



Discussing Stigma and Language (SUD focus)

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Training Objectives – Power of Language

- Review how we define stigma
- Discuss the impact stigma can have on people and our practices
- Identify ways we can work to reduce stigma related to substance use and/or disorders through the language we **ALL** use





The What and Why of Stigma





What is Stigma?

“Stigma can be understood as an attribute, behavior, or reputation that is socially discrediting, and substance-related problems appear to be particularly susceptible to stigma.”

- John F. Kelly

Stigma often results in discrimination and alienation

Examples of

- Substance Use Disorders and some Substance Use (especially in pregnancy)
- Mental Illnesses
- Obesity
- Incarceration
- Homelessness
- Many others



The Impact of Stigma

“The biggest **killer** out there is stigma. **Stigma** keeps people in the shadows. Stigma keeps people from coming forward and asking for help. Stigma keeps families from admitting that there is a problem.”

- Jerome Adams, U.S. SURGEON GENERAL

“Today, the **stigma** of addiction is seen as a **primary barrier** to effective addiction prevention, treatment and recovery efforts at the individual, family, community and societal levels.”

- Hazelden Betty Ford Foundation



Two Levels of Stigma

"I'm fine."

Feeling
I'm
Nothing
to Everyone



empowering recovery, no
SHAME leaves us feeling
unlovable and
disconnected from others. -
Brené Brown



SOCIAL STIGMA

large groups endorsing
stigmatized stereotypes

STRUCTURAL STIGMA

rules, policies, and
procedures that restrict rights
and opportunities for
stigmatized groups





The Impact of Internalized Stigma =



- When we become aware of negative stereotypes and public stigma and accept those beliefs about ourselves

feelings of
hopelessness
low self-
esteem

low
motivation to
make positive
changes

poorer health
and other
outcomes

People struggle to remain engaged and to sustain change without a sense of
hope and **self-efficacy**

“Perceptions of discrimination were a significant predictor of treatment completion, with greater perceived discrimination associated with increased dropout.”



Two Domains of Bias Central to Substance Use Disorders

Did the person **CAUSE** it?

The appearance of intentional participation in the development of a condition.

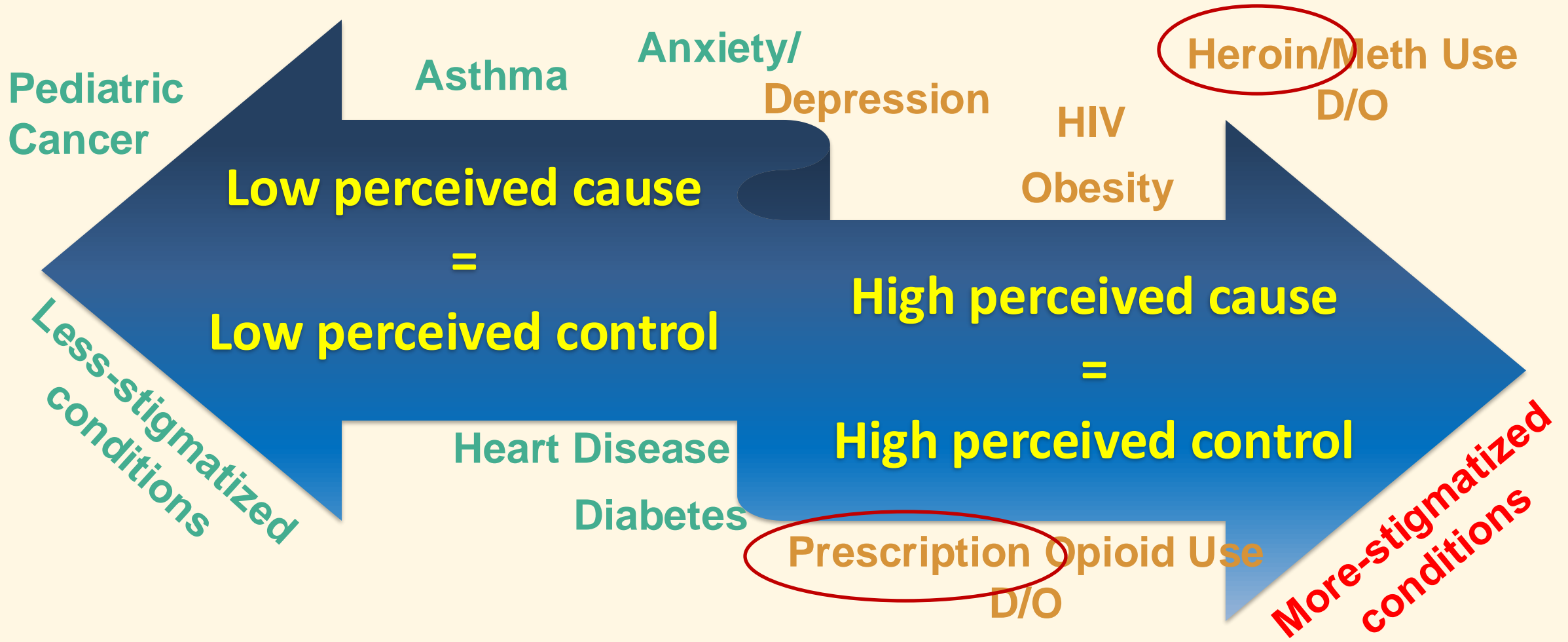
Can the person **CONTROL** it?

Are there factors within a person's abilities to interrupt the course of illness?

*“They found a way to get drugs, **why can't they find their way to get treatment?**”*



Cause and Control Continuum





The Impact of Language on our Perception of People

“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.

VS

“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.



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Clinicians assigned the “substance abuser” vignette were significantly more likely to endorse the idea that “Mr. Williams” was personally responsible for his condition and more likely to agree that punitive measures be taken as compared with clinicians assigned the “substance use disorder” vignette



The Impact Extends to Non-Clinicians as well

One person was referred to as a "substance abuser"



