Words Matter:
How Language Choice Can Reduce Stigma

> *Protest any labels that turn people into things. Words are important. If you want to care for something, you call it a 'flower;' if you want to kill something, you call it a 'weed.'"* [i]

Stigma is defined as a mark of disgrace or infamy, a stain or reproach, as on one's reputation.[ii] Substance use disorders carry a high burden of stigma; fear of judgment means that people with substance use disorders are less likely to seek help, and more likely to drop out of treatment programs in which they do enroll.

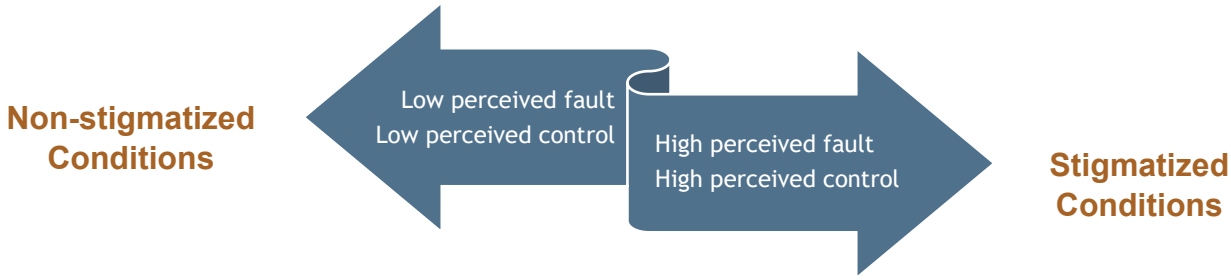
As prevention practitioners, we are in a unique position to reduce the stigma surrounding substance misuse. The language we use to discuss substance use disorders (SUDs) either formally, as part of prevention messaging, or informally, in conversations with colleagues and stakeholders, can either increase or decrease SUD stigma. In the context of the growing opioid crisis, the language we use becomes particularly important as we find ourselves working in partnership with people who actively misuse substances and confront directly the myriad societal stigmas associated with having an SUD.

This tool looks at the role of language in perpetuating SUD stigma, followed by tips for assessing when and how we may be using stigmatizing language, and steps for ensuring that the language we use and messages we deliver are positive, productive, and inclusive.

GETTING INFORMED: UNDERSTANDING THE IMPACT OF SUD STIGMA

Two main factors affect the burden of stigma placed on a particular disease or disorder: perceived *control* that a person has over the condition and perceived *fault* in acquiring the condition. When we believe a person has acquired their illness through no fault of their own, and/or that they have little control over it, we typically attach no stigma to either the person or the illness. Consider hard-to-treat cancers, for example. By contrast, many people mistakenly believe mental health conditions, including substance misuse disorders, are both within a person's control and partially their fault. For these reasons, they frequently attach more stigmas to them.[iii] The potential for stigma is greater still when someone is using an illegal substance, which carries the additional perception of criminality.

Developed under the Substance Abuse and Mental Health Services Administration's Center for the Application of Prevention Technologies task order. Reference #HHSS283201200024I/HHSS28342002T. November 2017



For people with a substance use disorders, stigma disproportionately influences health outcomes and mental well-being. Fear of being judged and/or discriminated against can prevent people with substance use disorders, or who are at risk of substance use disorders, from getting the help they need. It can also prevent caregivers and others in the position to help from providing needed services, including medical care. Consider the following:

- **Substance use disorder is among the most stigmatized conditions in the US and around the world.**[iv] People do not want to work with, be related to, or even see people with a substance use disorder in public. Further, many believe that people with a substance use disorder can or should be denied housing, employment, social services, and health care.[v]
- **Health care providers treat patients who have substance use disorders differently.**[vi, vii] Clinicians have lower expectations for health outcomes for patients with substance use disorders; this in turn can affect whether the provider believes the patient is deserving of treatment. Some health care providers, falsely believing that substance use disorders are within a person's control, cite feelings of frustration and resentment when treating patients with substance use disorders [viii]
- **People with a substance use disorder who expect or experience stigma have poorer outcomes.**[ix, x] People who experience stigma are less likely to seek out treatment services and access those services. When they do, people who experience stigma are more likely to drop out of care earlier. Both of these factors compound and lead to worse outcomes overall.

