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”
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
- Bupropion
  - 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”
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.”
References

- Gabbard's Treatments of Psychiatric Disorders, 4th Edition
- American J on Addictions, 19:59-72, 2009 Benzodiazepines, Methadone and Buprenorphine: Interactions and Clinical Management