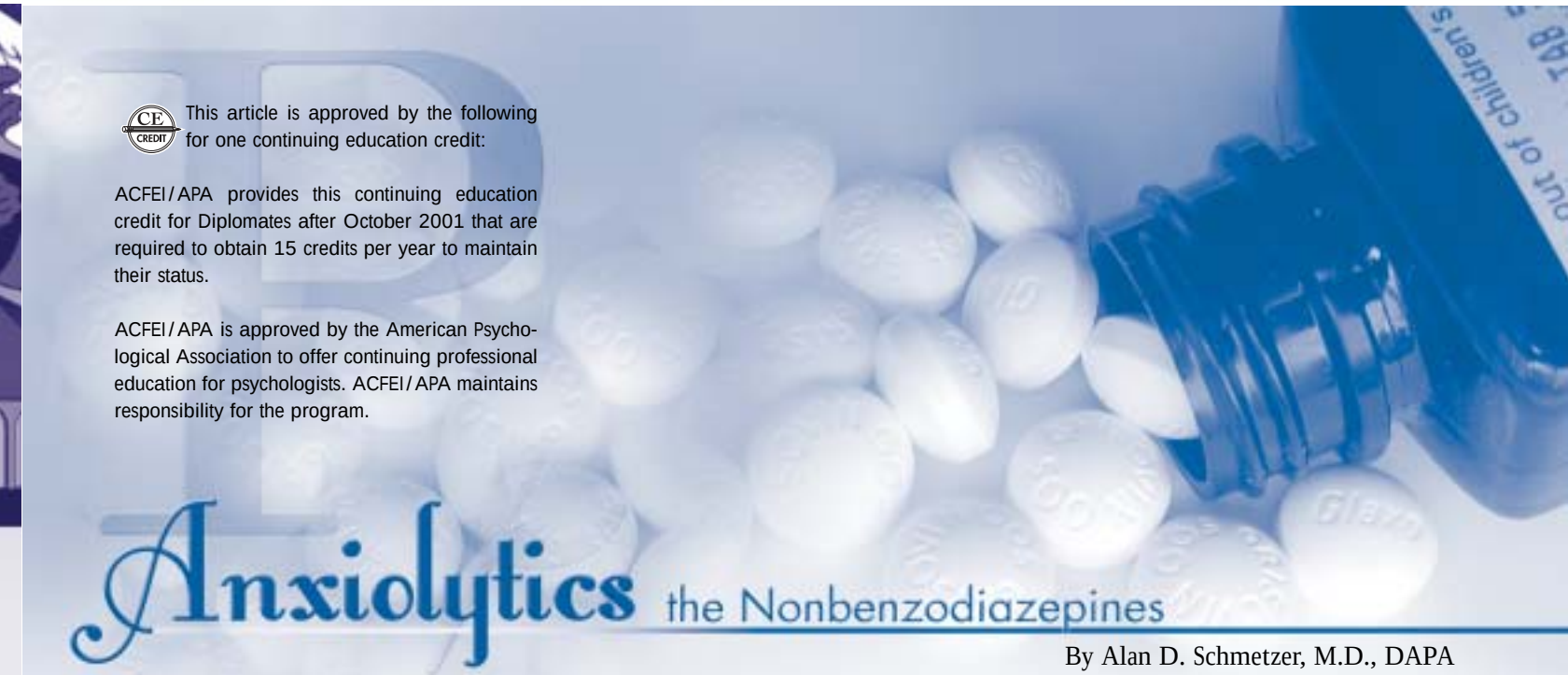

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Anxiolytics the Nonbenzodiazepines

By Alan D. Schmetzer, M.D., DAPA

Besides the antidepressants and benzodiazepines described in previous "Primer of Prescription Medication" articles, there are additional medication approaches that may augment psychotherapy for anxiety disorders. The first of these we will discuss is buspirone (BuSpar™). BuSpar is an azaspirone and does not directly affect the gamma-aminobutyric (GABA) system as the benzodiazepines do, nor does it block reuptake of serotonin like the antidepressants. It acts as a partial agonist at the serotonin type 1-A receptor in the brain and has minimal effects on any other organ system. It was superior to placebo and equal to the benzodiazepines against which it was tested in pre-marketing trials. Among its benefits, BuSpar does not decrease alertness, which is rare among anxiolytics. Second, it has very few clinically significant interactions with other medicines, although it can raise the serum level of haloperidol (Haldol™) and should not be used within a two-week period of monoamine oxidase inhibitors (MAOIs).

Most importantly, BuSpar does not cause tolerance or withdrawal and is not significantly addicting. The drawbacks, however, are equally numerous. It takes two to three weeks to work, and usually the dose must be started low and gradually increased to prevent nausea and restlessness. Because of its short half-life, it should be given three times a day. It is approved by the Food and Drug Administration (FDA) for only one type of anxiety, generalized anxiety disorder, which is probably not the most common form of anxiety. There are also those who claim the medicine does not work at all. This may be partly because patients who are switched from benzodiazepines do not feel the sedation that they are accustomed to with their usual anxiolytic, and they stop taking the medication before it has a chance to work. BuSpar has also been used as an adjunct to antidepressants for augmentation in treatment-resistant depressions and to antipsychotics for reduction of agitation, with some success. It is being tested in children as a possible treatment for attention deficit/hyperactivity disorder.

