When Alcohol Use Disorder Isn't the Only Diagnosis

Navigating Co-occurring Psychiatric Conditions

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Disclosure Information

- Smita Das, MD, PhD, MPH- *No Disclosures*
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PCSS Medications for Alcohol Use Disorder Providers Clinical Support System

Learning Objectives

- Apply validated screening and diagnostic tools to identify co-occurring psychiatric conditions in patients presenting with alcohol use disorder (AUD).
- Develop integrated and interdisciplinary treatment plans that address both AUD and co-occurring psychiatric conditions using evidence-based pharmacologic and behavioral interventions.
- Assess common barriers to care for patients with co-occurring disorders and implement strategies to improve treatment engagement and outcomes.

Agenda

1. Understanding the Relationship Between AUD and Co-occurring Psychiatric Conditions
2. Screening & Diagnosis
3. Evidence-based Treatment Approaches
4. Addressing Barriers and Enhancing Outcomes
5. Conclusion & Q&A

1. Understanding the Relationship Between AUD and Co-occurring Psychiatric Conditions

AUD & Mental Health Conditions

- Alcohol use disorder (AUD) frequently co-occurs with:
  - **Bipolar disorder**
  - **Major depressive disorder**
  - **Generalized anxiety disorder**
  - **Post-traumatic stress disorder (PTSD)**
- The relationship is **complex and bidirectional**, shaped by:
  - **Biological**
  - **Psychological**
  - **Social** factors that influence both conditions simultaneously
- AUD and psychiatric illness often worsen each other when unrecognized or undertreated

National Institute of Mental Health. *Finding Help for Co-Occurring Substance Use and Mental Disorders.* National Institute of Mental Health, U.S. Department of Health and Human Services, National Institutes of Health. https://www.nimh.nih.gov/health/topics/substance-use-and-mental-health. Last reviewed March 2025. Accessed January 14, 2026.

Biopsychosocial Framework for Co-occurrence

Biological factors	Psychological factors	Social factors
• Shared genetic vulnerability • Overlapping neurobiological pathways (mood, reward, stress)	• Use of alcohol to cope with mood symptoms, anxiety, or trauma • Impulsivity and affective instability	• Trauma exposure • Chronic stressors (work, finances, relationships) • Reduced access to consistent care

These factors interact to ***increase risk*** *for both AUD and psychiatric disorders*

National Institute on Drug Abuse. *Common Comorbidities with Substance Use Disorders Research Report.* Bethesda, MD: National Institutes of Health; April 2020. Available from: https://www.ncbi.nlm.nih.gov/books/NBK571451/

AUD and Bipolar Disorder: A High-risk Combination

- Alcohol is the **most commonly used substance** among individuals with bipolar disorder
- **40–70%** of individuals with bipolar disorder have co-occurring AUD
- Co-occurrence is associated with:
  - Earlier onset of bipolar disorder
  - Higher hospitalization rates
  - More severe illness course
- AUD and bipolar disorder each independently increase suicide risk, and risk is higher when both are present

Grunze H, Schaefer M, Scherk H, Born C, Preuss UW. Comorbid bipolar and alcohol use disorder—a therapeutic challenge. *Front Psychiatry*. 2021;12:660432.

Genetic Links Between AUD and Bipolar Disorder

- Strong evidence supports shared genetic vulnerability:
  - **10-fold higher familial association** between AUD and **bipolar depression**
    - Odds ratio **14.5** for bipolar depression + AUD
    - Compared to **1.7** for unipolar depression + AUD
  - **47–57% of genetic variants** predisposing to bipolar disorder also increase risk for AUD
  - Shared genetic loci identified
- *This is not just behavioral overlap; there is a biological connection*

Carmiol N, Peralta JM, Almasy L, et al. Shared genetic factors influence risk for bipolar disorder and alcohol use disorders. *European Psychiatry*. 2014;29(5), 282-287. doi: 10.1016/j.eurpsy.2013.10.001

AUD and Major Depressive Disorder (MDD)

- Up to **33%** of people in AUD treatment meet criteria for MDD
- Differences in sex:
  - Women with AUD are more likely to have MDD
  - Depression often precedes AUD in women
  - AUD often precedes depression in men
- Alcohol abstinence often improves depressive symptoms within **3–4 weeks**
- Remission of one condition increases the likelihood of remission of the other

McHugh RK, Weiss RD. Alcohol use disorder and depressive disorders. *Alcohol Res*. 2019;*40*(1). doi:10.35946/arcr.v40.1.01

AUD and Generalized Anxiety Disorder (GAD)

- Up to **50%** of individuals treated for AUD have an anxiety disorder
- Women with AUD are more likely to have co-occurring anxiety than men
- Having either condition increases the risk of developing the other
- Alcohol is commonly used to manage anxiety in the short term
- Anxiety worsens with chronic alcohol use and acute withdrawal

Anker JJ, Kushner MG. Co-occurring alcohol use disorder and anxiety: bridging psychiatric, psychological, and neurobiological perspectives. *Alcohol Res. 2019. 40*(1). doi:10.35946/arcr.v40.1.03.

