ANXIETY DISORDERS INFO SHEET

SUBSTANCE/MEDICATION INDUCED ANXIETY DISORDER:

The new and slightly altered criteria for anxiety disorder induced by a medication or substance are part of a substantial reconfiguring of this group of disorders in DSM-5, in which the DSM-4-TR anxiety disorders, which included phobias, repetitive behaviors and conditions arising from stress and trauma, were divided into 3 groups: anxiety, obsessive-compulsive and trauma and stressor-related disorders. Previous age requirements were also eliminated, a usual time course of 6 months or more for anxiety disorders was recognized and it was no longer considered necessary for the patient to recognize that his or her fears or worries were excessive or unreasonable.

Anxiety disorders are themselves a relatively recent construct, although states of fear, worry and panic have been recognized since antiquity and a relationship between them and drug, alcohol and medication use has been recognized. The term anxietas was applied in medieval times to the unease that many Christians felt about their prospects for eternal life on account of sin and shortcomings. Although he was a clergyman, Robert Burton in The Anatomy of Melancholy (1621) sought to describe worry and sadness of earthly origin, and observed that some melancholic individuals would spontaneously turn “red, pale, tremble, sweat…sudden cold and heat come over the body, palpitation of the heart, syncope, etc.” and become “astonished and amazed” with fright. French physicians described angoisse while German writers adopted the term Angst for inappropriate fear and dread, and Spanish clinicians termed the state of breathless and hyperventilating agitation angustia. The term panic was coined in 1879 for the most dramatic physical manifestations, derived from the god Pan, who made uncanny noises in the woodlands that induced terror in his hearers. At about the same time, Bénédict-Augustin Morel ascribed anxiety to the newly-recognized autonomic nervous system, Freud introduced the concept of “anxiety neurosis” in 1895. With the escalating use of alcohol-laced patent medicines, cocaine and other stimulants and a variety of opioids derived from morphine during the late 19th and early 20th centuries, it became clear to the predominantly hospital-based neuropsychiatric physicians of the time that the effects of alcohol and illicit or medicinal drugs could aggravate or precipitate anxiety and panic (Pichot, 1996; Angst, 1998; Makari, 2012)

SYMPTOMS:

The disorder is characterized by anxiety or fear, sometimes accompanied by such physical symptoms as racing heart, breathless and shakiness, caused by the effects of a medication or psychoactive substance. Although “anxiety” and “fear” are often used interchangeably, the former term generally means an unpleasant emotional state for which the cause is not apparent or which is perceived to be uncontrollable, while the latter is usually the emotional and physical response to an identifiable threat. It has been said that anxiety is the anticipation of future events, while fear is a reaction to current events.

These symptoms may occur while the patient is under the influence of the drug (intoxication) or after use of the drug has stopped (withdrawal). Generalized anxiety, panic attacks or manifestations of phobia may be precipitated by substance use or withdrawal; obsessions and compulsions were formerly considered anxious manifestations of substance use, but are now categorized separately as substance or medicine-induced obsessive-compulsive disorder. Anxiety caused by the drug may persist as long as use continues, while withdrawal-related symptoms may first manifest themselves up to four weeks after cessation of use (Galanter and Kleber, 2008). Prolonged psychiatric symptoms, including anxiety and panic, can continue for up to six months, and have rarely been reported for years, after cessation of alcohol, benzodiazepine, opioid and occasionally antidepressant use (DeSoto, O’Donnell and DeSoto, 1989).

Alcohol, amphetamine and its derivatives, cannabis, cocaine, hallucinogens, intoxicants and phencyclidine (PCP) and its relatives have been reported to cause the symptoms of anxiety during intoxication. Withdrawal from alcohol, cocaine, illicit opioids and also caffeine and nicotine can also cause manifestations of anxiety. Many prescription and even over-the-counter drugs can precipitate anxiety: anesthetic agents, antibiotics (particularly the fluoroquinolones such as moxofloxacin), anticholinergic drugs for movement disorders, anticonvulsants, antihistamines, antihypertensives, bronchodilators (particularly the sympathomimetic agents such as epinephrine), various cardiovascular medication ,cough and cold preparations, contraceptives, corticosteroids, insulin and sometimes oral hypoglycemic drugs,opioid and some non-opioid pain medications, psychotropic agents (antidepressants, antipsychotics and lithium), statin drugs for elevated cholesterol, thyroid preparations and various medications for ulcers and heartburn. Carbon dioxide retention and carbon monoxide poisoning can manifest as anxiety, as can aromatic chemicals, fuel, paint and turpentine among them, as well as organophosphate insecticides and a number of industrial substances and solvents, whether through incidental exposure or abuse (Johnson, 2011).

CAUSES:

The incidence and prevalence of the disorder are not known, but it is likely that many if not most patients with anxiety disorder induced by alcohol or psychoactive drugs have or will develop alcohol and drug problems, and that some individuals who develop anxiety on medications also have or will develop an anxiety disorder. Substance abuse, a pattern of maladaptive use of one or another substance that harms the user or others, and substance dependence, the compulsive use of a substance in order to function normally, have been combined in DSM-5 into substance use disorder (American Psychiatric Association, 2013). Substance use disorder is most common in adolescents and young adults, predominates in males and is more frequent among urban residents. Approximately 20 per cent of the patients in general medical facilities may have substance-related disorders, and over 50 per cent of patients with substance-related disorders have been found to have comorbid psychiatric disorders, chiefly anxiety disorder or depression, dysthymia or personality disorder (Leikin, 2007).

MANAGEMENT:

Anxiety symptoms induced by medications or substances will usually subsided when the offending drug is eliminated; the persistence of anxious manifestations is therefore often determined by the half-life of the drug(s). The simplest treatment is discontinuation of the responsible medication when possible, or cessation of use thereafter of the responsible substance. A diagnostic evaluation for underlying anxiety disorder should be carried out, particularly if symptoms persist after the suspected cause has been discontinued and eliminated. This in turn requires the clinical and laboratory consideration of the extensive differential diagnosis of anxiety and panic (Sadock and Sadock, 2007). An inquiry into substance use and possible disorder is also appropriate (Johnson, 2011). If addiction has previously been identified or suspected, the onset of substance-induced anxiety is a strong indication for the initiation of outpatient or inpatient substance use disorder treatment.

Persistent anxiety symptoms warrant continuing treatment. Antidepressants are preferable to benzodiazepines, particularly if dependence concerns are also present: SSRI and SNRI agents have lower side-effect profiles, but tricyclic antidepressants are occasionally and MAO inhibitors rarely warranted (Ipser et al., 2006). Antidepressant initiation is linked, however, to a particular syndrome of anxiety, irritability and "jitteriness" (Sinclair et al., 2009). Buspirone has limited efficacy but may be safer in patients prone to adverse medication effects. If benzodiazepines are necessary, clonazepam is often recommended because of a longer half-life that limits the potential for withdrawal and rebound anxiety.

Cognitive psychotherapy helps patients to see how automatic thoughts and false beliefs lead to exaggerated emotional responses such as anxiety. Behavioral therapy involves gradual and desensitizing exposure to anxiety-provoking situations and stimuli, and may include relaxation training to moderate the physiological responses to these. Both types of therapy are effective for anxiety, and a combination generally yields superior results (Hunot et al., 2007).