ORIGINAL RESEARCH

Patients' Anxiety Levels and Their Reactions Towards the Needed Adaptation of Policies in Methadone Maintenance Treatment Following the October 7th, 2023, Hamas Attack

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Background: A war state followed the October 7th, 2003, Hamas vast attack on civilians and military in the southern part of Israel, requiring an immediate adaptation of the routine functioning of the methadone maintenance treatment (MMT) clinics – typically, through the expansion of the take-home dose (THD) policies.

Aim: To evaluate the level of anxiety and its relation to patients' satisfaction regarding THD expansion one month post-attack.

Methods: Of the 320 current patients in one MMT clinic, 297 (92.8%) were interviewed for anxiety (GAD-7) and rated whether the THD expansion benefited them (1 to 5). Substance in urine, sociodemographic, and addiction history details were taken.

Results: Of the participants, 35% were found to have no anxiety, 22.2% with mild, 21.9% with moderate, and 20.9% had severe anxiety. Logistic regression for anxiety found cocaine in urine and not opioids in urine (Odds Ratio (OR) = 3.6), history of having experienced physical violence (OR = 1.8), and not working (OR = 2.1) as risk factors. THD expansion benefited (scored ≥ 4) 82.2% of the responders, and in logistic regression for severe anxiety, not satisfied with THD expansion (OR = 2.9), being Israeli born (OR = 2.1), and not working (OR = 2.5) were included. Substance use did not change pre- and post-Hamas attack.

Conclusion: Most patients were satisfied with the THD expansion. However, severe anxiety levels characterized those who were not, emphasizing the need for anxiety monitoring to determine those patients. Additional intervention and augmenting these patients' frequency of visits to the clinic (instead of THD expansion) is recommended so they have further meetings with their therapist and reduce their anxiety.

Keywords: anxiety, methadone maintenance treatment, take-home dose, satisfaction

Introduction

On October 7, 2023, Hamas launched a vast attack on civilians and military in the southern part of Israel. The casualties of the attack were over 1,200 deaths, over 9,000 injured, and 251 persons abducted into Gaza. Most were civilians, including many children and the elderly.[1] The attack was accompanied by the continuous launch of thousands of missiles covering an extensive part of the country. The state of war that was declared required an immediate adaptation of the routine functioning of the methadone maintenance treatment (MMT) clinics – and an expansion of the take-home methadone doses (THD) regulations was made possible nationally by the Israel Ministry of Health (like that done previously during the COVID-19 pandemic lockdowns).[2,3]

Normally, individuals with opioid use disorder in MMT need to drink while being supervised on their medication daily in the clinic. The privilege to be trusted and be granted take-home medications in MMT is the hallmark of the contingency management positive reinforcement approach for motivating patients to discontinue the abuse of illicit and

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non-prescribed drugs.[4] Achieving THD may help patients lead a normal lifestyle; the more THD achieved, the more normal the daily routine.[5,6] MMT patients are highly critical of the limited access to take-home doses and the consequent need for daily or near-daily clinic attendance.[7] In addition, they report that not having to attend the clinic daily frees energy and resources to tend to other responsibilities and enhances engagement by increasing satisfaction and motivation.[8] Based on these studies, it can be assumed that most of the patients would be satisfied to get THD (without having to "work" for it), it was questionable whether patients who get THD, not as a result of their efforts, are satisfied; moreover, it is unclear whether, at a chaotic non-regular traumatic circumstance such as the war, it was the right action to take. Moreover, even patients who were satisfied to receive THD may retrospectively find it differently.

