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Opinion

Perpetrators and Perpetuators: Clinicians and Stigmatizing Language

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Opinion

As a longtime practitioner and counselor educator, I frequently spend time thinking about how seeming simple things like the language we use as clinicians to refer to people with mental health and substance use disorders may help contribute to the stigma that our patients and clients experience on a daily basis. In fact, I believe that those of us who should be models for how best to use non-stigmatizing language are often the worst at this simple, yet important, task.

This was first pointed out to me by the estimable David Mee-Lee, an American psychiatrist and a well-known trainer in the addiction treatment field, at a training he did many years ago. He asked his audience how many people had described a positive drug test by a client as a "dirty urine." Many hands, mine included, were sheepishly raised by attendees, and Mee-Lee noted that this was not unusual. He went on to challenge the audience-clinicians all—to use language for our patients and clients just as we would for individuals with any other health conditions. He rhetorically asked if a physician would tell a patient with high cholesterol that he or she had "dirty cholesterol." Ultimately, he urged us to simply tell the patient that the test was positive for whatever substance and then to move on and adjust the treatment plan accordingly.

Ashford RD, et al. [1], continued this theme in an article focusing on what they called "recovery dialects" relating specifically to those with substance use disorders. The authors distinguished between language used in mutual help meetings (such as Alcoholics Anonymous and Narcotics Anonymous) and that used in public in medical settings, with clients, and in the press. They wisely suggested that some language (such as the words "alcoholic" and "addict") might be acceptable in familiar setting such as recovery meetings, but would not be appropriate in public settings or directly with clients—again pointing out that professionals might be regular purveyors of the language of stigma, while offering concrete proposals on alternative non-stigmatizing language.

So, what are some of the terms that clinicians should avoid?

I would like to highlight two in this discussion: "suffering" and "frequent flyer."

It has become commonplace to refer to an individual with a particular diagnosis as "suffering" from that particular condition. Take a moment to reflect on that. We do not presume to speak for individuals with diabetes, heart disease, hypertension, and other chronic conditions as "suffering" from those. In fact, many people live highly normal lives with well-managed health conditions such as these. For some reason, however, we insist on labeling those with substance use and mental health disorders (bipolar disorder, anxiety disorders, alcohol and opioid use disorders, etc.) as "suffering" from them—even when stable recovery has been achieved. We can and should do better.

The term "frequent flyer" has lingered around the fringes of the health and mental health fields for years, if not decades, and continues to be an offensive, inappropriate way of referring to individuals who utilize services at a high level or with high frequency. In fact, as noted by Joy M, et al. [2], the term has even at times been accompanied by an airplane symbol on patient charts or medical records to flag individuals with this profile, raising the questions of whether a treating clinician can approach such a patient with objectivity, compassion, and dignity that are ethical imperatives.

In summary, as much as we clinicians may like to point fingers at the general public, perhaps it is we who are at times the worst offenders. From awareness and concerted dialogue comes change—perhaps these thoughts might influence some to reconsider their words or thoughts. More than political correctness, this is a moral and ethical obligation.

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Conflict of Interest

Author declare no conflict of interest.