'Substance Use Disorder' Diagnosis Gains Favor

DSM-5 work group questions current distinction between substance 'abuse' and 'dependence.'

BY BETSY BATES

FROM THE ANNUAL MEETING OF THE AMERICAN PSYCHIATRIC ASSOCIATION

NEW ORLEANS — Proposed changes to the Diagnostic and Statistical Manual will likely put an end to separate diagnoses of substance "abuse" and "dependence," distinctions that puzzled even addiction experts, members of the DSM-5 work group on substance-related disorders said at the annual meeting of the American Psychiatric Association.

On the basis of discussions held during the meeting, it seems probable that both categories will be subsumed within the general diagnosis, "substance use disorder," under an expanded DSM addiction section that will include for the first time a behavioral addiction, compulsive gambling.

"Change is good if change can be shown to do more good than bad and can be supported by data," said Dr. Marc A. Schuckit during a progress report presented by the APA DSM-5 substance-related disorders work group at the meeting.

If the prime objectives for inclusion in the DSM are making diagnoses that are clear, straightforward, flexible enough to be clinically useful, valid, "moderately" reliable, predictable, and inclusive of "the people who need help," current substance use categories in the DSM-IV-R admittedly are "out of focus," said Dr. Schuckit, professor of psychiatry at the University of California, San Diego.

However, the committee wants to be cautious, so that they do not "go from one very useful but not perfectly focused image to another very useful but not very well focused image," he said, noting that a rich database has been exceedingly useful in guiding directions for change.

For example, when data from studies representing more than 100,000 subjects were analyzed by the committee, DSM-IV diagnostic criteria for substance dependence were highly reliable and valid, but those for substance abuse were much lower and more variable, said Deborah S. Hasin, Ph.D., professor of clinical public health at Columbia University, New York, a work group committee member, and cochair of the meeting symposium.

The hierarchical relationship between abuse and dependence (with abuse only diagnosed in the absence of dependence) was "often misunderstood, even by people functioning at a very senior level [of the substance abuse research community]," she noted.

Confusion led to widely held, but false beliefs, such as the notion that abuse is a milder disorder than dependence, or that all individuals who are dependent also meet criteria for abuse, Dr. Hasin said.

The extensive data review conformed to what clinicians were seeing, that severity of dependence and of abuse, like other criteria, were intermixed, and that patients could have one of the disorders, or both.

A factor analysis of patient characteristics found "there really wasn't good rationale to keep abuse and dependence separate," Dr. Hasin said.

"The evidence seemed quite overwhelming."

The new DSM, then, will most likely contain 11 potential diagnostic criteria for combined substance use disorder, with severity gauged on the number of criteria met. A patient who meets two criteria would merit a diagnosis of a disorder; a patient who met four or more would be considered to have a severe form of the disorder.

The specific diagnostic criteria for a substance use disorder also will likely change in the DSM-5, with craving being considered a potentially core feature of addiction for the first time.

Likely to be dropped from the list of criteria will be recurrent substance-related legal problems, which tend to only occur when patients fulfill so many other criteria for addiction that the category becomes virtually meaningless, Dr. Hasin said in an interview.

Nicotine use disorder is highly likely to be included under the substance use disorder umbrella, again on the basis of analysis of characteristics of patients enrolled in many studies that show convergence with other substance use disorders.

The new inclusion of a behavioral disorder—compulsive gambling—might appear as an addiction alongside substance use disorders for the first time, based on years of study, said committee member Dr. Eric Hollander, director of the Compulsive, Impulsive, and Autism Spectrum Disorders Program at Montefiore Medical Center and Albert Einstein College of Medicine, New York.

Currently classified as an impulse control disorder, a large body of evidence now supports compulsive gambling as an addiction, he said in an interview.

"Based on extensive studies, we now know a lot about the clinical features and the course of the illness … the brain circuitry, neurotransmitter features, and the genetic features," Dr. Hollander said.

Other behavioral disorders eventually might make their way into the DSM based on the weight of a similar body of evidence, but data are lacking for them at this point, he said.

