

Rediscovering Alcoholism, Addiction and Dependence

Ray Daugherty



PRIME for Life/PRIME Solutions

841 Corporate Drive, Suite 300

Lexington, Kentucky 40503

(859) 223-3392

© 2000, 2005, 2008 Prevention Research Institute, All rights reserved

*"I know that you **believe** you understand
What you **think** I said,
But I am not sure you realize that what you **heard**
Is not what I **meant**."*

Variously attributed to Richard Nixon,
Robert McCloskey,
and a 1970s poster...

Introduction



Our paradigms can simultaneously enlighten us and blind us. They provide a lens through which we look at our world and make sense of it. No lens can bring everything into sharp focus at once. By accepting one paradigm as our lens we will simultaneously see some things more clearly while others may become more obscure.

The addictions profession works from at least three overlapping paradigms: alcoholism, addiction, and dependence. You know what you mean when using these words and I know what I mean. But are we sure we know what each other means? And as we move toward more evidence-based practices, are counselors who apply research on alcoholism, addiction, and dependence using these words in the same way as those who are doing the research; and vice versa? And did the framers of DSM-IV (and those now creating DSM-V) mean the same thing as most counselors when using the word “dependence.”

A misleadingly simple answer to all these questions would be, *“Of course; they are all the same.”* Indeed, the view that dependence, alcoholism, and addiction are synonyms – that they all reflect a single paradigm – is perhaps one of the most commonly shared perspectives of our field. George Koob (a preeminent researcher on addiction and the brain) expressed this view clearly when attempting to clarify the difference in how animal researchers and clinical researchers use the word “dependence.” (Research Society on Alcoholism Conference, June, 2008, Washington, DC) He did this by posing the question, “What is addiction?” and answering as follows:

“Substance Dependence (with a big “D”)-compulsive uncontrollable drug use with impairment in social and occupational functioning; equivalent to “addiction” and ‘alcoholism’”

“Substance dependence (with a little “d”)-manifestation of a withdrawal syndrome”

That he would answer the question, “What is addiction?” by defining “dependence” is a statement of how easily we treat these words as synonyms. What Koob called “Dependence with a big D” is, in my experience, precisely what the vast majority of alcohol and drug counselors also mean when they use the word “dependence.” What he called “dependence with a little d” is used by animal researchers, and in clinical settings

it would partly be covered by DSM Dependence with Physiological Dependence (but that qualifier also includes those who exhibit tolerance but no withdrawal.)

Focusing on the definition of “Dependence with a big D,” one may ask, “What is the issue; are we not all saying the same thing?” To answer that question I ask the reader to reflect on what you mean when you use the words “alcoholism” or “addiction.” If when you use these words you *only* mean “any three dependence symptoms” and *do not* include loss of control as a defining characteristic, then there is no problem at all with treating dependence and alcoholism/addiction as synonyms. But, if like most addictions professionals, you consider alcoholism/addiction to be characterized by loss of control such that regaining ongoing control over use is an impractical goal for most people, then there is potentially a major problem in treating them as synonyms. DSM dependence requires *only* three of *any* combination of the seven DSM symptoms and may not necessarily include loss of control at all. I am suggesting that contrary to popular belief, and perhaps contrary to the intent of the DSM workgroup, DSM-IV does not diagnose a condition that is characterized by, “*compulsive uncontrollable drug use...equivalent to [what most counselors mean when they use the words] ‘addiction’ and ‘alcoholism.’*” This is evident in data such as the NESARC, the NAES, and other studies explored below. As noted by one of the chairs of the DSM V Work Group, dependence is about *either* loss of control *or* impaired control. That difference may have important implications for both treatment and research.

The paradigms of “alcoholism/addiction” and “dependence” have distinct and separate histories and intended meaning. Using these words as synonyms creates confusion and makes it difficult for counselors to interpret, apply, or even accept certain important research findings. It also makes it difficult for researchers to grasp what counselors are saying about their clinical experience and reduce that experience to measurable analysis.

