Why taking drugs to treat addiction doesn't mean you're 'still addicted'

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A patient came to see me after his most recent near-fatal opioid overdose. Once again, he had stopped his prescribed medication, even though we had agreed together that the safest course of action was to continue. Once again, he had relapsed — and had to be revived with naloxone. It wasn't that he didn't find the medication helpful or that he had side effects — on the contrary, it had nearly eliminated his cravings and stabilized his mood.

But his family and friends kept telling him he wasn't "truly sober" or "really in recovery." And inside, he, too, believed that taking one of only two FDA-approved medications that have been shown to cut opioid addiction death rates by 50 percent or more meant that he was "still addicted."

My patient was lucky: He didn't die because of a widely held, and completely inaccurate, definition of addiction — one that was recently supported by remarks from Health and Human Services Secretary Tom Price[1], who disparaged medication use as merely "substituting one opioid for another." But until politicians, the media, and the public catch up with addiction science, we will not be able to stop the epidemic of overdose deaths.

As the medical director of Massachusetts General Hospital Substance Use Disorder Initiative, I treat patients with addiction; my coauthor, Maia Szalavitz, is a journalist who herself experienced opioid addiction during her 20s. We, and many of our colleagues, are greatly concerned by how common misunderstandings about addiction like this undermine evidence-based care. While semantic issues are often dismissed as trivial, in this case, they are having devastating results.

Here's what has gone wrong. In 1987, the authors of the Diagnostic and Statistical Manual — the "bible" that lists official psychiatric diagnoses and their attributes — designated two acceptable substance-related diagnoses. They were "substance abuse" for short-term but potentially dangerous problems (think: college binge drinking), and "substance dependence" for the chronic, relapsing condition we typically call addiction.

Unfortunately, both of these terms turned out to be inaccurate and actively harmful: This is why, in 2013, they were dropped from DSM-5 and replaced with a spectrum category called "substance use disorder," which runs from mild to severe. In the case of opioids, the diagnosis is labeled "opioid use disorder," and when it is "severe," this corresponds with what most people call addiction. But the media and the public don't seem to have gotten the memo.

Instead, dependence is frequently used as a synonym for addiction, which causes numerous problems. Most importantly, depending on a drug to function without withdrawal symptoms is not itself pathological: This is a normal, physiological result of taking certain medications long-term. If "drug dependence" was the best way to define addiction, then people with diabetes would have "insulin addiction," people with high blood pressure would have "antihypertensive addiction," and everyone would have "food, water, and air addiction."

In contrast, addiction, as defined by the DSM and the National Institute on Drug Abuse, isn't simply needing a substance. It is compulsive drug use that continues despite harm.

This definition accurately includes cocaine as addictive — even though it doesn't involve significant physical illness during withdrawal — while accurately excluding appropriate use of medication in chronic disease. It also means that people stabilized on medications like methadone are not addicted — they don't engage in compulsive use despite consequences — but merely dependent. (When opioids are taken in a steady, regular dose appropriate for a particular patient, that person will not be impaired and can safely drive, work, and parent.)

The phrase "drug abuse" also misleads. It derives from a term meaning "willful misconduct," which basically labels addiction as a sinful choice. "Abuse" is also associated with harms to children and sexual assault: It's not a word that belongs in our medical lexicon.

These may sound like academic distinctions, but they can have deadly implications. Labels affect even highly trained clinicians. One study, for example, found that doctoral and masters level therapists were significantly more likely to recommend punitive measures such as sending a court-ordered patient to jail for relapse when that person was labeled as a "substance abuser," rather than as a "person with substance use disorder." And research shows that harsh methods actually backfire in treating addiction.

Moreover, confusing "dependence" and "addiction" spurs bias against the most effective known treatment for opioid addiction: long-term use of methadone or buprenorphine (Suboxone).

Decades of research show that these medications dramatically reduce the risk of death, HIV infection, and recurrence of drug use. (A recent review of the scientific literature involving more than 100,000 patients found that death rates were two to three times lower for people in methadone or buprenorphine treatment, compared to people not taking medication). No other method — including abstinence-only residential rehab — has such strong support.

Yet the common myth is that people taking these medications are "still addicted" and that residential treatment is a better option. Failure to understand that addiction is not dependence leads many — including family members and people with addiction themselves — to avoid lifesaving care.

Mistaking dependence for addiction can also harm patients with chronic pain. Those who benefit from opioid therapy can be mislabeled as addicted, when, in fact, they are physically dependent. This can lead to cessation of an effective treatment — and sometimes even suicide.

If, as a society, we really believe that addiction is a disease, we can't exempt it from the standards we use to discuss other illnesses. That means dropping inaccurate medical terms from the past. It also means that addiction physicians must do a much better job of educating the public and even other doctors — especially non-specialists like Tom Price — about how our understanding of addiction has changed and why using medication to treat it is not just continuing the problem.

The language that we use about addiction helps determine what we do about it and how we treat people who are affected. People with addiction won't get appropriate, evidence-based care until both addiction physicians and the media explain in up-to-date and unbiased terms what that really means and why it matters.

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