What's In A Name? In This Case, That Which We Call Addiction Is Not Dependence

Jennifer Schneider MD, PhD, digs into a common—and frustrating—misunderstanding in pain medicine terminology.

> **Even after the DSM-5 clarified opioid addiction as Opioid Use Disorder, dependence has remained the preferred term for professionals.**

FDA approved the buprenorphine implant, branded as Probuphine, in 2016 "for the maintenance treatment of opioid dependence."[1] Was it approved for the treatment of what we now call Opioid Use Disorder? Or was the intent to approve it for physical dependence, a condition found in most opioid-treated chronic pain patients as well as opioid addicts? It is not clear from the language.

The Trouble with Time and Terminology

To understand how this confusion came about, we need to go back in time. Since 1952, the American Psychiatric Association (APA) has published several editions of its Diagnostic and Statistical Manual of Mental Disorders (the DSM), a classification of psychiatric diagnoses. Over the years, as the understanding of various psychological disorders has changed, the association has updated this widely accepted manual. In the early editions, the APA referred to addictive disorders as an addiction. But in 1994, the fourth edition (DSM-4) replaced the term "addiction" with dependence, apparently with a goal of using a less pejorative word.[2] Thus, an addict was now considered to be dependent on a drug, so that a heroin addict was now termed "opioid dependent." Ever since, dependence has remained the preferred term for professionals when describing addiction.

Unfortunately, this term created a new problem for patients being treated with opioids for chronic pain. Most patients on more than minimal doses of opioids for more than a couple of weeks will develop a specific set of withdrawal symptoms if they stop the drug suddenly. This reaction is not addiction, but rather physical dependence, a physiological change in the body in response to ongoing use of certain drugs. This type of change may occur not only with opioids but also with corticosteroids (which is why patients who no longer need prednisone need to be tapered rather than just stopped), with some antidepressants such as paroxetine (Paxil), and with beta-blockers in patients with heart disease. As a result of the change in addiction terminology in 1994, someone who was addicted to an opioid was called "opioid dependent," and so were most compliant opioid-treated chronic pain patients who were physically dependent. It is known that opioids may lead to both addiction and physical dependence but being physically dependent does not mean the person is addicted.

Both the DSM-4 criteria, as well as the current DSM-5 version released in 2013, require three elements to diagnose substance use disorder (ie, addiction):

- loss of control (also termed compulsive use)
- continuation despite significant adverse consequences
- preoccupation or obsession with obtaining, using, and recovering from the effect of the substance.

Addiction is a behavioral disorder, as seen from the elements above, and thus represents a different phenomenon from physical dependence and withdrawal. Yes, most patients on chronic opioids do develop a physical dependence on opioids (and thus

Opioid Addiction Terminology: A Brief History

Based on the *Diagnostic and Statistical Manual of Mental Disorders (DSM)*, of the American Psychiatric Association (APA)

1952 – 1993: The DSM I, II, and III, termed addictive substance disorders, including opioid addiction, as "addiction."

1994: The DSM-4 relabeled substance "addiction" as "dependence" meaning a heroin addict would be called "opioid dependent."

2013: The DSM-5 introduced the term Opioid Use Disorder (OUD) to describe opioid addiction. The term "dependence" was dropped from the manual altogether; neither "opioid dependence" nor "drug dependence" can be found in its extensive index. Given that the main characteristic of physical dependence is the presentation of withdrawal symptoms upon stopping the substance, the DSM-5 does note that "withdrawal" is one of the 11 criteria for diagnosing OUD, stating: "This criterion is not considered to be met for those individuals taking opioids solely under appropriate medical supervision." In other words, the APA is noting that physical dependence is not a criterion for addiction in patients being prescribed opioids.

withdrawal symptoms), but for such patients, the current DSM-5 guideline (see below) specifically says that "this criterion [withdrawal] is not considered to be met for those individuals taking opioids solely under appropriate medical supervision."[3] In other words, any withdrawal symptoms in a patient on prescribed opioids are not a tell-all sign of addiction.

What about the definition confusion? The solution enacted by psychiatrists almost 20 years after their disruptive change in terminology, was once again to change the name of addiction – this time to Substance Use Disorder, the official term used in the DSM-5, which was published in 2013. For opioid addiction, specifically, they introduced the term Opioid Use Disorder (OUD) while entirely deleting any mention of the term "dependence."

But the term dependence, meaning addiction, was so entrenched by then that even the FDA in 2016, as shown in the language used in their approval of Probuphine,[1] was still using the term dependence when they meant addiction. In fact, they approved Probuphine for the treatment of Opioid Use Disorder (OUD) which is how the drug is used in practice today.

Consequences for the Patient and Public

The misunderstanding between physical dependence and addiction has had negative consequences far beyond confusion in medical records and scholarly papers. A major consequence is that the majority of prescribers, the lay public, the media, and government officials still believe that a majority of patients on chronic opioids become addicted. For example, a 2018 study[4] of almost 400 prescribers found that, when asked their belief about this statement, "I anticipate that my patient will become addicted to the opioid that I am prescribing for him/her for chronic pain," 60% said "always," 23% said "sometimes," and 40% said "rarely or never."

The reality is that several studies have shown that the likelihood of addiction to opioids from prescribed opioid therapy is closer to 2 to 5%. Nora D. Volkow, MD, director of the National Institute on Drug Abuse, part of NIH, wrote, "Although published estimates of iatrogenic addiction vary substantially from less than 1% to more than 26% of cases, part of this variability is due to confusion in the definition. Rates of carefully diagnosed addiction have averaged less than 8% in published studies."[5] She stated in the same paper, "Addiction occurs in only a small percentage of persons who are exposed to opioids — even among those with pre-existing vulnerabilities."[5]

A review of the likelihood of developing addiction found that "incidence ranged from 0 to 24% (median 0.5%); prevalence ranged from 0 to 31% (median 4.5%).[6] Note that the average risk was 0.5 to 4.5%, even though some studies found a figure of 24% or 31%. Those high figures most likely were conflating addiction with physical dependence. •

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