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Language, Substance Use Disorders, and Policy: The Need to Reach Consensus on an “Addiction-ary”

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ABSTRACT

The language used to describe health conditions reflects and influences our attitudes and approaches to addressing them, even to the extent of suggesting that a health condition is a moral, social, or criminal issue. The language and terminology we use is particularly important when it comes to highly stigmatized and life-threatening conditions, such as those relating to alcohol and other drugs. Scientific research has demonstrated that, whether we are aware of it, the use of certain terms implicitly generates biases that can influence the formation and effectiveness of our social and public health policies in addressing them. Such research has made it difficult to trivialize or dismiss the terminology debate as merely “semantics” or a linguistic preference for “political correctness.” Furthermore, given that alcohol and other drug-related conditions are among the top public health concerns in the United States and in most English speaking countries globally (e.g., United Kingdom, Australia, Ireland), this is no trivial matter. In this article, the authors detail the conceptual and empirical basis for the need to avoid using certain terms and to reach consensus on an “addiction-ary.” The authors conclude that consistent use of agreed-upon terminology will aid precise and unambiguous clinical and scientific communication and help reduce stigmatizing and discriminatory public health and social policies.

KEYWORDS

Language; stigma; terminology; policy; addiction; substance abuse; substance use disorders

Language evolution

Language is a collection of standardized and universally accepted sounds and symbols intended to convey specific meanings. Words and phrases tacitly trigger networks of cognitive scripts that activate a serial chain of connected thoughts (“schema”) that, ultimately, can cue specific action patterns. As such, it is our central method of human communication. It is natural also for our language to evolve. The English language in the time of Chaucer is hardly recognizable as English, and even the English prose of William

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Shakespeare must be read slowly and carefully in order to comprehend the gist of much of its intent. In the addiction and mental health arenas, too, language has rightfully evolved over time. We no longer use terms such as “dipsomania” or “inebriety” to describe alcohol use disorder, nor use terms such as “lunatics,” “idiots,” or “insane asylums” to describe patients with psychiatric illness or psychiatric hospitals. The use of language and terminology is more serious when we consider highly stigmatized conditions where people’s health and lives are at stake. Certain terms can exacerbate or diminish stigma, even when we are unaware of it, and directly impact clinical care (Kelly, Dow, & Westerhoff, 2010; Kelly, Wakeman, & Saitz, 2015; Kelly & Westerhoff, 2010; White & Kelly, 2011). As our scientific knowledge and understanding of the causes and impacts of other health conditions have evolved so too has our language; and it has evolved to avoid stigma too for these other conditions. For example, people suffering from Hansen’s disease were called “lepers,” a word that came to mean a person who is to be avoided for moral or social reasons. In the early 1980s, HIV disease was initially called Gay-Related Immune Deficiency, a term that focused on a particular socially defined group of people. Modern terminology changed in order to more accurately capture and reflect the true nature of these diseases (Babor, Campbell, Room, & Saunders, 1994). The WHO has issued guidance on naming new infectious diseases to minimize unnecessary negative effects (Fukuda, Wang, & Vallat, 2015). For addiction, the time has come to update our lexicon.

The terminology and language we use to describe social and criminal issues and health conditions influences and reflects our attitudes and approaches to addressing them. Language is typically a dynamic, slowly evolving, entity that sometimes shifts more abruptly due to technological innovations or changes in response to new knowledge and understanding. Some words and terms just gradually fade and fall out of fashion; others, societies decide to change, disregard, or stop using intentionally, because the connotation conveyed becomes inaccurate or even offensive. The choice of language and terminology used is particularly important when it comes to alcohol or drug use disorders because whether we are aware of it or not, the use of certain terms can perpetuate stigmatizing attitudes that influence the effectiveness of our social and public health policies for addressing them. In fact, rigorous scientific investigations have now shown that certain commonly used terms in the addiction field, may actually induce implicit cognitive biases against those suffering from addiction (Kelly et al., 2010; Kelly & Westerhoff, 2010). Such research has made it difficult to trivialize and dismiss the terminology debate as merely “semantics” or a linguistic preference for “political correctness.” Furthermore, given that alcohol and other drug related conditions are top public health concerns and a leading cause of morbidity and mortality in the United States and in most English-speaking

countries globally (e.g., United Kingdom, Australia, Ireland), this is no trivial matter. Our language and terminology implicitly form and reflect the frameworks for how we approach these conditions and, as such, should be considered carefully and seriously.

