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The Label "Substance Abuser" Does Something Measurable

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A mother stands at the kitchen counter with a rehab intake form in front of her and stops at the line that reads, "In your own words, describe the patient." She has a pen and two vocabularies, both handed to her by people who sounded certain. Does she write that her son is a drug abuser, or that he has a substance use disorder? The form does not care which she chooses; there is no scoring box beside that line. She has faced far larger decisions than this one in the past year, sat through worse phone calls, signed harder papers. She has no idea that this small choice, the one she is about to make without thinking, has been put in a laboratory and measured.

It has, more than once, and the results point somewhere a frightened family can actually use. Over the last fifteen years researchers have run controlled experiments on exactly that word swap, and what they keep finding is that the word a household reaches for is not merely manners, and that choosing it with care is not denial. It is a small, evidence-backed lever that a family genuinely controls, and using it deliberately is a sane and defensible act of love, not a retreat from how bad things have become. That is the argument of this article: not that the right word fixes anything, but that the word is one of the few parts of an impossible situation that still belongs to the people living through it.

To see why the choice carries any weight at all, it helps to notice that families are handed two competing vocabularies for the same life. One is the language of blame most of us grew up inside: junkie, addict, "using again," a person who is "clean" or "dirty" depending on a test result. The other is the plainer, more clinical language of a condition a person has rather than a crime a person commits. The difference between them is not only tone. A word like "abuser" does two things in a single breath. It

names a behavior, and it passes a sentence: it casts the person as someone doing wrong on purpose, a wrongdoer to be corrected, rather than someone who is ill and might be helped. The phrase "has a substance use disorder" describes the same life and the same hard facts, but it frames them as an illness a person is carrying rather than a verdict a person has earned.

Which of those vocabularies is correct is not a settled matter of politeness, and it has not been treated as one. National health authorities have taken a public position. The National Institute on Drug Abuse, in the language guidance it publishes for clinicians, frames the whole question as the difference between words that say a person is the problem and words that say a person has one. It warns that the first kind quietly attaches blame, feeds the assumption that addiction is a moral failing rather than a medical condition, and can push people away from the very help they need (National Institute on Drug Abuse). That is a strong claim for a federal institute to make in a professional guidance document, and it rests on more than sentiment. It rests, in part, on experiments.

What follows is that evidence, and what it means for a family in particular. Two studies show that a single label measurably changes how the same person is judged, not only by the general public but by professionals who were trained specifically to look past labels. A family should care about this for one blunt reason: the frame those words build is one of the very few parts of this crisis that stays in their hands. Almost nothing else about a loved one's addiction is controllable from the outside. The words are.

The most striking evidence comes from a study led by John Kelly, a Harvard addiction researcher, with his colleague Cara Westerhoff, published in 2010 in the International Journal of Drug Policy. They recruited 516 clinicians, most of them doctoral-level, all attending mental-health conferences, and gave them an identical description of a person with a substance-related problem. Everything in that description

was the same for everyone, with one exception. Half the clinicians read that the individual was "a substance abuser." The other half read that the same individual "has a substance use disorder." One noun phrase, swapped; nothing else touched. Then the clinicians rated the person.

They did not rate him the same. The clinicians who had read "substance abuser" were significantly more likely to judge the person as personally to blame for his condition, to see him as a willful actor who should be able to control himself, and to lean toward punishment rather than treatment as the appropriate response (Kelly and Westerhoff). What makes this experiment so hard to wave away is precisely who was moved by it. These were not frightened relatives running on no sleep. They were professionals paid to see past exactly this kind of surface cue, people who would have told you, sincerely, that a single word could not possibly change their clinical judgment. It changed it anyway, on a case where every clinical fact was identical, and most of them never knew it had. If the label can reach into the reasoning of a room full of trained clinicians, it is worth asking what it does at a kitchen table.

That question is answered, at least in part, by a second study from the same year, published by Kelly and colleagues in the Journal of Drug Issues. This time the researchers ran the comparison not with professionals but with an ordinary community sample: everyday people, the kind who make up a neighborhood. The design was the same one-word contrast, and so was the direction of the result. People who read that someone was "a substance abuser" tended to see that person as more to blame for his difficulties, as more of a social threat, as less likely to benefit from treatment, and as more able to simply stop on his own without help, compared with people who read that the very same individual "has a substance use disorder" (Kelly et al.). The two descriptions were of one identical person. The judgments diverged on the strength of the label alone.

This is the finding that reaches all the way into the kitchen, because it is not a study about clinics. It is a study about ordinary people, which is to say the neighbors who ask how he is doing, the relatives around the holiday table who have opinions, the co-workers, the old friends, and, most uncomfortably of all, the family itself. When a parent or a partner reaches, out of exhaustion, for the vocabulary of blame, the research suggests they are not just describing the situation. They are absorbing the same verdict everyone else absorbs: that this person is more culpable, more dangerous, less reachable, and more capable of just stopping if he really wanted to. That last belief in particular, that he could stop if he simply chose to, is the one that turns a disorder back into a character flaw, and it is the one the harsher word quietly reinforces every time it is used.

The reach does not stop with the person who is using, either. In a 2023 editorial in the journal Substance Abuse Treatment, Prevention, and Policy, Appleseth and colleagues turn attention to a group usually left out of these conversations entirely: the children of parents with substance use disorders. They argue that these children are stigmatized by association, carried along by the labels attached to their parents, and that even as person-first language has slowly improved how adults with substance problems are described, children have largely been excluded from that progress. Older labels, the authors note, persist around them. The children themselves, they write, are too often left "invisible, shameful, isolated, and forgotten," even inside the settings built to help their parents (Appleseth et al.). Their point is not, and this matters, that a worried parent's vocabulary is what wounds a child. It is that stigmatizing language travels through an entire household, settling on everyone in it, and that the people with the least power in the story tend to absorb the most of it without anyone noticing.