There are multiple medicines useful to some patients with severe anxiety. Antihistamines such as hydroxyzine (Vistaril™ and Atarax™) can be useful for some anxious patients. Vistaril is frequently used in emergency rooms for hyperventilation. The effect of antihistamines tends to diminish over time, which limits usefulness in chronic anxiety states. Hydroxyzine is used in chronic itching, and various antihistamines are used for acute allergic reactions. Medicines from this family, such as diphenhydramine (Benadryl™), can be used for insomnia. Antihistamines are often used to decrease the extrapyramidal side effects of the antipsychotics. Histamine receptor type 2 (H2) blockers are also useful in gastrointestinal disorders such as ulcers. Side effects may include sedation, dizziness, decreased blood pressure, urinary retention, dry mouth, blurred vision, constipation, and restlessness. The antihistamines are not particularly addicting, which is another potential advantage.

Introduced in 1903, barbiturates were the first effective tranquilizers. Phenobarbital, butabarbitol (Butisol™), and secobarbital (Seconal™) were commonly used as anxiolytics and sedatives until the benzodiazepines became available. Although many barbiturates still have

FDA approval for these indications, they are rarely used today except when patients do not respond to the safer treatments. Intravenous methohexital (Brevital™) is used as a short-acting anesthetic for procedures such as electro-convulsive therapy (ECT). Barbiturates are still occasionally used as anti-epileptics. These medicines have a low therapeutic index; the therapeutic dose is near the toxic dose. They can cause a general decrease in alertness, worsen depression, and can be addictive. Their use in addictive withdrawal has also decreased because they can be deadly when combined with alcohol or other CNS depressants. Meprobamate (Eqanil™ and Miltown™) is very similar to the barbiturates in most respects.

Finally, beta-adrenergic blockers such as propranolol (Inderal™) are used for anticipatory anxieties, such as pre-test anxiety and the “jitters” that public speakers sometimes have. This is not an FDA approved indication; these medicines are primarily used for cardiovascular disorders. When used for anxiety, the major side effects include excessive decreases in heart rate and blood pressure.

References

Kaplan, H.I. and Sadock, B.J. *Synopsis of psychiatry* (8th Edition). Chapter 35.3.2, pp.973-978; 35.3.4. pp. 982-985; 35.3.5, pp. 985-989; and 35.3.9, pp. 1004-1006. Williams & Wilkins, 1998.

Physicians desk reference (56th Edition). Medical Economics Company, 2002.

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The End of FRIENDSHIPS

By Irene Rosenberg-Javors

Several of my clients have been dealing with the subject of friendship; in particular, the end of long-term friendships. After years of being friends, my clients report that what was thought of as a "forever" friendship has become empty and repetitive. They ask me if everyone gets to this place with their old friends.

I think that this is an excellent and thought-provoking question. I look at my friendships and I realize that many of my "old friends" are not central to my present life. I think about our times together with great nostalgia, but the truth is they are not actively involved with me in the here and now. We send e-mails and birthday and holiday greetings, but we hardly see each other. Yet, in my interior universe these friends occupy front row seats.

What is this all about?

Somewhere along the way the proverbial steam went out of the friendship. Whatever attracted us to each other—interests, work, shared problems—unglued, so to speak. We moved on. We became involved with other people and things. We became less neurotic and less attracted to people and situations that fed our neurosis. We matured and no longer found our shared jokes funny or entertaining.

We have different needs and wants, but it is very difficult to let go of these "old friendships." We hang on to them long after we have let go of the actual people. I think that we do this in order to avoid experiencing the death of the friendship. We keep the relationship alive within our inner world. There is no loss, hence there is nothing to grieve.

My experience tells me that it is very important to recognize that some friendships do not go on forever. We need to recognize these as losses and allow ourselves time to grieve and mourn their passing. By doing so, we make space for ourselves to understand and integrate the meaning of these relationships into the narratives of our lives. This helps us to make room for new people and experiences.

As we develop and grow in self-awareness, we find ourselves attracted to different people. We change. We make new friends. Mary Oliver, in her wonderful poem, "The Journey," describes the process of letting go:

But little by little,
as you left their voices behind,
the stars began to burn
through the sheets of clouds,
and there was a new voice
which you slowly
recognized as your own,
that kept you company
as you strode deeper and deeper
into the world.....

This "new voice" will lead you forward to new people and places. Listen to her, she is your new best friend!

Reference

Oliver, Mary. “The Journey.” Roger Housden, ed. *Risking Everything*. Harmony Books, 2003, pp. 39-40.

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