

# An obstacle for alcohol abstinence

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## Abstract

We report a case of 'alcohol dependence' with anxiety to highlight importance of addressing co morbid psychiatric problem for effective management of alcohol dependence. A 53-year-old lady presented with anxiety for five years, more in the initial days of attempts at abstinence. She had been drinking for thirty years, regularly for ten years and more for the last six years. After developing Hypertension five years back, she had been trying to stop drinking. Upon such attempts, she suffered from restlessness, profuse sweating, tremors and sleeplessness and would feel better only after taking alcohol. Since 2-3 months, after having GI bleed, she was compelled to stop drinking and was struggling in spite of anxiety. Finally, she drank herself to intoxication and her children brought her to psychiatric OPD. With the diagnosis of 'alcohol dependence syndrome with anxiety disorder', after investigations, she was put on fluoxetine, clonazepam and thiamine-vitamin B supplementation along with psychological interventions to enhance motivation and prevent relapses. She responded well and remained abstinent and asymptomatic at 3-year-follow ups. Blood pressure was also under control.

**Key words:** alcohol, alcohol dependence, anxiety disorder, panic, psychiatric co morbidity.

## Introduction

Excessive and prolonged use of alcohol is associated with substantial psychiatric and physical co-morbidity.<sup>1-3</sup> Alcohol dependent people have been repetitively assessed as having higher incidence of psychiatric disorder than the general population.<sup>3</sup> The psychiatric co morbidity is significantly more common in the clinical setting.<sup>4-5</sup> There is significant co morbidity between alcohol dependence and anxiety; and other psychiatric disorders like affective, conduct/ antisocial and other substance related disorders.<sup>6</sup>

Failure to deal with psychiatric problems may lead to missed opportunities to lessen the intensity of emotional states that are driving the substance abusing behavior. Conversely, failure to deal effectively with the substance abuse is more likely to worsen the symptoms of the psychiatric disorder and impair patient's judgment, motivation and insight.<sup>7</sup>

We report a case of alcohol dependence syndrome (ADS)

with co morbid anxiety disorder which could improve only after the management of the later.

## Case Report

A 53 year-old lady was brought by her children to the psychiatric out patient clinic after referral by a physician with the complaints of thirty years alcohol abuse and anxiety for the last five years.

Most of the adults in her family were accustomed to drinking. She had been offered locally brewed alcoholic beverage 'jand' by senior family members after her first delivery. They have a common belief that this will nourish the mother and increase milk secretion. Since then, for the last 30 years, she had been drinking alcoholic beverages; initially in social gatherings for 5-6 years, then also in home and later, slowly regularly for 10 years. Amount reached to 4-6 liters of *jand* (6-7% by volume) or 3-4 liters of distilled local preparation (about 25%) a day. For the last six years, she had to drink

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from morning to quench her cravings and feel fresh. Her drinking pattern kept her intoxicated, away from self, child and home care. She suffered from severe pain abdomen associated with nausea, vomiting, retching, water brash and eructation six years back suggestive of peptic ulcer disease and was also found to have high blood pressure needing antihypertensive. She was strongly advised to quit further alcohol consumption. She was restless, her limbs trembled and she could not sleep for about a week after she stopped alcohol. Though she was not so anxious in the initial days of abstinence, she gradually developed anxiety and distress and realized that she could not do her daily chores, deal with people efficiently and had difficulty falling asleep. One day at a social gathering, some relatives shared that they benefited with alcohol drink when they had such problems. After about three months of abstinence, she again took jand and felt much better and since then, she could not give it up. Rather, she started drinking from the morning because of increased craving and anxiety.

As she neglected household chores, got into arguments frequently and was intoxicated most of time, her husband got frustrated and left her to work in a nearby city. This removed further restrictions and there was no bar to her drinking more and more. Her son studying in the city used to advise her against drinking and when her grown up daughters cried, she would make up her mind to not to drink. But, she could not be able to sustain it because only drinking could comfort her from the distress of anxiety, shaking and craving. About three months prior to psychiatric consultation, she had to be admitted in medical ward for upper gastrointestinal bleeding and her blood pressure was also not under control. After strong family pressure and stern warnings from her physician, she was determined not to drink any more. Despite anxiety and distress, she was trying hard until after about two months she developed frequent panic attacks. She was helpless and could not stand any more and she drank herself to intoxication, one day prior to psychiatric consultation.

