Recovering Individuals' Feelings About Addict and Alcoholic as Stigmatized Terms: Implications for Treatment

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ABSTRACT

Background: The current emphasis among addiction treatment providers is to use person-first language, such as "a person with a substance use disorder," as a way to reduce stigma around addiction and resulting barriers to treatment. This study considers how individuals recovering from substance use feel about the terms "alcoholic" and "addict," particularly how they self-identify and whether they believe the terms carry stigma.

Method: Thirty-five individuals were interviewed, recruited primarily, but not exclusively, from 12-step meetings (Alcoholics Anonymous, Narcotics Anonymous), from 3 locations throughout a rural New England state. Interviews were transcribed and coded in Atlas Ti qualitative analysis software, and a content analysis of text coded with "stigma" was conducted.

Results: Some comments reflected a belief that the terms "addict" and "alcoholic" carry a stigma. However, more comments rejected the notion of these being stigmatized terms; or acknowledged the stigma but reflected the subject's lack of internalizing of any stigma. Comments reflected other themes including a sense of pride, identity and ownership when self-identifying as an addict or alcoholic. Several comments suggested that person-first language is part of a larger movement to "soften everything," without changing the underlying condition (addiction). The findings may reflect the fact that subjects were recruited from 12-step programs, where the convention is to self-identity using the terms "alcoholic" and/or "addict."

Conclusions: Some individuals seeking treatment for addiction may prefer self-identifying using old-school terminology (addict, alcoholic) rather than person-first language, for a variety of reasons (eg, they do not internalize the stigma of such terms).

KEYWORDS: Addiction, substance abuse, stigma, recovery

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Introduction

According to the National Institutes of Health's (NIH) HEAL—Helping to End Addiction Long-term—Initiative[1] and the NIH's Justice Community Opioid Innovation Network[2] (JCOIN), "Words describing substance use disorders (SUD) have a significant impact on those struggling with their disease and how they are treated."[3] In this vein, the use of person-first language intends to communicate respect and compassion for the individual. This can help to minimize discriminatory practices toward a person with addiction.[3] Person-first language begins with the individual (eg, a "person with a substance addiction"), rather than leading with a condition or characteristic (eg, "drug addict").[4,5] While individuals themselves may opt to self-identify as an "addict" or "alcoholic," these terms are not foisted on them by others according to the rationale of person-first language.

A primary concern among advocates for person-first language is that assigning a label like "addict" or "alcoholic" to another is stigmatizing, connoting that the individual is somehow lesser than others.[6] Stigma impacts how society at large approaches conditions such as chronic substance use.[6] Prior research[7] has found that health professionals tend to hold negative opinions of patients with substance use disorders, and this in turn adversely affects the type of healthcare they provide. Sensing others' judgment, individuals may pick up on the stigma associated with their condition and internalize that negative judgment.[8,9,10,11] This contributes to feelings of worthlessness[8] and possibly sets up an additional obstacle to treatment for their condition.

The issue of stigma is relevant to the study of substance addiction and treatment as individuals mired in addiction *and* feeling stigma around their condition may be reluctant to get into, or remain in, treatment. In short, stigma in its various forms is a barrier to recovery[12] as documented in prior research[13,14,15] published in *Substance Abuse: Research and Treatment* and elsewhere. There are multiple sources of stigma[16] around substance abuse, such as a person's own internalized stigma[17] and stigma emanating from the public which can

result in problems like stereotyping addicted individuals as dangerous.[18] Other sources include anticipated stigma, which happens when individuals with a socially stigmatized identity are aware of others' negative attitudes toward them and *preemptively* expect to be rejected once their identity is revealed.[16] Enacted stigma encompasses actions like discrimination and social distancing; that is, how public stigma plays out through others' behaviors.[16] These behaviors may include emotional reactions such as fear or revulsion.[18] Friends and family of a person with a stigma may experience a "courtesy stigma"[16] through their connection to the individual with the stigmatized identity. Finally there is structural stigma, or the ways that societies stifle individuals with stigmatized identities via policies, institutions and (lack of) resources.[16,19]

This paper considers how individuals with a substance use disorder—alcohol, other drugs—feel about the use of person-language; whether terms like "addict" and "alcoholic" are stigmatizing; and how they refer to themselves in the context of their recovery (eg, in 12-step fellowship meetings).