"Waiting in the wings" … perhaps for DSM-6, may be compulsive overeating, video gaming, shopping, and even overexercise.

The scientific bar for inclusion will be held high, stressed Nancy M. Petry, Ph.D., professor of psychiatry at the University of Connecticut, Farmington.

Even with an extensive database of studies, consistency is lacking in the characterization of Internet gaming as a potentially diagnosable addiction, with prevalence estimates, for example, ranging from 0.9% to 64%, she said.

"Until we can better define what this addiction is, it doesn't seem like it's ready yet," Dr. Petry said.

"Are we going to end up with chocolate addiction in DSM-6?"

The working group members disclosed no relevant financial conflicts of interest with regard to the DSM-5. ■

Injectable Naltrexone Helps Patients Remain Opioid-Free

BY DOUG BRUNK

Once-monthly treatment with extended-release injectable naltrexone helped patients who were dependent on opioids maintain an opioid-free state after detoxification, results from a placebo-controlled study demonstrated.

After 24 weeks of treatment, patients in the naltrexone treatment group had significant improvements compared with the placebo group in reduced opioid use, craving, and improved treatment retention.

Extended-release injectable naltrexone, marketed by Alkermes Inc. as Vivitrol, is an opioid antagonist administered once monthly by intramuscular injection and is approved in the United States for the treatment of alcohol dependence.

It is not currently approved by the Food and Drug Administration for the treatment of opioid dependence, but Alkermes has submitted a supplemental new drug application for that indication. The application has been designated as a priority review, "which means we're on an accelerated timetable and we're one step closer to making this treatment option available to patients with opioid dependence." Dr. David R. Gastfriend, vice president for scientific communications at Alkermes, said at a press telebriefing held during the American Psychiatric Association's annual meeting in New Orleans.

'Patients on extended-release naltrexone had a rapid decline in craving to half of their baseline level.'

DR. GASTFRIEND

He called opioid dependence a growing public health crisis in the United States. "The number of Americans addicted to prescription opioids or heroin has more than doubled since the year 2000," he said. "There are now more than 1.3 million American adults who are opioid dependent."

For the study, 250 patients who had completed an opioid detoxification within the previous week and were off all opioids for at least 7 days were randomized to 24 weeks of double-blind treatment with monthly injectable naltrexone 380 mg or to placebo.

The primary efficacy outcome was the response profile based on the rate of urine screening results negative for opioids during the last 20 weeks of the treatment period. Secondary outcomes included retention, physiologic evidence of opioid dependence per naloxone challenge, and a visual analog scale (VAS) of craving.

The mean age of study participants was 30 years and 88% were male. Dr. Gastfriend reported that a significantly higher proportion of patients in the injectable naltrexone group had opioid-negative urine screenings during the final 20 weeks of double-blind treatment compared with patients in the placebo group (90% vs. 35%, respectively). A higher proportion of them also tended to stay in treatment for the entire 24 weeks compared with those in the placebo group (53% vs. 38%).

Other differences that significantly favored the naltrexone group over the placebo group were the incidence of positive naloxone challenge and reductions in the VAS craving score. "Patients on placebo continued to crave opioids throughout the study at the same level that they started with at baseline," Dr. Gastfriend noted.

"In contrast, the patients on extended-release naltrexone had a rapid decline in craving to half of their baseline level, and that was maintained throughout the study."

No significant differences between the groups were observed in the incidence of clinical adverse events, and no severe adverse events or premature discontinuations attributable to adverse events occurred in the naltrexone group.

The most common adverse events experienced by patients in the naltrexone group were nasopharyngitis and insomnia.

"We believe these are compelling clinical data," Dr. Gastfriend concluded. "Extended-release naltrexone may provide patients and physicians with a new treatment option: a non-addictive, once-monthly treatment for opioid dependence."

The study, which was presented during a poster session at the meeting, was funded by Alkermes Inc. Dr. Gastfriend is a full-time employee of the company. ■