Correspondence

"The Evil Genius of the Habit": DSM-5 Seen in Historical Context

Dear Editor:

In 1804, Thomas Trotter published a founding text on alcohol problems (Trotter, 1804). His advice to physicians was that it would inevitably be of no avail to treat a drinker's gout, gastritis, or any other of the then-recognized alcohol-related disorders if the practitioner failed to deal with what he termed "the evil genius of the habit" (p. 178). Trotter used that evocative phrase to identify a syndrome, the elements of which he detailed. He saw "habit" as the pathological basis for the recognizable clinical entity that he designated as "a disease of the mind" (p. 179). He did not, however, introduce any new terminology for this condition, but rested content with "the habit of drunkenness" (p. 181). The quest to find a name for Trotter's syndrome, and the status to be given it, continues to this day, most recently with the debate provoked by the proposed handling of the topic in the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (DSM-5) (*Addiction,* Vol. 106, pp. 866–897). This letter will attempt to give current concerns their historical context before commenting on the present situation.

Trotter on occasion used the word *addiction,* not as a technical term but with what was then its common or lay meaning. The origin of the words *addiction* and *addicted* is lost in the mists of time, but for *addicted,* the *Shorter Oxford English Dictionary* (1944) offers "attached by one's own act (to a person, etc.)" with a date identified as 1709 (p. 21). The word *addiction* is traced back further to 1604. Examples of usage that are quoted include, "The . . . day he addicts . . . to study" (1670); "to addict themselves to Sack" (from Shakespeare); and "we be virgins, and addicted to virginitie" (p. 21). There can be no doubt that over several centuries, "addiction" was a widely generic concept with alcohol and tobacco sometimes caught in the net.

When in the latter part of the 19th century the medical profession in the United States, and somewhat later in the United Kingdom, began to campaign for the institutional treatment of the excessive drinker, the technical term used to designate the syndrome was *inebriety* (American Association for the Study and Care of Inebriety, 1893; *Shorter Oxford English Dictionary,* 1944). The journal now published under the title of *Addiction* was first published in 1884 as the *Proceedings of the Society for the Study and Cure of Inebriety.* From 1902 to 1945 it was named the *British Journal of Inebriety* (Kerr, 1888), and only in 1946 did it change its name to the *British Journal of Addiction to Alcohol and Other Drugs* (Edwards, 2006). The corresponding American society also used "inebriety" in its title and that of its journal. The terms *inebriate* and *inebriety* were originally confined to alcohol but soon became generic to embrace other substances, with textbooks offering chapters on opiate inebriety, and inebriety related to a wide range of other drugs (American Association for the Study and Care of Inebriety, 1893; Kerr, 1888). These terms were in common use up to the early part of the 20th century. *Addiction* was also used as a technical term in the latter part of the 19th century in relation to alcohol and other drugs, and gradually it replaced *inebriety* as identifier of the compulsive habit (Edwards, 2006, 2010). But no one legislated this change in terminology, and the transition occurred before the era of diagnostic manuals. The alcohol world, however, somewhat kept its distance from other drugs, with the emergence of the "alcoholic" as a key concept.

Introduction of the term "dependence"

In 1964, a World Health Organization (WHO) expert committee (WHO, 1964) proposed that *dependence* rather than *addiction* should be the term used to identify the compulsive habit. The dominant motivation for this recommendation was probably the wish to escape from the mindset engendered by opiate addiction as the template for all addictions. Previously, the compulsive problem with alcohol had been downgraded by the WHO to "habituation" because it did not resemble the stereotype of opiate addiction. The inherent invitation contained in that WHO proposal was to see the dependences produced by different drugs as deserving description each in their own right (Edwards et al., 1982) rather than their having to fit with the opiate picture. Nicotine, cannabis, benzodiazepines, and cocaine were, for instance, caught within this new thinking (Edwards et al.,

1982), all in due time becoming candidates for empirical consideration (Schuckit, 1979). Those sorts of development would have been more difficult within the constraints of the traditional addiction concept.

In 1975, WHO thinking on taxonomic issues was further developed when the National Institute on Alcohol Abuse and Alcoholism (NIAAA) approached WHO-Geneva with a request for assistance with definition of the term *alcoholic.* NIAAA funding supported a WHO exercise to focus on that question. A report of these deliberations was published by Edwards et al. (1977) (and discussed in Edwards, 2007), but shortly before that report, Edwards and Gross (1976) offered a detailed clinical description of the alcohol dependence syndrome. A later WHO memorandum (Edwards et al., 1982) developed the syndrome concept in relation to other drugs. The 1987 WHO report was also important in that it distinguished between the dependence dimension and the problem dimension—a direct extension of Trotter's insight of 1804. A further innovation was the suggestion that dependence, rather than being an all or none condition as was often envisaged with "addiction," had within it degrees of intensity. The latent importance of this report was that it invited a multidisciplinary and multinational perspective with no one profession or country dominating. Neurobiologists, epidemiologists, social scientists, psychologists, and medical practitioners of wide national backgrounds supported this formulation.

The WHO's concept of substance-specific and graded dependence syndromes, and the two-dimensional formulation, were taken up both by the International Classification of Diseases (ICD) and the DSM. Unlike the tide of history, which had led to the introduction of "inebriate" and its substitution by "addict," here was a very intentional act by the international scientific community, under the leadership of the WHO and with generous American funding, aimed at influencing taxonomy.

