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Alcohol Use Disorder

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Alcohol use disorder (AUD) refers to a cluster of cognitive, behavioral, and physiological symptoms associated with the loss of or impaired control of alcohol consumption, impairment resulting from drinking, risky use of alcohol (e.g., while driving a vehicle or operating machinery), and physiological dependence (referred to as alcoholism or alcohol addiction). Alcohol use is common among various age groups in the United States; alcohol is used to socialize, relax, and celebrate, among other reasons. However, problematic alcohol use can result in various medical, psychological, social, spiritual, and financial problems for the individual, family, and society. This entry first presents information on alcohol consumption and its consequences. Then, the entry examines various factors of alcohol-related disorders. The entry concludes with a discussion of treatment and relapse.

Alcohol Consumption and Its Consequences

A standard alcoholic drink has about 14 grams of ethanol, which is found in a 12-oz. bottle or can of beer, one wine cooler, a 5-oz. glass of wine, or a standard 1.5-oz. shot of 80-proof spirits, such as gin, vodka, or whiskey. According to the National Institute on Alcohol Abuse and Alcoholism (NIAAA), moderate alcohol consumption—up to one drink per day for women and two for men—may decrease the risk for heart disease, stroke, and diabetes for some individuals. However, individuals under the age of 21 years and pregnant women are advised to abstain from drinking alcohol.

Individuals whose alcohol consumption exceeds these limits are at risk for harmful consequences. NIAAA reports that excessive drinking can lead to motor impairment, confusion, memory problems, and concentration problems, and contribute to AUD and alcohol dependence. Drinking excessively can also lead to vehicle and other accidents, violence, suicide, or homicide. For instance, about 60% to 70% of reported domestic violence incidents involve alcohol use. Half of all violent crime is alcohol or drug related (victims and perpetrators). Even mild to moderate alcohol problems can cause harm to individuals, families, and communities.

NIAAA reports and other surveys and studies reveal the following:

- Nearly two thirds of 12th graders, one half of 10th graders, and more than one fourth of 8th graders have consumed alcohol during their lifetime; during the past month, 37.4% of 12th graders, 23.5% of 10th graders, and 9% of 8th graders have drunk alcohol.
- College students drink more often, including binge drinking (five or more drinks per occasion) or heavy drinking (five or more drinks five or more times per month), than same-age peers not in college.
- Nearly 700,000 college students are assaulted and nearly 100,000 are sexually assaulted or raped each year by other students who have been drinking.
- Nearly 1 in 5 college students meet the criteria for an AUD, and 1 in 4 report academic consequences from drinking.

Alcohol-related problems are the third leading cause of preventable deaths in the United States; only smoking and obesity account for more deaths. Each year in the United States, more than 88,000 deaths are attributed to alcohol, at a cost of hundreds of billions of dollars. Globally, alcohol problems represent the fifth leading risk factor for premature death and disability and the first leading factor among people between 15 and 49 years of age. Alcohol contributes to more than 200 medical diseases and injuries, and in 2012, it accounted for 3.3 million deaths, almost 6% of all deaths in the world.

Alcohol affects every organ system in the body. It affects several neurotransmitter systems in the brain, including the opioidergic, gamma-aminobutyric acid, glutamate, serotonin, and dopamine systems. Increased opiate levels help explain the euphoric effect of alcohol, whereas its effects on the gamma-aminobutyric acid system cause anxiolytic (antianxiety) effects. Long-term excessive use of alcohol increases the risk for heart disease, elevated blood pressure, and stroke. Heavy and prolonged drinking causes neurological and mental health problems related to brain and peripheral nervous system damage. Chronic alcohol use is associated with deficits in problem-solving skills, problems in remembering and retrieving information, and personality changes. Chronic alcohol abuse can lead to gastritis and pancreatitis and to severe damage to the liver, including cirrhosis of the liver, which occurs in 10% to 20% of all individuals who are severely addicted to alcohol.

Persons who have a severe addiction to alcohol are prone to alcohol withdrawal syndrome, which is characterized by anxiety, tremulousness, elevated pulse and blood pressure, and possible seizures and confusion, which could lead to death if untreated. Dementia, suicide, and homicide are serious consequences of severe alcohol addiction. Alcohol is also responsible for a number of other conditions, such as mouth and oropharyngeal cancers, esophageal cancer, liver cancer, and breast cancer.

