From DSM-IV to DSM-5: Significant Changes for Substance Abuse Professionals

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DSM-5

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- The standard diagnostic nomenclature
- Enables mental health professionals to determine:
  - (1) whether clients merit one or more diagnoses and, if they do,
  - (2) what those diagnoses are.
- The only diagnoses of substance-related disorders currently recognized by third-party payers are listed in the DSM-5.
Chronology of the DSM

- **DSM-I**: 1952
  - First national nomenclature
  - Was actually written by a very small group of male, senior psychiatrists, relying on their clinical experience but no data.
  - The nomenclature was very short. It described only 120 disorders, none of them thoroughly enough for a reliable diagnosis.
  - Developed because of experiences during WWII, included diagnoses for both psychotic and nonpsychotic disorders.
  - The War Department, the Veterans Administration, and the American Psychiatric Association began to develop DSM-I at the end of World War II.

- **DSM-II**: 1968
- **DSM-III**: 1980
- **DSM-III-R**: 1987
- **DSM-IV**: 1994
- **DSM-IV-TR**: 2000
- **DSM-5**: May, 2013
**Chronology of the DSM**

**DSM-II: 1968**
- Like DSM-I, diagnoses were heavily influenced by psychoanalytic and Meyerian theory, thereby contributing to the unreliability of diagnoses.
- Also like DSM-I, the nomenclature was created by a small group of male, senior psychiatrists, who relied on their clinical experience rather than empirical data to create the diagnostic categories.
- Also like DSM-I, the descriptions of the diagnostic conditions were very brief and sketchy, making reliable diagnosis very difficult.

**DSM-III: 1980**
- This edition of DSM was revolutionary.
- It increased the number of diagnoses by 2.5 times so that many conditions which had not been included in the DSM were included.
- A chapter on childhood and adolescent disorders was created that elicited a good deal of criticism from child psychologists and psychiatrists,
- It included operational criteria, decision rules, and thorough symptom descriptions, a number of which were based on data from epidemiological studies.
Chronology of the DSM

• **DSM-III: 1980 (continued)**
  – As a result, the reliability of diagnoses was very much improved.
  – The five axes of the multiaxial system for each diagnosis were designed to increase the validity of diagnoses.
  – A more diverse group of clinicians, including women, individuals of color, and nonpsychiatrists participated in the development of the nomenclature, making it more reflective of the diversity of the U.S. population.

• **DSM-III-R: 1987**
  – DSM-III-R revised both the text of its predecessor and a few of the operational criteria as a result of new research findings.
Chronology of the DSM

• **DSM-IV: 1994**
  – This edition of the DSM maintained the 300+ diagnoses included in DSM-III and DSM-III-R, although it did make a few additions and deletions.
  – DSM-IV developed a large number of field trials to test out the validity of diagnostic cues.
  – Reports on the field trials were published in a five-volume set so that in the future researchers and clinicians could understand the basis for changes in diagnoses.
  – A conscious effort was made to limit new diagnoses, in the belief that the DSM already included an overabundance of diagnoses.
  – The developers of DSM-IV were even more diverse than had been those of DSM-III.

• **DSM-IV-TR: 2000**
  – This edition of DSM-IV involved a text revision designed to bring the descriptions of the diagnostic syndromes included in the nomenclature up to date as a result of new findings on epidemiology, etiology, and treatment.
  – However, no changes were made in operational criteria.
Chronology of the DSM

- **DSM-5: May, 2013**
  - This new edition of the DSM has been widely criticized in several books and countless articles and Op-Ed pieces in prominent newspapers.
  - One of the most critical books was written by Alan Frances, Task Force Chair of the DSM-IV effort, who criticized the DSM-5 for overdiagnosis, undue influence on the diagnostic process by large drug companies, and overpromising the development of biomarkers and dimensional diagnosis, which went largely unrealized.
  - DSM-5 has essentially maintained the number of diagnoses included in DSM-IV but it has eliminated the multiaxial system, a separate chapter on childhood and adult disorders, and such well-known categorical distinctions as substance abuse and dependence and the subtypes of schizophrenia.

Reliable Diagnoses

- **DSM-5 is designed to increase diagnostic reliability**
- **Diagnoses on which experienced clinicians agree are reliable diagnoses**
Reliable Diagnoses

Reliable diagnoses are essential for:

– guiding treatment recommendations,
– identifying prevalence rates for mental health service planning,
– identifying patient groups for clinical and basic research, and
– documenting important public health information such as morbidity and mortality rates.

