The New DSM-5 and Addictive Disorders: What You Need to Know

Laurence M. Westreich, M. D.
Division of Alcoholism and Drug Abuse, Dept. of Psychiatry, N.Y.U. School of Medicine
Disclaimer

- Consultant on Drugs of Abuse to the Commissioner of Major League Baseball
- No other industry affiliation
- Many of the below slides are adapted from APA materials
- All opinions expressed are mine alone.

Laurence M. Westreich, M. D.
OUTLINE

1. General Facts About the DSM-5
2. Addiction in the DSM-5
3. ADHD in the DSM-5
4. Disability and Forensic Matters in the DSM-5
5. Clinical Correlations in the DSM-5
6. Insurance Implications of the DSM-5
General Facts About the DSM-5
Good!
Bad!
Task Force/Work Group Members

- Psychiatrists: 120
- Psychologists: 40
- Other HCPs: 7

Diagram showing the distribution of members across different healthcare provider categories.
DSM- 5 Structure

- Section I: DSM-5 Basics
- Section II: Essential Elements: Diagnostic Criteria and Codes
- Section III: Emerging Measures and Models
- Appendix
- Index
Section III: Purpose

Section III serves as a designated location, separate from diagnostic criteria, text, and clinical codes, for items that appear to have initial support in terms of clinical use but require further research before being officially recommended as part of the main body of the manual.
DSM-5: Definition of a Mental Disorder

A mental disorder is a syndrome characterized by clinically significant disturbance in an individual’s cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning. Mental disorders are usually associated with significant distress or disability in social, occupational, or other important activities. An expectable or culturally approved response to a common stressor or loss, such as the death of a loved one, is not a mental disorder. Socially deviant behavior (e.g., political, religious, or sexual) and conflicts that are primarily between the individual and society are not mental disorders unless the deviance or conflict results from a dysfunction in the individual, as described above.
The diagnosis of a mental disorder should have clinical utility: it should help clinicians to determine prognosis, treatment plans, and potential treatment outcomes for their patients. However, the diagnosis of a mental disorder is not equivalent to a need for treatment.
Personality Disorders in DSM-5

1. Diagnostic Criteria for 10 Personality Disorders in Section II of DSM-5 are (mostly) unchanged from DSM-IV.

2. AXIS II has been deleted

Slide adapted from Andrew Skodol, MD/APA
Non-Mental Illness Codes in DSM-5

- V/Z Codes
- Documentation of factors that may affect the patient’s diagnosis, prognosis, or treatment (i.e., the former AXIS IV)
Changes in Number of DSM Disorders (Net Difference is -15)

<table>
<thead>
<tr>
<th></th>
<th>DSM-IV</th>
<th>DSM-5</th>
</tr>
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<tbody>
<tr>
<td>Specific Mental Disorders</td>
<td>172</td>
<td>157</td>
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</table>
DSM-5 New Disorders

- 1. Social (Pragmatic) Communication Disorder
- 2. Disruptive Mood Dysregulation Disorder
- 3. Premenstrual Dysphoric Disorder (DSM-IV appendix)
- 4. Hoarding Disorder
- 5. Excoriation (Skin-Picking) Disorder
- 6. Disinhibited Social Engagement Disorder (split from Reactive Attachment Disorder)
- 7. Binge Eating Disorder (DSM-IV appendix)
- 8. Central Sleep Apnea (split from Breathing-Related Sleep Disorder)
- 9. Sleep-Related Hypoventilation (split from Breathing-Related Sleep Disorder)
- 10. Rapid Eye Movement Sleep Behavior Disorder (Parasomnia NOS)
- 11. Restless Legs Syndrome (Dyssomnia NOS)
- 12. Caffeine Withdrawal (DSM-IV Appendix)
- 13. Cannabis Withdrawal
- 14. Major Neurocognitive Disorder with Lewy Body Disease (Dementia Due to Other Medical Conditions)
- 15. Mild Neurocognitive Disorder (DSM-IV Appendix)
DSM-5 Eliminated Disorders

- 1. Sexual Aversion Disorder
- 2. Polysubstance-Related Disorder
Goal of DSM-5: To Make Diagnosis Neuroscience Based

- Biomarkers in psychiatry are not sufficiently reliable and available for clinical practice
- NIMH Research Domain Criteria for next iteration of DSM (one hopes)
Addiction in the DSM-5
DSM – 5 Substance Use Disorders
Principal Changes

1. Changed “Abuse/Dependence” to “Mild/Moderate/Severe”

2. Two symptoms is diagnostic threshold. (But remember DSM-IV abuse required only 1 symptom!)

3. “Dependence” is pharmacologic dependence only.