As prevention practitioners, it is incumbent upon us to do what we can to reduce the burden of SUD stigma. An important first step is to examine—and, if needed, change—the language we use.

CHECKING YOURSELF: ARE YOU PERPETUATING SUD STIGMA?

The language practitioners use to talk about substance misuse shapes how the public views substance use disorders. Unintentionally stigmatizing language can perpetuate negative stereotypes about the types of people who are affected by substance misuse and can decrease public support for prevention and treatment programs.

By contrast, language that supports pro-health activities, even if a person is actively using substances, can help decrease stigmas.[xi, xii, xiii] For example, prevention messages that highlight the self-efficacy of people with SUDs to use naloxone to reverse opioid overdose frames them as

capable and important community members, and directly tackles existing stigmas of people with SUDs as selfish and lazy.

How can you tell if your prevention messages are stigmatizing? Consider these five questions:

Are you using "person first" language?[xiv]

Person first language (for example, reference to "a person with substance use disorder") suggests that the person *has* a problem that can be addressed. By contrast, calling someone a "drug abuser" implies that the person *is* the problem.

Are you conflating substance use and substance use disorder?[xv]

While some substance use may be illegal or unhealthy, we should limit language about substance use disorders exclusively to situations where a clinical diagnosis has been made. For prevention practitioners, keeping this distinction clear is key to avoid perpetuating stigmas associated with substance use. For example, a person who has used heroin should not be targeted in the language of a prevention effort aimed at people who meet the clinical definition of opioid addiction or dependence.

Are you using technical language with a single, clear meaning instead of colloquialisms or words with inconsistent definitions?[xvi]

Consider the difference between the terms "negative urine drug screen" and "clean urine." The first is a clear description of test results; the second a value-laden term that implies drug use creates "dirty" urine. Similarly, "pharmacotherapy for opioid use disorder" is a technical term for medications that can be used to treat an illness, while "substitution/replacement treatment" falsely implies that one opioid is being substituted for another, perpetuating the stigma of "once an addict, always an addict."

Are you using sensational or fear-based language?[xvii, xviii, xix]

Prevention practitioners often walk a fine line between wanting to inspire action and inadvertently inflating the burden of illness and associated consequences due to a health issue. Referring to emerging drug threats as "newer," "bigger," "scarier," or "unlike anything ever seen before" can be perceived as inauthentic by people who use those substances. It further compounds stigma by conveying the message that anyone who uses such a "terrible" substance is stupid, dangerous, or illogical.

Are you unintentionally perpetuating drug-related moral panic?

From publicizing stories about "crack babies" in the 1980s to "opioid babies" today, the tendency toward moral panic has a long history in prevention messaging and media coverage of substance use disorders. Moral panics inevitably marginalize people who are vulnerable and often bring their morality or even humanity into question. This moral panic may prevent mothers who use drugs from accessing prenatal care because they are afraid of being judged or mistreated by medical professionals, or of being forced into the child welfare system.

BREAKING THE CYCLE:
TIPS FOR AVOIDING STIGMATIZING LANGUAGE

Paying attention to how prevention language can exacerbate stigma is difficult work. Individual habits can be hard to break—changing how we communicate within and across systems to support the use of more respectful and inclusive language can be even more challenging. Having an increased awareness of the relationship between language and stigma is key to breaking this cycle. Here are some concrete tips for doing so:

Perform a "language audit" of existing materials for language that may be stigmatizing, then replace with more inclusive language.

For example, using the search and replace function for electronic documents: search for "addict" and replace with "person with a substance use disorder," or search for "abuse" and replace with "use" or "misuse." Make sure to review both internal documents (mission statements, policies) as well as external ones (brochures, patient forms).

Critically reflect on the types of information you choose to disseminate (for example, an email alert) to ensure that you are doing so responsibly. Ask yourself:

- *What is the source of the message?* Is it reputable? Do you trust this source?
- *Does the message contain information that is grounded in research and/or evidence-based?* If not, what is the basis for the claims?
- *Are you conveying the information accurately?* Are you unintentionally editorializing or adding oommentary that would bias the message?
- *Does the message point to a "victim" or "bad guy"?* If yes, who is that person? Are there any unintended consequences of labeling that person or group as "victims" or "bad" that would be compounded by diseminating the message more widely?