The rationale for this study was to examine patients' attitudes toward the clinic's THD policy and their mental anxiety levels. We have chosen to study anxiety since it is one of the most observed mental health problems in opioid use disorder.[9] Based on systematic review and meta-analyses, among people with OUD, the prevalence of current anxiety was 29.1% (95% CI: 24.0–33.3%), and lifetime anxiety was 27.2% (95% CI: 22.8–31.5%). It was higher among women (39.2%, 95% CI 28.2–50.2%) vs. men 24.7% (95% CI 17.0–32.4%). Within MMT, anxiety was found to be related to poor sleep quality,[10] to use cannabis,[11] and in a study of 177 mmT patients, the level of anxiety inversely correlated with their quality of life.[12] One previous study in a war in 2009 in Israel examined the distress of patients in MMT[13] and found an association between levels of exposure to war events and anxiety levels. A report of the war in Ukraine also leads to changes in methadone treatment provision[14] and, the Ukraine war influences treatment policies and leads to meaningful changes in THD regulations.[15] However, while it is important to assess the impact of such changes on patients' satisfaction during the war, no such study was reported.

This study had two objectives: (1) to assess patients' levels of anxiety a 1-month post-attack, during the nationally stressful ongoing war, which is characterized by missile attacks on the population, and (2) to examine the patients' satisfaction following THD policy changes, which occurred because of the war. We hypothesized that patients in MMT will report higher anxiety levels at a time of war and that patients will report higher satisfaction levels following expansion changes in THD policy.

Material and Methods

All participants provided written informed consent. The study was approved by the Tel-Aviv Sourasky Medical Center (TASMC) Institutional Review Board (IRB) ("Helsinki Committee" Protocol no. 07–111).

Study Population

The MMT Clinic is part of a large tertiary university-affiliated medical center in Tel Aviv, Israel, accredited by CARF International. It treats up to 330 patients who meet criteria similar to those of the USA Federal Regulations for entering methadone treatment (ie, DSM-IV-TR criteria of dependence with multiple self-administrations of heroin per day for at least one year). Characterization, demography, and clinic effectiveness have been reported elsewhere.[16] Of the 320 current MMT patients and a few temporary guests who evacuated from north Israel, 297 (92.8%) were interviewed between November 7 and December 7, a month following the Attack by their therapist. Sociodemographic, addiction history and clinical variables were taken from their chart. The reasons for the 23 who were not studied were: seven were hospitalized, six were cognitively impaired, four refused, three left, and three were missed for technical causes. The not studied group differed from the others, specifically had higher proportion of patients with cocaine (56.5% vs 21.3%, p < 0.001) and opioids (26.1% vs 10.1%, p = 0.03) in urine, fewer were working (23.8% vs 50%, p = 0.02), more living alone (87% vs 63.1%, p = 0.02) and fewer with children (43.5% vs 66.2%, p = 0.04), with no other differences (data not shown).

Questionnaires

GAD-7 for anxiety (GAD-7)[17] was used. The questionnaire rated the frequency of existence of seven aspects over the last 14 days, between not at all (0) and every day (3) (see response distribution for each item in Box 1). The GAD-7 severity score is calculated by adding the response (0–3) for the seven questions. GAD-7 score severity ranged between 0 and 21 and was stratified into four severity categories: 0–4 no anxiety, 5–9 mild, 10–14 moderate, and 15–21 severe anxiety.

Box 1 Response Distribution n (%) of Each of the GAD-7 Item

| GAD-7 Items	0 (Not at all)	1	2	3 (Every day)
Feeling nervous, anxious or on edge	78(26.3)	73(24.6)	43(14.5)	103(34.7)
Not being able to stop or control worrying	124(41.9)	51(17.2)	53(23.0)	68(23.0)
Worrying too much about different things	90(30.4)	54(18.2)	57(19.3)	95(32.1)
Trouble relaxing	150(50.8)	55(18.6)	40(13.6)	50(16.9)
Being so restless that it is hard to sit still	171(58.0)	51(17.3)	35(11.9)	38(12.9)
Becoming easily annoyed or irritable	129(43.4)	71(23.9)	46(15.5)	51(17.2)
Feeling afraid as if something awful might happen	120(40.4)	47(15.8)	55(18.5)	75(25.3)

Satisfaction from the THD expansion was rated between no (1) and very much (5) by two separate questions, with the same meaning, but from two directions, about what benefited or harmed them. "Rank your level of agreement (1 not agree and five very highly agree) on the following sentences: 1. THD at the current period benefits your condition 2. THD at the current period harms your condition. For each question, the response was divided into "No" less agree (rank 1–3) and "Yes" highly agree (rank 4–5).

