References

**NEW AND REMAINING PROBLEMS WITH DSM-V**

DSM is a preferred diagnostic instrument in many European countries for clinical research in the addictions. The proposed changes for DSM-V could result in reconsidering this preference. Three issues are at stake here: re-introduction of the term ‘addiction’ into the diagnostic scheme, elimination of substance abuse as a diagnostic entity, persistent heterogeneity of the substance use disorder criteria.

1. Most of O’Brien’s paper [1] is about re-introducing addiction as a diagnostic term. There is no doubt about the stigmatization of addicts. The attribution that addiction reflects moral weakness is frequent, in spite of its classification as a medical condition. Further, punitive attitudes and a basic mistrust of addicts can still be found in many professional staff working in addiction services [2]. The support of professionals for using the word ‘addiction’ is not indicative of its acceptability by patients or its connotations by the public at large. Indeed, the exemption of pain patients with physiological dependence only from the addiction spectrum indicates how discriminating the term is perceived to be. However, it is difficult to say how much stigmatization is due to terminology or rather to stereotypical connotations of addictive behaviour. It is up to research translation into practice, not to reinforce the negative images of hopeless skid-row alcoholics and ‘junkies’.

2. The removal of substance abuse as a diagnostic entity is based on a poor inter-rater reliability of the definition criteria in DSM-IV. However, the diagnosis of harmful use (documented negative health consequences of substance use) can be well distinguished by the absence of behavioural criteria indicating a ‘loss of consumption control’. High-risk use and hazardous use liable to precede health and social consequences were other diagnostic labels introduced by the World Health Organization (WHO) [3]. High-risk use and harmful use are relevant: for prognosis because the progression to dependence occurs in the minority of cases, for epidemiological research because of its frequency, and as clinical diagnoses because early brief interventions are evidenced to have good outcomes, but not in cases of substance dependence [4–6], and effective delivery of such interventions by non-specialists in primary care became a major public health effort [7]. Significant improvements of brief interventions are also documented for heroin and cocaine users [8]. Replacing the abuse category by a severity indicator which is based on the number of criteria does not help to identify harmful use. Further, the cut-off at two or three criteria is not conclusive: e.g. a study on cannabis dependence showed a significant cut-off only between four and five DSM-IV criteria being met [9]. In summary, there is a need for ‘a non-dependence disorder that is of clinical consequence, and a sub-threshold disorder that indicates risks to individuals and populations’ [10].

3. The diagnostic concept of substance dependence in DSM-IV is characterized by a heterogeneity of criteria (physiological, behavioural, cognitive–psychological, social), without defining subtypes of symptom clusters. Such subtypes would open interesting avenues for empirical research on differences in aetiology, prognosis, treatment indications and treatment outcomes. The majority of research was based on a dependence diagnosis where the relative importance of tolerance, loss of behavioural control, health and/or social sequelae are not identified. The exemption of physiological symptoms in patients treated for pain control is a problematic step towards such a subtype, because it is applicable in a limited number of substance use disorders, and because there are frequent opioid-related problems in chronic opioid treatment patients which do not qualify for an opioid-use disorder [11].
The question of valid clinical subtypes is dealt with in the case of alcohol dependence, using a range of characteristics, but—with one exception—without data on outcomes, thereby limiting their clinical usefulness [12]. Similar research on subtypes of illicit drug abuse is scarce, e.g. on cocaine dependence [13]. The deficit in identifying symptom clusters (as a basis for typology) within the DSM-V criteria for substance abuse disorders continues to be a handicap for clinical work. This could be part of a future research agenda [14,15].

What can be expected from the proposed changes? European drug policy has a strong focus on all problematic forms of substance use besides dependent use, and prevention as well as treatment have developed interventions tailored to the type of disorder, differentiating harmful and dependent use. In research, the proposed changes might affect the present preference for this instrument.

Declaration of interest

None.

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Why do we care? Notes from the periphery

Changes in US diagnostic terminology have more immediate impact in countries where addiction treatment and treatment access is determined by private insurances and the medical profession. History tells us, however, that they may also influence perceptions and practices in countries such as Sweden and Finland, where substance use problems have been defined traditionally as social problems and recognized as a matter of care, as well as cure, and control [1]. In the present Nordic situation, where politicians have diverted the responsibility for problem handling decisions to the ‘market’ (economists) or the (medical) professions [2, 3], the impact of changes in the DSM system may possibly be observed fairly quickly and directly.

The primary motives for the change from ‘addiction’ to ‘dependence’, as presented by O’Brien [4], do not seem obviously relevant from a Swedish or Finnish point of view. As social scientists, we are not convinced that the most important issue is to draw a sharp line between people who are dependent on doctors’ prescribed drugs and those who are dependent on drugs they have acquired without this help.

Terms matter in the addiction field: but simply changing a word will not lead automatically to greater...