Mutual Impact: How AUD and Psychiatric Conditions Worsen Each Other

AUD can:

- Worsen mood and anxiety symptoms
- Disrupt sleep and medication adherence
- Increase risk of return to use, hospitalization, and suicidality

Psychiatric conditions can:

- Increase alcohol use via self-medication of symptoms
- Reduce adherence to AUD treatments
- Impair insight and judgment during acute episodes

*This reciprocal relationship fuels **clinical instability when both aren't adequately managed***

2. Screening & Diagnosis

Screening & Diagnosis

Accurately diagnosing co-occurring psychiatric conditions alongside alcohol use disorder is ***essential*** *but often* ***challenging***

Why Diagnosis Is Challenging in AUD

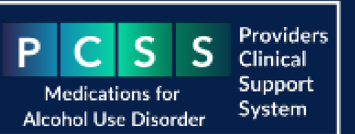
- Alcohol use can:
  - Mimic psychiatric symptoms
  - Exacerbate underlying mental illness
  - Mask the presence of a primary psychiatric disorder
- A key diagnostic question: ***“Are symptoms caused by alcohol, a psychiatric condition, or both?”***
- Misdiagnosis can lead to:
  - Inappropriate treatment
  - Delayed recovery
  - Worsening symptoms

General Symptom Overlap in Co-occurring Conditions

Common overlapping symptoms include:

Anxiety	**Depressed mood**	**Sleep disturbances**
Impulsivity	**Impaired judgment**	**Cognitive changes**

Alcohol intoxication, withdrawal, and post-acute withdrawal
can all produce psychiatric-like symptoms

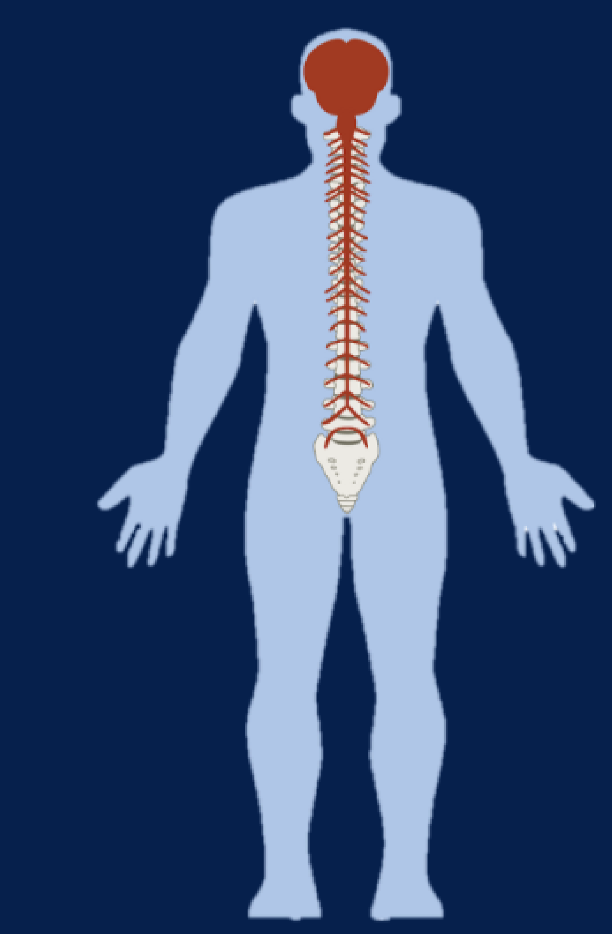


Symptom Overlap Example: “Hangxiety”

- “Hangxiety” (non-clinical term):
  - Anxiety occurring after heavy drinking
  - Often during hangovers or withdrawal
  - Can worsen between drinking episodes
- Clinical challenge:
  - Anxiety symptoms may reflect alcohol withdrawal, not an anxiety disorder
  - Timing in relation to alcohol use is key

Alcohol as a CNS Depressant

- Alcohol depresses the central nervous system, leading to:
  - Slowed movement
  - Poor coordination
  - Slurred speech
  - Reduced motivation
- These effects may resemble:
  - Major depressive disorder
  - Psychomotor agitation
- Alcohol can also impair judgment and increase risk-taking behaviors



Impaired Judgment and Diagnostic Confusion

- Alcohol-related impairment may appear as:
  - **Depression**: acute thoughts of death or dying during intoxication
  - **Bipolar disorder**: impulsivity and poor decision-making during intoxication
- Important reminder:
  - DSM-5-TR criteria require ruling out substance-induced symptoms

The Importance of Creating a Timeline

- Creating a symptom and substance use timeline helps clarify the diagnosis.
- Key questions:
  - *Were symptoms present in a period without the effects of alcohol?*
  - *Did symptoms occur before alcohol use began?*
  - *Are there previous episodes independent of alcohol?*
- Even if causality is unclear, **both conditions** warrant assessment and treatment

Components of a Comprehensive Psychiatric Assessment

According to APA guidelines, assessment includes:

- ☑ History of present illness
- ☑ Psychiatric history
- ☑ Substance use history
- ☑ Medical history
- ☑ Review of systems
- ☑ Family history
- ☑ Personal and social history
- ☑ Trauma history
- ☑ Mental Status Examination (MSE)

Safety assessment is always a priority

American Psychiatric Association. Neurodevelopmental Disorders. In: *Diagnostic and Statistical Manual of Mental Disorders.* 5th ed. American Psychiatric Association; 2013.

Mental Status Examination (MSE)

- The MSE is the psychiatric equivalent of a physical exam
- Includes:
  - Appearance and behavior
  - Speech
  - Mood and affect
  - Thought process and content
  - Cognition
  - Insight and judgment
- For example, in bipolar disorder:
  - Rapid speech
  - Difficulty being interrupted
  - Decreased need for sleep can be key diagnostic clues

Screening vs Diagnosis

Screening	Diagnosis
• Identify the likelihood of a disorder • Support measurement-based care • Do *not* establish a diagnosis	• Requires DSM-5-TR criteria • Clinical judgment • Longitudinal assessment

*Both are **essential** and **complementary***

Screening Tools

Major Depressive Disorder

PHQ-9
- 9-item self-report
- Assess as severity
- Includes a suicidality item

DSM-5-TR criteria used for diagnosis

Bipolar Disorder

Altman Mania Rating Scale (AMRS)
- 5 questions
- Score ≥6 suggests mania/hypomania