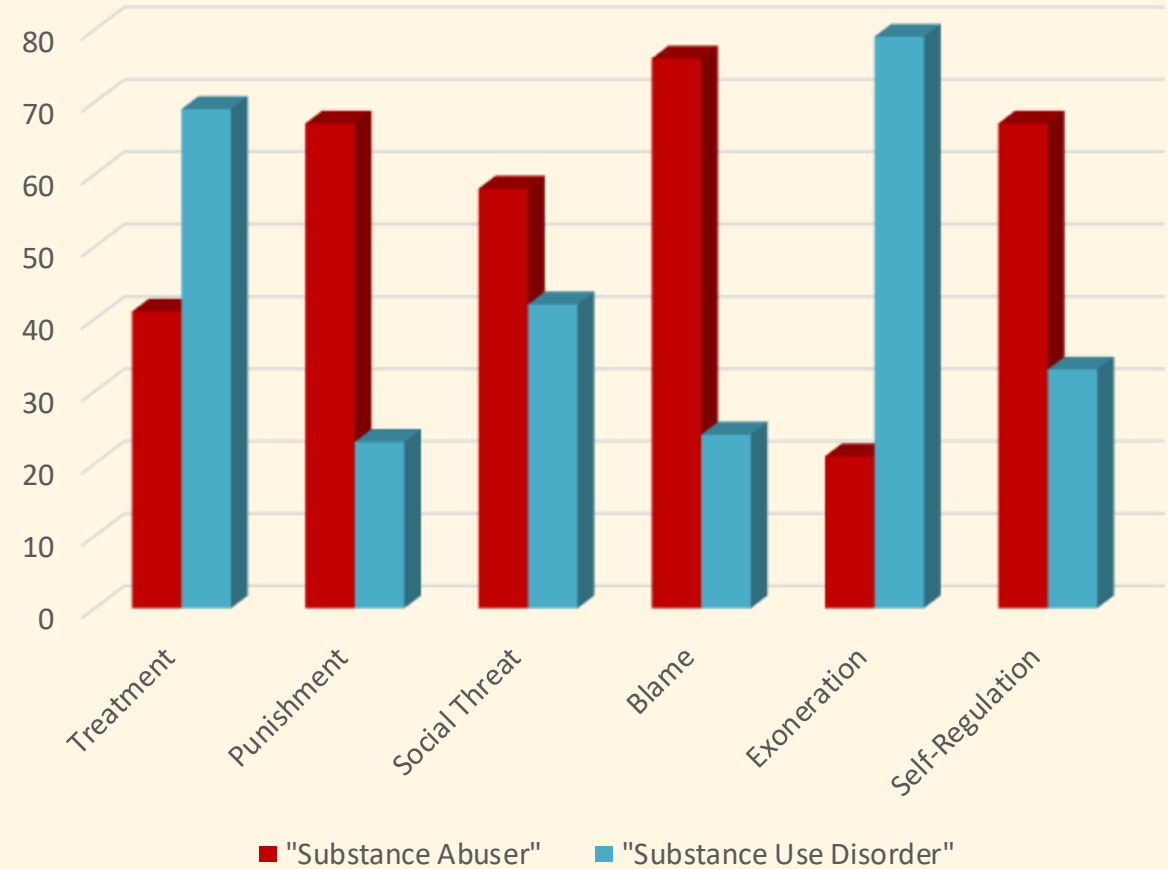
The other person as "having a substance use disorder"



No further information was given about these hypothetical individuals.

THE STUDY DISCOVERED THAT PARTICIPANTS FELT THE "SUBSTANCE ABUSER" WAS:

- less likely to benefit from treatment
- more likely to benefit from punishment
- more likely to be socially threatening
- more likely to be blamed for their substance related difficulties and less likely that their problem was the result of an innate dysfunction over which they had no control
- they were more able to control their substance use without help

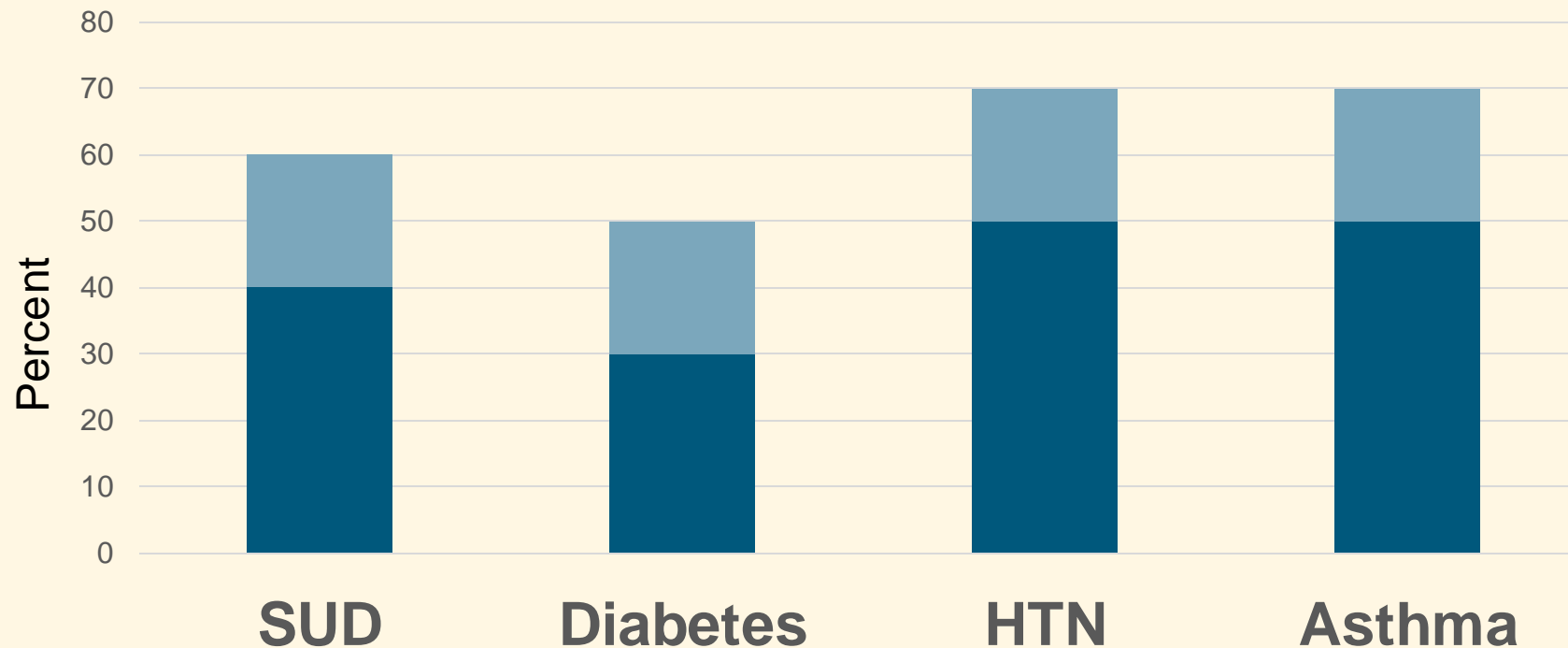




Biases Around Perceived Effectiveness of Interventions

- Substance Use Disorders are often seen as having poorer outcomes than other diseases

“Relapse is a part of recovery” is a common refrain





Other Ways Stigma and Bias can Exert Influence

The Criteria for Program Participation

- Require/Expect motivation to stop all substance use? (Bias - People need to come in action phase of change – otherwise in “denial”)
- Require agreement to contracts around attendance (Bias - People with SUD are unreliable and don't follow recommendations)
- A push for an “All-in” approach? (Bias - People who are not internally motivated do not do as well as those who are externally motivated)





