PALLIATIVE CARE NETWORK OF WISCONSIN

FAST FACTS AND CONCEPTS #429
DE-STIGMATIZING THE LANGUAGE OF ADDICTION

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Background Discrimination and stigmatization of patients who use psychoactive drugs or who have addiction is common in healthcare (1–4). Using people-first, medically accurate, and stereotype-reducing language with colleagues, trainees, and in documentation (5), is fundamental to dispelling stigma (6) and misperceptions, such as the myth of addiction as a willful, personal choice or moral failing. The right words can convey empathy and reduce mistrust in healthcare for patients who have often faced a history of marginalization. This *Fast Facts* discusses healthcare stigmatization of patients who use drugs or have addiction, and will present preferred language that respects personhood, supports recovery, and promotes accurate knowledge about the full spectrum of substance use and an understanding of addiction as a chronic, treatable condition (*see Fast Fact* #127).

Stigma in healthcare Stigma is a social process that occurs in the context of power (7), characterized by labeling, stereotyping, and discrimination based on real or perceived attributes. Stigma towards people who use drugs or develop addiction, as well as medications to treat this condition, are long-standing. Opioid use disorder (OUD) has long been treated apart from mainstream medicine in the US, from the 1914 Harrison Narcotics Act which separated treatment of OUD away from mainstream healthcare (8), to the racist “War on Drugs” which treated drug use as a criminal-legal issue removed from public health. Clinicians themselves commonly have negative biases about addiction (9–11) which is often reinforced during medical training via stigmatizing language (12). For example, patients described as "substance abusers" were perceived by clinicians as more threatening, more worthy of blame, and less likely to benefit from treatment compared with “persons with an SUD” (13). Altogether, stigma worsens the mental and physical health of people who use drugs (14–16), disproportionately affects communities of color (17), and harms patients on long-term therapeutic opioids (18,19). It even underlies the crisis of overdose deaths, as only 12.5% of people with OUD receive medication proven to reduce accidental overdose (18,19). The table below presents preferred language for clinicians.

Preferred language (20,21)	**Non-preferred language**
Substance use disorder (SUD), *opioid use disorder* (OUD), *alcohol use disorder* (AUD), *unhealthy/risky use* (preferred to *misuse*), *non-medical use*, *addiction* (which can be used to mean severe SUD per the DSM 5)	*Substance/drug/alcohol abuse*, *drug/drinking problem*. The terms d*ependence* and *addiction* are both used by patients; however, *dependence* clinically refers to physiologic withdrawal reactions when a substance is stopped. It may occur without a SUD and should not be used synonymously by clinicians with SUD/addiction.
Addiction is a chronic condition characterized by the compulsive use of a substance despite harmful consequences.	Using language like *choice*, *lifestyle, moral failing*, *lack of will power*, or *personal failure* to describe SUD/addiction.
Person with a SUD, person with addiction, person who uses drugs, person who injects drugs (PWID)	*Addict, drug/substance abuser, person with a drug habit, alcoholic, IV drug user, drug-seeker*
Person not actively using, person in remission from SUD, person in recovery	*Clean, former addict*. The term s*ober* is generally not used by clinicians, though some patients use it themselves.
Substance *present/not present* in urine screen	*Dirty/clean* urine. Describing urine as *positive* or *negative* for a substance can be clinically confusing.
Medications for OUD (MOUD), *Medication for addiction treatment* (MAT), *Opioid agonist therapy* (OAT)	*Opioid replacement therapy* and *opioid substitution* are not preferred as they stigmatize MOUD as ‘replacing one addiction with another.’ *Medication assisted treatment* is

	not preferred because MOUD alone can save lives without additional treatment for some patients.
Patient-directed discharge, patient left before treatment completion despite medical recommendations, patient declined further treatment after informed consent	*Leaving against medical advice, AMA, eloped:* these clinical designations have no clinical, regulatory, or professional standards. As such they can stigmatize patients, worsen health outcomes, and disproportionately affect vulnerable populations (22)
Undertreated pain, risky opioid use (e.g., self-titration of meds, etc.) related to undertreated pain (instead of pseudoaddiction) *Using opioids to treat non-pain symptoms* (instead of chemical coping)	*Pseudoaddiction, chemical coping:* these non-diagnostic euphemisms are applied inconsistently and subject to unconscious bias by, for example, clinicians to describe patients with OUD, for whom the clinician does not feel comfortable 'labeling' as having OUD. This stigmatizes OUD and can prevent appropriate treatment (23)
Opioids	*Narcotics* (which is used in a legal context to refer to multiple classes of illegal substances not just opioids)

Summary The language used to describe substance use and addiction must convey respect for individuals, an accurate understanding of the full spectrum of substance use (from non-problematic use to chaotic use and addiction), and effective treatment. Avoid perpetuating negative stereotypes by first recognizing, addressing, and combatting misunderstandings and stigma.

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