Mood Disorder Questionnaire (MDQ)
- Longer yes/no format

DSM-5-TR criteria confirm diagnosis

Generalized Anxiety Disorder

GAD-7
- 7-item self-report
- Used for severity tracking

DSM-5-TR criteria require ≥6 months of symptoms

Alcohol Use

AUDIT-C

NIAAA Single Alcohol Screening Question

Timeline follow-back for ongoing assessment

Fauman MA. DSM-IV: Diagnostic and statistical manual of mental disorders. American Psychiatric Association, 1994. Fourth edition. *American Journal of Psychiatry.* 2002; 151(8), 1234-1235. doi: 10.1176/ajp.151.8.1234

Diagnostic Challenges: Sleep as a Core Symptom

- Sleep disturbance occurs across diagnoses:
  - **MDD**: hypersomnia or insomnia
  - **Bipolar disorder**: decreased need for sleep
  - **GAD**: difficulty falling asleep
  - **PTSD**: nightmares, hyperarousal
- Key diagnostic strategy:
  - Use multiple screeners
  - Apply DSM time-frame criteria
  - Create a longitudinal timeline

Integrated Screening & Global Functioning

- Effective assessment requires integration:
  - Repeated screening over time
  - Measurement-based care
  - Clear documentation
- Global functioning tools:
  - WHODAS-II (replaces GAF)
  - WEMWBS
- These help:
  - Track overall functioning
  - Clarify progress when multiple diagnoses are present
  - Guide treatment planning

Case Study: Meet Alex

- **Meet Alex**
  - 45-year-old female
  - No prior psychiatric treatment
  - Presents with multiple overlapping symptoms
  - Initial information gathered by the medical assistant
- Reported symptoms:
  - Irritability
  - Trouble concentrating
  - Agitation
- These symptoms are non-specific and **overlap across multiple psychiatric conditions**

Discussion Question

What differential items might you consider?

Initial Diagnostic Challenge: Symptom Overlap

- **Irritability**
  - Bipolar Disorder
  - Anxiety Disorders
  - PTSD
- **Trouble concentrating**
  - Bipolar Disorder
  - Depression
  - Anxiety
  - PTSD
  - ADHD
- **Agitation**
  - Bipolar Disorder
  - Depression
  - Anxiety
  - PTSD

*At this stage, the **diagnosis is unclear**→ a deeper clinical assessment is required*

Discussion Question

What are the components of the deeper clinical assessment?

Before Seeing the Patient: Clinical Framing

- Before the encounter, it's important to recognize:
  - These symptoms do not point to a single diagnosis
  - Screening tools alone are insufficient
  - A thorough clinical history will be essential
- Key next steps:
  - ☑History of Present Illness (HPI)
  - ☑Psychiatric Review of Systems (ROS)
  - ☑Timeline of symptoms
  - ☑Substance use assessment

History of Present Illness (HPI)

- Alex reports:
  - Significant stress at work
  - Declining job performance
  - Poor sleep
  - Decreased appetite
  - Difficulty concentrating for several days
- Notable incident:
  - Accidentally drove into her mailbox after days of poor focus
- Functional impairment is present
- Safety concerns warrant careful assessment

Psychiatric Review of Systems: Depression

- Symptoms endorsed consistent with **Major Depressive Disorder**:
  - Depressed mood: ✓
  - Loss of interest or pleasure: ✓
  - Appetite changes: ✓
  - Sleep disturbance: ✓
  - Fatigue: ✓
  - Purposeless physical activity or slowed movements or speech: ✗
  - Feelings of guilt or worthlessness: ✓
  - Difficulty concentrating: ✓
  - Thoughts of death or suicidal ideation: ✗
- Symptoms have been present for several months
- Meets DSM-5-TR duration threshold for MDD (≥2 weeks)

Psychiatric Review of Systems: Bipolar Disorder

- Evaluation for manic/hypomanic symptoms:
  - Inflated self-esteem or grandiosity: ?
  - Decreased need for sleep: ✗
  - Pressured speech: ✗
  - Racing thoughts: ✗
  - Distractibility: ✓
  - Increased goal-directed activity or agitation: ✓
  - Risky behavior: ?
- Insufficient evidence for a manic or hypomanic episode
- Late-onset bipolar disorder is less likely

Psychiatric Review of Systems: Anxiety

- Anxiety-related symptoms endorsed:
  - Restlessness: ✓
  - Fatigue: ✓
  - Difficulty concentrating: ✓
  - Irritability: ✓
  - Muscle tension: ✓
  - Disturbed sleep: ✓
- However:
  - Symptoms present for **~4 months**
  - Does **not meet 6-month DSM-5-TR criterion for GAD**
- Anxiety symptoms present but **secondary**

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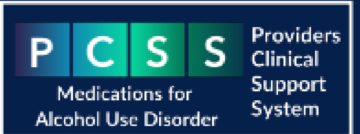


Psychiatric Review of Systems: PTSD

- PTSD-related symptoms endorsed:
  - Traumatic event: ?
  - Intrusive memories, dreams, dissociative reactions, psychological and/or physiological reactions to stimuli: ✗
  - Avoidance of stimuli: ✗
  - Negative alterations in cognitions and mood associated with the event: ✗
  - Irritability: ✓
  - Reckless or self-destructive behavior: ✗
  - Hypervigilance: ✗
  - Exaggerated startle response: ✗
  - Difficulty concentrating: ✓
  - Sleep disturbance: ✓
- However:
  - Symptoms present for **~4 months**
  - Does **meet some of the 1-month DSM-5-TR criterion for PTSD; however, no traumatic event experienced**
- Some PTSD symptoms present, but **more likely MDD and GAD**

