

# Mental Health & Alcohol Misuse Project

## Factsheet 4: Anxiety Disorders and Alcohol Misuse

This factsheet outlines recent research and treatment options for the management of concurrent alcohol misuse and anxiety disorders. The factsheet also suggests actions that Local Implementation Teams (LITs) and Primary Care Trusts (PCTs) can undertake to address these conditions, in conjunction with a range of local service providers.

### Target audience:

This factsheet is intended for a wide audience, including people working in PCTs, mental health trusts, LITs, alcohol services and primary care. Information on research findings and treatment options for people with concurrent anxiety and alcohol misuse will perhaps be of most interest to those engaged in clinical and supportive work.

### Summary: The factsheet at a glance

- Anxiety disorders are among the most common mental health problems, affecting 10% of the population
- While alcohol consumption may temporarily relieve some feelings of anxiety, prolonged alcohol misuse often heightens anxiety
- The ongoing misuse of alcohol to “self-medicate” anxiety, can lead to a vicious cycle of dual alcohol misuse and anxiety problems
- In treating concurrent alcohol misuse and anxiety it is important to try to determine whether an anxiety disorder is present in order to formulate appropriate treatment, since further treatment of an anxiety disorder may be required
- The Mental Health National Service Framework indicates that anxiety is a common disorder that can be treated effectively in primary care
- Nevertheless, anxiety disorders and symptomology present in a range of clinical settings. Given the scope of anxiety and alcohol misuse in the community, it is also important that alcohol and mental health services are appropriately equipped and trained to treat people with these conditions
- LITs and PCTs should work with local services to ensure that appropriate care and treatment pathways are available. (See recommendations on page 6).

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The Mental Health & Alcohol Misuse Project (MHAMP) provides factsheets, a newsletter and web pages aimed at sharing good practice between clinicians and professionals working in the mental health and alcohol fields. MHAMP promotes the inclusion of alcohol in strategies developed for the Mental Health National Service Framework, and updates the mental health and alcohol fields.

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# Anxiety & Anxiety Disorders: Introduction

Anxiety has been described as “a feeling of discomfort or unease”, manifest in physical symptoms such as sweating, a racing heart, palpitations or rapid breathing (Borrill & Bird 1999-2000).

While it is normal to feel anxious when facing something dangerous or difficult, it is not usual to feel anxious all the time or to feel that anxiety is ruling one’s life (Borrill & Bird 1999-2000). Severe anxiety occurs when someone’s body overreacts and respond with anxiety to something which is not really dangerous. The perception of a situation may lead people to exaggerate how difficult or dangerous something will be. Severe anxiety can also occur when people are under stress or dwell on past difficulties and experiences (Borrill & Bird 1999-2000).

Severe anxiety may persist because people avoid something that they fear. Each time something is avoided, anxiety levels start to drop, and so in the short term they may feel better. However, anxiety continues and becomes a long-lasting problem when someone adopts the habit of avoiding what s/he fears rather than facing it (Borrill & Bird 1999-2000). Therefore, anxiety disorders are characterised by intensity, duration, autonomy (that is, “it has a life of its own”) and functional impairment (that is, often characterised by changes in behaviour) (Lingford-Hughes et al. 2002).

Anxiety is one of the most common forms of mental distress, with one in ten people suffering problematic anxiety or phobias at some point in their lives. Most, however, never ask for treatment (Royal College of Psychiatrists 1998).

## Types of anxiety disorders

There are several different types of anxiety disorders, outlined briefly below.

### **Generalised Anxiety Disorder (GAD)**

GAD is exaggerated worry and tension over everyday events and decisions (National Institute of Mental Health [NIMH] 1999). In addition to chronic worry, GAD symptoms include trembling, muscular aches, insomnia, abdominal upsets, dizziness, and irritability (Anxiety Disorders Association of America [ADAA] 2003).

### **Obsessive-Compulsive Disorder (OCD)**

OCD is characterised by intrusive, unwanted, repetitive thoughts and rituals performed out of a feeling of critical need (NIMH 1999). Obsessions may lead a person to perform a ritual or routine (compulsions) such as washing hands, repeating phrases or hoarding to ease the anxiety caused by the obsession (ADAA 2003).

