Terminology Related to the Spectrum of Unhealthy Substance Use

Background

Terminology in Addiction Medicine has presented challenges to clinicians, patients, family members, policy makers, the media, and the general public. Even the name of the American Society of Addiction Medicine (ASAM) has evolved from previous terms found in the titles of predecessor organizations: alcoholism, alcohol and other drug dependencies, addictionology, and addiction medicine.

ASAM has adopted policies which define Addiction and Treatment of Addiction. The ASAM Board endorsed the establishment of a Descriptive and Diagnostic Terminology Action Group (DDTAG) to develop additional terms to clarify matters for the various stakeholders in clinical and policy approaches to substance use, addiction, treatment, and recovery. Addiction commonly involves the pathological pursuit of reward and/or relief via the use of substances such as ethanol (e.g., in alcoholic beverages), nicotine (e.g., in tobacco products), or certain pharmaceuticals (e.g., opioid analgesics or psychostimulant drugs). Addiction Medicine physicians and other specialist and generalist physicians and others may work with individuals who have an unhealthy pattern of use of substances, even if addiction is not present. In fact, addiction is best conceptualized not as an abnormality in substance use, but as an abnormality in the brain’s response when a person with the disease uses substances as a pathological source of reward or relief. In ASAM’s definition of addiction, developed by ASAM’s DDTAG, it is stated that “a characteristic aspect of addiction is the qualitative way in which the individual responds to such exposures, stressors and environmental cues” more that addiction being distinguished by “the quantity or frequency of alcohol/drug use, engagement in addictive behaviors (such as gambling or spending), or exposure to other external rewards (such as food or sex).” Thus some persons can use substances frequently or in large amounts and not have addiction; and some persons with addiction actually do not have a pattern of use involving high dose or high frequency exposure to psychoactive substances.

The scope of practice of Addiction Medicine, as defined by the American Board of Addiction Medicine, includes providing “medical care within the bio-psycho-social framework for persons with addiction” but also providing medical care for “the individual with substance-related health conditions, for persons who manifest unhealthy substance use, and for family members whose health and functioning are affected by another’s substance use or addiction.” Non-addictive but otherwise unhealthy use of alcohol, tobacco, and other drugs, including some prescription drugs, is thus germane to the practice of Addiction Medicine and to the members of the American Society of Addiction Medicine (ASAM).
This aim of this document is to provide definitions for terms that address the entire spectrum of alcohol and other drug use associated with health consequences. The focus is on terms that do not describe “addiction” or DSM-V “substance use disorder,” though it is recognized that addiction and substance use disorders are included in the spectrum and are of course harmful to health. Definitions for terms that are specifically related to addiction can be found elsewhere. Terms that are not preferred, and the rationale for not using them in professional discourse, appear at the end of this document.

Recommendations

In light of the need to clarify terminology, the DDTAG has drafted and the ASAM Board has approved the following terms, and ASAM recommends their use to describe various non-addictive states of substance use.

I. Overview of Preferred Terms for the spectrum of alcohol and other drug use:

1) Low or lower risk use (and non-use)
2) Unhealthy (alcohol, other drug) use
   a) Hazardous use or at-risk use
   b) Harmful use
   c) Addiction (not defined in this document)

Note: “Unhealthy” covers the entire spectrum including all use related to health consequences including addiction. Hazardous and harmful are mutually exclusive of each other, and of diagnosable disease (i.e., addiction).

Note also: The terms herein have been largely defined, studied and used for substances (alcohol and other drugs). They also include prescription (and non-prescription or over-the-counter drugs). However, although there has been less theoretical discussion of and empirical evidence accumulated for other potentially addictive behaviors (e.g. gambling), the framework and preferred terms in this document are also applicable to those behaviors (e.g. low or lower risk gambling, unhealthy gambling, hazardous gambling, harmful gambling).

Specific definitions:

1. Low risk use (alternatively, Lower risk use), including no use

Definition: Consumption of an amount of alcohol or other drug below the amount identified as hazardous (see below), and use in circumstances not defined as hazardous.

Discussion: The term recognizes that risk may not be entirely absent at low levels of consumption. In fact, no amount of use of smoked tobacco has been defined as safe, risk-free or healthy, and no amount of substance use during pregnancy has been defined as safe, risk-free or healthy. The term has been most often applicable to alcohol but may be applied to other drug use, though it is recognized that risks associated with use of specific amounts of other drugs associated with risk are not well-delineated.

2. Unhealthy use¹
**Definition:** Unhealthy alcohol and other drug (substance) use is any use that increases the risk or likelihood for health consequences (hazardous use), or has already led to health consequences (harmful use).