Stigma around Medications for Substance Use Disorders

- Within the stigmatization of individuals with an SUD, there is further stigmatization of those who are on medications for SUD.
 - Has real consequences related to barriers in seeking care, continuing with care, and in the delivery of care

Hadland SE, Park TW, Bagley SM. Stigma associated with medication treatment for young adults with opioid use disorder: a case series. *Addict Sci Clin Pract.* 2018;13(1):15. Published 2018 May 7. doi:10.1186/s13722-018-0116-2

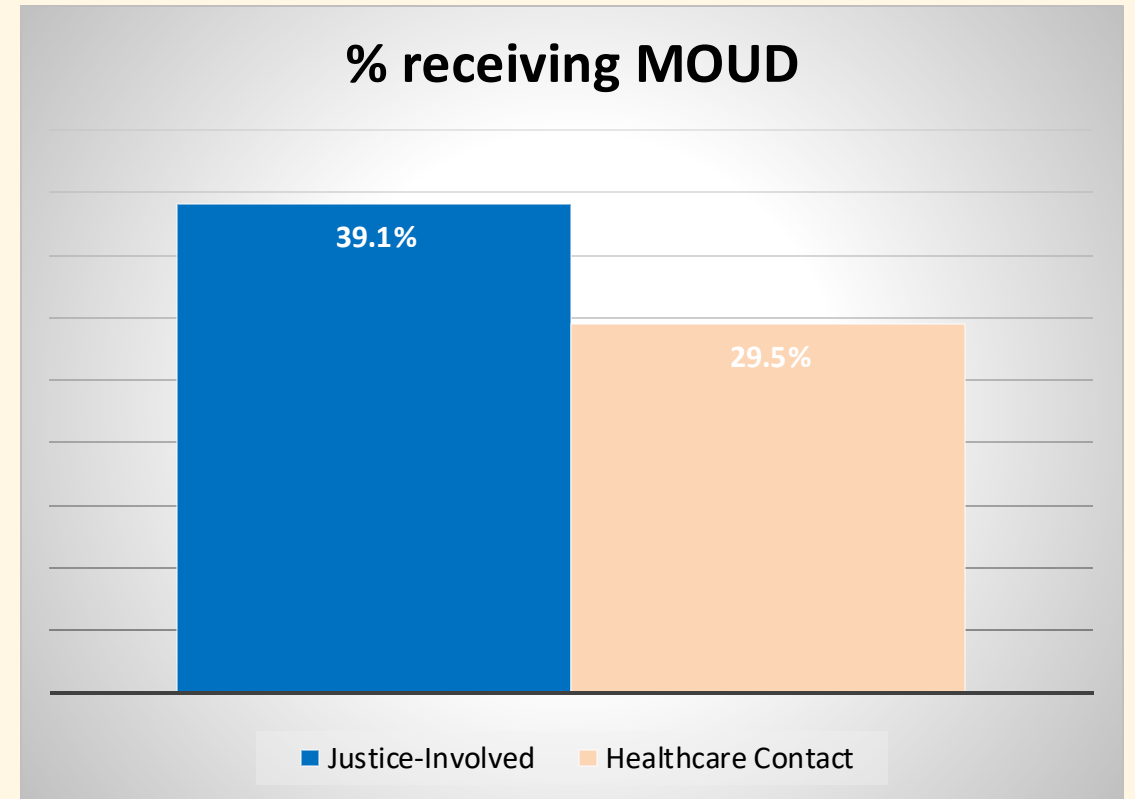
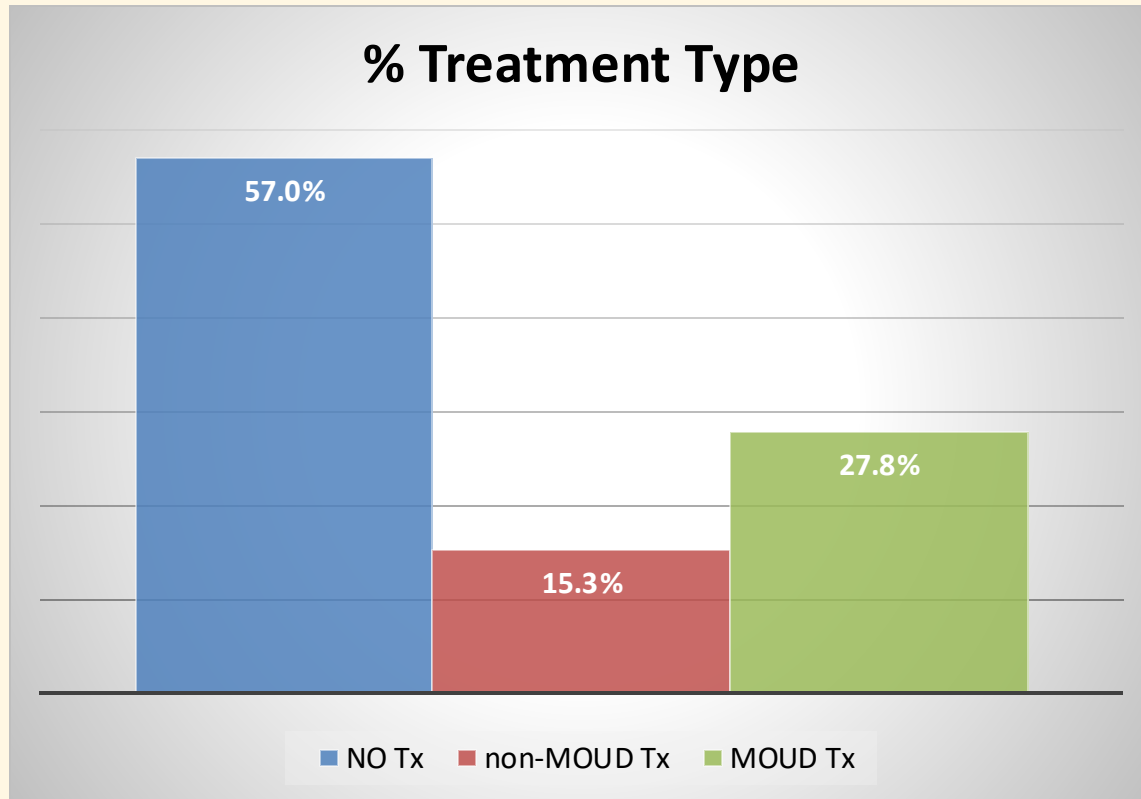
“I find it inspiring and encouraging that in recent years, people in abstinence-based recovery and people in harm reduction have finally started to realize what they have in common.”

