DISCUSS THE VALUE OF A SPECIFIC DIAGNOSTIC CATEGORY IN CURRENT PSYCHOLOGICAL PRACTICE

Introduction

The Diagnostic Statistical Manual (DSM-IV-TR, 2000) dictates that certain criteria must be met in order to diagnose a person with alcohol dependence. The assessment and diagnosis of mental illnesses and disorders are an essential element to ensuring treatment is focused in the appropriate direction and to maximise therapeutic effectiveness. Although use of the Diagnostic and Statistical Manual (DSM) is clearly evident in mental health practice, there are those professionals who question whether the DSM is being utilized properly.

This assignment will discuss a number of issues. Initially, a definition of alcohol dependence will be described, followed by a discussion of the strengths and limitations of using the DSM for diagnosing mental illness/disorders. Next, a critical look at the disease model will be presented, and then finally I will discuss the multicultural approaches to alcohol-related issue.

Definition of Alcohol Dependence

Alcohol Dependence is recognised by the American Psychiatric Association (APA) as an alcohol-use disorder. It is defined in the DSM as a cluster of cognitive, behavioral and physiological symptoms (American Psychiatric Association, 2000 p.192) that results in a prolonged and noticeable reduction in the person's ability to function psychologically, socially, or occupationally or otherwise negatively affects the areas of the individual's family, health or financial security (Burman, 1994).

Whilst this definition has some important components, I do not think it matters whether the need for alcohol is physical or only psychological. The effect is the same, as the person may have a regular need for whatever alcohol provides for them (e.g. to calm the nerves or relieve stress). To argue that a person is not an alcoholic because their need is only psychological or they are only a problem drinker becomes a mute point.

Strength and Limitations of the DSM system of diagnosis

The concept of alcohol dependence in the DSM has developed measurably since the first edition. These changing concepts have mirrored and helped shape the way the research and clinical communities think about alcohol dependence (Crowley, Helzer, Nathan, Schuckit, & Woody, 1991). There are many strengths and limitations of the DSM.

Strengths: I view the DSM as a simplistic checklist (of symptoms) which offers a starting point for diagnosis and therapeutic intervention and allows for some consistency in understanding between mental health professionals, particularly amongst multidisciplinary teams (e.g. psychiatrist, psychologist, social worker, occupational therapist) (Eriksen & Kress, 2005). The DSM provides a label for a client's experience; this may be beneficial as the client has a name for what they are experiencing which can be empowering for some. For some client's, the DSM can provide their friends and family with an opportunity to learn more about their illness or disorder, allowing them a great understanding of their experiences (Anderson, Reiss & Hogarty, 1986, cited in Eriksen & Kress, 2005). Furthermore, the DSM introduces a holistic approach to diagnosis. Axes III, IV and V are not diagnostic (not a checklist) which allows for more detail and in conjunction with the diagnostic Axes I and II it provides a more complete picture of the client leading to a more accurate diagnosis(American Psychiatric Association, 2000) .

Limitations: Individuality of the client can be limiting; a checklist of symptoms may be easy and convenient to use but it does not allow for discovering the "essence of the person" or to consider other influential factors such as culture, financial stability or availability of support networks (Eriksen & Kress, 2005). Labeling is disempowering and stigmatizing; once a person is labeled it can be viewed as something that is permanent and a person may begin to identify themselves as their disorder. In addition, a DSM diagnosis often results in the person experiencing stigma from others due to society's lack of knowledge and understanding and negative media coverage of mental illness/disorders (e.g. a person who has killed someone who happens to be schizophrenic is portrayed as "…a schizophrenic today killed…"). The DSM focuses only on people's inadequacies - people's strengths are not considered, thereby treating people as "someone who is somehow imperfect" not as a complete person with strengths and weaknesses. Furthermore, people sharing the same diagnosis/label may not have the same etiology, or need the same treatment (as the DSM contains no information on treatment or cause for this reason) (Eriksen & Kress, 2005). The DSM has a very strong western viewpoint in that it is written by a western society (America) for western societies and predominantly does not allow for other cultural groups e.g. eastern societies.

These are only a few strengths and limitations of the DSM but it provides some factors to be considered during assessment and before diagnosing a client.

The Disease Concept

The DSM-IV criteria for substance dependence support the disease model of addiction, in that the person is viewed as a passive recipient of a disease, over which he or she has no control (Crowley, Helzer, Nathan, Schuckit, & Woody, 1991). Gorski (1996) proposed that "*it is appropriate to describe people with severe alcohol problems that met the DSM-IV criteria of substance dependence as having a disease*".

