

BRIEF COMMUNICATION

Recovery Dialects: A Pilot Study of Stigmatizing and Nonstigmatizing Label Use by Individuals in Recovery From Substance Use Disorders

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Previous research has found language used to describe individuals with a substance use disorder (SUD; e.g., “addict,” “substance abuser”) contributes to and elicits negative bias among the general public and health care professionals. However, the prevalence in which recovering individuals use these labels to self-identify and the impact of such labels are unknown. The current pilot study, a cross-sectional design, examined the usage of two labels (“addict,” “person with a SUD”) as well as the differences in recovery outcomes among individuals in recovery. Participants ($n = 54$) used both labels at high rates (“addict”: 66.67%; “person with a SUD”: 38.89%), though mutually exclusive use was lower (“addict” only: 35.19%, “person with a SUD” only: 7.5%). Common label use settings included mutual-aid recovery meetings, with friends and family, and on social media. Analysis of variance tests found no statistically significant differences between label groups for recovery capital, self-esteem, internalized stigma and shame, flourishing, or length in recovery. Descriptively, participants using only “person with a SUD” had more positive outcomes, although these individuals also had higher levels of internalized shame. Results suggest that language may have only a marginal impact on individuals in recovery, although professionals and the general public should continue to avoid using stigmatizing labels. Additionally, many individuals in recovery have the ability to discern context and setting, switching between positive and negative labels as appropriate. Future research is warranted given these pilot findings and should focus on long-term impacts of self-labeling and internalized stereotypes among individuals in recovery.

Public Health Significance

The current pilot study reports on the prevalence of both stigmatizing and nonstigmatizing labels (“addict,” “person with a substance use disorder”) among a cohort of individuals in recovery. While the labels individuals use for themselves do not seem to be associated with common recovery outcomes (e.g., recovery length, recovery capital, self-esteem, etc.), many individuals use both stigmatizing and nonstigmatizing labels depending on context. This level of discernment suggests individuals in recovery are aware of the potential for labels to elicit stigma and may attempt to moderate it by using less stigmatizing language in public settings, with friends and family, and their colleagues.

Keywords: language, substance use disorder, stigma, bias, linguistics

Supplemental materials: <http://dx.doi.org/10.1037/pha0000286.supp>

This article was published Online First April 18, 2019.

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Preparation of the manuscript was supported in part by NIDA Grant R01DA039457.

We thank Brent Canode for his contributions to the study.

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Stigma is commonly experienced by individuals who have a substance use disorder (SUD) or are in recovery from a SUD. In fact, SUDs are one of the most stigmatized diseases across the world (Room, Rehm, Trotter, Paglia, & Üstün, 2001). While stigma is considered a multidimensional construct (Goffman, 1963), one important facet contributing to SUD stigma is the language used to describe and identify individuals with a SUD or in recovery (Ashford, Brown, & Curtis, 2018c; Kelly, Saitz, & Wakeman, 2016). Most SUD linguistics research to date has focused on either the general public (Ashford et al., 2018a, 2018b, 2018c; Goodyear, Haass-Koffler, & Chavanne, 2018; McGinty, Goldman, Pescosolido, & Barry, 2015), health care professionals (P Goddu et al., 2018; van Boekel, Brouwers, van Weeghel, & Garretsen, 2013), or SUD treatment professionals (Kelly & Westerhoff, 2010). However, the exact role that language and labels play in individuals in recovery from a SUD is unknown.

Previous research has identified several stigmatizing terms (e.g., “addict,” “substance abuser”) that elicit greater negative bias (Ashford et al., 2018c; Goodyear et al., 2018; Kelly & Westerhoff, 2010). Less stigmatizing terms have also been identified (e.g., “person with a SUD,” “pharmacotherapy,” “person with an opioid use disorder”; Ashford et al., 2018c; Goodyear et al., 2018; Kelly & Westerhoff, 2010). Only one series of recent studies (Ashford et al., 2018c, 2018b, 2018c; Ashford, Brown, & Curtis, 2019) has included individuals in recovery in the sample, however. As such, the magnitude of elicited attitudes (positive or negative) or potential impacts is difficult to estimate.

