

## Methadone as a Mood Stabilizer

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TO THE EDITOR: The positive effect of opioid agonists in psychotic disorders has repeatedly been hypothesized. Methadone has been noted as interfering positively with depressive affects and psychotic rage (3); buprenorphine has been considered for its antidepressant activity (2).

We report a case in which methadone seems to have a role in the treatment of a bipolar mood disorder.

Mr. A was admitted to a methadone maintenance treatment program (MMTP) at age 26, after three years of heroin addiction. Upon intake he exhibited major depression (according with DSM-III-R), with anxiety, guilt and suicidal thinking, which subsided within 10 days of treatment with methadone (50 mg/day). The MMTP, lasting three years, was interrupted because of six months' incarceration for old crimes. Mr. A was readmitted to a MMTP two months after release, relating his heroin-relapse to a new depressive episode begun while in prison. Major depression was again ascertained, subsiding only with methadone treatment (40 mg/day).

After four years of heroin-free MMTP (morphinuria-results confirmed), Mr. A requested detoxification, as he had the chance to commute impending imprisonment for a therapeutic community programme. After a complete medical and psychiatric evaluation, detoxification was started and accomplished within 7 days of in-patient treatment with clonidine and benzodiazepines. At discharge, the patient started feeling extraordinarily well, attractive and successful. This status evolved rapidly into mania (according to DSM-IV), with euphoria, insomnia, delusions and hallucinations. Over the next two months the patient was repeatedly hospitalized and treated with neuroleptics and benzodiazepines. While euphoria, delusions and hallucinations subsided, restlessness, nervousness and insomnia increased. There were rapid mood shifts from dysphoria to depression, and suicidal thoughts appeared. Mr. A started stating that only methadone could give him relief. A mixed status was diagnosed (according to DSM-IV), and treatment started with lithium and carbamazepine (serum concentration were 0.70 mEq/L and 9.5 µg/mL, respectively), as well as clonazepam and clotiapine (6 and 80 mg/day, respectively). After one month without improvement, Mr. A came to the service,

claiming heroin use in the preceding three days in order to be allowed to re-enter the MMTP. After toxicological urinalysis confirmation, he was re-accepted into the programme and medicated with methadone (30 mg/day). In a few days his mood improved, and anxiety, insomnia and dysphoria subsided. This improvement continued with the increase of the daily dose to 50 mg. Upon follow-up, two months later, his mood was stable and the urine samples were consistently morphine-free. The patient was still taking methadone (50 mg/day), clotiapine (40 mg/day), lithium and carbamazepine (serum concentrations were 0.65 mEq/L and 9.4 µg/mL, respectively).

The improvement of depression and psychotic symptoms in patients on methadone has been previously reported (3), as has the existence of psychosis during methadone detoxification (1); thus methadone appears to share some characteristics of mood stabilizers like lithium or carbamazepine.

Our case seems to confirm the mood-stabilizing effect of methadone. Our patient spent a total of seven years in methadone maintenance and only one year out of it, both polarities of mood disorder being concentrated within this short period of time and resolved rapidly on re-entering the MMTP. Thus methadone may have played some role in preventing mood disorder relapses.

### **References**

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