Chapter Order

• DSM-5’s chapters have been rearranged to reflect a lifespan, developmental approach
  • Aligns more closely with the World Health Organization’s ICD-11

• Disorders more frequently diagnosed in childhood appear at the beginning of the manual
  – Neurodevelopmental disorders
    • Intellectual disabilities; autism spectrum disorders
  – Schizophrenia Spectrum Disorder and Related Disorders
Chapter Order (continued)

- Diagnoses more common in adolescence and young adulthood occupy the manuals’ middle.
  - Bipolar, depressive, and anxiety disorders
- Diagnoses of adulthood and later life appear at the end of the manual
  - Substance-related disorders
  - Neurocognitive disorders
    - Alzheimer’s Disease
    - Korsakoff’s

Chapter Changes

**DSM-III and DSM-IV include:**

- Independent chapters on disorders usually first diagnosed in infancy, childhood, or adolescence

**Instead DSM-5 includes:**

- Disorders of childhood and adolescence at the start of chapters
  - from previous editions of the DSM
  - and several new chapters

**DSM-5 no longer includes a Chapter on Disorders of Childhood and Adolescence**
Diagnostic System Changes

**DSM-III and DSM-IV:**
- Multiaxial diagnostic system
- Global Assessment of Functioning Scale (GAF)

**DSM-5:**
- Combines Axes I, II, and III, with separate notations for:
  - Psychosocial and contextual factors (formerly Axis 4)
  - Disability (formerly Axis 5)

DSM-5 no longer includes the Multiaxial Diagnostic System, including the GAF

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**DSM-III and DSM-IV:**
- Emphasis on discrete diagnostic categories
  - Alcohol abuse
  - Alcohol dependence

**DSM-5:**
- Emphasis on *dimensional* assessment
  - Mild to Severe

DSM-5 Diagnoses have become increasingly dimensional
Substance-Related and Addictive Disorders and Neurocognitive Disorders in the DSM-5

• The DSM-5 chapter on Substance-Related and Addictive Disorders includes 10 substance-related disorders:
  – Alcohol-Related Disorders
  – Caffeine-Related Disorders
  – Cannabis-Related Disorders
  – Hallucinogen-Related Disorders
  – Inhalant-Related Disorders
  – Opioid-Related Disorders
  – Sedative-, Hypnotic-, or Anxiolytic-Related Disorders
  – Stimulant-Related Disorders
  – Tobacco-Related Disorder
  – Other Substance-Related Disorders.
Substance Use Disorders

• Almost all substance-related disorders in DSM-5 include:
  – Substance use disorders
  – Substance intoxication
  – Substance withdrawal

• Almost all specify that the substance use disorders be rated mild, moderate, or severe.

• Exceptions include:
  – Caffeine-Use Disorders: no severity ratings
  – Hallucinogen-Use Disorders: no intoxication or withdrawal
  – Inhalant-Use Disorder: no intoxication
  – Tobacco-Use Disorder: no intoxication

Alcohol Use Disorders
Alcohol Use Disorders

• Alcohol-Related Disorders include:
  – Alcohol Use Disorders (mild, moderate, and severe)
  – Alcohol Intoxication
  – Alcohol Withdrawal
  – Other Alcohol-Related Disorder

The distinction between alcohol abuse and dependence has been eliminated in DSM-5.

Alcohol Use Disorders

• Mild Alcohol Use Disorder
  – 2-3 symptoms present

• Moderate Alcohol Use Disorder
  – 4-5 symptoms present

• Severe Alcohol Use Disorder
  – 6 or more symptoms present
Alcohol Use Disorder

Alcohol use disorder is a problematic pattern of alcohol use leading to clinically significant impairment or distress, as manifested by:

• at least 2 of 11 listed symptoms
• occurring within a 12-month period.

Symptoms of Alcohol Use Disorder

1. Often taking alcohol in larger amounts or over a longer period than intended
   “Even when I go out to a bar or a party having resolved to drink no more than three beers or spend no more than two hours, by the end of the evening I discover I’ve consumed 10 beers over four hours.”

2. A persistent desire or unsuccessful efforts to cut down or control alcohol use
   “Time and again, I’ve tried to control my drinking, but I’ve never been able to do so.”

3. Spending a great deal of time in activities necessary to obtain alcohol, use alcohol, or recover from its effects
   “Alcohol takes up a lot of time in my life, what with getting the money to buy it, spending time at bars consuming it and talking to friends, and then getting over whatever hangover I might have developed from my drinking.”
4. Craving, or a strong desire or urge to use alcohol (New Symptom)
   - “When I haven’t been drinking for a day or two, I’ll begin to experience strong craving for alcohol, which stays with me until I take a drink to get rid of the craving.”

5. Recurrent alcohol use resulting in a failure to fulfill major role obligations at work, school, or home
   - “It will sometimes happen that my drinking makes it impossible for me to go to work or take care of my family. This makes me feel terrible, but I still do it. Why?”

6. Continued alcohol use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of alcohol
   - “Even though I have a tendency to become angry and, sometimes, violent when I’ve been drinking, I continue to drink and then to suffer the consequences of my anger and fights.”

7. Important social, occupational, or recreational activities are given up or reduced because of alcohol use
   - “I used to like to dance and visit with my friends and family but since I’ve started to drink so much, I’ve given up almost everything that doesn’t involve drinking.”