Additional Information

Sociodemographics, addiction history, and trauma history were taken from patients' charts, which include updated information (working, living in a couple or alone, having children, etc).

Urine Tests

Throughout the entire length of MMT, around two observed and random urine tests are routinely taken during one month for the detection of opiates, cocaine metabolite (benzoylecgonine), benzodiazepines (BDZ), cannabis, and methadone metabolite using enzyme immunoassay systems (DRI® and CEDIA®).[18] In addition, kits for alcohol, pregabalin, OxyContin, fentanyl, and Ritalin are tested every 3 months, and results from Dec 2023 were taken for analysis. A monthly urine test for each drug was defined as "negative" if the drug tested negative and "positive" if at least one of the tests was positive. The data of all current MMT patients between April 2023 and April 2024, 6 months pre- and post-October 7, were taken (Figure 1).
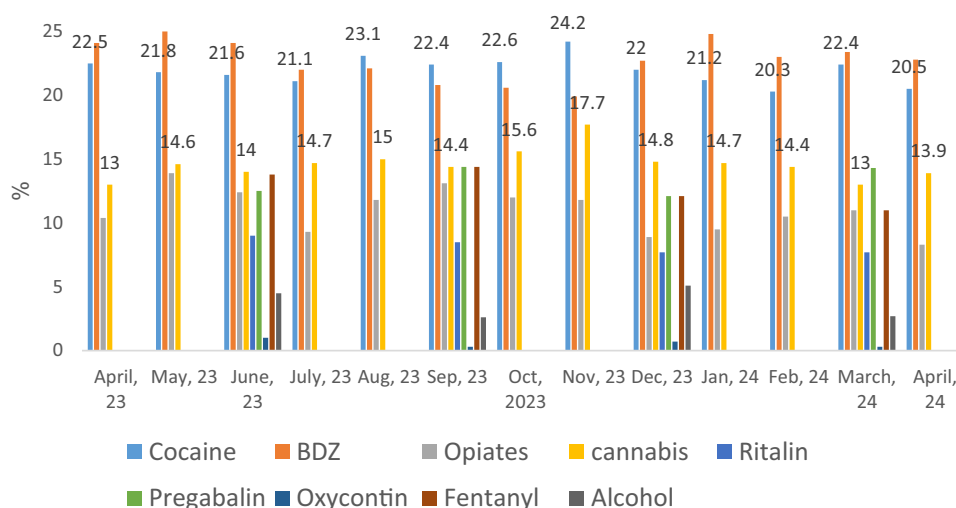
Figure 1 Monthly prevalence (%) of opiates, cocaine, cannabis, and BDZ (benzodiazepine) in urine every month, and alcohol, pregabalin, oxycodone, fentanyl, and Ritalin every 3 months.

Statistical Analyses

IBM SPSS Version 29.0 was used. A comparison of the anxiety level sub-groups and the THD benefit and THD harm categories with potential categorical covariate variables (gender, evacuated, living in a couple or alone, having children, being immigrant, working, any urine positive drug test (specifically, BDZ, cocaine, opioids, cannabis, pregabalin), history experience physical violence) we used chi-square analyses, presenting significant p-value for chi-square linear association or chi-square likelihood ratio. To compare continuous variables' potential covariates, we used ANOVA analyses (age, duration of usage, duration in MMT, education years). Chi-square analyses were also used to find a significant relation between anxiety level sub-groups and the THD benefit and THD harm categories. Logistic regression (Forward Conditional) was used to compare two anxiety group models (No vs mild to severe and Severe vs others), including variables that were significant in univariate analyses ($p \leq 0.1$) when a comparison between No vs mild to severe, and Severe vs others was done (see Tables S1 and S2). The variables are listed in the results, multivariate analyses section.

Results

Characteristics of MMT Patients

A total of 297 mmT patients, 21.9% females, aged 56 ± 10, who were admitted to MMT at age 43.5 ± 11 with a history of 20.6 ± 11.5 years of opioid use and in MMT during 10.4 ± 9.1 years, were studied.

