Recommended Use of Terminology in Addiction Medicine

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The American Society of Addiction Medicine (ASAM)'s *Journal of Addiction Medicine* and other leading journals have encouraged the use of precise nonstigmatizing terminology.[1–4] Furthermore, the International Society of Addiction Journal Editors (ISAJE) published a recommendation statement against the use of stigmatizing terms.[5] The ASAM has published policy statements on the issue of terminology.[6,7] The US Office of National Drug Control Policy posted a draft statement on changing the language in our field.[8]

Stigmatizing terms can negatively impact quality of care.[9–11] For example, research demonstrates that when patients are described as having substance ''abuse'' instead of a ''disorder,'' clinicians are more likely to recommend punitive approaches.[9,10] Examples of terms that can be stigmatizing include the use of the terms ''alcoholic,'' ''abuser,'' ''drunk,'' ''user,'' ''addict,'' or ''junkie.'' While the use of terms such as ''alcoholic'' and ''addict'' are acceptable in 12-step or other nonmedical settings, these terms could easily be replaced with more medically defined and less stigmatizing terms that incorporate person-first language (eg, patient with ''alcohol use disorder'' and not ''alcoholic,'' etc).

Several terms are preferred when discussing the spectrum of unhealthy alcohol and other drug use.[12] Much of this section appeared in an ASAM policy statement.[6]

1. *Low-risk use (or lower risk) or no use* refers to consumption of an amount of alcohol or other drugs below the amount identified as physically hazardous and use in circumstances not defined as psychosocially hazardous. This amount could be any (even a small) amount and is empirically derived for each substance.
2. *''Unhealthy''* covers the entire spectrum including all use related to health consequences including addiction. Unhealthy alcohol and other drug (substance) use is any use that increases the risk or likelihood for health consequences (hazardous use) or has already led to health consequences (harmful use). Unhealthy use is an umbrella term that encompasses all levels of use relevant to health, from at-risk use through addiction. Unhealthy use is a useful descriptive term referring to all the conditions or states that should be targets of preventive activities or interventions.
   The exact threshold for unhealthy use is a clinical and/or public health decision based on epidemiologic evidence for measurably increased risks for the occurrence of use-related injury, illness, or other health consequences. The term ''unhealthy'' (just as with the descriptors ''unsafe'' or ''hazardous'' or ''harmful'' or ''misuse'') does not imply the

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existence of "healthy" or "safe" or "nonhazardous" or "harmless" use or that there is a way to use the substances properly (ie, without "misuse").

a. *Hazardous or at-risk use* is the use that increases the risk for health consequences. These terms refer only to use that increases the risk or likelihood of health consequences. They do not include use that has already led to health consequences. Thresholds are defined by the amount and frequency of use and/or by circumstances of use. Some of these thresholds are substance specific and others are not. For example, use of a substance that impairs coordination, cognition, or reaction time while driving or operating heavy machinery is hazardous. Nonmedical use or use in doses more than what is prescribed of prescription drugs can be hazardous. Use of substances that interact (eg, 2 medications with sedative effects like benzodiazepines and opioids) is hazardous. Use of substances contraindicated by medical conditions is hazardous (eg, alcohol use and hepatitis C virus infection or alcohol use and postgastrectomy states). Any cocaine use can increase risk for myocardial infarction; 1-time use of hydrocarbon inhalants can lead to sudden cardiac death; no known level of tobacco use is considered risk-free; any alcohol or nicotine use during pregnancy is hazardous; any use by youth likely increases risk for later consequences; use of any potentially addictive substance is more hazardous for persons with a family history or genetic predisposition to addiction than it is to those at average risk in the general population. Alcohol is a known carcinogen, so there is likely no use that is completely risk-free. On the other hand, there are thresholds at which the risk increases for alcohol, and these hazardous or at-risk amounts have been specified.[12] The exact definitions may change with evolving epidemiologic evidence and can also vary by preferences of those making clinical or public health decisions regarding thresholds.[13,14] In addition, individual factors beyond age, sex, and other characteristics can affect risk (eg, weight), and thresholds are not individualized; although they are useful guides clinically, they cannot be thought of as absolute. For example, it is not the case that drinking just under the threshold is associated with no risk or that drinking just above the threshold confers a substantially greater risk. Finally, some drugs (including alcohol) may have beneficial effects (just like medications have risks and benefits), and these may accrue to different conditions (eg, possible benefits for pain or heart disease, risks for cancer).

