IMPACT OF THE DSM-IV TO DSM-5 CHANGES ON THE NATIONAL SURVEY ON DRUG USE AND HEALTH

Substance Abuse and Mental Health Services Administration
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Rockville, Maryland 20857

June 2016

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Contract No. HHSS283201000003C
RTI Project No. 0212800.001.108.006.026

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June 2016

Recommended Citation: Center for Behavioral Health Statistics and Quality. (2016). *Impact of the DSM-IV to DSM-5 Changes on the National Survey on Drug Use and Health*. Substance Abuse and Mental Health Services Administration, Rockville, MD.

Acknowledgments

This report would not be possible without the guidance and input of staff from the Center for Behavioral Health Statistics and Quality. In particular, at the Substance Abuse and Mental Health Services Administration: Janet Kuramoto, Dicy Painter, and Peggy Barker. At RTI International (a trade name of Research Triangle Institute), Mark Edlund, Justin Landwehr, and Jennifer Schoden.

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Executive Summary

- The *Diagnostic and Statistical Manual of Mental Disorders* (DSM) is a manual detailing diagnostic criteria for mental health disorders and substance use disorders (SUDs). In May 2013, the DSM-5 was released, the first major revision since the publication of DSM-IV in 1994. The DSM-5 revision contains changes in structure, content, and criteria, based upon research developments over the past 20 years, including the addition and removal of several disorders as well as changes to criteria for specific disorders.
- The National Survey on Drug Use and Health (NSDUH) and the Mental Health Surveillance Study (MHSS) clinical interview assess SUDs and mental health disorders based on DSM-IV criteria. DSM-5–based disorder prevalence estimates may differ from those obtained using DSM-IV criteria, causing NSDUH and MHSS clinical study estimates to diverge from DSM-5 estimates. Evaluation of criteria changes for SUD indicates that current DSM-IV–based NSDUH estimates may underestimate DSM-5 diagnosed SUDs, depending on the substance being examined. The prevalence of single-item endorsement for SUDs, indicates that alcohol, hallucinogens, and prescription pain relievers have the highest risk for misclassification of SUD resulting from unassessed criteria (i.e., substance craving).
- Research on the expected difference between DSM-IV– and DSM-5–based estimates is limited. Available data suggest DSM-5–based prevalence estimates among adults may be marginally higher than DSM-IV–based prevalence estimates. Therefore, the current MHSS may provide an underestimate of DSM-5 disorders, which could lead to a higher rate of false negatives in the any mental illness (AMI) and serious mental illness (SMI) algorithms used in NSDUH. Several additional disorders may merit inclusion in future MHSSs, which may improve the sensitivity and specificity of the AMI/SMI algorithm in NSDUH. However, the addition of disorders to the MHSS would increase the respondent burden and lengthen the interview. Priority should be given to disorders with a high prevalence and/or a high clinical relevance (i.e., SMI). Also, disorders that are likely to affect the overall prevalence of AMI or SMI should be given consideration. If a particular disorder is highly comorbid with another, already assessed disorder, then adding the new disorder would not have a strong effect on the overall prevalence of AMI/SMI. Attention deficit hyperactivity disorder, binge eating disorder, and conduct disorder may offer the best tradeoff of information gained versus added respondent burden.
- One additional change to the DSM may merit further consideration. The DSM-5 has eliminated the global assessment of functioning (GAF) score, which was an important component for determining mental illness severity in the AMI/SMI algorithm. It has been suggested that the World Health Organization Disability Assessment Schedule (WHODAS) be used as a replacement for the GAF in determining severity of mental illness. If the WHODAS were used to identify impairment instead of the GAF, then the WHODAS data collected in the MHSS would be used to identify the cases with a clinical diagnosis of SMI, while the WHODAS data collected in the main NSDUH interview would be used in the model that predicts SMI.

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1. Introduction

The *Diagnostic and Statistical Manual of Mental Disorders* (DSM) is a manual used to classify mental disorders. It provides a classification system for clinicians, insurance providers, researchers, and policymakers to use in matters related to the diagnosis, research, and treatment of mental illness. In 2013, the DSM, 4th edition (DSM-IV), which had been used for over a decade was replaced with the 5th edition (DSM-5) [1,2]. This revision contained changes in organization and numerous changes to the diagnostic criteria of nearly every DSM-IV disorder. Some disorders underwent only minor wording changes, whereas others had extensive criteria changes. There have also been additions and removals of disorders.

The changes from DSM-IV to DSM-5 have significance across many domains. They are relevant to mental health and substance use diagnosis and treatment, medical billing procedures, and mental health research. Furthermore, they are potentially relevant to policy making if the revisions lead to significant alterations in the estimate of disease burden in the United States. In addition, these changes are particularly relevant to the National Survey on Drug Use and Health (NSDUH), which used the DSM-IV to provide national and state-level data on the use of tobacco, alcohol, and illicit drugs (including nonmedical use of prescription drugs) and mental health in the United States. NSDUH is sponsored by the Substance Abuse and Mental Health Services Administration (SAMHSA), and supervised by SAMHSA's Center for Behavioral Health Statistics and Quality (CBHSQ). NSDUH data provide the substance use and mental health prevention, treatment, and research communities with current, relevant information on the nation's substance use and mental health status. These data also provide important information to stakeholders and policymakers about disease burden, temporal trends, and consequences of substance use and mental illness and help identify high-risk groups.

Each year, NSDUH collects substance use and mental health information from approximately 70,000 residents of households and noninstitutional group quarters (e.g., shelters, rooming houses, dormitories) and from civilians living on military bases. The survey excludes homeless people who do not use shelters, military personnel on active duty, and residents of institutional group quarters, such as jails and hospitals. Although NSDUH has collected data annually since 1971, this report focuses on data collection from 2002 onward as methodological changes to the survey make prior years difficult to compare. NSDUH currently assesses three DSM-IV–based disorders and indicators: substance use disorders (SUDs), major depressive episodes (MDE), and indicators of mental illness, including degrees of severity (any mental illness [AMI], low/mild mental illness [LMI], moderate mental illness [MMI], and serious mental illness [SMI]). The assessment of SUDs and MDE will be directly affected by the change between DSM-IV and DSM-5, whereas the measurement of AMI, LMI, MMI, and SMI will be indirectly affected as a result of the process for measuring mental illness (discussed below).[1]

In 2008, NSDUH underwent an important modification so that the survey could provide estimates of mental illness in the population. Two measures of functional impairment were added to NSDUH using a split sample design; a randomly selected half of NSDUH respondents

[1] More information about NSDUH survey methodology can be found in the 2012 National Findings Reports [3].

reporting past year psychological distress (measured by the Kessler-6; K6 [4]) were administered a modified version of the World Health Organization Disability Assessment Schedule (WHODAS [5]) and half were administered the Sheehan Disability Scale (SDS [6]). After 2008, all respondents reporting past year psychological distress received the WHODAS measure of functional impairment. The K6 and WHODAS, in combination with several other indicators are used to generate a predictive probability of mental illness among adult NSDUH participants. This is accomplished using a predictive model developed in the Mental Health Surveillance Study (MHSS).

The MHSS is a multicomponent study consisting of short scales included in a large sample of the population, detailed diagnostic data collected from a small subsample (using a revised version of the Structured Clinical Interview for DSM-IV Axis I Disorders, research version [SCID-I-RV], nonpatient edition [7]), and statistical analysis of the combined dataset to produce estimates of mental illness. That is, the MHSS collects data in a separate clinical follow-up study on a subsample of NSDUH respondents. Prediction models of SMI and AMI were developed from this subsample of respondents, using the data reported by these respondents from short scales on psychological distress and impairment that are within the NSDUH, combined with their clinical interview data. These models are used to produce predicted probabilities of SMI for each of the adult respondents in the main NSDUH, which are then used to produce national estimates of SMI [8,9].[2] This procedure means that changes in the underlying diagnostic criteria will also indirectly affect estimates of mental illness in NSDUH by altering the outcome measure against which the predictive model is calibrated.

The purpose of this report is twofold: (1) to describe the changes in diagnostic criteria from DSM-IV to DSM-5, and (2) to evaluate their potential impact on NSDUH estimates using the best available evidence. This report is divided into three sections. Chapter 2 focuses on changes in SUD criteria and their impact on NSDUH. We start by delineating the overall changes to SUD criteria and then explore the potential impact on estimates of specific substances of abuse. Chapter 3 focuses on changes to other psychiatric diagnoses for adults. It begins with an evaluation of high-level organizational and conceptualization changes from DSM-IV to DSM-5 and then examines criteria changes for individual disorders. Individual disorders are grouped into three sections. The first section focuses on changes to disorders currently included in the MHSS. The second section examines disorders that could be considered for inclusion in the MHSS as a result of changes to the DSM that may affect prevalence or other important factors (e.g., disease burden). Finally, there is a brief discussion of disorders that are not included in the MHSS and the reasons supporting their continued exclusion from the MHSS.

[2] More information about the measurement of AMI and SMI can be found in *The NSDUH Report: Revised estimates of mental illness from the National Survey on Drug Use and Health* [8,10].

2. Substance Use Disorders

2.1 Overview

Substance use disorders (SUDs), as described in DSM-IV, are part of a class of disorders (substance-related disorders) that are "related to the taking of a drug of abuse (including alcohol)" [1 p. 175]. Although the transition from DSM-IV to DSM-5 involves changes at multiple levels for SUDs, this basic definition remains unchanged [1,2]. However, changes have occurred at the class level (the specific disorders considered within the overall group of disorders), at the substance level (which substances are considered "drugs of abuse"), at the disorder level (the template of criteria that are applied, with some deviations, across all substances), and at the individual criteria level (the number and types of symptoms needed to meet criteria for a disorder). The following section delineates the specific changes from DSM-IV to DSM-5 and evaluates, to the extent possible given the available data, how these changes may affect the measurement of substance use disorders in the National Survey on Drug Use and Health (NSDUH) and the Mental Health Surveillance Study (MHSS). Table 2.1 provides a cross-cutting comparison of diagnostic criteria for both DSM-IV and DSM-5, which is important for framing the discussion of diagnostic changes across versions.

NSDUH SUD assessments map closely to the DSM-IV criteria; however, NSDUH diverges occasionally from DSM-IV. Changes discussed below note the differences in NSDUH from DSM-IV criteria and the changes from DSM-IV to DSM-5. Currently available literature focuses on changes from DSM-IV to DSM-5; thus, in places where NSDUH diverges from the DSM-IV criteria, the impact of DSM-5 criteria changes on NSDUH may be difficult to quantify. These limitations are noted, as are the limitations in the current literature overall.

2.2 Categorization Changes

A disorder "class" is the term used to describe groups of similar disorders in the DSM (e.g., anxiety disorders and mood disorders). The DSM-5 contains numerous changes in the classification system and one of these changes has been to the classification of SUDs. In DSM-IV, SUDs belonged to the class substance-related disorders, which included only substance/drug-based disorders. In DSM-5 this classification has been broadened to include gambling disorder, and the section has been renamed Substance-Related and Addictive Disorders. Although this change will have no impact on prevalence estimates for SUDs, ensuring precise language in Substance Abuse and Mental Health Services Administration (SAMHSA) documentation and reports will be important to avoid equating prevalence estimates for any substance use disorder with prevalence estimates of the broader category of substance-related and addictive disorders.

Table 2.1 Comparison of DSM-IV, DSM-5, and NSDUH Substance Use Disorder Assessment

Characteristic	DSM-IV	DSM-5	NSDUH
Disorder Class	Substance-related disorders, included only SUDs	Substance-related and addictive disorders class now includes SUDs and gambling disorder (formerly pathological gambling)	Same as DSM-IV
Disorder Types[1]	Abuse and dependence hierarchical diagnostic rules meant that people ever meeting criteria for dependence did not receive a diagnosis of abuse for the same class of substance	SUD, substance abuse and dependence have been eliminated in favor of a single diagnosis, SUD	Same as DSM-IV
Substances Assessed	11 classes of substances assessed, plus 2 additional categories	10 classes of substances assessed, plus 2 additional categories	Modules for 13 substances, plus 2 additional categories
	• Alcohol	• Alcohol	• Alcohol
	• Amphetamine and similar sympathomimetics	• Stimulant use disorder, which includes amphetamines, cocaine, and other stimulants	• Stimulants
	• Caffeine (intoxication only)	• Caffeine (intoxication and withdrawal)	• Not assessed
	• Cannabis (no withdrawal syndrome)	• Cannabis (with withdrawal syndrome)	• Cannabis (no withdrawal syndrome)
	• Cocaine	• Combined with other stimulants (e.g., amphetamines) under stimulant use disorder	• Cocaine
			• Crack
	• Hallucinogens • Phencyclidine and similar arylcyclohexylamines	• Separated into phencyclidine use disorder and other hallucinogen use disorder	• Hallucinogens
	• Inhalants (no withdrawal syndrome)	• Inhalants (no withdrawal syndrome)	• Inhalants
	• Nicotine (dependence only)	• Tobacco	• Cigarette dependence (measured by two non-DSM–based scales), other tobacco products (use only)
	• Opioids	• Opioids	• Heroin
			• Pain reliever
		• Merged with hallucinogens	
	• Sedatives, hypnotics, and anxiolytics	• Sedatives, hypnotics, and anxiolytics	• Sedatives
			• Tranquilizers
	• Other drug abuse/dependence	• Any other SUD	• Other drugs (use only)
	• Polysubstance dependence	• Dropped polysubstance use disorder	• Polysubstance dependence

(continued)

Table 2.1 Comparison of DSM-IV, DSM-5, and NSDUH Substance Use Disorder Assessment (continued)

	DSM-IV	DSM-5	NSDUH
Disorders Assessed	**Substance abuse: One or more symptoms**	**SUD: Two out of 11 criteria clustering in a 12-month period are needed to meet disorder threshold**	**Substance abuse: One or more symptoms in the past year**
	• Recurrent substance-related legal problems	• Dropped	• DSM-IV criterion assessed
	• Recurrent substance use in situations where it is physically hazardous	• Same	• Assessed
	• Recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home	• Same	• Assessed
	• Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance	• Same	• Assessed
		• Added: Craving or a strong desire or urge to use the substance	• DSM-5 craving criterion not assessed
	Substance dependence: Three or more symptoms in the same 12-month period (or one symptom if dependence criteria have been met previously in the lifetime)		**Substance dependence: Three or more symptoms in the past year**
	• Substance is taken in larger amounts or over a longer period than was intended	• Same	• Assessed
	• There is a persistent desire or unsuccessful efforts to cut down or control substance use	• Same	• Assessed
	• A great deal of time is spent in activities necessary to obtain the substance, use the substance, or recover from its effects	• Same	• Assessed
	• Important social, occupational, or recreational activities are given up or reduced because of substance use	• Same	• Assessed
	• Substance 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 substance use	• Same	• Assessed

(continued)

Table 2.1 Comparison of DSM-IV, DSM-5, and NSDUH Substance Use Disorder Assessment (continued)

	DSM-IV	DSM-5	NSDUH
	• Tolerance, as defined by either: (1) a need for markedly increased amounts of substance to achieve intoxication or desired effect or (2) a markedly diminished effect with continued use of the same amount of the substance	• Same	• Assessed
	• Withdrawal, as manifested by either: (1) the characteristic withdrawal syndrome for the substance (excludes Cannabis, Hallucinogens, and Inhalants see Table 2.2) (2) the substance (or a similar substance) is taken to relieve or avoid withdrawal symptoms	• Withdrawal, as manifested by either: (1) the characteristic withdrawal syndrome for the substance (excludes Phencyclidine, Other Hallucinogens, and Inhalants; see Table 2.2) (2) the substance (or a closely related substance) is taken to relieve or avoid withdrawal symptoms Note: This criterion is not considered met for those taking opioids, sedatives, hypnotics or anxiolytics, or stimulant medications solely under appropriate medical supervision.	• Assessed, see Table 2.2 for variations from DSM-IV
Severity	No severity criteria	Severity is assessed in terms of the number of symptoms that meet criteria: Mild: two to three symptoms Moderate: four to five symptoms Severe: six or more symptoms	• No severity criteria assessed
Additional Specifications	With or without physiological dependence, early full remission, early partial remission, sustained full remission, sustained partial remission, on agonist therapy, and in a controlled environment	Early or sustained remission and if the person is in a controlled environment where access to the substance is restricted	• Not assessed

DSM-IV = *Diagnostic and Statistical Manual of Mental Disorders*, 4th edition; DSM-5 = *Diagnostic and Statistical Manual of Mental Disorders*, 5th edition; NSDUH = National Survey on Drug Use and Health; SUD = substance use disorder.

[1] Table does not include substance/medication-induced disorders with the exception of notations for withdrawal and caffeine intoxication.

2.3 Types of Substances

NSDUH contains 13 modules assessing specific substances and substance types (tobacco, alcohol, marijuana, cocaine, crack, heroin, hallucinogens, inhalants, prescription pain relievers [opioids], tranquilizers, stimulants, and sedatives) and 1 module assessing special substance use, which assesses primarily methods of use.[3] It also has the capacity to determine polysubstance dependence. The substances assessed vary somewhat from DSM-IV specified substances (see Table 2.1). Specific differences in NSDUH from DSM-IV include the following:

- Separate modules for assessing free-base (crack) cocaine and salt forms of cocaine (e.g., cocaine hydrochloride), which are combined in DSM-IV;
- Separate modules for heroin and prescription pain relievers, which are combined as opioids in DSM-IV;
- Assessment of only cigarette dependence, instead of nicotine dependence (NSDUH does assess use of alternate forms of tobacco, but does not assess dependence for these products); measured by non-DSM–based scales: the Nicotine Dependence Syndrome Scale (NDSS) [11]and the Fagerstrom Test for Nicotine Dependence (FTND) [12].
- Assessment of use of other drugs not specifically asked about in existing modules is done by using open respondent-provided options in the hallucinogens, inhalants, and all of the prescription drug modules (stimulants, pain relievers, sedatives, tranquilizers). However, NSDUH does not assess SUDs for substances listed in the open respondent-provided items (e.g., "bath salts"). Not assessing abuse and dependence for other illicit drugs and other forms of tobacco likely leads to a slight underestimate of these disorders at the population level.

Changes from DSM-IV to DSM-5 in the types of substances assessed have been minor, but some reclassification has occurred. Primarily, cocaine (including crack) and amphetamines have been combined with other stimulants (excluding caffeine) into a single stimulant class based on evidence that they have similar mechanisms of action (increasing synaptic dopamine), symptom profiles, consequences, and prognoses. NSDUH-based reports could provide the estimates of the newly combined categories in addition to substance-specific estimates (e.g., providing an estimate for amphetamine use disorder and providing the estimate for all stimulants combined) in the future to enable comparisons with other datasets, track trends for the new diagnostic categories, and improve consistency with DSM-5 conventions.

2.4 Criteria for Substance Use Disorders

NSDUH assesses substance abuse and substance dependence. DSM-IV and DSM-5 also assess substance intoxication, intoxication delirium, withdrawal syndrome, and withdrawal delirium for relevant substances. Because NSDUH does not assess those additional disorders, this report focuses only on changes to substance abuse and dependence criteria.

[3] In the current NSDUH questionnaire, the stimulants module includes questions on methamphetamine use. Beginning in 2015, questions on methamphetamine use will comprise a separate module in the NSDUH questionnaire.

2.4.1 Substance Abuse and Substance Dependence

A major change from DSM-IV to DSM-5 is the combination of substance abuse disorder and substance dependence disorder into a single SUD. The DSM-IV substance abuse diagnosis required the endorsement of one or more symptoms (out of four, at any time) and no history of substance dependence for that category of substances (see Table 2.1 for the specific criteria). The substance dependence criteria required the endorsement of three or more symptoms (out of seven) in a 12-month period. DSM-IV diagnostic hierarchy rules also specified that people who met criteria for both substance abuse and substance dependence for a particular substance were diagnosed as having substance dependence only. The purpose of this was to reflect the increased severity of dependence over the abuse diagnosis [13]. The DSM-5 has eliminated the distinct abuse and dependence disorders for several reasons: (1) the distinction provided little guidance for treatment; (2) the distinction created "diagnostic orphans" (individuals who endorsed two dependence symptoms and no abuse symptoms and therefore did not meet any diagnostic criteria); (3) the hierarchical structure did not follow the anticipated relationship between abuse and dependence (that abuse was largely a less severe prodrome[4] of dependence); and (4) the separation caused the abuse diagnosis to suffer from significant reliability problems [13,15-21]. The DSM-5 combines the abuse and dependence criteria under the new rubric substance use disorder, which requires 2 out of 11 criteria in a 12-month period for diagnosis. In addition, the DSM-5 has eliminated the abuse criterion related to recurrent substance-related legal problems (e.g., arrests for substance-related disorderly conduct [1]) and added a craving criterion. The legal problems criterion was dropped due to low endorsement, poor fit with other items, and the poor discrimination of this item (almost all people endorsing the legal criteria endorsed other criteria also) [13]. This was further verified by estimates using NSDUH data, discussed further in Section 2.5, Specific SUDs.

Under DSM-5 criteria, craving is defined as a "strong desire or urge to use the substance." DSM-5 text further adds that the phenomenon of craving "makes it difficult to think of anything else" and "often results in the onset" of use [2, p. 492]. Examination of general population studies indicated that craving, as an indicator of an SUD, did not add to the total information offered by other **dependence** criteria. That is, other dependence criteria (e.g., tolerance, withdrawal, and continuing use despite health problems) overlapped with craving so that the addition of craving identified very few people who did not already meet the threshold for a disorder through the other dependence criteria. However, the inclusion of craving with the **abuse** criteria added significantly to the diagnostic information and there is some indication that craving may become a target for biological treatments [22]. Notably, craving was already a component of the International Classification of Diseases, 10th revision (ICD-10), diagnostic system, which is used outside of the United States, and thus the DSM-5 craving addition improves consistency across classification systems.

NSDUH does not assess the craving criterion. If no changes were made to NSDUH questions and existing data were used to approximate the estimates by modifying the diagnostic algorithm, the impact would be seen on threshold-level cases (i.e., individuals who endorsed only one criterion). Data from other studies that assessed craving (such as the National

[4] A "prodrome" is "an early or premonitory symptom of a disease," according to *Stedman's Medical Dictionary*, 27th edition [14].

Epidemiologic Study of Alcohol and Related Conditions [NESARC] and the National Longitudinal Alcohol Epidemiologic Survey [NLAES]) could be used to impute the frequency of people who would reach diagnostic threshold if the craving criterion was present. Imputation could be done with the population-level estimates or at the individual level. However, the current data that would be used to generate these estimates are between 10 (NESARC) and 20 (NLAES) years old and do not include adolescents. Imputation could increase the chances of misclassification, which may bias statistical results, particularly in analyses involving a large number of people close to the diagnostic threshold. In addition, the prevalence and characteristics of people endorsing the craving criterion may vary by substance. This is discussed in more detail later in this report in the context of the individual substances.

2.4.2 Withdrawal Criteria

An additional criterion that has undergone some revisions in DSM-5 is the dependence criterion of withdrawal. Unlike other criteria, withdrawal symptoms are specific to the physiological effect of the substance (Table 2.2). In both DSM-IV and DSM-5, withdrawal is manifested by either (1) a person having the characteristic withdrawal symptoms for the substance, or (2) a person using the same or closely related substance to avoid the substance-specific withdrawal symptoms. DSM-IV and DSM-5 withdrawal criteria are unchanged for all substances except cannabis. Research conducted after the publication of the DSM-IV has identified a cluster of symptoms associated with cannabis withdrawal, and this new information has been included in the DSM-5 [2]. Cannabis withdrawal syndrome is defined by the presence of three or more symptoms developing within approximately 1 week of cessation of heavy and prolonged cannabis use. Symptoms can include (1) irritability, anger, or depression; (2) nervousness or anxiety; (3) sleep difficulties (e.g., insomnia or disturbing dreams); (4) decreased appetite or weight loss; (5) restlessness; (6) depressed mood; and (7) at least one physical symptom that causes significant discomfort (abdominal pain, shakiness/tremors, sweating, fever, chills, or headache).

NSDUH assesses withdrawal (except cannabis withdrawal) as one part of the dependence criteria. However, NSDUH departs from DSM-IV criteria in several ways. With respect to specific substances, NSDUH diverges in three cases (see Table 2.2). First, NSDUH does not assess tobacco withdrawal. Second, there are some deviations from the withdrawal criteria for sedatives, hypnotics, or anxiolytics. DSM-IV specifies two or more symptoms to meet criteria for sedative, hypnotic, or anxiolytic withdrawal, although the NSDUH instrument specifies only that one symptom is necessary. This particular deviation is addressed in the future redesign, planned for 2015, and to conform with DSM-IV and DSM-5 withdrawal criteria. Moreover, DSM-IV criteria for sedative, hypnotic, or anxiolytic withdrawal specify only the symptom of insomnia, but NSDUH includes insomnia or hypersomnia. These differences may have led to an overestimate of the number of people who met criteria for sedative, hypnotic, or anxiolytic withdrawal and therefore substance dependence. Third, NSDUH has not historically assessed tranquilizer withdrawal leading to a potential underestimate of tranquilizer dependence.

Table 2.2 DSM-IV to DSM-5 Withdrawal Symptom Comparison

Substance	Symptom	DSM-IV	DSM-5	NSDUH
Alcohol	Two or more symptoms	√	√	√
	Autonomic hyperactivity	√	√	√
	Increased hand tremor	√	√	√
	Insomnia	√	√	√
	Nausea or vomiting	√	√	√
	Transient visual, tactile, or auditory hallucinations or illusions	√	√	√
	Psychomotor agitation	√	√	√
	Anxiety	√	√	√
	Generalized tonic-clonic seizures (formerly grand mal seizures)	√	√	√
Cannabis	Three or more symptoms		√	
	Irritability, anger, or aggression		√	
	Nervousness or anxiety		√	
	Sleep difficulty (i.e., insomnia, disturbing dreams)		√	
	Decreased appetite or weight loss		√	
	Restlessness		√	
	Depressed mood		√	
	At least one of the following physical symptoms causing significant discomfort: abdominal pain, shakiness/tremors, sweating, fever, chills, or headache		√	
Cocaine	Dysphoric mood and two or more symptoms	√	(See Stimulant Use)	√
	Fatigued	√		√
	Vivid, unpleasant dreams	√		√
	Insomnia or hypersomnia	√		√
	Increased appetite	√		√
	Psychomotor retardation or agitation	√		√
Hallucinogens and Phencyclidine	No withdrawal diagnosis			
Inhalants	No withdrawal diagnosis			
Opioid	Three or more symptoms	√	√	√[1] √[2]
	Dysmorphic mood	√	√	√[1] √[2]
	Nausea or vomiting	√	√	√[1] √[2]
	Muscle aches	√	√	√[1] √[2]
	Lacrimation or rhinorrhea	√	√	√[1] √[2]
	Yawning	√	√	√[1] √[2]
	Pupillary dilation, piloerection, or sweating	√	√	√[1] √[2]
	Diarrhea	√	√	√[1] √[2]
	Fever	√	√	√[1] √[2]
	Insomnia	√	√	√[1] √[2]

(continued)

Table 2.2 DSM-IV to DSM-5 Withdrawal Symptom Comparison (continued)

Substance	Symptom	DSM-IV	DSM-5	NSDUH
Sedative, Hypnotic, or Anxiolytic	Two or more symptoms	√	√	
	One or more symptoms			√[3,4]
	Autonomic hyperactivity	√	√	√[4]
	Hand tremor	√	√	√[4]
	Insomnia	√	√	
	Insomnia or hypersomnia			√[4]
	Nausea or vomiting	√	√	√[4]
	Transient visual, tactile, or auditory hallucinations or illusions	√	√	√[4]
	Psychomotor agitation	√	√	√[4]
	Anxiety	√	√	√[4]
	Grand mal seizures	√	√	√[4]
Stimulant	Dysphoric mood and two or more additional symptoms	√	√	√
	Fatigue	√	√	√
	Vivid, unpleasant dreams	√	√	√
	Insomnia or hypersomnia	√	√	√
	Increased appetite	√	√	√
	Psychomotor retardation or agitation	√	√	√
Tobacco	Four or more symptoms	√	√	
	Irritability, frustration, or anger	√	√	
	Anxiety	√	√	
	Difficulty concentrating	√	√	
	Increased appetite		√	
	Increased appetite or weight gain	√		
	Restlessness	√	√	
	Depressed mood	√	√	
	Insomnia	√	√	
	Decreased heart rate	√		
Other Substance	A syndrome of substance-specific symptoms that causes clinically significant distress or impairment in social, occupational, or other areas of functioning	√	√	

DSM-IV = *Diagnostic and Statistical Manual of Mental Disorders*, 4th edition; DSM-5 = *Diagnostic and Statistical Manual of Mental Disorders*, 5th edition; NSDUH = National Survey on Drug Use and Health.

NOTE: Caffeine is not included in NSDUH assessments in any form and is therefore excluded from this table.

[1] Specifically asked for heroin.

[2] Specifically asked for pain relievers.

[3] This is being changed to two or more symptoms in the 2015 redesign.

[4] NSDUH assesses sedatives and tranquilizers in separate modules; withdrawal symptoms are not assessed for tranquilizers.

Conceptually, NSDUH diverges from DSM (IV and 5) withdrawal criteria in several ways (for all substances with a withdrawal component), which may lead to estimates that do not completely reflect DSM withdrawal criteria. Withdrawal criteria in DSM-5 consist of two items:

1. Criteria A and B from the specified characteristic withdrawal syndrome for the substance.

2. The substance (or a closely related substance) is taken to relieve or avoid withdrawal symptoms.

Criteria A and B differ slightly across substances but follow a general template. Criterion A specifies that the person has to have ceased (or reduced) heavy and prolonged use of the substance. Criterion B specifies that a certain number of symptoms, from a list provided (see Table 2.2) developed within several hours of a few days after the cessation (or reduction) from Criterion A. Deviations from this general pattern occur for sedative, hypnotic, or anxiolytics and stimulants, wherein the Criterion A specifies only prolonged use (not heavy), and cannabis, which specifies that the Criterion B symptoms develop within approximately 1 week of ceasing or reducing use.

In NSDUH, withdrawal is assessed with a series of questions that follow a unified template for all substances with withdrawal symptoms (except the new cannabis withdrawal). First, respondents have to answer affirmative to a question about having tried to cut down or quit before they are routed to the main withdrawal questions. This is potentially problematic because the DSM does not specify that the person had to intentionally try to go without the substance to meet withdrawal criteria (e.g. if a person runs out of their supply of a substance they may experience withdrawal even though they did not try to cut down or quit). This routing pattern may lead to an underestimate of the prevalence of withdrawal in NSDUH.

The second question for assessing withdrawal asks: "Please look at the symptoms listed below. During the past 12 months, did you have" # (varies by substance) "or more of these symptoms after you cut back or stopped using *substance*?" This is followed by a list of the specific withdrawal symptoms for that substance. If respondents answer affirmatively, then they receive another question about withdrawal that varies slightly from the previous: "Please look at the symptoms listed below. During the past 12 months, did you have # or more of these symptoms at the same time that lasted for longer than a day after you cut back or stopped" using *the substance*? Respondents are only considered to have met withdrawal criteria if they endorsed the second question. These questions have several points of potential deviation from DSM criteria.

- The question wording, in addition to the noted skip pattern and the question's proximity to questions asking about intentional reduction in use may lead to respondents believing that only intentional efforts to reduce or stop qualify for this question.
- The questions do not include the DSM description of stopping after heavy or prolonged use (they are asked of people who used at all in the past year).

- The items add an additional caveat that the symptoms happened "at the same time," which may be taken literally. This is not specified in the DSM-5 criteria, and withdrawal symptoms, while clustering in time, do not necessarily occur simultaneously.
- The NSDUH items also specify that the symptoms had to last longer than a day. This is not specified by DSM-5. Moreover, this question could be interpreted in two ways: the respondent may think that each of the specified number of symptoms had to last for longer than a day (so if the question specified two or more symptoms then at least two had to last for longer than a day); alternatively they may interpret it as meaning that the combined duration of the symptoms lasted at least a day.

The final deviation from DSM (IV and 5) criteria is that NSDUH does not assess the second part of the withdrawal item, which is taking the substance or a closely related substance to avoid withdrawal. This would likely lead to an underestimate of withdrawal symptoms because of missing individuals who preemptively avoided withdrawal symptoms by using the substance or a closely related substance.

With the potential for adding an assessment of cannabis withdrawal, these deviations should be considered since new items will need to be developed for cannabis and there is the opportunity to better map NSDUH to DSM criteria while other changes are being implemented. Because these deviations are specific to NSDUH, it is difficult to quantify the impact of their revision on prevalence estimates. Overall, it is probable that estimates would increase, but the magnitude of increase in unknown.

2.4.3 Severity Criteria

The DSM-IV did not specifically assess the severity of SUDs, although in general, dependence was considered more severe than abuse and people receiving the dependence diagnosis did not receive an abuse diagnosis even if the criteria for abuse were met [13]. DSM-5 has added a symptom count-based severity indicator, with two to three symptoms being classified as mild, four to five symptoms classified as moderate, and six or more symptoms being classified as severe. The severity index addition was driven by research, which suggested a simple symptom count was as effective at measuring severity as more complicated algorithms [23]. Calculation of severity using NSDUH could be accomplished with little effort if the craving criterion were added to the survey.

2.5 Specific SUDs

Thus far, changes in diagnostic criteria have been evaluated at the overall diagnostic level (the template applied to each substance, Table 2.1). However, criteria changes may not affect estimates for every substance equally and some substances deviate slightly from the general SUD template. This section discusses the impact of the DSM-5 revisions to each substance-specific SUD in terms of prevalence and measurement considerations.

2.5.1 Alcohol Use Disorder

Assessment of alcohol use disorder (AUD) aligns with the DSM-IV and DSM-5 SUD template discussed previously (i.e., DSM-IV assessed alcohol abuse [1 or more of 4 criteria] and

alcohol dependence [3 or more of 7 criteria], and DSM-5 assesses AUD [2 or more of 11 criteria], Table 2.1). The changes from DSM-IV to DSM-5 included the addition of the craving criterion, the removal of the legal problems criterion, and the change in threshold for diagnosis. Evidence for how the DSM-5 revision will affect this estimate is mixed. In an examination of responses in the second wave of the NESARC, a nationally representative household-based survey of over 34,000 U.S. adults, Agrawal, Heath, and Lynskey reported a DSM-IV past year AUD prevalence of 9.7 percent (weighted) and a prevalence of DSM-5 AUD of 10.8 percent, a relative increase of 11 percent [24]. Similarly, in a recent analysis of an aggregated dataset including 7,543 individuals from family-based and case-control genetic studies of substance dependence (86.6 percent of whom had an SUD), Peer et al. found that discordant subjects (those who had AUD under either DSM-IV or DSM-5 criteria, but not both), were more likely to have gone from no diagnosis under DSM-IV criteria to having a diagnosis under DSM-5 criteria rather than the reverse [25]. In the Peer et al. sample, the prevalence of AUD increased from 63.0 percent under DSM-IV to 63.5 percent under DSM-5 criteria. However, this study was primarily composed of individuals with an SUD and the impact on NSDUH estimates may not be the same. Results of a nationally representative study conducted in Australia, suggest that the increase may be more substantial in a more generalizable sample. The study, which included 10,641 adults sampled from representative households across Australia, found that there was a 61.7 percent increase (from 6.0 to 9.7 percent) in the prevalence of AUD among past year alcohol users when the criteria were changed from DSM-IV to DSM-5 [26].

Not all studies have found an increase in prevalence under DSM-5 criteria. In a population-based study of 5,443 current drinkers aged 18 to 64 in the Netherlands, 5.4 percent (weighted) of current drinkers had a past year AUD using DSM-IV criteria, whereas 4.4 percent of current drinkers met DSM-5 criteria (including craving) for past year AUD [27]. Comparisons across these studies are difficult because of the differences in the study population and also because of the denominator used to calculate estimates (e.g., all participants, participants who used alcohol in the past year, current drinkers).

Direct changes in AUD prevalence estimates resulting from each specific criteria change have also been examined in a handful of studies. The removal of the legal problems' criterion is expected to have little impact on the prevalence estimates because studies have found that this item has a low rate of endorsement and contributes little information beyond the other AUD criteria [24,28]. This is consistent with data from NSDUH, which indicates that, although 0.8 percent (Table 2.3, weighted) of respondents endorsed the legal criterion item in NSDUH, only 0.1 percent of respondents endorsed only the legal criterion (additional tables providing weighted Ns can be found in Appendix A, and corresponding prevalence estimates among past year substance using respondents as opposed to all respondents that are presented below are in Appendix B).

Preliminary evidence suggests that the addition of the craving item will increase the population prevalence of DSM-5 AUD. Table 2.4 contains a summary of the craving symptom endorsement prevalence reported in several studies. Estimates for the alcohol-craving symptom endorsement ranged from 1.3 to 7.0 percent for past year endorsement, but there was a much larger range for lifetime craving, which depending on the sample was from 3.5 percent in a nationally representative sample and 26 percent in a high-risk sample [13,25,29-31]. In the previously discussed study of primarily substance users, Peer et al., examined the causes of

DSM-IV and DSM-5 criteria status changes on AUD estimates and found that only 1 percent of status changes were caused by the addition of the craving criterion [25]. However, the results of this nonnationally representative study must be interpreted with caution based on the oversampling of substance-dependent participants, which may not generalize to a population-based sample. Agrawal and colleagues' analysis of the wave 2 NESARC data (a more generalized sample) suggested a slightly larger impact resulting from the addition of the craving criterion [24]. Of the 3,026 people who endorsed only 1 of the 10 DSM-5 criteria (excluding craving), 4.1 percent (unweighted, less than 1 percent of the total population) met DSM-5 criteria resulting from endorsement of the craving item.

Table 2.3 Alcohol Legal Criterion Endorsement among People Aged 12 or Older, by Demographic Characteristic: Weighted Percentages, Annual Averages Based on 2002-2012 NSDUHs

Demographic Characteristic	DSM-IV Legal Criterion Endorsement	Respondents Who Endorsed Only the DSM-IV Legal Criterion	Respondents Who Endorsed the DSM-IV Legal Criterion and One other DSM-IV SUD Criterion
TOTAL	0.8	0.1	0.1
GENDER			
Male	1.4	0.1	0.1
Female	0.3	0.0	0.0
HISPANIC ORIGIN AND RACE			
Not Hispanic or Latino	0.7	0.0	0.1
White	0.6	0.0	0.1
Black or African American	1.1	0.1	0.1
American Indian or Alaska Native	4.1	0.3	0.3
Native Hawaiian or Other Pacific Islander	1.5	0.0	0.1
Asian	0.4	0.0	0.1
Two or More Races	1.0	0.1	0.1
Hispanic or Latino	1.5	0.1	0.2
AGE			
12-13	0.1	0.0	0.0
14-15	0.8	0.1	0.1
16-17	1.5	0.1	0.2
18-25	2.0	0.1	0.2
26-35	1.2	0.1	0.1
36-45	0.8	0.0	0.1
46-55	0.7	0.0	0.1
56-64	0.3	0.0	0.1
65 or Older	0.1	0.0	0.0

*Low precision; no estimate reported.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2002-2005, 2006-2010 (Revised 3/12), 2011-2012.

Table 2.4 Prevalence of DSM-5 Alcohol Use Disorder Craving Criterion from Available Studies

Study *N*	Prevalence of Craving (Time Frame)	Study and Population	Item Wording
7,543	26% (lifetime)	Peer et al. (2013)[25] Subjects were aggregated from family-based and case-control genetic studies of substance dependence.	"In situations where you could not drink, did you ever have such a strong desire for it that you could not think of anything else?"
18,352	3.5% (lifetime)	Keyes et al. (2011)[31] The 1991-1992 National Longitudinal Alcohol Epidemiologic Survey, a nationally representative survey of noninstitutionalized adults (18 or older) in the United States.	"have a very strong desire or urge to drink"
42,862	7% (past year)	Compton et al. (2013)[30] The 1991-1992 National Longitudinal Alcohol Epidemiologic Survey, a nationally representative survey of noninstitutionalized adults (18 or older) in the United States.	"have a very strong desire or urge to drink"
7,746	3.5% (past year)	Mewton et al. (2011)[26] Data are from the 2007 National Survey of Mental Health and Wellbeing, a stratified, multistage area probability sample of people aged 16 to 85 years living in private dwellings in Australia.	"(The next questions are about some other problems you may have had because of drinking.) Was there ever a time in your life when you often had such a strong desire to drink that you couldn't stop yourself from taking a drink or found it difficult to think of anything else?"
34,653	3.1% (past year)	Agrawal, Heath, & Lynskey (2011)[24] Wave 2 of the National Epidemiologic Survey of Alcohol and Related Conditions, a nationally representative sample of adults aged 18 or older residing in households in the United States.	Stem: "Since your LAST interview, did you" "Feel a very strong desire or urge to drink?"
18,352	1.3% (past year)	Keyes et al. (2011)[31] The 1991-1992 National Longitudinal Alcohol Epidemiologic Survey, a nationally representative survey of noninstitutionalized adults (18 or older) in the United States.	"have a very strong desire or urge to drink"

DSM-5 = *Diagnostic and Statistical Manual of Mental Disorders*, 5th edition.

Preliminary evidence suggests that the addition of the craving item will increase the population prevalence of DSM-5 AUD. Table 2.4 contains a summary of the craving symptom endorsement prevalence reported in several studies. Estimates for the alcohol-craving symptom endorsement ranged from 1.3 to 7.0 percent for past year endorsement, but there was a much larger range for lifetime craving, which depending on the sample was from 3.5 percent in a nationally representative sample and 26 percent in a high-risk sample [13,25,29-31]. In the previously discussed study of primarily substance users, Peer et al., examined the causes of DSM-IV and DSM-5 criteria status changes on AUD estimates and found that only 1 percent of status changes were caused by the addition of the craving criterion [25]. However, the results of this nonnationally representative study must be interpreted with caution based on the oversampling of substance-dependent participants, which may not generalize to a population-based sample. Agrawal and colleagues' analysis of the wave 2 NESARC data (a more generalized sample) suggested a slightly larger impact resulting from the addition of the craving criterion [24]. Of the 3,026 people who endorsed only 1 of the 10 DSM-5 criteria (excluding craving), 4.1 percent (unweighted, less than 1 percent of the total population) met DSM-5 criteria resulting from endorsement of the craving item.

Evaluating response patterns from NSDUH provides some information regarding the impact of AUD criteria changes on prevalence estimates. Current estimates in NSDUH indicate that from 2002 to 2012 the past year prevalence of DSM-IV AUD was 7.4 percent weighted (Table 2.5). If the NSDUH diagnostic algorithm was altered to exclude the legal criterion and change the threshold to 2 or more symptoms (out of 10), without including the new craving criterion then the prevalence estimate for past year AUD would increase to 8.5 percent (a 1.1 percent increase). This increase was seen across all subgroups, including by sex, race, and age. This increase in prevalence is being driven by diagnostic orphans who endorsed two dependence criteria but no abuse criteria, and therefore meet DSM-5 but not DSM-IV criteria. NSDUH estimates suggest that 2.4 percent of the population were diagnostic orphans, which has implications both for the prevalence estimates of AUD, as well as "who" is meeting diagnostic criteria and their associated characteristics.

The above change in diagnostic algorithm would introduce the possibility of misclassification as a result of not including the craving criterion, which would lead to an underestimate of disorder prevalence. In evaluating the prevalence of single criterion endorsement and who may have endorsed the missing craving criterion thereby being at risk for misclassification, NSDUH data indicate that up to 8.7 percent of the population is at risk for misclassification. Moreover, the prevalence of endorsing one AUD criterion was not equal across groups, suggesting a higher probability for misclassification among males and people aged 18 to 35, in particular. Analyses showed that tolerance (3.3 percent) and spending a great deal of time in activities necessary to obtain, use, or recover from alcohol (2.8 percent) were the two criteria most likely to be endorsed alone (Table 2.6), and based on data from Hasin and colleagues [22], tolerance is highly correlated with craving.

Table 2.5 Alcohol Use Disorder among People Aged 12 or Older under DSM-IV and DSM-5 Criteria, by Demographic Characteristic: Weighted Percentages, Annual Averages Based on 2002-2012 NSDUHs

Demographic Characteristic	DSM-IV[1]	DSM-5[2]	Diagnostic Orphans[3]	Respondents Who Endorsed Only One Criteria
TOTAL	7.4	8.5	2.4	8.7
GENDER				
Male	10.0	11.1	3.0	10.6
Female	4.9	6.0	1.9	6.9
HISPANIC ORIGIN AND RACE				
Not Hispanic or Latino	7.3	8.3	2.4	8.6
White	7.6	8.4	2.3	8.7
Black or African American	6.3	8.3	2.8	8.6
American Indian or Alaska Native	13.9	15.5	3.2	7.6
Native Hawaiian or Other Pacific Islander	7.9	10.6	3.4	11.2
Asian	3.5	5.2	2.3	7.3
Two or More Races	8.3	9.4	2.6	8.9
Hispanic or Latino	7.8	9.3	2.7	8.9
AGE				
12-13	0.9	1.1	0.3	1.1
14-15	4.5	5.2	1.4	4.3
16-17	9.6	11.3	3.1	8.5
18-25	16.5	19.3	5.3	15.0
26-35	10.7	12.0	3.3	11.7
36-45	7.6	8.4	2.4	9.3
46-55	5.8	6.7	2.0	8.0
56-64	3.5	4.3	1.6	5.9
65 or Older	1.5	2.0	0.9	4.7

*Low precision; no estimate reported.

[1] Alcohol use disorder is based on definitions found in the 4th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV).

[2] Alcohol use disorder is based on definitions found in the 5th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5), excluding the new craving criterion.

[3] Diagnostic orphans include individuals who endorsed two DSM-IV dependence criteria and no abuse criteria.

[4] Excludes DSM-IV legal problem criterion.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2002-2005, 2006-2010 (Revised 3/12), 2011-2012.

Table 2.6 Respondents Who Endorsed Only One Alcohol Use Disorder Criterion among People Aged 12 or Older, by Criterion and Demographic Characteristic: Weighted Percentages, Annual Averages Based on 2002-2012 NSDUHs

Demographic Characteristic	Hazardous Use Only	Role Failure Only	Continued Use Despite Social Problems Only	Longer/ More Use Only	Failure to Cut Down Only	Spent a Great Deal of Time Only	Reduced Activities Only	Continued Use Despite Physical Problems Only	Tolerance Only	Withdrawal Only
TOTAL	1.0	0.1	0.1	0.2	0.4	2.8	0.2	0.3	3.3	1.4
GENDER										
Male	1.4	0.1	0.2	0.3	0.5	3.3	0.3	0.3	4.0	2.0
Female	0.6	0.1	0.1	0.2	0.3	2.4	0.1	0.3	2.7	0.9
HISPANIC ORIGIN AND RACE										
Not Hispanic or Latino	1.1	0.1	0.1	0.2	0.4	2.8	0.2	0.4	3.3	1.3
White	1.2	0.1	0.1	0.2	0.4	2.9	0.2	0.4	3.0	1.2
Black or African American	0.5	0.1	0.1	0.2	0.4	2.3	0.1	0.1	4.5	1.9
American Indian or Alaska Native	0.9	0.0	0.2	0.2	0.1	2.6	0.3	0.2	3.0	4.5
Native Hawaiian or Other Pacific Islander	0.3	0.3	0.0	0.1	0.2	3.3	1.1	0.1	5.6	2.5
Asian	0.4	0.1	0.0	0.2	0.3	2.3	0.3	0.3	3.3	0.8
Two or More Races	0.8	0.2	0.3	0.3	0.2	3.0	0.2	0.3	3.4	1.7
Hispanic or Latino	0.7	0.2	0.1	0.2	0.4	2.9	0.2	0.2	3.7	2.2
AGE										
12-13	0.0	0.1	0.0	0.0	0.0	0.2	0.0	0.0	0.6	0.3
14-15	0.3	0.1	0.1	0.1	0.1	0.9	0.1	0.1	2.4	1.1
16-17	0.8	0.2	0.1	0.1	0.2	2.2	0.2	0.2	4.4	1.6
18-25	1.8	0.2	0.2	0.3	0.3	5.0	0.3	0.4	6.3	2.4
26-35	1.6	0.1	0.1	0.3	0.4	4.2	0.3	0.4	4.0	2.1
36-45	1.2	0.1	0.1	0.2	0.4	3.3	0.2	0.3	3.1	1.8
46-55	0.8	0.0	0.1	0.2	0.6	2.6	0.2	0.5	2.8	1.4
56-64	0.6	0.0	0.1	0.1	0.5	2.0	0.1	0.3	2.1	0.7
65 or Older	0.3	0.0	0.1	0.2	0.4	1.0	0.1	0.2	2.3	0.4

*Low precision; no estimate reported.

NOTE: Alcohol use disorder is based on definitions found in the 4th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV).

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2002-2005, 2006-2010 (Revised 3/12), 2011-2012.

2.5.2 Caffeine Use Disorder

NSDUH and MHSS do not assess caffeine use; therefore, changes in diagnostic criteria are not discussed in depth. However, some changes between DSM-IV and DSM-5 are noteworthy. Caffeine use disorder is a new addition to DSM-5. DSM-IV diagnoses included only caffeine intoxication, caffeine-induced disorders (anxiety and sleep), and caffeine-related disorder not otherwise specified. First, caffeine withdrawal syndrome has been added as a substance-related and addictive disorder in DSM-5. Second, caffeine use disorder has been added to DSM-5 Section 3, Conditions for Further Study. The addition of caffeine use disorder to Conditions for Further Study was based on preliminary evidence indicating the clinical significance of withdrawal and dependence and concern over a rise in case reports of fatalities due to caffeine intoxication from energy drinks and diet pills, as well as concerns over the safety of caffeine–alcohol combination beverages that have drawn U.S. Food and Drug Administration (FDA) attention [13,29,32,33].

2.5.3 Cannabis Use Disorder

The DSM-IV assessed cannabis abuse and cannabis dependence, but no withdrawal syndrome was specified for dependence diagnosis [1]. This was based upon a lack of data identifying withdrawal symptoms. Since the DSM-IV's initial publication, however, research has identified symptoms of withdrawal that produce clinically significant impairment, and the revised DSM-5 recognizes these symptoms [34]. Criteria for DSM-5 cannabis withdrawal symptoms include three or more symptoms occurring within approximately 1 week of cessation of heavy and prolonged cannabis use, including irritability/anger/aggression; nervousness/anxiety; sleep difficulty, such as insomnia or disturbing dreams; decreased appetite or weight loss; restlessness; depressed mood; and at least one physical symptom that causes significant discomfort: abdominal pain, shakiness/tremors, sweating, fever, chills, or headache (Table 2.2).

Data from wave 1 of NESARC indicates that approximately 34.4 percent (weighted) of frequent cannabis using adults (≥ 3 times per week, n=2,613) reported three or more symptoms of cannabis withdrawal in their lifetime [34]. However, in the previously mentioned study of a sample of primarily substance users, Peer et al., reported a lower prevalence of lifetime cannabis withdrawal (18 percent) [25]. Only one study assessed the prevalence of past year cannabis use. Data from the NLAES, a household-based study of 42,862 adults in the United States, found that 7.4 percent of past year cannabis users met criteria for cannabis withdrawal [30].

Along with the addition of cannabis withdrawal in DSM-5, cannabis use disorder also underwent changes in diagnostic threshold, merging of cannabis abuse and dependence, removal of the legal criterion, and the addition of the craving criterion. Published comparisons suggest little overall difference in the prevalence of DSM-IV and DSM-5 cannabis use disorder despite criteria changes. In a sample of a primarily substance-dependent population, the prevalence of DSM-IV lifetime cannabis use disorder was 39.4 percent and for DSM-5 criteria was 41.0 percent [25]. In a more generalized sample in Australia, the prevalence of past year cannabis use disorder was lower using DSM-5 criteria (5.4 percent) compared with DSM-IV criteria (6.2 percent) [35].

The removal of the legal criterion is expected to have little effect on prevalence estimates of cannabis use disorder. The removal of this criterion was based on low endorsement rates and because repeated studies found that the criterion provided little information beyond what was captured by other criteria [17,35,36]. Examination of NSDUH data indicated an estimated 0.2 percent of respondents endorsed the legal criterion and less than 0.1 percent (Table 2.7, weighted) only endorsed the legal criterion.

Table 2.7 Marijuana Legal Criterion Endorsement among People Aged 12 or Older, by Demographic Characteristic: Weighted Percentages, Annual Averages Based on 2002-2012 NSDUHs

Demographic Characteristic	DSM-IV Legal Criterion Endorsement	Respondents Who Endorsed Only the DSM-IV Legal Criterion	Respondents Who Endorsed the DSM-IV Legal Criterion and One Other DSM-IV SUD Criterion
TOTAL	0.2	0.0	0.0
GENDER			
Male	0.4	0.0	0.0
Female	0.1	*	0.0
HISPANIC ORIGIN AND RACE			
Not Hispanic or Latino	0.2	0.0	0.0
White	0.2	0.0	0.0
Black or African American	0.4	0.0	0.1
American Indian or Alaska Native	0.6	0.0	0.1
Native Hawaiian or Other Pacific Islander	0.2	*	*
Asian	0.1	*	*
Two or More Races	0.4	0.0	0.0
Hispanic or Latino	0.4	0.0	0.0
AGE			
12-13	0.1	0.0	0.0
14-15	0.8	0.0	0.1
16-17	1.2	0.0	0.1
18-25	0.8	0.0	0.1
26-35	0.2	0.0	0.0
36-45	0.1	*	0.0
46-55	0.1	0.0	0.0
56-64	0.0	*	0.0
65 or Older	0.0	*	*

*Low precision; no estimate reported.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2002-2005, 2006-2010 (Revised 3/12), 2011-2012.

The impact of craving on DSM-5 cannabis use disorder prevalence is poorly understood because of a paucity of research. No studies were identified that quantified the number of people

meeting criteria only because they endorsed craving. The reduction in prevalence discussed above suggests that the impact of adding the craving criterion on prevalence estimates will be minor; however, the missing craving criteria may affect NSDUH prevalence estimates because of the fewer number of criteria available to meet requirements. Estimates from Compton et al. put the prevalence of past year craving of cannabis at approximately 13.9 percent [30]; however, studies of lifetime endorsement range from 2.5 to 18 percent, demonstrating an imprecision among existing studies (Table 2.8) [12,37]. Calculating the impact on NSDUH estimates of cannabis use disorder, specifically, is complicated by the fact that NSDUH does not assess cravings or the new withdrawal syndrome, which introduces two points of uncertainty leading to an inability to draw inferences with any degree of certainty.

Table 2.8 Prevalence of DSM-5 Cannabis Use Disorder Craving Criterion from Available Studies

Study *N*	Prevalence of Craving (Time Frame)	Study and Population	Item Wording
7,543	18% (lifetime)	Peer et al. (2013)[25] Subjects were aggregated from family-based and case-control genetic studies of substance dependence.	"In situations where you could not use [drug], did you ever have such a strong desire for it that you could not think of anything else?"
1,639	2.5% (lifetime)	Mewton, Slade, & Teesson (2013) [35]. Data are from the 2007 National Survey of Mental Health and Wellbeing, a stratified, multistage area probability sample of people aged 16 to 85 years living in private dwellings in Australia.	"Was there ever a time in your life when you often had such a strong desire to use [DRUG] that you couldn't stop using or found it difficult to think of anything else?"
42,862	13.9% (past year)	Compton et al. (2013)[30] The 1991-1992 National Longitudinal Alcohol Epidemiologic Survey, a nationally representative survey of noninstitutionalized adults (18 or older) in the United States.	"have a very strong desire or urge to use [drug]"

DSM-5 = *Diagnostic and Statistical Manual of Mental Disorders*, 5th edition.

2.5.4 Phencyclidine Use Disorder and Other Hallucinogen Use Disorder

Disorder criteria for phencyclidine (PCP) use disorder and other hallucinogen use disorder vary slightly from the overall SUD template in that a withdrawal syndrome has not been identified for these substances. This is consistent in DSM-IV and DSM-5 and with NSDUH assessment. DSM-IV had separate diagnostic subcategories for phencyclidine use disorder, hallucinogen use disorder, and their respective substance-related diagnoses; however, the DSM-5 includes phencyclidine use disorder, other hallucinogen use disorders, and their respective substance-related disorders under one diagnostic subcategory, hallucinogen-related disorders. NSDUH combines phencyclidine and other hallucinogenic substance use into one assessment and diagnosis, which is more closely aligned with DSM-5's subcategory classification (hallucinogen-related disorders) than the DSM-IV; however, phencyclidine and other hallucinogens have separate SUD diagnoses. In order to be aligned with DSM-5, the NSDUH

would need to assess phencyclidine use disorder separately from other hallucinogen use disorder. Alternatively, a more precise use of terminology in NSDUH reports and related documentation could be used to match the DSM-5 usage of the phrases "phencyclidine use disorder or other hallucinogen use disorder" or "any hallucinogen-related substance use disorders" to clarify which substances are included in the category.

The other diagnostic changes (i.e., combining abuse and dependence, changing the diagnostic threshold, and dropping and adding criteria) will still affect the estimates for the hallucinogen-related disorders; however, little data are available to help quantify the impact on current estimates. Consistent with other substances, removal of the legal criterion is expected to have little impact on the estimates of this disorder [38,39]. This was confirmed using data from NSDUH, which indicated that less than 0.1 percent (Table 2.9, weighted) of respondents endorsed the legal criterion item, and so few respondents endorsed only the legal criterion that the data are suppressed.

Other information on the prevalence rates of the DSM-5 phencyclidine use disorder and other hallucinogen use disorder and the frequencies of craving endorsement for these two diagnoses have not been published. There is an indication that the DSM-IV hallucinogen use disorder diagnostic criteria produce more diagnostic orphans (i.e., individuals who endorse one or two dependence criteria but no abuse criteria) than do most of the other substances. Lynskey and Agrawal examined the prevalence of diagnostic orphans among the NESARC sample and found that 1.28 percent of people who had used phencyclidine or other hallucinogens in their lifetime would be considered diagnostic orphans (those meeting two dependence criteria and no abuse criteria), suggesting that the new criteria would increase the prevalence estimates for these two diagnoses [39].

Analyses of NSDUH data suggest a slight increase in the prevalence of phencyclidine and other hallucinogen use disorder. Between 2002 and 2012 an annual average of 0.2 percent of NSDUH respondents (weighted) met DSM-IV criteria (Table 2.10). Excluding the legal problems criterion from the diagnostic algorithm and changing the threshold to two or more symptoms indicates a similar percentage in the prevalence among NSDUH respondents (0.2 percent). However, this does not include the possibility of misclassification caused by the missing craving criterion. An estimated 0.2 percent of NSDUH respondents endorse one of the nine criteria and are therefore at risk for misclassification. Adolescents and adults aged 16 to 25, American Indian or Alaska Native adults, and adults of two or more races had the highest prevalence of single criterion endorsement. Tolerance was the most frequently endorsed single criteria (0.1 percent; Table 2.11).

Table 2.9 Phencyclidine or Other Hallucinogen Use Legal Criterion Endorsement among People Aged 12 or Older, by Demographic Characteristic: Weighted Percentages, Annual Averages Based on 2002-2012 NSDUHs

Demographic Characteristic	DSM-IV Legal Criterion Endorsement	Respondents Who Endorsed Only the DSM-IV Legal Criterion	Respondents Who Endorsed the DSM-IV Legal Criterion and One Other DSM-IV SUD Criterion
TOTAL	0.0	*	*
GENDER			
Male	0.0	*	*
Female	0.0	*	*
HISPANIC ORIGIN AND RACE			
Not Hispanic or Latino	0.0	*	*
White	0.0	*	*
Black or African American	0.0	*	*
American Indian or Alaska Native	0.2	*	0.0
Native Hawaiian or Other Pacific Islander	*	*	*
Asian	0.0	*	*
Two or More Races	0.0	*	*
Hispanic or Latino	0.1	*	*
AGE			
12-13	0.0	0.0	0.0
14-15	0.1	0.0	0.0
16-17	0.1	*	0.0
18-25	0.1	*	0.0
26-35	0.0	*	*
36-45	0.0	*	*
46-55	0.0	*	*
56-64	*	*	*
65 or Older	*	*	*

*Low precision; no estimate reported.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2002-2005, 2006-2010 (Revised 3/12), 2011-2012.

Table 2.10 Phencyclidine Use Disorder or Other Hallucinogen Use Disorder among People Aged 12 or Older under DSM-IV and DSM-5 Criteria, by Demographic Characteristic: Weighted Percentages, Annual Averages Based on 2002-2012 NSDUHs

Demographic Characteristic	DSM-IV[1]	DSM-5[2]	Diagnostic Orphans[3]	Respondents Who Endorsed Only One Criterion[4]
TOTAL	0.2	0.2	0.0	0.2
GENDER				
Male	0.2	0.2	0.0	0.2
Female	0.1	0.1	0.0	0.1
HISPANIC ORIGIN AND RACE				
Not Hispanic or Latino	0.1	0.1	0.0	0.2
White	0.1	0.1	0.0	0.2
Black or African American	0.1	0.1	0.0	0.1
American Indian or Alaska Native	0.4	0.5	0.1	0.4
Native Hawaiian or Other Pacific Islander	0.2	0.1	0.0	0.2
Asian	0.0	0.1	0.0	0.1
Two or More Races	0.3	0.3	0.0	0.3
Hispanic or Latino	0.2	0.2	0.0	0.2
AGE				
12-13	0.1	0.1	0.0	0.1
14-15	0.5	0.4	0.1	0.4
16-17	0.8	0.8	0.2	0.7
18-25	0.6	0.6	0.2	0.7
26-35	0.1	0.1	0.0	0.2
36-45	0.0	0.0	0.0	0.0
46-55	0.0	0.0	*	0.0
56-64	0.0	0.0	0.0	0.0
65 or Older	*	*	*	*

*Low precision; no estimate reported.

[1] Phencyclidine and other hallucinogen use disorder is based on definitions found in the 4th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV).

[2] Phencyclidine and other hallucinogen use disorder is based on definitions found in the 5th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5), excluding the new craving criterion.

