

## Disorders Related to Use of Psychoactive Substances in DSM-5: Changes and Challenges

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### ABSTRACT

In the most recent edition of Diagnostic and Statistical Manual (DSM) that is DSM-5 many modifications have been made in substance use disorder section. These include changes in terminology; sections and categories; diagnostic criteria; threshold for diagnosis; severity; and specifier. Additionally, there have been certain additions and omissions from the earlier version. Critical evaluation of the changes made to the section on disorders related to use of psychoactive substances in India context has not been published so far. The current paper presents a critique of the changes made to the substance use disorder section in DSM-5. The rationale for these changes put forth by DSM-5 work group on substance related disorders have been discussed. Additionally, attempt has been made to highlight the possible future challenges consequent to the current nosological revision for substance use disorder category. Overall DSM-5 seems to be promising in fulfilling its goal of DSM-ICD harmonisation and movement towards an internationally compatible and practical diagnostic system for mental health disorders. It has increased the scope of addiction by inclusion of behavioural addiction. It has also tried to balance the categorical and dimensional approach to diagnosis. However, the real test of this newer edition of one of the most commonly used nosological systems will be during clinical care and research. This will help address the debatable issues regarding the changes that DSM-5 brings with it.

**Key words:** Abuse, addiction, dependence, DSM 5, substance use disorders


### INTRODUCTION

The revision of DSM-4 to DSM-5<sup>[1]</sup> was felt due to several reasons including recent advances in neurosciences, clinical and public health; identified problems with DSM-4 criteria;<sup>[2]</sup> and a desire to ensure better alignment with the international classification of diseases and its upcoming 11<sup>th</sup> edition- the ICD-11.

These changes have gained attention of academics and researchers globally and have been discussed at length.<sup>[3-5]</sup> However, a critical review of these changes in the Indian context has been restricted to only a few disorders and sections.<sup>[6-8]</sup> Substance use disorder section in DSM-5 includes changes in terminology; sections and categories; diagnostic criteria; threshold for diagnosis; severity; and specifier. Critical evaluation of the changes made to the section on disorders related to substance use in Indian context has not been published so far.

#### Terminology, sections and categories

In DSM-4 TR disorders associated with use of psychoactive substances were grouped under the category 'substance related disorders'. In DSM-5 these disorders have been categorized as 'substance related and

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*addictive disorders*' in section II, the change necessitated by inclusion of the category of behavioural addiction.<sup>[1]</sup>

DSM-5 has introduced three sections encompassing introduction, diagnostic criteria/codes and emerging measures/models in respective sections. DSM-4 categories of substance abuse and substance dependence have been clubbed together into a single disorder. This change is based on the rationale that reliability and validity of abuse has been found to be much lower than those for dependence; some of the abuse criteria indicated clinically severe problems; clinicians faced issue of 'diagnostic orphans' when it was difficult to fit patient in either of two categories; and factor analysis of dependence and abuse criteria suggested that criteria should be combined to represent a single disorder.<sup>[9]</sup>

Some of the important changes in DSM-5 for disorders related to use of psychoactive substances have been summarized in Table 1.

**Commentary on changes**

One of the most significant changes in new classification system is abolition of substance dependence and abuse as separate categories. This change has addressed the debate on whether abuse and dependence are separate disorders or are on a continuum. Also, previously there was much confusion among clinicians on dependence and addiction with many considering these terms as synonymous. This was especially so in case of opioid use for pain where dependence was often wrongly labeled as addiction. This undue and unjustified concern with the abuse liability on opioid analgesics lead to increased restrictions on morphine use in terminally ill patients.

