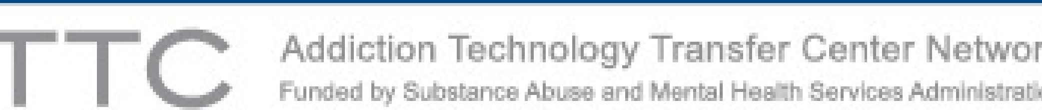
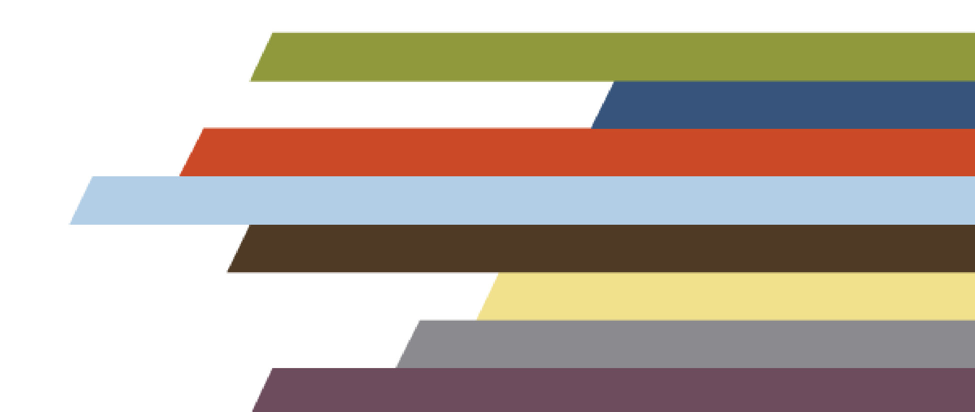


The Northwest & Pacific Southwest ATTCs and the CTN Western States Node present:

Attitudes & Stigma Around Addiction

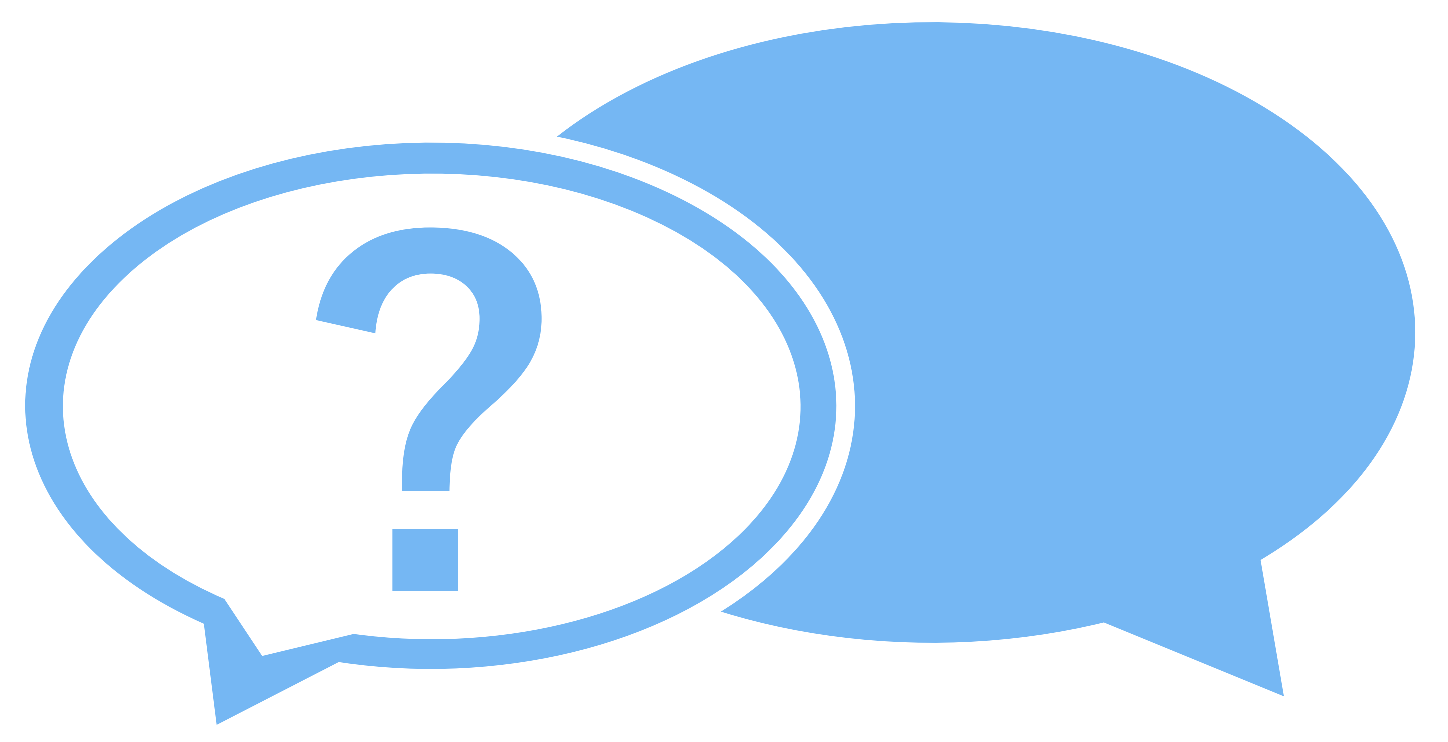
Thank you for joining us!
The webinar will begin shortly.

- **Got questions?** Type them into the chat box at any time and they will be answered at the end of the presentation.
- Slides and a recording of this presentation will be made available on our website at: http://attcnetwork.org/northwest later this week



Q&A

Questions? Please type them in the chat box!



ATTC Survey, Slides, Recording

Look for our survey in your inbox!

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Every survey we receive helps us improve and continue offering our programs.

A link to the slides and recording will also be provided in this email.

Course Evaluation & Certificates

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Within the evaluation, you will be asked to attest to your hours of participation. Upon completion of the evaluation and attestation, your transcript will be updated with the appropriate CME/CE credit hours.

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- Following the web training, participating psychologists, registered nurses, LMFTs, LCSWs, and SUD counselors will receive an email from Shannon Bertea with the links to two different brief online CE course evaluations (one for PSY/RN and a second for LMFTs/LCSWs/counselors)
- Once you submit the your CE evaluation form, a CE Certificate will be emailed to you within 6-8 weeks
- Reach out to Shannon with questions (sbertea@mednet.ucla.edu)

Certificate of Attendance

If you requested a “certificate of attendance” rather than specific CME/CE, you will receive that certificate from the Northwest ATTC automatically via email within a week.

Attitudes and Stigma around Addiction

John F. Kelly, PhD, ABPP

Stanford and Northwest ATTC, NIDA Clinical Trials Network

October 27 2021

John F. Kelly, PhD ABPP

Elizabeth R. Spallin Professor of Psychiatry in Addiction Medicine
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No disclosures.

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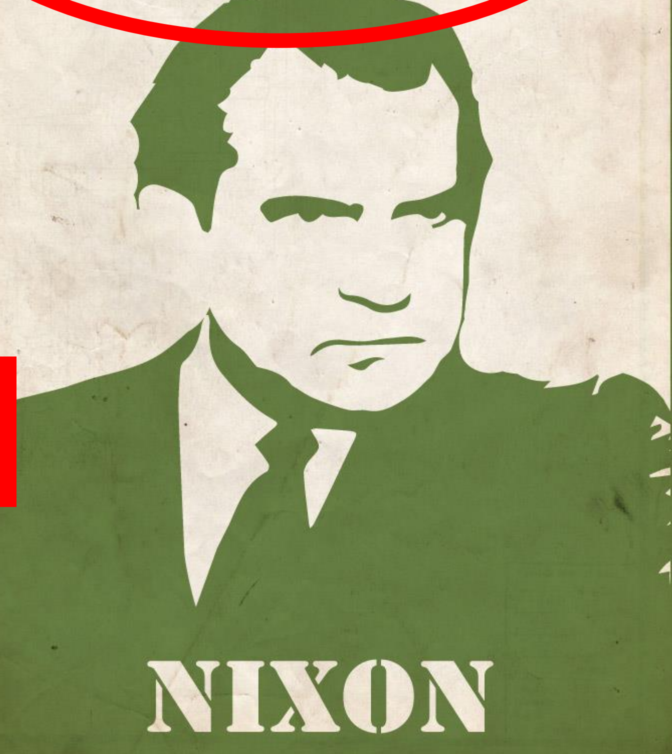
50 years....
1971-2021

1970

During the past 50 yrs since "War on Drugs" declared, we have moved from "Public Enemy No. 1" to "Public Health Problem No. 1"



The Last 50 Years in Addiction Laws

1965 → 2017

1973 — Reorganizational Plan No. 2
Creation of the Drug Enforcement Agency (DEA), consolidating a number of different entities to form a single federal agency to enforce government drug control policy.

1996 — Charitable Choice
Charitable choice allows direct U.S. government funding of religious organizations to provide substance use prevention & treatment.

2006 — Sober Truth on Preventing Underage Drinking Act (STOP Act)
Passed in 2006, the STOP act created a grant program to target underage drinking within communities & established the federal Interagency Coordinating Committee on the Prevention of Underage Drinking (ICCPUD) with high-level leadership from across 15 federal agencies to coordinate government efforts to address underage drinking.

2010 — Fair Sentencing Act
Passed in 2010, the act reduces the sentencing disparity between crack & powder cocaine from 100:1 to an 18:1 ratio.

2016 — Comprehensive Addiction & Recovery Act (CARA)
Passed in 2016, CARA increased access to overdose treatment, naloxone (overdose reversal medication), & medication assisted treatments (MAT), reauthorized an opioid treatment program for pregnant & postpartum women, & allocated money for creation of opioid epidemic response plans on the state level.

