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TERMINOLOGICAL CONSIDERATIONS ON THE ADDICTION CONCEPT REGARDING THE NEW DSM-V

While there are many working definitions of addiction, the essence of the construct is still not clear. Recognizing the semantic problems, it was already suggested by the autors that, while seeking a strict operational definition, one should also keep in mind that the comparison of different study results with different methodological methods is bound to be problematic. DSM-5 has now arrived. It is critical to recognize that addictive disease itself has not changed with this new publication. The disease is what it was. We may use different terminology, as "abuse» is now gone, and "dependence» has returned to its pharmacologic roots where it will again refer to the development of tolerance and withdrawal. We applaud DSM-5 for using the term "addictive disorders» within its overall framework. However, also the new definition of addictive disorders within the DSM-V raises more problems than solutions.

Introduction. The following article is based on conducting scientific studies for many years regarding the addiction phenomenon by the author (Giacomuzzi 2008; 2013; 2014). While there are many working definitions of addiction, the essence of the construct has remained elusive.

Consequently, as stated before by the autor addiction remains still an imprecise concept or phenomenon (Shaffer 1999; Giacomuzzi 2008; 2013). Approaching the twenty-first century, many important addiction-related issues remain therefore unresolved (Giacomuzzi 2008; 2013; 2014). In many ways, current definitions incorporate only the most superficial levels of our understandings of addiction. It seems that researchers and clinicians alike are still uncertain about what they mean by the concept of addiction. However, in general, the term addiction is often synonymous with (substance) dependence.

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While this may seem like a simplistic conceptual concern, the authors of this work are quite certain that there is nothing at all simple about it (Giacomuzzi 2008; Giacomuzzi 2013). More objective, underlying neuropsychobiological dysfunctions – such as disrupted chemical balance in the brain – are not taken into account, largely because they cannot easily be clinically assessed.

Addiction: still a terminological minefield. Drug addiction is a complex behaviour, likely to be influenced by genes, environmental factors, and gene-gene and gene-environment interactions. Various aspects of addiction are studied by different disciplines. Animal studies are providing increasing insight into brain regions and genes associated with addiction. Epidemiological studies are establishing the factors increasing risk for initiation and continuation of substance use.

Substance abuse and dependence may undermine certain aspects of ethnicity and ethnic affiliations, by interfering with traditional values, attitudes, preferred behaviours, and interpersonal relationships.

It is crucial to recognize that – as in the case of opioid use in the nineteenth-and twentieth-century – addictive patterns of drug use do not depend solely, or even largely, on the amount of the substance in use at a given time and place.

Twin and adoption studies are increasing our understanding of the complex mechanisms involved in substance use, including comorbidity and gene-environment interaction (Van den Bree 2005). Finally, molecular genetic studies in humans are starting to yield some converging findings. It is argued and illustrated with examples that greater awareness of progress in other disciplines can speed up our understanding of the complex processes involved in addiction.

The term addiction is often commonly used. Many dislike this term because it can convey physical forces that compel the individual to be out of control, and can imply a pre-determined individual condition, divorced from the environment (Gossp 1996). Considerable confusion exists also regarding the nature of addiction. It is critically important to understand the meaning of this term because of its clinical relevance to the management of addiction.

The World Health Organisation (Who 1957) defined drug addiction as a state of periodic or chronic intoxication, detrimental to the individual and to society, produced by repeated consumption of a drug (natural or synthetic). Its characteristics include: 1: an overpowering desire or need (compulsion) to continue taking the drug and to obtain it by any means; 2: a tendency to increase the dose; and 3: a psychic (psychological) and sometimes physical dependence on the effects of the drug. Within this definition some drugs (e.g. heroin) are physically addictive, and there is a potential for most other drugs for psychological addiction.

In its 13th report the World Health Organisation Expert Committee On Addiction- Producing Drugs strongly recommended that the term drug dependence, defined as a state arising from repeated administration of a drug on a periodic or continuous basis, should be the preferred nomenclature instead of the term addiction (Who 1964).

However, today the term addiction is still in use by the scientific community. Regarding the nature and meaning of addiction, it is suggested that addiction in scientific literature should be seen more as a generic concept. Also the use of the term addiction by the public and scientific community is very often synonymous with (substance) dependence.

In the 1960s, pharmacologists identified two kinds of drug dependence, physical and psychic. A recent definition by the Commission of Public Records defines addiction as a neurobehavioral syndrome with genetic and environmental influences that results in psychological dependence on the use of substances for their psychic effects and is characterized by compulsive use despite harm (Commission of Public Records 2003, American Academy of Pain Medicine and the American Pain Society 1997). Addiction continues to be referred to by terms such as drug dependence and psychological dependence (Federation of State Medical Boards of the United States 1998). Addiction were also defined as a behaviour over which an individual has impaired control with harmful consequences (Cottler 1993).

