Transcript Details
This is a transcript of an educational program accessible on the ReachMD network. Details about the program and additional media formats for the program are accessible by visiting: https://reachmd.com/programs/clinicians-roundtable/alternative-therapies-intervening-in-addiction-therapy/10393/

ReachMD
www.reachmd.com
info@reachmd.com
(866) 423-7849

Alternative Therapies Intervening in Addiction Therapy

Dr. Johnson:
It's an unfortunate reality that different types of addiction, such as drug, alcohol, even gaming, are on the rise. In fact, more than 20 million Americans suffer from an addiction, and with that number steadily increasing, more and more attention is focusing on alternative approaches to treatment. But what are those techniques, and how could they benefit these patients? Welcome to the Clinician's Roundtable on ReachMD. I'm Dr. Shira Johnson, and joining me to talk about the diagnosis and treatment of addiction is Dr. David Clements, psychiatrist and owner of Southeastern Executive Health located in the heart of Rittenhouse Square, Philadelphia, Pennsylvania.

Dr. Clements, welcome to the program.

Dr. Clements:
Thanks so much for having me, Dr. Johnson.

Dr. Johnson:
Can you tell our listeners a little bit about yourself and your practice and what areas you're specializing in?

Dr. Clements:
Sure. So, I'm from the city of Philadelphia. I went to college near here. I went to medical school at Temple, and I practice now in the city. Our practice kind of focuses on all types of psychiatry, anything from mood disorders, anxiety, attention issues, psychosis and, of course, addiction. It's myself and a physician's assistant, and we work together to try to make it easy for patients to get access to psychiatric care where maybe there were barriers there beforehand.

Dr. Johnson:
So, let's turn to addiction. What trends have you been seeing in your practice, and what are some therapies that you've been implementing to treat different types of addiction, such as gaming, which we're very interested in, and, of course, opioid, which is on the rise?

Dr. Clements:
Yes, so when we talk about trends, I think it's hardly a week goes by that there's not an article on the front page of a newspaper about the opioid epidemic, overdose deaths; but really, in a practical manner, we are seeing in our practice more and more people struggling with addiction, people coming in with anxiety, depression, and then halfway through the appointment kind of opening up and saying that they have got a problem with alcohol or they have got a problem with stimulants or with opiates. We actually are getting a lot of people who are referring family members for things like gaming addiction. When we talk about kind of the overarching

way that we diagnose and assess addiction, a lot of people kind of have an “aha moment” that maybe a child of theirs, a niece, a nephew or a sibling may be struggling with an addiction to screens, a gaming addiction. But when we’re talking about therapies for addiction, the one that I’m most excited about right now is in the treatment of opioid addiction. We’re implementing a new medication called Sublocade. I should say that I’m not affiliated with the company at all before I start talking about it. But we are using this shot. It’s a once-a-month subcutaneous shot that treats opioid addiction with a time-released Suboxone, and it’s been just fantastic in our practice, and our patients are absolutely loving it. Yes, so that’s kind of the newest medication that we’re excited about at our practice.

Dr. Johnson:
And I know you’re also implementing some alternative therapies, such as biofeedback and genetic testing. When and how do you implement these treatment strategies into the care of your patients?

Dr. Clements:
When patients come in for treatment, I think the most important thing is a therapeutic framework. It doesn’t matter if you’ve got the right medication. It doesn’t matter if you’ve got access. If the patient doesn’t feel like they’re engaged in their care, it’s very hard to see good outcomes. And really, we’re talking about quality of life when we’re talking about treatment plans with patients. These 2 tools, genetic testing and biofeedback, we use to kind of reinforce that relationship. With the genetic testing, a lot of patients can feel like they kind of had medications thrown at them without much explanation, especially when they’re being treated in the context of addiction. We know that when patients present with alcohol withdrawal and stimulant withdrawal or intoxication, they can have symptoms that can be diagnosed as bipolar, schizophrenic, depressed, anxious, but days and weeks go by, and as they have had some sobriety, their presentation changes dramatically. When we use genetic testing, we talk about how our bodies metabolize the medications and how certain medications can be more effective or less effective as a result, so we take the guesswork out of some of these prescribing practices and recommend that we start with the genetic testing, and patients feel like they’re being treated as a person, that they’re individually being taken kind of as a whole patient, and then we go forward. The great thing is then they have that with them for the rest of their lives. I can’t tell you how many of my patients that have told me they have used this genetic testing material at other physicians when they move or go to different providers, and they absolutely love having the information.