ICD and DSM: Methods of working

The 11th edition of the ICD is forthcoming. The ICD is aimed at an international audience, and it carries the authority of the WHO. Membership of its committees is determined by the WHO's secretariat, and participants are invited because of their personal experience and expertise, not as representatives of any national, professional, or other interest group. It is possible for votes to be taken, but its intention is to achieve consensus, with all members signing up to the final report. The model used is essentially that of cabinet-style decision making. When deciding on terminology, attention is likely to be paid to linguistics and the feasibilities of translation into other languages.

The DSM is a production of the American Psychiatric Association, and its primary responsibility is thus to an American audience. Such, however, is its prestige that it has been widely used internationally. For instance, in English law courts, an expert witness is as likely to rely on the DSM as the ICD when giving evidence. But in the international research community, the DSM and the ICD are probably at present viewed with equal favor as guidelines. In the drafting of the DSM, there is no inherent responsibility to ensure sensitivity to foreign languages. The DSM's methods of working perhaps differ in some ways from the ICD's. It seems likely, for instance, that DSM working groups can be more willing to vote than look for consensus: O'Brien (2011) has revealed that in the DSM-III-R working group, "the word 'dependence' was chosen by the margin of a single vote" (p. 866).

DSM-5 takes new directions

In his recent *Addiction* article, Dr. Charles O'Brien (2011), the highly experienced and respected addiction scientist who chaired the APA group tasked with preparation of DSM-5's chapter on substance-related problems, outlined the new directions that DSM-5 proposes. The same issue of *Addiction* carried commentaries on O'Brien's article from 32 experts from eight countries (*Addiction,* Vol. 106). On the basis both of the review of the historical evolution of ideas in this field, which must provide the context for any presently proposed further developments, and with due note taken of the recent comprehensive debate stimulated by O'Brien's statement, this text now seeks to update history with some comments on aspects of DSM-5's new directions.

(1) *"Dependence" eliminated and "substance abuse disorder" adopted.* The DSM appears to have played with the idea of bringing back the term *addiction* as a replacement for the term *dependence.* The case is argued by O'Brien in terms of "addiction" being softened to embrace "addiction to pink" in lay usage. He is, in fact, reminding us that *addiction* has for centuries had its lay usage, as with "addicted to virginitie." That is not, however, really the issue; by analogy, the word *lunacy,* although having an innocent lay meaning ("lunatic fringe"), is still distinctly pejorative if applied to mental illness. O'Brien also argues that a revision in the nomenclature is needed to assist better handling of chronic pain by the physicians, but that is a problem more likely to be met by improved professional education than by any word change. He finally argues that *dependence* is a word already in use psychiatrically in another sense and may therefore give rise to confusion if applied to substances. The empirical evidence to support that contention is not adduced, and it is perhaps rather difficult to imagine the real-life circumstances under which such confusion might arise. Under this subheading, one is left feeling that, although a number of debatable points are being made, no convincing case, either clinical or scientific, is established for the proposed change in nomenclature. With awareness of the historical shifts from "the habit of drunkenness" to "inebriety," to "addiction," to "depen-

dence," with *narcomania* briefly emerging and *alcoholism* also having had a place in official nomenclature, and all this in the course of about 200 years, one might expect that further proposals for taxonomic change would be rigorously evidence based. In the absence of any more cogent scientific arguments for DSM's proposed revision on an aspect of this field's core terminology, the impression is given of a field in disarray. Revisions are sometimes necessary, but unnecessary revisions are likely to be without benefit.

(2) *Abolishing the abuse category.* O'Brien (2011) states that the "abuse category" has been eliminated from DSM-5 "because of the lack of data to support an intermediate state between drug use and drug addiction" (p. 867). This decision goes against clinical experience, which suggests that people can develop destructive and disruptive drinking behavior without clinical symptoms of dependence. A significant body of epidemiological (Room, 1977) and anthropological (MacAndrew and Egerton, 1970) research is being passed by too lightly. DSM-5 thinking may have been influenced toward substituting one dimension for the previous two by overreliance on certain recent American survey reports (Cunningham and McCambridge, 2012; Saha et al., 2006). That work is interpreted as showing that, at the population level, there is no distinct entity of dependence that is discontinuous with nondependent drinking problems. The possibility exists, however, that the questions used in that type of research are technically insufficient to discriminate troubled drinking without dependence from the dependence syndrome (Caetano and Babor, 2006). This is not the place to enter into an extended methodological critique of alcohol epidemiology, but with large-scale problems with underrepresentation, there is need for caution.

(3) *The "problems" dimension lost.* The previous "abuse" category (the ICD's "misuse") is partly a categorization of drinking, but it was implicitly based on the idea of "problems" without dependence and was thus a representation of the two-dimensional concept. Its loss from the DSM-5 taxonomy is retrogressive: To apprehend the totality of the problem with alcohol really does require more than a one-dimensional view.

DSM-5 and the future for a widely respected endeavor

There can be no doubt that DSM-5 will be a publication received with respect by the international scientific community. It seems possible, however, that the drug and alcohol chapter will considerably deviate from the ICD-11, and, if so, researchers will be faced with a choice as to which terminology they will use in the future. This would be the first time that significant disagreement would have occurred between DSM and ICD. The consequence may be that the DSM comes to be seen as enshrining an American point of view, whereas the ICD would be the international currency.

Science has traveled a long way since Trotter, but the quest continues for terminology that can capture "the evil genius of the habit" as an identifiable disorder while acknowledging that not all problems with psychoactive substances relate to that syndrome.

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