4. Delete legal symptom

5. Add craving

6. Gambling Disorder is with SUDs. (Taken from Impulse Disorders)

7. Add Cannabis Withdrawal

8. Add Internet Gaming to Section 3

9. Add Neurobehavioral Disorder Associated with Prenatal Alcohol Exposure to Section 3

10. Add Caffeine Use Disorder to Section 3
Substance Abuse DSM-IV

- Maladaptive use within 12 month period (one or more)
  - 1. Failure to fulfill major role obligations
  - 2. Recurrent use in hazardous situations
  - 3. Recurrent substance use disorders
  - 4. Continued use despite consistent social or interpersonal problems
Does DSM-5 Diagnose More Addiction?

- Not much
- National Epidemiological Survey of Alcohol and Related Conditions (NESARC) 2004-2005
  - 29,993 reporting lifetime alcohol use
  - DSM-IV Alcohol Abuse/Dependence – 9.7%
  - DSM-5 Alcohol Use Disorder – 10.8%
  - DUI Alcohol Abuse became non-diagnosed in DSM-5
  - Legal criterion did not significantly affect prevalence

DSM-5 Substance Use Disorder

- Tolerance*
- Withdrawal*
- More use than intended
- Craving for Substance
- Unsuccessful attempt to cut down
- Spends excessive time in acquisition
- Activities given up because of use
- Uses despite negative effects
- Failure to fulfill major role obligations
- Recurrent use in hazardous situations
- Continued use despite social or interpersonal problems

* not counted if prescribed by a physician.
DSM-5 Severity Markers

- Mild: 2-3 Symptoms
- Moderate: 4-6 Symptoms
- Severe: 7-11 Symptoms
“STRESSED” is “DESSERTS” spelled backwards
“Craving for alcohol is indicated by a strong desire to drink that makes it difficult to think of anything else and that often results in the onset of drinking*...”

* DSM-5 p. 492
The PACS is a five-item self-administered instrument for assessing craving. Frequency, intensity, and duration of thoughts about drinking are assessed along with ability to resist drinking. The final item asks the responder to provide an average rating of his/her craving over the course of the past week. The questions on the PACS use descriptors coupled with numerical ratings ranging from 0 to 6.

Craving vs. Relapse

1. How often have you thought about drinking or about how good a drink would make you feel during this period?

Never, that is, 0 times during this period of time. = 0
Rarely, that is, 1 to 2 times during this period of time. = 1
Occasionally, that is, 3 to 4 during this period of time. = 2
Sometimes, that is, 5 to 10 times during this period or 1 to 2 times a day. = 3
Often, that is, 11 to 20 times during this period or 2 to three times a day. = 4
Most of the time, that is, 20 to 40 during this period or 3 to 6 times a day. = 5
Nearly all of the time, that is, more than 40 times during this period or more than 6 times a day. = 6
2. At its most severe point, how strong was your craving during this period?

None at all. = 0
Slight, that is a very mild urge. = 1
Mild urge. = 2
Moderate urge. = 3
Strong urge, but easily controlled. = 4
Strong urge and difficult to control. = 5
Strong urge and would have drunk alcohol if it were available. = 6
3. How much time have you spent thinking about drinking or about how good a drink would make you feel during this period?

- None at all = 0
- Less than 20 minutes = 1
- 21-45 minutes = 2
- 46-90 minutes = 3
- 90 minutes-3 hours = 4
- Between 3 to 6 hours = 5
- More than 6 hours = 6
4. How difficult would it have been to resist taking a drink during this period of time if you had known a bottle were in your house?

- Not difficult at all. = 0
- Very mildly difficult. = 1
- Mildly difficult. = 2
- Moderately difficult. = 3
- Very difficult. = 4
- Extremely difficult. = 5
- Would not be able to resist. = 6
"If the law supposes that," said Mr. Bumble, squeezing his hat emphatically in both hands, "the law is a ass - a idiot*."