**Discussion:** The term is an “umbrella” term because it encompasses all levels of use relevant to health, from at-risk use through addiction. Unhealthy use is a useful descriptive term referring to all the conditions or states that should be targets of preventive activities or interventions. It is not a diagnosis.

The exact threshold for unhealthy use is a clinical and/or public health decision based on epidemiological evidence for measurably increased risks for the occurrence of use-related injury, illness or other health consequences. For some substances, any use is considered unhealthy (i.e. any cocaine use can increase risk for myocardial infarction; one-time use of hydrocarbon inhalants can lead to sudden cardiac death; no known level of tobacco use is considered risk-free; alcohol is a known carcinogen so there is likely no use that is completely risk free). On the other hand, there are thresholds at which the risk increases substantially for alcohol, and these have been specified widely (see “at-risk” use).

Note: the term “unhealthy” (just as with the descriptors “unsafe” or “hazardous” or “harmful” or “misuse”) does not imply the existence of “healthy” or “safe” or “non-hazardous” or “harmless” use, or that there is a way to use the substances properly (i.e. without “misuse”).

---

**2.a. Hazardous use (alternatively, At-risk use)**

**Definition:** Use that increases the risk for health consequences.

**Discussion:** This term refers only to use that increases the risk or likelihood of health consequences. The term does not include use that has already led to health consequences. Thresholds are defined by amount and frequency of use and/or by circumstances of use. Some of these thresholds are substance specific and others are not. For example, use of a substance that impairs coordination, cognition or reaction time while driving or operating heavy machinery is hazardous. Non-medical use or use in doses more than were prescribed of prescription drugs can be hazardous. Any alcohol or nicotine use during pregnancy is hazardous. Any use by youth likely increases risk for later consequences. Use of any potentially addictive substance is more hazardous for persons with a family history or genetic predisposition to addiction than it is to those at average risk in the general population. Use of substances that interact (e.g. two drugs with sedative effects like benzodiazepines and buprenorphine) is hazardous. Use of substances contraindicated by medical conditions is hazardous (e.g. alcohol use and hepatitis C virus infection or alcohol use and post-gastrectomy states). At-risk amounts of alcohol are discussed below.

Hazardous use has been defined previously (consistent with this current definition) as a level or pattern of use that confers a risk of harmful health consequences.²-⁴

The concept of “risk factor” is relevant here. Just like an elevated cholesterol or consumption of excessive calories are risk factors or increase risk for worse health outcomes, hazardous use increases risk for use related consequences.

An acceptable variation in the use of the terms “hazardous use” or “at-risk use” is to refer to hazardous or at-risk amounts where these have been defined (as for alcohol). Hazardous (or at-risk) amounts of alcohol consumption including heavy drinking episode/heavy episodic
drinking have been defined for the US and elsewhere. In the US, hazardous amounts of alcohol consumption are, for men, 5 or more standard 12 gram drinks (e.g. 1.5 oz 80 proof liquor, 4-5 oz. wine of regular strength, 12 oz regular strength beer) in a day or more than 14 drinks per week on average. Thresholds for women, and for men 65 years and older, are 4 or more drinks in a day or more than 7 drinks in a week on average. A heavy drinking episode occurs whenever a person’s alcohol consumption meets or exceeds the daily threshold of 5 drinks or more for men or 4 drinks or more for women, and for men 65 years and older). Heavy episodic drinking is defined as repeated heavy drinking episodes.

Hazardous amounts of alcohol consumption for adults are determined by consensus and epidemiological evidence. Similar definitions exist in other countries (with amounts defined and described in more culturally relevant terms for those countries). These terms have only been defined and are therefore only applicable to alcohol use. The exact definitions may change with evolving epidemiological evidence and can also vary by preferences of those making clinical or public health decisions regarding thresholds. In addition, the thresholds are not individualized and although they are useful guides clinically, they cannot be thought of as absolute. For example, it is not the case that drinking just under the threshold is associated with no risk, or that drinking just above the threshold confers a substantially greater risk. Furthermore, individual factors beyond age, sex and other risks as listed above can affect risk (e.g. weight).

2.b. Harmful use

**Definition:** Harmful substance use is use with health consequences in the absence of addiction.

**Discussion:** The International Classification of Diseases uses this term as a diagnosis, and see Appendix defined as repeated consumption that has actually caused some form of physical or mental damage. The ICD 10 definition also implies that the person with harmful use does not have ICD 10 dependence. The full definition appears below the references in an Appendix.

Non-medical use or use more than prescribed of prescription drugs (or of over-the-counter medications not as directed) can be harmful.

