**Anxiety Disorders Transcript.**

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**Dr Ian Collings. Consultant Psychiatrist & Honorary Clinical Senior Lecturer, Swansea Bay UHB; HEIW Medical Deanery Director of Medic Professional Support & Development.**

0:01 **Chair**: Good afternoon, everybody, and welcome to our live webinar on anxiety disorders. This is Ian’s third webinar for us. Ian is a Consultant Psychiatrist with Swansea Bay University Health Board. I shall hand over to him to tell us all of his expertise on anxiety disorders. Thank you, Ian.

0:30 **Speaker**: Thanks very much, Nicola, and thank you for inviting me. I'm sure you're getting tired of me doing these webinars. I won’t come back for a while, I promise, and thank you for taking the time over your lunch hour to log in and discuss anxiety disorders with me. As Nicola said, know I'm more than happy to take any questions at the end or to discuss any scenarios that you may have. I understand as GPs you probably face quite a lot of challenges in supporting people with anxiety disorders. Mostly because of the lack of access to psychological therapies, which obviously first line treatment for all of the anxiety disorders and something I will be talking about later when we speak about treatment of anxiety disorders. And you will notice the title of my presentation today is Anxiety and Fear Related Disorders, and I want it to be up to date and precise with terminology. And this is what ICD 11 now refers to these types of disorders. Of course, if you look at ICD 10 and go to the mental and behavioural disorders section, look for anxiety, you wouldn’t see anxiety disorders listed anywhere. You'll see neurotic disorders, stress related disorders and somatoform disorders all lumped together. I think neurotic neurosis is quite a pejorative term in some ways, and I'm glad in ICD 11 they've changed the terminology and brought the terminology up to date and talk about anxiety and fear related disorders. And I will be speaking about those disorders today during the presentation.

2:40 **Speaker**: But let's start with the question and a poll, if we may, just to get your grey cells working. A 24 year old man attends your surgery after having a number of panic attacks in the preceding three months. He has had them in a variety of contexts, including at the local supermarket and in a busy town centre. He's also had them at home. At the times of the panic attack he believes he's going to die. He gets very sweaty and feels his heart racing. These episodes usually last 20 to 30 minutes and have no apparent trigger. Now this is the traditional presentation of a panic disorder type picture, where individuals suffer panic attacks in a range of context. There aren't specific triggers unlike the panic attacks that may be associated with the other phobic anxiety disorders, there aren't specific triggers in panic attacks. But because individuals have panic attacks in a wide range of contexts, in the future they start to avoid those contacts and their life becomes increasingly more restricted because of that.

But let's talk about treatment. This is a gentleman presenting for the first time with a probable diagnosis of panic disorder. What is the most appropriate first line treatment for this man?

1. Venlafaxine
2. Active monitoring.
3. Psychodynamic psychotherapy.
4. Referral to secondary mental health services

4:30 **Speaker**: So we have a poll and be grateful if you could answer what you think the most appropriate first line treatment is for this young man with panic disorder.

4:46 **Speaker**: OK, so the large majority of you have suggested active monitoring. So thank you for that. That is correct. That is what the NICE guidelines for panic disorder suggest. I mean, active monitoring alongside some signposting to self-help resources alongside some advice may be around if there is use of substances, perhaps or caffeine; alongside some advice around exercise and mindfulness and yoga is an appropriate first line treatment for this man. So you're absolutely correct. Well done.

5:39 **Speaker**: So what are we going to talk about today? Well, I'm going to talk about the range of disorders that fall under the category of anxiety and fear related disorders in ICD 11. And I'm going to talk about the symptoms and touch on the epidemiology. I also want to give you an overview of some of the aetiological factors involved in the development of these anxiety disorders. And I suppose, more importantly for you on the call, I want to talk about the pharmacological and psychological management of these disorders. And I thought also, although I’m an adult psychiatrist, I thought it would be helpful thanks to a colleague of mine who gave me some advice, I thought it would also be helpful to briefly touch upon issues related to anxiety in children and young people, and how you might approach these issues in children and young people, and what kinds of criteria you may consider before making the referral to child and adolescent mental health services. If you take nothing away from today's talk, I would like you to take away the fact that it is absolutely first line treatment to consider psychological therapy over pharmacological therapy for the management of anxiety disorders. However, there are a number of caveats to that, not least availability of appropriate resources, and which I will talk about when we talk about more detail in terms of treatment.

7:24 **Speaker**: So these are the main disorders listed under this category in ICD 11: anxiety and fear related disorder. It's these disorders and these on the second slide. And I just thought it would be helpful just to give you an overview of what each of these disorders are.