Identifying the Missing Piece: Timeline

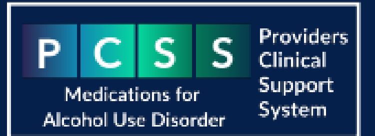
- Timeline clarifies diagnosis:
  - ☑Symptoms present for ~4 months
  - ☑Significant functional impairment
  - ☑Depression symptoms precede and dominate anxiety symptoms
- Diagnostic implications:
  - **Major Depressive Disorder**: most likely primary diagnosis
  - **Anxiety symptoms**: co-occurring but subthreshold for GAD
- Timeline helps differentiate primary disorder vs secondary symptoms

Expanding the Assessment: Full History

- Additional history reveals:
  - **Psychiatric history**: No prior diagnoses or treatment
  - **Substance use**:
    - Initially reports "some wine daily"
    - Further questioning reveals ~1 bottle/day for 2 months
  - **Medical history**: Unremarkable
  - **Family history**: Mother with psychiatric illness
  - **Social history**: Job and family stressors
- Alcohol use may be ***exacerbating symptoms***

Mental Status Examination (MSE)

- Key MSE domains to assess:
  - Appearance and behavior
  - Mood and affect
  - Thought process and content
  - Cognition
  - Insight and judgment
  - Suicidal or homicidal ideation
- MSE provides:
  - A real-time snapshot of functioning
  - Additional evidence to support the diagnosis
  - Safety assessment



Coming to a Diagnosis

- Based on:
  - History
  - ROS
  - Timeline
  - MSE
- Most likely diagnosis: **Major Depressive Disorder**
- Additional considerations:
  - Significant anxiety symptoms
  - Problematic alcohol use likely meets AUD criteria
- Co-occurring conditions must be addressed together

Discussion Question

What screening tools could be useful for Alex?

Screening Tools Applied to Alex

- Recommended screening tools:
  - **PHQ-9**
    - Assess depression severity
    - Track treatment response
  - **GAD-7**
    - Quantify anxiety symptoms
  - **AUDIT-C / NIAAA Single Question**
    - Screen for unhealthy alcohol use
- These tools:
  - Support diagnosis
  - Enable measurement-based care
  - Facilitate longitudinal monitoring

Case Summary: Key Learning Points

- Alex's case highlights:
  - Symptom overlap across disorders
  - Importance of a timeline
  - Value of a comprehensive psychiatric assessment
  - Role of validated screening tools
  - Need to assess alcohol use even when not initially disclosed
- Primary diagnosis:
  - Major Depressive Disorder with:
    - Significant anxiety symptoms
    - Co-occurring alcohol use disorder
- **Screening and diagnosis are iterative processes** that require integration of history, DSM criteria, and standardized tools

3. Evidence-based Treatment Approaches

Why Integrated Treatment Matters: Evidence-based Approaches

- Treating only the psychiatric condition (including major depressive disorder, bipolar disorder, and generalized anxiety disorder) or AUD alone is often insufficient
- Integrated treatment approaches are associated with:
  - Improved symptom control
  - Better treatment engagement
  - Improved long-term outcomes
- Support systems and psychosocial resources are essential components of care

Overview: Treating Bipolar Disorder

- Bipolar disorder is a chronic, cyclical condition with periods of:
  - Mania or hypomania
  - Depression
  - Euthymia
- Treatment goals:
  - Stabilize acute episodes
  - Prevent future mood episodes
  - Maintain long-term functioning
- Pharmacotherapy is a core treatment
- Psychotherapy is adjunctive, and not an alternative to medication

Guideline Frameworks for Bipolar Disorder

- Multiple evidence-based guidelines inform treatment, including:
  - **VA/DoD Bipolar Disorder Guidelines**
  - **CANMAT (Canadian Network for Mood and Anxiety Treatments)**
  - NICE Guidelines
  - World Federation of Societies of Biological Psychiatry

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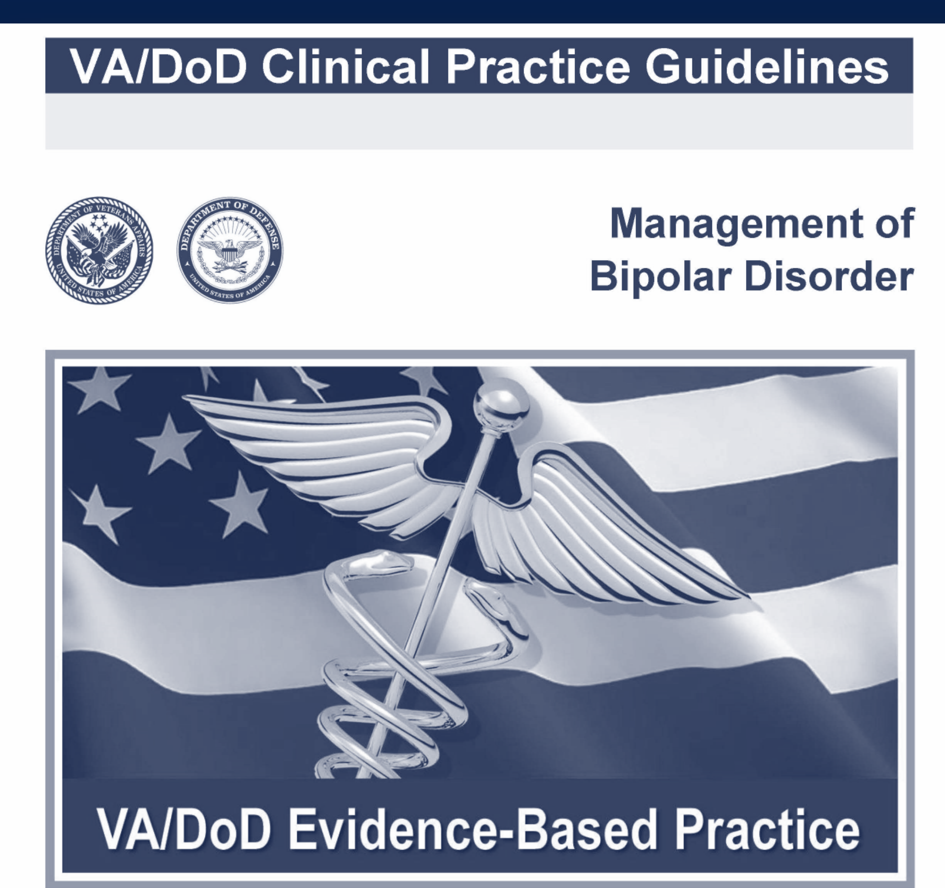
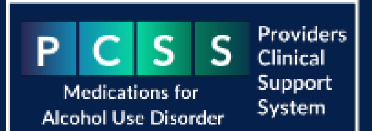
U.S. Department of Veterans Affairs. (*VA/DoD clinical practice guideline for the management of bipolar disorder in adults.* U.S. Department of Veterans Affairs. Date unknown. Retrieved September 19, 2024. Available at https://www.healthquality.va.gov/guidelines/mh/bd/