Literature Review

Origins of person-first language

Person-first language dates back to the 1970s to 1980s and the disability rights movement,[20] wherein advocates pushed for language recognizing that people are not defined solely by their disability[21] As Bedell et al[21] write, "labels can serve to 'other' people and signify a lower social position based on a conflation of a person with a socially devalued trait" (p. 1141). Other fields (medicine, epidemiology) were slower to adopt this, but the philosophy has since permeated much of the health fields. Person-first language is championed by the American Psychological Association[22]; supported by advocates for individuals with autism[23,24,25]; and widely used in nursing and other healthcare fields.[4,26], Losorelli et al[27] recently recommended purging medical and surgery literature of prejudicial terminology, and instead choosing language that is clear, descriptive, precise, and non-stigmatizing.

Word matters: Use of person-first language across disciplines

Person-first language emphasizes the individual first—their abilities, needs, strengths—rather than their disability.[4,5] Word choice and how it is perceived by others matters, particularly between patient and care provider.[26] Poor language choice can contribute to poor treatment and patient outcomes, ultimately wasting resources and increasing healthcare costs.[26] The use of person-first language can also help reduce stigma around a condition.[5] One study[5] found that when person-first language was used regarding individuals with autism, additional stigmatizing language was subsequently avoided as well.

That said, there is some disagreement on the utility of person-first language. Debate around the use of person-first versus identity-first language has been particularly passionate in the autism community.[28] Surveying over 700 U.S. autism stakeholders, Taboas et al[29] found differing preferences across different groups, including professionals, parents of autistic youth, and adults with autism. Whereas a majority of surveyed autistic adults preferred self-identifying using identify-first, a non-small minority preferred person-first language. By contrast, professionals tended to use person-first language.[29]

Person-first language, addiction and stigma

In the past 2 decades, there has been a sizeable increase in overdose-related deaths, much of this linked to an epidemic of opioid use.[30,31] In addition to shouldering an addiction, individuals with substance use disorders are confronted with the stigma often attached to drug use, a ubiquitous phenomenon that can adversely affect treatment outcomes, care providers and research and policies more broadly.[6,32] Stigmatizing language around drug use can communicate—both intentionally and unintentionally—that not being able to stop using substances is rooted in weak willpower and a lack of personal self-control; in other words, personal failings.[6,31] By contrast, a destigmatized view frames addiction as a brain disease.[6] A review[7] of 28 studies of health professionals' attitudes about addiction found that negative opinions about patients with a substance use disorder were frequent, and linked to poor care provision toward these patients.

In general stigma is associated with stereotyping, discrimination and the loss of a person's status.[31] With regards to stigma around substance abuse, individuals anticipating being stigmatized for their substance abuse may conceal it, engage in high-risk practices and socially isolate.[31] Having internalized the stigma, individuals with a substance use disorder may avoid seeking out help. At the broader societal level, public stigma around addiction contributes to discrimination in employment and housing, and resistance to have community-based resources established in some neighborhoods.[31] As an example, harm reduction initiatives such as safe injection sites have traditionally received low support from the public,[33] underscoring policy implications of stigma around addiction.

The issue of stigma around substance addiction has been studied both in the U.S. and internationally.[18] A review[18] of published studies, 15 of which were non-U.S. based, found that stigma reactions to substance addiction were stronger than toward other types of mental health disorders. Individuals with substance use disorders were often blamed for their condition. A U.K. study[34] of smoking during pregnancy found that women who smoked while pregnant typically faced negative judgment from the public, including healthcare providers, which contributed to them smoking in private. In other words, the stigma achieved no positive outcome (ie, it did not decrease the women's smoking) and served only to shame the women. A recent study[35] of addiction stigma conducted in Australia notes that

stigma can undermine trust between an individual and their healthcare provider, weakening the quality of the care. A 2021 cross-national study[36] (U.S., Canada, Australia) of public stigma toward substance addiction found that substance addiction was more stigmatized than other types of medical or psychiatric disorders, and was viewed as a personal moral failing.

