Published in final edited form as:

Am J Addict. 2012 ; 21(3): 280–282. doi:10.1111/j.1521-0391.2012.00217.x.

Proposed DSM-5 Substance Use Disorders for Adolescents: If You Build It, Will They Come?

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It appears that the DSM-5 workgroup on substance use disorders (SUDs) is proposing to include this domain with another related group of disorders labeled “Addictive Disorders.”¹ Also, the proposed DSM-5 eliminates the diagnosis of substance abuse and defines a single addictive disorder using a set of 11 symptoms.

We appreciate that the SUD domain will have three subtypes: mild, moderate, and severe, and that so far there is no direct use of the nomenclature of “addiction” within this scheme. But we still see two problems with the proposed revisions.

One issue pertains to the proposed title of this section, “Substance Use Disorders and Addictive Disorders.” The title implies that an SUD (even the mild version) is an addiction. The term addiction was derived from Latin meaning “bound to” or “enslaved by.” With respect to substances, addiction is associated with continued and compulsive drug use in the presence of negative consequences. Whereas a teenager who reports the presence of the majority of the 11 symptoms is likely dependent, it is not clear that a mild or moderate case (eg, presence of two or three criteria) represents a behavioral disorder that is at the low-end of an addiction.

In prior DSM systems, this severe end of drug use was accompanied by a less advanced but clinically relevant concept of abuse. This historical point leads us to our other concern. The removal of the abuse concept is problematic. The diagnostic abuse category, despite its faults (eg, DSM-IV’s liberal rule that the presence of one criterion was sufficient for an abuse diagnosis) is particularly appropriate for adolescents. There is a large body of scientific literature that addresses the differences between patterns, trajectories, and implications for intervention for adolescents and adult drug involvement.² This body of work, often referred to as a biobehavioral developmental perspective, indicates that adolescents with an SUD, whether with or without a coexisting mental or behavioral disorder,³ are not simply “miniature adults.” Empirical data indicate that the progression from drug use, which usually begins in adolescence, to a severe-end state of addiction represents a heterogeneous clinical continuum. This perspective supports the notion that drug involvement by youth at the early stages routinely involves the emergence of significant social and psychological consequences that merit early detection and referral to nonintensive treatments. The current construction of DSM-5 with its absence of an abuse category may greatly cloud the public health value and clinical decision making for such nonsevere cases.

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The final manuscript has benefited from thoughtful input from Drs. Sandra Brown, Michael Dennis, and Christopher Martin.

Those clinicians and clinical researchers working with teenagers and their families are aware how difficult it is to engage with these adolescents and motivate them to come for an assessment and treatment without coercion. Whereas we appreciate that there is growing acceptance of the concept of addiction in our society,⁴ we are concerned that this perception is far from the truth for youth and their families. Families may too often reject the term, and this may enable the perception that their child does not have a drug problem. The abuse concept provides a more palatable “opening to the perception door” that a teenager at the early stage of drug involvement may need clinical attention. Naturally, the abuse concept needs to be scientifically valid for inclusion in DSM-5; it cannot be included just for the purpose of addressing concerns about stigmatization.

The fact that the committee’s work is still in progress is a sign that there is room for adjustments. We urge the group to remove the term “Addiction” in the same category title as “Substance Use Disorders,” and to make necessary developmental changes to the criteria as already suggested.⁵

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