

Lifestyle Risks

This section discusses the regulation of “lifestyle risks”, a term that can apply to both substances and behaviours. Lifestyle risks take place along the line of “abstinence – consumption – abuse – addiction”. This can concern substances such as food, alcohol or drugs, as well as behaviours such as gambling or sports. The section also addresses the question of the appropriate point of equilibrium between free choice and state intervention (regulation), as well as the question of when risks can be considered to be acceptable or tolerable.

In line with the interdisciplinary scope of the journal, the section aims at updating readers on both the regulatory and the scientific developments in the field. It analyses legislative initiatives and judicial decisions and at the same time it provides insight into recent empirical studies on lifestyle risks.

DSM-5: What's New?

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The recently published 5th edition of the Diagnostic and Statistical Manual of Mental Disorders has incorporated significant changes. This report aims to outline the changes that are most relevant for readers with an interest in lifestyle risks.

During May 2013, the 5th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) was released after many years of revision.¹ Many mental health professionals around the globe use the DSM 5 and its diagnostic, which is published by the American Psychiatric Association (APA). The DSM-5 brings significant adjustments that are also likely to impact the forthcoming 11th edition of the *International Statistical Classification of Diseases and Related Health Problems (ICD-11)*, the other leading diagnostic manual, whose publication by the World Health Organization (WHO) is expected during 2015.²

It is normal that revisions of such a central reference book receive mixed reviews. The DSM-5 has

caused particularly harsh criticism. The allegations mainly relate to ‘over-medicalisation’ (new diagnoses) and ‘over-diagnosis’ (lowering of diagnostic thresholds).³ Observers have criticised its dominant biomedical model for serving the interests of the pharmaceutical industry. And the overuse of drug prescription is seen critically both from a public health and public finance perspective bearing in mind the financial problems that many welfare states are presently facing.⁴ The revised chapter about personality disorders has received particular criticism for being largely based on symptoms reflecting current normative social expectations instead of objective criteria.⁵

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1 *Diagnostic and Statistical Manual of Mental Disorders: DSM-5*, American Psychiatric Association (ed.), American Psychiatric Publishing: Washington DC / London 2013.

2 *Ibid.*, Preface p. xli, and pp. 10–12.

3 The critics inter alia include the Chair of the DSM-IV Task Force: Allen Frances, *Saving Normal: An Insider's Revolt Against Out-of-Control Psychiatric Diagnosis, DSM-5, Big Pharma, and the*

Medicalization of Ordinary Life Hardcover, HarperCollins Publishers: New York 2013; Allen Frances, *Essentials of Psychiatric Diagnosis: Responding to the Challenge of DSM-5*, revised edition, The Guilford Press: New York / London 2013.

4 Patrick Landman, *Why Does the Publication of the DSM-5 Concern European Psychiatry?*, p. 2, available at <<http://stop-dsm.org/index.php/es/articulos-y-contribuciones/60-articulos-y-contribuciones/77-why-does-publication-dsm5-concern-patrick-landman-es>>.

5 The British Psychological Society, *Response to the American Psychiatric Association: DSM-5 Development*, available at <http://apps.bps.org.uk/_publicationfiles/consultation-responses/DSM-5%202011%20-%20BPS%20response.pdf>.

In spite of all the criticism, DSM-5 undoubtedly brings some laudable adjustments as far as *lifestyle risks* such as alcohol use or tobacco use are concerned. The positive developments include the abandoning of the distinction between *substance abuse and substance dependence*; the clarification that *physical dependence is not to be confused with addiction*; and the merging of *substance-related addictions and behavioural addictions* into one joint category.

