a

term related to either anxiety, depression, or mental health in general by selecting an option that ranged from “strongly disagree” to “strongly agree.” Participants were then asked to rank order the same terms related to either anxiety, depression, or mental health in general from most to least offensive. The first series of survey questions from the section of “terms for anxiety” are depicted in Figure 3 below:

Figure 3:

Please indicate your preference for the following terms being used to describe anxiety with the 5-point scale below.

I prefer to use the following terms:

	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
Anxiety Disorder	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Neurotic Disorder	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Anxiety Spectrum	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Anxiety	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Pathological Anxiety	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Excessive Fear and Anxiety	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Please rank order the following terms from most to least preferred (1 = most preferred, 6 = least preferred) by dragging and dropping them.

Anxiety Disorder	1
Neurotic Disorder	2
Anxiety Spectrum	3
Anxiety	4
Pathological Anxiety	5
Excessive Fear and Anxiety	6

Please indicate how offensive you find the following terms being used to describe anxiety with the 5-point scale below.

I am offended by the following terms:

	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
Anxiety Disorder	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Neurotic Disorder	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Anxiety Spectrum	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Anxiety	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Pathological Anxiety	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Excessive Fear and Anxiety	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Please rank order the following terms from most to least offensive (1 = most offensive, 6 = least offensive) by dragging and dropping them.

Anxiety Disorder	1
Neurotic Disorder	2
Anxiety Spectrum	3
Anxiety	4
Pathological Anxiety	5
Excessive Fear and Anxiety	6

After each section of terms, participants were allowed the opportunity to indicate other terms that they prefer to use but were not included on the survey.

Data Analysis

All data analyses were conducted using a statistical software named SPSS Version 28.

To explore preference and offensiveness ratings of each term, means and standard deviations were calculated for the data produced from Likert-scale questions to determine overall preference for and offensiveness of terms related to anxiety, depression, and mental health in general. In addition, independent samples t-tests, including mean differences and p-values, were calculated to compare responses between individuals with and individuals without a clinical or suspected diagnosis of the condition related to the terms being explored (e.g. for anxiety terms, comparisons were made between individuals with and individuals without a clinical or suspected diagnosis of anxiety; for depression terms, comparisons were made between individuals with and individuals without a clinical or suspected diagnosis of depression; for mental health terms,

comparisons were made between individuals with and individuals without a clinical or suspected diagnosis of anxiety and/or depression).

To explore which terms were endorsed by the sample, frequencies were used to find the percentage of individuals with and the percentage of individuals without a clinical or suspected diagnosis of anxiety/depression that endorsed a specific term. A term was considered “endorsed” by a participant if they selected either “strongly agree” or “agree” in response to Likert-scale questions about preference for terms. These calculations for percent endorsed utilized the same division of groups as the calculations for means and standard deviations described above.

In addition to Likert-scale questions, the survey also utilized rank ordering questions to explore preference and offensiveness for each term. Rank orders could range from 1 (most preferred/offensive term) to either 5 or 6 (least preferred/offensive term) depending on the specific number of terms included within the set. This section of data analysis only included participants with a clinical or suspected diagnosis of the category being explored (e.g. only those with anxiety were included in exploring terms related to anxiety; only those with depression were included in exploring terms related to depression; only those with anxiety and/or depression were included in exploring terms related to mental health in general). Overall rank orders and weighted means were calculated using Freidman tests. Following these calculations, descriptive statistics were used to assess the total number and percentage of participants that ascribed a specific rank order to a specific term.

Reliability and Validity

This study was an exploratory analysis as the intention was not to confirm results from pre-existing studies, but rather survey the public’s current thoughts, preferences, and opinions. To measure the public’s preferences and levels of perceived offensiveness for terms related to

anxiety, depression, and mental health in general, this study did not utilize a preexisting instrument or aim to develop a new instrument for future research. Instead, the survey questions were adapted from another study conducted by researchers Simon Bury et al. (2020) which measured similar constructs in relation to terms used to label autistic adults.

Face validity suggests that the content included on the survey has been verified by experts as being sufficient at measuring the intended constructs (Salazar et al., 2015). The primary investigator of this study is currently receiving training on mental health related concepts within psychology courses for an undergraduate degree. Additionally, the primary investigator works closely with the population of interest for a local mental health care organization. The primary investigator's research advisor is an assistant professor within the College of Nursing and Health Sciences at the University of Vermont and has extensive experience in research on topics related to mental health. Additionally, an Interprofessional Health Sciences Ph.D. candidate with experience as a speech-language pathologist contributed to the present study by imparting their knowledge about rigorous research practices and content related to mental health and disability studies.

Aside from a research team composed of individuals with expertise on the topic of mental health and general research practices, a number of the terms presented on this survey were extracted from widely accepted sources within the professional psychology community such as the DSM-5 and ICD-10. To reflect the language used both within clinical and colloquial discourse, the additional survey terms were found within blogs, social media posts, and websites related to the topic of mental health. The use of these social sources is in line with the minority model of disability, recognizing those with lived experience as experts of their own bodies and acknowledging the language they deem appropriate to describe their experiences.

CHAPTER 4: RESULTS

Demographic Description of Sample

A total of 125 participants started the survey, however, sample sizes are reported for each question to account for missing data from attrition. Participants ranged in age from 18-78 years old ($M = 28.0565$) and a majority identified as female both through their sex assigned at birth ($n = 102, 83.6\%$) and gender ($n = 90, 72.6\%$). Additionally, most participants were White ($n = 102, 82.3\%$) and *not* of Hispanic, Latino, or Spanish origin ($n = 115, 92.7\%$). A majority of respondents selected the United States as their country of residence ($n = 93, 75.0\%$), however, an additional 14 countries were represented including Canada ($n = 8, 6.5\%$), the United Kingdom ($n = 7, 5.6\%$), Germany ($n = 3, 2.4\%$), Australia ($n = 2, 1.6\%$), and Poland ($n = 2, 1.6\%$). The remaining countries not included in this list were only selected by one participant each. Additional information about the sample is included in Table 1.

Table 1: Demographic Characteristics of Sample (n = 124)*

	n	%
Age		
Mean: 28.0565 years		
Range: 18-78 years		
Gender		
Male	17	13.7
Female	90	72.6
Transgender Male	4	3.2
Unsure/Questioning	2	1.6
Agender	1	0.8
Non-Binary	8	6.5
Prefer not to respond	2	1.6
Sex Assigned at Birth		
Male	19	15.6
Female	102	83.6
Intersex	1	0.8
Hispanic, Latino, or Spanish Origin		
Yes	9	7.3
No	115	92.7
Ethnicity		
White	102	82.3
Hispanic or Latino/a/x	4	3.2
Black or African American	1	0.8
Asian	8	6.5
Multi-Racial	9	7.3
Highest Level of Education		
Some High School	3	2.4
High School Graduate	22	17.7
Trade/Technical/Vocational Training	2	1.6
Some College	43	34.7
College Graduate	34	27.4
Some Post-Graduate Work	2	1.6
Post-Graduate Degree	18	14.5
Current Employment Status		
Employed Full-Time	31	25
Employed Part-Time	27	21.8
Student	46	37.1
Homemaker	2	1.6
Unemployed	14	11.3
Unable to Work/Disabled	4	3.2

*125 participants started the survey, however, 124 completed demographic questions.

Mental Health Background of Sample

A majority of participants indicated that they *do* have either a clinical or suspected diagnosis of a mental health disorder (n = 104, 83.9%). Most of these participants indicated a clinical (n = 58, 46.4%) or suspected (n = 28, 22.4%) diagnosis of anxiety and a clinical (n = 43, 34.4%) or suspected (n = 25, 20.0%) diagnosis of depression. However, an additional 32 (25.6%) participants indicated that they have a clinical diagnosis for another psychiatric condition while 12 (9.6%) indicated that they have a suspected diagnosis for another psychiatric condition. Participants identified these other psychiatric conditions as: attention deficit hyperactivity disorder (ADHD), autism spectrum disorder (ASD), post-traumatic stress disorder (PTSD), obsessive-compulsive disorder (OCD), bipolar disorder, panic disorder, persistent depressive disorder, borderline personality disorder (BPD), gender dysphoria, agoraphobia, nonverbal learning disorder (NVLD), narcolepsy, schizotypal personality disorder (STPD), premenstrual dysphoric disorder (PMDD), and “some kind of neurodevelopmental disorder.” The participants who *do not* have a clinical or suspected diagnosis of a mental health disorder (n = 23, 18.5%) still have a relationship with these conditions either by being a family member (n = 9, 7.2%), friend (n = 8, 6.4%), or clinician (n = 3, 2.4%) of someone else with a mental disorder. Additional information about the mental health of the sample is summarized in Table 2.

Table 2: Mental Health Background of Sample (n = 124)

Suspected or Clinical Diagnosis	n	%
Overall		
Yes	104	83.9
No	20	16.1
Anxiety Disorder		
Diagnosis from Provider	58	46.4
Suspected Diagnosis	28	22.4
Depressive Disorder		
Diagnosis from Provider	43	34.4
Suspected Diagnosis	25	20
Other Psychiatric Condition		
Diagnosis from Provider	32	25.6
Suspected Diagnosis	12	9.6
Association with Anxiety, Depression, or Mental Health in General		
Family Member	9	7.2
Friend	8	6.4
Clinician	3	2.4

Preference and Offensiveness Ratings

In this section, participants rated terms on a 5-point Likert-type scale to indicate their level of preference and their level of offensiveness for each term. For questions related to preference, higher ratings indicate more preferred terms, with scores above 3 indicating a preferred term and scores under 3 representing a term that is not preferred (a score of “3” represents a neutral score). For questions related to offensiveness, higher ratings indicate more offensive terms, with scores above 3 indicating an offensive term and scores under 3 representing a term that is not offensive (a score of “3” represents a neutral score).

Anxiety-Related Terms

Terms for “Anxiety.” Table 3 shows the mean preference ratings for anxiety-related terms between individuals with and individuals without anxiety. Participants with either a self-reported clinical or suspected diagnosis were regarded as having anxiety. The anxiety-related term that both groups preferred the most was “Anxiety” with the mean preference rating by

individuals with anxiety being 4.51 (SD = 0.623), and the mean preference rating by individuals without anxiety being 4.17 (SD = 0.857). This term was closely followed by the term “Anxiety Disorder.” Notably, both of these terms were rated significantly higher (i.e., more preferred) by individuals with anxiety than individuals without anxiety. Individuals with anxiety indicated that “Neurotic Disorder” was their least preferred term ($M = 1.80$, $SD = 0.805$), while individuals without anxiety indicated that “Pathological Anxiety” was their least preferred term ($M = 2.00$, $SD = 0.874$).

Table 4 shows the mean offensiveness ratings for anxiety-related terms between individuals with and individuals without anxiety. Both groups found “Neurotic Disorder” to be the most offensive anxiety-related term with the mean offensiveness rating for individuals with anxiety being 3.38 (SD = 1.311), and the mean offensiveness rating for individuals without anxiety being 3.03 (SD = 1.425). Additionally, both groups indicated that “Anxiety Disorder” and “Anxiety” were the least offensive anxiety-related terms, though individuals with anxiety were significantly more likely to find the term “Anxiety Disorder” offensive than those without anxiety (mean difference = 0.475, $p = 0.013$). Overall, five out of the six anxiety-related terms received a mean offensiveness rating below 3.00 by both individuals with and without anxiety demonstrating that most terms were not perceived as offensive.

