Addiction
EDITORIAL
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What is the purpose of diagnosing addiction or dependence and what does this mean for establishing diagnostic criteria?

The primary function of diagnosis is to give a label to an abnormality of structure or function to help determine how it is best addressed. In the case of diagnosing someone with 'addiction/dependence' it forms the basis for considering some form of 'treatment' instead of relying solely on punishment or persuasion to change his or her behaviour. Arguably, such a diagnosis should be given to anyone engaging in, or at significant risk of returning to, harmful use of drugs or behaviours known to have significant addictive potential. If so, do we need the more complex and differentiated diagnostic criteria embodied in DSM?

This issue of *Addiction* includes a number of papers on the challenges and issues associated with the upcoming changes to the *Diagnostic and Statistical Manual* of the American Psychiatric Association (DSM-V). There are many different elements to this discussion. O'Brien [1] has provided an excellent centrepiece, while others have contributed commentaries which explore the issue from many different viewpoints. This editorial sets the scene with a question that some may find controversial. It suggests that if one were not 'starting from here', one might perhaps adopt a simpler and more pragmatic approach than is embodied in DSM to the question: how should we decide whether an individual is currently suffering from 'addiction'?

Medical diagnosis involves assigning a category label to a putative condition which differentiates it from other conditions and ascribes it certain features [2]. Its primary function is to establish whether and what kind of medical treatment or care may be appropriate. It also establishes a prognosis so that people affected by a condition can make whatever adjustments may be needed, and provides a basis for studies to determine the extent and nature of a problem, its causation, prevention and optimum management.

It is helpful to keep these purposes in mind when devising a set of diagnostic criteria. In the case of addiction or dependence (using the terms interchangeably here), we have no definitive anatomical or physiological delineating features and there is significant cultural and individual variation with regard to the definition [3]. (Of course, this is true of almost all psychiatric, and many other types, of diagnoses.) Therefore, it is all the more important not to lose sight of the main purpose and to recognize that there are important choices to be made in the light of this.

Consider John, who injects heroin several times a day and whose health is suffering because of neglect and unhygienic injection practices. He does not have a job and deals and steals in order to fund his life-style. John expresses no interest in changing his behaviour and makes it clear that he prefers this way of life to an alternative that, to him, looks bleaker. In his eyes he is making an informed choice.

Consider now Robert, who has not smoked any form of tobacco for 3 months. Most of the time he is fine but every now and then he gets a strong urge to smoke. He also feels that something is missing from his life and believes that smoking is helpful in coping with stress.

Let us turn to Pete, a frequent gambler. He spends about 40% of his disposable income on gaming machines. His family has to go without holidays and many of life's comforts because of lack of money and he has been known to raid his wife's purse for money when he is short. He is highly conflicted about his behaviour and vacillates between determination to 'cut down' on his gambling and unrestrained spending on this activity.

Finally, we have Tom. He drinks 40 units of alcohol each week and usually starts around lunchtime. He feels anxious when he does not drink, but otherwise he feels reasonably well. He is not convinced that he is drinking too much, but some people have started to comment that his work is not up to scratch and he has frequent arguments at home.

Thinking about the purposes of diagnosis, it would be rational to classify all these individuals as addicted. They could all potentially benefit from treatment and a diagnosis would be informative about their future behavioural and health trajectory; yet, for different reasons, these individuals could easily fall outside the current DSM classification system [4].

What they have in common is that they engage in, or have recently engaged in, behaviours which research has found often leads to a pathological distortion of the motivational system [5]. Further, there is evidence of significant harm or potential harm. Requiring them to recognize that they have a problem (or even feel conflicted) denies the reality that many addicts believe that their behaviour is serving a function (such as the

amelioration of trauma symptoms). Requiring them to experience cravings or to have failed in attempts to control their behaviour presumes that they have abstained or felt sufficiently motivated to try to abstain.

Thus, perhaps all that is required for a diagnosis is the mere fact that an individual is engaging in, or is at risk of returning to, a particular behaviour pattern (injecting heroin daily, having recently smoked, spending a lot of money of gaming machines, drinking heavily) that is known to have addictive potential. Whether or not the addict admits it, there is a reasonable presumption that significant harm will ensue if the behaviour pattern continues or resumes. Other information may be helpful in determining what kind of help or support to offer or provide, but it is not relevant to the main diagnosis.