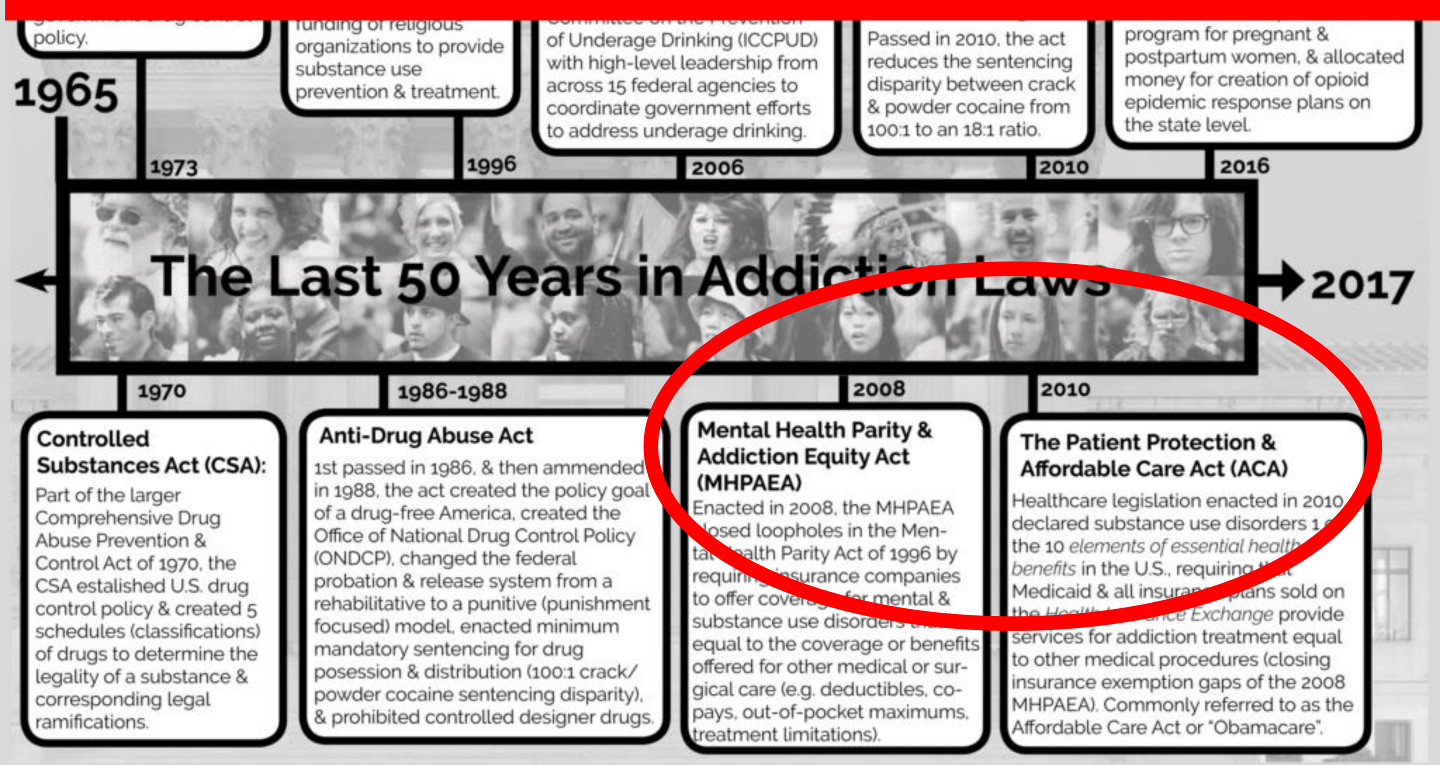
1970 — Controlled Substances Act (CSA):
Part of the larger Comprehensive Drug Abuse Prevention & Control Act of 1970, the CSA estalished U.S. drug c[illegible]trol policy & created 5 sche[illegible]les (classifications) of drugs to [illegible]termine the legality of a subst[illegible] & corresponding legal ramifications.

1986-1988 — Anti-Drug Abuse Act
1st passed in 1986, & then ammended in 1988, the act created the policy goal of a drug-free America, created the Office of National Drug Control Policy (ONDCP), changed the federal probation & release system from a rehabilitative to a punitive (punishment focused) model, enacted minimum mandatory sentencing for dr[illegible] posession & distributi[illegible] 100:1 crack/ powder cocaine sentencing disparity), & prohibited controlled designer drugs.

2008 — Mental Health Parity & [illegible]ddiction Equity Act ([illegible]HPAEA)
En[illegible]cted in 2008, the MHPAEA cl[illegible]sed loopholes in the Men- t[illegible] Health Parity Act of 1996 by [illegible]equiring insurance companies to offer coverage for mental & substance use disorders that is equal to the coverage or benefits offered for other medical or surgical care (e.g. deductibles, co-pays, out-of-pocket maximums, treatment limitations).

2010 — The Patient Protection & Affordable Care Act (ACA)
Healthcare legislation enacted in 2010, declared substance use disorders 1 of the 10 *elements of essential health benefits* in the U.S., requiring that Medicaid & all insurance plans sold on the *Health Insurance Exchange* provide services for addiction treatment equal to other medical procedures (closing insurance exemption gaps of the 2008 MHPAEA). Commonly referred to as the Affordable Care Act or "Obamacare".

Laws passed in the past 50 yrs have moved from more punitive ones to public health oriented ones…. increasing availability, accessibility and affordability of treatment..



the WHITE HOUSE PRESIDENT BARACK OBAMA

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HOME · BLOG

ONDCP Hosts First-Ever Drug Policy Reform Conference

DECEMBER 11, 2013 AT 10:57 AM ET BY CAMERON HARDESTY

On Monday, Director Kerlikowske and Deputy Directo
discussion at the White House on the future of drug p
approximately 140 people attended to engage in a co
hundreds more watched online. Limited video on dem

2013 ONDCP Director Kerlikowske declares move away from "war on drugs" toward broader public health approach

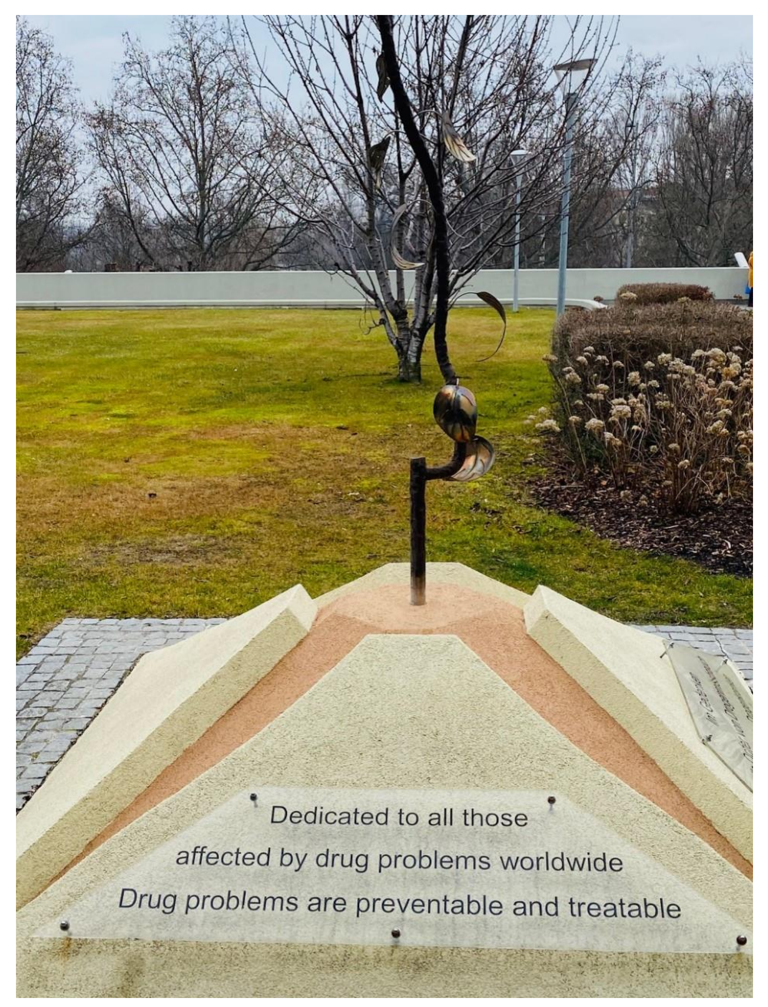
Public Health Approaches to Addressing Drug-Related Crime: Drug Courts