Although Ashford and colleagues (2018c) hypothesized that the use of stigmatizing labels may negatively affect recovery outcomes (e.g., recovery length, recovery capital, etc.), previous research also suggests that individuals in recovery may benefit from the use of otherwise stigmatizing labels (e.g., “addict”) due to its cathartic effect in popular recovery programs, such as mutual-aid 12-step-based programs, and role in identity reformation, which is considered critical to the recovery process (Ashford et al., 2018c; Goffman, 1963; Hughes, 2007; McIntosh & McKeganey, 2001). The prevalence of individuals in recovery who use either negative or positive labels is also unknown, although negative labels are embedded within the literature of prominent recovery programs (e.g., Alcoholics Anonymous and Narcotics Anonymous), so it is plausible that usage of such terms such as “addict” and “alcoholic” may be high among recovering individuals.

In an effort to expand the working knowledge of SUD and recovery linguistics, the current pilot study has two aims. The first is to identify the rates in which individuals in SUD recovery use the label “addict” and “person with a SUD,” as well as the settings in which these labels are used (e.g., in mutual-aid meetings, with family, with friends, etc.). The second is to explore group differences between individuals using different self-labeling schema (“addict” only, “person with a SUD” only, both labels, or neither) on common recovery outcomes (e.g., recovery length, recovery capital, self-esteem, flourishing, internalized and perceived stigma, and internalized shame).

Method

Participants

Fifty-four adult (age 18+) participants were recruited through private SUD recovery groups on Facebook using a snowball sampling method. Participants ($n = 54$) had a mean age of 41.89 years

($SD = 11.48$), 51.9% were female, 94.4% were White, 11.1% were of Latino origin or descent, 51.9% were married or in a domestic partnership, 61.1% held bachelor’s or graduate degrees, 77.7% were employed, 55.5% had annual incomes over \$50,000, 90.7% lived in their own apartment or home, and 53.7% had never been on probation or parole. All participants identified as a person in recovery from a SUD. Participants in different labels used groups (e.g., “addict” only, “person with a SUD” only, etc.) did not statistically significantly differ on any demographic variables (all chi-square results $p > .05$). Full participant demographics are available in Table 1.

Design

A cross-sectional survey was completed by all recruited participants following institutional review board approval from the University of the Sciences (Protocol #1316481–2, Study Title: Catharsis and Identity in Recovery). Consenting participants completed a demographics questionnaire, did a series of standardized

Table 1
Participant Demographic Characteristics ($n = 54$)

Variable	n (%)
Age (years), M (SD)	41.89 (11.48)
Gender	
Male	26 (48.1)
Female	28 (51.9)
Race	
White	51 (94.4)
Black	1 (1.9)
Multiracial	1 (1.9)
Asian Pacific Islander	1 (1.9)
Ethnicity	
Hispanic/Latino	6 (11.1)
Sexual orientation	
Heterosexual	40 (74.1)
Homosexual	5 (9.3)
Bisexual	5 (9.3)
Other	4 (7.4)
Marital status	
Single	14 (26.0)
Married/domestic partnership	28 (51.9)
Divorced/widowed/separated	12 (22.1)
Educational Status	
High school graduate/GED	8 (14.8)
Associate’s degree	13 (24.1)
Bachelor’s degree	9 (16.7)
Graduate degree	24 (44.4)
Employment status	
Employed	42 (77.7%)
Annual income level	
Less than \$10,000	2 (3.7)
\$10,001–\$29,999	11 (20.4)
\$30,000–\$49,999	11 (20.4)
\$50,000 or more	30 (55.5)
Housing status	
Recovery residence/transitional housing	2 (3.7)
Living with family member or loved one	3 (5.6)
Living in own apartment or home	49 (90.7)
Currently on probation or parole	
Yes	3 (5.6)
No, but was previously	22 (40.7)
No	29 (53.7)

Note. GED = General Education Development.

recovery outcome measurements (e.g., recovery capital, self-esteem, shame, stigma, and flourishing), and responded to several self-report questions of which SUD-centric labels they used and the settings in which these labels were used.