### **Panic Attacks/Panic Disorder**

For people with panic disorder, feelings of intense fear and dread occur unexpectedly and repeatedly for no apparent reason, accompanied by extreme physical symptoms (NIMH 1999). Symptoms of panic disorder include heart palpitations, chest pain or discomfort, sweating, trembling, tingling sensations, feeling of choking, fear of dying and losing control, and feelings of unreality (ADAA 2003).

### **Post-Traumatic Stress Disorder (PTSD)**

PTSD can follow an exposure to a traumatic event such as a sexual or physical assault, witnessing a death, or a natural disaster. Symptoms associated with PTSD include "reliving" the traumatic event (such as flashbacks and nightmares), avoidance behaviours (such as avoiding places linked to the trauma), emotional numbing (detachment from others), and physiological arousal such difficulty sleeping, irritability or poor concentration (ADAA 2003).

### **Social Anxiety Disorder (Social Phobia)**

Social Anxiety Disorder (SAD) is characterised by extreme anxiety about being judged by others or behaving in a way that might cause embarrassment or ridicule, such as anxiety about speaking in public (ADAA 2003; Borrill & Bird 1999-2000). SAD leads to avoidance behaviour. Physical symptoms associated with this disorder include heart palpitations, faintness, blushing and sweating (ADAA 2003).

### **Specific Phobias (Simple Phobia)**

People with specific phobias suffer from an intense fear reaction to a particular object or situation (such as spiders, dogs, or heights); the level of fear is usually inappropriate to the situation, and is acknowledged by the sufferer as being irrational. This extreme fear can lead to the avoidance of common, everyday situations (ADAA 2003).

### **Agoraphobia**

Agoraphobia is often described as a fear of open spaces, but it may be more helpful to regard it as a fear of being in places from which it is difficult to escape – for example, crowds and public spaces such as shops and public transport (Borrill & Bird 1999-2000).

## **The Paradox of Anxiety & Alcohol Misuse**

While anxiety and alcohol consumption are interlinked, the question of which condition precedes the other is dependent on a range of factors, including; the amount of alcohol consumed (that is, 'use' or 'misuse' of alcohol), the duration of alcohol misuse, and whether or not a person has a diagnosed anxiety disorder or is merely showing the symptoms of anxiety.

There is a widespread belief that alcohol can act as an anxiolytic – that is, alcohol can help to dispel feelings of anxiety. For example, many socially anxious people believe that alcohol may reduce social anxiety, helping them to feel more comfortable in social situations (Book & Randall 2002).

Although alcohol is a fast-acting anxiolytic that may temporarily relieve feelings of anxiety, *long-term* alcohol misuse and acute alcohol withdrawal often *increase* anxiety levels (cf. Lingford-Hughes et al. 2002; Trevisan et al. 1998; Modesto-Lowe & Kranzler 1999). For this reason, alcohol may be consumed in increasing quantities by people with a drinking problem, embroiling them in a vicious cycle; drinking to 'self-medicate' their anxiety, but in so doing, furthering their anxiety in the long-term (Lingford-Hughes et al. 2002).

The Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) defines a diagnosis of substance-induced anxiety disorder as present "when there is evidence that persistent anxiety symptoms, including panic attacks, obsessions, or compulsions have arisen out of use of or withdrawal from either prescribed or "recreational" drug use [including alcohol]".

*Diagnosed* anxiety disorders generally precede alcohol problems or dependence. However, importantly, alcohol can also lead to increased levels of anxiety, as alcohol intake increases (Lingford-Hughes et al. 2002). Panic disorder does not necessarily follow this pattern, with panic disorder sometimes following alcohol dependence (Lingford-Hughes et al. 2002).

However, feelings of anxiety are most likely a *consequence* rather than a cause of heavy drinking – with alcohol acting as an anxiogenic (that is, generating feelings of anxiety) with repeated and prolonged misuse. However, rather than resulting in a *diagnosed* anxiety disorder, alcohol misuse may result in *symptoms* of anxiety, which are mostly temporary, though sometimes severe (Schukit & Hesselbrock 1994).