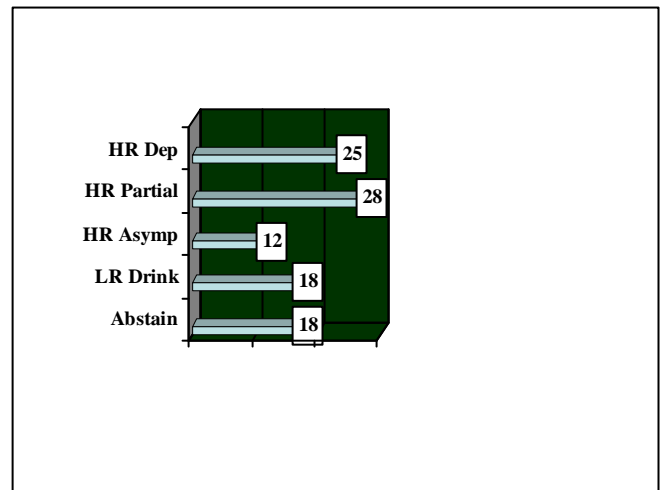
By clarifying the paradigms we can make research findings more relevant to a larger number of counselors; and counselor perspectives more meaningful to researchers. Making conscious the difference in the paradigms can also help resolve decades-old conflicts between research and clinical experience and prepare the addictions field for a new era of treatment reaching a broader range of people. Changes planned for DSM V have the potential of greatly facilitating this process; particularly if we clarify the paradigms. This paper is a call for us to become aware of the paradigm differences and shifts that are occurring while reflecting on what the words associated with these paradigms mean to each of us and to others. It is also a call for researchers (as the producers) and counselors (as consumers and appliers of research) to better understand each other. Over a decade ago, Schuckit (1996) looked toward DSM V and called on researchers to, at least temporarily, use “alcoholism” as a generic term to include “abuse” or “dependence” but to work to carefully define what they mean when they use the terms as we work toward clearer use of the terms. This paper is offered in the belief we now have enough information to more carefully define the terms in a way that will be useful for both counselors and researchers. This paper further suggests that by “untangling” the paradigms we can resolve some enduring conflicts between research and clinical experience, allow research to more effectively impact addictions services, and allow researchers to more accurately frame questions that can address issues commonly encountered by counselors.

An example of an enduring conflict in need of paradigm clarification

Cahalan and Room (1974) published results from two national surveys indicating that a high percentage of alcohol *problems* seemed to go away over time. People were not sure what to do with those findings and after an initial flurry of controversy they were largely forgotten. But the phenomenon would not go away. Filmore (1974, 1975) reported similar findings in following up Straus and Bacon's (1953) college *problem drinkers* 27 years later.

Dawson et al. (1996) reported in the National Alcohol Epidemiological Study (a general population study) that almost half of those ever qualifying for a DSM III *dependence* diagnosis later returned to drinking without problems. The rates varied greatly with time elapsed, age, and treatment status but the phenomenon occurred in each group and for some appeared to be sustained for at least two decades.

In a more recent general population study, the NESARC, Dawson et al. (2005) analyzed results for 4422 people who had at some point in their life qualified for a DSM IV dependence diagnosis and found that during the past twelve months 28% were still drinking high-risk quantities but were in partial remission, 12% were drinking high-risk quantities but were in full remission, and 18% were drinking low-risk quantities and were in remission. The amount drinking low-risk quantities was equal (18%) to those who were abstaining.



Through further analysis of the NESARC data on "dependence" researchers (Moss, Chen, and Yi, 2007) concluded there were five different type of "alcoholism" represented in this general population sample of dependent drinkers:

- Young Adult Subtype (31.5%)
- Young Antisocial Subtype (21%)
- Functional Subtype (19.5%)
- Intermediate Familial Subtype (19%)
- Chronic Severe Subtype (9%)

These findings, and the new categorization of "types of alcoholism," are intriguing, troubling, clarifying or nonsensical depending on the reader's point of view (or paradigm/lens used). The NAES and the NESARC clearly show people with "dependence" returning to low-risk drinking, just as Cahalan, Room, and Filmore showed earlier with "problem drinkers." Further, the idea of types of alcoholism is by no means new. But the new categorization being embraced by NIAAA proposes a type of "alcoholism" that is age-limited. How do we square those findings with the

preponderance of clinical experience to the contrary, or the prevailing concept that alcoholism is progressive and irreversible?

For those who are not new to the addictions profession, these findings may also be reminiscent of a separate but related controversy of whether people with *alcoholism* can return to “controlled” drinking. Many remember the flurry (and fury) caused first by the RAND Report (Armor, Polich, and Stambul 1976) and then the Sobels (1976) reporting that some alcoholics return to moderate drinking; and the vindication of more traditional views when Pendery et al. (1982) found the Sobel’s success stories to have all relapsed. Yet this too is a story that will not go away with many other studies finding a variety of long-term outcomes ranging from abstinence, to drinking without problems, to drinking with continued life chaos. (Vaillant, 1995; Miller & Rollnick, 1991)

It is tempting to “cherry pick” the findings most compatible with our own paradigm while discounting the others. This response would let us continue doing whatever we are currently doing, but may miss a golden opportunity to stretch our concepts to fit a larger reality seemingly unfolding from a now sizable body of research. Counselors working from the traditional disease model need not fear these findings but could benefit from seeing the paradigms unfolding before us. Considering the history and research of our field along with the definitions and paradigms that guide us we can turn this conundrum into a clarification and come to see new ways to approach our work.

Are we asking the right questions?

In discussing the above findings, a well known researcher commented to me that, “*We now know alcoholism is not irreversible, but most counselors are not ready to accept that.*” Most clinicians flatly reject this assertion based on their clinical experience. But what if the researcher and the counselors are not talking about the same condition; or more accurately, what if he is describing a broad continuum while the counselors are describing only the end of that continuum? What if Edwards was correct in his original assertion that dependence is a continuum with different outcomes depending on how severely dependent the person is? Is it meaningful to think of one part of that continuum as representing alcoholism (as more classically defined) and the rest representing another part of the dependence spectrum with a likely different set of outcomes?