Prevalence of Anxiety Level

Of the 297 participants, 35% were found to have no anxiety, 22.2% with mild, 21.9% with moderate, and 20.9% with severe anxiety.

Distribution of Anxiety Groups by Selected Variables (Table 1)

Anxiety levels were distributed differently by gender (Linear by linear association chi-square 4.0, $p = 0.046$); specifically, the female proportion was lower among those with no anxiety (16%) and higher among those with severe anxiety (30.6%). Severe anxiety characterized the eight patients evacuated from their homes on the northern border of Israel ($p = 0.007$). A higher proportion of severe anxiety and a lower proportion of no anxiety were observed among the Israeli-born patients ($p = 0.035$). A similar pattern was observed in not working patients ($p < 0.001$), in those whose urine tested positive for any substance ($p = 0.048$), particularly BDZ ($p=0.002$), and in those who experienced physical violence ($p = 0.018$).

Satisfaction with the THD Expansion

Most patients (82.2%) were highly satisfied (ranked 4 or 5) with the THD expansion, while 51 were less or not satisfied (scored 1–3). One of the eight evacuated persons (12.5%), compared with 84.2% of non-evacuated patients, were highly satisfied with the THD expansion ($p < 0.001$). No other covariate variables were significantly related to satisfaction with THD expansion (data not shown). Nine patients (3.1%) highly agreed (scored 4 or 5) that the THD expansion harmed them. These groups were comparable with the other patients by any tested variables (data not shown), except for a history of experienced physical violence, which was reported by 89.1% of them (n = 8) as compared with only 38.1% of the other patients ($p = 0.003$).

Anxiety and Satisfaction with the THD Expansion (Table 2)

The severe anxiety group had the lowest proportion (66.1%) of satisfied patients, compared with above 80% of the no anxiety, mild, and moderate subgroups ($p = 0.004$) (Table 1). No significant association was observed between the level of anxiety and the proportion of patients who reported that THD expansion harmed them.

Multivariate Analyses (Table 3a and b)

A forward conditional logistic regression model comparing no anxiety (GAD-7 scored < 5) and mild to severe anxiety (GAD-7 scored 5–21) including in model sex, evacuated, working, any substance in urine, BDZ, cocaine, opioids, and experienced physical violence (see Table S1), found cocaine in urine (OR = 4.2, 95% CI 1.4–12.6, $p = 0.011$), no opioids