Measures

Demographics. Participants provided self-report answers to basic demographics (e.g., age, gender, sexual orientation, housing and education status, etc.).

Recovery outcomes. Standardized measures included in the survey included the Brief Assessment of Recovery Capital (BARC-10; Vilsaint et al., 2017), a 10-item measure of individual recovery capital ($\alpha = .90$; scores range from 10–60, with higher scores indicating greater recovery capital); the Rosenberg Self-esteem Scale (Rosenberg, 1965), a 10-item measure of global self-esteem ($\alpha = .88$; scores range from 8–40, with higher scores indicating greater self-esteem); the Perceived Stigma of Addiction Scale (PSAS-8; Luoma, O’Hair, Kohlenberg, Hayes, & Fletcher, 2010), an 8-item measure of public stigma of substance use disorders ($\alpha = .73$; scores range from 8–32, with higher scores indicating greater perceived stigma); the Internalized Shame Scale (ISS; Cook, 1996), a 30-item measure of individual internalized shame ($\alpha = .85$; scores range from 0–90, with higher scores indicating greater internalized shame); the Human Flourishing Scale (Diener et al., 2010), an 8-item measure of well-being comprising participants’ perceived sense of success in relationships, self-esteem, purpose, and optimism ($\alpha = .61$ –.77; scores range from 8–56, with higher scores indicating greater overall well-being); and the Internalized Stigma of Substance Abuse Scale (ISSA; Luoma et al., 2013), an adapted measure of the Internalized Stigma of Mental Illness Scale, which measures internalized stigma of individuals with a SUD ($\alpha = .92$; scores range from 29–116, with higher scores indicating greater internalized stigma). Participants also reported their length in recovery at the time of the survey (in years and months), their primary recovery pathway from a list of mutually exclusive options (e.g., abstinence-based 12-step, abstinence-based non-12-step, etc.), their history of mental health disorder diagnosis, and their lifetime treatment engagement history.

SUD labels and settings. Participants self-reported whether they regularly used the label “addict” (yes or no) or “person with a substance use disorder” (yes or no) to describe themselves through response to the following questions: (a) Do you regularly identify, or otherwise label yourself, as an “addict”? and (b) Do you regularly identify, or otherwise label yourself, as a “person with a substance use disorder”? Use of the labels was not mutually exclusive (e.g., participants could respond yes to both label questions). We did create mutually exclusive groups on a post hoc basis, resulting in four groups: (a) participants who use “addict” only, (b) participants who use “person with a SUD” only, (c) participants who use both labels, and (d) participants who use neither label. Additionally, participants were asked to answer either yes or no to a list of settings in which they used labels they responded affirmatively to. Setting questions were multiresponse format, worded as follows: (a) In what settings do you regularly identify, or otherwise label yourself, as an “addict” (select all that apply)? and (b) In what settings do you regularly identify, or otherwise label yourself, as a “person with a substance use disorder”

(select all that apply)? Settings that could be selected by participants included the following: in mutual-aid (12-step-based) meetings, mutual-aid (non-12-step based) meetings, with family members, with friends, with coworkers in their place of employment, when speaking publicly, or in social media communications.

Data Analysis

Descriptive statistics, including mean, standard deviation, and percentages, were completed for participant demographics, recovery outcomes, and SUD labels and settings. Pearson chi-square tests were completed comparing participant groups on demographics and recovery outcomes. Analysis of variance (ANOVA) tests were used to examine between-group differences (e.g., participants using “addict” only, “person with a SUD” only, both, or neither) of recovery outcomes.

For multi-item measures (e.g., standardized measures) with missing data and at least 50% of items completed, we imputed missing values using pooled estimates from the multiple imputation automatic procedure in Version 23.0 of SPSS. Overall, 15 items were imputed for 13 individuals and included items within the BARC-10, ISS, ISSA, and PSAS-8 measures.