Interestingly, Alcoholic’s Anonymous has from its inception accepted that some who clearly have serious problems with alcohol can and do return to drinking without problems. For example, the book *Alcoholics Anonymous* states, “*Then we have a certain type of **hard drinker**. He may have the habit badly enough to gradually **impair him physically and mentally**. It may cause him to **die a few years before his time**. If a sufficiently strong reason—ill health, falling in love, change of environment...this man **can stop or moderate** [stop on his own or return to low risk choices] **although he may find it difficult and troublesome and may even need medical attention** [treatment].” (Emphasis added) Little treatment for alcoholism existed at the time early AA members penned these words, yet they definitively stated that—in their experience—even some people whose drinking is so severe it may shorten their life or require them to enter treatment or seek “medical attention” for their use of alcohol can and do moderate their drinking.*

Often people assume AA rejects the idea that some people with alcohol problems can return to low-risk drinking (Roizen), but this passage offers clear evidence to the contrary. In fact, AA

members have traditionally encouraged those who were uncertain of the need to abstain to try drinking two drinks everyday. For many years this was known as “Marty Mann’s Test” (Mann,). Marty Mann was the first woman in AA and she went on to found the National Council on Alcoholism. Yet, she was not alone in giving this advice. The ‘Big Book’ (page 31-32), has advice for those who are uncertain whether they have alcoholism; “...you can quickly diagnose yourself. Step over to the nearest barroom and try some controlled drinking. Try to drink and stop abruptly. Try it more than once.” It is fair and accurate to say that AA firmly holds to the belief that those with alcoholism will ultimately need to abstain to recover, but it is not at all accurate say that AA holds this to be true for everyone who has serious alcohol problems. They only claim it to be true for “*alcoholics like us.*”

Whatever one chooses to call this phenomenon, it seems that both the experience of AA, as well as later research, indicates it exists. It seems equally true that a deep reservoir of experience and a number of studies also find a return to drinking without problems to be unlikely for others. It may be, then, that this is an unnecessary controversy created by lack of clarification of our paradigms. Perhaps we have also been asking the wrong question. Rather than asking, “Is alcoholism irreversible?” it might be more productive to ask, “Is there a phase in the progression of alcohol problems when people are likely to be able to return to low-risk drinking?” and “Is there a phase in the progression of alcohol problems when people are unlikely to return to low-risk drinking?” If the answer is “yes” to both then we do not need to engage in debates over whether people with alcoholism can return to low-risk drinking. Instead, we might more productively refine our understanding of “When is it alcoholism?” and “What are the likely outcomes of alcohol and other substance abuse disorders at different phases in the progression?”

But do counselors and researchers agree on the terms?

Most counselors and most researchers diagnose alcoholism by using a DSM IV dependence diagnosis; so there is agreement to that point. However, in our experience, most front-line counselors define alcoholism/addiction as a “progressive and irreversible disease characterized by loss of control” and add this assumption to the “any three symptoms” required by DSM for a dependence diagnosis. By contrast, our experience is that most researchers simply mean “any 3 symptoms” and do not make the assumption that alcoholism/addiction is “a progressive and irreversible disease characterized by loss of control.” There is agreement between counselors and researchers that dependence can be diagnosed with “any three symptoms” but deep differences in what this means once we equate dependence with alcoholism or addiction.

In addition, many researchers consider either DSM alcohol abuse or dependence to be “alcoholism.” In fact, the guidelines of the *Journal of Studies on Alcohol and Drugs* require articles being published to refer to either as “alcoholism.” While this may work well for research, it can be confusing in a clinical setting trying to apply research findings, or in judicial or other settings that rely on clinical advice. By contrast, most counselors do not consider alcohol abuse to be alcoholism. This can make a difference. The vast majority of DSM Alcohol Abuse is carried by one symptom; far from what most counselors mean by “alcoholism.” It also makes a difference in many findings. For example, heritability is considerably lower for abuse than for dependence.

Finally, there is not agreement in how those doing research on animals and those doing research on humans use the word “dependence.” One cannot establish that a laboratory animal meets the criteria for DSM Dependence. Animal researchers, instead, often define dependence as “withdrawal.”

Definitions are in the mind and come about through consensus. So we cannot say one of these approaches is right and the others wrong. What we can say is they are different and we need to be conscious of the differences. Otherwise (paraphrasing Nixon) “Counselors and researchers may understand what we think the other has said without realizing that we heard is not what they meant.” Since the meaning of words does come about by consensus, we can forge a new consensus.