Public Health Approaches to Law Enforcement

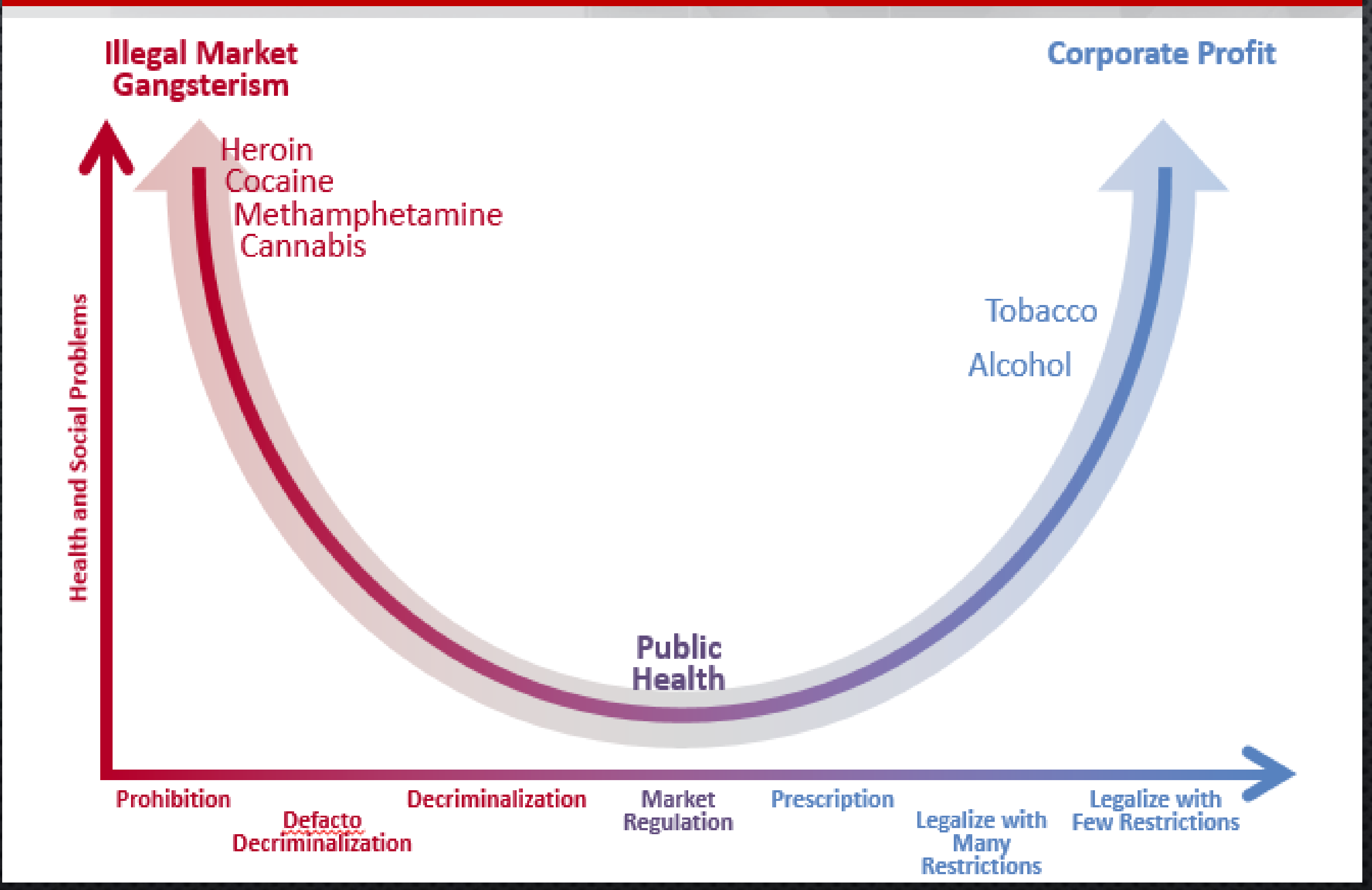
- Chief Campanello
  - Angel Program

“Help not Handcuffs”

United
Nations

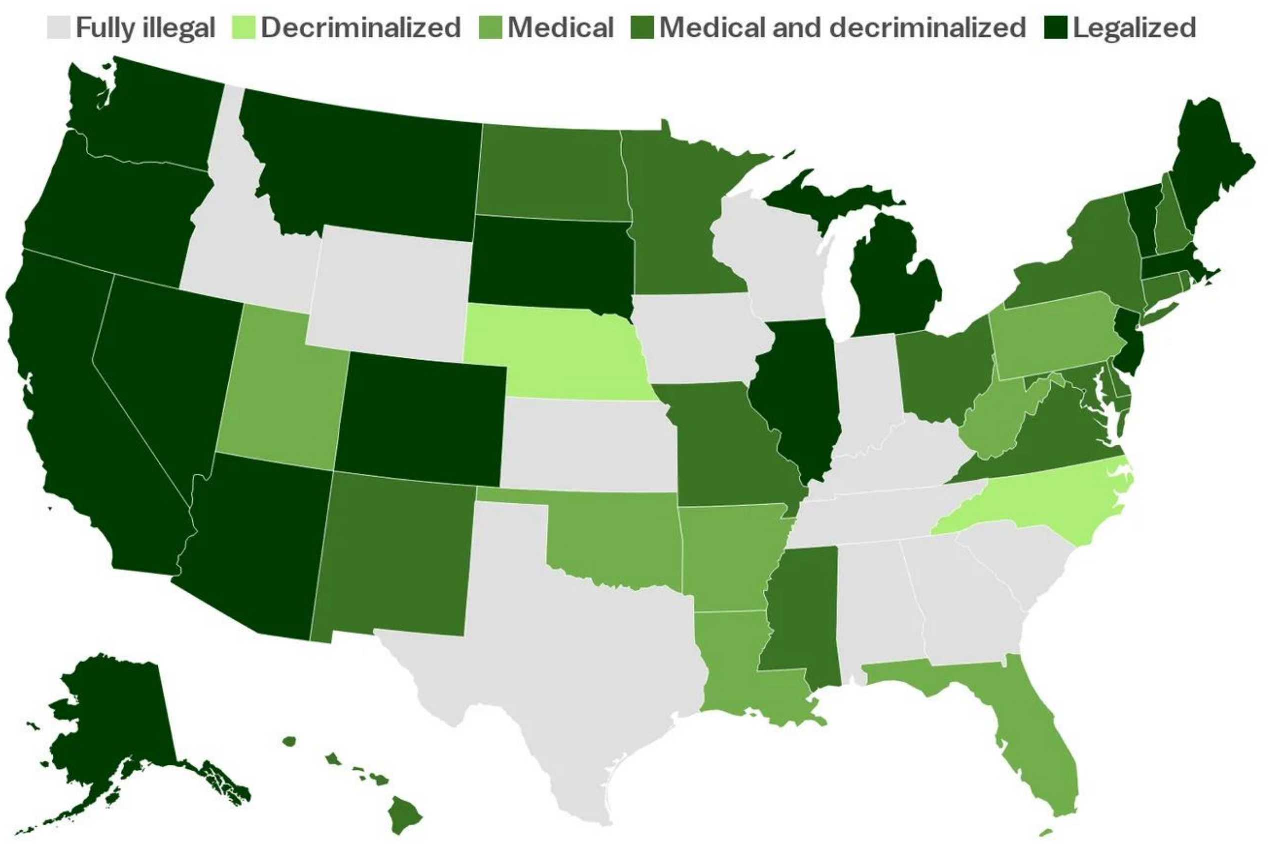

Dedicated to all those
affected by drug problems worldwide
Drug problems are preventable and treatable

National (Portugal) and State Drug Policy Positions are shifting across the US including decriminalization of possession of small amounts of all drugs (Oregon) and legalization and commercialization of others (cannabis)…



Source: Canada Drug Policy Coalition

Marijuana laws in the US



*Washington, DC, legalized marijuana for recreational purposes, but doesn't allow sales.

Source: Marijuana Policy Project

PAST 50 YRS GONE FROM…

"War on drugs"

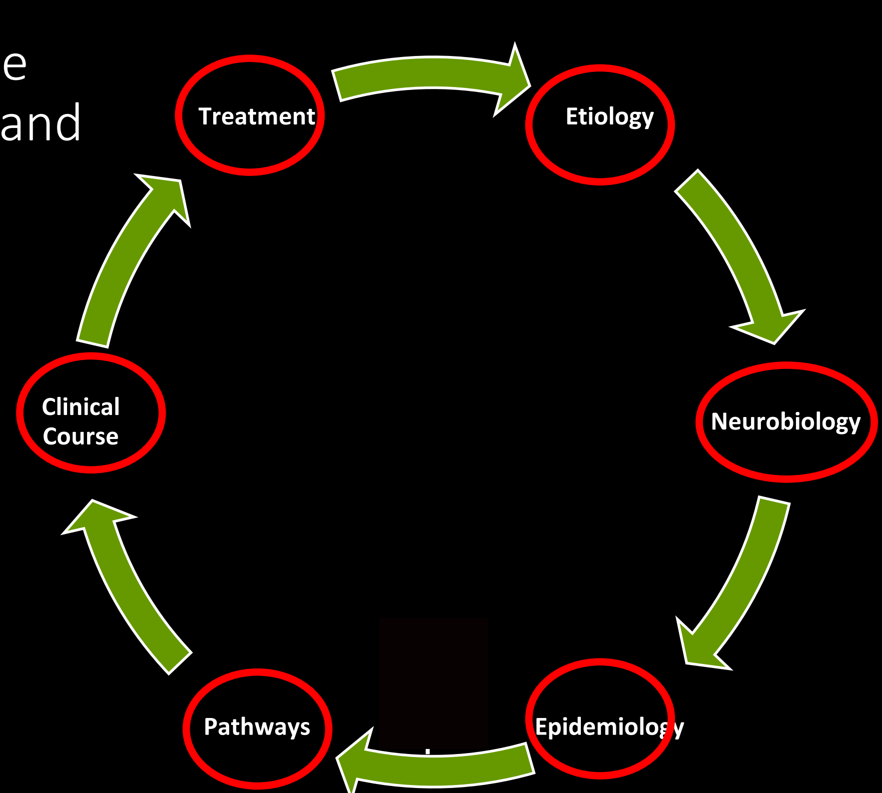
"War on the war" on drugs

BUT… not just about interdiction, supply reduction, incarceration….

Also, a great deal carried out on the demand reduction side…

The “war on drugs” rhetoric reflected a national concerted effort to reduce “supply” but also “demand” that created treatment and public health oriented federal agencies..

Past 50 yrs since declaration of "War on drugs" led to large-scale federal appropriations and a number of paradigm shifts…



INCREASED KNOWLEDGE ABOUT NATURE OF ADDICTION – ITS GENETIC INFLUENCES AND NEUROBIOLOGICAL IMPACTS - BUT STIGMA PERSISTS…

WHAT CAN BE DONE?

What can we do about stigma and discrimination in addiction?

Education about essential nature of these conditions

Personal witness (putting a face and voice on recovery)

Change our language/terminology to be consistent with the nature of the condition and the policies we wish to implement to address it

WHAT IS STIGMA?

An attribute, behavior, or condition, that is socially discrediting

WHAT IS DISCRIMINATION?

The unfair treatment of individuals with the stigmatized condition/problem

Please see if you can correctly identify all of the pictures which feature addiction treatment facilities, and which treat other health conditions

I'm not a robot

People suffering from SUD
or are in recovery are not robots…

They have a heart

They have feelings

They deserve to be treated in respectful, dignified, environments just like other health conditions

I'm a human being who deserves respect

reCOVERY

Stigma and Discrimination

- People with SUD often get treated in second-rate dilapidated buildings, which gives them the impression they have a second-class illness.

- Not only do they worry they will get poorer-quality care because of the stigma of their disease, they also get the message that they are not worthy of high-quality care and environments where people with *real* diseases get treated.

- Is “good enough for addicts” good enough?