Results

Recovery Outcomes

Participants had an average recovery length of 11.85 years ($SD = 9.70$), used a primary recovery program of mutual aid (12-step) most often (68.5%), and had a polysubstance use preference (61.1%). Most self-reported a co-occurring mental health disorder diagnosis in their lifetime (74.1%) and engaged in SUD treatment (53.7%). Less than a third of participants had engaged in mental health disorder treatment (33.3%) or lived in a recovery residence (22.2%). Full participant recovery outcomes are available in [online supplemental Tables S1–S3](#). Participant groups differed on primary recovery pathway, $\chi^2(15, N = 54) = 26.95, p = .029$, and history of SUD treatment engagement, $\chi^2(3, N = 54) = 8.16, p = .043$, such that participants in the “neither” labels used group were less likely to report a 12-step mutual-aid recovery pathway but more likely to report a professional therapy or combination of multiple pathways, and participants in the “person with SUD” only group were less likely to have history of SUD treatment engagement.

SUD Labels Used and Settings

Combined, a majority of participants (66.6%) reported use of the label “addict,” while only 38.89% reported use of the label “person with a SUD.” The mutually exclusive grouping of participants resulted in 35.19% using “addict” only, 31.48% using both “addict” and “person with a SUD,” 25.92% using neither labels, and 7.4% using “person with a SUD” only. Descriptively, those participants using “person with a SUD” had the longest recovery lengths ($M = 18.18$ years), the greatest recovery capital scores ($M = 55.5$), the greatest flourishing scores ($M = 52.25$), the lowest perceived stigma scores ($M = 20.5$), the lowest internalized stigma scores ($M = 43.0$), but the greatest internalized shame scores ($M = 34.5$). Participants using neither label had the greatest self-esteem

scores ($M = 33.79$). See online supplemental Tables S2–S3 for full descriptive results. ANOVA test results (see online supplemental Table S4) revealed no statistically significant differences between mutually exclusive label groups on any recovery outcome. Partial eta-squared effect sizes were 8.3% of variance explained for recovery length, 7.2% for flourishing, 4.2% for internalized shame, 1.6% for self-esteem, 1.1% for recovery capital, 1.0% for perceived stigma, and 0.8% for internalized stigma.

Of those participants reporting use of the label “addict,” the most common settings where this label was used were mutual-aid (12-step based) meetings (94.3%), with friends (77.1%), and with family (77.1%). Of those using “person with a SUD,” speaking in public (61.9%), on social media (42.9%), with coworkers (42.9%), and with friends (42.9%) were most common.

Following post hoc grouping (see Table 2), participants reporting the use of the “addict” label only used the label most often in mutual-aid (12-step-based) meetings (94.4%), with friends (77.8%), and with family (72.2%). Of note, all settings for this group were above 50% except for mutual-aid (non-12-step based) meetings (16.7%). Of participants reporting use of the “person with a SUD” label only, the most common settings were on social media (100%), speaking in public (100%), and with family (100%). All settings for the “person with a SUD” only category were at or above 75% except for mutual-aid (12-step-based) meetings (25%) and mutual-aid (non-12-step-based) meetings (0%). Participants who used both labels had higher rates of using “person with a SUD” when speaking publicly but lower rates in all other settings.

Discussion

The current study provides the first exploration of the dynamics of self-labeling among a group of participants in recovery from SUD. Previous research has suggested that labels commonly used to describe individuals in recovery or with a SUD (e.g., “addict,” “person with a SUD”) may impact intrapersonal recovery outcomes (Ashford et al., 2018c), similar to its correlation with decreased help-seeking behavior (Substance Abuse and Mental Health Services Administration, 2018), increased desire for social distance (McGinty et al., 2015), and increased stigma and bias (Ashford et al., 2018a, 2018b, 2018c). However, results from the current study suggest that these external effects of language (e.g., help-seeking behavior, desire for social distance, etc.) may not traverse into the individual sphere, at least insofar as it impacts

common recovery-related outcomes such as recovery capital, self-esteem, shame and stigma, and flourishing.