Every time you develop a prevention message, consider it as an opportunity to dispel myths and convey respect. Ask yourself:

- *Who is my intended audience, and how can I use language to reduce stigma when communicating with this group*? For example, when developing a message to encourage people with opioid use disorders to carry and use naloxone, include language that fosters self-worth and encourages self-efficacy.
- *Am I correcting negative attitudes held by potential allies?* For example, in some communities, first responders may be reluctant to carry naloxone because they characterize people who misuse opioids as criminals who should be punished for breaking the law. You can help to change this perspective by using language that acknowledges the presence of these stereotypes while educating about the nature of addiction and affirming the shared priority of saving lives.

- *Am I maximizing connection, worth, and community membership?* If not, might shame, isolation, or "othering" be implied by the language used?

When developing new materials, seek input from various stakeholders, including people who use drugs.

Ask them if the main points are believable, authentic, trustworthy, and helpful for the intended audience, and if the language is appropriate and respectful.

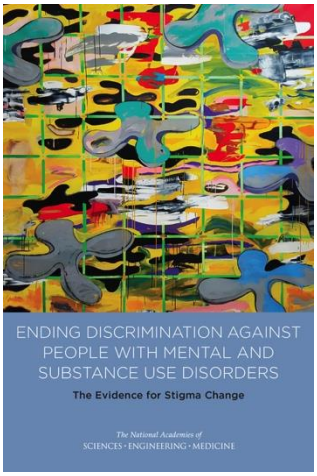
Train staff on issues related to substance use and stigma, including the important negative health and community outcomes related to perpetuating stigma.

Focus on the inadvertent ways that staff may be perpetuating stigma in day-to-day conversation. Ask them to think about the perceptions they hold of people with substance use disorders and the words and language they use in discussing individuals or cases. How can they explore alternative language? How can they adopt this alternative language?

With careful attention to language, we can reduce the burden of stigma surrounding substance use disorders, improve access to health care for people with substance use disorders, and save lives. What we say, and how we say it, matters. Let's get started!

TO LEARN MORE

Ending Discrimination Against People with Mental and Substance Use Disorders: The Evidence for Stigma Change. The Office of the Assistant Secretary for Planning and Evaluation (ASPE) and the Substance Abuse and Mental Health Services Administration (SAMHSA) of the U.S. Department of Health and Human Services asked the National Academies of Sciences, Engineering, and Medicine to undertake a study of the science of stigma change. The report reviews and discusses evidence on (1) the change in behavioral health norms needed to support individuals with mental and substance use disorders to seek treatment and other supportive services; (2) discrimination, negative attitudes, and stereotyping faced by individuals with mental or substance use disorders; and (3) public knowledge about behavioral health, including how to seek help for people with such disorders.



Four Facts Every Journalist Should Know When Covering The Opioid Epidemic. According to the Columbia Journalism Review, "a long tradition of shaming substance users has made the press less inclined to talk about addiction as a public health crisis rather than a moral one." This article seeks to remedy this.

Changing the Language of Addiction. This memo from Michael Botticelli, former Director Of The White House Office Of National Drug Control Policy, highlights the relationship between language and stigma.

How Changing The Language Of Addiction Affects Policy And Treatment. In this interview on WBUR's *Here & Now*, former National Drug Czar Michael Botticelli discusses the impact of language on the current opioid crisis.

Why We Should Say Someone Is A 'Person With An Addiction,' Not An Addict. The new edition of the Associated Press' widely used AP Stylebook declares that "addict" should no longer be used as a noun. "Instead," it says, "choose phrasing like *he was addicted, people with heroin addiction* or *he used drugs*." In short, separate the person from the disease.

---

[i] http://www.williamwhitepapers.com/blog/2013/07/moral-panics-the-limits-of-science-professional-responsibility.html

[ii] Stigma. (n.d.). Dictionary.com Unabridged. Retrieved July 10, 2017 from Dictionary.com website http://www.dictionary.com/browse/stigma

[iii] Toward An Addiction-Ary: Language, Stigma, Treatment, and Policy. John F. Kelly, Ph.D. National Association of Drug Court Professionals. Anaheim, CA, June 2016.