Participants identified other terms not included on the survey that they prefer to use to describe anxiety as follows: Fearful, generalized anxiety/GAD, coping with anxiety, anxiety management, social anxiety, feeling anxious, excessive worry, rumination, fight/flight response/stress response/fear response, anxiety condition, and “fucky/scaries/creeps.” A number of participants also commented that the term “Anxiety” alone is sufficient, or that they do not know of any other terms used to describe anxiety that were not already included on the survey.

One participant provided a lengthy response to this item which is included in Figure 4 within Appendix A.

Table 3: Mean Preference Ratings for Anxiety Terms Between Participants With and Without Anxiety

Item	Anxiety Diagnosis (n = 75)	No Anxiety Diagnosis (n = 35)	Difference Between-Groups
	M(SD)	M(SD)	Mean Difference (p value)
Anxiety	4.51(0.623)	4.17(0.857)	0.335(0.022)*
Anxiety Disorder	4.01(0.993)	3.40(1.117)	0.613(0.005)**
Anxiety Spectrum	2.75(1.015)	2.46(0.852)	0.290(0.146)
Excessive Fear and Anxiety	2.64(1.098)	2.74(1.291)	0.103(0.666)
Pathological Anxiety	2.07(0.811)	2.00(0.874)	0.067(0.696)
Neurotic Disorder	1.80(0.805)	2.06(1.027)	0.257(0.157)

*p < 0.05, **p < 0.01

Table 4: Mean Offensiveness Ratings for Anxiety Terms Between Participants With and Without Anxiety

Item	Anxiety Diagnosis (n = 74)	No Anxiety Diagnosis (n = 34)	Difference Between-Groups
	M(SD)	M(SD)	Mean Difference (p value)
Neurotic Disorder	3.38(1.311)	3.03(1.425)	0.349(0.214)
Pathological Anxiety	2.89(1.177)	2.76(1.394)	0.127(0.624)
Excessive Fear and Anxiety	2.65(1.276)	2.29(1.142)	0.355(0.169)
Anxiety Spectrum	2.19(1.131)	2.32(1.036)	0.134(0.558)
Anxiety Disorder	1.55(0.862)	2.03(1.00)	0.475(0.013)*
Anxiety	1.41(0.681)	1.50(0.826)	0.095(0.532)

*p < 0.05

Terms for “Person with Anxiety.” Table 5 shows the mean preference ratings for terms that identify a person with anxiety, compared between individuals with and individuals without anxiety. Individuals with anxiety reported similar levels of preference for the terms “Individual with Anxiety,” “Individual Living with Anxiety,” and “Individual Experiencing Anxiety,” with “Individual with Anxiety” being the most preferred term ($M = 3.88$, $SD = 1.031$). Likewise, “Individual with Anxiety” was the most preferred term among individuals without anxiety ($M = 4.17$, $SD = 0.805$). The terms “Individual Living with Anxiety” and “Individual Experiencing Anxiety” were rated significantly higher (i.e., more preferred) by individuals without anxiety compared to individuals with anxiety. The term “Anxious Individual” was the least preferred term for both individuals with anxiety ($M = 2.85$, $SD = 1.243$) and individuals without anxiety ($M = 2.83$, $SD = 1.197$).

Table 6 shows the mean offensiveness ratings for terms that identify a person with anxiety, compared between individuals with and individuals without anxiety. Scores were less than 3.00 across all terms, indicating that none of these terms were particularly offensive to participants. Both groups found “Anxious Individual” to be the most offensive term.

Table 5: Mean Preference Ratings for Person-First and Identity-First Anxiety Terms Between Participants With and Without Anxiety

Item	Anxiety Diagnosis (n = 66)	No Anxiety Diagnosis (n = 29)	Difference Between-Groups
	M(SD)	M(SD)	Mean Difference(p value)
Individual with Anxiety	3.88(1.031)	4.17(0.805)	0.294(0.177)
Individual Living with Anxiety	3.48(1.113)	3.90(0.673)	0.412(0.029)*
Individual Experiencing Anxiety	3.39(1.188)	4.07(0.884)	0.675(0.003)**
Individual Suffering from Anxiety	3.00(1.215)	3.45(1.242)	0.448(0.103)
Anxious Individual	2.85(1.243)	2.83(1.197)	0.021(0.939)

*p < 0.05, **p < 0.01

Table 6: Mean Offensiveness Ratings for Person-First and Identity-First Anxiety Terms Between Participants With and Without Anxiety

Item	Anxiety Diagnosis (n = 66)	No Anxiety Diagnosis (n = 29)	Difference Between-Groups
	M(SD)	M(SD)	Mean Difference (p value)
Anxious Individual	2.40(1.272) [†]	2.69(1.257)	0.290(0.309)
Individual Suffering from Anxiety	2.32(1.230)	2.31(1.168)	0.008(0.977)
Individual Experiencing Anxiety	2.09(1.003)	1.72(0.960)	0.367(0.100)
Individual Living with Anxiety	1.95(0.999)	1.72(0.996)	0.230(0.303)
Individual with Anxiety	1.61(0.762)	1.86(0.990)	0.256(0.173)

[†] (n = 65)

Depression-Related Terms

Terms for “Depression.” Table 7 shows the mean preference ratings for depression-related terms between individuals with and individuals without depression. Participants with either a self-reported clinical or suspected diagnosis were regarded as having depression. Both groups found “Depression” to be the most preferred anxiety-related term with the mean preference rating for individuals with depression being 4.44 (SD = 0.725), and the mean preference rating for individuals without depression being 4.15 (SD = 0.802). The mean difference between individuals with and individuals without depression for the term “Depression” was not statistically significant (mean difference = 0.294, $p = 0.079$). The other depression-related terms that elicited more than a neutral response from both individuals with and individuals without depression were “Clinical Depression” and “Depressive Disorder.”

Table 8 shows the mean offensiveness ratings for depression-related terms between individuals with and individuals without depression. Both groups found “Sad, Empty, or Irritable Mood” to be the most offensive depression-related term with the mean offensiveness rating for individuals with depression being 3.22 (SD = 1.460), and the mean offensiveness rating for individuals without depression being 2.63 (SD = 1.353). The mean difference for the term “Sad, Empty, or Irritable Mood” neared statistical significance (mean difference = 0.597, $p = 0.055$) as individuals with depression were more likely to find this term offensive than individuals without depression. The mean difference for the term “Depressive Disorder” was statistically significant (mean difference = 0.533, $p = 0.013$), however, both individuals with and individuals without depression ascribed a mean offensiveness rating lower than 3.00 to this term demonstrating that it was not perceived as offensive.

Participants identified other terms not included on the survey that they prefer to use to describe depression as follows: Dealing with depression, low mood, and mood condition. Other participants either indicated that their most preferred term was already included on the survey, or that they could not think of any additional terms. One participant provided a lengthy response to this item which is included in Figure 5 within Appendix A.

Table 7: Mean Preference Ratings for Depression Terms Between Participants With and Without Depression

Item	Depression Diagnosis (n = 45)	No Depression Diagnosis (n = 40)	Difference Between-Groups
	M(SD)	M(SD)	Mean Difference (p value)
Depression	4.44(0.725)	4.15(0.802)	0.294(0.079)
Clinical Depression	3.98(0.988)	3.80(1.091)	0.178(0.433)
Depressive Disorder	3.38(1.134)	3.08(1.185)	0.303(0.232)
Mood Disorder	2.71(1.141)	2.93(1.289)	0.214(0.419)
Depression Spectrum	2.44(0.943)	2.70(1.114)	0.256(0.255)
Sad, Empty, or Irritable Mood	2.38(1.319)	2.78(1.310)	0.397(0.168)

Table 8: Mean Offensiveness Ratings for Depression Terms Between Participants With and Without Depression

Item	Depression Diagnosis (n = 45)	No Depression Diagnosis (n = 40)	Difference Between-Groups
	M(SD)	M(SD)	Mean Difference (p value)
Sad, Empty, or Irritable Mood	3.22(1.460)	2.63(1.353)	0.597(0.055)
Mood Disorder	2.29(1.100)	2.58(1.279)	0.286(0.271)
Depression Spectrum	2.29(1.014)	2.25(1.080)	0.039(0.865)
Depressive Disorder	1.67(0.798)	2.20(1.137)	0.533(0.013)*
Clinical Depression	1.51(0.727)	1.70(0.883)	0.189(0.283)
Depression	1.36(0.609)	1.63(0.740)	0.269(0.069)

*p < 0.05

Terms for “Person with Depression.” Table 9 shows the mean preference ratings for terms that identify a person with depression, compared between individuals with and individuals without depression. Individuals with depression reported similar levels of preference for the terms “Individual with Depression,” “Individual Suffering from Depression,” and “Individual Living with Depression,” with “Individual with Depression” being the most preferred term ($M = 3.65$, $SD = 1.066$). However, the most preferred term amongst individuals without depression was “Individual Experiencing Depression” ($M = 4.21$, $SD = 0.777$) and this term was rated significantly higher (i.e., more preferred) by individuals without depression compared to individuals with depression (mean difference = 0.908, $p < 0.001$). The second most preferred term amongst individuals without depression was “Individual Living with Depression” and this term was also rated significantly higher (i.e., more preferred) by individuals without depression compared to individuals with depression (mean difference = 0.465, $p = 0.032$). The term “Depressed Individual” was the least preferred for both individuals with depression ($M = 3.21$, $SD = 1.226$) and individuals without depression ($M = 2.74$, $SD = 1.288$).

Table 10 shows the mean offensiveness ratings for terms that identify a person with depression, compared between individuals with and individuals without depression. Scores were less than 3.00 across all terms, indicating that none of these terms were particularly offensive to participants. Both groups found “Depressed Individual” to be the most offensive term. The least offensive term according to individuals with depression was “Individual with Depression” ($M = 1.51$, $SD = 0.688$), however, this term was rated significantly higher (i.e., more offensive) by individuals without depression than individuals with depression (mean difference = 0.462, $p = 0.012$). Individuals without depression found “Individual Experiencing Depression” to be the least offensive term.

