The Role of Diagnostic Systems in the Continued Stigmatization of Patients With Opioid Dependence

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Since the Harrison Act of 1914, in which physicians were essentially outlawed from using opioids to treat opioid-dependent patients, individuals struggling with opioid addiction have been treated differently from those addicted to other substances. In 1919 the United States Treasury Department created the Narcotics Division to oversee efforts to stop physicians from treating opioid-addicted individuals with opioids if the patients had no problem except addiction. As a result, many physicians were arrested and, by 1925, all known "maintenance clinics" had been closed. In the late 1960s methadone treatment was limited to specific, highly regulated clinics, which only helped increase the stigma of opioid addiction in the eyes of the general public, the medical community, and in many cases the addicted individuals themselves. Recent changes in federal regulations governing methadone clinics and the introduction of office-based treatment with buprenorphine have helped to lessen some of this stigma, but current widely used diagnostic schemes continue to support a bias against patients with opioid dependence who are being effectively treated.

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DSM-IV-TR

DSM-IV-TR (1) is the major diagnostic classification system used to diagnose substance use disorders in the United States. Compared with earlier versions, such as *DSM-III* (2), in which either tolerance or withdrawal was a necessary criterion for the diagnosis of substance dependence, subsequent versions of *DSM* have placed a stronger emphasis on the substance-related impairment in functioning than on the presence of tolerance or withdrawal. This useful shift in thinking helped to facilitate the identification and appropriate treatment of more individuals with substance use problems.

Unfortunately, despite the positive changes, later versions of *DSM*, such as *DSM-IV* and *DSM-IV-TR* (1,3), included "on agonist therapy" as an additional course specifier, which appears to apply to a single class of substances, opioids. Although the wording is somewhat unclear, *DSM-IV-TR* does not appear to allow for persons with a diagnosis of opioid dependence who are receiving agonist therapy, such as methadone, to be considered to be in remission from their opioid dependence until they have stopped receiving the agonist therapy for at least one month. This additional specifier also applies to partial agonists, such as buprenorphine, but not, interestingly, to antagonist therapies, such as naltrexone. Earlier versions of *DSM* differed because they allowed for all individuals with a diagnosis of a substance dependence disorder to be in remission if they no longer met the criteria for the disorder.

None of the descriptions of other substance use disorders in *DSM-IV-TR* mention whether or not a patient is receiving medication. When naltrexone is used to treat alcohol dependence, no qualifier, such as "on anti-craving or reinforcing therapy," is used, nor is there a comparable qualifier when disulfiram is used. Similarly for nicotine dependence, *DSM-IV-TR* appears to allow for an individual to be considered in full, sustained remission whether or not they are taking bupropion. In fact, *DSM-IV-TR* does not appear to apply the qualifier of "on agonist therapy" to nicotine dependence. A person could be using nicotine gum or a patch and still be considered to be in remission.

In addressing other psychiatric conditions, *DSM-IV-TR* allows for the patient to be considered to be in remission as long as no symptoms are experienced for a specified amount of time. With major depressive episode, for example, "full remission" requires a period of at least two months in which the patient has no significant symptoms of depression. Both bipolar disorder and schizophrenia allow for "partial remission" and "full remission." Recurrent major depression and bipolar disorder also allow for the specifier of "full interepisode recovery." Schizophrenia allows for the specifier of "with no interepisode residual symptoms." For the single episode and chronic categories, the qualifiers are strictly based

on the absence of specific symptoms of the disorder, with no mention of whether the patient is receiving pharmacologic—or for that matter, psychosocial—treatment.

ICD-10

The other major system used internationally for the classification of substance use disorders is *ICD-10* (4). Rather than using the term "in remission," *ICD-10* uses the term "currently abstinent" as a qualifier for persons who are not exhibiting the signs and symptoms of substance dependence. Like *DSM-IV-TR, ICD-10* provides a separate, apparently mutually exclusive, qualifier for persons receiving methadone: "currently on a clinically supervised maintenance or replacement regime (controlled dependence)." As with *DSM-IV-TR,* the person is not considered to be currently abstinent from the original substance of abuse, such as heroin, if he or she is taking methadone. In addition, the term used in parenthesis, "controlled dependence," confuses the two primary meanings of the word "dependence": the definition used to describe addiction—a behavioral syndrome—and the definition used to describe physical or physiologic dependence with no impairment in functioning—"neuroadaptation."