The biofeedback is also very exciting. We know that mindfulness-based therapies work very well. The data shows that they are a great therapy modality when we’re talking about anxiety, depression, attention issues. And in my opinion, addiction is just a symptom of kind of a larger issue, whether that’s interpersonal relationships, conflicts with family or issues with anxiety, depression. But one of the issues with mindfulness is it’s hard for people to buy in. Meditation, mindfulness, Yoga breathing, is something that we teach, but it’s hard for people to do the homework. Biofeedback offers an opportunity for us to directly have a connection with the patient where they have assigned work they do at home. Right now we use a real-time Bluetooth EEG and a heart rate monitor that connects to their phone and then goes directly to our servers. We partner with a company called NeuroFlow to streamline that whole process, and the patients love it because we can see in real time kind of how they’re doing, how often they’re meditating, how often they’re doing their Yoga breathing and then how well they’re doing. Then the patients can also see that... We’ll talk about things like trauma or anxiety, and we’ll watch the patient’s heart rate go up, we’ll watch the patient’s EEG change, and then through mindfulness techniques watch it come down again. Technology is playing such a big part in our practice, and the results we’re seeing is patients staying engaged, patients staying longer in treatment, and really reinforcing that therapeutic framework, the foundation of good treatment.

Dr. Johnson:
Can you just tell us a little more about that? We know about heartbeat monitoring with your Smartphone from everything, Fitbit and all those other apps, but how does it do the EEG monitoring? How is that carried out?

Dr. Clements:
Sure. So the hardware is called Muse, M-u-s-e. I think it’s been around for about a year. The company NeuroFlow took the hardware and synced it through Bluetooth to this great software package. It monitors, I think, 4 waves. It’s got a band that goes

around the forehead and tucks behind the ears, and it's in real time. The data that it gets vary. It's an interesting thing, because they are still working on the data to correlate certain patterns to things like anxiety, depression, and kind of being stimulated or not as much. And so from a research perspective or kind of a standard of care, we don't pitch it to our patients as if your delta wave looks like this, then you're going to be less depressed, but what we do show is that when a patient is anxious, when a patient is activated, there's a lot of activity going on. When the patient is calmer, taking deeper breaths, slowing down their heart rate, turning on their parasympathetic nervous system, their brainwave readings start to calm down, the amplitudes get lower, and it's a way to reinforce, again, the deep breathing—which we know at the end, mindfulness therapies themselves work, and this is kind of a tool to reinforce those therapeutic modalities.

Dr. Johnson:
And I'm just guessing, but, I mean, maybe younger people are more into this and more receptive to it because, number 1, it's in real time, and number 2, it's electronics, which they understand.

Dr. Clements:
Absolutely. The name of the game when it comes to therapy is engagement. If someone can do their therapy on their cell phone with a piece of hardware that they put on and they can see in real time their results of the work they're doing, my patient population really engages with that, whereas doing homework, writing down their notes, bringing them to your appointment, I don't have much success with that. So I'm not even just talking about younger patients. Across all age groups this has been a great kind of boon for our engagement from our patients. The other thing is, a lot of times patients feel like with their psychiatrists, they see them once a month, they see them every 3 months, that's it; you don't really know much. With us you get mood questionnaires, anxiety depression questionnaires, weekly. We see your trending work in terms of the biofeedback. And then when we meet, we've got all this material to discuss. It really is a great kind of reinforcement of that relationship that we prioritize in our treatments.

Dr. Johnson:
I could see that. So tell us a little more about your decision-making process, how you chose what therapy for what patient? Two people could be the same age, have the same type of addiction, but I imagine your approach might be totally different to engage them.

Dr. Clements:
Absolutely. You know, when we talk about the standard of care for certain addiction treatments, I'm not someone who says that you have to do it one way or the other. When it comes to things like opiate use disorder, alcohol use disorder, we have to prioritize maintenance medications. I think the data is there, that if we don't at least inform our patients about the dangers of abstinence-based-only therapies, we're not practicing the standard of care, but some patients are able to engage in more complicated therapies than others. We always start with supportive therapy, establishing that therapeutic framework, and then we work from there. Not every patient needs genetic testing. If this is your first antidepressant or first medication, we don't usually do that. I've got my own medications I like to start with, but a lot of times when we see patients, they have been through a couple of psychiatrists already, and it's important that we find the right treatment plan for them. Again, I think that specifically when it comes to addiction, one of the things that we prioritize at our practice that I learned when I was a fellow at University of Pennsylvania is the difference in abstinence-based treatment versus managed medications and trying to break the stigma of medications like Suboxone, Vivitrol and methadone.

Dr. Johnson:
For those of you just joining us, you're listening to the Clinician's Roundtable on ReachMD. I'm Dr. Shira Johnson, and today I'm speaking with Dr. David Clements about the various management approaches to addiction that are new to the field.

We spoke a bit earlier about diagnosing and managing these patients, but now I'd like to talk about an unfortunately common part of recovery, which is relapse. How do you deal with that, and how do you prepare your patients for it?