Jennifer Reynolds, MPH, CHES
Section Manager, Health Communications,
Marketing and Training ORAU, 2018*



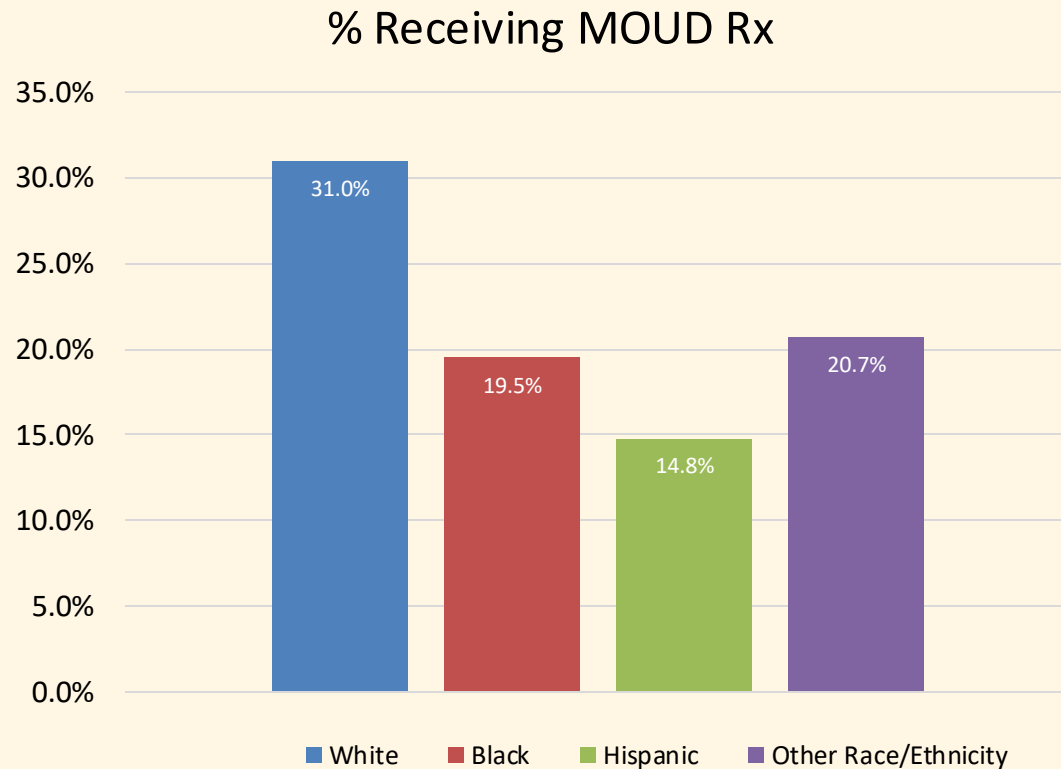


Only a minority of patients with OUD receive MOUD

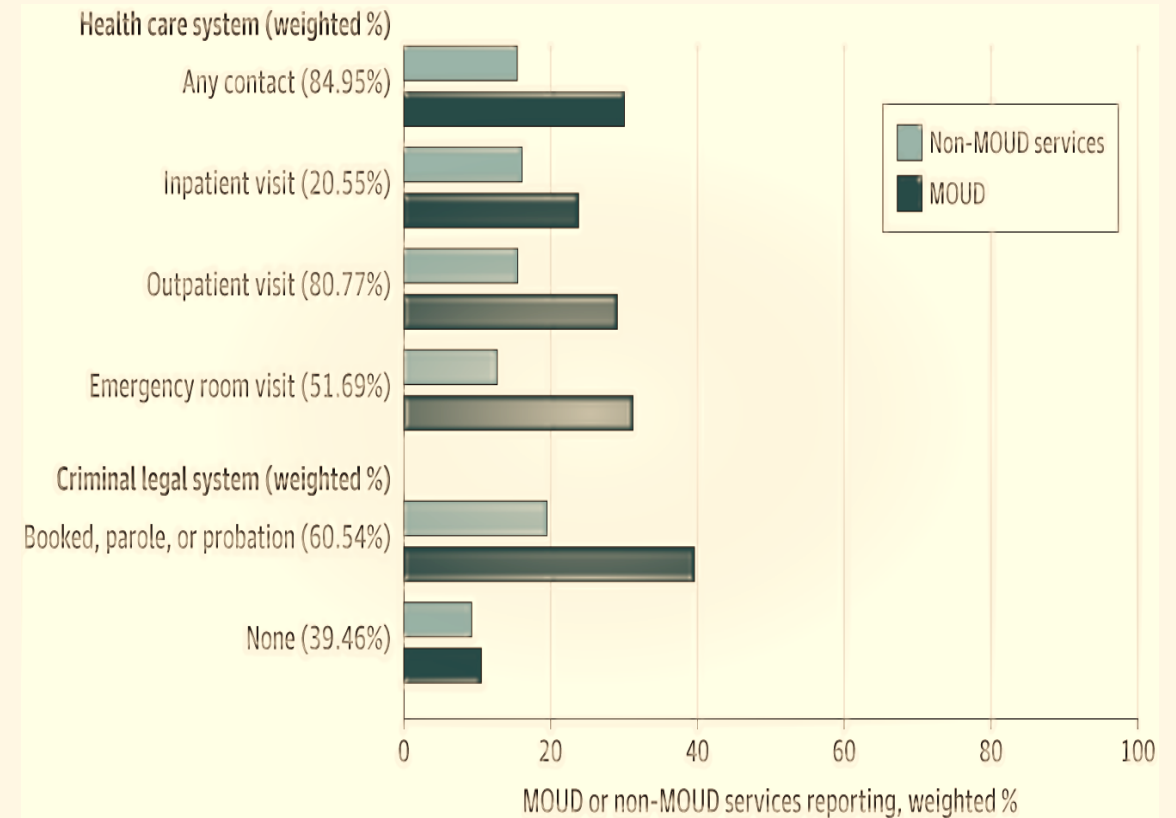




Racial Disparities