VA/DoD Bipolar Disorder: Key Concepts

- Treatment depends on the phase of illness:
  - Treatment of acute (hypo)mania
  - Treatment of acute bipolar depression
  - Maintenance of euthymia via prevention of acute depression and acute (hypo)mania
- Mood stabilizers, antipsychotics, or combinations are recommended





VA/DoD: Core Medication Options

- Medications with broad utility across all phases:
  - Quetiapine
  - Olanzapine
  - Lithium (not recommended for acute bipolar depression in VA/DoD)
- Some medications are phase-specific:
  - e.g., Lumateperone and lurasidone are recommended for acute bipolar depression, not mania
  - Lamotrigine is primarily used for the maintenance of euthymia, not acute depression treatment, and it has no utility in acute mania

VA/DoD: Combination Therapy Principles

- Combination therapy is common in bipolar disorder
- Typical combinations include:
  - Antipsychotic + lithium
  - Antipsychotic + valproate
  - Lamotrigine + lithium
  - Lamotrigine + quetiapine
- Combinations including multiple antipsychotics are not recommended, whereas multiple non-antipsychotics may be combined

CANMAT: Bipolar Maintenance (First-Line)

- First-line monotherapy options* for preventing any mood episode:
  1. Lithium (most preferred)
  2. Quetiapine
  3. Divalproex
  4. Lamotrigine
  5. Asenapine
  6. Aripiprazole (oral or long-acting injectable)
- CANMAT emphasizes:
  - Long-term safety
  - Tolerability
  - Evidence strength

DOI: 10.1111/bdi.12609

ORIGINAL ARTICLE

WILEY | BIPOLAR DISORDERS

Canadian Network for Mood and Anxiety Treatments (CANMAT) and International Society for Bipolar Disorders (ISBD) 2018 guidelines for the management of patients with bipolar disorder

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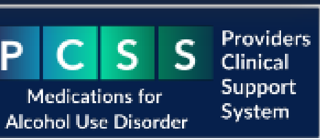
**listed in order of preference according to the guidelines*

Yatham LN, et al. Canadian Network for Mood and Anxiety Treatments (CANMAT) and International Society for Bipolar Disorders (ISBD) 2018 guidelines for the management of patients with bipolar disorder. *Bipolar Disord*. 2018;20(2):97-170. doi: 10.1111/bdi.12609



CANMAT: Acute Bipolar Mania (First-Line)

- First-line monotherapy options*:
  1. Lithium (most preferred)
  2. Quetiapine
  3. Divalproex
  4. Asenapine
  5. Aripiprazole
  6. Paliperidone (dose >6 mg/day)
  7. Risperidone
  8. Cariprazine
- Combination therapies can also be used, but 2 antipsychotics should generally not be combined

*listed in order of preference according to the guidelines

Yatham LN, et al. Canadian Network for Mood and Anxiety Treatments (CANMAT) and International Society for Bipolar Disorders (ISBD) 2018 guidelines for the management of patients with bipolar disorder. *Bipolar Disord*. 2018;20(2):97-170. doi: 10.1111/bdi.12609

CANMAT: Acute Bipolar Depression (First-Line)

- First-line monotherapy or combination options*:
  1. Quetiapine (most preferred)
  2. Lurasidone + lithium
  3. Lurasidone + divalproex
  4. Lithium monotherapy
  5. Lamotrigine (limited by slow titration to therapeutic dose)

**listed in order of preference according to the guidelines*

Yatham LN, et al. Canadian Network for Mood and Anxiety Treatments (CANMAT) and International Society for Bipolar Disorders (ISBD) 2018 guidelines for the management of patients with bipolar disorder. *Bipolar Disord*. 2018;20(2):97-170. doi: 10.1111/bdi.12609

Behavioral Therapies in Bipolar Disorder

- Psychotherapy is **adjunctive** to medication, and **medication is life-long**
- Recommended approaches:
  - ☑ Psychoeducation about bipolar disorder as a cyclical condition with periods of euthymia and periods of symptoms flares or episodes (first-line)
  - ☑ Cognitive Behavioral Therapy (CBT)
  - ☑ Family-focused therapy
  - ☑ Interpersonal and social rhythm therapy
  - ☑ Peer support
- Additional priorities:
  - Motivational interviewing
  - Addressing medication adherence and considering long-acting options (e.g., injections)
  - Identifying early warning signs of a bipolar flare (aka [hypo]manic or depressive symptom emergence)

