DSM-5: Changes in Substance-Related Disorders

Presented by Dr. Deborah S. Hasin
OVERVIEW

The “Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition,” is the American Psychiatric Association's classification and diagnostic tool. In the U.S., the DSM serves as a universal authority for psychiatric diagnosis. Treatment recommendations, as well as payment by health care providers, are often determined by DSM classifications, so the newest version has significant practical importance. After 20 years with DSM-4, it was updated in 2013. This session offers a look at the recent changes to the DSM-5 and its new criteria as it relates to “addictions and related disorders.”

CONTEXT

The purpose of this session is to provide an explanation about the changes in criteria to the DSM-5 by one of the people who contributed expertise to the process. The DSM is an instrument used for different purposes, and sometimes those purposes don’t align for all of the users.

Time for a Change: DSM Upgrade

DSM-5: AN INSTRUMENTAL TOOL

Although the DSM-4 was the standard in diagnostic tools, it had been around since 1994 and was overdue for an upgrade. NIH, WHO and APA planning conferences took place between 2003 and 2008. In 2008, more than 30 workgroups convened to offer updates for the different sections. During this period, the DSM-5 website received more than 500 comments. After the review period, final decisions were made in December 2012. The new DSM-5 was published in May 2013 to some controversy, which was a surprise to those who had carefully crafted the changes.

“Quite a lot of time and work went into this. And we made presentations to more than 30 audiences to get input.”

DSM-5 SUBSTANCE DISORDER WORKGROUP MEMBERS

- Charles O’Brien, M.D., chairman
- Mark Aricombe, Ph.D.
- Guillaume Borges, Ph.D.
- Katharine Buchholz, Ph.D.
- Alan Budey, Ph.D.
- Thomas Crowley, M.D.
- Wilson Compton, M.D.
- Bridget Grant, Ph.D.
- Deborah Hasin, Ph.D.
- Walter Ming, M.D.
- Nancy Petry, Ph.D.
- Marc Schukit, M.D.
**SUBSTANCE USE DISORDER CRITERIA**

It’s worthwhile to take a look at the old criteria for DSM-4. Many clinicians seldom used the criteria themselves, and it allowed clinicians to classify mild cases as abuse and serious cases to be dependents. And they didn’t need to click through the criteria to make those assessments.

**To classify abuse, you only needed one or more of the following:**

- Failure to fulfill major role obligations;
- Hazardous use.
- Substance-related legal problems;
- Social/interpersonal substance-related problems.

**To classify dependence, you only needed three or more of the following:**

- Tolerance;
- Withdrawal;
- Persistent desire/unsuccesful efforts to cut down;
- Using more or over for longer than was intended;
- Neglect of important activities;
- Great deal of time spent in substance activities;
- Psychological/physical use-related problems.

*If you had dependence, you couldn’t be diagnosed with abuse.*

**Issues to Address**

**ABUSE VS. DEPENDENCE**

Many professionals began debating issues surrounding the substance-related abuse, specifically:

- Should abuse be combined with dependence to create a single disorder?
- Should new criteria be added or old criteria be removed?
- Can nicotine criteria be aligned with other substances?
- Can cannabis withdrawal be included?
- What should be the diagnostic threshold?
- How to indicate severity?
- Should nonsubstance “addictions” be included?

**DIAGNOSING SUBSTANCE DEPENDENCE & ABUSE AS SEPARATE DISORDERS IS PROBLEMATIC**

- Confusion about relationship of abuse to dependence because abuse is assumed to be milder than dependence, which leads to thinking abuse is prodromal to dependence and that all cases of dependence meet criteria for abuse;
- Reliability and validity of dependence is excellent;
- Reliability and validity of abuse is much lower, more variable than dependence;
- 50 percent diagnosed with abuse met only one criteria: hazardous use, which lead to diagnostic “orphans.” They wouldn’t be eligible for dependence if you were following criteria carefully.

“This is a diagnosis you could hit with a hammer and it wouldn’t break.”
WORKGROUP ANALYSIS: ADDING AND SUBTRACTING CRITERIA

**ANALYSIS METHOD: ITEM RESPONSE THEORY**

- Many factor analyses showed abuse and dependence criteria formed 1 factor, or two highly correlated factors;
- Item Response Theory analysis extends factor analysis, providing more information;
- Item characteristic curves (graphed) show relationship of abuse and dependence criteria to each other;
- Total information curves (TOC) allow comparison of two or more sets of criteria.