II. Terms that are not preferred to be used in clinical or research contexts:

1) Misuse
2) Problem Use
3) Inappropriate Use
4) Binge or binge drinking

Note: This list is not exhaustive. Terms that have been used widely were chosen for discussion here.

**Specific Definitions**

**1. Misuse**

The WHO Lexicon defines misuse as use for a purpose not consistent with legal or medical guidelines. It notes that the term “misuse” may be less pejorative than the term “abuse.” In its screening efforts, the US Department of Veterans Affairs describes misuse as the target of screening and intervention. The definition in that context has been the spectrum of use that
increases consequences (similar to unhealthy use as defined above). A journal, *Substance Use and Misuse*, has been published in the United Kingdom since 1996. The main reason the term misuse is not preferred is because there is confusion about whether or not it includes addiction or substance use disorders. For example, the Department of Veterans Affairs uses “severe misuse” to mean dependence. But “misuse” is not an appropriate descriptor for “dependence” or “addiction” because it minimizes the seriousness of the disorder and suggests the disorder is due to choice (to “misuse” the substance). “Misuse” also seems to have value judgment at least potentially implied, as if it were an accident, mistake, or alternatively purposeful, neither of which would be appropriate for describing the varied states incorporated in “unhealthy use.”

“Misuse” is often used to refer to hazardous or harmful prescription (or non-prescription but potentially addictive) drug use. However, for similar reasons as those described above, it is not a preferred term. “Misuse” of prescription or non-prescription over the counter drugs has been used to describe the spectrum of unhealthy use or to denote hazardous or harmful use but not addiction. In addition, “misuse” in this context is sometimes used to refer to non-adherence to (e.g. non-psychoactive) medication (e.g. missed doses of an anti-hypertensive medication). Therefore to avoid confusion and to clearly describe use of potentially addictive drugs in ways that risk or have caused consequences, ASAM recommends the preferred terminology framework described in this document.

2. Problem use

The meaning of this term is the same as “harmful” use. The term is not preferred because when used with patients it has connotations that are not helpful and can be seen as pejorative if the patient is viewed as being the problem or having a problem, as opposed to the substance being a problem.

3. Inappropriate use

The definition of “inappropriate” is unclear and some may find it pejorative. Questions arise as to who determines if use is “inappropriate” and adjudged by what criteria.

4. Binge or binge drinking

These terms can be useful in public health discourse because a “binge” is often understood to be a heavy drinking episode. The US Centers for Disease Control uses the term to mean heavy drinking episode. However, because it is used variably with different meaning it is not generally preferred. Some who have heavy drinking episodes will consider “binge” to be pejorative. Heavy drinking episode is simply descriptive and therefore preferred for that use. The *Journal of Studies on Alcohol and Drugs* proscribes use of the term “binge” because it has been used to mean many different things, from 4 standard drinks in a day for a woman, to a “bender” during which a person drinks continuously for several days in a row. The general public often uses the terms “binge” and “bender” interchangeably to describe a days-long episode of heavy drinking. The National Institute on Alcohol Abuse and Alcoholism has a specific definition for a “binge.”5 and Appendix The NIAAA definition can be useful for research purposes. But even in research, data definitions have not been used in various studies with consistency: “binge drinking” can mean drinking in a “binge” (a single heavy-drinking episode) once per week, twice per week, once per month, twice per month, etc. Similarly, some have
used the term “frequent binge drinking” but there is no standardly accepted sense of how “frequently” an individual must “binge drink” to be described as a “frequent binge drinker.”

III. Diagnostic and Statistical Manual of Mental Disorder (DSM) terms

The Diagnostic and Statistical Manual of Mental Disorders (DSM) has been published by the American Psychiatric Association for decades and is the most commonly used manual of nosology for insurance coding and claims payment and for epidemiological research, at least in North America. The fourth edition of the DSM (DSM-IV), described two Substance Use Disorder conditions: Substance Abuse and Substance Dependence. The fifth edition (DSM-V), includes a list of Substance Use Disorders (from mild to moderate to severe) and abandons the use of the terms Substance Dependence and Substance Abuse. DSM terms are not particularly relevant to defining the spectrum of substance use that affects health. The same is true for the International Classification of Diseases. The reason is that unlike for other medical conditions (e.g., impaired glucose tolerance and diabetes, pre-hypertension, hypercholesterolemia and heart disease), the bodies responsible for the development and publication of DSM and ICD have ignored the spectrum of relevance to health and have not addressed “sub-threshold” conditions or risk factors. They define “disorders” and not substance use states that fail to meet their own diagnostic criteria for a “disorder.”

