

Drug treatment of anxiety

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6.1 Are there really any effective medications for chronic anxiety?

Yes, but there are problems with them being used on a chronic basis. Thus benzodiazepines such as diazepam, at a low dosage, 5 mg two to three times a day, can be effective for some individuals, even though there is a technical risk of developing tolerance. Likewise, continuing low-dose antidepressants, such as imipramine or amitriptyline (e.g. 25–50 mg – or even higher doses of 100–200 mg) show little evidence of long-term side-effects. The important thing is to monitor dosage, and adjust as required, particularly as people get older, and always to consider potential psychological interventions. Chronic anxiety is discomfoting but not health-threatening, and is best dealt with by education, teaching relaxation techniques, and avoidance of stressors (e.g. excess caffeine, busy schedules). Judgements may have to be made as to upsetting the apple-cart in patients continually ‘worried’ but stable, and trying to force patients out of their (possibly cultural) limited social roles. The old Hippocratic saying ‘first do no harm’ comes to mind.

6.2 Are there effective medications for acute anxiety?

Table 6.1 lists drugs used in anxiety. Benzodiazepines, particularly those with a fast onset of action, such as lorazepam, are extremely effective and very simple to use. Every GP should carry oral and intramuscular (i.m.) preparations in an emergency bag, because acute anxiety reactions, whether in the home or at the road side after a crash, are very common. Depending on age and previous usage, 5–10 mg of diazepam orally, or 1–2 mg of lorazepam orally, or i.m. lorazepam 1–2 mg (even for psychotic illnesses) are standard treatments. Short-term usage, for several days, or for a week or two at most, while tapering off the dose, is also important so as to avoid the beginnings of tolerance or withdrawal effects. Clarifying the underlying diagnosis during this time will help with treatment afterwards, particularly if there is an on-going panic disorder. Introducing self-relaxation methods

TABLE 6.1 Drugs used in anxiety

Benzodiazepines	Diazepam, lorazepam (brief/p.r.n. courses)
SSRIs	Citalopram, paroxetine, sertraline,* venlafaxine*
Tricyclics	Imipramine, clomipramine, amitriptyline
MAOIs	Phenelzine; tranylcypromine, moclobemide (reversible)
Others	Buspirone, propranolol, hypnotics (p.r.n.), mirtazapine

* Not formally licensed for use in anxiety disorders

early, by demonstrating a technique or having an accessible psychologist, is also good management.

6.3 Why does medication so often seem ineffective?



This is not surprising since even in the best-run trials, with their nicely cooperative patients, only 50–60% improve, while about a quarter tend to drop out, whether given medication or placebo. Since ‘real’ patients, as seen by GPs (rather than by researchers) are more likely to have co-morbid disorders like depression or alcohol abuse, difficult partners or fractious children, and variable compliance, these drug trial figures should probably be halved. The nature of the condition, in itself, makes it fluctuate in response to life situations, and the problems of misdiagnosis, sensitivity to side-effects and the difficulties of dosage all contribute to this. A systematic review of treatments, symptoms, social situation and patient attitudes can be worth the time spent doing it. Not taking the tablets – or stopping after one prescription – are much commoner than is recognized.

6.4 Are there any genuinely effective ‘alternative’ medications such as herbs?

There have been numerous trials, of varying quality, of homeopathy, drugs like St John’s Wort, and a number of other substances. Looked at overall, doing better than placebo, which helps up to 30% or 40% of patients, is quite difficult, and there is no substantial proof for any one approach. Individual patients may swear by what they have received (e.g. from a ‘herbalist’ or complementary therapist), making them ‘truly grateful’, but as often as not they have responded to a longer consultation time, a sense of feeling listened to, and the active ingredient (for example in St John’s Wort). Whether smoking cigarettes, drinking alcohol, or chewing khat or betel nut, people resort to a wide range of available, minor, anxiolytics, which is why for a low-grade, up-and-down, chronic anxiety state, psychological and relaxation approaches are always worth trying.