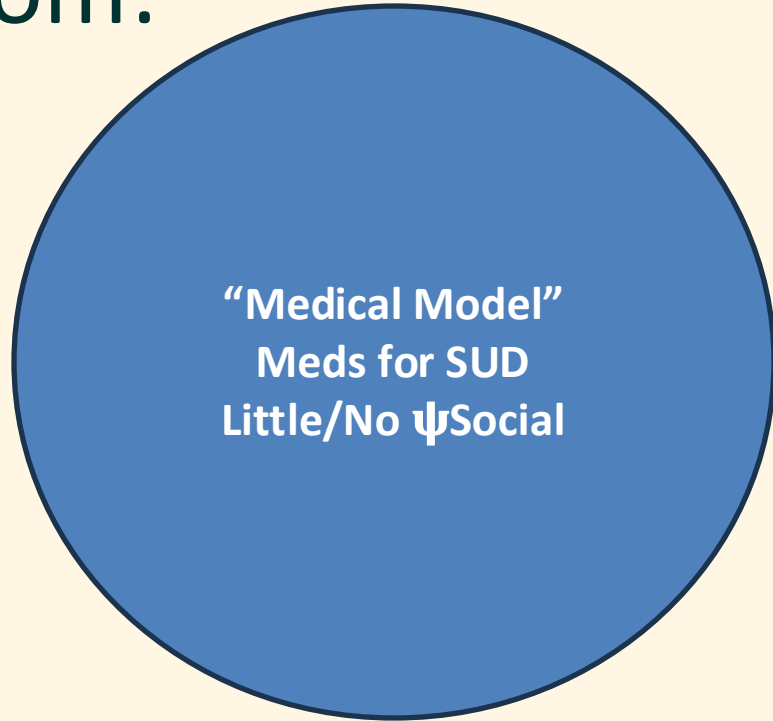


Contextual Disparities

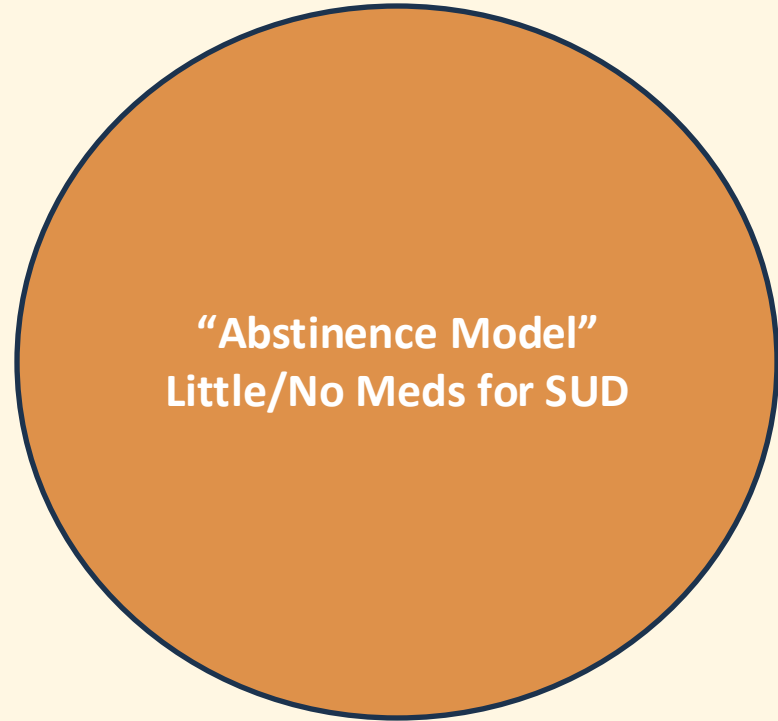




Shift in Perspective – Moving from:



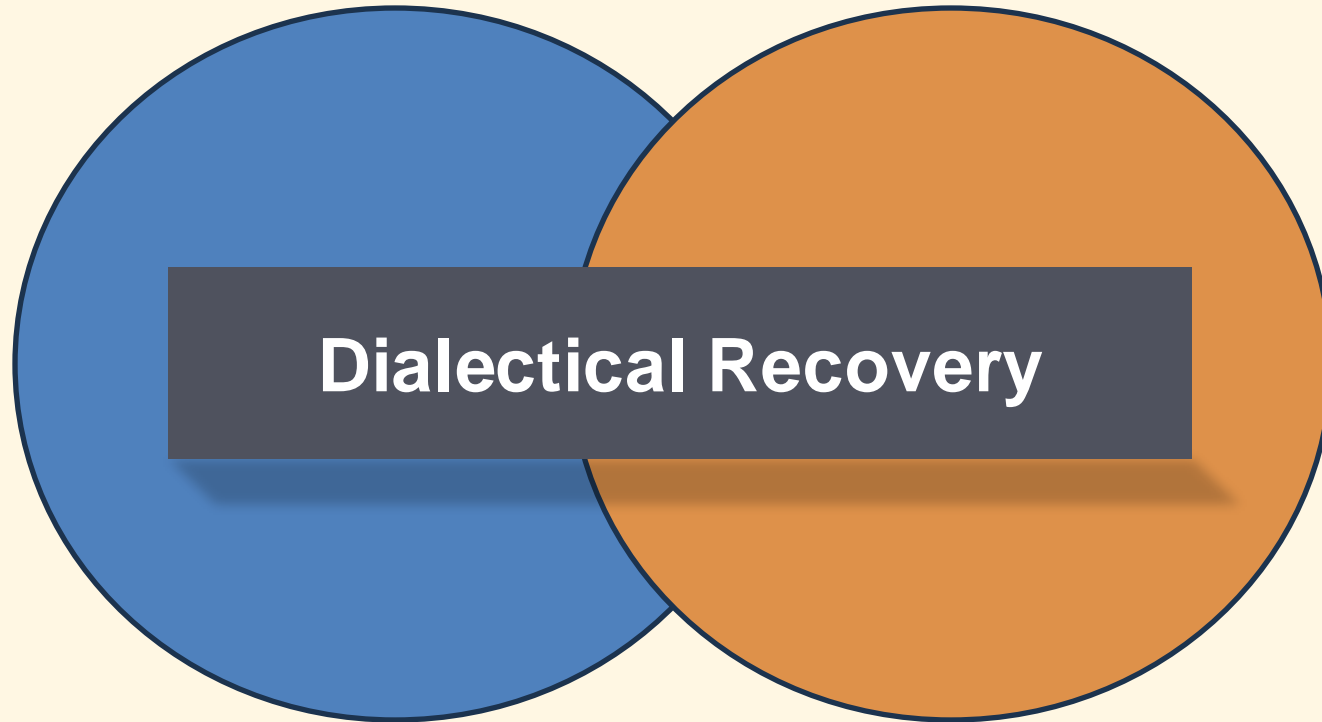
VS





To this:

AND





So, isn't this just substituting one drug for another?