And rather than sort of bombard you with slides, I thought it was just helpful to briefly talk about each of these disorders in turn.

8:01 **Speaker**: So what is generalised anxiety disorder? Well, generalised anxiety disorder is a condition characterised by excessive worrying about normal day-to-day things, a range of different contexts the individual can worry about. It's often referred to as free-floating anxiety, and the individual just feels generally anxious, tense, you know, has some muscle rigidity, worries about normal day-to-day things. I notice a hand has gone up that I'd be grateful if I could take questions at the end, if possible. So that is what generalised anxiety disorder is. It's often characterised by this general low level anxiety, free floating anxiety. Sometimes people have initial insomnia, whereby they find it very difficult to get to sleep because there are worries going around in their head and they just can't switch off. So that's generalised anxiety.

8:53 **Speaker**: Panic disorder we've already spoken about in the scenario I've just shared with you. And this is where individuals have panic attacks. These panic attacks, and I'm sure and if any of you have ever had a panic attack you know what I'm talking about, these panic attacks are generally short lived. They usually last around 30 minutes, but they're actually brought on in panic disorder by no identifiable trigger. And, you know, panic attacks are quite scary for the individuals who experience them. They get all of those physical symptoms of anxiety and the psychological symptoms of anxiety as well. So their heart is racing, they have butterflies in the stomach, they may get tingling, they may get sweating. And of course, in their mind, their catastrophizing. So that is the sort of predominant sort of thinking pattern that's going on in their mind during a panic attack. I'm going to die; I'm going to lose control. And generally to people who feel or having panic attacks, they do believe they're going to die. To be diagnosed with panic disorder you need to have been having panic attacks every week for a period of at least a month. And the important thing is they're not triggered by anything in particular. So as I've already said, they can happen in all types of contexts.

What happens in the future is, once you've had a panic attack, in one particular context, like a supermarket or a town centre, you worry that you can have a panic attack going into those places again and you avoid them. This is the overwhelming defence mechanism that people have in anxiety disorders - avoidance; avoidance of the thing that causes the anxiety. And of course, this then perpetuates the anxiety and reinforces the anxiety and people with panic disorder avoid increasing context. And obviously that kind of narrows their lives.

10:55 **Speaker**: Agoraphobia is a condition. Well, ‘agora’ is an ancient Greek word, meaning sort of gathering together and also means sort of marketplace. And so agoraphobia is literally Greek for fear of the marketplace. And what actually we mean by that is people with agoraphobia fear leaving their homes. They fear travelling away from home. They fear busy, crowded places. You can often have agoraphobia with panic disorder. So what will happen is individuals in busy places leaving home will have panic attacks, but the context is very specific. And that's why we can define it as agoraphobia, fear of the marketplace, crowded places, travelling away from home.

11:53 **Speaker**: And of course, you have a whole range of specific phobias ranging from, you know, phobia of snakes to phobia of needles with a whole range of different, quite discrete phobias in between. And the whole point of specific phobias is the phobia only arises with a particular, well-demarcated trigger. If you like an associated with a specific phobia, you get anticipatory anxiety. So you get worried and anxious when you think about the fact that you may be exposed to the particular thing the phobic about. And for a lot of people, specific phobias are not particularly limiting of their lives because they don't frequently come across the thing that triggers the phobia. For example, phobia of snakes - it's not something you come across every day in the UK. However, if you have a phobia of pigeons, for example, as I once had a patient who did, that potentially is quite life restricting and life limiting because pigeons are all over the place. So it’s a very specific trigger to individuals with specific phobia.

13:12 **Speaker**: And then there's social anxiety disorder called so in ICD 11 (it used to be called social phobia). Social anxiety disorder is where the trigger for anxiety and panic type symptoms is social situations. So there’s scrutiny. So public speaking, for example, is one of the contexts that individuals may experience social anxiety disorder or eating with friends, for example, or being in crowded situations with people you know. These can be triggers for social anxiety. That sort of scrutiny being watched, being looked at, being judged by other people kind of triggers the anxiety associated with social anxiety.

14:01 **Speaker**: For the next two disorders, this is where ICD 11 (I know probably it's not particularly important to know this, but I find this quite interesting) departs slightly from ICD 10 because the next two disorders are disorders of childhood and adolescence. In ICD 10 these are actually categorised in their own separate category of childhood and adolescent disorders. However, because they're fuelled really by anxiety and trigger anxiety, in ICD 11 they're categorised in this main category of anxiety and fear related disorder.