I. Abandoned distinction between abuse and dependence

DSM-IV made a distinction between drug ‘abuse’ and ‘dependence’. For instance, alcohol abuse was defined by diagnostic criteria different from those regarding alcohol dependence. The threshold for a diagnosis was one criterion (out of three) for abuse, and three criteria (out of seven) for dependence.⁶ Generally speaking, clinicians considered alcohol abuse to be a less severe disorder than alcohol dependence. But it was hard to see any empirical justification for this strict dichotomy. On the contrary, the distinction went against the empirical evidence that *addiction problems take place along a problem continuum* ranging from less severe to more severe.⁷

DSM-5 has now abandoned this categorical distinction, summarising most of the criteria formerly relating to abuse and dependence under one diagnosis: ‘*substance use disorder*’ (e.g., alcohol use disorder). The continuum of varying severity now finds expression in the qualifiers ‘mild’ (2–3 criteria fulfilled), ‘moderate’ (4–5), and ‘severe’ (6 or more).⁸

Furthermore, DSM-5 no longer uses the *controversial criterion of ‘recurrent substance-related legal problems’*. Indeed, this criterion appeared arbitrary. Whether someone with alcoholism, for instance, is arrested for disorderly conduct might have more to do with the local practice of law enforcement rather than with the severity of the disorder. Similarly, a person who drinks only occasionally but then excessively can get arrested for disorderly conduct – without that being an accurate reflection of an ‘alcohol use disorder’.

II. Dependence versus addiction

Another laudable terminological change regards the distinction between addiction and dependence. In

popular media, these terms are often used as interchangeable terms. Neuroadaptive phenomena such as withdrawal and tolerance – often referred to as physical dependence – are indeed typical for addictive disorders.⁹ But DSM-5 now clearly holds that *mere neuroadaptive reactions of the body (dependence)* are not sufficient to conclude an addiction (e.g., opioid use disorder). Therefore, the manual notes regarding opioid use (and other substances) that the tolerance and withdrawal criteria are “not considered to be met for those individuals taking opioids solely under appropriate medical supervision.”¹⁰ Patients who receive painkillers (e.g., morphine, methadone) and subsequently experience withdrawal symptoms such as sweating, insomnia, diarrhoea, etc. are not necessarily addicts.¹¹ This clarification was essential since the confusion of dependence and addiction among practitioners historically had resulted in *withholding adequate doses of opioids from patients*.¹² Doctors were afraid of “producing addiction” to their patients.¹³ DSM-5 clearly does away with the myth that a substance causes addiction.

III. Merging of substance-related addictions and behavioural addictions

DSM-5 has taken a big step in bringing substance-related and behavioural expressions of addiction under the same heading. The chapter ‘substance-related and addictive disorders’ now comprises *ten classes of substances* (alcohol; caffeine; cannabis; hallu-

6 *Diagnostic and Statistical Manual of Mental Disorders: DSM-IV-TR*, American Psychiatric Association (ed.), American Psychiatric Publishing: Washington DC / London 2000.

7 Whelan, J., Steenbergh, T., and Meyers, A., *Problem and Pathological Gambling*, Cambridge MA: 2007; Shaffer, H.J., Hall, M.N., and Vander Bilt, J., *Estimating the Prevalence of Disordered Gambling Behaviour in the United States and Canada: A Meta-Analysis*, Harvard Medical School: Cambridge MA 1997.

8 *Diagnostic and Statistical Manual of Mental Disorders: DSM-5*, American Psychiatric Association (ed.), American Psychiatric Publishing: Washington DC / London 2013, pp. 481 et seq.

9 *Ibid.*

10 *Ibid.*, p. 541.

11 *Ibid.*, pp. 547–8.

12 *Ibid.*, Preface p. xlii, and p. 484.

