Treatment of Anxiety in the Methadone Maintained Patient

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Outline

I Introductory comments

II Benzodiazepine issues

III Key points prior to initiating treatment for anxiety

IV Pharmacological treatment of anxiety

V Non-Pharmacologic treatment of anxiety

I Introductory Comments

“Lessened Anxiety Hour 5-6”

Thought Process

- Me: I liked the 800mg of Ibuprofen b/c it treated the pain

- My Patient: I prefer [opiate] because then I don’t care about the pain

"Could we up the dosage? I still have feelings."

II Benzodiazepines issues

Note

- This talk will not cover how to medically taper a patient off of benzodiazepines
- Patients with substance use disorders (SUD) are at high risk for misusing/abusing medications with addictive potential and therefore these medications should be avoided whenever possible
- Benzodiazepines have the potential to be addictive, especially in patients with other addiction disorders
- It can be lethal to mix methadone and benzodiazepines

Benzodiazepines in Tx of Anxiety

- Generally safe for patients WITHOUT SUD
  - Often prescribed by primary care doctor or psychiatrist because they work quickly

- Standard of care to avoid in the patient with SUD
  - Because of the high risk of addiction

Benzodiazepines

- Lifetime benzodiazepine use reported to be 66% – 100% in MMT population
- Current use 51% - 70%*
- Estimated abuse/dependence 18% - 50%*

*in tx agonist/partial agonist therapy or not in tx

III Key points prior to initiating treatment

“Your therapy will be a combination of drugs and clowns”

"Your therapy will be a combination of drugs and clowns."

Prior to treatment

- Strong doctor-patient relationship
- Make sure your treatment goal = patient's treatment goal
  - Eg pt wants to numb their feelings
- Treat co-morbid medical or psychiatric disorders
- Promote healthy behaviors
  - Sleep hygiene
  - Decreased caffeine
  - Decreased (no) EtOH – can cause rebound anxiety
- Educate Patient on what to expect
  - understanding of rebound vs. return of original anxiety
  - Time frame for medication to work

Medication Issues

- Patient's with panic disorder sensitive to side effects medications
  - Discuss with patient expected side effects
- Start low – go slow
  - Allow Patient to stay at lower dose until they feel comfortable increasing it
- Make sure patient isn't under dosed
  - Common reason for treatment failure
- Make sure they have anxiety disorder and not substance induced anxiety disorder
  - Eg cocaine induced panic attacks/depression

III Pharmacological treatment of anxiety

-FDA approved

-Off label

-PRNs

Top 3 Medications for Anxiety disorders

- SSRI
- SSRI
- SSRI

Medications for Anxiety Disorder

- SSRI's
  - Not all are FDA approved for treatment of anxiety d/o's, but in practice all are generally effective
  - Choose based on patient
    - See next slide
  - Not 100% effective
- SNRI's
  - Venlafaxine
- TCA's
  - Safety issues
  - Increased side effect profile

Gabbard's Treatment of Psychiatric Disorders, 4th ed, Chap. 29 Panic Disorder

Choosing a Medication

- Has patient found one helpful in the past?
  - The patient who has tried them all
- Has a family member found one helpful in the past?
- Has a friend found one helpful in the past?
- Is there a second reason they would want to take it?
  - May help increase compliance

Meds Without Supportive Data

- Mirtazapine
  - Individual pt's may appreciate sedating effect
- Trazadone
  - Risk of priapism in men
  - Individual pt's may appreciate sedating effects
- Buproprion
  - No effect on anxiety
  - Stimulant effect may worsen symptoms

Problem: These medications take weeks to work

What do you and the patient do in the mean time?

- PRN medications
- Use non-pharmacologic options
  - Next section

Antiepileptics as PRN medications *exciting new option*

- Gabapentin
  - One study showed no difference from placebo for panic d/o
  - BUT subanalysis showed for moderate to severely ill patients that there was a significant improvement
  - More research needed

- Valproate
  - Small non-RCT showed improvement for social anxiety disorder (SAD)

Antiepileptics – con't

- Pregabalin
  - Multiple DBPC randomized studies have shown there is a decrease in anxiety in patients with generalized anxiety d/o

PRN Medications

- Hydroxyzine aka Vistaril aka Atarax
  - Large dosing range options
  - Instructions to patient

- Buspirone
  - Generally not useful for pt's with h/o benzo use

- Atypical Antipsychotics
  - Risks: TD, NMS, metabolic syndrome, DM
    - Avoid first line
  - Some now have street value

IV Non-Pharmacologic treatment of anxiety

Next slide is an example of the wrong way to treat anxiety

“I medicate first and ask questions later”

“I medicate first and ask questions later.”

CBT

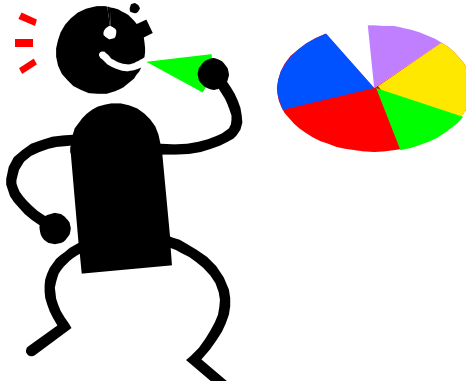
- Effective for GAD and panic d/o
- Effective 1-1 or in group setting
- One study (Clark et al, 1999) showed 5 session CBT + self study was essentially as good as 12 session (for panic d/o)
  - 71-79% panic free at 12mn f/u

Generalized Anxiety Disorder

- Psychodynamic psychotherapy
- CBT
- Relaxation techniques – must practice
  - Progressive muscle relaxation
  - Biofeedback
  - Relaxing imagery
  - Meditation
  - Breathing techniques

Conclusion

- Anxiety disorders are very common in the methadone maintained patient population
- In general there isn't one "whole pie" we can give our patients but we can help them get a whole pie made up with several different treatment pieces
- We must have belief in our patients until they are able to have it for themselves



"You will have a nice day."

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