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Psychiatry and Addictions Case Conference

UW Medicine | Psychiatry and Behavioral Sciences

WHEN SHOULD I WORRY ABOUT ANXIETY IN ALCOHOL USE DISORDER?

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SPEAKER DISCLOSURES

✓ Any conflicts of interest?

PLANNER DISCLOSURES

The following series planners have no relevant conflicts of interest to disclose; other disclosures have been mitigated.

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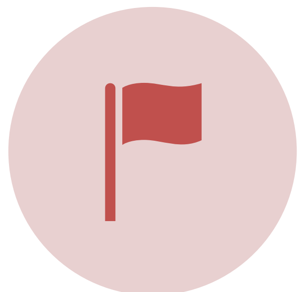
OBJECTIVES

1. Describe the **epidemiology, bidirectional risk, and shared neurobiology** of anxiety and AUD

2. Differentiate **alcohol-induced vs primary anxiety** using timelines and DSM-5



3. Identify **red flags** that require treatment or referral

4. Apply **integrated, evidence-based treatment** for comorbid anxiety and AUD

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WHY ANXIETY AND ALCOHOL USE DISORDER ARE TIGHTLY LINKED?

- High rates of co-occurrence
- Reciprocal and reinforcing relationship
- Shared stress circuitry

(Anker & Kushner, 2019; McHugh et al., 2015; Zabik & Blackford, 2025; Koob & Volkow, 2016; NIAAA, 2025)

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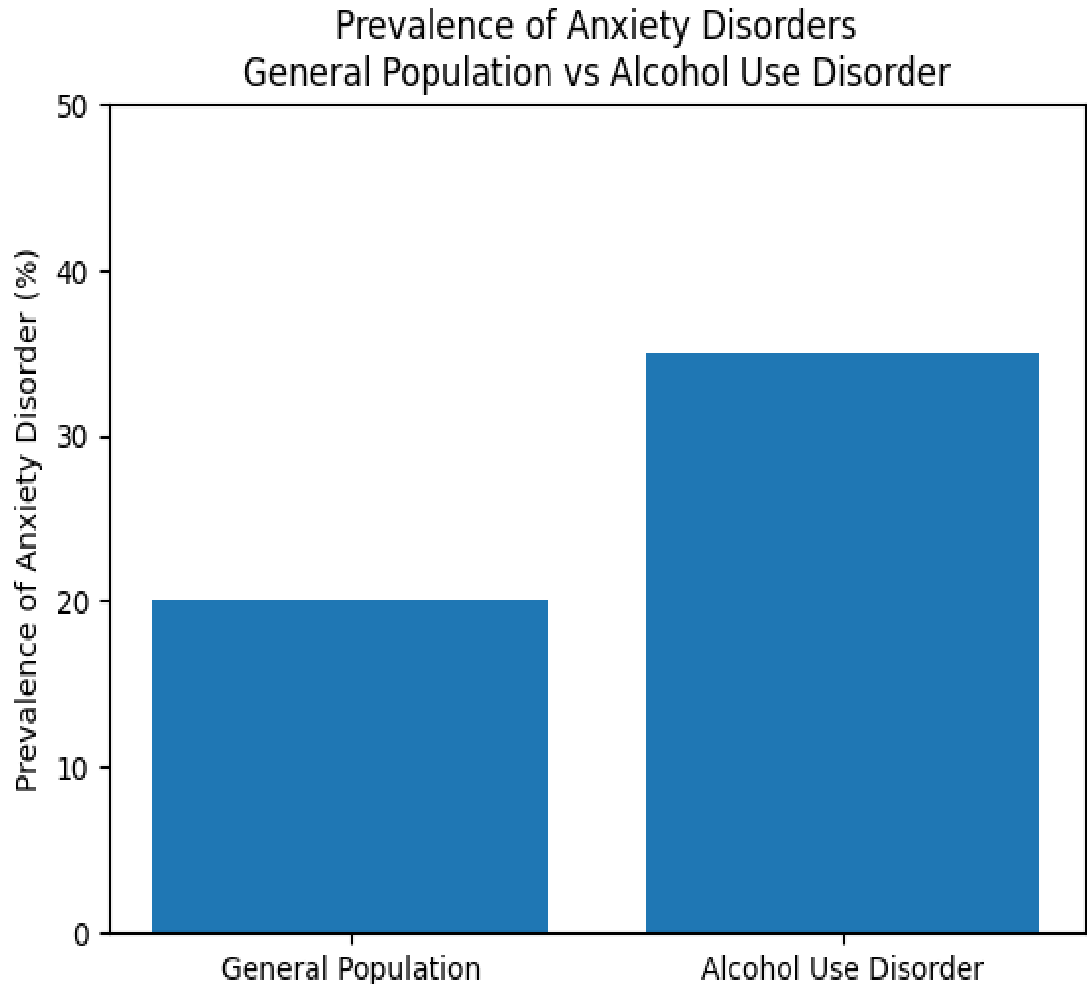
EPIDEMIOLOGY OF CO-OCCURRENCE