The disease model of addiction views alcohol dependence to be a biological disease that involves a loss of control over the behaviour, and believes that total abstinence or treatment is the only effective cure. According to the disease theorists, such loss of control is evidence of the physiological 'need' for alcohol and therefore alcohol dependence is the product of a physiological craving for alcohol (Burman, 1994).

That aside, genes have long been suspected to play a role in the etiology of alcoholism. Genetic influences first were suggested in family studies demonstrating that the incidence of alcoholism among relatives of alcoholics is several times higher than that observed among relatives of non-alcoholics (Cotton 1979). Since then, genetic influences have been confirmed in studies of adopted children whose biological parents were alcoholic in the studies of twins (Burman, 1994).

Regardless of its benefits, the disease model perspective is unable to adequately account for alcoholism. I think that as society changes, so too does our cultural milieu, as there is increasing emphasis on lifestyle values with much importance on health, nutrition, and physical fitness. In this type of environment, alcohol dependence may be viewed as a personal failure in adequately caring for oneself (Niedermayer, 1990).

Personally, I do not view alcohol dependence as a disease, but I strongly believe it is a serious problem. I believe people suffering from alcohol dependence are like the rest of society; they suffer from problems. Their troubles may be different from others but the differences are often only surface and not necessarily qualitative. There problems may include a different genetic makeup, a particular family background, cultural or historical factors, different attitudes, and different demands from their peer groups, financial difficulties, or unemployment. They differ only in that their attempt to find a solution to their problems led them to alcohol dependence, and in the process they added one more problem to their list: alcoholism (Burman, 1994).

There are a number of theoretical flaws in the disease model that not only deny its validity as a scientific model, but also limit its practicality of researching, identifying, or treating alcoholism (Niedermayer, 1990).

The approach taken by the DSM-IV-TR and Gorski (1996) supports the notion that dependence on alcohol or other substances is irreversible due to the diseased nature of the diagnosis, and that the person would need treatment in order to recover from their disease. Ironically, it is also insinuated in many treatment programs such as Alcoholics Anonymous (AA) that this recovery process would last for the entirety of one's life span, and that one will never fully recover from their addictive behaviours (Niedermayer, 1990). Peele (1989) argues that Alcoholics Anonymous (AA) and for-profit alcohol treatment centres promote the "myth" of alcoholism as a lifelong disease. He challenges the disease concept by saying that it "*excuses alcoholics for their past, present, and future irresponsibility" and points out that most people can overcome addiction on their own"*. Interestingly, a poll found that almost 90 percent of American people believe that alcoholism is a disease. In contrast a survey of physicians reported that 80 percent of responding doctors perceived alcohol dependence as simply bad behaviour (Gallup Poll, 1997)

Walsh (1985, cited in Peele, 1989) supports the argument that physicians have negative views about alcoholics. He cites empirical data showing physicians continue to have stereotypical attitudes about alcoholics and that non-psychiatrists tend to view alcohol problems as principally the concern of psychiatrists. He also argues that many doctors have negative attitudes towards patients with alcohol problems because the bulk of their clinical exposure is with late-stage alcohol dependence (Niedermayer, 1990).

Lastly, the disease theorist explains that some people who are abusive drinkers can be taught to drink in control. It argues that they are not alcohol dependent but only heavy drinkers. The theory therefore differentiates between problem drinkers and alcoholics. Such a differentiation allows a

convenient loophole for those alcoholics who wish to define themselves as merely problem drinkers (Milam and Ketcham, 1985, cited in Niedermayer, 1990). In this way, they can attempt to avoid treatment or counseling. Ambiguity does the theory no service at all. It only services to limit the applicability of the disease perspective in excluding definite cases of alcohol abuse by labeling these cases as non-alcoholic abuse (Niedermayer, 1990).

It is obvious that there are serious limitations to the disease model yet this model is not without its own merit. I believe it is important to carefully incorporate the best of the old models when trying to develop a new perspective. The disease model specifically has an advantage in that it removes the blame from the alcoholic and places them on other factors. The focus that the disease model puts on physiology should not be ignored, yet such a single focus is less than fair to the other factors contributing to the overall problem of alcohol dependence (Burman 1994).

Multicultural Approaches

Alcohol plays a significant role in most cultures across the world. The impact of alcohol varies between countries and regions due to different levels of its use by populations, and differences in population age structures and disease patterns (Peele, 1984).