6.5 Is cannabis helpful for anxiety?

Cannabis is probably one of the most relaxing preparations – primarily owing to its active ingredient tetra-hydrocannabinol (THC) – and is available ‘naturally’. Terms like ‘mellow’, ‘laid-back’, and ‘chilling out’, are integral to the culture of ‘weed’, ‘spliff’, ‘dope’, or what you will. In this respect it is like alcohol, certain cultural groups preferring to smoke a ‘joint’ – quaintly called a ‘reefer’ in the older literature – rather than turn to the sherry bottle. There is also some evidence that it can help some people with

alcohol abuse reduce their consumption, while chronic use does lead to a sense of demotivation and mild memory problems. Patients who get unpleasant reactions, for example enhanced paranoia, usually are sensible enough to give it up quickly. Its possible effectiveness in chronic pain or dystonic conditions may well be associated with this anxiolytic property. There has, as yet, been no formal trial of cannabis in the treatment of panic disorders.

6.6 How addictive are benzodiazepines?



The simple answer is that they are very addictive in those likely to become addicted. Anything that causes anxiety relief is powerfully reinforcing, because patients simply feel so much more comfortable, and wish they could be like that all the time. Whether one calls this euphoria, or an understandable human aspiration, the clinical problem is ensuring anxiety relief while avoiding tolerance or unpleasant withdrawal effects. Abuse is highly unlikely in patients without a history of drug or alcohol abuse, but the benzodiazepine withdrawal syndrome is very distressing. Depending on the patient, a withdrawal programme (*see Box 6.1*) may take up to a year, or

BOX 6.1 Benzodiazepine withdrawal

1. Agree outline plan and rationale with patient.
2. Agree on only one prescribing source.
3. Switch to equivalent dose of diazepam, nocte or twice daily at most.
4. Reduce diazepam by 1 mg to 2.5 mg per fortnight, or even per month if necessary.
5. Provide parallel relaxation training/anxiety management/CBT (whichever is available) and patient support group if possible.
6. If withdrawal symptoms develop, maintain current dosage for longer – use appropriate medications, e.g. SSRIs or MAOIs, if symptoms reflect returning illness.
7. Slow is better than quick. A year or two may be needed.

even longer, and will always need to be linked to encouraging psychological approaches, such as self-relaxation or even a course of cognitive therapy. Switching patients to diazepam equivalents (*see Table 6.2*), whatever their current benzodiazepine, is also good practice since dosages can be nicely and carefully adjusted down.

6.7 Is it safe to give benzodiazepines on a regular basis?

The fact of the matter is that benzodiazepines are very safe drugs, and while pharmacological tolerance is demonstrable, many people feel

TABLE 6.2 Benzodiazepine doses equivalent to diazepam 5 mg

Chlordiazepoxide	15 mg
Loprazolam	0.5–1 mg
Lorazepam	0.5 mg
Lormetazepam	0.5–1 mg
Nitrazepam*	5 mg
Oxazepam	15 mg
Temazepam	10 mg
Flunitrazepam (Rohypnol)*†	0.5–1 mg
Flurazepam (Dalmene)*†	15 mg

* Prolonged half-life creates hangover effect; repeat doses tend to be cumulative, especially in the elderly

† Not available for prescription via the NHS

psychologically stable without dose increases. While the guidelines and emphasis over the last 10 years have been to reduce consumption, this needs to be on an individual basis. Many patients are living positive, non-insomniac and relatively relaxed lives on say 5–10 mg of diazepam twice a day alongside a low-dose antidepressant, and why shouldn't they? Benzodiazepines are safe in overdose, have minimal interactions with other drugs, and have no long-term physical problems associated with them, unless excessive, accumulating dosages are used, for example in elderly patients. While long-term benzodiazepine treatment should not be actively encouraged, it may be a least bad option for some chronically anxious patients.

6.8 Are antidepressants potentially addictive as well?



No. The core features of addiction, namely tolerance – increasing doses with less and less positive effect – and craving for more, are simply not part of the antidepressant profile. Nevertheless, research has shown that there is a strong public belief associating 'drugs' with addiction, and a tendency to muddle antidepressants with tranquillizers. This is not surprising, given their widespread use for anxiety relief, pain relief, and – in some people's eyes – relief of social difficulties. However, they do have withdrawal effects, which is not surprising since depression and anxiety tend to be chronic conditions that readily relapse. Deciding whether or not to discontinue antidepressants may involve lowering dosage and possibly thereby reawakening symptoms. Sudden stopping of medications should of course always be avoided, gradual discontinuation over several months being good practice. The short half-life of paroxetine, among the SSRIs, does seem to give it a greater likelihood of having a withdrawal effect, probably reflecting its greater, immediate, anxiety relief.