Descriptively, participants who reported using previously identified nonstigmatizing labels (e.g., “person with a SUD”; Ashford et al., 2018a, 2018b, 2018c) also had greater levels of recovery capital, and flourishing; longer lengths in recovery; and lower levels of internalized stigma and shame. However, statistically, no significant differences among standardized recovery outcomes were found among participants who reported use of a previously identified stigmatizing label, “addict,” or participants who used neither label or both labels. Effect sizes ranged from moderate (8.3%: recovery length; 7.2%: flourishing) to small (1.6%: self-esteem; 1.1%: recovery capital), suggesting that in an adequately powered sample, individual choice in labels may be an important variable to consider, especially for recovery length, flourishing, and internalized shame. While this lack of significant difference may be explained by a low magnitude effect of labels on intrapersonal recovery outcomes or the small pilot sample of the current study, this does not diminish the need for the general public, professionals, and other individuals to avoid using stigmatizing terms to label others. For medical professionals providing pharmacotherapy to individuals with opioid use disorders, who often face increased stigma among their recovering peers (White, 2011), this may be perhaps more relevant, as any opportunity to reduce stigma should be taken.

Among the results is an indication that among individuals in recovery, there exists an awareness of the stigmatizing nature of labels and terms—evidenced by the large percentage of participants who used both “addict” and “person with a SUD.” This phenomenon, which we have labeled “recovery dialects,” suggests that depending on setting and context, recovering individuals use certain labels that are more appropriate. For example, among those who reported using both labels, “person with a SUD” was used most often when speaking publicly, while “addict” was used most often in mutual-aid (12-step-based) meetings or when speaking with friends. This ability to discern context and thus use context-dependent labeling implies that individuals can use labels that may be publicly stigmatizing in relatively safe ways without putting them at risk for reduced intrapersonal success or increased internalized stigma. It is also plausible, given the relationship between self-reported primary recovery pathway and history of SUD treatment engagement and the labels used, that the past experience of individuals in recovery with certain systems and contexts (i.e.,

Table 2
Settings Where Labels Are Used by Participants

Variable	Addict ^a ($n = 36$), n (%)	SUD ^a ($n = 21$), n (%)	Addict only ($n = 19$), n (%)	SUD only ($n = 4$), n (%)	Both ($n = 17$), n (%)	
					Addict	SUD
MA meetings (12-step)	33 (94.3)	4 (19.0)	17 (94.4)	1 (25.0)	16 (94.1)	3 (17.6)
MA meetings (non-12-step)	7 (20.0)	1 (4.8)	3 (16.7)	—	4 (23.5)	1 (5.9)
With family	22 (62.9)	8 (38.1)	13 (72.2)	4 (100)	9 (52.9)	4 (23.5)
With friends	27 (77.1)	9 (42.9)	14 (77.8)	3 (75.0)	13 (76.5)	6 (35.3)
With coworkers	17 (48.6)	9 (42.9)	10 (55.6)	3 (75.0)	7 (41.2)	6 (35.3)
Speaking in public	20 (57.1)	13 (61.9)	12 (66.7)	4 (100)	8 (47.1)	9 (52.9)
On social media	17 (48.6)	9 (42.9)	9 (50.0)	4 (100)	8 (47.1)	5 (29.4)

Note. Percentage totals greater than 100% due to multiple selection options. SUD = substance use disorder; MA = mutual-aid.

^a Nonmutually exclusive.

treatment centers or mutual-aid programs) may impact the labels they choose to use. However, the inverse is also equally plausible that individuals using certain labels to self-identify seek out like-minded peers in specific contexts. Future research should seek to parse out the exact nature of this relationship.

There is also a large subset of participants that used neither label. Previous research has suggested that although terms like “addict” and “substance abuser” elicit stigma, terms such as “person with a SUD” are not net positive, only less negative or less stigmatizing (Ashford et al., 2018c). This subset of individuals using neither label supports this finding, suggesting participants may not prefer to use any label concerning their recovery or SUD. While it may not always be possible to avoid labels, even those employing person-first language, finding ways to do so may be advantageous in both public and clinical settings.