b. *Harmful* substance use is the use that has resulted in health consequences. The ICD-10 definition of harmful use can be summarized as repeated use that has caused physical or mental damage.[15] Hazardous and harmful are mutually exclusive of each other. These terms apply also to prescription (and nonprescription or over-the-counter medications). The terms could also apply to potentially addictive behaviors.

c. *Terms that are inaccurate or unclear.* The WHO lexicon defines misuse as the use for a purpose not consistent with legal or medical guidelines.[16] However, "misuse" is also a term used to describe not taking (nonaddictive or others) medication as directed or missing doses (eg, of an antihypertensive medication). The US Department of Veterans Affairs describes misuse as the target of alcohol screening and intervention, including disorder and addiction (and labels that severe misuse). "Misuse" is not an appropriate descriptor for "substance dependence," "addiction," or "substance use disorder" because it minimizes the seriousness of the disorder (to "misuse" the substance). "Misuse" also seems to have a value judgment at least potentially implied, as if it were an accident, mistake, or alternatively purposeful (a choice), neither of which would be appropriate for describing the varied states of unhealthy use. As such, "misuse" can be seen as pejorative or stigmatizing.
"Problem" use is not preferred because it is not well-defined, used sometimes to refer to harmful use but other times to encompass the spectrum, and can lead to stigmatizing discussion (eg, "you have a problem" or "you are a problem"). "Inappropriate" is not well-defined and carries a pejorative nuance. "Binge or binge drinking" can be useful for public health messaging but needs to be clearly defined as it is sometimes used to mean a heavy drinking episode but also used to mean several days of long episode of heavy drinking or other drug use (eg, cocaine). "Moderate" drinking (or use) is not preferred as a term because it implies safety, restraint, avoidance of excess, and, even, health. Since alcohol is a carcinogen and cancer risk appears at amounts lower than those generally defined as hazardous, and lower limit amounts harmful to the fetus are not well-defined, better terms for amounts lower than amounts defined as risky or hazardous include "lower-risk" or "low-risk" amounts or simply the term "alcohol use."

d. When referring to the *disease,* terms that have been defined and agreed upon should be used. This specificity is essential in allowing clinicians to accurately communicate with each other and researchers and policy makers to accurately compare populations. Examples of terms that typically indicate a medical disease and that are roughly synonymous include "addiction," "substance use (or gambling) disorder," and "substance dependence." "Addiction" is a term long used by laypeople, patients, and healthcare providers to indicate a condition that can be described as "characterized by an inability to consistently abstain, impairment in behavioral control, craving, diminished recognition of significant problems with one's behaviors and interpersonal relationships, and a dysfunctional emotional response."[7] However, the term "addicted" can be problematic because it often incorrectly conflates addiction and physical dependence.

In past decades, the American Psychiatric Association (APA) and the World Health Organization International Classification of Diseases developed criteria to provide a consensus definition of this disease known commonly as addiction.[15–18] We provide some historical context here.

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The APA's Diagnostic and Statistical Manual of Mental Disorders (DSM) Committee on Substance-Related Disorders had ''good agreement among committee members as to the definition of the medical disease known as addiction, but there was disagreement as to the label that should be used.''[19] ''Addiction'' was a consideration; however, there was concern that labeling it as such could be pejorative and invite stigma. While there was agreement that the term ''addiction'' would ''convey the appropriate meaning of the compulsive drug-taking condition and would distinguish it well from 'physical' dependence,'' the concern for stigma resulted in changing the term from ''addiction'' to (substance) ''dependence.'' Thus, ''addiction'' and ''substance dependence'' were considered as synonymous and describing the same clinical disease. In fact, a vote for (substance) ''dependence'' to be used and not ''addiction'' was won by only one committee member vote.