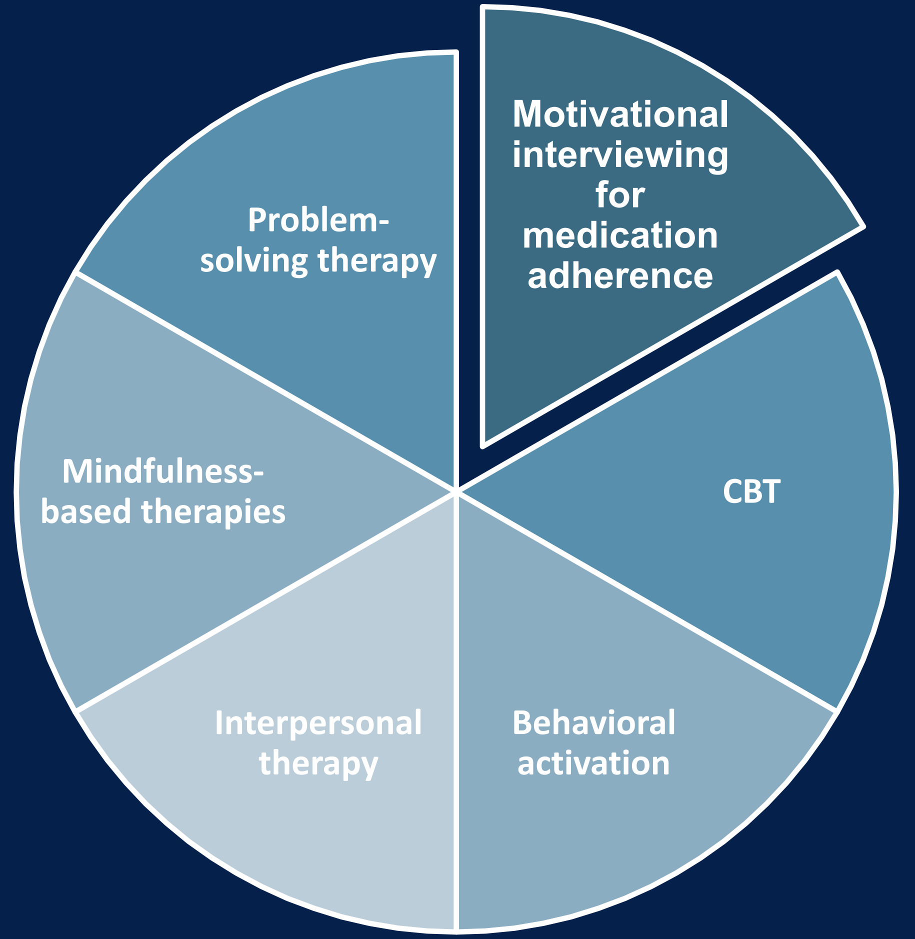
Yatham LN, et al. Canadian Network for Mood and Anxiety Treatments (CANMAT) and International Society for Bipolar Disorders (ISBD) 2018 guidelines for the management of patients with bipolar disorder. *Bipolar Disord*. 2018;20(2):97-170. doi: 10.1111/bdi.12609

VA/DoD Guideline Recommendations: Major Depressive Disorder Pharmacotherapy

- Pharmacotherapy is first-line for a moderate depression
- Combined pharmacotherapy and psychotherapy is first line for severe depression
- First-line medication classes:
  - SSRIs
  - SNRIs
  - Bupropion
  - Mirtazapine
- **Not** recommended first-line:
  - Ketamine / esketamine
  - MAOIs
  - Tricyclic antidepressants

U.S. Department of Veterans Affairs. *VA/DoD Clinical Practice Guideline for the Management of Major Depressive Disorder.* 2016. Retrieved August 21, 2024. Available at https://www.healthquality.va.gov/guidelines/MH/mdd/

Psychotherapy for MDD



U.S. Department of Veterans Affairs. *VA/DoD Clinical Practice Guideline for the Management of Major Depressive Disorder.* 2016. Retrieved August 21, 2024. Available at https://www.healthquality.va.gov/guidelines/MH/mdd/

VA/DoD Guideline Recommendations: Generalized Anxiety Disorder (GAD)

- First-line pharmacotherapy:
  - SSRIs: escitalopram, sertraline, paroxetine
  - SNRIs: duloxetine, venlafaxine
- Second-line options:
  - CBT
  - Buspirone (around the clock; not PRN)
  - Pregabalin or gabapentin
  - Hydroxyzine (PRN)
- In patients with AUD, buspirone, gabapentin, and pregabalin have supportive evidence for GAD

Bandelow B, et al. World Federation of Societies of Biological Psychiatry (WFSBP) guidelines for the treatment of anxiety, obsessive-compulsive, and posttraumatic stress disorders–Version 3. Part I: Anxiety disorders. *The World Journal of Biological Psychiatry.* 2023; 24(2), 79-117. doi: 10.1080/15622975.2022.2086295

GAD, AUD, and Clinical Pearls

- **Benzodiazepines are not recommended** first-line for GAD, especially with co-occurring AUD
- SSRIs
  - may be less effective with ongoing alcohol use
  - may increase alcohol cravings in some patients
- Post-acute alcohol withdrawal symptoms (PAWS) can mimic anxiety symptoms for months to years and are worsened by PAWS-related insomnia

Bandelow B, et al. World Federation of Societies of Biological Psychiatry (WFSBP) guidelines for the treatment of anxiety, obsessive-compulsive, and posttraumatic stress disorders–Version 3. Part I: Anxiety disorders. *The World Journal of Biological Psychiatry.* 2023; 24(2), 79-117. doi: 10.1080/15622975.2022.2086295

Discussion Question

What treatment would you recommend for Alex?

