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Confronting Inadvertent Stigma and Pejorative Language in Addiction Scholarship: A Recognition and Response

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Abstract

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Appropriate use of language in the field of addiction is important. Inappropriate use of language can negatively impact the way society perceives substance use and the people who are affected by it. Language frames what the public thinks about substance use and recovery, and it can also affect how individuals think about themselves and their own ability to change. But most importantly, language intentionally and unintentionally propagates stigma: the mark of dishonor, disgrace, and difference that depersonalizes people, depriving them of individual or personal qualities and personal identity. Stigma is harmful, distressing, and marginalizing to the individuals, groups, and populations who bear it. For these reasons, the Editorial Team of *Substance Abuse* seeks to formally operationalize respect for personhood in our mission, our public relations, and our instructions to authors. We ask authors, reviewers, and readers to carefully and intentionally consider the language used to describe alcohol and other drug use and disorders, the individuals affected by these conditions, and their related behaviors, comorbidities, treatment, and recovery in our publication. Specifically, we make an appeal for the use of language that (1) respects the worth and dignity of all persons (“people-first language”); (2) focuses on the medical nature of substance use disorders and treatment; (3) promotes the recovery process; and (4) avoids perpetuating negative stereotypes and biases through the use of slang and idioms. In this paper, we provide a brief overview of each of the above principles, along with examples, as well as some of the nuances and tensions that inherently arise as we give greater attention to the issue of how we talk and write about substance use and addiction.

Keywords

Criminal justice; language; mental disorders; publishing; social stigma; substance-related disorders

One of our goals as the Editorial Team for *Substance Abuse* is to provide ongoing support for the Association for Medical Education and Research in Substance Abuse’s (AMERSA) mission to “improve health and well-being through interdisciplinary leadership in substance use education, research, clinical care, and policy.” We believe improving health and well-being requires interdisciplinary leadership regarding the language that we use in our scholarship. Appropriate use of language in the field of addiction is important. Inappropriate use of language can negatively impact the way society perceives substance use and the people who are affected by it. Language frames what the public thinks about substance use and recovery,¹ and it can also affect how individuals think about themselves and their own ability to change. But most importantly, language intentionally and unintentionally propagates stigma: the mark of dishonor, disgrace, and difference that depersonalizes people, depriving them of individual or personal qualities and personal identity.^{2–5} Stigma is harmful, distressing, and marginalizing to the individuals, groups, and populations who bear it, whether based on fear and exclusion, authoritarianism, or even benevolent intentions.⁶

For these reasons, the Editorial Team of *Substance Abuse* seeks to formally operationalize respect for personhood in our mission, our public relations, and our instructions to authors. To our knowledge, few journals have explicitly taken this step,^{7–12} and we are the first scientific addiction journal to do so. Our overarching call is threefold. First, we are asking *authors* to carefully and intentionally consider the language they use to describe alcohol and

other drug use and disorders, the individuals affected by these conditions, and their related behaviors, comorbidities, treatment, and recovery. Second, we are asking *reviewers* to assist the Editorial Team in promoting the use of these guidelines when considering the work of others for publication. Lastly, we are asking for *readers* to engage with us through our upcoming series of editorials about more specific issues related to language in our field. In this first editorial in the series, we present new guidelines for our Author Instructions that specifically make an appeal for the use of language that:

- Respects the worth and dignity of all persons (“people-first language”)
- Focuses on the medical nature of substance use disorders and treatment
- Promotes the recovery process
- Avoids perpetuating negative stereotypes and biases through the use of slang and idioms

Our goal is to provide a brief overview of each of the above principles, along with examples. We also present some of the nuances and tensions that inherently arise as we give greater attention to the issue of how we talk and write about substance use and addiction. We do not seek to issue a formal or final dictum on language use for our authors and reviewers, but instead to encourage thoughtful and deliberate consideration of language that is most consistent with operationalizing respect for personhood in our journal policies and practices.

The Use of “People-First Language”

Disability and mental health advocates have been pioneers in promoting “people-first language” to promote respect for the worth and dignity of all persons. People-first language literally puts the words referring to the individual before words describing his/her behaviors or conditions. This practice helps highlight the fact that an individual’s condition, illness, or behavior is “only one aspect of who the person is, not the defining characteristic.”¹² In the realm of addiction, terms such as “alcoholics,” “addicts,” and even the more generic “users” are terms that group, characterize, and label people by their illness, and in so doing, linguistically erase individual differences in experience. To a large extent, these terms also presume a homogeneity in experience, character, and motivation that depersonalizes the people to whom the terms are applied.¹³ Instead, referring to the person first, e.g., “person with a cocaine use disorder,” “adolescent with an addiction,” or “individuals engaged in risky use of substances,” reinforces the affected individual’s identity as a person first and foremost.