[3] Diagnostic orphans include individuals who endorsed two DSM-IV dependence criteria and no abuse criteria.

[4] Excludes DSM-IV legal problems criterion.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2002-2005, 2006-2010 (Revised 3/12), 2011-2012.

Table 2.11 Respondents Who Endorsed Only One Phencyclidine Use Disorder or Other Hallucinogen Use Disorder Criterion among People Aged 12 or Older, by Criterion and Demographic Characteristic: Weighted Percentages, Annual Averages Based on 2002-2012 NSDUHs

Demographic Characteristic	Hazardous Use Only	Role Failure Only	Continued Use Despite Social Problems Only	Longer/ More Use Only	Failure to Cut Down Only	Spent a Great Deal of Time Only	Reduced Activities Only	Continued Use Despite Physical Problems Only	Tolerance Only	Withdrawal Only
TOTAL	0.0	0.0	*	*	*	0.0	0.0	0.0	0.1	--
GENDER										
Male	0.0	0.0	*	0.0	0.0	0.1	0.0	0.0	0.1	--
Female	0.0	*	*	*	*	0.0	*	0.0	0.0	--
HISPANIC ORIGIN AND RACE										
Not Hispanic or Latino	0.0	*	*	*	*	0.0	0.0	0.0	0.1	--
White	0.0	*	*	*	*	0.1	0.0	0.0	0.1	--
Black or African American	0.0	0.0	*	0.0	0.0	0.0	*	0.0	0.0	--
American Indian or Alaska Native	0.0	0.0	*	*	0.0	0.1	0.1	0.0	0.2	--
Native Hawaiian or Other Pacific Islander	0.1	*	*	*	*	0.0	*	*	0.1	--
Asian	0.0	*	*	0.0	*	0.0	*	*	0.0	--
Two or More Races	0.1	0.0	*	*	*	0.1	0.0	0.0	0.1	--
Hispanic or Latino	0.0	0.0	0.0	*	0.0	0.0	0.0	0.0	0.1	--
AGE										
12-13	*	0.0	*	*	*	0.0	0.0	*	0.0	--
14-15	0.1	0.0	0.0	*	0.0	0.1	0.0	0.0	0.1	--
16-17	0.1	0.0	0.0	0.0	0.0	0.2	0.0	0.0	0.2	--
18-25	0.1	0.0	0.0	0.0	0.0	0.2	0.0	0.0	0.3	--
26-35	0.0	*	*	0.0	0.0	0.0	0.0	0.0	0.0	--
36-45	*	*	*	*	*	0.0	*	*	0.0	--
46-55	*	*	*	*	*	*	*	0.0	*	--
56-64	*	*	*	*	*	*	*	*	0.0	--
65 or Older	*	*	*	*	*	*	*	*	*	--

*Low precision; no estimate reported.

--: Not applicable.

NOTE: Phencyclidine and other hallucinogen use disorder is based on definitions found in the 4th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV).

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2002-2005, 2006-2010 (Revised 3/12), 2011-2012.

2.5.5 Inhalant Use Disorder

Inhalant use disorder criteria are similar to DSM-IV and DSM-5 SUD templates with slight variation. DSM-IV and DSM-5 do not include a withdrawal syndrome as a dependence/SUD criterion. Changes from DSM-IV to DSM-5 include dropping the legal problems criterion, adding the craving criterion, and combining diagnoses for inhalant abuse and inhalant dependence into one diagnosis (inhalant use disorder) with the new threshold (e.g., 2 or more of 10).

To date, very little has been published on the impact of criteria changes on prevalence estimates of inhalant use disorder. One study using wave 1 data from NESARC found that similar to studies of other substances, a single dimensional construct of inhalant use disorder was a better fit to the underlying construct of inhalant addiction than the separate diagnostic categories of abuse and dependence [38]. Moreover, studies using both clinical treatment and community samples of adolescents and adults have repeatedly found that the legal criterion had low endorsement and added little additional information to the measurement of this disorder [39-41]. Data from NSDUH indicate that less than 0.1 percent of the population endorsed the legal criterion (Table 2.12).

Speculating on what little data are available, combining the inhalant abuse and inhalant dependence criteria under one diagnosis will likely increase the prevalence of inhalant use disorder slightly over prevalence estimates based on the DSM-IV since more of the diagnostic orphans (those meeting two dependence criteria and no abuse criteria) are classified as cases under DSM-5. Past year prevalence estimates in NSDUH suggest an annual average of 0.1 percent of respondents (weighted) met DSM-IV criteria and a similar percent endorsed two or more of the nine criteria assessed in NSDUH (excluding legal criterion and craving). It is difficult to quantify the impact of adding the craving criterion because frequency estimates are not available at this time. However, data from the existing NSDUH instrument suggests that 0.1 percent of NSDUH respondents endorse only one of the symptom criteria and therefore up to 0.1 percent might be reclassified by endorsement of the additional craving criterion (Table 2.13). The potential for misclassification was not equal across all subgroups, with youth aged 12 to 17 having the highest rates of single criterion endorsement. Sample size estimates limit the evaluation of individual criterion endorsement, but tolerance appears to be the criterion most likely to be endorsed alone (Table 2.14).

Table 2.12 Inhalant Legal Criterion Endorsement among People Aged 12 or Older, by Demographic Characteristic: Weighted Percentages, Annual Averages Based on 2002-2012 NSDUHs

Demographic Characteristic	DSM-IV Legal Criterion Endorsement	Respondents Who Endorsed Only the DSM-IV Legal Criterion	Respondents Who Endorsed the DSM-IV Legal Criterion and One Other DSM-IV SUD Criterion
TOTAL	0.0	*	*
GENDER			
Male	0.0	*	*
Female	0.0	*	*
HISPANIC ORIGIN AND RACE			
Not Hispanic or Latino	0.0	*	*
White	0.0	*	*
Black or African American	0.0	*	*
American Indian or Alaska Native	0.0	*	*
Native Hawaiian or Other Pacific Islander	0.0	*	0.0
Asian	0.0	*	*
Two or More Races	0.0	*	*
Hispanic or Latino	0.0	*	0.0
AGE			
12-13	0.0	0.0	0.0
14-15	0.1	0.0	0.0
16-17	0.1	0.0	0.0
18-25	0.0	*	*
26-35	0.0	*	*
36-45	0.0	*	*
46-55	0.0	*	*
56-64	*	*	*
65 or Older	*	*	*

*Low precision; no estimate reported.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2002-2005, 2006-2010 (Revised 3/12), 2011-2012.

Table 2.13 Inhalant Use Disorder among People Aged 12 or Older under DSM-IV and DSM-5 Criteria, by Demographic Characteristic: Weighted Percentages, Annual Averages Based on 2002-2012 NSDUHs

Demographic Characteristic	DSM-IV[1]	DSM-5[2]	Diagnostic Orphans[3]	Respondents Who Endorsed Only One Criterion[4]
TOTAL	0.1	0.1	0.0	0.1
GENDER				
Male	0.1	0.1	0.0	0.1
Female	0.1	0.1	0.0	0.1
HISPANIC ORIGIN AND RACE				
Not Hispanic or Latino	0.1	0.1	0.0	0.1
White	0.1	0.1	0.0	0.1
Black or African American	0.1	0.1	0.0	0.1
American Indian or Alaska Native	0.3	0.3	0.0	0.3
Native Hawaiian or Other Pacific Islander	0.2	0.1	0.0	0.3
Asian	0.1	0.1	0.0	0.1
Two or More Races	0.1	0.1	0.0	0.2
Hispanic or Latino	0.1	0.1	0.0	0.2
AGE				
12-13	0.3	0.4	0.1	0.6
14-15	0.5	0.5	0.1	0.7
16-17	0.3	0.3	0.1	0.4
18-25	0.1	0.1	0.0	0.1
26-35	0.0	0.0	0.0	0.1
36-45	0.1	0.0	0.0	0.0
46-55	0.0	0.0	*	0.0
56-64	*	0.0	0.0	0.0
65 or Older	*	*	*	*

*Low precision; no estimate reported.

[1] Inhalant use disorder is based on definitions found in the 4th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV).

[2] Inhalant use disorder is based on definitions found in the 5th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5), excluding the new craving criterion.

[3] Diagnostic orphans include individuals who endorsed two DSM-IV dependence criteria and no abuse criteria.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2002-2005, 2006-2010 (Revised 3/12), 2011-2012.

Table 2.14 Respondents Who Endorsed Only One Inhalant Use Disorder Criterion among People Aged 12 or Older, by Criterion and Demographic Characteristic: Weighted Percentages, Annual Averages Based on 2002-2012 NSDUHs

Demographic Characteristic	Hazardous Use Only	Role Failure Only	Continued Use Despite Social Problems Only	Longer/ More Use Only	Failure to Cut Down Only	Spent a Great Deal of Time Only	Reduced Activities Only	Continued Use Despite Physical Problems Only	Tolerance Only	Withdrawal Only
TOTAL	0.0	0.0	*	*	0.0	0.0	0.0	*	0.0	--
GENDER										
Male	0.0	0.0	*	*	0.0	0.0	0.0	*	0.0	--
Female	0.0	*	*	*	*	0.0	0.0	*	0.0	--
HISPANIC ORIGIN AND RACE										
Not Hispanic or Latino	0.0	*	*	*	0.0	0.0	*	*	0.0	--
White	0.0	0.0	*	*	0.0	0.0	*	*	0.0	--
Black or African American	*	*	*	*	*	0.0	0.0	*	0.0	--
American Indian or Alaska Native	0.0	0.0	*	*	*	0.1	*	*	0.2	--
Native Hawaiian or Other Pacific Islander	0.0	*	*	*	*	0.0	0.0	*	0.2	--
Asian	*	0.0	*	*	*	0.0	0.0	0.0	0.0	--
Two or More Races	0.0	*	0.0	*	0.0	0.0	0.0	*	0.1	--
Hispanic or Latino	0.0	0.0	*	0.0	0.0	0.0	0.0	*	0.1	--
AGE										
12-13	0.0	0.0	0.0	0.0	0.0	0.1	0.1	0.0	0.3	--
14-15	0.1	0.1	0.0	0.0	0.0	0.1	0.0	0.0	0.3	--
16-17	0.1	0.0	*	0.0	0.0	0.1	0.0	0.0	0.2	--
18-25	0.0	0.0	*	0.0	0.0	0.0	*	*	0.1	--
26-35	*	*	*	*	0.0	0.0	0.0	*	0.0	--
36-45	0.0	0.0	*	*	*	*	*	*	0.0	--
46-55	0.0	*	*	*	*	*	*	*	0.0	--
56-64	*	*	*	*	*	0.0	*	*	*	--
65 or Older	*	*	*	*	*	*	*	*	*	--

*Low precision; no estimate reported.

--: Not applicable.

NOTE: Inhalant use disorder is based on definitions found in the 4th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV).

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2002-2005, 2006-2010 (Revised 3/12), 2011-2012.

2.5.6 Opioid Use Disorder

Opioid use disorder is an addiction to a class of chemicals that activate the body's opioid receptors. This includes drugs like heroin and opioid-based prescription pain relievers (e.g., hydrocodone, morphine, and codeine). Changes in the DSM criteria for opioid use disorder follow the overall criteria for SUDs. Summarizing the impact of these changes on population prevalence at the population level are difficult because many studies present statistics for a particular substance (e.g., heroin or oxycodone) and these changes may not be applicable to the overall DSM category of opioid use disorder. In addition, NSDUH varies from DSM-IV and DSM-5 by assessing abuse and dependence separately for heroin and prescription pain relievers (which are primarily, but not completely opioid based due to an open ended response option). This makes generalizing findings from the heroin literature on NSDUH easier, but complicates the evaluation of DSM changes on prescription pain relievers.

Consistent with studies on other substances, studies of opioid abuse and dependence in both community and clinical samples consistently find that a single construct of addiction that combines abuse and dependence criteria is a better fit in measuring the underlying construct of opioid addiction, rather than a separate and hierarchical construct of abuse and dependence [22,36,42-44]. This supports the unification of abuse and dependence under DSM-5. However, the impact on opioid use disorder estimates of combining abuse and dependence into a single disorder, changing the diagnostic threshold, and replacing the legal criterion with craving is not entirely clear. One small study using a sample of 705 chronic pain patients suggested a 2 percent decrease in the prevalence of opioid use disorder under DSM-5 criteria compared with that found under DSM-IV criteria [45]. However, Peer et al. in their study consisting of primarily participants with a substance use disorder suggested almost no difference in the prevalence of DSM-IV and DSM-5 opioid use disorder (34.7 and 34.8 percent, respectively) [25]. No studies examining heroin use disorder and prescription opioid use disorder separately were identified, and studies using samples closer to the NSDUH sampling frame are not available.

Data on the removal of the legal criterion are conflicting. Studies consistently report that it is the least frequently endorsed criterion; however, the rate of endorsement varies by study population and substance. Hasin et al. examined a substance-using sample recruited from inpatient hospitals, outpatient clinics, and methadone clinics and found that 7.97 percent of the 364 patients (a mixture of inpatient and outpatient participants) who had used heroin in the past 12 months endorsed the legal problem criterion [22]. A similar lifetime prevalence (8 percent) was found among the sample of substance-dependent participants examined by Peer et al. [25]. The next lowest rate of endorsement was for hazardous use, which was endorsed by 30.22 percent of past year users. However, Shand et al. examined a sample of opioid-dependent adults (any type) participating in opioid pharmacotherapy clinics and found that, although still the least frequently endorsed criterion, it was endorsed by 73 percent of the 1,511 participants [42]. In a more generalizable study using NESARC data, 2.26 percent of opioid-ever users endorsed the legal problems' criterion [36]. Unfortunately, none of these studies reported on the number of participants who met criteria only through their endorsement of the legal criterion. Data from NSDUH indicates that less than 0.1 percent of respondents endorsed the legal criterion for heroin use (Table 2.15, weighted), only 0.1 percent endorsed the legal criterion for pain relievers (Table 2.16, weighted), and only 0.1 percent (Table 2.17, weighted) endorsed the legal criterion for either heroin or pain relievers when the data were combined.

Table 2.15 Heroin Legal Criterion Endorsement among People Aged 12 or Older, by Demographic Characteristic: Weighted Percentages, Annual Averages Based on 2002-2012 NSDUHs

Demographic Characteristic	DSM-IV Legal Criterion Endorsement	Respondents Who Endorsed Only the DSM-IV Legal Criterion	Respondents Who Endorsed the DSM-IV Legal Criterion and One Other DSM-IV SUD Criterion
TOTAL	0.0	*	*
GENDER			
Male	0.1	*	*
Female	0.0	*	*
HISPANIC ORIGIN AND RACE			
Not Hispanic or Latino	0.0	*	*
White	0.0	*	*
Black or African American	0.1	*	*
American Indian or Alaska Native	0.0	*	*
Native Hawaiian or Other Pacific Islander	*	*	*
Asian	*	*	*
Two or More Races	0.1	*	*
Hispanic or Latino	0.1	*	*
AGE			
12-13	0.0	*	*
14-15	0.0	*	0.0
16-17	0.0	*	*
18-25	0.1	*	*
26-35	0.1	*	*
36-45	0.0	*	*
46-55	0.0	*	*
56-64	*	*	*
65 or Older	*	*	*

*Low precision; no estimate reported.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2002-2005, 2006-2010 (Revised 3/12), 2011-2012.

Table 2.16 Pain Reliever Legal Criterion Endorsement among People Aged 12 or Older, by Demographic Characteristic: Weighted Percentages, Annual Averages Based on 2002-2012 NSDUHs

Demographic Characteristic	DSM-IV Legal Criterion Endorsement	Respondents Who Endorsed Only the DSM-IV Legal Criterion	Respondents Who Endorsed the DSM-IV Legal Criterion and One Other DSM-IV SUD Criterion
TOTAL	0.1	0.0	0.0
GENDER			
Male	0.1	0.0	0.0
Female	0.1	*	*
HISPANIC ORIGIN AND RACE			
Not Hispanic or Latino	0.1	0.0	*
White	0.1	*	*
Black or African American	0.1	0.0	0.0
American Indian or Alaska Native	0.5	0.1	0.0
Native Hawaiian or Other Pacific Islander	0.1	0.0	*
Asian	0.0	*	0.0
Two or More Races	0.1	0.0	*
Hispanic or Latino	0.1	0.0	0.0
AGE			
12-13	0.1	*	*
14-15	0.1	0.0	0.0
16-17	0.2	0.0	0.0
18-25	0.2	0.0	0.0
26-35	0.1	0.0	0.0
36-45	0.1	0.0	0.0
46-55	0.1	*	*
56-64	0.0	*	*
65 or Older	0.0	*	*

*Low precision; no estimate reported.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2002-2005, 2006-2010 (Revised 3/12), 2011-2012.

Table 2.17 Heroin/Pain Reliever Legal Criterion Endorsement among People Aged 12 or Older, by Demographic Characteristic: Weighted Percentages, Annual Averages Based on 2002-2012 NSDUHs

Demographic Characteristic	DSM-IV Legal Criterion Endorsement	Respondents Who Endorsed Only the DSM-IV Legal Criterion	Respondents Who Endorsed the DSM-IV Legal Criterion and One Other DSM-IV SUD Criterion
TOTAL	0.1	0.0	0.0
GENDER			
Male	0.2	0.0	0.0
Female	0.1	*	*
HISPANIC ORIGIN AND RACE			
Not Hispanic or Latino	0.1	0.0	0.0
White	0.1	*	*
Black or African American	0.2	0.0	0.0
American Indian or Alaska Native	0.5	0.1	0.0
Native Hawaiian or Other Pacific Islander	0.1	0.0	*
Asian	0.0	*	0.0
Two or More Races	0.2	0.0	*
Hispanic or Latino	0.2	0.0	0.0
AGE			
12-13	0.1	*	0.0
14-15	0.2	0.0	0.0
16-17	0.2	0.0	0.0
18-25	0.2	0.0	0.0
26-35	0.2	0.0	0.0
36-45	0.1	0.0	0.0
46-55	0.1	*	*
56-64	0.0	*	*
65 or Older	0.0	*	*

*Low precision; no estimate reported.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2002-2005, 2006-2010 (Revised 3/12), 2011-2012.

The impact of adding the craving criterion is as yet undetermined. Two studies were identified that examined the prevalence of endorsement of the craving criterion (Table 2.18). In the Peer et al. study, 29.0 percent of adults who had used opioids in their lifetime endorsed the craving criterion. In a more generalizable sample using data from the nationally representative NLAES, past year craving was endorsed by 7.8 percent of past year opioid users [30]. No studies were identified that examined craving separately for heroin and prescription pain relievers, making the comparison more difficult.

Table 2.18 Prevalence of DSM-5 Opioid Use Disorder Craving Criterion from Available Studies

Study *N*	Prevalence of Craving (Time Frame)	Study and Population	Item Wording
7,543	29.0% (lifetime)	Peer et al. (2013)[25] Subjects were aggregated from family-based and case-control genetic studies of substance dependence.	"In situations where you could not use [drug], did you ever have such a strong desire for it that you could not think of anything else?"
42,862	7.8% (past year)	Compton et al. (2013)[30] The 1991-1992 National Longitudinal Alcohol Epidemiologic Survey, a nationally representative survey of noninstitutionalized adults (18 or older) in the United States.	"have a very strong desire or urge to use [drug]"

DSM-5 = *Diagnostic and Statistical Manual of Mental Disorders*, 5th edition.

Existing NSDUH data suggest that the prevalence of heroin use disorder will change little between DSM-IV and DSM-5 criteria (Table 2.19). DSM-IV diagnosed heroin use disorder among NSDUH respondents was estimated at 0.1 percent annually from 2002 to 2012 (weighted). The same prevalence estimate was found when the legal criterion was excluded and the threshold was set at two or more symptoms. Furthermore, less than 0.1 percent of participants (actual estimate suppressed) only endorsed one criterion (primarily withdrawal only; Table 2.20) suggesting that the possibility of misclassification from the missing craving criterion is very low.

Data from NSDUH examining prescription pain relievers show a different pattern of responses. The prevalence of DSM-IV defined prescription pain reliever use disorder was 0.7 percent in the population (Table 2.21, weighted). The prevalence under DSM-5 criteria, excluding the craving item, was slightly higher at 0.8 percent. One percent of respondents endorsed only one criterion and therefore were at risk of being misclassified without the craving criterion. This risk was not equivalent across groups. American Indian or Alaska Native respondents and those between the ages of 16 to 25 had the highest rates of single criterion endorsement. The most commonly endorsed single criterion was withdrawal (0.5 percent) followed by tolerance (0.3 percent; Table 2.22).

To mimic the DSM-5 criteria of opioid use disorder, diagnostic criteria were combined to generate a combined diagnosis. Data were combined at the criterion level. For example, if an individual endorsed hazardous use for heroin but not for pain relievers, the combined hazardous use criterion was considered met. The diagnostic algorithm was then run on the combined criteria; one or more abuse criteria (including the legal criterion) or three or more dependence criteria were considered DSM-IV heroin/pain reliever use disorder (this is not referred to as opioid use disorder because of the small possibility for endorsement of nonopioid pain relievers). Two or more of any of the combined criteria (excluding the legal criterion) was considered DSM-5 heroin/pain reliever use disorder. Weighted prevalence estimates for the combined diagnoses among NSDUH respondents indicated an increase from DSM-IV to DSM-5 criteria (0.8 to 0.9 percent; Table 2.23). Approximately 0.6 percent of the population had one of the combined criteria. The most frequently reported single criterion was withdrawal (0.5 percent) followed by tolerance (0.3 percent; Table 2.24).

Table 2.19 Heroin Use Disorder among People Aged 12 or Older under DSM-IV and DSM-5 Criteria, by Demographic Characteristic: Weighted Percentages, Annual Averages Based on 2002-2012 NSDUHs

Demographic Characteristic	DSM-IV[1]	DSM-5[2]	Diagnostic Orphans[3]	Respondents Who Endorsed Only One Criterion[4]
TOTAL	0.1	0.1	0.0	0.0
GENDER				
Male	0.2	0.2	0.0	0.0
Female	0.1	0.1	0.0	0.0
HISPANIC ORIGIN AND RACE				
Not Hispanic or Latino	0.1	0.1	0.0	0.0
White	0.1	0.1	0.0	0.0
Black or African American	0.1	0.2	0.0	0.0
American Indian or Alaska Native	0.1	0.1	*	0.0
Native Hawaiian or Other Pacific Islander	0.2	0.2	*	*
Asian	*	0.0	*	*
Two or More Races	0.2	0.2	0.0	0.0
Hispanic or Latino	0.2	0.2	0.0	0.0
AGE				
12-13	0.0	0.0	*	0.0
14-15	0.1	0.1	0.0	0.0
16-17	0.1	0.1	0.0	0.0
18-25	0.3	0.3	0.0	0.0
26-35	0.2	0.2	0.0	0.0
36-45	0.1	0.1	0.0	0.0
46-55	0.1	0.1	0.0	0.0
56-64	0.0	0.0	0.0	0.0
65 or Older	0.0	0.0	*	*

*Low precision; no estimate reported.

[1] Heroin use disorder is based on definitions found in the 4th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV).

[2] Heroin use disorder is based on definitions found in the 5th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5), excluding the new craving criterion.

[3] Diagnostic orphans include individuals who endorsed two DSM-IV dependence criteria and no abuse criteria.

[4] Excludes DSM-IV legal problem criterion.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2002-2005, 2006-2010 (Revised 3/12), 2011-2012.

Table 2.20 Respondents Who Endorsed Only One Heroin Use Disorder Criterion among People Aged 12 or Older, by Criterion and Demographic Characteristic: Weighted Percentages, Annual Averages Based on 2002-2012 NSDUHs

Demographic Characteristic	Hazardous Use Only	Role Failure Only	Continued Use Despite Social Problems Only	Longer/ More Use Only	Failure to Cut Down Only	Spent a Great Deal of Time Only	Reduced Activities Only	Continued Use Despite Physical Problems Only	Tolerance Only	Withdrawal Only
TOTAL	*	*	*	*	*	*	*	*	0.0	0.1
GENDER										
Male	*	*	*	*	*	0.0	*	*	0.0	0.1
Female	*	*	*	*	*	*	*	*	*	0.1
HISPANIC ORIGIN AND RACE										
Not Hispanic or Latino	*	*	*	*	*	*	*	*	0.0	0.1
White	*	*	*	*	*	*	*	*	0.0	0.1
Black or African American	*	*	*	*	*	*	0.0	*	0.0	0.1
American Indian or Alaska Native	*	0.0	*	*	*	0.0	*	*	*	0.0
Native Hawaiian or Other Pacific Islander	*	*	*	*	*	*	*	*	*	0.0
Asian	*	*	*	*	*	*	*	*	*	0.0
Two or More Races	*	*	*	*	*	0.0	*	*	*	0.2
Hispanic or Latino	*	*	*	*	*	0.0	*	*	*	0.1
AGE										
12-13	*	*	*	*	*	*	*	*	*	0.0
14-15	*	*	*	*	*	*	*	*	0.0	0.0
16-17	*	*	*	*	*	0.0	*	*	0.0	0.1
18-25	*	*	*	*	*	0.0	*	*	0.0	0.2
26-35	*	*	*	*	*	*	0.0	*	0.0	0.2
36-45	*	*	*	*	*	*	*	*	*	0.1
46-55	*	*	*	*	*	0.0	*	*	*	0.1
56-64	*	*	*	*	*	0.0	*	*	*	0.0
65 or Older	*	*	*	*	*	*	*	*	*	0.0

*Low precision; no estimate reported.

NOTE: Heroin use disorder is based on definitions found in the 4th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV).

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2002-2005, 2006-2010 (Revised 3/12), 2011-2012.

Table 2.21 Pain Reliever Use Disorder among People Aged 12 or Older under DSM-IV and DSM-5 Criteria, by Demographic Characteristic: Weighted Percentages, Annual Averages Based on 2002-2012 NSDUHs

Demographic Characteristic	DSM-IV[1]	DSM-5[2]	Diagnostic Orphans[3]	Respondents Who Endorsed Only One Criterion[4]
TOTAL	0.7	0.8	0.2	0.6
GENDER				
Male	0.8	0.9	0.2	0.6
Female	0.6	0.8	0.2	0.6
HISPANIC ORIGIN AND RACE				
Not Hispanic or Latino	0.7	0.9	0.2	0.6
White	0.7	0.9	0.2	0.6
Black or African American	0.5	0.6	0.2	0.5
American Indian or Alaska Native	1.8	2.2	0.6	0.9
Native Hawaiian or Other Pacific Islander	0.6	0.9	0.3	0.5
Asian	0.3	0.4	0.1	0.4
Two or More Races	0.8	1.0	0.2	0.7
Hispanic or Latino	0.6	0.7	0.2	0.7
AGE				
12-13	0.4	0.5	0.2	0.5
14-15	1.0	1.2	0.3	1.0
16-17	1.5	1.9	0.6	1.6
18-25	1.6	2.0	0.6	1.4
26-35	1.0	1.2	0.3	0.7
36-45	0.7	0.7	0.1	0.5
46-55	0.4	0.6	0.2	0.4
56-64	0.2	0.2	0.1	0.2
65 or Older	0.0	0.1	0.0	0.1

*Low precision; no estimate reported.

[1] Pain reliever use disorder is based on definitions found in the 4th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV).

[2] Pain reliever use disorder is based on definitions found in the 5th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5), excluding the new craving criterion.

[3] Diagnostic orphans include individuals who endorsed two DSM-IV dependence criteria and no abuse criteria.

[4] Excludes DSM-IV legal problem criterion.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2002-2005, 2006-2010 (Revised 3/12), 2011-2012.

Table 2.22 Respondents Who Endorsed Only One Pain Reliever Use Disorder Criterion among People Aged 12 or Older, by Criterion and Demographic Characteristic: Weighted Percentages, Annual Averages Based on 2002-2012 NSDUHs

Demographic Characteristic	Hazardous Use Only	Role Failure Only	Continued Use Despite Social Problems Only	Longer/More Use Only	Failure to Cut Down Only	Spent a Great Deal of Time Only	Reduced Activities Only	Continued Use Despite Physical Problems Only	Tolerance Only	Withdrawal Only
TOTAL	0.0	0.0	*	0.0	0.0	0.2	0.0	0.0	0.3	0.5
GENDER										
Male	0.1	0.0	*	0.0	0.0	0.2	0.0	0.0	0.3	0.5
Female	0.0	0.0	*	0.0	0.0	0.2	0.0	0.0	0.2	0.4
HISPANIC ORIGIN AND RACE										
Not Hispanic or Latino	0.0	0.0	*	0.0	0.0	0.2	0.0	0.0	0.3	0.5
White	0.0	0.0	*	0.0	0.0	0.2	0.0	0.0	0.3	0.5
Black or African American	0.0	0.0	*	0.0	0.1	0.1	0.0	*	0.2	0.4
American Indian or Alaska Native	0.1	0.1	*	*	0.1	0.3	0.0	0.1	0.3	1.2
Native Hawaiian or Other Pacific Islander	*	*	*	*	*	0.2	0.0	0.0	0.1	0.4
Asian	0.0	0.0	*	0.0	0.0	0.1	0.0	*	0.1	0.2
Two or More Races	0.0	0.0	*	0.0	0.0	0.2	0.0	0.0	0.3	0.7
Hispanic or Latino	0.1	0.0	*	0.0	0.0	0.2	0.0	0.0	0.3	0.5
AGE										
12-13	0.0	0.0	*	0.0	0.0	0.1	0.0	0.0	0.2	0.2
14-15	0.0	0.1	0.0	0.0	0.1	0.2	0.0	0.0	0.4	0.6
16-17	0.1	0.1	0.0	0.0	0.1	0.4	0.0	0.0	0.7	0.9
18-25	0.1	0.0	0.0	0.0	0.0	0.4	0.0	0.0	0.7	1.1
26-35	0.1	0.0	*	*	0.0	0.2	0.0	0.0	0.3	0.7
36-45	0.1	0.0	*	*	0.0	0.2	0.0	0.0	0.2	0.5
46-55	0.0	0.0	*	*	0.0	0.1	0.0	0.0	0.2	0.3
56-64	0.0	*	*	0.0	0.0	0.1	*	*	0.1	0.1
65 or Older	*	*	*	*	*	0.0	*	*	0.0	0.0

*Low precision; no estimate reported.

NOTE: Pain reliever use disorder is based on definitions found in the 4th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV).

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2002-2005, 2006-2010 (Revised 3/12), 2011-2012.

Table 2.23 Heroin/Pain Reliever Use Disorder among People Aged 12 or Older under DSM-IV and DSM-5 Criteria, by Demographic Characteristic: Weighted Percentages, Annual Averages Based on 2002-2012 NSDUHs

Demographic Characteristic	DSM-IV[1]	DSM-5[2]	Diagnostic Orphans[3]	Respondents Who Endorsed Only One Criterion[4]
TOTAL	0.8	0.9	0.2	0.6
GENDER				
Male	0.9	1.0	0.2	0.6
Female	0.6	0.8	0.2	0.6
HISPANIC ORIGIN AND RACE				
Not Hispanic or Latino	0.8	0.9	0.2	0.6
White	0.8	1.0	0.2	0.6
Black or African American	0.6	0.8	0.2	0.6
American Indian or Alaska Native	1.9	2.2	0.5	0.9
Native Hawaiian or Other Pacific Islander	0.7	1.0	0.3	0.5
Asian	0.3	0.4	0.1	0.4
Two or More Races	0.9	1.1	0.2	0.7
Hispanic or Latino	0.7	0.8	0.2	0.7
AGE				
12-13	0.4	0.5	0.2	0.5
14-15	1.1	1.3	0.3	1.0
16-17	1.6	2.0	0.6	1.6
18-25	1.8	2.2	0.6	1.4
26-35	1.1	1.3	0.3	0.7
36-45	0.7	0.8	0.2	0.5
46-55	0.5	0.7	0.2	0.4
56-64	0.2	0.3	0.1	0.2
65 or Older	0.1	0.1	0.0	0.1

*Low precision; no estimate reported.

[1] Heroin/pain reliever use disorder is based on definitions found in the 4th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV).

[2] Heroin/pain reliever use disorder is based on definitions found in the 5th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5), excluding the new craving criterion.

[3] Diagnostic orphans include individuals who endorsed two DSM-IV dependence criteria and no abuse criteria.

[4] Excludes DSM-IV legal problem criterion.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2002-2005, 2006-2010 (Revised 3/12), 2011-2012.

Table 2.24 Respondents Who Endorsed Only One Heroin/Pain Reliever Use Disorder Criterion among People Aged 12 or Older, by Criterion and Demographic Characteristic: Weighted Percentages, Annual Averages Based on 2002-2012 NSDUHs

Demographic Characteristic	Hazardous Use Only	Role Failure Only	Continued Use Despite Social Problems Only	Longer/ More Use Only	Failure to Cut Down Only	Spent a Great Deal of Time Only	Reduced Activities Only	Continued Use Despite Physical Problems Only	Tolerance Only	Withdrawal Only
TOTAL	0.0	0.0	*	0.0	0.0	0.2	0.0	0.0	0.3	0.5
GENDER										
Male	0.1	0.0	*	0.0	0.0	0.2	0.0	0.0	0.3	0.5
Female	0.0	0.0	*	0.0	0.0	0.2	0.0	0.0	0.2	0.4
HISPANIC ORIGIN AND RACE										
Not Hispanic or Latino	0.0	0.0	*	0.0	0.0	0.2	0.0	0.0	0.3	0.5
White	0.0	0.0	*	0.0	0.0	0.2	0.0	0.0	0.3	0.5
Black or African American	0.0	0.0	*	0.0	0.1	0.1	0.0	*	0.2	0.4
American Indian or Alaska Native	0.1	0.1	*	*	0.1	0.3	0.0	0.1	0.3	1.2
Native Hawaiian or Other Pacific Islander	*	*	*	*	*	0.2	0.0	0.0	0.1	0.4
Asian	0.0	0.0	*	0.0	0.0	0.1	0.0	*	0.1	0.2
Two or More Races	0.0	0.0	*	0.0	0.0	0.2	0.0	0.0	0.3	0.7
Hispanic or Latino	0.1	0.0	*	0.0	0.0	0.2	0.0	0.0	0.3	0.5
AGE										
12-13	0.0	0.0	*	0.0	0.0	0.1	0.0	0.0	0.2	0.2
14-15	0.0	0.1	0.0	0.0	0.1	0.2	0.0	0.0	0.4	0.6
16-17	0.1	0.1	0.0	0.0	0.1	0.4	0.0	0.0	0.7	0.9
18-25	0.1	0.0	0.0	0.0	0.0	0.4	0.0	0.0	0.7	1.1
26-35	0.1	0.0	*	*	0.0	0.2	0.0	0.0	0.3	0.7
36-45	0.1	0.0	*	*	0.0	0.2	0.0	0.0	0.2	0.5
46-55	0.0	0.0	*	*	0.0	0.1	0.0	0.0	0.2	0.3
56-64	0.0	*	*	0.0	0.0	0.1	*	*	0.1	0.1
65 or Older	*	*	*	*	*	0.0	*	*	0.0	0.0

*Low precision; no estimate reported.

NOTE: Heroin/pain reliever use disorder is based on definitions found in the 4th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV).

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2002-2005, 2006-2010 (Revised 3/12), 2011-2012.

2.5.7 Sedative, Hypnotic, or Anxiolytic Use Disorder

DSM-IV groups sedatives, hypnotics, and anxiolytics into the same group for the purposes of assessing this SUD. Sedative is a general term for any substance that has a calming or sleep-inducing effect, including anxiolytics and hypnotics. The difference in terms between anxiolytics and hypnotics is based on purpose: hypnotics are sleep aids and anxiolytics are antianxiety medications. However, there is considerable overlap in function across substances (i.e., a substance can be both an anxiolytic and hypnotic) because they all work to activate GABA (gamma-aminobutyric acid) receptors in the brain. Currently, NSDUH assesses sedatives and tranquilizers. However, "tranquilizer" is not a term used in the DSM-IV or DSM-5. Tranquilizers are central nervous system depressant drugs classified as sedative-hypnotics, and are therefore captured under the broader category of sedatives/anxiolytic/hypnotics in the DSM.

Sedative, hypnotic, and anxiolytic use disorder underwent all of the criteria changes from DSM-IV to DSM-5 that have been previously discussed, including adding craving, removing the legal problems criterion, merging the abuse and dependence categories, and changing the threshold. However, like inhalant use disorder, phencyclidine use disorder, and other hallucinogen use disorder, there has been little review of the impact of criteria changes on generating prevalence estimates based on the DSM-5 compared with the DSM-IV [13]. No published estimates were identified for the prevalence of sedative, hypnotic, or anxiolytic use disorder based on the DSM-5. No studies were identified that assessed the frequency of the craving criterion for the sedative, hypnotic, or anxiolytic use disorder. The removal of the legal criteria is expected to have limited impact on DSM-IV to DSM-5 changes in estimates [36,39,46]. Data from NSDUH indicate that less than 0.1 percent of respondents endorsed the legal criterion for sedatives (Table 2.25, weighted), and less than 0.1 percent of the population met the legal criterion for tranquilizers (Table 2.26). Even when combined (Table 2.27), the endorsement of the legal criterion for sedative or tranquilizer abuse is less than 0.1 percent.

NSDUH's tranquilizer abuse and dependence module does not currently assess tranquilizer withdrawal symptoms. This may lead to an underestimate of DSM-IV sedative/hypnotic/anxiolytic dependence and DSM-5 sedative/hypnotic/anxiolytic use disorder. Withdrawal symptoms for tranquilizers are the same as those assessed for other sedatives assessed in NSDUH. Therefore, the same questions used to assess withdrawal in the sedative module could be added to the tranquilizer module to align the assessment or tranquilizer dependence and tranquilizer use disorder with DSM criteria. This would marginally add to the assessment length and may disrupt trend estimates, but would improve face validity with the DSM.

NSDUH currently assesses sedatives and tranquilizers separately, whereas the DSM makes no diagnostic distinction between the two, which means that NSDUH's reporting of sedative, hypnotic, or anxiolytic use disorder does not directly map onto the DSM categories. Although this would disrupt current trend estimates, the sedatives and tranquilizer modules could be combined to increase concordance with DSM and also reduce participant burden. Alternatively, future NSDUH-based publications could report the combined prevalence to facilitate comparison with other research if tranquilizer withdrawal were added to the assessment.

Table 2.25 Sedative Legal Criterion Endorsement among People Aged 12 or Older, by Demographic Characteristic: Weighted Percentages, Annual Averages Based on 2002-2012 NSDUHs

Demographic Characteristic	DSM-IV Legal Criterion Endorsement	Respondents Who Endorsed Only the DSM-IV Legal Criterion	Respondents Who Endorsed the DSM-IV Legal Criterion and One Other DSM-IV SUD Criterion
TOTAL	0.0	*	*
GENDER			
Male	0.0	*	*
Female	0.0	*	*
HISPANIC ORIGIN AND RACE			
Not Hispanic or Latino	0.0	*	*
White	0.0	*	*
Black or African American	0.0	*	*
American Indian or Alaska Native	0.0	*	*
Native Hawaiian or Other Pacific Islander	0.0	*	*
Asian	0.0	*	*
Two or More Races	0.0	*	*
Hispanic or Latino	0.0	*	*
AGE			
12-13	0.0	*	*
14-15	0.0	*	*
16-17	0.0	*	0.0
18-25	0.0	*	*
26-35	0.0	*	*
36-45	0.0	*	*
46-55	0.0	*	*
56-64	0.0	*	*
65 or Older	0.0	*	*

*Low precision; no estimate reported.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2002-2005, 2006-2010 (Revised 3/12), 2011-2012.

Table 2.26 Tranquilizer Legal Criterion Endorsement among People Aged 12 or Older, by Demographic Characteristic: Weighted Percentages, Annual Averages Based on 2002-2012 NSDUHs

Demographic Characteristic	DSM-IV Legal Criterion Endorsement	Respondents Who Endorsed Only the DSM-IV Legal Criterion	Respondents Who Endorsed the DSM-IV Legal Criterion and One Other DSM-IV SUD Criterion
TOTAL	0.0	*	*
GENDER			
Male	0.0	*	0.0
Female	0.0	*	*
HISPANIC ORIGIN AND RACE			
Not Hispanic or Latino	0.0	*	*
White	0.0	*	*
Black or African American	0.0	*	*
American Indian or Alaska Native	0.1	0.0	*
Native Hawaiian or Other Pacific Islander	*	*	*
Asian	0.0	*	*
Two or More Races	0.1	0.1	*
Hispanic or Latino	0.0	0.0	*
AGE			
12-13	0.0	*	*
14-15	0.1	*	0.0
16-17	0.1	0.0	0.0
18-25	0.1	0.0	0.0
26-35	0.0	0.0	*
36-45	0.0	*	*
46-55	0.0	*	*
56-64	*	*	*
65 or Older	0.0	*	0.0

*Low precision; no estimate reported.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2002-2005, 2006-2010 (Revised 3/12), 2011-2012.

Table 2.27 Sedative/Tranquilizer Legal Criterion Endorsement among People Aged 12 or Older, by Demographic Characteristic: Weighted Percentages, Annual Averages Based on 2002-2012 NSDUHs

Demographic Characteristic	DSM-IV Legal Criterion Endorsement	Respondents Who Endorsed Only the DSM-IV Legal Criterion	Respondents Who Endorsed the DSM-IV Legal Criterion and One Other DSM-IV SUD Criterion
TOTAL	0.0	*	*
GENDER			
Male	0.1	*	*
Female	0.0	*	*
HISPANIC ORIGIN AND RACE			
Not Hispanic or Latino	0.0	*	*
White	0.0	*	*
Black or African American	0.1	*	*
American Indian or Alaska Native	0.1	0.0	*
Native Hawaiian or Other Pacific Islander	0.0	*	*
Asian	0.0	*	*
Two or More Races	0.1	0.1	*
Hispanic or Latino	0.1	0.0	*
AGE			
12-13	0.0	*	*
14-15	0.1	0.0	0.0
16-17	0.1	0.0	0.0
18-25	0.1	0.0	0.0
26-35	0.1	0.0	*
36-45	0.0	*	*
46-55	0.0	*	*
56-64	0.0	*	*
65 or Older	0.0	*	*

*Low precision; no estimate reported.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2002-2005, 2006-2010 (Revised 3/12), 2011-2012.

The impact of adding the craving criterion to the DSM-5 criteria for sedatives, hypnotics, or anxiolytics is unclear. There is a paucity of estimates on craving endorsement for sedatives, hypnotics, or anxiolytics. However, DSM-IV–defined sedative use disorder criteria are met by an estimated 0.1 percent of the population (Table 2.28) and a similar percentage of respondents met DSM-5 criteria, excluding the craving criterion. Approximately 0.1 percent of respondents endorsed only one criterion, suggesting the risk of misclassification because of the missing craving criterion is only 0.1 percent at most. Moreover, the risk of misclassification was largely similar across all subgroups. The withdrawal criterion was the most frequently endorsed solitary criterion (0.1 percent; Table 2.29). Data are unavailable for tranquilizers specifically since the lack of tranquilizer withdrawal makes estimates of the craving impact unreliable (as there are multiple points of uncertainty).

Table 2.28 Sedative Use Disorder among People Aged 12 or Older under DSM-IV and DSM-5 Criteria, by Demographic Characteristic: Weighted Percentages, Annual Averages Based on 2002-2012 NSDUHs

Demographic Characteristic	DSM-IV[1]	DSM-5[2]	Diagnostic Orphans[3]	Respondents Who Endorsed Only One Criterion[4]
TOTAL	0.1	0.1	0.0	0.1
GENDER				
Male	0.1	0.1	0.0	0.1
Female	0.1	0.1	0.0	0.1
HISPANIC ORIGIN AND RACE				
Not Hispanic or Latino	0.1	0.1	0.0	0.1
White	0.1	0.1	0.0	0.1
Black or African American	0.0	0.0	0.0	0.0
American Indian or Alaska Native	0.2	0.2	*	0.1
Native Hawaiian or Other Pacific Islander	0.1	0.1	*	*
Asian	0.0	0.0	*	0.0
Two or More Races	0.1	0.1	0.0	0.0
Hispanic or Latino	0.1	0.1	0.0	0.0
AGE				
12-13	0.0	0.1	0.0	0.0
14-15	0.1	0.1	0.0	0.1
16-17	0.1	0.1	0.0	0.1
18-25	0.1	0.1	0.0	0.1
26-35	0.1	0.1	0.0	0.1
36-45	0.1	0.1	0.0	0.1
46-55	0.1	0.1	*	0.1
56-64	0.0	0.0	0.0	0.0
65 or Older	0.0	0.0	*	0.0

*Low precision; no estimate reported.

[1] Sedative use disorder is based on definitions found in the 4th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV).

[2] Sedative use disorder is based on definitions found in the 5th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5), excluding the new craving criterion.

[3] Diagnostic orphans include individuals who endorsed two DSM-IV dependence criteria and no abuse criteria.

[4] Excludes DSM-IV legal problem criterion.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2002-2005, 2006-2010 (Revised 3/12), 2011-2012.

Table 2.29 Respondents Who Endorsed Only One Sedative Use Disorder Criterion among People Aged 12 or Older, by Criterion and Demographic Characteristic: Weighted Percentages, Annual Averages Based on 2002-2012 NSDUHs

Demographic Characteristic	Hazardous Use Only	Role Failure Only	Continued Use Despite Social Problems Only	Longer/ More Use Only	Failure to Cut Down Only	Spent a Great Deal of Time Only	Reduced Activities Only	Continued Use Despite Physical Problems Only	Tolerance Only	Withdrawal Only
TOTAL	*	*	*	*	*	0.0	*	*	0.0	0.1
GENDER										
Male	0.0	*	*	*	*	0.0	*	*	0.0	0.0
Female	*	*	*	*	*	0.0	*	*	0.0	0.1
HISPANIC ORIGIN AND RACE										
Not Hispanic or Latino	*	*	*	*	*	0.0	*	*	0.0	0.1
White	0.0	*	*	*	*	0.0	*	*	0.0	0.1
Black or African American	*	*	*	*	*	*	*	*	0.0	0.0
American Indian or Alaska Native	*	*	*	*	*	*	*	0.0	0.1	0.2
Native Hawaiian or Other Pacific Islander	*	*	*	*	*	*	*	*	*	*
Asian	*	*	*	*	*	*	*	*	*	*
Two or More Races	*	*	*	*	*	0.0	*	*	0.0	0.1
Hispanic or Latino	0.0	*	*	*	0.0	*	*	*	0.0	0.1
AGE										
12-13	*	0.0	*	*	0.0	*	0.0	*	0.0	0.0
14-15	*	0.0	*	*	*	0.0	0.0	*	0.0	0.1
16-17	0.0	*	*	*	*	0.0	0.0	0.0	0.0	0.1
18-25	0.0	*	*	*	*	0.0	*	*	0.0	0.1
26-35	0.0	*	*	*	*	0.0	*	*	0.0	0.1
36-45	0.0	*	*	*	*	0.0	*	*	0.0	0.1
46-55	*	*	*	*	0.0	0.0	*	*	0.0	0.1
56-64	*	*	*	*	*	*	*	*	0.0	0.0
65 or Older	*	*	*	*	*	*	*	*	0.0	*

*Low precision; no estimate reported.

NOTE: Sedative use disorder is based on definitions found in the 4th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV).

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2002-2005, 2006-2010 (Revised 3/12), 2011-2012.

2.5.8 Stimulant Use Disorder

The DSM-IV to DSM-5 criteria changes for stimulant use disorder followed the overall SUD template changes with one additional change—the amphetamine use disorder and the cocaine use disorder (including crack use) were combined into a single stimulant use disorder diagnosis in DSM-5. This change was made based on the similarity of effect for amphetamines and cocaine [2]. NSDUH does not follow the DSM-IV criteria precisely in its assessment of stimulants. NSDUH collects data on cocaine, crack, and other stimulants in three separate modules (methamphetamine, although not a prescription drug, is assessed in the prescription drug stimulant module). In order to produce DSM-5 consistent estimates, NSDUH would need to either combine the cocaine and stimulant (which includes amphetamines) modules or provide separate and combined estimates for these substances in future publications. This would provide additional comparison options for researchers and provide data for service providers who may need estimates based on the DSM-5 for planning purposes.

The impacts of specific diagnostic changes have been examined in a few published studies, and the changes in population prevalence estimates have been examined in a few studies of cocaine addiction only. In a study conducted among a sample of recently incarcerated correctional inmates, past year cocaine use disorder prevalence based on the DSM-IV was 12.7 percent, whereas the prevalence using DSM-5 criteria was 11.0 percent [47]. Notably, about 50 percent of inmates who met the DSM-IV criteria for cocaine abuse did not meet the DSM-5 criteria for cocaine use disorder [48]. The prevalence of this disorder was largely stable as a result of capturing more diagnostic orphans (individuals who met one or two dependence criteria and no abuse criteria). However, it is unclear how consistent these results will be for other stimulant types.

As was found with other substances, the combination of abuse and dependence into a single diagnosis was demonstrated to be a more accurate measurement of the underlying construct of stimulant addiction [22,36,39]. The legal criterion was found to add little diagnostic information and had a low rate of endorsement; thus, its removal is expected to have little impact on prevalence estimates [22,36]. Data from NSDUH suggests that less than 0.1 percent of respondents endorsed the legal criterion for stimulants (Table 2.30, weighted), 0.1 percent endorsed the legal criterion for cocaine (Table 2.31, weighted), and 0.1 percent of the population endorsed the legal criterion for either stimulants or cocaine when combined (Table 2.32).

Data examining the impact of the craving criterion addition are only available for cocaine. Peer et al. reported a lifetime prevalence of cocaine craving of 45 percent among adults in a high-risk, largely substance-using sample [25]. Compton et al. reported a past year craving prevalence among a nationally representative sample of 27 percent among adults who had used cocaine in the past year [30] (Table 2.33).

Table 2.30 Stimulant Legal Criterion Endorsement among People Aged 12 or Older, by Demographic Characteristic: Weighted Percentages, Annual Averages Based on 2002-2012 NSDUHs

Demographic Characteristic	DSM-IV Legal Criterion Endorsement	Respondents Who Endorsed Only the DSM-IV Legal Criterion	Respondents Who Endorsed the DSM-IV Legal Criterion and One Other DSM-IV SUD Criterion
TOTAL	0.0	*	*
GENDER			
Male	0.0	*	*
Female	0.0	*	*
HISPANIC ORIGIN AND RACE			
Not Hispanic or Latino	0.0	*	*
White	0.0	*	*
Black or African American	0.0	*	*
American Indian or Alaska Native	0.3	*	0.1
Native Hawaiian or Other Pacific Islander	0.2	*	0.0
Asian	0.0	*	*
Two or More Races	0.1	0.0	*
Hispanic or Latino	0.0	*	*
AGE			
12-13	0.0	*	*
14-15	0.1	*	0.0
16-17	0.1	*	0.0
18-25	0.1	0.0	*
26-35	0.1	0.0	*
36-45	0.0	*	*
46-55	0.0	*	*
56-64	*	*	*
65 or Older	*	*	*

*Low precision; no estimate reported.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2002-2005, 2006-2010 (Revised 3/12), 2011-2012.

Table 2.31 Cocaine Legal Criterion Endorsement among People Aged 12 or Older, by Demographic Characteristic: Weighted Percentages, Annual Averages Based on 2002-2012 NSDUHs

Demographic Characteristic	DSM-IV Legal Criterion Endorsement	Respondents Who Endorsed Only the DSM-IV Legal Criterion	Respondents Who Endorsed the DSM-IV Legal Criterion and One Other DSM-IV SUD Criterion
TOTAL	0.1	*	*
GENDER			
Male	0.2	*	0.0
Female	0.1	*	*
HISPANIC ORIGIN AND RACE			
Not Hispanic or Latino	0.1	*	*
White	0.1	*	*
Black or African American	0.3	0.0	0.0
American Indian or Alaska Native	0.1	*	0.0
Native Hawaiian or Other Pacific Islander	0.3	*	*
Asian	0.0	*	*
Two or More Races	0.2	*	*
Hispanic or Latino	0.2	0.0	0.0
AGE			
12-13	0.0	*	*
14-15	0.1	*	0.0
16-17	0.1	0.0	0.0
18-25	0.2	0.0	0.0
26-35	0.2	0.0	0.0
36-45	0.2	0.0	*
46-55	0.1	*	*
56-64	0.0	*	*
65 or Older	0.0	*	*

*Low precision; no estimate reported.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2002-2005, 2006-2010 (Revised 3/12), 2011-2012.

Table 2.32 Stimulant/Cocaine Legal Criterion Endorsement among People Aged 12 or Older, by Demographic Characteristic: Weighted Percentages, Annual Averages Based on 2002-2012 NSDUHs

Demographic Characteristic	DSM-IV Legal Criterion Endorsement	Respondents Who Endorsed Only the DSM-IV Legal Criterion	Respondents Who Endorsed the DSM-IV Legal Criterion and One Other DSM-IV SUD Criterion
TOTAL	0.1	*	0.0
GENDER			
Male	0.2	0.0	0.0
Female	0.1	*	*
HISPANIC ORIGIN AND RACE			
Not Hispanic or Latino	0.1	*	0.0
White	0.1	*	*
Black or African American	0.3	0.0	0.0
American Indian or Alaska Native	0.3	*	0.1
Native Hawaiian or Other Pacific Islander	0.4	*	0.0
Asian	0.0	*	*
Two or More Races	0.3	0.0	*
Hispanic or Latino	0.2	0.0	0.0
AGE			
12-13	0.0	*	*
14-15	0.1	0.0	0.0
16-17	0.2	0.0	0.0
18-25	0.3	0.0	0.0
26-35	0.2	0.0	0.0
36-45	0.2	0.0	*
46-55	0.1	*	*
56-64	0.0	*	*
65 or Older	0.0	*	*

*Low precision; no estimate reported.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2002-2005, 2006-2010 (Revised 3/12), 2011-2012.

Table 2.33 Prevalence of DSM-5 Cocaine Use Disorder Craving Criterion from Available Studies

Substance	Study *N*	Prevalence of Craving (Time Frame)	Study and Population	Item Wording
Cocaine	7,543	45% (lifetime)	Peer et al. (2013)[25] Subjects were aggregated from family-based and case-control genetic studies of substance dependence.	"In situations where you could not use [drug], did you ever have such a strong desire for it that you could not think of anything else?"
Cocaine	42,862	27% (past year)	Compton et al. (2013)[30] The 1991-1992 National Longitudinal Alcohol Epidemiologic Survey, a nationally representative survey of noninstitutionalized adults (18 or older) in the United States.	"have a very strong desire or urge to use [drug]"

DSM-5 = *Diagnostic and Statistical Manual of Mental Disorders*.

Data from NSDUH indicate that there will be an increase in the prevalence of stimulant use disorder under DSM-5 criteria. The annual average weighted prevalence of past year DSM-IV–defined stimulant use disorder was 0.2 percent (Table 2.34). Under DSM-5 criteria, excluding the craving criterion, the prevalence of stimulant use disorder was similar to DSM-IV and 0.1 percent of respondents (weighted) endorsed only one criterion; therefore, the risk of from the missing craving criterion is up to 0.1 percent. Withdrawal (0.1 percent) was the most frequently endorsed single criterion (Table 2.35).

The data for cocaine use disorder differed from that of stimulants. The prevalence for past year DSM-IV was slightly lower than DSM-5 cocaine use disorder, excluding the craving criterion (0.5 percent and 0.6 percent, respectively; Table 2.36). Up to 0.2 percent of respondents were at risk for misclassification (primarily from withdrawal endorsement, Table 2.37). Combining NSDUH criteria data for stimulant and cocaine, to closer approximate the DSM-5 combined category indicated a slight increase in past year prevalence between DSM-IV and DSM-5 (0.6 to 0.7, Table 2.38) and a 0.3 prevalence of single criterion endorsement among respondents. The most frequently endorsed single criterion for combined stimulants and cocaine was withdrawal (Table 2.39).

Table 2.34 Stimulant Use Disorder among People Aged 12 or Older under DSM-IV and DSM-5 Criteria, by Demographic Characteristic: Weighted Percentages, Annual Averages Based on 2002-2012 NSDUHs

Demographic Characteristic	DSM-IV[1]	DSM-5[2]	Diagnostic Orphans[3]	Respondents Who Endorsed Only One Criterion[4]
TOTAL	0.2	0.2	0.0	0.1
GENDER				
Male	0.2	0.2	0.0	0.1
Female	0.2	0.2	0.0	0.1
HISPANIC ORIGIN AND RACE				
Not Hispanic or Latino	0.2	0.2	0.0	0.1
White	0.2	0.2	0.1	0.2
Black or African American	0.1	0.1	0.0	0.1
American Indian or Alaska Native	0.5	0.5	0.0	0.2
Native Hawaiian or Other Pacific Islander	0.3	0.3	0.0	0.1
Asian	0.0	0.1	0.0	0.1
Two or More Races	0.2	0.2	0.0	0.3
Hispanic or Latino	0.1	0.1	0.0	0.1
AGE				
12-13	0.1	0.1	0.0	0.1
14-15	0.3	0.4	0.1	0.3
16-17	0.5	0.5	0.1	0.5
18-25	0.4	0.5	0.1	0.4
26-35	0.2	0.3	0.1	0.1
36-45	0.1	0.2	0.0	0.1
46-55	0.1	0.1	0.0	0.1
56-64	0.0	0.0	0.0	0.0
65 or Older	0.0	0.0	*	*

*Low precision; no estimate reported.

[1] Stimulant use disorder is based on definitions found in the 4th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV).

[2] Stimulant use disorder is based on definitions found in the 5th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5), excluding the new craving criterion.

[3] Diagnostic orphans include individuals who endorsed two DSM-IV dependence criteria and no abuse criteria.

[4] Excludes DSM-IV legal problem criterion.

Table 2.35 Respondents Who Endorsed Only One Stimulant Use Disorder Criterion among People Aged 12 or Older, by Criterion and Demographic Characteristic: Weighted Percentages, Annual Averages Based on 2002-2012 NSDUHs

Demographic Characteristic	Hazardous Use Only	Role Failure Only	Continued Use Despite Social Problems Only	Longer/ More Use Only	Failure to Cut Down Only	Spent a Great Deal of Time Only	Reduced Activities Only	Continued Use Despite Physical Problems Only	Tolerance Only	Withdrawal Only
TOTAL	0.0	0.0	*	*	0.0	0.0	*	0.0	0.0	0.1
GENDER										
Male	0.0	0.0	*	*	0.0	0.0	0.0	0.0	0.1	0.1
Female	0.0	*	*	*	0.0	0.0	*	0.0	0.0	0.1
HISPANIC ORIGIN AND RACE										
Not Hispanic or Latino	0.0	0.0	*	*	0.0	0.0	*	0.0	0.1	0.1
White	0.0	*	*	*	0.0	0.0	*	0.0	0.1	0.1
Black or African American	*	0.0	*	*	0.0	0.0	*	0.0	0.0	0.0
American Indian or Alaska Native	0.0	0.0	*	0.0	*	0.1	0.0	*	0.1	0.3
Native Hawaiian or Other Pacific Islander	0.0	*	*	*	*	*	*	*	0.1	0.3
Asian	*	*	*	*	0.0	0.0	*	*	0.0	0.0
Two or More Races	0.0	*	*	0.0	0.0	0.0	0.0	*	0.1	0.2
Hispanic or Latino	0.0	0.0	*	*	*	0.0	*	0.0	0.0	0.1
AGE										
12-13	*	0.0	*	*	0.0	0.0	0.0	*	0.0	0.1
14-15	0.0	0.0	0.0	*	0.0	0.0	0.0	0.0	0.1	0.2
16-17	0.0	0.0	0.0	0.0	0.0	0.1	*	0.0	0.2	0.3
18-25	0.0	0.0	0.0	*	0.0	0.1	0.0	0.0	0.2	0.3
26-35	*	0.0	*	*	*	0.0	0.0	0.0	0.1	0.2
36-45	0.0	*	*	*	0.0	0.0	*	0.0	0.0	0.1
46-55	0.0	*	*	*	*	0.0	*	0.0	0.0	0.1
56-64	*	*	*	*	*	0.0	*	*	*	0.0
65 or Older	*	*	*	*	*	*	*	*	*	*

*Low precision; no estimate reported.

NOTE: Stimulant use disorder is based on definitions found in the 4th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV).

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2002-2005, 2006-2010 (Revised 3/12), 2011-2012.

Table 2.36 Cocaine Use Disorder among People Aged 12 or Older under DSM-IV and DSM-5 Criteria, by Demographic Characteristic: Weighted Percentages, Annual Averages Based on 2002-2012 NSDUHs

Demographic Characteristic	DSM-IV[1]	DSM-5[2]	Diagnostic Orphans[3]	Respondents Who Endorsed Only One Criterion[4]
TOTAL	0.5	0.6	0.1	0.2
GENDER				
Male	0.7	0.8	0.1	0.3
Female	0.4	0.4	0.1	0.2
HISPANIC ORIGIN AND RACE				
Not Hispanic or Latino	0.5	0.6	0.1	0.2
White	0.5	0.5	0.1	0.2
Black or African American	0.9	1.0	0.1	0.2
American Indian or Alaska Native	0.8	0.8	0.1	0.4
Native Hawaiian or Other Pacific Islander	0.5	0.6	0.1	0.3
Asian	0.1	0.1	0.0	0.1
Two or More Races	0.9	0.9	0.1	0.4
Hispanic or Latino	0.7	0.7	0.1	0.3
AGE				
12-13	0.0	0.0	0.0	0.0
14-15	0.3	0.3	0.0	0.1
16-17	0.6	0.7	0.2	0.4
18-25	1.1	1.2	0.3	0.7
26-35	0.9	0.9	0.1	0.4
36-45	0.8	0.8	0.1	0.2
46-55	0.5	0.5	0.1	0.1
56-64	0.1	0.2	0.0	0.0
65 or Older	0.0	0.0	*	0.0

*Low precision; no estimate reported.

[1] Cocaine use disorder is based on definitions found in the 4th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV).

[2] Cocaine use disorder is based on definitions found in the 5th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5), excluding the new craving criterion.