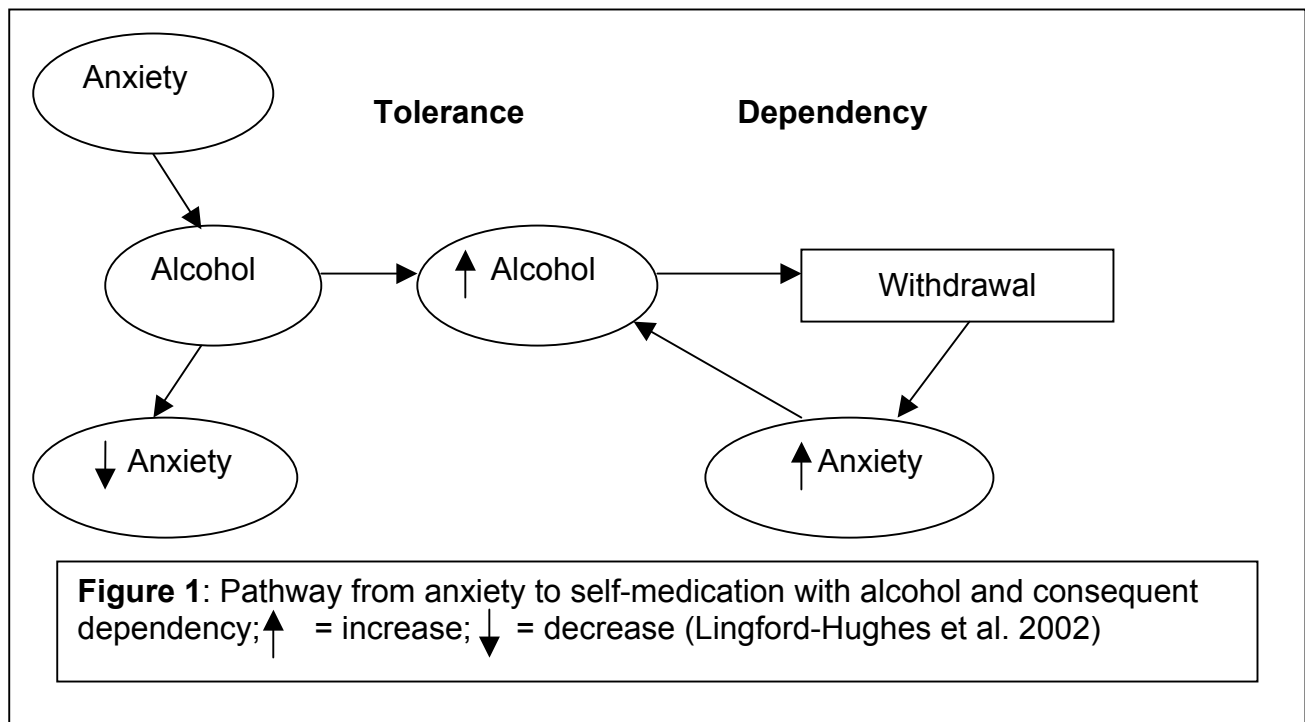
Research shows that the majority of alcohol dependent patients present with anxiety symptoms (for example, palpitations, sweatiness, light-headedness and fear of objects or social situations), but these decrease rapidly if the patients stops drinking (see Schukit et al. 1990; Allan 1995; Modesto-Lowe & Kranzler 1999). Some patients, however, will experience persistent symptoms (and may have a diagnosed anxiety disorder), which can then be treated using pharmacological or cognitive-behavioural approaches (Allan 1995).

The following examples from the research literature demonstrate aspects of the complex (and sometimes inconsistent) relationship between alcohol and anxiety:

- Together with mood disorders such as depression and antisocial personality disorder, anxiety disorders is one of the psychiatric disorders that occurs most frequently among alcohol dependent people (Modesto-Lowe & Kranzler 1999).
- The symptoms of anxiety are common among problem drinkers – both during periods of drinking and in withdrawal. An American study of veterans admitted for a primary diagnosis of alcoholism on an alcohol treatment course found that 98% of patients reported at least one symptom of anxiety during drinking or withdrawal, with 80% experiencing problems with palpitations and/or shortness of breath, and 4% being subject to at least one panic attack lasting 1-4 or more hours (Schukit et al. 1990).
- One review of the research literature found little proof of a close relationship between *lifelong* anxiety disorders and alcohol dependence (Schukit & Hesselbrock 1994). The authors of the review postulate that the high rates of co-morbidity found in some studies may reflect a mix of true anxiety disorders equal to or slightly higher than the general population, combined with temporary, though sometimes severe, substance-induced anxiety *symptoms*. Such symptoms include phobic behaviours, a condition that resembles generalised anxiety disorder and repetitive panic attacks (Schukit & Hesselbrock 1994).
- There may be a variable relationship between different anxiety disorders and alcohol misuse. For example, one study found that:
  - In the case of agoraphobia and social phobia, alcohol problems follow from attempts to self-medicate
  - Panic disorder and generalised anxiety disorder follow from pathological alcohol consumption
  - Simple (or 'specific') phobia does not seem to be related to alcohol problems in any significant way (Kushner 1990).
- There is evidence that there is an increased risk of alcohol misuse among people with a *diagnosed* anxiety disorder. One study found that the risk of alcoholism in people with panic disorder is 4.3 times higher than the general population. The risk of alcoholism in people with obsessive-compulsive disorder is 3.4 times higher, and in people with any phobia, it is 2.4 times higher than the general population (Boyd et al. 1984, cited in Wesner 1990).
- Agoraphobia, social phobias, panic disorder and generalised anxiety are all more commonly reported by heavy drinkers than the general population (Stockwell 1995).
- Alcohol also acts on neurotransmitter systems. GABA (Gamma-aminobutyric acid) is the major inhibitory neurotransmitter of the central nervous system. Although short-term exposure to alcohol increases GABA-ergic function, long-term exposure is associated with reduced GBzR (GABA-benzodiazepine receptor) levels and function (Lingford-Hughes et al. 2002). In other words, alcohol may initially reduce anxiety, but its long-term use reduces "anxiolytic" receptor function in the brain.
- Some studies have found that alcohol seems to have a greater effect on anxiety in individuals who have either a family history of alcoholism or a personal history of antisocial traits (for examples, see Wesner 1990). However, a study by Schukit and colleagues (1995) examined the rate of anxiety-related diagnoses in close relatives of alcohol dependent people in order to evaluate whether alcoholism and major anxiety disorders might share a common genetic basis. Results did not show a significantly

high rate of anxiety disorders among close relatives of alcoholic dependent people. This finding does not support evidence of a common genotype for the two disorders (Schukit et al. 1995).

While some of the findings from the research literature are sometimes contradictory, Lingford-Hughes and colleagues (2002) have represented the relationship between alcohol and anxiety in figure 1, below. Here, we see alcohol can be an anxiolytic, but leading, paradoxically, to increased levels of anxiety as alcohol intake increases.



In spite of the correlation between alcohol consumption and anxiety, the two factors do not always advance in tandem towards increasing severity. In addition, the relationship between alcohol and anxiety may differ between genders. One study of hospitalised male and female depressive patients found that there was a strong association between anxiety and alcohol misuse for women and a weaker association for men (Fischer & Goethe 1998). Whereas the correlation appeared to be linear for men, with increased anxiety associated with greater consumption of alcohol, for women depressives, those patients in the *moderate*-anxiety subgroup had the biggest difficulty with alcohol (Fischer & Goethe 1998). For women, the percentage of alcohol misuse rose substantially from low to moderate levels of anxiety, but then declines at the highest levels of anxiety (Fischer & Goethe 1998).

Evidence from the research literature indicates that withdrawal from alcohol misuse is associated with raised levels of anxiety (see, for example, Thevos et al. 1991). Furthermore, for those with a co-existing anxiety disorder, the withdrawal process can be more severe than for those without a diagnosed anxiety disorder (see studies by Thevos et al. 1991; Johnston et al. 1991). Acute withdrawal symptoms among people with a diagnosed anxiety disorder might include nausea and vomiting, tremor, sweating, auditory disturbance, agitation and headaches (Johnston et al. 1991).

Importantly, the symptoms of anxiety during withdrawal may suggest but not indicate a discrete anxiety disorder. Schukit and colleagues (1990) note that a number of studies have documented a high prevalence of anxiety during the first 2-4 weeks following cessation of drinking. However, these symptoms are likely to decrease with continued abstinence and may not represent an independent anxiety disorder (Schukit et al. 1990). For example, hyperventilation may occur during acute alcohol withdrawal, leading to disturbed blood chemistry and resulting in symptoms that may be indistinguishable from those that occur in

anxiety disorders (Kushner et al. 1990).

