



# Anxiety or Addiction

## Where Do We Draw the Line?

Linda Lewaniak, LCSW, CAADC

Director of Intensive Outpatient Services

Patrick B. McGrath, Ph.D.

Center for Anxiety and Obsessive Compulsive Disorders

AMITA Health Alexian Brothers Behavioral Health Hospital

# Goals

- Anxiety disorders
- Substance Use disorders
- What are some Similarities and Differences in symptomology
- Treatment Interventions

## DSM - V Anxiety Disorders

Panic Disorder

Agoraphobia

Obsessive Compulsive Disorder

Generalized Anxiety Disorder

Separation Anxiety Disorder

Post Traumatic Stress Disorder

Specific Phobia

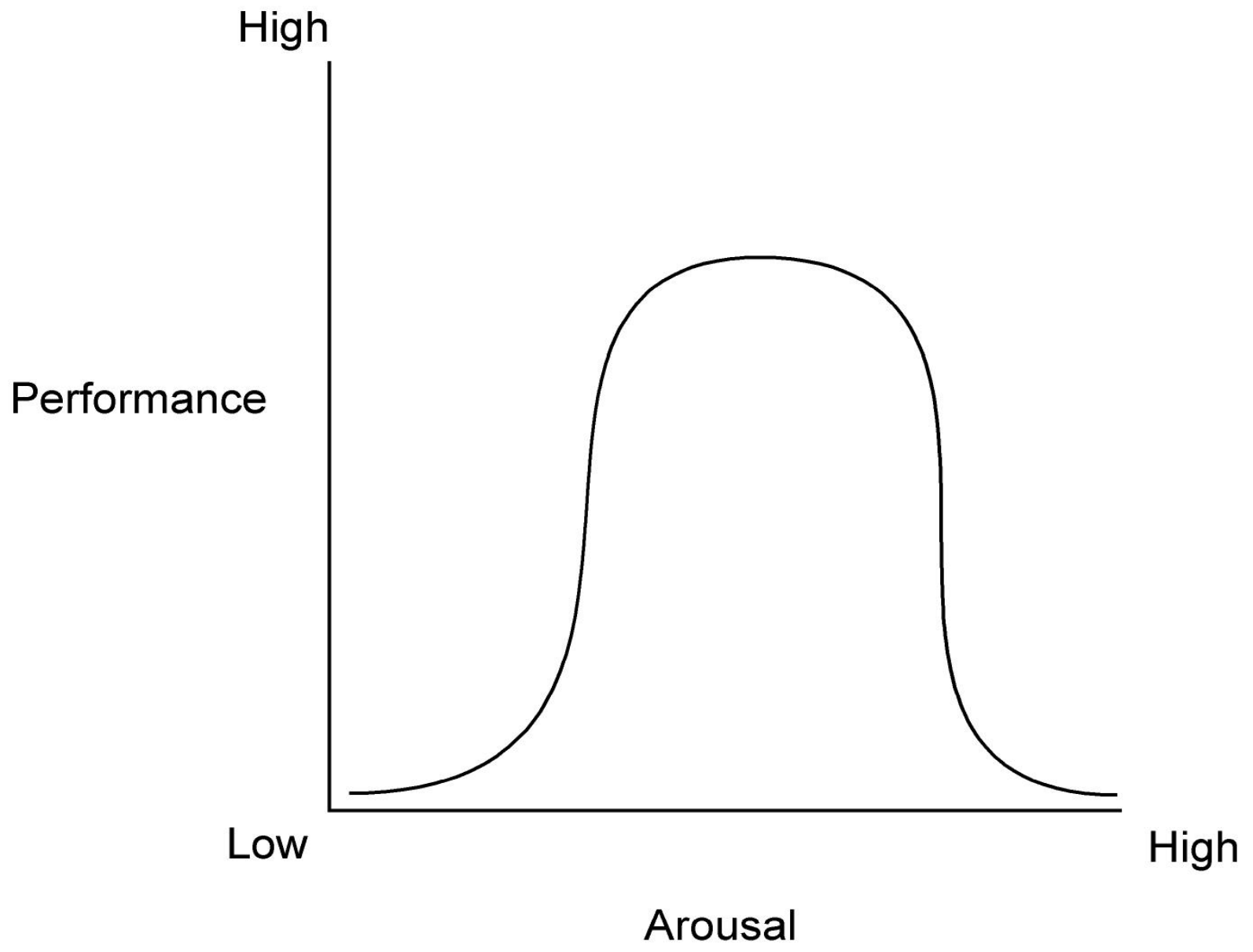
Social Phobia

# Anxiety Disorders are:

- Highly prevalent (most common class of mental disorder)
- Real & potentially disabling
- Found in all groups of people
- Under-recognized & under-treated
- Variable in presentation
- Treatable

# What is Anxiety?

- Normal, natural, built in through evolutionary processes
- Response to the perception of future threat or danger
- We need this to prepare for future potential difficulties
- Some anxiety is actually good for performance (Yerkees-Dobson)



