**Should we embrace the term ‘preaddiction’?**

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***This manuscript has been accepted for publication at Neuropsychopharmacology as of October 30, 2023.***

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**Background and Intended Benefits**

McLellan and colleagues1 recently proposed the term “preaddiction” to improve identification of and interventions for early stage, or less severe, manifestations of substance use disorder (SUD), including “mild” and “moderate” SUD per the *Diagnostic and Statistical Manual of Disorders, Fifth Edition* (DSM-5). Following this, the National Institute on Drug Abuse (NIDA) and National Institute on Alcohol Abuse and Alcoholism (NIAAA) solicited feedback on the proposed label2, noting that “preaddiction” would replace the terms “problematic substance use,” “mild substance use disorder,” and “moderate substance use disorder.” Additional goals described included raising awareness about harmful substance use, increasing screening and brief interventions, and preventing overdose.

**Potential Pitfalls**

Though NIAAA and NIDA identify important goals, they seem unlikely to be achieved through the introduction of a new label for already existing constructs. Indeed, terms capturing harmful substance use and early-stage SUD already existsuch as the *International Classification of Diseases* (ICD-11) harmful pattern of substance use, or theDSM-5 criteria count indicating SUD severity (i.e., “mild” [endorsing 2-3 criteria], “moderate” [4-5 criteria], and "severe” [6+ criteria] designations of SUD). However, these categories are on empirically shaky ground with respect to their validity and clinical utility given the heterogeneity of the SUD symptoms themselves, particularly for DSM-5. For example, meeting criteria on the basis of craving and withdrawal (considered more severe and fundamental features of addiction) is likely different from a person who meets criteria on the basis of hazardous use (e.g., drinking and driving) and drinking despite physical/psychological problems (less severe criteria and likely secondary features of addiction3–5), though both individuals would meet “mild” SUD, or “preaddiction”, criteria). If current mild and moderate categories are not adequately raising awareness about harmful use and increasing screening and brief interventions, we should not expect improvements simply as a result of relabeling these categories to “preaddiction”. Thus, attaching additional labels to flawed severity designations would be a misstep and the field should avoid reifying a limited diagnostic systems.

Adopting “preaddiction” has potentially damaging consequences for people with SUD — an already marginalized group. As McLellan and colleagues1 note, addiction and substance use are highly stigmatized, which can result in multiple harmful consequences6. However, claiming “preaddiction” would avoid stigmatizing consequences because it centers on addiction and not the person lacks empirical support. Similarly, claiming “preaddiction has inherent motivational properties” (p. 750) for promoting clinical action and patient change is also speculative and arguably counter to evidence about the potential costs of framing addiction as a “disease”6–8. Further, “preaddiction” risks implying substance use is a one-way progressive path to addiction, counter to findings that most people with harmful substance use and even SUD recover, often without formal treatment9.

Relatedly, “preaddiction” may exacerbate existing stigma, particularly among those with other marginalized identities10. This may serve to further deter intervention and exacerbate health inequities among the most vulnerable people in society. If a person who uses substances knew that a provider might label them as “preaddicted”, a label that would be in their medical record and available to other providers long-term, they may be less likely to seek care for their substance use.

The “preaddiction” label may also be used to empower exploitative addiction treatment industries and force people into involuntary treatment, an often ineffective approach accompanied by the potential for human rights abuses11. For example, the NIDA and NIAAA request for information proposes that “preaddiction” might also be used to describe “…any problematic substance use prior to meeting criteria for [SUD] per the DSM-5, such as substance use by adolescents...”. Pushing an adolescent into treatment under the premise that any substance use during this developmental period is “preaddiction” may be more likely to cause harm than lead to meaningful change11,12.

**Addiction, Diabetes, and Lessons from Prediabetes**

McLellan and colleagues’1 compared “preaddiction” to “prediabetes”, a label intended to capture those at risk for type 2 diabetes with the goal of intervening earlier. However, addiction is *not*akin to diabetes in that addiction is contested as a medical disease7, and lacks biological markers comparable to those for diabetes (e.g., hemoglobin A1C). The conditions also likely differ in the certainty with which an at-risk phase will progress to diabetes or addiction, and in the rates of natural recovery for such phases13. Further, use of “prediabetes” has not been fully embraced by expert groups14. The World Health Organization15 recommends against its usage because it does not reliably predict progression to diabetes and might exacerbate stigma – mirroring our concerns about “preaddiction”. Lastly, prediabetes interventions mainly include pharmacological and lifestyle interventions, often overlooking relevant psychosocial and systemic factors. Taking a similar approach with addiction may reinforce a narrow conceptualization of addiction that diverts attention from key sociopolitical and environmental determinants.

**Alternative Solutions**

Though we doubt that “preaddiction” will be successful in achieving the goals outlined by NIDA and NIAAA, we agree that there is an urgent need to identify and address harmful substance use, SUD, and related outcomes like overdose. Instead, we propose a continuum-based, public health approach to substance-related challenges can better achieve these goals (e.g., early-stage intervention) whilst avoiding the pitfalls of “preaddiction”. Such an approach would view harms resulting from substance use on a continuum without thresholds or cutoffs (e.g., preaddiction/addiction, harmful use, mild/moderate/severe SUD)8 and avoid the risk of people being labeled “preaddicts”. Though clinical cutoffs may be necessary in clinical practice, embracing a continuum model does not conflict with this and would have the added benefit of promoting coverage and treatment access across the spectrum of substance use, as previously advocated for by the Institute of Medicine in their 1990 report (interested readers are referred to Morris and colleagues8 for further applications). Beliefs consistent with continuum models are associated with greater problem recognition and reduced stigma and may encourage a greater focus on public health and prevention approaches that recognize social and structural determinants of health (e.g., inequities, availability)8. Our efforts as a field are best spent advocating for continuum-based, public health models of substance-related harm that avoid arbitrary and empirically questionable categories like “preaddiction”.

**Author Contributions**

CLB, KK, and JM all contributed to conception of the work, drafting, and final approval. We all agree to be accountable for the work’s accuracy and integrity.

**Funding**

Investigator effort partially supported by NIAAA K08AA030301 (PI: Boness).

**Competing Interests**

Dr. Boness receives research support from the National Institute on Alcohol Abuse and Alcoholism. The remaining authors declare no conflicts.

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