5. Addressing Barriers & Enhancing Outcomes

Why Language Matters

- Stigmatizing language
  - Labels the person as the condition
  - Reinforces shame and hopelessness
  - Discourages help-seeking
- Person-first language
  - “Person with AUD”
  - “In recovery”
  - “Experiencing symptoms”
- **Language shapes outcomes**

ALCOHOL USE DISORDER UNDERSTANDING STIGMATIZING LANGUAGE

WHAT IS STIGMA

- Stigma is discrimination against an identifiable group of people, place, or nation.[1]

- For people with alcohol use disorder (AUD), stigma might include inaccurate or unfounded thoughts (e.g., people with alcohol use disorder are lazy or at fault for their condition).[1]

EFFECTS OF STIGMA

- Feeling stigmatized can reduce the willingness of individuals with alcohol use disorder to seek care for alcohol use problems, prenatal needs, basic primary health, or mental health.[1]

- Stigmatizing language can negatively influence health care professional's perceptions of people with AUD, which can impact the care they provide.[1]

- People with AUD can feel isolated or rejected because they have come to believe that the negative attitudes and false beliefs that they hear from others, may apply to them.[2]

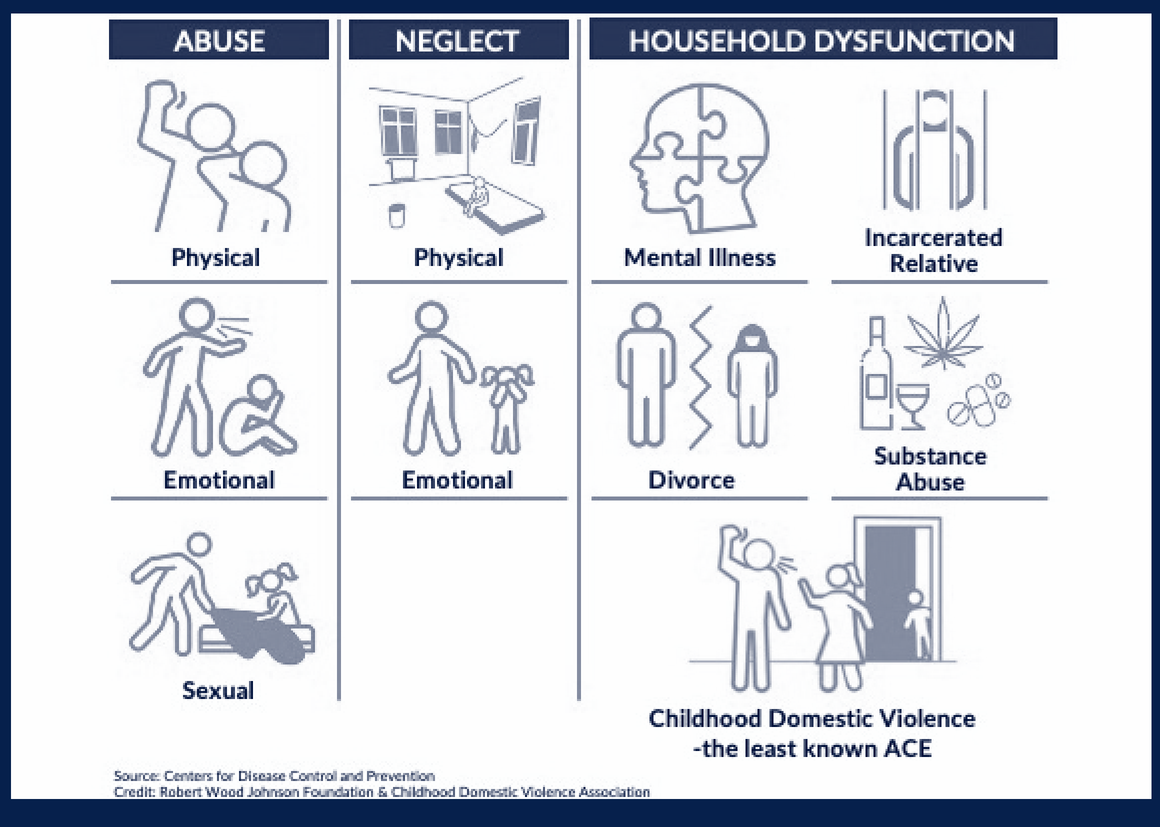
Saitz R, Miller SC, Fiellin DA, Rosenthal RN. Recommended Use of Terminology in Addiction Medicine. *Journal of Addiction Medicine*. 2021;15(1), 3–7. doi:10.1097/adm.0000000000000673

Social Determinants of Health

- Up to **60% of health outcomes** are determined by:
  - Zip code (more predictive than genetic code)
  - Economic stability
  - Housing, transportation, access to care
  - Environmental and structural inequities
- *These directly affect treatment access and adherence*

Adverse Childhood Experiences (ACEs)

- Examples of ACEs
  - Abuse (physical, sexual, emotional)
  - Household substance use or mental illness
  - Violence or incarceration in the home
- Higher prevalence among:
  - Women
  - Younger individuals
  - Racial and ethnic minority populations



Felitti, VJ, Anda RF, Nordenberg D, et al. Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. The Adverse Childhood Experiences (ACE) Study. *Am J Prev Med*. 1998; 14(4):2. doi: 10.1016/s0749-3797(98)00017-8.

Trauma as a Shared Risk Factor

Adverse Childhood Experiences (ACEs):

- Highly prevalent in the general population
- Strongly associated with:
  - AUD
  - Depression
  - Bipolar disorder
  - Suicide risk

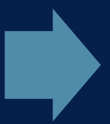
Dose-response relationship:

- ≥4 ACEs:
  - ~7.5× higher likelihood of AUD
  - ~5× higher likelihood of depressive episodes
  - ~12× higher likelihood of suicide attempts
- Trauma is a powerful, shared driver of co-occurring disorders
- **Trauma-informed care** is essential

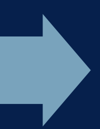
Felitti VJ, Anda RF, Nordenberg D, et al. Reprint of: Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: the adverse childhood experiences (ACE) study. *American Journal of Preventive Medicine. 2019. 56*(6), 774-786. doi: 10.1016/j.amepre.2019.04.001.