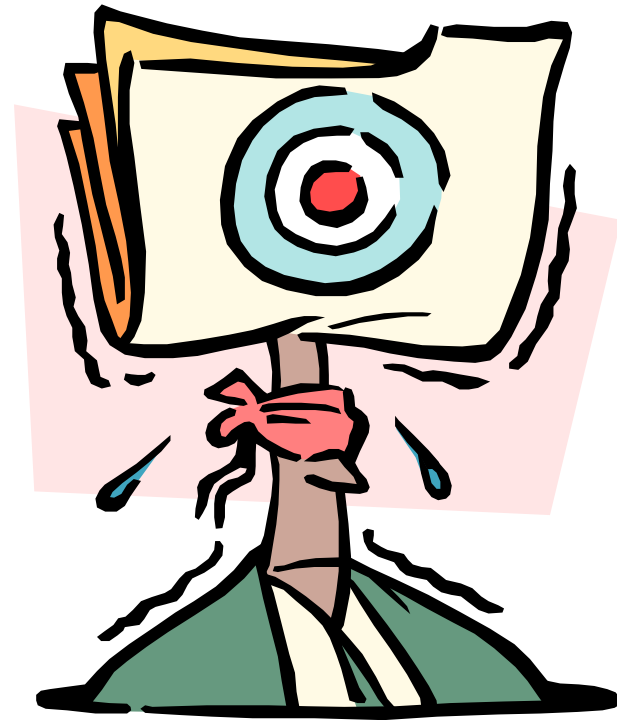
# What is Panic?

- Normal, natural, built in through evolution
- Response to the perception of immediate threat or danger
- We need this to protect ourselves from danger

# Four Basic Fears

Threats to the integrity of:

- \*Physical Status
- \*Mental Status
- \*Social Status
- \*Spiritual Status





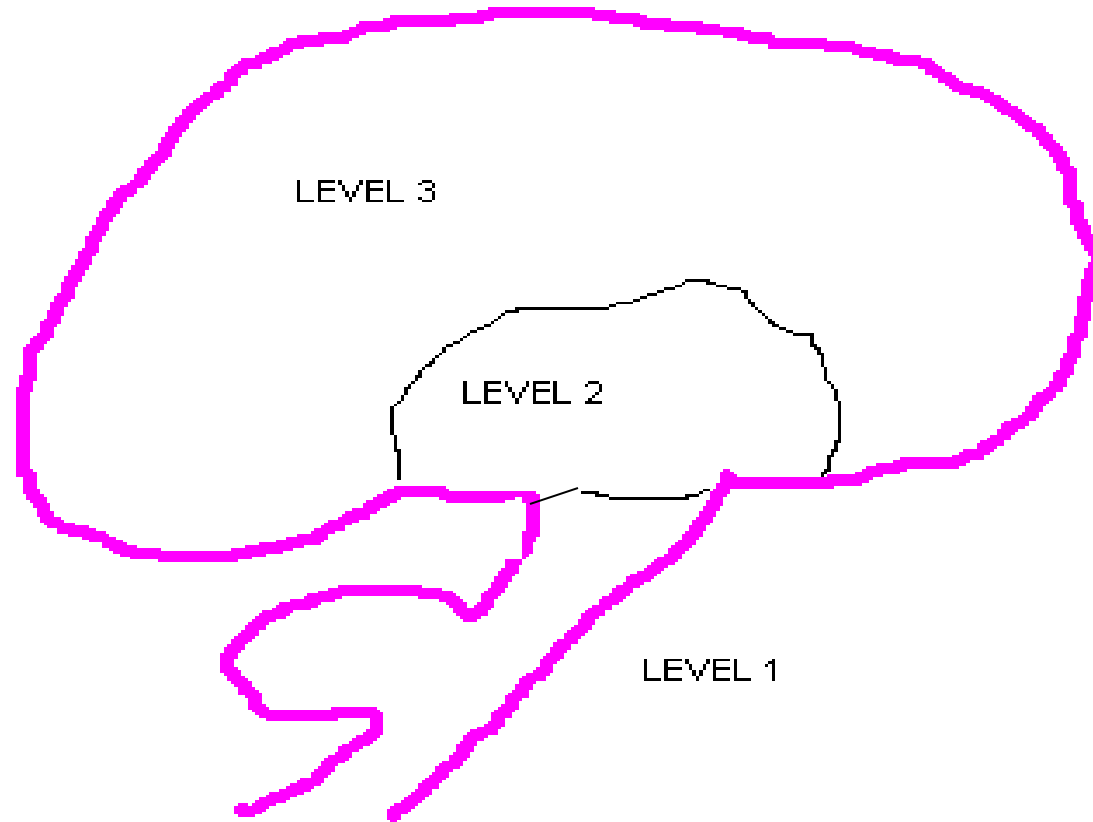
# Common Distortions

- Severity
  - It will be the worst thing in the world and I will die
- Probability
  - It will definitely happen, no question
- Efficacy
  - I will not be able to handle it