*Dickens, Charles. *Oliver Twist*, 1838
April 24, 2011

Multiple Inequities

“For a generation, in one of the law’s gross inequities that has fallen unduly on African-Americans, 1 gram of crack cocaine was treated the same as 100 grams of powder cocaine in federal courts......”
US Drug Use Deaths

US Recreational Drugs Deaths
Special New Release of BBSNews Faqlet #1 (98) July 2002

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<td>Alcohol</td>
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<td>PharmaCo</td>
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<td>Marijuana</td>
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<table>
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<th>Year</th>
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<th>PharmaCo</th>
<th>Alcohol</th>
<th>Tobacco</th>
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<td>2001</td>
<td>19,162</td>
<td>106,000</td>
<td>116,000</td>
<td>406,290</td>
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</table>
Cannabis Withdrawal DSM-5

- A. Cessation of heavy or prolonged cannabis use
- B. 3 or more of the below
  - 1. Irritability, anger, aggression
  - 2. Nervousness/anxiety
  - 3. Sleep difficulty
  - 4. Decreased appetite or weight loss
  - 5. Restlessness
  - 6. Depressed Mood
  - 7. At least one of: stomach pain, shakiness/tremors, sweating, fever, chills, headache.
- C. Clinically significant distress or impairment
- D. Not attributable to another medical condition or mental disorder, including intoxication or withdrawal

Adapted from DSM-5
Why add Gambling Disorder?

- Strong comorbidity with SUD, Pathological Gambling, Antisocial Disorders
- Convincing genetic literature: “behavioral disinhibition” is a heritable phenotype with high heritability that underlies antisocial disorders, SUDs, gambling.
- Considerable shared neurobiology: imbalance of motivation/reward system vs. inhibitory systems

Slide adapted from Charles O'Brien, MD/APA
Issues that Affect Addiction Treatment

- 1. No more abuse and dependence (Categorical)
- 2. Severity measured by number of symptoms. (Continuum)
- 3. Agonist maintenance for “Moderate to severe opioid use disorder.”

Slide adapted from Charles O'Brien, MD/APA
ADHD in the DSM-5
1. Changed “Subtypes” to “Current Presentation”
2. Age of onset changed from 7 YO to 12 YO
3. Reduced threshold (adults and ≥ 17 YO) from 6 to 5
4. “Being with friends/relatives” added as setting.
5. Changed “impairment” to “interfere with or reduced the quality of social, academic, or occupational....functioning.”
6. Changed examples for adults and older teens.
DSM-5 ADHD

- New Criterion Descriptions for Adults

1. Difficulty focusing during lectures, conversations, or lengthy reading

2. Often forgetful in daily activities (e.g., doing chores, running errands; for older adolescents and adults, returning calls, paying bills, keeping appointments.)

3. Often interrupts (e.g., butts into conversations, games or activities; uses other peoples things without asking; might intrude into or take over what others are doing.)
Disability and Forensic Matters in the DSM-5
WHODAS 2.0

WORLD HEALTH ORGANIZATION

DISABILITY ASSESSMENT SCHEDULE 2.0

Page 1 of 4 (36-item, self-administered)

36-item version, self-administered

This questionnaire asks about difficulties due to health conditions. Health conditions include diseases or illnesses, other health problems that may be short or long lasting, injuries, mental or emotional problems, and problems with alcohol or drugs. Think back over the past 30 days and answer these questions, thinking about how much difficulty you had doing the following activities. For each question, please circle only one response.
WHO DAS 2.0 Questions

- In the past 30 days, how much difficulty did you have in: Understanding and communicating
- D1.1 Concentrating on doing something for ten minutes?
  - None Mild Moderate Severe Extreme or cannot do
- D1.2 Remembering to do important things?
  - None Mild Moderate Severe Extreme or cannot do
- D1.3 Analysing and finding solutions to problems in day-to-day life?
  - None Mild Moderate Severe Extreme or cannot do
- D1.4 Learning a new task, for example, learning how to get to a new place?
  - None Mild Moderate Severe Extreme or cannot do
- D1.5 Generally understanding what people say?
  - None Mild Moderate Severe Extreme or cannot do
- D1.6 Starting and maintaining a conversation?
  - None Mild Moderate Severe Extreme or cannot do
- Getting around
- D2.1 Standing for long periods such as 30 minutes?
  - None Mild Moderate Severe Extreme or cannot do
The Americans with Disabilities Act