Defining Alcoholism: Past, Present, Future

This leads us back to the opening questions of how we define words such as “alcoholism,” “addiction,” and “dependence.” Starting with “alcoholism,” it is natural to assume we all mean the same thing when we use the word. In reality, though, there are many variations on how people define and diagnose alcoholism (Moyers and Miller, 1993). As noted, most counselors in addictions treatment programs consider a DSM-IV dependence diagnosis to be alcoholism, while adding to the DSM paradigm of “any three symptoms” the paradigm that alcoholism is characterized by loss of control and is progressive and irreversible. We must ask, “Why should one assume that “any three symptoms” would equal loss of control, irreversible, or progressive. A look at the seven DSM symptoms reveals that it is quite possible for a person to have three symptoms with none of them being “loss of control.” Increasingly the framers of DSM refer to “impaired control” which is not the same as what people generally mean by “loss of control.”

In making a diagnosis, some clinicians follow DSM explicitly and exclusively. Hasin observed that others give a DSM diagnosis because a funding source requires it, but use another source or their own criteria to make a working diagnosis. (Hasin, 2006) Our experience confirms this. We have met some clinicians who, in practice, consider alcoholism to be present based on single criteria such as tolerance, blackouts, daily drinking, or more commonly, the presence of problems. While some are shocked to find that anyone would diagnose alcoholism using a single criterion, that approach is implied by the commonly used definition that “alcoholism is any drinking that leads to problems.” The confusion that exists around the word “alcoholism” has led some to abandon use of the word entirely. For others, it has created a quest to more clearly define it.

The struggle to define alcoholism is not new and we can learn from those who have gone before us. Mark Keller (1982), the long-time editor of *The Journal for Studies on Alcohol*, wrote an interesting history of the use of the word. He notes that Magnus Huss, a Swedish physician, coined the word alcoholism in 1849, to connote alcohol addiction. E.M. Jellinek (1960), who is considered the “father of the Disease Concept,” agreed and specified that addiction is the basis for considering alcoholism to be a disease. Twenty years earlier, E.M. Jellinek and Carl Bowman (1941) had published a thorough review of the alcoholism treatment literature, and the ways in which alcoholism had been defined. In this early writing they also limited alcoholism to alcohol addiction. In speaking of

Bowman and Jellinek's work, Keller said "...they designated (alcoholism) by alcohol addiction. For the latter choice they had the best of reasons: All the expert descriptions converged on addiction..." We ask the reader to keep in mind that in both the origin of the word and of the disease concept, addiction was the criterion that distinguished alcoholism from other forms of problem drinking.

Keller noted that as time passed, the word alcoholism fell into **popular use** where its meaning became **broadened**. *"The word became common...and thereby experienced the fate of many ordinary words: It was made more and more useful. Its meaning was popularly enriched – and thereby **technically impoverished**. It ceased to be solely a diagnostic term for a condition identified by specifiable symptoms. And popular usage is not without influence on professionals."* He went on to say, *"The meaning of alcoholism became soft, vague, and non-technical. **The term came to be applied to pre-alcoholistic behaviors...sometimes (applied to) people who would never make it into alcoholism,** (and applied) to manifest troubles with drinking which have always been common in young people during the stage between adolescence and settling down; to heavy drinking, excessive drinking, deviant drinking and unpopular drinking....Robert Straus wittily observed that the number of alcoholics in the United States nearly doubled in a single day, when a Federal agency casually redefined alcoholism."* (emphasis ours)

In *The Disease Concept of Alcoholism*, Jellinek struggled to make sense of the loose ways in which the word alcoholism had come to be used. He said that if we were going to define alcoholism so broadly as "any drinking that leads to problems," then he could identify five types of alcoholism to which he assigned Greek letters – Alpha, Beta, Gamma, Delta, and Epsilon. Many times these are referred to as though each represents disease. In reality, Jellinek suggested that only two types, Gamma and Delta, represented disease. Both were characterized by addiction with Gamma representing loss of control and Delta representing inability to abstain without withdrawal. Alpha alcoholism was characterized only by psychological dependence, and was neither a disease nor irreversible. Alpha, Beta, and Epsilon were "alcoholism" only using the broad definition that had come into use, but they did not meet the criteria for disease, and they were not depicted as irreversible conditions. Keller quoted Jellinek on this and added his own commentary as follows, *"Referring to the fact that some people 'who never become addicted' were being labeled as alcoholics, Jellinek wrote: 'In order to do justice to these ...differences, we have termed as alcoholism any use of alcoholic beverages that causes any damage to the individual or society or both.' Five lines later on the same page, he added: 'such a vague definition is useless.' This, then, was his rationale for proposing to substitute the several species of alcoholism labeled with Greek letters."* Keller went on to say, *"The conception of disease should not be applied to mere heavy drinking, or mere misbehaving with alcohol, or mere getting into trouble on account of drinking, or mere getting drunk x times. The conception of alcoholism as a disease applies only to those who manifest the symptoms of addiction. It is a diagnostic problem."*

Keller made it clear that as the word "alcoholism" fell into popular use, the definition broadened beyond addiction to "any drinking that leads to problems." This included a wide variety of reversible problem states, and many professionals adopted this usage. He also noted that the alcoholism field fell into this same broad usage. This left us in the position of holding onto the belief that alcoholism is a disease which leaves people unable to return to low-risk drinking, while broadening our use of the word to apply to people for whom this was not true.