The Use of Language That Reflects the Medical Nature of Substance Use Disorders and Treatment

We recognize that a myriad of physical, social, psychological, environmental, economic, and political factors contribute to addiction. We also recognize that there are many modalities for, and many paths to, recovery. However, as an editorial team of clinicians, researchers, educators, and policymakers, we favor the medical framing of addiction for two reasons. First, a variety of common terms such as “abuser,” “junkie,” and “habit” perpetuate

stigmatizing notions that addiction is a failure of morals, personality, or willpower.^{3,5} The focus remains on the individual's behavior as the source of the addiction, with virtually no attention to the multitude of physiological, genetic, psychological, and sociocultural factors that contribute to its development.^{5,13} Although it is perhaps surprising, our journal has received submissions that contain explicitly morally laden language, e.g., referring to the “depraved and degenerate lives” of individuals who use substances. In contrast, terms such as “substance use disorder” and “addictive disease” frame addiction as a health issue.

Second, presenting addiction and its treatment through a medical lens helps draw attention to the growing foundation of evidence-based treatment options and services available to support whole-person recovery—treatment options and services that are unfortunately, unavailable or inaccessible to many affected individuals.⁵ For example, in the past, “opioid substitution therapy” had been the term used to describe treatment modalities such as buprenorphine and methadone for opioid addiction. But the term is a misnomer because of its conflation of physiological dependence and compulsive behavior—and its presumed equivalence in the use of medications and illicit substances. Instead, the term “medication-assisted treatment” avoids these conflations and more accurately speaks to medication as one controlled component of treatment. Some authors have gone one step further and recommended that we “just call it treatment,” noting that the “-assisted” suffix is not used as a descriptor in reference to the multicomponent treatment of other conditions such as diabetes, which include medication, counseling, physical activity, and dietary change.¹⁴

Nonetheless, we are behooved to acknowledge that for some communities or individuals, the medicalization of substance use may be perceived as problematic instead of helpful.¹³ Framing substance use as a medical problem with a medical solution inherently converts individuals into disempowered “patient” roles vis-a-vis health care providers or “the system,” and can promote medication and medically-oriented treatment as the most important aspect of recovery, failing to recognize the proverbial notion that “pills don't teach skills.” This implicit conversion and narrow perspective on treatment may be perceived as antithetical to the autonomy, empowerment, and partnership inherent to the comprehensive recovery process. A medication focus also raises legitimate questions about the extent of pharmaceutical company influence on the field and our conceptions of treatment and recovery. We recognize the cogency of these points. At this time, we assert our preference for language that reflects the medical nature of substance use disorders and treatment and encourage more discussion on the ambivalence and tension. At the same time, we commit to defining “the nature of this disease in a manner that is scientifically defensible,”¹³ and will continue to promote the whole range and diversity of recovery options available.¹⁵

The Use of Language That Promotes Recovery

Recovery-oriented language refocuses the lens from pathology and suffering to resilience and healing. Recovery-oriented language also changes the discussion from one rooted in notions of onetime, acute treatments or interventions to one that appreciates the long-term modalities and strategies needed to sustain recovery.¹³ Because of its parallels and overlap with scholarship, another relevant dimension of recovery-oriented language involves the language used in our formal clinical correspondence and documentation.¹⁶ Many of the

words used in these contexts can also inadvertently label individuals and/or fail to acknowledge individual autonomy in decision-making around treatment and recovery. For example, adjectives such as “noncompliant,” “unmotivated,” or “resistant” can subtly reinforce paternalistic models of health care. Alternatively, the use of phrases such as “not in agreement with the treatment plan,” “opted not to,” “has not begun,” and “experiencing ambivalence about change” recognizes the person’s agency, choice, and preferences in the recovery process, even when incongruent with the professional’s recommendations.¹⁶

The Avoidance of Slang and Idioms

Slang and idioms are used by individuals, families, the health care/treatment community, and the general public as verbal shorthands that are rich in metaphor and symbolism. Although this figurative language can be illustrative and evocative, the pictures painted can contribute to stigma because of their implicit moral or pejorative tone. Although the use of most addiction-related slang is rare in the context of professional written scholarship (e.g., “dope fiend,” “pot head,” “strung out,” or “wrestling with demons”), terms such as “addict,” “speedball,” and “clean”/“dirty” urine have appeared in submissions to our journal. We categorically discourage the use of slang terms to describe individuals’ involvement with substance use.

We also encourage thoughtful consideration of how we speak and write about other stigmatizing conditions and circumstances that are often a part of their lives.¹⁷ People-first language and medical orientation apply to mental illness and criminal justice system involvement as well. Regarding mental illness, “woman with bipolar disorder” is preferred over a mere label such as “bipolar patient,” and “woman having delusional thoughts” is preferable over “delusional patient.” With respect to criminal justice system involvement, one perspective asserts that language that defines people (a) “by the crime for which they were convicted (e.g., murderer, robber, drug dealer, or burglar) or (b) their legal “status” (e.g., drug offender, drunk driver, or felon) may be considered dehumanizing.¹⁸ Instead, the call is to respond to people, “... people involved in the criminal justice system, people in prison, people on parole, etc.”¹⁸ Generally speaking, overall, people-first terms such as “a person charged with driving under the influence” or “a person who is incarcerated” are preferred over “convict” or “felon.” Similarly, “person in community reentry” is preferable to “ex-con” or “ex-offender.”¹⁹ In a related vein, a term that originated in the criminal justice arena that is often used in the clinical context is “recidivism.” Although this word “refers to a person’s relapse into criminal behavior, often after the person receives sanctions or undergoes intervention for a previous crime,”²⁰ we hear individuals who have resumed substance use and are reentering treatment as “recidivists.” This use of the word inappropriately denotes clinical relapse as a “reoffense”— a concept rarely applied to individuals attempting to manage other chronic health conditions with varying degrees of success or “adherence.”