Table 9: Mean Preference Ratings for Person-First and Identity-First Depression Terms Between Participants With and Without Depression

Item	Depression Diagnosis (n = 43)	No Depression Diagnosis (n = 38)	Difference Between-Groups
	M(SD)	M(SD)	Mean Difference (p value)
Individual with Depression	3.65(1.066)	3.84(0.718)	0.191(0.343)
Individual Suffering from Depression	3.56(1.278)	3.21(1.212)	0.348(0.214)
Individual Living with Depression	3.53(1.077)	4.00(0.805)	0.465(0.032)*
Individual Experiencing Depression	3.30(1.145)	4.21(0.777)	0.908(<0.001)***
Depressed Individual	3.21(1.226)	2.74(1.288)	0.472(0.095)

*p < 0.05, ***p < 0.001

Table 10: Mean Offensiveness Ratings for Person-First and Identity-First Depression Terms Between Participants With and Without Depression

Item	Depression Diagnosis (n = 43)	No Depression Diagnosis (n = 38)	Difference Between-Groups
	M(SD)	M(SD)	Mean Difference (p value)
Depressed Individual	2.21(1.125)	2.71(1.228)	0.501(0.059)
Individual Suffering from Depression	2.14(1.265)	2.42(1.177)	0.282(0.305)
Individual Experiencing Depression	2.07(1.100)	1.71(0.694)	0.359(0.087)
Individual Living with Depression	1.86(1.082)	1.87(0.844)	0.008(0.971)
Individual with Depression	1.51(0.668)	1.97(0.944)	0.462(0.012)*

*p < 0.05

Mental Health-Related Terms

Terms for “Mental Health.” Table 11 shows the mean preference ratings for mental health-related terms between individuals with and individuals without a mental health condition. Participants with either a self-reported clinical or suspected diagnosis of anxiety and/or depression were regarded as having a mental health condition. Both groups found “Mental Health Condition” to be the most preferred mental-health related term with the mean preference rating for individuals with a mental health condition being 4.27 (SD = 0.880), and the mean preference rating for individuals without a mental health condition being 3.84 (SD = 0.958). The mean difference between individuals with and individuals without a mental health condition for the term “Mental Health Condition” was not statistically significant (mean difference = 0.425, $p = 0.077$) suggesting that both groups equally preferred this term. Both groups found “Emotional Disturbance” to be the least preferred mental-health related term with the mean preference rating for individuals with a mental health condition being 1.82 (SD = 0.854), and the mean preference rating for individuals without a mental health condition being 2.11 (SD = 1.049). The mean difference between groups for the term “Emotional Disturbance” was also not statistically significant (mean difference = 0.289, $p = 0.228$).

Table 12 shows mean offensiveness ratings for mental-health related terms between individuals with and individuals without a mental health condition. Both groups found “Emotional Disturbance” to be the most offensive mental health-related term with the mean offensiveness rating for individuals with a mental health condition being 3.53 (SD = 1.308), and the mean offensiveness rating for individuals without a mental health condition being 2.74 (SD = 1.593). Individuals with a mental health condition rated the term “Emotional Disturbance” significantly higher (i.e., more offensive) than individuals without a mental health condition

(mean difference = 0.796, $p = 0.031$). Individuals with a mental health condition ascribed a mean offensiveness rating lower than 3.00 to five out of the six mental health-related terms while individuals without a mental health condition ascribed a mean offensiveness rating lower than 3.00 to all six mental health-related terms. This suggests that overall, the mental health-related terms presented on the survey were not perceived as offensive. With this being said, both groups found “Mental Health Condition” to be the least offensive mental-health related terms with the mean offensiveness rating for individuals with a mental health condition being 1.55 (SD = 0.723), and the mean offensiveness rating for individuals without a mental health condition being 1.74 (SD = 0.806).

Participants identified other terms not included on the survey that they prefer to use to describe mental health as follows: Mental health challenges, mental ill health, mental health disorder, mental health disability, and “madness (especially in the context of the Mad Pride movement).” Other participants either indicated that they could not think of any additional terms that were not already included on the survey, or commented generally that terms such as “disorder” and “illness” should be avoided due to negative connotations. One participant provided a lengthy response to this item which is included in Figure 6 within Appendix A.

Table 11: Mean Preference Ratings for Mental Health Terms Between Participants With and Without Anxiety/Depression

Item	Anxiety/Depression Diagnosis (n = 60)	No Anxiety/ Depression Diagnosis (n = 19)	Difference Between-Groups
	M(SD)	M(SD)	Mean Difference (p value)
Mental Health Condition	4.27(0.880)	3.84(0.958)	0.425(0.077)
Mental Illness	3.90(1.062)	3.63(1.212)	0.267(0.360)
Psychological Disorder	3.10(1.145)	2.53(1.073)	0.574(0.057)
Psychiatric Disorder	2.92(1.169)	2.63(1.212)	0.285(0.361)
Mental Disorder	2.90(1.298)	2.89(1.100)	0.005(0.987)
Emotional Disturbance	1.82(0.854)	2.11(1.049)	0.289(0.228)

Table 12: Mean Offensiveness Ratings for Mental Health Terms Between Participants With and Without Anxiety/Depression

Item	Anxiety/Depression Diagnosis (n = 60)	No Anxiety/Depression Diagnosis (n = 19)	Difference Between-Groups
	M(SD)	M(SD)	Mean Difference (p value)
Emotional Disturbance	3.53(1.308)	2.74(1.593)	0.796(0.031)*
Mental Disorder	2.65(1.300)	2.37(1.300)	0.282(0.413)
Psychiatric Disorder	2.45(1.048)	2.68(1.493)	0.234(0.448)
Psychological Disorder	2.37(1.025)	2.58(1.346)	0.212(0.469)
Mental Illness	1.82(1.017)	2.05(1.079)	0.236(0.388)
Mental Health Condition	1.55(0.723)	1.74(0.806)	0.187(0.343)

*p < 0.05

Terms for “Person with a Mental Health Condition.” Table 13 shows the mean preference ratings for terms that identify a person with a mental health condition, compared between individuals with and individuals without a mental health condition. Both groups found “Individual with a Mental Health Condition” to be the most preferred term with the mean preference rating for individuals with a mental health condition being 4.17 (SD = 0.827), and the mean preference rating for individuals without a mental health condition being 4.11 (SD = 0.809). The only other term that received a mean preference rating greater than neutral from individuals with and individuals without a mental health condition was “Individuals with a Mental Illness.” The two least preferred terms according to individuals with and individuals without a mental health condition were “Individual with an Emotional Disturbance” and “Emotionally Disturbed Individual.” Notably, individuals without a mental health condition rated the terms “Individuals with an Emotional Disturbance” and “Emotionally Disturbed Individual” significantly higher (i.e., more preferred) than individuals with a mental health condition. The mean difference for the term “Individual with an Emotional Disturbance is 0.718 ($p = 0.002$), and the mean difference for the term “Emotionally Disturbed Individual” is 0.500 ($p = 0.020$).

Table 14 shows the mean offensiveness rating for terms that identify a person with a mental health condition, compared between individuals with and individuals without a mental health condition. Both groups found “Emotionally Disturbed Individual” to be the most offensive term with the mean offensiveness rating for individuals with a mental health condition being 4.12 (SD = 1.209), and the mean offensiveness rating for individuals without a mental health condition being 3.26 (SD = 1.558). Individuals with a mental health condition rated the term “Emotionally Disturbed Individual” significantly higher (i.e., more offensive) than individuals without a mental health condition (mean difference = 0.854, $p = 0.015$). Additionally, the second

most offensive term according to individuals with and individuals without a mental health condition was “Individual with an Emotional Disturbance.” Again, individuals with a mental health condition rated the term “Individual with an Emotional Disturbance” significantly higher (i.e., more offensive) than individuals without a mental health condition (mean difference = 0.772, $p = 0.022$). Both groups found “Individuals with a Mental Health Condition” to be the least offensive term.

Table 13: Mean Preference Ratings for Person-First and Identity-First Mental Health Terms Between Participants With and Without Anxiety/Depression

Item	Anxiety/Depression Diagnosis (n = 60)	No Anxiety/Depression Diagnosis (n = 19)	Difference Between-Groups
	M(SD)	M(SD)	Mean Difference(p value)
Individual with a Mental Health Condition	4.17(0.827)	4.11(0.809)	0.061(0.778)
Individual with a Mental Illness	3.83(1.076)	3.74(0.991)	0.096(0.730)
Individual with a Mental Disorder	2.90(1.189)	2.89(1.197)	0.005(0.987)
Mentally Ill Individual	2.45(1.213)	2.74(1.240)	0.287(0.374)
Individual with an Emotional Disturbance	1.65(0.799)	2.37(1.065)	0.718(0.002)**
Emotionally Disturbed Individual	1.50(0.701)	2.00(1.054)	0.500(0.020)*

* $p < 0.05$, ** $p < 0.01$

Table 14: Mean Offensiveness Ratings for Person-First and Identity-First Mental Health Terms Between Participants With and Without Anxiety/Depression

Item	Anxiety/Depression Diagnosis (n = 60)	No Anxiety/Depression Diagnosis (n = 19)	Difference Between-Groups
	M(SD)	M(SD)	Mean Difference(p value)
Emotionally Disturbed Individual	4.12(1.209)	3.26(1.558)	0.854(0.015)*
Individual with an Emotional Disturbance	3.67(1.203)	2.89(1.410)	0.772(0.022)*
Mentally Ill Individual	2.95(1.254)	2.79(1.512)	0.161(0.645)
Individual with a Mental Disorder	2.57(1.079)	2.63(1.165)	0.065(0.823)
Individual with a Mental Illness	1.95(1.016)	2.21(1.134)	0.261(0.346)
Individual with a Mental Health Condition	1.58(0.766)	1.89(0.937)	0.311(0.148)

*p < 0.05

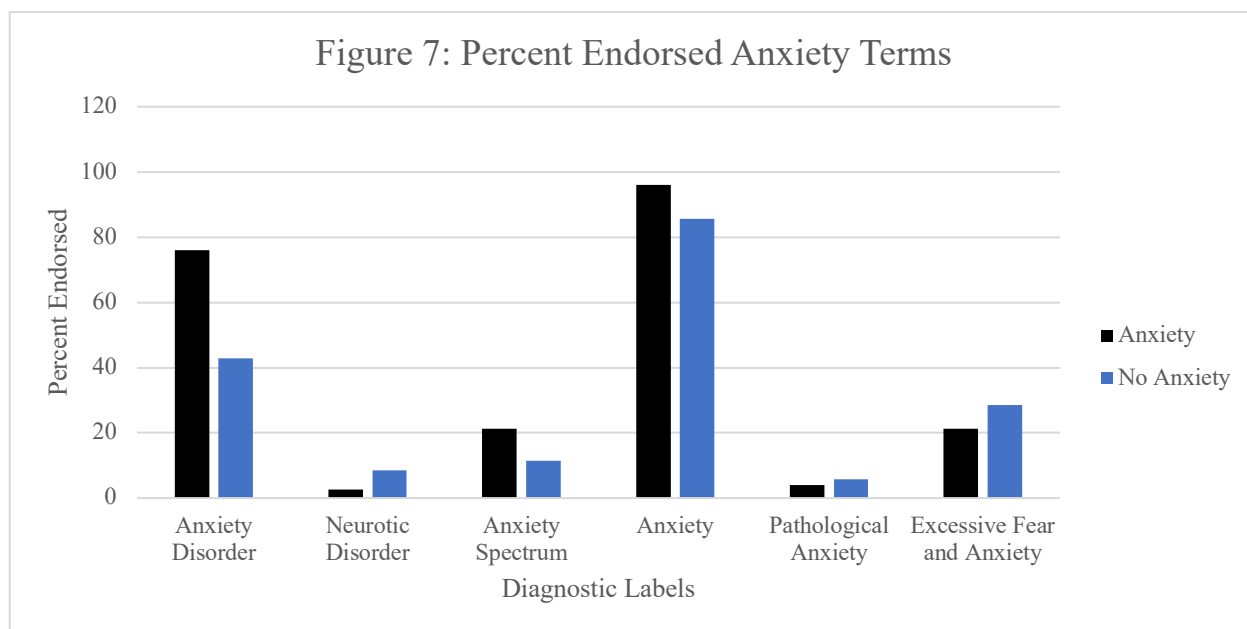
Endorsement of Terms

To determine whether a term was “endorsed” by the sample, we explored the percent of participants who indicated that they either “agreed” or “strongly agreed” that they preferred to use a specific term related to either anxiety, depression, or mental health in general. Comparisons were drawn between individuals with and individuals without the mental health condition for each category.