[iv] Barry, C. L., McGinty, E. E., Pescosolido, B. A., & Goldman, H. H. (2014). Stigma, discrimination, treatment effectiveness, and policy: public views about drug addiction and mental illness. *Psychiatric Services, 65*(10), 1269-1272.

[v] Committee on the Science of Changing Behavioral Health Social Norms; Board on Behavioral, Cognitive, and Sensory Sciences; Division of Behavioral and Social Sciences and Education; National Academies of Sciences, Engineering, and Medicine. Ending Discrimination Against People with Mental and Substance Use Disorders: The Evidence for Stigma Change. Washington (DC): National Academies Press (US); 2016 Aug 3. 2, Understanding Stigma of Mental and Substance Use Disorders. Available from: https://www.ncbi.nlm.nih.gov/books/NBK384923/

[vi] Kelly, J. F., Dow, S. J., &Westerhoff, C. (2010). Does our choice of substance-related terms influence perceptions of treatment need? An empirical investigation with two commonly used terms. *Journal of Drug Issues, 40,* 805–818.

[vii] Kelly, J. F., Wakeman, S. E., & Saitz, R. (2015). Stop talking 'dirty': Clinicians, language, and quality of care for the leading cause of preventable death in the United States. *American Journal of Medicine, 128,* 8–9.

[viii] Van Boekel, L. C., Brouwers, E. P., Van Weeghel, J., & Garretsen, H. F. (2013). Stigma among health professionals towards patients with substance use disorders and its consequences for healthcare delivery: systematic review. *Drug and alcohol dependence, 131*(1), 23-35.

[ix] Brener, L., von Hippel, W., von Hippel, C., Resnick, I., & Treloar, C. (2010). Perceptions of discriminatory treatment by staff as predictors of drug treatment completion: utility of a mixed methods approach. *Drug and Alcohol Review, 29*(5), 491-497.

[x] Keyes, K. M., Hatzenbuehler, M. L., McLaughlin, K. A., Link, B., Olfson, M., Grant, B. F., & Hasin, D. (2010). Stigma and treatment for alcohol disorders in the United States. *American Journal of Epidemiology, 172*(12), 1364-1372.

[xi] Wallack, W. D. L. (1999). A critical perspective on the drug czar's antidrug media campaign. *Journal of Health Communication, 4*(2), 155-160.

[xii] Hornik, R., Judkins, D., Golub, A., Johnson, B., Duncan, D., Westat, .. & United States of America. (2000). Evaluation of the National Youth Anti-Drug Media Campaign: Historical trends in drug use and design of the Phase III Evaluation. Report prepared for the National Institute on Drug Abuse (Contract No. NO1DA-8-5063), published by the Office of National Drug Control Policy. Washington, DC: US Government Printing Office.

[xiii] Wagner, K. D., Davidson, P. J., Iverson, E., Washburn, R., Burke, E., Kral, A. H., ... & Lankenau, S. E. (2014). “I felt like a superhero”: The experience of responding to drug overdose among individuals trained in overdose prevention. *International Journal of Drug Policy, 25*(1), 157-165.

[xiv] International Society of Addiction Journal Editors. Addiction Terminology Statement. Annual meeting, Budapest, Hungary, August 31-September 2, 2015. http://www.parint.org/isajewebsite/terminology.htm

[xv] Kelly, J. F. (2004). Toward an Addictionary: A Proposal for More Precise Terminology. *Alcoholism Treatment Quarterly, 22*(2), 79-87.

[xvi] Kelly, J. F., Wakeman, S. E., & Saitz, R. (2015). Stop talking 'dirty': Clinicians, language, and quality of care for the leading cause of preventable death in the United States. *American Journal of Medicine, 128,* 8–9.

[xvii] Miller, P. G. (2007). Media reports of heroin overdose spates: Public health messages, moral panics or risk advertisements?.*Critical Public Health, 17*(2), 113-121.

[xviii] Kerr, T., Small, W., Hyshka, E., Maher, L., & Shannon, K. (2013). ‘It's more about the heroin’: Injection drug users' response to an overdose warning campaign in a Canadian setting. *Addiction, 108*(7), 1270-1276

[xix] Stengel, C. (2014). The risk of being ‘too honest’: Drug use, stigma and pregnancy. *Health, Risk & Society, 16*(1), 36-50.