ICD-10 also has a separate qualifier code for "currently abstinent, but receiving treatment with aversive or blocking drugs," which might be used for an individual with heroin dependence who is taking naltrexone or, presumably, for a person with alcohol dependence taking disulfiram. This qualifier appears to take a somewhat intermediate position in which there is acknowledgment that the individual is currently not using the drug of choice and is presumably not experiencing negative consequences from it. However, "currently abstinent" is instantly qualified and partially negated with the term "but receiving treatment with aversive or blocking drugs." This qualifier implies that somehow the treatment is inferior to other treatments and that the individual's abstinence is inferior to that of the individual who is not taking a medication to treat their substance dependence.

In a separate but related discrepancy, it is not clear whether this qualifier would be used to describe the individual with alcohol dependence who is taking naltrexone. In this case, it is not clear that the relevant mechanism of action for the medication is directly related to its mu-opioid receptor blockade. Does the opioid-dependent individual taking naltrexone have a different type of "current abstinence" than the alcohol-dependent individual taking the same medication?

As with *DSM-IV-TR, ICD-10* does not mention the absence of medication when qualifying remission in any psychiatric disorders other than opioid dependence. In fact, for both recurrent depressive disorder and bipolar affective disorder, the remission criterion specifically states that "the patient may, however, be receiving treatment to reduce the risk of future episodes."

In other areas of medicine, *ICD-10* also allows for a diagnosis of "in remission" with no requirement for the person to be free of medication or other treatment. Leukemia, both acute and chronic, can be diagnosed as being in remission, as can multiple myeloma. As with schizophrenia, mania, and depression, the specifier for being in remission from leukemia does not mention whether or not the patient is taking medication.

A need to change our thinking and our terminology

There may be some reluctance to say that a person with a history of opioid dependence is in remission while receiving agonist therapy, because he or she continues to have physiologic dependence. This viewpoint finds itself on the other side of the slippery slope on which many patients with pain syndromes that require treatment with opioids find themselves, confusing the term "dependence" as applied to physiologic dependence with the term "dependence" as applied to addiction. Patients, health care professionals, and the general public who are already confused and ambivalent about this issue are not helped by the current failure of our diagnostic schema to allow a patient who is receiving agonist therapy to also be considered in remission.

Besides the potential message that the current diagnostic standards send—that opioid dependence is different from all other substance dependence disorders, as well as from other psychiatric disorders and medical disorders—these standards can also affect individual patients in a negative way. When filling out social services forms for a patient with a history of opioid dependence who is doing very well on a methadone program, a physician has the choice of writing "on agonist therapy," which the patient may or may not want disclosed, or nothing at all, with the possible implication that the illicit opioid use is still problematic. The fact that a patient receiving agonist therapy is doing well and is no longer exhibiting symptoms of opioid dependence, per *DSM-IV-TR* or *ICD-10,* cannot be documented with the clear "in sustained full remission" as it can be with any of the other substance dependence disorders.

With the increasing number of opioid-dependent patients receiving agonist and partial agonist therapies for their addiction, it is time that we rethink the unique position that opioid dependence appears to hold in our diagnostic schemes. No matter what treatment a patient uses, the patient who is doing well and meets no criteria for dependence, except for tolerance and withdrawal, as defined by *DSM-IV-TR* or *ICD-10,* should be allowed to be considered to be "in remission." The qualifiers for the diagnosis, as with all other diagnoses, should be based on the patient's behavior and not on the treatment. Persons with a diagnosis of opioid dependence already tend to be viewed differently from individuals with other substance dependence disorders. As health care professionals, the least we can do is try to minimize the stigma that is conveyed in such a basic thing as our diagnoses. ♦

References

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