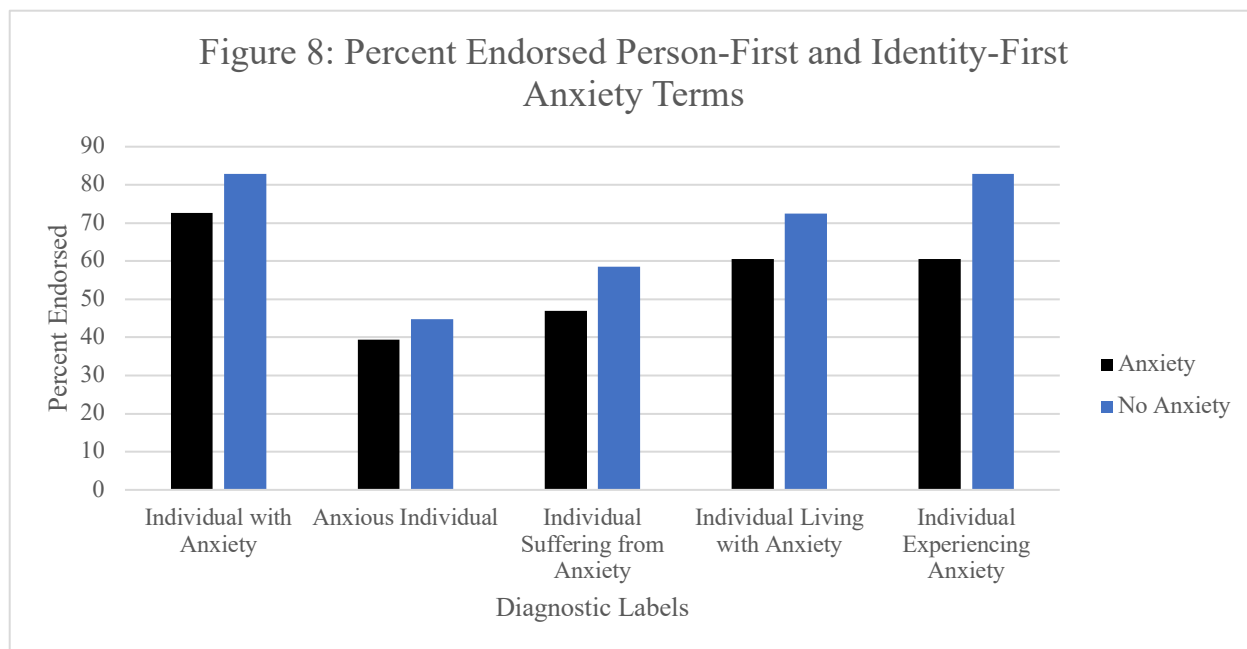
Anxiety-Related Terms

Terms for “Anxiety.” Figure 7 shows the percent of individuals with and individuals without anxiety who endorse these anxiety-related terms. Participants with either a self-reported

clinical or suspected diagnosis were regarded as having anxiety. The term “Anxiety” received the highest percent endorsed by both individuals with anxiety (96%) and individuals without anxiety (85.7%). The anxiety-related term that received the second highest percent endorsed was “Anxiety Disorder.”

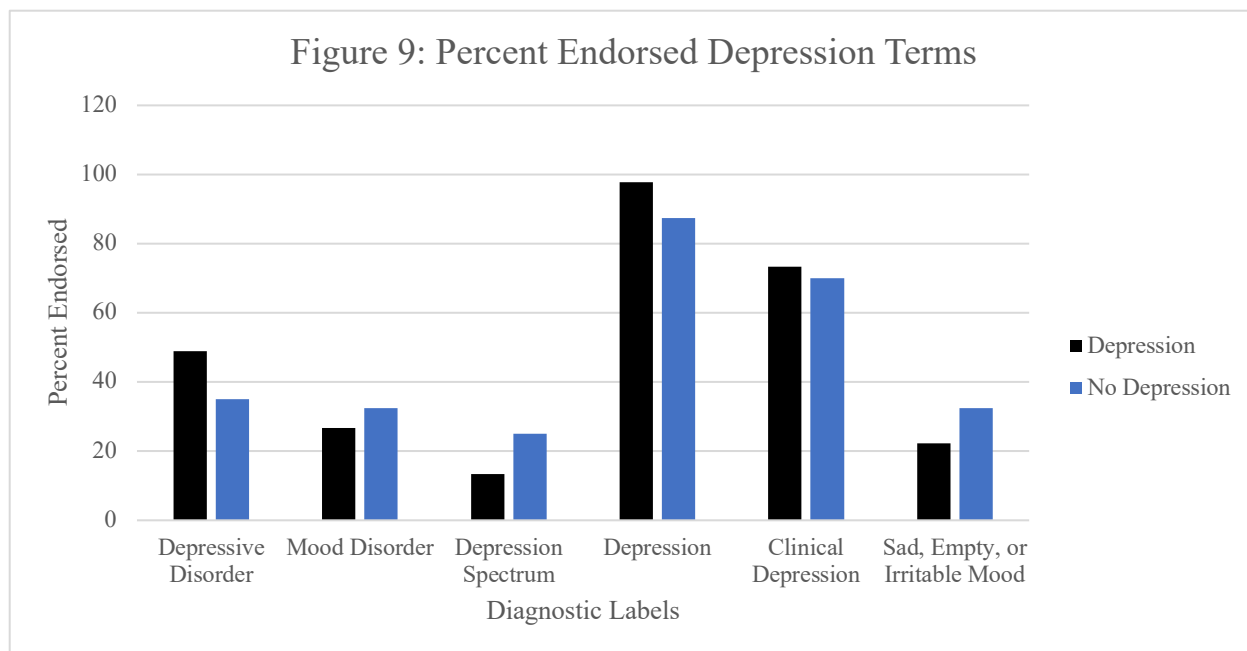


Terms for “Person with Anxiety.” Figure 8 shows the percent of individuals with and individuals without anxiety who endorse terms that identify a person with anxiety. More than half of individuals with and individuals without anxiety endorse the terms “Individual with Anxiety,” “Individual Living with Anxiety,” and “Individual Experiencing Anxiety,” with “Individual with Anxiety” as the most frequently endorsed term by both groups (with anxiety 72.7%; without anxiety 82.8%).

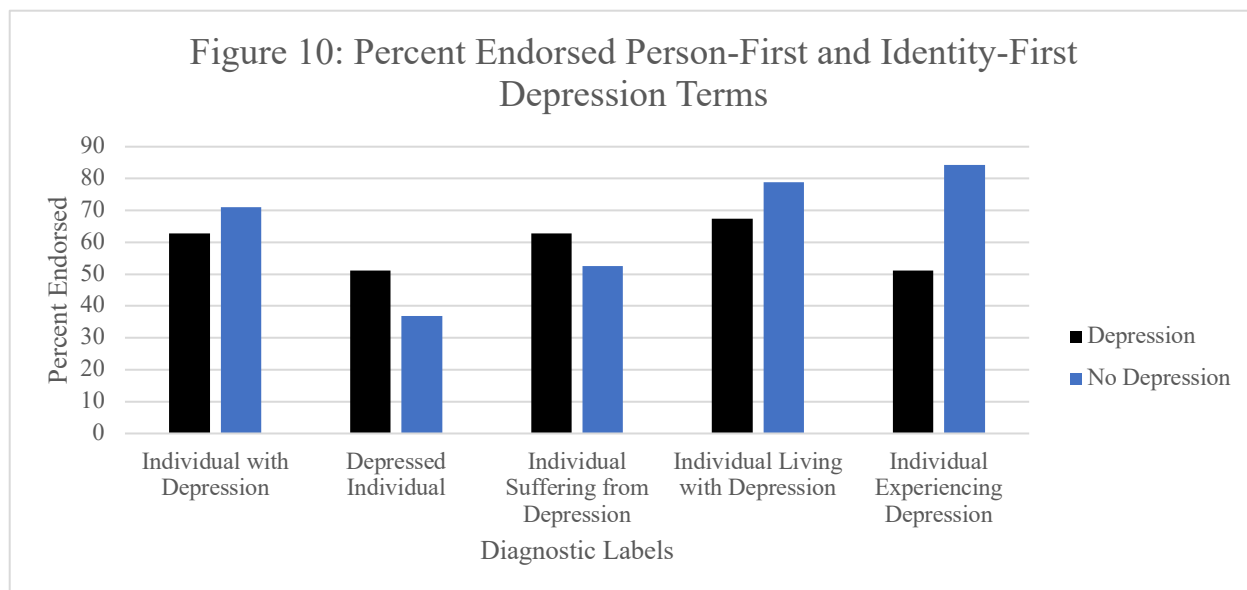


Depression-Related Terms

Terms for “Depression.” Figure 9 shows the percent of individuals with and individuals without depression who endorse these depression-related terms. Participants with either a self-reported clinical or suspected diagnosis were regarded as having depression. The term “Depression” received the highest percent endorsed by both individuals with depression (97.8%) and individuals without depression (87.5%). The depression-related term that received the second highest percent endorsed was “Clinical Depression.”

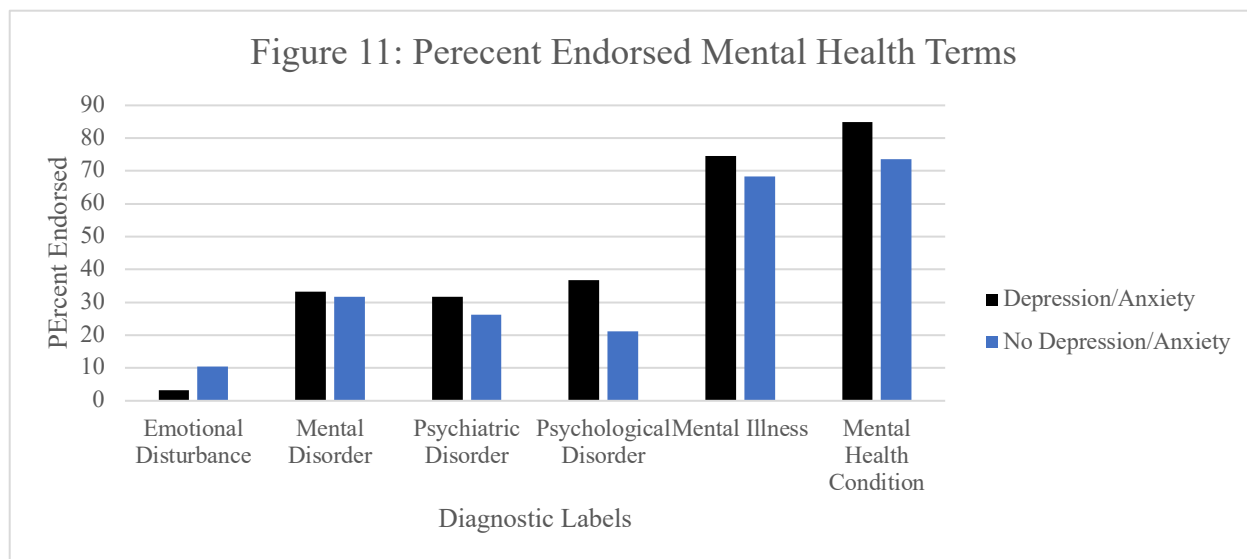


Terms for “Person with Depression.” Figure 10 shows the percent of individuals with and individuals without depression who endorse terms that identify a person with depression. The term “Individual Living with Depression” received the highest percent endorsed by individuals with depression (67.4%) while the term “Individual Experiencing Depression” received the highest percent endorsed by individuals without depression (84.2%). More than half of individuals without depression endorsed every term except for “Depressed Individual” (36.8%). Additionally, just more than half of individuals with depression endorsed every term, however, the terms “Depressed Individual” and “Individuals Experiencing Depression” received the lowest percent endorsed (51.2%).