Set against all of that, the practical guidance is refreshingly concrete, and it asks less of a family than one might fear. What the public-health

bodies recommend is a shift toward what specialists call person-first language, and the rule of thumb is simple: name the person first, then the condition second. Where the old vocabulary said "an addict" or "a substance abuser," the NIDA guidance points toward "a person with a substance use disorder." Where a drug test was reported as "clean" or "dirty," a pairing that quietly calls a person filthy, it suggests the plain clinical words a lab would actually use: "negative" or "positive" (National Institute on Drug Abuse). Where the reflex is to say a person is their diagnosis, the reframe is to say they have it, the same way we would say someone has diabetes or has cancer rather than that they are it.

Notice what none of these swaps requires. They do not ask a family to pretend the addiction is not happening. They do not ask anyone to lower a boundary, drop a consequence, or feel a way they do not feel. A parent can say, in flat, person-first language, "my son has a substance use disorder, and he cannot live in this house while he is using," and that sentence is both accurate and immovable. Person-first language is not soft language. It changes the frame, not the facts, and it is fully compatible with the hardest boundary a family ever has to hold.

It helps to see where these words actually live for a family, because it is rarely in an essay and never in the abstract. They live on the intake form at the counter. They live in the phone call to the insurance company, when a tired voice has to describe a person to a stranger who will make decisions based on the description. They live in the moment a loved one is introduced to a new counselor, or a sponsor, or a doctor in an emergency room at the worst hour. They live in what the family says to itself when no one is around, the private running commentary that decides, over months, whether the person at the center of all this is a problem to be managed or a person to be helped. That inner vocabulary is not visible to anyone else, and it may be the one that matters most, because it is the one the family lives inside every single day.

None of this means the choice of words is beyond question, and the honest thing is to take the strongest objection to it seriously rather than to flatter the argument by knocking over a weak one. The strongest objection is not subtle, and any parent in crisis has felt it: this is word-policing while my child is dying. Softening "abuser" into "a person with a disorder" can sound like exactly the kind of euphemism that lets everyone off the hook, a way of managing feelings instead of managing a catastrophe. My energy, that parent might reasonably say, belongs on getting him into a bed, into treatment, onto medication, on holding a line that might keep him alive, not on curating my vocabulary while the house burns down.

The honest answer to that objection is the experiment at the very top of this article. If the word were only manners, the trained clinicians in the 2010 study would have rated the identical case identically, because the clinical facts they were given did not change. They did not rate it identically. The word moved the recommendations of experts who did not believe a word could move anything, which means the word is not decoration; it is doing quiet work on real judgments, including the judgments of the people a family has to persuade to help. That is not a reason to police how a grieving family talks, and it is certainly not a reason to add shame about vocabulary to a family already drowning in it. It is a reason to recognize that the frame is doing work whether a family attends to it or not, and that, unlike almost everything else in an addiction, this particular part is theirs to set. And it costs nothing. It does not compete with treatment, medication, or boundaries; it takes not one dollar or one ounce of energy away from any of them.

There is a second objection, quieter and more sophisticated: that calling addiction a disorder medicalizes it and quietly removes the person's accountability, letting a loved one off the hook for real harm done to a real family. But the research points the other way. It was the harsher label, "substance abuser," that led people to see the person as more able

to just stop on his own, which is the least accurate and least compassionate reading of a genuine disorder, and, not incidentally, the reading that most easily curdles into giving up on him as hopeless. Naming a condition honestly is not lowering the bar. A family can hold a person completely accountable for his choices and their consequences without defining the whole of him by the worst available word. Accountability and contempt are not the same thing, and the vocabulary of blame tends to smuggle in the second while pretending to be the first.

And there is a third complication, one that comes from the research itself rather than from a critic, and it is important enough that it narrows the claim. Person-first language is not universally preferred, and it is not a rule to be imposed on anyone. A survey of 450 people in treatment for opioid use disorder, described by the Recovery Research Institute, found that most of them did prefer medically accurate, person-first terms and firmly rejected labels like "junkie," but a meaningful minority, especially those active in twelve-step recovery, embraced the word "addict" as an honest, even empowering way to name themselves, a claiming rather than a slur (Recovery Research Institute). The lesson the institute draws from its own data is not "always use this word and never that one." It is that preferences differ from one person to the next, and that the genuinely respectful move, wherever it is possible, is simply to ask the person how they want to be spoken about. For a family, that turns the entire matter from a rule into something gentler and more human: not a correct vocabulary to enforce on a loved one, but a less condemning frame to offer, and a question worth asking the person it actually concerns.

Which brings us back to the mother at the counter, pen still hovering over that line on the form. She cannot control whether her son uses tonight; that was never on the line to begin with, and no word she writes will change it. But the word she writes there, and the word she uses at her own table when the house has finally gone quiet, and the word she

uses in her own head at three in the afternoon and again at midnight, is hers. The research makes no promise that changing it will change what her son does, and it would be dishonest to pretend otherwise. What it says is smaller and steadier and, in its way, more durable than a promise: that the word is not weightless, that it shapes how her son is seen even by people paid to judge him fairly, that it shapes, over time, how she sees him too, and that choosing to call him a person with a substance use disorder rather than a substance abuser is neither denial nor wordplay. It is one of the few consequential choices still left in her hands. And it is entirely her own to make.

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