So separation anxiety and is found in children when they are separated from their primary caregiver, be that parent or guardian and they experience anxiety symptoms. And this is related to attachment. Some of the theories postulated by Bowlby and his theory of attachment. Children suffer anxiety and excessive anxiety. I mean, it's normal. And just to caveat that, it is normal for children to experience anxiety in a wide range of contexts. And we mustn't pathologize that necessarily. So it is normal for children to feel anxious when they go to a new school that is not the same as separation anxiety. Separation anxiety occurs when there's any separation from the primary caregiver. And the anxiety response is marked and exaggerated, and hence we can diagnose a separation anxiety disorder.

15:38 **Speaker**: Moving on to selective mutism. This is a condition where a child has normal language, absolutely normal language, and will speak absolutely normally and communicate normally in home circumstances, perhaps. But often they will stop talking when they're at school. And again, this mutism, this failure to talk in a school context, and it most often happens in a school context, is fuelled by anxiety and symptoms.

So all categories of anxiety disorder in ICD 11 as are a whole range of substance induced anxiety disorders. You name it, that is a diagnostic criterion for substance induced anxiety sort of ranging from caffeine to alcohol to illegal drugs like cocaine, amphetamine, cannabis, volatile substances like glue sniffing, ketamine - all have categories of substance induced anxiety. And that's why it's really important to rule out in individuals presenting with anxiety type disorders for the first time. Rule out the use of substances because that will be the first line thing that an individual needs to address if they're suffering from anxiety as a relation to a range of substance misuse disorders.

17:20 **Speaker**: Hypochondriasis is a pejorative term. I prefer to talk about health anxiety. People with hypochondriasis or health anxiety can have good insights into the hypochondriasis or have poor insights. Clearly, people with health anxieties worry that they have something seriously wrong with them. Life threatening or serious illness. And they will check themselves regularly and they will seek reassurance regularly and they will research – you know they'll go on the internet, checking symptoms, they'll come to doctors like yourselves regularly. And that is a classic health anxiety picture.

18:04 **Speaker**: And then you have the final catch all really secondary anxiety disorder particularly if individuals have chronic physical health conditions that trigger anxiety, then it's likely that it's the physical health condition that is triggering those anxiety symptoms. So these are the main categories of anxiety and fear related disorders in ICD 11, and hopefully, I’ve given you a nice overview of each of those.

18:32 **Speaker**: So what's the difference between normal anxiety, that we get in a wide variety of contacts at all ages, and pathological anxiety? Well, the difference is that people with anxiety disorders often have very severe and protracted anxiety that is very much out of context with the individual context they're in. It's normal to feel anxious when public speaking, meeting people for the first time. But when the anxious anxiety leads to full blown panic attacks, or it's very prolonged and marked, that it becomes pathological. And as you know, as I've already alluded to, there is a range of physical and psychological symptoms of anxiety. And, you know, physical symptoms can affect all parts of your body really related to anxiety. And then there are the ongoing psychological symptoms - lack of control, fear of losing control, fear of dying, catastrophizing, those kinds of thinking patterns that are going on inside someone's mind when they're suffering from anxiety.

19:50 **Speaker**: Common anxiety disorders. About 18% of people in most studies will suffer from an anxiety that at some point in a year and that rises to nearly a third of people, will suffer from an anxiety disorder at some point in their lives. So, you know, they're by far the most common of the mental disorders. And no doubt you know, there's probably not a day that goes by where you don't see some form of anxiety disorder coming through the door into your surgery. And often for many of the anxiety disorders that are often two prevalence peaks. So you get a first prevalence peak in childhood and adolescence, and then you get a kind of reduction in prevalence and then you get another peak then in the age 40s-50s. Generally women are more susceptible to anxiety disorders than men and that applies to all anxiety disorders that I've listed. I’ve put OCD in there. OCD is not characterised or categorised as an anxiety disorder. However, anxiety is one of the main symptoms of OCD, though you do have a unique set of psycho pathology as well in terms of the obsessions and the compulsions. OCD has an equal prevalence in men and women. But generally for all the anxiety disorders I've listed today apart from OCD, they have a higher prevalence in females over males. I'm not going to talk about OCD. I could talk about OCD today. I could talk about all of the stress related disorders like PTSD and complex PTSD and all the somatoform disorders as well. But unfortunately, I really wouldn't have the time to address those today. So perhaps that's a webinar for the future.