Traditional addiction treatment approach: Burning building analogy

- **Putting out the fire** -good job
- **Preventing it from re-igniting** (RP) - less emphasis
- **Re-building materials (recovery capital) –**largely neglected
- **Granting "rebuilding permits"** (removing barriers) –largely neglected

Addiction may be most stigmatized condition in the US and around the world: Cross-cultural views on stigma

Across 14 countries and 18 of the most stigmatized conditions…

Illicit drug addiction ranked 1st

Alcohol addiction ranked 4th

Stigma, social inequality and alcohol and drug use

ROBIN ROOM

Centre for Social Research on Alcohol and Drugs, Stockholm University, Stockholm, Sweden

- **Sample:** Informants from 14 countries
- **Design:** Cross-sectional survey
- **Outcome:** Reaction to people with different health conditions

Room, R., Rehm, J., Trotter, R. T. II, Paglia, A., & Üstün, T. B. (2001). Cross-cultural views on stigma valuation parity and societal attitudes towards disability. In T. B. Üstün, S. Chatterji, J. E. Bickenbach, R. T. Trotter II, R. Room, & J. Rehm (Eds.), *Disability and culture: Universalism and diversity* (pp. 247–291). Seattle, WA: Hofgrebe & Huber.

Studies have shown that…

SUD is more stigmatized compared to other psychiatric disorders

Compared to other psychiatric disorders, **people with SUD are perceived as more to blame** for their disorder

Describing SUD as treatable helps

Patients themselves who hold **more stigmatizing beliefs** about SUD **less likely to seek treatment; discontinue sooner**

Physicians/clinicians shown to hold stigmatizing **biases against those with SUD**; view SUD patients as unmotivated, manipulative, dishonest; **SUD-specific education/training helps**

Kelly, J. F., & Westerhoff, C. M. (2010). Does it matter how we refer to individuals with substance-related conditions? A randomized study of two commonly used terms. *International Journal of Drug Policy, 21*(3), 202–207. doi:10.1016/j.drugpo.2009.10.010

Stigma Consequences: Public and Personal

- Public:
  - Public stigma can lead to:
    - Differential public and political support for treatment policies
    - Differential public and political support for criminal justice preferences
    - Barriers to employment/education/training
    - Reduced housing and social support
    - Increased social distance (social isolation)
- Personal:
  - Internalization of public stigma can lead to:
    - Shame/guilt
    - Lowered self-esteem
    - Rationalization/minimization; lack of problem acknowledgment
    - Delays in help-seeking
    - Less treatment engagement/retention; lowered chance of remission/recovery

Commonly Studied Dimensions of Stigma

Blame – are they responsible for causing their problem/disorder?

Prognostic pessimism/optimism – will they ever recover "be normal", "trustworthy"?

Dangerousness – are they unpredictably volatile, a threat to my/others' safety?

Social distance – would I have them marry into my family, share an apartment with them, have them as a babysitter?

SO, WHY IS ADDICTION SO STIGMATIZED COMPARED TO OTHER SOCIAL PROBLEMS AND HEALTH CONDITIONS, AND OTHER MENTAL ILLNESSES?

What Factors Influence Stigma?

Cause	Controllability	Stigma
"It's not their fault"	"They can't help it"	Decreases
"It is their fault"	"They really can help it"	Increases

In terms of cause…Biogenetics

If Drugs Are so Pleasurable, Why Aren't We All Addicted?

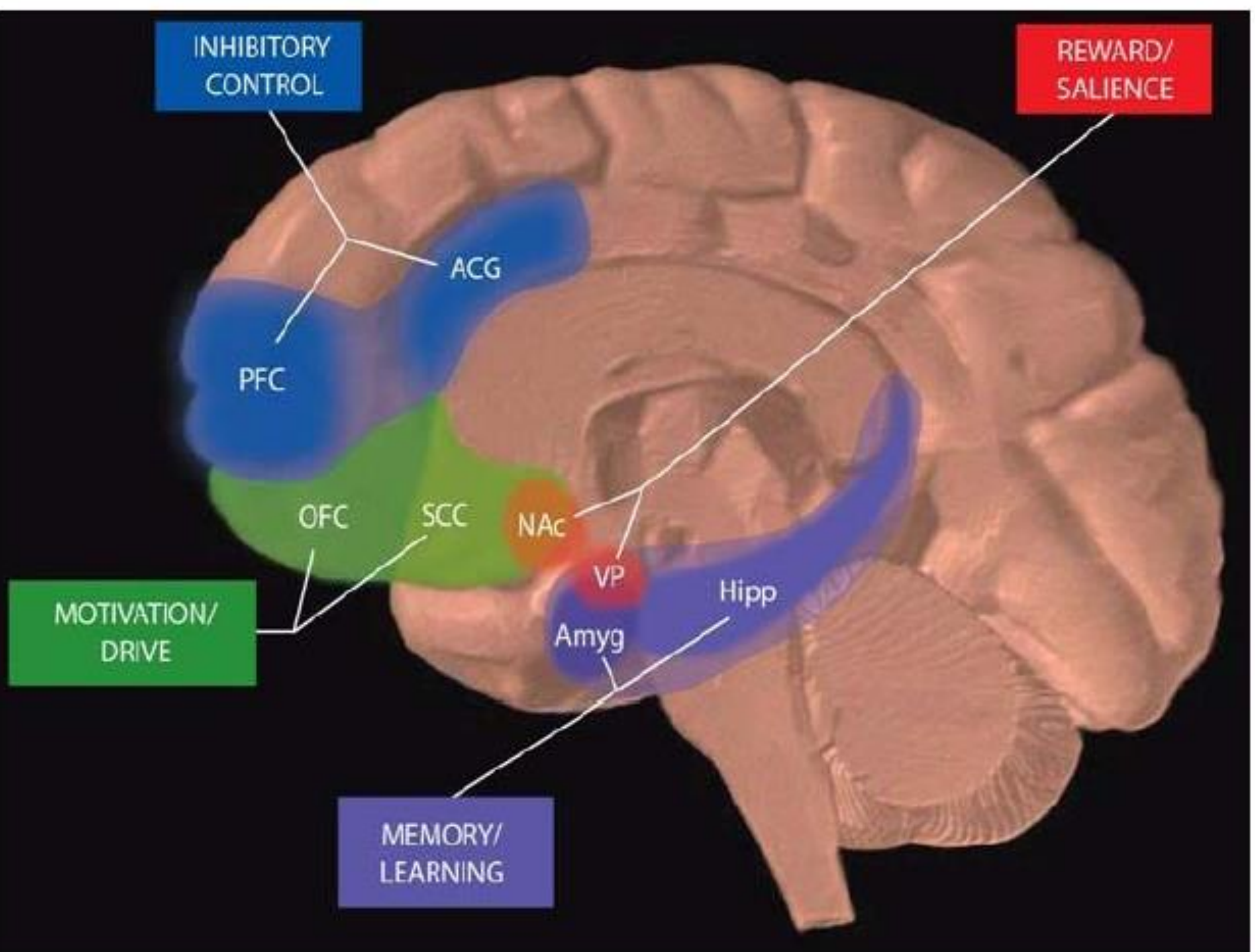
Genetically mediated response, metabolism, reward sensitivity…

- Genetics substantially influence addiction risk
- Genetic differences affect subjective preference and degree of reward from different substances/activities

National Institute on Drug Abuse (2019). *Teaching Addiction Science: The Neurobiology of Drug Addiction*. Retrieved from https://www.drugabuse.gov/publications/teaching-addiction-science/neurobiology-drug-addiction

In terms of controllability…Neurobiology

Neural Circuits Involved in Substance Use Disorders



National Institute on Drug Abuse (2019). *Teaching Addiction Science: The Neurobiology of Drug Addiction*. Retrieved from https://www.drugabuse.gov/publications/teaching-addiction-science/neurobiology-drug-addiction

Normal
43-year-old

Alcoholic
43-year-old

HUMAN BRAIN IMAGES

Moderate Drinker

Alcoholic

Frontal
Cortex

Axial magnetic resonance images from a healthy 57-year-old man (left) and a 57-year-old man with a history of alcoholism (right). D. Pfefferbaum

Pfefferbaum, A. (2000). The Neurotoxicity of Alcohol. In U.S. Department of Health and Human Services (Ed). *10th Special Report to the U.S. Congress on Alcohol and Health* (134-142).

What can we do about stigma and discrimination in addiction?

Education about essential nature of these conditions

Personal witness (putting a face and voice on recovery)

Change our language/terminology to be consistent with the nature of the condition and the policies we wish to implement to address it

IF WE WERE TO EMPHASIZE THE BIOLOGICAL CAUSES (E.G., GENETICS) AND BIO-IMPACTS (E.G., NEUROBIOLOGY) WOULD IT REDUCE STIGMA?

Biogenetic explanations as ways to reduce stigma…

- Meta-analysis of 28 experimental studies found biogenetic explanations:
  - Reduced blame, but increased…
  - Social distance
  - Dangerousness
  - Prognostic Pessimism

Clinical Psychology Review 33 (2013) 782–794

Contents lists available at SciVerse ScienceDirect

Clinical Psychology Review

The 'side effects' of medicalization: A meta-analytic review of how biogenetic explanations affect stigma

Erlend P. Kvaale [a,*], Nick Haslam [a], William H. Gottdiener [b]

[a] Melbourne School of Psychological Sciences, University of Melbourne, Parkville, Australia
[b] Department of Psychology, John Jay College of Criminal Justice, City University of New York, NY, USA

HIGHLIGHTS

- Biomedical perspectives shape contemporary thinking about psychological problems.
- We quantitatively reviewed how biogenetic explanations affect stigma.
- Biogenetic explanations reduce blame, but induce pessimism about recovery.
- Biogenetic explanations do not affect desire for distance.
- Medicalization is no cure for stigma and may create barriers to recovery.

ARTICLE INFO

Article history:
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Accepted 12 June 2013
Available online 18 June 2013

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Medicalization
Biomedical model
Biogenetic explanations
Stigma
Prejudice

ABSTRACT

Reducing stigma is crucial for facilitating recovery from psychological problems. Viewing these problems biomedically may reduce the tendency to blame affected persons, but critics have cautioned that it could also increase other facets of stigma. We report on the first meta-analytic review of the effects of biogenetic explanations on stigma. A comprehensive search yielded 28 eligible experimental studies. Four separate meta-analyses ($Ns = 1207–3469$) assessed the effects of biogenetic explanations on blame, perceived dangerousness, social distance, and prognostic pessimism. We found that biogenetic explanations reduce blame (Hedges $g = -0.324$) but induce pessimism (Hedges $g = 0.263$). We also found that biogenetic explanations increase endorsement of the stereotype that people with psychological problems are dangerous (Hedges $g = 0.198$), although this result could reflect publication bias. Finally, we found that biogenetic explanations do not typically affect social distance. Promoting biogenetic explanations to alleviate blame may induce pessimism and set the stage for self-fulfilling prophecies that could hamper recovery from psychological problems.