- Passed July 26th, 1990

- Goals were to:
  1. “...provide a national mandate for the elimination of discrimination against individuals with disabilities
  2. ”...provide clear, strong, enforceable standards...”
  3. ”..ensure a central role for the federal government in enforcing the act...”
  4. “...use the regulation of commerce to protect persons with disabilities from discrimination.”
ADA Coverage of Alcoholism

- Covered if no direct threat to others
- Covered if no specific workplace rules are broken
- ADA does NOT supersede the Drug Free Workplace Act or statutes established by the Department of Transportation, Department of Defense, or the Nuclear Regulatory Commission
ADA Coverage of Drug Addiction

- “current” drug use not covered
- “illegal drug use” includes prescription medications not properly prescribed
- coverage is provided for “an individual who has competed a supervised drug rehabilitation program and is no longer engaging in the use of illegal drugs, or has otherwise been rehabilitated successfully and is no longer engaging in such use.”

42 USC § 104 12114
“Reasonable Accommodations” for Addiction

- Modified schedule to allow daily methadone pick-up
- Job restructuring to relieve employee of marginal tasks that may compromise recovery
- Temporary reassignment to a vacant non-safety sensitive position while he completes treatment

Weber EM” Employing and Accommodating.....Legal Action Center, Washington DC, 2000, p.4
Cautionary Statement for Forensic Use

“…..When DSM-5 categories, criteria, and textual descriptions are employed for forensic purposes, there is a risk that diagnostic information will be misused or misunderstood. These dangers arise because of the imperfect fit between the questions of ultimate concern to the law and the information contained in a clinical diagnosis.......the use of DSM-5 should be informed by an awareness of the risks and limitations of its use in forensic settings. In most situations the clinical diagnosis of a DSM-5 mental disorder....does not imply that an individual with such a condition meets legal criteria for the presence of a mental disorder or a specified legal standard (e.g., for competence, criminal responsibility, or disability). For the latter, additional information is usually required beyond that contained in the DSM-5 diagnosis...”

- DSM-5, p. 25
Landmark Cases in Addiction

- Robinson v. California
  - stopped by LAPD, who found needle tracks
  - convicted of misdemeanor of being addicted to narcotics
  - USSC reversed, finding that punishing a person for the “status” of being addicted violated the 8th/14th amendments
  - “Even one day in prison would be cruel and unusual punishment for the ‘crime’ of having the common cold.”

82 S. Ct. 1417 (1962)
Landmark Cases in Addiction

- Powell v. Texas
  - arrested, convicted for public intoxication
  - asserted that he was an alcoholic, that alcoholism is a disease, and that charges should be dropped
  - USSC upheld conviction for public intoxication
  - attempt to avoid creating a constitutional defense to criminal responsibility

88 S. Ct. 2145(1968)
Landmark Cases in Addiction

- **People v. Saille**
  - leaving a bar, Saille told the bouncer “I’m going to get a gun and kill you.”
  - returned later, killed a bar patron with a rifle
  - BAL .19 mg/dl
  - voluntary intoxication (or any mental illness) does not *of itself* negate malice, per CA Senate Bill 54
  - upheld by CASC, although voluntary intoxication may be relevant if it *actually* prevented the defendant from forming requisite intent

88 S. Ct. 2145(1968)
Voluntary Intoxication

- *not* the common sense or clinical meaning of “voluntary”
- A “Mickey Finn” would not be voluntary intoxication
- Poor patient information about a sedating drug would not be voluntary intoxication
Forensic Implications of DSM-5

1. Mere fact of the change to DSM-5 demonstrates the fluidity and subjectivity of psychiatric diagnosis*.

2. Neurocognitive Disorders (Intellectual Disability)

3. Pedophilic Disorder (”’has acted on urges, at least 16 YO, at least 5 years older than the child in criterion A....”

* an argument likely to be made by attorneys!
Clinical Correlations in the DSM-5
I'm getting worried about all these steroid hormones you've been giving me, coach.

