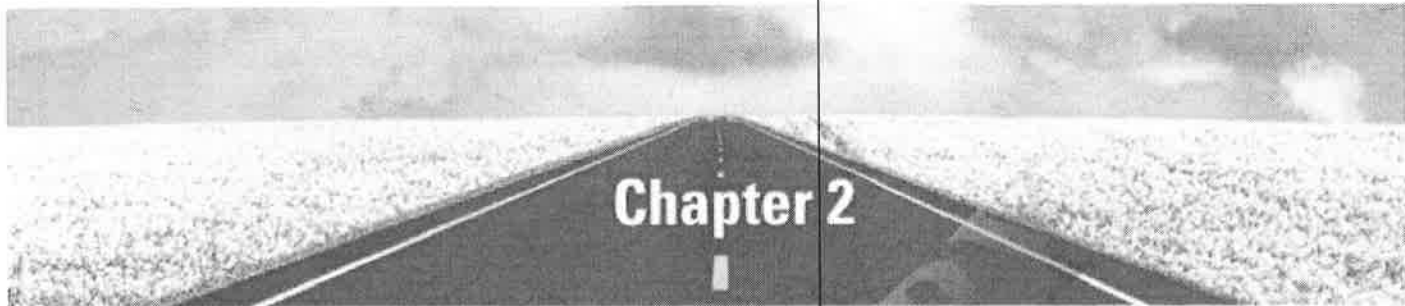




## Chapter 2

# Diagnostic Criteria of Substance-Related Disorders

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**Key Terms:** diagnostic criteria, tolerance, withdrawal, severity, specifier

**Key Objectives:** This chapter will allow students to (a) understand the background of the development of the diagnostic criteria for substance use disorders; (b) be able to apply *DSM-5* diagnostic criteria for substance use disorders to case study examples.

## Introduction

In 2013, the American Psychiatric Association (APA) published the 5th edition of the *Diagnostic and Statistical Manual of Mental Disorders*, more commonly called the *DSM-5*. It provides counselors with a complete guide for diagnosing mental health disorders, including substance use disorders (SUDs). This chapter will provide counselors with a thorough overview of the history, features, and techniques associated with substance use diagnostics and the *DSM*.

## Historical Background

### The Disease Model

As you will recall from Chapter 1, for thousands of years, humans have been seeking out plants, herbs, and other concoctions to treat ailments, relieve stress, increase health and longevity, enhance mood, and to get high and as long as humans have been using these substances, humans have also been struggling with the consequence of their use. For centuries, SUDs were thought of as defect of character or a moral failing. The moral model has led to misunderstanding and stigma of those with SUDs throughout history. And, even treatment professionals have followed the moral model in the past, leading to mistreatment of individuals with SUD. However, in the early 19th century, Dr. Benjamin Rush (1745–1813), the Father of American Psychiatry, became the first to describe addiction as a brain disease. Rush wrote the first psychiatric textbook in the United States in 1812 (Penn Medicine, 2017).

In 1947, scientist E. M. Jellinek developed the *disease concept* of alcoholism. Jellinek proposed that certain individuals have a biological sensitivity or “allergy” to alcohol, and, if they consume alcohol, they risk developing the disease of alcoholism. He outlined the path to alcoholism as follows (cited in Benshoff & Janikowski, 2000):

*Normal drinking* > > *heavy/frequent drinking* > > *drunken bouts/secret drinking/morning drinking* > > *blackouts/tolerance/withdrawal* > > *loss of control over drinking* > > *slavery to alcohol/death*

## The Diagnostic and Statistical Manual (DSM)

In 1952, the APA published its first edition of the DSM (Kawa & Giordano, 2012). This early predecessor included 102 disorders and was based largely on a psychodynamic approach to psychological disorders. The first DSM used the term *alcoholism* and defined it as having an "alcohol addiction." It did not provide any specific criteria, however. Both alcoholism and drug dependence were considered a subset of sociopathic personality disorders along with antisocial personality disorder, sexual deviations, and homosexuality (Roget & Fischer, 2009). Moreover, this earliest version of the DSM described alcoholism and drug dependence from a moral model approach in which the person continues using because of a lack of willpower and a defect of character. Sadly, the classification and definitions of alcoholism and drug dependence remained virtually unchanged in the DSM until its third revision in 1980. The *DSM-III* introduced the term "substance use disorders" and reclassified them as their own category. Also, the *DSM-III* was the first to differentiate between substance abuse and substance dependence. *Substance abuse* was defined as "a pattern of pathological use, impairment in social or occupational functioning due to substance use, and minimal duration of disturbance of at least one month" (APA, 1980, p. 163). *Substance dependence*, on the other hand, was defined as a more severe form of substance use which included "tolerance or withdrawal" (APA, 1980, p. 163). Five classes of substances were described in terms of both substance abuse and dependence in the *DSM-III*. These were alcohol, barbiturates or similarly acting sedative/hypnotics, opioids, amphetamines, and cannabis. Phencyclidine (PCP), cocaine, and hallucinogens were only associated with substance abuse because of a lack of evidence for physiological dependence (APA, 1980).