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Kvaale, E. P., Haslam, N., & Gottdiener, W. H. (2013). The 'side effects' of medicalization: a meta-analytic review of how biogenetic explanations affect stigma. *Clinical Psychology Review, 33*(6), 782-794. doi: 10.1016/j.cpr.2013.06.002

Neurobiological explanations as ways to reduce stigma…

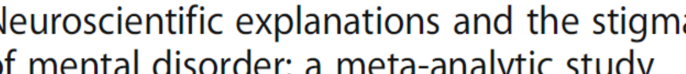
Neurobiological explanation studies found they increased:

- Social distance
- Dangerousness
- Prognostic pessimism
- had no effect on reducing blame

Loughman and Haslam *Cognitive Research: Principles and Implications* (2018) 3:43
https://doi.org/10.1186/s41235-018-0136-1

Cognitive Research: Principles and Implications

ORIGINAL ARTICLE Open Access



Neuroscientific explanations and the stigma of mental disorder: a meta-analytic study

Amy Loughman[1,2] and Nick Haslam[2*]

Abstract

Genetic and other biological explanations appear to have mixed blessings for the stigma of mental disorder. Meta-analytic evidence shows that these "biogenetic" explanations reduce the blame attached to sufferers, but they also increase aversion, perceptions of dangerousness, and pessimism about recovery. These relationships may arise because biogenetic explanations recruit essentialist intuitions, which have known associations with prejudice and the endorsement of stereotypes. However, the adverse implications of biogenetic explanations as a set may not hold true for the subset of those explanations that invoke neurobiological causes. Neurobiological explanations might have less adverse implications for stigma than genetic explanations, for example, because they are arguably less essentialist. Although this possibility is important for evaluating the social implications of neuroscientific explanations of mental health problems, it has yet to be tested meta-analytically. We present meta-analyses of links between neurobiological explanations and multiple dimensions of stigma in 26 correlational and experimental studies. In correlational studies, neurobiological explanations were marginally associated with greater desire for social distance from people with mental health problems. In experimental studies, these explanations were associated with greater desire for social distance, greater perceived dangerousness, and greater prognostic pessimism. Neurobiological explanations were not linked to reduced blame in either set of studies. By implication, neurobiological explanations have the same adverse links to stigma as other forms of biogenetic explanation. These findings raise troubling implications about the public impact of psychiatric neuroscience research findings. Although such findings are not intrinsically stigmatizing, they may become so when viewed through the lens of neuroessentialism.

Keywords: Essentialism, Stigma, Mental disorder, Psychiatric disorder, Brain disease, Blame

Significance

Neuroscientific explanations of mental health problems are increasingly prominent in the psychiatric and psychological literature, and they are becoming more widely endorsed by the general public. At the same time, mental health problems continue to be heavily stigmatized and there are few signs that this stigma is abating. It has been argued that biological explanations might play a role in reducing psychiatric stigma, but the evidence to date indicates that they are a double-edged sword, reducing some forms of stigma but exacerbating others. However, no previous studies have examined how the narrower set of neurobiological explanations are linked to stigma, and whether they might have less adverse links to stigma than other forms of biological explanation (e.g., genetic explanations). The present study reports meta-analyses of correlational and experimental studies on this question, and indicates that neurobiological explanations tend to be associated with greater stigma, especially in experimental studies. These findings suggest that laypeople apprehend neuroscientific research findings with an essentialist bias that leads them to ascribe mental health problems to fixed and unchanging pathological essences. The study has implications for how neuroscientific research findings on mental health should be communicated so as to minimize adverse effects on stigma.

Background

How people respond to neuroscientific explanations is emerging as a dynamic field of research in cognitive psychology. Researchers have explored why these explanations have a particular allure relative to mentalistic explanations (Weisberg, Keil, Goodstein, Rawson, &

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Full list of author information is available at the end of the article

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Loughman, A. & Haslam, N. (2018). Neuroscientific explanations and the stigma of mental disorder: a meta-analytic study. *Cognitive Research: Principles and Implications, 43*. doi: 10.1186/s41235-018-0136-1

CAN THE USE OF CERTAIN TYPES OF MEDICAL TERMINOLOGY USED TO DESCRIBE **DRUG-RELATED IMPAIRMENT ITSELF** HELP REDUCE STIGMA AND DISCRIMINATION?

ADDICTION

RESEARCH REPORT

doi:10.1111/add.15333

A US national randomized study to guide how best to reduce stigma when describing drug-related impairment in practice and policy

John F. Kelly[1,2], **M. Claire Greene**[3] & **Alexandra Abry**[1]

Department of Psychiatry, MA General Hospital, Recovery Research Institute, Boston, MA, USA,[1] Department of Psychiatry, Harvard Medical School, Boston, MA, USA[2] and Department of Psychiatry, Columbia University, New York, NY, USA[3]

ABSTRACT

Background and Aims Drug-related impairment is persistently stigmatized delaying and preventing treatment engagement. To reduce stigma, various medical terms (e.g. 'chronically relapsing brain disease', 'disorder') have been promoted in diagnostic systems and among national health agencies, yet some argue that over-medicalization of drug-related impairment lowers prognostic optimism and reduces personal agency. While intensely debated, rigorous empirical study is lacking. This study investigated whether random exposure to one of six common ways of describing drug-related impairment induces systematically different judgments. **Design, Setting and Participants** Cross-sectional survey, US general population, among a nationally representative non-institutionalized sample (n = 3635; 61% response rate; December 2019–January 2020). **Intervention** Twelve vignettes (six terms × gender) describing someone treated for opioid-related impairment depicted in one of six ways as a(n): 'chronically relapsing brain disease', 'brain disease', 'disease', 'illness', 'disorder' or 'problem'. **Measurements** Multi-dimensional stigma scale assessing: blame; social exclusion; prognostic optimism, continuing care, and danger (a = 0.70–0.83). **Findings** US adults [mean age = 47.81, confidence interval (CI) = 47.18–48.44; 52.4% female; 63.14% white] rated the same opioid-impaired person differently across four of five stigma dimensions depending on which of six terms they were exposed to. 'Chronically relapsing brain disease' induced the lowest stigmatizing blame attributions ($P < 0.05$); at the same time, this term decreased prognostic optimism [mean difference (MD) = 0.18, 95% CI = 0.05, 0.30] and increased perceived need for continuing care (MD = –0.26, 95% CI = –0.43, –0.09) and danger (MD = –0.13, 95% CI = –0.25, –0.02) when compared with 'problem'. Compared with a man, a woman was blamed more for opioid-related impairment (MD = –0.08, 95% CI = –0.15, –0.01); men were viewed as more dangerous (MD = 0.13, 95% CI = 0.06, 0.19) and to be socially excluded (MD = 0.16, 95% CI = 0.09, 0.23). **Conclusions** There does not appear to be one single medical term for opioid-related impairment that can meet all desirable clinical and public health goals. To reduce stigmatizing blame, biomedical 'chronically relapsing brain disease' terminology may be optimal; to increase prognostic optimism and decrease perceived danger/social exclusion use of non-medical terminology (e.g. 'opioid problem') may be optimal.

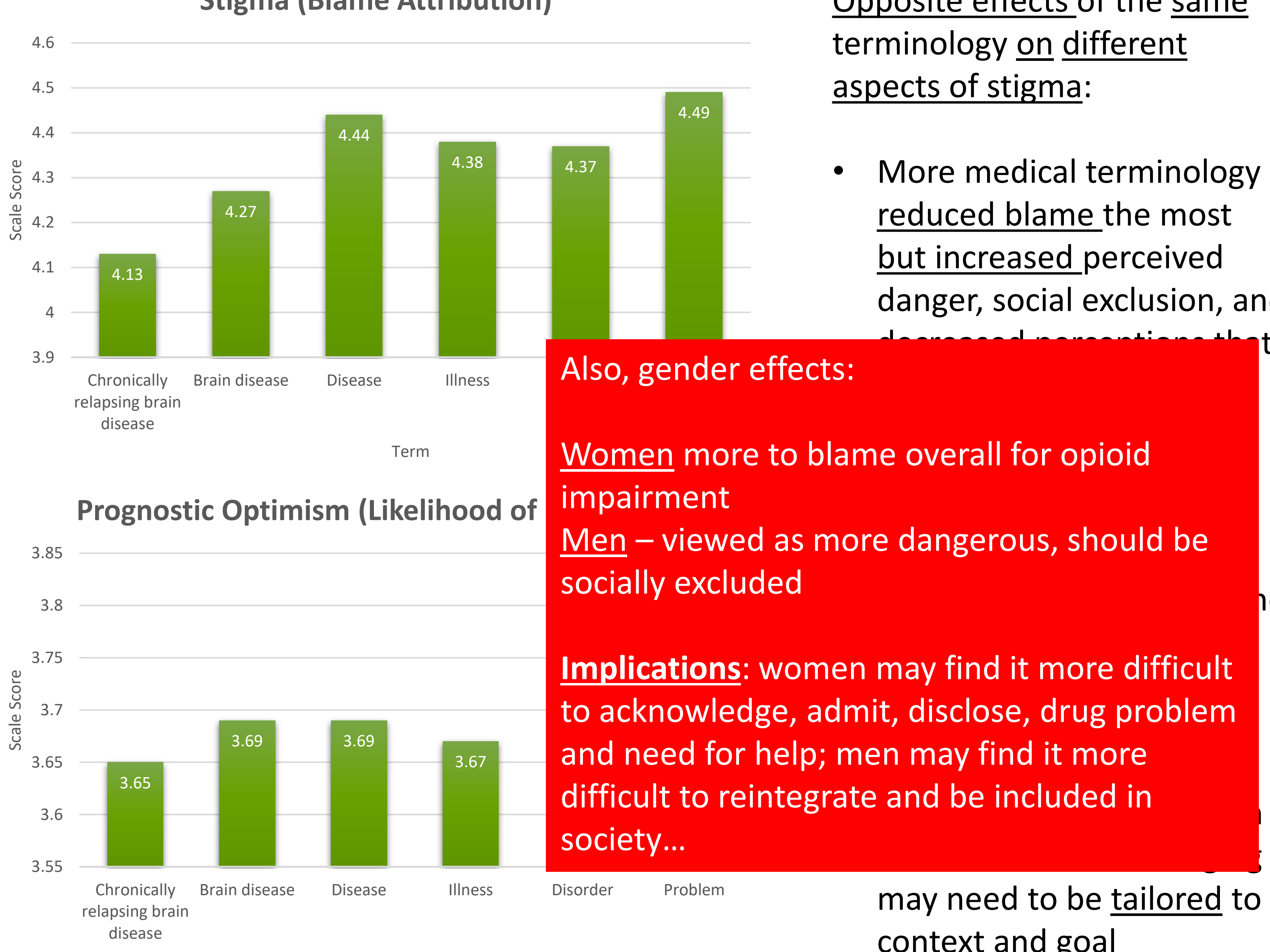
Terminology:

What's the best way to describe drug-related impairment to reduce stigma/discrimination?

