RESPECTFUL LANGUAGE AND STIGMA
REGARDING PEOPLE WHO USE SUBSTANCES

Background

Healthcare workers and the media can greatly influence the way in which the public perceive people who use drugs (PWUDs). Therefore there is a need to address the language surrounding substance use disorders and drug addiction and those who use drugs. While the stigma around drug use has traditionally served as a deterrent, it is becoming increasingly recognised that the stigmatisation, discrimination and isolation of PWUDs has led to poorer health outcomes and further marginalisation. With the escalating opioid crisis in British Columbia, reframing the way in which we think about and describe PWUDs is a key component in reducing the stigma of drug use, and the subsequent reluctance of PWUDs to accessing healthcare.

What is Stigma?

Stigma is defined as "an attribute or quality which 'significantly discredits' an individual in the eyes of others".[1] In medicine, stigma around a health condition is influenced by two main factors: cause and controllability.[2] Substance use disorders are more highly stigmatised than other health conditions as society generally considers drug use to be a "choice" and repeated use to be a result of poor "self-control".[2] This is in contrast to conditions such as cancer, where society often attributes no blame for the cause or controllability of the disease to the patient. The negative attitudes towards drug use are further ingrained in the law where illegal drug use is a criminal offence. Current research in addiction medicine demonstrates that developing a substance use disorder is multifactorial, often with a strong biological component.[3] Reframing the language around drug use is essential in changing the perceptions of healthcare workers and the public, as it shifts the focus of drug addiction from being a moral, social or criminal issue to a medical issue, which deserves treatment.

How Does Stigma Influence Health?

The negative consequences of stigmatisation can manifest in several ways. The most obvious of these is enacted stigma, otherwise known as discrimination, in which PWUDs may experience direct negative behaviour towards them, such as difficulty in obtaining employment, reduced access to housing, or poor support for treatment.[1] In a professional setting, enacted stigma is easier to recognise and address. Self-stigma is more subtle and refers to the negative thoughts and feelings (for example, shame, negative self-evaluative thoughts, fear) that develop as a result of identifying with a stigmatised group.[1] Because of this, those who experience self-stigma are less likely to seek employment, find it difficult to develop intimate contacts and are more likely to avoid treatment. The language we use to address PWUDs can have damaging effects; terms such as "drug abuser" and "addict" carry negative connotations. When PWUDs adopt these terms for themselves they are likely to experience self-stigma and "accept" that they cannot recover. Unless

we can reverse the effects of self-stigmatisation, those who experience it are unlikely to facilitate change in themselves or seek help.

Stigma has been identified as a significant barrier towards accessing healthcare and this has direct detrimental consequences for PWUDs. Research has shown that those who access treatment frequently experience stigma from healthcare workers, and healthcare workers generally have a negative attitude towards PWUDs.[4] These negative attitudes can lead to poor patient care and, in turn, decreased the use of appropriate healthcare services. Studies show that only about 14.6% of those needing specialty treatment for illegal drug use receive treatment.[5] One particular concern is the negative effect that stigma has towards public health interventions such as harm reduction, one of the four pillars towards reducing harms from drug use. Stigma decreases public support for proven strategies which reduce drug-related harms and improve engagement with services such as needle distribution programs and supervised consumption facilities despite the large body of evidence supporting it.[6]

It is estimated that around the world, 350,000 people die each year due to illegal drug use, and local reports demonstrate that the opioid crisis is at an all-time high, with 922 deaths recorded in British Columbia in 2016 alone.[7] Because of these increasing pressures, we can no longer ignore the overdose epidemic and must take all steps, including reducing the stigma around drug use, to prevent further avoidable deaths.