21:52 **Speaker**: I quickly want to touch on aetiology before I move on to treatment. Just to remember that when we think of aetiology as psychiatrists, we like to think of aetiology in terms of predisposing, precipitating and maintaining factors. So predisposing factors are the factors that make this person get ill compared to the next person. What is it in them that has predisposed them to get this condition compared to the next person? Precipitating factors is related to the factors that make the individual ill now, as opposed to next week, next year or in ten years’ time. And the maintaining factors are those factors that prevent the person getting better once they have the illness.

22:39 **Speaker**: And I thought I'd helpfully put this into a slide. And generally these aetiological factors apply to most of the anxiety disorder. Where a particular factor applies more to a particular anxiety disorder, I've put it in brackets afterwards. If we think about predisposing factors (and I'm not going to dwell on this slide because I'm not sure it's a particularly relevant I'm sure your keener to hear about treatment) clearly there is a genetic predisposition for all of the anxiety disorders. If you have anxiety disorders running in the family, if you have first degree relatives suffering from anxiety disorder, you are more likely to suffer from anxiety disorders yourself. However, the aetiological force would be less because there's often a lot more of a multifactorial element to anxiety disorders than perhaps schizophrenia or autism or bipolar disorder, for example. But still, there is a genetic aetiology.

And then there's some sort of neurotransmitter predisposing factors as well. And really, the main evidence for the neurotransmitter hypothesis with regards to the aetiology of anxiety disorders is the fact that we use drugs that affect these neurotransmitters to treat anxiety disorders. So GABA, as you know, is the main inhibitory neurotransmitter system in the brain and actually benzodiazepines or pregabalin or agonists are through GABA pathway and therefore potentiate that inhibitory system in the brain. So dampens things down in the brain. And again, with neurotransmitter and 5HT, the majority of our SSRIs and our SNRIs, our serotonin and noradrenaline reuptake inhibitors have an effect by causing inhibition of reuptake of noradrenaline in 5HT and work and help people with anxiety disorders. I will talk more about the pharmacological management of anxiety disorders later on.

25:03 **Speaker**: So these are clearly important biological predisposing factors. What about psychosocial predisposing factors? Well, the first one is very important because this is where we get CBT from. Proposed by Aaron Beck and who's a psychiatrist in America. In fact, you know, I think he's about 100 now Aaron Beck, and he's still an Emeritus Professor of Psychiatry at Stanford University. And he was the first to propose the cognitive behavioural model, which underpins where he started with mood disorders and moved to anxiety disorders. But basically, what do we mean by the cognitive behavioural model? Well, we all have thoughts, feelings and behaviours, and each fuels the next. Our thoughts fuel our feelings, which fuel our behaviours and typically in people with anxiety disorders, they have maladaptive thinking patterns whereby they overestimate the risk, perhaps from a particular context or trigger, and underestimate their ability to cope with that particular context or particular trigger. That in itself leads to abnormal thinking patterns, catastrophisation, for example, which leads to abnormal feelings, the physical symptoms of anxiety and then the behaviours associated with those feelings, which are often avoidance. As I've already said - what you do when something frightens you, is the flight response and that is often the case in anxiety disorders. And this is the way we treat anxiety disorders through CBT. We try to overcome that avoidance. We get the individuals suffering from the anxiety, so to confront the trigger. We do things like graded desensitisation, for example, where an individual with support from the therapist, but also learning techniques to manage their anxiety relaxation techniques, for example, face increasingly sort of stimulating this. So for example, if you have a spider phobia, it starts off with a picture of a spider and eventually, after a stepwise progression, could end up with spider on your hand. And that is the treatment of the cognitive behavioural therapy approach to the treatment of anxiety disorders. And that's what Aaron Beck postulated, that people with anxiety had these maladaptive ways of thinking which fuelled their anxiety.

27:33 **Speaker**: Childhood trauma is particularly associated with panic disorder later on in life. If you've got an individual who is generally just an anxious person, has an anxious personality or has dependent personality where they rely on others to make decisions, you're more likely to develop anxiety disorder later on in life. Parenting - anxious parents lead to anxious children and we'll talk about your approach to that later on. I've struck through, as you can see, Freud's theory of unconscious conflict. I'm not going to go into it in detail. But Freud suggested that anxiety arose from the conflict associated between the ID, the ego and the superego. Those theories are very much defunct now, but interesting, nevertheless. And then this is really interesting theory related to preparedness - Seligman Preparedness Theory. Seligman proposed that as a species evolutionarily we are hardwired to fear certain situations and certain triggers and those certain situations and certain triggers potentially could end the species. So, for example, evolutionary when we were roaming the Great Plains of Africa, probably all snakes and all spiders would quite easily kill us. And therefore we are now hardwired to fear those situations because ultimately, if we didn't run away from those situations, and it could mean the end of our species. And that's what Seligman proposed when he speaks about the preparedness theory. Very interesting. If you're interested in that, I would commend that to you.