- 30–40% of individuals with AUD have a comorbid anxiety disorder

- Individuals with anxiety disorders have a 2–3× increased risk of developing AUD

- Comorbidity is associated with:
  - Greater symptom severity
  - Higher relapse rates
  - Poorer functional outcomes
  - Increased suicide risk



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LONGITUDINAL EVIDENCE OF BIDIRECTIONAL RISK

- Large population-based longitudinal cohort study
- Netherlands Mental Health Survey and Incidence Study-2 (NEMESIS-2)
- AUD predicts future anxiety onset (adjusted OR ≈ 1.6–2.0)
- Anxiety disorders increase risk of future AUD
- Supports a reciprocal risk model over time

(Ummels et al., 2022)

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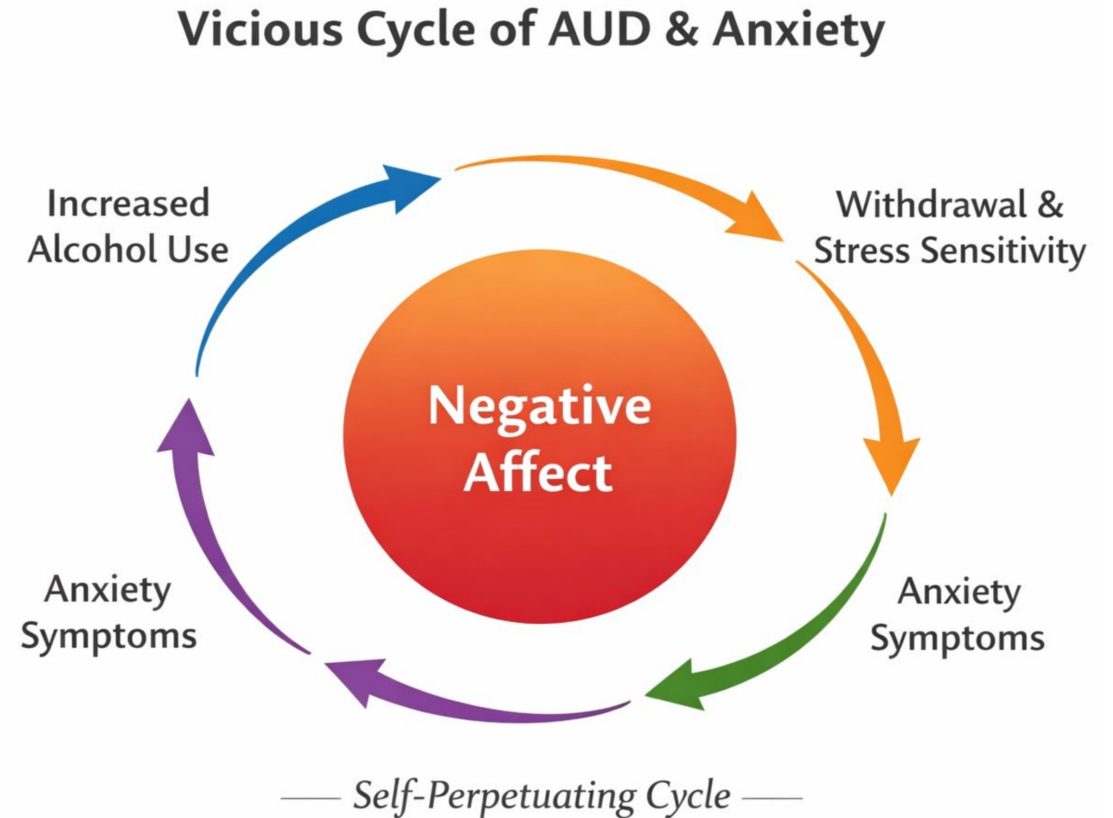
NEGATIVE AFFECT AS THE CENTRAL DRIVER