[3] Diagnostic orphans include individuals who endorsed two DSM-IV dependence criteria and no abuse criteria.

[4] Excludes DSM-IV legal problem criterion.

Table 2.37 Respondents Who Endorsed Only One Cocaine Use Disorder Criterion among People Aged 12 or Older, by Criterion and Demographic Characteristic: Weighted Percentages, Annual Averages Based on 2002-2012 NSDUHs

Demographic Characteristic	Hazardous Use Only	Role Failure Only	Continued Use Despite Social Problems Only	Longer/ More Use Only	Failure to Cut Down Only	Spent a Great Deal of Time Only	Reduced Activities Only	Continued Use Despite Physical Problems Only	Tolerance Only	Withdrawal Only
TOTAL	0.0	0.0	0.0	0.0	0.0	0.1	0.0	0.0	0.1	0.2
GENDER										
Male	0.0	0.0	0.0	0.0	0.0	0.1	0.0	0.0	0.1	0.3
Female	0.0	0.0	*	*	0.0	0.0	0.0	0.0	0.1	0.2
HISPANIC ORIGIN AND RACE										
Not Hispanic or Latino	0.0	0.0	*	0.0	0.0	0.1	0.0	0.0	0.1	0.2
White	0.0	0.0	0.0	*	0.0	0.0	0.0	0.0	0.1	0.2
Black or African American	0.0	0.0	*	0.0	0.0	0.1	0.0	0.0	0.1	0.4
American Indian or Alaska Native	0.1	0.0	*	*	0.0	0.1	*	*	0.2	0.4
Native Hawaiian or Other Pacific Islander	0.0	*	*	*	*	0.1	0.0	*	0.1	0.2
Asian	*	*	*	*	*	0.0	*	*	0.0	0.1
Two or More Races	0.1	0.0	*	*	*	0.1	0.0	*	0.1	0.3
Hispanic or Latino	0.0	0.0	0.0	0.0	0.0	0.1	0.0	0.0	0.1	0.3
AGE										
12-13	*	*	*	*	*	0.0	*	*	0.0	0.0
14-15	0.0	0.0	*	*	0.0	0.0	0.0	*	0.0	0.1
16-17	0.0	0.0	0.0	0.0	0.0	0.1	0.0	0.0	0.2	0.3
18-25	0.1	0.0	0.0	0.0	0.0	0.2	0.0	0.0	0.3	0.5
26-35	0.0	0.0	0.0	0.0	0.0	0.1	0.0	0.0	0.1	0.3
36-45	0.0	0.0	0.0	*	*	0.1	0.0	0.0	0.1	0.3
46-55	0.0	0.0	*	*	0.0	0.0	0.0	*	0.0	0.2
56-64	*	*	*	*	*	0.0	*	0.0	0.0	0.1
65 or Older	*	*	*	*	*	*	*	*	*	*

*Low precision; no estimate reported.

NOTE: Cocaine use disorder is based on definitions found in the 4th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV).

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2002-2005, 2006-2010 (Revised 3/12), 2011-2012.

Table 2.38 Stimulant/Cocaine Use Disorder among People Aged 12 or Older under DSM-IV and DSM-5 Criteria, by Demographic Characteristic: Weighted Percentages, Annual Averages Based on 2002-2012 NSDUHs

Demographic Characteristic	DSM-IV[1]	DSM-5[2]	Diagnostic Orphans[3]	Respondents Who Endorsed Only One Criterion[4]
TOTAL	0.6	0.7	0.1	0.3
GENDER				
Male	0.8	0.9	0.2	0.4
Female	0.5	0.6	0.1	0.3
HISPANIC ORIGIN AND RACE				
Not Hispanic or Latino	0.6	0.7	0.1	0.3
White	0.6	0.7	0.1	0.3
Black or African American	0.9	1.0	0.1	0.3
American Indian or Alaska Native	1.2	1.2	0.1	0.5
Native Hawaiian or Other Pacific Islander	0.8	0.9	0.1	0.3
Asian	0.1	0.2	0.1	0.2
Two or More Races	1.0	1.0	0.1	0.6
Hispanic or Latino	0.7	0.8	0.1	0.4
AGE				
12-13	0.1	0.1	0.0	0.1
14-15	0.5	0.6	0.1	0.4
16-17	0.9	1.0	0.3	0.8
18-25	1.4	1.6	0.4	1.0
26-35	1.0	1.1	0.2	0.5
36-45	0.9	0.9	0.1	0.3
46-55	0.5	0.6	0.1	0.2
56-64	0.1	0.2	0.1	0.0
65 or Older	0.0	0.0	*	0.0

*Low precision; no estimate reported.

[1] Stimulant/cocaine use disorder is based on definitions found in the 4th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV).

[2] Stimulant/cocaine use disorder is based on definitions found in the 5th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5), excluding the new craving criterion.

[3] Diagnostic orphans include individuals who endorsed two DSM-IV dependence criteria and no abuse criteria.

[4] Excludes DSM-IV legal problem criterion.

Table 2.39 Respondents Who Endorsed Only One Stimulant/Cocaine Use Disorder Criterion among People Aged 12 or Older, by Criterion and Demographic Characteristic: Weighted Percentages, Annual Averages Based on 2002-2012 NSDUHs

Demographic Characteristic	Hazardous Use Only	Role Failure Only	Continued Use Despite Social Problems Only	Longer/ More Use Only	Failure to Cut Down Only	Spent a Great Deal of Time Only	Reduced Activities Only	Continued Use Despite Physical Problems Only	Tolerance Only	Withdrawal Only
TOTAL	0.0	0.0	0.0	0.0	0.0	0.1	0.0	0.0	0.1	0.3
GENDER										
Male	0.0	0.0	0.0	0.0	0.0	0.1	0.0	0.0	0.2	0.4
Female	0.0	0.0	0.0	*	0.0	0.1	0.0	0.0	0.1	0.3
HISPANIC ORIGIN AND RACE										
Not Hispanic or Latino	0.0	0.0	0.0	0.0	0.0	0.1	0.0	0.0	0.1	0.3
White	0.0	0.0	0.0	0.0	0.0	0.1	0.0	0.0	0.1	0.3
Black or African American	0.0	0.0	*	0.0	0.0	0.1	0.0	0.0	0.1	0.4
American Indian or Alaska Native	0.1	0.0	*	0.0	0.0	0.1	*	*	0.2	0.7
Native Hawaiian or Other Pacific Islander	0.0	*	*	*	*	0.1	0.0	*	0.1	0.6
Asian	*	*	*	*	0.0	0.1	*	*	0.0	0.1
Two or More Races	0.1	0.0	0.0	*	0.0	0.1	0.1	*	0.3	0.4
Hispanic or Latino	0.1	0.0	0.0	0.0	0.0	0.1	0.0	0.0	0.1	0.4
AGE										
12-13	*	0.0	*	*	0.0	0.0	0.0	*	0.1	0.1
14-15	0.0	0.0	0.0	0.0	0.0	0.1	0.0	0.0	0.1	0.3
16-17	0.1	0.0	0.0	0.0	0.0	0.2	0.0	0.0	0.3	0.5
18-25	0.1	0.0	0.0	0.0	0.1	0.3	0.0	0.0	0.4	0.7
26-35	0.0	0.0	0.0	0.0	0.0	0.1	0.1	0.0	0.2	0.5
36-45	0.0	0.0	0.0	*	0.0	0.1	0.0	0.0	0.1	0.4
46-55	0.0	0.0	*	*	0.0	0.0	0.0	0.0	0.0	0.3
56-64	*	*	*	*	*	0.0	*	0.0	0.0	0.1
65 or Older	*	*	*	*	*	*	*	*	*	*

*Low precision; no estimate reported.

NOTE: Stimulant/cocaine use disorder is based on definitions found in the 4th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV).

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2002-2005, 2006-2010 (Revised 3/12), 2011-2012.

2.5.9 Tobacco Use Disorder

Significant changes have occurred to diagnostic criteria for nicotine or tobacco use disorders. DSM-IV–only assessed nicotine dependence and alternate scales, such as the Fagerström Nicotine Dependence Scale [12], were frequently used to assess nicotine dependence in some studies [37]. However, based on evidence that abuse criteria, such as use in hazardous situations (e.g., smoking in bed) and continued use despite problems (e.g., inability to work in nonsmoking positions), are increasingly relevant because of an increase in laws prohibiting smoking in public places, the DSM-5 has brought criteria for nicotine addiction in line with other SUDs. The DSM-5 refers to nicotine dependence as tobacco use disorder to acknowledge the departure from the former dependence diagnosis.

NSDUH currently uses two nicotine dependence scales among respondents who smoked in the past month—the Fagerström Nicotine Dependence Scale [12] and the Nicotine Dependence Syndrome Scale [11]. These scales, although correlated with DSM-IV–defined dependence, do not match DSM-IV criteria precisely and make it difficult to determine the impact of criteria changes on NSDUH. Tests of the expanded DSM-5 criteria indicate a higher prevalence of tobacco use disorder than nicotine dependence as defined by the DSM-IV; therefore, without changes, NSDUH will likely underestimate the prevalence of tobacco use disorder in the general population [37]. The amount of misclassification is difficult to quantify and may not be equivalent across population groups. A small study of adolescents and young adults who had smoked cigarettes in the past year found that the prevalence of tobacco use disorder was double (68.7 percent) the prevalence of DSM-IV nicotine dependence (33.0 percent) among adolescents (aged 14 to 18) and the prevalence of tobacco use disorder (86.0 percent) was over a third greater than DSM-IV nicotine dependence (59.6 percent) among young adults (aged 18 to 35) [49]. To collect DSM-5 nicotine use disorder, NSDUH would need to add the three "abuse" criteria (i.e., hazardous use, failure to fulfill obligations due to use, and continued use despite social problems cause by use), modify the existing questions to better align with DSM-5 "dependence" symptoms (e.g., spending a great deal of time obtaining nicotine), and assess substance "abuse and dependence" of other forms of nicotine (e.g., chew, snuff).

2.5.10 Other Considerations

Two overarching limitations are apparent in the currently available literature on the DSM-IV to DSM-5 conversion. First, there is very little information available on measurement issues related to the assessment of the new DSM-5–defined SUDs. Reliability is the ability of any measure to produce consistent results, and multiple studies of DSM-IV diagnoses found that measures of substance abuse were consistently less reliable than measures of substance dependence [50,51]. This suggests that the criteria for abuse were more difficult and less consistent to measure than the dependence criteria. Reliability can be worse if the criteria for a disorder do not clearly reflect the underlying construct. Therefore, combining the abuse and dependence diagnoses may have a bearing on instrument reliability. On one hand, reliability may be increased as a result of diagnostic criteria that more accurately measure the underlying construct. However, combining the abuse criteria with the dependence criteria and changing the threshold for diagnosis may introduce additional variability to the measure, which could result in lower instrument reliability. Currently, there is little research assessing this aspect of the impact of diagnostic changes with one exception. Data examining the reliability of AUD assessment

suggests that reliability may be in between that of alcohol abuse and alcohol dependence; however, this study did not use fully standardized assessments, which may increase reliability substantially [52]. Reliability is important since an unreliable measure threatens the validity of estimates made using the measure. It is possible that previously established reliability of the NSDUH instrument may not be the same if modifications are made to increase concordance with DSM-5 criteria and the concern over the overall reliability of criteria may make it more difficult to establish reliability of the revised instrument.

The second limitation is that the majority of studies on the DSM-IV to DSM-5 conversion have been conducted among adults. Few studies were identified that considered the impact among adolescents, and no studies were identified that examined younger children. In a review of the limited literature, Winters concluded that merging abuse and dependence into a single disorder diagnosis and the elimination of the legal criterion would improve the validity of the diagnosis for adolescent substance use; however, changing the threshold for diagnostic classification may lead to a higher rate of false positives among this population because of the overlap of some criteria (e.g., tolerance) with a maturation effect [53]. Moreover, no studies were identified that evaluated how the diagnostic changes might affect prevalence estimates in this population [53].

2.6 Substance Use Disorders in NSDUH

The changes for the DSM-IV to the DSM-5 were designed to facilitate an immediate transition for clinicians and insurers. Phasing out the DSM-IV began immediately after the release of the DSM-5, with the American Psychiatric Association's expectation for insurance industry conversion to be completed in early 2014 [54]. As the transition progresses, the field (insurers, clinicians, and researchers) will move away from DSM-IV diagnostic criteria. This transition will be further solidified by the federally mandated transition from ICD-9-CM to ICD-10-CM in 2015 because a DSM-5 to ICD-10 crosswalk has been included in DSM-5 (something not available in DSM-IV). The changes in the field coupled with the fact that revisions to DSM-5 are meant to reflect advancements in scientific knowledge, mean that continued use of DSM-IV diagnostic criteria will introduce questions regarding the face validity of NSDUH. This supports transitioning of NSDUH to better reflect DSM-5 criteria. However, modifications to the instrument should be considered in conjunction with their impact on trend estimates, respondent burden, questionnaire design issues, and stakeholder interests.

To balance these concerns, changes to NSDUH can be considered at two levels. Changes could be made at the analytic level (i.e., changes only during the estimation process with no changes to the questionnaire), which would not introduce context effects and would potentially enable estimation of estimates under differing definitions but would be insufficient to meet all of the DSM-5 revisions. Alternatively, changes could be made to the questionnaire, which introduces the possibility that it may no longer be able to be used to compute DSM-IV–based SUD estimates and therefore affect the ability to assess trends. To balance the needs for trend preservation with data validity, potential changes for alcohol and other illicit drug use modules are discussed below. No changes to the NSDUH tobacco use module are suggested, despite a deviation from DSM criteria, because the NSDUH already uses the most frequently used measure of cigarette dependence in the research field.

Several changes in alcohol and illicit drug use disorder algorithms could be made that would improve alignment with DSM-5, although these changes alone would not be sufficient to align NSDUH with DSM-5. These changes involve creating new algorithms to:

1. Reflect the DSM-5 combining of the abuse and dependence criteria.
2. Remove the legal criterion from the computation of SUD without removing the item from the survey, thereby allowing for DSM-IV estimates to be produced in addition to estimates closer to DSM-5 and for trend estimates to continue.
3. Set the cut point for DSM-5 substance use disorder at two or more symptoms.
4. Produce a severity score of summed SUD symptoms (i.e., 2-3 symptoms = mild, 4-5 symptoms = moderate, and 6 or more symptoms = severe).
5. Generate combined estimates for all sedatives/hypnotics/anxiolytics (sedative and tranquilizer modules), opioids (heroin and pain reliever modules), and stimulants (stimulant and cocaine module, and the new 2015 methamphetamine module) to provide additional information to stakeholders about overall DSM drug classes.

Changes to the NSDUH questionnaire designed to better align it with DSM-5 criteria may include:

1. Change the withdrawal symptom text for sedatives to reflect insomnia only, rather than insomnia and hypersomnia. This is expected to have little impact on estimates because hypersomnia is not typically a symptom experienced after stopping sedative use.
2. Add an item assessing craving to each abuse/dependence module. The text for the items would be consistent across modules (with a substitution for the name of the substance), and adding this item at the end of the modules would minimize the introduction of context effects for that module. There would be potential context effects for subsequent modules.
3. Add tranquilizer withdrawal. This could mirror the sedative withdrawal questions since the symptom is the same; however, this has the potential to increase estimates and introduce context effects. Alternatively, if the frequency of withdrawal from tranquilizers is similar to the frequency of withdrawal from other sedatives, it may be possible to use existing NSDUH data to impute the withdrawal for tranquilizers. This analysis may be more reliable because of the availability of recent applicable data (unlike data for craving). However, the use of imputation techniques may draw criticism because of the increased imprecision of the estimate.
4. Add new items assessing cannabis withdrawal. Placing the withdrawal criteria at the end of the existing abuse/dependence module would appear to reduce the impact of context effects. However, withdrawal symptoms rely on attempts to cut down or stop substance use. The questions that assess these attempts are located in the middle of the module. If withdrawal-symptom assessment makes respondents more cognizant of the presence of the subsequently assessed symptoms, the endorsement of these items might increase. Context effects introduced by adding cannabis withdrawal would then

need to be evaluated and statistical back adjustments may be needed to reconcile changes in trends.

5. Revise the withdrawal questions to remove inappropriate skip patterns and unnecessary questions. Also, separately evaluate an additional item to assess the second part of withdrawal: taking the substance or a similar one to avoid symptoms. These changes will likely lead to an increase in the number of people meeting withdrawal criteria and thereby an increase in the overall prevalence of SUDs. However, there is insufficient data to quantify these increases and the changes may introduce context effects therefore statistical back adjustments may be needed to reconcile changes in trends. In addition, considering the number of potential changes, it might not be possible to statistically assess the magnitude of the context effects. A split design for the survey might assist in measuring these effects but may be impractical from a resources perspective as it leads to reduced sample sizes and statistical power for the main survey. Additionally, determine which question version is optimal for determining withdrawal symptoms and clarify the wording to note that cutting down or stopping use does not need to be intentional.

3. Mental Illness

3.1 Mental Illness in NSDUH and MHSS: Overview

In the previous section, we discussed the *Diagnostic and Statistical Manual of Mental Disorders,* 4th edition (DSM-IV) to DSM, 5th edition (DSM-5) diagnostic criteria revisions for substance use disorders (SUDs) as they related directly to the National Survey on Drug Use and Health (NSDUH). This section focuses on DSM criteria changes to other mental illnesses. These changes have the potential to impact three areas:

- The NSDUH directly—Major depressive episodes are directly assessed among all respondents in the NSDUH
- The Mental Health Surveillance Study (MHSS)—a study conducted with a subsample of NSDUH respondents who are directly assessed for specific mental disorders
- The predictive model—developed in the MHSS and is used to estimate the probability of any mental illness (AMI) and serious mental illness (SMI) in NSDUH

To understand the impact of diagnostic changes on NSDUH and MHSS, it is important to delineate the history, purpose, and interplay between these three areas.

In 1992, the Public Law No. 102-321, the Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA) Reorganization Act, established a block grant for states within the United States to fund community mental health services for adults with SMI. The law required states to include prevalence estimates in their annual applications for block grant funds. This legislation also required the Substance Abuse and Mental Health Services Administration (SAMHSA) to develop a definition for the term "adults with SMI." SAMHSA defined adults with SMI as people aged 18 or older who currently or at any time in the past year had a diagnosable mental, behavioral, or emotional disorder (excluding developmental and substance use disorders) of sufficient duration to meet diagnostic criteria specified by DSM-IV that has resulted in serious functional impairment[55]. The overarching goal of the MHSS was to develop a method to provide accurate estimates of SMI among adults aged 18 or older at both the national and state levels, with a secondary goal of providing accurate estimates of AMI[10].

The MHSS was conducted between 2008 and 2012 with a subsample of adult (aged 18 or older) NSDUH respondents. Past year mental illness was measured in the MHSS clinical interviews using an adapted version of the Structured Clinical Interview for DSM-IV-TR Axis I Disorders and was differentiated by the level of functional impairment based on the Global Assessment of Functioning (GAF) scale [56]. The revised version of the SCID (Structured Clinical Interview for DSM) used in the MHSS, which included the GAF scale, will be referred to as the MHSS SCID to distinguish it from the unrevised version of the SCID, which will be referred to as the DSM-IV SCID. Past year disorders that were assessed through the MHSS SCID included mood disorders (e.g., major depressive disorder [MDD], bipolar I disorder, dysthymic disorder), anxiety disorders (panic disorder, generalized anxiety disorder [GAD], posttraumatic stress disorder [PTSD], obsessive-compulsive disorder [OCD], social phobia, specific phobia, agoraphobia), eating disorders (e.g., anorexia nervosa, bulimia nervosa),

intermittent explosive disorder, and adjustment disorder. In addition, the presence of psychotic symptoms (delusions and hallucinations) was assessed. Substance use disorders also were assessed, although these disorders were not used to produce estimates of mental illness [55].

The MHSS SCID disorder data and GAF scale score were used to determine whether clinical interview respondents had mental illness.

- Respondents were classified as having AMI if they were determined to have any of the mental disorders assessed in the MHSS SCID (not including substance use disorders), regardless of the level of functional impairment.
- Respondents were classified as having low (mild) mental illness if they had any of the mental disorders assessed in the MHSS SCID (not including substance use disorders), but these disorders resulted in no more than mild impairment, based on GAF scores of greater than 59.
- Respondents were classified as having moderate mental illness if they had any of the mental disorders assessed in the MHSS SCID (not including substance use disorders), and these disorders resulted in moderate impairment, based on GAF scores of 51 to 59.
- Respondents were classified as having SMI if they had any of the mental disorders assessed in the MHSS SCID (not including substance use disorders), and these disorders resulted in substantial impairment in carrying out major life activities, based on GAF scores of 50 or below.

For the SMI prediction model that was fit on the clinical data, the dependent variable was a diagnosis of SMI (1 = yes; 0 = no). The predictor variables were based on the Kessler-6 (K6), World Health Organization Disability Assessment Schedule (WHODAS), major depressive episodes (MDE), suicidality, and age items collected in the main NSDUH interview. The model was used to produce a predicted probability of having SMI for each clinical interview respondent in this sample. A cut point was established among the fitted probabilities of having SMI, such that if adults with probabilities at or above the cut point were predicted to have SMI and the rest were not, the weighted number of adults in the MHSS that were incorrectly predicted to have SMI (i.e., false positives) came as close as possible to equaling the weighted number of adults that were incorrectly predicted not to have SMI (i.e., false negatives).

Because the predictor variables in the model had been collected in the main interview, a probability of having SMI was computed for every NSDUH adult respondent in the MHSS sample using the appropriate model parameters. A dichotomous variable, indicating whether a person was predicted to have SMI, was produced (1 = predicted to have SMI; 0 = predicted not to have SMI) by employing the appropriate cut point from the model. The dichotomous SMI variable with values for all adult NSDUH respondents then was used to compute prevalence estimates of SMI for adults. SMI probabilities and SMI predicted values were computed for respondents in NSDUH samples from the 2008 WHODAS half sample and from 2009 to 2012 using the parameters estimated from the model. The probabilities of having SMI from the MHSS regression model also were used to make predictions for AMI for all adult respondents in the main NSDUH interview for 2008 through 2012. A second cut point was determined such that if adults with probabilities at or above the cut point were predicted to have AMI and the rest were

not, the weighted totals of false positives and false negatives for AMI in the clinical sample would come as close as possible to being equal.

As mentioned previously, changes to DSM criteria could affect NSDUH's mental illness prevalence estimation and assessment directly because of revisions in the MDE criteria. The impact on AMI and SMI estimation, however, is more complicated. Diagnostic criteria changes may

- Change the population prevalence of the disorders measured in the MHSS clinical interview
- Change the group of people who meet criteria for a mental illness, thereby changing who is being classified as a "case" and their associated characteristics.

These changes would impact the MHSS by altering who is being determined to have AMI and SMI, thereby impacting AMI/SMI estimation by altering the outcome (i.e. "caseness") in the predictive model. That is, new people might meet diagnostic criteria and existing "cases" may no longer meet diagnostic criteria under DSM-5. Furthermore, if changes in criteria affect the base rate of disorders not measured in MHSS or reflect other clinical changes (e.g., the addition of a new disorder), there may be a need to consider the addition or removal of disorders from the MHSS study and the prediction models of AMI/SMI. The selection of disorders for inclusion in the MHSS has several considerations:

- Prevalence
- Clinical importance (severity [i.e., SMI], functional impairment)
- Feasibility of assessment in a time-limited telephone interview
- Shareholder interest (e.g., importance for treatment provision or societal costs)
- Comorbidity (disorders that co-occur frequently with other disorders may not need to be assessed because they would be "captured" under the other disorder)

The next sections examine the anticipated effects of changes in diagnostic criteria from DSM-IV to DSM-5 to the best of available knowledge and discuss the possible impact of these changes and how they may affect NSDUH estimation of AMI/SMI and the MHSS. We first focus on changes to the conceptualization and organization of DSM-5 and then approach specific diagnostic changes.

3.2 Overarching Structural Changes in the DSM

3.2.1 Elimination of the Multi-Axial System

One of the key changes from DSM-IV to DSM-5 is the elimination of the multi-axial system. DSM-IV approached psychiatric assessment and organization of biopsychosocial information using a "multi-axial" formulation [2]. There were five different axes. Axis I consisted of mental health and SUDs; Axis II was reserved for coding personality disorders and mental retardation; Axis III was used for coding medical conditions; Axis IV was to note psychosocial and environmental problems (e.g., housing, employment); and Axis V was a

numerical assessment of overall functioning known as the GAF. Although the impact of removing the overall multi-axial structure in DSM-5 is unknown, there is concern among clinicians that eliminating the disciplined approach for gathering and organizing clinical assessment data that was required under the multi-axial system will hinder clinical practice [57]. However, the direct impact of eliminating the multi-axial structure on NSDUH/MHSS is likely to be negligible since it will not affect the characteristics of diagnoses. Of note, Axis II developmental disorders are specifically excluded from the definition of SMI. The removal of the axis system, in addition to disorder re-categorization, which is discussed in more detail later, may necessitate a more specific delineation of what is defined as a "developmental disorder" for exclusion.

3.2.2 Removal of the GAF score

The removal of the GAF score, an assessment of overall functioning, introduces a level of uncertainty in the measurement of SMI in MHSS and NSDUH. The federal government defines adults with SMI as people aged 18 or older who currently have or at any time during the past year had a diagnosable mental behavioral or emotional disorder of sufficient duration to meet diagnostic criteria (excluding SUDs, dementia, and developmental disorders) that has resulted in functional impairment, which substantially interferes with or limits one or more major life activities [58]. In addition, those who had a psychiatric disorder in the past that resulted in serious impairment, but are now improved due to treatment are considered to have an SMI. MHSS/NSDUH follows this definition, using the GAF score to indicate impairment, with the exception that NSDUH and MHSS only assess past year disorders. At the end of the MHSS interview, the clinical interviewer assigned a GAF score to the respondent. Representing the DSM-IV Axis V assessment, the GAF score ranges from 1 to 100, based on a two-dimensional continuum of (1) psychiatric symptoms—from severe mental illness to superior mental health, and (2) psychosocial functioning—from severe impairment to superior functioning. For example, a GAF score of 5 would indicate very serious psychiatric symptoms and/or grossly impaired functioning; a GAF score of 95 would indicate no symptoms and superior functioning across a wide range of psychosocial and occupational activities; and a GAF score of 50 would indicate serious symptoms or serious impairment in social, occupational, or school functioning. Impairment in functioning caused by physical or environmental limitations is not included when assigning a GAF score.

In the MHSS SCID, the clinical interviewer was directed to record the GAF score that represented the respondent's worst symptoms or level of functioning in the past year, reflecting whichever dimension was lower. As mentioned previously, a respondent would be classified as having SMI if (1) the GAF score was 50 or lower and (2) one or more nonsubstance use disorders were present in the past year.

The GAF scale was dropped from the DSM-5 because of its conceptual lack of clarity (i.e., including symptoms, suicide risk, and disabilities in the descriptors) and questionable psychometric properties [2]. The American Psychological Association's (APA's) observation of ongoing problems with the GAF is supported by the MHSS data, which found high interrater reliability between the clinical interviewers' and clinical supervisors' consensus ratings for symptoms, but not for the GAF scale (Table 3.1). Symptom-level agreement was calculated using the total number of variables in the clinical interview as the denominator, and without

penalty for omissions and commissions from earlier errors within the same disorder. As shown in Table 3.1, symptom-level agreement improved and was consistently high after the first year, averaging 96 percent. There was also consistently high agreement for having one or more mental disorders, with an average of 99 percent. Clinical interviewers' kappa scores steadily improved each year, with 100 percent of clinical interviewers having high kappa scores for the last seven quarters of the study. Less consistent agreement was found for GAF (0 to 95 percent) and SMI (0 to 100 percent). The majority of error for GAF and SMI ratings was caused by clinical interviewers' GAF ratings that were lower than the clinical supervisors' consensus GAF ratings. Discussions during the interrater reliability prediction conference calls indicated that clinical interviewers' biases toward lower GAF scores were because of overestimating the severity of the respondent's symptoms (e.g., the seriousness of suicidal thoughts, the danger of driving while impaired by alcohol).

Several steps were taken to improve consistency within the MHSS team of clinical interviewers and clinical supervisors. First, quarterly interrater reliability data collection was conducted with group conference calls to discuss and "calibrate" the team's interrater reliability ratings. Second, all clinical interviewer and clinical supervisor training sessions incorporated GAF lectures and exercises. Third, the clinical interviewers and clinical supervisors were provided with training and/or supervision by Dr. Michael First (the SCID developer). Despite these efforts, the interrater reliability remained fair to poor.

Table 3.1 Interrater Reliability Exercise Performance: 2008-2012 MHSS

			CI Performance					Case Description	
Year	Q	CIs Participating/ Employed	Agreement: Symptoms	Agreement: ≥ 1 Diagnosis	Agreement: GAF Decile	Agreement: SMI	CIs with Kappa ≥ 0.61	CS GAF	SMI
2008	**1**	22/22 (100%)	90%	100%	67%	95%	100%	43	SMI
	2	22/25 (88%)	80%	100%	18%	100%	23%	20	SMI
	3	21/23 (91%)	91%	100%	81%	100%	100%	85	Non-SMI
	4	21/21 (100%)	93%	100%	95%	100%	100%	52	Non-SMI
2009	**1**	8/8 (100%)	97%	100%	88%	88%	100%	58	Non-SMI
	2	--	--	--	--	--	--	--	--
	3	7/7 (100%)	97%	86%	43%	100%	71%	65	Non-SMI
	4	6/7 (86%)	99%	100%	83%	100%	100%	45	SMI
2010	**1**	8/8 (100%)	99%	100%	25%	25%	100%	49	SMI
	2	8/8 (100%)	96%	100%	0%	0%	100%	49	SMI
	3	8/8 (100%)	97%	100%	75%	100%	100%	45	SMI
	4	8/8 (100%)	99%	100%	38%	100%	100%	32	SMI
2011	**1**	20/21 (95%)	96%	100%	60%	60%	95%	50	SMI
	2	18/20 (90%)	98%	100%	89%	89%	100%	53	Non-SMI
	3	23/26 (88%)	98%	100%	91%	96%	100%	45	SMI
	4	23/24 (96%)	96%	96%	57%	66%	100%	53	Non-SMI
2012	**1**	22/23 (96%)	98%	100%	68%	68%	100%	53	Non-SMI
	2	22/22 (100%)	98%	100%	55%	55%	100%	50	SMI
	3	21/21 (100%)	98%	95%	90%	100%	100%	66	Non-SMI
	4	19/21 (90%)	99%	100%	63%	63%	100%	50	SMI
Average		96%	96%	99%	62%	78%	94%	51	--

-- Not available.

CI = clinical interviewer; CS = clinical supervisor; GAF = Global Assessment of Functioning; Q = Quarter; SMI = serious mental illness.

To address this limitation and still provide a global measure of disability, the World Health Organization Disability Assessment Schedule version 2.0 (WHODAS 2.0) is included, for further study, in DSM-5 and was included in the DSM-5 field trial. The WHODAS 2.0 assesses disability among adults aged 18 or older across six domains: cognition, mobility, self-care, getting along with others, life activities (e.g., household, work and/or school), and participation in society. In each item the individual is asked to rate how much difficulty he or she has had in specific areas of functioning in the past 30 days: "none" (1), "mild" (2), "moderate" (3), "severe" (4), and "extreme" (5). The WHODAS 2.0 comes in two lengths. The 36-item WHODAS 2.0 yields subscale scores for each of the six domains of functioning along with the overall functioning score and requires approximately 20 minutes to administer. The 12-item WHODAS 2.0 yields an overall functioning score that explains 81 percent of the variance of the 36-item version and requires approximately 5 minutes to administer. The WHODAS 2.0 is available in interviewer-, self-, and proxy-administered forms. Domain scores and summary scores are calculated by adding the ratings using the simple or complex rating system. Using the simple rating system, scores are summed according to the assigned scores for each item, from "none" (1) to "extreme" (5), while the complex scoring system differentially weights the items and levels of severity using a computer program (available from the WHO website). The scoring is done by summing the recorded item scores within each domain, adding the six domain scores, and converting the summary score into a metric ranging from 0 to 100 (where 0 = no disability and 100 = full disability). Population norms for item response theory (IRT)-based scores of the WHODAS 2.0 are also available at the WHO website.

The WHODAS has several strengths:

- It is easy to administer by either the respondent or interviewer.
- It is applicable in both clinical and general population settings.
- It is applicable across cultures and in all adult populations.
- It produces standardized disability levels and profiles.
- It is a direct conceptual link to the International Classification of Functioning, Disability and Health (ICF).
- It has good psychometric properties (e.g., 0.82 to 0.98 reliability coefficient for the full-length WHODAS: http://www.who.int/classifications/icf/whodasii/en/index2.html).
- The WHODAS 2.0 allows for a clinician to override the respondent's answers in cases where information gathered in the clinical interview indicates that another answer is more accurate.
- It is the method increasingly used by researchers.

Likewise, there are several limitations to using the WHODAS 2.0 in place of the GAF. One potential limitation is that the WHODAS is used as a predictive variable in the MHSS prediction model. If the WHODAS were to replace the GAF, then the outcome (severity of mental illness as indicated by the WHODAS) would include one of the model predictors (the presence of impairment as indicated by the WHODAS). This may not be problematic because the score from the WHODAS used in the clinical interview may be altered to reflect the clinical judgment of the interviewer rather than the respondent's perceptions; however, there is likely to

be substantial overlap. This overlap may improve AMI and SMI measurement if the WHODAS is a psychometrically strong indicator of impairment (which is suggested by the literature [59,60]), or it may increase imprecision in areas of measurement weakness. Therefore, while replacing the GAF with the WHODAS 2.0 in the MHSS may improve the reliability and ease of classifying the severity of mental illness cases in the MHSS (e.g., AMI, SMI), it may create difficulties in measuring mental illness (i.e., SMI and AMI) in NSDUH. A stronger limitation of replacing the GAF with the WHODAS to be considered is that the two assessments are dissimilar in what they measure. The GAF provides a measure of the respondent's symptoms and functioning whereas the WHODAS measures only disability. Replacing the GAF with the WHODAS 2.0 would require creating new prediction model for SMI and AMI to reflect the differences between these two assessments. Given the concerns of this replacement, it may be more efficient to retain using the GAF score in MHSS, but problems with the GAF interrater reliability may make replacement preferable. Other assessments of disability might be considered to replace either the WHODAS in NSDUH or the GAF in the MHSS (e.g., the Short Form 36 [SF-36] [61]; the Sheehan Disability Scale [SDS] [62]; the Life Functioning Questionnaire [LFQ] [63]) after considering factors like context effects, timing, and breaks in trends.

3.2.3 Disorder Reclassification

DSM-IV and DSM-5 categorize disorders into "classes" with the intent of grouping similar disorders (particularly those that are suspected to share etiological mechanisms or have similar symptoms) to help clinician and researchers use the manual. From DSM-IV to DSM-5, there has been a reclassification of many disorders that reflects advancements in the field. Table 3.2 lists the disorder classes included in DSM-IV and DSM-5. In DSM-5, six classes were added and four were removed. As a result of these changes in the overall classification system, numerous individual disorders were reclassified. Table 3.3 lists DSM-IV and DSM-5 disorders and their classification scheme.

The reclassification of disorders does not have a direct impact on estimates produced by MHSS or NSDUH; however, it does warrant consideration when documenting disorders that may have changed classes. For example, an estimate for "any anxiety disorder," using the DSM-IV classification would include PTSD and OCD, while the DSM-5 classification would not. Therefore, the DSM version and included disorders should be clearly documented in all relevant SAMHSA products that report class-level estimates.

Table 3.2 Disorder Classes Presented by the DSM-IV and DSM-5, as Ordered in DSM-IV

DSM-IV	DSM-5
1. Disorders usually first diagnosed in infancy, childhood, or adolescence	Dropped and recategorized[1]
	1. Neurodevelopmental disorders
	11. Elimination disorders
2. Delirium, dementia, and amnestic and other cognitive disorders	17. Neurocognitive disorders
3. Mental disorders due to a general medical condition	Dropped[1]

(continued)

Table 3.2 Disorder Classes Presented by the DSM-IV and DSM-5, as Ordered in DSM-IV (continued)

DSM-IV	DSM-5
4. Substance-related disorders	16. Substance-related and addictive disorders (including gambling)
5. Schizophrenia and other psychotic disorders	2. Schizophrenia spectrum and other psychotic disorders
6. Mood disorders	3. Bipolar and related disorders
	4. Depressive disorders
7. Anxiety disorders	5. Anxiety disorders
	6. Obsessive-compulsive and related disorders
	7. Trauma- and stressor-related disorders
8. Somatoform disorders	9. Somatic symptom and related disorders
9. Factitious disorders	dropped[1]
10. Dissociative disorders	8. Dissociative disorders
11. Sexual and gender identity disorders	13. Sexual dysfunctions
	14. Gender dysphoria
	19. Paraphillic disorders
12. Eating disorders	10. Feeding and eating disorders
13. Sleep disorders	12. Sleep-wake disorders
14. Impulse-control disorders not elsewhere classified	15. Disruptive, impulse-control, and conduct disorders
15. Adjustment disorders	Dropped[1]
16. Personality disorders	18. Personality disorders
N/A	
N/A	
N/A	
N/A	
N/A	20. Other mental disorders
N/A	21. Medication-induced movement disorders and other adverse effects of medication

[1] A notation of "dropped" does not imply that the specific disorders were removed; rather the overall classification is not included in DSM-5. Disorders in those classes were mainly recategorized.

Table 3.3 Disorder Classification in the DSM-IV and DSM-5

Disorder Types (version)	DSM-IV Disorder Class	DSM-5 Disorder Class
Mental retardation (DSM-IV) intellectual disabilities (DSM-5)	Disorders usually first diagnosed in infancy, childhood, or adolescence	Neurodevelopmental disorders
Learning disorders (DSM-IV) Specific learning disorder (DSM-5)	Disorders usually first diagnosed in infancy, childhood, or adolescence	Neurodevelopmental disorders
Motor skills disorders (DSM-IV) Motor disorders (DSM-5)	Disorders usually first diagnosed in infancy, childhood, or adolescence	Neurodevelopmental disorders
Communication disorders	Disorders usually first diagnosed in infancy, childhood, or adolescence	Neurodevelopmental disorders

(continued)

Table 3.3 Disorder Classification in the DSM-IV and DSM-5 (continued)

Disorder Types (version)	DSM-IV Disorder Class	DSM-5 Disorder Class
Pervasive developmental disorders (DSM-IV) Autism spectrum disorder (DSM-5)	Disorders usually first diagnosed in infancy, childhood, or adolescence	Neurodevelopmental disorders
Attention-deficit/hyperactivity disorder	Disorders usually first diagnosed in infancy, childhood, or adolescence	Neurodevelopmental disorders
Conduct disorder	Disorders usually first diagnosed in infancy, childhood, or adolescence	Disruptive, impulse-control, and conduct Disorders
Oppositional defiant disorder	Disorders usually first diagnosed in infancy, childhood, or adolescence	Disruptive, impulse-control, and conduct Disorders
Feeding and eating disorders of infancy or early childhood	Disorders usually first diagnosed in infancy, childhood, or adolescence	Feeding and eating disorders
Tic disorders	Disorders usually first diagnosed in infancy, childhood, or adolescence	Neurodevelopmental disorders
Elimination disorders	Disorders usually first diagnosed in infancy, childhood, or adolescence	Elimination disorders
Separation anxiety disorder	Disorders usually first diagnosed in infancy, childhood, or adolescence	Anxiety disorders
Selective mutism	Disorders usually first diagnosed in infancy, childhood, or adolescence	Anxiety disorders
Reactive attachment disorder	Disorders usually first diagnosed in infancy, childhood, or adolescence	Trauma- and stressor-related disorders
Disinhibited social engagement disorder (DSM-5)	N/A	Trauma- and stressor-related disorders
Delirium	Delirium, dementia, and amnestic and other cognitive disorders	Neurocognitive disorders
Dementia (DSM-IV) major or mild neurocognitive disorder due to ___. (DSM-5)	Delirium, dementia, and amnestic and other cognitive disorders	Neurocognitive disorders
Amnestic disorders (DSM_IV)	Delirium, dementia, and amnestic and other cognitive disorders	N/A
Catatonic disorder due to a general medical condition	Mental disorders due to a general medical condition	Schizophrenia Spectrum and Other Psychotic Disorders
Personality change due to a general medical condition	Mental disorders due to a general medical condition	Personality disorders

(continued)

Table 3.3 Disorder Classification in the DSM-IV and DSM-5 (continued)

Disorder Types (version)	DSM-IV Disorder Class	DSM-5 Disorder Class
Mental disorder not otherwise specified due to a general medical condition	Mental disorders due to a general medical condition (also classified the mental disorder that was caused by the medical condition)	These disorders are coded under the mental disorder that was caused by the medical condition
Substance abuse	Substance-related disorders	Substance-related and addictive disorders
Substance dependence	Substance-related disorders	Substance-related and addictive disorders
Substance-induced disorders	Substance-related disorders	These disorders are coded under the disorder that was induced
Schizophrenia	Schizophrenia and other psychotic disorders	Schizophrenia spectrum and other psychotic disorders
Schizophreniform disorder	Schizophrenia and other psychotic disorders	Schizophrenia spectrum and other psychotic disorders
Schizoaffective disorder	Schizophrenia and other psychotic disorders	Schizophrenia spectrum and other psychotic disorders
Delusional disorder	Schizophrenia and other psychotic disorders	Schizophrenia spectrum and other psychotic disorders
Brief psychotic disorder	Schizophrenia and other psychotic disorders	Schizophrenia spectrum and other psychotic disorders
Shared psychotic disorder	Schizophrenia and other psychotic disorders	N/A
Major depressive disorder	Mood disorders	depressive disorders
Dysthymic disorder (DSM-IV) Persistent depressive disorder (DSM-5)	Mood disorders	depressive disorders
Disruptive mood dysregulation disorder (DSM-5)	N/A	depressive disorders
Premenstrual dysphoric disorder (DSM-5)	N/A	depressive disorders
Bipolar I disorder	Mood disorders	Bipolar and related disorders
Bipolar II disorder	Mood disorders	Bipolar and related disorders
Cyclothymic disorder	Mood disorders	Bipolar and related disorders
Panic disorder	Anxiety disorders	Anxiety disorders
Agoraphobia	Anxiety disorders	Anxiety disorders
Specific phobia	Anxiety disorders	Anxiety disorders
Social phobia	Anxiety disorders	Anxiety disorders
Obsessive-compulsive disorder	Anxiety disorders	Obsessive-compulsive and related disorders
Hoarding disorder (DSM-5)	N/A	Obsessive-compulsive and related disorders
Posttraumatic stress disorder	Anxiety disorders	Trauma- and stressor-related disorders

(continued)

Table 3.3 Disorder Classification in the DSM-IV and DSM-5 (continued)

Disorder Types (version)	DSM-IV Disorder Class	DSM-5 Disorder Class
Acute stress disorder	Anxiety disorders	Trauma- and stressor-related disorders
Generalized anxiety disorder	Anxiety disorders	Anxiety disorders
Somatization disorder (DSM-IV) Somatic symptoms disorder (DSM-5)	Somatoform disorders	Somatic symptom and related disorders
Undifferentiated somatoform disorder (DSM-IV) Unspecified somatic symptoms and related disorder (DSM-5)	Somatoform disorders	Somatic symptom and related disorders
Conversion disorder	Somatoform disorders	Somatic symptom and related Disorders
Pain disorder	Somatoform disorders	Somatic symptom and related Disorders
Hypochondriasis (DSM-IV) illness anxiety disorder (DSM-5)	Somatoform disorders	Somatic symptom and related disorders
Body dysmorphic disorder	Somatoform disorders	Obsessive-compulsive and related disorders
Factitious disorder	Factitious disorders	Somatic symptom and related disorders
Dissociative amnesia	Dissociative disorders	Dissociative disorders
Dissociate fugue	Dissociative disorders	Dissociative disorders
Dissociative identity disorder	Dissociative disorders	Dissociative disorders
Depersonalization disorder (DSM-IV) Depersonalization/Derealization disorder (DSM-5)	Dissociative disorders	Dissociative disorders
Hypoactive sexual desire disorder	Sexual and gender identity disorders	Sexual dysfunctions
Sexual aversion disorder	Sexual and gender identity disorders	Sexual dysfunctions
Female sexual arousal disorder	Sexual and gender identity disorders	Sexual dysfunctions
Male erectile disorder	Sexual and gender identity disorders	Sexual dysfunctions
Female orgasmic disorder	Sexual and gender identity disorders	Sexual dysfunctions
Male orgasmic disorder	Sexual and gender identity disorders	Sexual dysfunctions
Premature ejaculation	Sexual and gender identity disorders	Sexual dysfunctions
Dyspareunia (DSM-IV) Genito-pelvic pain/penetration Disorder (DSM-5)	Sexual and gender identity disorders	Sexual dysfunctions

(continued)

Table 3.3 Disorder Classification in the DSM-IV and DSM-5 (continued)

Disorder Types (version)	DSM-IV Disorder Class	DSM-5 Disorder Class
Vaginismus Genito-pelvic pain/penetration disorder (DSM-5)	Sexual and gender identity disorders	Sexual dysfunctions
Exhibitionism (DSM-IV) Exhibitionistic disorder (DSM-5)	Sexual and gender identity disorders	Paraphilic disorders
Fetishism (DSM-IV) Fetishistic disorder (DSM-5)	Sexual and gender identity disorders	Paraphilic disorders
Frotteurism (DSM-IV) Frotteuristic disorder (DSM-5)	Sexual and gender identity disorders	Paraphilic disorders
Pedophilia (DSM-IV) pedophilic disorder (DSM-5)	Sexual and gender identity disorders	Paraphilic disorders
Sexual masochism	Sexual and gender identity disorders	Paraphilic disorders
Sexual sadism	Sexual and gender identity disorders	Paraphilic disorders
Transvestic fetishism (DSM-IV) Transvestic disorder (DSM-5)	Sexual and gender identity disorders	Paraphilic disorders
Voyeurism (DSM-IV) Voyeuristic disorder (DSM-5)	Sexual and gender identity disorders	Paraphilic disorders
Gender identity disorder	Sexual and gender identity disorders	Gender dysphoria
Anorexia nervosa	Eating disorders	Feeding and eating disorders
Bulimia nervosa	Eating disorders	Feeding and eating disorders
Primary insomnia	Sleep disorders	Sleep-wake disorders
Primary hypersomnia (DSM-IV) Primary hypersomnolence (DSM-5)	Sleep disorders	Sleep-wake disorders
Narcolepsy	Sleep disorders	Sleep-wake disorders
Breathing-related sleep disorder	Sleep disorders	Sleep-wake disorders
Circadian rhythm sleep disorder	Sleep disorders	Sleep-wake disorders
Parasomnias	Sleep disorders	Sleep-wake disorders
Intermittent explosive disorder	Impulse-control disorders not elsewhere classified	Disruptive, impulse-control, and conduct disorders
Kleptomania	Impulse-control disorders not elsewhere classified	Disruptive, impulse-control, and conduct disorders
Pyromania	Impulse-control disorders not elsewhere classified	Disruptive, impulse-control, and conduct disorders
Pathological gambling	Impulse-control disorders not elsewhere classified	Substance-related and addictive disorders
Trichtillomania	Impulse-control disorders not elsewhere classified	Obsessive-compulsive and related disorders
Excoriation (Skin picking) disorder (DSM-5)	N/A	Obsessive-compulsive and related disorders
Adjustment disorder	Adjustment disorders	Trauma- and stressor-related disorders
Paranoid personality disorder	Personality disorders	Personality disorders
Schizoid personality disorder	Personality disorders	Personality disorders

(continued)

Table 3.3 Disorder Classification in the DSM-IV and DSM-5 (continued)

Disorder Types (version)	DSM-IV Disorder Class	DSM-5 Disorder Class
Schizotypal personality disorder	Personality disorders	Schizophrenia spectrum and other psychotic disorders & personality disorders
Antisocial personality disorder	Personality disorders	Disruptive, impulse-control, and conduct disorders & personality disorders
Borderline personality disorder	Personality disorders	Personality disorders
Histrionic personality disorder	Personality disorders	Personality disorders
Narcissistic personality disorder	Personality disorders	Personality disorders
Avoidant personality disorder	Personality disorders	Personality disorders
Dependent personality disorder	Personality disorders	Personality disorders
Obsessive-compulsive personality disorder	Personality disorders	Personality disorders

3.3 Changes to NSDUH/MHSS Included Diagnoses

Thus far, a general overview of changes between DSM-IV and DSM-5 has been provided to orient the reader to the new edition of the DSM. However, these structural changes will have less of a direct impact on NSDUH and MHSS estimates than the specific criteria changes for the disorders assessed in these two studies. The next section explores specific criteria changes for the disorders assessed in either the NSDUH (MDE) or the MHSS (MDD, dysthymic disorder, manic episode/bipolar I disorder, agoraphobia without panic disorder, panic disorder [with or without agoraphobia], specific phobia, social phobia, OCD, PTSD, generalized anxiety disorder, anorexia, bulimia, intermittent explosive disorder, adjustment disorder, and psychotic symptoms).

3.3.1 Major Depressive Episode/Disorder (NSDUH and MHSS)

An MDE is characterized by the combination of depressed mood or loss of interest or pleasure (anhedonia) lasting for most of the day, nearly every day, or both for 2 weeks or more [2]. The primary symptom (depressed mood or anhedonia) must be accompanied by four or more additional symptoms (Table 3.4), or 3 or more if both depressed mood and anhedonia are present, and must cause clinically significant distress or impairment. NSDUH and the MHSS directly assess MDE, and the MHSS also assesses MDD. The primary difference between MDE and MDD is that MDD includes all of the criteria for MDE but also includes the exclusionary criteria for bereavement, mania, and hypomania (discussed in Section 3.2.3); that is, an individual with MDD cannot ever have experienced a manic or hypomanic episode.

Changes in the MDE/MDD criteria from DSM-IV to DSM-5 have been minimal (Table 3.4). There have been some wording changes in the way that "mixed states" are described for diagnostic coding (mixed states now fall under the specifier "with mixed features"). In addition, the examples provided to describe a depressed mood have been expanded in DSM-5 from "e.g. feels sad or empty" [1, p. 327] to "e.g. feels sad, empty, hopeless" [2, p. 160] This change in wording has not received much attention [64]. However, the wording change has the possibility of increasing the prevalence of MDE/MDD if survey respondents and clinicians were

not already equating feeling hopeless with feeling sad, empty, or depressed. NSDUH's assessment of MDE in adults and youth (aged 12 to 17) varies slightly to take into account maturation differences in these groups. Assessment of part of Criterion A1 in adults asks: "Have you ever had a period of time lasting several days or longer when most of the day you were **very discouraged about** how things were going in your life." In youth this question is phrased: "Have you ever had a period of time lasting several days or longer when most of the day you felt very **discouraged or hopeless** about how things were going in your life?" Thus, hopelessness is already being assessed among youth in NSDUH and no changes in the youth MDE module are indicated to maintain alignment with DSM criteria. Among adults, NSDUH could replace the language used in the adult module with that used in the youth module and thereby maintain alignment with DSM. This has the potential to increase the prevalence estimates generated by NSDUH and alter trend estimates. It may also introduce context effects. However, in a review of DSM-5 criteria changes, Uher et al. noted that in a treatment sample, only 8 percent of patients with MDD reported feeling hopelessness but not sadness [64]. Moreover, NSDUH also assesses feelings of emptiness, depression, and discouragement, thereby increasing the likelihood that individuals experiencing feelings of hopelessness will also endorse one of the other symptoms and therefore be included in the diagnostic tally.

The more substantive change is that the formal bereavement exclusion for MDE/MDD in DSM-IV has been removed from DSM-5. The bereavement exclusion criterion has been a longstanding feature of MDE/MDD, designed to allow clinicians to distinguish between normal grieving and a mental illness [65]. It has been replaced with text noting that MDE/MDD should not be confused with normal and appropriate grief but that the presence of bereavement is not prohibitive of an MDE/MDD diagnosis. This change had several rationales. First, there was the need to remove the implication that bereavement typically lasts only 2 months, whereas the duration is more commonly years [66]. Second, bereavement is a psychosocial stressor, similar to other nonexcluded stressors that can precipitate an MDE [67]. Third, when MDD occurs in the context of bereavement, it adds an additional risk for suffering, feelings of worthlessness, suicidal ideation, poorer somatic health, worse interpersonal and work functioning, and an increased risk for persistent complex bereavement disorder, which is now described with explicit criteria in Conditions for Further Study in DSM-5 Section III [68]. Fourth, bereavement-related major depression is associated with similar genetic and biological risk factors, personality characteristics, patterns of comorbidity, and risks of chronicity and/or recurrence as nonbereavement-related MDD [69]. Finally, the depressive symptoms associated with bereavement-related depression respond to the same treatments as nonbereavement-related depression [69]. It should be noted, however, that the removal of this exclusion criterion is one of the more controversial changes made in DSM-5 [70,71].

The changes in exclusion criteria are not anticipated to affect NSDUH estimates. NSDUH already does not apply the bereavement or mixed-episode criteria. Rather, the elimination of these exclusions may lead to NSDUH generating population prevalence estimates that are closer to the population prevalence of DSM-5 MDE. Therefore, changes do not appear to be needed to the NSDUH MDE module at this time. However, it should be noted that DSM-5 divided the DSM-IV mood disorders into two groups, depressive disorders and bipolar and related disorders. This change makes it impossible to classify an individual with MDE in NSDUH into either group because NSDUH does not assess mania/hypomania which enables the

determination of which class of disorders MDE falls under (depressive disorders or bipolar and related disorders).

The MHSS assesses MDD, which is impacted by the changes from DSM-IV to DSM-5 because it includes the exclusion criterion for bereavement and mixed episodes. The removal of these exclusion criteria is expected to increase the prevalence of MDE/MDD. Quantitative analysis of the impact of bereavement-related criterion changes on MDE prevalence using nationally representative data from the National Epidemiologic Study of Alcohol and Related Conditions (NESARC) indicated that an estimated 7.7 percent of participants with depressive episodes had bereavement-related episodes [72]. This corresponded to an estimated increase of MDE/MDD prevalence of 1.17 percent (unweighted). In the MHSS, this would lead to an underestimate of MDD prevalence. In the AMI/SMI predictive model, there would be some misclassification of the AMI/SMI outcome of "caseness" (individuals excluded for bereavement would be misclassified as not having MDD). However, the impact resulting from the change in bereavement-related exclusionary criteria on AMI/SMI estimates in NSDUH is likely to be minimal because MDE from NSDUH is part of the predictive algorithm, with an estimated 98.8 percent (weighted) of NSDUH respondents who have MDE reach the cut-point for AMI. Of more concern is the change in mixed episode-related exclusionary criteria. A mixed episode is defined as co-occurring symptoms of mania and depression lasting at least 1 week in DSM-IV (Table 3.9); quantitative estimates of the impact of removing this criterion have not been identified, but a review of the available evidence suggests this change will lead to a slight increase in the prevalence estimates of MDE [73]. A 2011 critical review of the bipolar literature suggested that 40 to 50 percent of people with MDD have met subthreshold features of mania/hypomania in their lifetime, although the use of past year diagnoses in MHSS would reduce the number of cases being captured that had both MDD and a mixed episode [74]. Data from the DSM-5 field trials was mixed, with some sites noting a slight decrease, others noting a slight increase, and one site recording a substantial increase in the point prevalence of DSM-IV and DSM-5 defined MDD (range of DSM-IV MDD: 0.21 to 0.49; range of DSM-5 MDD: 0.19 to 0.37) [75]. The variation in this data and their reliance on patient samples limits their direct applicability to NSDUH/MHSS. Moreover, the test-retest reliability for MDD in the field trials averaged in the questionable range (sites ranged from unacceptable [Intraclass Kappa=0.13] to good [Intraclass Kappa=0.42], no sites had very good reliability for MDD).

Table 3.4 DSM-IV to DSM-5 Major Depressive Episode/Disorder Comparison

Criteria[1]	DSM-IV	DSM-5[2]	NSDUH
Class: Mood Disorders	√		√
Class: Depressive Disorders		√	
Five or more of the following A Criteria (at least one includes A1 or A2)	√	√	√
A1 Depressed mood—indicated by subjective report or observation by others (in children and adolescents, can be irritable mood).	√	√	√
A2 Loss of interest or pleasure in almost all activities—indicated by subjective report or observation by others.	√	√	√

(continued)

Table 3.4 DSM-IV to DSM-5 Major Depressive Episode/Disorder Comparison (continued)

Criteria[1]	DSM-IV	DSM-5[2]	NSDUH
A3 Significant (more than 5 percent in a month) unintentional weight loss/gain or decrease/increase in appetite (in children, failure to make expected weight gains).	√	√	√
A4 Sleep disturbance (insomnia or hypersomnia).	√	√	√
A5 Psychomotor changes (agitation or retardation) severe enough to be observable by others.	√	√	√
A6 Tiredness, fatigue, or low energy, or decreased efficiency with which routine tasks are completed.	√	√	√
A7 A sense of worthlessness or excessive, inappropriate, or delusional guilt (not merely self-reproach or guilt about being sick).	√	√	√
A8 Impaired ability to think, concentrate, or make decisions—indicated by subjective report or observation by others.	√	√	√
A9 Recurrent thoughts of death (not just fear of dying), suicidal ideation, or suicide attempts.	√	√	√
The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.	√	√	√
The symptoms are not due to the direct physiological effects of a substance (e.g., drug abuse, a prescribed medication's side effects) or a medical condition (e.g., hypothyroidism).	√	√	
The symptoms do not meet criteria for a mixed episode (See Table 3.9).[3]	√		
There has never been a manic episode or hypomanic episode.	√	√	
MDE is not better explained by schizophrenia spectrum or other psychotic disorders.	√	√	
The symptoms are not better accounted for by bereavement (i.e., after the loss of a loved one, the symptoms persist for longer than 2 months or are characterized by marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation).[4]	√		

[1] The symptom must either be new or must have clearly worsened compared with the person's pre-episode status and must persist most of the day, daily, for at least 2 weeks in a row. Exclude symptoms that are clearly due to a general medical condition, mood-incongruent delusions, or mood-incongruent hallucinations.

[2] Symptom must persist most of the day, daily, for at least 2 weeks in a row, *excluding A3 and A9*.

[3] A mixed episode is characterized by the symptoms of both a major depressive episode and a manic episode occurring almost daily for at least a 1-week period. This exclusion does not include episodes that are substance induced (e.g., caffeine) or the side effects of a medication.

[4] This differentiation requires clinical judgment based on cultural norms and the individual's history.

3.3.2 Dysthymic Disorder (MHSS)

Dysthymic disorder is a disorder characterized by a persistently depressed mood that occurs most of the day, for more days than not, for a period of at least 2 years (at least 1 year or more in children and adolescents; Table 3.5) [2]. In the DSM it has been re-named persistent depressive disorder. This name change reflects the consolidation of DSM-IV chronic major depressive disorder and dysthymic disorder that occurred in DSM-5. Previously, in DSM-IV, a diagnosis of dysthymic disorder was contraindicated if the patient met criteria for MDD in the

first 2 years after the symptoms arose. In DSM-5 this exclusion has been removed. DSM-5 estimates the 12-month prevalence of persistent depressive disorder at approximately 2 percent, a combination of the estimated prevalence of dysthymia (1.5 percent) and chronic MDD (0.5 percent) [2]. In a nationally representative study of Australian households, the estimated lifetime prevalence of persistent depressive disorder was 4.6 percent [76].

The NSDUH main interview and the MHSS do not assess chronic major depression; therefore, estimates of persistent depressive disorder will be an underestimate of the population prevalence of persistent depressive disorder by approximately 0.5 percent for past year estimates [2]. However, the impact on AMI/SMI estimates would likely be minimal because most if not all individuals with chronic major depression would be classified as having MDE/MDD, and therefore, would be counted as having a mental illness for inclusion in the predictive algorithm. If the DSM-IV to DSM-5 criteria changes for persistent depressive disorder are not included in MHSS, SAMHSA should ensure clarity of language in MHSS documentation to prevent confusion in estimates for only dysthymia rather than the new term, persistent depressive disorder.

Table 3.5 DSM-IV to DSM-5 Dysthymic Disorder Comparison

DSM-IV	DSM-5
Name: Dysthymic Disorder	Name: Persistent Depressive Disorder
Class: Mood Disorders	Class: Depressive Disorders
Depressed mood for most of the day, for more days than not, as indicated by subjective account or observation by others, for at least 2 years.	Same
Presence while depressed of two or more of the following: Poor appetite or overeating Insomnia or hypersomnia Low energy or fatigue Low self-esteem Poor concentration or difficulty making decisions Feelings of hopelessness	Same
During the 2 year period of the disturbance, the person has never been without symptoms from the above two criteria for more than 2 months at a time.	Same
The disturbance is not better accounted for by MDD or MDD in partial remission.	Criteria for MDD may be continuously present for 2 years, in which case patients should be given comorbid diagnoses of persistent depressive disorder and MDD.
There has never been a manic episode, a mixed episode, or a hypomanic episode and the criteria for cyclothymia have never been met.	Same
The disturbance does not occur exclusively during the course of a chronic psychotic disorder.	The symptoms are not better explained by a psychotic disorder.
The disturbance is not due to the direct physiological effects of a substance (e.g., a drug of abuse or a medication) or a general medical condition.	Same
The symptoms cause clinically significant distress or impairment in important areas of functioning.	Same

3.3.3 Manic Episode and Bipolar I Disorder (MHSS)

Bipolar I disorder, at one time referred to as manic-depressive disorder, is defined by the occurrence of at least one manic episode, which is a period of abnormally and persistently elevated, expansive, or irritable mood that is accompanied by increased energy or activity, which results in clinically significant impairment in functioning or the need for hospitalization [2]. Manic episodes and bipolar I disorder are assessed in MHSS and thereby incorporated into the SMI estimate based on the clinical sample that is used in the development of the prediction model.