To begin to tackle the issue of stigma around substance abuse, some[37,38] have called for using person-first language (eg, an individual with a substance use disorder, an individual with an alcohol use disorder) rather than terms like "alcoholic" or "addict," viewing them as both stigmatizing and non-medical in nature. Change in language may result in greater public support for the treatment for opioid addiction,[32] for example. Sattler, Escande, Racine et al[39] note that while stigma-rooted negative attitudes toward people with a substance use disorder can adversely affect those individuals' lives, there remains a lack of research on this area compared to other areas (eg, the effect of stigma on other mental illnesses). The focus now shifts to how recovering individuals feel about the words "addict" and "alcoholic," and whether they consider those terms to hold stigma.

The Present Study

This article presents preliminary findings on recovering individuals' feelings about the words "addict" and "alcoholic" being stigmatized terms, and how their view affects how they self-identify (eg, in 12-step fellowship meetings). These findings are part of a larger study examining the impact of COVID-19 on individuals' substance abuse and recovery. (See the funding statement for details about the larger study.)

Method

From June 2022 through May 2024, the principal investigator (PI) is in the process of interviewing up to 100 individuals recovering from substance abuse, recruited from different socio-economic areas throughout a rural state in the New England region of the United States. Two-third of the state's residents (under 1 million people) live in rural areas.[40] Individuals recovering from substance abuse disorders in rural areas face unique challenges[41] including needing to travel far to access treatment, and limited substance abuse counselors and peer support available.[42] To date, 35 individuals have been interviewed.

Recruitment

Approval from the PI's university's institutional review board (IRB) was obtained prior to subject recruitment beginning. To recruit subjects, the PI visited and announced the study at 12-step meetings of the Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) fellowships that were designated as open to the public, meaning that an attendee does not need to be in recovery from substance abuse themselves to attend. The PI initially selected 12-step meetings in a city with a population around 44 000 (recruitment location #1); a rural, poor town (recruitment location #2); and an affluent, suburban town (recruitment location #3). Twelve-step meeting times and locations were obtained through 2 apps that were downloaded to the PI's phone. The PI also hung recruitment signs in recovery centers, clubhouses, and church basements where 12-step meetings sometimes convene. Additionally, PI asked subjects if they knew anyone else with whom the PI might speak (ie, snowball sampling[43]), at the conclusion of an interview. Subjects were offered a $20 Amazon gift card as an incentive to participate in the interview.

While the language varies slightly between the 2 fellowships, the twelve steps[44,45] of the AA and NA are essentially the same, recommending a sequence of behavioral changes beginning with admitting to having no control over the individual's abuse of substance(s) (step 1). Subsequent steps include the individual committing to participate in the program (eg, attend regular meetings) (step 3); writing down a personal inventory of past misdeeds connected to substance abuse, and people they had harmed (step 4), and then sharing the personal inventory with an AA or NA sponsor (step 5). (A sponsor is a mentor with more time in the fellowship than the individual.) In later steps, the individual asks a higher power (eg, God, in whatever form they understand God to be) to remove their character defects (steps 6-7); and makes amends to individuals they have harmed in the past (steps 8-9). In the final step (step 12), individuals may choose to participate in fellowship service such as going on speaking engagements in rehabilitation facilities and/or prisons, to carry the recovery message to other individuals struggling with substance addiction.