- Chronically relapsing brain disease
- Brain disease
- Disease
- Illness
- Disorder
- Problem

?

Kelly, J. F., Greene, M. C., & Abry, A. (2020). A U.S. national randomized study to guide how best to reduce stigma when describing drug-related impairment in practice and policy. *Addiction,* [Epub ahead of print]. doi: doi.org/10.1111/add.15333



Kelly, J. F., Greene, M. C., & Abry, A. (2020). A U.S. national randomized study to guide how best to reduce stigma when describing drug-related impairment in practice and policy. *Addiction,* [Epub ahead of print]. doi: doi.org/10.1111/add.15333

CAN THE USE OF CERTAIN TYPES OF MEDICAL TERMINOLOGY USED TO DESCRIBE THE **PERSON** SUFFERING FROM DRUG-RELATED IMPAIRMENT HELP REDUCE STIGMA AND DISCRIMINATION?

What is language?

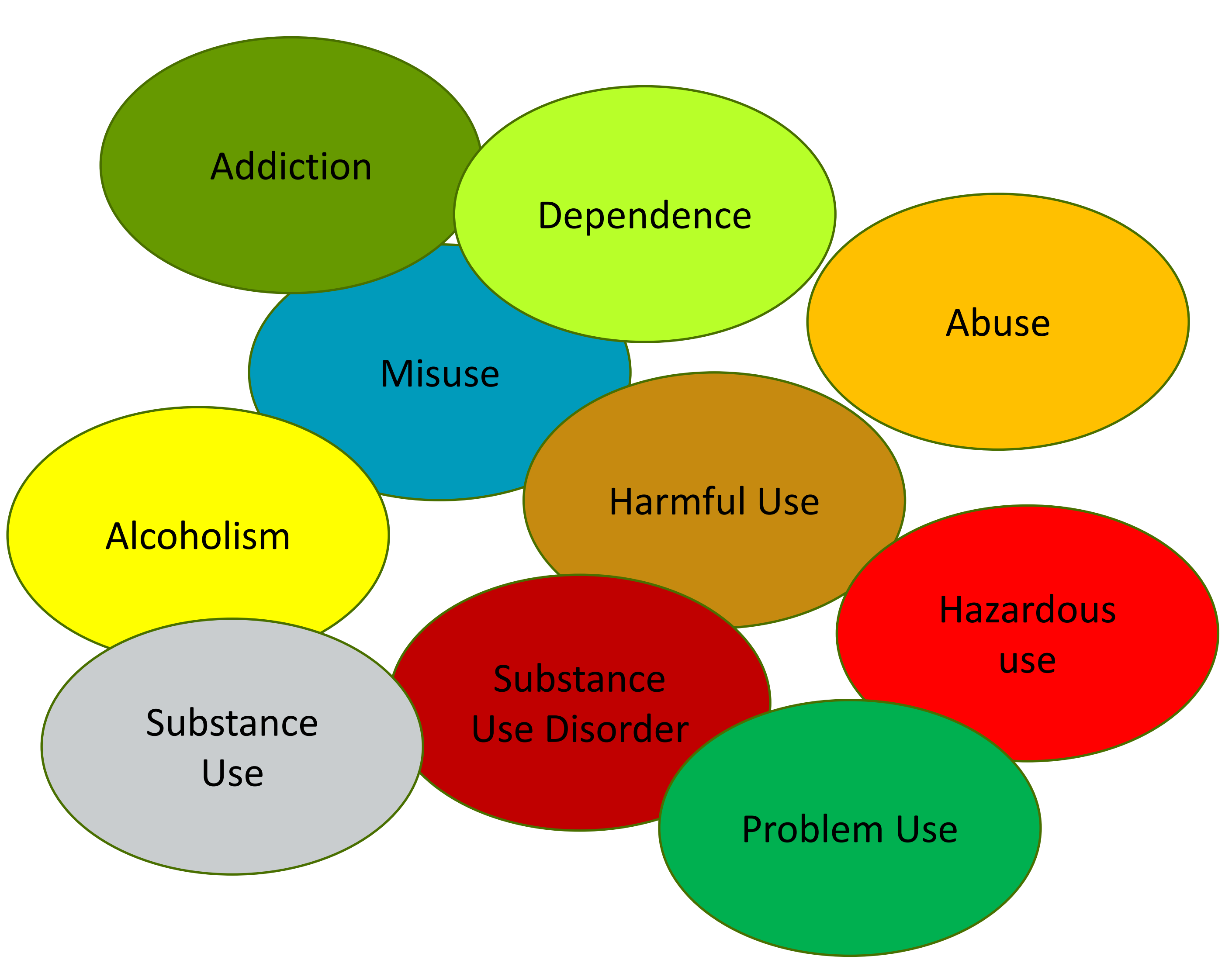
- A standardized collection of sounds and symbols that trigger networks of cognitive scripts, activating chains of thought that influence appraisal, attitudes, and action
- Evolves over time

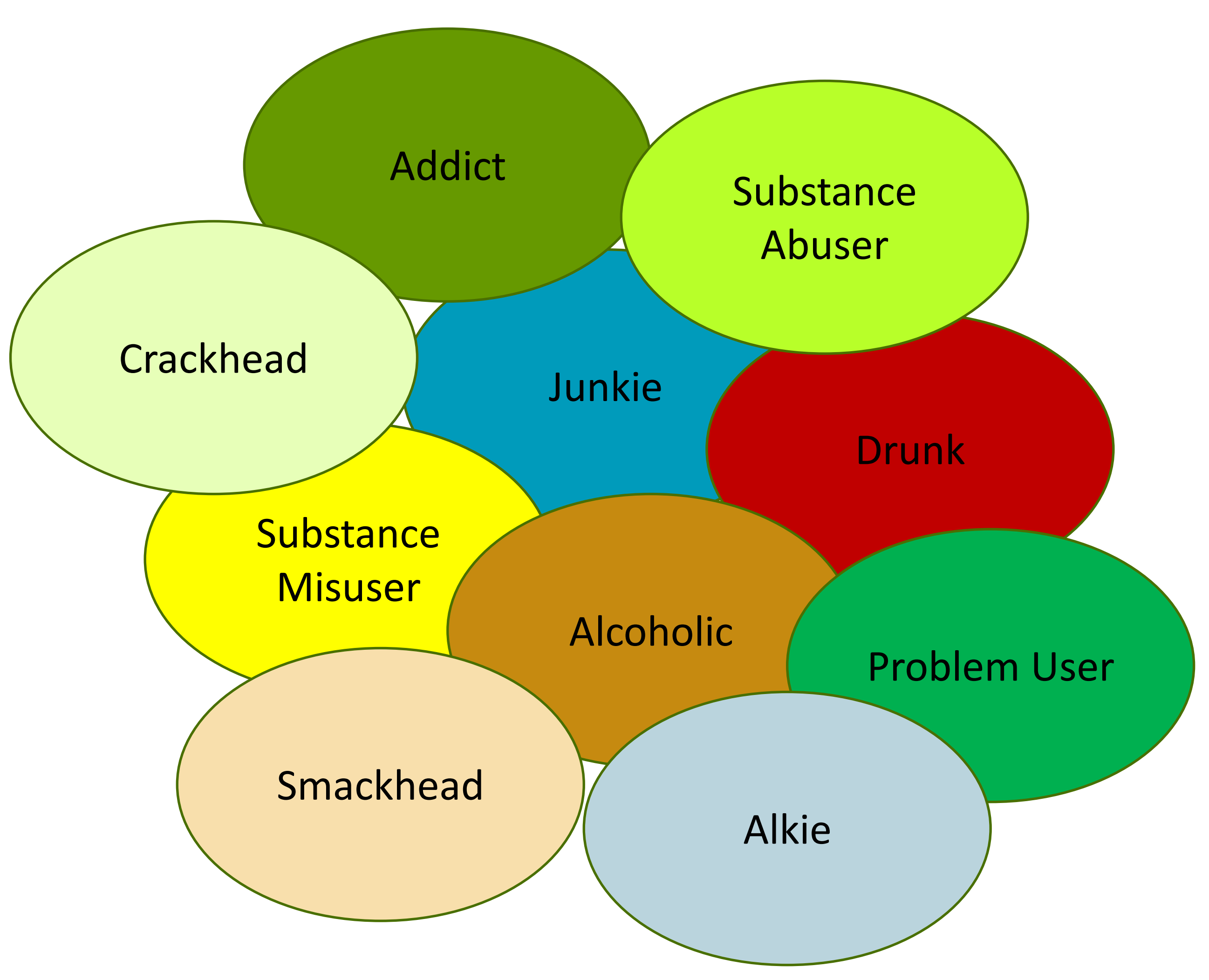
Factors at play in choosing alcohol and drug –related clinical language …

Clinical precision and accuracy - is the terminology precise enough to convey clinically meaningful and relevant information

Interpretation and utility -is the terminology understood by most people in the way it is intended; does it capture sufficient information to make it useful

Stigma and discrimination - is the terminology known to induce implicit/explicit biases (stigma) that might undermine clinical/public health efforts


Addiction
Dependence
Abuse
Misuse
Alcoholism
Harmful Use
Hazardous use
Substance Use Disorder
Substance Use
Problem Use


Addict
Substance Abuser
Crackhead
Junkie
Drunk
Substance Misuser
Alcoholic
Problem User
Smackhead
Alkie

Question…

People with eating-related conditions are always referred to as "**having an eating disorder**", **never as "food abusers".**

So why are people with substance-related conditions referred to as **"substance abusers"** and not as **"having a substance use disorder"?**

Two Commonly Used Terms…

- Referring to someone as…
  - “a **substance abuser**” – implies willful misconduct (it is their fault and they can help it)
  - “**having a substance use disorder**” – implies a medical malfunction (it’s not their fault and they cannot help it)
  - But, does it really matter how we refer to people with these (highly stigmatized) conditions?
  - Can’t we just dismiss this as a well-meaning point, but merely “semantics” and “political correctness”?