Drug	Medication
Used for euphoric effect	Used to prevent or treat disease
Used intermittently, when one wants	Used regularly, as prescribed
Used to avoid withdrawal	Used to prevent/reduce drug use
Often obtained illicitly off the street/internet	Prescribed by treating physician/provider

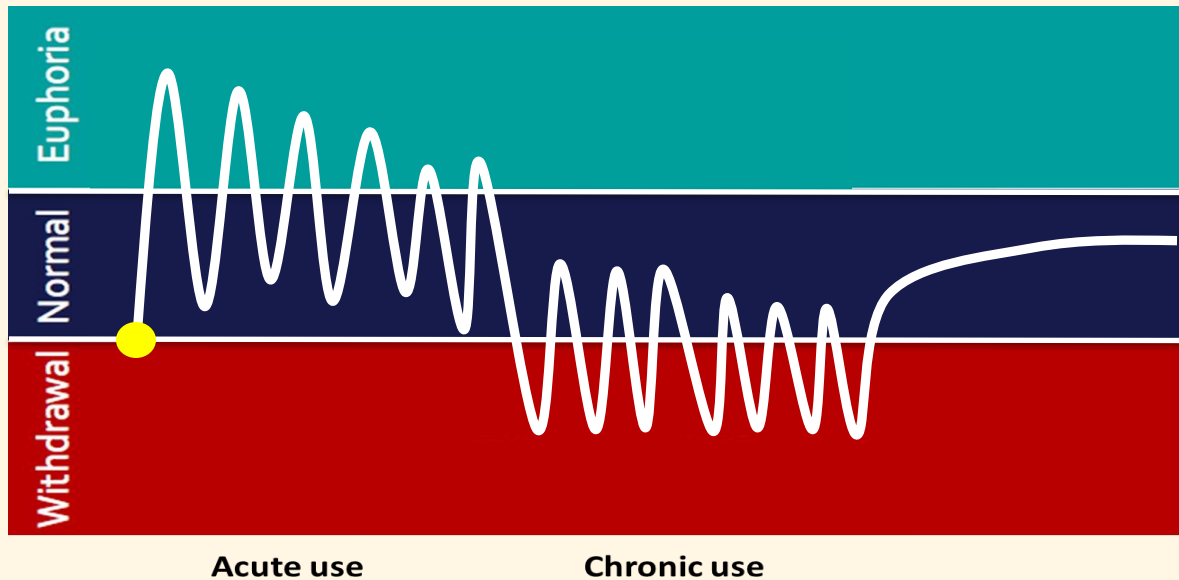
- Framing and context important for successful integration of Meds
- Helpful for patients, family, and staff training
- Increases patient and family “buy-in”
- Misuse and diversion can (and will) occur with some patients
- The key is compassionate framing and processing
- Some patients will require a transition to a different level of care



The “One Drug for Another Drug” Bias

Noteworthy relative dopamine levels...

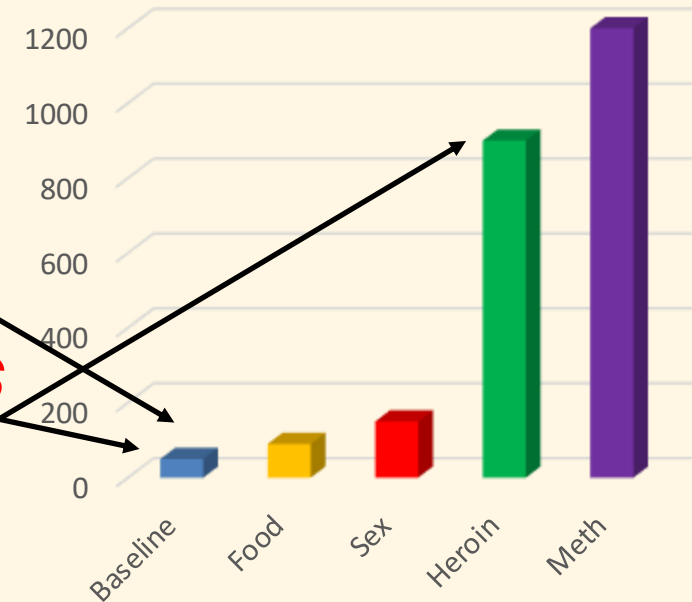
- Dopamine levels usual baseline... 50-60ng/dL
- Dopamine levels after opioid detox....10ng/dL
- Dopamine levels during MOUD... 50-60ng/dL



Adapted from Alford et al. ASAM Buprenorphine course for office-based treatment of opioid use disorders. CME training course

Dopamine in Reward

Relative DA release



This
Again, this
NOT this

Source: Excerpt of a 2015 presentation for GHCF by addiction specialist R. Corey Waller, MD, medical director of the Center for Integrative Medicine at Spectrum Health Medical Group in Michigan. National Institute on Drug Abuse



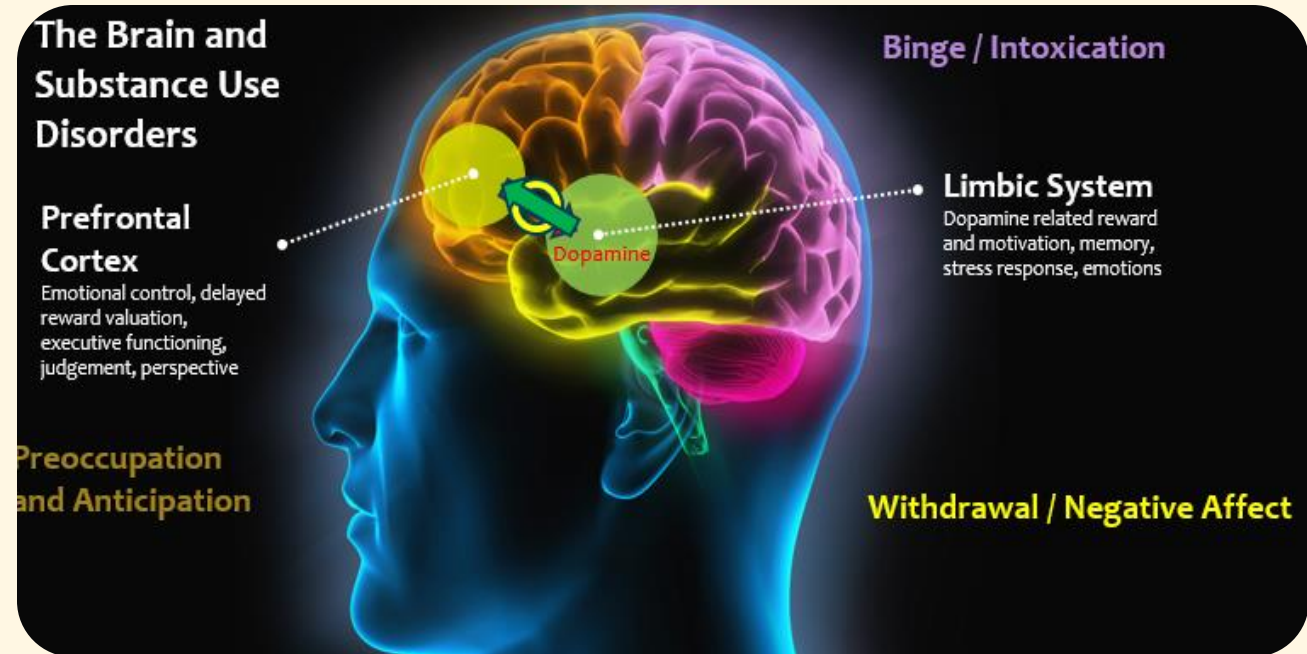
What Can We Do?