Subjects

Of the 35 subjects, 19 are male, 13 are female, and 3 are gender non-binary. All but 2 were White, in keeping with the largely White population of the state. (Of the 2 non-White subjects, 1 female was Hispanic and 1 male was Native American.) Subjects' ages ranged from 22 years old to 75 years old, with a mean age range of late-30's. For comparison purposes, the demographics[46] of the greater U.S. are 75% of the population is White-alone; 13.6% of the population is Black-alone; 1.3% is Native American and/or Alaska Native; and 3% is multi-racial. Nearly 14% of the U.S. population is Hispanic. The biggest notable difference between the present study's sample and the greater U.S. population is the lack of African Americans in the study's sample. As per the U.S. Census,[46] male persons comprise 50.6% of the U.S. population and female persons comprise 50.4% of the U.S. population. According to Pew Research Center data,[47] 1.6% of the U.S. population is transgender or non-binary. The mean age of the greater U.S. population is 38.9 years.[46]

Fourteen individuals self-identified as an addict; 17 self-identified as an alcoholic; 3 individuals self-identified as both an alcoholic and an addict; and 1 individual did not use a label in self-identifying. Ten subjects indicated they attend NA exclusively; 15 attend AA exclusively; 7 subjects attend both 12-step fellowships; and 3 subjects do not attend 12-step fellowship meetings but rather other types of recovery mechanisms such as intensive outpatient meetings or medication assisted treatment (MAT) meetings. Nine individuals indicated that they had recently relapsed with substances.

Demographic comparison of the sample by location (ie, city, affluent suburb, rural poor town) did not show meaningful differences in gender, race or ethnicity. There were differences in mean age (50's) of subjects recruited from the affluent suburb, as compared to individuals from the other 2 recruitment locations (30's). These differences should be interpreted with caution given the small sample size and non-random nature of the sampling. There were some non-significant differences by recruitment location in the type of 12-step fellowship attended, with individuals from the rural site being more likely to indicate they attended N.A. mainly or exclusively; individuals from the suburban site more likely to say they attended AA mainly or exclusively; and interviewees from the city site more likely to indicate they attended both fellowships equally. There were no differences by recruitment location in terms of length of recovery or attendance at virtual meetings. Individuals recruited from the suburban location were more likely to report having encountered Internet obstacles (eg, buffering, URL link not working) to attending virtual meetings during the pandemic period than individuals recruited from the other 2 locations.

Interview protocol, data, coding, analysis

Subjects' interviews were recorded and subsequently transcribed using an outside transcription firm. The interview transcripts were uploaded into Atlas Ti qualitative analysis software which has been used in other qualitative public health research.[48,49] Subject answers to open-ended questions were coded using a code list created based on the interview protocol. Using codes from a code list is an initial step in conducting a content analysis[50] of responses to open-ended questions. Content analysis is a method of analyzing written communication, such as interview transcripts.[51] The researcher tags sections of text (sentences and paragraphs) with content-relevant codes[52] in the software program (Atlas Ti, in the present study). Once all text has been appropriately coded, the researcher then performs a search in Atlas for all so-coded text, beginning the content analysis process. Two student research assistants independently performed the initial coding of the qualitative data (ie, words and phrases) in the transcripts, and for interrater reliability checked each other's coding. The PI subsequently checked the research assistants' coding.

Once all the verbatim text from the interview transcripts was coded with the broad code "stigma," a qualitative data analysis approach[53] was employed, reviewing and downloading coded text into an Excel spreadsheet. Coded text was then further categorized into 8 recurrent themes pertaining to whether or not the subject felt the terms "alcoholic" or "addict" were stigmatizing. The recurrent stigma-relevant themes were then further categorized into 2 opinion dimensions (see Table 2): whether the terms carry a stigma, and other thoughts about the terms. The results are discussed both in terms of the number of *subjects* that responded a particular way (Table 1), as well as the number of *comments* linked to a particular theme (Table 2).

Table 1. Respondents' feelings about the terms "alcoholic" and "addict" being stigmatized.

	N	PERCENT
Yes, the terms are stigmatized	14	41.2
No, the terms are not stigmatized	19	55.9
Not sure	1	2.9
Total	34[a]	100.0

[a]One subject did not give a clear response to the question. One subject did not answer the question.

