

VIEWPOINT

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Changing the Language of Addiction

Words matter. In the scientific arena, the routine vocabulary of health care professionals and researchers frames illness¹ and shapes medical judgments. When these terms then enter the public arena, they convey social norms and attitudes. As part of their professional duty, clinicians strive to use language that accurately reflects science, promotes evidence-based treatment, and demonstrates respect for patients.

However, history has also demonstrated how language can cloud understanding and perpetuate societal bias. For example, in the past, people with mental illness were derided as “lunatics” and segregated to “insane asylums.” In the early days of human immunodeficiency virus, patients were labeled as having “gay-related immune deficiency,” with public discourse dominated by moral judgments. Other examples apply to disability and some infectious diseases. In all of these cases, stigma and discrimination can arise when patients are labeled, linked to undesirable characteristics, or placed in categories to separate “us” from “them.”

Today, these complex themes have special relevance for addiction. Scientific evidence shows that addiction to alcohol or drugs is a chronic brain disorder with potential for recurrence. However, as with many other chronic conditions, people with substance use disorders (SUDs) can be effectively treated and can enter recovery. For example, medication-assisted treatment such as buprenorphine hydrochloride, methadone hydrochloride, and naltrexone hydrochloride—provided in conjunction with behavioral counseling—can be life extending for patients with an opioid use disorder.

However, individuals with or in recovery from SUDs continue to be viewed with stigma, sometimes greater than that seen with physical or psychiatric disabilities.² Commonly used terms can imply, or even explicitly convey, that the individuals with SUDs are morally at fault for their disease. Patients may be referred to as “junkies,” “crackheads,” or other pejorative terms that describe them solely through the lens of their addiction or their implied personal failings. These word choices matter. Language related to SUDs does influence perceptions and judgments, even among health care professionals with substantial experience and expertise. For example, in one study involving a case vignette, doctoral-level mental health and SUD clinicians were significantly more likely to assign blame and to concur with the need for punitive actions when an individual was described as a “substance abuser” rather than as a “person with a substance use disorder.”³ In a second study, mental health care practitioners attending professional conferences were less likely to believe individuals deserved treatment when they were described as a “substance abuser” rather than as a “person with a substance use disorder.”¹

Stigma isolates people, discourages people from coming forward for treatment, and leads some clinicians, knowingly or unknowingly, to resist delivering evidence-based treatment services. The 2014 National Survey on Drug Use and Health⁴ estimates that of the 22.5 million people (aged ≥ 12 years) who need specialty treatment for a problem with alcohol or illicit drug use, only an estimated 2.6 million received treatment in the past year; of the 7.9 million specifically needing specialty treatment for illicit drug use, only 1.6 million received treatment. The survey noted that reasons for not seeking treatment included fears that receiving it would adversely affect the individual's job or the opinion of neighbors or other community members. Lack of insurance coverage, cost concerns, and not perceiving a need for treatment also contributed. Among health care professionals, negative attitudes regarding people with SUDs have led to diminished feelings of empowerment among patients, lower levels of empathy and engagement among health care professionals, and poorer outcomes.⁵ Not surprisingly, medication-assisted treatment remains isolated within SUD treatment systems, which in turn have historically been separated from the rest of health care.

To help address these concerns, the American Medical Association has called on physicians across the nation to reduce the stigma of SUDs and enhance access to comprehensive treatment.⁶ The American Society of Addiction Medicine and major addiction journals have urged the adoption of clinical, nonstigmatizing language in communicating about addiction, as has the subspecialty of addiction medicine (established in 2015 by the American Board of Medical Specialties).⁷ Also, the 2013 *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5)* has replaced earlier categories of substance “abuse” and “dependence” with a single classification of “substance use disorder.”

The federal government is now announcing new steps. The White House Office of National Drug Control Policy is releasing guidance entitled *Changing the Language of Addiction*.⁸ Developed in consultation with the National Institute on Drug Abuse, the National Institute on Alcohol Abuse and Alcoholism, the Substance Abuse and Mental Health Services Administration, and other federal agencies and stakeholders, this document will guide federal agencies in the accurate use of language regarding SUDs. The guidance offers ways to replace commonly used stigmatizing terms with alternative language more aligned with science. For example, the guidance recommends the following: replacing “drug abuser” with “person with a substance use disorder,” consistent with *DSM-5*; referring to a person as “in recovery” rather than being “clean,” because the latter term implies that people with this disease are

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dirty or socially unacceptable; and avoiding use of the term “drug habit,” which inaccurately portrays SUDs as simply a matter of personal choice.

The new guidance will apply to internal and external forms of communication, including publications, press and web materials, and funding announcements. It will reach federal officials, contractors, and grantees, among others, and encourage wider use of nonstigmatizing language in future public discourse. The adoption of clinically accurate terminology could help serve as an impetus toward better science-based public health policies and more integrated SUD services within broader health systems.

Language changes alone are insufficient, of course. Education and policy must also reduce stigma and the historical isolation of patients with SUDs from the rest of health care. For example, the Mental Health Parity and Addiction Equity Act of 2008 requires that services for mental health and SUDs be offered at parity with those for other physical conditions; rules were finalized in 2012. However, a 2016 US Department of Labor report on its implementation found that health care plans were still imposing inconsistent preauthorization requirements for SUD treatment, not disclosing the criteria for determining medical necessity or reasons for benefit denials for patients with SUDs, and making patients endure less effective, “fail first” therapies

before providing the standard of care (eg, treatment with US Food and Drug Administration–approved medication for opioid use disorder).⁹ A 2016 White House Mental Health and Substance Use Disorder Parity Task Force is now addressing how best to ensure adherence to the parity regulations.

Furthermore, the Patient Protection and Affordable Care Act requires most health insurance plans to offer SUD services as one of 10 essential benefits. In addition, a 2015 presidential memorandum requires federal agencies to review health care benefit requirements, drug formularies, program guidelines, medical management strategies, drug utilization review programs, and all other relevant policies and tools to identify barriers preventing individuals with opioid use disorders from accessing medication-assisted treatment.

Changing language and related policies and programs will take time. Some stigmatizing terms and stereotypes related to SUDs have been ingrained in society for generations. For instance, the word “abuse” continues to appear in the titles of highly respected addiction journals and in the names of federal government agencies. By beginning to change the language of addiction, it is possible to foster a better future for people with SUDs. Doing so could help remove barriers that continue to hold back too many people from the lifesaving treatment they need.

ARTICLE INFORMATION

Conflict of Interest Disclosures: Both authors have completed and submitted the ICMJE Form for Disclosure of Potential Conflicts of Interest and none were reported.

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