

DOES OUR CHOICE OF SUBSTANCE-RELATED TERMS INFLUENCE PERCEPTIONS OF TREATMENT NEED? AN EMPIRICAL INVESTIGATION WITH TWO COMMONLY USED TERMS

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Substance-related terminology is often a contentious topic because certain terms may convey meanings that have stigmatizing consequences and present a barrier to treatment. Chief among these are the labels, "abuse" and "abuser." While intense rhetoric has persisted on this topic, little empirical information exists to inform this debate. We tested whether referring to an individual as "a substance abuser (SA)" versus "having a substance use disorder" (SUD) evokes different judgments about treatment need, punishment, social threat, problem etiology, and self-regulation. Participants (N = 314, 76% female, 81% White, M age 38) from an urban setting completed an online 35-item assessment comparing two individuals labeled with these terms. Dependent t-tests were used to examine subscale differences. Compared to the SUD individual, the SA was perceived as engaging in willful misconduct, a greater social threat, and more deserving of punishment. The "abuser" label may perpetuate stigmatizing attitudes and serve as a barrier to help-seeking.

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INTRODUCTION

According to nationally representative surveys, approximately 23 million Americans aged 12 or older meet diagnostic criteria for a past-year DSM-IV diagnosis of substance abuse or dependence (Substance Abuse and Mental Health Services Administration [SAMHSA], 2008). Substance-related conditions confer a massive burden of disease, huge social costs, and a financial impact which far exceeds that of highly prevalent medical disorders, such as heart disease or cancer (Gmel & Rehm, 2003; Harwood, 2000). Treatment is strongly associated with reducing the negative social and personal impact of substance-related disorders (Rehm, Taylor, & Room, 2006), yet only a small percentage of affected individuals access treatment (SAMHSA, 2008). Stigma surrounding substance-related conditions is cited as one of the major reasons why such individuals do not seek treatment (SAMHSA, 2008).

Stigma can be understood as an attribute, behavior, or reputation that is socially discrediting, and substance-related problems appear to be particularly stigmatized. A cross-cultural study conducted by the World Health Organization (WHO) in 14 countries examined 18 of the most stigmatized conditions (e.g., being a criminal, HIV positive, or homeless) and found that alcohol addiction was ranked as the fourth most stigmatized, while other drug addiction was ranked first, as the number one most stigmatized condition (Room, Rehm, Trotter, Paglia, & Üstün, 2001). Such stigmatizing attitudes appear to be pervasive, even among experienced mental health professionals. Psychiatrists ($N = 144$) with an average of 20 years experience rated a psychiatric patient with a prior alcohol dependence diagnosis as less compliant, having a poorer prognosis, and more annoying, and were less likely to express sympathy towards the individual when compared to psychiatrists assigned the same case vignette but without the alcohol dependence diagnosis (Farrell & Lewis, 1990).

Substance-related problems are particularly stigmatized because of their strong association with crime and other serious social harms that extend well beyond the individual using the substance. However, the degree of stigma is often moderated by the perceived cause ("It's not their fault") and extent of perceived controllability ("They can't help it"). Causes perceived to be uncontrollable tend to elicit pity and sympathy, while perceived controllability tends to elicit anger, hostility, and blame, as well as a low desire to help (Hegarty & Golden, 2008). Observers may view an individual with a substance-related condition as able to control their behavior (e.g., "Why don't they just stop?"), especially since substance use initially involves an individual's choice to experiment. However, this behavior may continue to be viewed as a free choice long after functional dysregulation and structural alterations have occurred in brain areas and systems that regulate impulses (e.g., orbitofrontal/prefrontal cortex), radically impairing the successful execution of adaptive decisions

(i.e., to abstain) even in spite of substantial personal harm (Edwards, 1986; Erickson, 2008; Koob & Le Moal, 2006; West, 2006).