Years later, the DSM's committee chair as well as the directors of the National Institute on Drug Abuse and National Institute on Alcohol Abuse and Alcoholism published an editorial recognizing that the use of ''substance dependence'' and not ''addiction'' as the label for this clinical disease was ''a serious mistake,'' as ''this has resulted in confusion among clinicians regarding the difference between 'dependence' in a DSM sense, which is really 'addiction,' and (physical) 'dependence' as a normal physiological adaptation to repeated dosing of a medication.'' As such, they urged the APA to adopt the word ''addiction'' for DSM-5.

With the publication of DSM-5 in 2013, the previous DSM terms ''substance abuse'' and ''substance dependence'' were made obsolete.[18] This was after consistent findings from studies of over 200,000 study participants revealing that these 2 terms ''abuse'' and ''dependence'' were clinically and statistically recognized as representing a single disease with varying degrees of severity, renamed in DSM-5 as ''substance use disorder'' with mild, moderate, or severe severity ratings. Criteria for the disorder no longer included legal problems but did (newly) include craving. In addition, rather than have the threshold as one or more criteria (as in ''substance abuse'') or 3 or more criteria (as in ''substance dependence''), the threshold was set at 2 or more criteria for ''substance use disorder.''[20] Again, the Committee on Substance-Related Disorders chose against using the term ''addiction'' to avoid possible stigma, even though feedback to the committee from the College on Problems of Drug Dependence in 2009 and the Research Society on Alcoholism (2010) supported the use of the term ''addiction.''[21]

''Substance use disorder'' is well-defined,[18] and the features of ''addiction'' are carefully described.[7] Each can be appropriately used if referenced. The terms overlap and have similar meaning. However, DSM-5 criteria do not define ''addiction.'' The DSM-5 clarifies ''addiction'' was not chosen as the label for substance use disorder, not only because of stigma but also because of a desire to avoid conflict with the varied ways the construct is used. While ''addiction'' is ''in common usage in many countries to describe severe *problems*'' (not necessarily DSM *criteria*) ''related to compulsive and habitual use of substances,'' and ''some clinicians will choose to use the word *addiction* to describe more extreme presentations,''[18 p. 485] the DSM-5 does not state that addiction should only be used to represent a ''severe'' substance use disorder. The DSM-5 does not exclude addiction as present in a ''moderate'' or ''mild'' substance use disorder, nor does a diagnosis of addiction require that six (or more) criteria of a substance use disorder be present.[22]

Finally, with respect to the term ''dependence,'' if this term is used, it should be clearly defined as the ICD-10 disorder, as the DSM-IV disorder, or as physical dependence, which does not necessarily indicate any disorder or addiction and may simply reflect a pharmacologic effect.

TREATMENTS

Medication (including opioid agonist) treatment of addiction has been mislabeled ''drug,'' ''medication assisted,'' ''substitution,'' or ''replacement.'' These terms are inaccurate; their pejorative nature and their implicit communication that pharmacotherapy is in some way inferior to psychosocial or mutual help pathways to remission of substance use disorders may be partly responsible for the slow uptake in practice of these efficacious treatments. These treatments do not substitute for, reproduce the effects of, or replace illicit drugs. And medications do not ''assist'' treatment, they are treatments shown to be efficacious on their own, and studies often fail to show additional benefits of added psychosocial therapies.[23–27] More accurate alternatives would be medication treatment, treatment, opioid agonist treatment, or even psychosocially assisted pharmacotherapy.[28] The jarring nature of the sound of this last example (from a guide published by the World Health Organization [WHO] in 2009) demonstrates how important language and terminology are in shaping how patients and treatments are viewed. Describing patients as ''using'' medications, rather than ''taking'' medications, reflects an even subtler stigma that equates receipt of medications with drug use.