The diagnostic criteria for manic episodes have undergone several changes between DSM-IV and DSM-5 (Table 3.6). Criterion A now requires that mood changes are accompanied by abnormally and persistently goal-directed behavior or energy. Second, wording has been added to clarify that (1) symptoms must represent a noticeable change from usual behavior, and (2) these changes have to be present most of the day, nearly every day during the minimum 1 week duration.

Exclusion criteria for manic episodes have also changed. Mania that emerge after antidepressant treatment can be classified as bipolar I disorder diagnosis in the DSM-5, whereas this was a substance-induced manic disorder in DSM-IV. The criteria for bipolar I disorder has also undergone a slight change (Table 3.7). In DSM-IV, six subtypes of bipolar I diagnoses were presented according to the features of the most recent mood episode. However, in DSM-5 these subtypes were converted to specifiers instead (i.e., specify most recent episode type according to its features).

Manic episodes and bipolar I disorder are assessed in the MHSS directly and are included in the operational definition of AMI/SMI used in NSDUH. The literature on how diagnostic changes will impact prevalence estimates is limited. Data from the DSM-5 field trials suggest that the impact will be minimal. Prevalence estimates from the two clinical sites where bipolar I was evaluated both found the same point prevalence estimates of 0.25 to 0.28 percent under both DSM-IV and DSM-5 criteria. However, the DSM-5 field trials used patient populations for estimation, and therefore, these findings may not be generalizable to the general population [75].

In addition to the changes in manic episode criteria, there have been changes to the overall diagnostic criteria for bipolar I disorder. In DSM-IV, bipolar I disorder was diagnosed by "type," which was characterized by the nature of the most recent episode (bipolar I disorder, single manic episode; bipolar I disorder, most recent episode hypomanic; bipolar I disorder, most recent episode manic; bipolar I disorder, most recent episode mixed; bipolar I disorder, most recent episode depressed; and bipolar I disorder, most recent episode unspecified). Each of these "types" had slightly varying criteria (Table 3.7). In DSM-5 the diagnostic description has been simplified and these "types" have been relegated to the role of specifiers. Diagnostic procedure indicates that clinicians should first provide the bipolar I diagnosis then specify the characteristics of the most recent episode, in addition to several other specifiers. Although important to understanding the general change in diagnostic approach, these changes are geared toward communicating a more streamlined diagnostic description rather than reflecting a change in the diagnostic criteria and will not have an impact on NSDUH or MHSS beyond those changes discussed with regard to manic episode criteria changes.

Table 3.6 DSM-IV to DSM-5 Manic Episode Criteria Comparison

DSM-IV Criteria	DSM-5 Criteria
A. A distinct period of abnormally and persistently elevated, expansive, or irritable mood, lasting at least 1 week (or any duration if hospitalization is necessary).	A. A distinct period of abnormally and persistently elevated, expansive, or irritable mood and abnormally and persistently goal-directed behavior or energy, lasting at least 1 week and present most of the day, nearly every day (or any duration if hospitalization is necessary).
B. During the period of mood disturbance, three (or more) of the following symptoms have persisted (four if the mood is only irritable) and have been present to a significant degree: 1. inflated self-esteem or grandiosity 2. decreased need for sleep (e.g., feels rested after only 3 hours of sleep) 3. more talkative than usual or pressure to keep talking 4. flight of ideas or subjective experience that thoughts are racing 5. distractibility (i.e., attention too easily drawn to unimportant or irrelevant external stimuli) 6. increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation	B. During the period of mood disturbance and increased energy or activity, three (or more) of the following symptoms have persisted (four if the mood is only irritable) are present to a significant degree and represent a noticeable change from usual behavior: 1. Same 2. Same 3. Same 4. Same 5. distractibility (i.e., attention too easily drawn to unimportant or irrelevant external stimuli), as reported or observed. 6. Same
7. excessive involvement in pleasurable activities that have a high potential for painful consequences (e.g., engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments)	7. excessive involvement in activities that have a high potential for painful consequences (e.g., engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments).
C. The symptoms do not meet criteria for a mixed episode (Table 3.9).	Dropped
D. The mood disturbance is sufficiently severe to cause marked impairment in occupational functioning or in usual social activities or relationships with others, or to necessitate hospitalization to prevent harm to self or others, or there are psychotic features.	C. The mood disturbance is sufficiently severe to cause marked impairment in social or occupational functioning or to necessitate hospitalization to prevent harm to self or others, or there are psychotic features.
E. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication, or other treatment) or a general medical condition (e.g., hyperthyroidism).	D. The episode is not attributable to the direct physiological effects of a substance (e.g., a drug of abuse, a medication, or other treatment) or another medical condition.
Note: Manic-like episodes that are clearly caused by somatic antidepressant treatment (e.g., medication, electroconvulsive therapy, light therapy) should not count toward a diagnosis of bipolar I disorder.	Note: A full manic episode that emerges during antidepressant treatment (e.g., medication, electroconvulsive therapy) but persists at fully syndromal level beyond the physiological effect of that treatment is sufficient evidence for a manic episode and therefore a bipolar I diagnosis.

Table 3.7 DSM-IV to DSM-5 Bipolar I Disorder Comparison

DSM-IV Disorder	DSM-IV Criteria	DSM-5 Disorder	DSM-5 Criteria
Disorder Class	Mood Disorders	Disorder Class	Bipolar and Related Disorders
Bipolar Disorder	DSM-IV specified 6 "types" of bipolar I disorder: Bipolar I disorder, single manic episode Bipolar I disorder, most recent episode hypomanic Bipolar I disorder, most recent episode manic Bipolar I disorder, most recent episode mixed Bipolar I disorder, most recent episode depressed Bipolar I disorder, most recent episode unspecified	Bipolar I Disorder	A. Criteria have been met for at least one manic episode (Table 3.6). The manic episode may have been preceded by and may be followed by hypomanic (see Table 3.8) or major depressive episodes (see Table 3.3).
			B. The occurrence of the manic and major depressive episode(s) is not better explained by schizoaffective disorder, schizophreniform disorder, delusional disorder, or other specified or unspecified schizophrenia spectrum and other psychotic disorder.
			Note: Major depressive episodes are common in bipolar I disorder but are not required for the diagnosis of bipolar I disorder.
			Note: Hypomanic episodes are common in bipolar I disorder but are not required for the diagnosis of bipolar I disorder.
			Specify: With anxious distress With mixed features With rapid cycling With melancholic features With atypical features With mood-congruent psychotic features With mood-incongruent psychotic features With catatonia With peripartum onset With seasonal pattern *Specify:* Remission status if full criteria are not currently met for a manic, hypomanic, or major depressive episode.

(continued)

Table 3.7 DSM-IV to DSM-5 Bipolar I Disorder Comparison (continued)

DSM-IV Disorder	DSM-IV Criteria	DSM-5 Disorder	DSM-5 Criteria
Bipolar I Disorder, Single Manic Episode	A. Presence of only one manic episode (see Table 3.6) and no past major depressive episodes (see Table 3.4). Note: Recurrence is defined as either a change in polarity from depression or an interval of at least 2 months without manic symptoms. B. The manic episode is not better accounted for by schizoaffective disorder and is not superimposed on schizophrenia, schizophreniform disorder, delusional disorder, or psychotic disorder not otherwise specified. *Specify* if: Mixed: if symptoms meet criteria for a mixed episode (See Table 3.9) *Specify* (for current or most recent episode): Severity/psychotic/remission specifiers With catatonic features With postpartum onset		Bipolar I episode "types" dropped from criteria tables, but diagnostic procedure still includes noting most recent episode type.
Bipolar I Disorder, Most Recent Episode Hypomanic	A. Currently (or most recently) in a hypomanic episode. B. There has previously been at least one manic episode or mixed episode. C. The mood symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning. D. The mood episodes in Criteria A and B are not better accounted for by schizoaffective disorder and are not superimposed on schizophrenia, schizophreniform disorder, delusional disorder, or psychotic disorder not otherwise specified. *Specify*: Longitudinal course specifiers (with and without interepisode recovery) With seasonal pattern (applies only to the pattern of major depressive episodes) With rapid cycling		Bipolar I episode "types" dropped from criteria tables, but diagnostic procedure still includes noting most recent episode type.

(continued)

Table 3.7 DSM-IV to DSM-5 Bipolar I Disorder Comparison (continued)

DSM-IV Disorder	DSM-IV Criteria	DSM-5 Disorder	DSM-5 Criteria
Bipolar I Disorder, Most Recent Episode Manic	A. Currently (or most recently) in a manic episode. B. There has previously been at least one major depressive episode, manic episode, or mixed episode. C. The mood episodes in Criteria A and B are not better accounted for by schizoaffective disorder and are not superimposed on schizophrenia, schizophreniform disorder, delusional disorder, or psychotic disorder not otherwise specified. *Specify* (for current or most recent episode): Severity/psychotic/remission specifiers With catatonic features With postpartum onset *Specify*: Longitudinal course specifiers (with and without interepisode recovery) With seasonal pattern (applies only to the pattern of major depressive episodes) With rapid cycling		Bipolar I episode "types" dropped from criteria tables, but diagnostic procedure still includes noting most recent episode type.
Bipolar I Disorder, Most Recent Episode Mixed	A. Currently (or most recently) in a mixed episode. B. There has previously been at least one major depressive episode, manic episode, or mixed episode. C. The mood episodes in Criteria A and B are not better accounted for by schizoaffective disorder and are not superimposed on schizophrenia, schizophreniform disorder, delusional disorder, or psychotic disorder not otherwise specified. *Specify* (for current or most recent episode): Severity/psychotic/remission specifiers With catatonic features With postpartum onset *Specify*: Longitudinal course specifiers (with and without interepisode recovery) With seasonal pattern (applies only to the pattern of major depressive episodes) With Rapid Cycling		Bipolar I episode "types" dropped from criteria tables, but diagnostic procedure still includes noting most recent episode type.

(continued)

Table 3.7 DSM-IV to DSM-5 Bipolar I Disorder Comparison (continued)

DSM-IV Disorder	DSM-IV Criteria	DSM-5 Disorder	DSM-5 Criteria
Bipolar I Disorder, Most Recent Episode Depressed	A. Currently (or most recently) in a major depressive episode. B. There has previously been at least one manic episode or mixed episode. C. The mood episodes in Criteria A and B are not better accounted for by schizoaffective disorder and are not superimposed on schizophrenia, schizophreniform disorder, delusional disorder, or psychotic disorder not otherwise specified.		Bipolar I episode "types" dropped from criteria tables, but diagnostic procedure still includes noting most recent episode type.
	Specify (for current or most recent episode): Severity/Psychotic/Remission Specifiers Chronic With Catatonic Features With Melancholic Features With Atypical Features With Postpartum Onset		
	Specify: Longitudinal Course Specifiers (With and without Interepisode Recovery) With Seasonal Pattern (applies only to the pattern of major depressive episodes) With Rapid Cycling		

(continued)

Table 3.7 DSM-IV to DSM-5 Bipolar I Disorder Comparison (continued)

DSM-IV Disorder	DSM-IV Criteria	DSM-5 Disorder	DSM-5 Criteria
Bipolar I Disorder, Most Recent Episode Unspecified	A. Criteria, except for duration, are currently (or most recently) met for a manic, a hypomanic, a mixed, or a major depressive episode. B. There has previously been at least one manic episode or mixed episode. C. The mood symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning. D. The mood symptoms in Criteria A and B are not better accounted for by schizoaffective disorder and are not superimposed on schizophrenia, schizophreniform disorder, delusional disorder, or psychotic disorder not otherwise specified. E. The mood symptoms in Criteria A and B are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication, or other treatment) or a general medical condition (e.g., hyperthyroidism). *Specify*: Longitudinal course specifiers (with and without interepisode recovery) With seasonal pattern (applies only to the pattern of major depressive episodes) With rapid cycling		Dropped

Table 3.8 DSM-IV to DSM-5 Hypomania Criteria Comparison

DSM-IV	DSM-5
A distinct period of persistently elevated, expansive, or irritable mood, lasting throughout at least 4 days, that is clearly different from the usual nondepressed mood.	A distinct period of abnormally and persistently elevated, expansive, or irritable mood and abnormally and persistently increased activity or energy, lasting at least 4 consecutive days and present most of the day, nearly every day.
During the period of mood disturbance, three (or more) of the following symptoms have persisted (four if the mood is only irritable) and have been present to a significant degree: 1. inflated self-esteem or grandiosity 2. decreased need for sleep (e.g., feels rested after only 3 hours of sleep) 3. more talkative than usual or pressure to keep talking 4. flight of ideas or subjective experience that thoughts are racing 5. distractibility (i.e., attention too easily drawn to unimportant or irrelevant external stimuli) 6. increase in goal-directed activity (at work, at school, or sexually) or psychomotor agitation 7. excessive involvement in pleasurable activities that have a high potential for painful consequences (e.g., engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments)	During the period of mood disturbance and increased energy or activity, three (or more) of the following symptoms have persisted (four if the mood is only irritable), represent a noticeable change from usual behavior, and have been present to a significant degree: 1. SAME 2. SAME 3. SAME 4. SAME 5. distractibility (i.e., attention too easily drawn to unimportant or irrelevant external stimuli), as reported or observed. 6. SAME 7. excessive involvement in activities that have a high potential for painful consequences (e.g., engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments).
The episode is associated with an unequivocal change in functioning that is uncharacteristic of the person when not symptomatic.	SAME
The disturbance in mood and the change in functioning are observable by others.	SAME
The mood disturbance is not severe enough to cause marked impairment in social or occupational functioning, or to necessitate hospitalization, and there are no psychotic features.	The episode is not severe enough to cause marked impairment in social or occupational functioning or to necessitate hospitalization. If there are psychotic features, the episode is, by definition, manic.
The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication or other treatment) or a general medical condition (e.g., hyperthyroidism)	The episode is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication or other treatment).
Note: Hypomanic-like episodes that are clearly caused by somatic antidepressant treatment (e.g., medication, electroconvulsive therapy, light therapy) should not count toward a diagnosis of bipolar I or II disorder.	Note: A full hypomanic episode that emerges during antidepressant treatment (e.g., medication, electroconvulsive therapy) but persists at a fully syndromal level beyond the physiological effect of that treatment is sufficient evidence for a hypomanic episode diagnosis. However, caution is indicated so that one or two symptoms (particularly increased irritability, edginess, or agitation following antidepressant use) are not taken as sufficient for diagnosis of a hypomanic episode, nor necessarily indicative or a bipolar diathesis.

Table 3.9 DSM-IV to DSM-5 Mixed Episode Criteria Comparison

DSM-IV Name	DSM-IV	DSM-5 Name	DSM-5
Mixed Episode	A. The criteria are met both for a manic episode (Table 3.6) and for a major depressive episode (Table 3.4) (except for duration) nearly every day during at least a 1-week period	Manic or Hypomanic Episode with Mixed Features	A. Full criteria are met for a manic or hypomanic episode, and at least three of the following symptoms are present during the majority of days of the current or most recent episode of mania or hypomania: 1. Prominent dysphoria or depressed mood as indicated by either subjective report (e.g., feels sad or empty) or observation made by others (e.g., appears tearful) 2. Diminished interest or pleasure in all, or almost all, activities (as indicated by either subjective report or observation made by others) 3. Psychomotor retardation nearly every day (observable by others; not merely subjective feelings of being slowed down) 4. Fatigue or loss of energy 5. Feelings of worthlessness or excessive or inappropriate guilt (not merely self-reproach or guilt about being sick) 6. Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.
	B. The mood disturbance is sufficiently severe to cause marked impairment in occupational functioning or in usual social activities or relationships with others, or to necessitate hospitalization to prevent harm to self or others, or there are psychotic features.		B. Mixed symptoms are observable by others and represent a change from the person's usual behavior.
	C. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication, or other treatment) or a general medical condition (e.g., hyperthyroidism).		C. For individuals whose symptoms meet full episode criteria for both mania and depression simultaneously, the diagnosis should be manic episode with mixed features, due to the marked impairment and clinical severity of full mania.
	Note: Mixed-like episodes that are clearly caused by somatic antidepressant treatment (e.g., medication, electroconvulsive therapy, light therapy) should not count toward a diagnosis of bipolar I disorder.		D. The mixed symptoms are not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication, other treatment).

3.3.4 Panic Disorder and Agoraphobia (MHSS)

Panic disorder is an anxiety disorder characterized by panic attack(s) and the ongoing concern about experiencing additional panic attacks [2] (Table 3.10). A panic attack is an abrupt, but quickly peaking, surge of intense fear or discomfort, accompanied by a series of physical symptoms. Agoraphobia is an anxiety disorder characterized by an intense fear or anxiety triggered by the real or anticipated exposure to a number of situations (i.e., using public transportation, being in open spaces, being in enclosed spaces, standing in line, being in a crowd, or being outside the home), which causes clinically significant distress or impairment (Table 3.10) [2]. In DSM-IV, panic disorder and agoraphobia were conceptually linked. The diagnoses in DSM-IV included panic disorder with agoraphobia, panic disorder without agoraphobia, and agoraphobia without history of panic disorder. In DSM-5, however, panic disorder and agoraphobia have been separated and individuals meeting criteria for both disorders are considered to have comorbid mental illnesses.

Panic disorder and agoraphobia are both assessed in the MHSS and criteria changes may affect AMI/SMI estimates. Examining the comparison of panic disorder criteria specifically (Table 3.10), with the exception of the disaggregation of agoraphobia, the criteria are similar between DSM-IV and DSM-5. There are minor wording changes to the description of panic attacks that may have slight implications to the prevalence of panic disorder under DSM-5. Under DSM-IV the specification was made that panic attacks were discrete periods of intense fear or discomfort that peaked within 10 minutes. In DSM-5, panic attacks are described as an abrupt surge of intense fear or intense discomfort that peak within a few minutes. The wording changes reflect two conceptual issues. First, the change in wording from a discrete event to an abrupt surge broadens criteria based on evidence that panic attacks do not necessarily arise "out of the blue," but can arise during periods of anxiety or other distress and that it is the sudden increase in fear/discomfort that is the hallmark of a panic attack. In addition, they have removed the 10-minute criterion in favor of the less precise but implicitly shorter descriptive of "within minutes" [2 p. 214]. The diagnostic changes in panic disorder will impact NSDUH and the MHSS insofar as they alter the prevalence of the disorder or the population being classified as having a disorder. Literature on the impact of these changes is limited at this time, the wording changes are minimal, and the overall concept and threshold for the disorder remain unchanged; therefore, the impact on MHSS and AMI/SMI estimates will likely be nominal.

More substantive changes have occurred with the criteria for agoraphobia (Table 3.10). In addition to being separated conceptually from panic disorder (meaning those who were excluded from having agoraphobia cause by panic disorder will now qualify for the agoraphobia diagnosis), a more formalized set of criteria have been developed. First, a formalized threshold for the number of fear or anxiety provoking situations has been two or more situations from a list of five. Second, in DSM-5 the anxiety is not restricted to a fear of having a panic attack, as it was in DSM-IV, rather the anxiety is related to a fear of having trouble escaping or obtaining help should panic-like symptoms or other incapacitating or embarrassing symptoms occur. Third, a new criterion is that the fear or anxiety must be consistent and that the same situation almost always provokes the reaction. Fourth, the fear or anxiety has to be out of proportion to the situation. Fifth, a duration criterion has been added stating that the fear, anxiety, or avoidance typically lasts 6 months or more. Finally, the agoraphobia symptoms must cause significant distress and impairment.

Table 3.10 Panic Disorder and Agoraphobia Criteria Changes from DSM-IV to DSM-5

DSM-IV Disorder	DSM-IV Criteria	DSM-5 Disorder	DSM-5 Criteria
Diagnostic Class: Anxiety Disorders		SAME	
Panic Attack[1]	A discrete period of intense fear or discomfort, in which four or more of the following symptoms developed abruptly and reached a peak within 10 minutes Palpitations, pounding heart, or accelerated heart rate Sweating Trembling or shaking Sensations of shortness of breath or smothering Feeling of choking Chest pain or discomfort Nausea or abdominal distress Feeling dizzy, unsteady, lightheaded, or faint Derealization (feelings of unreality) or depersonalization (being detached from oneself) Fear of losing control or "going crazy" Fear of dying Paresthesias (numbness or tingling sensation) Chills or hot flushes.	Panic Attack[1]	An abrupt surge of intense fear or intense discomfort that reaches a peak within minutes and during which time four or more of the following symptoms occur. List is unchanged, except that "hot flushes" has been modified to "heat sensations" and there has been a reordering of symptoms.

(continued)

Table 3.10 Panic Disorder and Agoraphobia Criteria Changes from DSM-IV to DSM-5 (continued)

DSM-IV Disorder	DSM-IV Criteria	DSM-5 Disorder	DSM-5 Criteria
Agoraphobia[1]	Anxiety about being in places or situations from which escape might be difficult (or embarrassing) or in which help may not be available in the event of having an unexpected or situationally predisposed panic attack or panic-like symptoms. Agoraphobic fears typically involve characteristic clusters of situations that include being outside the home alone; being in a crowd or standing in a line; being on a bridge; and traveling in a bus, train, or automobile.	Agoraphobia	A marked fear or anxiety about two (or more) of the following five situations: Using public transportation Being in open spaces Being in enclosed spaces (e.g., shops, theaters, cinemas) Standing in line or being in a crowd Being outside the home alone.
	The situations are avoided (e.g., travel is restricted) or else are endured with marked distress or with anxiety about having a panic attack or panic-like symptoms, or require the presence of a companion.		SAME
	N/A		The agoraphobic situations almost always provoke fear or anxiety.
	N/A		The fear or anxiety is out of proportion to the actual danger posed by the agoraphobic situations and to the sociocultural context.
	N/A		The fear, anxiety, or avoidance is persistent, typically lasting 6 months or more.
	N/A		The fear, anxiety, or avoidance causes clinically significant distress or impairment in important areas of functioning.
	The anxiety or phobic avoidance is not better accounted for by another mental disorder.		SAME

(continued)

Table 3.10 Panic Disorder and Agoraphobia Criteria Changes from DSM-IV to DSM-5 (continued)

DSM-IV Disorder	DSM-IV Criteria	DSM-5 Disorder	DSM-5 Criteria
Agoraphobia without history of Panic Disorder	The presence of agoraphobia related to fear of developing panic-like symptoms.	Agoraphobia	The individual fears or avoids these situations because of thoughts that escape might be difficult or help might not be available in the event of developing panic-like symptoms or other incapacitating or embarrassing symptoms.
	Criteria for panic disorder have never been met.		DROPPED
	The disturbance not due to the direct physiological effects of a substance (e.g., a drug of abuse or a medication) or a general medical condition		DROPPED
	If an associated general medical condition is present, the fear described in Criterion A is clearly in excess of that usually associated with the condition.		SAME
Panic Disorder, with/without Agoraphobia	Both: Recurrent and unexpected panic attacks (see below) ≥ 1 attack has been followed by 1 month or more of 1 or more of the following Persistent concern about additional attacks Worry about the implications of the attack or its consequences A significant change in behavior related to the attacks	Panic Disorder	Both: Recurrent and unexpected panic attacks (see below) ≥ 1 attack has been followed by 1 month or more of 1 or both of the following Persistent concern about additional attacks or their consequences A significant maladaptive change in behavior related to the attacks
	The panic attacks are not due to the direct physiological effects of a substance (e.g., a drug of abuse or a medication) or a general medical condition		SAME
	The panic attacks are not better accounted for by another mental disorder.		SAME
	Without agoraphobia: Absence of agoraphobia (see below)		DROPPED
	With agoraphobia: Presence of agoraphobia		DROPPED

[1] Not a codable disorder, considered a feature of the specific disorder in which the panic attack/agoraphobia occurs.

All of these changes make it difficult to determine the change in prevalence or characteristics of individuals meeting DSM-5 diagnostic criteria for agoraphobia. Although the disaggregation of agoraphobia from panic disorder would increase the prevalence of agoraphobia, the more stringent diagnostic criteria may counter that increase to some extent. In addition to the alterations in prevalence, a direct concern for MHSS and subsequently how the definition of SMI and AMI is operationalized is that individuals who met DSM-5 criteria for agoraphobia may differ substantively from individuals who met DSM-IV agoraphobia (with or without panic disorder). Currently, there is no quantitative data on this possibility in children or adults.

3.3.5 Specific Phobia (MHSS)

Specific phobia is an anxiety disorder characterized by fear or anxiety about the presence of a specific object or situation [2]. DSM-IV to DSM-5 criteria changes for specific phobia consists of numerous minor wording changes (Table 3.11). The two major changes include the elimination of the DSM-IV requirements that the person recognizes that the fear is excessive or unreasonable and a specification that the duration for everyone is typically 6 months or longer (as opposed to requiring that minimum duration just for children). The elimination of the DSM-IV criterion that specifies that the person has insight that the fear is excessive or unreasonable is expected to increase the prevalence of specific phobia; however, research into the degree of impact is inconsistent [77]. In a study of 3,000 psychiatric outpatients (average age = 38.5, range not specified) and 1,800 prospective bariatric surgical patients (average age = 42.3, range not specified) receiving care through a Rhode Island hospital system, comparisons of diagnostic rates with and without the insight criterion indicated that less than 1 additional percent of each population met criteria for lifetime-specific phobia as a result of dropping the insight criterion [78]. Of the 12.3 percent of psychiatric outpatients who met either DSM-IV or DSM-5 criteria for lifetime specific phobia, 4.1 percent met criteria without having insight into the excessive/unreasonableness of their fear. This is consistent with other research that identified age differences in criterion endorsement for specific phobia [77]. In a study of older, community-sampled adults (aged 65 or older), the prevalence of past year specific phobia was 2.0 percent, and over half of those meeting DSM-IV specific phobia criteria (excluding the insight criterion) did not have insight into the excessive/unreasonableness of their fear [79]. This suggests that the overall prevalence of specific phobia may be slightly increased (approximately 1 percent) under DSM-5 criteria (because of the removal of the insight criterion), thereby affecting AMI/SMI estimation, but this effect may not be uniform across all ages.

The change in the duration criterion was recommended to increase reliability of the diagnosis among adults [77]; however, there are little data about how significant this change will be with respect to population prevalence estimates and any resulting misclassification, thereby making it difficult to determine the impact on MHSS and subsequently NSDUH. Anecdotal evidence suggests that if the duration of specific phobia is sufficiently long that this change is likely to have little impact on prevalence estimates [77].

Table 3.11 DSM-IV to DSM-5 Specific Phobia Comparison

DSM-IV	DSM-5
Disorder Class: Anxiety Disorders	SAME
Marked and persistent fear that is excessive or unreasonable, cued by the presence or anticipation of a specific object or situation (e.g., flying, heights, animals, receiving an injection, seeing blood).	Marked fear or anxiety about a specific object or situation (e.g., flying, heights, animals, receiving an injection, seeing blood).
Exposure to the phobic stimulus almost invariably provokes an immediate anxiety response, which may take the form of a situationally bound or situationally predisposed panic attack.	The phobic object or situation almost always provokes immediate fear or anxiety.
The person recognizes that the fear is excessive or unreasonable.	The fear or anxiety is out of proportion to the actual danger posed by the specific object or situation and to the sociocultural context.
The phobic situation(s) is avoided or else is endured with intense anxiety or distress.	The phobic object or situation is actively avoided or endured with intense fear or anxiety.
The avoidance, anxious anticipation, or distress in the feared situation(s) interferes significantly with the person's normal routine, occupational (or academic) functioning, or social activities or relationships, or there is marked distress about having the phobia.	The fear, anxiety, or avoidance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
In individuals under age 18 years, the duration is at least 6 months.	The fear, anxiety, or avoidance is persistent, typically lasting for 6 months or more.
The anxiety, panic attacks, or phobic avoidance associated with the specific object or situation are not better accounted for by another mental disorder, such as obsessive-compulsive disorder (e.g., fear of dirt in someone with an obsession about contamination), posttraumatic stress disorder (e.g., avoidance of stimuli associated with a severe stressor), separation anxiety disorder (e.g., avoidance of school), social phobia (e.g., avoidance of social situations because of fear of embarrassment), panic disorder with agoraphobia, or agoraphobia without History of panic disorder.	The disturbance is not better explained by the symptoms of another mental disorder, including fear, anxiety, and avoidance of situations associated with panic-like symptoms or other incapacitating symptoms (as in agoraphobia); objects or situations related to obsessions (as in obsessive-compulsive disorder); reminders of traumatic events (as in posttraumatic stress disorder); separation from home or attachment figures (as in separation anxiety disorder); or social situations (as in social anxiety disorder).
Specify type: Animal Type (e.g., spiders, insects, dogs)	SAME
Specify type: Natural Environment Type (e.g., heights, storms, water)	SAME
Specify type: Blood-Injection-Injury Type (e.g., needles, invasive medical procedures)	SAME
Specify type: Situational Type (e.g., airplanes, elevators, enclosed places)	SAME
Specify type: Other Type (e.g., phobic avoidance of situations that may lead to choking, vomiting, or contracting an illness; in children, avoidance of loud sounds or costumed characters)	SAME

3.3.6 Social Phobia (MHSS)

Social phobia is an anxiety disorder characterized by fear of social situations wherein the individual may be exposed to scrutiny by others [2]. Diagnostic criteria for social phobia have undergone several minor wording changes from DSM-IV to DSM-5 (Table 3.12). One additional change is anticipated to have a broader impact on estimates of social phobia. In DSM-IV, criteria for social phobia required that an individual "recognizes that the fear is excessive or unreasonable" (i.e., the insight criterion). In DSM-5 this has been changed to note that "the fear or anxiety is out of proportion to the actual threat posed by the social situation and to the sociocultural context." This means that the patient does not need to have insight that their fear is unreasonable, so long as the clinician can determine that the fear is unreasonable.

In a study of 3,000 psychiatric outpatients (average age = 38.5, range not specified) and 1,800 prospective bariatric surgical patients (average age = 42.3, range not specified) receiving care through a Rhode Island hospital system, comparisons of diagnostic rates for social phobia with and without the insight criterion indicated that less than 1 additional percent of each population met criteria for lifetime social phobia after dropping this criterion [78]. Among the 31.2 percent of psychiatric outpatients who had lifetime social phobia (without applying the insight criterion restriction), only 2.1 percent did not have insight into the excessive or unreasonableness of their fear. The results were slightly lower among the 12.1 percent of bariatric surgery patients who met lifetime criteria for social phobia. Only 3.7 percent of bariatric patients meeting lifetime criteria for social phobia did not have insight into their condition. This suggests that the removal of the insight criterion will lead to a slight increase in the prevalence of social phobia; however, this study was conducted in a sample of patients (psychiatric and bariatric) from one hospital system and makes direct applicability to MHSS difficult.

Table 3.12 DSM-IV to DSM-5 Social Phobia Comparison

DSM-IV	DSM-5
Disorder Class: Anxiety Disorders	SAME
A. A marked and persistent fear of one or more social or performance situations in which the person is exposed to unfamiliar people or to possible scrutiny by others. The individual fears that he or she will act in a way (or show anxiety symptoms) that will be humiliating or embarrassing.	A. Marked fear or anxiety about one or more social situations in which the individual is exposed to possible scrutiny by others. Examples include social interactions (e.g., having a conversation, meeting unfamiliar people), being observed (e.g., eating or drinking), and performing in front of others (e.g., giving a speech). The individual fears that he or she will act in a way or show anxiety symptoms that will be negatively evaluated (i.e., will be humiliating or embarrassing; will lead to rejection or offend others).
B. Exposure to the feared social situation almost invariably provokes anxiety, which may take the form of a situationally bound or situationally predisposed panic attack.	C. The social situations almost always provoke fear or anxiety.
C. The person recognizes that the fear is excessive or unreasonable.	B. The fear or anxiety is out of proportion to the actual threat posed by the social situation and to the sociocultural context.

(continued)

Table 3.12 DSM-IV to DSM-5 Social Phobia Comparison (continued)

DSM-IV	DSM-5
D. The feared social or performance situations are avoided or else are endured with intense anxiety or distress.	D. The social situations are avoided or endured with intense fear or anxiety.
E. The avoidance, anxious anticipation, or distress in the feared social or performance situation(s) interferes significantly with the person's normal routine, occupational (academic) functioning, or social activities or relationships, or there is marked distress about having the phobia.	G. The fear, anxiety, or avoidance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
F. In individuals under age 18 years, the duration is at least 6 months.	F. The fear, anxiety, or avoidance is persistent, typically lasting for 6 months or more.
(G. The fear or avoidance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition and is not better accounted for by another mental disorder (e.g., panic disorder with or without agoraphobia, separation anxiety disorder, body dysmorphic disorder, a pervasive developmental disorder, or schizoid personality disorder).	H. The fear, anxiety, or avoidance is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition.
	I. The fear, anxiety, or avoidance is not better explained by the symptoms of another mental disorder, such as panic disorder, body dysmorphic disorder, or autism spectrum disorder.
H. If a general medical condition or another mental disorder is present, the fear in Criterion A is unrelated to it (e.g., the fear is not of stuttering, trembling in Parkinson's disease, or exhibiting abnormal eating behavior in anorexia nervosa or bulimia nervosa).	J. If another medical condition (e.g., Parkinson's disease, obesity, disfigurement from burns or injury) is present, the fear, anxiety, or avoidance is clearly unrelated or is excessive.
Specify if: Generalized: if the fears include most social situations (also consider the additional diagnosis of avoidant personality disorder)	*Specify* if: Performance only: if the fear is restricted to speaking or performing in public.

3.3.7 Obsessive-Compulsive Disorder (MHSS)

OCD, formerly classified as an anxiety disorder and given its own classification under DSM-5 (Obsessive-Compulsive and Related Disorders, which also includes hoarding, trichotillomania, and excoriation disorders), is characterized by the presence of obsessions (recurrent, persistent thoughts that cause anxiety or distress) and/or compulsions (repetitive behaviors or mental acts) that cause clinically significant distress or impairment [1,2]. OCD criteria have undergone significant changes in diagnostic criteria that are anticipated to have a substantial impact on prevalence estimates (Table 3.13). The primary changes include a slight but significant wording change in the definition of obsessions, the removal of three exclusionary criteria, and a more detailed explanation of the remaining exclusionary diagnoses. In DSM-IV obsessions were defined as "recurrent persistent thoughts, impulses, or images…" under DSM-5 criteria, obsessions were defined as "recurrent and persistent thoughts, **urges**, or images…." Two of the eliminated exclusion criteria also apply to the assessment of obsessions. In DSM-IV, the obsessions could not be simply excessive worries about real-life problems. In DSM-5 this criterion has been removed. Second, DSM-IV criteria required that a person recognize that the obsessions were a product of the person's own mind, whereas DSM-5 has eliminated this exclusion criterion. Third, DSM-5 also dropped the overall (not obsession specific) criterion that the person recognize the obsessions or compulsions were excessive or unreasonable. Finally,

DSM-5 expanded the examples of exclusionary diagnoses (other diagnoses that might better explain the symptoms) to note a much larger list of potentially similar disorders.

The removal of several exclusionary criteria may contribute to an increase the population prevalence of OCD under DSM-5 criteria. However, to date, prevalence estimates for the DSM-5 revised diagnosis of OCD have not been identified to evaluate the impact of diagnostic changes on population estimates. Regarding the impact on AMI/SMI estimation, the existing DSM-IV estimates would underestimate the prevalence of DSM-5 AMI/SMI because individuals who were classified as not having OCD because of the exclusion criteria would have been classified as having no mental illness, unless they met criteria for another disorder assessed in MHSS. Comorbidity of OCD is high; reports from the National Comorbidity Survey-Replication (NCS-R) indicate that 90.0 percent of people with a lifetime DSM-IV diagnosis of OCD also met criteria for another lifetime DSM-IV diagnosis [80]. This finding suggests that the diagnostic revisions would have only minimal impact on AMI and SMI estimation [80].

Table 3.13 DSM-IV to DSM-5 Obsessive-Compulsive Disorder Comparison

DSM-IV	DSM-5
Disorder Class: Anxiety Disorders	Disorder Class: Obsessive-Compulsive and Related Disorders
Either obsessions or compulsions: *Obsessions as defined by (1),(2), (3) and (4):* 1. Recurrent and persistent thoughts, impulses, or images that are experienced, at some time during the disturbance, as intrusive and inappropriate and that cause marked anxiety or distress. 2. The thoughts, impulses, or images are not simply excessive worries about real-life problems. 3. The person attempts to ignore or suppress such thoughts, impulses, or images or to neutralize them with some other thought or action. 4. The person recognizes that the obsessional thoughts, impulses, or images are a product of his or her own mind (not imposed from without as with thought insertion).	Presence of obsessions, compulsions, or both: *Obsessions are defined by (1) and (2):* 1. Recurrent and persistent thoughts, urges or images that are experienced, at some time during the disturbance, as intrusive, unwanted, and that in most individuals cause marked anxiety or distress. DROPPED 2. The individual attempts to ignore or suppress such thoughts, urges, or images, or to neutralize them with some thought or action (i.e., by performing a compulsion). DROPPED
Compulsions as defined by (1) and (2): 1. Repetitive behaviors (e.g., hand washing, ordering checking) or mental acts (e.g., praying, counting, repeating words silently) that the person feels driven to perform in response to an obsession, or according to the rules that must be applied rigidly. 2. The behaviors or mental acts are aimed at preventing or reducing distress or preventing some dreaded event or situation. However, these behaviors or mental acts either are not connected in a realistic way with what they are designed to neutralize or prevent or are clearly excessive.	*Compulsions are defined by (1) and (2):* 1. SAME 2. SAME
At some point during the course of the disorder, the person has recognized that the obsessions or compulsions are excessive or unreasonable.	DROPPED

(continued)

Table 3.13 DSM-IV to DSM-5 Obsessive-Compulsive Disorder Comparison (continued)

DSM-IV	DSM-5
The obsessions and compulsions cause marked distress, are time consuming (take more than 1 hour a day), or significantly interfere with the person's normal routine, occupational (or academic) functioning, or usual social activities or relationships.	The obsessions or compulsions are time consuming (e.g., take more than 1 hour per day) or cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
If another Axis I disorder is present, the content of the obsessions or compulsions is not restricted to it (e.g., preoccupation with food in the presence of an eating disorder, hair pulling in the presence of trichotillomania; concern with appearance in the presence of body dysmorphic disorder: preoccupation with drugs in the presence of a substance use disorder: preoccupation with having a serious illness in the presence of hypochondriasis; preoccupation with sexual urges or fantasies in the presence of a paraphilia: or guilty ruminations in the presence or major depressive disorder).	The disturbance is not better explained by the symptoms of another mental disorder (e.g., excessive worries, as in generalized anxiety disorder; preoccupation with appearance, as in body dysmorphic disorder; difficulty discarding or parting with possession, as in hoarding disorder; hair pulling, as in trichotillomania [hair-pulling disorder]; skin picking, as in excoriation [skin-picking] disorder); stereotypies, as in stereotypic movement disorder; ritualized eating behavior, as in eating disorders; preoccupation with substances or gambling, as in substance-related and addictive disorders; sexual urges or fantasies, as in paraphilic disorders; impulses, as in disruptive, impulse-control, and conduct disorders; guilty ruminations, as in major depressive disorder; thought insertion or delusional preoccupations, as in schizophrenia spectrum and other psychotic disorders; or repetitive patterns of behavior, as in autism spectrum disorder).
The disturbance is not due to the direct physiological effects of a substance (e.g., drug of abuse, a medication) or a general medical condition.	SAME
Specify if: With poor insight: If, for most of the time during the current episode, the person does not recognize that the obsessions and compulsions are excessive or unreasonable.	*Specify* if: With good or fair insight: The individual recognizes that obsessive-compulsive beliefs are definitely or probably not true or that they may or may not be true. With poor insight: The individual thinks obsessive-compulsive disorder beliefs are probably true. With absent insight/delusional beliefs: The individual is completely convinced that obsessive-compulsive disorder beliefs are true. *Specify* if: Tic related: The individual has a current or past history of a tic disorder.

3.3.8 Posttraumatic Stress Disorder (MHSS)

PTSD, which was classified as an anxiety disorder under DSM-IV and has been reclassified into a new class called Trauma- and Stressor-Related Disorders, is characterized by the development of a pattern of symptoms following exposure to a traumatic event (i.e., the stressor). These symptom types include re-experiencing the traumatic event (e.g., recurrent intrusive and distressing recollections of the event), avoidance of stimuli associated with the trauma, persistent negative alterations in cognition (e.g., feelings of detachment or estrangement from others), and a numbing of general responsiveness (e.g., diminished interest in activities), and increased symptoms of arousal (e.g., exaggerated startle response).

DSM-5 criteria for PTSD differ significantly from those in DSM-IV (Table 3.14). First, the stressor criterion (Criterion A) is more explicit about how an individual experienced "traumatic" events. Second, the subjective reactive criterion (Criterion A2) has been eliminated. Third, whereas there were three major symptom clusters in DSM-IV—re-experiencing, avoidance/numbing, and arousal—there are now four symptom clusters in DSM-5 because the avoidance/numbing cluster is divided into two distinct clusters: avoidance and persistent negative alterations in cognitions and mood. Fourth, for the latter cluster of symptoms, persistent negative emotional states have been added to the criteria. Fifth, the final cluster—alterations in arousal and reactivity—now also includes irritable or aggressive behavior and reckless or self-destructive behavior. Finally, PTSD is now developmentally sensitive in that diagnostic thresholds have been lowered for children and adolescents. Furthermore, separate criteria have been added for children aged 6 years or younger with PTSD.

Results from the DSM-5 field trials of patient populations suggests a 0.4 to 0.5 percent decrease in PTSD point prevalence under the revised DSM-5 criteria [51]. However, since the DSM-5 field trial relied on patient populations that may limit the generalizability to household-based samples. Moreover, MHSS uses past year diagnoses rather than point-in-time diagnoses so results should be interpreted with caution.

Table 3.14 DSM-IV to DSM-5 Posttraumatic Stress Disorder Comparison

DSM-IV: PTSD	DSM-5: PTSD
Disorder Class: Anxiety Disorders	Disorder Class: Trauma- and Stressor-Related Disorders
A. The person has been exposed to a traumatic event in which both of the following were present: 1. The person experienced, witnessed or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others. 2. The person's response involved intense fear, helplessness, or horror.	A. Exposure to actual or threatened death, serious injury, or sexual violence in one or more of the following ways: 1. Directly experiencing the traumatic event(s). 2. Witnessing, in person, the event(s) as it occurred to others. 3. Learning that the traumatic event(s) occurred to a close family member or close friend. In cases of actual or threatened death of family member or friend, the event(s) must have been violent or accidental. 4. Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responders collecting human remains; police officers repeatedly exposed to details of child abuse). Note: Criterion A4 does not apply to exposure through electronic media, television, movies, or pictures, unless this exposure is work related.

(continued)

Table 3.14 DSM-IV to DSM-5 Posttraumatic Stress Disorder Comparison (continued)

DSM-IV: PTSD	DSM-5: PTSD
B. The traumatic event is persistently re-experienced in one or more of the following ways. 1. Recurrent and intrusive distressing recollections of the event, including images thoughts or perceptions. 2. Recurrent distressing dreams of the event. 3. Acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur on awakening or when intoxicated). 4. Intense psychological distress at exposure to the internal or external cues that symbolize or resemble an aspect of the traumatic event. 5. Physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.	B. Presence of one or more of the following intrusion symptoms associated with the traumatic event(s), beginning after the traumatic event(s) occurred: 1. Recurrent, involuntary, and intrusive distressing memories of the traumatic event(s). 2. Recurrent distressing dreams in which the content and/or effect of the dream are related to the traumatic event(s). 3. Dissociative reactions (e.g., flashbacks) in which the individual feels or acts as if the traumatic event(s) were recurring. (Such reactions may occur on a continuum, with the most extreme expression being a complete loss of awareness of present surroundings.) 4. Intense or prolonged psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event(s). 5. Marked psychological reactions to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).
C. Persistent avoidance of stimuli associated with the trauma and the numbing of general responsiveness (not present before trauma), as indicated by three or more of the following: 1. Efforts to avoid thoughts, feelings, or conversations associated with the trauma. 2. Efforts to avoid the activities, places, or people that arouse recollections of the trauma. 3. Inability to recall important aspect of the trauma. 4. Markedly diminished interest or participation in significant activities. 5. Feelings of detachment or estrangement from others. 6. Restricted range of affect (e.g., unable to have loving feelings). 7. Sense of a foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span).	C. Persistent avoidance of stimuli associated with the traumatic event(s), beginning after the traumatic event(s) occurred, as evidenced by one or both of the following: 1. Avoidance of or efforts to avoid distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s). 2. Avoidance of or efforts to avoid external reminders (people, places, conversations, activities, objects, situations) that arouse distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).

(continued)

Table 3.14 DSM-IV to DSM-5 Posttraumatic Stress Disorder Comparison (continued)

DSM-IV: PTSD	DSM-5: PTSD
	D. Negative alterations in cognitions and mood associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two or more of the following: 1. Inability to remember an important aspect of the traumatic event(s) (typically due to dissociative amnesia and not to other factors such as head injury, alcohol, or drugs). 5. Markedly diminished interest or participation in significant activities. 6. Feelings of detachment or estrangement from others. 7. Persistent inability to experience positive emotions (e.g., inability to experience happiness, satisfaction, or loving feelings). 4. Persistent negative emotion state (e.g., fear, horror, anger, guilt, or shame). 2. Persistent and exaggerated negative beliefs or expectations about oneself, others, or the world (e.g., "I am bad; " "No one can be trusted;" "The world is completely dangerous;" "My whole nervous system is permanently ruined"). 3. Persistent, distorted cognitions about the cause or consequences of the traumatic event(s) that lead the individual to blame himself/herself or others.
D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two or more of the following: 1. Difficulty falling or staying asleep 2. Irritability or outbursts of anger 3. Difficulty concentrating 4. Hyper vigilance 5. Exaggerated startle response	E. Marked alterations in arousal and reactivity associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidence by two (or more) of the following: 6. Sleep disturbance (e.g., difficulty falling or staying asleep or restless sleep). 1. Irritable behavior and angry outbursts (with little or no provocation) typically expressed as verbal or physical aggression toward people or objects. 5. Problems with concentration. 3. Hyper-vigilance. 4. Exaggerated startle response. 2. Reckless or self-destructive behavior.
E. Duration of the disturbance (symptoms in criteria B, C and D) is more than 1 month.	F. Duration of the disturbance (Criteria B, C, D, and E) is more than 1 month.
F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.	G. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
	H. The disturbance is not attributable to the physiological effects of a substance (e.g., medication, alcohol) or another medical condition.
Specify if: Acute: if duration of symptoms is less than 3 months. *Specify* if: Chronic: if duration of symptoms is 3 months or more.	DROPPED

(continued)

Table 3.14 DSM-IV to DSM-5 Posttraumatic Stress Disorder Comparison (continued)

DSM-IV: PTSD	DSM-5: PTSD
	Specify whether: With dissociative symptoms: The individual's symptoms meet the criteria for posttraumatic stress disorder, and in addition, in response to the stressor, the individual experiences persistent or recurrent symptoms of either of the following: 1. Depersonalization: Persistent or recurrent experiences of feeling detached from, and as if one were an outside observer of, one's mental processes or body (e.g., feeling as though one were in a dream; feeling a sense of unreality of self or body or of time moving slowly). 2. Derealization: Persistent or recurrent experiences of unreality of surroundings (e.g., the world around the individual is experienced as unreal, dreamlike, distant, or distorted). Note: To use this subtype, the dissociative symptoms must not be attributable to the physiological effects of a substance (e.g., blackouts, behavior during alcohol intoxication) or another medical condition (e.g., complex partial seizures).
Specify if: With delayed onset: If onset of symptoms is at least 6 months after the stressor.	*Specify* if: With delayed expression: If the full diagnostic criteria are not met until at least 6 months after the event (although the onset and expression of some symptoms may be immediate).

3.3.9 Generalized Anxiety Disorder (MHSS)

Generalized anxiety disorder (GAD) is an anxiety disorder characterized by excessive anxiety and worry that is not focused on a single trigger (e.g., fear of social situations, fear of having a panic attack, or fear of a specific event/situation). There have been very few changes made to GAD criteria in DSM-IV (Table 3.15). The DSM-IV criteria for GAD included that the anxiety and worry does not occur exclusively due to PTSD, a mood disorder, a psychotic disorder, or a pervasive developmental disorder. In DSM-5 this has been replaced with text indicating that "the disturbance is not better explained by another mental disorder." According to reports from the DSM-5 field trials of people seeking treatment, there was a small but significant decrease in DSM-5 prevalence estimates of GAD compared with the DSM-IV clinical screening diagnosis [75]. This may suggest that current estimates for GAD generated by the MHSS are a slight overestimate of the DSM-5 population prevalence. Moreover, this is the first disorder examined thus far for which estimates are expected to decrease. However, these findings were based on assessments of treatment seeking participants at only one of the seven field trial sites; therefore, results must be interpreted with caution as site-specific effects may affect the estimates and the use of a treatment sample may not be generalizable to a nationally representative household-based survey like NSDUH.

Table 3.15 DSM-IV to DSM-5 Generalized Anxiety Disorder Comparison

DSM-IV	DSM-5
Disorder Class: Anxiety Disorders	SAME
A. Excessive anxiety and worry (apprehensive expectation), occurring more days than not for at least 6 months, about a number of events or activities (such as work or school performance).	SAME
B. The person finds it difficult to control the worry.	SAME
C. The anxiety and worry are associated with three or more of the following six symptoms (with at least some symptoms present for more days than not for the past 6 months). 1. Restlessness or feeling keyed up or on edge 2. Being easily fatigued 3. Difficulty concentrating or mind going blank 4. Irritability 5. Muscle tension 6. Sleep disturbance (difficulty falling or staying asleep, or restless unsatisfying sleep)	SAME
D. The focus of the anxiety and worry is not confined to features of an Axis I disorder (e.g., the anxiety or worry is not about having a panic attack [as in panic disorder], being embarrassed in public [as in social phobia], being contaminated [as in obsessive-compulsive disorder] being away from home or close relatives [as in separation anxiety disorder], gaining weight [as in anorexia Nervosa], or having a serious illness [as in hypochondriasis]), and the anxiety and worry do not occur exclusively during posttraumatic stress disorder.	F. The disturbance is not better explained by another mental disorder (e.g., anxiety or worry about having panic attacks in panic disorder, negative evaluation in social anxiety disorder [social phobia], contamination or other obsessions in obsessive-compulsive disorder, separation from attachment figures in separation anxiety disorder, reminders of traumatic events in posttraumatic stress disorder, gaining weight in anorexia nervosa, physical complaints in somatic symptom disorder, perceived appearance flaws in body dysmorphic disorder, having a serious illness in illness anxiety disorder, or the content of delusional beliefs in schizophrenia or delusional disorder).
E. The anxiety, worry, or physical symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.	SAME (part D)
F. The disturbance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hyperthyroidism) and does not occur exclusively during a mood disorder, a psychotic disorder, or a pervasive developmental disorder.	E. The disturbance is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition (e.g., hyperthyroidism).

3.3.10 Anorexia Nervosa (MHSS)

Anorexia nervosa is an eating disorder characterized by an intense fear of gaining weight and the refusal to maintain a minimally normal body weight. Individuals with anorexia also exhibit a misperception of body shape and/or size. There have been several DSM-5 criteria changes (Table 3.16). In DSM-IV, a diagnosis of anorexia nervosa was excluded if the patient maintained bodyweight at or above the 85th percentile for his or her height/age. In DSM-5 this criteria is similar, but adds sex, developmental norms, and physical health and uses body mass

index data. The DSM-5 adds "persistent behavior that interferes with weight gain" as an added way to meet a criteria. The DSM-5 does not include criteria on menstruating females' absence of three consecutive menses, as the DSM-IV does. The restrictive type and binge-eating/purging types differ in that DSM-IV specifies "during the current episode" and DSM-5 specifies "during the past 3 months." The DSM-5 adds criteria for partial and full remission, while the DSM-IV does not include this information.

There is a paucity of research into the impact of these criteria changes on disorder prevalence in the population. In a small study of 364 women, Brown et al., reported that DSM-5 criteria for anorexia nervosa produced higher lifetime frequency estimates than reported for DSM-IV anorexia nervosa [81]. However, these results may not be generalizable to findings in MHSS (and thus NSDUH) as they were drawn from a sample of female university students and not a nationally representative sample.

Table 3.16 DSM-IV to DSM-5 Anorexia Nervosa Comparison

DSM-IV	DSM-5
Class: Eating Disorders	Class: Feeding and Eating Disorders
Refusal to maintain bodyweight at or above minimally normal weight for height/age (less than 85th percentile).	Refusal to maintain bodyweight at or above minimally normal weight for age, sex, developmental norms, and physical health (less than minimally normal/expected[1]).
Intense fear of gaining weight or becoming obese, even though underweight.	Intense fear of gaining weight or becoming obese, even though underweight; or persistent behavior that interferes with weight gain.
Disturbed by one's body weight or shape, self-worth influenced by body weight or shape, or persistent lack of recognition of seriousness of low bodyweight.	SAME
In menstruating females, absence of at least 3 consecutive non-synthetically induced menstrual cycles.	DROPPED
Restricting type: During the current episode, has not regularly engaged in binge-eating or purging.[2]	Restricting type: During the last 3 months…SAME.
Binge-eating/purging type: During the current episode, has regularly engaged in binge-eating or purging.[2]	Binge-eating/purging type: During the last 3 months…SAME.
	Partial remission: After full criteria met, low bodyweight has not been met for sustained period, BUT at least one of the following two criteria still met: intense fear of gaining weight/becoming obese or behavior that interferes with weight gain OR disturbed by weight and shape.
	Full remission: After full criteria met, none of the criteria met for sustained period of time.

[1] Severity is based on body mass index (BMI) derived from World Health Organization categories for thinness in adults; corresponding percentiles should be used for children and adolescents: Mild: BMI greater than or equal to 17 kg/m^2, Moderate: BMI 16-16.99 kg/m^2, Severe: BMI 15-15.99 kg/m^2, Extreme: BMI less than 15 kg/m^2.

[2] Purging is self-induced vomiting or misuse of laxatives, diuretics, or enemas.

3.3.11 Bulimia Nervosa (MHSS)

Bulimia nervosa is an eating disorder characterized by binge eating followed by inappropriate compensatory behaviors designed to prevent weight gain. In addition, the self-evaluation of individuals with bulimia nervosa is excessively influenced by weight and body shape. DSM-IV to DSM-5 criteria changes may have a substantial impact (Table 3.17). The major change in criteria for diagnosis of bulimia nervosa is reducing the binge frequency threshold from twice per week in DSM-IV to once per week in DSM-5. The other differences include the DSM-IV differentiating between purging and nonpurging type (the DSM-5 does not) and the DSM-5 specifying criteria for partial remission, full remission, and severity, while the DSM-IV does not.

Data from an Australian cohort study of 2,822 adolescents and young adults (57.0 percent female) whose parents were recruited from antenatal clinics at a single hospital and followed through age 20, indicate that rates of bulimia nervosa are higher when applying the DSM-5 criteria versus the DSM–IV [82]. The prevalence of past month DSM-IV diagnosed bulimia nervosa in males aged 20 was 0.3 percent and the corresponding DSM-5 based rate was 0.7 percent. In females, the past month prevalence of DSM-IV bulimia nervosa was 2.4 percent among 20 year olds but 7.9 according to DSM-5 criteria. This suggests that the MHSS, if left unchanged, would underestimate DSM-5 prevalence of bulimia nervosa, particularly among females. However, the degree of underestimation is unclear because of differences in the population covered by the regional Australian study and the nationally representative (of the United States) sample drawn by NSDUH.

Table 3.17 DSM-IV to DSM-5 Bulimia Nervosa Comparison

DSM-IV	DSM-5
Class: Eating Disorders	Class: Feeding and Eating Disorders
A. Recurrent episodes of binge eating, as characterized by both: 1. Eating, within any 2-hour period, an amount of food that is definitively larger than what most individuals would eat in a similar period of time under similar circumstances. 2. A feeling that one cannot stop eating or control what or how much one is eating.	SAME
B. Recurrent inappropriate compensatory behaviors in order to prevent weight gain such as self-induced vomiting; misuse of laxatives, diuretics, or other medications; fasting or excessive exercise.	SAME
C. The binge eating and inappropriate compensatory behaviors occur, on average, at least twice a week for 3 months.	C. The binge eating and inappropriate compensatory behaviors occur, on average, at least once a week for 3 months.
D. Self-evaluation is unjustifiability influenced by body shape and weight.	SAME
E. The disturbance does not occur exclusively during episodes of anorexia nervosa.	SAME

(continued)

Table 3.17 DSM-IV to DSM-5 Bulimia Nervosa Comparison (continued)

DSM-IV	DSM-5
Specify type: Purging type: During the current episode, the person has regularly engaged in self-induced vomiting or the misuse of laxatives, diuretics, or enemas. Nonpurging Type: During the current episode, the person has used inappropriate compensatory behaviors, such as fasting or excessive exercise, but has *not* regularly engaged in self-induced vomiting or the misuse of laxatives, diuretics, or enemas.	Not a criterion.
Not a criterion.	*Specify if*: Partial remission: After full criteria were previously met, *some but not all* of the criteria have been met for a sustained period of time. Full remission: After full criteria were previously met, *none* of the criteria have been met for a sustained period of time.
Not a criterion.	*Current severity*[1]: Mild: An average of 1-3 episodes of inappropriate compensatory behaviors per week. Moderate: An average of 4-7 episodes of inappropriate compensatory behaviors per week. Severe: An average of 8-13 episodes of inappropriate compensatory behaviors per week. Extreme: An average of 14 or more episodes of inappropriate compensatory behaviors per week.

[1] The level of severity may be increased to reflect other symptoms and the degree of functional disability.

3.3.12 Intermittent Explosive Disorder (MHSS)

Intermittent explosive disorder (IED) is an impulse-control disorder characterized by episodes in which an individual fails to resist aggressive impulses, resulting in serious aggressive acts such as assault or significant property damage. Moreover, the degree of expressed anger is disproportionate to the degree of provocation or experienced stressor. The DSM-IV to DSM-5 revision presents important criteria changes for IED (Table 3.18). Specific criteria underwent significant wording changes, including a more precise definition of "several episodes" to twice weekly for at least 3 months. Furthermore, DSM-5 added the opportunity to meet diagnostic criteria through acts of verbal aggression, which was not available in DSM-IV, thereby slightly expanding the definition of outbursts. Finally, DSM-5 contains three additional criteria:

- The recurrent aggressive outbursts specified in DSM-IV have been changed to note that they are not premeditated and are not committed to achieve some tangible objective.
- The recurrent outbursts cause either marked distress in the individual or impairment in occupational or interpersonal functioning, or are associated with financial or legal consequences.

- Patients must be at least 6 years old or the developmental equivalent (aggressive behavior that occurs as part of an adjustment disorder in 6 to 18 year olds should not be considered for this diagnosis).

According to a study of a nationally representative household-based sample of 9,282 adults aged 18 or older carried out in 2001 to 2003 (NCS-R), the lifetime prevalence of DSM-IV IED in adults was 7.3 percent and the 12-month prevalence was 3.9 percent [83]. Current literature could not be found on estimates of prevalence for IED using the DSM-5 criteria. The majority of criteria added to the DSM-5 IED diagnosis were restrictive in nature (i.e., they do not add ways to meet criteria, but add additional requirements to meet criteria), which would suggest that prevalence estimates under DSM-5 would be lower than that of DSM-IV. However, it is difficult to determine how much adding verbal aggression (the only expansive criteria change) would expand inclusion, making it impossible to determine the impact on MHSS estimates based on current literature.

Table 3.18 DSM-IV to DSM-5 Intermittent Explosive Disorder Comparison

DSM-IV	DSM-5
Disorder Class: Impulse-Control Disorders Not Elsewhere Classified	Disorder Class: Disruptive, Impulse-Control, and Conduct Disorders
A. Several discrete episodes of failure to resist aggressive impulses that result in serious assaultive acts or destruction of property.	A. Recurrent behavioral outburst representing a failure to control aggressive impulses as manifested by either of the following: 1. Verbal aggression (e.g., temper tantrums, tirades, verbal arguments or fights) or physical aggression toward property, animals, or other individuals, occurring twice weekly, on average, for a period of 3 months. The physical aggression does not result in damage or destruction of property and does not result in physical injury to animals or other individuals. 2. Three behavioral outbursts involving damage or destruction of property and/or physical assault involving physical injury against animals or other individuals occurring within a 12-month period.
B. The degree of aggressiveness expressed during the episodes is grossly out of proportion to any precipitating psychosocial stressors.	B. The magnitude of aggressiveness expressed during the recurrent outbursts is grossly out of proportion to the provocation or to any precipitating psychosocial stressors.

(continued)

Table 3.18 DSM-IV to DSM-5 Intermittent Explosive Disorder Comparison (continued)

DSM-IV	DSM-5
C. The aggressive episodes are not better accounted for by another mental disorder (e.g., antisocial personality disorder, borderline personality disorder, a psychotic disorder, a manic episode, conduct disorder, or attention-deficit/hyperactivity disorder) and are not because of to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., head trauma, Alzheimer's disease).	F. The recurrent aggressive outbursts are not better explained by another mental disorder (e.g., major depressive disorder, bipolar disorder, disruptive mood dysregulation disorder, a psychotic disorder, antisocial personality disorder, borderline personality disorder) and are not attributable to another medical condition (e.g., head trauma, Alzheimer's disease) or to the physiological effects of a substance (e.g., a drug of abuse, a medication). For children ages 6 to 18 years, aggressive behavior that occurs as part of an adjustment disorder should not be considered for this diagnosis.
	C. The recurrent aggressive outbursts are not premeditated (i.e., they are impulsive and/or anger-based) and are not committed to achieve some tangible objective (e.g., money, power, intimidation).
	D. The recurrent aggressive outbursts cause either marked distress in the individual or impairment in occupational or interpersonal functioning, or are associated with financial or legal consequences.
	E. Chronological age is at least 6 years (or equivalent developmental level).

