Anxiety – Treatment Options and Relapse Prevention after Opiate Detox
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Objectives

1). Identify the natural history of anxiety symptoms following detox and the relationship to preexisting anxiety disorders
2). Discuss the rationale for treatment of anxiety during this period of early recovery.
3). Identify the pharmacological treatment options and discuss the Pros and Cons of medications in current use.
4). Identify various complementary and alternative treatments presently used in recovery and discuss rationale for use.

What Is Anxiety

There are a multitude of definitions of anxiety which span a wide variety of emotional states and specific disorders5 (MM- 5).

• Anxiety is a multisystem response to a perceived threat or danger, produced by the anticipation of future events.
• It can be a chronic condition (trait anxiety) or an acute (state) response to a particular event.
• It reflects a combination of biochemical changes in the body which are manifested by the individual’s personality, personal history and memory.
Demographics of Anxiety

› Population in General
  - Approximately 25% of people in the US will be diagnosed with an anxiety disorder during their life. Often this diagnosis is made prior to age 18 (Kessler et al., 2005).

› Opiate/Alcohol population
  - Up to 50% of individuals with Substance use disorders are thought to have preexisting (trait) anxiety (Clark & Sautter, 2011).

› Anxiety In early recovery (F10.280, F11.288)
  - Empirical evidence suggests that almost all individuals will have significant anxiety during the initial weeks of treatment and early recovery. During this post-acute withdrawal period, many of the symptoms associated with stress or anxiety abate without treatment. However, the risk of relapse due to anxiety persists far beyond this time period (e.g., Baldi, Crabbe, 2010).

Symptoms of Anxiety

The symptoms experienced may be:

- Somatic: headaches, dizziness or lightheadedness, elevated heart rate, nausea or vomiting, diarrhea, tingling, sweating, numbness, difficulty in breathing, or sensations of tightness or muscle spasms in neck, shoulders, or hands, difficulty sleeping or bring easily fatigued.

- Behavioral: trembling, general restlessness, hyperventilation, pressed speech, hand wringing, finger tapping or tremor.

- Cognitive: recurrent or obsessive thoughts, persistent worry, feelings of doom, morbid or fear-inducing thoughts or ideas, mind going blank, or inability to concentrate.

- Emotional: nervousness, feeling “hyper”, “keyed up” or “on edge”.

Variables affecting Anxiety

› Trauma – previous trauma is almost universal among women, somewhat less in men
› Mental Illness – Bipolar / depression
› Personality – higher incidence of borderline and antisocial
› Legal issues – court mandated, felonies
› Social Support – family burnout
› Cortisol response – varied based on individual factors
Core feelings associated with Anxiety in Substance Abuse Withdrawal

- Pain – evident in both opiate and alcohol w/d
- Coping – difficulty dealing with emotions/past
- Craving – fear of relapse
- Stress – family pressures, failure

Neurophysiology of anxiety

- Prefrontal cortex – cognitions
- Hippocampus – memories
- Amygdala – emotions
- HPA axis – Cortisol response

Physiological Response (to stress > anxiety)
Allostasis

- The Theory of Allostasis is conceptualized as a process that allows for ongoing evaluation and neurochemical adjustments between internal and external psychological demands on the individual (Ganzel, Morris, & Wethington, 2010).
- Allostasis is a central nervous system driven response which integrates appraisal, coping, learning and memory into the physiological response to these demands.
- Cortisol is produced when allostasis is not achieved (high allostatic load) and is a response to fear.

Cortisol Response to Stress

- Increased cortisol production occurs during periods of increased emotional stress (Selye, 1936).
- This occurs in early recovery from substance abuse and is manifested by anxiety. Sustained elevations of cortisol are known to occur during this time (Li, Li, Epstein, Zhang, Kosten, & Lu, 2008; Li et al., 2000; Sinha, Fox, Hong, Hansen, Tal, & Kreek, 2011).

