

COMMENTARY
(February, 2010)

**Alcohol/Drug/Substance “Abuse”:
The History and (Hopeful) Demise of a Pernicious Label**

William L. White, M.A. and John F. Kelly, Ph.D.

Words are important. If you want to care for something, you call it a “flower”; if you want to kill something, you call it a “weed.”
--Don Coyhis

The language used to label alcohol and other drug (AOD) problems exerts a significant influence on people experiencing such problems and on how professional helpers, policy makers, and the public view such people. Whether AOD-related problems are viewed primarily in terms of medicine (illnesses), psychology (habits), sociology (norms), morality (vices), religion (sins), or law (crimes) rests on a choice of concepts and words. America’s enduring and ambivalent relationship with psychoactive drugs is replete with cycles of stigmatization/de-stigmatization/re-stigmatization, criminalization/decriminalization/recriminalization, and medicalization/de-medicalization/re-medicalization. Put simply, we can’t seem to make up our collective minds about these substances and the people who use them to excess. As a result, we have not achieved any enduring consensus on the language that best depicts AOD-related problems (White, 2004).

This brief commentary is about two such word choices—*abuse/abuser*—whose origins and shortcomings we will explore. We join a growing list of addiction professionals who have advocated the immediate and permanent removal of *abuse/abuser* from the lexicon of the addictions field and discouragement of their use in broader cultural discussions of AOD problems. Five arguments support this recommendation.

1. *The term abuse applied to substance use disorders is technically inaccurate.* Common definitions of the term *abuse* focus on acts of willful mistreatment, verbal intimidation/insult/humiliation, physical injury or deception (Abuse, 2010). To suggest that people with serious alcohol and other drug problems disregard, mistreat, or defile the psychoactive substances they consume is a ridiculous notion. They do not *abuse* alcohol or drugs; they treat these substances with the greatest devotion and respect at the expense of themselves and everyone and everything else of value in their lives. The following anecdote illustrates the ridiculousness of this notion. When asked many years ago what he thought would constitute the *abuse* of alcohol, Alex B., a person in long-term alcoholism recovery, cryptically responded to the author (W.W.), “mixing Jack Daniels Tennessee Whiskey with Hawaiian Punch: anyone who would commit such an abhorrent act deserves serious punishment.”

2. *The terms alcohol/drug/substance abuse/abuser reflect the misapplication of a morality-based language to depict a medical condition.* The historical roots of the

application of the term *abuse* to severe and sustained alcohol and other drug problems are found not in medicine but in religion. References to alcohol/drug/substance *abuse* are rooted in centuries of religious and moral censure (Benezet, 1774). In 1673, Increase Mather in his sermon, “Woe to Drunkards” proclaimed that alcohol was the “good creature of God” but that the “abuse of drink” was “from Satan” (Lender, 1973, p. 353). The *abuse/abuser* vocabulary has long implied the willful commission of abhorrent (wrong and sinful) acts involving forbidden pleasure, e.g., the historical condemnation of masturbation as *self-abuse* (Renaud, 1989). The terms have also come to characterize those of violent and contemptible character—those who abuse their partners, their children, or animals.

The weight of this history led the National Commission on Marihuana and Drug Abuse (1973) to conclude that “continued use of this term [*abuse*] with its emotional overtones, will serve only to perpetuate confused public attitudes about drug using behavior.” It also led noted alcoholism scholar Mark Keller (1982) to castigate the term *alcohol abuse* as “opprobrious, vindictive, pejorative,” and an “inherently nasty” phrase. There is no medical diagnosis other than *alcohol/substance abuse* to which the term *abuse* is applied as a diagnostic term.

3. *The terms abuse/abuser contribute to the social and professional stigma attached to substance use disorders and may inhibit help-seeking.* To refer to addicted individuals as alcohol, drug, or substance *abusers* misstates the nature of their condition and may contribute to their social rejection, sequestration, and punishment (Kelly, 2004). Allegation of this effect has been made for quite some time, but recent scientific studies confirm that the words we use to depict individuals with AOD problems do make a very real difference in how people perceive and respond to these problems. In one recent randomized study, health care workers attending two addiction/mental health conferences ($N = 728$) were asked to complete a survey, which included a short paragraph describing an individual as either a “substance abuser” or as “having a substance use disorder.” The vignette described “Mr. Williams,” who was having difficulty complying with a court-ordered substance-related treatment protocol. Half the study participants received the paragraph describing him as a “substance abuser,” the other half received the paragraph describing him as having a “substance use disorder,” with the rest of the wording identical. Participants were asked to read the paragraph and then answer a number of questions that assessed whether he ought to receive more punitive or therapeutic measures, whether he was a social threat, and whether he was more to blame for his failure to comply. Those receiving the “abuser” paragraph were significantly more likely to agree that Mr. Williams should be punished and was more to blame for his condition and failure to comply with the treatment protocol (Kelly & Dow, 2009; Kelly & Westerhoff, 2009). Thus, even among highly trained mental health clinicians, exposure to the *abuser* label produced a reliably different and more punitive and blaming attitude toward the same individual.