A potentially modifiable influence on the perception of substance-related conditions is the language used to describe individuals who are affected by them. There are a variety of different ways used to describe individuals with substance-related problems that may convey certain meanings about cause and controllability of the condition. This, in turn, may either perpetuate or attenuate stigma (Kelly, 2004; Kelly, Dow, & Westerhoff, 2009). Furthermore, the variety of descriptive terms used can be confusing as they are often used inconsistently both among specialists as well as laypeople, such terms include “problem user/drinker,” “alcoholic,” “addict,” “substance abuser.” These terms are often used interchangeably, despite differences in the meanings. The lack of precision and consistency in the use and definition of these terms is evident at the highest scientific levels.

Terminology describing mental illness and substance-related disorders is clearly a contentious topic (Barbor & Hall, 2007; Edwards, Gross, Keller, Moser, & Room, 1977; White, 2004). While various labels are in use as noted above, by far the most contentious of these terms has been the use of the “abuser” label. This has been viewed as particularly offensive for many years by influential researchers, policy makers, and clinicians (Keller, 1977; SAMHSA, 2004; White, 2006). Over 30 years ago, the WHO published an important paper on alcohol use disorders and substance-related terminology (Edwards et al., 1977). It was noted that the diagnostic term “abuse” would inevitably generate the descriptive term “alcohol abuser,” which is laden with negative implications (e.g., child abuser). The report therefore recommended the abuser label “should be avoided by scientists and especially by professionals who claim therapeutic motivation” (Keller, 1977, pp. 32). Yet the term has flourished and is commonly used generically and indiscriminately to refer to all individuals across the entire range of substance-related problems, not just those meeting criteria for a DSM “abuse” diagnosis. It should be noted that this type of term has not been adopted in other clinical areas. For instance, individuals suffering from eating-related problems are uniformly referred to as having an “eating disorder” rather than as “food abusers” (Kelly, 2004).

Even today in published materials from federal, state, and local agencies, individuals with a substance-related condition are commonly referred to as “substance abusers.” This, in spite of the fact that the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Substance Abuse Treatment (CSAT) published a document in 2004 (“Substance Use Disorders: A Guide to the Use of Language”; SAMHSA, 2004) that specifically addressed the issue of language, stating that “abuse” was stigmatizing and should not be used. SAMHSA states that the term “abuse” is a stigmatizing word because it “negates the

fact that addictive disorders are a medical condition” and “it blames the illness solely on the individual with the illness, ignoring environmental and genetic factors, as well as the ability of the substances to alter brain chemistry.” Also, that the “abuser” label is “demeaning” because it “labels a person by his/her illness” and denies “the human dignity and humanity of the individual” (SAMHSA, 2004). This publication integrates information from numerous interviews, focus groups, and documents from the substance-related field, but none were research based.

Despite the sometimes intense rhetoric against using the “abuse/abuser” term, there has been little empirical investigation on how this term may be perceived or may elicit different responses when compared to other terms (e.g., substance use disorder). It is possible that these common and often indiscriminately used labels may carry with them implicit assumptions about personal choice and culpability (Kelly, 2004; Kelly et al., 2009; White, 2006). For instance, referring to an individual as a “substance abuser” may evoke perceptions of volitional, purposeful action and self-regulatory ability, conveying the idea that the individual is a “perpetrator” engaging in willful misconduct (Renaud, 1989). This perception may lead the individual to be seen as less deserving of sympathy, more blameworthy, more dangerous, and more deserving of punitive action rather than therapeutic intervention. Alternatively, describing an individual as having a “substance use disorder” may result in the individual being viewed as a “victim” of a biomedical process (e.g., due to genetics/biology/chemical imbalances) with less ability to self-regulate substance use behavior (impaired control), and therefore less personally culpable.

In the current study, we presented these two terms with minimal information about the labeled individual and asked participants to choose between the two across these different domains. This implied there was a difference between the described individuals, but it was left up to respondents to decide the nature and extent of any perceived differences. As a result, the survey respondents had to create their own interpretation of the individual using only the terms “substance abuser” and “substance use disorder” as guidelines. In the real world, when these terms are used to label an individual with a substance-related problem, there is often little or no descriptive information given regarding severity or related consequences of use.

