The Role of Language in Reducing Stigma Around Behavioral Support

Words do something before we even consciously register them which then create an everlasting impact even if we don't realize it. They arrive with histories, carry assumptions, stereotypes that stick and stay mentally forever. That is why the question of which words we use to describe mental health and behavioral support is not merely a matter of "politeness or political correctness". It is,a question of whether people get help when needed or not.

Words used to describe mental illnesses and substance use of disorders can directly affect their likelihood that people will seek help, as well as the quality of the help they provide and receive (Volkow et al., 2021). Research has shown that stigma contributes significantly to negative health outcomes and acts as a barrier to seek treatment, with 35% of people with serious mental illness in the United States, and nearly 90% of people with substance use disorders, receiving no treatment at all (Volkow et al., 2021). Nine out of ten people with a substance use disorder go untreated, and stigma, understood as the network of negative attitudes, assumptions, and social penalties attached to these conditions or disorders is a central reason why. A systematic review of 144 studies involving over 90,000 participants found a consistent negative association between stigma and seeking help, with internalisation and treatment, stigma being most strongly linked to reduced help-seeking behavior (Clement et al., 2015). Stigma does not just make people uncomfortable i t silences them and does not give them a voice of reason.

Language is one of the primary mechanisms where stigma travels through. The word "crazy," used casually to mean chaotic or extreme, and has double meaning as a label that has historically been applied to people with psychiatric conditions in ways that stripped them of credibility and agency. Stigmatizing language perpetuates to negative perceptions, which

can result in people being excluded from jobs, housing, social activities, and relationships, which may make people begin to believe the negative things that are said about them, which delays their recovery (Mental Health First Aid USA, 2022). This internalization is one of the most damaging consequences of stigmatizing language. When a person with a mental illness or substance use disorder continuously experiences stigma, they may begin to internalize it, developing self-stigma that lowers self-esteem, reduces feelings of self-worth, and can worsen symptoms while creating further barriers to treatment (Volkow et al., 2021).

Language, then, does not just reflect social attitudes. It actively reproduces them inside the people it needs the most or are becoming targets of it. The clinical world is not immune to this either. A study done by analyzing nearly one million clinical encounter notes for patients with opioid use found that stigmatizing language appeared more frequently in notes from older patients, women, and minority groups such as Black or Hispanic patients, suggesting that linguistic bias in healthcare is impacted throughout. discrimination (Adekkanattu et al., 2024).

The most well-documented evidence for the real-world consequences of word choice comes from addiction medicine. Research at Harvard used case vignettes to show that doctoral-level clinicians were more likely to favor a jail sentence over treatment for a person described as a "substance abuser," compared to when the same person was described as having a "substance use," with all other words in the descriptions being identical the same person, the same behavior, the same facts. One label produced a punitive response; the other produced a therapeutic one.

This finding matters because it demonstrates that the effect of language is not limited to public attention and attitudes or casual prejudice. It reaches into the professional judgment of trained clinicians andthe widely used term "medication-assisted treatment" (MAT) carries

a similar problem, as it frames addiction pharmacotherapy as a supplementary measure rather than a legitimate first-line medical intervention. i In a way that medications for cancer, HIV, or hypertension never are (Volkow et al., 2021). Framing shapes expectation, and expectation shapes care.

The most widely adopted framework for addressing stigmatizing language in healthcare and advocacy is first-person language, which places the individual before the diagnosis. "A person with schizophrenia" rather than "a schizophrenic." "Someone experiencing depression" rather than "being depressive." The logic is coherent: foregrounding a person's humanity before naming their condition resists the tendency to collapse an entire individual into a single medical category, and there is evidence that this kind of framing shapes clinical behavior (Volkow et al., 2021). First-person language helps validate individuals' experiences without reducing them to a diagnosis, and it fosters greater understanding, dignity, and respect for everyone involved (Mental Health First Aid USA, 2022).

But first-person language is not the whole answer, and within some communities it is actively contested. Although it is taught in many North American health professions programs and mandated by many medical journals, identity-first language is often preferred by people with lived experience, particularly outside the United States where disability rights communities have pushed back on first-person norms (Dunn & Andrews, 2015). Identity-first language, where someone is described as "an autistic person" or simply "disabled," treats the condition as an integral part of identity rather than something to be linguistically separated from the actual person. In the autistic community, for instance, first-person language tends to be preferred by parents and advocates, while identity-first language is preferred by autistic people, which is why the Autistic Self-Advocacy Network exposes identity-first terminology

(Autistic Self-Advocacy Network, 2021). The argument is that separating identity from condition assumes the condition is something shameful that needs to be distanced. We do not say "a person with queerness" or "a person with Americanness," because those are not qualities someone merely possesses; they are part of who a person is.

Many people in the Deaf community have made a similar point, rejecting first-person language entirely on the grounds that deafness is not a deficiency but a cultural norm and linguistic identity (National Institutes of Health, 2021). The tension between first-person and identity-first frameworks is not a reason to give up on thoughtful language reform. It is a reason to approach it with more humility, and to center the preferences of the people being described over the habits of the people doing the describing.

Beyond clinical settings, the words used in public discourse and advocacy carry their own weight. Prevention messages that highlight the agency and self-efficacy for people with substance use disorders, rather than framing them as passive victims or dangerous deviants, have been shown to reduce stigma by changing how those individuals are perceived, and how they perceive themselves (Substance Abuse and Mental Health Services Administration, 2017). Media coverage has historically been one of the most persistent sources of stigmatizing framing, from the moral panic around "crack babies" in the 1980s to contemporary coverage of opioid overdoses that centers on criminality rather than illness. These frames do not exist in isolation from behavior. They influence how legislators allocate funding, how communities respond to treatment facilities opening in their neighborhoods, and how families talk to struggling relatives about whether seeking help is even possible.

A shift in language is therefore not only a clinical or interpersonal concern; it is also about the conditions that determine whether care and housing systems get built and funded by the state and government in the first place (Volkow et al., 2021).

None of this should be taken to mean that changing words alone will fix the structural problems in how societies respond to mental health and behavioral challenges. Stigma is particularly difficult to eliminate even with educational and other interventions, and carefully considered language is only one part of addressing it (Volkow et al., 2021). There are also genuinely mixed findings in the research. One study with surveying over 3,000 people with a current or past history of mental illness found no significant differences in stigma and behavioral levels across terms such as "mental illness," "mental health problem," "psychological disorder," and "emotional distress," suggesting that swapping one neutral clinical term for another may matter less than the broader social context in which those terms are used (American Psychiatric Association, 2024). But this does not simplify the case for language reform. It sharpens it. The problem with stigmatizing language is not simply that it uses the wrong label; it is that it encodes moral values and ideals.

The relationship between language and stigma is not a simple one. Language does not single-handedly create stigma, and changing language does not automatically dismantle it. But it is one of the most immediate levers available, one that every clinician, journalist, educator, and regular people that pulls every day, often without thinking about it. The research is fairly clear on the core point: diagnostic labels that emphasize moral failure discourage help-seeking, person-centered framing reduces the tendency to collapse individuals into their conditions, and the preferences of the people being described should take priority over the habits of the people doing the describing. Language is one of the places where the gap between the society we have and the one we want shows up most clearly, and also one of the places where individual choices can, over time, contribute to closing it.

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