

# Language matters: How and why the DSM has changed and what this means for librarians working in the addictions field

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The American Psychiatric Association (APA)'s *Diagnostic and Statistical Manual of Mental Disorders*, usually referred to as the DSM, is the uniformly accepted diagnostic tool/instrument for accessing and diagnosing behavioral health disorders. It consists of sets of criteria that identify, describe, and categorize all recognized psychological disorders. In a sense it is similar to the librarians' classification systems such as LC subject headings and the NLM's MESH: the DSM is what researchers and practitioners use to organize and apply knowledge throughout the mental health world, including in addiction studies. Because of the critical role performed by the DSM in the addictions field, it is important for librarians working in this area to be aware of current usage as determined by the DSM and in particular what kinds of changes have been made to it over the years.

LC subject headings are much more numerous and varied than the terms found in the DSM. They range from subjects not even included in the DSM such as 'Sex addiction — Religious aspects — Buddhism', to obsolete terms like 'Substance Abuse' (which also happens to be the superordinate LC subject heading). Such variety attests to the very different purposes for which the two sets of terms are used. The publication of the [ETOH thesaurus](#) was an attempt to bridge the gap between addiction as it was studied and treated and bibliographic practices.

Traditional medical diagnoses are typically based on *biological markers* such as blood tests, heart rate, urine samples, biopsies, etc. However, for *behavioral health* diagnoses there are far fewer biological indicators to rely upon and so instead a set of behavioral criteria needs to be agreed upon and established by experts in the field in order to diagnose disorders.

These diagnoses are needed in order to confirm that an individual has a particular behavioral disorder – particularly important in countries without free universal mental health coverage, like the United States, where patients must have a confirmed diagnosis in order to claim coverage for treatment under such provisions as *The Mental Health Parity and Addiction Equity Act*. The DSM is also used as the basis for the determination of diversion to treatment, the level and type of treatment, scholarly research, and the design of public health policy.

When it was first published in 1952 the DSM contained about 50 separate psychiatric disorders. There was no separate category for Addiction, which was then subsumed under ‘Sociopathic Personality Disturbance’ (SPD), and the subject only had its own independent terms in the 1987 edition – DSM III – in which there appeared two categories of disorder – *Substance Abuse* and *Substance Dependence*.

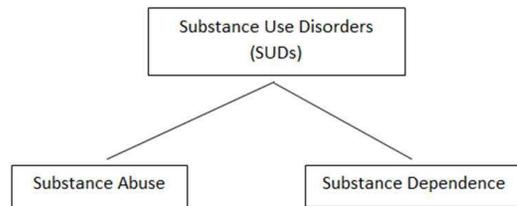
Subsequently, the 1994 – DSM IV – had 172 disorders and in fact the most recent 2013 edition – DSM 5 – has 20 fewer disorders at 152. These disorders have not simply disappeared; instead, they have been redefined and reorganized, grouped with or merged into other diagnoses.

The recent changes made to the DSM include dropping *Substance Use Disorders* (IV) and replacing it in 5 with *Substance Related*

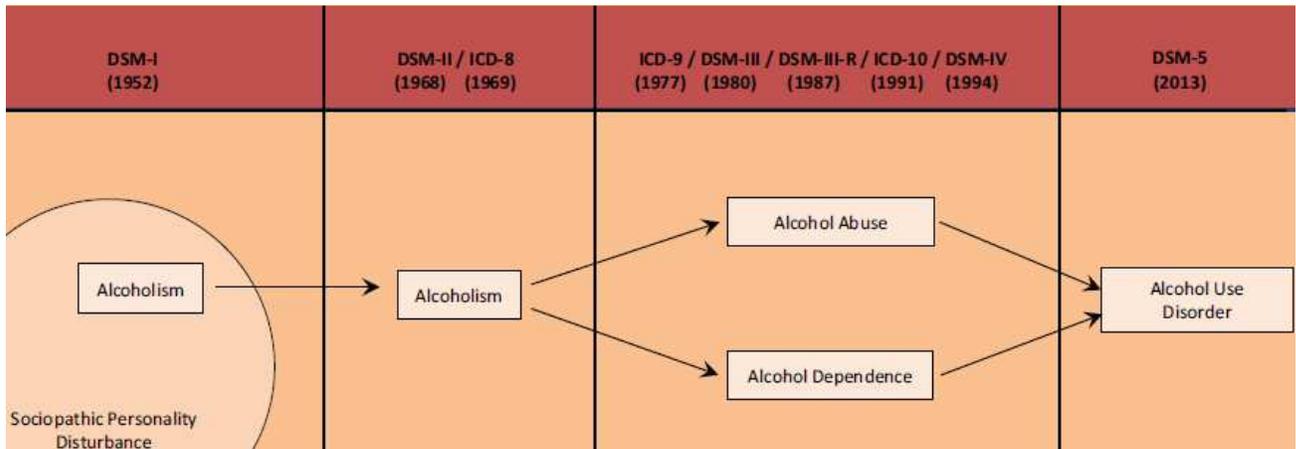
*Disorders*. But these are superordinate empty categories; they are headings or placeholders. The specific disorders and operative criteria for diagnosis are nested beneath them. (Martin, 2008).