It is important to note that there is overlap between some terms for the spectrum of use as found herein, and the conditions which constitute DSM-V substance use disorder and ICD 10 dependence. Some with hazardous or harmful use will meet criteria for a DSM-V substance use disorder (most likely “mild” or “moderate”). Harmful use described above is essentially an ICD 10-defined condition (except that ICD 10 requires recurrence in a specific time frame—see Appendix).

IV. Moderate drinking

Moderate drinking is not preferred as a term because it implies safety, restraint, avoidance of excess and even, health. Since alcohol is a carcinogen (and breast cancer risk increases at amounts lower than those generally defined as hazardous, and lower limit amounts harmful to the fetus are not well defined), better terms for amounts lower than at-risk amounts include “lower risk” or “low risk” amounts or simply the term “alcohol use.”

REFERENCES

5. NIAAA Newsletter, winter 2004, Number 3, page 3.
Harmful use

Definition
A pattern of psychoactive substance use that is causing damage to health. The damage may be physical (e.g. hepatitis following injection of drugs) or mental (e.g. depressive episodes secondary to heavy alcohol intake). Harmful use commonly, but not invariably, has adverse social consequences; social consequences in themselves, however, are not sufficient to justify a diagnosis of harmful use.

The term was introduced in ICD-10 and supplanted “non-dependent use” as a diagnostic term. The closest equivalent in other diagnostic systems (e.g. DSM-IV) is substance abuse, which usually includes social consequences.

ICD-10 Clinical description
A pattern of psychoactive substance use that is causing damage to health. The damage may be physical (as in cases of hepatitis from the self-administration of injected drugs) or mental (e.g. episodes of depressive disorder secondary to heavy consumption of alcohol).

ICD-10 Diagnostic guidelines
The diagnosis requires that actual damage should have been caused to the mental or physical health of the user.

Harmful patterns of use are often criticized by others and frequently associated with adverse social consequences of various kinds. The fact that a pattern of use or a particular substance is disapproved of by another person or by the culture, or may have led to socially negative consequences such as arrest or marital arguments is not in itself evidence of harmful use.

Acute intoxication, or “hangover” is not in itself sufficient evidence of the damage to health required for coding harmful use.

Harmful use should not be diagnosed if dependence syndrome, a psychotic disorder, or another specific form of drug- or alcohol-related disorder is present.

ICD-10 Diagnostic criteria for research
There must be clear evidence that the substance use was responsible for (or substantially contributed to) physical or psychological harm, including impaired judgment or dysfunctional behavior, which may lead to disability or have adverse consequences for interpersonal relationships.
The nature of the harm should be clearly identifiable (and specified).

The pattern of use has persisted for at least 1 month or has occurred repeatedly within a 12-month period.

The disorder does not meet the criteria for any other mental or behavioral disorder related to the same drug in the same time period (except for acute intoxication).

National Institute on Alcohol Abuse and Alcoholism definition of “binge”
NIAAA Newsletter, winter 2004, Number 3, page 3.

On February 5, 2004, the NIAAA National Advisory Council approved the following definition/statement:

A “binge” is a pattern of drinking alcohol that brings blood alcohol concentration (BAC) to 0.08 gram percent or above. For the typical adult, this pattern corresponds to consuming 5 or more drinks (male), or 4 or more drinks (female), in about 2 hours.

In the above definition, a “drink” refers to half an ounce of alcohol (e.g., one 12-oz. beer, one 5-oz. glass of wine, or one 1.5-oz. shot of distilled spirits). Binge drinking is distinct from “at-risk” drinking (reaching a peak BAC between .05 gram percent and .08 gram percent) and a “bender” (2 or more days of sustained heavy drinking). For some individuals (e.g., older people or people taking other drugs or certain medications), the number of drinks needed to reach a binge-level BAC is lower than for the “typical” adult.

Adopted by the ASAM Board of Directors July 2013

© Copyright 2013. American Society of Addiction Medicine, Inc. All rights reserved. Permission to make digital or hard copies of this work for personal or classroom use is granted without fee provided that copies are not made or distributed for commercial, advertising or promotional purposes, and that copies bear this notice and the full citation on the first page. Republication, systematic reproduction, posting in electronic form on servers, redistribution to lists, or other uses of this material, require prior specific written permission or license from the Society. ASAM Public Policy Statements normally may be referenced in their entirety only, without editing or paraphrasing, and with proper attribution to the Society. Excerpting any statement for any purpose requires specific written permission from the Society. Public Policy statements of ASAM are revised on a regular basis; therefore, those wishing to utilize this document must ensure that it is the most current position of ASAM on the topic addressed.