Results

As seen in Table 1 above, a lesser percentage of subjects (41.2%) agreed that the terms "addict" and "alcoholic" are stigmatizing. A greater percentage of subjects (55.9%) disagreed that the terms hold a stigma. Crosstab analyses (not shown in table format) did not reveal any patterns in views on the stigma of the terms based on (a) type of 12-step program attended (AA vs NA vs both); (b) recruitment location; (c) preferred substance; (d) length of time in recovery; or (d) subject age. The 1 pattern that did emerge was that of subjects who had used cocaine in the past (n = 24), 75% of whom did *not* view the terms "addict" or "alcoholic" as stigmatizing.

Some subjects' comments (n = 16) reflected a belief that the terms "addict" and "alcoholic" carry a stigma. "It's horrible to identify myself as hi, I'm an addict." "If you go out on a date and you drop addict or alcoholic in there, it changes everything, because of their, you know, the perception and that's informed by medical literature, and plays, and movies, and stuff in the public sphere." "I believe that the term is absolutely heavily stigmatized, because so little is known about addiction." "I think the language needs to be changed. I think too often we call ourselves something that's kinda demoralizing, like an addict or an alcoholic."

There was some nuance in this. Five comments reflected a belief that while there is a stigma attached to the terms in general, the interviewee did not internalize the stigma. "I mean, I will agree that it is kind of stigmatized. But me, personally, I don't see anything wrong with acknowledging myself as an alcoholic because it's, quite frankly, the truth." And "we're not stigmatizing against each other. At least I don't feel that way. I actually feel like that's one of the only places I've been able

Table 2. Common themes about stigma of the terms "addict" and "alcoholic" across the interviews.

OPINION DIMENSIONS	DO THE TERMS CARRY A STIGMA?			OTHER THOUGHTS ABOUT THE TERMS				
Recurrent themes	Yes	Yes, but don't internalize it	No	Pride, identity	Uses the term because it's the convention of the 12-step program	Critical of person-first language	Stigma depends on the type of substance	Not sure they're an addict or alcoholic
Total number of comments	16	5	30	12	8	6	2	2

to say that comfortably. But I can understand, like from an outsider, why that would be kind of, like, a precarious thing to say." One comment reflected support for the person-first approach: "I do like to say my name is _____and I am an addict. I think because first and foremost, I'm a person, that's who I am. I think addiction is just another part, not me as a whole." A number of comments reflected the view that outsiders (ie, individuals who did not have a substance use disorder) might see the terms as stigmatized because they couldn't understand, being outsiders.

Many more comments (n = 30) reflected a rejection of the idea that the terms "addict" and "alcoholic" carry a stigma. "I don't have a problem saying 'I'm an alcoholic'." "It's [addict] not a bad label today." "At the end of the day, you can label it whatever you want, I'm still an addict." "I don't really think it's stigmatizing. I mean, I think maybe somebody that's like 10 years in recovery might, like, not appreciate being called a junkie [laughs] or something." "I don't have any issues that people want to if people want to like, like split hairs when it comes to semantics. I say go for it, if you if you feel comfortable identifying yourself as someone with a substance misuse disorder, as opposed to just saying that you're an alcoholic, go for it, but I personally had zero issues with just saying I'm an alcoholic." "I never felt stigmatized by being an alcoholic."

Pride, identity

Rather than expressing fear of stigma around use of "addict" or "alcoholic," 12 comments reflected a sense of pride and identity about the terms' use. "I want to call myself an alcoholic because I want to own that every day." "I think of it more of a—not a right of passage but like a privilege, you know, to say that I'm an addict who's still alive and, you know, in recovery more than a stigma . . . it's not a bad label today." "I like to identify as alcoholic 'cause that's how I first came to kinda identify when I first came into the room." "But like being called, you know, being an addict or an alcoholic, like, that's how we self-identify, you know?" "If I were to say it any other way of putting it, I would be putting it lightly and not giving it the importance that the word 'alcoholic' to me gives it, and that it would be taking away of like the seriousness of it, just in my opinion, for me, that it'd be, like, taking away the seriousness of what alcoholic says." "I say I'm an alcoholic because I go to AA meetings, and I feel like it's not so much honoring the program as some people put it, it's more about, I guess, just being simple and humble." "I think we just call a spade a spade. I'm an addict. I'm addicted to drugs. I'm addicted to alcohol, pretty much anything that alters my state of mind." "Openly admitting out loud that I'm an addict has really helped me to see that I've spent a long time not being real with myself, not really being honest about what I was doing, or how I was acting. So, now when I say I'm an addict, it makes me feel more like I'm being true to myself."