It was hypothesized that the participants would view an individual labeled as a “substance abuser” as a more dangerous “perpetrator” who was in greater control of his substance use and less deserving of sympathy. As such, the “substance abuser” would be more deserving of punishment. Conversely, it was hypothesized an individual labeled as having a “substance use disorder” would be viewed more as a “victim” who was unable to regulate his substance use behavior and therefore, more worthy of sympathy. As a result, the individual with a “substance use disorder” would be viewed as in greater need of treatment.

METHOD*PARTICIPANTS*

Participants ($N = 314$) constituted a convenience sample recruited through an advertisement posted in the Massachusetts General Hospital (MGH) Research Studies in Need of Volunteers Weekly Broadcast e-mail (57.3%) and on the Clinical Trials at MGH Partners Website (27.4%), as well as through a general e-mail to the MGH Department of Psychiatry (4.5%) and by word of mouth (10.7%). The study sample ranged in age from 17 to 68 years ($M = 31.1$, $SD = 11.8$) and was comprised mainly of White (81.2%), single (55.7%), female (75.8%) participants. The majority of the sample held a Bachelors-level degree (47.1%) with just over a quarter (26.4%) reporting a Masters- or Doctoral-level degree. The professional healthcare focus of the sample was evenly split across research (23.6%) and clinical (22.6%). A further 20.1% were students and 29.3% reported a profession outside of the healthcare field (e.g., accountant, technician) or were unemployed/retired. A minority (4.5%) did not provide a response.

MEASURES*DEMOGRAPHICS:*

Age, race, marital status, education, and occupation were obtained using a brief demographics questionnaire.

SUBSTANCE-RELATED TERMINOLOGY STIGMA SCALE:

The questionnaire consisted of a brief initial descriptive narrative labeling two individuals as either “a substance abuser” (SA) or as “having a substance use disorder” (SUD), as follows: “Two individuals are actively using drugs and alcohol. One is a substance abuser and one has a substance use disorder. The following questions ask you to compare these two individuals.” There was a total of 35 questions, 18 questions formulated by the authors, 15 questions obtained from the 1996 General Social Survey (Pescosolido et al., 1996) and 2 questions adapted from research on stigma in mental illness/chemical dependence (Kloss & Lisman, 2003; see Table 1). There were six sub-scales:

1. treatment (6 items; $\alpha = .70$)
2. punishment (6 items; $\alpha = .67$)
3. social threat (6 items; $\alpha = .89$)
4. causal attribution (blame) (7 items; $\alpha = .73$)
5. causal attribution (exoneration) (4 items; $\alpha = .88$)
6. self-regulation (5 items; $\alpha = .81$)

Examples of the items are: “Which of these two individuals is more likely to benefit from inpatient care?” “Which of these two individuals would be more likely to benefit from probationary monitoring?” (see Table 1).