Don't be ridiculous, Jennifer.
Clinical Implications of DSM-5
Therapeutic Use Exemptions

Vs.
Clinical Implications of DSM-5
Clinical Implications of DSM-5
Talking to Addicted People and Their Loved ones
The Spectrum of Addiction Treatment Voluntariness

Informal pressure
Friends
Family
Employer

Formal intervention
Enters treatment with penalty for leaving

Criminal penalties, less penalty
Treatment
DUI
Drug possession

Patient sentenced to prison boot camp/DWI jail in lieu of prison

Civil commitment after volunteering

Breath/urine monitoring
Treatment changes on results

Loss of benefits if no cooperation with treatment
Public housing

Probation/parole if participating in treatment

Patient imprisoned
Reduced sentence for in-prison treatment program

Patient adjudicated "incompetent" because of drugs/alcohol, committed involuntarily

Adapted from Blume S, Involuntary Treatment for Substance Use Disorders, Unpublished Paper, 1999
Insurance Implications in the DSM-5
Insurance Implications of DSM-5

- DSM-5 is compatible with ICD-9-CM coding
- ICD-10-CM is coming in October 2014
- Former Axes I-III are combined: some insurance companies may lag and require a 5-AXIS diagnosis
- Contributing psychosocial or environmental factors may be listed as ICD-9-CM V codes, and ICD-10-CM Z codes
Insurance Implications of DSM-5 (2)

- Some insurance carriers may delay updating their coding systems
- Some insurance companies may delay deleting the multiracial diagnostic system
- Place all mental and medical disorders on a single list – with ICD codes and name of disorders
- WHODAS 2.0 provides disability rating
- No replacement for GAF has been approved as of now
## Six New DSM-5 Diagnoses

<table>
<thead>
<tr>
<th>DSM-5 Disorder</th>
<th>ICD-9-CM Code</th>
<th>ICD-9 Title</th>
<th>ICD-10-CM Code</th>
<th>ICD-10-CM Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social (Pragmatic) Communication Disorder</td>
<td>315.39</td>
<td>Other developmental speech or language disorder</td>
<td>F80.89</td>
<td>Other developmental disorders of speech and language</td>
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<td>Disruptive Mood Dysregulation Disorder</td>
<td>296.99</td>
<td>Other specified Episodic Mood Disorder</td>
<td>F34.8</td>
<td>Other persistent Mood (Affective) Disorder</td>
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<td>Premenstrual Dysphoric Disorder (from DSM-IV appendix)</td>
<td>625.4</td>
<td>Premenstrual tension syndromes</td>
<td>N94.3</td>
<td>Premenstrual tension syndrome</td>
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### Six New DSM-5 Diagnoses

<table>
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<tr>
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<th>ICD-9-CM Code</th>
<th>ICD-9 Title</th>
<th>ICD-10-CM Code</th>
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<tr>
<td>Hoarding Disorder</td>
<td>300.3</td>
<td>Obsessive Compulsive Disorders</td>
<td>F42</td>
<td>Obsessive Compulsive Disorder</td>
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<td>Excoriation (Skin-Picking) Disorder</td>
<td>698.4</td>
<td>Dermatitis factitia (artefacta)</td>
<td>L98.1</td>
<td>Factitial Dermatitis</td>
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<td>Binge-eating Disorder (from DSM-IV Appendix)</td>
<td>307.51</td>
<td>Bulimia Nervosa</td>
<td>F50.2</td>
<td>Bulimia Nervosa</td>
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<td>Substance Use Disorders</td>
<td>Coding will be applied based on severity: ICD Codes associated with substance abuse will be used to indicated mild SUD: ICD Codes associated with substance dependence will be used to indicated moderate or severe SUD.</td>
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Summary

- The DSM-5 is an attempt to classify mental illness, based on the available science of 2013
- Addiction has been defined as a spectrum condition, with craving as one new criterion
- The diagnosis of ADHD has been broadened
- The DSM-5 is an imperfect instrument for forensic or disability matters
- The DSM-5 is not a treatment manual
CONTACT INFORMATION

Laurence M. Westreich, M. D.
212-579-7845
Lwestreich@parkwestassociates.com

127 West 79th # 1N
NY NY 10024