In summary:

- The symptoms of anxiety are common among heavy drinkers.
- A diagnosed anxiety disorder may precede heavy drinking. However, an anxiety disorder (for example, panic disorder) can also follow excess drinking.
- While some alcohol may relieve the symptoms of anxiety (such as social anxiety), heavy and prolonged drinking increases levels of anxiety. This heightened anxiety can emerge both as the symptoms of anxiety (that is, increasingly anxious feelings, though no 'disorder' is present) and in greater levels of anxiety among those with a diagnosed anxiety disorder.
- Levels of anxiety frequently increase when people withdraw from alcohol misuse.

## **The Mental Health National Service Framework & Anxiety**

The treatment of anxiety disorders fits largely under standards two and three of the Mental Health National Service Framework (MHNSF). These standards aim "to deliver better primary mental health care, and to ensure consistent advice and help for people with mental health needs..." (Department of Health [DoH] 1999: 28).

Standards two and three indicate that service users in contact with a primary health care team should have common mental health problems identified and assessed and be offered effective treatments, including referrals if required. People with common mental health problems should also be able to make 24-hour contact with the local services necessary to meet their needs and receive adequate care (DoH 1999). As one of the most common mental health problems, anxiety will be treated largely within primary care. The MHNSF also makes special mention of the relationship between alcohol and anxiety, noting that people who have anxiety symptoms may consume more alcohol than those without, increasing their risk of poor physical health (DoH 1999).

Given the scale of both alcohol misuse and anxiety disorders in the community, Local Implementation Teams and Primary Care Trusts should work with services and primary care teams to address this issue.

Besides primary care teams, other services are also engaged in the treatment and care of people with common mental health problems. This is particularly relevant to anxiety and alcohol problems, since these dual conditions (and/or disorders) commonly present at both alcohol and mental health services.

Local Implementation Teams (LITs) and Primary Care Trusts (PCTs) should work with local services to ensure that:

- Resources are developed and available within general practices to assess anxiety and alcohol misuse (see, for example, information on the AUDIT alcohol screening tool on pp. 7-8).
- Clinicians possess the skills and competencies to manage comorbid anxiety and alcohol misuse (through, for example, training strategies).
- Agreed assessment and management protocols for the treatment of anxiety disorders are implemented across the PCT. Protocols should ensure that complex cases have access to skilled specialist assessment and treatment.
- Specialist services are included in referral and treatment protocols, furthering joint working aimed at improving service provision. These specialist services should include mental health services and alcohol agencies. The role of specialist services in the treatment of people with concurrent mental health and substance misuse problems is highlighted in the *Dual Diagnosis Good Practice Guide* (see DoH 2002).

# Treatments for Anxiety & Alcohol Misuse

There are a number of reasons why people with anxiety disorders initiate and maintain alcohol misuse and why subsequent management of these problems is not always ideal. These include the availability of alcohol, failure of patients and doctors to recognise pathological anxiety, and uncertainty or lack of knowledge about treatment options (Lingford-Hughes et al. 2002). The education of patients and clinicians is important in addressing these factors (Lingford-Hughes et al. 2002). Examining a number of international research studies and recommendations, this section is not a clinical guideline, but instead sequentially maps out some of the salient issues in the treatment of alcohol misuse and anxiety.

## Diagnosis & assessment

In approaching the treatment of co-existent alcohol misuse and anxiety an important question to ask is: does the client have a co-morbid anxiety *disorder*, or is s/he experiencing the *symptoms* of anxiety brought on by alcohol misuse? In making a diagnosis, it is important to note the possibility that two disorders may be present (Schukit & Monteiro 1988). After treatment has been initiated, clinicians must monitor both drinking behaviour and psychiatric symptoms, since alcohol dependence and anxiety disorders both tend to have a relapsing course (Modesto-Lowe & Kranzler 1999).

According to Lingford-Hughes and colleagues (2002), three questions should be asked when assessing a patient “with anxiety”:

1. Is the patient suffering from an anxiety disorder?
2. What type of anxiety disorder is it?
3. Is there any comorbidity?

In making a diagnosis, panic attacks are often not identified because the clinician asks only about the recent past, whereas the natural history of panic attacks frequently results in a reduction in their intensity with time (Lingford-Hughes et al. 2002). A helpful question to ask is whether the patient has ever experienced a sudden surge in anxiety that felt overwhelming and was accompanied by the usual somatic and cognitive symptoms (Lingford-Hughes et al. 2002).