In terms of precipitating factors for anxiety disorders, physical illness is known to precipitate panic disorder, and life events generally can precipitate a range of anxiety disorders, particularly panic and generalised anxiety disorder. In terms of perpetuating factors comorbidity, physical and mental health problems could maintain or perpetuate anxiety disorders as can of substance misuse. In terms of psychosocial perpetuating factors - avoidance is the big one. And that's what we want to try and deal with through the cognitive behavioural therapy. As is family and friends colluding with the individual that has anxiety. (I’ll talk a bit about that later in another case) As can social isolation - that can perpetuate and reinforce the avoidance that you get with anxiety disorders. So that's just an overview of the aetiology of anxiety. So let's hope you find that and helpful.

30:27 **Speaker**: Let's talk about another scenario if we may. A 42 year old woman who suffers with agoraphobia has failed to respond to online CBT and guided self-help. She's becoming increasingly reclusive and finds it impossible to leave the house, as she frequently has panic attacks. The thought of leaving the house fills her with dread and panic. Her family do everything for her, get her shopping, prescriptions, etc. And this is the point - the family are colluding with her here. They may think they're doing good by her and doing things in her best interest, but actually they're reinforcing the issue themselves. They're reinforcing the issue of her not leaving the house. But anyway, this is the case, and she's now requesting medication for her difficulties because nothing else has worked.

31:18 **Speaker**: What is the next appropriate treatment option

1. Amitriptyline
2. Duloxetine
3. Sertraline
4. Olanzapine
5. Moclobemide

So we are going to have another poll now. So if you could answer, that would be great. We'll have a minute quickly for that.

Excellent. Well, you didn't need me to come along today to the talk about anxiety because it would absolutely be Sertraline. Generally, Sertraline is cited in the NICE guidelines as first line treatment first line pharmacological treatment for the range of anxiety disorders that we've got NICE guidelines for anyway. It's safe, it's tolerable and has very few interactions and it's cheap and all the rest of it. So actually it's a very effective antidepressant. So, well done.

32:18 **Speaker**: OK, let's talk about treatment now of anxiety disorders in the next 10 to 12 minutes. Let's start off with some general approaches/key messages for the treatment of anxiety disorders. NICE guidelines often speak about a stepped approach to care, don't they? Whereby primary care is responsible for sort of recognition and sort of lower level interventions, guided self-help, CBT, pharmacological management and as the condition becomes progressively worse or treatment resistant or is associated with functional impairment or is associated with risks then you go up the steps in terms of referral to more specialist sets. And ultimately, although, it is quite rare for people with anxiety to be admitted to hospital, that is an option. It's always important, clearly because I've already spoken about the aetiological factors, to assess for any co-morbidity. And as I said, the take home message is psychological treatments should be offered as first line, though that's not always easy is it, because of our access to psychological therapy? However, there are a number of caveats to that. If the condition is so severe that, well, actually a person would not be able to engage with psychological therapy because psychological therapy is hard and involves commitment over a fairly significant period of time. 16 to 18 sessions of CBT, for example, involves homework, involves confronting your fears. So, you know, if a person has such a severe anxiety disorder or they just don't want to do it, they don't want to do psychological therapy, then you'd obviously consider pharmacological therapies first line. And also, as with in many areas of the UK, it depends on availability of appropriate services as well.

34:33 **Speaker**: The second key message that I probably like you to take out today is first line generally is SSRI. Plump for Sertraline. As I've said, it's the least likely to cause side effects and most tolerable. However, it is so important to advise people you start SSRIs on or SNRIs on, that anxiety can initially increase. As in some cases, suicidality, particularly with those antidepressants that have the shorter half-lives. That's why we don’t use Paroxetine or Seroxat anymore because it has just such a terribly short half-life and causes discontinuation symptoms. But generally, anxiety can increase initially. And I think as long as you tell your patients so that they're aware that can happen, I think generally they're able to tolerate SSRIs.

35:25 **Speaker**: So we only have NICE guidelines for generalised anxiety disorder and panic disorder and social anxiety disorder currently. But I would say generally that the guidelines for, you know, particularly GAD and panic disorder holds true for all the anxiety disorders, excluding those ones in childhood and adolescence. Selective mutism and separation anxiety – there is obviously a different approach to those conditions in child and adolescent than in adults with panic disorder or GAD.