Use of the terms because of the convention of 12-step programs

Eight comments reflected the subject's self-identification as an addict or an alcoholic out of respect for the norms of 12-step programs. "People in meetings don't use the person-first language. You'd be kicked out." "People say it because it's like, let's just get this part of the meeting over with, we're just introducing ourselves. Like I don't ascribe any—when I say I'm so and so, I'm an alcoholic, or I'm so and so, I'm an addict, I do it for the sake of time and convenience." "Like what's the problem with just using the term alcoholic? Because you definitely drank in a problematic way, and used everything the same, so why not? And I also got sober in like, kind of a more conservative AA type of community." "But I think in these rooms specifically, in the AA room specifically, in my experience, it feels like a safe space to use those words." "It was important for me to identify that way [as an alcoholic]. And honestly, I think because that was sort of the cultural norm within AA. That was relatively easy for me to latch onto, and do it because that's what the majority of people also did." "That doesn't define me as a person, but that defines who we are in those meetings." "But in AA meetings, I do like to say an alcoholic and an addict because I'm not just an alcoholic."

"Softening everything" and "more of a mouthful": Critical of person-first language

In response to the PI's question about whether the terms "alcoholic" and "addict" were more stigmatizing than, for example, "person with a substance use disorder," subjects made 6 comments that can be considered critical of person-first language. "Like they can change the name, it doesn't change what the actual disease is, you know?" "My belief is that there is an enabling that has occurred by the government and by society generally—not that that's not needed, I believe that an

alcoholic or addict is gonna hit their bottom, and maybe my approach is wrong, but, you know, that you don't hit until you hit it and I've seen people die because of not getting there." "It's a load of shit. They don't know what they're talking about. You have to be in the culture in order—it's like, that's my word, motherfucker." "I think it's society's way of softening. Not a supporter of that." "I'm not up to par with that kind of world of softening everything, I guess." "I think that also, the term 'disorder' kind of like, it makes me . . . When somebody says that about me, that makes me feel like there's something about me that's defective, which that might be the case. But for me, that language is not helpful; it's more of a mouthful." "There's a big part of me that wonders if the people who decided that these terms are stigmatizing are people who are not addicts or alcoholics themselves."

Stigma depends on the type of substance (alcohol)

A small number of comments made the point that stigma related to addiction varies by substance type, specifically referencing alcohol. Both comments were made by subjects who primarily identified as alcoholics and were recruited via AA. As 1 subject explained, "there's still stigma—but for alcohol, there's not as much stigma as it sorta used to be." Another interviewee explained, "I never felt stigmatized by being an alcoholic . . .. And I wished I was an alcoholic, because to me, that seemed more acceptable, so I didn't think of being an alcoholic as stigmatized. I did have to deal with stigma with bipolar and mental health, I did have to deal with stigma being more—you know, I mean, there was stigma like for people that are heavy [overweight], you know, I had to deal with that more." The stigma of any other specific substances (eg, heroin) did not emerge in any of the comments.