Dr. Clements:

I think one of the first things that I bring up when we start treatment, especially if this is the first time someone is entering treatment, is that relapse is an unfortunate reality of recovery. Even when I'm talking to patients, especially when I'm talking to patients using tobacco products, to talk about kind of the compulsion and the ritual of addiction when it comes to smoking, that these are difficult things for us to break, difficult patterns for us to break. With opiates, the use of opiates, use of any kind of drug of abuse, there's a hijacking of a system that's tens of thousands of years old. It's an evolutionary system that has told us to eat steaks instead of pine cones. We get pleasure out of certain things, but the reason is because it's what kept us alive. Unfortunately, in this modern age these drugs of abuse hijack that system and trick our brains into pushing to consume those. So to let someone know that relapse is a part of their recovery is practicing good medicine, but the next part of that is preparing for relapse, and that's where when we talk about programs that treat using only abstinence-based treatments, that's where there's an issue, because when someone relapses off of any substance like opiates, we're talking about overdose, we're talking about death. Especially with some sobriety, their tolerance goes down; they're more susceptible to the overdose. A dose that used to get them "well" now can kill them.

Dr. Johnson:
I guess any addiction could be life-threatening, but opiates in particular. When you first meet with clients or their family, do you try to prepare them that they could slip, and if they slip and fall, they will get up again; it's part of the process? But maybe they don't want to hear that when they start treatment, so how do you address that?

Dr. Clements:
Absolutely. I think one of the hardest conversations that I have with families and one of the most objectively necessary conversations is about Narcan. When a patient comes into my office, I always prescribe them a Narcan rescue kit whenever they leave, which is a... Narcan is an intranasal rescue medication for an opiate overdose. And I try to stress the importance of patients coming with their family. And when you talk to a family member and you're explaining to them how to save their family member's life using this medication, it's not just about the procedure of putting the Narcan into someone's nose and pushing the button. It's about understanding the severity of the situation. A lot of the way that addiction thrives is in secrecy, and I've found that when people are in active addiction, more often than not they're isolated, people around them don't know the whole story of their issues, and once you start to do things like involve family members and explain to them that relapse is a reality and one that we have to prepare for because the consequences are so great, there is certainly a breakthrough period where there's a lot of conflict and emotion—that all in all I think it makes for a much better outcome because you have more than one set of eyes on what's going on.

Dr. Johnson:
But I'm sure there are other times when you have patients that don't have that type of a support system, correct?

Dr. Clements:
Unfortunately, that's usually the norm. A lot of times addiction is a symptom of something of a bigger issue, and psychosocial isolation can be a huge cause. A lot of people are left alone, whether they're on the street or alone in terms of being ostracized by their family or alone—they have lost their job or whatever it is. Unfortunately, not everyone has the support of a loved one to work through their recovery, and that's when it gets very complicated, and that's where we look towards things like recovery houses, group therapy, encouraging participation in any kind of recovery program, whether it's AA, NA. Avoiding isolation is one of the things that I stress to my patients, and actually, that's in any of my treatment plans. One of the questions I always get when I start treatment with a patient is, "How will you know when I'm doing better?" And an easy answer would be, "Maybe your depression screener scores will be lower." But really, the one that I found that holds true for almost all my patients is we'll be talking about real interpersonal interactions that you're having on a day-to-day basis. We'll be talking about real relationships that you're having. And as the number of those real relationships increases, the likelihood is you're going to be improving in terms of your mood, in terms of your addiction. Most of mental illness, I believe, thrives in isolation.

Dr. Johnson:
We all have these patients in our practice or in our life and in our families. Is there any final thoughts you'd like to share with our listeners in our audience in terms of things to watch out for, successes you've had, any take-home points? There's a lot of

information out there on this, but you sound like you're very experienced, and you must have had some good successes—as well as there's always some bad outcomes. What would you want to tell to our audience?

Dr. Clements:
Absolutely. I would say that the illness of addiction is not an isolated issue, and there's always something going on, either around the person or had happened to the person or is happening to the person, and I think the best thing you can do for a loved one or someone that you want to help is to show empathy any way you can and try to understand what they're going through. It's not just about the substance that they're using but about a bigger issue in their life. When we're talking about identifying risk factors, one of the biggest ones that I've consistently seen is isolation. When someone is not making appointments, when someone is not speaking with family, when someone is hard to get a hold of, more likely than not there's something wrong, so I would say that encouraging people to look for treatment—there's more and more treatment programs that are practicing the standard of care— encouraging people to use maintenance medications. Abstinence-based treatment we found does not work. With opiates, only 5% of people can stay sober for 6 months in abstinence-based treatments. When you add Suboxone, it goes up to 40%, 50%. These things we have to encourage and end that stigma of isolating people who struggle with addiction.

Dr. Johnson:
Those are some great thoughts for us to keep with us as we come to the end of today's program. I want to thank my guest, Dr. David Clements, for joining me to discuss new techniques and approaches to addiction that we as physicians can use to help stop this nationwide health crisis.

Dr. Clements, it was great having you on the program.

Dr. Clements:
Thank you so much for having me, Dr. Johnson.

Dr. Johnson:
I'm Dr. Shira Johnson. To access this and other episodes, visit ReachMD.com where you can Be Part of the Knowledge. Thank you for listening.