TABLE 1. PAIRED T-TESTS, MEANS (SD) FOR SIX SUBSCALES AND INDIVIDUAL ITEMS, AND STANDARDIZED EFFECT SIZES

Source	Treatment	.41 (.23)	.69 (.22)	$t(313) = -11.81, p < .001$	$d = -1.22$
III	Recommend treatment to decrease substance use	.67 (.47)	.85 (.36)		
III	Need for substance related inpatient treatment	.29 (.43)	.71 (.43)		
I	Benefit from prescription medication	.19 (.38)	.81 (.38)		
I	Need a referral to a psychiatrist	.23 (.40)	.77 (.40)		
I	Benefit from referral to a self-help group	.68 (.45)	.32 (.45)		
I	Referred to a primary care physician	.33 (.45)	.67 (.45)		
Punishment		.67 (.27)	.23 (.24)	$t(313) = 16.03, p < .001$	$d = 1.83$
III	Recommend punishment to decrease substance use	.33 (.47)	.15 (.36)		
III	Benefit from disciplinary procedures	.73 (.44)	.27 (.44)		
III	Benefit from a "wake-up-call" (e.g., jail time)	.79 (.40)	.21 (.40)		
III	Benefit from probationary monitoring	.74 (.43)	.27 (.44)		
III	Benefit from compulsory attendance at a substance awareness program	.67 (.45)	.33 (.45)		
III	Deserve fines for his use	.84 (.35)	.16 (.35)		
Social Threat		.58 (.39)	.42 (.39)	$t(308) = 3.66, p < .001$	$d = .41$
I	Willing to have as a neighbor	.42 (.49)	.58 (.49)		
I	Prefer to have as an employee	.43 (.49)	.57 (.49)		
III	Do something violent	.63 (.46)	.38 (.46)		
I	Happier to have as one of your close friends	.47 (.50)	.53 (.50)		
I	Do something violent to others	.63 (.46)	.37 (.46)		
I	Happier to have as a co-worker	.45 (.49)	.55 (.49)		
Attribution Blame		.76 (.24)	.24 (.24)	$t(309) = 19.26, p < .001$	$d = 2.16$
III	Substance problem caused by a reckless lifestyle	.85 (.35)	.15 (.35)		
II	Responsible for the consequences of his use	.77 (.40)	.23 (.41)		
I	Problem caused by stressful life circumstances	.66 (.45)	.34 (.45)		
III	Problem caused by his own choices	.84 (.35)	.17 (.36)		
III	Problem is related to his current environment	.79 (.40)	.21 (.40)		
III	Problem that is due to his personality	.65 (.47)	.35 (.47)		
III	Feel sympathy towards	.22 (.40)	.78 (.40)		
Attribution Exoneration		.21 (.32)	.79 (.32)	$t(309) = -15.99, p < .001$	$d = -1.81$
I	Problem that is more likely inherited	.25 (.42)	.75 (.42)		
I	Problem that is genetic in origin	.23 (.41)	.77 (.41)		
I	Problem caused by a chemical imbalance in the brain	.18 (.37)	.82 (.37)		
III	Problem related to a neuropsychological problem	.16 (.35)	.84 (.35)		
Self-Regulation		.67 (.34)	.33 (.34)	$t(309) = 8.72, p < .001$	$d = 1.00$
I	Able to make competent decisions in his life	.50 (.49)	.50 (.49)		
III	Able to stop using alcohol and drugs if he wanted	.73 (.44)	.27 (.44)		
II	Overcome his problem without professional help	.72 (.44)	.28 (.44)		
III	Able to control substance use if he put his mind to it	.78 (.40)	.22 (.40)		
I	Have the more severe substance problem	.37 (.47)	.63 (.47)		

SA= Substance abuser, SUD = Substance use disorder; Higher scores indicate agreement with the statement on left.
 I= Pescosolido et al., 1996, II= Kloss & Lisman, 2003, III= Kelly et al., 2009

These constructs were chosen because they relate to the central stigmatizing issues of controllability (“They can’t help it”) and etiology (“It’s not their fault”) as noted above. For example, greater stigma would be present if the condition is seen to be caused by factors that lie within the control of the individual, such as his/her own lifestyle choices, and others as noted in the Attribution Blame scale in Table 1. On the other hand, stigma is less likely if the individuals’ condition is perceived to be extraneous and not under the individual’s control, such as biologically-oriented factors as specified in the Attribution Exoneration scale of Table 1. Similarly, greater stigma would occur if the individual is perceived to be able to control and regulate their own behavior. From this perspective, substance use and related problems are seen as a choice which, in turn, would evoke a more blaming and punitive attitude toward the individual. Also, greater social threat would be evoked by someone who is perceived to be able to control their substance use but who nevertheless continues to engage in intoxicated, objectionable, and “reckless” behavior. We conjecture that individuals judged to be in control and more to blame for the problems’ origins are more likely to be perceived as needing punishment. On the other hand, an individual judged to be not in control (poor self-regulation) and not to blame (because of genetic variation/neuropsychological deficits, for example) would be more likely to receive a sympathetic and therapeutic response. Because the “abuser” label has been associated with perpetuating stigma among those with substance-related conditions we wanted to test empirically whether, given a choice, individuals would associate this term with significantly greater blame, self-regulatory ability, social threat, and punishment, and significantly lower exoneration and treatment need.

