DSM-V and the Definitions: Time to Get It Right

The Past DSM

Over the decades, the Diagnostic and Statistical Manual of Mental Disorders (DSM) [1] has made very important contributions to the mental health field in the classification of mental illness. However, as the manual is updated, some members of the American Psychiatric Association DSM-V Committee believe the word “addiction” is still too stigmatizing and argue that the term “dependence” should remain [2]. In our opinion, perpetuating this ambiguity is in no one’s best interest. Much in the same way as we in addiction treatment hope our patients will come to see things “the way they are, not the way they wish they were,” the so-called “Golden Moment” [3], we would encourage the DSM-V committee to approach this unique situation as a “golden opportunity” to restore the term “addiction” to its rightful place in the medical lexicon.

The Problem—Dependence and Addiction Are Not the Same Things

Unfortunately, while the terms “physical dependence” and “addiction” are often used interchangeably, they are not the same at all. In fact, a joint committee comprised of members of the American Pain Society, the American Society of Pain Medicine, and the American Society of Addiction Medicine, the Liaison Committee for Pain and Addiction, in 2001 developed consensus definitions for physical dependence, addiction, and tolerance that were approved by the governing bodies of each organization [4]. The key point here is that physical dependence is an expected, neuroadaptive consequence of chronic exposure to an agonist class of drug while addiction is a complex, multidimensional biopsychosocial phenomenon that occurs in at risk individuals when elective reward transitions into compulsive use [5].

It is instructive to examine the current DSM-IV “Criteria for Substance Dependence,” which defines substance dependence as “A maladaptive pattern of substance use, leading to clinically significant impairment or distress, as manifested by three (or more) of the following, occurring at any time in the same 12-month period.” It then lists seven criteria for diagnosing this disorder (Table 1).

A pain patient can easily meet five of the seven listed criteria simply on the basis of requiring opioids for pain treatment [6]. The first two are based on expected physiologic changes of tolerance and withdrawal, the second two are based on therapeutic need, and the fifth may be due to challenges often met by those seeking to obtain much needed pain treatment that may not be locally available. Consequently, a pain patient on opioids may be misdiagnosed with the disease of addiction when he or she is actually experiencing a normal physiologic consequence of using agonist medication, or simply requiring opioids for the management of pain [6]. Unfortunately, an active addict may also experience both acute and chronic pain. In this case, the co-occurring and very treatable substance use disorder may “hide” behind the diagnosis of pain.

Why Does It Matter?

Of course, the obvious question is “Why does it matter?” Unfortunately, the term “dependence” is shared between many disciplines including research and clinical fields. For example, dependence to the endocrinologist (i.e., insulin dependence), pulmonologist (i.e., steroid-dependent asthma), pharmacologist (i.e., opioid dependence), and psychiatrist (i.e., alcohol dependence) means different things to each group. What is unique between psychiatry and the other examples is that in the case of alcohol dependence, there is no therapeutic indication for alcohol in the treatment of that condition. In fact, the diagnosis of “addiction” to a drug with a therapeutic indication poses significant challenges to the clinician. When a drug does more to you than for you, and yet you continue to use, frank addiction rather than simple dependence should be considered [7].

Media reports often interchange dependence and addiction, sometimes to the detriment of the
truth. For example, babies born to mothers whose lives have been successfully transformed by involvement in maintenance agonist treatment with methadone, have inappropriately been labeled as having been born “addicted” to that medication, when they are in fact “physically dependent” on the opioid-class of drug. Similarly, many mothers managed appropriately on opioid medications for chronic pain suffer needless guilt, thinking that they and now their newborn babies are addicted to drugs. Again, physical dependence and the expected withdrawal syndrome that accompanies this phenomenon are being mislabeled as addiction. In the authors’ opinion, the concept of a baby being “addicted” to anything is absurd.