- Shift from reward-driven to relief-driven drinking
- Withdrawal amplifies anxiety and stress sensitivity
- Repeated cycles sensitize stress circuitry
- Anxiety becomes a driver of continued alcohol use



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NEUROBIOLOGICAL SHIFT: FROM REWARD TO RELIEF

- **Early Stage:**

- Reward-driven drinking
-Dopamine-mediated reinforcement

- **Chronic Stage:**

-Negative reinforcement dominates
- Alcohol used to relieve anxiety

- **Neuroadaptation:** • Persistent activation of stress circuitry
  – Amygdala
  – BNST

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LOSS OF TOP-DOWN CONTROL UNDER STRESS

- Chronic alcohol use weakens **prefrontal cortex (PFC) regulation**
- Stress and anxiety further suppress executive control
- Reduced ability to:
  - Regulate emotions
  - Inhibit urges
  - Delay gratification
- Anxiety + impaired control = **high relapse vulnerability**
- *(Koob & Volkow model; NIAAA Core Resource; Anker & Kushner, 2019)*

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KINDLING IN ALCOHOL USE DISORDER

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DIFFERENTIATING ALCOHOL-INDUCED ANXIETY FROM PRIMARY ANXIETY DISORDERS

- **Why Differentiation Matters Clinically**

Not all anxiety in AUD requires the same treatment

Anxiety symptoms are common during intoxication, withdrawal, and early abstinence

Alcohol-induced anxiety can mimic primary anxiety disorders

Misdiagnosis leads to inappropriate pharmacotherapy and poorer outcomes

Accurate differentiation guides timing, treatment choice, and referral
(NIAAA Core Resource, 2025; DSM-5-TR, 2022)

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PRIMARY VS ALCOHOL-INDUCED ANXIETY

PRIMARY ANXIETY DISORDERS

- Symptoms precede onset of alcohol use.
- **Persists > 1 month after acute withdrawal** or severe intoxication.
- Occurs during **extended periods of abstinence.**
- Independent disorder requiring targeted treatment

ALCOHOL-INDUCED ANXIETY DEVELOPS

- Develops **during or soon** after intoxication or withdrawal.
- Typically improves **within days to weeks of** sustained abstinence.
- Closely tied to drinking pattern.
- Often resolves with stabilization and sobriety.

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TIMELINE-BASED ASSESSMENT: THE MOST IMPORTANT TOOL

- Age of onset of anxiety symptoms vs alcohol use
- Longest period of abstinence
- Presence or absence of anxiety during abstinence
- Pattern of anxiety during intoxication, withdrawal, and craving
- Family history of anxiety disorders and AUD (NIAAA Core Resource, 2025)

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DSM-5-TR CRITERIA SUPPORTING AN INDEPENDENT ANXIETY DISORDER

Anxiety symptoms **precede substance use**

Symptoms **persist ≥1 month** after cessation of acute withdrawal or intoxication

History of **recurrent non-substance-related anxiety episodes**

Anxiety present during prolonged abstinence
(DSM-5-TR, 2022)

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ALCOHOL-INDUCED ANXIETY: TYPICAL CLINICAL FEATURES

- Anxiety tightly linked to drinking or withdrawal cycles
- Prominent autonomic symptoms (tremor, sweating, palpitations)
- Fluctuates with alcohol intake
- Improves significantly with abstinence
- Often coexists with sleep disturbance and irritability (NIAAA, 2025; ASAM, 2020)

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- **“ONCE WE CAN DIFFERENTIATE EXPECTED ANXIETY FROM PRIMARY ANXIETY, THE NEXT QUESTION BECOMES: *WHEN SHOULD ANXIETY IN AUD ACTUALLY WORRY US CLINICALLY?*”**

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RED FLAGS: WHEN TO BE CLINICALLY CONCERNED

- Anxiety **persists >1 month** after withdrawal or intoxication
- Causes **significant distress or impairment** in daily functioning
- **Panic attacks** or severe anxiety exceed expected withdrawal patterns
- Anxiety **worsens over time** or fails to improve with abstinence
- Logical link to **relapse triggers** (craving, stress)*(NIAAA Core Resource, 2025; ASAM, 2020; DSM-5-TR, 2022)*

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SUICIDE RISK: A CRITICAL RED FLAG

- AUD independently increases suicide risk (~3× odds)

- Anxiety disorders independently increase suicide risk (~2–3× odds)

- Comorbid anxiety + AUD → amplified suicidal ideation and attempt risk

Panic symptoms are particularly associated with elevated suicide risk

- Acute intoxication increases short-term attempt risk (up to 7×)

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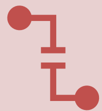
SYNDROME-SPECIFIC RED FLAGS

Presence of **panic attacks, social avoidance, phobias, or persistent generalized worry** *(DSM-5-TR, 2022)*.