She felt anxious both during abstinence and when drunk, but less when drunk. She had panic attacks when her blood pressure was controlled with antihypertensive medications. Before she started drinking, she did not suffer from excessive anxiety. She had not sustained any head injuries, loss of consciousness or disorientation. She also did not have thyroid abnormalities, diabetes mellitus or any previous mental illnesses. Except for substance abuse, she did not have any relatives with mental illness. Besides alcohol consumption, she also smoked. She had been smoking occasionally for the last 10 years and was dependent for 7-8 years. Her smoking had increased with the escalation of

squabble at home.

She was anxious and restless. Her pulse was 108 per minute and blood pressure (BP) 170/110 mmHg. Though she was oriented to time, place and person and respond well to questions, she could not concentrate. She revealed anticipatory anxiety about panic attacks. There was no obsession, compulsion, delusion, hallucination, helplessness, hopelessness, worthlessness, sustained sadness or elevation of mood, flashbacks. Her hematological and biochemical parameters including urine routine, electrocardiogram, chest X-Ray and thyroid function tests were normal but the liver enzymes (AST, ALT and GGT) were elevated. With the diagnosis of 'ADS- withdrawal with anxiety disorder', she was put initially on Lorazepam which was later changed to clonazepam along with Fluoxetine and Vitamin B complex including thiamine supplementation. She required adequate cover of long acting benzodiazepine- 'clonazepam' for almost 3-4 weeks with gradual tapering of doses. In subsequent visits, she was much better and in a condition to cooperate for motivation enhancement sessions to remain abstinent and comply with treatment- both pharmacological and non-pharmacological e.g. life style modification. Her anxiety gradually disappeared after about 6-8 weeks of treatment. She has remained abstinent, her BP is under control and her husband regularly accompanies her for consultations in a three year follow up.

## Discussion

Some psychiatric disorders including anxiety increase the risk of subsequent alcohol abuse at one hand and on the other hand, alcohol abuse may induce or aggravate many psychiatric problems like mood, affective or anxiety disorders.<sup>8</sup> Large proportion of these disorders are alcohol induced and they tend to dissipate in conditions of abstinence. In some patients, they both probably result from a common genetic influence and are independent.<sup>9</sup> Clinical difference between primary and secondary psychiatric disorders are small and it is difficult to ascertain about the cause and effect relationship between alcohol use and psychiatric disorders.<sup>10</sup> However, it is consistently seen that high proportion of alcohol abuse or dependent cases have psychiatric disorders both in community and clinical settings.<sup>4-5, 11</sup>

If psychiatric syndromes persist even after four weeks of abstinence, present consensus is that both alcohol abuse and psychiatric disorders coexist. This consideration has a great significance for clinical approach, management and prognosis of the psychiatric disorders.

Anxiety disorders usually precede the onset of alcohol

intake. As alcohol eliminates anxiety symptoms to some extent, it promotes pathological alcohol use.<sup>12</sup> Abstinence as well as heavy drinkers are at increased risk of anxiety and depressive symptoms.<sup>13</sup> The lifetime risk of independent anxiety disorders is found to be significantly higher in alcoholics than in controls.<sup>8</sup>

Co-morbid anxiety disorders predict poor outcome of treatment of alcohol dependence syndromes.<sup>12</sup> If co-morbid psychiatric problems like anxiety is not diagnosed and treated, patient may start, continue or increase substance abuse to decrease associated distress and anxiety. The reference case continued, rather increasing the amount of alcohol to relieve anxiety despite of repeated medical advices, strong family pressure and many physical and social constraints. Once the co-morbid anxiety was dealt with, the patient could remain abstinent and comply with the treatment and her BP was also under control.

Failure to deal effectively with the substance abuse is highly likely to worsen the symptoms of psychiatric disorder and impair the patient's judgment, motivation, and insight.<sup>7</sup> In fact, alcohol or substance use along with mental illness mainly depression and hopelessness have been described as the deadliest combination for the worst result, i.e. suicide.

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