Limitations

Results should be viewed in light of several limitations. The current study was a pilot, and as such, the sample was relatively small and included a nonrepresentative number of White, highly educated individuals who use a mutual-aid, 12-step-based primary program of recovery. Additionally, the average length in recovery of participants was several years with a large variance between participants, possibly obfuscating the effects of label usage via confounding factors associated with increased lengths in recovery. Each of these factors limits the generalizability of the results, and future studies should replicate the methodology with representative demographic samples as well as those with varied lengths in recovery or with an active SUD.

Future Directions

In addition to implementation of the current study methodology with a larger, representative sample, additional exploration into linguistics, stigma, and impact on recovery outcomes is needed. The identification of factors that lead to an individual labeling one way versus another (e.g., the terms used in treatment settings) would be beneficial to inform health communication best practices in the SUD field, as well as interventions designed to promote positive, nonstigmatizing language. Although additional research is needed on the use of different labels and associations with individual outcomes, the documented effects on the general public and health care professionals (Ashford et al., 2018c; Goodyear et al., 2018; Kelly & Westerhoff, 2010; McGinty et al., 2015) would suggest that such interventions may be helpful even if only to impact social norms and reduce public and professional stigma. Long-term effects of internalized stereotypes are also worthy of examination among individuals in recovery, people who use drugs, the general public, and service professionals. As noted in the limitations, recovery length and participant demographics should be a focus in future research on this topic. The potential for extraneous factors that may be associated with increased lengths in recovery (e.g., higher self-efficacy, self-esteem, etc.) or demographic factors (e.g., socioeconomic status, housing, race and ethnicity, etc.) may play an important role in the relationship between labels used and outcomes, such as internalized stigma and shame, and should be fully modeled with representative samples, including participants from several stages of the recovery process, cor-

responding with recovery lengths such as 0–11 months, 1–4 years, and 5 or more years.

Conclusion

SUD recovery linguistics research has continued to evolve and expand its focus over the past several years. To date, few studies have examined the impact of previously identified stigmatizing and nonstigmatizing labels on individuals in SUD recovery. As previously suggested, the labels that individuals in recovery use for themselves do not appear to impact intrapersonal recovery outcomes. Among individuals in recovery, there also appears to have formed a “recovery dialect” that allows individuals to oscillate between positive and negative labels depending on context and setting. Although the impact on individuals in recovery appears to be marginal, the general public and professionals should continue to avoid stigmatizing labels.

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Received January 14, 2019

Revision received March 6, 2019

Accepted March 6, 2019 ■

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If you are interested in reviewing manuscripts for APA journals, the APA Publications and Communications Board would like to invite your participation. Manuscript reviewers are vital to the publications process. As a reviewer, you would gain valuable experience in publishing. The P&C Board is particularly interested in encouraging members of underrepresented groups to participate more in this process.

If you are interested in reviewing manuscripts, please write APA Journals at Reviewers@apa.org. Please note the following important points:

- To be selected as a reviewer, you must have published articles in peer-reviewed journals. The experience of publishing provides a reviewer with the basis for preparing a thorough, objective review.
- To be selected, it is critical to be a regular reader of the five to six empirical journals that are most central to the area or journal for which you would like to review. Current knowledge of recently published research provides a reviewer with the knowledge base to evaluate a new submission within the context of existing research.
- To select the appropriate reviewers for each manuscript, the editor needs detailed information. Please include with your letter your vita. In the letter, please identify which APA journal(s) you are interested in, and describe your area of expertise. Be as specific as possible. For example, “social psychology” is not sufficient—you would need to specify “social cognition” or “attitude change” as well.
- Reviewing a manuscript takes time (1–4 hours per manuscript reviewed). If you are selected to review a manuscript, be prepared to invest the necessary time to evaluate the manuscript thoroughly.

APA now has an online video course that provides guidance in reviewing manuscripts. To learn more about the course and to access the video, visit <http://www.apa.org/pubs/journals/resources/review-manuscript-ce-video.aspx>.