It is important to try to establish the chronology of the development of clinical problems. This will help determine whether the anxiety disorder was primary or secondary to alcohol misuse (Lingford-Hughes et al. 2002). To assist a person with anxiety and alcohol misuse, Schukit and Monteiro suggest obtaining information from the patient and a resource person to help map the cycle of problems. Such information could include when alcohol misuse commenced. Using a timeline approach, the *absence* of major anxiety syndromes antedating the onset of alcoholism or during periods of protracted abstinence is likely to indicate a high probability of spontaneous improvement in anxiety (Schukit & Monteiro 1988). However, significantly, problems may arise in trying to determine a true chronology of symptoms among problem drinkers – given, for example, possible difficulties recalling life events (Allan 1995).

Just as substance misuse services should be aware of the possibility of anxiety in alcohol dependent patients, mental health professionals caring for anxious patients should be aware of the possibility of secondary alcohol misuse (Wesner 1990). Every patient who presents with anxiety symptoms should be asked about alcohol intake (Lingford-Hughes et al. 2002). A useful tool to gauge alcohol consumption is the Alcohol Use Disorders Identification Test (AUDIT) questionnaire, developed by the World Health Organization.

The second edition of the **AUDIT** questionnaire (1992) can be downloaded at:  
[http://www.who.int/substance\\_abuse/PDFfiles/auditbro.pdf](http://www.who.int/substance_abuse/PDFfiles/auditbro.pdf)

Download the companion document, *Brief intervention for hazardous and harmful drinking: A manual for use in primary care* (2002):  
[http://www.who.int/substance\\_abuse/PDFfiles/bimanbro.pdf](http://www.who.int/substance_abuse/PDFfiles/bimanbro.pdf)

## **Withdrawal from alcohol/reducing alcohol misuse**

Once a diagnosis and assessment has taken place, research evidence suggests that, since a patient may use alcohol to ‘medicate’ anxiety symptoms, alcohol misuse should be tackled first (that is, *before* the anxiety) (see, for example, Randall et al. 2001; Lingford-Hughes et al. 2002). However, an anxiety disorder – if present - should be kept in mind, and treatment for the anxiety should commence as soon as possible (Lingford-Hughes et al. 2002).

Withdrawing from alcohol can temporarily increase severe anxiety (Schukit & Monteiro 1988). Anxiety may take the form of panic attacks, phobias and generalised anxiety. With education and reassurance, these symptoms will likely decrease fairly rapidly over the first month, after which there will be slow improvement (Schukit & Monteiro 1988).

Given the rise then fall of anxiety levels following cessation of drinking, it is important to “detoxify” the patient and reassess after 2-3 weeks sobriety (Lingford-Hughes et al. 2002). A re-assessment of the extent and nature of disorders will help to ensure a more accurate diagnosis before treatment is commenced (Oei & Loveday 1997). For patients who do not wish to discontinue alcohol consumption altogether, minimising the intake and therefore contribution of alcohol to the patient’s mental state is desirable (Lingford-Hughes et al. 2002).

## **Ongoing treatment**

In the treatment phase, it is important to keep in mind that anxiety disorders are made up of subcomponents - for example, panic disorder with or without agoraphobia – and are not a single unitary concept (that is, not ‘anxiety disorders’). The most effective therapies should be considered and initiated, with parallel and simultaneous treatment of both disorders (Oei & Loveday 1997).

Although the literature is constantly being updated, a number of treatments have indicated some successful application, including cognitive-behavioural therapy, pharmacological treatments, and a range of other therapies and anxiety management techniques such as social skills and assertiveness training, self-control training and stress management (Oei & Loveday 1997). However, there is no fully validated treatment package for the treatment of co-existent anxiety disorders and alcohol misuse (Oei & Loveday 1997); there is “no universal panacea” (Lingford-Hughes et al. 2002).

## **Pharmacological treatment**

Benzodiazepines may be useful in the treatment of alcohol withdrawal (Williams & McBride 1998). The risk of dependency associated with benzodiazepines should be avoided if use of the drug is restricted to the withdrawal period (Williams & McBride 1998).