Table 1 Level of Anxiety by Potential Covariate Variables

	N (%)	No 0–4	Mild 5–9	Moderate 10–14	Severe 15–21	P value*
Gender						**0.046**
Female	65(21.9)	17(16.3)	15(22.7)	14(21.5)	19(30.6)	
Male	232(78.1)	87(83.7)	51(77.3)	51(78.5)	43(69.4)	
Evacuated						**0.007**
Yes	8(2.3)	0(0)	2(3.0)	1(1.5)	5(8.1)	
No	289(97.7)	104(100)	64(97)	64(98.5)	57(91.9)	
Age (y)	56±10	56±9.8	56.5±10.5	55.3±9.9	56.4±10.2	0.9
Opioid usage (y)	20.6±11.5	21.1±11.5	21.1±12.9	19.0±10.3	20.9±11.0	0.6^
Duration in MMT (y)	10.4±9.1	9.4±8.3	12.7±10.0	10.9±8.5	9.3±9.6	0.09^
Living way						0.9
Alone	185(63.1)	63(60.6)	45(69.2)	40(62.5)	37(61.7)	
In couple	108(36.9)	41(39.4)	20(30.8)	24(37.5)	23(38.3)	
Children						0.4
Yes	190(66.2)	72(69.9)	43(67.2)	36(57.1)	39(68.4)	
No	97(33.8)	31(30.1)	21(32.8)	27(42.9)	18(31.6)	
Immigrant						**0.035**#
Yes	117(39.4)	39(37.5)	31(47.0)	31(47.7)	16(25.8)	
No	180(60.6)	65(62.5)	35(53.0)	34(52.3)	46(74.2)	
Education (y)	10.2±3.0	10.3±2.9	10.3±3.1	10.4±3.2	9.6±2.6	0.3^
Working						**<0.001**
Yes	148(50.0)	66(63.5)	31(47.7)	31(47.7)	20(32.3)	
No	148(50.0)	38(36.5)	34(52.3)	34(52.3)	42(67.7)	
Any drug						**0.048**
Yes	115(38.7)	32(30.8)	27(40.9)	28(43.1)	28(45.2)	
No	182(61.3)	72(69.2)	39(59.1)	37(56.9)	34(54.8)	
BDZ						**0.002**
Yes	59(19.9)	11(10.6)	14(21.2)	16(24.6)	18(29.5)	**0.013**#
No	237(80.1)	93(89.4)	52(78.8)	49(75.4)	43(70.5)	
Cocaine						0.1
Yes	63(21.3)	16(15.4)	17(25.8)	14(21.5)	16(26.2)	
No	233(78.7)	88(84.6)	49(74.2)	51(78.5)	45(73.8)	
Opioids						0.056
Yes	30(10.1)	16(15.4)	6(9.1)	3(4.6)	5(8.2)	
No	266(89.9)	88(84.6)	60(90.9)	62(95.4)	56(91.8)	
Cannabis						0.5
Yes	48(16.2)	13(12.5)	13(19.7)	13(20.0)	9(14.8)	
No	248(83.8)	91(87.5)	53(83.0)	52(80.0)	52(85.2)	
Pregabalin						0.09
Yes	34(12.1)	11(10.7)	3(4.9)	10(16.4)	10(18.2)	
No	246(87.9)	92(89.3)	58(95.1)	51(83.6)	45(81.8)	
Experienced physical violence						**0.018**
Yes	106(39.3)	29(30.5)	21(34.4)	34(54.0)	22(43.1)	
No	164(60.7)	66(69.5)	40(65.6)	29(46.0)	29(56.9)	

Notes: *Chi-Square Linear-by-Linear Association #Chi Square Likelihood Ratio ^ANOVA, Statistical significance (p<0.05) is presented in Bold.
Abbreviations: BDZ, benzodiazepine; THD, take home doses.

in urine (OR = 8.5, 95% CI 2.4–29.7, p < 0.001), experienced physical violence (OR = 1.8, 95% CI 1.0–3.1, p = 0.041), and not working (OR = 2.5, 95% CI 1.4–4.5, p = 0.011) to characterize patients with mild to severe level of anxiety. (Hosmer & Lemeshow test, p = 0.9) (Table 3a).

Table 2 Level of Anxiety by Benefit and Harm with THD Expansion

	N (%)	No 0–4	Mild 5–9	Moderate 10–14	Severe 15–21	P value*
Benefit Yes No	 235(82.2) 51(17.8)	 84(83.2) 17(16.8)	 57(89.1) 7(10.9)	 55(88.7) 7(11.3)	 39(66.1) 20(33.9)	**0.004#** **0.033**
Harm Yes No	 9(3.1) 277(96.9)	 2(2.0) 99(98.0)	 1(1.6) 63(98.4)	 3(4.8) 59(95.2)	 3(5.1) 56(94.9)	0.2

Notes: *Chi-Square Linear-by-Linear Association #Chi Square Likelihood Ratio. Statistical significance (p<0.05) is presented in Bold.

Table 3 Logistic Regression Models for Anxiety (a) and Severe Anxiety (b)

	Odds Ratio	95% Confidence Interval	P value
a. Anxiety			
Cocaine in urine	4.2	1.4–12.6	0.011
No opioid in urine	8.5	2.4–29.7	<0.001
Experienced physical violence	1.8	1.0–3.1	0.041
Not working	2.5	1.4–4.5	0.011
b. Severe Anxiety			
Israeli born	2.4	1.2–4.6	0.013
Not working	2.4	1.3–4.5	0.007
Not satisfied with THD expansion	2.8	1.4–5.5	0.003

Similar findings were observed in a model that included interaction between opioid and cocaine; cocaine-positive and opiate-negative (OR = 3.6, 95% CI 1.2–10.7, p = 0.024), experienced physical violence (OR = 1.9, 95% CI 1.1–3.2, p = 0.025), and not working (OR = 2.3, 95% CI 1.3–3.9, p = 0.003). (Hosmer & Lemeshow test, p = 1).

