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# Language Matters: It Is Time We Change How We Talk About Addiction and its Treatment

*Aleksandra E. Zgierska, MD, PhD, DFASAM, Michael M. Miller, MD, DFASAM, DLFAPA, David P. Rabago, MD, Florence Hilliard, MSH, Patty McCarthy, MS, Penney Cowan, and Edwin A. Salsitz, MD, DFASAM*

The way we communicate about addiction, its treatment, and treatment outcomes matters to individuals affected by addiction, their families, and communities.

Stigmatizing language can worsen addiction-related stigma and outcomes. Although non-professional terminology may be used by individuals with addiction, the role of clinicians, educators, researchers, policymakers, and community and cultural leaders is to actively work toward destigmatization of addiction and its treatment, in part through the use of non-stigmatizing language. Role-modeling better approaches can help us move away from the inaccurate, outdated view of addiction as a character flaw or moral failing deserving of punishment, and toward that of a chronic disease requiring long-term treatment. Non-stigmatizing, non-judgmental, medically-based terminology and the adoption of person-first language can facilitate improved communication as well as patient access to and engagement with addiction care. Person-first language, which shifts away from defining a person through the lens of disease (eg, the term “a person with addiction” is recommended over the terms “addict” or “addicted patient”), implicitly acknowledges that a patient’s life extends beyond a given disease. While such linguistic changes may seem subtle, they communicate that addiction, chronic pain and other diseases are only one aspect of a person’s health and

quality of life, and can promote therapeutic relationships, reduce stigma and health and disparities in addiction care. This article provides examples of stigmatizing terms to be avoided and recommended replacements to facilitate the dialogue about addiction in a more intentional, therapeutic manner.

**Key Words:** addiction, recovery, stigma, substance use disorder

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The Editorial<sup>1</sup> by Drs Saitz, Miller, Fiellin, and Rosenthal, “Recommended Use of Terminology in Addiction Medicine,” emphasizes the importance of medically-accurate, non-stigmatizing terminology to be used by health care professionals when referring to addiction-related diagnoses and management. As individuals who represent clinicians, individuals with a lived experience, and patient advocates, we are in full support of the non-stigmatizing terminology proposed in the Editorial. We appreciate the opportunity to expand the discussion about addiction-related language and to provide descriptions and recommendations for the use of non-stigmatizing “person-first” language.<sup>2,3</sup>

The way we communicate about addiction, its treatment, and treatment outcomes matters to individuals affected by addiction, their families, and communities.<sup>4</sup> Non-stigmatizing, non-judgmental, medically-based language in public discourse, community-level conversations and clinical encounters surrounding addiction can facilitate improved patient access to and engagement with care.<sup>2</sup> The converse is also true; stigmatizing language, regardless of intent, can perpetuate stigma, including “self-stigma” (internalization of stigma),<sup>5</sup> with feelings of shame, inferiority and fault (“It’s all my fault.” “I’m a bad person.”), and deter people from disclosing and discussing addiction and receiving treatment.<sup>6–8</sup> “Courtesy stigma” can extend stigma and its negative consequences by association to family members and loved ones, and even impact clinician and public health level responses, contributing to health and care delivery disparities in addiction.<sup>8–12</sup>

Treatment for addiction is effective but only if the affected individual receives it. Pharmacotherapy for addiction involving opioid use reduces mortality by 50%; yet only a minority of people with opioid addiction receive it.<sup>13</sup> This dramatic gap between efficacy and receipt of pharmacotherapy cannot be solely explained by inadequate treatment capacity. Although access to pharmacotherapy for opioid

From the Professor, Department of Family and Community Medicine, College of Medicine, Pennsylvania State University, PA (AEZ), Past President, American Society of Addiction Medicine, Past Director, American Board of Addiction Medicine, Past Director, American College of Academic Addiction Medicine, Clinical Adjunct Professor, Department of Psychiatry, School of Medicine and Public Health, University of Wisconsin-Madison, WI (MMM), Professor, Department of Family and Community Medicine, College of Medicine, Pennsylvania State University, PA (DPR), Director, Wisconsin Voices for Recovery, Department of Family Medicine and Community Health, School of Medicine and Public Health, University of Wisconsin-Madison, WI (FH), Chief Executive Officer, Faces & Voices of Recovery, Washington, DC (PM), Founder and CEO, American Chronic Pain Association, CA (PC), Associate Clinical Professor of Psychiatry, Icahn School of Medicine, Mount Sinai Beth Israel, New York City (EAS).