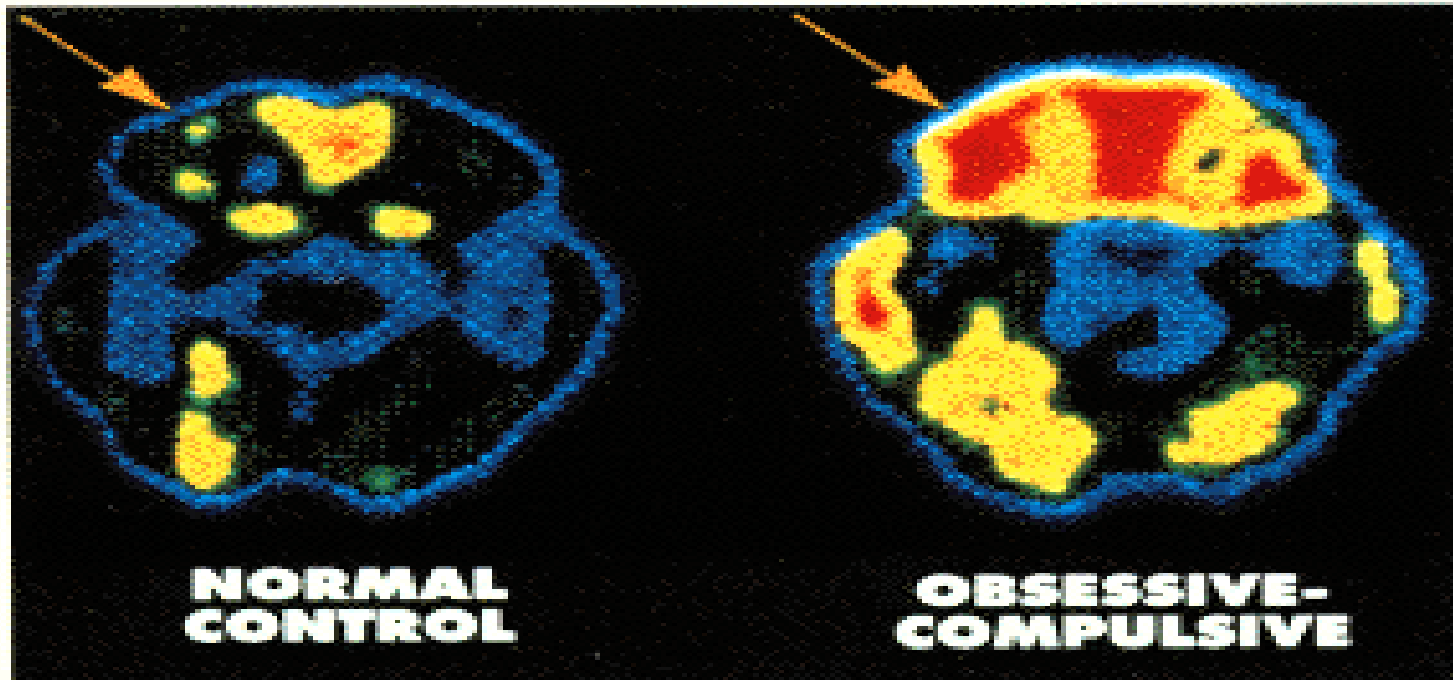
LEVEL 1 = BASE BRAIN AND AUTOMATIC FUNCTIONS