4. *The terms abuse/abuser inaccurately portray the role of personal volition in substance use disorders.* These terms define AOD problems exclusively in terms of personal values, character, and personal decision-making. By implying that AOD problems are a function of bad choices and that people should be accountable for such choices, the terms provide a rationale for policies of forced sequestration and mass incarceration of people with severe AOD problems. Use of these terms ignores how

volitional control over AOD-related decision-making can be compromised by personal vulnerabilities and drug-induced neurological changes in the brain. The terms, by focusing on the individual casualties of AOD consumption, also deny the culpability of corporations whose financial interests are served by promoting high frequency, high quantity AOD consumption.

5. *The use of the abuse diagnosis by the American Psychiatric Association's Diagnostic and Statistical Manual (DSM-IV) perpetuates and legitimizes the continued stigmatization of people with AOD problems.* This, in addition to growing concerns about the scientific validity of *alcohol/substance abuse* as a diagnostic classification (Harrison, Fulkerson, & Beebe, 1998; Hasin et al., 2003; Hasin, Hatzenbueler, Keyes, & Ogburn, 2006) and the widespread social convention of describing all adolescent substance use as *abuse* (Harrison et al., 1998), should be grounds for considering abandonment of the *abuse* language with the diagnostic nomenclature of psychiatry.

The terms *abuse* and *abuser* should be now and forever abandoned in reference to alcohol and other drug-related problems and those experiencing such problems. Such an action would include dropping *abuse* from the field's diagnostic language and changing the names of the field's major research and policy organizations: The National Institute on Alcohol Abuse and Alcoholism, the National Institute on Drug Abuse, and the Center for Substance Abuse Treatment (White, 2006). If we truly believe that substance use disorders constitute serious health problems, legitimate medical disorders, and at their core, brain diseases, then why do we continue to have departments and centers of substance *abuse*? It is time—no, past time—that the terms *abuse/abuser* were dropped from the lexicon of addiction professionals and recovery advocates.

Acknowledgement: This commentary is dedicated to Mark Keller, James Royce, Mel Schulstad, Neil Scott, and other addiction professionals and recovery advocates who for years have been calling for the field to abandon the *abuse* language.

About the Authors: William L. White is a Senior Research Consultant at Chestnut Health Systems and a volunteer consultant to Faces and Voices of Recovery. Dr. John Kelly is the Program Director of the Addiction Recovery Management Service (ARMS) and Associate Director of the Center for Addiction Medicine at the Massachusetts General Hospital (MGH) and also serves as an Associate Professor in Psychiatry at Harvard Medical School.

References

- A Lover of Mankind (Benezet, Anthony). (1774). *Mighty destroyer displayed in some account, of the dreadful havock made by the mistaken use as well as abuse of distilled spiritous liquors*. Philadelphia: Joseph Crukshank.
- Abuse. (2010). In *Merriam-Webster Online*. Retrieved February 2, 2010 from <http://www.merriam-webster.com/netdict/abuse>.
- Harrison, P. A., Fulkerson, J. A., & Beebe, T. J. (1998). DSM-IV substance use disorder criteria for adolescents: A critical examination based on a statewide school survey. *American Journal of Psychiatry*, 155, 486-492.

- Hasin, D. S., Hatzenbuehler, M. L., Keyes, K., & Ogburn, E. (2006). Substance use disorders: Diagnostic and Statistical Manual of Mental Disorders, fourth edition (DSM-IV) and International Classification of Diseases, tenth edition (ICD-10). *Addiction, 101*(Suppl 1), 59-75.
- Hasin, D. S., Schuckit, M. A., Martin, C. S., Grant, B. F., Bucholz, K. K., & Helzer, J. E. (2003). The validity of DSM-IV alcohol dependence: What do we know and what do we need to know? *Alcoholism: Clinical and Experimental Research, 27*, 244-252.
- Keller, M. (1982). On defining alcoholism: With comment on some other relevant words. In L. Gomberg, H. White, & J. Carpenter (Eds.), *Alcohol, science and society revisited* (pp. 119-133). Ann Arbor: The University of Michigan Press.
- Kelly, J. F. (2004). Toward an addiction-ary: A proposal for more precise terminology. *Alcoholism Treatment Quarterly, 22*, 79-87.
- Kelly, J. F., & Dow, S. (2009). Stigma in addiction: Does it matter how we refer to individuals with substance-related conditions? *Alcoholism: Clinical Experimental Research, 33*(Supplement), 129A.
- Kelly, J. F., & Westerhoff, C. (2009). Does it matter how we refer to individuals with substance-related conditions? A randomized study of two commonly used terms. *International Journal of Drug Policy*. Advance online publication. doi: 10.1016/j.drugpo.2009.10.010
- Lender, M. (1973). Drunkenness as an offense in early New England: A study of Puritan attitudes. *Quarterly Journal of Studies on Alcohol, 34*(2), 353-366
- National Commission on Marihuana and Drug Abuse. (1973). *Marihuana: A signal of misunderstanding*. Washington, D.C.: U.S. Government Printing Office.
- Renaud, J. (1989). Substance abuse is language abuse. *The Counselor, 7*(4), 26-27.
- White, W. (2004). The lessons of language: Historical perspectives on the rhetoric of addiction. In S. Tracy & S. Acker (Eds.), *Altering American consciousness: Essays on the history of alcohol and drug use in the United States, 1800-2000* (pp. 33-60). Amherst: University of Massachusetts Press.
- White, W. (2006). The rhetoric of recovery advocacy. In W. White, *Let's go make some history: Chronicles of the new addiction recovery advocacy movement* (pp. 37-76). Washington, D.C.: Johnson Institute and Faces and Voices of Recovery.