Recommendations for Change

Adapted from Broyles L et al. Confronting Inadvertent Stigma and Pejorative Language in Addiction Scholarship: A Recognition and Response.[8]

Stigma is a social, cultural and moral process, and therefore undoing stigma takes time and a concerted effort from all stakeholders. While it may just seem like semantics, research has shown that language influences cognitive biases, especially around drug use.[9] To reduce the stigma around drug use, Broyles and colleagues recommend four guidelines on using non-stigmatising language[8]:

1. Use “people-first language”
2. Use language that reflects the medical nature of substance use disorders and treatment
3. Use language that promotes recovery
4. Avoid slang and idioms

1. Use “People-First Language”

People-first language is exactly how it sounds – referring to the person before describing his or her behaviour or condition. For example, it is more appropriate to describe someone as a “person with a cocaine use disorder” rather than a “cocaine user” or “addict”. This type of language is important as it respects the person’s individuality and recognises their condition, illness or behaviour is only one aspect of who the person is and not the defining characteristic.[8] It is interesting to note that this language is already being used with other conditions – for example, we are likely to talk about a “person with an eating disorder” rather than a “food abuser”.[2] When we describe people as “addicts” and “users” it labels them by their illness, dehumanises them and can easily lead to us making broad-sweeping generalisations about them; this divide between “us” and “them” creates barriers in communication and treatment.

2. Use Language that Reflects the Medical Nature of Substance Use Disorders and Treatment
When talking about drug use, we can easily be swayed by emotional language; however, we now understand that there are a multitude of factors contributing to drug addiction, ranging from personal factors to social, environmental and political, and the language we used to describe drug addiction should reflect this. When we refer to PWUDs as “abusers” or “junkies”, the focus shifts towards beliefs that addiction is a ”failure of morals or personality”; [8] however, terms such as “substance use disorder” and “addictive disease” bring the attention back to the medical aspect of the disease. By presenting addiction in this way, we can more easily recognise the multimodal basis for care, treatment, and particularly, the evidence-based medical treatment of such disorders.

Recommendations Specific for Healthcare Professionals

3. Use Language that Promotes Recovery
Recovery-orientated language refers to using language that conveys hope, optimism and supports recovery, and should be the standard for all healthcare professionals working with patients with addiction issues. There are multiple guides how to use recovery-oriented language, but the core principles are to respect the person’s individuality and autonomy, emphasise their skills and strengths, and avoid reinforcing paternalistic models of healthcare.[10] In more practical terms, this means avoiding terms such as “unmotivated” and “non-compliant,” as this suggests to other health practitioners that the patient is resistant to treatment, and sets the person up for failure. Instead, health practitioners should focus on the individual’s personal attributes when referring to other practitioners, and use phrases such as “not in agreement with the treatment plan,” or “opted not to” as this recognises the individual’s personal preference and gives the opportunity for the practitioner to explore the factors influencing this decision.

4. Avoid Slang and Idioms
Slang terms and idioms such as “dope fiend,” and “crack head” have negative connotations and a significant level of stigma attached to them and should thus be avoided wherever possible. While this type of language is rarely used in professional literature, it is important to also avoid it when speaking to other colleagues or healthcare professionals, even in a private setting, as it clouds our own implicit bias when treating our patients.[9] In the same fashion, healthcare professionals should also avoid referring to test results as “dirty” if they are positive for illegal drugs or “clean” if they do not, as this also reinforces the notion that those who have used drugs are morally corrupt, and stigmatises them further. Instead, test results should be reported as “positive” for the substances found, and “negative” if no substances are detected.[2] Thoughtful use of our language will encourage others to consider how their language affects others.

Conclusion

As healthcare providers and members of the media we have a responsibility to use appropriate language which will in turn influence the public discourse and reduce stigma around disease and drug use. It is important to recognise in our daily practice that language influences all stakeholders: the public, healthcare providers, those with substance use disorders, and their families. While the suggested changes may appear cumbersome at first, as we move towards more respectful language, these terms will hopefully become more commonplace in time. It is in everyone’s best interests to reduce stigma around drug use to combat the current opioid overdose epidemic. We can no longer ignore the problem, especially if we are the ones contributing to it.

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