Co-morbidity Between Anxiety Disorders and Substance Use Disorders

Co-morbidity is defined as the presence of any co-occurring condition in a patient with an index disease (Kranzler & Rosenthal, 2003). Epidemiologic surveys of psychopathology in the United States have found that while approximately half of the general population will experience a major psychiatric illness at some point over their lifetime, the majority of affected individuals will simultaneously meet diagnostic criteria for two or more disorders (Kessler et al., 1994). Co-morbidity has important clinical implications including: more severe symptoms, more functional disability, longer illness duration, and higher treatment service utilization (see de Graaf, Bijl, ten Have, Beekman, & Vollebergh, 2004).

One of the most common co-morbid conditions is anxiety disorder co-occurring with substance use disorder. Studies that have examined rates of alcohol dependence in anxiety disorder outpatient samples suggest ranges from 15% to 30% depending on the particular anxiety disorders (see Barlow, 1997). Other epidemiologic studies cite lifetime prevalence rates of clinically significant anxiety disorders in patients with alcohol dependence as ranging from 25% to 45% (Kushner et al., 2005). These rates of alcohol dependence in anxiety disorder patients, and of anxiety disorders in alcoholism patients, are markedly elevated relative to base-rates in the general population. Nonetheless, co-morbidity studies with patient populations can lead to overestimates of co-morbidity due to the issue of “Berkson’s bias” – the fact that individuals with more than one disorder may be more likely to seek treatment than those with only one disorder (Galbaud du Fort, Newman, & Bland, 1993). Thus, population-based studies are important to examine “true” rates of co-morbidity of anxiety and substance use disorders.

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In the Epidemiological Catchment Area Survey (ECA), which included more than 20,000 respondents from five communities in the United States, alcoholics were significantly more apt to have a co-morbid anxiety disorder than non-alcoholics (19.4% vs. 13.1%) (Regier et al., 1990). Moreover, the ECA survey found that individuals with any anxiety disorder had a 50% increase in the odds of being diagnosed with a lifetime alcohol use disorder (alcohol abuse or dependence). Co-morbid psychiatric symptoms, such as anxiety, can make accurate assessment of substance use more difficult and is associated with a poorer substance use outcome following treatment (Kranzler & Rosenthal, 2003). Indeed, anxiety disorders may especially complicate the treatment of substance use disorders in that they have been found to take significantly longer to remit as compared to mood disorders (Wagner, Krampe, & Stawicki, 2004).

Another issue relates to whether the anxiety disorder is seen as being “independent” of the substance use disorder or “substance-induced”. The former views onset of an anxiety disorder occurring before that of an alcohol disorder and/or persisting after the substance abuse is resolved and in need of specific treatment. The latter views onset of an anxiety disorder occurring after that of an alcohol disorder due to substance intoxication and/or withdrawal and not in need of specific treatment; rather, substance-induced anxiety disorders will resolve as the substance abuse is brought under control. Using the criteria of the Diagnostic and Statistical Manual of Mental Disorders (4th ed. [DSM-IV]; American Psychiatric Association [APA], 1994) in a large epidemiologic survey, Grant et al. (2004) concluded that the vast majority of the anxiety disorders found in the general population and in alcoholism treatment settings are independent of substance abuse (see chapter 1).

Approaches to Treatment of Co-morbidity

Traditionally, two approaches have been used in the treatment of individuals with co-morbid disorders: serial treatment (where either one or the other disorder is addressed first and the other is addressed next, if necessary) and parallel treatment (where both disorders are addressed concurrently but typically without formal interaction of clinicians or programs involved) (Kranzler & Rosenthal, 2003). Current research suggests the greater effectiveness of a more integrated approach to the treatment of co-morbidity. For example, there is some evidence that the addition of cognitive-behavioral therapy (CBT) focused on the concurrent disorder to traditional treatment programs for substance abuse/dependence enhances efficacy of treatment for substance use disorder co-morbid with both unipolar and bipolar depression (Brown, Evans, Miller, Burgess, & Mueller, 1997; Weiss et al., 2000); personality disorders (Fisher & Bentley, 1996); schizophrenia (see Drake, Mercer-McFadden, Mueser, McHugo, & Bond, 1998); and anxiety disorders, such as posttraumatic...