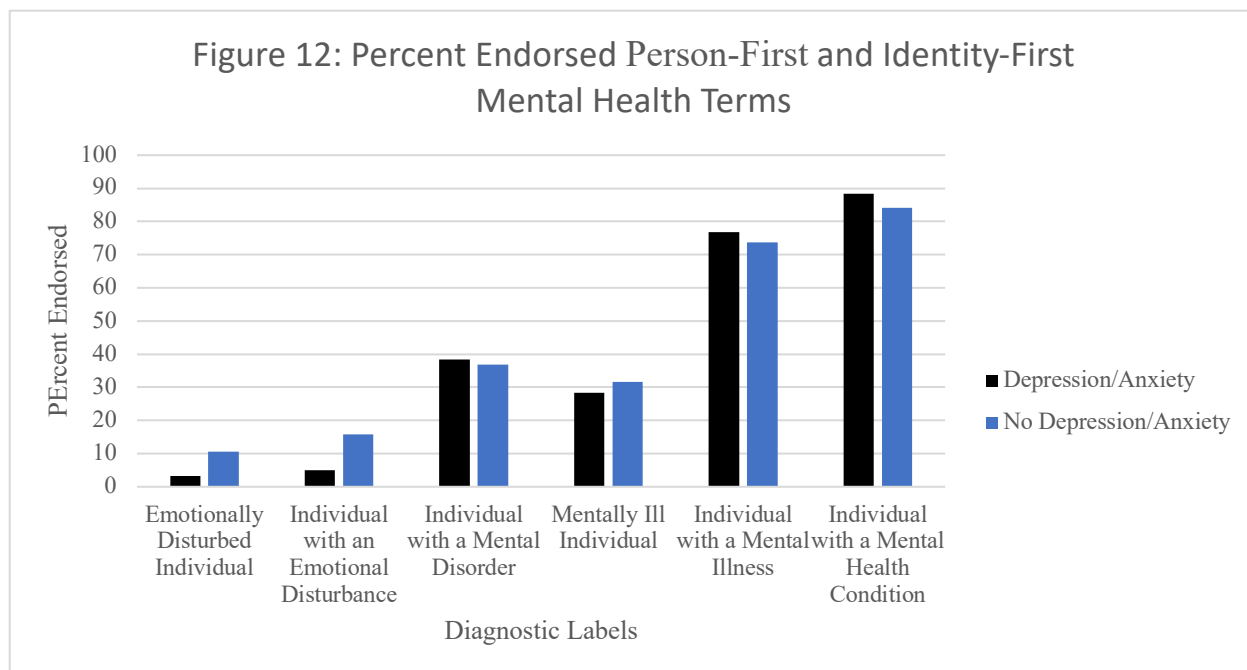


Mental Health-Related Terms

Terms for “Mental Health.” Figure 11 shows the percent of individuals with and individuals without a mental health condition who endorse mental health-related terms. Participants with either a self-reported clinical or suspected diagnosis of anxiety and/or depression were regarded as having a mental health condition. The term “Mental Health Condition” received the highest percent endorsed by both individuals with a mental health condition (85%) and individuals without a mental health condition (73.7%). The mental health-related term that received the second highest percent endorsed by both groups was “Mental Illness.”



Terms for “Person with a Mental Health Condition.” Figure 12 shows the percent of individuals with and individuals without a mental health condition who endorse terms that identify a person with a mental health condition. The term “Individual with a Mental Health Condition” received the highest percent endorsed by both individuals with a mental health condition (88.3%) and individuals without a mental health condition (84.2%). The term that received the second highest percent endorsed by both groups was “Individual with a Mental Illness.”



Rank Ordering

In this section, participants ranked terms from their most preferred to least preferred, with lower scores (5 or 6 terms per category) indicating a more preferred term. In addition, participants ranked terms from their most offensive to least offensive, with lower scores (5 or 6 terms per category) indicating a more offensive term. To identify those terms that are most endorsed by the population living with the mental health condition, samples for this section were limited to those with the related condition. Thus, this section will report rank ordering by individuals with anxiety for anxiety-related terms, individuals with depression for depression-related terms, and individuals with anxiety and/or depression for mental health-related terms.

Anxiety-Related Terms

Terms for “Anxiety.” Table 15 shows the weighted mean rank order for each term as ranked by individuals with a self-reported clinical or suspected diagnosis of anxiety. The term with the highest preference rank order from individuals with anxiety was “Anxiety,” with a weighted mean preference rank order of 1.45. Additionally, the term “Anxiety” was indicated as

being the most preferred (i.e., a rank order of 1) by 62.7% of the sample ($n = 47$) and in the top three terms for all participants with anxiety. The term with the lowest preference rank order was “Neurotic Disorder,” with a weighted mean preference rank order of 5.37 and indicated as being the least preferred (i.e., a rank order of 6) by 57.3% of the sample ($n = 43$). These preferences were paralleled in questions related to offensiveness (displayed in Table 16), with the term “Neurotic Disorder” ranked as the most offensive term ($M = 1.73$) and “Anxiety” ranked as the least offensive term ($M = 5.38$).

Table 15: Preference Rank Orderings for Anxiety Terms by Participants with Anxiety (Suspected or Dx)

Terms	Rank*	M**	Preference Rankings: Frequency(Valid Percent)					
			1	2	3	4	5	6
Anxiety	1	1.45	47(62.7)	22(29.3)	6(8.0)	0(0.0)	0(0.0)	0(0.0)
Anxiety Disorder	2	1.89	26(34.7)	37(49.3)	7(9.3)	4(5.3)	1(1.3)	0(0.0)
Anxiety Spectrum	3	3.41	2(2.7)	8(10.7)	36(48.0)	17(22.7)	10(13.3)	2(2.7)
Excessive Fear and Anxiety	4	4.07	0(0.0)	6(8.0)	20(26.7)	22(29.3)	17(22.7)	10(13.3)
Pathological Anxiety	5	4.8	0(0.0)	2(2.7)	4(5.3)	21(28.0)	28(37.3)	20(26.7)
Neurotic Disorder	6	5.37	0(0.0)	0(0.0)	2(2.7)	11(14.7)	19(25.3)	43(57.3)

*Overall rank based on Freidman test

**Weighted mean rank from Freidman test

Table 16: Offensiveness Rank Orderings for Anxiety Terms by Participants with Anxiety (Suspected or Dx)

Terms	Rank*	M**	Offensiveness Rankings: Frequency(Valid Percent)					
			1	2	3	4	5	6
Neurotic Disorder	1	1.73	42(56.8)	20(27.0)	7(9.5)	2(2.7)	1(1.4)	2(2.7)
Pathological Anxiety	2	2.24	14(18.9)	34(45.9)	21(28.4)	4(5.4)	1(1.4)	0(0.0)
Excessive Fear and Anxiety	3	2.91	13(17.6)	11(14.9)	28(37.8)	16(21.6)	4(5.4)	2(2.7)
Anxiety Spectrum	4	3.88	1(1.4)	7(9.5)	13(17.6)	36(48.6)	13(17.6)	4(5.4)
Anxiety Disorder	5	4.86	1(1.4)	1(1.4)	5(6.8)	11(14.9)	38(51.4)	18(24.3)
Anxiety	6	5.38	3(4.1)	1(1.4)	0(0.0)	5(6.8)	17(23.0)	48(64.9)

*Overall rank based on Freidman test

**Weighted mean rank from Freidman test

Terms for “Person with Anxiety.” Table 17 shows the weighted mean rank order for each term as ranked by individuals with anxiety. The term “Individual with Anxiety” has the highest preference rank order ($M = 1.68$) amongst individuals with anxiety. Additionally, the term “Individual with Anxiety” was indicated as being the most preferred (i.e., a rank order of 1) by 57.1% of the sample ($n = 36$) and in the top 3 for 98.3% of the sample ($n = 62$). Likewise, the term was ranked as the least offensive term ($M = 4.06$) (displayed in Table 18). The term “Anxious Individual” ranked as both the lowest preference term ($M = 3.79$) as well as the most offensive term ($M = 2.45$).

Table 17: Preference Rank Orderings for Person-First and Identity-First Anxiety Terms by Participants with Anxiety (Suspected or Dx)

Terms	Rank*	M**	Preference Rankings: Frequency(Valid Percent)				
			1	2	3	4	5
Individual with Anxiety	1	1.68	36(57.1)	13(20.6)	13(20.6)	0(0.0)	1(1.6)
Individual Living with Anxiety	2	2.89	7(11.1)	20(31.7)	15(23.8)	15(23.8)	6(9.5)
Individual Experiencing Anxiety	3	3.1	8(12.7)	10(15.9)	22(34.9)	14(22.2)	9(14.3)
Individual Suffering from Anxiety	4	3.54	8(12.7)	10(15.9)	6(9.5)	18(28.6)	21(33.3)
Anxious Individual	5	3.79	4(6.3)	10(15.9)	7(11.1)	16(25.4)	26(41.3)

*Overall rank based on Freidman test

**Weighted mean rank from Freidman test

Table 18: Offensiveness Rank Orderings for Person-First and Identity-First Anxiety Terms by Participants with Anxiety (Suspected or Dx)

Terms	Rank*	M**	Offensiveness Rankings: Frequency(Valid Percent)				
			1	2	3	4	5
Anxious Individual	1	2.45	27(42.2)	10(15.6)	9(14.1)	7(10.9)	11(17.2)
Individual Suffering from Anxiety	2	2.5	22(34.4)	16(25.0)	7(10.9)	10(15.6)	9(14.1)
Individual Experiencing Anxiety	3	2.78	10(15.6)	19(29.7)	17(26.6)	11(17.2)	7(10.9)
Individual Living with Anxiety	4	3.2	3(4.7)	13(20.3)	22(34.4)	20(31.3)	6(9.4)
Individual with Anxiety	5	4.06	2(3.1)	6(9.4)	9(14.1)	16(25.0)	31(48.4)

*Overall rank based on Freidman test

**Weighted mean rank from Freidman test

Depression-Related Terms

Terms for “Depression.” Table 19 shows the weighted mean rank order for each term as ranked by individuals with a self-reported clinical or suspected diagnosis of depression. The term with the highest preference rank order from individuals with depression was “Depression,” with a weighted mean preference rank order 1.58. Additionally, the term “Depression” was indicated as being the most preferred (i.e., a rank order of 1) by 66.7% of the sample ($n = 30$) and in the top four terms for all participants with depression. The term with the lowest preference rank order was “Sad, Empty, or Irritable Mood,” with a weighted mean preference rank order of 5.27 and indicated as being the least preferred (i.e., a rank order of 6) by 71.1% of the sample ($n = 32$). These preferences were paralleled in questions related to offensiveness (displayed in Table 20), with the term “Sad, Empty, or Irritable Mood” ranked as the most offensive term ($M = 2.11$) and “Depression” ranked as the least offensive term ($M = 5.2$).

