National Institute on Alcohol Abuse and Alcoholism

Alcohol Use Disorder: A Comparison Between DSM–IV and DSM–5

In May 2013, the American Psychiatric Association issued the 5th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM–5). Although there is considerable overlap between DSM–5 and DSM–IV, the prior edition, there are several important differences:

Changes Disorder Terminology

- DSM–IV described two distinct disorders, alcohol abuse and alcohol dependence, with specific criteria for each.
- DSM–5 integrates the two DSM–IV disorders, alcohol abuse and alcohol dependence, into a single disorder called alcohol use disorder (AUD) with mild, moderate, and severe sub-classifications.

Changes Diagnostic Thresholds

- Under DSM–IV, the diagnostic criteria for abuse and dependence were distinct: anyone meeting one or more of the "abuse" criteria (see items 1 through 4) within a 12-month period would receive the "abuse" diagnosis. Anyone with three or more of the "dependence" criteria (see items 5 through 11) during the same 12-month period would receive a "dependence" diagnosis.
- Under DSM–5, anyone meeting any two of the 11 criteria during the same 12-month period would receive a diagnosis of AUD. The severity of an AUD—mild, moderate, or severe—is based on the number of criteria met.

Removes Criterion

- DSM–5 eliminates legal problems as a criterion.

Adds Criterion

- DSM–5 adds craving as a criterion for an AUD diagnosis. It was not included in DSM–IV.

Revises Some Descriptions

- DSM–5 modifies some of the criteria descriptions with updated language.

DSM History and Background

The *Diagnostic and Statistical Manual of Mental Disorders* (DSM) initially developed out of a need to collect statistical information about mental disorders in the United States. The first attempt to collect information on mental health began in the 1840 census. By the 1880 census, the Bureau of Census had developed seven categories of mental illness. In 1917, the Bureau of Census began collecting uniform statistics from mental hospitals across the country.

Not long afterwards, the American Psychiatric Association and the New York Academy of Medicine collaborated to produce a "nationally acceptable psychiatric nomenclature" for diagnosing patients with severe psychiatric and neurological disorders. After World War I, the Army and Veterans Administration broadened the nomenclature to include disorders affecting veterans.

In 1952, the American Psychiatric Association Committee on Nomenclature and Statistics published the first edition of the *Diagnostic and Statistical Manual: Mental Disorders* (DSM–I). The DSM–I included a glossary describing diagnostic categories and included an emphasis on how to use the manual for making clinical diagnoses. The DSM–II, which was very similar to the DSM–I, was published in 1968. The DSM–III, published in 1980, introduced several innovations, including explicit diagnostic criteria for the various disorders, that are now a recognizable feature of the DSM. A 1987 revision to the DSM–III, called the DSM–III–R, clarified some of these criteria and also addressed inconsistencies in the diagnostic system. A comprehensive review of the scientific literature strengthened the empirical basis of the next edition, the DSM–IV, which was published in 1994. The DSM–IV–TR, a revision published in 2000, provided additional information on diagnosis. Since 1952, each subsequent edition of the DSM aimed to improve clinicians' ability to understand and diagnose a wide range of conditions.

A Comparison Between DSM–IV and DSM–5

DSM–IV		DSM–5	
Any 1 = ALCOHOL ABUSE	Recurrent alcohol use resulting in a failure to fulfill major role obligations at work, school, or home (e.g., repeated absences or poor work performance related to alcohol use; alcohol-related absences, suspensions, or expulsions from school; neglect of children or household.	1	Alcohol is often taken in larger amounts or over a longer period than was intended. (See DSM–IV, criterion 7.)
	Recurrent alcohol use in situations in which it is physically hazardous (e.g., driving an automobile or operating a machine when impaired by alcohol abuse).	2	There is a persistent desire or unsuccessful efforts to cut down or control alcohol use. (See DSM–IV, criterion 8.)
	Recurrent alcohol-related legal problems (e.g., arrests for alcohol-related disorderly conduct). ****This is not included in DSM–5****	3	A great deal of time is spent in activities necessary to obtain alcohol, use alcohol, or recover from its effects. (See DSM–IV, criterion 9.)
	Continued alcohol use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the alcohol (e.g., arguments with spouse about the consequences of intoxication, physical fights).	4	Craving, or a strong desire or urge to use alcohol. ****This is new to DSM–5****
Any 3 = ALCOHOL DEPENDENCE	Tolerance, as defined by either of the following: a) A need for markedly increased amounts of alcohol to achieve intoxication or desired effect b) Markedly diminished effect with continued use of the same amount of alcohol	5	Recurrent alcohol use resulting in a failure to fulfill major role obligations at work, school, or home. (See DSM–IV, criterion 1.)
	Withdrawal, as manifested by either of the following: a) The characteristic withdrawal syndrome for alcohol b) Alcohol is taken to relieve or avoid withdrawal symptoms	6	Continued alcohol use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of alcohol. (See DSM–IV, criterion 4.)
	Alcohol is often taken in larger amounts or over a longer period than was intended.	7	Important social, occupational, or recreational activities are given up or reduced because of alcohol use. (See DSM–IV, criterion 10.)
	There is a persistent desire or unsuccessful efforts to cut down or control alcohol use.	8	Recurrent alcohol use in situations in which it is physically hazardous. (See DSM–IV, criterion 2.)
	A great deal of time is spent in activities necessary to obtain alcohol (e.g., driving long distances), use alcohol, or recover from its effects.	9	Alcohol 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 alcohol. (See DSM–IV, criterion 11.)
	Important social, occupational, or recreational activities are given up or reduced because of alcohol use.	10	Tolerance, as defined by either of the following: a) A need for markedly increased amounts of alcohol to achieve intoxication or desired effect b) A markedly diminished effect with continued use of the same amount of alcohol (See DSM–IV, criterion 5.)
	Alcohol 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 the substance (e.g., continued drinking despite recognition that an ulcer was made worse by alcohol consumption).	11	Withdrawal, as manifested by either of the following: a) The characteristic withdrawal syndrome for alcohol (refer to criteria A and B of the criteria set for alcohol withdrawal) b) Alcohol (or a closely related substance, such as a benzodiazepine) is taken to relieve or avoid withdrawal symptoms. (See DSM–IV, criterion 6.)

The presence of at least 2 of these symptoms indicates an **Alcohol Use Disorder (AUD).**

The severity of the AUD is defined as:

Mild: The presence of 2 to 3 symptoms

Moderate: The presence of 4 to 5 symptoms

Severe: The presence of 6 or more symptoms

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