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Commentary on O'Brien's "Addiction and Dependence in DSM-V": There is potential for cultural and social bias in DSM-V

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Keywords

DSM-V; alcohol disorders; bias

This comment focuses on the applicability of O'Brien's [1] discussion of the DSM-V nomenclature for substance use disorder, particularly the use of the words "addiction" and "dependence", to the U.S. population of Latin American origin (Hispanics or Latinos). This group constituted about 15% of the country's population in July 2007 [2] and is projected to increase to 30% by 2050 [3]. The discussion about the meaning of "addiction" and "dependence" is both important and well intentioned. It is also U.S. and English-centric, and as such, not necessarily applicable to immigrant groups in the U.S. such as Hispanics. While many in this group are fluent in English, many are not, and irrespective of language use, Hispanics as a group remain strongly connected to their Latin cultural roots. Further, it is quite plausible that the concerns with word meaning expressed by O'Brien are also not applicable to Spanish and Portuguese-speaking countries in Latin America and Southern Europe, such as Portugal and Spain.

Obviosuly, the lack of relevance stems from the different words used to identify alcohol and drug use disorders in English, Spanish and Portuguese. Both in Spanish and Portuguese, the words "addiction" and "dependence" are recognized and used. In Spanish, they translate as "addicción" and "dependencia"; in Potuguese as "adicao" and "dependencia". However, there also are other words used to designate alcohol or drug dependence in Spanish and Portuguese, which are usually considered more pejorative than these two. I am thinking here of Portuguese words such as "toxicomano" (toxicomaniac), "drogado" (drugged, but indicating a permanent state) or "viciado (from the Latin vitiosus, meaning "corrupt, full of faults"). The words "toxicomano", "tecate" and "drogado" are also pejorative in Spanish.

I suspect that for professionals working with Spanish and Portuguese speaking populations in the U.S. and other countries, issues about the cross-cultural applicability of the proposed DSM-V concept of substance use disorder are probably more important than the discussion around the meaning of the terms addiction and dependence. Past research shows that the frequency with which different indicators of abuse and dependence occur and the interpretation of the meaning of some dependence indicators varies across cultures [4-6]. For instance, the WHO's Cross-Cultural Applicability Study (CAR), conducted in 9 countries, reported that tolerance to alcohol was seen as a positive characteristic in Mexico. Compulsion to drink and craving were recognized as problems but seen as synonyms of dependence or impairment of control. Preoccupation in obtaining alcohol was not seen as a

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problem in “wet” societies such as Spain, where alcohol can be purchased so easily at all times that no one would be “preoccupied” in obtaining it. The threshold at which symptoms were recognized was dependent on how “wet” or “dry” a given society was, with “dry” societies operating at a lower threshold than wet ones.

Cross-cultural differences also affect the identification of diagnostic categories, such as alcohol abuse, across U.S. ethnic groups and across countries. For instance, in the U.S. general population, 69% of alcohol abusers are so identified based on positive reports of hazardous drinking (drinking and driving in most cases) [7-8]. The proportion of alcohol abusers identified by this criterion alone among U.S. Hispanics is 36% and in Brazil it is 27% [9]. The difference between the overall rate for the U.S. and that among U.S. Hispanics is most probably due to diminished access to cars among the latter. The difference between the U.S. and Brazil is due to less access to cars plus less strict enforcement of drinking and driving laws. Thus, the diagnosis of alcohol abuse by virtue of the cultural centredness of the hazardous drinking indicator became culture-bound, something that should not happen with a medical diagnosis category [9].

In the proposed DSM-V, the criteria that are now part of DSM-IV alcohol abuse will become indicators of the new alcohol use disorder diagnosis. These criteria, such as hazardous use, carry a strong potential for cultural and or social bias, which will certainly affect this new DSM-V diagnostic category. Further, given that the presence of 2 criteria is enough to warrant a positive diagnosis of alcohol use disorder in DSM-V, many individuals may be positively diagnosed solely based on criteria that are subject to cultural and social bias. The obvious remedy for this is to exclude such criteria from the diagnosis, retaining only psychiatric symptoms that indicate biological pathology, and problems in behavioral or psychological functioning.

The applicability of DSM-V terminology to U.S. ethnic populations is a legitimate concern. In this regard, it is unfortunate that the DSM-V field trials proposed by the American Psychiatric Association (APA), as described in the DSM-V website [10], do not seem to pay attention to the cross-ethnic applicability of DSM-V to ethnic groups in the U.S. Finally, some may think it is perhaps unfair to extend concern about DSM-V applicability to populations outside the U.S. borders. After all, the DSM-V is the product of the APA, and not of an international organization such as the World Health Organization, which is responsible for the International Classification of Diseases. Still, DSM diagnostic criteria have been applied internationally in Latin American, Asian and European nations [e.g., 11]. Because of the influence of American psychiatry, the DSM has become almost like a de facto international psychiatric classification. So, I think it would be fair to say to the framers of DSM-V: “For unto whomsoever much is given, of him shall be much required” (Luke 12:48).

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