Table 19: Preference Rank Orderings for Depression Terms by Participants with Depression (Suspected or Dx)

Terms	Rank*	M**	Preference Rankings: Frequency(Valid Percent)					
			1	2	3	4	5	6
Depression	1	1.58	30(66.7)	7(15.6)	5(11.1)	3(6.7)	0(0.0)	0(0.0)
Clinical Depression	2	2.42	9(20.0)	20(44.4)	8(17.8)	4(8.9)	4(8.9)	0(0.0)
Depressive Disorder	3	3	2(4.4)	13(28.9)	19(42.2)	7(15.6)	2(4.4)	2(4.4)
Mood Disorder	4	4.16	2(4.4)	2(4.4)	5(11.1)	15(33.3)	20(44.4)	1(2.2)
Depression Spectrum	5	4.58	1(2.2)	0(0.0)	6(13.3)	13(28.9)	15(33.3)	10(22.2)
Sad, Empty, or Irritable Mood	6	5.27	1(2.2)	3(6.7)	2(4.4)	3(6.7)	4(8.9)	32(71.1)

*Overall rank based on Freidman test

**Weighted mean rank from Freidman test

Table 20: Offensiveness Rank Orderings for Depression Terms by Participants with Depression (Suspected or Dx)

Terms	Rank*	M**	Offensiveness Rankings: Frequency(Valid Percent)					
			1	2	3	4	5	6
Sad, Empty, or Irritable Mood	1	2.11	29(64.4)	4(8.9)	3(6.7)	2(4.4)	1(2.2)	6(13.3)
Mood Disorder	2	2.44	8(17.8)	21(46.7)	9(20.0)	4(8.9)	1(2.2)	2(4.4)
Depression Spectrum	3	2.91	6(13.3)	12(26.7)	12(26.7)	12(26.7)	1(2.2)	2(4.4)
Depressive Disorder	4	3.71	1(2.2)	5(11.1)	13(28.9)	15(33.3)	9(20.0)	2(4.4)
Clinical Depression	5	4.62	1(2.2)	2(4.4)	5(11.1)	7(15.6)	20(44.4)	10(22.2)
Depression	6	5.2	0(0.0)	1(2.2)	3(6.7)	5(11.1)	13(28.9)	23(51.1)

*Overall rank based on Freidman test

**Weighted mean rank from Freidman test

Terms for “Person with Depression.” Table 21 shows the weighted mean rank order for each term as ranked by individuals with depression. The term “Individual with Depression” has the highest preference rank order ($M = 2$) amongst individuals with depression. Additionally, the term “Individual with Depression” was indicated as being either the most or second most preferred (i.e., a rank order of 1 or 2) by 68.3% of the sample ($n = 28$). Likewise, the term “Individual with Depression” was ranked as the least offensive term ($M = 4.15$) (displayed in Table 22). The term “Depressed Individual” ranked as both the least preferred term ($M = 3.66$) as well as the most offensive term ($M = 2.51$).

Table 21: Preference Rank Orderings for Person-First and Identity-First Depression Terms by Participants with Depression (Suspected or Dx)

Terms	Rank*	M**	Preference Rankings: Frequency(Valid Percent)				
			1	2	3	4	5
Individual with Depression	1	2	19(46.3)	9(22.0)	9(22.0)	2(4.9)	2(4.9)
Individual Suffering from Depression	2	2.83	12(29.3)	9(22.0)	4(9.8)	6(14.6)	10(24.4)
Individual Living with Depression	3	3	5(12.2)	9(22.0)	13(31.7)	9(22.0)	5(12.2)
Individual Experiencing Depression	4	3.51	2(4.9)	6(14.6)	10(24.4)	15(36.6)	8(19.5)
Depressed Individual	5	3.66	3(7.3)	8(19.5)	5(12.2)	9(22.0)	16(39.0)

*Overall rank based on Freidman test

**Weighted mean rank from Freidman test

Table 22: Offensiveness Rank Orderings for Person-First and Identity-First Depression Terms by Participants with Depression (Suspected or Dx)

Terms	Rank*	M**	Offensiveness Rankings: Frequency(Valid Percent)				
			1	2	3	4	5
Depressed Individual	1	2.51	17(41.5)	7(17.1)	3(7.3)	7(17.1)	7(17.1)
Individual Suffering from Depression	2	2.63	13(31.7)	9(22.0)	6(14.6)	6(14.6)	7(17.1)
Individual Experiencing Depression	3	2.8	6(14.6)	11(26.8)	13(31.7)	7(17.1)	4(9.8)
Individual Living with Depression	4	2.9	5(12.2)	10(24.4)	13(31.7)	10(24.4)	3(7.3)
Individual with Depression	5	4.15	0(0.0)	4(9.8)	6(14.6)	11(26.8)	20(48.8)

*Overall rank based on Freidman test

**Weighted mean rank from Freidman test

Mental Health-Related Terms

Terms for “Mental Health.” Table 23 shows the weighted mean rank order for each term as ranked by individuals with a mental health condition (i.e., a self-reported clinical or suspected diagnosis of depression and/or anxiety). The term with the highest preference from individuals with a mental health condition was “Mental Health Condition,” with a weighted mean preference rank order of 2.12. Additionally, the term “Mental Health Condition” was indicated as being either the most or second most preferred term (i.e., a rank order of 1 or 2) by 72.9% of the sample ($n = 43$). The term with the lowest preference rank order was “Emotional Disturbance,” with a weighted mean preference rank order of 5.22 and indicated as being the least preferred (i.e., a rank order of 6) by 66.1% of the sample ($n = 39$). These preferences were paralleled in questions related to offensiveness (displayed in Table 24) with the term “Emotional Disturbance” ranked as the most offensive term ($M = 1.98$) and “Mental Health Condition” as the least offensive term ($M = 4.98$).

Table 23: Preference Rank Orderings for Mental Health Terms by Participants with Anxiety/Depression (Suspected or Dx)

Terms	Rank*	M**	Preference Rankings: Frequency(Valid Percent)					
			1	2	3	4	5	6
Mental Health Condition	1	2.12	26(44.1)	17(28.8)	7(11.9)	4(6.8)	2(3.4)	3(5.1)
Mental Illness	2	2.37	21(35.6)	19(32.2)	6(10.2)	5(8.5)	5(8.5)	3(5.1)
Psychological Disorder	3	3.71	2(3.4)	8(13.6)	15(25.4)	15(25.4)	18(30.5)	1(1.7)
Mental Disorder	4	3.75	4(6.8)	7(11.9)	15(25.4)	14(23.7)	12(20.3)	7(11.9)
Psychiatric Disorder	5	3.83	5(8.5)	4(6.8)	13(22.0)	17(28.8)	14(23.7)	6(10.2)
Emotional Disturbance	6	5.22	1(1.7)	4(6.8)	3(5.1)	4(6.8)	8(13.6)	39(66.1)

*Overall rank based on Freidman test

**Weighted mean rank from Freidman test

Table 24: Offensiveness Rank Orderings for Mental Health Terms by Participants with Anxiety/Depression (Suspected or Dx)

Terms	Rank*	M**	Offensiveness Rankings: Frequency(Valid Percent)					
			1	2	3	4	5	6
Emotional Disturbance	1	1.98	31(57.4)	11(20.4)	2(3.7)	4(7.4)	4(7.4)	2(3.7)
Mental Disorder	2	2.76	11(20.4)	14(25.9)	11(20.4)	14(25.9)	3(5.6)	1(1.9)
Psychiatric Disorder	3	3.17	6(11.1)	13(24.1)	17(31.5)	8(14.8)	4(7.4)	6(11.1)
Psychological Disorder	4	3.81	1(1.9)	7(13.0)	14(25.9)	16(29.6)	11(20.4)	5(9.3)
Mental Illness	5	4.3	4(7.4)	5(9.3)	6(11.1)	6(11.1)	22(40.7)	11(20.4)
Mental Health Condition	6	4.98	1(1.9)	4(7.4)	4(7.4)	6(11.1)	10(18.5)	29(53.7)

*Overall rank based on Freidman test

**Weighted mean rank from Freidman test

Terms for “Person with a Mental Health Condition.” Table 25 shows the weighted mean rank order for each term as ranked by individuals with a mental health condition. The term “Individual with a Mental Health Condition” has the highest preference rank order ($M = 1.52$) amongst individuals with a mental health condition. Additionally, the term “Individual with a Mental Health Condition” was indicated as being the most preferred (i.e., a rank order of 1) by 63.3% of the sample ($n = 38$) and was in the top four terms for all participants with a mental health condition. Likewise, the term “Individual with a Mental Health Condition” was ranked as the least offensive term ($M = 5.5$) (displayed in Table 26). The term “Emotionally Disturbed Individual” ranked as both the least preferred term ($M = 5.47$) as well as the most offensive term ($M = 1.5$). The term “Emotionally Disturbed Individual” was ranked as the least preferred term (i.e., a rank order of 6) by 65.0% of the sample ($n = 39$) and as the most offensive term (i.e., a rank order of 1) by 76.8% of the sample ($n = 43$).

Table 25: Preference Rank Orderings for Person-First and Identity-First Mental Health Terms by Participants with Anxiety/Depression (Suspected or Dx)

Terms	Rank*	M**	Preference Rankings: Frequency(Valid Percent)					
			1	2	3	4	5	6
Individual with a Mental Health Condition	1	1.52	38(63.3)	14(23.3)	7(11.7)	1(1.7)	0(0.0)	0(0.0)
Individual with a Mental Illness	2	2.13	17(28.3)	28(46.7)	9(15.0)	3(5.0)	2(3.3)	1(1.7)
Individual with a Mental Disorder	3	3.27	3(5.0)	10(16.7)	23(38.3)	20(33.3)	0(0.0)	4(6.7)
Mentally Ill Individual	4	4.1	2(3.3)	3(5.0)	15(25.0)	17(28.3)	13(21.7)	10(16.7)
Individual with an Emotional Disturbance	5	4.52	0(0.0)	4(6.7)	2(3.3)	19(31.7)	29(48.3)	6(10.0)
Emotionally Disturbed Individual	6	5.47	0(0.0)	1(1.7)	4(6.7)	0(0.0)	16(26.7)	39(65.0)

*Overall rank based on Freidman test

**Weighted mean rank from Freidman test

Table 26: Offensiveness Rank Orderings for Person-First and Identity-First Mental Health Terms by Participants with Anxiety/Depression (Suspected or Dx)