LEVEL 2 = MID OR REPTILIAN BRAIN - LOCATION OF FIGHT OR FLIGHT

LEVEL 3 = CORTEX - LOCATION OF HIGHER ORDER COGNITIONS

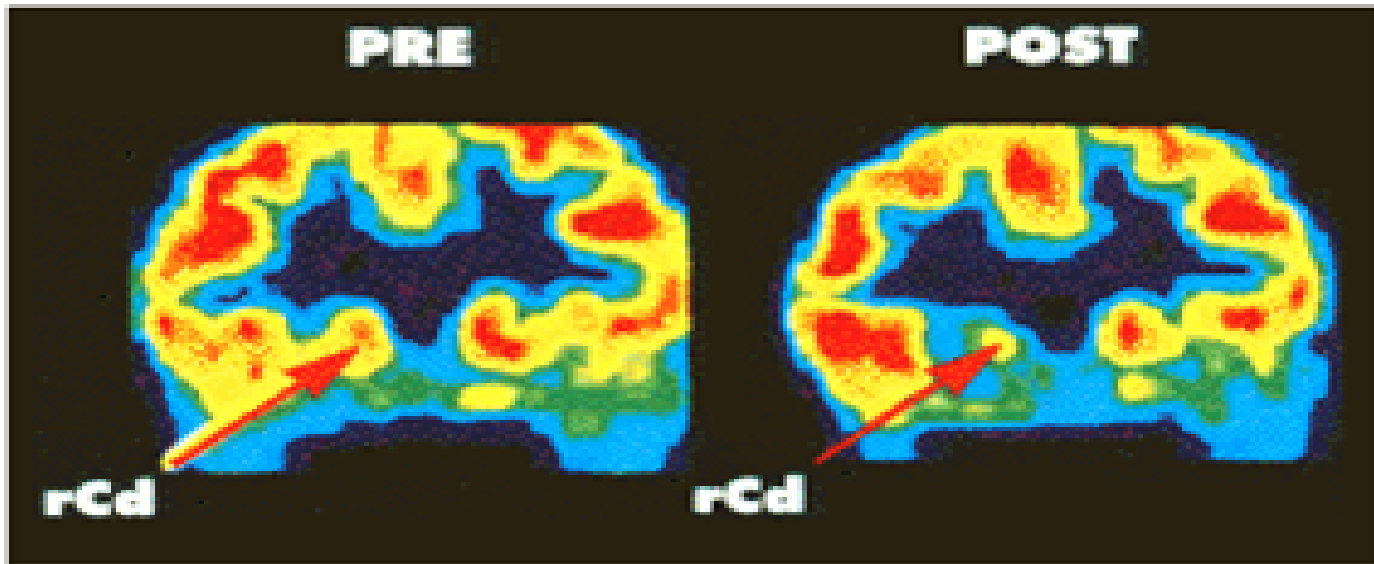


# PET Scans



**HIGH ENERGY USE IN THE BRAIN OF A TYPICAL PERSON WITH OCD**

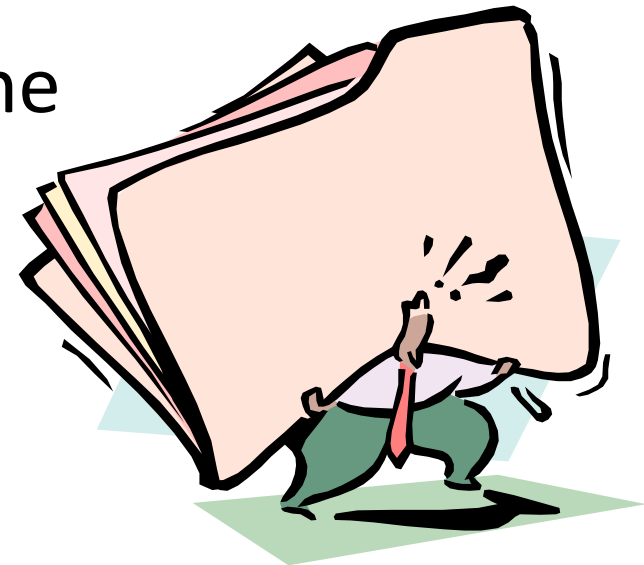
# PET Scans



Pre and post CBT and ERP  
for an OCD patient

# Anxiety Disorders

- Our Fight, Flight, or Freeze system gets activated when it does not need to
- The fear is perceived but, by most standards, is far less than it is judged to be
- Everyday occurrences become overwhelming
- Behaviors interfere with daily functioning



# A few things to note

- Impulse versus Compulsion
  - Impulses feel good when done, even if there was dread leading up to doing them
  - Compulsions relieve the obsession
- We **do not** all have a little OCD
- You cannot talk someone out of being anxious

# Substance use disorders

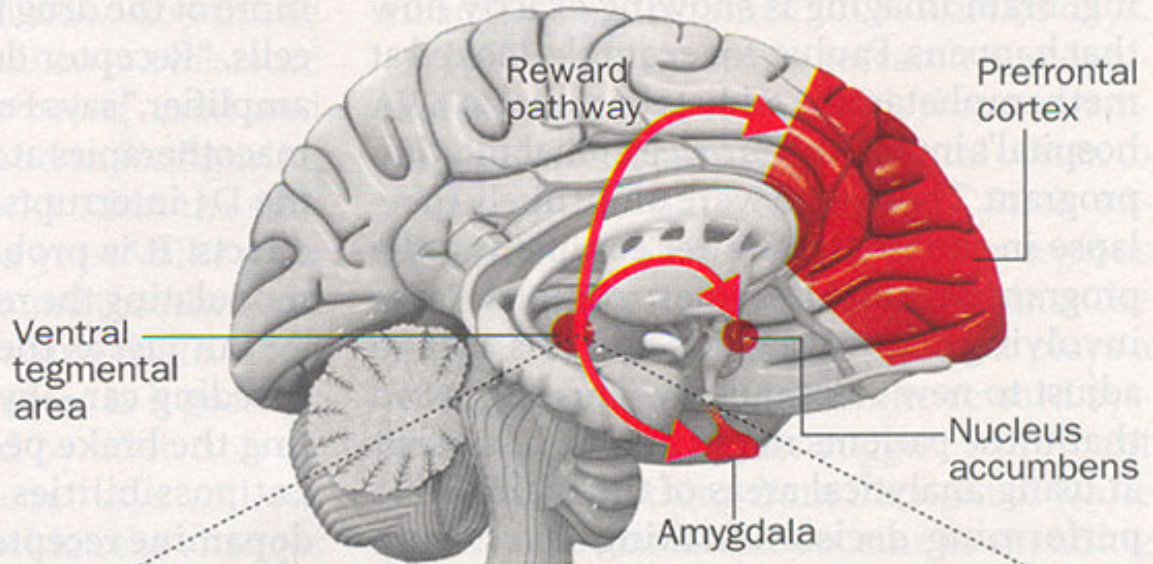
Mark Willenbring, M.D., Director of the Division of Treatment and Recovery Research at the National Institute on Alcohol Abuse and Alcoholism (NIAAA).

- Addiction is now understood to be a **brain disease** because scientific research has shown that alcohol and other drugs can change brain structure and function.
- Advances in brain imaging science make it possible to see inside the brain of an addicted person and pinpoint the parts of the brain affected by drugs of abuse —
  - This provides knowledge that will enable the development of new approaches to prevention and treatment.