**ABUSE & DEPENDENCE STUDIES: MORE THAN 200,000 PARTICIPANTS**

Statistical studies were taken from committees or otherwise published from Australia, Israel, Poland, Mexico, France and the U.S. It was important to use these worldwide studies so that it wasn't considered idiosyncratic to the United States.

**RESULT:** After studying the results of the criteria, they decided to combine abuse and dependence into one diagnosis.

**LEGAL PROBLEMS**

Definitely a serious problem for some substance abusers, but should it be a criterion for substance use disorders?

Clinical concerns about dropping criteria:
May be the only thing clients will admit and may be the only thing qualifying patients for reimbursement.

**CONCLUSION:** Regarding legal problems, drop from DSM-5 list of substance disorder criteria.

**SHOULD CRAVING BE CRITERIA?**

Craving is a serious problem for some substance abusers, but should it be a criterion for substance use disorders? Craving is already a dependence criterion in ICD-10, and it will presumably be retained in ICD-11.

- Craving is seen as a promising target for pharmaceutical intervention
- Craving may arise in conjunction with stress and substance cues
- Craving of interest because of neural basis, as show in brain imaging studies
- Relationships ad methodology are complex

**QUESTIONS TO CONSIDER**

- Is it unidimensional with other criteria?
- Does it have reasonable severity and discrimination?
- Does it add information to the existing criteria set?

**CRAVINGS: PROS VS. CONS**

**Pros**
- Unidimensional with existing criteria
- Addition aligns DSM-5 with ICD-10
- Well received by clinicians

**Cons**
Nicotine: Abuse, Dependence, Craving

NICOTINE USE DISORDERS

Could DSM-5 criteria be aligned with the other substance use disorders?
- In DSM-4, dependence only, not abuse
- Expert opinion 25 years ago: Abuse criteria don’t apply to nicotine
- This picture appears differently today
- Nicotine experts are interested in craving

*CONCLUSION: Align nicotine disorder criteria with those for alcohol and drugs.

Cannabis

CANNABIS WITHDRAWAL

There’s a ton of information and evidence supporting cannabis withdrawal, however, findings from analysis and graphic inspection do not indicate continuous condition. Basis for threshold therefore:
- Diagnostic cut-off providing best agreement between prevalence of DSM-5 substance use disorder and prevalence of DSM-4 abuse, plus dependence
- Best agreement: Threshold of two or more criteria

Defining Criteria

DSM-5 IMPROVEMENTS

Leaders of DSM-5 wanted to put move it into nonsubstance disorders.
- Frontal lobe dysfunction
- Impulse disregulation
- Genetics

Dependents: DSM-4 vs. DSM-5

HOW DO THE DSMs COMPARE?

DSM-4 dependence diagnoses used for decisions about use of medication for alcohol and opioid disorders.
In the case of DSM-4, had best agreement for case identification with four or more criteria, but for cannabis you needed six or more.
What severity threshold produces the best agreement?
Nonsubstance Addictions

**GAMBLING**

Levels of service should be driven by the nature of the chief complaint. This ensures that a proper medical history and exam are documented.

*CONCLUSION:* No consensus on what constitutes Internet/gaming addiction or its criteria, but it’s added to DSM.

**OTHER NONSUBSTANCE ADDICTIONS**

- Sexual
- Eating
- Shopping
- Exercise
- Work.

*CONCLUSION:* More research needed before adding other nonsubstance addictions to DSM.

Controversies

**DSM-5 CONTROVERSIES ABOUND**

Five concerns surrounding DSM changes:

1) New York Times article from May 2013 indicated that millions more will be wrongly diagnosed with DSM-5;
2) Concerns about losing the abuse category;
3) NIMH is steering away from DSM-5;
4) Concerns about validity of mild-severity disorders; and
5) How to ask about the criteria.

Conclusion

**STRUCTURED INTERVIEWS**

Suggested questions to use in asking about DSM-5 criteria:

Interviewers in a recent, large validation study found that using structured interviews helped them frame questions easily when working with patients. Standardized wording made interviews easier.

SPEAKER / AUTHOR BIOGRAPHY

Dr. Deborah Hasin is a professor at Columbia University Medical Center of Epidemiology in Psychiatry. She has a joint appointment in the Department of Psychiatry at Columbia, is a research scientist at New York State Psychiatric Institute and has published more than 250 papers. Hasin's research covers several areas, including gene-environment interaction, nosology, factors affecting longitudinal course and the nature of comorbidity between substance and psychiatric disorders. She is an internationally recognized expert who has participated in World Health Organization studies, recently completed a two-year term as head of the Measurement Group for the national NIDA Clinical Trials Network, and she is a current member of the American Psychiatric Association's DSM-V workgroup on substance use disorders.