While there are many working definitions of addiction, the essence of the construct is still not clear. To be successful, an addiction or dependence model must blend the multidimensional aspects associated with it. It should account for regional and cultural variations, interpersonal preferences as well as hold true for the variety of addictions. In addition, a good model will describe a cycle that exists, that encourages increasing use until the addiction is overwhelming and leaves the host lame. Lastly, theories must be able to describe addiction as it occurs in human beings. Although animal studies can aid in understanding behaviour, results need to be carefully interpreted before they are applied to the much more complex human situation. In large part, the utility of these theories lies in their ability to generate novel hypotheses which in turn lead to useful predictions. Thus, a successful theory should enable prediction of circumstances in which the addiction phenomenon is more likely to occur and give insights into how it can be prevented, controlled or treated.

The new DSM V and it`s addiction/dependence concept. The American Psychiatric Association – the former Diagnostic and Statistical Manual of Mental Disorders IV-TR – did not use the term addiction at all; rather, it used substance dependence (Apa 2000). And, to be more precise, the particular drug involved was specified: e.g., heroin dependence, alcohol dependence, etc.

Substance Dependence was considered in the Diagnostic and Statistical Manual IV-TR as a maladaptive pattern of substance use leading to significant impairment or distress in three (3) or more of the following 7 areas during a 12-month period:

1. Tolerance – defined by either: a) a need for increased amounts of substance to achieve intoxication or desired effects, b) diminished effect with continued use of the same amount of substance.
2. Withdrawal – evident by either: a) characteristic, uncomfortable abstinence signs/symptoms for the particular substance, b) the same (or closely related) substance is taken to relieve or avoid the withdrawal syndrome.
3. The substance is used in greater quantities or for longer periods than intended.
4. There is a persistent desire or unsuccessful efforts to cut down or control substance use.
5. Considerable time and effort are spent in obtaining or using the substance or in recovering from its effects.
6. Important social, employment, and recreational activities are given up or reduced

because of an intense preoccupation with substance use.

7. Substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or worsened by the substance. For example, depression caused by cocaine, or an ulcer made worse by alcohol.

The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) is the 2013 update to the American Psychiatric Association's (APA) classification and diagnostic tool. In the United States the DSM serves as a universal authority for psychiatric diagnosis. Treatment recommendations, as well as payment by health care providers, are often determined by DSM classifications, so the appearance of a new version has significant practical importance. The DSM-5 was published on May 18, 2013, superseding the DSM-IV-TR, which was published in 2000 (The DSM-5 in German was e.g. published by december 2014).

Notable changes include e.g. dropping Asperger syndrome as a distinct classification; loss of subtype classifications for variant forms of schizophrenia; dropping the «bereavement exclusion» for depressive disorders; a revised treatment and naming of gender identity disorder to gender dysphoria, and removing the A2 criterion for posttraumatic stress disorder (PTSD) because its requirement for specific emotional reactions to trauma did not apply to combat veterans and first responders with PTSD.

It is critical to recognize that addictive disease itself has not changed. The disease is what it was. We may use different terminology, as "abuse» is

now gone, and «dependence» has returned to its pharmacologic roots where it will again refer to the development of tolerance and withdrawal. We applaud DSM-5 for using the term «addictive disorders» within its overall framework as Stuart Gitlow says. DSM-5 still does, as stated by Gitlow, not, however, «speak to addiction“ but rather to some of the markers seen with addictive illnesses.

Substance use disorder in DSM-5 combines the DSM-IV categories of substance abuse and substance dependence into a single disorder measured on a continuum from mild to severe. Each specific substance (other than caffeine, which cannot be diagnosed as a substance use disorder) is addressed as a separate use disorder (e.g., alcohol use disorder, stimulant use disorder, etc.), but nearly all substances are diagnosed based on the same overarching criteria. In this overarching disorder, the criteria have not only been combined, but strengthened. Whereas a diagnosis of substance abuse previously required only one symptom, mild substance use disorder in DSM-5 requires two to three symptoms from a list of 11. Drug craving will be added to the list, and problems with law enforcement will be eliminated because of cultural considerations that make the criteria difficult to apply internationally.

Cannabis dependence or cannabis use disorder is defined in the fifth revision of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) as a condition requiring treatment.

Let`s have a closer look to Opioid Use Disorder Criteria in DSM-5:

A minimum of 2-3 criteria is required for a mild substance use disorder diagnosis, while 4-5 is moderate, and 6-7 is severe (APA, 2013). Opioid Use Disorder is specified instead of Substance Use Disorder, if opioids are the drug of abuse. Note: A printable checklist version is linked below

1. Taking the opioid in larger amounts and for longer than intended
2. Wanting to cut down or quit but not being able to do it
3. Spending a lot of time obtaining the opioid
4. Craving or a strong desire to use opioids
5. Repeatedly unable to carry out major obligations at work, school, or home due to opioid use
6. Continued use despite persistent or recurring social or interpersonal problems caused or made worse by opioid use
7. Stopping or reducing important social, occupational, or recreational activities due to opioid use
8. Recurrent use of opioids in physically hazardous situations
9. Consistent use of opioids despite acknowledgment of persistent or recurrent physical or psychological difficulties from using opioids
10. *Tolerance as defined by either a need for markedly increased amounts to achieve intoxication or desired effect or markedly diminished

effect with continued use of the same amount. (Does not apply for diminished effect when used appropriately under medical supervision)

11. Withdrawal manifesting as either characteristic syndrome or the substance is used to avoid withdrawal (Does not apply when used appropriately under medical supervision).- this criterion is not considered to be met for those individuals taking opioids solely under appropriate medical supervision.