The Consequences

Unfortunately, the consequences of this imprecision in terminology are significant at many levels. In the research world, failure to accurately characterize the population under study or the phenomena observed may lead to inaccuracy in the resultant data set, making comparisons between studies difficult or impossible. Unfortunately, this can also lead to communication breakdown between clinicians and their patients, resulting in diagnostic errors and inappropriate labeling of problematic use of prescribed medications as “addiction.” As a result, patients who should be at the forefront of the treatment team may become resistant participants in a well-intentioned but sometimes inappropriate addictions-focused treatment plan [8].

What We Need

The DSM-V committee has now been empanelled and the debate, commenced. Hopefully, there will be careful review of the DSM classification of substance use disorders. It should be clear that any harm that might occur due to the pejorative connotation of the word “addiction” is completely outweighed by the tremendous harm that is now being done to those who have suffered needlessly as a result of this well-intentioned but unnecessary confusion in terms. The societal impact of the term “addiction” needs to be dealt with through education and understanding, not with “softer terms.”

Addiction is a perfectly acceptable term [2]. It is used in the names chosen by two major American societies and their respective journals for research into and treatment of addictive medical and psychiatric disorders: the American Society of Addiction Medicine and the American Association of Addiction Psychiatrists. In fact, on June 28, 2007, the Senate Health, Education, Labor, and Pensions Committee passed Senate Bill 1011, the Recognizing Addiction as a Disease Act of 2007, which will result in name changes for two, major federal institutions. Of significance in this debate is a change in the National Institute on Drug Abuse (NIDA) to the National Institute on Diseases of Addiction (NIDA) [9].

The bill, introduced by Senators Biden, Kennedy, and Enzi, reflects recent scientific research finding addiction to be a disease that affects both brain and behavior. Removing the pejorative term “abuse” from the title of NIDA and replacing it with the words “diseases” and “addiction” clearly demonstrates these concepts are related. It also represents an important step in reducing the stigma associated with addictive disorders, and correctly renames the Institute to recognize that addiction is in fact a disease [9].

In conclusion, it would be most unfortunate if other areas of medicine were to embrace the term

Table 1 Criteria for a diagnosis of substance dependence

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<th>Substance Dependence</th>
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<td>A maladaptive pattern of substance use, leading to clinically significant impairment or distress, as manifested by the occurrence of three (or more) of the following during the same 12-month period:</td>
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<td>1. Tolerance, as defined by either of the following:</td>
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<td>(a) a need for markedly increased amounts of a substance to achieve intoxication or a desired effect,</td>
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<td>(b) markedly diminished effect with continued use of the same amount of a substance</td>
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<td>2. Withdrawal, as manifested by either of the following:</td>
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<td>(a) symptoms characteristic of withdrawal from a substance,</td>
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<td>(b) the ability to take a substance or one closely related to it, to relieve or avoid withdrawal symptoms</td>
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<td>3. A need to take a substance in larger amounts or over a longer period than intended.</td>
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<td>4. A persistent desire or unsuccessful efforts to cut down or control substance use.</td>
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<td>5. A great deal of time spent in activities necessary to obtain a substance (e.g., visits to multiple doctors or driving long distances), to use a substance (e.g., chain-smoking), or to recover from its effects.</td>
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<td>6. Abandonment of or absence from important social, occupational, or recreational activities because of substance use.</td>
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<td>7. Continued substance use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance (e.g., continued cocaine use despite recognition of cocaine-induced depression, or continued drinking despite recognition that an ulcer is made worse by alcohol consumption).</td>
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“addiction” while the DSM-V retains the ideological term “dependence” to describe this important public health problem. We believe that precise terminology will facilitate improved understanding and ultimately improved care for all our patients, especially if they have pain, the disease of addiction, or both. Addiction is a treatable brain disease [10] that causes much suffering, as does the undertreatment of pain. To answer the question posed by Drs. C. O’Brien, N. Volkow, and T.K. Li in their editorial published in the American Journal of Psychiatry titled “What’s in a Word?” [2]: A lot of confusion if terminology does not keep up with basic science and best clinical practices.

Acknowledgment
The authors gratefully acknowledge the assistance of Judith A. Heit in the writing and editing of this article.

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References