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Addiction: Challenging the dual diagnosis construct

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The current 'official' nosology (e.g. DSM-IV) of addiction is largely limited to manifestations that can be objectively observed and suited to the maintenance of an 'atheoretical' perspective. However, addicted subjects display other psychic symptoms (in particular, those related to mood, anxiety, or impulse-control dimensions) that affect their well-being and social functioning. In practice, these symptoms are typically considered as being 'comorbid', thereby contributing to multiplying comorbid diagnoses in addiction. However, a close relationship can be detected between these symptoms and addiction, as underlined by the high frequency of association with that disorder, and by their strong neurobiological and neuropsychological links.

There are several reasons for taking these symptoms into account in clinical presentations of substance-use disorders.

First, the pre-existence of psychic precursors. Even if they are essentially viewed as the result of drug effects, af-

fective, anxiety and antisocial-related symptoms may precede drug abuse and work as a specific risk factor in addiction. A psychiatric diagnosis may be absent, but specific psychological/psychiatric vulnerabilities such as dysmodulation in motivation and reward, stress resiliency, mood reactivity, impulsiveness-control imbalance, temperamental assets, and subthreshold mental disorders may constitute a background for the development of addictive disorders, by exerting an impact on willingness to try drugs and/or the progression to addiction [5, 6, 13].

Second, the short-term consequences of the interaction between psychopharmacologically active substances and their neurobiological substrates may have connections with vigilance, orientation, perception, cognitive functions, affects and mood, ways of thinking, and will. Psychiatric symptoms that accompany the use of specific substances, including irritability, sleep difficulties, anxiety, and attention/

concentration problems, are not necessarily so intense as to warrant a 'disorder' level; however, they may substantially contribute to compromising the individual well-being and social functioning of people with addictive disorders.

Third, more stable psychopathological manifestations depend on the prolonged interaction of substances with a predisposed neurobiological substrate and its active reaction. The resulting changes may not only justify the strictly behavioural presentation of addiction as a specific disorder – and psychological/psychiatric correlates such as craving and dyscontrol –, but also the onset/worsening of other psychiatric symptoms. Hypofunction of limbic dopamine circuits, hypoactivity of prefrontal brain regions, changes in the reward and stress systems, and gene expression dysregulation, are all potential candidates underlying depression, dysphoria, anxiety and impulsiveness preceding addiction, featured moreover as an outcome of addictive processes [1, 2, 14].

Fourth, clinical manifestations produced as a consequence of addictive processes do not seem to merely add to those previous encounters with substances. Interactions between the above factors should be considered, particularly in view of the fact that while predisposing psychic conditions may facilitate substance use and activate addictive processes, these, in turn, by acting on the same neuronal background, induce a worsening of psychic conditions in the same domains [3, 4, 10-12].

DSM nosology does not seem to grasp the complexity of the interaction between the psychic structures involved, and neurobiological and physiopathological processes activated by encounters with substances of abuse. On these bases, an integrative unified perspective explaining the pathophysiology and phenomenology of addiction has been proposed [7-9].

The validation of an articulated clinical condition, encompassing part of the grey area of symptomatology that exists between addiction itself and other 'independent' psychopathologies would certainly imply the need to carry out specific research programmes. In the meantime, the possible benefit afforded by mention of the presence of symptoms pertaining to the domain of impulse-control, anxiety and mood spectrum in the DSM V description of substance-use disorders should be taken into consideration. Even in the absence of their specific inclusion among diagnostic criteria, the act of signalling their presence could induce clinicians to refrain from making possibly inappropriate dual or multiple diagnoses, encourage an integrated evaluation of symptoms consistent with psychic precursors, substance effects, addictive processes and psychic consequences, thus allowing a more comprehensive and appropriate treatment.

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