Rationale for the use and avoidance of certain terms

The burden of disease attributable to alcohol and other drug-related conditions is staggering and growing. Worldwide, alcohol now kills 3.3 million each year, and another 350,000 die due to other illicit drugs (World Health Organization, 2014). Alcohol and other drug-related conditions are the number one public health concern in the United States and unintentional overdose is the leading cause of accidental death (Warner, Chen, Makuc, Anderson, & Minino, 2011). There are approximately 23 million individuals who meet criteria for a substance use disorder in the US and the economic cost attributable to substance use from lost productivity, health care expenditures, and criminal justice involvement, is approximately \$600 billion annually. We are in the midst of another opioid epidemic; this time stemming from increased availability and accessibility of over-prescribed opioid pain medications that have been diverted and misused with the perception that these once-prescribed medications, are safe (Centers for Disease Control, 2015). Despite the high prevalence of substance use conditions and about 14,000 treatment facilities and 100,000 recovery mutual-aid support chapters meeting weekly across the US, only about 10% of affected individuals receive some form of help for their substance use disorder in any given year. A main barrier to seeking and receiving help is stigma.

Stigma and discrimination

Stigma is defined as an attribute, behavior, or condition that is socially discrediting. No other conditions are more stigmatized than addiction. International studies conducted by the World Health Organization (WHO) indicate illicit drug addiction as well as alcohol addiction are among the most stigmatized “social problems.” In a study across 14 countries of 18 of the most stigmatized issues, including being a criminal, illicit drug addiction was number one, and alcohol addiction number four (Room, Rehm, Trotter, Paglia, & Üstün, 2001). Stigma is influenced by two main factors: cause and controllability. In terms of cause, to the extent people believe an individual is not responsible for the attribute, behavior, or condition (i.e., “It’s not their fault”), stigma is diminished. Similarly with controllability, to the extent that people believe that the attribute, behavior, or condition is beyond the individual’s personal control (i.e., “they can’t help it”), stigma is lessened. Continued stigma is due to the fact that many people still perceive addiction as a “choice” and

that addicted individuals really *can* control it (“why can’t they just stop?”). It is true that people must choose to use for the first time. Yet, studies reveal that the response to that initial exposure is perceived as more or less pleasurable, even aversive, depending on genetics. In fact, approximately half the risk for addiction is conferred by genetics. Because initial experimentation and use is mostly rewarding with few negative consequences, use continues. With repeated exposure and unsuspected by the person using the substance, that individual’s ability to self-regulate impulses to use the drug increasingly is impaired to the point where individuals actually are using the drug *against* their will often unable to honor their own sincere and genuine desire to abstain or moderate use, even for a few hours and despite the threat of severe consequences. We now understand that this sometimes radical decay in the rational ability to regulate impulses to use substances despite the threat of harm is due to functional and structural changes in the brain affecting the neurocircuitry of impulse control, judgment, reward, memory and motivation.

Stigmatizing language

These stigmatizing beliefs regarding cause and controllability give rise to specific ways of describing individuals suffering from these conditions. Describing someone as a “substance abuser,” for example, conveys a notion of willful misconduct, and that the person “is” the problem. In contrast, describing the same person as having a “substance use disorder” conveys the notion of a medical malfunction and that the person “has” a problem, rather than “is” the problem. Rigorous research has shown that our use of such terms may influence judgments pertaining to admonishment or exoneration as well as the need for punishment versus treatment.

Opposition has persisted since the 1970’s regarding use of stigmatizing language in the addiction field, but there was little science on the issue to inform this debate until recently. In one study two case vignettes were randomly assigned to more than 500 doctoral-level mental health and addiction clinicians describing an individual in legal trouble due to alcohol and drugs. In half the vignettes the individual was described as “a substance abuser,” in the other half, he was described as “having a substance use disorder”; otherwise, the scenarios were identical. Clinicians exposed at random to the “substance abuser” term were significantly more likely to judge the person as deserving of blame and punishment than the exact same individual described as “having a substance use disorder” (Kelly & Westerhoff, 2010). The same terms were tested in a general population sample and an even stronger relationship between negative and punitive judgments and the “abuser” term emerged (Kelly et al., 2010). These findings indicate that, even among well-trained mental health and addiction specialists, exposure to terms like “abuser” creates an implicit cognitive bias that

results in punitive judgments that may perpetuate stigmatizing attitudes toward individuals suffering from addiction. Of note, this kind of terminology has not been adopted in other mental health fields: individuals with eating-related problems, for instance, are uniformly described as “having an eating disorder,” never as “food abusers.” There has been a strong push too in the mental health field for the consistent use of “person first” language (e.g., an individual with, or suffering from, bipolar disorder, instead of “a manic-depressive”).

Stop talking “dirty”

Use of “abuse” and “abuser” terminology may evoke implicit punitive biases compromising the quality of medical care and also may create unintended barriers to honest self-disclosure and treatment engagement for those suffering from alcohol or drug use conditions. For individuals receiving treatment for addiction, describing urine toxicology screen results as “dirty” or “clean” instead of “positive” or “negative,” in a similar way may evoke more negative and punitive implicit cognitions (Kelly et al., 2015). Such language is inconsistent with other medical language and standards. People themselves, also, can be described as being “clean” or “dirty.” Use of such terms may also decrease patients’ own sense of hope and self-efficacy for change diminishing the effectiveness of treatment. One systematic review of health care professionals’ attitudes toward patients suffering from alcohol and other drug use conditions concluded that providers’ attitudes were frequently negative, and found to diminish patients’ own feelings of empowerment for change and to contribute to suboptimal health care (van Boekel, Brouwers, van Weeghel, & Garretsen, 2013).