The endorsed choice was coded as a “1”, the non-endorsed choice as a “0”. Endorsed items within each subscale were then summed and the subscale mean was then calculated. Participants were specifically asked to choose one individual, but the questionnaire allowed for both to be endorsed, which occurred in 4.5% of cases, or neither to be endorsed, which occurred in 3.8% of cases. Items where participants endorsed both contributed a score of 0.5 to the subscale total. The last question was open-ended and asked participants to describe their perceived similarities and differences between the two individuals.

PROCEDURE

A public advertisement was posted online for two weeks beginning on June 26, 2009 through July 10, 2009 with a link provided to the online survey. All participants were presented with an informed consent form and indicated their agreement by continuing to the survey. Participants first completed seven demographic questions followed by the comparison questions. Upon completion of the online questionnaire, participants were thanked and given the option to submit their e-mail address. Those who submitted an e-mail address were entered into a lottery where five individuals

were randomly selected to receive fifty dollars. Personal e-mail addresses and survey responses were kept separate. There were no eligibility or exclusion requirements. Participants consisted of all who responded to the online advertisements in addition to those informed of the study by others. Participants self-identified their racial, educational, and professional background along with other demographics. The study was evaluated and approved by the IRB of the Massachusetts General Hospital, Partners Healthcare System.

DESIGN AND ANALYSIS

Subscales were summed and mean scores calculated. Six dependent samples t-tests were computed to test for differences between terms on each subscale. Given the potential for type I error inflation with multiple comparisons, we used a Bonferroni-adjusted alpha level for statistical significance of .008 (i.e., $0.05/6$) for the main hypothesis tests. Standardized effect sizes (Cohen's delta) were also computed (see Table 1). All data were analyzed using SPSS 17.0.

RESULTS

DEMOGRAPHIC DIFFERENCES ACROSS SUBSCALES

Four independent t-tests were conducted to examine the relationship between demographic variables and the six subscales for the SA and SUD terms. To control for multiple tests in these analyses, we did not use a Bonferroni-corrected alpha level, as we did for the main hypothesis tests, but we did use a more stringent alpha level of $p < .01$, to help protect against type I error inflation. No significant differences were found between gender, race, or educational level on subscale scores for the SA and the SUD terms. However, single participants ($M = .72$) had a significantly higher punishment subscale score for the SA term than married participants ($M = .61$), $t(199) = 3.45, p < .001$. Conversely, married ($M = .28$) participants had a significantly higher punishment subscale score for the SUD term than single participants ($M = .20$), $t(282) = -2.85, p < .005$.

We also tested whether there were any differences across the six subscales by professional focus (students vs. health-related vs. research-related) using one-way ANOVAs. No significant differences were observed across professional focus on these six sub-scales ($ps > .07$).