6.9 Which is the front-line treatment for anxiety today?

The benchmark is a combination of medication and psychological approaches. Every study has shown greater efficacy when these are combined, and greater durability when, in particular, cognitive behavioural treatment is involved. The current limited availability of this, at least within the British NHS, has tended to put the pressure in primary care back on to the use of medication. All patients diagnosed with an anxiety condition, whether generalized anxiety, panic attacks, social phobia or mixed anxiety/depression, require a full explanation of their symptoms. A standardized leaflet, as provided by the Royal College of Psychiatrists, and time spent in an anxiety management class, should be as routine as basic perinatal screening. Medication will depend on the patient's particular pattern of symptoms, physical health, age, and attitudes to 'drugs'.

6.10 What are the best treatments for panic attacks?



Treatments for panic attacks need to be considered in the short and long term. Benzodiazepines are the drug of choice, immediately giving good relief. They will not stop panic attacks recurring, however, and continuing treatment will require medication, ideally in combination with relaxation or cognitive behavioural therapy. Current first-line drugs would be either an SSRI (paroxetine and citalopram have the best literature base) or a tricyclic antidepressant such as imipramine, clomipramine or even amitriptyline. All will take time to work, need to be taken for at least 6 weeks, and probably 3 months to maximize their effect, and panic patients are very sensitive to side-effects. Using benzodiazepines as well for the first 2 or 3 weeks can help with this, and dosage needs to be increased slowly while monitoring the response.

Assuming no previous treatments – and it is always worth checking on what has been tried in the past – using an SSRI, then a tricyclic, and then a monoamine oxidase inhibitor (MAOI), probably the most effective but most difficult to use, would be a practical progression. Constant advice, education and clarification of the treatment programme, warning that it may take up to a year to get things right, is also essential (see Fig. 6.1).

6.11 Are SSRIs better than tricyclics in the treatment of anxiety or panic disorders?

Neither type of drug is more efficacious, but SSRIs seem to have fewer side-effects. Anxious patients are hypervigilant, and seem to magnify every little symptom, whether muscle tension, headache, a bowel movement or a heart flutter. Thus it is essential to use low doses first. That means 10–20 mg of

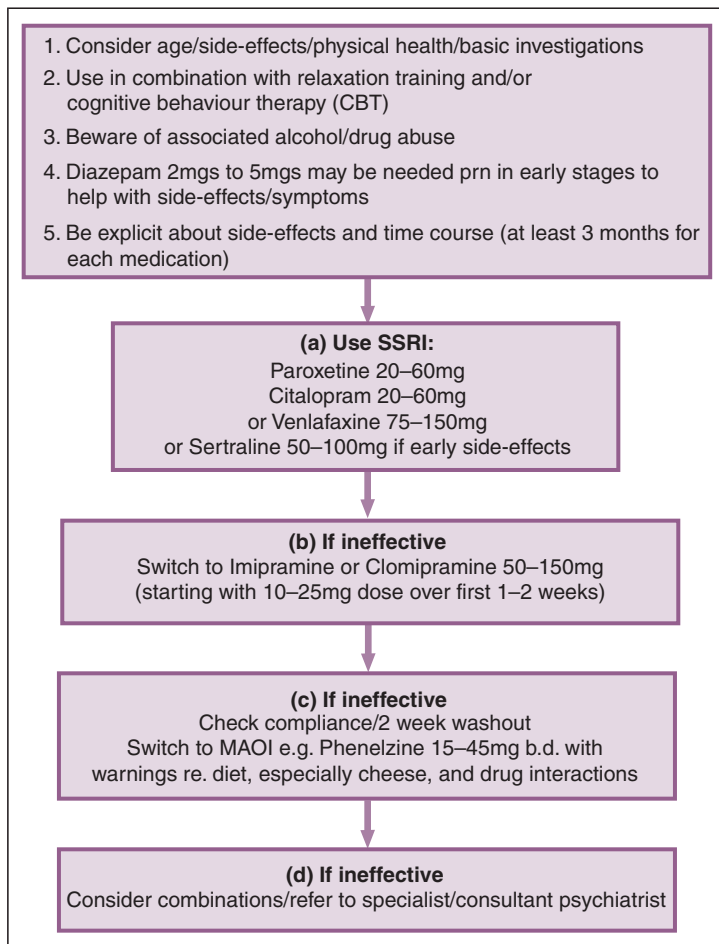


Fig. 6.1 Use of medications for anxiety/panic disorder.

paroxetine, citalopram or fluoxetine, 25–50 mg of sertraline, 37.5–75 mg of venlafaxine, etc. Tricyclics such as imipramine, clomipramine or amitriptyline should be started at doses of 10–25 mg, and only increased slowly. SSRIs are probably simpler to use, in terms of avoiding cardiac, overdose or sedation problems, whereas tricyclics will do better in those with bowel symptoms or previous bad reactions to SSRIs.

