Critiquing the Construction of Addiction:

Dependence, Disorder and the DSM V

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Addiction

A hybrid moral – medical category defined by pathological desire: both quantitatively and qualitatively different from normal desires.

Substance Dependence DSM IV

Maladaptive pattern of substance use, characterized by 3 (or more) of following symptoms in a 12-month period:

1. Tolerance
2. Withdrawal
3. Substance taken in larger amounts or over a longer period than intended
4. Persistent desire or unsuccessful efforts to cut down or control substance use
5. Great deal of time spent obtaining, using, or recovering from effects of the substance
6. Important social, occupational, or recreational activities are given up or reduced
7. Substance use continued despite harmful consequences

The rise of diagnostic psychiatry

Diagnosis produces diseases –

in the case of the DSM - ‘mental disorders’

Mental Disorder

- A behavioral or psychological syndrome
- Associated with distress or disability
- Must be a manifestation of **dysfunction in the individual**
- Not an expectable response to particular event
- Not deviance or conflict between individual and society

DSM: Descriptive Diagnosis

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The Internal Dysfunction of Addiction: Early Version

Physiological dependence

(withdrawal and tolerance)

The Problem of Dualism

The distinction between physical and psychic dependence is ‘not consistent with the view that all drug effects on the individual are potentially understandable in biological terms’

(WHO expert committee: 1993)

Neuroscience: All drug effects are brain effects

Substance Dependence DSM IV

Maladaptive pattern of substance use, characterized by 3 (or more) of following symptoms in a 12-month period:

1. **Tolerance (need for more or diminished effect)**
2. **Withdrawal (characteristic symptoms)**
3. Substance taken in larger amounts or over a longer period than intended
4. Persistent desire or unsuccessful efforts to cut down or control substance use
5. Great deal of time spent obtaining, using, or recovering from effects of the substance
6. Important social, occupational, or recreational activities are given up or reduced because of substance use
7. Substance use continued despite harmful consequences

Substance Abuse DSM IV

Maladaptive pattern of substance use, characterized by 1 (or more) of following symptoms in a 12-month period:

1. Recurrent substance use resulting in failure to fulfill major role obligations
2. Recurrent substance use in situations in which it is physically hazardous
3. Recurrent substance-related legal problems
4. Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance

*** The symptoms have never met the criteria for Substance Dependence for this class of substance*

The Internal Dysfunction of Addiction: A Current Model

NIDA Model: Addiction is a ‘chronic and relapsing brain disease’

The Dopamine Hypothesis

‘Groundbreaking discoveries about the brain have revolutionized our understanding of drug addiction, enabling us to respond effectively to the problem’ (NIDA 2008)

Addiction as a Brain Disease

Using drugs causes ‘fundamental and persistent neuroadaptive changes’.

The addicted individual is in ‘a different brain state’ .

(Alan Leshner , then head of NIDA, 2001)

DSM V: A new paradigm ?

DSM IV criteria are heuristic and 'probably do not mirror nature'

Neuroscience and genetics promise 'a diagnostic classification system for mental disorder which is based on etiology and pathophysiology'

(Hyman 2007)

...but not yet

Progress in neurobiology ‘has not yet reached a stage where it can contribute usefully to individual disease definitions’.

(Hyman 2010)

DSM V : Proposed Revisions

Removal of substance abuse as a separate disorder

Describes bad behaviour – no 'underlying dysfunction in internal mechanisms'

(Martin et al. 2008)

Lack of data to support 'intermediate stage' between drug use and drug addiction

(O' Brien 2010)

DSM V : Substance Use Disorder

1. Failure to fulfil role obligations
2. Use when hazardous
3. Social or interpersonal problems
4. Tolerance
5. Withdrawal
6. Using larger amounts or for longer than intended
7. Persistent desire & unsuccessful efforts to cut down
8. Great deal of time spent
9. Other activities given up or reduced
10. Use despite physical or psychological problems
11. Craving

DSM V : Addiction Reinstalled

Section named ‘substance-related disorders’ replaced with ‘addiction and related disorders’

Allows inclusion of behavioural addictions (eg. gambling)

DSM V : Dependence Normalised

- The diagnostic category Substance Dependence replaced by Substance Use Disorder

- DSM IV: produces confusion between substance dependence (addiction) and physiological dependence (not addiction)

- Negative impact on pain patients

(O' Brien et al. 2006)

“dependence” as a label for compulsive...drug use has been problematic. It has been confusing to physicians and has resulted in patients with *normal tolerance and withdrawal* being labelled as “addicts.’

(APA work group)

‘The current classification is an unintentional violation of the Hippocratic oath’ (O’ Brien 2006)

Addiction in Pain Medicine

In pain medicine opiates act as effective medications which enhances quality of life.

Opiate therapy for chronic pain as safe and humane, with a low risk of addiction.

Physiological dependence as a normal and expected response to extended opiate therapy:

Although it may produce ‘a constellation of signs and symptoms associated with a sudden decrease in opiate use’ this is not necessarily a clinical problem because ‘the abrupt withdrawal of opioid therapy is rarely necessary’ in ‘skilled and sensitive’ treatment (Jovey et al. 2003).

Addiction in Pain Medicine

Addiction as a rare complication of opiate treatment, identified by aberrant and illegal behaviour and limited to ‘high-risk’ patients.

Pseudoaddiction

An iatrogenic syndrome caused by poor treatment of pain.

The patient exhibits aberrant ‘drug-seeking behaviour’ but once the pain is properly treated the behaviour ceases

Reflecting on pseudoaddiction, Passik & Kirsh note that it is:

‘a somber realization that patients can be pushed to uncharacteristic ways of behaving, which are driven by our failure to optimally treat them’ (291).

DSM V: end of the drug problem?

Addiction becomes ‘drug independent’

How do we manage the consumption of dopamine precursors?