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Send correspondence to Aleksandra E. Zgierska, MD, PhD, University of Pennsylvania State University, Hershey, PA. E-mail: azgierska@pennstatehealth.psu.edu

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use disorder is suboptimal, even when medications are available, patients may be hesitant and even decline to start or continue them due to addiction treatment-related stigma and numerous misconceptions (“It’s replacing one addiction with another.”) and vilification (“You are not in recovery until you’re off these drugs.”) of these life-saving treatment options.<sup>14</sup>

The ongoing opioid crisis has also brought stigmatization to the opioid-based management of pain.<sup>15</sup> Individuals

treated with appropriately prescribed long-term opioids for chronic non-cancer pain often experience stigma, discrimination and even hostility from healthcare professionals, exacerbating patient suffering. Physical dependence and withdrawal, expected in those treated with long-term daily opioids, make the diagnosis of opioid use disorder challenging because these phenomena are also 2 of the diagnostic criteria for the diagnosis of substance use disorder (Table 1).

**TABLE 1.** Proposed Person-first Terminology to Reduce Stigmatization of and Improve Clarity of Communication Related to Addiction and its Treatment

Stigmatizing Language	Proposed Terminology	Comments
Abuser; addict; street addict; former or reformed addict; alcoholic, boozier; crackhead, cokehead; pothead, weed user; dope addict; narco; junkie; druggie; twaker; dope fiend; alkie; lush	Person with [substance] use or [substance use or behavior] disorder or addiction involving [substance use or behavior]. Person in remission from a [substance use or behavior] disorder. Person with [substance use or behavior] disorder who is homeless.	Some of these terms can refer to a person with or without a substance use or behavior disorder. A disorder is diagnosed if the DSM-5 criteria for use or behavior disorder are met. See Editorial for guidance on the diagnosis-related terminology. <sup>1</sup>
Having a drug habit or bad habit; having a drug of choice, drug of abuse	Having a [substance use or behavior] disorder or addiction involving [substance use or behavior].	Addiction is a chronic disease, not a habit; the term ‘habit’ or ‘choice’ implies that it is merely a problematic behavior and something that a person can ‘fix’ by simply desiring a change. “Cigarette habit” and “heroin habit” are examples of such problematic terms.
Smoker	Person with cannabis and/or tobacco or nicotine use disorder, or addiction involving cannabis / tobacco / nicotine use.	With the increasing use of vaping and e-cigarettes, it is suggested to use the term ‘nicotine’ rather than ‘tobacco’ as it encompasses both tobacco chewing and smoking, and the use of non-combustible nicotine delivery systems.
Addicted baby; crack baby; meth baby	Neonate (or newborn, child) with [substance] withdrawal; or with neonatal withdrawal syndrome; or with <i>in utero</i> exposure to [named substance]	Children can be exposed <i>in utero</i> to substances. They can develop a physical or physiological dependence with prolonged <i>in utero</i> exposure to certain substances that can lead to a withdrawal syndrome post-birth. They are not born with addiction – they do not meet the diagnostic criteria for SUD.
Being clean or sober	Being substance-free. Being abstinent. Being in remission. Toxicology test testing “negative” for a [substance].	Remission occurs when the symptoms of a disease subside. Recovery extends beyond the remission phase. See Editorial for guidance on the remission related terminology. <sup>1</sup>
Being dirty	Using [substances]. Toxicology test testing “positive” for a [substance].	“Dirty urine” implies that the person is a “dirty” person.
Getting/being high; stoned; wasted	Being intoxicated; being under the influence of [substance]	
Shooting up, jacking up, slamming, banging, pinning Kicking the habit	Intravenous drug use; injection drug use  Initiate abstinence; receive/ start treatment; enter remission, etc.	Intravenous drug use refers to substance use and does not automatically mean that the individual has addiction. The commonly used phrase ‘kick the habit’ implies that it is a habit not a disease, and that the ‘treatment’ occurs simply based on sufficient ‘willpower’ to stop the behaviors.
Being in detox	Undergoing a detoxification treatment; withdrawal management/treatment; tapering off medications	
Being in rehab	Undergoing intensive addiction treatment or management; intensive pain rehabilitation or restoration program	
Replacement or substitution treatment for OUD; Medication-Assisted Treatment (MAT)	Medication treatment; pharmacotherapy	Misconceptions about agonist medications, buprenorphine and methadone (such as “they replace one addiction for another”), imply that this evidence-based treatment for OUD is a continuation of drug use; statements that people treated with agonist medications are not in remission because they are not “drug free” convey a similar message. Using the term Medication-Assisted Treatment can imply that medication <i>per se</i> is not a treatment. <sup>1</sup> Because the acronym MAT has now deep cultural roots, the change to “Medications for Addiction Treatment” could preserve the commonly-used acronym while changing its full name to a non-stigmatizing one.
Having dirty / clean urine	Toxicology test testing positive / negative for a [substance]. Results are unexpected / expected; inconsistent / consistent with the prescribing record.	
Recidivism	Remission	See Editorial for guidance on the remission-related terminology. <sup>1</sup>