6.12 Are there any particular SSRIs that seem to be specifically indicated for anxiety or panic disorders?

Several of the SSRIs have obtained specific indications, in terms of their data sheet, for the management of these anxiety disorders, but studies seem to show that all are, essentially, equivalently efficacious. It is accepted that fluoxetine seems to have a tendency to make people more anxious or agitated for the first week or two, thus requiring additional benzodiazepines. This may be true for any of the SSRIs, but paroxetine and citalopram appear to have more of an in-built calming effect. Whatever the SSRI chosen, if enhanced anxiety or other side-effects limit its usefulness, it is always worth considering one of those two as an alternative before switching to a tricyclic or MAOI (see Table 6.3).

6.13 Is it rational or safe to combine SSRIs and tricyclics?



Such combinations of drugs are best avoided, if at all possible, and specialist advice should be sought. They are used for the treatment of resistant depression, but their role in the management of anxiety or panic attacks remains uncertain. The likelihood of doubling the range of side-effects is high, and compliance with complex regimes – especially taking tablets two or three times a day – is known to be poor. To be rational one would have to use an SSRI only with tricyclics that have a primarily noradrenergic effect (i.e. imipramine, desipramine).

TABLE 6.3 SSRIs and related drugs in anxiety, depression and related conditions

Drug (brand name)	GAD	Panic	Depression	OCD	Social phobia
SSRIs					
Citalopram (Cipramil)	✓	✓	✓	?	✓?
Fluoxetine* (Prozac)			✓	✓	
Fluvoxamine (Faverin)			✓	✓	
Paroxetine (Seroxat)	✓	✓	✓	✓	✓
Sertraline (Lustral)		✓?	✓	✓?	
Other drugs affecting serotonin					
Mirtazapine (Zispin)	✓?	✓?	✓		
Nefazodone (Dutonin)			✓		
Venlafaxine (Efexor)	✓	✓?	✓	✓	

GAD, generalized anxiety disorder; OCD, obsessive-compulsive disorder

* Requires high dose – up to 60 mg

Nevertheless, if an individual feels 'better' by having an SSRI in the morning and a tricyclic, for example, in the evening to help with sleep and relaxation, that may be rational for that patient. Remember, combining either of these with an MAOI is extremely risky. Leave that to a consultant with a special interest in psychopharmacology, who is dealing with only the most resistant cases.

6.14 Is there any role for lithium in the treatment of anxiety?

The evidence for lithium is very thin. While being an established treatment for the prevention of relapse in patients with manic depressive (bipolar) disorders, acting as a mood stabilizer, and having some role as supplementation in antidepressant therapy (for resistant patients), it does not seem to be effective in the anxiety disorder, anxiety/depression spectrum of conditions. It has no obvious sedative effect, and can be problematic when used with some SSRIs. However, other mood stabilizers such as carbamazepine, sodium valproate, gabapentin and lamotrigine (newer anticonvulsants), do seem to benefit certain patients. These are well worth considering in refractory conditions, but more treatment trials are required at present, and again a specialist review should be obtained.

6.15 Are there any other medications, not having antidepressant activity, that can be helpful with anxiety?

The drug buspirone can be used in anxiety disorder, is not one of the benzodiazepines, and seems to be less sedating than them. In particular, it does not seem to have any addictive potential, but there is a lag in onset (several weeks) and there are conflicting studies as to how effective it is. Alternatively, the use of a beta-blocker such as propranolol can be helpful in those with specific, essentially physical, complications of anxiety, such as a tremor when faced with public speaking. This is best used on an 'as required' basis, rather than as continuing therapy. The use of non-benzodiazepine hypnotics such as zolidem or zopiclone, as a short-term treatment for insomnia, may also help at the beginnings of treatment if getting off to sleep is a problem.