3.3.13 Adjustment Disorder (MHSS)

Adjustment disorder, which has been reclassified from its own class in DSM-IV to the trauma- and stressor-related disorders class in DSM-5 (which also includes acute and PTSD), is a mental illness characterized by the development of clinically relevant emotional or behavioral symptoms (e.g., anxiety or depression) resulting from experiencing a psychosocial stressor(s). There have been only minor criteria changes to adjustment disorder in DSM-5, primarily adding clarification to the DSM-IV language and making note of potential cultural differences (Table 3.19). There is only one change that has the possibility of affecting disorder prevalence. The DSM-IV broadly states that the symptoms do not represent bereavement and the DSM-5 specifies the symptoms do not represent *normal* bereavement. This might increase the prevalence of this disorder; however, no studies were identified that quantified the impacts of this change. Of concern is the broad range of prevalence estimates produced under DSM-IV criteria, suggesting that the underlying prevalence for either version is unknown. In a cross-sectional survey of a representative sample of 3,815 patients from 77 primary health care centers in Catalonia, Spain, the point prevalence was 2.9 percent [84]. According to the DSM-5, the prevalence of adjustment disorders in outpatient mental health treatment patients ranges from approximately 5 to 20 percent. In hospital psychiatric consultation settings, it can often reach 50 percent [2]. Estimates from the 2008 to 2012 MHSS Clinical Study suggest a past year prevalence of 6.9 percent in the U.S. adult population [85].

Table 3.19 DSM-IV to DSM-5 Adjustment Disorders Comparison

DSM-IV	DSM-5
A. The development of emotional or behavioral symptoms in response to an identifiable stressor(s) occurring within 3 months of the onset of the stressor(s).	SAME
B. These symptoms or behaviors are clinically significant as evidenced by either of the following: 1. Marked distress that is in excess of what would be expected from exposure to the stressor. 2. Significant impairment in social or occupational (academic) functioning.	B. These symptoms or behaviors are clinically significant, as evidenced by one or both of the following: 1. Marked distress that is out of proportion to the severity or intensity of the stressor, taking into account the external context and the cultural factors that might influence symptom severity and presentation. 2. Significant impairment in social, occupational, or other important areas of functioning.
C. The stress-related disturbance does not meet the criteria for another specific Axis I disorder and is not merely an exacerbation of a preexisting Axis I or Axis II disorder.	C. The stress-related disturbance does not meet the criteria for another mental disorder and is not merely an exacerbation of a preexisting mental disorder.
D. The symptoms do not represent bereavement.	D. The symptoms do not represent normal bereavement.
E. Once the stressor (or its consequences) has terminated, the symptoms do not persist for more than an additional 6 months.	SAME
Specify if: Acute: If the disturbance lasts less than 6 months Chronic: If the disturbance lasts for 6 months or longer	Not specified.
Adjustment disorders are coded based on the subtype, which is selected according to the predominant symptoms. The specific stressor(s) can be specified on Axis IV. 309.0 With Depressed Mood 309.24 With Anxiety 309.28 With Mixed Anxiety and Depressed Mood 309.3 With Disturbance of Conduct 309.4 With Mixed Disturbance of Emotions and Conduct 309.9 Unspecified	*Specify* whether: 309.0 (F43.21) With depressed mood: Low mood, tearfulness, or feelings of hopelessness are predominant. 309.24 (F43.22) With anxiety: Nervousness, worry, jitteriness, or separation anxiety is predominant. 309.28 (F43.23) With mixed anxiety and depressed mood: A combination of depression and anxiety is predominant. 309.3 (F43.24) With disturbance of conduct: Disturbance of conduct is predominant. 309.4 (F43.25) With mixed disturbance of emotions and conduct: Both emotional symptoms (e.g., depression, anxiety) and a disturbance of conduct are predominant. 309.9 (F43.20) Unspecified: For maladaptive reactions that are not classifiable as one of the specific subtypes of adjustment disorder.

3.3.14 Psychotic Disorders (MHSS)

In DSM-5, the psychotic disorders class includes: schizophrenia; schizophreniform disorder; schizoaffective disorder; delusional disorder; brief psychotic disorder; psychotic disorder due to another medical condition; substance/medication-induced psychotic disorder; unspecified schizophrenia spectrum and other psychotic disorder; and other specified schizophrenia spectrum and other psychotic disorder. These disorders share a common set of characteristic symptoms or key features that include delusions (fixed beliefs that are not amenable to change in light of conflicting evidence); hallucinations (perception-like experiences that occur without an external stimulus); disorganized thinking/speech (e.g., frequent derailment or incoherence); grossly disorganized (e.g., childlike silliness or unpredictable agitation) or catatonic behavior (a marked decrease in reactivity to the environment, or purposeless and excessive motor activity without obvious cause); and negative symptoms such as affective flattening (diminished emotional expression), avolition (lack of motivation to achieve meaningful goals), or alogia (diminished speech output) [2].

Changes between DSM-IV and DSM-5 include the dropping of shared psychotic disorder and the reclassification of psychotic disorder not otherwise specified into unspecified schizophrenia spectrum and other psychotic disorder, and other specified schizophrenia spectrum and other psychotic disorder (Table 3.20). Other changes between the two editions of the DSM include minor wording changes and larger changes, including

- removing the note in Criterion A of schizophrenia that specifies, in cases where there are bizarre hallucinations, or those consisting of a voice keeping a running commentary, or two voices conversing that only one Criterion A symptom is necessary;
- adding a stipulation in Criterion A of schizophreniform disorder that at least one of the two or more schizophrenia Criterion A symptoms must be delusions, hallucinations, or disorganized thinking/speech;
- removing the stipulation in Criterion A of delusional disorder that the delusions be nonbizarre; and
- adding a criterion requiring clinically significant distress or impairment for the diagnoses of psychotic disorder due to another medical condition, and substance/medication-induced psychotic disorder.

The MHSS does not assess specific psychotic disorders, instead it includes a screener for psychotic symptoms (i.e., delusions and hallucinations) that are psychogenic in nature (i.e., delusions or hallucinations that are not possibly or definitely the result of the use of medications, drugs, or alcohol or a general medical condition such as a high fever). Because these symptoms may also be present in mood disorders with psychotic features, their presence alone cannot be used make a diagnosis of a psychotic disorder. The purpose of the screener for psychotic symptoms in the MHSS has been to identify people experiencing delusions and/or hallucinations and classify them as having SMI. Whereas the changes reflected in DSM-5 do have an effect on the hierarchy within this class of disorders, there are no changes that will have an effect on the use of a screener of this type for psychotic symptoms as an indicator of SMI.

Table 3.20 DSM-IV to DSM-5 Psychotic Disorders

DSM-IV	DSM-5
Disorder Class: Schizophrenia and Other Psychotic Disorders	Disorder Class: Schizophrenia Spectrum and Other Psychotic Disorders
Schizophrenia A. *Characteristic symptoms*: Two (or more) of the following, each present for a significant portion of time during a 1-month period (or less if successfully treated): 1. delusions 2. hallucinations 3. disorganized speech (e.g., frequent derailment or incoherence) 4. grossly disorganized or catatonic behavior 5. negative symptoms (i.e., affective flattening, alogia, or avolition)	**Schizophrenia** A. SAME with the exception that language expressing the negative symptoms has changed (e.g. affective flattening is now referred to as *diminished* emotional expression) and alogia is no longer presented as an example of a prominent negative symptom.
(Note: Only one Criterion A symptom is required if delusions are bizarre or hallucinations consist of a voice keeping up a running commentary on the person's behavior or thoughts, or two or more voices conversing with each other.) B. *Social/occupational dysfunction*: For a significant portion of the time since the onset of the disturbance, one or more major areas of functioning such as work, interpersonal *relations*, or self-care are markedly below the level achieved prior to the onset (or when the onset is in childhood or adolescence, failure to achieve expected level of interpersonal, academic, or occupational achievement).	B. SAME
C. *Duration*: Continuous signs of the disturbance persist for at least 6 months. This 6-month period must include at least 1 month of *symptoms* (or less if successfully treated) that meet Criterion A (i.e., active-phase symptoms) and may include periods of prodromal or residual symptoms. During these prodromal or residual periods, the signs of the disturbance may be manifested by only negative symptoms or two or more symptoms listed in Criterion A present in an attenuated form (e.g., odd beliefs, unusual perceptual experiences). D. *Schizoaffective and mood disorder exclusion*: Schizoaffective disorder and mood disorder with psychotic features have been ruled out because either (1) no major depressive, manic, or mixed episodes have occurred concurrently with the active-phase symptoms; or (2) if mood episodes have occurred during active-phase symptoms, their total duration has been brief relative to the duration of the active and residual periods. E. *Substance/general medical condition exclusion*: The disturbance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition.	C. SAME D. SAME E. SAME

(continued)

Table 3.20 DSM-IV to DSM-5 Psychotic Disorders (continued)

DSM-IV	DSM-5
F. *Relationship to a pervasive developmental disorder*: If there is a history of autistic disorder or another pervasive developmental disorder, the additional diagnosis of schizophrenia is made only if prominent delusions or hallucinations are also present for at least a month (or less if successfully treated).	F. SAME
Schizophreniform Disorder A. A, D, and E of schizophrenia are met. B. An episode of the disorder (including prodromal, active, and residual phases) lasts at least 1 month but less than 6 months. (When diagnosis must be made without waiting for recovery, it should be qualified as "Provisional.")	**Schizophreniform Disorder** A. Two (or more) of the following, each present for a significant portion of time during a 1-month period (or less if successfully treated). At least one of these must be (1), (2), or (3): 1. delusions 2. hallucinations 3. disorganized speech (e.g., frequent derailment or incoherence) 4. grossly disorganized or catatonic behavior 5. negative symptoms,(i.e., diminished emotional expression or avolition) (D & E criteria of schizophrenia are included as C & D criteria of schizophreniform disorder.) B. SAME
Schizoaffective Disorder A. An uninterrupted period of illness during which, at some time, there is either a major depressive episode., a manic episode, or a mixed episode concurrent with symptoms that meet Criterion A for schizophrenia.	**Schizoaffective Disorder** A. SAME
B. During the same period of illness, there have been delusions or hallucinations for at least 2 weeks in the absence of prominent mood symptoms. C. Symptoms that meet criteria for a mood episode are present for a substantial portion of the total duration of the active and residual periods of the illness. D. The disturbance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition.	B. SAME C. SAME D. SAME.
Delusional Disorder A. Nonbizarre delusions (i.e., involving situations that occur in real life, such as being followed, poisoned, infected, loved at a distance, or deceived by spouse or lover, or having a disease) of at least 1 month's duration. B. Criterion A for schizophrenia has never been met. Note: Tactile and olfactory hallucinations may be present in delusional disorder if they are related to the delusional theme.	**Delusional Disorder** A. The presence of one (or more) delusions with a duration of 1 month or longer. B. SAME except for note: Hallucinations, if present, are not prominent and are related to the delusion theme (e.g., the sensation of being infested with insects associated with delusions of infestation.

(continued)

Table 3.20 DSM-IV to DSM-5 Psychotic Disorders (continued)

DSM-IV	DSM-5
C. Apart from the impact of the delusion(s) or its ramifications, functioning is not markedly impaired and behavior is not obviously odd or bizarre. D. If mood episodes have occurred concurrently with delusions, their total duration has been brief relative to the duration of the delusional periods. E. The disturbance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition.	C. SAME D. SAME E. The disturbance is not attributable to the physiological effects of a substance or another medical condition and is not better explained by another mental disorder, such as body dysmorphic disorder or obsessive-compulsive disorder.
Brief Psychotic Disorder A. Presence of one (or more) of the following symptoms: 1. delusions 2. hallucinations 3. disorganized speech (e.g., frequent derailment or incoherence) 4. grossly disorganized or catatonic behavior Note: Do not include a symptom if it is a culturally sanctioned response pattern. B. Duration of an episode of the disturbance is at least 1 day but less than 1 month, with eventual full return to premorbid level of functioning. C. The disturbance is not better accounted for by a mood disorder with psychotic features, schizoaffective disorder, or schizophrenia and is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition.	**Brief Psychotic Disorder** A. Presence of one (or more) of the following symptoms. At least one of these must be (1), (2), or (3): 1. delusions 2. hallucinations 3. disorganized speech (e.g., frequent derailment or incoherence) 4. grossly disorganized or catatonic behavior Note: Do not include a symptom if it is a culturally sanctioned response pattern. B. SAME C. The disturbance is not better explained by major depressive or bipolar disorder with psychotic features or another psychotic disorder such as schizophrenia or catatonia, and is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition.
Shared Psychotic Disorder (Folie á Deux) A. A delusion develops in an individual in the context of a close relationship with another person(s), who has an already-established delusion. B. The delusion is similar in content to that of the person who already has the established delusion. C. The disturbance is not better accounted for by another psychotic disorder (e.g., schizophrenia) or a mood disorder with psychotic features and is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition.	DROPPED
Psychotic Disorder Due to a General Medical Condition A. Prominent hallucinations or delusions.	**Psychotic Disorder Due to Another Medical Condition** A. SAME

(continued)

Table 3.20 DSM-IV to DSM-5 Psychotic Disorders (continued)

DSM-IV	DSM-5
B. There is evidence from the history, physical examination, or laboratory findings that the disturbance is the direct physiological consequence of a general medical condition.	B. SAME
C. The disturbance is not better accounted for by another mental disorder.	C. SAME
D. The disturbance does not occur exclusively during the course of delirium.	D. SAME
	E. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
Substance-Induced Psychotic Disorder	**Substance/Medication-Induced Psychotic Disorder**
A. Prominent hallucinations or delusions. Note: Do not include hallucinations if the person has insight that they are substance induced.	A. Presence of one or both of the following symptoms: 1. Delusions 2. Hallucinations
B. There is evidence from the history, physical examination, or laboratory findings that either (1) or (2): 1. the symptoms in Criterion A developed during, or within a month of, substance intoxication or withdrawal 2. medication used is etiologically related to the disturbance	B. SAME
C. The disturbance is not better accounted for by a psychotic disorder that is not substance induced. Evidence that the symptoms are better accounted for by a psychotic disorder that is not substance induced might include the following: the symptoms precede the onset of the substance use (or medication use); the symptoms persist for a substantial period of time (e.g., about a month) after the cessation of acute withdrawal or severe intoxication, or are substantially in excess of what would be expected given the type or amount of the substance used or the duration of use; or there is other evidence that suggests the existence of an independent nonsubstance-induced psychotic disorder (e.g., a history of recurrent nonsubstance-related episodes).	C. SAME
D. The disturbance does not occur exclusively during the course of delirium.	D. SAME E. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

(continued)

Table 3.20 DSM-IV to DSM-5 Psychotic Disorders (continued)

DSM-IV	DSM-5
Psychotic Disorder Not Otherwise Specified This category includes psychotic symptomatology (i.e., delusions, hallucinations, disorganized speech, grossly disorganized or catatonic behavior) about which there is inadequate information to make a specific diagnosis or about which there is contradictory information, or disorders with psychotic symptoms that do not meet the criteria for any specific psychotic disorder.	**Unspecified Schizophrenia Spectrum and Other Psychotic Disorder** This category applies to presentations in which symptoms characteristic of a schizophrenia spectrum and other psychotic disorder that cause clinically significant distress or impairment in social, occupational, or other important areas of functioning predominate but do not meet the full criteria for any of the disorders in the schizophrenia spectrum and other psychotic disorders class. The unspecified schizophrenia spectrum and other psychotic disorder category is used in situations in which the clinician chooses *not* to communicate the specific reason that the presentation does not meet the criteria for any specific schizophrenia spectrum her psychotic disorder, and includes presentations in which there is insufficient information to make a more specific diagnosis (e.g., emergency room settings). **Other Specified Schizophrenia Spectrum and Other Psychotic Disorder** This category applies to presentations in which symptoms characteristic of a schizophrenia spectrum and other psychotic disorder that cause clinically significant distress or impairment in social, occupational, or other important areas of functioning predominate but do not meet the full criteria for any of the disorders in the schizophrenia spectrum and other psychotic disorders class. The other specified schizophrenia spectrum and other psychotic disorder category is used in situations in which the clinician chooses to communicate the specific reason that the presentation does not meet the criteria for any specific schizophrenia spectrum and other psychotic disorder. This is done by recording "other specified schizophrenia spectrum and other psychotic disorder" followed by the specific reason (e.g., persistent auditory hallucinations).

3.4 Additional Disorders for Consideration

Changes in diagnostic criteria and the addition of some disorders may indicate that additional disorders should be considered for inclusion in MHSS. These disorders may be new or may have undergone criteria changes that are expected to impact the prevalence or clinical importance. The following section examines a number of disorders that might be considered for addition to the MHSS, with a critical appraisal of the benefits and disadvantages for each and relevance to the estimation of AMI and SMI. These disorders were specifically chosen for detailed examination based on disorder prevalence and clinical importance (i.e., functional impairment and mental distress). However, the ultimate determination for inclusion in MHSS

will also depend on factors such as ability to reliably assess the disorder and comorbidity of the disorder. The disorders have been organized by diagnostic categories as they appear in DSM-5.

3.4.1 Neurodevelopmental Disorders

Attention Deficit/Hyperactivity Disorder

Attention-deficit/hyperactivity disorder (ADHD) is a chronic neurodevelopmental disorder characterized by a persistent and pervasive pattern of inattention and/or hyperactivity-impulsivity that interferes with functioning or development. ADHD among adults is associated with significant functional impairment. Community-based studies have repeatedly shown that adults with ADHD were less likely to have graduated high school or completed college and were more likely to have been arrested, abuse substances, be unemployed, and report dissatisfaction with their personal and professional lives [58,86-89].

The diagnostic criteria for ADHD in DSM-5 are similar to those in DSM-IV (Table 3.21). The same 18 symptoms are used as in DSM-IV, and continue to be divided into two symptom domains (inattention and hyperactivity/impulsivity), of which at least 6 symptoms in 1 domain are required for diagnosis. The primary reason for excluding ADHD from MHSS was because ADHD was largely conceptualized as a childhood disorder. However, several changes have been made in DSM-5 that might suggest considering it for inclusion in future MHSS's. First, examples have been added to criteria to facilitate application across the life span rather than focusing primarily on children. Second, the onset criterion has been changed from "symptoms that caused impairment were present before age 7 years" to "several inattentive or hyperactive-impulsive symptoms were present prior to age 12." Third, a symptom threshold change has been made for adults to reflect substantial evidence of clinically significant ADHD impairment, with the cutoff for ADHD of five symptoms, instead of the six required for younger people (this includes inattention, hyperactivity, and impulsivity). Finally, ADHD was placed in the neurodevelopmental disorders chapter to reflect brain developmental correlates with ADHD and the DSM-5 decision to eliminate the DSM-IV chapter that includes all diagnoses usually first made in infancy, childhood, or adolescence.

The majority of ADHD criteria changes focused on improving detection of ADHD among adults [90], thereby increasing the relevance to the estimation of AMI and SMI. DSM-IV ADHD was the most common neurodevelopmental disorder among children and adults and has the capacity to significantly raise the prevalence of mental illness in MHSS if it were included. Prevalence estimates of DSM-5 diagnosed ADHD among adults have not been identified. However, a point prevalence estimate of DSM-IV ADHD in adults aged 18 to 44, was 4.4 percent in 1990 to 1992, based on a subsample of respondents in the nationally representative NCS-R [84]. This is likely to be an underestimate given the relaxed diagnostic threshold under DSM-5 (five symptoms instead of six) and expanded age of onset (from age 7 to age 12) [90]. Notably, the comorbidity of ADHD with other disorders was estimated to be up to 47.1 percent (for any anxiety disorder [84]) indicating that the prevalence increase in the MHSS estimates, should ADHD be included, will not increase to the total prevalence of ADHD since about 50 percent of cases are being identified as cases in another diagnostic module currently assessed. However, the prevalence of this disorder and evidence of its clinical implications among adults

makes this disorder a strong candidate for inclusion in any future DSM 5-based NSDUH clinical study of mental disorders and AMI/SMI.

Table 3.21 DSM-IV to DSM-5 Attention-Deficit/Hyperactivity Disorder Comparison

DSM-IV	DSM-5
Disorder Class: Disorders Usually Diagnosed in Infancy, Childhood, and Adolescence	Disorder Class: Neurodevelopmental Disorders
A. Either (1) or (2): 1. Six (or more) of the following symptoms of inattention have persisted for at least 6 months to a degree that is maladaptive and inconsistent with developmental level:	A. A persistent pattern of inattention and/or hyperactivity-impulsivity that interferes with functioning or development, as characterized by (1) and/or (2): 1. Inattention: Six (or more) of the following symptoms have persisted for at least 6 months to a degree that is inconsistent with developmental level and that negatively impacts directly on social and academic/occupational activities: Note: The symptoms are not solely a manifestation of oppositional behavior, defiance, hostility, or failure to understand tasks or instructions. For older adolescents and adults (aged 17 or older), at least five symptoms are required.
Inattention a. often fails to give close attention to details or makes careless mistakes in schoolwork, work or other activities	a. Often fails to give close attention to details or makes careless mistakes in schoolwork, at work, or during other activities (e.g., overlooks or misses details, work is inaccurate).
b. often has difficulty sustaining attention in tasks or play activity	b. Often has difficulty sustaining attention in tasks or play activities (e.g., has difficulty remaining focused during lectures, conversations, or lengthy reading).
c. often does not seem to listen when spoken to directly	c. Often does not seem to listen when spoken to directly (e.g., mind seems elsewhere, even in the absence of any obvious distraction).
d. often does not follow through on instructions and fails to finish schoolwork, chores or duties in the workplace (not due to oppositional behavior or failure to understand instructions)	d. Often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace (e.g., starts tasks but quickly loses focus and is easily sidetracked).
e. often has difficulty organizing tasks and activities	e. Often has difficulty organizing tasks and activities (e.g., difficulty managing sequential tasks; difficulty keeping materials and belongings in order; messy, disorganized work; has poor time management; fails to meet deadlines).
f. often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (such as schoolwork or homework)	f. Often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (e.g., schoolwork or homework; for older adolescents and adults, preparing reports, completing forms, reviewing lengthy papers).

(continued)

Table 3.21 DSM-IV to DSM-5 Attention-Deficit/Hyperactivity Disorder Comparison (continued)

DSM-IV	DSM-5
g. often loses things necessary for tasks or activities (e.g., toys, school assignments, pencils, books or tools)	g. Often loses things necessary for tasks or activities (e.g., school materials, pencils, books, tools, wallets, keys, paperwork, eyeglasses, mobile telephones).
h. is often easily distracted by extraneous stimuli	h. Is often easily distracted by extraneous stimuli (for older adolescents and adults, may include unrelated thoughts).
i. is often forgetful in daily activities	i. Is often forgetful in daily activities (e.g., doing chores, running errands; for older adolescents and adults, returning calls, paying bills, keeping appointments).
2. Six (or more) of the following symptoms of hyperactivity-impulsivity have persisted for at least 6 months to a degree that is maladaptive and inconsistent with developmental level: ***Hyperactivity*** a. often fidgets with hands or feet or squirms in seat	2. Hyperactivity and impulsivity: Six (or more) of the following symptoms have persisted for at least 6 months to a degree that is inconsistent with developmental level and that negatively impacts directly on social and academic/occupational activities: Note: The symptoms are not solely a manifestation of oppositional behavior, defiance, hostility, or a failure to understand tasks or instructions. For older adolescents and adults (aged 17 or older), at least five symptoms are required. a. Often fidgets with or taps hands or feet, or squirms in seat.
b. often leaves seat in classroom or in other situations in which remaining seated is expected	b. Often leaves seat in situations when remaining seated is expected (e.g., leaves his or her place in the classroom, in the office or other workplace, or in other situations that require remaining in place).
c. often runs about or climbs excessively in situations in which it is inappropriate (in adolescents or adults, may be limited to subjective feelings of restlessness)	c. Often runs about or climbs in situations where it is inappropriate. (Note: In adolescents or adults, may be limited to feeling restless).
d. often has difficulty playing or engaging in leisure activities quietly	d. Often unable to play or take part in leisure activities quietly.
e. is often "on the go" or often acts as if "driven by a motor"	e. Is often "on the go" acting as if "driven by a motor" (e.g., is unable to be or uncomfortable being still for extended time, as in restaurants, meetings; may be experienced by others as being restless or difficult to keep up with).
f. often talks excessively	f. Often talks excessively.
Impulsivity g. often blurts out answers before questions have been completed	g. Often blurts out an answer before a question has been completed (e.g., completes people's sentences; cannot wait for turn in conversation).
h. often has difficulty awaiting turn	h. Often has trouble waiting his/her turn (e.g., while waiting in line).

(continued)

Table 3.21 DSM-IV to DSM-5 Attention-Deficit/Hyperactivity Disorder Comparison (continued)

DSM-IV	DSM-5
i. often interrupts or intrudes on others (e.g., butts into conversations or games)	i. Often interrupts or intrudes on others (e.g., butts into conversations, games, or activities; may start using other people's things without asking or receiving permission; for adolescents and adults, may intrude into or take over what others are doing).
B. Some hyperactive-impulsive or inattentive symptoms must have been present before age 7 years.	B. Several inattentive or hyperactive-impulsive symptoms were present before age 12 years.
C. Some impairment from the symptoms is present in at least two settings (e.g., at school [or work] and at home).	C. Several inattentive or hyperactive-impulsive symptoms are present in two or more settings, (e.g., at home, school or work; with friends or relatives; in other activities).
D. There must be clear evidence of clinically significant impairment in social, academic, or occupational functioning.	D. There is clear evidence that the symptoms interfere with, or reduce the quality of, social, school, or work functioning.
E. The symptoms do not occur exclusively during the course of a pervasive developmental disorder, schizophrenia, or other psychotic disorders and is not better accounted for by another mental disorder (e.g., mood disorder, anxiety disorder, dissociative disorder, or a personality disorder).	E. The symptoms do not occur exclusively during the course of schizophrenia or another psychotic disorder and are not better explained by another mental disorder (e.g., mood disorder, anxiety disorder, dissociative disorder, personality disorder, substance intoxication or withdrawal).
Code based on type: 314.01 Attention-Deficit/Hyperactivity Disorder, Combined Type: if both Criteria A1 and A2 are met for the past 6 months 314.00 Attention-Deficit/Hyperactivity Disorder, Predominantly Inattentive Type: if Criterion A1 is met but Criterion A2 is not met for the past 6 months 314.01 Attention-Deficit/Hyperactivity Disorder, Predominantly Hyperactive-Impulsive Type: if Criterion A2 is met but Criterion A1 is not met for the past 6 months	*Specify* whether: Combined presentation: If enough symptoms of both criteria inattention and hyperactivity-impulsivity were present for the past 6 months Predominantly inattentive presentation: If enough symptoms of inattention, but not hyperactivity-impulsivity, were present for the past 6 months Predominantly hyperactive-impulsive presentation: If enough symptoms of hyperactivity-impulsivity but not inattention were present for the past 6 months.
Coding note: For individuals (especially adolescents and adults) who currently have symptoms that no longer meet full criteria, "In Partial Remission" should be specified.	*Specify* if: In partial remission: When full criteria were previously met, fewer than the full criteria have been met for the past 6 months, and the symptoms still results in impairment in social, academic, or occupational functioning.

(continued)

Table 3.21 DSM-IV to DSM-5 Attention-Deficit/Hyperactivity Disorder Comparison (continued)

DSM-IV	DSM-5
	Specify current severity: Mild: Few, if any, symptoms in excess of those required to make the diagnosis are present, and symptoms result in no more than minor impairments in social or occupational functioning. Moderate: Symptoms or functional impairment between "mild" and "severe" are present. Severe: Many symptoms in excess of those required to make the diagnosis, or several symptoms that are particularly severe, are present, or the symptoms result in marked impairment in social or occupational functioning.

3.4.2 Schizophrenia Spectrum and Other Psychotic Disorders

Schizophrenia

Schizophrenia is a mental disorder characterized by delusions, hallucinations, and/or disorganized speech, which cause significant distress and functional impairment. These symptoms involve a range of cognitive, behavioral, and emotional dysfunctions although there is great variation across individuals presenting with these symptoms. Schizophrenia is considered a chronic mental illness with lifetime prevalence between 0.3 percent and 0.7 percent. Despite its low prevalence, schizophrenia is responsible for over $7.6 billion annually in direct costs (e.g., mental health service use, law enforcement costs) and an additional $32.4 billion in annual indirect costs (e.g., loss of productivity) [91].

Two changes have been made to DSM-5 Criterion A for schizophrenia (Table 3.22). First, the special attribution of bizarre delusions and Schneiderian first-rank auditory hallucinations (e.g., two or more voices conversing) has been eliminated. Under DSM-IV criteria, if the delusions were bizarre or if there were Schneiderian first-rank auditory hallucinations then only this one symptom was necessary to meet Criterion A. This special attribution was removed because of the nonspecificity of Schneiderian symptoms and the poor reliability in distinguishing bizarre from nonbizarre delusions. Therefore, in DSM-5, two Criterion A symptoms are required for any diagnosis of schizophrenia. The second change in DSM-5 is the addition of a requirement in Criterion A that the individual must have at least one of these three symptoms: delusions, hallucinations, and disorganized speech. At least one of these core "positive symptoms" is necessary for a reliable diagnosis of schizophrenia. In addition to these two Criterion A changes, the DSM-IV subtypes of schizophrenia (i.e., paranoid, disorganized, catatonic, undifferentiated, and residual types) were eliminated because of their limited diagnostic stability, low reliability, and poor validity. Instead, a dimensional approach to rating severity for the core symptoms of schizophrenia was included to capture the heterogeneity in symptom type and severity expressed across individuals with psychotic disorders.

The MHSS clinical study already assesses some symptoms of schizophrenia through its use of a psychotic symptom screener. Therefore, the consideration is whether to add a separate module to specifically assess schizophrenia. Despite being one of the most debilitating and costly mental illnesses with a substantial public health impact, schizophrenia has a very low prevalence. Also, its assessment is complicated by one important factor. Although the DSM-IV and DSM-5 SCID have modules for assessing schizophrenia, it was designed to be administered in person by a clinician. The MHSS uses a telephone interviewing procedure. This works well for almost all psychiatric symptoms, which are based on patient self-report. However, disorganized speech, disorganized behavior, and negative symptoms (symptom 5 of Criteria A) are based on clinician observation, not by patient self-report. These symptoms are difficult to assess over the phone without visual cues. This concern, combined with the very low prevalence of the disorder and the fact that the estimation SMI includes psychotic symptoms, continues to justify the exclusion of the schizophrenia-specific module in the MHSS.

Table 3.22 DSM-IV to DSM-5 Schizophrenia Comparison

DSM-IV	DSM-5
Disorder Class: Schizophrenia and Other Psychotic Disorders	Disorder Class: Schizophrenia Spectrum and Other Psychotic Disorders
A. *Characteristic symptoms*: Two (or more) of the following, each present for a significant portion of time during a 1-month period (or less if successfully treated): 1. delusions 2. hallucinations 3. disorganized speech (e.g., frequent derailment or incoherence) 4. grossly disorganized or catatonic behavior 5. negative symptoms (i.e., affective flattening, alogia, or avolition) Note: Only one Criterion A symptom is required if delusions are bizarre or hallucinations consist of a voice keeping up a running commentary on the person's behavior or thoughts, or two or more voices conversing with each other.	A. Two (or more) of the following, each present for a significant portion of time during a 1-month period (or less if successfully treated). At least one of these must be (1), (2), or (3): 1-4. SAME 5. Negative symptoms (i.e., diminished emotional expression or avolition).
B. *Social/occupational dysfunction*: For a significant portion of the time since the onset of the disturbance, one or more major areas of functioning such as work, interpersonal relations, or self-care are markedly below the level achieved prior to the onset (or when the onset is in childhood or adolescence, failure to achieve expected level of interpersonal, academic, or occupational achievement).	B. For a significant portion of the time since the onset of the disturbance, level of functioning in one or more major areas, such as work, interpersonal relations, or self-care, is markedly below the level achieved prior to the onset (or when the onset is in childhood or adolescence, there is failure to achieve expected level of interpersonal, academic, or occupational functioning).

(continued)

Table 3.22 DSM-IV to DSM-5 Schizophrenia Comparison (continued)

DSM-IV	DSM-5
C. *Duration*: Continuous signs of the disturbance persist for at least 6 months. This 6-month period must include at least 1 month of symptoms (or less if successfully treated) that meet Criterion A (i.e., active-phase symptoms) and may include periods of prodromal or residual symptoms. During these prodromal or residual periods, the signs of the disturbance may be manifested by only negative symptoms or two or more symptoms listed in Criterion A present in an attenuated form (e.g., odd beliefs, unusual perceptual experiences).	C. SAME
D. *Schizoaffective and Mood Disorder exclusion*: Schizoaffective Disorder and Mood Disorder With Psychotic Features have been ruled out because either (1) no Major Depressive, Manic, or Mixed Episodes have occurred concurrently with the active-phase symptoms; or (2) if mood episodes have occurred during active-phase symptoms, their total duration has been brief relative to the duration of the active and residual periods.	D. Schizoaffective disorder and depressive or bipolar disorder with psychotic features have been ruled out because either (1) no major depressive or manic episodes have occurred concurrently with the active-phase symptoms, or (2) if mood episodes have occurred during active-phase symptoms, they have been present for a minority of the total duration of the active and residual periods of the illness.
E. *Substance/general medical condition exclusion*: The disturbance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition.	E. The disturbance is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition.
F. *Relationship to a Pervasive Developmental Disorder*: If there is a history of Autistic Disorder or another Pervasive Developmental Disorder, the additional diagnosis of Schizophrenia is made only if prominent delusions or hallucinations are also present for at least a month (or less if successfully treated).	F. If there is a history of autism spectrum disorder or a communication disorder of childhood onset, the additional diagnosis of schizophrenia is made only if prominent delusions or hallucinations, in addition to the other required symptoms of schizophrenia, are also present for at least 1 month (or less if successfully treated).

(continued)

Table 3.22 DSM-IV to DSM-5 Schizophrenia Comparison (continued)

DSM-IV	DSM-5
Classification of longitudinal course (can be applied only after at least 1 year has elapsed since the initial onset of active-phase symptoms): Episodic With Interepisode Residual Symptoms (episodes are defined by the reemergence of prominent psychotic symptoms); also specify if: With Prominent Negative Symptoms Episodic With No Interepisode Residual Symptoms Continuous (prominent psychotic symptoms are present throughout the period of observation); also specify if: With Prominent Negative Symptoms Single Episode In Partial Remission; also specify if: With Prominent Negative Symptoms Single Episode In Full Remission Other or Unspecified Pattern	*Specify* if: The following course specifiers are only to be used after a 1-year duration of the disorder and if they are not in contradiction to the diagnostic course criteria. First episode, currently in acute episode: First manifestation of the disorder meeting the defining diagnostic symptom and time criteria. An acute episode is a time period in which the symptom criteria are fulfilled. First episode, currently in partial remission: Partial remission is a period of time during which an improvement after a previous episode is maintained and in which the defining criteria of the disorder are only partially fulfilled. First episode, currently in full remission: Full remission is a period of time after a previous episode during which no disorder-specific symptoms are present. Multiple episodes, currently in acute episode: Multiple episodes may be determined after a minimum of two episodes (i.e., after a first episode, a remission and a minimum of one relapse). Multiple episodes, currently in partial remission Multiple episodes, currently in full remission Continuous: Symptoms fulfilling the diagnostic symptom criteria of the disorder are remaining for the majority of the illness course, with subthreshold symptom periods being very brief relative to the overall course. Unspecified

(continued)

Table 3.22 DSM-IV to DSM-5 Schizophrenia Comparison (continued)

DSM-IV	DSM-5
	Specify if: With catatonia (refer to the criteria for catatonia associated with another mental disorder for definition). Coding note: Use additional code 293.89 (F06.1) catatonia associated with schizophrenia to indicate the presence of the comorbid catatonia. *Specify* current severity: Severity is rated by a quantitative assessment of the primary symptoms of psychosis, including delusions, hallucinations, disorganized speech, abnormal psychomotor behavior, and negative symptoms. Each of these symptoms may be rated for its current severity (most severe in the last 7 days) on a 5-point scale ranging from 0 (not present) to 4 (present and severe). (See Clinician-Rated Dimensions of Psychosis Symptom Severity in the chapter "Assessment Measures.") Note: Diagnosis of schizophrenia can be made without using this severity specifier.
Paranoid Type (295.30): A type of Schizophrenia in which the following criteria are met: A. Preoccupation with one or more delusions or frequent auditory hallucinations. B. None of the following is prominent: disorganized speech, disorganized or catatonic behavior, or flat or inappropriate affect.	DROPPED
Disorganized Type (295.10): A type of Schizophrenia in which the following criteria are met: A. All of the following are prominent: 1. disorganized speech 2. disorganized behavior 3. flat or inappropriate affect B. The criteria are not met for Catatonic Type.	DROPPED

(continued)

Table 3.22 DSM-IV to DSM-5 Schizophrenia Comparison (continued)

DSM-IV	DSM-5
Catatonic Type (295.20): A type of Schizophrenia in which the clinical picture is dominated by at least two of the following: 1. motoric immobility as evidenced by catalepsy (including waxy flexibility) or stupor 2. excessive motor activity (that is apparently purposeless and not influenced by external stimuli) 3. extreme negativism (an apparently motiveless resistance to all instructions or maintenance of a rigid posture against attempts to be moved) or mutism 4. peculiarities of voluntary movement as evidenced by posturing (voluntary assumption of inappropriate or bizarre postures), stereotyped movements, prominent mannerisms, or prominent grimacing 5. echolalia or echopraxia	DROPPED
Undifferentiated Type (295.90): A type of Schizophrenia in which symptoms that meet Criterion A are present, but the criteria are not met for the Paranoid, Disorganized, or Catatonic Type.	DROPPED
Residual Type (295.60): A type of Schizophrenia in which the following criteria are met: A. Absence of prominent delusions, hallucinations, disorganized speech, and grossly disorganized or catatonic behavior. B. There is continuing evidence of the disturbance, as indicated by the presence of negative symptoms or two or more symptoms listed in Criterion A for Schizophrenia, present in an attenuated form (e.g., odd beliefs, unusual perceptual experiences).	DROPPED

3.4.3 Bipolar and Related Disorders

Bipolar II Disorder

Bipolar II disorder shares many similarities with bipolar I; it is characterized by periods of major depression and periods of elevated mood. The primary difference between bipolar II and bipolar I is that a person with bipolar II has only met criteria for a hypomanic episode and never a full manic episode (as in bipolar I) in their lifetime. The differences between hypomanic (Table 3.8) and full manic episodes (Table 3.6) are in duration (the duration criterion for hypomanic episodes is shorter [4 days vs. 1 week]) and in functional impairment. Hypomanic episodes are not accompanied by significant functional impairment.

Criteria changes to the *overall* bipolar II disorder (Table 3.23) from DSM-IV to DSM-5 have included minor wording changes; however, there have been changes to the criteria for MDE (discussed in Section 3.2.1) and to hypomanic episodes (Table 3.8), which are integral to the diagnosis of bipolar II. The changes in MDE criteria, as already discussed, have an as yet undetermined effect, but they are expected to raise the prevalence slightly. The primary change to hypomanic episodes is a restrictive change. Under DSM-IV, the main feature of a hypomanic

episode was described as "a distinct period of persistently elevated, expansive, or irritable mood, lasting throughout at least 4 days, that is clearly different from the usual nondepressed mood" [1, p. 338]. Under DSM-5, this has been changed to "a distinct period of abnormally and persistently elevated, expansive, or irritable mood and abnormally and persistently increased activity or energy, lasting at least 4 consecutive days and present most of the day, nearly every day" [2, p. 133]. These changes, which add an additional qualifier to the criteria, will likely result in a decrease in the prevalence of hypomanic episodes in the population. Results of the DSM-5 field trials suggest that the decrease in hypomania prevalence will result in a substantial reduction in bipolar II diagnosis, with the point prevalence of bipolar II disorder decreasing from 0.18 percent under DSM-IV criteria to 0.09 percent under DSM-5 criteria [75]. However, the results provided by the field trial also note that there was insufficient sample size (bipolar II was only assessed at one clinical site) to generate a stable prevalence estimate. National estimates derived from the NESARC suggest a lifetime DSM-IV prevalence of bipolar II disorder to be 1.12 percent. Considering the results of the field trials, the DSM-5 lifetime prevalence of bipolar II disorder to be very roughly between 0.56 percent (half that of the DSM-IV estimate) and the DSM-IV NESARC [92]. However, even these approximations must be made with caution because of the large variance around the estimate produced in the field trials.

The potential inclusion of bipolar II in the MHSS has three major considerations. First, is the overall prevalence, although a lifetime prevalence 1.12 percent is considered rare by epidemiological standards (rare is usually defined as less than 5 percent [93]), it translates into a large number of affected people. Second, lifetime treatment seeking among individuals with bipolar II is as high as 90 percent, suggesting that the disorder may place a demand on treatment services that exceeds that of other disorders (e.g., 27 percent among those with separation anxiety disorder) [94]. Third, there is the practical consideration of how many individuals with bipolar II are being identified as "cases" in the MHSS even though bipolar II is not assessed because they have a comorbid disorder that is assessed (this was the primary reason for bipolar II exclusion in prior MHSS). Evidence suggests that up to 48.0 percent of respondents in NESARC with a lifetime history of DSM-IV bipolar II disorder also met criteria for one of the anxiety disorders that is already assessed in MHSS [92]. Moreover, even though the hypomania for bipolar II is not being assessed in MHSS, MDE is assessed and individuals with bipolar II in the past year experiencing depression would be counted even if hypomania is not assessed.

Table 3.23 DSM-IV to DSM-5 Bipolar II Disorder Comparison

DSM-IV	DSM-5
Disorder Class: Mood Disorders	Disorder Class: Bipolar and Related Disorders
A. Presence (or history) of one or more major depressive episodes. B. Presence (or history) of at least one hypomanic Episode.	A. Criteria have been met for at least one hypomanic episode (see Table 3.8) and at least one major depressive episode (see Table 3.4).
C. There has never been a manic episode or a mixed episode.	B. There has never been a manic episode.
D. The mood symptoms in Criteria A and B are not better accounted for by schizoaffective disorder and are not superimposed on schizophrenia, schizophreniform disorder, delusional disorder, or psychotic disorder not otherwise specified.	C. The occurrence of the hypomanic episode(s) and major depressive episode(s) is not better explained by schizoaffective disorder, schizophrenia, schizophreniform disorder, delusional disorder, or other specified or unspecified schizophrenia spectrum and other psychotic disorder.

(continued)

Table 3.23 DSM-IV to DSM-5 Bipolar II Disorder Comparison (continued)

DSM-IV	DSM-5
E. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning. *Specify* current or most recent episode: Hypomanic: If currently (or most recently) in a Hypomanic Episode Depressed: If currently (or most recently) in a major depressive episode	D. The symptoms of depression or the unpredictability caused by frequent alternation between periods of depression and hypomania causes clinically significant distress or impairment in social, occupational, or other important areas of functioning. *Specify* current or most recent episode: Hypomanic Depressed
Specify (for current or most recent major depressive episode only if it is the most recent type of mood episode) Chronic With catatonic features With melancholic features With atypical features With postpartum onset *Specify*: Longitudinal course specifiers (with and without interepisode recovery) With seasonal pattern (applies only to the pattern of major depressive episodes) With rapid cycling	*Specify* course if full criteria for a mood episode are not currently met: In partial remission In full remission *Specify* severity if full criteria for a mood episode are met: Mild Moderate Severe *Specify* if: With anxious distress With mixed features With catatonia. With mood-congruent psychotic features With peripartum onset With seasonal pattern: Applies only to the pattern of major depressive episodes. With rapid cycling

3.4.4 Depressive Disorders

Premenstrual Dysphoric Disorder

Premenstrual dysphoric disorder (PMDD) had been included in DSM-IV as a "*criteria set provided for further study*," and has been included in DSM-5 as an official disorder. PMDD is characterized by low mood, anxiety, and irritability symptoms during the premenstrual phase of a woman's cycle that remits around the onset of menses. Criteria changes to PMDD (Table 3.24) from DSM-IV to DSM-5 include minimal wording changes to several of the criteria. This diagnosis continues to include several diagnostic exclusions for other medical conditions, mental health disorders, and the effects of substances used that may better explain the occurrence of symptoms. Past year prevalence estimates among menstruating women are between 1.8 and 5.8 percent. However, it is noted that estimates are significantly inflated if they are based on retrospective rather than prospective reports. This is an important consideration in determining whether PMDD should be included in the MHSS now that it is considered a verified condition.

Table 3.24 DSM-IV to DSM-5 Premenstrual Dysphoric Disorder Comparison

DSM-IV	DSM-5
Diagnostic Class: Conditions for further study[1]	Diagnostic Class: Depressive Disorders
A. In most menstrual cycles during the past year, five (or more) of the following symptoms occurred during the final week before the onset of menses, started to improve within a few days after the onset of menses, and were minimal or absent in the week postmenses, with at least one of the symptoms being either (1), (2), (3), or (4):	A. In the majority of menstrual cycles, at least five symptoms must be present in the final week before the onset of menses, start to *improve* within a few days after the onset of menses, and become *minimal* or absent in the week postmenses.
1. markedly depressed mood, feelings of hopelessness, or self-deprecating thoughts 2 marked anxiety, tension, feelings of being "keyed up" or "on edge" 3. marked affective lability (e.g., mood swings; feeling suddenly sad or tearful or increased sensitivity to rejection) 4. persistent and marked anger or irritability or increased interpersonal conflicts	B. One (or more) of the following symptoms may be present: 3. Marked depressed mood, feelings of hopelessness, or self-deprecating thoughts. 4. Marked anxiety, tension, and/or feelings of being keyed up or on edge. 1. Marked affective lability (e.g., mood swings; feeling suddenly sad or tearful or increased sensitivity to rejection). 2. Marked irritability or anger or increased interpersonal conflicts.
5. decreased interest in usual activities (e.g., work, school, friends, hobbies) 6. subjective sense of difficulty in concentration 7. lethargy, easy fatigability, or marked lack of energy 8. marked change in appetite, overeating, or specific food cravings 9. hypersomnia or insomnia 10. a subjective sense of being overwhelmed or out of control 11. other physical symptoms such as breast tenderness or swelling, joint or muscle pain, a sensation of "bloating," weight gain	C. One (or more) of the following symptoms must additionally be present, to reach a total of *five* symptoms when combined with symptoms from Criterion B above. 1. Decreased interest in usual activities (e.g., work, school, friends, hobbies). 2. Subjective difficulty in concentration. 3. Lethargy, easy fatigability, or marked lack of energy. 4. Marked change in appetite; overeating; or specific food cravings. 5. Hypersomnia or insomnia. 6. A sense of being overwhelmed or out of control. 7. Physical symptoms such as breast tenderness or swelling, joint or muscle pain, a sensation of "bloating," or weight gain.
Note: In menstruating females, the luteal phase corresponds to the period between ovulation and the onset of menses, and the follicular phase begins with menses. In nonmenstruating females (e.g., those who have had a hysterectomy), the timing of luteal and follicular phases may require measurement of circulating reproductive hormones.	Note: The symptoms in Criteria A-C must have been met for most menstrual cycles that occurred in the preceding year.
B. The disturbance markedly interferes with work or school or with usual social activities and relationships with others (e.g., avoidance of social activities, decreased productivity and efficiency at work or school).	D. The symptoms are associated with clinically significant distress or interferences with work, school, usual social activities or relationships with others (e.g., avoidance of social activities, decreased productivity and efficiency at work, school or home).

(continued)

Table 3.24 DSM-IV to DSM-5 Premenstrual Dysphoric Disorder Comparison (continued)

DSM-IV	DSM-5
C. The disturbance is not merely an exacerbation of the symptoms of another disorder, such as major depressive disorder, panic disorder, dysthymic disorder, or a personality disorder (although it may be superimposed on any of these disorders).	E. The disturbance is not merely an exacerbation of the symptoms of another disorder, such as major depressive disorder, panic disorder, persistent depressive disorder (dysthymia), or a personality disorder (although it may co-occur with any of these disorders).
D. Criteria A, B, and C should be confirmed by prospective daily ratings during at least two symptomatic cycles. (The diagnosis may be made provisionally prior to this confirmation.)	F. Criterion A should be confirmed by prospective daily ratings during at least two symptomatic cycles. (Note: The diagnosis may be made provisionally prior to this confirmation.)
	G. The symptoms are not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication, other treatment) or another medical condition (e.g., hyperthyroidism).

[1] In DSM-IV, individuals whose presentation meets these research criteria would be diagnosed as having depressive disorder not otherwise specified. The transient mood changes that many females experience around the time of menses should not be considered a mental disorder. Premenstrual dysphoric disorder should be considered only when the symptoms markedly interfere with work or school or with usual social activities and relationships with others.

3.4.5 Anxiety Disorders

Separation Anxiety Disorder

Separation anxiety disorder (SAD) is a psychological condition in which an individual experiences excessive anxiety, fear, or distress regarding separation from home or from people to whom the individual has a strong emotional attachment (e.g., a parent, grandparents, or siblings; Table 3.25). SAD is the inappropriate and excessive display of fear and distress when faced with situations of separation from the home or from a specific attachment figure. The anxiety that is expressed is categorized as being atypical of the expected developmental level and age and can be diagnosed among adults and children. The severity of the symptoms ranges from anticipatory uneasiness to full-blown anxiety about separation. SAD may cause significant negative effects within a person's everyday life, as well. These effects can be seen in areas of social and emotional functioning, family life, physical health, and within the academic context. The duration of this problem must persist for at least 4 weeks and must present itself before a person is 18 years of age to be diagnosed as SAD [2].

The primary change from DSM-IV to DSM-5 has been the reclassification of SAD from the Disorders Usually Diagnosed in Infancy, Childhood, and Adolescence section to Anxiety Disorders. Criteria changes from DSM-IV to DSM-5 are largely wording changes rather than major conceptual differences. The largest differences are related to broadening the criteria to better align with the presentation of SAD among adults. This is noteworthy as there is evidence that while prevalent among treatment samples, SAD is often not diagnosed among adults because of a clinical description that aligns only with childhood-based manifestations despite evidence of significant impairment among adults [95]. Data from the nationally representative NCS-R indicated the prevalence of DSM-IV SAD among adults to be 1.9 percent in the past 12 months and 6.6 percent across the lifetime [96]. Females were more likely to have SAD than males and

approximately a third of SAD cases in childhood persisted into adulthood. Comorbidity in SAD is high, with an estimated 88.5 percent of people meeting criteria for another disorder assessed in the NCS-R. This suggests that a large number of adult with SAD would be classified as having AMI through their endorsement of criteria for another disorder.

Table 3.25 DSM-IV to DSM-5 Separation Anxiety Disorder Comparison

DSM-IV	DSM-5
Disorder Class: Disorders Usually Diagnosed in Infancy, Childhood, and Adolescence	Disorder Class: Anxiety Disorders
A. Developmentally inappropriate and excessive anxiety concerning separation from home or from those to whom the individual is attached, as evidenced by three or more of the following: 1. recurrent excessive distress when separation from home or major attachment figures occurs or is anticipated 2. persistent and excessive worry about losing, or about possible harm befalling, major attachment figures 3. persistent and excessive worry that an untoward event will lead to separation from a major attachment figure (e.g., getting lost or being kidnapped) 4. persistent reluctance or refusal to go to school or elsewhere because of fear of separation 5. persistently and excessively fearful or reluctant to be alone or without major attachment figures at home or without significant adults in other settings 6. persistent reluctance or refusal to go to sleep without being near a major attachment figure or to sleep away from home 7. repeated nightmares involving the theme of separation 8. repeated complaints of physical symptoms (such as headaches, stomachaches, nausea, or vomiting) when separation from major attachment figures occurs or is anticipated	A. Developmentally inappropriate and excessive fear or anxiety concerning separation from those to whom the individual is attached, as evidenced by at least three of the following: 1. Recurrent excessive distress when anticipating or experiencing separation from home or from major attachment figures. 2. Persistent and excessive worry about losing major attachment figures or about possible harm to them, such as illness, injury, disasters, or death. 3. Persistent and excessive worry about experiencing an untoward event (e.g., getting lost, being kidnapped, having an accident, becoming ill) that causes separation from a major attachment figure. 4. Persistent reluctance or refusal to go out, away from home, to school, to work, or elsewhere because of fear of separation. 5. Persistent and excessive fear of or reluctance about being alone or without major attachment figures at home or in other settings. 6. Persistent reluctance or refusal to sleep away from home or to go to sleep without being near a major attachment figure. 7. SAME 8. SAME
B. The duration of the disturbance is at least 4 weeks.	B. The fear, anxiety, or avoidance is persistent, lasting at least 4 weeks in children and adolescents and typically 6 months or more in adults.
C. The onset is before age 18 years.	DROPPED
D. The disturbance causes clinically significant distress or impairment in social, academic (occupational), or other important areas of functioning.	SAME (part C)

(continued)

Table 3.25 DSM-IV to DSM-5 Separation Anxiety Disorder Comparison (continued)

DSM-IV	DSM-5
E. The disturbance does not occur exclusively during the course of a pervasive developmental disorder, schizophrenia, or other psychotic disorder and, in adolescents and adults, is not better accounted for by panic disorder with agoraphobia.	D. The disturbance is not better explained by another mental disorder, such as refusing to leave home because of excessive resistance to change in autism spectrum disorder; delusions or hallucinations concerning separation in psychotic disorders; refusal to go outside without a trusted companion in agoraphobia; worries about ill health or other harm befalling significant others in generalized anxiety disorder; or concerns about having an illness in illness anxiety disorder.
Specify if: Early Onset: if onset occurs before age 6 years	DROPPED

3.4.6 Obsessive-Compulsive and Related Disorders

Body Dysmorphic Disorder

Body dysmorphic disorder (BDD) is a mental illness characterized by a preoccupation with a perceived physical defect or flaw that is excessive and causes significant distress or functional impairment (Table 3.26). There have been several important changes in BDD criteria from DSM-IV to DSM-5. First, BDD has been reclassified from somatoform disorders in DSM-IV to obsessive-compulsive and related disorders under DSM-5. Second, DSM-5 BDD has an added diagnostic criterion indicating that the patient must have had repetitive behaviors or mental acts that were in response to preoccupations with perceived defects or flaws in physical appearance. Third, a "with muscle dysmorphia" specifier has been added to reflect a growing literature on the diagnostic validity and clinical utility of making this distinction in individuals with BDD. Finally, the delusional variant of BDD (which identifies individuals who are completely convinced that their perceived defects or flaws are truly abnormal in appearance) is no longer coded as both a delusional disorder (somatic type) and BDD. Under DSM-5 this presentation is designated only as BDD with the "absent insight/delusional beliefs" specifier and not as a delusional disorder.

Under DSM-IV criteria, BDD was a fairly common disorder affecting approximately 2.4 percent of the general population at any time (point prevalence) as estimated by a random sample telephone survey conducted in 2004 among 2,513 adults residing in the United States [97]. As a comparison, this is similar to point prevalence estimates of DSM-IV defined generalized anxiety disorder. Estimates under DSM-5 criteria are not currently available. However, criteria-induced changes in the estimates are likely to be minor. Over 90 percent of people with BDD report repetitive behaviors or mental acts in response to their preoccupation with a perceived physical deficit [98], and this was the only restrictive change to diagnostic criteria. BDD affects both males and females and has been identified in children as young as age 5 and as old as age 80 [98]. Moreover, patients with BDD report that unwanted, anxiety provoking obsessions related to BDD cause significant distress (e.g., avoidance of social situations due to anxiety of being ridiculed) and the repetitive behaviors are time consuming, functionally impairing (e.g., being late for work due to compulsive compensatory behavior), and can be dangerous (e.g., skin picking leading to infection). Suicidal thoughts is a significant concern among people with BDD;

suicidal ideation is as high as 80 percent in this population and one in four make a suicide attempt [98]. There are very few prospective studies of BDD, but retrospective studies suggest a mean onset of BDD around age 16 and indicate a chronic course with a low probability of remission without treatment [98]. The overall prevalence and significant clinical implications suggest that BDD may be suitable for inclusion in the MHSS. However, approximately 75 percent of those with BDD meet criteria for MDD as well, and therefore are also being captured as having SMI. However, the level of distress and severity of consequences associated with this disorder may merit BDD being included even if the comorbidity with other disorders is high.

Table 3.26 DSM-IV to DSM-5 Body Dysmorphic Disorder Comparison

DSM-IV	DSM-5
Disorder Class: Somatoform Disorders	Disorder Class: Obsessive-Compulsive and Related Disorders
A. Preoccupation with an imagined defect in appearance. If a slight physical anomaly is present, the person's concern is markedly excessive.	A. Preoccupation with one or more perceived defects or flaws in physical appearance that are not observable or appear slight to others. B. At some point during the course of the disorder, the individual has performed repetitive behaviors (e.g., mirror checking, excessive grooming, skin picking, reassurance seeking) or mental acts (e.g., comparing his or her appearance with that of others) in response to the appearance concerns.
B. The preoccupation causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.	SAME
C. The preoccupation is not better accounted for by another mental disorder (e.g., dissatisfaction with body shape and size in anorexia nervosa).	D. The appearance preoccupation is not better explained by concerns with body fat or weight in an individual whose symptoms meet diagnostic criteria for an eating disorder. *Specify* if: With muscle dysmorphia: The individual is preoccupied with the idea that his or her body build is too small or insufficiently muscular. This specifier is used even if the individual is preoccupied with other body areas, which is often the case. *Specify* if: Indicate degree of insight regarding body dysmorphic disorder beliefs (e.g., "I look ugly" or "I look deformed"). With good or fair insight: The individual recognizes that the body dysmorphic disorder beliefs are definitely or probably not true or that they may or may not be true. With poor insight: The individual thinks that the body dysmorphic beliefs are probably true. With absent insight/delusional beliefs: The individual is completely convinced that the body dysmorphic beliefs are true.

Trichotillomania

Trichotillomania (or hair-pulling disorder) is the compulsive urge to pull out (and in some cases, eat) one's own hair leading to noticeable hair loss, distress, and social or functional impairment (Table 3.27). Common areas for hair to be pulled out are the scalp, eyelashes, eyebrows, legs, arms, hands, and the pubic areas. Criteria changes from DSM-IV to DSM-5 include the reclassification of the disorder from impulse-control disorders to obsessive-compulsive and related disorders, the elimination of several criteria (sensations of tension prior and relief after the hair pulling), and the addition of a criteria specifying that there have been repeated attempts to decrease or stop hair pulling. The prevalence of lifetime or past year DSM-5 trichotillomania is unknown. Moreover, owing to the social implications the disorder is often underreported. The 12-month DSM-IV prevalence was estimated to be 1 percent to 2 percent among adults and adolescents [2,99]. Lifetime prevalence is estimated to be between 0.6 and 3.4 percent, with the disorder much more common among females [100]. However, these estimates come from studies that assessed college students and are not representative of the national population. Estimates of lifetime prevalence of trichotillomania in inpatient psychiatric samples have ranged from 1.3 to 4.4 percent [101]. The overall prevalence in the United States is unknown. Trichotillomania can cause significant distress to individuals with this disorder who may avoid social situations and cause permanent damage to the hair growth and quality and follows a chronic course with waxing and waning symptom levels [101].

Table 3.27 DSM-IV to DSM-5 Trichotillomania (Hair-Pulling Disorder) Comparison

DSM-IV	DSM-5
Disorder Class: Impulse-Control Disorders Not Classified Elsewhere	Disorder Class: Obsessive-Compulsive and Related Disorders
A. Recurrent pulling out of one's hair resulting in noticeable hair loss.	A. Recurrent pulling out of one's hair, resulting in hair loss.
B. An increasing sense of tension immediately before pulling out the hair or when attempting to resist the behavior.	DROPPED
	B. Repeated attempts to decrease or stop hair pulling.
C. Pleasure, gratification, or relief when pulling out the hair.	DROPPED
D. The disturbance is not better accounted for by another mental disorder and is not due to a general medical condition (e.g., a dermatological condition).	E. The hair pulling cannot be better explained by the symptoms of another mental disorder (e.g., attempts to improve a perceived defect or flaw in appearance, such as may be observed in body dysmorphic disorder). D. The hair pulling or hair loss cannot be attributed to another medical condition (e.g., a dermatological condition).
E. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.	SAME

It is difficult to evaluate the utility of adding trichotillomania to the MHSS because of the limited data available. Although there is evidence of a prevalence and clinical significance comparable to other disorders assessed in the MHSS, the prevalence estimates are based on data

that may not be generalizable to the national population and therefore NSDUH and MHSS. Moreover, data on the comorbidity of trichotillomania with other disorders is lacking. This makes it difficult to assess how many respondents with trichotillomania would be diagnosed with another, already assessed, disorder.

Excoriation (Skin Picking) Disorder

Excoriation disorder is an obsessive-compulsive–related disorder that is characterized by repetitive skin picking (Table 3.28). This disorder is associated with clinical distress and impairment as individuals often spend a great deal of time engaging in skin picking behaviors that results in lesions, possible infection, and scaring. The course of excoriation disorder is typically chronic, with waxing and waning in intensity in the absence of treatment. Excoriation is a new disorder in DSM-5 with an estimated lifetime prevalence of at least 1.4 percent among adults in the general population. The level of comorbidity in the general population is unknown but expected to be high, particularly with OCD, depression, and anxiety. Currently, there is little data available with regard to this disorder beyond general prevalence estimates. Prior to DSM-5, individuals with this disorder would likely have been characterized as having OCD or an impulse-control disorder not otherwise specified.

Table 3.28 Excoriation (Skin Picking) Disorder

DSM-5: Excoriation (skin picking) disorder
Disorder Class: Obsessive-Compulsive and Related Disorders
Recurrent skin picking resulting in skin lesions
Repeated attempts to decrease or stop skin picking
The skin picking causes clinically significant distress or impairment in social, occupational, or other important areas of functioning
The skin picking is not attributable to the physiological effects of a substance (e.g., cocaine) or another medical condition (e.g., scabies)
The skin picking is not better explained by symptoms of another mental disorder (e.g., delusions or tactile hallucinations in a psychotic disorder, attempts to improve a perceived defect or flaw in body dysmorphic disorder, stereotypies in stereotypic movement disorder, or intention to harm oneself in nonsuicidal self-injury).

