Will almost all people with a DSM-IV dependence diagnosis will get a severe diagnosis with the DSM-5?
A: Yes, the vast majority of those with a DSM-IV dependence diagnosis will get a severe diagnosis with the DSM-5. This is also true for getting a dependence diagnosis with the ICD-10- criteria given a dependence diagnosis with the DSM-IV.

This sustained remission definition makes no sense to me as a clinician. Frankly, who dreamed this up? It is NOT useful in practice.
A: Actually the definition of sustained remission as having no positive indications of a problem for 12 contiguous months is appropriate for both the chronic addicted and the transient misuser. For the addicted, this criterion will not be met without abstinence. For the misusers, who do not manifest a loss of control over use, modification of behaviors to eliminate problems with continued use is also an appropriate outcome. This is the first time we have a universally applicable outcome measure. Abstinence for misusers is overkill, while just reducing days of use is irrelevant for the addicted. The typical measure of outcome used in many research projects consists of reducing days of use, but does not address the nature and extent of continuing problems.

The DSM-5 definition of remission allows for a mild slip without calling treatment a complete failure. If an addicted individual has a brief slip in use, but does not experience a positive problem on any of the DSM-5 criteria and resumes abstinence, that individual could still qualify for sustained remission. This gets away from the “all or nothing” perspective to which treatment is often subjected.

Question about the Demographic Risk Scale: You indicated that a 20-30% increased risk for those who are positive for the scale factors. Wondering is that for EACH factor or if a number of factors. If so, how many factors predict 20-30% relapse and do you have a citation for this data? Thank you! Dr. Rowland
A: At this time, the only published study documented this level of increased risk was for three or four positive responses of the items. A study submitted for publication on individuals diverted into treatment from the courts found more of a linear relationship between the number of positive items and risk.

A proposal was submitted to explore the scale further to determine if there are differential implications for the individual items and whether the scale is generalizable across gender, ethnicity, diagnoses, and type of treatment. Those interested in these findings should contact me at evinceassessment@aol.com.

How does the ASAM criteria fit in with this?
A: The ASAM Criteria assume that the individual has a substance use disorder diagnosis. Once you have determined the diagnoses, the ASAM Criteria are useful in tailoring the treatment plan for the individual. In other words, the DSM-5 identifies what conditions require treatment and the ASAM Criteria guide the treatment plan.

One clarification of this is that a diagnosis of moderate or severe would be required for an intensive level of care while a diagnosis of not greater severity than mild would probably justify only Level 1 placement.
How does the 'Big Five' correlate with ASAM criteria?
A: The count of positive Big Five criteria constitutes a risk factor, which would be applicable to Dimension 5 (Risk factors) of the ASAM Criteria. In other words, positive Big Five items would weight in on that dimension of the ASAM Criteria.

Is it true that more people will get a substance use disorder diagnosis with the DSM-5 than with the DSM-IV?
A: While this might be the case for some populations, it does not seem to be the case for those in correctional or DWI/DUI populations. The deletion of the legal problems criterion and the requirement of at least two positive criteria for a DSM-5 diagnosis will result in about half of first-time DUI/DWI offenders not meeting DSM-5 criteria according to a study we have submitted for publication.

The so-called diagnostic orphans who were positive for two dependence criteria but no abuse criteria would get a diagnosis with the DSM-5 when they did not get one with the DSM-IV.

In short, the same proportion of cases is likely to get a diagnosis with the DSM-5. Whether this proportion is larger or smaller with the DSM-5 may depend on the specific population in question.

How can this not indicate loss of control? Driving under the influence, unplanned use, and great deal of time using are all indicators of loss of control?
A: Driving under the influence does not necessarily indicate a loss of control. Many individuals do not really appreciate that they are impaired when they drive after drinking or smoking marijuana. Or the individuals may feel that even if impaired they are still able to drive safely. A recent case in a town near where I live involved someone who drove a friend’s new car after dinner. The car owner had failed to put the new license plate on and so they were pulled over. The breath test was over the .08 limit and the person got a ticket for DUI. There is no indication of loss of control in this case – bad judgment but no loss of control.

Unplanned use as opposed to setting rules that are not followed does not necessarily constitute a loss of control. One might occasionally drink more than originally planed. An example would be someone in a social situation who had planed to leave when another friend came. As a result, the individual might have another drink that was not originally planed. This might happen occasionally to qualify as a positive criterion. As with some of the other criteria, the exact nature of why a criterion might be positive may be as important as whether it technically is positive. For example, if the unplanned use is pervasive and often results in other problems, that would seem more serious.

Likewise, spending a great deal of time using does not itself constitute a loss of control. The individual could plan to drink that much or that long. For example, someone who spends a few hours drinking most nights during the week and also parties much of the night on Saturday might qualify for this criterion. Again, in this example there is no evidence of true loss of control – the person intends to use that much.

In sharp contrast, setting rules to limit use that are not followed, missing work or school or other role fulfillment lapses due to use, sacrificing social or family activities due to use, and craving/compulsion to use clearly indicate a clear loss of control.