Moreover, prenatal exposure to alcohol can result in fetal alcohol syndrome, which involves mental and growth impairments, birth defects of the face and limbs, and behavioral problems including attention-deficit/hyperactivity disorder.

Alcohol-Related Disorders

According to the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (*DSM-5*), there are five categories of alcohol-related disorders: (1) alcohol use disorder, (2) alcohol intoxication, (3) alcohol withdrawal, (4) other alcohol-induced disorders, (5) and unspecified alcohol-related disorder.

Prevalence

Approximately 7.2% of (or 17 million) adults in the United States aged 18 and older had an AUD in 2012. This includes 11.2 million men and 5.7 million women. In 2012, an estimated 855,000 adolescents of ages 12 to 17 years had an AUD.

AUD is more prevalent among men, Whites, Native Americans, younger and unmarried adults, and those with lower incomes. The prevalence of AUD declines with increasing age. The prevalence in elderly populations is approximately 3%.

Screening

The U.S. Preventive Services Task Force and NIAAA recommend that clinicians screen all adult clients 18 years of age or older for alcohol use. The following screening tools can be used:

- The abbreviated three-question Alcohol Use Disorders Identification Test Consumption, which detects at-risk drinking and alcohol problems
- Single-question: “How many times in the past year have you had five (four for women) or more drinks in a day (more than the daily recommended NIAAA drinking limits)?”

- The CAGE (need to Cut down on drinking, Annoyance, feel Guilty about drinking, and need for Eye-opener), which is a short screening test for alcohol problems

When a client is identified as engaging in at-risk alcohol use, clinicians are advised to perform a full assessment, including analysis of consumption pattern; review of whether drinking pattern meets the criteria for AUD; evaluation for signs of physiological and behavioral dependence, cognitive impairment, and medical harm; and identification of motivation for change. Then, the clinician should engage the client in a discussion about hazardous drinking and provide the client with a brief motivational intervention to reduce the client's alcohol misuse.

Diagnosis

AUD is diagnosed when a person shows a problematic pattern of drinking leading to significant impairment or distress. Typically, this pattern includes a strong desire to take alcohol, difficulties in controlling its use, persisting in use despite harmful consequences, giving a higher priority to alcohol use than to other activities and obligations, increased tolerance, and a physical withdrawal state. In the *DSM-5,* AUD has specifiers for severity: mild, moderate, and severe. There are 11 possible symptoms (behavioral and physical) of the "use disorder," of which two are necessary to achieve a severity specifier of mild, four for moderate, and six for severe.

Comorbidities

Many individuals with AUD also have other substance-related or mental health disorders, such as antisocial or borderline personality, bipolar, schizophrenia spectrum, depressive, anxiety, or attention-deficit/hyperactivity disorder. Having an AUD increases the risk of a mental health disorder and can affect the individual's response to treatment. Similarly, having a mental health disorder raises the risk of having AUD and can affect response to treatment and recovery. Symptoms of either disorder can contribute to a relapse of the other disorder. The recommended treatment approach for co-occurring mental health and substance use disorders such as AUD is integrated treatment when possible by the same provider or treatment team. For maximum benefit, treatment needs to focus on both types of disorders.

Treatment

There are many evidence-based behavioral, pharmacological, and combined treatments for AUD, which can be offered in medical and clinical inpatient, residential, or ambulatory settings. Treatment aims to help the individual stop (or reduce) alcohol use and manage the challenges of recovery, such as cravings, negative thinking, social pressures to drink, and interpersonal conflict or upsetting emotional states.

Motivational interviewing helps clients strengthen their motivation and commitment to change their alcohol use. Motivational interviewing addresses ambivalence about change and elicits specific goals and reasons for change in an atmosphere of acceptance and empathy. *Contingency management* uses positive incentives to reward clients who abstain from alcohol (or other drugs) or adhere to treatment sessions. *Cognitive behavioral therapy* helps clients learn coping skills to maintain abstinence by identifying triggers to drink. Clients also learn problem-solving and behavioral skills to cope with high-risk situations and feelings that increase the risk of relapse. This treatment also helps clients counteract self-defeating

cognitions such as “I need a drink to feel relaxed” or “I need to drink if I want to fit in with my peers.”