It may be useful to keep in mind that the conceptualization of alcoholism evolved in the 1940-60 era; a time when only those most severely affected with alcohol problems were likely to make it into AA or into treatment, which usually meant institutionalization in a "mental hospital." If we think of alcohol-related problems as lying on a continuum, only those on the furthest end of the continuum were identifiable for research or treatment and these are the people who provided the basis for defining "alcoholism." After NIAAA was established, community treatment and early intervention programs such as DWI interventions began identifying people much earlier on the continuum. Rather than declaring them to be in a non-alcoholic or "a pre-alcoholismic state" as would have been suggested by Keller, they were more often referred to as "high bottom alcoholics." In doing this, the assumptions that seemed to hold true for the very advanced cases upon which the paradigm of alcoholism was developed, began to be applied to this group who in Keller's words "*would never make it into alcoholism [as defined by addiction].*"

Numerous studies began to show that when defined broadly, some people with such a diagnosis were indeed returning to drinking without problems. The response was to attack the research rather than understanding we, as a field, had overly applied the alcoholism paradigm without even realizing it. We were ripe for criticism and acrimony and in severe need of a new paradigm. The concept of dependence began to evolve as an alternative paradigm.

Is the "Dependence" Concept a Synonym for "Alcoholism?"

Griffith Edwards proposed the concept of dependence in a 1976 article in the *British Medical Journal*. The concept was then endorsed by the World Health Organization and became the basis for substance-related diagnosis in both the International Classification of Diseases (ICD 10) and the Diagnostic and Statistical Manual (DSM III-R and IV). Edwards (1986) later reflected on the origins of the concept and stated, "*It is to be noted that this formulation [dependence] carried with it no assumption as to whether the syndrome was progressive or irreversible, and no assumption as to the nature of any 'pathology' [disease state].*" He went on to note that people confuse the concept of dependence with the disease concept. He spent almost a page and a half in the article demonstrating that it was indeed a separate concept and concluded, "*...such issues cannot be adequately understood by the preservative rhetoric of the 'disease' debate. The projection of old conflicts about the disease concept onto the dependence formulation is unlikely to be helpful.*"

In our experience, the traditional view, and that held by many addictions counselors, is that alcoholism is somewhat like an on/off switch; you either have it or you don't. Rather than being viewed as an on/off switch in which a person does or does not have an irreversible condition, Edwards suggests the concept of dependence represents a continuum of severity in which the more severe the dependence, the less likely a person is to successfully return to low-risk drinking. Conversely, the less severe the dependence the more likely a person is to be able to return at some point to non-problem use. Research seems to support his position.

It may be useful to note that meaningful differences exist between Edward's concept of dependence and the current DSM criteria for dependence. Edwards suggested that

dependence is made up of the following criteria, which, taken together, also describe addiction:

1. Narrowing repertoire of drinking behavior. Early in the person's drinking there is a lot of variation in day-to-day drinking. Increasingly the person drinks similar amounts each day to avoid withdrawal. Finally, the behaviors become stereotyped.
2. Saliency of drinking behavior. The person increasingly gives priority to drinking over other things in life. The failure of negative consequences to deter drinking may be a measure of the degree of dependence.
3. Increased tolerance. The person will be able to "go about his business at blood alcohol levels that would incapacitate the normal person."
4. Repeated withdrawal symptoms. "At first symptoms are intermittent and mild and cause little incapacity. As dependence increases so do the frequency and severity of symptoms." Edwards lists four key withdrawal elements as tremor, nausea, sweating, and mood disturbance.
5. Drinking to avoid withdrawal. Initially withdrawal drinking may simply be experienced as the first drink of the day "straightening me up a bit." Later the need becomes desperate.
6. Subjective awareness of compulsion to drink. This may be experienced as loss of control or craving. Edwards says it may be best understood as intermittent ability to control rather than lost control, but the key element is compulsion to drink.
7. Reinstatement after abstinence. A normal part of the process is self-imposed times of abstinence followed by a return to drinking. Those moderately dependent may tend to return to drinking after weeks or months of abstinence. Those more severely dependent will tend to do so more quickly.

Does DSM IV Define Alcoholism?

DSM 1 used the word "alcoholism" and defined it as a personality disorder. DSM 2 also held that alcoholism was a personality disorder but suggested withdrawal was perhaps the most effective way of diagnosing it. (Consider for a moment a personality disorder being diagnosed by withdrawal.) NIAAA noted in 1995 that, "The evolution of diagnostic criteria for behavioral disorders involving alcohol reached a turning point in 1980 with the publication of the *Diagnostic and Statistical Manual of Mental Disorders, Third Edition* (14). In DSM-III, for the first time, the term "alcoholism" was dropped in favor of two distinct categories labeled "alcohol abuse" and "alcohol dependence"

The DSM manual uses Edward's concept of dependence, while somewhat altering the seven criteria. Compare the following DSM symptoms to those identified by Edwards:

1. Tolerance.
2. Withdrawal.
3. Substance often taken in larger amounts or over a longer period than was intended.
4. A persistent desire or unsuccessful efforts to cut down or control substance use.