A forward conditional logistic regression model comparing severe anxiety (GAD-7 scored 15–21) to all others (GAD-7 scored 0–14) including in model sex, evacuated, Immigrant or Israeli born, working, BDZ, and satisfied from THD (see Table S2), found being an Israeli born (OR = 2.4, 95% CI 1.2–4.6, p = 0.013), not working (OR = 2.4, 95% CI 1.3–4.5, p = 0.007), and not satisfied with THD expansion (OR = 2.8, 95% CI 1.4–5.5, p = 0.003) to be more likely be with severe level of anxiety. (Hosmer & Lemeshow test, p = 0.4) (Table 3b).

Changes in Substance Usage Pre- and Post-October 7 Attack

The monthly prevalence of substance usage 6 months pre- and post-October 7 showed no significant changes (Figure 1). However, the proportion of patients who tested positive for cannabis and cocaine was the highest in November 2023 (one month after the attack). Specifically, 17.7% tested positive for cannabis, and 24.2% tested positive for cocaine.

Discussion

This study aimed to examine patients' attitudes toward the clinic's THD policy and their mental well-being. Our first central finding was by our first hypothesis, reporting that 65% of the MMT patients suffer from anxiety, while one-fifth (20.9%) of the MMT patients suffer from severe anxiety. This finding corresponds with the finding of another study conducted in Israel during a military conflict in 2009 in which 17.6% of the patients reported high anxiety levels, and about 32% of the patients reported acute anxiety levels.[13] A possible explanation for this finding is that there is a robust increase in anxiety during war, especially in war-affected regions.[19] This explanation is supported by the findings of a recent study among a nationally representative sample of Israeli citizens (Jews and Arabs), which indicated a high increase in anxiety levels one month after the 7th of October 2023.[20]

The second central finding of the current study is that anxiety is associated with unemployment, cocaine use, not using opiates and a history of physical violence. The association between anxiety and a history of having experienced physical violence was already found among patients in MMT, both males and females.[21] A study of 625 patients from several MMT clinics found that individuals with a lifetime of only physical trauma were over three times more likely to endorse lifetime anxiety, and individuals with lifetime physical and sexual trauma were over 5 times more likely to endorse lifetime anxiety than those with no trauma history.

Unemployment was also associated with severe anxiety levels, and this finding corresponds with studies among the general population,[22] as well as among MMT patients. In a cross-sectional study among several MMT clinics in China (n = 1300) during the COVID-19 pandemic,[23] using Zung's anxiety self-rating scale (SAS), the prevalence of anxiety was 18.4% (95% CI = 16.3, 20.5), close to our prevalence of severe anxiety. As we found, employment status (p < 0.01) and positive results for the urine drug test (p = 0.04) were associated with anxiety in a multi-level mixed model.

Cocaine use was also associated with reporting any level of anxiety. Although cocaine has been shown to produce aversive anxiogenic effects,[24] some patients report calmness and tranquility following cocaine use.[25] Notice that no anxiety was reported if cocaine was accompanied by opiate, as well as opiate only.

Additional variables that related to anxiety in the univariate analyses included female gender, being evacuated, and being Israeli-born. In a previous study of MMT patients during a military conflict in Israel, women reported higher anxiety levels in comparison to men.[13] Similar gender differences in anxiety levels were found in studies in war zones across the world.[26]

Severe anxiety levels were also found among a few temporary guest patients who were evacuated from north Israel, and this finding is not surprising since evacuation during war is associated with high anxiety levels.[27] Thus, these findings are anecdotal due to their small number, and we could find no reports of such events among patients receiving MMT.