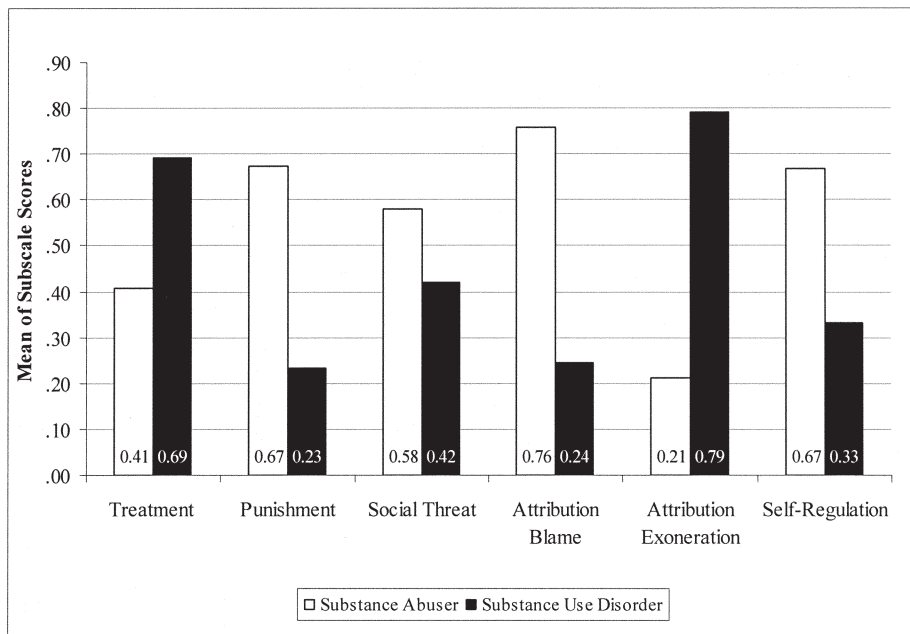
SUBSCALE COMPARISONS FOR SA AND SUD TERMS

The results from the six paired t-tests along with the means, standard deviations, and standardized effects sizes are displayed in Table 1. All of the comparisons were statistically significant at the type I error Bonferroni-protected level ($p < .008$) in the hypothesized direction. The largest effect sizes were found for the sub-scales assessing the perceived causes of the substance-related problem, specifically

the “causal attribution (blame)” subscale ($d = 2.14$) and the “causal attribution (exoneration)” subscale ($d = -1.83$; see Figure 1). On the “blame” subscale, individual-level items regarding problems being caused by “a reckless lifestyle” and “his own choices” had the largest differences. Participants were significantly more likely to choose the SA ($M = .85$) over the SUD ($M = .15$) when asked which individual’s substance problem was more likely caused by a reckless lifestyle, $t(306) = 17.29, p < .001$. Participants were also significantly more likely to choose the SA ($M = .84$) over the SUD ($M = .17$) when asked which individual’s substance problem was more likely caused by his own choices, $t(302) = 16.39, p < .001$.

Conversely, on the “exoneration” scale, the largest significant difference occurred on individual-level items regarding problems having a “genetic origin” and being related to a “neuropsychological problem.” Participants were significantly more likely to choose the SUD ($M = .77$) over the SA ($M = .23$) when asked which individual’s substance problem was more likely genetic in origin, $t(304) = -11.52, p < .001$. Participants were also significantly more likely to choose the SUD ($M = .84$) over the SA ($M = .16$) when asked which individual’s substance problem was more likely related to a neuropsychological problem, $t(303) = -16.89, p < .001$. Finally,

FIGURE 1. SUBSCALES COMPARING THE “SUBSTANCE ABUSER” AND “SUBSTANCE USE DISORDER” DESCRIPTIVE LABELS



the SUD label ($M = .78$) was significantly more likely to elicit sympathy than the SA term ($M = .22$), $t(293) = -11.91$, $p < .001$. The smallest difference was found for the “social threat” subscale ($d = .41$), in which participants’ views were more evenly split. Nevertheless, participants still perceived the SA ($M = .58$) as significantly more of a threat than the individual labeled as having an SUD ($M = .42$), $p < .001$.