Let`s take a futher look to the Alcolhol Disorder within the DSM-5 as a famous critized example by Stuart Gitlow, President oft he American Society of Addiction Medicine (ASAM):

DSM-5 has «Alcohol Use Disorder» which comes in mild, moderate and severe flavors, suggesting the inadequate pyramid approach. There are 11 possible symptoms of the "use disorder,» of which two are necessary to achieve a mild specifier, four for moderate and six for severe. «Alcohol use disorder is defined by a cluster of behavioral and physical symptoms» the authors of DSM-5 state. I have no problem with that except that some may confuse «alcohol use disorder» with addictive disease or with alcoholism or with what the field in general has defined as being a specific abnormality of the brain's reward system producing repetitive use despite negative consequences.

In DSM-5, mild alcohol use disorder, Gitlow says, is present if the patient has tolerance and withdrawal. Nothing else is necessary. Yet tolerance and withdrawal are measurable metabolic factors that are present for alcohol within just a few hours of use. How much tolerance and withdrawal are necessary to achieve this particular part of the diagnosis? In fact, anyone drinking a couple of glasses of wine with dinner each evening will have measurable and noticeable tolerance and withdrawal. It won't be present to the extent of causing significant dysfunction, but it will be quite evident on exam. That person now has a mild alcohol use disorder. But that shouldn't be confused with mild addiction or mild alcoholism, or even mild DSM-IV abuse. It isn't any of those things.

As for moderate alcohol use disorder, let's say that we have a patient who drinks in larger amounts or over longer periods than intended, persistently tries and fails to stop drinking, fails to fulfill major role obligations and recurrently uses alcohol in situations where such use is physically hazardous. If these are the only difficulties present Gitlow says, the patient has a moderate degree of severity of the illness. We'll hypothesize that the patient drinks only in a binge-like manner so tolerance/withdrawal do not develop to the point that either is counted. If they were present, we'd have someone with a severe alcohol use disorder, yet the individual drinking in a binge-like manner may well have greater risk of morbidity/mortality than the individual utilizing a consistent amount on a daily basis. So the moderate and severe specifiers in this case may

actually be the reverse of the actual case where we utilize such specifiers to indicate or suggest risk, danger and need for treatment.

In the opinion of Gitlow DSM-5 failed again to put alcohol use disorders together with sedative use disorders, continuing the scientifically inaccurate suggestion that the two somehow differ from one another, and undoubtedly leading yet another generation of clinicians to the inevitable conclusion that there is no problem prescribing a benzodiazepine to an individual with an «alcohol use disorder». Alcohol is simply a central nervous system depressant, like barbiturates and benzodiazepines, and the authors of DSM-5 seem to have overlooked the importance of grouping like substances together.

Ultimately, the definitions in DSM-5 are definitions for a new set of illnesses. They have different terminology and are accompanied by new defining structures. A patient who ends up in the ER only once each year due to a suicide attempt, car accident, slip/fall, barroom brawl, each time after imbibing considerable alcohol, does not meet criteria for even a mild alcohol use disorder. And a college student who is not an alcoholic does meet criteria for a mild alcohol use disorder if he has tolerance and hangovers.

Now it's up to us to remember that addictive illness is still addictive illness; it remains unchanged despite the arrival of DSM-5.

Conclusion. The construction of the American Psychiatric Association's diagnostic manual has been guided primarily by concerns of construct validity rather than of clinical utility, despite claims by its authors that the highest priority has in fact been clinical utility (Mullins-Sweatt, 2009). The function of the DSM is not simply a matter of addressing a scientific interest in understanding and explaining psychopathology; its ultimate purpose is to help reduce pain and suffering within the general population – more specifically, to facilitate the practice of clinicians administering clinical care. Recognizing the semantic problems, it is still suggested that, while seeking a strict operational definition, we should also keep in mind that the comparison of different study results with different methodological methods is bound to be problematic.

A better understanding and combining of methodological approaches would certainly fuel advances in prevention and treatment. Unfortunately, the environment has also been shifting and the opportunities and social forces leading to addiction have created new problems. In fact, some of the main advances in control of addiction have emerged without recourse to sophisticated theories. Consequently, addiction remains despite the DSM-5 still an imprecise concept.

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