THE AMERICAN JOURNAL of MEDICINE®

Stop Talking 'Dirty': Clinicians, Language, and Quality of Care for the Leading Cause of Preventable Death in the United States

A patient with diabetes has "an elevated glucose" level. A patient with cardiovascular disease has "a positive exercise tolerance test" result. A clinician *within* the health care setting addresses the results. An "addict" is not "clean"—he has been "abusing" drugs and has a "dirty" urine sample. Someone *outside* the system that cares for all other health conditions addresses the results. In the worst case, the drug use is addressed by incarceration.

On December 9, 2013, the first ever national drug policy reform summit was held at the White House. A major thrust of this summit was to mark a philosophical shift away from the "war on drugs" and toward a broader public health approach. Much of the summit was devoted to addressing the stigma surrounding addiction and the under-recognized importance of language.

Stigma is defined as an attribute, behavior, or condition that is socially discrediting. It is important because of the 23 million Americans who meet criteria for a substance use disorder each year, only 10% access treatment, and stigma is a major barrier to seeking help.[1] A World Health Organization study of the 18 most stigmatized social problems (including criminal behavior) in 14 countries found that drug addiction was ranked number 1, and alcohol addiction was ranked number 4.[2]

There are 2 main factors that influence stigma: cause and controllability. Stigma decreases when people perceive that the individual is not responsible for causing his/her problem (ie, "It's not his fault") and when he or she is unable to control it (ie, "She can't help it"). Research has taught us that half the risk for addiction is conferred by genetics. In addition, the chronic effects of substances on the central nervous system produce profound changes in brain structure and function that radically impair efforts to control use, despite harmful consequences. Yet, despite evidence of a strong causal role for genetics and impairment in inhibitory control, stigma is alive and well. Research is now revealing that one contributory factor to the perpetuation of stigma may be the type of language we use.

Use of the more medically and scientifically accurate "substance use disorder" terminology is linked to a public health approach that captures the medical malfunction inherent in addiction. Use of this term may decrease stigma and increase help-seeking. In contrast, tough, punitive, language, including the word "war," in "war on drugs," is intended to send an uncompromising message, "You use, you lose," in the hopes of deterring drug involvement. Accompanying this aggressive rhetoric are terms such as drug "abuse" and drug "abusers," implying willful misconduct (ie, "they *can* help it and it *is* their fault"). This language increases stigma and reduces help-seeking.

Since the 1970s, such language has become the norm. Even our federal health institutions that address addictions have the term "abuse" in their names (eg, National Institute on Drug Abuse), and their materials often refer to affected individuals as substance "abusers." But, does it really matter what we call it? Rhetorical opposition has persisted regarding the use of stigmatizing language, but there was little science on the issue to inform this debate. In a study presented at the White House Summit, a paragraph vignette (**Figure 1**) was randomly assigned to more than 500 doctoral-level mental health and addiction clinicians describing an individual in legal trouble because of alcohol and drugs. In half the vignettes, the individual was described as "a substance abuser," and in the other half he was described as "having a substance use disorder"; otherwise, the scenarios were identical. Clinicians exposed to the "substance abuser" term were significantly more likely to judge the person as deserving of blame and punishment than the same individual described as "having a substance use disorder."[3] The same terms were tested in a general population sample, and an even stronger relationship between punitive judgments and the "abuser" term emerged.[4]

These findings indicate that, even among well-trained clinicians, exposure to a term such as "abuser" creates an implicit cognitive bias that results in punitive judgments that

Funding: JFK and RS have received funding from the National Institutes of Health to conduct research on alcohol and other drug use disorders, and to speak at universities and government events. RS has testified as an expert witness for alcohol cases and provided consultation to UpToDate and the *British Medical Journal*. SEW has no conflicts of interest to report.

Conflict of Interest: None.

Authorship: The author had access to the data and played a role in writing this manuscript.

http://dx.doi.org/10.1016/j.amjmed.2014.07.043

"Substance Abuser"

Mr. Williams is a substance abuser and is attending a treatment program through the court. As part of the program Mr. Williams is required to remain abstinent from alcohol and other drugs. He has been compliant with program requirements, until one month ago, when he was found to have two positive urine toxicology screens which revealed drug use and a breathalyzer reading which revealed alcohol consumption. Within the past month there was a further urine toxicology screen revealing drug use. Mr. Williams has been a substance abuser for the past few years. He now awaits his appointment with the judge to determine his status.