Does it matter?

Much ado about nothing?

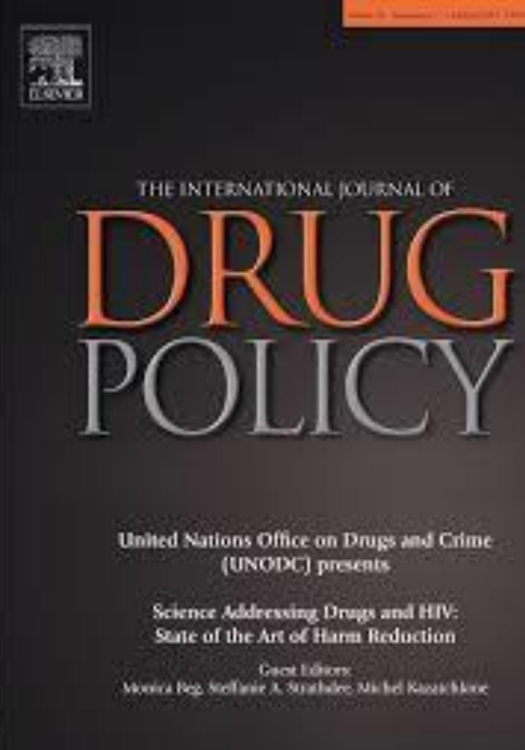
"Political correctness"?

Mere "semantics"?

Does it matter how we refer to individuals with substance-related conditions? A randomized study of two commonly used terms

John F. Kelly, Cassandra M. Westerhoff

International Journal of Drug Policy



How we talk and write about these conditions and individuals suffering them does matter

Kelly, J. F., & Westerhoff, C. M. (2010). Does it matter how we refer to individuals with substance-related conditions? A randomized study of two commonly used terms. *International Journal of Drug Policy, 21*(3), 202–207. doi:10.1016/j.drugpo.2009.10.010

“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…

“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…

Compared to those in “substance use disorder” condition, those in “substance abuser” condition agreed more with idea that individual was personally culpable, needed punishment

Kelly, J. F., & Westerhoff, C. M. (2010). Does it matter how we refer to individuals with substance-related conditions? A randomized study of two commonly used terms. *International Journal of Drug Policy, 21*(3), 202–207. doi:10.1016/j.drugpo.2009.10.010

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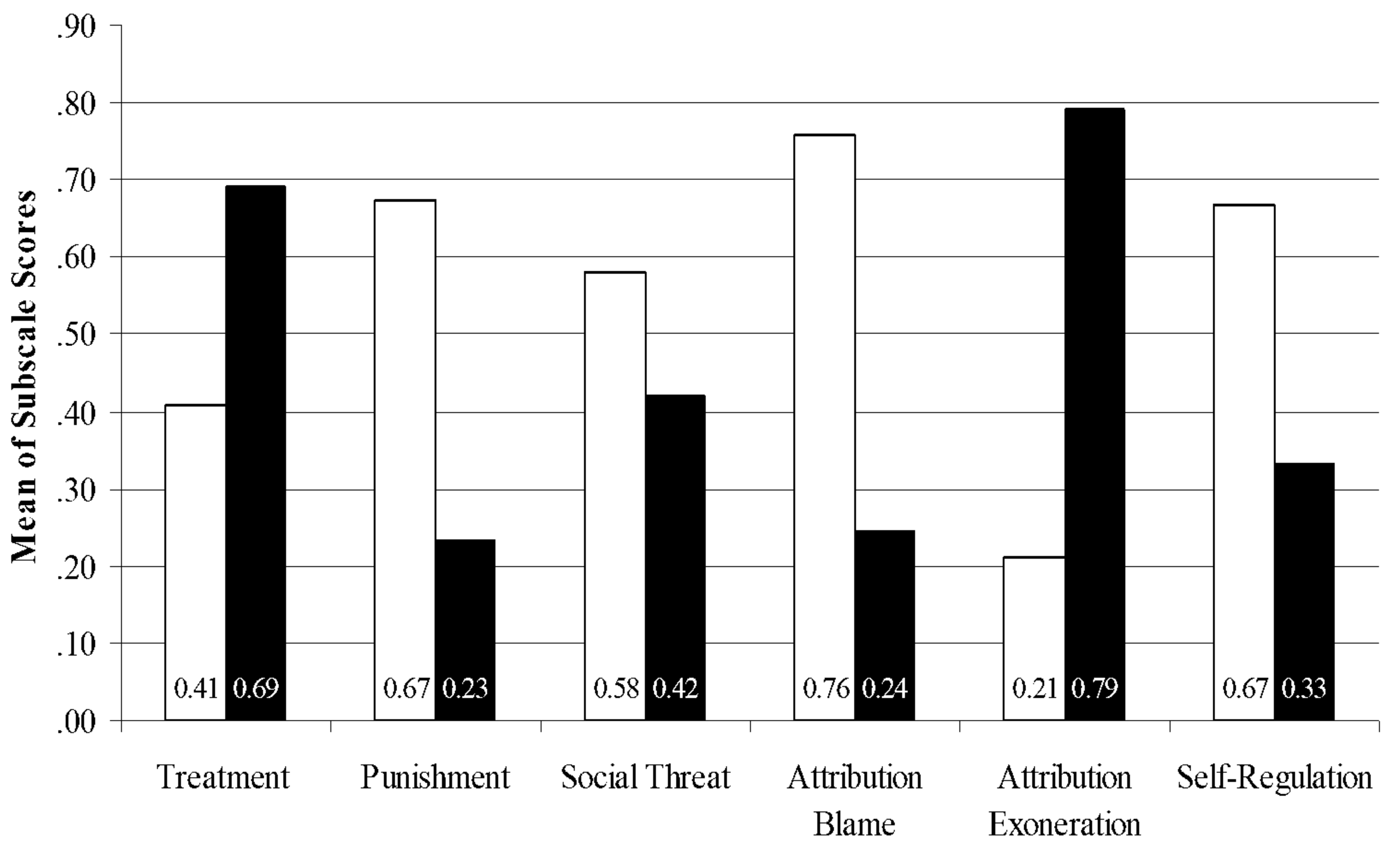
Does Our Choice of Substance-Related Terms Influence Perceptions of Treatment Need? An Empircal Investigation with Two Commonly Used Terms

John F. Kelly, Sarah J. Dow, Cara Westerhoff

Substance-related terminology is often a contentious topic because terms may convey meanings that have stigmatizing consequences and present a barrier to treatment. Chief among these are the labels, "abuse" and "abuser."

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*(4), 805-818. doi: 10.1177/002204261004000403



□ Substance Abuser ■ Substance Use Disorder

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*(4), 805-818. doi: 10.1177/002204261004000403

Implications

- Even well-trained clinicians judged same individual differently and more punitively depending on which term exposed to
- Use of “abuser” term may activate implicit cognitive bias perpetuating stigmatizing attitudes–could have broad effects (e.g., treatment/funding)
- Let’s learn from allied disorders: people with “eating-related conditions” uniformly described as “having an eating disorder” NEVER as “food abusers”
- Referring to individuals as having “substance use disorder” may reduce stigma, may enhance treatment and recovery

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*(4), 805-818. doi: 10.1177/002204261004000403

EDITORIAL

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

THE AMERICAN JOURNAL *of* MEDICINE.
AJM

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.

despite harmful conseque
strong causal role for gene
control, stigma is alive and
that one contributory fact
may be the type of langua
Use of the more medi
"substance use disorder" t
health approach that ca

- Avoid "dirty," "clean," "abuser" language
- Negative urine test for drugs

http://www.amjmed.com/article/S0002-9343(14)00770-0/abstract

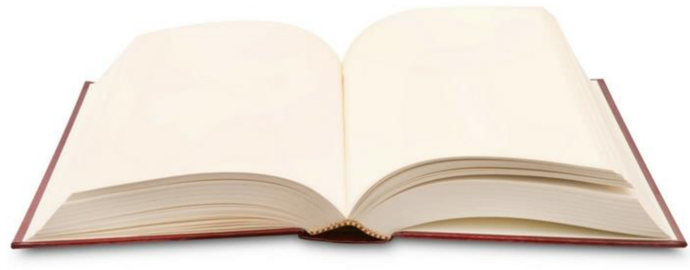
Kelly, J. F., Wakeman, S. E., & Saitz, R. (2015). Stop talking 'dirty': clinicians, language, and quality of care for the leading cause of preventable death in the United States. *American Journal of Medicine, 128(1*), 8-9. doi: 10.1016/j.amjmed.2014.07.043

Recommended language examples…

Don't say…	Instead, say…
"drug abuser"	"Person/individual/patient with a substance use disorder"
"alcoholic"	"Person/individual/patient with an alcohol use disorder"
"dirty urine"	"the urine was positive for…."
"heroin addict"	"Person/individual/patient with an opioid use disorder"

ADDICTION-ARY

IF WE WANT ADDICTION DESTIGMATIZED, WE NEED A LANGUAGE THAT'S UNIFIED.



www.recoveryanswers.org

The words we use matter. Caution needs to be taken, especially when the disorders concerned are heavily stigmatized as in substance use disorders.