Hence, under the heading ‘Substance Use Disorders’ in the DSM IV there were distinguished two categories of the disorder or two discrete entities: Substance ABUSE [harmful use] and Substance DEPENDENCE [addiction]. These were defined by a mutually exclusive set of criteria, which for the sake of simplicity and brevity this paper will not fully explore (Compton, 2013; O’Brien, 2010).

Although the term ‘Addiction’ had been used in earlier editions of the DSM, it was not used in the DSM IV, which used ‘Abuse’ and ‘Dependence’ instead.



The same sort of variance in terminology across time can be seen with ‘Alcoholism’ in the figure below.



From Sellman, J. D., Foulds, J. A., Adamson S. J., et al., 2014

In the DSM 5, however, both the terms ABUSE and DEPENDENCE were rejected. The reason given for the rejection of 'Dependence' is that it could be too easily muddled with tolerance. As defined in the DSM IV, 'dependence' could apply to both

1. *Physiological dependence on a substance*
- and 2. *Addiction involving that substance*

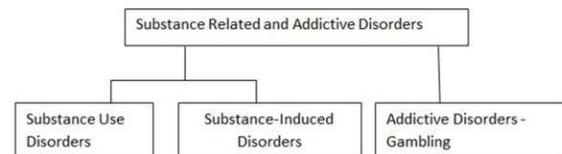
Those working in the field of palliative care were at pains to point out that *dependence* and *addiction* were *not* the same. For example, a cancer patient who needs his or her pain medication can become *dependent* on the medication *without* becoming addicted. They can experience tolerance and suffer from withdrawal, which would be key indicators of dependence, but neither tolerance nor withdrawal in this case would make that cancer patient an addict. He may experience an increase in pain as he becomes more tolerant toward the drug and he may therefore demand greater amounts of the drug but we would not consider the patient an addict. (Heit, & Gourlay, 2009; Erickson, 2008). Palliative care doctors claimed that because patients sometimes showed signs of dependence doctors would under-prescribe pain medication in order to avoid the patient becoming addicted. However dependence is a normal physiological adaptation to repeated dosing of a medication. As a consequence of these arguments 'Dependence' was dropped from the DSM 5.

The reason for dropping 'Abuse' from the DSM 5 was more obvious in that 'Abuse' has pejorative connotations: classifying an activity as abuse implies a moral judgment (Kelly, J. F., & Westerhoff, C. M., 2010; Wakeman, S. E., 2013).

The use of 'Addiction' was reintroduced in the DSM 5 such that the DSM IV's heading *Substance Use Disorders* (SUDs) became *Substance-Related and Addictive Disorders*. The first part of this heading (*Substance-Related Disorders*) is used to include two distinct forms: i) *Substance Use Disorders* and ii) *Substance-Induced Disorders*. These two

terms replaced the DSM IV's use of *Dependence* and *Abuse*.

The first part, *Substance Use Disorders*, refers to problems arising from the direct use of specific products, i.e. alcohol, caffeine, cannabis, hallucinogens, inhalants, opioids, and tobacco. *Substance-Induced Disorders* include such psychological states as withdrawal, anxiety, depression, psychosis, etc. which are often shared across different substances.



In the DSM 5 *Substance Use Disorders* are viewed as a sliding scale from Moderate to Severe: a continuous uni-dimensional phenomenon where differences are measured only by degrees of severity. By contrast, the DSM IV had two distinct dichotomous disorders: *Substance Abuse* and *Substance Dependence*.

Although both IV and 5 include *Substance Use Disorders*, they do so differently. In the case of IV it is an over-arching heading under which are subordinated two actual diagnoses, *Substance Abuse* and *Substance Dependence*; now, in DSM 5, it is a diagnosis in its own right.

The second part of the heading (*Addictive Disorders*) refers to the inclusion of Non-Substance or Behavioral Disorders that are addictive. In other words, these are disorders that are of an addictive nature and that do *not* involve substances. As a result of this gambling was included in the DSM 5 as an example of an *Addictive Disorder* whereas in the DSM IV gambling was classified as an *Impulse Control Disorder*. Post-DSM 5, gambling has come to be regarded as a prototypical example of a 'behavioral addiction' (Petry, N. M, Blanco, C., Auriacombe, M. et al., 2014 ; Robbins, T. W., & Clark, L., 2015).

This in turn has opened up the possibility of other behaviors that have a compulsive component such as shopping, sex, food, and use of the internet to be included in future editions of the DSM as examples of an ‘Addictive Disorder’. All of these behaviors were considered for inclusion in the DSM 5 but were rejected by the committee for lack of evidence. Subsequently many articles have been published that attempt to justify the inclusion of these other addictive-like behaviors. If more behaviors are added to gambling, the subject field in which most SALIS librarians now operate will expand enormously (Yau, Y. H., & Potenza, M. N., 2015).