8. Recurrent alcohol use in situations in which it is physically hazardous
   - “I’ve had three DWIs, and have been in two accidents because of my drinking in which I was pretty seriously injured. But every time I am able to drive, I’ve been drinking.”
9. **Alcohol use is continued** despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by alcohol

   "Even though I almost always get very depressed after I've been drinking for some time, I continue to drink. I don't know why. It doesn't make sense to me."

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**Symptoms of Alcohol Use Disorder**

**Tolerance**

10. A need for markedly increased amounts of alcohol to achieve intoxication or desired effect, or

11. A markedly diminished effect with continued use of the same amount of alcohol

**Withdrawal**

12. The characteristic withdrawal syndrome for alcohol, or

13. Alcohol (or a closely related substance, such as a benzodiazepine) is taken to relieve or avoid withdrawal symptoms
# Alcohol Use Specifier Changes

**DSM-IV:**
- **Physiologic dependence specifier**
  - With physiologic dependence
  - Without physiologic dependence

**DSM-5:**
- **Severity specifier:**
  - Mild
  - Moderate
  - Severe
- **Patient status specifier:**
  - Early remission
  - Sustained remission
  - Controlled environment

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# Gambling Disorders

![Image of gambling chips]
Pathological Gambling in DSM-5

• The Substance-Related and Addictive Disorders chapter also includes a non-substance-related disorder, Gambling Disorder.
• The inclusion of gambling disorder with the substance-related disorders reflects the fact that the two disorders are characterized by most of the same symptoms, they share many etiologic features, and the brain mechanisms which underlie them are very similar.

Gambling Disorder Specifiers

• As with the substance use disorders, clinicians are asked to specify severity by number of symptoms:
  – Mild
  – Moderate
  – Severe
• Clinicians are also asked to specify whether the gambling disorder is:
  – Episodic
  – Persistent
Neurocognitive Disorders

• Included within the Neurocognitive Disorders chapter are:
  – Substance Intoxication Delirium and
  – Substance Withdrawal Delirium
• Essential features of a delirium are:
  – a disturbance in attention and awareness accompanied by
  – a disturbance in cognition.
• These symptoms cannot be better accounted for by a preexisting or evolving neurocognitive disorder
Substance-Induced Delirium

• The substance-induced delirium typically
  – Develops over a short period of time
    • Hours to days
  – Tends to fluctuate during the course of the day

• For example, these deliriums are associated with
  – Alcohol intoxication at relatively high levels (*Alcohol Intoxication Delirium*) or
  – Alcohol withdrawal (*Alcohol Withdrawal Delirium*), which includes
    Delirium Tremens

Alcohol-Induced Major or Mild Neurocognitive Disorders (NCD)

• These disorders include:
  – Alcohol (major neurocognitive disorder), nonamnestic-confabulatory type
    • Replaces DSM-IV’s Alcohol-Induced Persisting Dementia
  – Alcohol (major neurocognitive disorder), amnestic-confabulatory type
    • Replaces DSM-IV’s Alcohol-Induced Persisting Amnestic Disorder (includes Korsakoff’s syndrome)
  – Alcohol (mild neurocognitive disorder)
Substance-Induced Major or Mild Neurocognitive Disorders

- Inhalant (major or mild neurocognitive disorder)
- Sedative, hypnotic, or anxiolytic (major or mild neurocognitive disorder)
- Other (or unknown) substance (major or mild neurocognitive disorder)

Alcohol-Induced Neurocognitive Disorders

- DSM-5 list four symptoms for both
  - Alcohol-Induced Major Neurocognitive Disorder
  - Alcohol-Induced Minor Neurocognitive Disorder
- Both include a specifier:
  - The cognitive deficits are due to alcohol use
Symptoms of Alcohol-Induced Major Neurocognitive Disorder

1. Evidence of significant cognitive decline from a previous level of performance
   - In one or more cognitive domains
     - complex attention, executive function, learning and memory, language, perceptual-motor, or social cognition
   - based on:
     1. Concern of the individual, a knowledgeable informant, or the clinician that there has been a significant decline in cognitive function; and
     2. A substantial impairment in cognitive function.

2. The cognitive deficits interfere with independence in everyday activities
3. The cognitive deficits do not occur exclusively in the context of a delirium
4. The cognitive deficits are not better explained by another mental disorder
   - e.g., major depressive disorder, schizophrenia

Specifier: The cognitive deficits are due to alcohol use
Symptoms of Alcohol-Induced Mild Neurocognitive Disorder

1. Evidence of mild cognitive decline from a previous level of performance
   - in one or more cognitive domains
     - complex attention, executive function, learning and memory, language, perceptual-motor, or social cognition
   - based on:
     1. Concern of the individual, a knowledgeable informant, or the clinician that there has been a mild decline in cognitive function; and
     2. A modest impairment in cognitive function

2. The cognitive deficits do not interfere with capacity for independence in everyday activities

3. The cognitive deficits do not occur exclusively in the context of a delirium

4. The cognitive deficits are not better explained by another mental disorder
   - e.g., major depressive disorder, schizophrenia

Specifier: The cognitive deficits are due to alcohol use.