5. A great deal of time spent in activities necessary to obtain the substance, use the substance, or recover from its effects.
6. Important social, occupational, or recreational activities are given up or reduced because of substance use.
7. The substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance.

The authors of DSM also added a diagnosis of abuse; then divided dependence into those with and without physiological dependence. DSM requires any three of the seven dependence symptoms to qualify for the diagnosis. The DSM strategy provides excellent reliability (different counselors will apply it the same) and has been very useful for research purposes while becoming the "gold standard" clinically. Still there are differing views on what it means and its application.

Edwards differed from DSM in suggesting that each of these symptoms exists on a continuum, thus giving the syndrome degrees of seriousness. Also, each symptom relates to all others rather than occurring independently. He suggested that the clinically relevant question was less one of "what symptoms does the person have" than "to what degree does the person have each symptom. Thus, according to Edwards, the syndrome is not made up of having "X" number of symptoms, but rather by the collection of the symptoms describing the degree to which, if at all, the person is dependent. It is also interesting to note that while Edwards tries to avoid, *"the semantic confusion over what is meant by the over-inclusive term 'alcoholism' and the social arbitrariness of the 'disease' label,"* he does suggest that *"society should be asked to realize that the person who has become dependent on alcohol is certainly ill; and the possibility of contracting this illness awaits anyone who drinks very heavily."* He further suggested that the more advanced the dependence, the less likely that person will return to drinking without resuming the dependence.

Edwards considers the DSM system of any three symptoms for diagnosing dependence as being "arbitrary." He explains that as follows, *"I think that DSM is arbitrary in its cut-off point as to what level of dependence will count as dependence. The arbitrariness attaches both to the way individual syndrome elements are handled and the totality of the syndrome."* (Personal communication, October 19, 2001)

One might also ask whether it seems reasonable that any three symptoms be considered equal to any other three. One person might qualify only for criteria 1, 5, and 6, while another qualifies for criteria 1, 2, and 3. Under DSM IV these two people would both have a diagnosis of "alcohol dependent with physiological dependence." Physiological dependence includes tolerance or withdrawal and many who will never experience withdrawal have high tolerance. Consider these combinations and ponder why they should be considered the same. Are they truly both physiologically dependent? Is there dependence the same? For those who work from the disease model we also ask whether there is a realistic basis for considering that they both have either loss of control or an irreversible disease condition (neither of which is claimed by DSM, only by many who used DSM.) Is the first combination giving us a profile of a fraternity member who will likely change his drinking when he gets married and "settles down" while the second profiles severe dependence that does fit the concept of alcoholism?

The problem here is not with DSM. It is with the assumption that DSM was diagnosing alcoholism, traditionally defined. Of the several thousand clinicians we have trained, we have met less than a dozen who already understood that DSM was not intended to be a synonym for alcoholism or to diagnose an irreversible condition. Unfortunately, that assumption is so deeply ingrained in our field that most of us received that message as part of our training in how to use DSM.

But the reader does not need to take our word for this, or rely on the word of whoever may have trained you in DSM. Instead, re-read the DSM manual with this new information in mind. To see that DSM is not diagnosing alcoholism (as traditionally defined) one only need ask "How many times does DSM IV use the word alcoholism?" The answer, of course, is zero. Also, think about the DSM requirement for a person to have a diagnosis of dependence, in full-sustained remission. When we ask clinicians what DSM requires for this qualifier, most say "12 months of abstinence." But look closely. What DSM requires is a year of being "symptom-free." Drinking is not one of the symptoms. Thus, according to DSM (and consistent with research), it is clearly possible for a person to be in full-sustained remission and still be drinking. In fact, in one sentence DSM-IV even raises the question of what it might take for a person to be considered "recovered." An answer is not given beyond a vague statement about the amount of time that the person is symptom-free.

If by "alcoholism" people only mean "any three dependence symptoms in the same 12-month period," then using alcoholism and dependence as synonyms is not a problem. But if by "alcoholism" or "addiction" we mean "loss of control, irreversibility, and progressive nature" then it matters very much. A number of combinations of symptoms will meet the criteria for DSM Dependence without reaching the threshold addiction counselors have in mind when diagnosing "alcoholism" or "addiction." The end result is exactly what Keller described as happening five decades earlier. *"The term [alcoholism] came to be applied to pre-alcoholistic behaviors...sometimes (applied to) people who would never make it into alcoholism..."*

Consistent with the suggestions of Edwards, a DSM dependence diagnosis was never intended to be a synonym for alcoholism as an irreversible disease. It was intended to provide a clinically useful *alternative* to the prevailing concept of alcoholism that would bypass the controversial questions of whether alcoholism is a disease and whether it is irreversible. Think of DSM as a clinical tool that can be useful both to those who accept that alcoholism is an irreversible condition and those who believe that people with alcoholism can return to drinking without problems. In fact, clinicians on both sides of this issue use DSM. The problem is that the difference in the paradigms has not been made clear and thus both researchers and counselors are too often talking past each other, using the same words but with different meanings.