Unsure of whether they're an alcoholic/addict

Finally, 2 subjects indicated that even though they use the term addict and/or alcoholic, they don't fully accept that the terms apply to them. As 1 individual said, "When I say I'm so and so, I'm an alcoholic, or I'm so and so, I'm an addict, I do it for the sake of time and convenience. It's not like, that I actually believe that I'm an addict or an alcoholic. I mean I really, in the truest sense of those definitions, I really don't believe that I am one." Another interviewee explained, "I remember the first time I ever went to rehab, and it was in 1995, and I was 23, 22 years old, and everybody kept telling me I had to define myself as an addict. And at the time, I knew that I had a problem with drugs, but I didn't, I believed that deep down, I wasn't really addicted, like I had a physical dependence, but like, I wasn't—it wasn't a lifetime thing, I wasn't an addict, I didn't wanna, I just remember it being, feeling resistance . . . everybody kept saying, just say you're an addict, and I'm like, but I'm not, I don't believe that, like I'm not doing this forever fucking thing, whatever this is. And when I finally said it, it was just to like, ease the tension in the room, it wasn't because I really believed it."

Discussion

This paper considers how individuals with a substance use disorder—alcohol, other drugs—feel about the use of person-language; whether they feel it is stigmatizing; and how they refer to themselves with regards to their recovery (eg, in 12-step fellowship meetings). This study relates to the current emphasis in the addiction treatment field to use person-first language to avoid stigmatizing individuals with addiction and potentially contribute to further substance abuse or relapse. The results presented in this paper reflect interviews with 35 individuals recruited largely from 12-step recovery programs.

The results show that more comments reflective of a non-stigma view of the terms "addict" and "alcoholic" than viewing the terms as stigmatized. This may reflect the fact that subjects were mainly recruited from 12-step programs, in which the norm is to introduce oneself and then self-identify using (typically) 1 of the 2 terms. There was some nuance to this, in that some comments reflected the interviewees' sense of pride and identity in self-identifying as an alcoholic or addict (or both). Other comments suggested that self-identifying using one of the terms indicated ownership of the condition, a taking-of-responsibility of their substance abuse and any behaviors stemming from it. Some comments suggested that self-identifying as an addict or alcoholic in the context of a 12-step meeting was a safe space to do so, surrounded by other similar individuals who would not judge them. A few comments expressed skepticism about person-first language, suggesting that it was overly wordy, and possibly softens phrasing around a serious condition (substance abuse) without actually changing the condition itself.

A few comments reflected that subjects did see stigma in the terms "addict" and "alcoholic," and liked the idea of reframing addiction using person-first language. Several comments indicated that while there is stigma attached to the terms, the subject did not internalize the stigma. Finally, some individuals disliked having to self-identify as an alcoholic or addict not because they found the terms stigmatizing, but because they did not completely accept the idea that they had a permanent substance abuse problem. One subject expressed a dislike of the term "disorder" in substance use disorder, suggesting that the term implies a personal defect. Rather than suggesting that words and phrases currently favored in the profession (eg, substance use disorder) are not effective, the take-away is perhaps that it is impossible to please everyone all the time. While multiple-word descriptive phrases may be more of a mouthful than straightforward one-word terms like "addict" or "alcoholic," the move toward such person-first language is rooted in a desire to destigmatize addiction, remove barriers to recovery, and be more respectful to vulnerable people—all good things.

Limitations

Given the modest sample size and how subjects were recruited, it is not possible to generalize the results to the larger state- or U.S.-population and the results should be interpreted with that caveat. As was discussed, the demographics of the sample differ from those of the greater U.S. population, in particular the lack of subjects who are African American. As individuals recovering from a substance use disorder sometimes exist on the fringes of society and grapple with additional issues such as homelessness, a convenience sampling approach seemed most feasible as opposed to random sampling. As additional individuals are recruited for interviews, the PI anticipates seeing more patterns in response types. It is possible, for instance, that patterns by type of substance used or program attended, and views on stigma, may emerge.

There may be bias in the data in that subjects were recruited primarily from 12-step treatment programs where acceptance of one's addiction is central to participating in the fellowships. (See, for example, the "Who is an addict?" brochure[54] published by N.A., typically available at meeting locations.) In this way, the subjects who were interviewed may not be representative of individuals who have not (yet) sought out treatment for substance addiction.

