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Language and Addiction

TO THE EDITOR: I wish to support the editorial published by Dr. O'Brien et al. Clearly, our field of addiction medicine has been plagued by problematic language (1). As the authors point out in their editorial, this affects the interaction between patient and clinician when dealing with pain and prescribing. However, the impact of such language on the practice of addiction medicine extends to two larger, and arguably more pervasive, issues in clinical practice.

In my experience, the use of the term "dependence" when working with patients with addiction disorders is highly problematic to the earliest stages of developing a therapeutic alliance and helping the patient gain insight into her/his disease. When patients hear this term applied to them, they often have difficulty internalizing this term as an accurate descriptor of their substance use. When asked how they themselves would define the clinical appearance of someone who is "substance dependent," they often focus more on *physical* manifestations of the illness (tolerance and withdrawal). Not surprisingly then, they describe an individual who daily uses or needs the drug regularly in order to display adaptive psychosocial functioning. This observation appears most pronounced for patients in the precontemplation or contemplation stages of change. Moreover, when asked to describe someone who is "addicted" to a substance, more accurate descriptions are given, including discussions about the *behavioral* and *psychological* manifestations of the illness.

A second additional problem this term creates is that its use automatically excludes nonsubstance-related behaviors from future consideration for a diagnosis of addiction; the best example being pathological gambling disorder. The categorization of pathological gambling has been previously debated in DSM planning meetings: Is it an impulse control disorder or in the same diagnostic cluster as substance use disorders (2)? Pathological gambling disorder has been increasingly defined by scientific and biological findings akin to substance use disorders, arguing for its diagnostic reclassification. Moreover, it has been recognized as perhaps one of the best sources of study for addiction disorders in humans because it is devoid of drug (of abuse) effects which may confound biological research findings (3).

I support the authors' timely discussion toward re-assessing the DSM's language prior to its next revision. Replacing "substance use disorders" with "addiction disorders" could benefit not only the care of patients with pain, but could also enhance the patient's understanding and acceptance of their newly diagnosed disease as well as open future options with respect to potential nondrug addictions and their classification.

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Please, Not "Addiction" in DSM-V

TO THE EDITOR: In the May 2006 issue of the *Journal*, Drs. O'Brien, Volkow, and Li touch on a very serious issue regarding the proper labeling of a drug-induced brain disease known as either "addiction" or "dependence." We agree with the authors' concerns and with the need to have a better word than "dependence" in the DSM-V.

However, "addiction" is not the word. "Addiction" is unscientific, overused, misunderstood (e.g., addicted to my cellphone), and clinically inaccurate (e.g., addicting antidepressants). What we have found in working with people in recovery is that the word is incredibly stigmatizing. The popular press is flooded with stories of crack-addicted babies and heroin addicts being thrown in jail. Sadly, in everyday use, "addiction" fails to differentiate between the medical (brain) disease associated with drug use by at-risk people and overinvolvement with drugs (abuse) or activities.

Stigma-driven discrimination is seen when those with "addiction" cannot use our newest scientific advances in treatment because of insurance problems. Stigmatization is one reason we have insufficient research dollars for the study of drug actions on the brain. We fear that continued use of the term "addiction" would forever prevent society from destigmatizing this chronic medical illness.

Our Center faculty believes that the answer lies in proper education regarding the now-diagnosable differences between pathological chemical dependence and "bad-choice" drug abuse.

We indicate that the old (1950) World Health Organization terms "psychological dependence" and "physical dependence" are outmoded and are being phased out. We teach that the term "dependence" is a specific descriptor of the adapted brain state studied so intensively by neuroscientists (1). Our publications on neuroscience-based workshops clearly show that these professionals "get it" (2). We believe the field terminology is changing (e.g., gambling "addiction" has been replaced in many treatment centers with "pathological gambling disorder").

To reduce confusion about "dependence," the use of a qualifier such as "chemical dependence" could be used. It is only through such diagnosable (and clearly articulated) distinctions that we can hope to convince policy makers and the public that a major drug-overuse problem we are treating is truly a chronic

medical illness (called "chemical dependence"), for which we need more treatment and research funds.

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Addiction Versus Dependence in Pain Management

TO THE EDITOR: The editorial by O'Brien, et al. argues that classification of substance use disorders should use the term "addiction" instead of "dependence," which involves normal physiological adaptations. They argue that confusing "dependence" with "addiction" prevents pain patients from getting needed "additional pain medication" (p. 764). A problem with this argument is the implicit underlying assumption that sustained opioid pain medication is continuously effective for chronic pain, and more opioid medication is more effective. The evidence, however, is to the contrary. Chronic opioid intake results in multiple, overlapping physiological adaptations that counteract the analgesic effects of opioids and even enhance pain sensitivity (1, 2). A recent review of the effects of sustained opioid intake concluded that opioids given chronically, at least in high doses, are neither safe nor effective (3). Differentiating addiction from dependence has been promulgated as a way to determine which chronic pain patients may safely be prescribed opioids. This belief corresponds with the marked increase in prescription of strong opioids in recent years and a simultaneous increase in morbidity and mortality from prescription drug dependence (4, 5). Psychiatrists are receiving more and more referrals of chronic pain patients dependent on opioids. In our experience, whether or not they have been behaviorally compliant, they usually do better when detoxified and treated with nonopioid analgesics and psychiatric support (6, 7). In contrast, increasing the opioid dose will provide no more than temporary benefit. We are aware that many patients can function satisfactorily while maintained on steady doses of opioids, such as methadone maintenance patients. When chronic pain patients are managed in this fashion, it may not be pain that is being treated, but rather this may be a form of office-based opioid maintenance. Whatever the terminology that is used for substance use disorders, the assumption that if a patient is not an addict they can be treated freely with opioids will not diminish suffering and will often increase it (8).

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Dr. O'Brien Replies

TO THE EDITOR: We thank the authors of the letters published here as well as the authors of the many more that were sent to us directly. Most of the letters that we received directly were heartfelt expressions of gratitude from clinicians, including nurses who care for chronic pain patients in hospices or who treat chronic pain with opiates and opioids. Along similar lines and in agreement with the letter by Dr. Miller, there have also been supportive letters from organizations of physicians who treat pain (American Pain Society, American Academy of Pain Medicine) and from the American Society of Addiction Medicine.

We have read carefully the only two dissenting letters that we have seen. Drs. Erickson and Wilcox seem to agree with our statement of the problem but find the word "addiction" to be distasteful. They are entitled to that position, but they should also feel the responsibility to come up with a better alternative. "Chemical dependence" would retain the same problems as the current version. We do find it a bit odd, however, that the title of Dr. Erickson's own office contains the term "addiction science." The word is also used without apparent prejudice as the name of one of the most venerable journals in the field as well as in the names of scientific societies and in the name of an official subspecialty of psychiatry.

Drs. Streltzer, Sullivan, and Johnson focus on the issues involved in long-term prescription of opioids. This is a controversial subject and was not addressed in our editorial. The reality is that many patients do receive opioids from their physicians, and both tolerance and "physical" dependence occur to some degree very rapidly. This normal response must be distinguished from compulsive drug-seeking behavior commonly known as "addiction."

Quite frankly, the current classification is an unintentional violation of the Hippocratic Oath: "First, do no harm." We have created a situation with our terminology that not only