As is evident from the discussions around DSM-V, one cannot escape from consideration of severity when forming a diagnosis [6]. The problem is, of course, that there are potentially many dimensions of severity, including the strength of the motivation to engage in the behaviour, the extent of overall distortion of the motivational system (which may include impairment of capacity for inhibition) and the degree of harm. Then there is the question of where to set thresholds. When one adds to this the fact that we lack accurate reliable measures of many of these key dimensions, one is perhaps forced to a more pragmatic view of the kind being proposed in this editorial which relies on a judgement of significant current or potential harm from engaging in a behaviour with known addictive potential.

The issue of severity can, and probably should, be addressed separately. The extent of distortion of the motivational system can potentially be measured by strength of urges or length of time that the individual can manage comfortably without engaging in the behaviour, as in the case of cigarettes [7]. Simple measures of frequency of the activity or level of consumption may be appropriate in the case of other addictions. However, this must be separated from severity in the sense of the extent and type of harm being caused, or potentially caused, by the behaviour. Assessing this is complex and depends on a large number of contextual factors, including whether the activity is illegal [8].

One needs to go beyond diagnosis when it comes to determining how best to help addicted individuals—whether they need medical support, advice and help regarding housing, in-patient treatment, one or another form of counselling, etc. This is not solely about a diagnosis of dependence but about obtaining a comprehensive clinical picture.

Finally, when it comes to the research agenda, it is hard to escape the view that questions such as 'how many people in the world are addicted to tobacco, alcohol, gambling and heroin?' can only be answered with regard to arbitrary definitions and that different definitions can lead to wildly varying estimates. Instead of pretending that we can answer such questions in absolute terms, it would be more helpful to use more objective metrics: how many daily smokers are there; how many people drink above recommended alcohol limits; how many injecting heroin users are there; how many people gamble more than x% of their disposable income?

To summarize, when one considers the purposes of diagnosis, the criteria for diagnosing addiction or dependence can perhaps be simplified to the questions: is the individual engaging in, or is s/he at risk of returning to, a behaviour that is known to have addictive potential and is this leading to harm or likely to lead to harm? If so, this potentially puts them in the frame for treatment. After this, judgements have to be made by considering severity, the precise nature of the problem being experiences and what treatment options are needed.

Of course, the question posed in this editorial takes no account of the social, political and scientific context. We are not starting with a blank slate, and when it comes to revising diagnostic criteria there are considerations of continuity with the past and a need for addiction science to possess a credible technology. The other papers in this issue of *Addiction* recognize these and other important considerations. In so doing they will help to refine the process of diagnosis of addiction in a way that makes it more useful. This editorial merely offers a small piece of 'grit in the oyster'.

Declarations of interest

Robert West undertakes research and consultancy for companies that develop and manufacture smoking cessation medications. He has a share of a patent on a novel nicoting delivery device. His research is funded primarily by Cancer Research UK and the English Department of Health and he is a trustee of the charity OUIT.

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References

1. O'Brien C. Addiction and dependence in DSM-V. *Addiction* 2011; **106**: 866–7.
2. *Free Online Dictionary*. 2011. Available at: http://www.thefreedictionary.com (accessed 1 February 2011).

3. Room R. Taking account of cultural and societal influences on substance use diagnoses and criteria. *Addiction* 2006; **101**: 31–9.
4. American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders,* 4th edn. Washington, DC: American Psychiatric Association; 1995.
5. West R. *Theory of Addiction*. Oxford: Blackwell; 2006.
6. Greenberg G. *Inside the Battle to Define Mental Illness*. Wired.com. 2010 (11 January).
7. Heatherton T. E., Kozlowski L. T., Frecker R. C., Fagerstrom K. O. The Fagerstrom Test for Nicotine Dependence: a revision of the Fagerstrom Tolerance Questionnaire. *Br J Addict* 1991; **86**: 1119–27.
8. Conway K. P., Levi J., Vanyukov M., Chandler R., Rutter J., Swan G. E. *et al*. Measuring addiction propensity and severity: the need for a new instrument. *Drug Alcohol Depend* 2010; **111**: 4–12.