"Substance Use Disorder"

Mr. Williams has a substance use disorder and is attending a treatment program through the court. As part of the program Mr. Williams is required to remain abstinent from alcohol and other drugs. He has been compliant with program requirements, until one month ago, when he was found to have two positive urine toxicology screens which revealed drug use and a breathalyzer reading which revealed alcohol consumption. Within the past month there was a further urine toxicology screen revealing drug use. Mr. Williams has had a substance use disorder for the past few years. He now awaits his appointment with the judge to determine his status.

Figure 1 Randomly assigned study vignettes describing the same individual as either a "substance abuser" or as "having a substance use disorder".

may perpetuate stigmatizing attitudes. Of note, such 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." In addition, there has been a push in the mental health field for the consistent use of "person first" language (eg, *an individual* who has schizophrenia, instead of "a schizophrenic").

In recent years, cultural competency, including the use of culturally sensitive language, has become a key component of medical training in the United States.[5] Professionalism, too, another trait deemed vital to clinician development, hinges on communication. Every day in our work, we see and hear individuals described as "alcohol/substance abusers" and urine toxicology screens coming back "dirty" with drugs. Clinicians may even praise a patient for staying "clean" instead of for having "a negative test result." We argue such language is neither professional nor culturally competent and serves only to perpetuate stigma. Use of such terms may evoke implicit punitive biases and decrease patients' own sense of hope and self-efficacy for change. A recent systematic review of health care professionals' attitudes toward addiction concluded that providers' attitudes were often negative, diminished patients' own feelings of empowerment, and contributed to suboptimal health care.[6]

We recommend referring to individuals with addiction as people with a "substance use disorder," not as substance "abusers" or "addicts." For those with consequences or risk, but who do not have a disorder (often referred to inaccurately as "abuse"), we recommend the terms "hazardous," "risky," or "harmful" use, or for the full spectrum that includes risk to a disorder, "unhealthy" use.

Growing up, we all heard and sometimes voiced the childish refrain, "Sticks and stones may break my bones, but words will never hurt me." But words can and do hurt, and in ways that we are not aware and cannot always anticipate. Because substance-related conditions are the number one public health concern in the United States and stigma is a major barrier to accessing treatment,[1] reducing stigma is vital for enhancing public health. One inexpensive way we could begin to do this would be to remove the terms "abuse" and "abuser," "dirty" and "clean" from our vocabulary and commit to a medically appropriate lexicon that conveys the same dignity and respect we offer to other patients. We should stop talking dirty.

John F. Kelly, PhD[a]
Sarah E. Wakeman, MD[b]
Richard Saitz, MD[c]
[a]*Massachusetts General Hospital and Harvard Medical School Boston*
[b]*Massachusetts General Hospital Boston*
[c]*Boston University Medical Center Boston, Mass*

References

1. Substance Abuse and Mental Health Services Administration. Results from the 2012 National Survey on Drug Use and Health: Summary of National Findings, NSDUH Series H-46, HHS Publication No. (SMA) 13-4795. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2013.
2. Room R, Rehm J, Trotter RT II, Paglia A, Üstün TB. Cross-cultural views on stigma valuation parity and societal attitudes towards disability. In: Üstün TB, Chatterji S, Bickenbach JE, et al., eds. *Disability and Culture: Universalism and Diversity*. Seattle, WA: Hogrefe & Huber; 2001:247-291.
3. Kelly JF, Westerhoff C. Does it matter how we refer to individuals with substance-related problems? A randomized study with two commonly used terms. *Int J Drug Policy*. 2010;21:202-207.
4. Kelly JF, Dow SJ, Westerhoff C. Does our choice of substance-related terms influence perceptions of treatment need? An empirical investigation with two commonly used terms. *J Drug Issues*. 2010;40:805-818.
5. Broyles LM, Binswanger IA, Finnell DS, et al. Confronting inadvertent stigma and pejorative language in addiction scholarship: a recognition and response. *Subst Abus*. 2014;35:217-221.
6. Van Boekel LC, Brouwers EP, van Weeghal J, Garretsen HF. Stigma among health professionals towards patients with substance use disorders and its consequences for healthcare delivery: a systematic review. *Drug Alcohol Depend*. 2013;131:23-35.