We acknowledge that disagreement exists around the preferred language for many substance use-, mental health-, or criminal justice-related terminology; a thoughtful and more comprehensive discussion of these contrasting perspectives, as well as the caveats, exceptions, and nuances of various terms, is available elsewhere.¹³ For example, although

the words “chronic disease” are often favored for describing addiction because they reflect the need for continued management over the life course, some people view the word “chronic” as enabling because it presumes or justifies eventual failure.²¹ In the criminal justice arena, the term “prisoner” may be considered dehumanizing to some¹⁸ but empowering to others, because it evokes a long history of advocacy for the rights of people confined to prisons. Finally, in certain research or clinical contexts, the use of various nonpreferred terms may be appropriate and/or favorable. Examples include reporting direct participant quotations in qualitative research, designing a user-friendly survey, or mirroring an individual’s own language in an effort to establish therapeutic rapport.

As the journal’s Editorial Team, we must be fully transparent regarding several points. First, many of us have previously used language in our clinical, research, or advocacy work that we might now question or consider inappropriate. We suspect that our authors may have similar experiences. Second, we fully acknowledge the inherent tension in presenting new language use guidelines when the title of our journal, *Substance Abuse*, is, in fact, a term that is now a diagnostic anachronism—and an arguably pejorative term:

Terms such as *alcohol abuse*, *drug abuse*, *substance abuse* all spring from religious and moral conceptions of the roots of severe alcohol and other drug problems. They define the locus of the problem in the willful choices of the individual, denying how that power can be compromised, denying the power of the drug, and denying the culpability of those whose financial interests are served by promoting and increasing the frequency and quantity of drug consumption.¹³

Substance abuse, like substance dependence, was a disease condition defined by the DSM-IV (*Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition). With the recent release of the DSM-5, where these diseases have been combined into a single category—substance use disorder, the appropriateness of the phrase “substance abuse” has been discussed among the Editorial Team and the Executive Board of AMERSA. We are not alone. Many other addiction journals and organizations that promote research and treatment for persons with addictions exist with names that could be considered pejorative. With over 20 journals addressing addiction scholarship (and roughly 4-fold more organizations), it is perhaps impractical to suggest that all publications change their masthead (or organizational name) to a “more appropriate” title. In addition, just as DSM-5 redefined and renamed the diseases we treat, who is to say that DSM-6 will not redefine and rename them again? Perhaps, in the future, “substance use disorder” may also come to be considered pejorative.

We have debated the complex, interrelated conceptual and practical considerations involved in retaining, or changing, the name of our journal and/or organization. The question is by no means resolved. In AMERSA’s Fall 2013 survey of its members, authors, and reviewers, respondents expressed a range of opinions and substantial ambivalence about the need and rationale for a potential name change for the organization and the journal, including the potential losses or gains the organization might encounter by doing so. While consideration of the conceptual, philosophical, and practical aspects of name changes continues, we believe that small steps can be taken to improve existing practices and facilitate ongoing discussion. As a first step, we believe that we have a responsibility to raise awareness of our field’s language difficulty—incidentally, a call that was initially made over 10 years ago by

the American Society of Addiction Medicine.²² At the same time, we will strive to ensure that the words contained within the journal's pages are carefully considered to optimize our public message and shape the field of addiction.

Ultimately, the respectfulness and inclusivity of language about a particular group should be determined by the group itself.^{10,13,21,23} Most importantly, we need to know much more about the thoughts and preferences of the individuals and families who are affected by drug and alcohol use: how do they feel about their own and others' use of the terminology discussed above? What language would they like us to use,²³ and what are the implications for the services and policies they need?²⁴ We cannot assume homogeneity in their perspectives. Furthermore, the possibility exists that affected individuals may want or need to use one identity or "language when [they] turn inward and another language when [they] turn outward to communicate with the larger society."^{4,13}

As we place respect for persons at the core of the addiction scholarship, care, and advocacy that we do, engaging the voices of these individuals is paramount. Yet, sustained culture change both within and arising from our field will also require engaging the voices of clinicians, researchers, policymakers, advocates, families, and community members. In our professional and personal lives, we ourselves belong to one or more of these stakeholder groups and can participate in a dialogue from multiple perspectives. We invite feedback from these various perspectives as well, through multiple channels and forums, including Letters to the Editor, Commentaries, your research and scholarly work, feedback on our Facebook page, and discussion forums at AMERSA's annual meeting, as we navigate these ever-changing waters of "the language issue," together.

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