Current social environment was found to be the most powerful predictor of drinking problems (Cahalan & Room, 1974). Social drinking has been identified not only as a key to causing drinking problems but as a force in socializing moderate drinking and modifying alcohol problems (Jessor & Jessor, 1975; Harford & Gaines, 1982; Zinberg & Fraser, 1979, as cited in Peele, 1984). The idea of using drinking environments to prevent the development of unhealthy drinking styles in the young remains a strong drive in social learning approaches

to alcoholism, one that has continued to exist despite a rising tide of disease conceptions (Peele, 1984).

Studies have found that demographic groups play an important role in alcohol dependency. It was identified that youth, lower socioeconomic status, minority status (black or Hispanic), and other conventional ethnic categories (Irish versus Jewish and Italian) as predicting drinking problems (Cahalan & Room, 1974). Greeley, McCready, and Theisen (1980, cited in Peele, 19984) continued to find "ethnic drinking subcultures" and their relationship to alcohol problems to be enormously resilient and to have withstood the otherwise apparent assimilation by ethnic groups into mainstream American values. Cahalan and Room (1974) also revealed an inconsistent tendency for drinkers from conservative Protestant sects or from dry regions to be binge drinkers. The predictive power of demographic traits is not limited to problem drinking or alcoholics seeking treatment. Vaillant (1983) found Irish Americans in his Boston sample to be alcohol dependent, seven times as often as those from Mediterranean backgrounds (Greeks, Italians, and Jews), and those in Vaillant's working class sample were alcohol dependent more than three times as often as those in his college sample (Peele, 1984).

In the United States, the availability of alcohol, has been linked to patterns of alcohol-related traffic crashes in communities (National Institute on Alcohol Abuse and Alcoholism, 2002) (NIAAA, 2002), as measured in terms of the geographic spread of alcohol sales outlets. Research has shown that greater mass of liquor stores are found in segregated minority neighborhoods. However, the apparent association between minority status and alcohol problems in some areas may reflect the disproportionate concentration of alcohol outlets in low-income communities rather than ethnicity per se (National Institute on Alcohol Abuse and Alcoholism, 2002).

As a New Zealand-born Samoan, acculturation has contributed to the drinking patterns of my own extended family members, who have come from Samoa, and adopted the values and beliefs of the 'kiwi' culture, and indulging in excessive drinking (a behaviour that is rarely seen or suppressed in traditional village life in Samoa). For my family members it was more about "fitting in" and absorbing and accepting the New Zealand lifestyle, although my younger relatives probably view it as "freedom". According to Johnson (1998, as cited in NIAAA, 2002), acculturation also is influenced by gender, religious beliefs, family traditions, personal expectations, and country of origin. Some researchers have advanced the concept of "acculturation stress," whereby drinking increases in response to the conflict between traditional values and beliefs and those of the mainstream culture. On the other hand, others have pointed out that many people, especially youth, learn to draw on support and resources from both cultures for protection against alcohol problems (Kim**,** Coletti, Williams, and Hepler, 1995, as cited in NIAAA 2002).

From my perspective, the cultural diversity of the New Zealand population has received little emphasis in the establishment of drug and alcohol services in this country. Little thought has been given to the values and heritage that dominate among different cultural communities, with the majority of drug and alcohol services available reflecting broader New Zealand community values. I believe that consulting with people of non-English-speaking background regarding alcohol-related problems, the prevention and treatment efforts may be more effective if it was based on an understanding of the ethnic context of drinking behaviors and their development.

One particular drug and alcohol prevention program in Auckland, Community and Alcohol and Drugs Services (CADS) has demonstrated success in the general population and have

championed the very first government funded Pacific unit which is catered more in cultural relevance for the various ethnic Pacific groups.

Conclusion:

The debate on whether alcohol dependence is a disease or a personal conduct problem will always be a continued discussion.

Some people believe that if alcohol dependence is viewed as a disease, then it is suggested that there condition is 'treatable', but sadly this is understood from a seemingly passive point of view. It is probably better to view addictive behaviour as a result of an interaction between ones environment, situation, and experience (Niedermayer, 1990).

My view is this. Alcoholics can recover from the devastating and debilitating condition. I believe they can resume their roles as fully functioning members of society, in family, occupational and social areas. There is probably a lack of understanding of the treatment or recovery by the alcohol dependents themselves, their families and friends and their employers and work colleagues. My answer to bridging this gap, is continuous education.

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