Neurobiology of SUD (using science to reduce stigma and bias)

Work to help all team member understand Substance Use Disorders (SUD) are brain diseases, and often require medical care. The science around the neurobiology of SUD can also help to shift biases around perceived “cause” and “control.”





Knowing is One Part



Education and the use of person-first language is important in reducing stigma, but education alone is rarely compelling to those who are firm in their stance/bias

We need to **share stories** of healing and recovery and gently, but unwaveringly, introduce the science of SUD and person-first language



Advocate for Increased Awareness

“A heightened **awareness** of the disease **has** unquestionably led to a **greater** number of women being screened for **breast cancer**,” said Tuite. “Patients are experiencing **better** outcomes as a result of early diagnosis, state-of-the-art **treatment** options and less extensive surgery.”



Catherine Tuite, MD:THRIVE, Oct 3, 2019



Imagine...





Work to Reduce Stigma

Make intentional efforts to change language and watch for ways **stigma** drives decisions in practice





Examples of Efforts

1

Have a component of Policy Review that brings a lens of anti-stigma when policies are updated and/or created.

2

Engage and support local awareness campaigns

3

Create weekly vocabulary change initiatives

4

Make a statement on a website and in common spaces at the place of work



Erasing Margins

“Then we imagine no one standing outside of that circle, moving ourselves closer to the margins so that the margins themselves will be erased.”

- Gregory Boyle, *Tattoos on the Heart: The Power of Boundless Compassion*





Language Matters

- Labels and the words we use to describe people can give negative images that limit our ability to help
- Changing how we describe people helps to improve our ability to connect and help
- We must be willing to question our beliefs and assumptions about language to be respectful to all points of view
- Language is a vital part of helping people who use substances change how they see themselves and the way they are seen by others





Person First Language

Putting the person before the descriptions can assist in interrupting the impact of stigma.

Language Matters

Language is powerful – especially when talking about addictions. Stigmatizing language perpetuates negative perceptions.

“Person first” language focuses on the person, not the disorder.

When Discussing Addictions...

SAY THIS	NOT THAT
Person with a substance use disorder	Addict, junkie, druggie
Person living in recovery	Ex-addict
Person living with an addiction	Battling/suffering from an addiction
Person arrested for drug violation	Drug offender
Medication is a treatment tool	Medication is a crutch
Had a setback	Relapsed
Maintained recovery	Stayed clean
Positive drug screen	Dirty drug screen

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STATE ASSOCIATIONS OF ADDICTION SERVICES
Stronger Together.



Example from Addictionary

RELAPSE

- **(stigma alert)** Relapse often indicates a recurrence of substance use. More technically, it would indicate the recurrence and reinstatement of a substance use disorder and would require an individual to be in remission prior to the occurrence of a relapse.
- This term has a stigma alert, as it can imply a moral failing for some people. Instead it may be preferable to use morally neutral terms such as experienced a “recurrence” of symptoms.

Hubbard et al., 1997; Hunt et al., 1971; White, 2010





Shifting the Language Toward Recovery

Can convey paternalistic treatment model	Acknowledges Agency/Choice
Non-compliant	Has not begun, or Is not in agreement with treatment plan
Unmotivated	Opted not to
Resistant	Experiencing ambivalence

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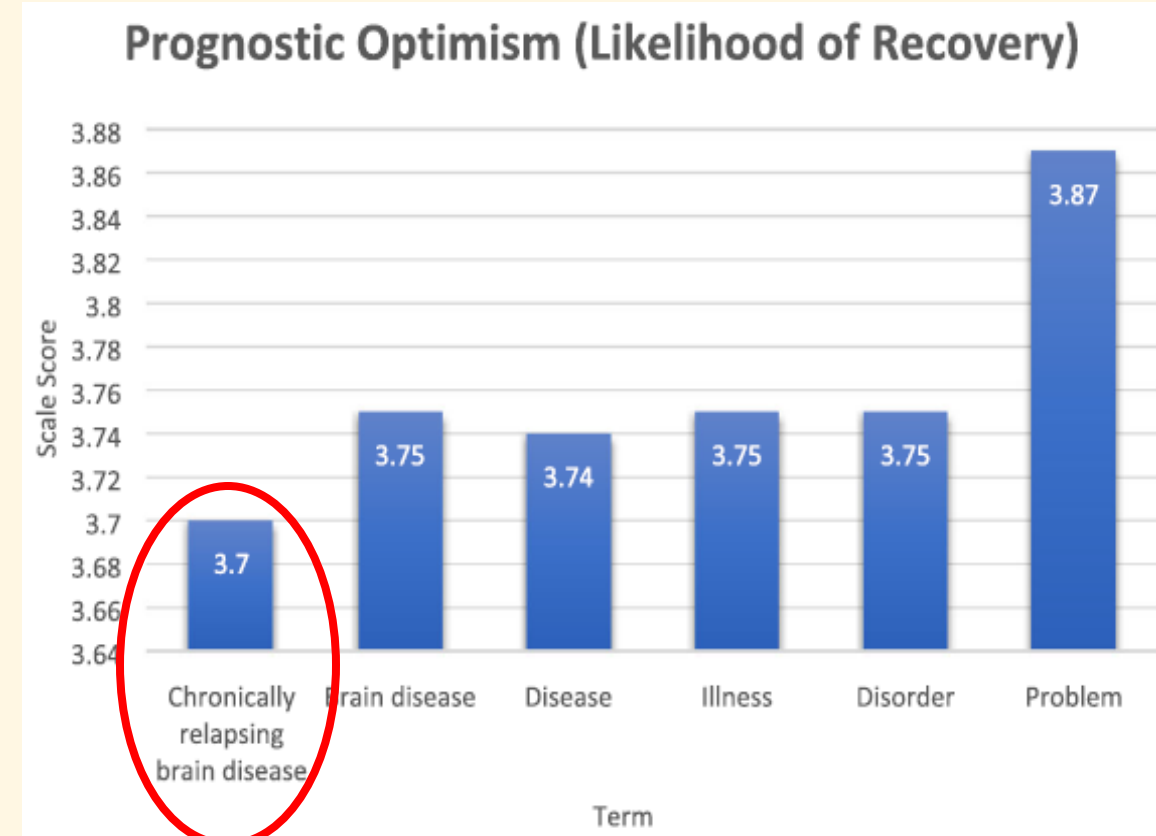
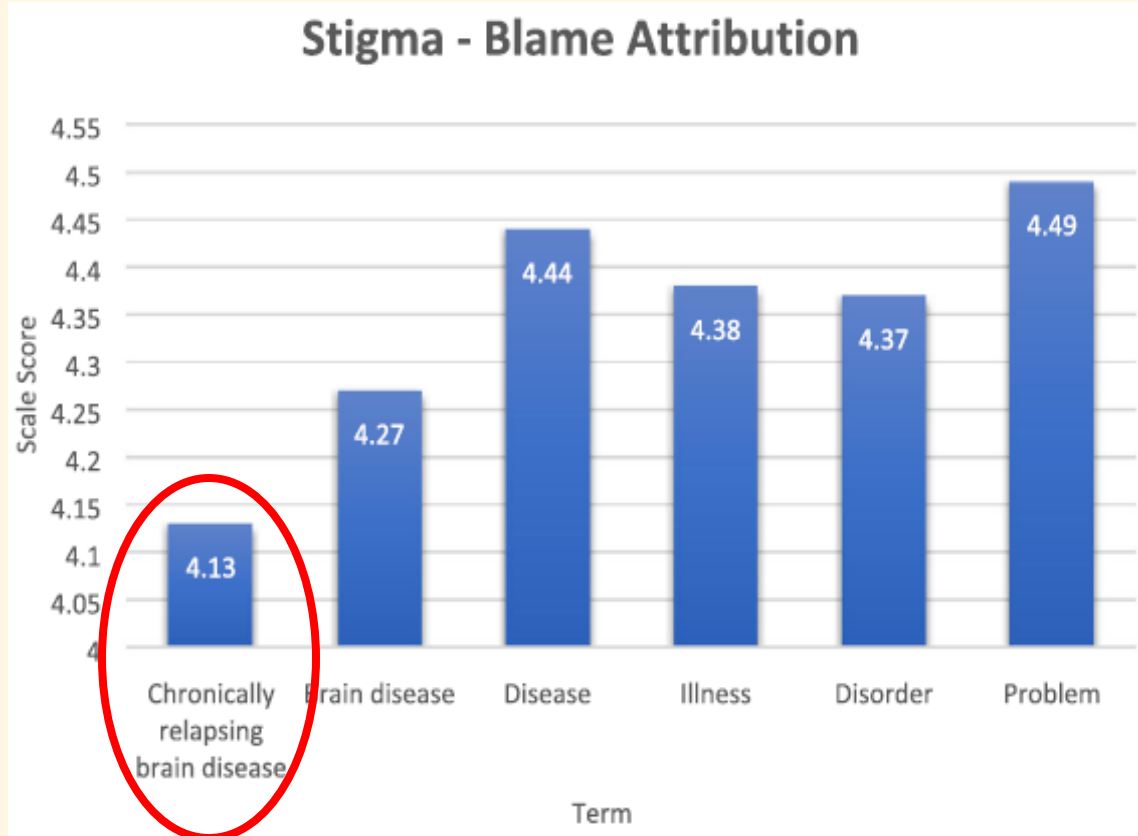
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Person with a substance use disorder	Addict, junkie, druggie
Person living in recovery	Ex-addict
Person living with an addiction	Battling/suffering from an addiction
Person arrested for drug violation	Drug offender
? Chooses not to at this point	Non-compliant/bombed out
Medication is a treatment tool	Medication is a crutch
Had a setback	Relapsed
Maintained recovery	Stayed clean
Positive drug screen	Dirty drug screen