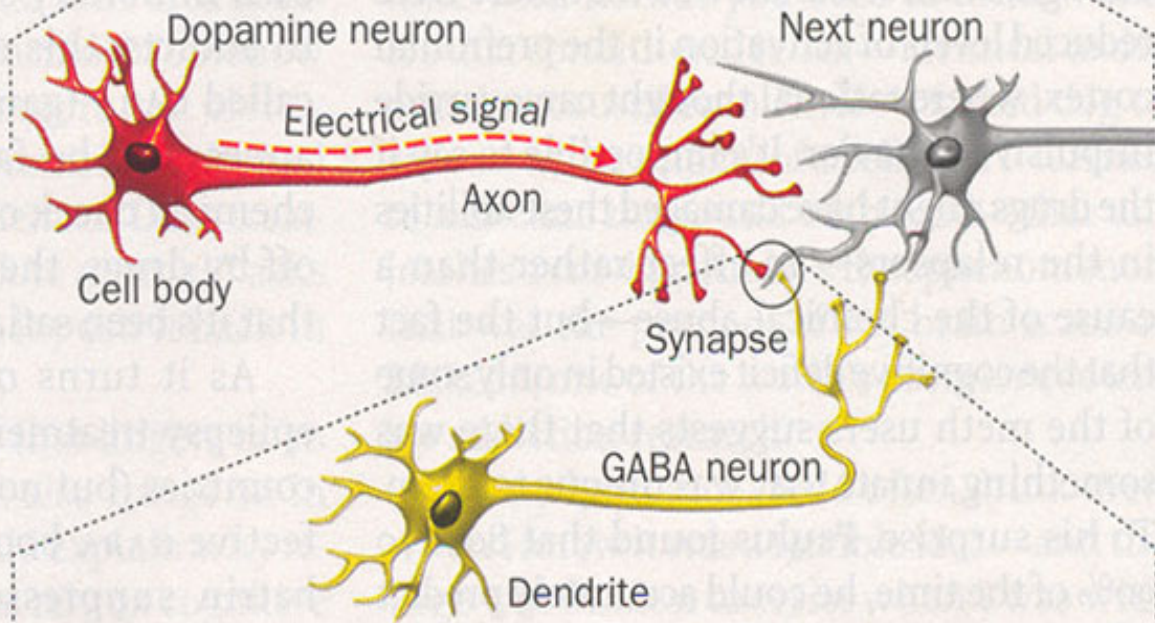


# What happens in the brain

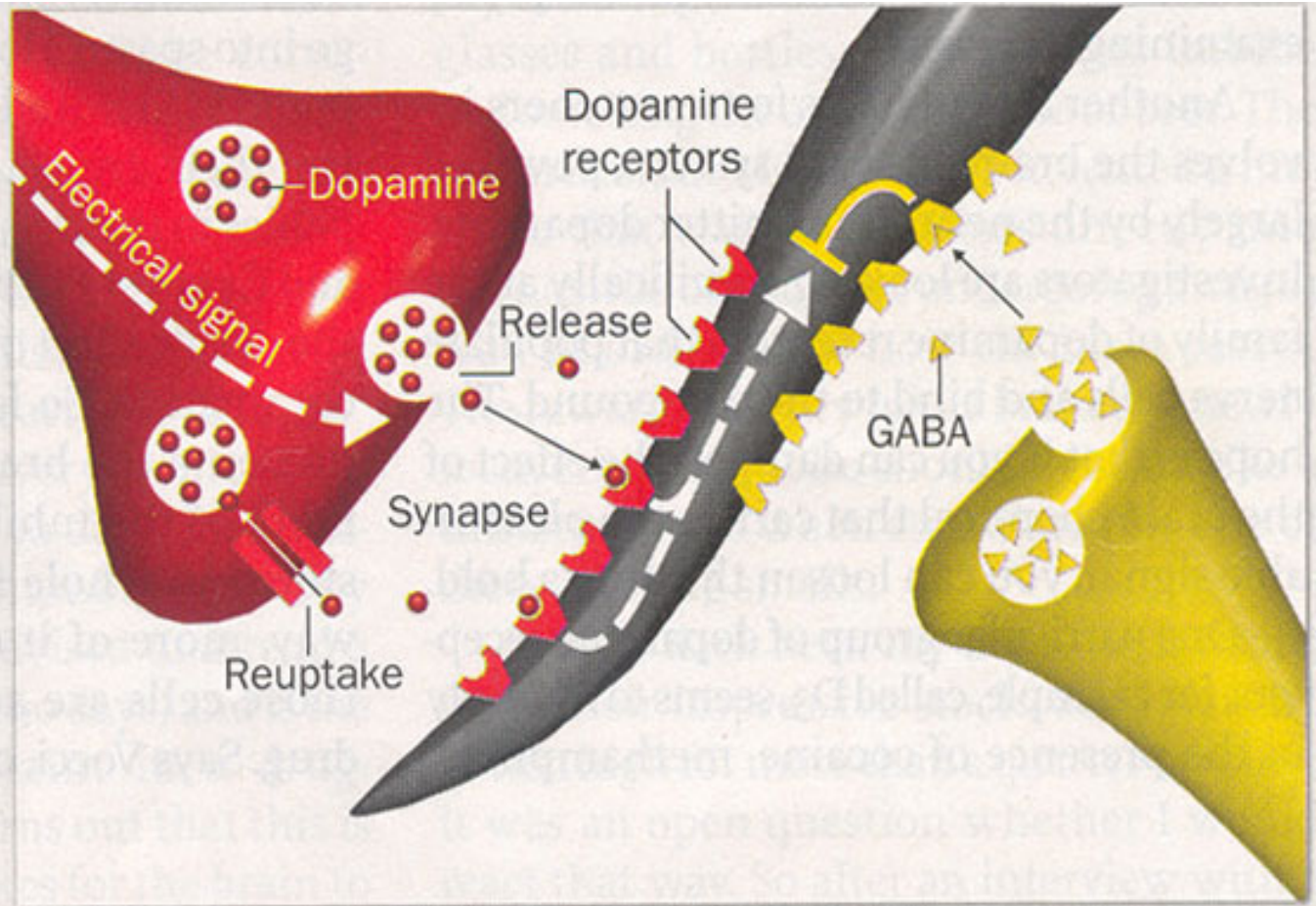
**1.** We feel good when neurons in the reward pathway release a neurotransmitter called dopamine into the nucleus accumbens and other brain areas.