**Table 1: Important changes introduced in DSM-5 for disorders related to use of psychoactive substances**

Diagnostic categories	Disorders due to use of psychoactive substances classified in the section 'substance related and addictive disorders' No separate categories of substance abuse and dependence Single category of substance use disorder
Threshold for diagnosis	2 out of 11 criteria for substance use disorder in place of 1 out of 4 for abuse and 3 out of 7 for dependence in DSM-IV
Severity specifier	Introduction of severity specifier Mild (2-3 criteria), moderate (4-5 criteria) and severe (6 or more criteria) depending on number of criteria fulfilled
Major omissions	Removal of legal criteria Removal of polysubstance dependence Removal of specifier for physiological dependence
Major additions	Addition of craving as a criteria Introduction of gambling disorder Introduction of cannabis withdrawal Introduction of caffeine withdrawal

In spite of being the largest producer of opium producer in the world, prescription of opioid in cancer pain and other terminal illness remains abysmally low in India.<sup>[10]</sup> While dependence is body's adaptation to particular drug, addiction is much more complex phenomenon that has genetic, environmental and psychosocial factors. Researchers in the area of addiction have expressed similar views earlier.<sup>[11,12]</sup> Another contentious issue regarding use of terms 'addiction' and 'addict' has been the moralistic and judgmental views associated with use of these terms. This tends to undermine the medical underpinnings of substance use disorders. Reasons such as trivialization of term 'addiction' in day-to-day conversation (e. g. chocolate addiction) have also been cited to avoid use of these terms in medical lexicon. Terms such as '*neuroadaptation*' and '*dependence*' have been used to demarcate behavioral dependence from a mere physical dependence.<sup>[13]</sup> Introduction of phrase '*addictive disorders*' in DSM-5 is likely to rekindle this debate.

We welcome the move to remove the legal criteria for substance use disorders. This is expected to bring down stigma associated with substance use disorders. This is of relevance for India where individuals as well as family members with substance use disorders continue to experience stigma. Involvement in illegal activities is understood as a usual concomitant to substance use disorders.

Further, the reduction in threshold for diagnosis will be useful in picking up milder cases that may benefit from intervention and also diagnostic orphans can now be diagnosed. This will also go a long way in offering appropriate early interventions for those in need. The addition of craving as a diagnostic criterion is another welcome change which will help strengthen the harmonization of DSM and ICD as it is included as one of the criteria for dependence in ICD-10.<sup>[14-16]</sup>

Specifier for severity of substance use disorder also makes its reappearance after being dropped from DSM-3 R. These were removed in the fourth edition, that is DSM-4. Reintroduction of severity specifier is likely to clinically beneficial. Such a distinction can help decide nature and intensity of intervention. For example, a comprehensive medication and non-pharmacological intervention based approach might be indicated in a case of severe alcohol use disorder. The milder variant of the same condition can benefit from brief intervention and motivational interviewing. Locus of intervention (in-patient or out-patient) can also be guided by severity of the condition. With increasing use of DSM-5 in clinical practice more treatment protocols based on severity are likely to emerge.<sup>[17]</sup> Moreover this triage would help in optimum

utilisation of limited mental health resources in developing country like India.

The addition of behavioral addiction namely gambling disorder can be seen as another important paradigm shift. Its introduction opens an avenue for inclusion of other behavioural addiction like sexual addiction, internet addiction, shopping addiction, etc. in future. This addition is likely to fuel more research in this area. Findings from these studies are likely to benefit our understanding and conceptualisation of substance use disorders as well.<sup>[18]</sup>

### Implications and future challenges

Though DSM-5 has followed dimensional approach in replacing abuse and dependence criteria with a single substance use disorder entity, diagnosis is still largely dependent on a “yes or no” decision for presence or absence of a particular criterion.<sup>[19]</sup> The decision to shift to a single diagnostic category of substance use disorder in lieu of separate categories for abuse and dependence is rooted in the one of basic guiding principle for DSM-5 that is to shift from stringent categorical approach to dimensional approach. However, in clinical practice, a syndromal model of diagnosis appears more promising which is bound to get diluted with these changes. The multi-axial system of DSM-4 TR, based on the bio-psycho-social approach has been discontinued. This move is likely to shift focus on biological factors as the major contributors to diagnostic categories, which could be detrimental to the bio-psycho-social approach to psychiatric disorders.

### CONCLUSION

Overall DSM-5 seems to be promising in fulfilling its goal of DSM-ICD harmonisation and movement towards an internationally compatible and practical diagnostic system for mental health disorders. It has increased the scope of addiction by inclusion of behavioural addiction. However, the real test of DSM-5 will be during clinical care and research.

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