Terms	Rank*	M**	Offensiveness Rankings: Frequency(Valid Percent)					
			1	2	3	4	5	6
Emotionally Disturbed Individual	1	1.5	43(76.8)	7(12.5)	1(1.8)	2(3.6)	2(3.6)	1(1.8)
Individual with an Emotional Disturbance	2	2.5	3(5.4)	33(58.9)	12(21.4)	5(8.9)	3(5.4)	0(0.0)
Mentally Ill Individual	3	3.09	6(10.7)	10(17.9)	22(39.3)	11(19.6)	5(8.9)	2(3.6)
Individual with a Mental Disorder	4	3.73	2(3.6)	2(3.6)	17(30.4)	24(42.9)	10(17.9)	1(1.8)
Individual with a Mental Illness	5	4.68	1(1.8)	4(7.1)	1(1.8)	10(17.9)	30(53.6)	10(17.9)
Individual with a Mental Health Condition	6	5.5	1(1.8)	0(0.0)	3(5.4)	4(7.1)	6(10.7)	42(75.0)

*Overall rank based on Freidman test

**Weighted mean rank from Freidman test

CHAPTER 5: DISCUSSION

Summary of Findings

Anxiety-, Depression-, and Mental Health-Related Terms

According to data generated by Likert-scale questions, the most preferred diagnostic labels amongst both individuals with and individuals without a clinical or suspected diagnosis of anxiety/depression are “Anxiety,” “Depression,” and “Mental Health Condition.” These preferences are also supported by the percent endorsed from both individuals with and individuals without anxiety/depression since the greatest number of participants indicated that they either “agree” or “strongly agree” with using the terms “Anxiety,” “Depression,” and “Mental Health Condition” compared to other terms. Additionally, overall preference for the terms “Anxiety,” “Depression,” and “Mental Health Condition” amongst individuals with anxiety/depression was supported by rank orderings as each term received the lowest mean preference rank ordering (i.e., most preferred) within their specific set of terms. One inconsistency with regards to language preferences between participants with varying relationships to anxiety/depression is that individuals with anxiety preferred the term “Anxiety” significantly more than individuals without anxiety.

According to data generated by Likert-scale questions, the most offensive diagnostic labels amongst both individuals with and individuals without a clinical or suspected diagnosis of anxiety/depression are “Neurotic Disorder,” “Sad, Empty, or Irritable Mood,” and “Emotional Disturbance.” For individuals with anxiety/depression, the least preferred terms illuminated through Likert-scale questions equated to the most offensive terms. Additionally, the terms “Neurotic Disorder,” “Sad, Empty, or Irritable Mood,” and “Emotional Disturbance” received the lowest mean offensiveness rank ordering (i.e., most offensive) within their specific set of

terms by individuals with anxiety/depression. However, while “Neurotic Disorder” and “Sad, Empty, or Irritable Mood” were identified as being the most offensive terms by individuals without anxiety/depression, the terms “Pathological Anxiety” and “Depression Spectrum” were rated as being the least preferred. This demonstrates that preference and offensiveness are two separate constructs that do not always have predictive value over one another. While individuals with varying relationships to anxiety/depression overall agreed with regards to the most offensive terms, the following incongruities emerged within the data: Individuals without anxiety found the term “Anxiety Disorder” significantly more offensive than individuals with anxiety and individuals without depression found the term “Depressive Disorder” significantly more offensive than individuals with depression. Additionally, individuals with anxiety/depression found the term “Emotional Disturbance” significantly more offensive than individuals without anxiety/depression.

Person-First and Identity-First Terms

According to data generated by Likert-scale questions, the most preferred terms amongst individuals with a clinical or suspected diagnosis of anxiety/depression are “Individual with Anxiety,” “Individual with Depression,” and “Individual with a Mental Health Condition.” These Likert-scale preferences are supported by the data elicited from rank orderings as each of these terms received the lowest mean preference rank ordering (i.e., most preferred) within their specific set of terms by individuals with anxiety/depression. However, the Likert-scale preferences amongst individuals with anxiety/depression differ slightly from the terms that had the highest percentage of participant endorsement. The terms “Individual with Anxiety,” “Individual Living with Depression,” and “Individual with a Mental Health Condition” received the greatest endorsements from individuals with anxiety/depression. With this being said, the

general preference for person-first language amongst individuals with anxiety/depression remained consistent across measures.

Compared to individuals with anxiety/depression, data generated by Likert-scale questions indicated that the most preferred terms amongst individuals without anxiety/depression are “Individual with Anxiety,” “Individual Experiencing Depression,” and “Individual with a Mental Health Condition.” These three terms also received the highest percentage of participant endorsement by this group, with the addition of “Individual Experiencing Anxiety” which had the same percent endorsed as “Individual with Anxiety.” Notably, individuals without anxiety/depression preferred the terms “Individual Living with Anxiety,” “Individual Experiencing Anxiety,” “Individual Living with Depression,” and “Individual Experiencing Depression” significantly more than individuals with anxiety/depression. Additionally, while the terms “Individual with an Emotional Disturbance” and “Emotionally Disturbed Individual” were on average the least preferred amongst all participants, individuals without anxiety/depression preferred these terms significantly more than individuals with anxiety/depression.

According to data generated by Likert-scale questions, the most offensive terms amongst both individuals with and individuals without a clinical or suspected diagnosis of anxiety/depression are “Anxious Individual,” “Depressed Individual,” and “Emotionally Disturbed Individual.” Across all participants, these terms received the lowest preference ratings, highest offensiveness ratings, and lowest percent endorsed. Overall, both individuals with and individuals without anxiety/depression expressed a lack of preference for and perceived offensiveness towards identity-first terms, however, there were some notable between-groups differences: Although participants did not find the term “Individual with Depression” to be overtly offensive, individuals without depression found this term significantly more offensive

than individuals with depression. Additionally, individuals with anxiety/depression found the terms “Emotionally Disturbed Individual” and “Individual with an Emotional Disturbance” to be significantly more offensive than individuals without anxiety/depression.

Comparing to Previous Literature

The DSM-5 includes a chapter titled “Anxiety Disorders” which is an umbrella term that encompasses more specific conditions such as separation anxiety disorder, specific phobia, social anxiety disorder, panic disorder, etc. The term “Anxiety Disorder” was extracted directly from the DSM-5 along with the phrase “Excessive Fear and Anxiety” which is used to characterize the symptomatology of anxiety: “Anxiety disorders include disorders that share features of excessive fear and anxiety and related behavioral disturbances” (APA, 2013, p. 234). Similarly, the ICD-10 includes a chapter titled “Neurotic, Stress-Related and Somatoform Disorders” which is where the survey term “Neurotic Disorder” was derived from (WHO, 2016). The DSM-5 dominates the professional and academic fields of psychology within the United States while the ICD-10 is a prominent diagnostic text within other countries (APA, 2013; WHO, 2016).

The data collected from the present study supports the continued utilization of the term “Anxiety Disorder” which was generally preferred and not offensive according to all participants, however, was significantly more preferred and significantly less offensive according to individuals with anxiety compared to individuals without anxiety. With this being said, the data also suggest that some of the terminology used within clinical settings is not reflective of community language preferences. For instance, the phrase “Excessive Fear and Anxiety” was indicated as being not preferred but also not offensive amongst both individuals with and individuals without anxiety. Additionally, the term “Neurotic Disorder” was even less preferred

than “Excessive Fear and Anxiety” and was actually perceived as being offensive by both groups of participants.

The DSM-5 includes another chapter titled “Depressive Disorders” which is once again an umbrella term that encompasses more specific conditions such as major depressive disorder and persistent depressive disorder. The term “Depressive Disorder” was extracted directly from the DSM-5 along with the phrase “Sad, Empty, or Irritable Mood” which is used to characterize the symptomatology of depression: “The common feature of all these disorders is the presence of sad, empty, or irritable mood, accompanied by somatic and cognitive changes that significantly affect the individual’s capacity to function” (APA, 2013, p. 200). Similarly, the ICD-10 includes a chapter titled “Mood [Affective] Disorders” which is where the survey term “Mood Disorder” was derived from (WHO, 2016).

Within the present study, the DSM-5 term “Depressive Disorder” received just above neutral preference ratings and was not perceived as overtly offensive according to both individuals with and individuals without depression. While individuals with depression preferred the diagnostic labels “Depression” and “Clinical Depression” more than “Depressive Disorder,” this language does not appear to be harmful. However, “Sad, Empty, or Irritable Mood” was indicated as being the least preferred and most offensive term according to individuals with depression. Furthermore, individuals with depression found the term “Sad, Empty, or Irritable Mood” to be significantly more offensive than individuals without depression. These findings suggest that the inclusion of this terminology within the DSM-5 does not reflect the preferences of individuals with depression and could possibly induce negative emotions within the individual being labeled. The ICD-10 term “Mood Disorder” received relatively neutral preference and

offensiveness ratings from individuals with and individuals without depression demonstrating that there are terms that are more preferred, but this term in and of itself is not harmful.

Two diagnostic labels from the mental health-related terms section of the survey include “Mental Disorder” and “Emotional Disturbance.” The term “Mental Disorder” was extracted from the title of the DSM-5 and according to the present study, was generally not preferred but also not offensive amongst both individuals with and individuals without anxiety/depression. This finding suggests that there are more preferred terms within the anxiety/depression communities that could replace the label of “Mental Disorder,” however, the continued use of this label does not elicit negative reactions.

The term “Emotional Disturbance” was extracted from the Individuals with Disabilities Education Act (IDEA) which is a law that was passed in 1975 to ensure equitable educational opportunities for students with disabilities (U.S. Department of Education, 2022). The IDEA has a specific set of criteria which outlines characteristics that a child with an “emotional disturbance” may exhibit including a depressed mood, difficulty building relationships, and physiological manifestations of fear (Center for Parent Information and Resources, 2021; U.S. Department of Education, 2017). Examples of “emotional disturbances” according to the IDEA are anxiety disorders, bipolar disorder, conduct disorder, obsessive-compulsive disorder, etc. (Center for Parent Information and Resources, 2021). If a child’s emotional disturbance interferes with their educational performance, they may be considered for special education services including an Individualized Education Program (IEP) (Center for Parent Information and Resources, 2021; U.S. Department of Education, 2017). However, as the results from the present study demonstrate, “Emotional Disturbance” as a stand-alone term, identity-first label, and person-first label is considered to be highly offensive according to the community of

individuals with anxiety/depression. Notably, individuals with anxiety/depression rated the term “Emotional Disturbance” as being significantly more offensive than individuals without anxiety/depression. Furthermore, individuals with anxiety/depression indicated finding the terms “Individual with an Emotional Disturbance” and “Emotionally Disturbed Individual” significantly more offensive than individuals without anxiety/depression. These data should prompt the term “Emotional Disturbance” to be reconsidered on the basis that it is perceived as harmful and elicits negative responses from the anxiety/depression community.

Diagnostic texts and legal writing can dictate, perpetuate, and impose the utilization of certain labels and terminology surrounding a community of people as demonstrated by the DSM-5, ICD-10, and IDEA. Similarly, professional organizations such as the American Psychological Association (APA) publish general recommendations for how disability should be addressed within clinical settings and academic writings. The APA suggests that person-first language should be the default and overall, the findings from the present study support this recommendation (APA, 2015). Similarly to the findings from Rottenstein (2014) which examined community language preferences amongst individuals with a range of disabilities, the present study found that individuals with varying relationships to anxiety/depression overall prefer person-first labeling and do not find it to be offensive. This coincides with other investigations of language preferences within the field of mental health as person-first labeling is found to increase the amount of expressed tolerance towards individuals with schizophrenia and individuals with substance use disorder (Ashford et al., 2019; Granello & Gorby, 2021). Generally, the preference for person-first language amongst individuals with varying relationships to anxiety/depression supports the APA recommendations.