Over 60 years since the first edition, the *DSM-5* is considered the reference for diagnostic criteria of psychological disorders in the United States. The *DSM-5* is far more reliable and valid than its earlier editions. It took hundreds of experts over 12 years to complete this newest revision. Evidence for the *DSM-5* comes from advancements in neuroscience, genetics, brain imaging, and epidemiology (APA, 2013). As a counselor, you will want training and experience in using the *DSM-5* to diagnose SUDs in your clients.

## Substance-Related Disorders

New terminology, along with an innovative conceptualization of SUDs, sets the *DSM-5* apart from its predecessors. The binary diagnoses of substance abuse and substance dependence were done away with in favor of a spectrum approach (Fetting, 2016) and after years of research, gambling disorder was finally included as an "addictive disorder" (APA, 2013) rather than an impulse control disorder.

## Using the *DSM-5*

Substance-related disorders in the *DSM-5* comprise 10 classes of drugs. These drugs are alcohol, caffeine, cannabis, hallucinogens, inhalants, opioids, sedative/hypnotic/anxiolytics, stimulants, tobacco, and other. There are two groups of substance-related disorders: SUDs and substance-induced disorders. SUD is the accepted terminology for what were previously known as substance abuse and dependence. And substance-induced disorders include intoxication, withdrawal, and other substance/medication-induced medical disorders.

When a person continues to use one or more classes of drugs despite having cognitive, behavioral, or physiological symptoms due to their use, the person may be considered to have a SUD. Use of all 10 classes of drugs, except caffeine, can result in a SUD. The *DSM-5* describes SUD as a pathological "pattern of use" and it divides criteria or symptoms into overall groupings of behaviors. These groupings are based on impaired control, social impairment, risky use, and pharmacological criteria. A person has *impaired control*

drug OxyContin, he or she experiences nausea, muscle aches, runny nose (rhinorrhea), watery eyes (lacrimation), and sweating (criterion 11). Every class of drug that produces withdrawal has specific withdrawal symptoms included in the *DSM-5*. Withdrawal symptoms have not been observed for hallucinogens or inhalants, therefore criterion 11 is not included for hallucinogen use disorder or inhalant use disorder.

### Severity and Specifiers

When diagnosing a SUD, a counselor is also to identify the level of severity of the disorder and certain specifiers. The *DSM-5* uses a severity range of mild, moderate, or severe. A client with two to three criteria for any one substance during the same 12-month period would be considered to have a *mild* SUD, four to five criteria for any one substance during the same 12-month period would qualify as *moderate* SUD, and six or more criteria would be considered a *severe* SUD. Moderate is what was previously referred to as *substance abuse* in the *DSM-IV-TR* and severe was once called *substance dependence* (APA, 2000). A specifier is used to identify if a client is in some level or type of remission. Specifiers include: in early remission, in sustained remission, on maintenance therapy, or in a controlled environment. Early remission should be specified if the client previously meeting the criteria for diagnosis of SUD has not experienced those symptoms for at least 3 months but less than 12 months. If a person diagnosed with SUD goes more than 12 months with no symptoms, he or she is said to be in sustained remission. If a client is taking a medication to help with his or her recovery (e.g., methadone for heroin use) the counselor should add the specifier "on maintenance therapy" after the diagnosis. Also, if a client is in an environment where he or she does not have access to substances (like jail or an inpatient treatment facility), the counselor should use the specifier "in a controlled environment." Here is an example of how a counselor should phrase a client diagnosis:

*303.90(F10.20) Severe Alcohol Use Disorder in early remission*

The first set of numbers (303.90) is the *DSM-5* code for either moderate or severe alcohol use disorder. The *DSM-5* has a separate code for every SUD and its severity level(s). The number in the parenthesis (F10.20) is the International Classification of Disorders (ICD) designation for each specific disorder. The *DSM-5* is unique in its harmonization with the World Health Organization's (WHO) ICD system (APA, 2013).

If your client has two to three symptoms of marijuana use disorder but has been in jail the last 30 days, his or her diagnosis would be: 305.20 (F12.10) Mild Cannabis Use Disorder in a controlled environment. When diagnosing a client with a disorder based on the use of a specific substance within a class of drugs, you would identify the name of the drug. For example, use 304.40 (F15.20) Severe Methamphetamine Use Disorder if your client has a stimulant use disorder related to methamphetamine use.

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## Case Study 1

Sami is a 25-year-old, Caucasian female. She is referred to you for counseling by the court following a second DUI charge. Sami tells you she first used alcohol at age 13 with her friends. She stated from the time she was 13 to around 17 she drank primarily on the weekends at parties. When she was 18 she started college and her drinking increased from only a couple times a week to three to four times per week. She says that's when her drinking first got "out of control" and she lost her scholarship and got kicked out of school. After that, she got a job at a convenience store and moved back home with her parents. Sami tells you she tried to "straighten up" for a while and was sober for a year after moving back home. At age 20, she says she began drinking again, only "casually at first" but then she started to increase to more regular use, at least three to four times per week, and she typically ended up drinking until she passed out. She says this pattern lasted until she was 23 and she got her first DUI. After her first DUI, she says she became very depressed and had a lot of financial problems due to fines, legal fees, and "spending too

increased from only a couple times a week to three to four times per week. And also at age 20 she says she began drinking again, only "casually at first" but then she started to increase to more regular use, at least three to four times per week. This indicates twice that an increase in her drinking occurred during the same 12-month period. She would, therefore, meet the first criterion.