Because language can help or harm, the intentional use of appropriate language in addiction-related communication is essential. We propose general principles and provide examples of intentional person-centered terminology, which we believe would improve treatment and its outcomes, if generally adopted. First, we suggest shifting away from language that defines a person through the lens of disease or through the lens of being a patient. Much as medical students are encouraged early in training to say “The person with appendicitis in Room 12” rather than “The appendicitis in Room 12,” addiction-related care would refer to “a person with addiction” or “a person with opioid-treated chronic pain” rather than “addict,” “addicted patient” or “opioid-treated chronic pain patient.” Such person-first language implicitly acknowledges that a patient’s life extends beyond a given disease,<sup>2,3</sup> and makes clear that having addiction does not change the reality that the afflicted individual is a person. While such linguistic changes are subtle, they communicate that addiction or chronic pain are only one aspect of a person’s health and quality of life, decrease stigma and encourage healing relationships.

Second, it is particularly important for health care professionals to use professional terms and avoid colloquial, imprecise, or stigmatizing terms. For example, when discussing the management and monitoring of the disease and treatment progress (eg, remission), the terminology needs to be professional and clear, without the use of vocabulary that may suggest judgement on the person’s character (“Your urine was dirty”). In addition, we must improve our portrayal of addiction treatment, especially medications for opioid addiction and overdose prevention, to avoid stigmatization of individuals who receive or consider such treatment. For example, referring to maintenance treatment of opioid use disorder (OUD) with buprenorphine or methadone as “replacement therapy” or “replacing one addiction for another” is not evidence-based and disparages long-term therapy. We also suggest that prescribed and medically-authorized pharmacotherapies be called “medications” rather than “drugs” to reduce the implicit associations between prescribed, monitored treatments (eg, methadone, buprenorphine and naltrexone for OUD) and misuse of non-prescribed (ie, illicitly-obtained) substances.

Although non-professional terminology may be used by individuals with addiction, the role of clinicians, educators, researchers, policymakers, and community and cultural leaders is to actively work toward destigmatization of addiction and its treatment, in part through the use of non-stigmatizing language. Role-modeling better approaches can help us move away from the inaccurate, outdated view of addiction as a character flaw or moral failing deserving of punishment, toward that of a treatable chronic disease requiring long-term treatment. Drawing upon our collective clinical, research, advocacy and personal experiences, and the published literature, we developed a list that expands the Editorial’s terminology,<sup>1</sup> and includes commonly used stigmatizing terms and their recommended replacements. This list is meant to offer a practical cross-walk between the stigmatizing terms to be avoided and more recommended diction to facilitate the dialogue about addiction in a more intentional, therapeutic manner. This linguistic cross-walk can be applied toward

future conversations among stakeholders or to conduct a “language audit” of existing materials for terms that may be stigmatizing and should be replaced with more person-first language. It should not be viewed as exhaustive or “final” though – language is dynamic, and the meaning of specific terms will change with the changing cultural and scientific landscapes.

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