DSM V should make this easier as it will almost certainly include some measure of severity. This is a huge change that will re-align DSM more closely with its roots and make it easier for counselors and researchers to talk. It will be easier to see that early dependence does not equal the traditional concept of alcoholism/addiction, but advanced dependence probably does. It will also make it easier to understand data such as the NESARC. But these benefits will only reach their full potential if we clarify our language and paradigms.

What are other ways to make sense of this?

On the other side of this issue, some ask why we should even continue to use the word alcoholism. We do so because the word and the paradigm are deep in the consciousness of both the public and professionals. Part of that indelible imprint is that alcoholism is characterized by loss of control – not just impaired control. Unless and until that imprint changes, treating them as synonyms will only confuse people. Even the concept of dependence acknowledges that there is a point in the progression where the dependence is so severe that it is highly unlikely the person will succeed in returning to low-risk drinking. At that point, the concept of dependence and the concept of alcoholism (as broadly accepted in our field) converge. As planned in DSM V, we need to make the distinction between early and advanced dependence and not continue to equate alcoholism to any dependence.

One educational intervention, PRIME for Life (www.primeforlife.org) offers a continuum approach to understanding Phases of alcohol and drug use that helps make the different paradigms. In this conception, Phase 1 represents low-risk drinking, Phase 2 represents high-risk drinking, Phase 3 represents the early part of the dependence continuum, and Phase 4 represents the part of the continuum that most resembles the traditional concept of alcoholism/addiction.

Our experience is that this conception makes sense to both the public and to most professionals. Their reaction leads us to believe the anticipated changes in DSM V will be equally well accepted and very clarifying – but only if we first clarify the differences in the paradigms.

Practical Implications

Once we accept dependence and alcoholism/addiction as different paradigms, and accept the continuum nature of dependence (from mild to severe) we are then ready to embark on a new era of treatment (which many are already doing) in which the norm becomes two tracks of treatment. We choose to think of these as a Recovery Track for those who know they want to abstain and a Discovery Track for those who are not yet sure what they are willing to do but are willing to participate in treatment. There are indications this approach can both reach more people (Miller and Rollnick, 1991) and can actually increase abstinent outcomes (Vaillant, 1995). Embracing this approach will call on many community treatment programs to change their policy of only accepting clients who are willing to commit to abstinence and dropping from treatment those who return to using. Programs would not place people in a track; rather, clients choose their own path by honestly stating what they are willing to commit to.

Too often treatment becomes dishonest, drifting toward “If you will pretend you want to abstain, I will pretend to believe you.” The majority of clients in publicly funded programs come through the court system and may be mandated because of an arrest rather than dependence or the degree of dependence. If treatment offers only one option then clients feel a pressure to say they want to abstain just to meet the mandate of the court. In their hearts they may be planning the biggest party in their lives as soon as the court sanction is removed. When this is the case, the two track system gives an

opportunity to make treatment an honest experience where the counselor can help the client discover whether their plans are workable, as opposed to telling them it is unworkable. The process of discovery is at the heart of meaningful change.

Sometimes counselors' first response to this suggestion is, "Isn't that giving clients permission to use?" In reality, we do not have such power. The choice to use or not use is, was, and always will be the client's alone. Our choice is to align the treatment experience with that reality or to choose to ignore it. We are not giving clients the choice to use or not use; we are standing by them in their struggle to make sense of their lives and become committed to change. But the change they choose will always be theirs. We deceive ourselves if we confuse treatment with telling them what they must do. We are now at a time where it is possible to revamp the treatment experience to be equally relevant to those who have mild dependence versus those with severe dependence. We do not have to wait for DSM V to do so. We have what we need to rethink treatment now.

References:

1. Armor, D.J., Polich, J.M. and Stambul, H.B. Alcoholism and treatment. Prepared for the U.S. National Institute on Alcohol Abuse and Alcoholism. Santa Monica, CA; Rand Corp.; 1976.
2. Bailey, S. (1999). The measurement of problem drinking in young adulthood. Journal of Studies on Alcohol, 60(2), 234-244.
3. Bowman K.M. and Jellinek, E.M. (1941). Alcohol addiction and its treatment. Quarterly Journal of Studies on Alcohol, 2, 98-176.
4. Bucholz, K.K., Heath, A.C., Reich, T. Hesselbrock, V.M., Dramer, J.R., Nurnberger, J.I., and Schuckit, M.A. (1996). Can we subtype alcoholism? A latent class analysis of data from relatives of alcoholics in a multicenter family study of alcoholism. Alcoholism: Clinical and Experimental Research, 20, 1462-1471.
5. Cahalan, D. and Room, R. (1974). **Problem Drinking Among American Males**. College and University Press, New Haven, Conn.
6. Cappell, H. & LeBlanc, E. (1983). The relationship of tolerance and physical dependence to alcohol abuse and alcohol problems. In B. Kissin & H. Begleiter (Eds.), The Biology of Alcoholism, Volume 7 (pp.359-414). New York: Plenum Press.
7. Dawson, D. (1996). Correlates of past-year status among treated and untreated persons with former alcohol dependence: United States, 1992. Alcoholism Clinical & Experimental Research, 20(4), 771-779.
8. Dawson, D. (1996). Gender differences in the risk of alcohol dependence. Addiction, 91(12), 1831-1842.
9. Dawson, D., Grant, B.F., Stinson, F.S., Chou, P.S., Huang, B. and Ruan, W.J. (2005). Recovery from DSM-IV alcohol dependence: United States, 2001-2002. Addiction, 100, 281-292.
10. Edwards, G. & Gross M.M. (1976). Alcohol dependence syndrome: provisional description of a clinical syndrome. British Medical Journal, 1, 1058-1061.
11. Edwards, G. (1986). The alcohol dependence syndrome: a concept as a stimulus to enquiry. British Journal of Addiction, 81, 171-183.

12. Fillmore, K.M. (1974). Drinking and Problem Drinking in Early Adulthood and Middle Age. Quarterly Journal for Studies on Alcohol, 35,819-840.
13. Fillmore, K.M. (1975). Relationships between specific drinking problems in early adulthood and middle age. Journal of Studies on Alcohol, 36(7), 882-907.
14. Hasin, D.S., Muthuen, B., Wisnicki, K.S., and Grant, B. (1994). Validity of the bi-axial dependence concept: A test in the US general population. Addiction, 89, 573-579.
15. Hasin, D., Rossem, R.V., McCloud, S., and Endicott, J. (1997). Alcohol dependence and abuse diagnoses: Validity in community sample of heavy drinkers. Alcoholism: Clinical and Experimental Research, 21, 213-219.
16. Hasin, D. (2006), in Sanders, JB, Schuckit, M., Sirovatka, PJ, and Regier, DA (Editors) Diagnostic Issues in Substance Use Disorders: Refining the Research Agenda for DSM-V
17. Jellinek, E.M. (1960). *The Disease Concept of Alcoholism*. College and University Press, New Haven, Connecticut.
18. Keller, M. (1982). On defining alcoholism: with comment on some other relevant words. In E.L. Gomberg, H.R. White, and J.A. Carpenter (Eds.), *Alcohol, Science, and Society Revisited* (pp. 119-133). The University of Michigan Press, Ann Arbor.
19. Miller, W.R. and Rollnick, S. (1991). **Motivational Interviewing: Preparing People to Change Addictive Behavior**. Guilford Press, New York.
20. Moss, Chen, and Yi, Subtypes of Alcoholism, Journal of Alcohol and Drug Dependence, 2007
21. Pendery, M.L., Maltzman, I.M. and West, I.J. (1982) Controlled drinking by alcoholics? New findings and a reevaluation of a major affirmative study. *Science*, 217, 169-175/
22. Raimo, E.B., Daepfen, J., Smith, T.L., Danko, G.P, and Schuckit, M.A. (1999). Clinical characteristics of alcoholism in alcohol-dependent subjects with and without a history of alcohol treatment. Alcoholism Clinical & Experimental Research, 23(4), 1605-1613.
23. Schuckit M.A. et.al. (1998). Clinical Relevance of the distinction between alcohol dependence with and without a physiological component. American Journal of Psychiatry. 155(6), 733-740.
24. Schuckit, M. A., Klein, J. L., Twitchell, G. R., & Springer, L. M. (1994). Increases in alcohol-related problems for men on a college campus between 1980 and 1992. Journal of Studies on Alcohol, 55, 739-742. Schuckit, M.A., Danko, G.P., Smith, T.L., Hesselbrock, V., Kramer, J., and Bucholz, K.. A 5-Year Prospective Evaluation of DSM-IV Alcohol Dependence With and Without a Physiological Component. *Alcohol Clin Exp Res* 27 (5):818-825, 2003.Schuckit, M.A., Daepfen, J.B., Danko, G.P., Tripp, M.L., Smith, T.L., Li, T.K., Hesselbrock, V.M., and Bucholz, K.K. (1999). Clinical implications for four drugs of the DSM-IV distinction between substance dependence with and without a physiological component. American Journal of Psychiatry, 156, 41-49.
27. Schuckit, M.A., and Smith, T.L. (2001). A comparison of correlates of DSM-IV alcohol abuse or dependence among more than 400 sons of alcoholics and controls. Alcoholism: Clinical and Experimental Research, 25, 1-8.

28. Sobell, M.B. and Sobell, L.C. (1976). Second year treatment outcomes of alcoholics treated by individualized behavior therapy: results. *Behavior Research and Therapy*, 14, 195-215.
29. Vaillant G. (1995) **The Natural History of Alcoholism Revisited**. Harvard University Press.