The DSM-5 Substance-Related Disorders Work Group published an article for clinical guidance[3] in which it discussed the various assessments and judgments that went into the criteria for substance use disorders in DSM-5. The decision was made to combine the previously separate categories of abuse and dependence. However, a continuum of severity was to be used based on counting the number of criteria. The more extreme or severe substance use disorder was considered an addiction, although the term was omitted because of the stigma attached to the word (Ref 2, p 485). The idea was that what was formerly considered abuse would now be considered a moderate substance use disorder, and what was formerly considered substance dependence (or addiction) would now be considered a severe substance use disorder. DSM-5 criteria thresholds are used that would yield the best agreement with the prevalence of DSM substance abuse and dependence disorders combined for a diagnosis of substance use disorder.

There were concerns that a threshold of two criteria was too low and that such low severity levels were not true cases (i.e., would not separate case from noncase).[3,4] The two-symptom threshold was too low to separate from no diagnosis.[4] Hence, DSM-5 subsequently used the two- to three-symptom threshold for public health purposes and to help with treatment of unhealthy behavior rather than for a specific abuse or addiction diagnosis.

The Work Group also clarified that craving was not particularly helpful in diagnosing addiction. Some studies have suggested that craving is redundant of the other criteria. The psychometric benefit of adding a craving criterion was equivocal, but the DSM-5 Work Group decided to use a suggested craving query while awaiting the development of biological craving indicators. Three of the SUD criteria (tolerance, withdrawal, and craving) do not specifically identify addicted behavior.

It does not make clinical or scientific sense, in that it lacks specificity, that the diagnosis changes from no diagnosis (2 of 11 criteria in field trials)[4] to the most severe form of the disorder (addiction) with the addition of 2 of 9 criteria/symptoms, if a threshold of 4 of 11 criteria is used. This is not a scientifically sound or clinically helpful method of diagnosing addiction or what was formerly called substance dependence. I would submit that the DSM-5 suggestion of considering addiction as the most severe or extreme form of SUD (Ref 2, p 485) makes the most sense in requiring 6 of 11 SUD criteria.

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Reply

We thank Dr. Samuel for continuing the conversation about the changes in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5)[1] related to substance use disorders. Although he expressed his disagreement with our "assessments and conclusions" we first wish to point out that we agree with some of his subsequent comments, as we expressed in our paper.[2] For example, we described the same concern expressed by Dr. Samuel that the new criterion of craving "does not contribute much to the diagnostic exercise and is thus not likely to have clinicolegal significance," but was added "in hopes of future biological treatments targeting craving" (Ref. 2, p 445). We also noted that concerns have been raised about the diagnostic threshold of two criteria for diagnosis of mild use disorder (Ref. 2, p 445) and, in fact, discussed at length the forensic significance of this choice by the DSM-5 Work Group. Hasin and colleagues (Ref. 3, pp 840–1) clearly noted this concern, but dismissed it in stating that the overall prevalence of the Fourth Edition (DSM-IV)[4] abuse and dependence disorders matched very closely with the total prevalence of use disorders when the threshold of two or more criteria is used. The concern expressed by Dr. Samuel in his last paragraph does not describe a disagreement with any of our conclusions, but rather with the decisions reached by the DSM-5 Work Group, about which we remained agnostic and merely descriptive in our paper.

There is a major area of confusion, however, related to the correlation of the former abuse and dependence categories with the levels of severity in the new use disorders, which is germane to the second and final paragraphs of Dr. Samuel's letter. This confusion may stem from the research literature itself, in which the terminology used to describe the severity of use disorders at various criteria levels was transformed in 2013. Early papers described the presence of two to three criteria as a moderate use disorder and the presence of four or more criteria as a severe use disorder.[5–8] Subsequent papers used the terminology ultimately adopted in DSM-5: two to three criteria for mild disorder, four to five for moderate, and six or more for severe.[2,9] Thus, when Dr. Samuel writes that "what was formerly considered abuse would now be considered moderate substance use disorder and what was formerly considered substance dependence . . . would now be considered severe substance use disorder," he is correct in regard to the terminology used in the earlier stages of the literature leading up to DSM-5. However, that was not the schema ultimately adopted by the Work Group. We noted that final decision, as described by the Vice Chair of the DSM-5 Task Force (Ref. 2, p 448). To add to that description, the DSM-5 code for mild alcohol use disorder is 305.00 (Ref. 1, p 491), the same code as was used in the Fourth Edition, Text Revision (DSM-IV-TR) for alcohol abuse (Ref. 10, p 214). The DSM-5 codes for moderate and severe alcohol abuse are both 303.90 (Ref. 1, p 491), the same code used for alcohol dependence in DSM-IV-TR (Ref. 10, p 213). Thus, in its final form, DSM-5 equates abuse to a mild use disorder and dependence to moderate and severe use disorders.

We agree with Dr. Samuels (and so noted in our paper; Ref. 2, p 445) that the decision to use a threshold of two criteria had a "public health purpose," in the same way that Hasin *et al.* noted the "need to identify all cases meriting intervention, including milder cases" (Ref. 3, p 841). In fact, this public health purpose was precisely the basis for our discussion about the clinicolegal significance of this change. If the medical profession believes that clinical intervention is appropriate at these lower levels of criteria, we predicted that attorneys will use this same argument in court in requesting diversion to treatment for their clients whose conditions do not rise to the level of what was formerly described as dependence or addiction, the condition which is the current basis of many of the diversion statutes that we reviewed.

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