NOTE: DSM-IV does not have criteria for this disorder, so no comparison is made.

Hoarding Disorder

Hoarding disorder is a new diagnosis in the DSM-5, and therefore was not a consideration in the prior development of the MHSS. Hoarding disorder is defined as a persistent difficulty in parting with possessions, which is independent of their value and results in a congestion of possessions that clutter living areas and compromise their intended use to such a degree that there is significant distress and impairment (Table 3.29). Compulsive hoarding behavior has been associated with health risks, impaired functioning, economic burden, and adverse effects on friends and family members. When clinically significant enough to impair functioning, hoarding can prevent typical uses of space so as to limit activities such as cooking, cleaning, moving through the house, and sleeping. It can also be dangerous if it puts the individual or others at risk from fire, falling, poor sanitation, and other health concerns. Hoarding is considered to be closely aligned with other obsessive and compulsive disorders (under DSM-IV hoarding was considered a symptom of OCD) and has been included in that disorder class. However, there are distinct differences that led to the disorder being separated from OCD [102].

For example, thoughts about hoarding are not usually perceived to be intrusive or unwanted but rather a normal part of the individual's thoughts. Moreover, distress is usually as a result of a third party's interference, such as relatives or the authorities, and as a result of the thought or action of removing the item rather than the acquisition.

DSM-5–based estimates for hoarding disorder range from 2 percent to 5 percent among adults based on a review of available epidemiological literature [2,102]. Descriptive epidemiological studies suggest that hoarding is found in similar proportion among males and females, with some sign of a slightly higher prevalence in males. Symptoms usually worsen across the lifespan and people with hoarding disorder frequently lack insight into their behavior. The average age of onset, based on retrospective studies, is estimated at age 12 to 13 with symptoms worsening over the lifespan and typically reaching clinical significance around the mid-30s [102]. Comorbidity among adults with hoarding disorder, like most disorders, is high, with approximately 75 percent having a comorbid depressive or anxiety disorder at some point in their lifetime [2].

Table 3.29 DSM-5 Hoarding Disorder

DSM-5: Hoarding Disorder
Disorder Class: Obsessive-Compulsive and Related Disorders
Persistent difficulty discarding or parting with possessions, regardless of their actual value.
This difficulty is due to a perceived need to save the items and to the distress associated with discarding them.
The difficulty discarding possessions results in the accumulation of possessions that congest and clutter active living areas and substantially compromises their intended use. If living areas are uncluttered, it is only because of the interventions of third parties (e.g., family members, cleaners, or the authorities).
The hoarding causes clinically significant distress or impairment in social, occupational, or other important areas of functioning (including maintaining a safe environment safe for oneself or others).
The hoarding is not attributable to another medical condition (e.g., brain injury, cerebrovascular disease, Prader-Willi syndrome).
The hoarding is not better explained by the symptoms of another mental disorder (e.g., obsessions in obsessive-compulsive disorder, decreased energy in major depressive disorder, delusions in schizophrenia or another psychotic disorder, cognitive defects in major neurocognitive disorder, restricted interests in autism spectrum disorder).
Specify if: With excessive acquisition: If difficulty discarding possessions is accompanied by excessive acquisition of items that are not needed or for which there is no available space. (Approximately 80 to 90 percent of individuals with hoarding disorder display this trait.) *Specify* if: With good or fair insight: The individual recognizes that hoarding-related beliefs and behaviors (pertaining to difficulty discarding items, clutter, or excessive acquisition) are problematic. With poor insight: The individual is mostly convinced that hoarding-related beliefs and behaviors (pertaining to difficulty discarding items, clutter, or excessive acquisition) are not problematic despite evidence to the contrary. With absent insight/delusional beliefs: The individual is completely convinced that hoarding-related beliefs and behaviors (pertaining to difficulty discarding items, clutter, or excessive acquisition) are not problematic despite evidence to the contrary.

Note: DSM-IV does not have criteria for this disorder, so no comparison is made.

3.4.7 Trauma- and Stressor-Related Disorders

Acute Stress Disorder

Acute stress disorder (ASD) is the development of symptoms following exposure to a traumatic event (i.e., an event resulting in extreme, disturbing, or unexpected fear; stress or pain; and that involves or threatens serious injury, perceived serious injury, or death). ASD is a potential physical and mental response to feelings (both perceived and real) of intense helplessness. In addition to exposure to a traumatic event, the criteria for an ASD diagnosis include 14 potential symptoms across five categories:

- intrusion symptoms (e.g., involuntary thoughts, memories, or dreams relating to the traumatic event);
- negative mood (i.e., the inability to experience positive emotions);
- dissociative symptoms (e.g., the inability to remember an important part of the traumatic event);
- avoidance symptoms (e.g., efforts are made to avoid external reminders of the traumatic event); and
- arousal symptoms (e.g., sleep disturbance or an exaggerated startle response).

A diagnosis of ASD requires 9 or more of the 14 symptoms developing or worsening after the traumatic event and persisting for 3 days to 1 month after the exposure. (Note: if the symptoms persist beyond 1 month after the exposure, a diagnosis of PTSD may be appropriate). The symptoms must cause clinically significant distress or impairment in at least one essential area of functioning.

In DSM-5, the criterion relating to experiencing a traumatic event is more limited than in DSM-IV (Table 3.30). DSM-IV required that exposure to a traumatic event may include "being confronted" with an event that involved actual or threatened death or serious injury or threat to the physical integrity of self or others. DSM-5 provides a more definitive description of being "confronted with an event" by stipulating that when a traumatic event involves learning about something that has happened to a close family member or close friend, the event must have been violent or accidental. Also, the DSM-IV criterion regarding the subjective reaction to the traumatic event (e.g., "the person's response involved intense fear, helplessness, or horror") has been eliminated in DSM-5. Based on evidence that acute posttraumatic reactions are very heterogeneous and that DSM-IV's emphasis on dissociative symptoms is overly restrictive, individuals may meet diagnostic criteria in DSM-5 for ASD if they exhibit at least 9 of 14 listed symptoms cross any of the categories.

Prevalence rates for ASD among the population are unavailable; however, prevalence among people exposed to trauma is estimated to be between 6 and 50 percent, depending on the nature of traumatic event [2]. A very rough estimate of the past year prevalence of ASD can be computed using a published estimate of the percentage of people who have experienced an event that qualifies as a traumatic event (21.0 percent [87]) by a published mean rate of ASD following various traumatic events (13.0 percent [103]) to arrive at a past year prevalence rate for ASD of

2.7 percent. ASD was introduced in DSM-IV as a means of identifying people having extreme stress reactions immediately following exposure to a traumatic event.

Table 3.30 DSM-IV to DSM-5 Acute Stress Disorder Comparison

DSM-IV	DSM-5
Disorder Class: Anxiety Disorders	Disorder Class: Trauma- and Stressor-Related Disorders
A. The person has been exposed to a traumatic event in which both of the following were present: 1. The person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others. 2. The person's response involved intense fear, helplessness, or horror.	A. Exposure to actual or threatened death, serious injury, or sexual violation in one (or more) of the following ways: 1. Directly experiencing the traumatic event(s). 2. Witnessing, in person, the event(s) as it occurred to others. 3. Learning that the event(s) occurred to a close family member or close friend. Note: In cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental. 4. Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responders collecting human remains, police officers repeatedly exposed to details of child abuse). Note: This does not apply to exposure through electronic media, television, movies, or pictures, unless this exposure is work related.
B. Either while experiencing or after experiencing the distressing event, the individual has three or more of the following dissociative symptoms: 1. a subjective sense of numbing, detachment, or absence of emotional responsiveness 2. a reduction in awareness of his or her surroundings 3. derealization 4. depersonalization 5. dissociative amnesia (i.e., inability to recall an important aspect of the trauma) C. The traumatic event is persistently re-experienced in at least one of the following ways: recurrent images, thoughts, dreams, illusions, flashback episodes, or a sense of reliving the experience; or distress on exposure to reminders of the traumatic event. D. Marked avoidance of stimuli that arouse recollections of the trauma (e.g., thoughts, feelings, conversations, activities, places, people). E. Marked symptoms of anxiety or increased arousal (e.g., difficulty sleeping, irritability, poor concentration, hypervigilance, exaggerated startle response, motor restlessness).	B. Presence of nine or more of the following symptoms from any of the five categories of intrusion, negative mood, dissociation, avoidance, and arousal, beginning or worsening after the traumatic event(s) occurred: Intrusion Symptoms 1. Recurrent, involuntary, and intrusive distressing memories of the traumatic event(s). Note: In children, repetitive play may occur in which themes or aspects of the traumatic event(s) occurred. 2. Recurrent distressing dreams in which the content and/or effect of the dream are related to the event(s). Note: In children, there may be frightening dreams without recognizable content. 3. Dissociative reactions (e.g., flashbacks) in which the individual feels or acts as if the traumatic event(s) were recurring. (Such reactions may occur on a continuum, with the most extreme expression being a complete loss of awareness of present surroundings.) Note: In children, trauma-specific reenactment may occur in play. 4. Intense or prolonged psychological distress or marked physiological reactions in response to internal or external cues that symbolize or resemble an aspect of the traumatic event(s). Negative Mood 5. Persistent inability to experience positive emotions (e.g., inability to experience happiness, satisfaction, or loving feelings).

(continued)

Table 3.30 DSM-IV to DSM-5 Acute Stress Disorder Comparison (continued)

DSM-IV	DSM-5
DSM-IV: Acute Stress Disorder	**DSM-5: Acute Stress Disorder**
	Dissociative Symptoms 6. An altered sense of the reality of one's surroundings or oneself (e.g., seeing oneself from another's perspective, being in a daze, time slowing). 7. Inability to remember an important aspect of the traumatic event(s) (typically due to dissociative amnesia and not to other factors such as head injury, alcohol, or drugs). Avoidance Symptoms 8. Efforts to avoid distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s). 9. Efforts to avoid external reminders (people, places, conversations, activities, objects, situations) that arouse distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s). Arousal Symptoms 10. Sleep disturbance (e.g., difficulty falling or staying asleep, restless sleep). 11. Irritable behavior and angry outbursts (with little or no provocation), typically expressed as verbal or physical aggression toward people or objects. 12. Hypervigilance. 13. Problems with concentration. 14. Exaggerated startle response.
F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning or impairs the individual's ability to pursue some necessary task such as obtaining necessary assistance or mobilizing personal resources by telling family members about the traumatic experience.	D. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
G. The disturbance lasts for a minimum of 2 days and a maximum of 4 weeks and occurs within 4 weeks of the traumatic event.	C. Duration of the disturbance (symptoms in Criterion B) is 3 days to 1 month after trauma exposure. Note: Symptoms typically begin immediately after the trauma, but persistence for at least 3 days and up to a month is needed to meet disorder criteria.
H. The disturbance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition, is not better accounted for by brief psychotic disorder, and is not merely an exacerbation of a preexisting Axis I or Axis II disorder.	E. The disturbance is not attributable to the physiological effects of a substance (e.g., medication or alcohol) or another medical condition (e.g., mild traumatic brain injury) and is not better explained by brief psychotic disorder.

The extant literature indicates that ASD has some overlap with two other disorders that have been measured in the MHSS—PTSD and adjustment disorder—although it is noted that

ASD is not reliably predictive of PTSD nor does ASD always precede PTSD [103,104]. Likewise, in the absence of an assessment for ASD, adjustment disorder may identify people who would have received an ASD diagnosis, but the diagnostic criteria for adjustment disorder are much broader than those for ASD [105]. Because the symptoms of ASD are relatively parallel to those of PTSD with the exception of the duration, it may be possible to assess for symptoms of ASD without adding appreciably to the burden of the clinical interview (by providing a coding option for an ASD diagnosis in the PTSD module if the requisite number of symptoms have been experienced and the duration has been at least 3 days but not more than 1 month).

3.4.8 Somatic Symptom and Related Disorders

Somatic Symptom Disorder

Somatic symptom disorder in DSM 5 reflects a significant change from the somatoform disorders included in DSM-IV (Table 3.31). Somatic symptom disorder is characterized by distressing somatic symptoms (i.e. physical symptoms such as pain or discomfort), that result in excessive thoughts, anxiety, or concern about health. In contrast, the somatoform disorders in DSM-IV had required that there be multiple somatic symptoms that were medically unexplained. Because of this dramatic change in the diagnostic criteria, prevalence rates of this disorder are unknown.

Table 3.31 DSM-IV to DSM-5 Somatic Symptom Disorder Comparison

DSM-IV	DSM-5
Name: Somatization Disorder	Name: Somatic Symptom Disorder
Disorder Class: Somatoform Disorders	Disorder Class: Somatic Symptom and Related Disorder
A. A history of many physical complaints beginning before age 30 years that occur over a period of several years and result in treatment being sought or significant impairment in social, occupational, or other important areas of functioning.	B. Excessive thoughts, feelings, or behaviors related to the somatic symptoms or associated health concerns as manifested by at least one of the following: 1. Disproportionate and persistent thoughts about the seriousness of one's symptoms. 2. Persistently high level of anxiety about health or symptoms. 3. Excessive time and energy devoted to these symptoms or health concerns.
	C. Although any one somatic symptom may not be continuously present, the state of being symptomatic is persistent (typically more than 6 months).

(continued)

Table 3.31 DSM-IV to DSM-5 Somatic Symptom Disorder Comparison (continued)

DSM-IV	DSM-5
B. Each of the following criteria must have been met, with individual symptoms occurring at any time during the course of the disturbance: 1. *four pain symptoms*: a history of pain related to at least four different sites or functions (e.g., head, abdomen, back, joints, extremities, chest, rectum, during menstruation, during sexual intercourse, or during urination) 2. *two gastrointestinal symptoms*: a history of at least two gastrointestinal symptoms other than pain (e.g., nausea, bloating, vomiting other than during pregnancy, diarrhea, or intolerance of several different foods) 3. *one sexual symptom*: a history of at least one sexual or reproductive symptom other than pain (e.g., sexual indifference, erectile or ejaculatory dysfunction, irregular menses, excessive menstrual bleeding, vomiting throughout pregnancy) 4. *one pseudoneurological symptom*: a history of at least one symptom or deficit suggesting a neurological condition not limited to pain (conversion symptoms such as impaired coordination or balance, paralysis, or localized weakness, difficulty swallowing or lump in throat, aphonia, urinary retention, hallucinations, loss of touch or pain sensation, double vision, blindness, deafness, seizures; dissociative symptoms such as amnesia; or loss of consciousness other than fainting)	A. One or more somatic symptoms that are distressing or result in significant disruption of daily life.
C. Either (1) or (2): 1. after appropriate investigation, each of the symptoms in Criterion B cannot be fully explained by a known general medical condition or the direct effects of a substance (e.g., a drug of abuse, a medication) 2. when there is a related general medical condition, the physical complaints or resulting social or occupational impairment are in excess of what would be expected from the history, physical examination, or laboratory findings	DROPPED
D. The symptoms are not intentionally feigned or produced (as in factitious disorder or malingering).	DROPPED

(continued)

Table 3.31 DSM-IV to DSM-5 Somatic Symptom Disorder Comparison (continued)

DSM-IV	DSM-5
	Specify if: With predominant pain (previously pain disorder): This specifier is for individuals whose somatic symptoms predominantly involve pain. *Specify* if: Persistent: A persistent course is characterized by severe symptoms, marked impairment, and long duration (more than 6 months). *Specify* current severity: Mild: Only one of the symptoms specified in Criterion B is fulfilled. Moderate: Two or more of the symptoms specified in Criterion B are fulfilled. Severe: Two or more of the symptoms specified in Criterion B are fulfilled, plus there are multiple somatic complaints (or one very severe somatic symptom).

The potential inclusion of somatic symptom disorder to the MHSS has two major considerations. First, there are multiple mental health disorders that may include somatic symptoms (e.g., depressive disorders, panic disorder, and obsessive-compulsive disorder). If the somatic complaints are experienced solely in the context of another disorder, then a diagnosis of somatic symptom disorder is not appropriate. Second, in cases where the somatic symptoms are associated with a physical illness, the degree of impairment must exceed the impairment expected to result from the physical illness. This may present challenges within the context of a telephone assessment conducted by a person not trained in impairment associated with physical illnesses.

Illness Anxiety Disorder

Formerly known as hypochondriasis in DSM-IV, illness anxiety disorder is a somatic symptom disorder characterized by the excessive preoccupancy or worry about having a serious illness in the absence of actual medical condition. Illness anxiety disorder often involves fears that minor bodily symptoms may indicate a serious illness, constant self-examination and self-diagnosis, and a preoccupation with one's body. Many individuals with illness anxiety disorder express doubt and disbelief in the doctors' diagnosis, and report that doctors' reassurance about an absence of a serious medical condition is unconvincing or short-lasting. The disorder can become a disabling torment for the individual, as well as his or her family and friends.

Illness anxiety disorder has undergone a number of criteria changes from its predecessor, hypochondriasis (Table 3.32). These changes reflect not only changes in understanding of the disorder itself, but the understanding of the entire class of somatoform disorders. In addition, hypochondriasis was renamed largely because the name was perceived as pejorative and not conducive to an effective therapeutic relationship. As a result of the criteria changes, most

individuals who would have been diagnosed with hypochondriasis under DSM-IV criteria would now receive a DSM-5 diagnosis of somatic symptom disorder because of the significant somatic symptoms they report. In DSM-5, individuals with high health anxiety without somatic symptoms would receive a diagnosis of illness anxiety disorder (unless their health anxiety was better explained by a primary anxiety disorder, such as generalized anxiety disorder). These changes would result in significant reduction in the prevalence estimates of illness anxiety disorder compared to hypochondriasis. The DSM-5 estimates that illness anxiety disorder affects between 1.3 percent to 10.0 percent of adults in the general population over a 1- to 2-year period with an equal distribution between males and females [5]. However, there are little data on DSM-5 illness anxiety disorder and no data on levels of comorbidity with other disorders. Although the prevalence of illness anxiety disorder prompts consideration for inclusion in MHSS, the lack of data makes it difficult to compare the benefit of its addition against the added respondent burden.

Table 3.32 DSM-IV to DSM-5 Illness Anxiety Disorder Comparison

DSM-IV	DSM-5
Name: Hypochondriasis	Name: Illness Anxiety Disorder
Disorder Class: Somatoform Disorders	Disorder Class: Somatic Symptom and Related Disorder
A. Preoccupation with fears of having, or the idea that one has, a serious disease based on the person's misinterpretation of bodily symptoms.	A. Preoccupation with having or acquiring a serious illness.
B. The preoccupation persists despite appropriate medical evaluation and reassurance.	DROPPED
	B. Somatic symptoms are not present or, if present, are only mild in intensity. If another medical condition is present or there is a high risk for developing a medical condition (e.g., strong family history is present), the preoccupation is clearly excessive or disproportionate.
C. The belief in Criterion A is not of delusional intensity (as in delusional disorder, somatic type) and is not restricted to a circumscribed concern about appearance (as in body dysmorphic disorder).	DROPPED
	C. There is a high level of anxiety about health, and the individual is easily alarmed about personal health status.
D. The preoccupation causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.	DROPPED
	D. The individual performs excessive health-related behaviors (e.g., repeatedly checks his or her body for signs of illness) or exhibits maladaptive avoidance (e.g., avoids doctor appointments and hospitals).

(continued)

Table 3.32 DSM-IV to DSM-5 Illness Anxiety Disorder Comparison (continued)

DSM-IV	DSM-5
E. The duration of the disturbance is at least 6 months.	E. Illness preoccupation has been present for at least 6 months, but the specific illness that is feared may change over that period of time.
F. The preoccupation is not better accounted for by generalized anxiety disorder, obsessive-compulsive disorder, panic disorder, a major depressive episode, separation anxiety, or another somatoform disorder.	F. The illness-related preoccupation is not better explained by another mental disorder, such as somatic symptom disorder, panic disorder, generalized anxiety disorder, body dysmorphic disorder, obsessive-compulsive disorder, or delusional disorder, somatic type.
Specify if: With poor insight: If, for most of the time during the current episode, the person does not recognize that the concern about having a serious illness is excessive or unreasonable.	*Specify* whether: Care-seeking type: Medical care, including physician visits or undergoing tests and procedures, is frequently used. Care-avoidant type: Medical care is rarely used.

3.4.9 Feeding and Eating Disorders

Avoidant/Restrictive Food Intake Disorder.

Avoidant/restrictive food intake disorder is a new disorder in DSM-5. It is derived from feeding disorder of infancy or early childhood in DSM-IV, but has been broadened to also include restrictive or avoidant eating beginning after the age of 6 and adapted to include symptoms of restrictive or avoidant food intake that may be seen in adolescence and adulthood. Avoidant/restrictive food intake disorder is differentiated from other feeding and eating disorders (i.e., anorexia nervosa and bulimia nervosa). In avoidant/restrictive food intake disorder, food is restricted or avoided because of sensory characteristics of the food (e.g., texture, odor, color) rather than concerns about weight or body weight/shape. The majority of changes in disorders and diagnostic criteria for eating disorders have been aimed at providing categorizations that reflect clinically meaningful differences between diagnoses (Table 3.33). Using the DSM-IV classifications, many people with an eating disorder received a diagnosis of eating disorder—not otherwise specified (ED-NOS) rather than either anorexia nervosa or bulimia nervosa. Several studies identified homogeneous groupings of symptoms among people diagnosed with ED-NOS; these groupings are reflected in the new disorders introduced in DSM-5 such as avoidant/restrictive food intake disorder and binge eating disorder [106-108].

Criterion A, which concerns how this disorder may be manifested, has been made more descriptive in the DSM-5 than its counterpart in the DSM-IV. Specifically, it calls for either significant weight loss, significant nutritional deficiency, dependence on tube feeding or nutritional supplements, or marked interference with psychosocial functioning. As noted previously, the restriction that onset must have occurred by age 6 has been removed. Additional diagnostic exclusions have been added; the symptoms should not be due to another medical condition (e.g., allergies or gastrointestinal disease) or another mental health disorder (e.g., autism spectrum disorder or specific phobia).

Table 3.33 DSM-IV to DSM-5 Avoidant/Restrictive Food Intake Disorder Comparison

DSM-IV	DSM-5
Name: Feeding Disorder of Infancy or Early Childhood	Name: Avoidant/Restrictive Food Intake Disorder
Disorder Class: Disorders Usually Diagnosed in Infancy, Childhood, and Adolescence	Disorder Class: Feeding and Eating Disorders
A. Feeding disturbance as manifested by persistent failure to eat adequately with significant failure to gain weight or significant loss of weight over at least 1 month. B. The disturbance is not due to an associated gastrointestinal or other general medical condition (e.g., esophageal reflux).	A. An eating or feeding disturbance (e.g., apparent lack of interest in eating or food; avoidance based on the sensory characteristics of food; concern about aversive consequences of eating) as manifested by persistent failure to meet appropriate nutritional and/or energy needs associated with one (or more) of the following: 1. Significant weight loss (or failure to achieve expected weight gain or faltering growth in children) 2. Significant nutritional deficiency. 3. Dependence on enteral feeding or oral nutritional supplements. 4. Marked interference with psychosocial functioning. D. The eating disturbance is not attributable to a concurrent medical condition or not better explained by another mental disorder. When the eating disturbance occurs in the context of another mental disorder, the severity of the eating disturbance exceeds that routinely associated with the condition or disorder and warrants additional clinical attention.
C. The disturbance is not better accounted for by another mental disorder (e.g., rumination disorder) or by lack of available food. D. The onset is before age 6 years.	B. The disturbance is not better explained by lack of available food or by an associated culturally sanctioned practice. C. The eating disturbance does not occur exclusively during the course of anorexia nervosa or bulimia nervosa, and there is no evidence of a disturbance in the way in which one's body weight or shape is experienced. DROPPED Specify if: In remission: After full criteria for avoidance/restrictive food intake disorder were previously met, the criteria have not been met for a sustained period of time.

Prevalence rates for this disorder among adults are unavailable. With the exception of pica (persistent eating of nonfood substances), disorders categorized as feeding or eating disorders are hierarchical and mutually exclusive. A diagnosis of anorexia nervosa precludes diagnoses of bulimia nervosa, binge eating disorder, and avoidant/restrictive food intake disorder; and a diagnosis of bulimia nervosa precludes a diagnosis of binge eating disorder and avoidant/restrictive food intake disorder.

Inclusion of avoidant/restrictive food intake disorder among disorders assessed in the MHSS may present several challenges because of the nature of several of the symptoms. Criterion A calls for evidence of an eating disturbance that results in a persistent desire to meet

appropriate nutritional and/or energy needs. Potential signs of this include potential weight loss or a significant nutritional deficiency. Both of these indicators are typically assessed through a physical exam, often including laboratory tests. The MHSS is a telephone interview that precludes the ability of interviewers to observe visual signs of unhealthy weight loss or nutritional deficiencies. Although the interviewers will have training in psychiatric assessment, few will likely have training in nutrition or be able to effectively probe for physical symptoms related to deficiencies of specific nutrients. Likewise, Criteria B and D exclude eating disturbances that result from cultural practices, lack of food, or other health conditions. Participants who do not have access to physical and/or mental health treatment may be less knowledgeable about whether they have other conditions that may contribute to their eating disturbance.

Binge Eating Disorder

Binge eating disorder had been included in DSM-IV as a "*criteria set provided for further study*," and has been included in DSM-5 as a disorder. This disorder is characterized by binge or out of control eating accompanied by significant distress about eating. Binge eating disorder is differentiated from bulimia nervosa in that there are no inappropriate compensatory behaviors (e.g., purging or excessive exercise) seen in binge eating disorder. As noted previously, this disorder was added into DSM-5 because a significant subset of people presenting with an eating disorder had exhibited binge eating behaviors that were not accompanied by any behaviors intended to compensate for the binge eating [106,109,110].

Changes between the criteria enumerated in DSM-IV and those in DSM-5 are minimal (Table 3.34). The only change, which represents a less stringent requirement in DSM-5, reduces the minimum frequency/duration of the binge eating behavior to at least once a week for 3 months (it had been at least 2 days a week for 6 months). The 12-month prevalence of binge eating disorder under DSM-IV among people aged 12 or older is 1.6 percent among females and 0.8 percent among males [2], which is higher than the 12-month prevalence of both eating disorders included in the MHSS. The 12-month prevalence of anorexia nervosa among young females is approximately 0.4 percent and the 12-month prevalence of bulimia nervosa among young females is between 1.0 and 1.5 percent [2]. The male-to-female ratio for binge eating disorder is far less skewed than those of anorexia nervosa and bulimia nervosa [111]. These are important considerations in making the decision about the inclusion of binge eating disorder in the assessment of feeding and eating disorders. The inclusion of binge eating in a DSM 5-based MHSS would likely improve the accuracy of prevalence rates for feeding and eating disorders derived from the MHSS data.

Table 3.34 DSM-IV to DSM-5 Binge-Eating Disorder Comparison

DSM-IV	DSM-5
Disorder Class: Criteria Sets and Axes Provided for Further Study	Disorder Class: Feeding and Eating Disorders
A. Recurrent episodes of binge eating. An episode of binge eating is characterized by both of the following: 1. Eating, in a discrete period of time (e.g., within any 2-hour period), an amount of food that is definitely larger than most people would eat in a similar period of time under similar circumstances 2. A sense of lack of control over eating during the episode (e.g., a feeling that one cannot stop eating or control what or how much one is eating)	SAME
B. The binge-eating episodes are associated with three (or more) of the following: 1. Eating much more rapidly than normal 2. Eating until feeling uncomfortably full 3. Eating large amounts of food when not feeling physically hungry 4. Eating alone because of feeling embarrassed by how much one is eating 5. Feeling disgusted with oneself, depressed, or very guilty after overeating	SAME
C. Marked distress regarding binge eating is present.	SAME
D. The binge eating occurs, on average, at least 2 days a week for 6 months. Note: The method of determining frequency differs from that used for bulimia nervosa; future research should address whether the preferred method of setting a frequency threshold is counting the number of days on which binges occur or counting the number of episodes of binge eating.	D. The binge eating occurs, on average, at least once a week for 3 months.
E. The binge eating is not associated with the regular use of inappropriate compensatory behaviors (e.g., purging, fasting, excessive exercise) and does not occur exclusively during the course of anorexia nervosa or bulimia nervosa.	SAME

(continued)

Table 3.34 DSM-IV to DSM-5 Binge-Eating Disorder Comparison (continued)

DSM-IV	DSM-5
	Specify if: In partial remission: After full criteria for binge-eating disorder were previously met, binge eating occurs at an average frequency of less than one episode per week for a sustained period of time. In full remission: After full criteria for binge-eating disorder were previously met, none of the criteria have been met for a sustained period of time. *Specify* current severity: Severity is also noted in the diagnosis, from mild to extreme: Mild: 1-3 binge-eating episodes per week Moderate: 4-7 binge-eating episodes per week Severe: 8-13 binge-eating episodes per week Extreme: 14 or more binge-eating episodes per week

3.4.10 Sleep-Wake Disorders

Hypersomnolence Disorder

Hypersomnolence disorder is characterized by excessive sleepiness despite having gotten at least 7 hours of sleep that results in significant distress or impairment. Criteria changes to hypersomnolence disorder (Table 3.35) from DSM-IV to DSM-5 have been made to better define the extent of the sleep/waking disturbance. Minimal wording changes have been made to several of the criteria. Criterion A has been more explicitly defined, and the frequency/duration have been revised to require that hypersomnolence occurs at least three times per week for at least 3 months (from almost daily for at least a month). This diagnosis continues to include several diagnostic exclusions for other medical conditions, mental health disorders, and the effects of substances used that may better explain the occurrence of symptoms.

The point prevalence of DSM-5 hypersomnolence disorder among U.S. adults is estimated at about 1 percent [2]. Mental health disorders (e.g., depression and anxiety) and other medical disorders (cancer, heart disease, Parkinson's disease) often accompany symptoms of sleep-wake disorders. The sleep-wake class of disorders have clinical significance in that they identify sleep-wake symptoms that will not be improved through treatment of the accompanying disorders and require targeted treatment [112]. There is frequently a complex, bidirectional relationship between sleep-wake disorders and other mental health and medical problems. Identifying and understanding what factors may be affecting a participant's sleep and waking behaviors is a formidable task. The MHSS is a telephone interview, which precludes the ability of interviewers to observe visual signs of physical disorders or other mental health disorders. MHSS participants who do not have access to physical and/or mental health treatment may be

less knowledgeable about whether they have other conditions that may better explain their hypersomnolence. Based on the difficulty of adequately assessing all of the diagnostic exclusions that must be considered and the high comorbidity, it appears that hypersomnolence disorder should continue to be excluded in the MHSS.

Table 3.35 DSM-IV to DSM-5 Hypersomnolence Disorder Comparison

DSM-IV	DSM-5
Name Primary Hypersomnia	Name: Hypersomnolence Disorder
Disorder Class: Sleep Disorders	Disorder Class: Sleep-Wake Disorders
A. The predominant complaint is excessive sleepiness for at least 1 month (or less if recurrent) as evidenced by either prolonged sleep episodes or daytime sleep episodes that occur almost daily.	A. Self-reported excessive sleepiness (hypersomnolence) despite a main sleep period lasting at least 7 hours, with at least one of the following symptoms: 1. Recurrent periods of sleep or lapses into sleep within the same day. 2. A prolonged main sleep episode of more than 9 hours per day that is nonrestorative (i.e., unrefreshing). 3. Difficulty being fully awake after abrupt awakening.
	B. The hypersomnolence occurs at least three times per week, for at least 3 months.
B. The excessive sleepiness causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.	C. The hypersomnolence is accompanied by significant distress or impairment in cognitive, social, occupational, or other important areas of functioning.
C. The excessive sleepiness is not better accounted for by insomnia and does not occur exclusively during the course of another sleep disorder (e.g., narcolepsy, breathing-related sleep disorder, circadian rhythm sleep disorder, or a parasomnia) and cannot be accounted for by an inadequate amount of sleep.	D. The hypersomnolence is not better explained by and does not occur exclusively during the course of another sleep disorder (e.g., narcolepsy, breathing-related sleep disorder, circadian rhythm sleep-wake disorder, or a parasomnia).
D. The disturbance does not occur exclusively during the course of another mental disorder.	F. Coexisting mental and medical disorders do not adequately explain the predominant complaint of hypersomnolence.
E. The disturbance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition.	E. The hypersomnolence is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication).
Specify if: Recurrent: If there are periods of excessive sleepiness that last at least 3 days occurring several times a year for at least 2 years	*Specify* if: With mental disorder, including substance use disorders With medical condition With another sleep disorder Coding note: The code 780.54 (G47. 10) applies to all three specifiers. Code also the relevant associated mental disorder, medical condition, or other sleep disorder immediately after the code for hypersomnolence disorder in order to indicate the association.

(continued)

Table 3.35 DSM-IV to DSM-5 Hypersomnolence Disorder Comparison (continued)

DSM-IV	DSM-5:
	Specify if: Acute: Duration of less than 1 month. Subacute: Duration of 1-3 months. Persistent: Duration of more than 3 months. *Specify* current severity: Specify severity based on degree of difficulty maintaining daytime alertness as manifested by the occurrence of multiple attacks of irresistible sleepiness within any given day occurring, for example, while sedentary, driving, visiting with friends, or working. Mild: Difficulty maintaining daytime alertness 1-2 days/week. Moderate: Difficulty maintaining daytime alertness 3-4 days/week. Severe: Difficulty maintaining daytime alertness 5-7 days/week.

Insomnia Disorder

Insomnia disorder is characterized by poor sleep quality or quantity, including having difficulty falling asleep, remaining asleep, or returning to sleep after awakening. Criteria changes to insomnia disorder (Table 3.36) from DSM-IV to DSM-5 have been made to better define the extent of the sleep disturbance. Minimal wording changes have been made to several of the criteria. Criterion A has been more explicitly defined, and the duration has been revised to require that insomnia is experienced at least 3 nights per week for at least 3 months (rather than 1 month as in DSM-IV). This diagnosis continues to include several diagnostic exclusions for other medical conditions, mental health disorders, and the effects of substances used that may better explain the occurrence of symptoms.

The point prevalence of DSM-5 defined insomnia disorder among adults is estimated at about 6 to 10 percent [2]. Mental health disorders (e.g., depression and anxiety) and other medical disorders (cancer, heart disease, Parkinson's disease) often accompany symptoms of sleep disorders. The sleep-wake class of disorders have clinical significance in that they identify sleep-wake symptoms that will not be improved through treatment of the accompanying disorders and require targeted treatment [112]. There is frequently a complex, bidirectional relationship between sleep-wake disorders and other mental health and medical problems. Identifying and understanding what factors may be affecting a participant's sleep and waking behaviors is a formidable task. The MHSS is administered over the telephone, which precludes the ability of interviewers to observe visual signs of physical disorders or other mental health disorders. MHSS participants who do not have access to physical and/or mental health treatment may be less knowledgeable about whether they have other conditions that may better explain their insomnia. The potential inclusion of insomnia disorder to the MHSS has two major considerations. First, there is a high prevalence of this disorder (6 to 10 percent). Second, there is

considerable difficulty of adequately assessing all of the diagnostic exclusions, which would likely add a significant burden to the clinical interview.

Table 3.36 DSM-IV to DSM-5 Insomnia Disorder Comparison

DSM-IV	DSM-5
Name: Primary Insomnia	Name: Insomnia Disorder
Disorder Class: Sleep Disorders	Disorder Class: Sleep-Wake Disorders
A. The predominant complaint is difficulty initiating or maintaining sleep, or nonrestorative sleep, for at least 1 month.	A. A predominant complaint of dissatisfaction with sleep quantity or quality, associated with one (or more) of the following symptoms: 1. Difficulty initiating sleep. (In children, this may manifest as difficulty initiating sleep without caregiver intervention.) 2. Difficulty maintaining sleep, characterized by frequent awakenings or problems returning to sleep after awakenings. (In children, this may manifest as difficulty returning to sleep without caregiver intervention.) 3. Early-morning awakening with inability to return to sleep. D. The sleep difficulty is present for at least 3 months.
B. The sleep disturbance (or associated daytime fatigue) causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.	B. The sleep disturbance causes clinically significant distress or impairment in social, occupational, educational, academic, behavioral, or other important areas of functioning.
	C. The sleep difficulty occurs at least 3 nights per week.
	E. The sleep difficulty occurs despite adequate opportunity for sleep.
C. The sleep disturbance does not occur exclusively during the course of narcolepsy, breathing-related sleep disorder, circadian rhythm sleep disorder, or a parasomnia.	F. The insomnia is not better explained by and does not occur exclusively during the course of another sleep-wake disorder (e.g., narcolepsy, a breathing-related sleep disorder, a circadian rhythm sleep-wake disorder, a parasomnia).
D. The disturbance does not occur exclusively during the course of another mental disorder (e.g., major depressive disorder, generalized anxiety disorder, a delirium).	H. Coexisting mental disorders and medical conditions do not adequately explain the predominant complaint of insomnia.
E. The disturbance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition.	G. The insomnia is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication).

(continued)

Table 3.36 DSM-IV to DSM-5 Insomnia Disorder Comparison (continued)

DSM-IV	DSM-5
	Specify if: With nonsleep disorder mental comorbidity, including substance use disorders With other medical comorbidity With other sleep disorder Coding note: The code 780.52 (G47.00) applies to all three specifiers. Code also the relevant associated mental disorder, medical condition, or other sleep disorder immediately after the code for insomnia disorder in order to indicate the association. *Specify* if: Episodic: Symptoms last at least 1 month but less than 3 months. Persistent: Symptoms last 3 months or longer. Recurrent: Two (or more) episodes within the space of 1 year. Note: Acute and short-term insomnia (i.e., symptoms lasting less than 3 months but otherwise meeting all criteria with regard to frequency, intensity, distress, and/or impairment) should be coded as another specified insomnia disorder

3.4.11 Disruptive, Impulse-Control, and Conduct Disorders

Conduct Disorder

Conduct disorder is a disorder classified in DSM-5 under "Disruptive, Impulse-Control, and Conduct Disorders." Conduct disorder is usually first diagnosed in childhood and was categorized in DSM-IV under the category of the same name (Table 3.37). Conduct disorder is characterized by repetitive and persistent pattern of behavior that violates the rights of others or major societal norms. People with conduct disorder often show aggression to people and animals, destruction of property, deceitfulness or theft, and/or serious violations of rules. Criteria changes between DSM-IV and DSM-5 are expected to impact prevalence estimates.

Table 3.37 DSM-IV to DSM-5 Conduct Disorder Comparison

DSM-IV: Conduct Disorder	DSM-5: Conduct Disorder
A. A repetitive and persistent pattern of behavior in which the basic rights of others or major age-appropriate societal norms or rules are violated, as manifested by the presence of three (or more) of the following criteria in the past 12 months, with at least one criterion present in the past 6 months:	A. A repetitive and persistent pattern of behavior in which the basic rights of others or major age-appropriate societal norms or rules are violated, as manifested by the presence of three (or more) of the following 15 criteria in the past 12 months from any of the categories below, with at least one criterion present in the past 6 months:

(continued)

Table 3.37 DSM-IV to DSM-5 Conduct Disorder Comparison (continued)

DSM-IV: Conduct Disorder	DSM-5: Conduct Disorder
Aggression to people and animals	**Aggression to people and animals**
1. often bullies, threatens, or intimidates others	1. SAME
2. often initiates physical fights	2. SAME
3. has used a weapon that can cause serious physical harm to others (e.g., a bat, brick, broken bottle, knife, gun)	3. SAME
4. has been physically cruel to people	4. SAME
5. has been physically cruel to animals	5. SAME
6. has stolen while confronting a victim (e.g., mugging, purse snatching, extortion, armed robbery)	6. SAME
7. has forced someone into sexual activity	7. SAME
Destruction of property	**Destruction of property**
8 has deliberately engaged in fire setting with the intention of causing serious damage	8. SAME
9. has deliberately destroyed others' property (other than by fire setting)	9. SAME
Deceitfulness or theft	**Deceitfulness or theft**
10. has broken into someone else's house, building, or car	10. SAME
11. often lies to obtain goods or favors or to avoid obligations (i.e., "cons" others)	11. SAME
12. has stolen items of nontrivial value without confronting a victim (e.g., shoplifting, but without breaking and entering; forgery)	12. SAME
Serious violations of rules	**Serious violations of rules**
13. often stays out at night despite parental prohibitions, beginning before age 13 years	13. SAME
14. has run away from home overnight at least twice while living in parental or parental surrogate home (or once without returning for a lengthy period)	14. SAME
15. is often truant from school, beginning before age 13 years	15. SAME
B. The disturbance in behavior causes clinically significant impairment in social, academic, or occupational functioning.	B. SAME
C. If the individual is age 18 years or older, criteria are not met for Antisocial Personality Disorder.	C. SAME

(continued)

Table 3.37 DSM-IV to DSM-5 Conduct Disorder Comparison (continued)

DSM-IV: Conduct Disorder	DSM-5: Conduct Disorder
Code based on age at onset: 312.81 Conduct Disorder, Childhood-Onset Type: onset of at least one criterion characteristic of Conduct Disorder prior to age 10 years 312.82 Conduct Disorder, Adolescent-Onset Type: absence of any criteria characteristic of Conduct Disorder prior to age 10 years 312.89 Conduct Disorder, Unspecified Onset: age at onset is not known	*Specify* whether: 312.81 (F91.1) Conduct Disorder, Childhood-Onset Type: Individuals show at least one symptom characteristic of conduct disorder prior to age 10 years 312.82 (F91.2) Conduct Disorder, Adolescent-Onset Type: Individuals show now symptom characteristic of conduct disorder prior to age 10 years 312.89 (F91.9) Conduct Disorder, Unspecified Onset: Criteria for a diagnosis or conduct disorder are met, but there is not enough information available to determine whether the onset of the first symptom was before or after age 10 years.
	Specify if: With limited prosocial emotions: To qualify for this specifier, an individual must have displayed at least two of the following characteristics persistently over at least 12 months and in multiple relationships and setting. These characteristics reflect the individual's typical pattern of interpersonal and emotional functioning over this period and not just occasional occurrences in some situations. Thus, to assess the criteria for the specifier, multiple information sources are necessary. In addition to the individual's self-report, it is necessary to consider reports by others who have known the individual for extended periods of time (e.g., parents, teachers, coworkers, extended family members, peers). Lack of remorse or guilt: Does not feel bad or guilty when he/she does something wrong (excluding remorse when expressed only when caught and/or facing punishment). The individual shows a general lack of concern about the negative consequences of his or her actions. For example, the individual is not remorseful after hurting someone or does not care about the consequences of breaking rules.
	Callous—lack of empathy: Disregards and is unconcerned about the feelings of others. The individual is described as cold and uncaring. The person appears more concerned about the effects of his or her actions on himself or herself, rather than their effects on others, even when they result in substantial harm to others. Unconcerned about performance: Does not show concern about poor/problematic performance at school, work, or in other important activities. The individual does not put forth the effort necessary to perform well, even when expectations are clear, and typically blames others for his or her poor performance.

(continued)

Table 3.37 DSM-IV to DSM-5 Conduct Disorder Comparison (continued)

DSM-IV: Conduct Disorder	DSM-5: Conduct Disorder
	Shallow or deficient affect: Does not express feelings or show emotions to others, except in ways that seem shallow, insincere, or superficial (e.g., actions contradict the emotion displayed; can turn emotions "on" or "off" quickly) or when emotional expressions are used for gain (e.g., emotions displayed to manipulate or intimidate others).
Specify severity: Mild: few if any conduct problems in excess of those required to make the diagnosis and conduct problems cause only minor harm to others Moderate: number of conduct problems and effect on others intermediate between "mild" and "severe" Severe: many conduct problems in excess of those required to make the diagnosis or conduct problems cause considerable harm to others	*Specify* current severity: Mild: Few if any conduct problems in excess of those required to make the diagnosis are present, and conduct problems cause relatively minor harm to others (e.g., lying, truancy, staying out after dark without permission, other rule breaking). Moderate: The number of conduct problems and the effect on others are intermediate between those specified in "mild" and those in "severe" (e.g., stealing without confronting a victim, vandalism). Severe: Many conduct problems in excess of those required to make the diagnosis are present, or conduct problems cause considerable harm to others (e.g., forced sex, physical cruelty, use of a weapon, stealing while confronting a victim, breaking and entering).

Conduct disorder is believed to be on a spectrum between oppositional defiant disorder (see Table 3.39) and antisocial personality disorder. If a person meets criteria for antisocial personality disorder, they are precluded from receiving a diagnosis of conduct disorder. Data from wave 1 of NESARC indicate that approximately 75 percent of adults meeting conduct disorder criteria also meet antisocial personality disorder criteria [113]. Within the NESARC sample, the point prevalence of conduct disorder in the absence of antisocial personality disorder was 1.4 percent (unweighted, weighted data not reported) among males and 0.7 percent among females. Estimates of the comorbidity of conduct disorder (absent antisocial personality disorder) with other mental illnesses are available mainly in children and adolescents and it is unclear how this will generalize to adults. However, a review of studies on conduct disorder in children under age 18 suggested that 30 percent to 50 percent of youth with conduct disorder also met criteria for ADHD [99]. Conduct disorder has significant public health implications as it places a burden on both the treatment and criminal justice sectors [114] and is associated with increased risk-taking behaviors that lead to a higher prevalence of injuries, substance use, sexually transmitted infections, etc. [115]. Additional consideration might also be given to screening for antisocial personality disorder if disorder-specific estimates were to be generated using MHSS data. DSM-5 hierarchy specifies that individuals who meet both conduct disorder criteria and antisocial personality disorder criteria, only receive the antisocial personality disorder criteria. Without assessing antisocial personality disorder, it would be impossible to tease out the two disorders. Notably, not all national studies included the antisocial personality disorder exclusionary criteria (e.g., NCS-R) and for the purpose quantifying AMI this specific exclusion is not be necessary.

3.4.12 Substance-Related and Addictive Disorders

Gambling Disorder

Gambling disorder (called pathological gambling in DSM-IV) is an addictive disorder characterized by the persistent and maladaptive risking of something of value in the hopes of obtaining something of greater value, which results in disruption of personal, family, or vocational pursuits (Table 3.38). In an important departure from DSM-IV, gambling disorder has been reclassified from impulse control disorders to the substance-related and addictive disorders class. This change reflects the increasing and consistent evidence that some behaviors, such as gambling, activate the brain reward system with effects similar to those of drugs of abuse [2].

Table 3.38 DSM-IV to DSM-5 Gambling Disorder Comparison

DSM-IV	DSM-5
Name: Pathological Gambling	Name: Gambling Disorder
Disorder Class: Impulse-Control Disorders Not Classified Elsewhere	Disorder Class: Substance-Related and Addictive Disorders
A. Persistent and recurrent maladaptive gambling behavior as indicated by **five** (or more) of the following:	Persistent and recurrent problematic gambling behavior **leading to clinically significant impairment or distress**, as indicated by the individual exhibiting **four** (or more) of the following **in a 12-month period**:
1. is preoccupied with gambling (e.g., preoccupied with reliving past gambling experiences, handicapping or planning the next venture, or thinking of ways to get money with which to gamble)	4. Is often preoccupied with gambling (e.g., having persistent thoughts of reliving past gambling experiences, handicapping or planning the next venture, thinking of ways to get money with which to gamble).
2. needs to gamble with increasing amounts of money in order to achieve the desired excitement	1. SAME
3. has repeated unsuccessful efforts to control, cut back, or stop gambling	3. SAME
4. is restless or irritable when attempting to cut down or stop gambling	2. SAME
5. gambles as a way of escaping from problems or of relieving a dysphoric mood (e.g., feelings of helplessness, guilt, anxiety, depression)	5. Often gambles when feeling distressed (e.g., helpless, guilty, anxious, depressed).
6. after losing money gambling, often returns another day to get even ("chasing" one's losses)	6. SAME
7. lies to family members, therapist, or others to conceal the extent of involvement with gambling	7. SAME
8. has committed illegal acts such as forgery, fraud, theft, or embezzlement to finance gambling	DROPPED
9. has jeopardized or lost a significant relationship, job, or educational or career opportunity because of gambling	8. SAME
10. relies on others to provide money to relieve a desperate financial situation caused by gambling	9. SAME

(continued)

Table 3.38 DSM-IV to DSM-5 Gambling Disorder Comparison (continued)

DSM-IV	DSM-5
B. The gambling behavior is not better accounted for by a Manic Episode. N/A	B. The gambling behavior is not better explained by a manic episode. *Specify* if: Episodic: Meeting diagnostic criteria at more than one time point, with symptoms subsiding between periods of gambling disorder for at least several months. Persistent: Experiencing continuous symptoms, to meet diagnostic criteria for multiple years.
	Specify if: In early remission: After full criteria for gambling disorder were previously met, none of the criteria for gambling disorder have been met for at least 3 months but for less than 12 months. In sustained remission: After full criteria for gambling disorder were previously met, none of the criteria for gambling disorder have been met during a period of 12 months or longer. *Specify* current severity: Mild: 4-5 criteria met. Moderate: 6-7 criteria met. Severe: 8-9 criteria met.

There have been several important criteria changes from DSM-IV pathological gambling to DSM-5 gambling disorder. The main changes include:

- A decrease in the number of criteria required to meet the diagnostic threshold from five or more under DSM-IV to four or more under DSM-5
- The addition of a 12-month window for clustering of symptoms
- The addition of a clinically significant distress or impairment criterion
- The removal of a legal criterion.

Estimates of 12-month gambling disorder under DSM-IV ranged from 0.2 percent to 0.3 percent in the general population, with a higher prevalence among males [4]. The reduction in the number of symptoms required to meet diagnostic criteria will likely lead to an increased prevalence of DSM-5 gambling disorder. In a study of callers to a gambling helpline, the prevalence of gambling disorder increased by 9 percent because of the lowered threshold [116]. In a study by Petry et al., which included a small random sample as well as targeted sampling of intervention and treatment facilities, the prevalence of gambling disorder increased from 16.2 percent under DSM-IV to 18.1 percent under DSM-5 [117]. The effect of criteria changes on prevalence estimates in the general population are unknown, however, since the random sampled component of the Petry study was too small to derive reliable estimates.

3.4.13 Personality Disorders

DSM-5's removal of the multiaxial system leads to the removal of the boundary between personality disorders and the other mental disorders. Personality disorders are associated with ways of thinking and feeling about oneself and others that significantly and adversely affect how an individual functions in many aspects of life. Personality disorders fall within 10 distinct types: paranoid personality disorder, schizoid personality disorder, schizotypal personality disorder, antisocial personality disorder, borderline personality disorder, histrionic personality, narcissistic personality disorder, avoidant personality disorder, dependent personality disorder, and obsessive-compulsive personality disorder. A personality disorder diagnosis requires characteristics described in the criteria to be pathological (i.e., outside the range of normal variation), persistent (i.e., frequently present over a period of at least the last 5 years with onset by early adulthood), and pervasive (i.e., apparent in a variety of contexts, such as at work and at home, or in the case of items concerning interpersonal relations, occurs in several different relationships). Aside from the removal of personality disorders from a separate axis, the 10 personality disorders did not undergo any changes to the diagnostic criteria.

Data from the NCS-R indicate that an estimated 9.1 percent of adults have met criteria for one or more personality disorders in the past year [118]. In this study, the prevalence of antisocial personality disorder was 1.0 percent, avoidant personality disorder was 5.2 percent, and borderline personality disorder was 1.6 percent. Data from the 2001-2002 NESARC suggests a prevalence rate of 4.4 percent for paranoid personality disorder, 3.9 percent for schizotypal personality disorder, 3.1 percent for schizoid personality disorder, 0.5 percent for dependent personality disorder, and 1.9 percent for histrionic personality disorder [119]. Prevalence rates for obsessive-compulsive personality disorder range from 2.1 percent and 7.9 percent, and from less than 0.1 percent to 6.2 percent for narcissistic personality disorder [2]. Criteria changes from DSM-IV to DSM-5 have included dropping two of the personality disorders that were included in Appendix B of DSM-IV (Criteria Sets and Axes Provided for Further Study): depressive personality disorder and passive-aggressive personality disorder. People with personality disorders often have significant functional impairment and a poorer treatment prognosis making these disorders of clinical importance. However, personality disorders are frequently comorbid with other disorders, meaning that their unique contribution to the assessment of AMI/SMI may be limited. Data from the NCS-R indicated that comorbidity with another DSM-IV Axis I disorder ranged from 40 percent to 85 percent depending on the specific personality disorder [118]. Development of a SCID personality disorders screener and assessments for specific disorders are under development.

3.4.14 Disorders Due to a Medical Condition, Substance Use, or Medications

Disorders caused by a medical condition can closely resemble the disorders not arising from medical conditions or substance use, including the level of impairment and need for treatment. Thus, knowing the extent of the prevalence of these disorders is important for estimating need for treatment and evaluating mental health system capacity. The assessment of several of these disorders is already a part of the MHSS procedure; therefore, their inclusion will not add substantially to the response burden. Moreover, the definition of SMI and AMI does not distinguish between the sources of these disorders. If additions are made to MHSS, the following modules could be considered.

- Anxiety (caused by a medical condition and substance induced)
- Bipolar (caused by a medical condition and substance induced)
- Depressive Disorder (caused by a medical condition and substance induced)
- Obsessive-Compulsive and Related Disorder (caused by a medical condition and substance induced)
- Sleep Disorder (substance-induced only)

Of these, only substance-induced sleep disorders are not currently assessed and would potentially increase the response burden.

3.4.15 Other Specified Disorders

Each class of disorders under DSM-IV included a "Not Otherwise Specified" diagnostic category. This diagnostic category has been broken into two categories under DSM-5: other specified disorders and unspecified disorders. Related to symptom characteristics, these categories are the same; the distinction is one of clinician information. The former category is used in situations where the clinician communicates the reason other diagnostic categories do not apply, whereas the latter is used in instances where the clinician does not specify the reasons (e.g., lack of time for full assessment in an emergency room). Otherwise, these diagnostic categories are identical and include disorder presentations characteristic of the disorder class (e.g., anxiety disorders or depressive disorders) that cause "clinically significant distress or impairment in social, occupational, or other important areas of functioning" [2], which do not meet the diagnostic criteria for a specific disorder. Exact prevalence estimates for these disorders are unknown. However, based upon the prevalence estimates of other disorders within the classes, inclusion of the following DSM-5 SCID modules may have an impact on SMI and other MI estimates.

- Other Specified Bipolar Disorder: This module includes both other specified Bipolar Disorder and Cyclothymia. Cyclothymia is characterized by chronic (2 or more years among adults), fluctuating mood disturbance involving numerous separate periods of hypomanic symptoms, and periods of depressive symptoms. It has low lifetime prevalence, between 0.4 and 1 percent making it more suitable to be assessed in combination with other specified bipolar disorder.
- Other Specified Depressive Disorder
- Other Specified Eating Disorder
- Other Specified Obsessive-Compulsive and Related Disorder

3.5 Other Disorders in the DSM

Thus far this report has focused on disorders currently assessed directly in the NSDUH main interview or the MHSS and disorders that might be considered for future inclusion in a DSM-5 MHSS. However, this is only a select number of disorders that are enumerated in the DSM-5. Many other disorders exist that have certain considerations that would contraindicate their inclusion in the MHSS. These considerations include:

- Having a low prevalence, which would make the time and respondent burden prohibitive for the number of identified cases
- Not being part of the formal definition of SMI (e.g., substance use disorders and developmental disabilities)
- High levels of comorbidity, which would indicate the "cases" are counted in existing modules
- Having complex assessments that require physical measures or direct clinical judgment
- Substantial concerns over respondent refusal and drop-out related to sensitive topics being assessed over the telephone

Table 3.39 contains a list of these disorders along with details as to why they may not be suitable for inclusion in the MHSS.

Table 3.39 DSM-5 Disorders Not Suggested for Inclusion in the MHSS

DSM-5 Disorder Class	Disorder/s	Basic Description[1]	Reasons for Exclusion
Neurodevelopmental Disorder	Intellectual Disability	A disorder characterized by intellectual deficits and impairment in every day adaptive functioning.	Excluded as part of SMI definition (developmental disability) Diagnosis requires extensive IQ testing. Respondents with an intellectual disability may not comprehend assessment or be able to provide informed consent.
	Communication Disorders	A set of disorders characterized by deficits in language, speech, and communication.	Excluded as part of SMI definition (developmental disability) The majority of children with a communication disorder will receive treatment and not meet criteria by adulthood.
	Autism Spectrum Disorder	Autism spectrum disorder (formerly autism and Asperger's disorder) is characterized by persistent impairment in reciprocal social communication and restricted, repetitive patterns of behavior interest or activities.	Excluded as part of SMI definition (developmental disability) Differential diagnosis requires substantial clinical assessment.
	Specific Learning Disorder	A disorder that involves difficulty in learning and using academic skills.	Excluded as part of SMI definition (developmental disability) Assessment of learning disabilities is complex and time consuming.
	Motor Disorders	Motor disorders are a set of disorders that involve problems with coordination, stereotypic movements, and motor/vocal tics.	Excluded as part of SMI definition (developmental disability) While prevalence is high among children (e.g., 5 percent to 6 percent for developmental coordination disorder), the majority of cases have an amelioration of symptoms by early adulthood. Serious cases are often comorbid with intellectual disabilities and/or autism spectrum disorder.

(continued)

Table 3.39 DSM-5 Disorders Not Suggested for Inclusion in the MHSS (continued)

DSM-5 Disorder Class	Disorder/s	Basic Description[1]	Reasons for Exclusion
Schizophrenia Spectrum and Other Psychotic Disorders	Delusional Disorder	Delusional disorder is characterized by the presence of one or more delusions that persist for at least 1 month in people who have not met Criteria A for schizophrenia.	Extremely low lifetime prevalence, estimated at 0.2 percent [2]. There would be too few cases to calculate a stable estimate. However, the psychoses screener would likely capture these cases.
	Brief Psychotic Disorder	Brief psychotic disorder is characterized by a sudden onset of delusions, hallucinations, disorganized speech, or grossly abnormal psychomotor behavior.	The prevalence of brief psychotic disorder is largely unknown, but one study conducted in The Netherlands found an incidence rate substantially less than schizophrenia, with too few cases to calculate a stable estimate [120]. However, the psychoses screener would likely capture these cases.
	Schizophreniform Disorder	Core symptoms for schizophreniform disorder match schizophrenia, except that the total duration is between 1 and 6 months (schizophrenia requires a duration of over 6 months).	Low lifetime prevalence (between 0.3 percent and 0.7 percent [2]), difficulty in distinguishing schizophreniform from schizophrenia new onset cases. However, the psychoses screener would likely capture these cases.
	Schizoaffective Disorder	Schizoaffective disorder is a serious mental illness characterized by the Criterion A psychotic symptoms of schizophrenia with additional symptoms of depression or mania.	Very low lifetime prevalence, estimated at 0.3 percent [2]. However, the psychoses screener would likely capture these cases.
Anxiety Disorder	Selective Mutism	A disorder characterized by lack of initiation and reciprocation of speech in social situations.	Rare disorder (point prevalence of 0.03 to 1 percent), most often found in children [2]. The MHSS focuses on adults and would not capture these cases.
Trauma- and Stressor-Related Disorders	Reactive Attachment Disorder	Reactive attachment disorder is a rare disorder in children characterized by a pattern of disturbed and developmentally inappropriate attachment behaviors.	Disorder is only identified in children. The MHSS focuses on adults and would not capture these cases.
	Disinhibited Social Engagement Disorder	Disinhibited social engagement disorder is a rare disorder in children characterized by a pattern of behavior that involves culturally inappropriate, overly familiar behavior with relative strangers.	Disorder is only identified in children. The MHSS focuses on adults and would not capture these cases.
Dissociative Disorders	All	Dissociative disorders are characterized by disruption of the normal integration of consciousness, memory, identity, depersonalization, and behavior.	A SCID module for these disorders is not in development. There is a high level of comorbidity with dissociative disorders; therefore, the MHSS will likely classify these individuals as "cases" based on other modules.

(continued)

Table 3.39 DSM-5 Disorders Not Suggested for Inclusion in the MHSS (continued)

DSM-5 Disorder Class	Disorder/s	Basic Description[1]	Reasons for Exclusion
Somatic-Symptom and Related Disorders	Conversion Disorder	This disorder is characterized by one or more symptoms of altered voluntary motor or sensory function in the absence of an identified neurological disease	Extremely low, undetermined prevalence. Incidence is estimated at 2 to 4 people per 100,000 people annually [2]. Requires extensive neurological testing for differential diagnosis.
	Factitious Disorder	This disorder is characterized by the recurrent falsification of physical or psychological symptoms or induction of injury or disease in oneself or another in the absence of obvious external rewards.	The prevalence is largely unknown but it is considered rare (less than 1 percent). Moreover, the degree of deception in this disorder makes assessment difficult.
Feeding and Eating Disorders	Pica	A disorder characterized by the persistent eating of nonnutritive, nonfood substances.	The prevalence of pica is unknown. It frequently appears among individuals with serious developmental disabilities (who would not be assessed in MHSS) and is considered rare outside of this population.
	Rumination Disorder	A disorder characterized by the repeated regurgitation of food after feeding or eating, which occurs over at least 1 month.	The prevalence of rumination disorder is unknown. It frequently appears among individuals with serious developmental disabilities (who would not be assessed in MHSS) and is considered rare outside of this population.
Elimination Disorders	All	Elimination disorders are characterized by the inappropriate elimination of urine or feces and are usually diagnosed in childhood or adolescence.	Primarily disorders identified in children. Among adults there is concern over low prevalence and respondent refusal and drop-out.
Sleep-Wake Disorders	Narcolepsy	A disorder characterized by an irrepressible need to sleep, lapsing into sleep, or napping occurring within the same day.	Very rare (point prevalence is 0.02 to 0.04 percent [2]), assessment requires physical diagnostics.
	Breathing-Related Sleep Disorders	A set of three disorders [obstructive sleep apnea hypopnea, central sleep apnea, and sleep-related hypoventilation] that are characterized by breathing problems occurring during sleep.	Involved medical assessments required for differential diagnosis.
	Circadian Rhythm Sleep-Wake Disorders	A set of disorders characterized persistent or recurrent pattern of sleep disruption due to an alteration of the circadian system or a misalignment of the circadian system and the sleep-wake schedule required by an individual's environment.	Very low prevalence (point prevalence estimate 0.17 percent) [2].
	Parasomnias	Parasomnias are characterized by abnormal behavioral, experiential, or physiological event occurring during sleep.	With the exception of restless legs syndrome, the prevalence of these disorders in adults are largely unknown but are considered rare (less than 1 percent for each who meet the distress/impairment criteria).