**2.** Neurons in the reward pathway communicate by sending electrical signals down their axons. The signal is passed to the next neuron across a small gap called the synapse.



**3.** Dopamine is released into the synapse, crosses to the next neuron and binds to receptors, providing a jolt of pleasure. Excess dopamine is taken back up by the sending cell. Other nerve cells release GABA, an inhibitory neurotransmitter that works to prevent the receptor nerve from being overstimulated.



## The DSM

DSM system is not based on whether a drug is legal or not, but rather on how drug use impairs the person's physiological and psychological functioning.



# Diagnostic Criteria

- The individual may take the substance in larger amounts or over a longer period than was originally intended.
- The individual may express a persistent desire to cut down or regulate substance use and may report multiple unsuccessful efforts to decrease or discontinue use .
- The individual may spend a great deal of time obtaining the substance, using the substance, or recovering from its effects.
- **Craving** is manifested by an intense desire or urge for the substance that may occur at any time but is more likely when in an environment where the substance previously was obtained or used.
- Recurrent substance use may result in a failure to fulfill major role obligations at work, school, or home.
- The individual may continue substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance.
- Important social, occupational, or recreational activities may be given up or reduced because of substance use.
- Recurrent substance use in situations in which it is physically hazardous.
- Continued substance use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance.

# Diagnostic criteria continued

- **Tolerance**
  - A need for markedly increased amounts of a substance to achieve intoxication or desired effect
  - A markedly diminished effect with continued use of the same amount of the substance
- **Withdrawal**
  - Withdrawal symptoms for a particular substance.
  - A substance is used to avoid or relieve symptoms

# Severity Scale

- 0 criteria to 1 criteria – no diagnosis
- 2 to 3 criteria – mild substance use disorder
- 4 to 5 criteria – moderate substance use disorder
- 6 or more criteria – severe substance use disorder

# Substance Use Disorder Criteria

- Two changes for remission specifiers:
- **Early remission** - abstinence lengthened to three months
- **Full remission** - requires no symptoms at all for 12 months – except craving (everybody has cravings, even active users have cravings)

# Specifier

- **On maintenance therapy:** The individual is taking a long-term maintenance medication, such as nicotine replacement medication, and no criteria for tobacco use disorder have been met for that class of medication (except tolerance to, or withdrawal from, the nicotine replacement medication).
- **In a controlled environment:** This additional specifier is used if the individual is in an environment where access to tobacco is restricted.



## Common co-occurring diagnoses for Anxiety and Substance use disorders

Post Traumatic Stress Disorder – Drugs can be used to help a person sleep more so that they will not be awake and have flashbacks, or to have a person stay awake so that they will not have nightmares.

Panic Disorder – Drugs can be used to numb feelings of panic. These can be legal drugs and illegal drugs.

Social Phobia – Alcohol is often used at parties as a way to loosen up and decrease inhibitions.

GAD- Chronic worry can lead to chronic distractions through substances

**Substance--**

# Similarities or Differences in Symptoms

- Substance use disorders look at symptoms as behavioral, emotional, cognitive. social and physiological.
- Anxiety disorders look at symptoms as behavioral, emotional, and cognitive.
- Safety Seeking Behaviors for Anxiety:
  - **Avoidance**
    - Experiential Avoidance-A learned style of dealing with unwanted private events (thoughts, feelings, memories, sensations) and distressing external events that involves emotional escape, numbing or other methods of experiential control – even when they don't achieve the desired result consistently or for long enough
  - **Reassurance**
    - Desiring others to confirm that all is well, and yet doubting the sincerity of that conformation at the same time.
  - **Distraction**
    - Doing something to avoid a stressor immediately. Drugs, alcohol, video games, self soothing exercises.

## Traditional Treatment interventions

- **Exposure and Response Prevention (ERP)**
- **Motivational Enhancement Therapy (MET)**
- **Cognitive-Behavioral Therapy (CBT)**
- **Dialectical Behavior Therapy (DBT) Mindfulness**
- **Acceptance and Commitment Therapy (ACT)**
- **Matrix Model**
- **Family Therapy and Education**
- **Twelve Step Facilitation (TSF)**



# Unified Protocol (UP) for the Transdiagnostic Treatment Of Emotional Disorders

- Incorporates common principles of evidence--based CBT treatments
  - Reevaluate cognitive appraisals
- Change action tendencies associated with reduced emotion avoidance
- Utilize (emotion) exposure procedures to promote reduction and tolerance of distress
- Emotional patterns and responses affect regions of the brain
- **Talking the best of what is – Creates a unified language -**

GOAL: To increase patient acceptance and willingness to experience strong emotions and create positive coping skills and increase functioning.