36:07 **Speaker**: So let's talk about the approach to generalised anxiety disorder now. And again, you know, we talk about a stepped approach within primary care. It's about recognition and assessment and it's about education and treatment. And this is where, you know, active monitoring can be really important because actually people through their lives will have waves of anxiety related to personal contexts, life events etc. And in the majority of patients that will settle once that individual perhaps is adjusted to that context or have gotten over that life event. So actually active monitoring is a perfectly acceptable approach. What NICE doesn’t say and what I would recommend and what charities like MIND recommend is exercise, meditation, yoga, aromatherapy - some of those of the complementary therapies. Not homeopathy, but those sort of complementary type things can actually be very helpful in some people. I mean, it's not for everybody but exercise, meditation can be helpful in some people to distract themselves from their thoughts, slow their thinking down. They can be really helpful interventions. And that's how I would approach first presentations of mild anxiety disorders and mild generalised anxiety disorder. If that hasn't worked and the active monitoring and those other suggestions haven't really helped, it's then you would suggest a sort of low intensity psychological therapy, guided self-help and self-education. And I will list a number of useful and guided self-help resources that you can use at the end.

38:00 **Speaker**: What is guided self-help? Well, all of those guided self-help books (but remember, there are apps as well these days) are basically underpinned by the CBT model. So they use elements of cognitive behavioural therapy to kind of support that guided self-help book. And I will list a whole range of books for you later on that you could recommend to patients, including some books for children.

But these are particularly useful apps recommended by the NHS and these are called ‘thrive’ which is a kind of an app that has a variety of exercises and strategies that you can follow; ‘worry tree’ is more of a sort of anxiety diary that you can use, and the ‘stress and anxiety companion’. All very helpful apps that have been very positively evaluated by patients with anxiety disorders and are free apps. Some of them have these in app purchases, but generally these are free. And I will talk about a range of books later on for all anxiety disorders.

39:09 **Speaker**: The whole point of CBT, just to reinforce what I said before with regards to Aaron Beck, it's about changing this cycle. Individual's anxiety disorders have these sort of abnormal thinking patterns; these maladaptive patterns of thinking often centred around catastrophe, catastrophisation. This is going to happen. It's a catastrophe. That leads to the anxiety feelings themselves. Physical symptoms of anxiety. Which leads to behaviour and avoidance, and you have to break that cycle, you have to work on the thoughts. Work on the feelings through relaxation techniques. This is where the cognitive and behavioural bit comes - cognitive behavioural therapy. And work on the behaviour, by getting the individual to confront the things that could trigger the anxiety.

40:00 **Speaker**: Moving on to this stepped approach to the generalised anxiety disorder. If the guided self-help or the low level psychological interventions haven't worked then a referral for CBT, perhaps to the local primary mental health support services, or where we would think about pharmacological treatment. And if it gets to step four, where you have people who are very severely anxious, who are risky, who have stopped looking after themselves/leaving that house, then obviously it's then what you need to think about a specialist intervention referral to CMHT for more complex treatments.

40:38 **Speaker**: What about drug treatment for GAD? Plump for Sertraline, that’s first line. You can have an SNRI Duloxetine and Venlafaxine is second line. Although remember they can increase anxiety and suicidal thoughts, you just need to be cautious with that and really review fairly regularly too. So NICE guidelines suggest that if a patient doesn't respond to these two types of drugs, then you might want to offer pregabalin. I'm cautious about pregabalin I have to say. I think it's the 21st century version of Valium. It's already got a street value. It's already being abused. So I would be quite cautious. We don't know the long term effects. We don't know the addictive potential. Benzodiazepines - if you're going to prescribe them, it has to be absolutely short term. I would only say a week maximum. And there's some evidence for low dose antipsychotics. But really, I would probably reserve those kinds of options to when you refer it to mental health services.

41:51 **Speaker**: What about panic disorder? Similar approach in terms of the different steps related to the treatment of panic disorder: recognition and low level interventions; some pharmacological management in primary care stepped up if it's severe or associated with risks.

42:16 **Speaker**: And again, the same principles apply - plump for an SSRI. Escitalopram or Sertraline first line. Paroxetine - I would try to steer clear actually because of its short half-life and discontinuation symptoms. And Venlafaxine is an option as well. There really isn't any evidence for any benzos or antihistamines or antipsychotics in the treatment of panic disorder. And I would try to steer clear of those drugs if possible.

