# How to Deliver a More Persuasive Message Regarding Addiction as a Medical Disorder

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Many members of our field are frustrated that the public does not see addiction as a legitimate medical disorder which should be compassionately addressed as a health problem rather than a criminal justice problem. Although some attribute the disconnect to the public's lack of scientific knowledge or attachment to outdated moral views regarding substance use, this commentary suggests that the problem may well be our own messaging. We would be more persuasive if we acknowledged that addiction is different from most medical disorders because of its high negative externalities, and that this understandably makes the public more scared of and angry about addiction than they are about conditions like asthma, type II diabetes, and hypertension. Relatedly, because of the amount of violence and other crimes associated with addiction, we should acknowledge that the public's belief that law enforcement has an important role to play in responding to addiction has a rational basis.

**Key Words:** addiction, attitude change, medical disorder, persuasion

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Many members of our field have tried for some time to persuade the public that addiction is a legitimate medical disorder meriting health-oriented preventive and treatment approaches like any other disorder. Yet, much of the public remains unconvinced and harbors punitive, stigmatizing views of people with addictions (Meurk et al., 2014). Within our field, the public's refusal to embrace the concept of addiction as a medical disorder is typically explained as a result of their being unaware of the relevant scientific evidence, their holding moralistic views of substance use, or both (Volkow et al., 2016). This commentary suggests that the fault lies not in the public, but in ourselves, specifically that how and what we say about the status of addiction as a health problem turns many people off, because it is incomplete in some respects and perhaps even inappropriately scolding in others. I write as someone who believes that addiction is best understood as a legitimate medical disorder, but who also believes that we need better messaging to persuade people outside of our bubble of wisdom of that view.

The case for seeing addiction as a chronic medical illness is sound in many respects. The most widely cited articulation of this view noted that addiction shares many features with medical disorders such as asthma, type II diabetes, and hypertension (McLellan et al., 2000). All come about in part due to voluntary behavior, but are difficult to manage behaviorally once they are established. All may be caused in part by genetic factors and all respond to treatment that is provided on an ongoing basis. All require at least some people who have them to engage in lifelong management of the condition. Most members of the field, including me, find these parallels compelling and consider them excellent reasons for health insurance plans to cover addiction treatment as they would for other medical disorders.

That said, analogies to medical disorders such as asthma, type II diabetes, and hypertension (and also ''brain disease'' formulations; Leshner, 1997) leave out something important about addiction. Let me suggest where the blind spot lies by asking my colleagues to consider some questions.

If you had a financial manager who would have access to all your accounts and personal information, would you consider that person developing a heroin addiction of any more consequence than him/her developing type 2 diabetes? If you were enrolling your child in a preschool, would you react in the same way if informed that the teacher was prone to methamphetamine binges as you would to learning that the teacher was prone to asthma attacks? If asked by a nonexpert from outside our field, how would you explain why millions of people have chosen to attend self-help groups and treatment programs focused on recovering from having had an ''alcoholic'' parent, but there is no demand for recovery programs focused on adult children of hypertensive patients?

Grappling with these questions illuminates the limitation of framing addiction as just another medical disorder. The public will not buy our current message, not because they are ignorant or stubborn, but because they know that people with high blood pressure are not prone to steal money from family and employees, people with asthma do not drive cars in a fashion that kills thousands of people a year, and people with type 2 diabetes do not have high rates of committing assault.

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To use a term from economics, addictions have high negative externalities that most medical disorders simply do not and that changes how perfectly decent and reasonable people respond to them.

Consider, for example, a woman who has been battered for years by a husband who is addicted to alcohol and crack cocaine. She may condemn him not because she is not smart enough to grasp the latest neuroscience research on self-control impairment or because she harbors morally backward concepts regarding substance use, but because she is filled with justifiable pain, terror, rage, and sadness. She is almost certainly not going to be open to hearing that her husband deserves compassion because he is suffering from a chronic medical disorder (or a brain disease) akin to asthma, type II diabetes, and hypertension. Nor is she likely to accept that calling the police during a substance-fueled beating would be as crazy as calling the police to deal with an asthma attack or a diabetic complication.

Given the number of individuals who have been victimized by people with addictions, intense negative feelings regarding these individuals should be expected. This in no way threatens the status of addiction as a legitimate medical disorder, but it should change how we convey that message. Within any audience to whom we pitch our addiction as health problem-framing, there will almost invariably be people who have suffered significantly from someone else's addiction. In such a context, a message from us that addiction is more or less like hypertension will often be inadvertently heard as an invalidation of the pain of the people in the audience. And uncritically mouthing the mantra that "addiction is a health-care problem and not a criminal justice problem" will call up memories where law enforcement intervention prevented injury or even saved a life.

I understand that some of us may be frustrated that intense emotions and traumatic experiences shape how people respond to what we think is a calmly delivered, evidence-based message. But recall how often we lecture the public about how people with addictions cannot fully control their brains, and consider that this is also true for the rest of humanity as well.

I have seen this dynamic many times in my career, from lectures halls to Congressional hearings. An expert characterizes addiction as just another medical disorder, victims feel de-legitimated and angry, leading the expert to talk down to them, for example, by saying that the scientific evidence is indisputable or that only moralistic convictions stand in the way of accepting the truth. Both sides leave the exchange feeling unheard, which is, in fact, what has happened.

Relatedly, health professionals in the addiction field should be more critical of the slogan that "addiction is a health problem, not a criminal justice problem." The public knows from bitter experience that it is both. Unlike people with hypertension, people with active addiction often break the law, including by perpetrating a significant amount of violence. Police do not have a clear role in responding to type II diabetes, but they, and not doctors, are the ones we call upon to deal with someone driving drunk down the highway or engaging in violence while high on methamphetamine. Lecturing the public otherwise can make us health professionals seem both self-interested and out of touch.

A better analogy than asthma, type II diabetes, and hypertension we could employ for addiction might be to liken it to chronic infectious illnesses (eg, HIV/AIDS). We accept that for infectious illnesses, some fear of people who have the disease is rational; indeed health professionals exhort people to engage in behavior designed to protect themselves from infected individuals (eg, insisting that a sexual partner with a sexually transmitted disease wear a condom, not personally cleaning the body of someone who died from Ebola). Further, we accept that there is a legitimate role for law enforcement—Typhoid Mary was prevented from continuing to infect people by police (Marinelli et al., 2013), not doctors. Analogizing addictions to infectious diseases has all the virtues of analogizing it to diseases with low externalities (eg, asthma) and also has the unique advantage of better matching the public's experience of the disorder (and it is them and not ourselves whom we need to persuade).

After many failures trying to persuade audiences that addiction should be viewed as a legitimate medical disorder, I have learned to open such sermons by acknowledging the pain addiction causes to those who do not have it, the compassion I have for those victims, and that I am not minimizing or excusing what happened to them when I say that addiction is a health problem warranting compassionate care. That simple acknowledgement—really nothing more than common decency—goes farther in opening hearts and minds than do a thousand Powerpoint slides on our latest amazing scientific findings or a critique of the audience's moralistic perspective on substance use. If we want the public to be compassionate towards people with addictions, we need to start with compassion towards the public.

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