Treatment Implications

The current emphasis in the addiction treatment community is to use person-first language with patients that have a substance-use condition, with the goal of reducing the stigma around addiction and thereby breaking down barriers to accessing treatment. At the heart of this practice is treating individuals with respect and kindness, which is a noble endeavor. That said, a take-away from the present study is that some people seeking treatment through a 12-step program may prefer to use "old-school" terminology (addict, alcoholic) when interacting with healthcare and medical professionals, for a variety of reasons (eg, it synchs with their 12-step program, they find the language more succinct, they do not internalize the stigma of such terms). The best approach for a treatment or other healthcare provider may be to ask the person, "How would you like me to refer to you?" and take the cue from the patient—even if it does not neatly fit with the provider's understanding of how individuals in their care like to be described. Some will like being "an individual with a substance use disorder," while others will find this a "mouthful."

Anecdotally, a number of subjects recounted interactions with doctors and nurses where the subject faced the dilemma of whether and how to explain to medical staff about their addiction history. In the U.S., fentanyl is linked to many opioid deaths, and yet it is commonly and safely used in hospitals and emergency rooms,[55] such as with patients recovering from surgery. One subject facing an operation whose past drug of choice was "pain killers" expressed notable fear about post-surgery medication. By contrast, another subject whose preferred substance was alcohol expressed ambivalence about receiving fentanyl post-surgery. ("I never liked the way opioids made me feel. I didn't like heroin. Like, I'm going to relapse on that [fentanyl]? No.") The hope is that should a recovering individual choose to disclose to treatment professions about their (past) substance abuse, this would not change the quality of care they receive.

Twelve step programs occasionally update their language as AA recently did to be more gender-inclusive, approving a change to the wording in its preamble statement to replace "men and women" with "people."[56] This change was not universally embraced,[57] with some responding that the fellowship had strayed from its original purpose. Anecdotally, the author observed some variations in these types of gender-language preferences by recruitment location. In recruitment location #1, for example, at 1 meeting participants typically introduced themselves by first name, their addiction status (usually either "alcoholic" or "alcoholic/addict"), and then their preferred pronouns (eg, she/her, they/them). The reason behind this practice is to create a safe space for transgender recovering individuals who face additional stigma[58] beyond just that of their substance addiction. By contrast, at a treatment location #3 meeting, an attendee prefaced his sharing by first explaining that he is "just" an alcoholic and did not require any other terms to make him "special" such as being a "left-handed alcoholic." The implication of such comments is that straying from originalist language of a 12-step program is unnecessary, and reflects a lack of understanding of why inclusiveness is necessary.

Changing language to try and reduce stigma around addiction is a good thing, although in and of itself it does not fix the underlying problem (addiction). Additionally, not everyone will "get the memo." One subject described a painful anecdote at work. He was assigned to be a liaison between a town's police department and local individuals not yet in recovery for their substance addiction. His status as a recovering individual was central to his professional role. While most of the police officers he interacted with were polite, 1 officer saw him through the lens of how he was unfortunately introduced to the police department: "a drug addict with mental health problems." That officer took the subject on a ride-along that included a tour of a legal marijuana dispensary. Afterwards, the officer asked the subject whether the tour had triggered him to want to use marijuana. Moving toward destigmatized language around addiction may have a mixed impact on public stigma. In short, there will always be jerks who say disrespectful things.

In summary, the take-away from the study's findings is that there is no one-size-fits-all when it comes to recovery from substance addiction, or the terminology around it. There may come a tipping point in terms of the "best" language to use—particularly if the push to overhaul terms to eliminate stigma originates with experts working in the addiction field but who are not themselves addicts or alcoholics. Treatment professionals should not assume that all individuals in recovery are comfortable with person-first language, despite this being the

preferred approach du jour. Recovering individuals who opt to use straightforward (if potentially stigmatized) terms like "addict" should not be told they are wrong. The choice of language around a person's addiction should be left to that individual.

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Author Contributions

Connie Hassett-Walker is the sole author of this article.

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