Recommendations for an addiction-ary

To reduce stigma and convey greater clinical and public health precision in communication around addiction disorders, there have been numerous calls to change or completely remove certain terms from our addiction lexicon (Keller, 1982; Kelly, 2004; Kelly et al., 2010; Kelly et al., 2015; Kelly & Westerhoff, 2010; Saitz, 2005; Wakeman, 2013; White, 2004; White & Kelly, 2011) and new language has been offered (Kelly, 2004; Saitz, 2005) including recent systematic efforts by the American Society of Addiction Medicine (2013). Also, some addiction journals provide suggestions and guidance on the appropriate use of non-stigmatizing person-first language for use in communication and reporting addiction science in their own journal (e.g., Broyles et al., 2014; “Instructions for Authors,” n.d.; “Language and Terminology Guidance,” n.d.). In general, person first language is always preferable (i.e., “persons with/suffering from a substance use

disorder) and the words “abuse” and “abuser” should never be used. Rather, this should be replaced with “use” or, for the circumstance when prescription drugs are being discussed, “misuse” or use for a purpose such as for “non-medical reasons” or to achieve euphoria instead. For heavy alcohol use, “harmful alcohol use,” “hazardous alcohol use” or “unhealthy alcohol use” could be used.

In the evolution of languages, there is a tacit goal toward enhanced utility and ever greater efficiency. Consequently, there is a definite tension between being clear and unambiguous and communicating in shorthand with more speed and efficiency. It does take longer to describe someone as “a person with, or suffering from, a substance use disorder” than describing that same person as “a substance abuser” or “addict.” However, modifying language has been important in the recognition of equity and the resolution of prior stigmatization. In this case where the lives of a historically marginalized population are at stake, there is a need to sacrifice efficiency in favor of accuracy and the potential of minimizing the chances for further stigma and negative bias.

On a related and important side note, in terms of precision and accurate communication, it is noteworthy that there is also no consensus on what is encompassed by the use of certain terms. Specifically, sometimes in the clinical and scientific literature “substance use” is used to describe all substances including alcohol and tobacco, and in other instances, it is used to distinguish substances other than alcohol. This can lead to miscommunication and confusion as well as faulty generalizations, decisions, and actions. We recommend using the word “substance” (e.g., as in “substance use disorder”) to refer to *all* substances (i.e., alcohol and other drugs). This is also in keeping with current *Diagnostic and Statistical Manual of Mental Disorders (DSM-V; 2013)* nomenclature.

In addition, the new broader single diagnostic category for “substance use disorder” in DSM-V (replacing the two prior DSM-IV substance-related diagnoses of “abuse” and “dependence”) has introduced even greater heterogeneity within a single category as someone with two or more, and up to eleven, symptoms, is labeled as having the same “disorder.” Severity specifiers (e.g., mild, moderate, severe) are recommended to be used with the new DSM-V category indicating severity by the number of symptoms met, and are clearly needed to distinguish degrees of severity and impairment. Oftentimes, however, an individual is described merely as having a “substance use disorder” without the severity specifier. A frustrating consequence of this is faulty scientific extrapolation and generalization as well the loss of useful clinical information that can aid in formulating treatment plans and in making prognostic predictions. Consequently, it is critical to use not only non-stigmatizing terminology, but to reach consensus on which specific substances (e.g., alcohol *and* other drugs vs. other drugs alone) terms actually

encompass and to encourage the use of specifiers that indicate the severity of substance involvement and related impairments.

Conclusions

The terminology we use to describe substance use-related conditions should be clear, precisely defined, and used consistently to aid unambiguous clinical and scientific communication and promote clearer appraisal of, and generalizations from, empirical findings emanating from the study of alcohol- and other drug use-related conditions. Furthermore, terms which carry with them specific suppositions regarding attributions of personal choice and responsibility and have important implications for affected individuals (e.g., stigma), help-seeking (e.g., treatment access) and policy (e.g., appropriation of criminal justice vs. healthcare funding) must be eliminated (Kelly, 2004).

Addiction is not a choice, but our language and terminology in how we, as a society, describe it and those suffering from it, is. Furthermore, because alcohol and other drug use conditions are not a trivial matter but rather are major contributors to premature mortality, morbidity, and disability in the US and in many English-speaking nations around the world, we need to be mindful and deliberate about using and avoiding certain language and to use agreed-upon terms consistently to aid precise clinical and scientific communication. In this spirit, we would like to close by stating clearly and unambiguously: now is the time to finally remove certain terms from our addiction lexicon and reach consensus on an addiction-ary.

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