(continued)

Table 3.39 DSM-5 Disorders Not Suggested for Inclusion in the MHSS (continued)

DSM-5 Disorder Class	Disorder/s	Basic Description[1]	Reasons for Exclusion
Sexual Dysfunctions	All	Sexual dysfunctions are a heterogeneous group of disorders characterized by a clinically significant disturbance in a person's ability to respond sexually or to experience sexual pleasure.	Concerns over respondent refusal and drop-out.
Gender Dysphoria	Gender Dysphoria	Gender Dysphoria is characterized by a marked incongruence between the gender a person was assigned to (usually at birth) and their experienced/expressed gender.	Extremely low lifetime prevalence estimates, range from 0.003 to 0.014 percent [2].
Disruptive, Impulse-Control, and Conduct Disorders	Pyromania	Pyromania is characterized by multiple episodes of deliberative fire setting associated with tension or affective arousal and a fascination with fire and related contexts.	Extremely low prevalence, only about 3.3 percent of people in the criminal justice system (who would not be assessed in MHSS) with *repeated fire setting* met criteria for pyromania. Estimates in the general population are unknown [2].
	Kleptomania	Kleptomania is characterized by a recurrent failure to resist impulses to steal items even though the items are not needed for personal use or their monetary value.	Low point prevalence estimates, approximately 0.3 to 0.6 percent [2].
	Oppositional Defiant Disorder	Oppositional defiant disorder is a disorder usually diagnosed in children characterized by a pattern of angry/irritable mood, argumentative/defiant behavior and vindictiveness.	Over 70 percent of cases remit by age 18, the remaining cases are highly comorbid with conduct disorder. Up to 90 percent of lifetime cases are comorbid with another mental illness [121].
Substance-Related Disorders	Caffeine-Induced Disorders	Recurrent consumption of caffeine that causes clinically significant distress or impairment related to the ingestion of or withdrawal from caffeine.	Lack of clinical impact. SUDs are not considered part of SMI definition
Neurocognitive Disorders	All	A group of disorders characterized by acquired deficits to cognitive function.	Diagnosis requires extensive physical assessments
Paraphilic Disorders	All	Paraphilic disorders are a group of disorders characterized by a paraphilia that is accompanied by distress or impairment or the risk of harm to self or others. Paraphilias are any intense and persistent sexual interest other than sexual interest in genital stimulation or preparatory fondling with mature and consenting human partners.	Concerns over respondent refusal and drop-out.

[1]Descriptions as provided in DSM-5.

3.6 Any Mental Illness, Serious Mental Illness, and Specific Disorders in NSDUH/MHSS

3.6.1 Impact of DSM Revisions on MHSS Estimates of SMI, AMI and Specific Disorders

The diagnostic revisions between DSM-IV and DSM-5 included both subtle (e.g., MDE adding the word hopeless) and some distinctive (e.g., somatic symptom disorder's complete reworking) changes. These changes have the potential to affect AMI, SMI, and specific disorder estimates in MHSS. Although many of the disorders have had at least minor changes under DSM-5, in most cases there is very little data available on how the changes will affect prevalence estimates. In most cases where there are data, the prevalence estimates appear to remain unchanged or to have increased only slightly. This would suggest that MHSS DSM-IV–based estimates will underestimate the disorders under DSM-5 criteria and subsequently the AMI/SMI estimation in NSDUH would likely be an underestimate. However, the data available for these changes has primarily come from treatment-based samples and may not be generalizable to the nationally representative sample in MHSS.

The changes from DSM-IV to DSM-5 may also lead to reevaluating which disorders are currently assessed by the MHSS. New disorders would need to be considered for inclusion based on a number of factors, including prevalence, clinical severity, assessment length, and comorbidity with other disorders, all of which are relevant to accurate estimation of AMI and SMI. Changes to existing disorders might result in changes in prevalence or severity and may also prompt a reevaluation of their inclusion in MHSS. Based on these considerations, this report explored a number of potential inclusions for MHSS. Table 3.40 summarizes the benefits and drawbacks for each disorder.

If additional disorders were to be added to the MHSS, ADHD, binge eating disorder, and conduct disorder may be the disorders with the highest potential return given the respondent burden. In addition, ASD, bipolar II, and body dysmorphic disorder may merit inclusion based on prevalence and/or clinical impairment. However, the addition of all of these disorders concurrently could significantly lengthen the assessment for individuals with high comorbidity; therefore, priority should be given to disorders of primary interest to NSDUH stakeholders and which would provide the greatest addition to the accuracy of AMI and SMI estimates in the population.

3.6.2 Impact on Estimates of Any Mental Illness/Serious Mental Illness

The model used to predict AMI and SMI status for the adult NSDUH sample are based, in part, on responses to the K6 scale and the WHODAS. The K6 scale has been validated against DSM-IV diagnostic criteria. However, assuming that the same variables would continue to be optimal to predict DSM-5-based SMI status, the K6 has not yet been validated against the DSM-5 diagnostic criteria. Therefore, either the K6 would need to be validated or another general mental distress scale that has been validated against DSM-5 would need to be identified. In addition to the impact to the NSDUH main interview because of a break in trends and contexts effects, it is unclear whether a measure of general mental distress that has been validated against DSM-5 exists. Further exploration in this area (with potentially a pilot study) would be needed.

Table 3.40 Summary of Options for Additional DSM-5 SCID Modules for the Future MHSS

Disorder	Approx. Length	Benefits of Inclusion	Drawbacks of Inclusion	Summary
Attention Deficit/Hyperactivity Disorder (ADHD)	2 to 10 minutes	Clinically significant Highly impairing disorder High prevalence expected	Expected to be highly comorbid with other disorders May be time consuming to assess	The respondent burden of adding this module may be outweighed by the added precision of the AMI/SMI estimates gained by the inclusion of this highly prevalent externalizing disorder. ADHD may also be a valuable addition to the MHSS specific disorder estimates.
Schizophrenia	3 to 8 minutes	Clinically significant Highly impairing	Very low prevalence expected Negative symptoms difficult to assess in a telephone interview Positive symptoms already assessed via screener	The very low prevalence of this disorder, significant challenges in accurately assessing this disorder, and increased respondent burden may outweigh any gains made over implementing a psychotic symptom screen in the precision of AMI/SMI estimates.
Bipolar II Disorder (lifetime and past year)	2 to 10 minutes	Clinically significant	Low prevalence May be time consuming to assess and challenging to accurately measure hypomanic episodes	The respondent burden and challenge associated with accurately assessing hypomanic episodes may outweigh the gains made in the precision of AMI/SMI estimates given that if bipolar II is not assessed, these respondents would be categorized as having MDD and thereby captured under the AMI category.
Premenstrual Dysphoric Disorder	0 to 6 minutes	Clinically significant Highly impairing	Reliable past year prevalence estimates are not available Exclusion criteria requires that respondents have knowledge of other medical and psychiatric diagnoses	The unknown prevalence of this disorder, challenges in accurately assessing this disorder, and increased respondent burden may outweigh any gains made in the precision of AMI/SMI estimates.
Separation Anxiety Disorder	1 to 6 minutes	Clinically significant Highly impairing	Low prevalence expected Time consuming to assess Highly comorbid with other disorders	The low prevalence of this disorder and increased respondent burden may outweigh any gains made in the precision of AMI/SMI estimates.

(continued)

Table 3.40 Summary of Options for Additional DSM-5 SCID Modules for the Future (continued)

Disorder	Approx. Length	Benefits of Inclusion	Drawbacks of Inclusion	Summary
Body Dysmorphic Disorder	2 to 8 minutes	Clinically significant Highly impairing High prevalence	Time consuming to assess Highly comorbid with MDD	Prevalence estimates of body dysmorphic disorder may be a valuable addition to the MHSS specific disorder estimates, but the inclusion of this disorder may not significantly add to the accurate diagnosis of SMI/AMI due to high comorbidity.
Trichotillomania	1 to 6 minutes	Clinically significant Highly impairing	Reliable past year prevalence estimates are not available	Insufficient data are available to adequately assess whether inclusion would be warranted.
Excoriation Disorder	2 to 6 minutes	Clinically significant Highly impairing	Low prevalence expected Time consuming to assess	The low prevalence of this disorder and increased respondent burden may outweigh any gains made in the precision of AMI/SMI estimates.
Hoarding Disorder	4 to 10 minutes	Clinically significant Highly impairing	Highly comorbid with MDD and anxiety disorders Because of poor insight among people experiencing this disorder, this may be a challenging disorder to assess telephonically	The challenges of assessing this disorder may outweigh any gains made in the precision of AMI/SMI estimates because this disorder is highly comorbid with MDD and other anxiety/obsessive-compulsive disorders.
Acute Stress Disorder (ASD)	1 to 10 minutes	Clinically significant Highly impairing Would only need to be assessed among those exposed to a traumatic event in the past month, which is a low probability	Expected to have significant overlap with adjustment disorder	Whereas ASD may be a valuable addition to the MHSS specific disorder estimates, The increased respondent burden may outweigh any gains made in the precision of AMI/SMI estimates the inclusion of this disorder may not significantly contribute to the accurate diagnosis of SMI/AMI.
Somatic Symptom Disorder	1 to 6 minutes	Clinically significant May be highly impairing	Reliable past year prevalence estimates are not available Exclusion criteria requires respondent knowledge of other medical and psychiatric diagnoses Difficult to assess, especially over the telephone	The unknown prevalence of this disorder, challenges in accurately assessing this disorder, and increased respondent burden may outweigh any gains made in the precision of AMI/SMI estimates.

(continued)

Table 3.40 Summary of Options for Additional DSM-5 SCID Modules for the Future (continued)

Disorder	Approx. Length	Benefits of Inclusion	Drawbacks of Inclusion	Summary
Illness Anxiety Disorder	2 to 7 minutes	Clinically significant Highly impairing	Reliable past year prevalence estimates are not available	The unknown prevalence of this disorder and increased respondent burden may outweigh any gains made in the precision of AMI/SMI estimates.
Avoidant/Restrictive Food Intake Disorder	1 to 10 minutes	Highly impairing	Low prevalence expected Difficult to assess in a telephone interview Requires respondent knowledge of other medical and psychiatric diagnoses	The low prevalence of this disorder, challenges of assessing this disorder accurately in a telephonic interview, and increased respondent burden may outweigh any gains made in the precision of AMI/SMI estimates.
Binge Eating Disorder	2 to 7 minutes	Clinically significant Highly impairing Would pick up eating disorder cases that do not meet criteria for bulimia but are clinically significant	Not a highly prevalent disorder, though more prevalent than anorexia or bulimia (both of which are assessed in MHSS)	The added precision in AMI/SMI estimates gained by including this disorder may outweigh the added respondent burden based on clinical significance.
Hypersomnolence Disorder	2 to 7 minutes	Clinically significant Highly impairing	Low prevalence expected Requires respondent knowledge of other medical and psychiatric diagnoses Difficult and time consuming to assess, especially over the telephone	The low prevalence of this disorder, challenges in accurately assessing this disorder, and increased respondent burden may outweigh any gains made in the precision of AMI/SMI estimates
Insomnia Disorder	2 to 7 minutes	High prevalence Clinically significant Highly impairing	Supportive sleep lab data needed for definitive diagnosis, although not needed for probable diagnosis Difficult and time consuming to assess, especially over the telephone	The challenges in accurately assessing this disorder, and increased respondent burden may outweigh any gains made in the precision of AMI/SMI estimates.
Conduct Disorder	4 to 12 minutes	Clinically significant	Time consuming to assess Assessing conduct disorder without applying the antisocial personality disorder hierarchy would result in false positives for conduct disorder-specific estimates (but not for AMI/SMI)	The benefit of adding this disorder may outweigh the added respondent burden based on clinical significance.

(continued)

Table 3.40 Summary of Options for Additional DSM-5 SCID Modules for the Future (continued)

Disorder	Approx. Length	Benefits of Inclusion	Drawbacks of Inclusion	Summary
Gambling Disorder	2 to 6 minutes	Clinically significant Highly impairing	Low prevalence expected	The low prevalence of this disorder and increased respondent burden may outweigh any gains made in the precision of AMI/SMI estimates.
Personality Disorders	5 to 30 minutes (for SCID screener)	Clinically significant Highly impairing Some personality disorders have a high prevalence	Difficult and time consuming to assess, especially over the telephone Some individual personality disorders have a low prevalence	The challenges in accurately assessing these disorders and increased respondent burden may outweigh any gains made in the precision of AMI/SMI estimates.
Disorders Due to a Medical Condition, Substance Use, or Medications (Substance-induced sleep Disorder)	0 to 3 minutes/ per disorder	Clinically significant Highly impairing	Past year prevalence estimates are not available	Because these disorders are already assessed for disorders measured in the MHSS SCID, there would be no need to make any changes to the way they are assessed.
Other Specified Disorders Other Specified Anxiety Disorder Other Specified Bipolar Disorder Other Specified Depressive Disorder Other Specified Eating Disorder Other Specified Obsessive-Compulsive and Related Disorder	0 to 3 minutes/ per disorder	Clinically significant May be highly impairing	Past year prevalence estimates are not available Difficult and time consuming to assess	The unknown prevalence of these disorders, challenges in accurately assessing these disorders, and increased respondent burden may outweigh any gains made in the precision of AMI/SMI estimates.

AMI = any mental illness; MDD = major depressive episode; PTSD = posttraumatic stress disorder; SMI = serious mental illness.

The removal of the GAF score from DSM-5 brings into question how functional impairment should be measured in MHSS. NSDUH could use the WHODAS 2.0, as described in DSM-5. This would provide a validated measure of disability for the clinical interview. However, a version of the WHODAS is also used to measure disability in the NSDUH interview. This may improve the precision of AMI and SMI estimation. However, such changes should be evaluated carefully. Other measures of disability, including retaining the GAF, could also be considered. However, the GAF has demonstrated issues with interrater reliability.

3.6.3 Impact on NSDUH Major Depressive Episode Estimates

In addition to being assessed in the MHSS, MDE is also assessed as part of the NSDUH interview. Although the diagnostic changes from DSM-IV to DSM-5 regarding mixed episodes and the bereavement exclusion will have no effect on NSDUH estimates of MDE, the addition of the term "hopeless" as a subjective descriptor of low mood (Criterion A1) may have an effect on these estimates. NSDUH could revise the MDE question about low mood in the adult depression module to include the word "hopeless." This would result in the questionnaire more accurately reflecting the revised wording of this symptom in DSM-5 (the adolescent depression module already contains the term "hopeless"). However, based on Uher's report that only 8 percent of a treatment sample reported feeling discouraged/hopeless but not feeling sad [64], this change is anticipated to have a minimal effect on prevalence rates for the general population.

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Appendix A: Additional Substance Use Disorder Tables: Weighted N among People Aged 12 or Older

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Table A.1 Alcohol Legal Criterion Endorsement among People Aged 12 or Older, by Demographic Characteristic: Weighted Numbers in Thousands, Annual Averages Based on 2002-2012 NSDUHs

Demographic Characteristic	DSM-IV Legal Criterion Endorsement	Respondents Who Endorsed Only the DSM-IV Legal Criterion	Respondents Who Endorsed the DSM-IV Legal Criterion and One Other DSM-IV SUD Criterion
TOTAL	2,070	151	227
GENDER			
Male	1,624	119	179
Female	445	32	48
HISPANIC ORIGIN AND RACE			
Not Hispanic or Latino	1,542	106	172
White	1,093	74	127
Black or African American	312	23	30
American Indian or Alaska Native	53	3	4
Native Hawaiian or Other Pacific Islander	12	0	1
Asian	43	2	7
Two or More Races	29	3	3
Hispanic or Latino	527	44	55
AGE			
12-13	12	1	1
14-15	65	4	9
16-17	122	9	15
18-25	659	47	68
26-35	471	34	45
36-45	334	21	41
46-55	276	21	26
56-64	94	3	18
65 or Older	37	10	3

*Low precision; no estimate reported.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2002-2005, 2006-2010 (Revised 3/12), 2011-2012.

Table A.2 Respondents Who Endorsed Only One Alcohol Use Disorder Criterion among People Aged 12 or Older, by Criterion and Demographic Characteristic: Weighted Numbers in Thousands, Annual Averages Based on 2002-2012 NSDUHs

Demographic Characteristic	Hazardous Use Only	Role Failure Only	Continued Use Despite Social Problems Only	Longer/ More Use Only	Failure to Cut Down Only	Spent a Great Deal of Time Only	Reduced Activities Only	Continued Use Despite Physical Problems Only	Tolerance Only	Withdrawal Only
TOTAL	2,508	220	287	546	1,034	7,011	496	806	8,229	3,526
GENDER										
Male	1,740	141	180	312	590	3,982	305	402	4,790	2,433
Female	768	79	107	234	444	3,029	191	404	3,439	1,094
HISPANIC ORIGIN AND RACE										
Not Hispanic or Latino	2,256	169	251	462	902	6,006	411	750	6,968	2,776
White	2,033	117	212	373	756	4,921	320	669	5,106	2,023
Black or African American	144	35	24	59	108	684	42	39	1,321	544
American Indian or Alaska Native	12	1	3	2	2	34	3	2	38	58
Native Hawaiian or Other Pacific Islander	2	2	0	1	2	26	8	1	45	20
Asian	40	8	4	18	28	251	33	30	355	81
Two or More Races	25	5	10	8	7	91	5	8	102	50
Hispanic or Latino	252	52	36	84	132	1,005	84	56	1,261	750
AGE										
12-13	4	5	1	1	4	13	3	1	52	27
14-15	28	12	7	6	11	74	10	4	201	92
16-17	71	14	11	11	15	187	16	15	368	131
18-25	603	66	53	95	105	1,636	105	125	2,085	782
26-35	622	48	56	115	178	1,664	135	162	1,590	825
36-45	530	45	47	101	191	1,389	106	146	1,300	759
46-55	360	19	59	102	250	1,105	78	192	1,177	585
56-64	179	3	31	42	133	557	23	87	592	193
65 or Older	111	9	21	72	147	386	21	73	864	131

*Low precision; no estimate reported.

NOTE: Alcohol use disorder is based on definitions found in the 4th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV).

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2002-2005, 2006-2010 (Revised 3/12), 2011-2012.

Table A.3 Marijuana Legal Criterion Endorsement among People Aged 12 or Older, by Demographic Characteristic: Weighted Numbers in Thousands, Annual Averages Based on 2002-2012 NSDUHs

Demographic Characteristic	DSM-IV Legal Criterion Endorsement	Respondents Who Endorsed Only the DSM-IV Legal Criterion	Respondents Who Endorsed the DSM-IV Legal Criterion and One Other DSM-IV SUD Criterion
TOTAL	604	36	74
GENDER			
Male	464	31	58
Female	140	*	16
HISPANIC ORIGIN AND RACE			
Not Hispanic or Latino	472	25	60
White	320	14	39
Black or African American	124	9	18
American Indian or Alaska Native	8	1	1
Native Hawaiian or Other Pacific Islander	1	*	*
Asian	7	*	*
Two or More Races	13	0	1
Hispanic or Latino	132	11	14
AGE			
12-13	12	1	1
14-15	66	4	7
16-17	105	4	8
18-25	260	12	32
26-35	87	11	14
36-45	42	*	5
46-55	23	4	5
56-64	4	*	3
65 or Older	4	*	*

*Low precision; no estimate reported.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2002-2005, 2006-2010 (Revised 3/12), 2011-2012.

Table A.4 Phencyclidine and Other Hallucinogen Use Legal Criterion Endorsement among People Aged 12 or Older, by Demographic Characteristic: Weighted Numbers in Thousands, Annual Averages Based on 2002-2012 NSDUHs

Demographic Characteristic	DSM-IV Legal Criterion Endorsement	Respondents Who Endorsed Only the DSM-IV Legal Criterion	Respondents Who Endorsed the DSM-IV Legal Criterion and One Other DSM-IV SUD Criterion
TOTAL	65	*	*
GENDER			
Male	44	*	*
Female	21	*	*
HISPANIC ORIGIN AND RACE			
Not Hispanic or Latino	46	*	*
White	31	*	*
Black or African American	11	*	*
American Indian or Alaska Native	2	*	0
Native Hawaiian or Other Pacific Islander	*	*	*
Asian	1	*	*
Two or More Races	1	*	*
Hispanic or Latino	19	*	*
AGE			
12-13	3	1	1
14-15	8	1	1
16-17	11	*	1
18-25	25	*	3
26-35	9	*	*
36-45	5	*	*
46-55	3	*	*
56-64	*	*	*
65 or Older	*	*	*

*Low precision; no estimate reported.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2002-2005, 2006-2010 (Revised 3/12), 2011-2012.

Table A.5 Respondents Who Endorsed Only One Phencyclidine and Other Hallucinogen Use Disorder Criterion among People Aged 12 or Older, by Criterion and Demographic Characteristic: Weighted Numbers in Thousands, Annual Averages Based on 2002-2012 NSDUHs

Demographic Characteristic	Hazardous Use Only	Role Failure Only	Continued Use Despite Social Problems Only	Longer/ More Use Only	Failure to Cut Down Only	Spent a Great Deal of Time Only	Reduced Activities Only	Continued Use Despite Physical Problems Only	Tolerance Only	Withdrawal Only
TOTAL	60	14	*	*	*	120	22	21	153	--
GENDER										
Male	42	9	*	7	8	78	17	11	97	--
Female	18	*	*	*	*	42	*	11	56	--
HISPANIC ORIGIN AND RACE										
Not Hispanic or Latino	53	*	*	*	*	104	19	19	129	--
White	45	*	*	*	*	91	17	16	106	--
Black or African American	4	2	*	3	3	4	*	1	12	--
American Indian or Alaska Native	0	0	*	*	0	1	1	0	2	--
Native Hawaiian or Other Pacific Islander	0	*	*	*	*	0	*	*	1	--
Asian	1	*	*	2	*	4	*	*	5	--
Two or More Races	2	0	*	*	*	4	0	0	3	--
Hispanic or Latino	7	5	2	*	2	15	2	2	24	--
AGE										
12-13	*	1	*	*	*	1	0	*	3	--
14-15	4	3	1	*	1	7	1	1	11	--
16-17	13	3	1	1	2	17	2	4	18	--
18-25	33	7	3	3	4	73	10	10	92	--
26-35	9	*	*	4	4	17	6	4	17	--
36-45	*	*	*	*	*	2	*	*	7	--
46-55	*	*	*	*	*	*	*	3	*	--
56-64	*	*	*	*	*	*	*	*	4	--
65 or Older	*	*	*	*	*	*	*	*	*	--

*Low precision; no estimate reported.

-- Not applicable.

NOTE: Phencyclidine and other hallucinogen use disorder is based on definitions found in the 4th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV).

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2002-2005, 2006-2010 (Revised 3/12), 2011-2012.

Table A.6 Inhalant Legal Criterion Endorsement among People Aged 12 or Older, by Demographic Characteristic: Weighted Numbers in Thousands, Annual Averages Based on 2002-2012 NSDUHs

Demographic Characteristic	DSM-IV Legal Criterion Endorsement	Respondents Who Endorsed Only the DSM-IV Legal Criterion	Respondents Who Endorsed the DSM-IV Legal Criterion and One Other DSM-IV SUD Criterion
TOTAL	32	*	*
GENDER			
Male	22	*	*
Female	10	*	*
HISPANIC ORIGIN AND RACE			
Not Hispanic or Latino	25	*	*
White	15	*	*
Black or African American	6	*	*
American Indian or Alaska Native	0	*	*
Native Hawaiian or Other Pacific Islander	0	*	0
Asian	3	*	*
Two or More Races	0	*	*
Hispanic or Latino	7	*	2
AGE			
12-13	4	0	1
14-15	9	1	3
16-17	5	1	1
18-25	4	*	*
26-35	3	*	*
36-45	4	*	*
46-55	3	*	*
56-64	*	*	*
65 or Older	*	*	*

*Low precision; no estimate reported.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2002-2005, 2006-2010 (Revised 3/12), 2011-2012.

Table A.7 Respondents Who Endorsed Only One Inhalant Use Disorder Criterion among People Aged 12 or Older, by Criterion and Demographic Characteristic: Weighted Numbers in Thousands, Annual Averages Based on 2002-2012 NSDUHs

Demographic Characteristic	Hazardous Use Only	Role Failure Only	Continued Use Despite Social Problems Only	Longer/ More Use Only	Failure to Cut Down Only	Spent a Great Deal of Time Only	Reduced Activities Only	Continued Use Despite Physical Problems Only	Tolerance Only	Withdrawal Only
TOTAL	26	18	*	*	16	48	14	*	103	--
GENDER										
Male	18	12	*	*	12	22	7	*	52	--
Female	8	*	*	*	*	27	7	*	52	--
HISPANIC ORIGIN AND RACE										
Not Hispanic or Latino	22	*	*	*	11	39	*	*	86	--
White	20	9	*	*	9	27	*	*	65	--
Black or African American	*	*	*	*	*	5	3	*	10	--
American Indian or Alaska Native	0	0	*	*	*	1	*	*	3	--
Native Hawaiian or Other Pacific Islander	0	*	*	*	*	0	0	*	2	--
Asian	*	1	*	*	*	5	1	1	3	--
Two or More Races	0	*	0	*	0	1	1	*	2	--
Hispanic or Latino	4	8	*	2	5	9	5	*	18	--
AGE										
12-13	1	3	0	1	4	7	6	2	28	--
14-15	5	5	1	1	4	12	2	1	29	--
16-17	6	1	*	1	2	8	2	1	13	--
18-25	8	3	*	3	3	11	*	*	19	--
26-35	*	*	*	*	4	5	3	*	6	--
36-45	2	5	*	*	*	*	*	*	5	--
46-55	3	*	*	*	*	*	*	*	4	--
56-64	*	*	*	*	*	4	*	*	*	--
65 or Older	*	*	*	*	*	*	*	*	*	--

*Low precision; no estimate reported.

-- Not applicable.

NOTE: Inhalant use disorder is based on definitions found in the 4th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV).
Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2002-2005, 2006-2010 (Revised 3/12), 2011-2012. .

Table A.8 Heroin Legal Criterion Endorsement among People Aged 12 or Older, by Demographic Characteristic: Weighted Numbers in Thousands, Annual Averages Based on 2002-2012 NSDUHs

Demographic Characteristic	DSM-IV Legal Criterion Endorsement	Respondents Who Endorsed Only the DSM-IV Legal Criterion	Respondents Who Endorsed the DSM-IV Legal Criterion and One Other DSM-IV SUD Criterion
TOTAL	105	*	*
GENDER			
Male	74	*	*
Female	31	*	*
HISPANIC ORIGIN AND RACE			
Not Hispanic or Latino	83	*	*
White	63	*	*
Black or African American	17	*	*
American Indian or Alaska Native	0	*	*
Native Hawaiian or Other Pacific Islander	*	*	*
Asian	*	*	*
Two or More Races	3	*	*
Hispanic or Latino	22	*	*
AGE			
12-13	1	*	*
14-15	2	*	0
16-17	3	*	*
18-25	25	*	*
26-35	35	*	*
36-45	20	*	*
46-55	17	*	*
56-64	*	*	*
65 or Older	*	*	*

*Low precision; no estimate reported.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2002-2005, 2006-2010 (Revised 3/12), 2011-2012.

Table A.9 Respondents Who Endorsed Only One Heroin Use Disorder Criterion among People Aged 12 or Older, by Criterion and Demographic Characteristic: Weighted Numbers in Thousands, Annual Averages Based on 2002-2012 NSDUHs

Demographic Characteristic	Hazardous Use Only	Role Failure Only	Continued Use Despite Social Problems Only	Longer/More Use Only	Failure to Cut Down Only	Spent a Great Deal of Time Only	Reduced Activities Only	Continued Use Despite Physical Problems Only	Tolerance Only	Withdrawal Only
TOTAL	*	*	*	*	*	*	*	*	13	246
GENDER										
Male	*	*	*	*	*	8	*	*	8	169
Female	*	*	*	*	*	*	*	*	*	77
HISPANIC ORIGIN AND RACE										
Not Hispanic or Latino	*	*	*	*	*	*	*	*	11	203
White	*	*	*	*	*	*	*	*	10	166
Black or African American	*	*	*	*	*	*	2	*	2	31
American Indian or Alaska Native	*	0	*	*	*	0	*	*	*	1
Native Hawaiian or Other Pacific Islander	*	*	*	*	*	*	*	*	*	0
Asian	*	*	*	*	*	*	*	*	*	1
Two or More Races	*	*	*	*	*	0	*	*	*	5
Hispanic or Latino	*	*	*	*	*	2	*	*	*	43
AGE										
12-13	*	*	*	*	*	*	*	*	*	1
14-15	*	*	*	*	*	*	*	*	1	3
16-17	*	*	*	*	*	1	*	*	1	4
18-25	*	*	*	*	*	3	*	*	5	77
26-35	*	*	*	*	*	*	3	*	3	68
36-45	*	*	*	*	*	*	*	*	*	36
46-55	*	*	*	*	*	3	*	*	*	45
56-64	*	*	*	*	*	1	*	*	*	8
65 or Older	*	*	*	*	*	*	*	*	*	3

*Low precision; no estimate reported.

NOTE: Heroin use disorder is based on definitions found in the 4th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV).

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2002-2005, 2006-2010 (Revised 3/12), 2011-2012.

Table A.10 Pain Reliever Legal Criterion Endorsement among People Aged 12 or Older, by Demographic Characteristic: Weighted Numbers in Thousands, Annual Averages Based on 2002-2012 NSDUHs

Demographic Characteristic	DSM-IV Legal Criterion Endorsement	Respondents Who Endorsed Only the DSM-IV Legal Criterion	Respondents Who Endorsed the DSM-IV Legal Criterion and One Other DSM-IV SUD Criterion
TOTAL	225	15	14
GENDER			
Male	153	9	9
Female	72	*	*
HISPANIC ORIGIN AND RACE			
Not Hispanic or Latino	190	12	*
White	146	*	*
Black or African American	30	4	5
American Indian or Alaska Native	6	1	0
Native Hawaiian or Other Pacific Islander	0	0	*
Asian	4	*	1
Two or More Races	4	0	*
Hispanic or Latino	35	2	4
AGE			
12-13	5	*	*
14-15	12	1	1
16-17	18	2	1
18-25	58	3	3
26-35	56	3	5
36-45	38	3	3
46-55	27	*	*
56-64	8	*	*
65 or Older	3	*	*

*Low precision; no estimate reported.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2002-2005, 2006-2010 (Revised 3/12), 2011-2012.

Table A.11 Respondents Who Endorsed Only One Pain Reliever Use Disorder Criterion among People Aged 12 or Older, by Criterion and Demographic Characteristic: Weighted Numbers in Thousands, Annual Averages Based on 2002-2012 NSDUHs

Demographic Characteristic	Hazardous Use Only	Role Failure Only	Continued Use Despite Social Problems Only	Longer/More Use Only	Failure to Cut Down Only	Spent a Great Deal of Time Only	Reduced Activities Only	Continued Use Despite Physical Problems Only	Tolerance Only	Withdrawal Only
TOTAL	109	35	*	18	68	389	50	34	664	1,013
GENDER										
Male	77	17	*	7	33	190	19	12	355	526
Female	32	18	*	11	35	199	30	22	309	487
HISPANIC ORIGIN AND RACE										
Not Hispanic or Latino	81	29	*	16	58	329	42	32	572	888
White	67	21	*	12	40	260	28	30	489	751
Black or African American	10	6	*	2	15	42	12	*	56	78
American Indian or Alaska Native	1	1	*	*	1	3	0	1	3	15
Native Hawaiian or Other Pacific Islander	*	*	*	*	*	2	0	0	1	3
Asian	3	1	*	1	2	16	2	*	13	23
Two or More Races	1	0	*	0	1	6	1	0	10	18
Hispanic or Latino	27	6	*	2	10	60	7	*	92	125
AGE										
12-13	1	3	*	1	3	9	3	1	15	20
14-15	3	6	1	1	6	20	3	2	34	51
16-17	7	5	1	2	5	32	4	3	59	76
18-25	35	10	4	4	14	119	11	8	230	321
26-35	29	5	*	*	10	69	7	12	135	225
36-45	22	3	*	*	7	64	12	4	91	166
46-55	6	*	*	*	13	39	8	4	70	112
56-64	5	*	*	5	10	21	*	*	15	32
65 or Older	*	*	*	*	*	15	*	*	15	11

*Low precision; no estimate reported.

NOTE: Pain reliever use disorder is based on definitions found in the 4th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV).

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2002-2005, 2006-2010 (Revised 3/12), 2011-2012.

Table A.12 Heroin/Pain Reliever Legal Criterion Endorsement among People Aged 12 or Older, by Demographic Characteristic: Weighted Numbers in Thousands, Annual Averages Based on 2002-2012 NSDUHs

Demographic Characteristic	DSM-IV Legal Criterion Endorsement	Respondents Who Endorsed Only the DSM-IV Legal Criterion	Respondents Who Endorsed the DSM-IV Legal Criterion and One Other DSM-IV SUD Criterion
TOTAL	305	15	16
GENDER			
Male	207	9	12
Female	98	*	*
HISPANIC ORIGIN AND RACE			
Not Hispanic or Latino	252	13	12
White	189	*	*
Black or African American	46	4	5
American Indian or Alaska Native	6	1	0
Native Hawaiian or Other Pacific Islander	0	0	*
Asian	4	*	1
Two or More Races	7	0	*
Hispanic or Latino	52	2	5
AGE			
12-13	6	*	1
14-15	14	1	2
16-17	20	2	1
18-25	77	4	4
26-35	85	3	7
36-45	50	3	3
46-55	41	*	*
56-64	8	*	*
65 or Older	5	*	*

*Low precision; no estimate reported.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2002-2005, 2006-2010 (Revised 3/12), 2011-2012.

Table A.13 Respondents Who Endorsed Only One Heroin/Pain Reliever Use Disorder Criterion among People Aged 12 or Older, by Criterion and Demographic Characteristic: Weighted Numbers in Thousands, Annual Averages Based on 2002-2012 NSDUHs

Demographic Characteristic	Hazardous Use Only	Role Failure Only	Continued Use Despite Social Problems Only	Longer/ More Use Only	Failure to Cut Down Only	Spent a Great Deal of Time Only	Reduced Activities Only	Continued Use Despite Physical Problems Only	Tolerance Only	Withdrawal Only
TOTAL	110	36	*	18	68	393	52	34	655	1,180
GENDER										
Male	77	18	*	7	33	194	21	12	347	634
Female	32	18	*	11	35	199	31	22	308	546
HISPANIC ORIGIN AND RACE										
Not Hispanic or Latino	82	29	*	16	58	332	43	32	566	1,017
White	68	22	*	13	40	261	28	30	482	847
Black or African American	10	6	*	2	15	44	12	*	56	106
American Indian or Alaska Native	1	1	*	*	1	3	0	1	3	15
Native Hawaiian or Other Pacific Islander	*	*	*	*	*	2	0	0	1	3
Asian	3	1	*	1	2	16	2	*	13	24
Two or More Races	1	0	*	0	1	6	1	0	10	22
Hispanic or Latino	28	7	*	2	10	61	9	2	88	162
AGE										
12-13	1	3	*	1	3	9	3	1	15	20
14-15	3	6	1	1	6	21	3	2	34	53
16-17	7	5	1	2	5	33	4	3	60	80
18-25	35	10	3	5	14	118	12	8	225	366
26-35	30	4	*	*	10	68	9	12	133	275
36-45	22	3	*	*	7	65	12	4	90	193
46-55	6	2	*	*	13	42	8	4	69	147
56-64	5	*	*	5	10	23	*	*	14	34
65 or Older	*	*	*	*	*	15	*	*	15	12

*Low precision; no estimate reported.

NOTE: Heroin/pain reliever use disorder is based on definitions found in the 4th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV).

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2002-2005, 2006-2010 (Revised 3/12), 2011-2012.

Table A.14 Sedative Legal Criterion Endorsement among People Aged 12 or Older, by Demographic Characteristic: Weighted Numbers in Thousands, Annual Averages Based on 2002-2012 NSDUHs

Demographic Characteristic	DSM-IV Legal Criterion Endorsement	Respondents Who Endorsed Only the DSM-IV Legal Criterion	Respondents Who Endorsed the DSM-IV Legal Criterion and One Other DSM-IV SUD Criterion
TOTAL	37	*	*
GENDER			
Male	25	*	*
Female	12	*	*
HISPANIC ORIGIN AND RACE			
Not Hispanic or Latino	30	*	*
White	23	*	*
Black or African American	5	*	*
American Indian or Alaska Native	0	*	*
Native Hawaiian or Other Pacific Islander	0	*	*
Asian	1	*	*
Two or More Races	1	*	*
Hispanic or Latino	8	*	*
AGE			
12-13	1	*	*
14-15	2	*	*
16-17	3	*	1
18-25	9	*	*
26-35	9	*	*
36-45	6	*	*
46-55	3	*	*
56-64	2	*	*
65 or Older	2	*	*

*Low precision; no estimate reported.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2002-2005, 2006-2010 (Revised 3/12), 2011-2012.

Table A.15 Respondents Who Endorsed Only One Sedative Use Disorder Criterion among People Aged 12 or Older, by Criterion and Demographic Characteristic: Weighted Numbers in Thousands, Annual Averages Based on 2002-2012 NSDUHs

Demographic Characteristic	Hazardous Use Only	Role Failure Only	Continued Use Despite Social Problems Only	Longer/ More Use Only	Failure to Cut Down Only	Spent a Great Deal of Time Only	Reduced Activities Only	Continued Use Despite Physical Problems Only	Tolerance Only	Withdrawal Only
TOTAL	*	*	*	*	*	29	*	*	63	128
GENDER										
Male	7	*	*	*	*	16	*	*	33	54
Female	*	*	*	*	*	13	*	*	30	74
HISPANIC ORIGIN AND RACE										
Not Hispanic or Latino	*	*	*	*	*	28	*	*	58	109
White	9	*	*	*	*	27	*	*	51	91
Black or African American	*	*	*	*	*	*	*	*	5	12
American Indian or Alaska Native	*	*	*	*	*	*	*	0	1	3
Native Hawaiian or Other Pacific Islander	*	*	*	*	*	*	*	*	*	*
Asian	*	*	*	*	*	*	*	*	*	*
Two or More Races	*	*	*	*	*	0	*	*	1	3
Hispanic or Latino	2	*	*	*	2	*	*	*	4	19
AGE										
12-13	*	1	*	*	0	*	1	*	1	2
14-15	*	1	*	*	*	1	1	*	3	8
16-17	1	*	*	*	*	2	0	1	3	7
18-25	3	*	*	*	*	7	*	*	11	24
26-35	2	*	*	*	*	4	*	*	11	23
36-45	5	*	*	*	*	3	*	*	10	22
46-55	*	*	*	*	3	11	*	*	12	35
56-64	*	*	*	*	*	*	*	*	4	4
65 or Older	*	*	*	*	*	*	*	*	8	*

*Low precision; no estimate reported.

NOTE: Sedative use disorder is based on definitions found in the 4th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV).

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2002-2005, 2006-2010 (Revised 3/12), 2011-2012.

Table A.16 Tranquilizer Legal Criterion Endorsement among People Aged 12 or Older, by Demographic Characteristic: Weighted Numbers in Thousands, Annual Averages Based on 2002-2012 NSDUHs

Demographic Characteristic	DSM-IV Legal Criterion Endorsement	Respondents Who Endorsed Only the DSM-IV Legal Criterion	Respondents Who Endorsed the DSM-IV Legal Criterion and One Other DSM-IV SUD Criterion
TOTAL	87	*	*
GENDER			
Male	57	*	6
Female	30	*	*
HISPANIC ORIGIN AND RACE			
Not Hispanic or Latino	74	*	*
White	56	*	*
Black or African American	13	*	*
American Indian or Alaska Native	1	1	*
Native Hawaiian or Other Pacific Islander	*	*	*
Asian	2	*	*
Two or More Races	3	2	*
Hispanic or Latino	13	3	*
AGE			
12-13	1	*	*
14-15	5	*	1
16-17	9	2	1
18-25	25	2	3
26-35	16	3	*
36-45	14	*	*
46-55	11	*	*
56-64	*	*	*
65 or Older	3	*	2

*Low precision; no estimate reported.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2002-2005, 2006-2010 (Revised 3/12), 2011-2012.

Table A.17 Sedative/Tranquilizer Legal Criterion Endorsement among People Aged 12 or Older, by Demographic Characteristic: Weighted Numbers in Thousands, Annual Averages Based on 2002-2012 NSDUHs

Demographic Characteristic	DSM-IV Legal Criterion Endorsement	Respondents Who Endorsed Only the DSM-IV Legal Criterion	Respondents Who Endorsed the DSM-IV Legal Criterion and One Other DSM-IV SUD Criterion
TOTAL	112	*	*
GENDER			
Male	73	*	*
Female	39	*	*
HISPANIC ORIGIN AND RACE			
Not Hispanic or Latino	92	*	*
White	69	*	*
Black or African American	17	*	*
American Indian or Alaska Native	1	1	*
Native Hawaiian or Other Pacific Islander	0	*	*
Asian	2	*	*
Two or More Races	3	2	*
Hispanic or Latino	20	3	*
AGE			
12-13	2	*	*
14-15	7	0	1
16-17	11	2	1
18-25	32	2	2
26-35	23	3	*
36-45	18	*	*
46-55	13	*	*
56-64	2	*	*
65 or Older	3	*	*

*Low precision; no estimate reported.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2002-2005, 2006-2010 (Revised 3/12), 2011-2012.

Table A.18 Respondents Who Endorsed Only One Sedatives/Anxiolytic/Hypnotics Use Disorder Criterion among People Aged 12 or Older, by Criterion and Demographic Characteristic: Weighted Numbers in Thousands, Annual Averages Based on 2002-2012 NSDUHs

Demographic Characteristic	Hazardous Use Only	Role Failure Only	Continued Use Despite Social Problems Only	Longer/ More Use Only	Failure to Cut Down Only	Spent a Great Deal of Time Only	Reduced Activities Only	Continued Use Despite Physical Problems Only	Tolerance Only	Withdrawal Only
TOTAL	66	24	*	*	43	112	25	13	221	128
GENDER										
Male	41	11	*	*	19	52	15	6	111	54
Female	25	13	*	*	24	60	10	7	111	74
HISPANIC ORIGIN AND RACE										
Not Hispanic or Latino	56	18	*	*	34	102	18	12	206	109
White	52	13	*	*	31	92	17	10	187	91
Black or African American	3	*	*	*	3	8	*	2	11	12
American Indian or Alaska Native	1	*	*	*	0	0	*	0	3	3
Native Hawaiian or Other Pacific Islander	*	*	*	*	*	0	0	*	0	*
Asian	*	4	1	*	*	*	*	*	2	*
Two or More Races	0	0	*	*	*	1	*	*	3	3
Hispanic or Latino	10	6	*	*	9	10	6	*	15	19
AGE										
12-13	*	1	*	*	1	1	1	*	2	2
14-15	1	2	1	1	1	3	1	1	10	8
16-17	5	2	1	*	1	8	3	1	18	7
18-25	26	5	2	*	7	34	6	4	66	24
26-35	18	3	*	*	2	30	5	3	50	23
36-45	9	4	*	*	3	17	*	*	29	22
46-55	3	4	*	*	15	14	5	*	26	35
56-64	4	4	*	*	9	4	2	*	8	4
65 or Older	*	*	*	*	3	*	*	*	12	*

*Low precision; no estimate reported.

NOTE: Sedatives/anxiolytic/hypnotics use disorder is based on definitions found in the 4th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV).

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2002-2005, 2006-2010 (Revised 3/12), 2011-2012.

Table A.19 Stimulant Legal Criterion Endorsement among People Aged 12 or Older, by Demographic Characteristic: Weighted Numbers in Thousands, Annual Averages Based on 2002-2012 NSDUHs

Demographic Characteristic	DSM-IV Legal Criterion Endorsement	Respondents Who Endorsed Only the DSM-IV Legal Criterion	Respondents Who Endorsed the DSM-IV Legal Criterion and One Other DSM-IV SUD Criterion
TOTAL	89	*	*
GENDER			
Male	56	*	*
Female	33	*	*
HISPANIC ORIGIN AND RACE			
Not Hispanic or Latino	77	*	*
White	63	*	*
Black or African American	6	*	*
American Indian or Alaska Native	3	*	1
Native Hawaiian or Other Pacific Islander	1	*	0
Asian	1	*	*
Two or More Races	2	0	*
Hispanic or Latino	12	*	*
AGE			
12-13	2	*	*
14-15	6	*	1
16-17	8	*	1
18-25	26	2	*
26-35	24	2	*
36-45	16	*	*
46-55	6	*	*
56-64	*	*	*
65 or Older	*	*	*

*Low precision; no estimate reported.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2002-2005, 2006-2010 (Revised 3/12), 2011-2012.

Table A.20 Respondents Who Endorsed Only One Stimulant Use Disorder Criterion among People Aged 12 or Older, by Criterion and Demographic Characteristic: Weighted Numbers in Thousands, Annual Averages Based on 2002-2012 NSDUHs

Demographic Characteristic	Hazardous Use Only	Role Failure Only	Continued Use Despite Social Problems Only	Longer/ More Use Only	Failure to Cut Down Only	Spent a Great Deal of Time Only	Reduced Activities Only	Continued Use Despite Physical Problems Only	Tolerance Only	Withdrawal Only
TOTAL	19	13	*	*	16	78	*	23	123	292
GENDER										
Male	11	7	*	*	7	37	7	9	67	129
Female	7	*	*	*	9	41	*	14	56	163
HISPANIC ORIGIN AND RACE										
Not Hispanic or Latino	17	11	*	*	14	69	*	20	114	258
White	16	*	*	*	9	57	*	18	103	232
Black or African American	*	2	*	*	2	6	*	3	4	10
American Indian or Alaska Native	0	0	*	0	*	1	0	*	1	4
Native Hawaiian or Other Pacific Islander	0	*	*	*	*	*	*	*	0	3
Asian	*	*	*	*	3	4	*	*	2	4
Two or More Races	0	*	*	0	1	1	1	*	4	5
Hispanic or Latino	2	2	*	*	*	9	*	2	9	34
AGE										
12-13	*	1	*	*	0	1	1	*	4	5
14-15	1	2	1	*	1	3	1	1	9	17
16-17	3	1	1	1	1	10	*	2	15	23
18-25	8	4	2	*	7	44	3	7	51	102
26-35	*	3	*	*	*	8	4	4	21	65
36-45	2	*	*	*	3	4	*	3	16	48
46-55	3	*	*	*	*	7	*	4	7	25
56-64	*	*	*	*	*	1	*	*	*	8
65 or Older	*	*	*	*	*	*	*	*	*	*

*Low precision; no estimate reported.

NOTE: Stimulant use disorder is based on definitions found in the 4th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV).

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2002-2005, 2006-2010 (Revised 3/12), 2011-2012.

Table A.21 Cocaine Legal Criterion Endorsement among People Aged 12 or Older, by Demographic Characteristic: Weighted Numbers in Thousands, Annual Averages Based on 2002-2012 NSDUHs

Demographic Characteristic	DSM-IV Legal Criterion Endorsement	Respondents Who Endorsed Only the DSM-IV Legal Criterion	Respondents Who Endorsed the DSM-IV Legal Criterion and One Other DSM-IV SUD Criterion
TOTAL	292	*	*
GENDER			
Male	198	*	7
Female	94	*	*
HISPANIC ORIGIN AND RACE			
Not Hispanic or Latino	236	*	*
White	136	*	*
Black or African American	90	2	4
American Indian or Alaska Native	2	*	1
Native Hawaiian or Other Pacific Islander	2	*	*
Asian	1	*	*
Two or More Races	6	*	*
Hispanic or Latino	56	2	2
AGE			
12-13	1	*	*
14-15	7	*	1
16-17	11	0	1
18-25	62	2	3
26-35	72	3	6
36-45	86	2	*
46-55	48	*	*
56-64	3	*	*
65 or Older	2	*	*

*Low precision; no estimate reported.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2002-2005, 2006-2010 (Revised 3/12), 2011-2012.

Table A.22 Respondents Who Endorsed Only One Cocaine Use Disorder Criterion among People Aged 12 or Older, by Criterion and Demographic Characteristic: Weighted Numbers in Thousands, Annual Averages Based on 2002-2012 NSDUHs

Demographic Characteristic	Hazardous Use Only	Role Failure Only	Continued Use Despite Social Problems Only	Longer/ More Use Only	Failure to Cut Down Only	Spent a Great Deal of Time Only	Reduced Activities Only	Continued Use Despite Physical Problems Only	Tolerance Only	Withdrawal Only
TOTAL	58	25	13	14	30	133	39	31	215	582
GENDER										
Male	44	18	7	10	20	83	25	20	148	355
Female	14	7	*	*	10	50	13	11	67	227
HISPANIC ORIGIN AND RACE										
Not Hispanic or Latino	42	21	*	12	24	110	32	27	175	492
White	37	19	10	*	15	83	22	25	145	365
Black or African American	2	2	*	3	9	20	8	2	19	104
American Indian or Alaska Native	1	0	*	*	0	1	*	*	2	5
Native Hawaiian or Other Pacific Islander	0	*	*	*	*	1	0	*	1	2
Asian	*	*	*	*	*	3	*	*	3	6
Two or More Races	2	0	*	*	*	3	1	*	4	9
Hispanic or Latino	16	3	2	3	6	23	7	4	40	90
AGE										
12-13	*	*	*	*	*	1	*	*	1	1
14-15	2	1	*	*	1	3	1	*	3	9
16-17	4	1	1	1	1	9	1	1	14	24
18-25	26	8	4	6	10	53	8	8	93	154
26-35	15	5	4	5	6	27	18	12	57	138
36-45	7	3	3	*	*	22	5	6	24	140
46-55	4	7	*	*	9	14	6	*	18	102
56-64	*	*	*	*	*	4	*	2	5	14
65 or Older	*	*	*	*	*	*	*	*	*	*

*Low precision; no estimate reported.

NOTE: Cocaine use disorder is based on definitions found in the 4th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV).

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2002-2005, 2006-2010 (Revised 3/12), 2011-2012.

Table A.23 Stimulant/Cocaine Legal Criterion Endorsement among People Aged 12 or Older, by Demographic Characteristic: Weighted Numbers in Thousands, Annual Averages Based on 2002-2012 NSDUHs

Demographic Characteristic	DSM-IV Legal Criterion Endorsement	Respondents Who Endorsed Only the DSM-IV Legal Criterion	Respondents Who Endorsed the DSM-IV Legal Criterion and One Other DSM-IV SUD Criterion
TOTAL	363	*	16
GENDER			
Male	240	8	11
Female	123	*	*
HISPANIC ORIGIN AND RACE			
Not Hispanic or Latino	297	*	13
White	189	*	*
Black or African American	91	2	4
American Indian or Alaska Native	4	*	1
Native Hawaiian or Other Pacific Islander	3	*	0
Asian	1	*	*
Two or More Races	8	0	*
Hispanic or Latino	66	3	3
AGE			
12-13	3	*	*
14-15	12	0	2
16-17	17	1	2
18-25	84	3	4
26-35	90	5	6
36-45	99	2	*
46-55	51	*	*
56-64	5	*	*
65 or Older	2	*	*

*Low precision; no estimate reported.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2002-2005, 2006-2010 (Revised 3/12), 2011-2012.

Table A.24 Respondents Who Endorsed Only One Stimulant/Cocaine Use Disorder Criterion among People Aged 12 or Older, by Criterion and Demographic Characteristic: Weighted Numbers in Thousands, Annual Averages Based on 2002-2012 NSDUHs

Demographic Characteristic	Hazardous Use Only	Role Failure Only	Continued Use Despite Social Problems Only	Longer/ More Use Only	Failure to Cut Down Only	Spent a Great Deal of Time Only	Reduced Activities Only	Continued Use Despite Physical Problems Only	Tolerance Only	Withdrawal Only
TOTAL	70	32	17	16	44	189	45	45	308	842
GENDER										
Male	51	21	10	11	26	108	28	24	199	469
Female	19	10	7	*	18	81	16	22	109	373
HISPANIC ORIGIN AND RACE										
Not Hispanic or Latino	53	27	14	14	36	159	38	39	262	721
White	47	22	13	10	22	122	27	36	222	571
Black or African American	3	4	*	3	10	23	9	3	23	114
American Indian or Alaska Native	1	0	*	0	0	2	*	*	3	9
Native Hawaiian or Other Pacific Islander	0	*	*	*	*	1	0	*	1	5
Asian	*	*	*	*	3	7	*	*	5	9
Two or More Races	2	0	0	*	1	4	2	*	8	13
Hispanic or Latino	18	5	3	2	8	31	7	6	46	122
AGE										
12-13	*	1	*	*	0	1	1	*	5	6
14-15	3	3	0	0	2	6	1	1	11	25
16-17	6	2	1	1	2	16	1	3	26	44
18-25	28	9	6	7	17	87	9	13	126	242
26-35	16	7	5	5	7	33	21	13	75	196
36-45	10	2	3	*	5	24	5	7	39	183
46-55	7	7	*	*	10	17	7	6	21	124
56-64	*	*	*	*	*	4	*	2	6	22
65 or Older	*	*	*	*	*	*	*	*	*	*

*Low precision; no estimate reported.

NOTE: Stimulant/Cocaine use disorder is based on definitions found in the 4th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV).

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2002-2005, 2006-2010 (Revised 3/12), 2011-2012.

Appendix B: Additional Substance Use Disorder Tables: Prevalence among Past Year Substance Using People Aged 12 or Older

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Table B.1 Alcohol Legal Criterion Endorsement among Past Year Alcohol Users Aged 12 or Older, by Demographic Characteristic: Weighted Percentages, Annual Averages Based on 2002-2012 NSDUHs

Demographic Characteristic	DSM-IV Legal Criterion Endorsement	Respondents Who Endorsed Only the DSM-IV Legal Criterion	Respondents Who Endorsed the DSM-IV Legal Criterion and One Other DSM-IV SUD Criterion
TOTAL	1.3	0.1	0.1
GENDER			
Male	1.9	0.1	0.2
Female	0.6	0.0	0.1
HISPANIC ORIGIN AND RACE			
Not Hispanic or Latino	1.1	0.1	0.1
White	0.9	0.1	0.1
Black or African American	1.9	0.1	0.2
American Indian or Alaska Native	7.3	0.5	0.6
Native Hawaiian or Other Pacific Islander	2.6	0.0	0.2
Asian	0.8	0.0	0.1
Two or More Races	1.5	0.2	0.1
Hispanic or Latino	2.6	0.2	0.3
AGE			
12-13	1.5	0.2	0.1
14-15	2.4	0.2	0.4
16-17	2.8	0.2	0.3
18-25	2.6	0.2	0.3
26-35	1.5	0.1	0.1
36-45	1.0	0.1	0.1
46-55	0.9	0.1	0.1
56-64	0.5	0.0	0.1
65 or Older	0.2	0.1	0.0

*Low precision; no estimate reported.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2002-2005, 2006-2010 (Revised 3/12), 2011-2012.

Table B.2 Alcohol Use Disorder among Past Year Alcohol Users Aged 12 or Older under DSM-IV and DSM-5 Criteria, by Demographic Characteristics: Weighted Percentages, Annual Averages Based on 2002-2012 NSDUHs

Demographic Characteristic	DSM-IV[1]	DSM-5[2]	Diagnostic Orphans[3]	Respondents Who Endorsed Only One Criteria[4]
TOTAL	11.1	12.8	3.7	13.1
GENDER				
Male	14.3	15.9	4.3	15.1
Female	7.8	9.6	3.1	11.1
HISPANIC ORIGIN AND RACE				
Not Hispanic or Latino	10.8	12.4	3.6	12.8
White	10.8	12.0	3.3	12.4
Black or African American	11.3	14.8	5.0	15.5
American Indian or Alaska Native	24.6	27.4	5.6	13.4
Native Hawaiian or Other Pacific Islander	13.3	17.9	5.8	19.0
Asian	6.7	10.0	4.3	14.0
Two or More Races	12.8	14.6	4.1	13.7
Hispanic or Latino	13.4	16.0	4.7	15.2
AGE				
12-13	8.7	10.8	3.4	10.9
14-15	14.3	16.5	4.4	13.7
16-17	18.4	21.8	6.0	16.5
18-25	21.2	24.8	6.7	19.2
26-35	13.7	15.3	4.1	14.9
36-45	10.1	11.1	3.1	12.3
46-55	8.2	9.4	2.8	11.3
56-64	5.4	6.7	2.5	9.1
65 or Older	3.0	4.0	1.8	9.3

*Low precision; no estimate reported.

[1] Alcohol Use Disorder is based on definitions found in the 4th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV).
[2] Alcohol Use Disorder is based on definitions found in the 5th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5).
[3] Diagnostic orphans include individuals who endorsed two DSM-IV dependence criteria and no abuse criteria.
[4] Excludes DSM-IV legal problem criterion.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2002-2005, 2006-2010 (Revised 3/12), 2011-2012.

Table B.3 Respondents Who Endorsed Only One Alcohol Use Disorder Criterion among Past Year Alcohol Users Aged 12 or Older, by Criterion and Demographic Characteristic: Weighted Percentages, Annual Averages Based on 2002-2012 NSDUHs

Demographic Characteristic	Hazardous Use Only	Role Failure Only	Continued Use Despite Social Problems Only	Longer/More Use Only	Failure to Cut Down Only	Time Spent Only	Reduced Activities Only	Continued Use Despite Physical Problems Only	Tolerance Only	Withdrawal Only
TOTAL	1.5	0.1	0.2	0.3	0.6	4.3	0.3	0.5	5.0	2.2
GENDER										
Male	2.1	0.2	0.2	0.4	0.7	4.7	0.4	0.5	5.7	2.9
Female	1.0	0.1	0.1	0.3	0.6	3.8	0.2	0.5	4.3	1.4
HISPANIC ORIGIN AND RACE										
Not Hispanic or Latino	1.6	0.1	0.2	0.3	0.6	4.2	0.3	0.5	4.9	1.9
White	1.7	0.1	0.2	0.3	0.6	4.2	0.3	0.6	4.3	1.7
Black or African American	0.9	0.2	0.1	0.4	0.7	4.2	0.3	0.2	8.1	3.3
American Indian or Alaska Native	1.6	0.1	0.4	0.3	0.2	4.6	0.4	0.3	5.2	7.9
Native Hawaiian or Other Pacific Islander	0.5	0.5	0.0	0.2	0.3	5.5	1.8	0.2	9.5	4.2
Asian	0.7	0.1	0.1	0.3	0.5	4.5	0.6	0.5	6.4	1.5
Two or More Races	1.3	0.3	0.5	0.4	0.4	4.7	0.2	0.4	5.3	2.6
Hispanic or Latino	1.3	0.3	0.2	0.4	0.7	5.0	0.4	0.3	6.3	3.7
AGE										
12-13	0.5	0.6	0.1	0.1	0.5	1.7	0.3	0.1	6.5	3.3
14-15	1.1	0.5	0.3	0.2	0.4	2.8	0.4	0.2	7.5	3.5
16-17	1.6	0.3	0.3	0.3	0.3	4.3	0.4	0.3	8.4	3.0
18-25	2.3	0.3	0.2	0.4	0.4	6.4	0.4	0.5	8.1	3.0
26-35	2.0	0.2	0.2	0.4	0.6	5.3	0.4	0.5	5.1	2.6
36-45	1.7	0.1	0.1	0.3	0.6	4.3	0.3	0.5	4.1	2.4
46-55	1.2	0.1	0.2	0.3	0.8	3.7	0.3	0.6	3.9	1.9
56-64	1.0	0.0	0.2	0.2	0.7	3.1	0.1	0.5	3.3	1.1
65 or Older	0.6	0.0	0.1	0.4	0.8	2.1	0.1	0.4	4.7	0.7

*Low precision; no estimate reported.

NOTE: Alcohol Use Disorder is based on definitions found in the 4th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV).

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2002-2005, 2006-2010 (Revised 3/12), 2011-2012.

Table B.4 Marijuana Legal Criterion Endorsement among Past Year Marijuana Users Aged 12 or Older, by Demographic Characteristic: Weighted Percentages, Annual Averages Based on 2002-2012 NSDUHs

Demographic Characteristic	DSM-IV Legal Criterion Endorsement	Respondents Who Endorsed Only the DSM-IV Legal Criterion	Respondents Who Endorsed the DSM-IV Legal Criterion and One Other DSM-IV SUD Criterion
TOTAL	2.2	0.1	0.3
GENDER			
Male	2.8	0.2	0.4
Female	1.3	0.1	0.1
HISPANIC ORIGIN AND RACE			
Not Hispanic or Latino	2.0	0.1	0.3
White	1.7	0.1	0.2
Black or African American	3.3	0.2	0.5
American Indian or Alaska Native	3.9	0.3	0.5
Native Hawaiian or Other Pacific Islander	1.4	*	*
Asian	1.5	0.1	0.0
Two or More Races	2.4	0.1	0.3
Hispanic or Latino	4.1	0.4	0.4
AGE			
12-13	5.9	0.5	0.7
14-15	6.0	0.3	0.6
16-17	4.8	0.2	0.4
18-25	2.7	0.1	0.3
26-35	1.5	0.2	0.2
36-45	1.1	0.0	0.1
46-55	0.8	0.1	0.2
56-64	0.4	*	0.3
65 or Older	*	*	*

*Low precision; no estimate reported.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2002-2005, 2006-2010 (Revised 3/12), 2011-2012.