In addition to widely accepted texts and organizational guidelines, the findings from the present study can also be compared to previous literature on disability language preferences. Within the anxiety- and depression-related term sections of this survey, the labels “Anxiety” and “Depression” were indicated as being the most preferred and least offensive by individuals with and individuals without anxiety/depression. These specific labels do not include any additional identifiers such as “disorder” or “spectrum,” however, labels that did end in “disorder” or “spectrum” generated lower preference ratings compared to just “Anxiety” and “Depression.” The study conducted by Bury et al. (2020) produced similar findings where the terms “person with autism spectrum disorder” and “person with autism spectrum condition” generated lower preference ratings compared to terms that excluded these additional identifiers (i.e., “person on the autism spectrum”). Simon Bury and colleagues suggest that the negative connotations associated with certain terms such as “disorder” and “condition” may overpower an individual’s preference for either person-first or identity-first language. While the present study demonstrated that additional identifiers such as “disorder” and “spectrum” are not the most preferred, one situation in which a term overpowered any preference for label structuring was with “Emotional Disturbance.” The results from the survey demonstrate that person-first language is overwhelming preferred and not perceived as offensive by individuals with and individuals without anxiety/depression. However, the terms “Individual with an Emotional Disturbance” and “Emotionally Disturbed Individual” were the least preferred and most offensive according to the study participants despite the presence of another identity-first label within the mental health section of the survey (i.e., “Mentally Ill Individual”). This finding suggests that the negative reactions elicited by the term “Emotional Disturbance” are enough to transcend any preference for either person-first or identity-first language.

Another study conducted by Kenny et al. (2016) demonstrated that individuals with different relationships to autism (i.e., have the diagnosis themselves or are a friend/family member/clinician of someone with autism) exhibit different language preferences. Within the present study, individuals with varying relationships to anxiety/depression exhibited similar preferences for and perceived offensiveness of anxiety-, depression-, and mental health-related terms. However, there were some statistically significant between-groups differences that support the findings from Kenny et al. (2016). For example, some survey terms including “Anxiety” and “Anxiety Disorder” were significantly more preferred by individuals with anxiety. However, other survey terms including “Individuals Experiencing Anxiety,” “Individual Living with Anxiety,” “Individual Living with Depression,” and “Individual Experiencing Depression” were significantly more preferred by individuals without anxiety/depression. Between-group differences exist for offensiveness ratings as well which demonstrates that the relationship a person has with anxiety/depression can influence which terms they prefer to use/find offensive.

Implications

Research

To complement the quantitative findings of this study, a qualitative study should be conducted to further explore the experiences that individuals have with language surrounding mental health, and the specific ways in which language has influenced the way mental health is viewed. A qualitative study on the topic of interest would allow for a deeper understanding of underlying attitudes, emotions, and beliefs surrounding an individual’s relationship with language rather than just the superficial and measurable constructs of preference and offensiveness. Additionally, future research should conduct a focus group or preliminary survey

so that the terms presented are better informed by the terminology that is readily used within the community.

Practice

Within clinical practice, the findings from this study can be used to inform the language used when addressing individuals with anxiety/depression. The findings from this study support the use of the terms “Anxiety,” “Depression,” and “Mental Health Condition” over other labels and phrases that identify individuals with anxiety/depression. Additionally, the data suggests that person-first language is overwhelmingly preferred over identity-first language within the anxiety/depression community. These community preferences should be incorporated into clinical settings (i.e., academic writings, diagnostic texts, therapeutic relationships) and everyday interactions to alleviate the negative reactions that harmful language can elicit within people with varying relationships to a condition. Despite these general guidelines, language preferences can still vary on an individual basis even among those who experience the same condition. Within patient encounters, the specific language preferences of the individual should be used by the clinician.

Education

Granello and Gibbs (2016) demonstrated how the phrases “the mentally ill” and “people with mental illness” can elicit different levels of expressed tolerance within undergraduate college students, members of a community center, and mental health professionals. Similarly, Granello and Gorby (2021) demonstrated how the phrases “schizophrenic” and “person with schizophrenia” can elicit different levels of expressed tolerance amongst professional counselors and counselors in training. These profound implications that language can have even within professional mental health care providers are important to amend through education. Educating

others about the language preferences of individuals with anxiety/depression may help reduce negative reactions elicited within professionals, society, and the individual with the diagnosis themselves. While general community language preferences can be derived from the findings of this study, it is still important to educate others about the nuances of language and labeling choices. Preference and offensiveness ratings for each term on the present survey were not unanimous which suggests that individual differences surrounding language exist and should be honored.

Limitations

One limitation of the present study concerns a demographic survey question that asked participants if they have been clinically diagnosed with a mental disorder, or suspect that they have a mental disorder? A response was required for this question in order to proceed with the survey and the options were either “yes” or “no.” Participants that answered “no” to this survey question were branched to a follow-up question that further explored their relationship to anxiety, depression, and other mental health conditions (i.e., friend, family member, clinician, etc.). Participants that answered “yes” to this survey question were branched to a separate follow-up question that further explored the nature of their diagnosis (i.e., clinical or suspected) and which mental health condition they identify as having (i.e., anxiety, depression, and/or another psychiatric condition). The limitation inherent within this binary branching is that it did not allow for participants to identify as having varying relationships and associations with anxiety, depression, and mental health in general. In other words, participants were unable to identify as personally having a clinical or suspected mental health condition *and* as being a friend, family member, and/or clinician for other individuals with a mental health condition. This limited the ability for participants to fully express their relationships with mental health

conditions and subsequently, the possible robustness of between-groups comparisons within the data analysis.

Another limitation of the present study concerns the breadth of between-groups data analyses that were conducted. The preexisting literature on related topics explored language preferences of a specific community within different contexts including the United Kingdom (Kenny et al., 2016), United States (Rottenstein, 2014), and Australia (Bury et al., 2020). These studies found that participants from different geographic locations preferred different labeling structures including identity-first language within the United Kingdom (Kenny et al., 2016), person-first language within the United States (Rottenstein, 2014), and a division between the two in Australia (Bury et al., 2020). For the present study, anyone 18 years or older was eligible to participate regardless of their geographic location. This unrestrictive criterion allowed for participants from a total of 15 countries to participate, with the majority being from the United States ($n = 93$, 75.0%). The other countries within the sample were only represented by anywhere between 1 to 8 participants. This did not allow for a between-groups comparison to be conducted between participants from different countries which limited the study's ability to contribute to the literature surrounding language preferences in relation to context and geographic location.

A third limitation of the present study concerns the grouping of participants for the between-group comparisons of mental health-related terms. For the between-group comparisons of anxiety-related terms, one group consisted of participants that identified as having anxiety while the comparison group consisted of participants that identified as not having anxiety. For the between-group comparisons of depression-related terms, one group consisted of participants that identified as having depression while the comparison group consisted of participants that

identified as not having depression. However, for the between-group comparisons of mental health-related terms, one group consisted of participants that identified as having anxiety and/or depression while the comparison group consisted of participants that identified as not having anxiety and/or depression, regardless of whether or not they had a different mental health condition. The purpose of the between-group comparisons was to illuminate the language preferences of the community that personally endures the impacts of the diagnostic labels and terminology with the preferences of a community that has a more distant relationship to these mental health conditions. The mental health-related terms could be applicable to any individual with a mental health condition, not just those with anxiety and/or depression.

Conclusion

The terms “Anxiety,” “Depression,” and “Mental Health Condition” were the most preferred and least offensive according to individuals with and individuals without anxiety/depression. Additionally, a person-first labeling structure (compared to identity-first) was preferred and not perceived as offensive amongst the study sample. The terms “Neurotic Disorder,” “Sad, Empty, or Irritable Mood,” and “Emotional Disturbance” were the most offensive according to individuals with and individuals without anxiety/depression.

The findings from this study can help revise the language used within clinical discourse (i.e., DSM-5 and ICD-10), legal writing (i.e., IDEA), and everyday interactions in a manner that respects community preferences and reduces the negative reactions that language can induce. Moving forward, future research should employ a qualitative design to gain a deeper understanding of the reasoning behind language preferences, and practice and education should allow these findings to inform their approach while also acknowledging that individual differences may arise.

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Appendix A

Figure 4: Participant Response for Other Terms Used to Describe Anxiety that were Not Included on Survey

“rage, anger, interpersonal stress and interpersonal traumatic experiences / psychosocial adversity or psychosocial disadvantage, physical stress, brain inflammation, brain swelling, suicidal ideation, etc.”

Figure 5: Participant Response for Other Terms Used to Describe Depression that were Not Included on Survey

“depression with or without unfavorable / adverse life experiences and circumstances (known by the patient themselves or at least, they have given enough info to the therapist about their history that if they are not self aware enough or struggle to give meaningful past information about themselves) with or without biological influence (the patient can either assert that there are biological causes for their depression or they may assert that they don’t know or do not believe it’s due to biological reasons, which could be things like bad brain chemistry, etc).”

Figure 6: Participant Response for Other Terms Used to Describe Mental Health that were Not Included on Survey

“qualitative functioning questions that provide a contextual analysis of things like unemployment in relation to certain psychosocial measures, such as whether the person ever sought mental health services, particularly in person, such as support groups, how much and often they did and what their experiences were from all this, and combining professionally diagnosed mental health conditions, etc.”

Appendix B

Study Notice

My name is Quinn Kirby and I am an undergraduate student at the University of Vermont.

I am conducting a research study for my Honors Thesis titled “Language Preferences Surrounding the Diagnostic Labels for Anxiety and Depression.” I am interested in discovering how people associated with anxiety and depression prefer to be addressed and labeled.

I am looking for volunteers to participate in this study! Anyone **18 years or older** is eligible to participate and **a clinical diagnosis of anxiety/depression is not required**. Participation is **entirely online** and includes answering an **anonymous survey** that will take approximately **10-15 minutes** to complete.

To find out more or to participate, please use the link below:

https://qualtrics.uvm.edu/jfe/form/SV_b8aOdURQg07bXRY

If you have any questions about this study, you can contact either me at quinn.kirby@uvm.edu or my faculty advisor (Dr. Laura Lewis) at laura.lewis@med.uvm.edu.

Thank you for your time and consideration.

Appendix C

Study Advertisement



SEEKING
VOLUNTEERS

TO PARTICIPATE IN A
RESEARCH STUDY ON LANGUAGE
PREFERENCES SURROUNDING
ANXIETY & DEPRESSION

The labels used when speaking and writing about mental health have an impact on the personal and public perceptions of an individual with the diagnosis. Anxiety and depression are two extremely prevalent mental health diagnoses. By participating in this research study, you will help to identify the language preferences for anxiety, depression, and mental health more generally.

If you are 18 years or older, you are eligible to participate by completing a short (10-15 minutes) and anonymous online survey.



A clinical diagnosis of anxiety or depression is not needed to participate.

Principle Investigator: Quinn Kirby, University of Vermont

Contact Information: quinn.kirby@uvm.edu

Title of Study: Language Preferences Surrounding the Diagnostic Labels for Anxiety and Depression