# The UP Modules

## **M1: Motivation enhancement for treatment engagement**

- Part I- Fostering and Enhancing Motivation
  - Decisional Balance
- Pros and cons of changing
  - Education about the consequences of substance abuse
  
- Part II- Enhancing Self-Efficacy
  - Treatment Goal Setting
- Emphasis on concrete goals and identifying specific steps

## M2: Understanding Emotional Experience

### Overarching Goal:

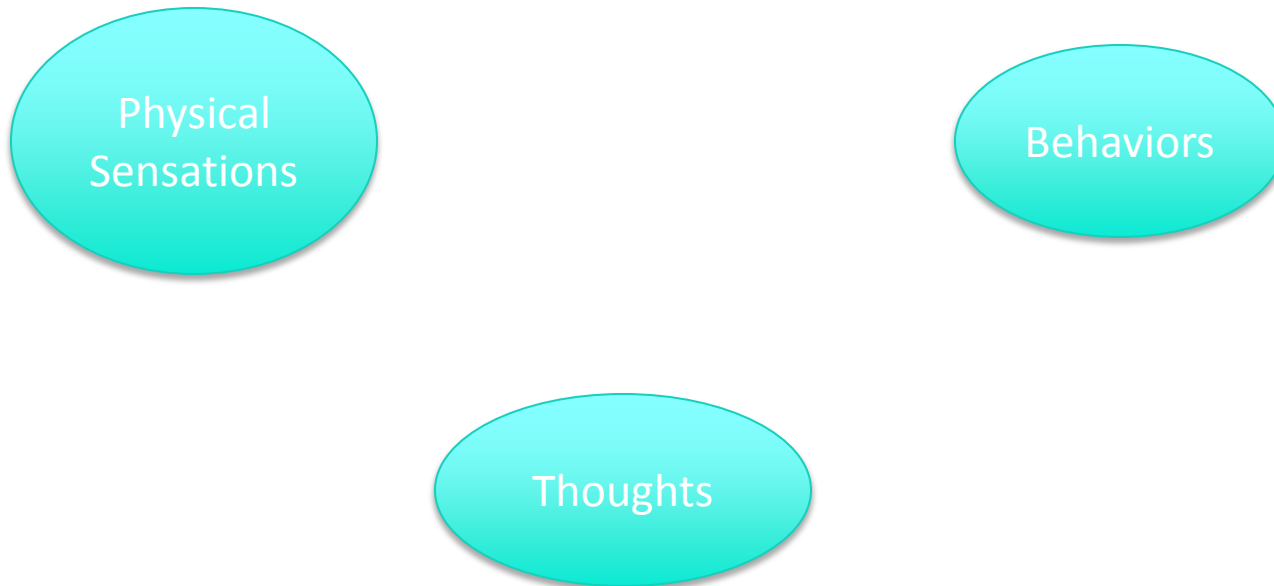
- Develop greater awareness of emotions as they occur, particularly interactions between physical sensations, thoughts, and behaviors

### Topics Covered:

- The adaptive nature of emotions
- 3 components of an emotional experience
- Antecedents and consequences of emotions

# M2: Understanding Emotional Experience

Goal: Understand the interacting components of an emotional experience



## M3: Emotional awareness training (Mindful Awareness)

### Overarching Goal:

- Cultivate non-judgmental, present focused attention to be used in response to emotional experiences

### Topics Covered:

- The difference between grounding and Mindfulness
- The consequences of judgmental and future/past focused attention
- Mindfulness exercise to practice this type of attention
- Anchoring in the present
- Music Mood Induction



# M3: Emotional Awareness Training

**Goal 1:** Increase present-focused attention regarding emotional experience

- Build awareness of emotional experiences in context, as they are happening right now
- Reactions often rooted in perceived past failures/future uncertainties

**Goal 2:** Develop a non judgmental stance toward emotional experiences

- Emotions as threatening, unwanted; emotional avoidance

**Goal 3:** Practice applying these skills in response to emotional experiences as they occur

# M4: Cognitive Appraisal and Reappraisal

## Goals

- Introduce cognitive appraisal, automatic appraisal
- Practice ways to evaluate and reevaluate thinking patterns (“ thinking traps”)
- Increase flexibility in appraisal

## Automatic appraisals

- Maladaptive appraisals (“Thinking Traps”)
  - Common Traps
- Probability overestimation or “ jumping to conclusions”
  - “Something must be wrong because my wife is late”
- Catastrophizing or “ thinking the worst”
  - ” She must have been in a terrible accident.”

## Flawed

# Practicing Reappraisal

## Countering probability overestimation

Look for evidence from past experience:

- Do I know for certain that \_\_\_\_\_ will happen?
- What evidence do I have for this fear or belief?
- What happened in the past in this situation?
- How much does it feel like \_\_\_\_\_ will happened?
- What is the true likelihood that \_\_\_\_\_ will happen?

## Decatastrophizing

Assess ability to cope:

- What is the worst that could happen? How bad is that?
- If \_\_\_\_\_ happened, could I cope with it? How would I handle it?
- Have I been able to cope with \_\_\_\_\_ in the past?
- So what?