We can summarize the main differences between the DSM IV and 5 as follows:

TERM	DSM IV	DSM 5
Addict*	NO	YES
Abuse	YES	NO
Dependence	YES	NO
Substance Use Disorder(s)	YES (as heading)	YES (as diagnosis)
Substance-Related Disorders	NO	YES

Although “Substance Use Disorder” appears in both the DSM IV and 5, it performs different functions. Much of the DSM 5 reclassification, e.g. the addition of *Addictive Behaviors*, was said to be motivated by studies that suggest similar brain functioning among those with substance use disorders and those with some kind of addictive behavioral disorder such as gambling. Neuroimaging criteria, however, are specifically excluded from making an individual diagnosis. Indeed, the ultimate justification for reclassifying gambling among addictive disorders was not observable brain activity but rather similar risk-taking behavior on the Cambridge Gamble Task.

Thus, the committee in charge of making the change from IV to 5 surprised observers by sticking with relatively traditional,

behavioral symptom-oriented descriptors and rejecting potential [biomarkers](#) as criteria. However, the role of neuroimaging in determining the extent to which ‘addictive behaviors’ share the same etiological foundations as substance-based addictions may pave the way for new diagnostic criteria in the future (Möller, H. J. et al., 2015).

The legal profession took up the DSM IV’s dependence/abuse dichotomy such that those who could be classed as ‘dependent’ came to be considered less responsible for their behavior and therefore more likely to be considered candidates for diversion to treatment. On the other hand, those who *abused* substances were considered more responsible for their behavior and so less deserving of treatment. (Norko, M. A., & Fitch W. L., 2014).

However the DSM 5’s recognition of just one descriptor *Substance Use Disorders* includes a heterogeneous population spanning from risky to hazardous use and this in turn has raised sentencing issues. The DSM 5 explicitly states that it was developed to meet the needs of clinicians and public health professionals and not those of the courts and the legal profession. However, the loss of ‘dependence’ and ‘abuse’ has implications for sentencing. There are 12 jurisdictions in the US where the criterion for diversion to treatment is based on terms like ‘dependent’ or ‘addicted’. Some have suggested that as many as one-fifth of individuals previously eligible for diversion may not be eligible using the DSM 5.

Changes in terminology can increase or decrease the population identified by the change. The number of those identified as being moderate, risky, or harmful users can shift depending on the criteria used to make the diagnosis. When researchers have compared prevalence among populations diagnosed using both IV and 5, consistency between the two has been shown to be high. But not always: for instance, the prevalence of cannabis use disorder decreased from DSM IV (6.2%) to DSM 5 (5.4%) (Kelly, S. M., et al., 2014; Lundin, A., et al., 2015).

Just as the DSM has shifted terminology over time, so too has MESH. For example in MESH, 'Drug Addiction' evolved to 'Drug Abuse', which was replaced by 'Drug Dependence' and then became 'Substance Related Disorders'. MESH uses both 'Alcoholism' and 'Alcohol related Disorders', whereas DMS 5 has just 'Alcohol Use Disorder'. (Keller, M., & Doria, J., 1991).

Today, both use the term *Substance-Related Disorders*. Unlike the DSM, MESH tends to refer to specific types of user or persons. It first referred to 'Skid Row Alcoholics' and 'Alcoholism' even though this was dropped after DSM II. However, there is not a great deal of consistency between the DSM 5 and MESH, which is unfortunate (McCray, A. T., & Kyungjoon, L., 2013).

As the 'disease' concept of addiction has become one of the more dominant notions by which addiction is understood and described, the use of the term 'disorder' has gradually been displaced. However, the DSM refers to all categories found under the heading *Substance Related and Addictive Disorders* as 'disorders'. A disorder is close in meaning to disease but is a weaker term and does not imply any structural change. However, which word you choose to use, 'disorder' or 'disease', can indicate a political choice as to

how you view addiction (Glantz, M. D., 2013). Using the term 'disease' positions addiction as more a physiological ailment than a mental one. One motivation for doing this is to avoid the idea that addiction is a mental condition which has a basis in psychology and hence the personality of the individual which in turn can be exposed to the idea of personal responsibility and will.

As more psychological disorders are shown to have structural or functional correlates in the brain the notion of disease may become dominant, but the term itself does not preclude the use of disorder and both can theoretically co-exist.

Such shifts in terminology as demonstrated by the change from the DSM IV to 5 have important consequences on how we understand the field in which we work and we should be aware of how and why these changes have come about and their consequences. But the DSM 5 is not the only game in town. There is also the ICD10 which refers to a *Dependence Syndrome* as opposed to *Substance-Related Disorders* thereby maintaining terminology that the DSM 5 has chosen to reject. SALIS is an international organization and such differences make it even more of a challenge to communicate with each other across borders.

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