ACEs Across the Lifespan

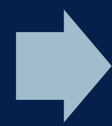
Childhood trauma → emotional & cognitive impairment



Adoption of high-risk behaviors (e.g., alcohol use)



Chronic illness, disability, and social problems



Early morbidity and mortality

Alcohol is often used as a ***maladaptive self-treatment***

Enhancing Engagement: Motivational Interviewing (MI)

- Key MI principles
  - Validate concerns and ambivalence
  - Roll with resistance
  - Emphasize autonomy and shared decision-making
- **Goal:** *Empower patients to actively engage in care*

Common Adherence Barriers

- Cost of medications
- Pharmacy access or transportation
- Adverse effects (real and/or anticipated)
- Lab monitoring fears
- Cognitive symptoms
- Medication fatigue and desire for a "holiday"
- Limited insight during an acute episode, esp (hypo)mania

→ Patient

*Solutions must be **individualized**, and **clinical pharmacists** are an underutilized resource*

Practical Strategies That Work

- Improving adherence
  - ☑ Use generics or assistance programs
  - ☑ Mail order or batched refills (when appropriate)
  - ☑ Long-acting injectable options
  - ☑ Pillboxes, phone reminders, habit-linking
- ***Small changes = Big impact***

Shared Decision-making in Action

Goal: Safe, realistic, sustainable treatment plans

Discuss Openly	Avoid
• Risks vs benefits of various medication options • What matters most to the patient • Likely adverse effects within a given patient	• Patients having to "pick and choose" medications alone (e.g., due to high costs for the overall treatment regimen)

*Tip: Consider consulting with a **board-certified psychiatric pharmacist** (BCPP)*

Clinical Example: Selecting among first-line AUD Treatment Choices

- **Naltrexone**
  - Oral
    - Lower cost, but daily medication taking required
    - Easier to manage acute severe pain (with opioids) because shorter duration in body after discontinued
  - Long-acting injectable
    - Higher cost, but monthly dosing improves adherence
    - Injection considerations including needle phobia and injection site reactions
    - Challenges with acute severe pain management (with opioids) due to long duration of action
- **Topiramate***
  - Lower cost, but daily medication taking required
  - Doesn't impact opioid response
  - Can help treat some co-occurring conditions such as migraines and seizures

**Not FDA-approved for AUD*

Key Takeaways Regarding Stigma

- ☑Stigma is a major, modifiable barrier
- ☑Language, attitudes, and connection matter
- ☑Social determinants and trauma shape outcomes
- ☑Motivational interviewing enhances engagement
- ☑Thoughtful, patient-centered strategies improve recovery
- ☑Addressing barriers = better outcomes

5. Conclusion & Key Takeaways

Conclusion & Key Takeaways

AUD & Psychiatric Conditions

- The relationship between AUD and psychiatric conditions is complex and fuels clinical instability when both aren't adequately managed

Screening & Diagnosis

- A key diagnostic question: *"Are symptoms caused by alcohol, a psychiatric condition, or both?"*
- Alcohol intoxication, withdrawal, and post-acute withdrawal can all produce psychiatric-like symptoms
- Screening and diagnosis are iterative processes that require integration of history, DSM criteria, and standardized tools

Treatment Approaches

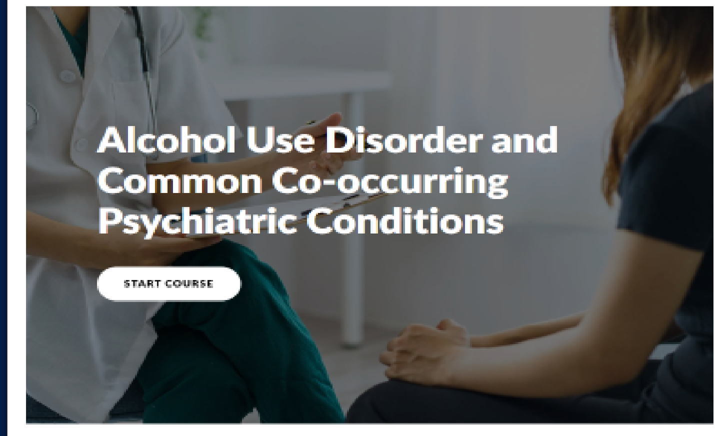
- Treating only the psychiatric condition or AUD alone is often insufficient
- Pharmacotherapy, support systems and psychosocial resources are essential components of care
- VA/DoD guidelines and CANMAT guidelines are helpful resources when treating co-occurring AUD and psychiatric conditions

Addressing Barriers & Enhancing Outcomes

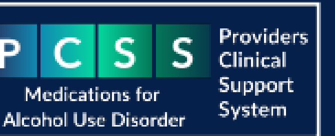
- Many patients experience barriers to treatment, so solutions must be individualized
- Clinical pharmacists are an underutilized but helpful resource
- Utilizing MI can empower patients to actively engage in care
- Practicing shared decision-making can help create safe, realistic, sustainable treatment plans

PCSS-MAUD Further Learning & Resources

- **Online Module:** Alcohol Use Disorder and Common Co-occurring Psychiatric Conditions
- **Online Module:** Motivational Interviewing for Alcohol Use Disorder Treatment
- **Online Module:** Pharmacotherapy for Alcohol Use Disorder: Best Practices and Clinical Strategies
- **Digital Resource:** The Link Between Trauma and Alcohol Use Disorder: Unified Trauma-informed Care as a Way Forward



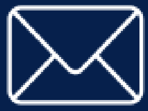
This module explores the complex interplay between alcohol use disorder (AUD) and common co-occurring psychiatric conditions, including bipolar disorder, major depressive disorder, and generalized anxiety disorder. Learners will gain an understanding of how these conditions interact, diagnostic tools and strategies for screening and diagnosis, and evidence-based treatment approaches. The module combines theoretical knowledge



Questions?

Wrap-up

www.pcss-maud.org



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