42:46 **Speaker**: Social anxiety disorder. Again, first line treatment would be CBT, guided self-help; probably guided self-help because that's the most accessible of the treatments and it's underpinned by CBT principles. Go the same route with medications. Only use them if it's severe or if it's through patient choice, or if this lack of services and again, Sertraline. And it's wise sometimes to switch between antidepressants in a class as well. So if you don't get response to Sertraline, try Citalopram because actually some patients will respond to a different type of antidepressant from the same class. So it's worth considering that or switching to venlafaxine. Actually, there's some evidence as well for psychodynamic psychotherapy in social anxiety disorder. As you know, the psychodynamic therapy tends to go back and understand some of the things that underpin a person's thinking patterns in terms of early life experiences. So there's some good evidence. Of course, this is not something that is particularly accessible in Wales, not in the NHS anyway, though it is quite accessible if your patient wants to fund themselves.

44:04 **Speaker**: And again, for social anxiety disorder, SSRI first line. Second line, I would say probably say an SNRI. And even the NICE guidelines talk about monoamine oxidase inhibitors for the treatment of social anxiety disorder. I've not ever prescribed a monoamine oxidase inhibitor. You know, everyone loves talking about them. Medical schools love examining students about them because of the tyramine cheese reaction. But actually, we never really prescribe them. But that's what NICE guidelines say, and it's an option. But again, I would reserve those to specialist care.

44:45 **Speaker**: Just briefly touch, if I may, on anxiety issues in kids. Anxiety is normal and can be normal in children. You know, it's normal for kids in their second year to be anxious about strangers.

It's normal for children to be anxious when they head to a new school or move up into a different set or move to a different class. And really, we shouldn't pathologize that, because it's actually quite normal. And it's important that if you get a parent bringing in children with anxiety, that you are sure to advise the parents that they need to talk to their kids about what worries them. They're more likely to open up to their parents. Maybe in some cases they will open up to you. I mean, your responsibility could be around exploring any changes in family and social circumstances that may be triggering anxieties. Importantly, anxious parents lead to anxious children, so parents who are anxious need to try and kind of separate that and keep it away from their children because they will just feed off some of those anxiety symptoms.

45:57 **Speaker**: There are some good self-help resources for children. Young Minds is a website to help children with anxiety disorders. Just highlighted separation anxiety, as I did selective mutism, is particular anxiety disorder seen in kids. And refer to CAMHS really if self-help is not working. It's having a functional effect on school family life and friendships, or the condition is worsening. In those situations I think getting a CAMHS review is probably appropriate.

46:31 **Speaker**: So we've come to the end of my talk. Just while you’re formulating some questions, I just want to say that hopefully we've covered the main learning outcomes that I listed and at the beginning of the webinar today.

46:55 **Speaker**: Here are some self-help books that I recommend to patients. I've listed the name of the book, plus the author of the book there.

47:06 **Speaker**: These are useful books for parents and children with anxiety. I particularly like Starving the Anxiety Gremlin, that's a particularly nice book that you can use for kids and young people, so I would recommend that.

47:28 **Speaker**: And finally, there is some good resources, both on the Royal College of Psychiatrists website, particularly for parents and young children suffering from anxiety disorder. And also on MIND that give you a range of resources available for people suffering from anxiety disorders. And I would commend those things to you.

So I hope you found the information in the webinar this lunchtime useful. And thank you very much for your attention, and I'd be delighted to answer any questions you may have. Thanks very much.

48:05 **Chair**: Lovely, thank you very much Ian for a fabulous presentation. We have had a couple of questions now.

So the first one from Sylvia has said: ‘Would you ever consider Mirtazapine off-label for anxiety disorders?

48:36 **Speaker**: Yes, Sylvia, I would but the point of that is, you're right, it would be off-label. And you know, some people are anxious about off-label prescribing. It isn't licenced for any of the anxiety disorders. However, you know, Mirtazapine is very helpful for people who can't sleep very well. And if you've got someone whose main symptom is, they just can't get to sleep because they're worrying, actually that I would tailor the treatment to the individual context. And I would consider Mirtazapine as an option. So, yes absolutely, I would consider that.

49:18 **Chair**: We have a question from Razak: ‘Is there any role of Propranolol in anxiety disorders?

49:26 **Speaker**: So again, it's not a part of the treatment algorithm in NICE guidelines. However, Propranolol I appreciate is used fairly frequently but generally Propranolol only works to deal with the physical symptoms of anxiety. To sort of slow things down in the body with regards to physical symptoms. So it won't have an effect on what's going on up here. You know, it may slow the heart rate. People may not feel sort of as panicked, it may help with the butterflies etc, sort of panicky feelings in their body. But actually, it's not really going to have an impact on any of their thinking patterns. So it is an option, but I would probably plump for, if you're going to choose a medication, plump for what I’ve listed there - an SSRI as first line.