Benzodiazepines are also widely used to treat anxiety (NIMH 1999). While benzodiazepines may provide short-term relief from severe anxiety, most GPs do not prescribe them for minor anxiety because of their addictive properties (Borrill & Bird 1999-2000). Benzodiazepines should only be taken for a short period when treating anxiety and are not recommended for

people with phobias or OCD (Borrill & Bird 1999-2000).

According to Petrakis and colleagues (2002), there is little evidence to suggest that benzodiazepines are unsafe for patients with co-morbid anxiety and alcohol misuse. Nevertheless, Petrakis and colleagues also cautiously advise consideration of effective alternatives before prescribing benzodiazepines for these patients (Petrakis et al. 2002). This may be, in part, because of the need for further research into the treatment of people with co-morbid alcohol and mental health problems (Petrakis et al. 2002).

Lingford-Hughes and colleagues (2002) concur that the use of benzodiazepines should not automatically be discounted in treating people with co-morbidity. These authors note, however, that patients who are severely alcohol dependent or with anti-social personality disorder or with polysubstance misuse are at the greatest risk of misusing benzodiazepines (Lingford-Hughes et al. 2002).

People abusing benzodiazepines (whether illicitly or by prescription) may take the drugs in dangerous combination with alcohol. For example, a large number of people arrested for drink driving have consumed both alcohol and minor tranquilizer benzodiazepines (O'Brien et al. 1992). In addition, the combination of minor tranquilizers and alcohol has been used to carry out suicides and is implicated in accidental deaths (O'Brien et al. 1992).

For a summary of the indications for pharmacotherapy and potential problems associated with prescribing drugs for people with co-morbid anxiety and alcohol misuse, see Lingford-Hughes et al. (2002).

### **Psychological therapies**

As noted above, several psychological therapies, such as relaxation training, stress management, and skills training, may be employed in the treatment of both anxiety and alcohol disorders (Petrakis et al. 2002; Oei & Loveday 2002). Because psychological therapy is usually tailored to the individual, one specialised area of focus may be the link between symptoms of anxiety and alcohol consumption – for example, techniques to identify and manage anxiety may also prevent relapse to alcohol use among comorbid patients (Petrakis et al. 2002).

Psychosocial treatment can be difficult for some patients with anxiety symptoms because of difficulties engaging with others. For example, patients with anxiety symptoms such as panic attacks or social phobia may have difficulty attending group meetings (Modesto-Lowe & Kranzler 1999). However, a number of alcohol services operate anxiety management groups or tackle a patient's anxiety in individual therapy (Lingford-Hughes et al. 2002).

### **Communicating with clients**

In communicating with clients, Cohen suggests avoiding terms like 'alcoholic' or 'heavy drinker' or 'abuse', as such words can make a client feel like s/he is being treated like a disobedient child and provoke a negative response. Giving a client a choice between substance and the *symptoms* of the substance (namely, anxiety) is more likely to succeed (Cohen 1995).

## Useful Resources

The **National Phobics Society** is a user led anxiety disorders charity:  
<http://www.phobics-society.org.uk/>

For information on anxiety self-help and links to anxiety related websites and organisations, see the anxiety pages of **Mindinfo.co.uk**:  
<http://www.cwgsy.net/community/mindinfo/anxiety.htm>

The **National Institute for Clinical Excellence (NICE)** is currently producing a clinical guidance, *Anxiety: management of generalised anxiety disorder (with or without agoraphobia) in adults in primary, secondary and community care*. It is expected to be completed in June 2004. The scope outlining the guidance is available at:  
<http://www.nice.org.uk/cat.asp?c=20113>

**No Panic** is a charity that aims those with anxiety disorders and to provide support for sufferers and their families and/or carers:  
<http://www.nopanic.org.uk/>

No Panic also operates a confidential helpline, freephone 0808 808 0545, open 10am – 10pm every day.

**Social Anxiety UK** is a volunteer led organisation for people with social anxiety problems and their supporters:  
<http://www.social-anxiety.org.uk/>

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## Request for Good Practice

The Mental Health & Alcohol Misuse Project is interested in examples of good practice in the mental health and alcohol-related fields to disseminate to other agencies. We are particularly interested in local service plans developed by **Local Implementation Teams** around dual diagnosis issues. If your organisation has developed examples of good practice in planning, training, protocols, care pathways or similar, please contact Slade Carter (tel. 020 7922 8657) or email [scarter@alcoholconcern.org.uk](mailto:scarter@alcoholconcern.org.uk)