Recovery Research Institute (2020). *Addictionary®*. Retrieved from https://www.recoveryanswers.org/addiction-ary

International Addiction Terminology Statement Sept 2015…

International Society of Addiction Journal Editors

National Addiction Center
4 Windsor Walk
London
SES 8A, UK

Addiction Terminology Statement

ISAJE editors adopted consensus statement advocating against use of stigmatizing language like "abuse" "abuser" "dirty," "clean" in addiction science in 2015

http://www.parint.org/isajewebsite/terminology.htm

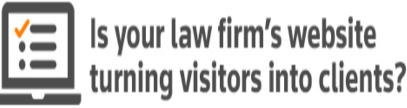
February 01, 2019

Addictionary

Share this:

The Recovery Research Institute at Massachusetts General Hospital and Harvard Medical School has developed the Addictionary, a very useful tool when writing or discussing addiction and people with addiction and in recovery. According to the site, "The words we use matter. Caution needs to be taken, especially when the disorders concerned are heavily stigmatized as in substance use disorders."

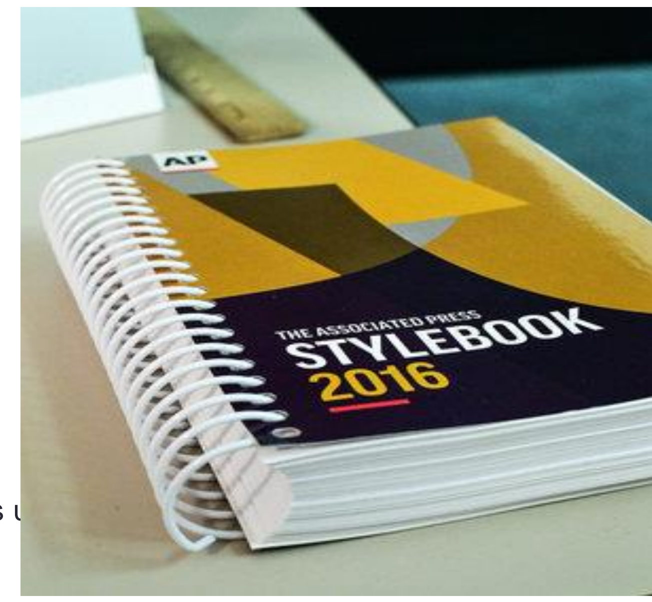
RECOVERY RESEARCH INSTITUTE
MASSACHUSETTS GENERAL HOSPITAL
HARVARD MEDICAL SCHOOL TEACHING HOSPITAL



FindLaw.

Impact around the U.S. and world…

- ONDCP –White House Office of National Drug Control Policy - efforts to change SUD terminology to reduce stigma
- NIH, SAMHSA, website/literature changes; SGR (2016)
- U.S. Associated Press (AP) style guide update on SUD
- World Federation for the Treatment of Opioid Dependence
- The European Pain Federation EFIC
- International Association for Hospice and Palliative Care
- International Doctors for Healthier Drug Policies
- Swiss Romany College for Addiction Medicine
- Swiss Society of Addiction Medicine
- … Also, called on medical journals to ensure that authors always u [illegible] ctful in relation to the use of psychoactive substances.



Google

Together, recovery is possible.

g.co/recovertogether

Anyone can support the recovery movement

With your words

The leaders of the modern recovery movement ask us all to be thoughtful with the words we use around addiction and recovery. Some common terms, even those historically used by those in recovery, can reinforce stigma and even discourage people struggling with addiction from seeking treatment. Here are some that label people or inadvertently pass judgment, with advice on how to replace them with objective descriptions of symptoms or behaviors.

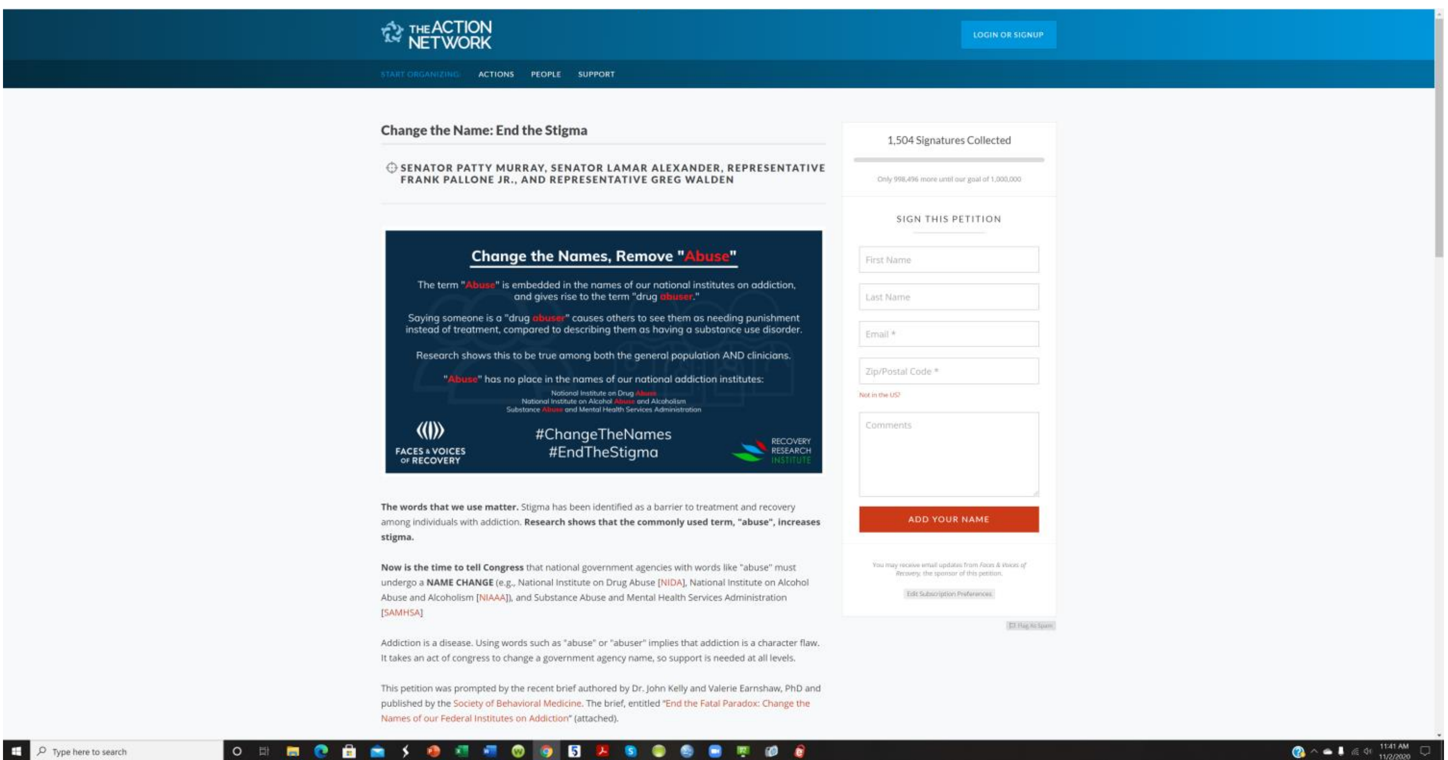
Old Term	Replace with
Addict/Alcoholic/Junkie	a person with, or suffering from, addiction or substance use disorder.
Lapse/Relapse/Slip	neutral terms such as "resumed," or experienced a "recurrence" of symptoms.
Clean	terms like "in remission or recovery"
Dirty	a person having positive test results or exhibiting symptoms of substance use disorder

Visit the Addictionary from the Recovery Research Institute for more terminology and guidance

Our national institutes on addiction have "abuse" embedded in their names… This needs to change

https://actionnetwork.org/petitions/change-the-name-end-the-stigma

#changethenames; #endthestigma



https://actionnetwork.org/petitions/change-the-name-end-the-stigma

Reps. Lisa McLean and David Trone Introduce Bipartison Legislation to change then names of NIDA/NIAAA/SAMHSA…

Reps. McClain, Trone Introduce Bipartisan Legislation to Confront the Stigma Surrounding Substance Use Disorders

June 30, 2021 **Press Release**

WASHINGTON -- In the wake of a record **89,000** drug overdose deaths last year alone, today, Representatives Lisa McClain (R-MI) and David Trone (D-MD) introduced the *Stopping Titles that Overtly Perpetuate (STOP) Stigma Act*. The legislation would change the names of federal agencies and programs that currently promote stigmatizing language. By changing the names of these agencies and grants we can end the stigma of addiction and encourage those who are battling this disease to get the help they need.

"Treating mental health like all other health is critically important. We've made tremendous strides over the years on mental health treatments, and we can't stop now," **said Congresswoman McClain.** "I'm proud to cosponsor the STOP Stigma Act which will examine further ways to destigmatize language around the broad areas of mental health, so individuals are not deterred or embarrassed, but willing and determined to ask for help and answers when they need it most."

"All too often addiction is treated like a moral failure instead of a disease that kills tens of thousands of people every year," **said Congressman David Trone, founder of the Bipartisan Addiction and Mental Health Task Force.** "The language we use matters and has weight, which is why it's our job as leaders to take action against these negative stereotypes. This bill begins to reframe our thinking around substance use disorder to emphasize that those who are battling addiction are not at fault for their illness. I want to thank my colleague Rep. McClain for joining me in this bipartisan effort.

"A shift is happening across the nation in how we talk about addiction and recovery by eliminating stigmatizing, harmful language. Now is the time for Congress to act on what we now know through research by removing the word "abuse" from the names of federal agencies related to substance use

Reducing Stigma in Clinical and Community Recovery Support Service Settings

Prescribe, model and reinforce, universal use of appropriate, person-first, non-stigmatizing terminology pertaining to alcohol/drug use disorders and related problems (especially removing “abuse”/”abuser” from printed materials/websites/names as soon as possible)

Provide continuing education on the nature (causes and impacts) of substance use to service leadership, practitioners, and all staff, on the importance of addressing substance use disorders on clinical, ethical, humanitarian, compassionate care grounds, as well as health economics grounds

Provide regular opportunity for interaction and exposure to recovering persons to help dismantle stereotypes and disabuse staff of faulty beliefs

Create a “recovery friendly” workplace that openly and continually supports treatment and recovery for employees suffering form SUD including employing individuals with SUD histories

Thank you for your attention!

Enhancing Recovery Through Science

recoveryanswers.org

Recovery Research Institute