INTRODUCTION TO THE ISSUE
Volume 4 (2023), No. 1, pp. i-iii
DOI: 10.15367/ch.v4i1.642

The Way We Communicate about Public Health Matters

DEBORAH A. CAI, PHD
Professor and Senior Associate Dean, Klein College of Media and Communication, Temple University

Correspondence: Deborah.cai@temple.edu (Deborah Cai)

In his 1963 book, *Stigma: Notes on the Management of a Spoiled Identity*, Erving Goffman proposed that individuals who were grouped by certain attributes could be stigmatized by society, whereby they may be stereotyped and dehumanized for those traits. Such attributes may be visible, such as disabilities or ethnicity, or not visible but still result in being publicly disparaged, such as having a disease. Goffman categorized stigmas into three types that can result in being treated as an outsider or ignored: tribal, such as ethnicity and religion; physical, such as disabilities or visible flaws or diseases; and character, such as sexual orientation and addiction. Now, 60 years later, we are still addressing how to prevent people from being discredited and ostracized. The collection of articles in this issue of *Common*Health each address how we can better understand and show compassion for various health concerns and how communication—especially language—can affect how patients are cared for and the type of care that they may seek—or avoid.

Stigmas are created within social contexts in which particular attributes are devalued within a society, such as obesity or addiction, so that anyone within that society perceived as having or exhibiting that attribute is also devalued (Yang et al., 2007). Bresnahan et al. (2020), for example, identified ways that stigma against breastfeeding in public is reinforced, such as "disapproving looks, insults, and name calling" (p. 395).

Communication is a central aspect of stigma. Bresnahan and Zhuang (2011) created a multidimensional measure to study stigma in which they identified distinct behaviors that related to stigmatizing other people. *Labeling* is using harmful descriptions of those who display a stigmatized attribute, or how people are talked about. *Negative attributions* are when character flaws and poor judgment are attached to those who are stigmatized, and *status loss* is when people assign lower social status to others because of the stigmatized attribute. These two dimensions affect the way in which people are spoken to by other people. And *distancing* is when people remove themselves from stigmatized individuals, which reduces the amount of communication others will have with a person who has been stigmatized.

Each of the four articles in this current issue of *Common*Health addresses how the use of language medical and public health professionals affects the way individuals are viewed and the quality of the treatment they may receive. The first article is a case report by Healy, Swyryn, Strand, and Dingman. The importance of their work is captured in the title of their article, which says "our words matter." This article describes an educational campaign to change how medical and public health professionals describe their patients. The campaign was developed by a multidisciplinary team, in consultation with people from the North Philadelphia community that is served by the Lewis Katz School of Medicine. The researchers sought feedback about the campaign from a wide range of stakeholders who would be affected by the change in language. The materials produced by the team provides examples of how to describe patients in ways

that supports rather than stigmatizes them. The core principles culminate in the following directive: "When in doubt, ask yourself: If I were the patient reading/hearing this, how would I feel?"

The opinion piece by Elyse and Keaton puts forth a compelling case for the importance of using gender-inclusive language when talking about pregnancy and abortion in order to protect every person who may become pregnant. Elyse and Keaton argue that gender-inclusive language is "a powerful tool that can be used to promote equality and end gender bias." Yet only 11 states plus the District of Columbia have adopted gender-inclusive language related to protecting access to abortion. In response to the Supreme Court decision, states have the opportunity to protect the right to have an abortion; using gender-inclusive language is an opportunity to move further ahead by protecting and promoting the rights of all people who can become pregnant.

Along these lines of gender-inclusive language, Sarwer, Bass, and O'Fallon take the conversation in a different direction. They begin their op-ed by citing a 2022 congressional hearing on abortion rights in which Dr. Bridges, a law professor from University of California, Berkeley, described "people with the capacity for pregnancy." Instead of providing the inclusivity—and accuracy—of language to describe people who may seek an abortion, the language itself became the focus of attention. Sarwer et al. use this example to challenge how academics, especially those in public health, communicate with the broader public outside of the academy. Instead of the internal echo chamber of ideas about public health, these authors argue that scholars need to think beyond traditional academic language and learn, instead, to communicate more effectively so that the general public can understand and learn from the knowledge and practice of scholars who research and write within the academy.

Finally, in Sarwer and Furey's op-ed, they argue that language needs to reflect respect for the whole person, rather than focusing attention on the disease the person may be experiencing. They describe two examples—Amyotrophic Lateral Sclerosis (ALS) and obesity—where changing how individuals are described can move away from stigmatizing individuals and toward recognizing the fuller experience that environmental and genetic factors have on the individuals experiencing these diseases. The authors write that, in the case of ALS, the acronym PALS has been "embraced by *persons living with ALS* to welcome a reality where they are no longer solely defined by their condition" (emphasis added). This type of person-first language is also recommended for people "living with the disease of obesity."

Across these four articles—one case report and three op-eds—the language of public health is the primary concern. Use of person-first language, especially, is strongly advocated to reduce the stigmatization of individuals. Each of these articles shows the importance of how we talk about people and how language affects both the way patients are viewed and how they are subsequently treated by medical and public health professionals. Moreover, language can affect whether patients are willing to seek the medical treatment they need. In other words, this issue of *Common*Health addresses a key concern in health communication: That our words do matter.

References

1. Bresnahan, M., Zhu, Y., Zhuang, J., & Yan, X. (2020). "He wants a refund because I'm breastfeeding my baby": A thematic analysis of maternal stigma for breastfeeding in public. *Stigma and Health, 5*(4), 394–403. https://doi.org/10.1037/sah0000208
2. Bresnahan, M., & Zhuang, J. (2011). Exploration and validation of the dimensions of stigma. *Journal of Health Psychology, 16*(3), 421-429. https://doi.org/10.1177/1359105310382583
3. Yang, L. H., Kleinman, A., Link, B. G., Phelan, J. C., Sing, L., & Good, B. (2007). Culture and stigma: Adding moral experience to stigma theory. *Social Science & Medicine, 64*(7), 1524-1535. https://doi.org/10.1016/j.socscimed.2006.11.013