# M4: Cognitive Appraisal and Reappraisal

Automatic appraisal → Downward Arrow

“ I won’t have anything to say.”

↓ (If that were true, then what)

“ They will think I am boring.”

↓ (If that were true, then what)

“ No one will want to be with me.”

↓ (If that were true, then what)

“ I’ll continue to be alone.”

↓ (If that were true, then what)

“ No one will ever love me.”

# M4: Cognitive Appraisal and Reappraisal

Automatic appraisal → Downward Arrow

“ I’m an addict/alcoholic, this is what we do”

↓ (If that were true, then what)

“ If I stop drinking/using my life will become boring.”

↓ (If that were true, then what)

“ I’ll have nobody to hang around with.”

↓ (If that were true, then what)

“ I’ll continue to be alone.”

↓ (If that were true, then what)

“ I will be all alone and have no choice but to drink or use.”

# M5: Emotion Avoidance and Emotion -- Driven Behaviors (EDBs)

## Goals

- Introduce emotional avoidance and EDBs
  - Demonstrate ironic effects of suppression
  - Practice identifying and countering EDBs
- 
- Introduce Emotional Avoidance
    - Any cognitive or behavioral strategy aimed at preventing full emotional experience or arousal
    - Emotional avoidance strategies differ from EDBs in that they occur before an emotion has occurred
  - Types of Emotional Avoidance Strategies
    - Situational Avoidance
    - Subtle Behavioral Avoidance
    - Cognitive Avoidance
    - Safety Signals

## Avoidance Strategy

## Disorders Associated

### Cognitive avoidance

Dissociation (depersonalization, derealization)	PDA, PTSD, SUD
Distraction (e.g., reading a book, watching tv, drinking/using)	GAD, DEP, PD/A, SUD
Avoidance of thoughts or memories about trauma	PTSD, SUD
Effort to prevent thoughts from coming into mind	OCD, PTSD, SUD
Worry	GAD, SUD
Rumination	DEP, SUD
Shame and Guilt	SUD
Thought suppression	All disorders

### Safety signals

Carrying a cell phone	PD/A, GAD
Holding onto “good luck” charms	OCD
Carrying water or medication bottles (ie Valium)	PD/A/SUD
Having reading material always on hand	SOC, GAD
Carrying self-protective materials (e.g., mace, siren, alcohol)	PTSD/SUD

# M5: EDBs & Emotional Avoidance

- Introduce Emotion Driven Behaviors (EDBs)
  - Emotions are associated with action tendencies
  - EDBs are action tendencies driven by the emotional experience itself
  - EDBs contribute to overall emotional experience and maintain the emotional response
- Practice identifying and countering EDBs
  - Engaging in incompatible behaviors, or acting, opposite, can help break the cycle of disordered emotions



# M6: Awareness and Tolerance of Physical Sensation

- This can include Interoceptive Exposures – Exposing patients to the actual sensations that they dislike to teach them how to handle them.
- Introduce rationale for provoking emotion through interoceptive activation
  - Physical feelings contribute to overall emotional experience
  - Repeated exposure to physical feelings facilitates habituation to the distress or discomfort about those feelings
- Conduct in-session symptom induction exercises
  - Breathing through a thin straw, hyperventilation, spinning in circles, running in place, etc.
- Virtual Reality creates a sensory experience to learn to tolerate symptoms as well.

## M7: Interoceptive and Situation-base Emotion exposures

- Provide rationale for emotion exposure in a situational context
  - Practice skills learned in treatment
  - Changing emotional reactions happens when they are experienced fully and EDBs are modified
  - By engaging in these situations, appraisals change & become more adaptive
- Create hierarchy and conduct emotion exposures
  - Situational exposure (+interoceptive exposure)
  - Imaginal exposure (+ interoceptive exposure)

## M8: Review and Relapse Prevention

### Goals

- Review skills for coping with emotions and behaviors
- identify and troubleshoot common/potential triggers
- Promote skill generalization
- Set long-term goals and discuss steps for independent pursuit of these goals
- Includes continued exposure practice

## M9 Family

- Goal is to meet the needs of all family members.
- **Interdependent nature** of family relationships and how these relationships affect the substance abusing patient
- Intervene in these **complex relational patterns** and to alter them in ways that bring about productive change for the entire family.
- Family therapy rests on the **systems perspective**:  
Changes in one part of the system can and do produce changes in other parts of the system, and these changes can contribute to either problems or solutions.

# Psychoeducation and Self-Monitoring

- Pain Management
- Acceptance and Commitment
- Spirituality/Values
- Disease Concept/ Bio-Psycho-Social-Spiritual Model of Addictions
- Problem Solving
- Surrender vs. Compliance
- Forgiveness
- 12 Step/ Support groups
- Medication Management group
- Gender Specific Groups
- Shame and Guilt
- Giving and Receiving Feedback
- Victim/Survivor
- Tobacco and Cross Addiction
- Stages of Change
- Relationships
- Leisure and Lifestyle Changes/ Time Management

Thanks for your attention:

Further questions?

[Linda.Lewaniak@alexian.net](mailto:Linda.Lewaniak@alexian.net)

[Patrick.McGrath@alexian.net](mailto:Patrick.McGrath@alexian.net)