DISCUSSION

This study examined the effect of substance-related terminology on perceptions of etiological cause, personal culpability, social threat, and self-regulatory behaviors of an individual with a substance-related condition, as well as the perceived need for punitive versus therapeutic measures. Significant differences were found in the hypothesized direction for all of the subscales. Participants were substantially more likely to view the SUD individual as more in need of treatment compared to the SA individual, who was viewed as more deserving of punitive measures, such as a jail sentence and fines. Examination of the individual-level items on the “blame” subscale reveals that participants were much more likely to view the SA individual’s problems as being associated with “willful misconduct” caused by personal recklessness and his own choices compared to the individual with a substance use disorder. Conversely, the “exoneration” sub-scale items revealed that participants were much more likely to view the SUD individual’s problems as stemming from more uncontrollable biological origins. The SA was also substantially less likely to elicit sympathy compared to the SUD individual. Finally, participants were much more likely to view the SA as being able to control or stop his substance use if he wanted to, more able overcome his problem without professional help and to have a less severe problem. Overall, this pattern of findings indicates that these two terms elicit very different judgments that may have implications for treatment and related policy.

Despite the long standing opposition to the use of this term, broad use of the “abuser” label persists and is commonly used even among committed substance-focused organizations dedicated to decreasing stigma (e.g., in published materials from the National Institute of Drug Abuse and the Substance Abuse and Mental Health Services Administration/Center for Substance Abuse Treatment). Moreover, the “abuser” label is used generically and indiscriminately to describe individuals across the broad array of substance-related problems, not just for those individuals meeting DSM “abuse” criteria. Consequently, its use may perpetuate global stigmatizing attitudes creating a barrier to treatment for those most in need of help (i.e., those with substance dependence). Influential organizations such as these set a normative tone for the media and society in general. As a result, it is possible that individuals with substance-related problems may internalize these stigmatizing beliefs when referred to as “abusers,” thereby increasing their sense of shame

and anxiety and creating a barrier to honest self-disclosure and treatment seeking (SAMSHA, 2008).

LIMITATIONS

Findings from the current study should be viewed with caution in light of several limitations. First, the sample was opportunistic and web-based, and consisted of mostly White, female, health care workers, limiting the extent to which our findings may be generalizable. However, findings did not differ across gender, ethnicity, or occupational status within our sample. The one exception is related to marital status, which showed a significant difference. Future studies with more truly random general population samples as well as more specific law/policy-making samples will provide further insight into how these terms influence attitudes, related decision making, and stigma.

A possible criticism of the study design is the way in which the terms were applied to the individual. In the case of the “abuser” label, the individual *is* a substance abuser, whereas the other individual *has* a substance use disorder. To say someone *is* something versus *has* something may carry its own distinct bias irrespective of what, specifically, the individual is or has. This may help explain, in part, why the abuser label evokes different judgments about behavioral self-regulation, social threat, and treatment vs. punishment. However, this is really the crux of the issue. These labels are applied to individuals in the real world in this exact manner and both terms are often used indiscriminately. We deliberately chose to present the terms in this way to reflect common usage. Use of the “abuser” label *requires* that it be directly applied to the person, whereas the “substance use disorder” term cannot be used in this way.

CONCLUSIONS

Results from this study suggest that it may matter how we refer to individuals with substance-related conditions and that use of, and exposure to, the “abuser” label may elicit or perpetuate stigmatizing attitudes, increase perceptions of the need for punitive action, and decrease perceptions of a need for treatment. Given that treatment is strongly associated with reducing the personal, social, and financial impact of substance-related disorders (Rehm et al., 2006), and that stigma is a documented barrier to treatment access (SAMSHA, 2008), an obvious public health policy goal should be to eradicate or minimize stigma whenever possible. One simple and inexpensive way to achieve this may be to uniformly refer to affected individuals as having a “substance use disorder,” as is done with eating disorders. Furthermore, since the “abuser” label does not appear to confer any unique advantage in descriptive precision, its non-use would be unlikely to produce any negative results. Finally, as the field moves toward DSM-V, it may be helpful to replace the “abuse” terminology

with a less pejorative term, such as “harmful use” or “misuse.” This is because, as argued by Keller (1977), the “abuse” term may contribute to the construction and continued use of the “abuser” label. Ultimately, the less stigmatized these conditions are, the more likely individuals will be to enter and remain in treatment.

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