Twelve-step facilitation therapy facilitates clients’ participation in Alcoholics Anonymous (AA). Sessions focus on acceptance of alcoholism as a disease, surrender to a higher power, acceptance of the fellowship and recovery program promoted by AA, and active involvement in twelve-step meetings, sponsorship, and other AA program activities. Mutual support programs (MSPs) such as AA help individuals manage AUD in the long term by participating in a fellowship with others in recovery who share experiences, hope, and strength. AA is the most common MSP for AUD. Those who are active in AA (attend meetings, have a sponsor, work the Twelve Steps, and use the “tools” of the program) are more likely to remain abstinent than those who only attend meetings. Other MSPs include Alcoholics for Christ and Alcoholics Victorious (Christian fellowships), LifeRing Secular Recovery (for all types of addiction and people of all faiths), Men for Sobriety and Women for Sobriety (programs that focus on emotional and spiritual growth), Rational Recovery and SMART Recovery (for all types of addiction), and Secular Organizations for Sobriety (a secular approach offered as an alternative to AA and other twelve-step recovery programs). MSPs promote recovery as a process that involves physical, cognitive, emotional, social, and spiritual change.

Marital and family approaches are used with adults and adolescents. These focus on helping the family member with the AUD engage in treatment, attend treatment sessions, complete treatment, stop or reduce alcohol use (e.g., less frequent and less severe relapses), and improve functioning (e.g., work, school, family, community). These approaches may also improve family interaction and communication, engage the family in treatment, and reduce the burden experienced by family members of a person with AUD. Family approaches are highly recommended for treatment of adolescents with AUD.

Because family systems and individual members are affected in many ways by a loved one’s AUD, participation in treatment and/or MSPs for families can help family members learn more effective coping strategies. Al-Anon is available for any family member or concerned other affected by a loved one’s alcohol problem. It offers a twelve-step program to help family members learn about alcohol problems, deal with their loved one with AUD, and address their own behaviors, reactions, feelings, and recovery needs. Al-Anon uses similar tools as AA (meetings, sponsorship, twelve-step readings). Adult Children of Alcoholics is a program for any individual who grew up in an alcoholic family. This program also uses tools similar to those of AA or Al-Anon. Ala-teen is an MSP for adolescents affected by a parent or other family member’s AUD.

Medications approved by the U.S. Food and Drug Administration to treat alcohol dependence include disulfiram, oral naltrexone, extended-release naltrexone, and acamprosate. Medications such as topiramate, which is approved for other conditions such as migraine headaches and epilepsy, show promise for alcoholism. Positive outcomes (e.g., less drinking, shorter relapses, and decrease in alcohol cravings) are found when these medications are combined with behavioral treatment. Referring clients for a medication evaluation and monitoring adherence are ways by which nonmedical clinicians can help individuals with AUD.

Relapse and Relapse Prevention

Many intrapersonal (e.g., emotions, thoughts, cravings) and interpersonal (e.g., social pressures to drink, conflict with others) factors may contribute to relapse. However, not using active coping skills ultimately determines if a relapse occurs. Incorporating interventions from

relapse prevention therapy can help clients (a) identify and manage early warning signs of relapse, (b) identify and manage high-risk relapse factors, (c) intervene early in a lapse or relapse to limit the damage, and (d) make lifestyle changes to achieve a better balance. If a client has a lapse or relapse, the focus is on learning from it to develop coping strategies for use in the future.

See alsoAlcohol Intoxication; Alcohol Use Disorder: Biological Factors; Alcohol Use Disorder: Cultural Factors; Alcohol Use Disorder: Diagnosis; Alcohol Use Disorder: Epidemiology; Alcohol Use Disorder: Gender and Sex Differences; Alcohol Use Disorder: Lifespan Perspectives; Alcohol Use Disorder: Psychological Factors; Alcohol Use Disorder: Risk for; Alcohol Use Disorder: Social Factors; Alcohol Use Disorder: Treatment; Alcohol Use Screening Measures; Alcohol Withdrawal; Alcoholics Anonymous

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Further Readings

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