Cortisol Response (HPA axis)
Blunted Cortisol Response

- A blunted cortisol response to short stressful situations has been identified in alcoholics and polysubstance abusers (Daughters, Lejuez, Kahler, Strong, Brown, 2005; Ondra et al., 2000).
- In addition, Daughters et al. (2005) noted that substance abusers were more likely to drop out of residential treatment if cortisol did not return to expected baseline after completing the stressful task.

Trauma and Stress response

GOAL is to optimally decrease sympathetic response in order to
- Improve/normalize sleep
- Decrease somatic symptoms
- Increase ability to concentrate/learn
- Insight into behavior/self
- Decrease need for opiates/alcohol and return to normal homeostasis (eliminate the allostatic load)

Rationale for treatment (Relapse prevention)
What do we treat?

- Change the Social Situation
- Psychotherapy
- Medication
- Alternative therapy (yoga/mindfulness/music)

How do we Treat Anxiety

Psychotherapy Present Standard of Care

- Psychoeducation
- Group Therapy
  - AA
  - NA
- Individual
  - CBT
  - EMDR
  - DBT
  - Contingency Management
Pharmacological Treatment

- Treat underlying Mental illness
- Anxiety symptoms
  - Serotonin (H1), Gaba, Dopamine
- Sleep
  - Antihistamine
  - Anticholinergic
- Cortisol dysregulation
  - Alpha Blockers
  - Beta Blockers

Pharmacological Tx of Anxiety

- Hydroxyzine (antihistamine)
- Buspirone (Serotonin H1)
- Baclofen (Gaba)
- Gabapentin (gaba)
- SSRIs (serotonin)
- SNRIs/welbutrin (norepinehrine/dopamine)
- Atypical antipsychotics (antihistamine/dopamine antagonism/serotonergic)

Pharmacologic treatment of sleep
(all are off label uses)

- Trazodone (SARI)
- Doxipen (TCA)
- Mirtazapine (tetracyclic)
- Quetiapine (SA, dopamine antagonism, antihistamine)
- Nortryptaline (TCA, some gaba effect)
- Amitrytpaline (TCA, some anxiolytic effect)
**Tx of sympathetic overload**

- Alpha 2 agonist – Clonidine
- Alpha 1 antagonist – Prazosin (nightmares)
- Beta antagonist – Propranolol – short acting
- Beta antagonist – Metoprolol – intermediate acting

**Other Related Pharmacological Treatments**

- NSAIDs for pain – not always helpful early
- Gabapentin – neuropathic pain (and mood)
- Robaxin – muscle spasms / cramping
- Baclofen – gaba effect decreases perception of pain (abuse potential)
- Vivitrol (LAI naltrexone) – full opiate antagonist – decreases anxiety by decreasing craving and fear of relapse

**Pearls for medication use**

- Focus on what you are prescribing for
- Discontinue (or increase) if ineffective
- Use short term
- Withdrawal anxiety usually peaks within 2–3 weeks
- Discuss goal and plan for meds at discharge early
- Avoid Rxs with misuse potential at discharge unless you are following them (quetiapine, baclofen, clonidine, gabapentin? bupropion?)
## Complementary and Alternative Therapies

- Mindfulness / meditation / Yoga
- Exercise
- Relaxation / massage therapy
- Alpha wave stimulation / DCS
- TMS / DBS
- Music / Binaural Beats
- Faith / religion

## Summary

Anxiety is both a predictor and consequence of substance abuse. Adequate treatment of anxiety is an important ingredient for maintaining sobriety. This may occur in part through the automatic reprogramming of the HPA axis that occurs a month or so after substance withdrawal. In line with the self-medication hypothesis, and the number of individuals with trait anxiety existing prior to initiation of substance use, it is critical for substance use treatment to not only address the state anxiety during treatment to enhance learning and internalizing of skills needed to remain substance free, but to ensure continued pharmacotherapy for those with residual (trait) anxiety in the long term.

You can’t stop the waves, but you can learn to surf.
Thank You

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References