Table B.5 Hallucinogen Legal Criterion Endorsement among Past Year Hallucinogen Users Aged 12 or Older, by Demographic Characteristic: Weighted Percentages, Annual Averages Based on 2002-2012 NSDUHs

Demographic Characteristic	DSM-IV Legal Criterion Endorsement	Respondents Who Endorsed Only the DSM-IV Legal Criterion	Respondents Who Endorsed the DSM-IV Legal Criterion and One Other DSM-IV SUD Criterion
TOTAL	1.5	0.1	0.1
GENDER			
Male	1.6	0.1	0.1
Female	1.3	0.0	0.1
HISPANIC ORIGIN AND RACE			
Not Hispanic or Latino	1.2	0.1	0.2
White	0.9	0.1	0.2
Black or African American	3.3	0.4	0.1
American Indian or Alaska Native	*	0.1	0.5
Native Hawaiian or Other Pacific Islander	*	*	*
Asian	0.8	*	0.2
Two or More Races	0.8	*	0.1
Hispanic or Latino	3.4	0.1	0.0
AGE			
12-13	5.1	1.1	1.1
14-15	3.5	0.3	0.5
16-17	2.2	0.1	0.3
18-25	1.1	0.1	0.1
26-35	1.1	0.2	*
36-45	2.5	*	*
46-55	*	*	0.2
56-64	*	*	*
65 or Older	*	*	*

*Low precision; no estimate reported.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2002-2005, 2006-2010 (Revised 3/12), 2011-2012.

Table B.6 Hallucinogen Use Disorder among Past Year Hallucinogen Users Aged 12 or Older under DSM-IV and DSM-5 Criteria, by Demographic Characteristics: Weighted Percentages, Annual Averages Based on 2002-2012 NSDUHs

Demographic Characteristic	DSM-IV[1]	DSM-5[2]	Diagnostic Orphans[3]	Respondents Who Endorsed Only One Criterion[4]
TOTAL	9.1	9.3	2.3	9.8
GENDER				
Male	8.9	8.7	2.0	10.0
Female	9.6	10.4	2.7	9.5
HISPANIC ORIGIN AND RACE				
Not Hispanic or Latino	8.5	8.6	2.1	9.7
White	8.1	8.3	2.2	9.6
Black or African American	12.3	11.8	1.6	8.8
American Indian or Alaska Native	10.3	11.6	2.6	9.9
Native Hawaiian or Other Pacific Islander	*	*	*	*
Asian	4.1	6.0	3.2	12.6
Two or More Races	10.3	9.2	1.3	11.4
Hispanic or Latino	13.6	14.1	3.0	10.7
AGE				
12-13	18.9	18.0	3.8	12.4
14-15	18.9	18.0	3.3	14.4
16-17	14.4	14.0	3.3	12.5
18-25	8.3	8.7	2.4	10.4
26-35	6.6	6.4	1.2	7.2
36-45	7.0	8.2	1.2	5.3
46-55	*	*	*	*
56-64	*	*	*	*
65 or Older	*	*	*	*

*Low precision; no estimate reported.

[1] Hallucinogen Use Disorder is based on definitions found in the 4th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV).
[2] Hallucinogen Use Disorder is based on definitions found in the 5th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5).
[3] Diagnostic orphans include individuals who endorsed two DSM-IV dependence criteria and no abuse criteria.
[4] Excludes DSM-IV legal problem criterion.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2002-2005, 2006-2010 (Revised 3/12), 2011-2012.

Table B.7 Respondents Who Endorsed Only One Hallucinogen Use Disorder Criterion among Past Year Hallucinogen Users Aged 12 or Older, by Criterion and Demographic Characteristic: Weighted Percentages, Annual Averages Based on 2002-2012 NSDUHs

Demographic Characteristic	Hazardous Use Only	Role Failure Only	Continued Use Despite Social Problems Only	Longer/More Use Only	Failure to Cut Down Only	Time Spent Only	Reduced Activities Only	Continued Use Despite Physical Problems Only	Tolerance Only	Withdrawal Only
TOTAL	1.4	0.3	0.1	0.2	0.3	2.9	0.5	0.5	3.6	--
GENDER										
Male	1.6	0.3	0.1	0.3	0.3	3.0	0.6	0.4	3.6	--
Female	1.1	0.4	0.3	0.1	0.3	2.8	0.3	0.7	3.6	--
HISPANIC ORIGIN AND RACE										
Not Hispanic or Latino	1.4	0.3	0.1	0.2	0.3	2.9	0.5	0.5	3.5	--
White	1.5	0.2	0.1	0.2	0.2	3.0	0.5	0.5	3.5	--
Black or African American	1.2	0.5	0.0	0.6	0.9	1.4	0.4	0.4	3.4	--
American Indian or Alaska Native	0.6	0.1	*	*	0.3	2.5	1.7	0.7	3.9	--
Native Hawaiian or Other Pacific Islander	*	*	*	*	*	*	*	*	*	--
Asian	0.9	0.5	*	*	0.5	3.6	0.1	0.3	4.8	--
Two or More Races	2.1	0.3	*	0.1	*	4.8	0.1	0.5	3.5	--
Hispanic or Latino	1.3	0.8	0.3	0.1	0.4	2.9	0.3	0.4	4.2	--
AGE										
12-13	0.1	2.4	0.3	*	0.6	2.5	0.7	0.1	5.7	--
14-15	2.0	1.2	0.6	0.1	0.6	3.6	0.7	0.4	5.2	--
16-17	2.7	0.6	0.2	0.2	0.3	3.6	0.4	0.8	3.7	--
18-25	1.4	0.3	0.1	0.1	0.2	3.3	0.4	0.5	4.0	--
26-35	1.1	0.1	*	0.4	0.4	2.0	0.8	0.5	1.9	--
36-45	*	0.0	*	*	*	1.1	*	*	3.1	--
46-55	0.3	0.2	*	*	*	*	*	*	0.4	--
56-64	*	*	*	*	*	*	*	*	*	--
65 or Older	*	*	*	*	*	*	*	*	*	--

*Low precision; no estimate reported.

-- Not applicable.

NOTE: Hallucinogen Use Disorder is based on definitions found in the 4th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV).

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2002-2005, 2006-2010 (Revised 3/12), 2011-2012.

Table B.8 Inhalant Legal Criterion Endorsement among Past Year Inhalant Users Aged 12 or Older, by Demographic Characteristic: Weighted Percentages, Annual Averages Based on 2002-2012 NSDUHs

Demographic Characteristic	DSM-IV Legal Criterion Endorsement	Respondents Who Endorsed Only the DSM-IV Legal Criterion	Respondents Who Endorsed the DSM-IV Legal Criterion and One Other DSM-IV SUD Criterion
TOTAL	1.6	0.1	0.3
GENDER			
Male	1.8	0.2	0.3
Female	1.2	0.1	0.2
HISPANIC ORIGIN AND RACE			
Not Hispanic or Latino	1.4	0.1	0.2
White	1.0	0.1	0.2
Black or African American	4.1	0.1	0.7
American Indian or Alaska Native	1.8	0.1	0.2
Native Hawaiian or Other Pacific Islander	*	*	*
Asian	3.7	0.4	*
Two or More Races	0.9	*	*
Hispanic or Latino	2.1	0.3	0.5
AGE			
12-13	1.3	0.2	0.2
14-15	2.3	0.2	0.7
16-17	1.6	0.3	0.3
18-25	0.7	0.1	0.1
26-35	1.3	*	*
36-45	3.6	*	*
46-55	*	*	*
56-64	*	*	*
65 or Older	*	*	*

*Low precision; no estimate reported.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2002-2005, 2006-2010 (Revised 3/12), 2011-2012.

Table B.9 Inhalant Use Disorder among Past Year Inhalant Users Aged 12 or Older under DSM-IV and DSM-5 Criteria, by Demographic Characteristics: Weighted Percentages, Annual Averages Based on 2002-2012 NSDUHs

Demographic Characteristic	DSM-IV[1]	DSM-5[2]	Diagnostic Orphans[3]	Respondents Who Endorsed Only One Criterion[4]
TOTAL	8.6	8.3	2.1	11.6
GENDER				
Male	8.4	7.5	1.9	10.5
Female	9.0	9.5	2.5	13.3
HISPANIC ORIGIN AND RACE				
Not Hispanic or Latino	7.8	7.7	2.1	10.9
White	7.1	7.0	2.1	10.0
Black or African American	9.9	10.5	2.1	13.8
American Indian or Alaska Native	*	*	2.1	*
Native Hawaiian or Other Pacific Islander	*	*	*	*
Asian	11.8	11.3	1.6	*
Two or More Races	7.6	9.0	2.7	11.8
Hispanic or Latino	12.8	11.1	2.3	15.1
AGE				
12-13	8.9	9.7	2.8	16.7
14-15	11.4	10.9	2.8	14.7
16-17	8.6	8.7	2.8	11.3
18-25	6.1	5.5	1.4	8.1
26-35	5.1	5.1	1.1	10.7
36-45	*	14.7	2.1	*
46-55	9.9	7.3	*	7.8
56-64	*	*	*	*
65 or Older	*	*	*	*

*Low precision; no estimate reported.

[1] Inhalant Use Disorder is based on definitions found in the 4th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV).
[2] Inhalant Use Disorder is based on definitions found in the 5th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5).
[3] Diagnostic orphans include individuals who endorsed two DSM-IV dependence criteria and no abuse criteria.
[4] Excludes DSM-IV legal problem criterion.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2002-2005, 2006-2010 (Revised 3/12), 2011-2012.

Table B.10 Respondents Who Endorsed Only One Inhalant Use Disorder Criterion among Past Year Inhalant Users Aged 12 or Older, by Criterion and Demographic Characteristic: Weighted Percentages, Annual Averages Based on 2002-2012 NSDUHs

Demographic Characteristic	Hazardous Use Only	Role Failure Only	Continued Use Despite Social Problems Only	Longer/More Use Only	Failure to Cut Down Only	Time Spent Only	Reduced Activities Only	Continued Use Despite Physical Problems Only	Tolerance Only	Withdrawal Only
TOTAL	1.3	0.9	0.1	0.2	0.8	2.3	0.7	0.3	5.0	--
GENDER										
Male	1.4	1.0	0.1	0.3	0.9	1.7	0.5	0.3	4.2	--
Female	1.0	0.6	0.1	0.2	0.5	3.3	0.9	0.3	6.3	--
HISPANIC ORIGIN AND RACE										
Not Hispanic or Latino	1.3	0.6	0.1	0.2	0.7	2.3	0.6	0.3	5.0	--
White	1.4	0.6	0.1	0.2	0.6	1.9	0.3	0.3	4.6	--
Black or African American	0.4	0.4	0.1	0.1	0.7	3.0	2.2	0.2	6.8	--
American Indian or Alaska Native	2.8	0.6	*	*	0.2	*	0.0	*	*	--
Native Hawaiian or Other Pacific Islander	*	*	*	*	*	*	*	*	*	--
Asian	0.7	0.9	0.1	*	*	*	1.2	*	4.5	--
Two or More Races	0.7	0.1	*	0.1	1.2	2.6	1.3	0.1	5.2	--
Hispanic or Latino	1.2	*	0.0	0.7	1.4	2.7	1.3	0.5	5.1	--
AGE										
12-13	0.4	1.1	0.2	0.2	1.3	2.1	1.8	0.7	9.0	--
14-15	1.2	1.2	0.2	0.1	0.9	3.0	0.5	0.2	7.3	--
16-17	1.9	0.4	0.1	0.2	0.6	2.6	0.6	0.4	4.5	--
18-25	1.3	0.5	0.0	0.5	0.4	1.9	0.2	0.1	3.1	--
26-35	1.0	0.0	*	*	1.8	2.6	*	*	3.1	--
36-45	*	*	*	*	*	*	*	0.2	4.3	--
46-55	2.5	0.1	*	*	*	0.7	*	*	*	--
56-64	*	*	*	*	*	*	*	*	*	--
65 or Older	*	*	*	*	*	*	*	*	*	--

*Low precision; no estimate reported.

-- Not applicable.

NOTE: Inhalant Use Disorder is based on definitions found in the 4th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV).

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2002-2005, 2006-2010 (Revised 3/12), 2011-2012.

Table B.11 Pain Reliever Legal Criterion Endorsement among Past Year Pain Reliever Users Aged 12 or Older, by Demographic Characteristic: Weighted Percentages, Annual Averages Based on 2002-2012 NSDUHs

Demographic Characteristic	DSM-IV Legal Criterion Endorsement	Respondents Who Endorsed Only the DSM-IV Legal Criterion	Respondents Who Endorsed the DSM-IV Legal Criterion and One Other DSM-IV SUD Criterion
TOTAL	1.9	0.1	0.1
GENDER			
Male	2.3	0.1	0.1
Female	1.3	0.1	0.1
HISPANIC ORIGIN AND RACE			
Not Hispanic or Latino	1.8	0.1	0.1
White	1.7	0.1	0.0
Black or African American	2.7	0.3	0.5
American Indian or Alaska Native	6.5	*	0.1
Native Hawaiian or Other Pacific Islander	1.1	0.2	*
Asian	1.4	*	*
Two or More Races	2.5	0.3	0.0
Hispanic or Latino	2.1	0.1	0.2
AGE			
12-13	2.1	0.2	0.2
14-15	2.3	0.3	0.2
16-17	2.0	0.3	0.1
18-25	1.5	0.1	0.1
26-35	2.1	0.1	0.2
36-45	2.0	0.2	0.2
46-55	2.2	0.1	0.0
56-64	1.7	0.1	*
65 or Older	*	*	*

*Low precision; no estimate reported.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2002-2005, 2006-2010 (Revised 3/12), 2011-2012.

Table B.12 Pain Reliever Use Disorder among Past Year Pain Reliever Users Aged 12 or Older under DSM-IV and DSM-5 Criteria, by Demographic Characteristics: Weighted Percentages, Annual Averages Based on 2002-2012 NSDUHs

Demographic Characteristic	DSM-IV[1]	DSM-5[2]	Diagnostic Orphans[3]	Respondents Who Endorsed Only One Criterion[4]
TOTAL	14.2	17.4	4.7	12.4
GENDER				
Male	14.6	17.0	4.1	11.7
Female	13.7	18.0	5.4	13.2
HISPANIC ORIGIN AND RACE				
Not Hispanic or Latino	14.3	17.9	4.9	12.1
White	14.5	18.1	4.8	11.8
Black or African American	13.3	16.5	5.1	14.4
American Indian or Alaska Native	24.7	29.8	7.7	12.1
Native Hawaiian or Other Pacific Islander	11.4	*	4.9	8.8
Asian	10.8	14.7	5.3	15.4
Two or More Races	13.3	16.5	4.1	12.1
Hispanic or Latino	13.0	14.5	3.8	14.0
AGE				
12-13	12.1	16.0	6.0	16.5
14-15	16.0	19.1	5.2	15.6
16-17	14.6	18.2	5.4	15.0
18-25	13.8	17.3	4.9	12.2
26-35	14.5	17.4	4.4	10.9
36-45	15.0	16.8	3.3	11.5
46-55	14.6	19.0	5.1	11.9
56-64	10.4	15.0	5.9	14.1
65 or Older	8.9	14.7	6.9	18.1

*Low precision; no estimate reported.

[1] Pain Reliever Use Disorder is based on definitions found in the 4th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV).
[2] Pain Reliever Use Disorder is based on definitions found in the 5th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5).
[3] Diagnostic orphans include individuals who endorsed two DSM-IV dependence criteria and no abuse criteria.
[4] Excludes DSM-IV legal problem criterion.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2002-2005, 2006-2010 (Revised 3/12), 2011-2012.

Table B.13 Respondents Who Endorsed Only One Pain Reliever Use Disorder Criterion among Past Year Pain Reliever Users Aged 12 or Older, by Criterion and Demographic Characteristic: Weighted Percentages, Annual Averages Based on 2002-2012 NSDUHs

Demographic Characteristic	Hazardous Use Only	Role Failure Only	Continued Use Despite Social Problems Only	Longer/More Use Only	Failure to Cut Down Only	Time Spent Only	Reduced Activities Only	Continued Use Despite Physical Problems Only	Tolerance Only	Withdrawal Only
TOTAL	0.9	0.3	0.1	0.1	0.6	3.3	0.4	0.3	5.6	8.5
GENDER										
Male	1.2	0.3	0.1	0.1	0.5	2.9	0.3	0.2	5.5	8.1
Female	0.6	0.3	0.1	0.2	0.6	3.7	0.6	0.4	5.7	9.0
HISPANIC ORIGIN AND RACE										
Not Hispanic or Latino	0.8	0.3	0.1	0.2	0.6	3.2	0.4	0.3	5.6	8.6
White	0.8	0.2	0.1	0.1	0.5	3.0	0.3	0.3	5.7	8.7
Black or African American	0.9	0.5	0.0	0.2	1.3	3.9	1.1	0.1	5.1	7.1
American Indian or Alaska Native	1.1	0.6	0.0	0.1	0.7	3.6	0.2	1.2	3.6	16.0
Native Hawaiian or Other Pacific Islander	*	0.0	*	*	*	*	0.1	*	2.1	7.7
Asian	1.1	0.2	0.1	0.4	0.8	6.0	0.8	0.1	4.9	8.8
Two or More Races	0.4	0.3	0.0	0.1	0.3	3.2	0.4	0.1	6.0	10.1
Hispanic or Latino	1.7	0.4	0.1	0.1	0.6	3.7	0.4	0.1	5.6	7.7
AGE										
12-13	0.4	1.3	0.1	0.4	1.2	3.7	1.0	0.3	6.0	7.9
14-15	0.6	1.0	0.2	0.2	1.1	3.7	0.6	0.4	6.1	9.3
16-17	0.8	0.6	0.1	0.2	0.5	3.6	0.4	0.3	6.7	8.6
18-25	0.9	0.3	0.1	0.1	0.4	3.1	0.3	0.2	6.0	8.4
26-35	1.1	0.2	0.0	0.1	0.4	2.6	0.3	0.5	5.1	8.4
36-45	1.2	0.2	*	0.1	0.4	3.4	0.6	0.2	4.9	9.0
46-55	0.4	0.1	0.0	0.0	1.0	3.1	0.6	0.3	5.5	8.8
56-64	1.1	0.0	*	1.2	2.2	4.9	*	0.1	3.5	7.5
65 or Older	0.5	*	*	*	*	7.5	0.8	*	7.5	5.4

*Low precision; no estimate reported.

NOTE: Pain Reliever Use Disorder is based on definitions found in the 4th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV).

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2002-2005, 2006-2010 (Revised 3/12), 2011-2012.

Table B.14 Heroin Legal Criterion Endorsement among Past Year Heroin Users Aged 12 or Older, by Demographic Characteristic: Weighted Percentages, Annual Averages Based on 2002-2012 NSDUHs

Demographic Characteristic	DSM-IV Legal Criterion Endorsement	Respondents Who Endorsed Only the DSM-IV Legal Criterion	Respondents Who Endorsed the DSM-IV Legal Criterion and One Other DSM-IV SUD Criterion
TOTAL	20.7	0.3	0.4
GENDER			
Male	21.2	0.4	0.5
Female	19.8	0.1	0.1
HISPANIC ORIGIN AND RACE			
Not Hispanic or Latino	19.4	0.4	0.2
White	17.9	0.5	0.2
Black or African American	*	0.0	0.3
American Indian or Alaska Native	*	*	*
Native Hawaiian or Other Pacific Islander	*	*	*
Asian	*	*	*
Two or More Races	*	*	*
Hispanic or Latino	*	*	1.3
AGE			
12-13	*	*	*
14-15	*	*	*
16-17	11.9	1.4	*
18-25	14.7	0.3	0.3
26-35	26.7	*	*
36-45	27.7	*	*
46-55	*	*	*
56-64	*	*	*
65 or Older	*	*	*

*Low precision; no estimate reported.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2002-2005, 2006-2010 (Revised 3/12), 2011-2012.

Table B.15 Heroin Use Disorder among Past Year Heroin Users Aged 12 or Older under DSM-IV and DSM-5 Criteria, by Demographic Characteristics: Weighted Percentages, Annual Averages Based on 2002-2012 NSDUHs

Demographic Characteristic	DSM-IV[1]	DSM-5[2]	Diagnostic Orphans[3]	Respondents Who Endorsed Only One Criterion[4]
TOTAL	57.4	61.4	5.2	6.9
GENDER				
Male	57.5	60.5	4.5	6.4
Female	57.2	63.5	6.8	8.1
HISPANIC ORIGIN AND RACE				
Not Hispanic or Latino	56.2	60.1	5.2	7.1
White	55.5	58.6	4.4	6.8
Black or African American	*	*	*	*
American Indian or Alaska Native	*	*	*	*
Native Hawaiian or Other Pacific Islander	*	*	*	*
Asian	*	*	*	*
Two or More Races	*	*	*	*
Hispanic or Latino	*	*	5.5	5.9
AGE				
12-13	*	*	*	*
14-15	41.4	39.9	4.7	17.8
16-17	33.4	34.1	2.9	10.5
18-25	51.9	54.8	4.2	7.2
26-35	63.4	68.2	6.2	5.7
36-45	67.7	71.4	3.7	3.5
46-55	*	*	*	*
56-64	*	*	*	*
65 or Older	*	*	*	*

*Low precision; no estimate reported.

[1] Heroin Use Disorder is based on definitions found in the 4th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV).
[2] Heroin Use Disorder is based on definitions found in the 5th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5).
[3] Diagnostic orphans include individuals who endorsed two DSM-IV dependence criteria and no abuse criteria.
[4] Excludes DSM-IV legal problem criterion.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2002-2005, 2006-2010 (Revised 3/12), 2011-2012.

Table B.16 Respondents Who Endorsed Only One Heroin Use Disorder Criterion among Past Year Heroin Users Aged 12 or Older, by Criterion and Demographic Characteristic: Weighted Percentages, Annual Averages Based on 2002-2012 NSDUHs

Demographic Characteristic	Hazardous Use Only	Role Failure Only	Continued Use Despite Social Problems Only	Longer/More Use Only	Failure to Cut Down Only	Time Spent Only	Reduced Activities Only	Continued Use Despite Physical Problems Only	Tolerance Only	Withdrawal Only
TOTAL	0.3	0.2	0.1	0.1	0.1	1.6	0.9	0.1	2.1	46.0
GENDER										
Male	0.3	0.3	0.1	0.2	0.1	1.7	0.5	0.1	1.9	45.3
Female	0.3	0.2	0.0	0.0	0.0	1.3	*	0.1	2.6	47.5
HISPANIC ORIGIN AND RACE										
Not Hispanic or Latino	0.3	0.2	0.1	0.1	0.1	1.3	0.7	0.1	2.5	44.8
White	0.4	0.2	0.1	0.2	0.1	1.1	0.3	0.1	2.7	45.1
Black or African American	*	0.1	*	*	*	*	*	*	2.3	*
American Indian or Alaska Native	*	*	*	*	*	*	*	*	*	*
Native Hawaiian or Other Pacific Islander	*	*	*	*	*	*	*	*	*	*
Asian	*	*	*	*	*	*	*	*	*	*
Two or More Races	*	*	*	*	*	*	*	*	*	*
Hispanic or Latino	0.1	0.4	*	0.0	0.1	2.8	*	0.2	0.0	*
AGE										
12-13	*	*	*	*	*	*	*	*	*	*
14-15	*	*	*	0.2	0.5	*	*	*	*	28.2
16-17	0.1	0.5	0.1	0.1	0.2	5.7	*	0.1	*	17.9
18-25	0.6	0.1	0.2	0.2	0.2	1.6	0.5	0.1	2.6	41.8
26-35	0.2	*	*	*	*	0.3	*	*	1.7	48.4
36-45	*	*	*	0.3	*	*	*	*	1.5	50.9
46-55	*	*	*	*	*	*	*	*	*	*
56-64	*	*	*	*	*	*	*	*	*	*
65 or Older	*	*	*	*	*	*	*	*	*	*

*Low precision; no estimate reported.

NOTE: Heroin Use Disorder is based on definitions found in the 4th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV).

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2002-2005, 2006-2010 (Revised 3/12), 2011-2012.

Table B.17 Heroin/Pain Reliever Legal Criterion Endorsement among Past Year Heroin and/or Pain Reliever Users Aged 12 or Older, by Demographic Characteristic: Weighted Percentages, Annual Averages Based on 2002-2012 NSDUHs

Demographic Characteristic	DSM-IV Legal Criterion Endorsement	Respondents Who Endorsed Only the DSM-IV Legal Criterion	Respondents Who Endorsed the DSM-IV Legal Criterion and One Other DSM-IV SUD Criterion
TOTAL	2.5	0.1	0.1
GENDER			
Male	3.1	0.1	0.2
Female	1.8	0.1	0.1
HISPANIC ORIGIN AND RACE			
Not Hispanic or Latino	2.4	0.1	0.1
White	2.2	0.1	0.1
Black or African American	4.0	0.3	0.5
American Indian or Alaska Native	6.8	*	0.1
Native Hawaiian or Other Pacific Islander	1.0	0.2	*
Asian	1.4	*	*
Two or More Races	3.9	0.3	0.0
Hispanic or Latino	3.1	0.1	0.3
AGE			
12-13	2.4	0.2	0.2
14-15	2.6	0.3	0.3
16-17	2.2	0.3	0.1
18-25	2.0	0.1	0.1
26-35	3.1	0.1	0.2
36-45	2.6	0.2	0.1
46-55	3.0	0.1	0.0
56-64	1.8	0.1	0.0
65 or Older	*	*	*

*Low precision; no estimate reported.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2002-2005, 2006-2010 (Revised 3/12), 2011-2012.

Table B.18 Heroin/Pain Reliever Use Disorder among Past Year Heroin and/or Pain Reliever Users Aged 12 or Older under DSM-IV and DSM-5 Criteria, by Demographic Characteristics: Weighted Percentages, Annual Averages Based on 2002-2012 NSDUHs

Demographic Characteristic	DSM-IV[1]	DSM-5[2]	Diagnostic Orphans[3]	Respondents Who Endorsed Only One Criterion[4]
TOTAL	15.4	18.7	4.7	12.2
GENDER				
Male	16.1	18.5	4.1	11.5
Female	14.7	18.9	5.4	13.1
HISPANIC ORIGIN AND RACE				
Not Hispanic or Latino	15.5	19.0	4.8	12.0
White	15.5	19.1	4.8	11.7
Black or African American	15.6	18.9	5.2	14.2
American Indian or Alaska Native	25.7	30.2	7.2	11.9
Native Hawaiian or Other Pacific Islander	*	*	4.8	8.4
Asian	10.8	14.7	5.3	15.3
Two or More Races	15.3	18.4	4.1	11.9
Hispanic or Latino	15.2	16.7	3.9	13.6
AGE				
12-13	12.5	16.4	6.0	16.5
14-15	16.5	19.4	5.2	15.7
16-17	15.0	18.5	5.4	15.0
18-25	15.0	18.4	4.8	12.0
26-35	16.2	19.2	4.4	10.7
36-45	16.3	18.2	3.4	11.3
46-55	16.3	20.8	5.2	12.0
56-64	11.6	16.3	5.9	13.5
65 or Older	9.5	15.1	6.8	17.9

*Low precision; no estimate reported.

[1] Heroin/Pain Reliever Use Disorder is based on definitions found in the 4th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV).
[2] Heroin/Pain Reliever Use Disorder is based on definitions found in the 5th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5).
[3] Diagnostic orphans include individuals who endorsed two DSM-IV dependence criteria and no abuse criteria.
[4] Excludes DSM-IV legal problem criterion.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2002-2005, 2006-2010 (Revised 3/12), 2011-2012.

Table B.19 Respondents Who Endorsed Only One Heroin/Pain Reliever Use Disorder Criterion among Past Year Heroin and/or Pain Reliever Users Aged 12 or Older, by Criterion and Demographic Characteristic: Weighted Percentages, Annual Averages Based on 2002-2012 NSDUHs

Demographic Characteristic	Hazardous Use Only	Role Failure Only	Continued Use Despite Social Problems Only	Longer/More Use Only	Failure to Cut Down Only	Time Spent Only	Reduced Activities Only	Continued Use Despite Physical Problems Only	Tolerance Only	Withdrawal Only
TOTAL	0.9	0.3	0.1	0.2	0.6	3.3	0.4	0.3	5.4	9.7
GENDER										
Male	1.2	0.3	0.1	0.1	0.5	2.9	0.3	0.2	5.2	9.5
Female	0.6	0.3	0.1	0.2	0.6	3.6	0.6	0.4	5.6	9.9
HISPANIC ORIGIN AND RACE										
Not Hispanic or Latino	0.8	0.3	0.0	0.2	0.6	3.2	0.4	0.3	5.4	9.7
White	0.8	0.3	0.1	0.1	0.5	3.0	0.3	0.3	5.5	9.7
Black or African American	0.8	0.5	0.0	0.2	1.3	3.8	1.1	0.1	5.0	9.1
American Indian or Alaska Native	1.1	0.7	0.0	0.1	0.7	3.5	0.2	1.2	3.5	16.1
Native Hawaiian or Other Pacific Islander	*	0.0	*	*	*	*	0.1	*	2.0	7.6
Asian	1.1	0.2	0.1	0.4	0.8	5.9	0.8	0.1	4.9	8.9
Two or More Races	0.4	0.3	0.0	0.1	0.3	3.3	0.4	0.1	5.8	12.2
Hispanic or Latino	1.7	0.4	0.1	0.1	0.6	3.7	0.5	0.1	5.3	9.6
AGE										
12-13	0.4	1.4	0.1	0.4	1.2	3.6	1.1	0.3	6.0	8.1
14-15	0.6	1.1	0.2	0.2	1.0	3.7	0.6	0.4	6.1	9.6
16-17	0.8	0.6	0.1	0.2	0.5	3.7	0.4	0.3	6.7	9.0
18-25	0.9	0.3	0.1	0.1	0.4	3.1	0.3	0.2	5.9	9.5
26-35	1.1	0.2	0.0	0.1	0.4	2.5	0.3	0.4	4.9	10.0
36-45	1.1	0.2	*	0.1	0.4	3.4	0.6	0.2	4.7	10.2
46-55	0.4	0.2	0.0	0.0	1.0	3.2	0.6	0.3	5.3	10.8
56-64	1.1	0.0	*	1.2	2.2	5.2	*	0.1	3.3	7.7
65 or Older	0.5	*	*	*	*	7.4	0.8	*	7.4	6.0

*Low precision; no estimate reported.

NOTE: Heroin/Pain Reliever Use Disorder is based on definitions found in the 4th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV).

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2002-2005, 2006-2010 (Revised 3/12), 2011-2012.

Table B.20 Sedative Legal Criterion Endorsement among Past Year Sedative Users Aged 12 or Older, by Demographic Characteristic: Weighted Percentages, Annual Averages Based on 2002-2012 NSDUHs

Demographic Characteristic	DSM-IV Legal Criterion Endorsement	Respondents Who Endorsed Only the DSM-IV Legal Criterion	Respondents Who Endorsed the DSM-IV Legal Criterion and One Other DSM-IV SUD Criterion
TOTAL	3.3	0.0	0.1
GENDER			
Male	5.0	0.1	0.1
Female	1.8	0.0	0.1
HISPANIC ORIGIN AND RACE			
Not Hispanic or Latino	2.9	0.0	0.1
White	2.7	0.0	0.1
Black or African American	6.0	0.0	0.6
American Indian or Alaska Native	*	*	*
Native Hawaiian or Other Pacific Islander	*	*	*
Asian	*	*	*
Two or More Races	0.6	*	*
Hispanic or Latino	6.4	0.2	0.1
AGE			
12-13	5.3	0.1	*
14-15	4.2	0.6	*
16-17	4.0	0.1	1.0
18-25	4.0	0.0	0.1
26-35	2.8	*	*
36-45	3.1	*	*
46-55	1.7	*	*
56-64	*	*	*
65 or Older	*	*	*

*Low precision; no estimate reported.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2002-2005, 2006-2010 (Revised 3/12), 2011-2012.

Table B.21 Sedative Use Disorder among Past Year Sedative Users Aged 12 or Older under DSM-IV and DSM-5 Criteria, by Demographic Characteristics: Weighted Percentages, Annual Averages Based on 2002-2012 NSDUHs

Demographic Characteristic	DSM-IV[1]	DSM-5[2]	Diagnostic Orphans[3]	Respondents Who Endorsed Only One Criterion[4]
TOTAL	17.1	19.2	3.6	10.0
GENDER				
Male	17.5	19.2	3.6	10.6
Female	16.7	19.3	3.6	9.5
HISPANIC ORIGIN AND RACE				
Not Hispanic or Latino	16.5	18.4	3.3	10.1
White	15.4	17.1	3.3	9.9
Black or African American	*	*	*	*
American Indian or Alaska Native	*	*	*	*
Native Hawaiian or Other Pacific Islander	*	*	*	*
Asian	*	*	*	*
Two or More Races	*	*	*	3.4
Hispanic or Latino	21.3	26.4	6.4	9.0
AGE				
12-13	16.6	19.4	5.0	12.4
14-15	22.5	26.0	5.3	13.8
16-17	20.2	21.1	3.8	10.6
18-25	15.3	17.6	3.6	10.7
26-35	14.8	19.1	5.2	8.2
36-45	18.9	19.2	3.8	7.8
46-55	19.8	21.0	1.2	11.8
56-64	*	*	*	*
65 or Older	*	*	*	*

*Low precision; no estimate reported.

[1] Sedative Use Disorder is based on definitions found in the 4th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV).
[2] Sedative Use Disorder is based on definitions found in the 5th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5).
[3] Diagnostic orphans include individuals who endorsed two DSM-IV dependence criteria and no abuse criteria.
[4] Excludes DSM-IV legal problem criterion.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2002-2005, 2006-2010 (Revised 3/12), 2011-2012.

Table B.22 Respondents Who Endorsed Only One Sedative Use Disorder Criterion among Past Year Sedative Users Aged 12 or Older, by Criterion and Demographic Characteristic: Weighted Percentages, Annual Averages Based on 2002-2012 NSDUHs

Demographic Characteristic	Hazardous Use Only	Role Failure Only	Continued Use Despite Social Problems Only	Longer/More Use Only	Failure to Cut Down Only	Time Spent Only	Reduced Activities Only	Continued Use Despite Physical Problems Only	Tolerance Only	Withdrawal Only
TOTAL	1.1	0.2	0.1	0.1	0.2	2.2	0.2	0.1	4.2	11.5
GENDER										
Male	1.6	0.1	0.1	0.1	0.1	2.1	0.2	0.1	4.7	9.7
Female	0.6	0.2	0.1	0.0	0.3	2.2	0.2	0.1	3.7	13.0
HISPANIC ORIGIN AND RACE										
Not Hispanic or Latino	1.1	0.2	0.1	0.1	0.1	2.3	0.2	0.1	4.4	10.8
White	1.2	0.2	0.1	0.0	0.1	2.6	0.1	0.1	3.9	10.4
Black or African American	*	0.3	0.7	*	0.8	0.7	0.7	0.3	*	13.4
American Indian or Alaska Native	*	*	*	*	*	*	*	*	*	*
Native Hawaiian or Other Pacific Islander	*	*	*	*	*	*	*	*	*	*
Asian	*	*	*	*	*	*	*	*	*	*
Two or More Races	0.0	*	*	*	*	1.1	*	*	1.8	*
Hispanic or Latino	1.1	0.0	*	*	*	1.0	0.7	0.1	2.4	16.4
AGE										
12-13	*	*	*	*	*	0.8	2.7	0.2	2.4	8.0
14-15	0.1	1.0	*	0.2	0.1	1.1	1.1	0.2	7.1	14.5
16-17	1.3	*	0.7	*	0.0	2.3	0.3	0.1	3.6	10.8
18-25	1.0	0.2	*	0.2	0.1	3.0	0.4	0.2	4.2	9.9
26-35	0.9	*	*	*	*	2.6	0.0	0.3	2.8	10.2
36-45	*	*	*	*	0.7	1.5	*	*	1.8	11.5
46-55	*	*	*	*	*	*	*	*	6.3	18.2
56-64	*	*	*	*	*	*	*	*	*	*
65 or Older	*	*	*	*	*	*	*	*	*	*

*Low precision; no estimate reported.

NOTE: Sedative Use Disorder is based on definitions found in the 4th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV).

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2002-2005, 2006-2010 (Revised 3/12), 2011-2012.

Table B.23 Tranquilizer Legal Criterion Endorsement among Past Year Tranquilizer Users Aged 12 or Older, by Demographic Characteristic: Weighted Percentages, Annual Averages Based on 2002-2012 NSDUHs

Demographic Characteristic	DSM-IV Legal Criterion Endorsement	Respondents Who Endorsed Only the DSM-IV Legal Criterion	Respondents Who Endorsed the DSM-IV Legal Criterion and One Other DSM-IV SUD Criterion
TOTAL	1.6	0.2	0.2
GENDER			
Male	2.2	0.2	0.2
Female	1.1	0.1	0.1
HISPANIC ORIGIN AND RACE			
Not Hispanic or Latino	1.6	0.1	0.1
White	1.3	0.1	0.1
Black or African American	5.1	0.1	0.3
American Indian or Alaska Native	*	*	*
Native Hawaiian or Other Pacific Islander	*	*	*
Asian	2.2	*	*
Two or More Races	3.7	*	*
Hispanic or Latino	2.5	0.5	0.2
AGE			
12-13	4.5	*	0.5
14-15	3.3	0.1	0.6
16-17	2.9	0.6	0.2
18-25	1.5	0.1	0.2
26-35	1.3	0.2	0.1
36-45	1.6	0.2	0.0
46-55	1.8	*	0.0
56-64	0.5	*	*
65 or Older	*	*	*

*Low precision; no estimate reported.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2002-2005, 2006-2010 (Revised 3/12), 2011-2012.

Table B.24 Tranquilizer Use Disorder among Past Year Tranquilizer Users Aged 12 or Older under DSM-IV and DSM-5 Criteria, by Demographic Characteristics: Weighted Percentages, Annual Averages Based on 2002-2012 NSDUHs

Demographic Characteristic	DSM-IV[1]	DSM-5[2]	Diagnostic Orphans[3]	Respondents Who Endorsed Only One Criterion[4]
TOTAL	9.1	9.1	1.9	8.4
GENDER				
Male	9.7	9.1	1.7	8.4
Female	8.5	9.1	2.2	8.3
HISPANIC ORIGIN AND RACE				
Not Hispanic or Latino	8.8	8.9	1.9	8.2
White	8.3	8.6	1.8	8.1
Black or African American	13.7	14.3	2.5	9.6
American Indian or Alaska Native	*	*	1.8	10.6
Native Hawaiian or Other Pacific Islander	*	*	*	*
Asian	*	5.5	1.2	*
Two or More Races	10.1	8.7	1.6	6.2
Hispanic or Latino	11.9	11.1	2.6	10.0
AGE				
12-13	17.3	21.2	6.3	13.6
14-15	15.9	15.8	2.7	12.2
16-17	12.5	11.7	2.2	11.0
18-25	8.9	9.0	2.2	8.1
26-35	8.7	8.1	1.2	8.2
36-45	7.5	8.4	2.1	6.2
46-55	9.2	10.2	2.2	8.4
56-64	8.8	7.0	1.4	10.7
65 or Older	*	*	*	*

*Low precision; no estimate reported.

[1] Tranquilizer Use Disorder is based on definitions found in the 4th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV).
[2] Tranquilizer Use Disorder is based on definitions found in the 5th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5).
[3] Diagnostic orphans include individuals who endorsed two DSM-IV dependence criteria and no abuse criteria.
[4] Excludes DSM-IV legal problem criterion.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2002-2005, 2006-2010 (Revised 3/12), 2011-2012.

Table B.25 Respondents Who Endorsed Only One Tranquilizer Use Disorder Criterion among Past Year Tranquilizer Users Aged 12 or Older, by Criterion and Demographic Characteristic: Weighted Percentages, Annual Averages Based on 2002-2012 NSDUHs

Demographic Characteristic	Hazardous Use Only	Role Failure Only	Continued Use Despite Social Problems Only	Longer/More Use Only	Failure to Cut Down Only	Time Spent Only	Reduced Activities Only	Continued Use Despite Physical Problems Only	Tolerance Only	Withdrawal Only
TOTAL	1.1	0.5	0.1	0.1	0.7	1.8	0.4	0.2	3.4	--
GENDER										
Male	1.4	0.5	0.1	0.1	0.6	1.6	0.5	0.2	3.3	--
Female	0.8	0.5	0.1	0.0	0.9	2.0	0.4	0.2	3.4	--
HISPANIC ORIGIN AND RACE										
Not Hispanic or Latino	1.1	0.4	0.1	0.0	0.6	1.8	0.4	0.2	3.4	--
White	1.1	0.3	0.1	0.0	0.6	1.8	0.4	0.2	3.5	--
Black or African American	1.1	0.4	0.1	0.1	1.1	3.3	0.3	0.5	2.7	--
American Indian or Alaska Native	2.1	0.0	*	*	0.2	0.7	0.0	*	7.1	--
Native Hawaiian or Other Pacific Islander	*	*	*	*	*	*	*	*	*	--
Asian	0.2	*	1.0	*	*	0.3	*	*	2.4	--
Two or More Races	0.4	0.5	0.1	*	0.1	1.5	0.1	0.1	3.6	--
Hispanic or Latino	1.5	1.3	0.1	0.4	1.4	1.7	1.0	0.1	2.6	--
AGE										
12-13	0.2	1.3	*	*	*	4.0	1.2	0.1	5.4	--
14-15	0.8	1.4	0.3	0.4	0.8	2.0	0.6	0.4	5.4	--
16-17	1.4	0.7	0.2	0.1	0.4	2.2	0.7	0.2	5.1	--
18-25	1.4	0.3	0.1	0.0	0.4	1.7	0.3	0.3	3.6	--
26-35	1.3	0.3	0.0	0.1	0.2	2.3	0.4	0.2	3.5	--
36-45	0.5	0.4	0.1	0.1	0.3	1.8	0.2	0.1	2.7	--
46-55	0.4	0.6	0.2	0.0	2.1	1.4	0.9	0.2	2.6	--
56-64	*	*	*	*	3.3	1.5	0.9	*	1.3	--
65 or Older	*	*	*	*	*	*	*	*	*	--

*Low precision; no estimate reported.

-- Not applicable.

NOTE: Tranquilizer Use Disorder is based on definitions found in the 4th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV).

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2002-2005, 2006-2010 (Revised 3/12), 2011-2012.

Table B.26 Respondents Who Endorsed Only One Tranquilizer Use Disorder Criterion among Past Year Tranquilizer Users Aged 12 or Older, by Criterion and Demographic Characteristic: Weighted Percentages, Annual Averages Based on 2002-2012 NSDUHs

Demographic Characteristic	Hazardous Use Only	Role Failure Only	Continued Use Despite Social Problems Only	Longer/More Use Only	Failure to Cut Down Only	Time Spent Only	Reduced Activities Only	Continued Use Despite Physical Problems Only	Tolerance Only	Withdrawal Only
TOTAL	1.1	0.5	0.1	0.1	0.7	1.8	0.4	0.2	3.4	--
GENDER										
Male	1.4	0.5	0.1	0.1	0.6	1.6	0.5	0.2	3.3	--
Female	0.8	0.5	0.1	0.0	0.9	2.0	0.4	0.2	3.4	--
HISPANIC ORIGIN AND RACE										
Not Hispanic or Latino	1.1	0.4	0.1	0.0	0.6	1.8	0.4	0.2	3.4	--
White	1.1	0.3	0.1	0.0	0.6	1.8	0.4	0.2	3.5	--
Black or African American	1.1	0.4	0.1	0.1	1.1	3.3	0.3	0.5	2.7	--
American Indian or Alaska Native	2.1	0.0	*	*	0.2	0.7	0.0	*	7.1	--
Native Hawaiian or Other Pacific Islander	*	*	*	*	*	*	*	*	*	--
Asian	0.2	*	1.0	*	*	0.3	*	*	2.4	--
Two or More Races	0.4	0.5	0.1	*	0.1	1.5	0.1	0.1	3.6	--
Hispanic or Latino	1.5	1.3	0.1	0.4	1.4	1.7	1.0	0.1	2.6	--
AGE										
12-13	0.2	1.3	*	*	*	4.0	1.2	0.1	5.4	--
14-15	0.8	1.4	0.3	0.4	0.8	2.0	0.6	0.4	5.4	--
16-17	1.4	0.7	0.2	0.1	0.4	2.2	0.7	0.2	5.1	--
18-25	1.4	0.3	0.1	0.0	0.4	1.7	0.3	0.3	3.6	--
26-35	1.3	0.3	0.0	0.1	0.2	2.3	0.4	0.2	3.5	--
36-45	0.5	0.4	0.1	0.1	0.3	1.8	0.2	0.1	2.7	--
46-55	0.4	0.6	0.2	0.0	2.1	1.4	0.9	0.2	2.6	--
56-64	*	*	*	*	3.3	1.5	0.9	*	1.3	--
65 or Older	*	*	*	*	*	*	*	*	*	--

*Low precision; no estimate reported.

-- Not applicable.

NOTE: Tranquilizer Use Disorder is based on definitions found in the 4th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV).

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2002-2005, 2006-2010 (Revised 3/12), 2011-2012.

Table B.27 Stimulant Use Disorder among Past Year Stimulant Users Aged 12 or Older under DSM-IV and DSM-5 Criteria, by Demographic Characteristics: Weighted Percentages, Annual Averages Based on 2002-2012 NSDUHs

Demographic Characteristic	DSM-IV[1]	DSM-5[2]	Diagnostic Orphans[3]	Respondents Who Endorsed Only One Criterion[4]
TOTAL	13.9	16.3	3.7	9.5
GENDER				
Male	13.4	15.4	3.4	8.7
Female	14.4	17.3	4.0	10.4
HISPANIC ORIGIN AND RACE				
Not Hispanic or Latino	14.0	16.5	3.7	9.5
White	13.8	16.4	3.8	9.3
Black or African American	19.4	19.8	2.7	10.9
American Indian or Alaska Native	23.3	22.0	1.8	7.6
Native Hawaiian or Other Pacific Islander	*	*	*	*
Asian	11.0	16.6	5.9	*
Two or More Races	10.4	11.9	1.7	11.2
Hispanic or Latino	12.5	14.7	3.6	9.7
AGE				
12-13	18.2	19.6	4.0	15.1
14-15	19.6	21.1	4.1	13.0
16-17	15.7	18.3	4.8	13.1
18-25	12.0	14.6	3.8	9.2
26-35	13.7	16.1	3.4	8.5
36-45	15.4	17.5	3.2	8.7
46-55	15.0	17.9	3.9	9.9
56-64	*	*	*	*
65 or Older	*	*	*	*

*Low precision; no estimate reported.

[1] Stimulant Use Disorder is based on definitions found in the 4th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV).
[2] Stimulant Use Disorder is based on definitions found in the 5th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5).
[3] Diagnostic orphans include individuals who endorsed two DSM-IV dependence criteria and no abuse criteria.
[4] Excludes DSM-IV legal problem criterion.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2002-2005, 2006-2010 (Revised 3/12), 2011-2012.

Table B.28 Respondents Who Endorsed Only One Stimulant Use Disorder Criterion among Past Year Stimulant Users Aged 12 or Older, by Criterion and Demographic Characteristic: Weighted Percentages, Annual Averages Based on 2002-2012 NSDUHs

Demographic Characteristic	Hazardous Use Only	Role Failure Only	Continued Use Despite Social Problems Only	Longer/More Use Only	Failure to Cut Down Only	Time Spent Only	Reduced Activities Only	Continued Use Despite Physical Problems Only	Tolerance Only	Withdrawal Only
TOTAL	0.6	0.4	0.2	0.1	0.4	2.3	0.2	0.6	3.5	8.7
GENDER										
Male	0.7	0.4	0.2	0.1	0.3	2.0	0.4	0.4	3.6	7.2
Female	0.4	0.4	0.2	0.2	0.6	2.7	0.1	0.9	3.5	10.2
HISPANIC ORIGIN AND RACE										
Not Hispanic or Latino	0.6	0.4	0.2	0.2	0.4	2.3	0.2	0.6	3.7	8.6
White	0.6	0.3	0.2	0.1	0.3	2.2	0.2	0.6	3.8	8.6
Black or African American	0.4	1.7	0.2	*	0.7	2.6	0.2	0.8	2.7	8.4
American Indian or Alaska Native	*	*	*	0.3	0.1	*	*	0.1	2.0	*
Native Hawaiian or Other Pacific Islander	*	*	*	*	*	*	*	*	*	*
Asian	0.1	0.2	*	*	*	*	0.1	0.3	2.0	7.0
Two or More Races	0.2	*	*	*	*	1.2	*	*	5.0	8.0
Hispanic or Latino	0.5	0.5	0.1	*	0.4	2.7	0.3	0.7	2.1	8.8
AGE										
12-13	0.6	1.9	*	*	0.5	0.9	0.9	0.5	8.8	8.1
14-15	0.5	1.5	0.3	0.1	0.6	2.0	0.5	0.8	5.3	10.4
16-17	1.1	0.5	0.1	0.3	0.4	3.7	0.0	0.8	4.9	8.1
18-25	0.6	0.3	0.2	0.1	0.3	3.2	0.2	0.5	3.3	7.5
26-35	0.3	0.4	0.3	0.3	0.1	1.1	0.4	0.7	2.9	9.4
36-45	0.5	0.4	0.1	*	0.9	1.1	0.3	0.2	4.0	10.1
46-55	1.1	*	*	0.1	*	2.2	0.2	1.5	2.7	9.6
56-64	*	*	*	*	*	*	*	*	*	*
65 or Older	*	*	*	*	*	*	*	*	*	*

*Low precision; no estimate reported.

NOTE: Stimulant Use Disorder is based on definitions found in the 4th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV).

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2002-2005, 2006-2010 (Revised 3/12), 2011-2012.

Table B.29 Cocaine Legal Criterion Endorsement among Past Year Cocaine Users Aged 12 or Older, by Demographic Characteristic: Weighted Percentages, Annual Averages Based on 2002-2012 NSDUHs

Demographic Characteristic	DSM-IV Legal Criterion Endorsement	Respondents Who Endorsed Only the DSM-IV Legal Criterion	Respondents Who Endorsed the DSM-IV Legal Criterion and One Other DSM-IV SUD Criterion
TOTAL	5.5	0.2	0.2
GENDER			
Male	5.7	0.1	0.2
Female	5.2	0.2	0.2
HISPANIC ORIGIN AND RACE			
Not Hispanic or Latino	5.2	0.1	0.2
White	3.7	0.1	0.1
Black or African American	15.8	0.4	0.7
American Indian or Alaska Native	3.9	*	*
Native Hawaiian or Other Pacific Islander	*	*	*
Asian	1.5	0.3	*
Two or More Races	6.2	0.1	0.1
Hispanic or Latino	7.2	0.3	0.3
AGE			
12-13	8.1	*	*
14-15	8.1	0.3	1.5
16-17	4.2	0.2	0.5
18-25	3.2	0.1	0.1
26-35	5.2	0.2	0.4
36-45	9.9	0.2	0.1
46-55	7.6	*	*
56-64	2.8	0.2	*
65 or Older	*	*	*

*Low precision; no estimate reported.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2002-2005, 2006-2010 (Revised 3/12), 2011-2012.

Table B.30 Cocaine Use Disorder among Past Year Cocaine Users Aged 12 or Older under DSM-IV and DSM-5 Criteria, by Demographic Characteristics: Weighted Percentages, Annual Averages Based on 2002-2012 NSDUHs

Demographic Characteristic	DSM-IV[1]	DSM-5[2]	Diagnostic Orphans[3]	Respondents Who Endorsed Only One Criterion[4]
TOTAL	25.5	27.9	4.5	11.1
GENDER				
Male	25.5	27.3	4.1	11.4
Female	25.6	29.1	5.2	10.7
HISPANIC ORIGIN AND RACE				
Not Hispanic or Latino	24.9	27.3	4.4	10.7
White	21.8	24.1	4.2	10.4
Black or African American	45.9	49.5	5.6	12.2
American Indian or Alaska Native	24.8	23.9	2.7	13.0
Native Hawaiian or Other Pacific Islander	*	*	*	*
Asian	15.0	21.1	7.1	10.9
Two or More Races	29.2	29.4	2.5	11.5
Hispanic or Latino	29.4	31.2	5.0	13.6
AGE				
12-13	19.8	23.6	4.8	14.1
14-15	26.3	26.1	4.1	14.2
16-17	19.7	22.0	5.3	13.9
18-25	18.4	20.8	4.4	11.8
26-35	25.0	26.9	4.2	11.2
36-45	38.1	39.3	3.2	9.4
46-55	33.5	36.9	5.3	10.1
56-64	25.6	*	*	10.1
65 or Older	*	*	*	*

*Low precision; no estimate reported.

[1] Cocaine Use Disorder is based on definitions found in the 4th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV).
[2] Cocaine Use Disorder is based on definitions found in the 5th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5).
[3] Diagnostic orphans include individuals who endorsed two DSM-IV dependence criteria and no abuse criteria.
[4] Excludes DSM-IV legal problem criterion.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2002-2005, 2006-2010 (Revised 3/12), 2011-2012.

Table B.31 Respondents Who Endorsed Only One Cocaine Use Disorder Criterion among Past Year Cocaine Users Aged 12 or Older, by Criterion and Demographic Characteristic: Weighted Percentages, Annual Averages Based on 2002-2012 NSDUHs

Demographic Characteristic	Hazardous Use Only	Role Failure Only	Continued Use Despite Social Problems Only	Longer/More Use Only	Failure to Cut Down Only	Time Spent Only	Reduced Activities Only	Continued Use Despite Physical Problems Only	Tolerance Only	Withdrawal Only
TOTAL	1.1	0.5	0.2	0.3	0.6	2.5	0.7	0.6	4.1	11.0
GENDER										
Male	1.3	0.5	0.2	0.3	0.6	2.4	0.7	0.5	4.3	10.2
Female	0.7	0.4	0.3	0.2	0.5	2.7	0.7	0.6	3.7	12.5
HISPANIC ORIGIN AND RACE										
Not Hispanic or Latino	0.9	0.5	0.2	0.3	0.5	2.5	0.7	0.6	3.9	10.9
White	1.0	0.5	0.3	0.2	0.4	2.2	0.6	0.6	3.9	9.8
Black or African American	0.4	0.4	0.1	0.6	1.6	3.5	1.5	0.4	3.5	18.7
American Indian or Alaska Native	1.9	0.2	*	*	0.3	3.2	0.1	*	5.7	12.4
Native Hawaiian or Other Pacific Islander	*	*	*	*	*	*	*	*	*	*
Asian	0.5	*	0.1	0.2	*	3.9	0.3	*	4.8	9.2
Two or More Races	1.7	0.3	0.1	0.1	0.1	3.6	0.9	0.0	4.5	9.1
Hispanic or Latino	2.0	0.4	0.3	0.4	0.8	2.9	0.9	0.5	5.1	11.6
AGE										
12-13	*	0.8	0.2	*	0.3	4.8	*	0.1	6.4	8.5
14-15	2.1	1.4	0.2	0.3	0.8	4.0	0.8	0.0	3.6	10.4
16-17	1.6	0.4	0.2	0.3	0.6	3.5	0.4	0.5	5.7	9.5
18-25	1.3	0.4	0.2	0.3	0.5	2.8	0.4	0.4	4.8	7.9
26-35	1.1	0.4	0.3	0.3	0.5	1.9	1.3	0.8	4.2	10.0
36-45	0.9	0.3	0.4	0.2	0.2	2.6	0.5	0.7	2.8	16.2
46-55	0.6	1.1	0.1	0.0	1.5	2.2	1.0	0.3	2.9	16.5
56-64	*	*	*	*	*	3.0	*	*	*	11.7
65 or Older	*	*	*	*	*	*	*	*	*	*

*Low precision; no estimate reported.

NOTE: Cocaine Use Disorder is based on definitions found in the 4th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV).

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2002-2005, 2006-2010 (Revised 3/12), 2011-2012.

Table B.32 Stimulant /Cocaine Legal Criterion Endorsement among Past Year Stimulant and/or Cocaine Users Aged 12 or Older, by Demographic Characteristic: Weighted Percentages, Annual Averages Based on 2002-2012 NSDUHs

Demographic Characteristic	DSM-IV Legal Criterion Endorsement	Respondents Who Endorsed Only the DSM-IV Legal Criterion	Respondents Who Endorsed the DSM-IV Legal Criterion and One Other DSM-IV SUD Criterion
TOTAL	4.9	0.1	0.2
GENDER			
Male	5.3	0.1	0.2
Female	4.2	0.1	0.2
HISPANIC ORIGIN AND RACE			
Not Hispanic or Latino	4.6	0.1	0.2
White	3.4	0.1	0.1
Black or African American	13.7	0.3	0.6
American Indian or Alaska Native	6.3	*	*
Native Hawaiian or Other Pacific Islander	*	*	0.2
Asian	1.4	0.2	*
Two or More Races	6.0	0.1	0.1
Hispanic or Latino	6.5	0.3	0.3
AGE			
12-13	4.5	0.2	0.5
14-15	5.6	0.2	0.8
16-17	3.7	0.1	0.4
18-25	3.1	0.1	0.1
26-35	4.8	0.2	0.3
36-45	8.6	0.2	0.2
46-55	6.3	*	*
56-64	2.7	0.1	*
65 or Older	*	*	*

*Low precision; no estimate reported.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2002-2005, 2006-2010 (Revised 3/12), 2011-2012.

Table B.33 Stimulant/Cocaine Use Disorder among Past Year Stimulant and/or Cocaine Users Aged 12 or Older under DSM-IV and DSM-5 Criteria, by Demographic Characteristics: Weighted Percentages, Annual Averages Based on 2002-2012 NSDUHs

Demographic Characteristic	DSM-IV[1]	DSM-5[2]	Diagnostic Orphans[3]	Respondents Who Endorsed Only One Criterion[4]
TOTAL	22.2	24.8	4.5	10.9
GENDER				
Male	22.5	24.6	4.2	10.9
Female	21.6	25.0	5.1	10.9
HISPANIC ORIGIN AND RACE				
Not Hispanic or Latino	21.8	24.4	4.5	10.6
White	19.5	22.1	4.4	10.3
Black or African American	41.1	44.2	5.1	12.1
American Indian or Alaska Native	25.2	25.1	2.4	9.7
Native Hawaiian or Other Pacific Islander	*	*	2.8	8.0
Asian	12.8	17.2	7.5	14.5
Two or More Races	23.0	23.5	2.2	12.8
Hispanic or Latino	24.6	26.9	4.9	13.1
AGE				
12-13	18.5	20.1	3.9	15.1
14-15	22.2	23.0	4.1	13.7
16-17	18.4	20.8	5.4	14.0
18-25	16.9	19.7	4.7	11.3
26-35	21.5	23.8	4.3	10.9
36-45	32.0	33.6	3.2	9.4
46-55	29.0	32.2	5.0	9.9
56-64	22.7	31.6	*	8.2
65 or Older	*	*	*	*

*Low precision; no estimate reported.

[1] Stimulant/Cocaine Use Disorder is based on definitions found in the 4th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV).
[2] Stimulant/Cocaine Use Disorder is based on definitions found in the 5th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5).
[3] Diagnostic orphans include individuals who endorsed two DSM-IV dependence criteria and no abuse criteria.
[4] Excludes DSM-IV legal problem criterion.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2002-2005, 2006-2010 (Revised 3/12), 2011-2012.

Table B.34 Respondents Who Endorsed Only One Stimulant/Cocaine Use Disorder Criterion among Past Year Stimulant and/or Cocaine Users Aged 12 or Older, by Criterion and Demographic Characteristic: Weighted Percentages, Annual Averages Based on 2002-2012 NSDUHs

Demographic Characteristic	Hazardous Use Only	Role Failure Only	Continued Use Despite Social Problems Only	Longer/More Use Only	Failure to Cut Down Only	Time Spent Only	Reduced Activities Only	Continued Use Despite Physical Problems Only	Tolerance Only	Withdrawal Only
TOTAL	0.9	0.4	0.2	0.2	0.6	2.5	0.6	0.6	4.0	11.3
GENDER										
Male	1.1	0.5	0.2	0.2	0.6	2.4	0.6	0.5	4.3	10.3
Female	0.6	0.4	0.3	0.2	0.6	2.8	0.5	0.7	3.7	12.7
HISPANIC ORIGIN AND RACE										
Not Hispanic or Latino	0.8	0.4	0.2	0.2	0.5	2.4	0.6	0.6	4.0	11.2
White	0.9	0.4	0.3	0.2	0.4	2.2	0.5	0.6	4.0	10.5
Black or African American	0.4	0.6	0.1	0.5	1.5	3.4	1.3	0.5	3.5	17.4
American Indian or Alaska Native	1.3	0.5	*	0.1	0.3	2.3	0.1	0.0	4.0	13.9
Native Hawaiian or Other Pacific Islander	0.7	*	*	0.1	*	*	*	*	*	*
Asian	0.4	0.1	0.1	0.1	*	6.4	0.2	*	3.7	8.9
Two or More Races	1.3	0.2	0.1	0.1	0.6	3.3	1.5	0.0	5.3	9.2
Hispanic or Latino	1.7	0.4	0.3	0.2	0.8	3.0	0.7	0.6	4.5	11.8
AGE										
12-13	0.5	1.7	0.0	*	0.5	1.4	1.0	0.5	8.6	8.6
14-15	1.1	1.7	0.2	0.2	0.7	2.8	0.6	0.6	4.7	11.4
16-17	1.4	0.5	0.2	0.2	0.5	3.6	0.2	0.7	5.6	9.8
18-25	1.0	0.3	0.2	0.3	0.6	3.1	0.3	0.4	4.5	8.8
26-35	0.9	0.4	0.3	0.3	0.4	1.8	1.1	0.7	4.1	10.6
36-45	0.8	0.2	0.3	0.1	0.4	2.1	0.4	0.5	3.4	15.5
46-55	0.8	0.9	0.1	0.0	1.3	2.2	0.8	0.7	2.6	15.8
56-64	*	*	*	*	*	2.2	*	*	3.5	11.8
65 or Older	*	*	*	*	*	*	*	*	*	*

*Low precision; no estimate reported.

NOTE: Stimulant/Cocaine Use Disorder is based on definitions found in the 4th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV).

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2002-2005, 2006-2010 (Revised 3/12), 2011-2012.