NATIONAL COUNCIL FOR BEHAVIORAL HEALTH
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Broyles LM, Binswanger IA, Jenkins JA, et al. Confronting inadvertent stigma and pejorative language in addiction scholarship: a recognition and response. *Subst Abus.* 2014;35(3):217-221



Language can be “Double-edged”



Small Group Exercise





Language Matters – but so does **CONTEXT**

- There ARE differences between a treatment context and criminal justice **CONTEXT**
- How do you speak of and address Abstinence vs Harm Reduction? How are returns to use addressed?
- How do you define “recovery?” What does it entail?
- How do we speak about people experiencing a return to use of a substance?
 - Did they relapse?
 - Are they a “relapser?”
 - Or, do we speak of a return to use as a “re-emergence of symptom of a chronic illness?”

Considering these different ways of approaching how we speak and address individuals not only changes their engagement, it changes our perspective and engagement with them.



Additional Examples of Shifts in Language

STIGMATIZING LANGUAGE	PREFERRED LANGUAGE
Addict	Person with a substance use disorder
Addicted to X	Has a X use disorder
Addiction	Substance use disorder
Alcoholic	Person suffering from alcohol addiction
Clean	In recovery
Clean screen	Substance free
Dirty	Actively using
Dirty screen	Testing positive for substance use
Drug habit	Regular substance use
Drug abuser	Person who uses drugs
Reformed addict or alcoholic	Person in recovery
Opioid replacement	Medication assisted treatment

SAY THIS ...	NOT THAT ...	BECAUSE ...
Substance use, substance use disorder, substance use challenge, unhealthy substance use, risky use	Substance abuse, drug habit	The word “abuse” holds connotations of criminal activity — think child abuse, domestic abuse. Therefore, calling it substance abuse further criminalizes a treatable health condition. Calling substance use a drug habit implies that a person is choosing to use substances and undermines that a SUD is a serious health condition.
Person with a substance (alcohol, opioids, stimulants) use disorder or challenge	Addict, junkie, user, alcoholic, drunk	Person-first language demonstrates the individual has a health condition. The other terms elicit negative associations and perpetuate stigma.
Person in recovery, person in long-term recovery	Former addict	Person-first language demonstrates the individual has a health condition. The other terms elicit negative associations and perpetuate stigma.
Use of x substance (alcohol, opioids, stimulants) Person with x substance (alcohol, opioid, stimulant) use disorder Person who is using x substance (alcohol, opioids, stimulants)	Drug of choice	An individual does not choose to have a substance use disorder or live with a substance use challenge; therefore, implying a choice in the matter undermines that a SUD is a serious health condition.
Positive/negative drug screen	Dirty/clean drug screen	Screens for other medical conditions are not referred to as “clean” or “dirty,” and using such language stigmatizes substance use and SUDs. Clinically accurate terms can be used to describe if a drug screen was positive or negative for substances.
Maintained recovery	Stayed clean	Recovery is a process of change to improve health. Using the term “clean” does not encompass this process and implies the person did not get “filthy,” which carries negative connotations.



Resources on Language and Stigma

- [Addictionary](#)
- [Language Matters When Discussing Substance Use](#)
- [NIDA - Words Matter: Preferred Language for Talking About Addiction](#)
- [Shatterproof Addiction Stigma Index](#)
- [Shatterproof Addiction Language Guide](#)
- [Language Matters Infographic](#)

"Words matter.
They're contagious.
And hopeful words infect people."

- Angela Maiers @angelamaiers

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**THANK
YOU!**