About a third of the US population has alcohol use disorder (AUD) at some point in their lifetime, which is higher than the prevalence of drug use disorder and tobacco use disorder combined.1 AUD often occurs with depression and anxiety disorders. The co-occurrence of these disorders negatively impacts psychiatric symptoms, worsens physical functioning, and increases health care utilization, which therefore increases cost.2-4 Despite treatment availability, dual diagnosis patients often do not receive appropriate intervention.5

The decision of whether to initiate treatment for depression or alcohol use first in this population is debated among clinicians.6 Therefore, the aims of this article are to provide clinicians with guidance that can help with diagnostic clarification of the 2 major types of presentations (alcohol-induced and independent disorders) and provide recommendations about the management of these patients in outpatient settings.

THE RELATIONSHIP BETWEEN ALCOHOL AND DEPRESSION OR ANXIETY SYMPTOMS

There is a strong bidirectional relationship between AUD and depression or anxiety symptoms. Untreated depression or anxiety may lead to “self-medication” with alcohol to relieve symptoms.7 Khantzian8 stated that drinking can be an attractive if temporary solution for individuals who want to relieve feelings derived from loneliness or emptiness. Individuals without baseline depression can also be at risk for the development of depression or anxiety if they have chronic exposure to alcohol. This could occur indirectly through the disruptive effect of alcohol on social relationships or directly through alcohol’s effect on the brain. Studies conducted in rats show that chronic alcohol exposure causes a reduction in cortical norepinephrine and hippocampal brain-derived neurotrophic factor, which are associated with depressive characteristics.9,10 A person’s genetics could also play a role in increasing vulnerability to both disorders.11 For example, individuals with alcohol sensitivity that is regulated by a specific genotype combination were at increased risk for AUDs as well as depressive and anxiety disorders in a Japanese population.12

ASSESSMENT AND DIAGNOSIS

The first, and perhaps the most important, step in determining the treatment focus for patients with dual disorders is to record an accurate and thorough patient history. Clinicians should start by first identifying and diagnosing the AUD and then investigating the relationship between AUD and the affective symptoms. This strategy facilitates determination of an independent versus alcohol-induced disorder. The clinical interview can start with investigating the onset of regular alcohol intake in relation to depressive symptoms. The clinician can then ask about the longest period of abstinence in order to determine the course of symptoms after abstinence achieved.11 An independent disorder is more likely if the onset of depression/anxiety was prior to heavy use of alcohol and/or if symptoms continued after at least a month of complete abstinence.13 A positive family history for mood disorders is also suggestive of an independent disorder.11 Another useful indicator is when the severity of depressive symptoms occurs “in excess” of the usually associated effect of the consumed amount or duration of alcohol use.11,14

Some patients, such as older adults, might present with alcohol adverse events such as falls or medication interactions due to age-related physiological changes that increase the sensitivity of the body to alcohol. At the same time, they may not meet the DSM criteria due to other age-related factors such as cognitive impairment that might affect reporting symptoms accurately, lack of awareness or denial of alcohol as a problem, and fewer work/family obligations than the general population.15 Therefore, it is important to differentiate these individuals using more flexible terms such as “at-risk drinker” that can be used to reflect the connection of alcohol with the psychiatry symptoms.15

It is not unusual for patients presenting for treatment to be intoxicated or in withdrawal from alcohol during the initial assessment. Recent heavy consumption of alcohol can lead to mental states resembling depression such as poor focus, and acute withdrawal that leads to autonomic hyperactivity can
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