Social anxiety disorder precedes AUD in up to 80% of cases, suggesting anxiety as a vulnerability factor *(Anker & Kushner, 2019)*.

Lifetime anxiety symptoms occur in ~40% of AUD patients, but **only one-third to one-half represent independent anxiety syndromes** *(Anker & Kushner, 2019; NIAAA, 2025)*.

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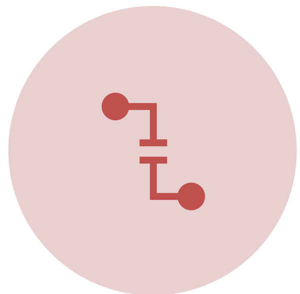
BROADER IMPACT OF UNTREATED COMORBIDITY

Unrecognized anxiety in AUD worsens social and functional outcomes

Increased risk of **unemployment and occupational safety issues** *(NIAAA, 2025)*



Higher rates of **housing instability, relationship conflict, and legal problems** *(NIAAA, 2025)*

Alcohol reduction alone may improve some issues, but **primary anxiety disorders require mental health treatment** *(NIAAA, 2025)*

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VALIDATED SCREENING TOOLS

Screening tools support—but do not replace—clinical assessment

GAD-7: Primary anxiety screening tool; sensitivity 60.6–89%, specificity 82–87.6%; useful for tracking symptom change over time *(USPSTF; NIAAA, 2025)*

PHQ-9: Essential for screening depression and suicide risk *(USPSTF)*

HADS: Assesses anxiety and depression simultaneously

AUDIT / AUDIT-C: High scores (≥20) strongly correlate with anxiety symptoms; ≥76% screen positive for anxiety at highest AUDIT levels *(NIAAA, 2025)*

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WHY SCREENING ALONE IS NOT ENOUGH

POSITIVE SCREENS REQUIRE STRUCTURED FOLLOW-UP

SCREENING TOOLS IDENTIFY **PROBABLE ANXIETY**, NOT DEFINITIVE DIAGNOSIS

FOLLOW-UP MUST ASSESS **SYMPTOM PERSISTENCE, DISTRESS, AND FUNCTIONAL IMPAIRMENT**

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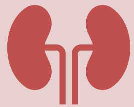
WHAT TO DO WHEN YOU WORRY

Do not delay anxiety treatment when red flags are present *(McHugh, 2015)*.



Treat AUD and anxiety **concurrently rather than sequentially** *(McHugh, 2015; NIAAA, 2025)*.

Integrated behavioral treatment improves outcomes more than AUD-only treatment *(Anker & Kushner, 2019)*.

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WHY INTEGRATED TREATMENT IS NECESSARY

Treating anxiety and AUD together improves outcomes

Treating anxiety or AUD in isolation leads to **poorer outcomes and higher relapse rates** *(NIAAA, 2025; McHugh, 2015)*

Anxiety often **drives alcohol use**, while alcohol worsens anxiety through neurobiological stress pathways *(Anker & Kushner, 2019)*

Integrated treatment addresses the **shared mechanisms** underlying both conditions *(NIAAA, 2025)*

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INTEGRATED BEHAVIORAL STRATEGIES IN COMORBID ANXIETY AND AUD

1️⃣ Breaks the Anxiety → Drinking Link

CBT targets coping-motivated drinking and cognitive distortions (McHugh, 2015)

2️⃣ Reduces Ambivalence Under Distress

MET strengthens commitment when anxiety undermines sobriety (NIAAA, 2025)

3️⃣ Builds Distress Tolerance

Mindfulness reduces reactive, relief-driven drinking (NIAAA, 2025)

4️⃣ Targets Shared Mechanisms

Addresses negative affect, stress sensitivity, and relapse vulnerability

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FINAL TAKE-HOME MESSAGE

1

Anxiety in AUD is common, but **not always clinically significant** *(NIAAA, 2025)*.

2

Persistence, pattern, and purpose of drinking matter more than symptom intensity *(Anker & Kushner, 2019)*.

3

Anxiety that **persists, precedes drinking, or predicts relapse** should prompt active intervention *(McHugh, 2015; Ummels et al., 2022)*.

4

Early recognition and integrated care improve outcomes for **both disorders** *(NIAAA, 2025)*

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