Not working was also found to characterize the severe level of anxiety in multivariate analyses (OR = 2.4) together with being Israeli-born (OR = 2.4) and not satisfied with THD expansion (OR = 2.8).

The second objective of this article was to examine the patients' satisfaction following THD policy changes that occurred following the war. We found that most patients (82.2%) were satisfied with THD expansion and highly agreed that it benefits their condition. This finding concords with our second hypothesis, and it is not surprising, particularly in a war situation with a risk of a possible missile attack.

Moreover, in normal situations, THD is a privilege, and serves as a positive reward, and patients "work" to achieve these privileges (drug abstinence, work or study, normative behavior), and getting them is at the base of the contingency management that helps discontinuation of drugs for which there is no medication. With satisfaction, such a provisory THD expansion was already done among our patients during the COVID-19 pandemic lockdowns.[2] However, anxiety was not tested then.

Currently, as the multivariate analyses found, those who were not satisfied with THD expansion were more likely to have severe anxiety. Notice that THD expansion, by definition, involves less contact with the clinic, which directly reduces personal psychosocial treatment, group therapy, and other interactions with clinic personnel, physicians, nurses, etc. Of the 17.8% of patients not satisfied with the THD expansion, most were unhappy with reducing their contact with the clinic services, primarily the in-person meetings and psychotherapy sessions, as well as other interactions with staff, but we did not explicitly ask why they were not satisfied. Importantly, nine patients highly agreed that their condition highly deteriorated because of THD expansion. Notice that eight of them experienced a history of physical violence. Thus, for these individuals with a history of physical violence (and we cannot exclude their current condition) being "confined" at home may be a seriously harmful condition, more than the fear of a possible missile attack while on their way to the clinic. We cannot exclude other reasons that may be involved, like social interaction with other patients, the need to go out and feel like there is no war, etc.

Interestingly, the prevalence of substance use did not change over 6 months post-attack compared to 6 months pre-attack among our MMT patients. This contrasts with the situation in the general population in Israel, where a dramatic increase in anxiolytic medication consumption was reported,[28] as well as an increased rate of anxiety, depression, and PTSD one-month post-attack as compared to 2 months before.[20] This may reflect a well-known phenomenon of

individuals with mental problems that cope better during general severe crisis trauma events, when "everybody is stressed out", and it becomes "the norm", they (the patients) do not stand out as "different".[29–31] Yet another possibility is that when facing a severe (potentially life-threatening) external crisis, many people manage to "recruit forces" and cope, breaking down only later once the danger has decreased.[32,33]

Limitations

The satisfaction of patients from THD was determined by a novel, reliable, but not validated assessment tool. An additional limitation is that we did not explicitly ask the reason for contributing or deteriorating. We must keep in mind that patients may be satisfied for other reasons, such as the possibility of diverting the THD or feeling "free" to manage their time without the need to visit the clinic daily, or for unrelated reasons, especially patients who have not yet gained any THD privileges. Our finding was limited to those who were studied and missed a small (7.2%) proportion of non-participants for various reasons, who may present severe anxiety as fewer of them worked.

Conclusions

There was a high increase in the anxiety levels of the patients following the war, but most of them were satisfied with THD expansion. However, those who were not were characterized with severe anxiety levels, emphasizing the need for anxiety monitoring to determine those patients. Additional intervention and augmenting these patients' frequency of visits to the clinic (instead of THD expansion, within the limits of reality) are recommended so they have additional meetings with their therapist and reduce their anxiety.

Data Sharing Statement

Data availability will be given upon personal request.

Ethics

The study complies with the Declaration of Helsinki.

Author Contributions

All authors made a significant contribution to the work reported, whether that is in the conception, study design, execution, acquisition of data, analysis, and interpretation, or all these areas; took part in drafting, revising, or critically reviewing the article; gave final approval of the version to be published; have agreed on the journal to which the article has been submitted; and agree to be accountable for all aspects of the work.

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Disclosure

None of the authors have any conflict of interest.

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