The second criterion looks for a pattern of being unsuccessful in attempts to quit or cut down. Sami told you about having been sober after being kicked out of college, but this is the only time she describes an attempt at sobriety. She does not meet criterion 2 because there is no pattern of trying to quit.

Criterion 3 is met when a client has devoted a lot of time to using, recovering from, or trying to obtain alcohol. Sami told you she moved in with a friend and they would drink and party "all the time." Notice she also stated that pattern had lasted for the past 2 years. Sami meets criterion 3.

Sami did not report to you any cravings or urges to use alcohol and so she does not meet criterion 4. Be careful not to assume she has had cravings simply because of meeting other criteria. Assumptions can lead to misdiagnosis.

Sami does report missing work repeatedly because of being hungover; therefore, she does meet criterion 5. She may also meet criterion 6 because of the arguing between her parents and her. However, it would be important to uncover if the arguing was related in any way to Sami's alcohol use.

Criterion 7 is also met by Sami because of her losing jobs repeatedly due to alcohol and criterion 8 is met because Sami told you "I have driven drunk so many times, it's a wonder I haven't died." Drinking while driving certainly qualifies as use in a situation in which it is physically hazardous.

From the information you have gathered from Sami it is difficult to determine if she meets criterion 9 (continued use despite physical or psychological problems associated with it). She did report having feelings of depression, but it is not clear that this was related to or exacerbated by alcohol. Always err on the safe side and remember to avoid assumptions. With the information you have, Sami does not meet criterion 9. Sami also does not report any symptoms of tolerance (criterion 10) or withdrawal (criterion 11).

Now you have determined that Sami does meet at least five of the criteria for alcohol use disorder (1, 3, 5, 7, and 8). It only takes two during any 12-month period for this diagnosis. Sami does report at least two of these occurring in the same 12-month period. She meets criteria for alcohol use disorder. Remember, however, you must also include a severity level and any specifiers. According to the diagnostic criteria, four to five symptoms fall into the moderate level of severity. She does not report any sustained amount of recovery during either the last 3 or 12 months, so her diagnosis does not require a remission specifier and Sami does not report taking any medication to manage her alcohol use nor is she in a controlled environment, therefore, no specifier is needed. Her diagnostic code based on what you currently know is: **303.90 (F10.20): moderate alcohol use disorder.**

In the following chapters of this text, you will learn about how to conduct a proper assessment, and you will be introduced to specific screening and assessment instruments. The *DSM-5* is the accepted guide on diagnostic criteria; however, as a counselor, it will be your responsibility to choose the right instrument. Moreover, only you can ensure that you have the appropriate training, competencies, and skills to provide your clients with an accurate and fair assessment.

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## Case Study 2

Mark, a 44-year-old African American male client has been told by his wife to seek help for his "smoking problem" or she will seek a divorce. He tells you he has been smoking marijuana since he was 20 years old. He and his wife, Tracy, have been married for 12 years and they have two children together, Elsie age 10 and Leon age 7. Mark works as a store manager for a large cell phone company and Tracy has a part-time job for a retail store. Mark tells you he has smoked daily for the past 3 years. He tells you

her thing, and, after she was 21, she really didn't drink. "I know it sounds weird, but I just never really liked the taste." When she was 22 Brenda started using cocaine. "Now, cocaine was awesome! It gave me energy. Made me feel great." She admits to using cocaine once every couple weeks during her 20s and then four to five times a week in her 30s. "When I was younger, I couldn't afford to use it much, but then the money started rolling in, and I could afford it." Brenda reports she waited tables from the time she was 13, but during her early 30s she started dealing drugs for money. "Pot, mostly, at first, but then I moved into the big time with meth." She denies any significant history of marijuana use. "I tried it once, but it didn't do it for me." Brenda tells you when she was 37 she got arrested for possession of marijuana. "I got busted with a bunch of weed, and I went to jail." She reports she served 12 months. At age 39, Brenda started using methamphetamine. She reports daily use up until the time she went to federal prison. She tells you without methamphetamine she wouldn't be able to function. "I'd just crash. . . I'd be shaking all over, all I'd want to do was sleep. . . and I'd get so depressed I couldn't stand it. By the end, it didn't matter what I had to do to get meth."

Using the information in the case study, what substances does Brenda have a history using?

Identify the criteria, severity level, specifiers, and diagnostic code(s) which apply to this client.

## Summary/Conclusion

The APA has been the source for diagnostic criteria for disorders, including substance-related disorders for decades. Currently in its 5th edition, the *DSM-5* provides counselors with the most up-to-date information for making an accurate diagnosis of a SUD. Counselors can match client assessment data to determine if they meet specific diagnoses and to what severity level. The *DSM-5* provides counselors with relevant and valid information to guide them in making accurate client assessments.

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