50:29 **Chair**: Lovely. Thank you. Charlotte has asked: ‘How do you manage a person with agoraphobia who cannot go out to access specialist mental health services, but is desperate?’

49:26 **Speaker**: If they've got to the point where they literally believe that Charlotte, well I would make the strong argument that a home visit is necessary for this individual. And I think if the argument is clear enough, I don't imagine there'd be many psychiatrists wouldn't do a home visit. I know it's difficult at the moment with COVID and all the rest of it. The other good thing about COVID actually, is telemedicine; we're all using these online video consultation systems now, aren't we? And actually, for somebody who's agoraphobic, can't leave the house, this could be helpful for them.

So that could be an option. However, one of the things we have to be concerned about with our patients, particularly our patients with mental health problems, is they often have a great deal of difficulty accessing these online telemedicine type services. And as a consequence, sometimes fall through the gaps. But you know, home visits or some form of telephone appointment or even a sort of video conferencing appointment could be an option. But I think that there would be many community psychiatrists who would be open to doing that.

52:19 **Chair**: Thank you. And Paul is asking: ‘Do you have a personal list of self-help apps that pass muster?

52:27 **Speaker**: Those are them, Paul. The ones I put up. And I think the ones that I've listed there. So there's the Anxiety Companion. There's Thrive and Worry Tree. These are all recommended by the NHS. If you go on the App Store and have a look. Some of them have in-app purchases, which is always a bit dodgy as far as I'm concerned, but they all have that. But they're all recommended by the NHS, and they’ve all been positively evaluated and some of the reviews would be very positive as well. So these are the ones that I would recommend. Headspace, again, is a useful app, as you know, for meditation and obviously there's plenty of apps to do various yoga type exercises that you could recommend as well. I think it's important to say to patients, you know, because sometimes I think patients will think you just fobbing them off when you say there's an app or there's a book, I think I think it's important to emphasise that actually these do work. There is evidence base for these things. They're really effective in helping people deal with anxiety disorders. And they're actually in some people more effective than medications are. I wouldn’t recommend them if they weren’t effective. Ultimately, the thing that's going to be most effective for treatment of anxiety disorder is something that delivers CBT, because CBT will get to the root of the problem, whereas medication just tends to deal with the symptoms.

54:13 **Chair**: I think this is another question that has just come in from Keiron and probably links into that. ‘Is there a single site that we can direct patients to for a collated list of self-help apps and online sites?’

54:26 **Speaker**: Probably the sites that I've recommended. I don't know if you have access to book prescriptions. Do you still do book prescriptions in general practice?

OK, well, the sites that I would recommend are the Royal College of Psychiatrists, and they have really useful pages for adults and for young people suffering from anxiety disorders as they do a range of mental disorders. And I would always recommend the Royal College of Psychiatrists and Minds as well. There's a lot of information out there on the internet as you know. Some of it's not particularly helpful. So I would recommend those two sites as a go-to first before looking at other websites.

55:19 **Chair**: Lovely. Raj has asked: ‘In the Health Pathways guidelines they mention using acute short term meds plus SSRI kick in, such as clonazepam. What are your thoughts on these?

55:32 **Speaker**: Well, short term, as I've said. Short term. I wouldn't just use benzos as a sort of, you know, a standard prescription every time I wrote up somebody for an SSRI for anxiety disorder. I would really look to review them. And I know this is a challenge and I appreciate that. But even if it's a quick telephone call, I would look to review them a few days after starting the SSRI to see if they are suffering from an increase in anxiety symptoms and if they can tolerate it. If they can't tolerate it because you've already told them that they can have an increase in anxiety symptoms and they're not bothered so much by it, then keep it like that. No need to add additional medications if you don't need to. If they are experiencing marked anxiety symptoms a couple of days in or a week in,

then by all means a week of short term benzodiazepines, a small dose of diazepam or clonazepam, I guess, would be helpful. But only for a short period of time. I think that's absolutely critical. Don't leave on a repeat prescription because it might just cause problems down the line.

56:49 **Chair:** Lovely. Thank you very much, Ian. And that appears to be the end of all the questions. We have just a lot of ‘thankyous’ for a useful the presentation coming through now. So thank you very much, everyone for attending. So we'll be signing off now by thanking Ian very much once again for a fabulous webinar on mental health issues.

57:13 **Speaker**: Thank you very much.