Also, during treatment, testing is often performed for addictive substances. In these cases, results should be presented like other medical tests—''positive'' versus ''negative'' and ''detected'' versus ''not detected''—and not ''dirty'' or ''clean,'' which are then often used to describe people in a highly stigmatizing way (''I am clean,'' ''your urine was dirty,'' ''I tested you today and you were dirty'').[29]

CONCLUSIONS

We do not make recommendations regarding what terms people with disorders should use. Some patients (eg, those succeeding in part with participation in social networks such as Alcoholics Anonymous) clearly find benefit to calling themselves an alcoholic or an addict even if it might reflect some internalized stigma. Other patients have strong negative associations to being labeled a drug addict or alcoholic that do not aid in their treatment engagement. Furthermore, patient acceptance of such labels has not been shown to be necessary to achieve good clinical outcomes. We also do not wish to police language used or to call out those who use a term with good intentions. It takes time for language to change in society and even in clinical practice. Doing so now in clinical and scientific speaking and writing is the beginning of that process and will ultimately lead to wider use of accurate nonstigmatizing terms.[31] We make recommendations regarding terms that

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TABLE 1. Recommendations for Nonstigmatizing, More Clinically Accurate Language

Avoid	Prefer
Abuse[1–5]	Use (or specify low-risk or unhealthy use; the latter includes at-risk/hazardous use, harmful use, substance use disorder, and addiction)
Addicted baby	Baby experiencing substance withdrawal
Addict, user, abuser, alcoholic, crack head, pot head, dope fiend, junkie	Person with (the disease of) addiction, a substance use disorder, or gambling disorder
Dirty vs clean urine[24]	Positive or negative, detected or not detected
Drunk, smashed, bombed, messed up, strung out	Intoxicated
Meth	Methamphetamine, methadone, methylphenidate
Medical marijuana	Consider using instead "cannabis as medicine"*
Misuse, problem†	More accurate terms include at-risk or risky use, hazardous use, unhealthy use to describe the spectrum from risky/at-risk/hazardous use through disorder
Inappropriate use	More accurate terms should specify what is meant
Fix	Dose, use
Binge‡	Heavy drinking episode
Relapse[§,30]	Use, return to use, recurrence (of symptoms) or disorder vs remission specifiers (early or sustained) as defined by DSM-5
Substitution, replacement, medication assisted treatment	Opioid agonist treatment, medication treatment, psychosocially assisted pharmacologic treatment, treatment
Smoking cessation‖	Tobacco use disorder treatment, reduction or cessation of tobacco use[32]
Moderate drinking (or drug use)	Low- or lower-risk use
Detoxification	Withdrawal management, withdrawal

*Currently marijuana (the plant leaf, stems, and seeds) is not typically sold as medicinal grade or conclusively researched as having more benefits than risks, nor is it FDA approved. Moreover, cannabis is the term more internationally used and is more descriptive relating to compounds being researched to explore medical value—such as cannabidiol.

†Could be used if clearly defined and most useful for prescription drug (misuse) when the nature or severity of the condition is unknown. Avoid calling the person a problem or their use a problem.

‡Can be useful for public health messaging but needs to be clearly defined as it is sometimes used to mean a heavy drinking episode but also used to mean several days of long episode of heavy drinking or other drug use (eg, cocaine).

§This term will likely continue to be used, but it should not imply a binary process (abstinent vs relapse) that does not reflect real typical clinical course (that can include lapses or in-between states).

‖A similar term is not typically used for other drugs with addiction liability. This term seems to place tobacco in a category different than other drugs, which may not be helpful considering its high addiction risk and high morbidity and mortality. More favored terms for "smoking" include "tobacco" (or "nicotine"). Further, "cessation" (or abstinence) while highly desired should not be the only goal. Smoking reduction may have limited health benefits related to smoking and may also reduce relapse rates with other substances used by the patient. However, the evidence for smoking reduction having health benefits related to smoking is low, and these results are small compared to complete abstinence.

should be preferred versus those that should be avoided. In general, stigmatizing terms should be avoided, as should disease first constructions. Terms to be avoided by clinicians and scientists because they may be potentially stigmatizing or clinically unclear are outlined in Table 1; however, this table is not exhaustive. Scientific and medical terms that are clearly defined and nonstigmatizing are preferred over vague inaccurate terms, terms that are difficult to define, and terms that are used to mean many different things. Better use of terminology can improve clear communication of addiction science and improve quality of care for patients.

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