13 DSM-5 Development – Substance-Related Disorders, formerly available at: <<http://www.dsm5.org/ProposedRevisions/Pages/Substance-RelatedDisorders.aspx>> (accessed 1 June 2012).

cinogens (phencyclidine and others); inhalants; opioids; sedatives, hypnotics, and anxiolytics; stimulants (amphetamine-type substances, cocaine, and other stimulants); tobacco; and other (or unknown) substances) along with the behavioural expression of addiction, ‘*gambling disorder*’, formerly referred to as ‘*pathological gambling*’.¹⁴ This *holistic understanding of addiction problems* rests on solid empirical evidence showing manifold commonalities between substance-related and behavioural expressions of addiction.¹⁵ Gambling behaviours, for instance, *activate the brain reward system* in similar ways as psychoactive substances, producing a powerful feeling of pleasure, and lead to *symptoms comparable to those regarding substance use disorders*.¹⁶

Other excessive or ‘disordered’ behaviours that scientists have studied relate to activities such as *Internet gaming, sex, exercise, and shopping*. The substance work group decided not to sanction these disorders as official DSM-5 diagnoses due to insufficient empirical evidence regarding the definition of diagnostic criteria and course description.¹⁷ ‘Internet gaming disorder’ was nevertheless incorporated in the separate Section III among ‘conditions for further studies’. It is hardly surprising that the *proposed*

provisional diagnostic criteria for Internet gaming disorder are very similar to those relating to gambling disorder and substance use disorders.¹⁸ The new joint categorisation of substance-related and behavioural expressions of addiction suggests that future DSM revisions will integrate additional behavioural expressions of addiction.

The recognition that behaviours constitute expressions of addiction has led to some criticism. The main argument against including behavioural expressions of addiction in the DSM is that, ultimately, everything and anything might be considered as an expression of addiction and reevaluating behaviours would mean to banalise drugs.¹⁹ It is true that psychoactive substances reliably activate the brain’s reward circuit. And addiction becomes apparent where a person compulsively and with loss of control seeks to re-experience the reward. However, this compulsive reward seeking, which continues in spite of detrimental consequences, also can be observed among people with various behavioural expressions of addiction – without there being a pharmacological reason. As neuroscientist Marc Lewis correctly argues, neuroscience can only make its fullest contribution if it makes contact with the significant role of subjective experience²⁰ – and this experience varies strongly among individuals across environmental contexts.

IV. No incorporation of quantitative diagnostic criteria

Finally, it should be noted that DSM-5 continues to rely exclusively on *qualitative* diagnostic criteria. While the manual recognises that changing severity of problems can be reflected by reductions or increases in the frequency and / or dose of substance use,²¹ the substance work group decided *not to define an actual quantitative criterion* (e.g., a certain number of alcoholic drinks or marijuana hits per week).²² The only “quantitative” element that DSM-5 uses regarding substance-related and addictive disorders is a given number of criteria to satisfy a diagnostic threshold (mild, moderate, and severe).

14 *Diagnostic and Statistical Manual of Mental Disorders: DSM-5*, American Psychiatric Association (ed.), American Psychiatric Publishing: Washington DC / London 2013, pp. 481–589.

15 Shaffer, H.J., LaPlante, D.A., LaBrie, R.A., et al. (2004), Toward a Syndrome Model of Addiction: Multiple Expressions, Common Etiology, *Harvard Review of Psychiatry* 12(6), pp. 367–74.

16 *Diagnostic and Statistical Manual of Mental Disorders: DSM-5*, American Psychiatric Association (ed.), American Psychiatric Publishing: Washington DC / London 2013, p. 481.

17 *Ibid.*

18 *Ibid.*, p. 795.

19 For a discussion, see Constance Holden (2001), ‘Behavioral’ Addictions: Do They Exist? *Science* 294(5544), pp. 980–982.

20 Marc Lewis, *Memoirs of an Addicted Brain: A Neuroscientist Examines his Former Life on Drugs*, Doubleday: Toronto 2011; see also his presentation ‘A Neurobiology of Addiction: Linking Memoir and Brain Science to Explain the Inexplicable’, available at <<http://www.youtube.com/watch?v=MBPBcJlZIsA>>.

21 *Ibid.*, p. 484.

22 Anna Lembke, “DSM-5 Gets It Right, But...”, available at <<http://www.thefix.com/content/dsm-5-spectrum-disorder-risky-drinking8269>>.