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Dual Dx: What is the Best Treatment Plan for Anxiety Plus Alcoholism?

In a mental health setting, the preferred approach is to treat the anxiety first and hope that the alcohol or substance problem resolves by itself; or, if it persists, then treat the drug abuse second, usually by referral to a specialized setting. In a substance abuse treatment setting, the approach is usually just the opposite.

However, this is not simply a minor problem of history and resource allocation as males and females with an anxiety disorder are three times the general population at risk for alcoholism while those who seek treatment for anxiety in a mental health setting are even at a greater risk for alcohol dependence. If either side of the dual diagnosis seesaw remains neglected, relapse risk of either condition rises enormously, leading to multiple treatment episodes and, in public health terms, dramatically increased health care costs.

What are the major conditions and ratios of concordance with alcohol dependence?[1]

	Female	Male
Panic disorder	3.7	3.8
Generalized anxiety disorder	3.4	3.6
Social phobia	3.6	2.6
All anxieties	3.3	3.2

There are three hypothetical models for co-morbidity or dual diagnosis:

1. The mental condition causes the abuse condition by means of self-medication to relieve the anxiety.
2. Substance abuse "induces" or causes the mental problem as a kind of stressor on the biological system.
3. There is present in some individuals an as-yet-to-be-defined genetic or physiological vulnerability that promotes both alcoholism (and other substance abuses) and anxiety disorders.

It has been demonstrated that the anxiety disorder usually precedes the substance abuse disorder.

[1] Kushner MG, et al. The relation between alcohol problems and the anxiety disorders. "Am J Psychiatry" 1990; 147: 685-95.

College freshmen that had an anxiety diagnosis are three times more likely to develop alcohol dependence before graduation, and in-coming freshmen that were alcohol dependent are four times more likely to develop an anxiety disorder within 6 years.[2]

It has finally been demonstrated in controlled studies that treatment of one condition of dual diagnosis does not bring about the hoped-for magical resolution of the other.

The three basic approaches, depending on setting, skill sets and resource allocation are: serial – treat one condition at a time; parallel – treat both conditions at the same time but in separate programs or locations; integrated – provide one treatment that especially focuses on both disorders as they interact with each other.

It is important to keep in mind that each approach has merits and weaknesses. The traditional approach is serial treatment in that it allows the well-established, familiar programs to address each side of the co-morbidity. The obvious disadvantage is that while awaiting treatment of the "other" disorder (as it is often delayed), the initial treatment gain may be undermined. Also, the usual pattern is to treat the patient for the problem that he defines, even if the "other" problem is more severe. For example, there is usually resistance to clinician-driven efforts at sobriety when the patient defines his problem as anxiety and the use of alcohol to calm himself or even for recreation.

Increasingly, in drug treatment programs, with access to psychiatric consultation, parallel treatments are becoming more frequent. Unfortunately, it is less common to see drug treatment paralleling psychiatric treatments in the mental health setting.

Finally, the Integrated Treatment approach allows for treating both of the co-morbidities at the same time.[3] It is important to note that these combined programs are rare. Training programs have not caught up with a major push toward cross-training, and institutional resources and supports are not yet lined up to incentivize integrated treatment.

What are the key elements of the Integrated Treatment Plan? (Keep in mind that preliminary data address alcoholism and co-morbid panic disorder.)

1. Standard alcoholism treatment
2. Psychoeducation
3. Cognitive Restructuring
4. Cue Exposure

Psychoeducation addresses the biopsychosocial model of anxiety formation, alcohol dependence and the interaction of the two disorders. Cognitive Restructuring involves recognizing the thinking patterns that bring on panic, anxiety and drinking behavior. CBT (Cognitive Behavioral Therapy) is very crucial to this aspect of combined treatment. Cue Exposure aims to decouple anxiety-inducing thoughts and fear-inducing situations from drinking urges and practice alternative, healthy coping strategies.

Pharmacotherapy with the newer FDA approved medications for alcoholism may be part of the treatment plan: naltrexone (Vivitrol), acamprosate (Campral), and disulfiram (Antabuse).

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[2] National Institute on Alcohol Abuse and Alcoholism. Alcoholism screening tools. http://pubs.niaaa.nih.gov/publications/arh28-2/7-79.htm.

[3] Kushner, MG, et al. Cognitive behavioral treatment of comorbid anxiety disorder in alcoholism patients: presentation of a prototype program and future directions. "J Mental Health" 2006; 15: 697-708.

Finally, if the drinking is severe and unresponsive, then referral to a specialized treatment setting may be required. And conversely, if the anxiety condition does not remit, referral to a specialty setting may be indicated.

One take-home message from preliminary clinical research is that Integrated Treatment appears to be more effective with patients who have the strongest belief that they need alcohol to control their anxiety.