6.16 What are the main problems associated with monoamine oxidase inhibitors (MAOIs)?



Although originally used as antidepressants, the MAOIs are best established in terms of their treatment for anxiety and particularly panic disorder. The main dilemma is ensuring that a patient adheres to the diet, which means avoiding tyramine-rich foods liable to cause the 'cheese effect'. That is to say, hypertensive episodes occurring because the enzyme designed to eliminate monoamines has been fully or partially blocked. Such

BOX 6.2 Monoamine oxidase inhibitors: important potential dietary and drug interactions

Dietary*

Cheese
 Bovril/Oxo/Marmite
 Pickled herring
 Broad bean pods
 Food going 'off', e.g. offal/game/fish
 Alcohol, especially Chianti/fortified wines

Drugs

Sympathomimetics (as in nasal decongestants)
 Tricyclics (e.g. clomipramine) and SSRIs
 Amfetamines
 Fenfluramine
 L-dopa/dopamine
 Pethidine
 Barbiturates

* An early warning symptom is a throbbing headache indicating a potential, severe, rise in blood pressure. The wide range of possible interactions means that practitioners should always check in the *British National Formulary* and warn patients as to what they eat and the risks of other medications (e.g. anaesthetics).

hypertensive crises can also derive from yeast extract (e.g. Marmite, Bovril), pickled foods, and stock cubes or packet soups (*see Box 6.2*).

The other core problem is the tendency for MAOIs to interact with every known drug in the book. Tricyclic antidepressants and over-the-counter cough and cold remedies are classic causes of difficulty, and most anaesthetists recommend discontinuation of MAOIs for at least a week if not longer before surgery. They are also dangerous in overdose. It is because MAOIs are such 'dirty' drugs, in terms of these interactions, that it is probably best to let initial treatment be managed by a consultant psychiatrist. The new 'reversible' MAOIs, such as moclobemide, may be safer but tend to be milder in their effects, though useful for anxiety without panic.

6.17 Is it safe to combine monoamine oxidase inhibitors (MAOIs) with other medications?

The simple answer is no, because of the many interactions that can occur between MAOIs and many other drugs in the *British National Formulary*. However, in rare cases of particularly resistant depression, the combination

with tricyclics can be remarkably effective. It should be remembered that a drug-free interval, several weeks usually, is required before switching from an MAOI to another antidepressant, whether tricyclic or SSRI. The same principle applies vice versa, depending on the half-life of the particular drug. Seeking advice from one's local clinical pharmacologist or even senior pharmacist is always good practice in this regard. The combination of MAOIs with other antidepressants does not really have a specific role in the management of anxiety or panic disorder, but can help in resistant agitated depression.

6.18 How quickly will medication start to have an effect on anxiety symptoms?

The delay in the reduction of symptoms is a key problem, particularly in the context of panic disorder or social phobia, and more so if obsessive-compulsive features are associated. Benzodiazepines, of course, will immediately make one feel calmer, and thus can be useful for initiating therapy, alongside the other drugs. Studies of the effectiveness of SSRIs or tricyclics in the management of panic disorder show that they usually require at least 6–12 weeks of treatment, and patients should be advised of this at the outset. It is not the kind of onset associated with antidepressant efficacy (2–4 weeks), but a much longer-term process. Given this, explanation, monitoring compliance, and combining psychological approaches (e.g. relaxation training) are a vital part of the treatment plan.

6.19 Are there specific drugs indicated for specific subtypes of anxiety such as social phobia or obsessive-compulsive disorder (OCD)?

There is a strong literature, generated in particular by the competition between SSRI manufacturers to carve a niche for their own product and to establish specific medications. This has been done in terms of the use of high-dose fluoxetine, for example, for OCD and anorexia/bulimia, and for paroxetine in the treatment of social phobia. These medications certainly are relatively effective, of the order of 50–60% benefit in standardized trials, but the more these conditions are studied with other formulations, the more one realizes it is a class effect rather than a specific effect.

Nevertheless, it is probably worth starting with a product which has an agreed indication for that condition – and it also looks good if patients check up in their own copy of the *British National Formulary* or on the Internet – provided one keeps an open mind in terms of alternative treatment. The use of clomipramine, for example, with its strong serotonin reuptake-inhibiting effect, in the treatment of OCD, is very well-established.

6.20 How long should one persist with any particular medication?

Assuming there are no side-effects, the treatment of anxiety and panic disorders requires a long-term strategy. Building up to a full dosage for at least 2–3 months, particularly in panic disorder, is the bare minimum. Giving drugs for 2 or 3 weeks, at half doses, in anxious patients, is a recipe for enhanced anxiety, non-response, and an impaired doctor–patient relationship. The failure to continue with treatments – or to comply with them – for a long enough time is the commonest problem in the drug treatment of anxiety.

6.21 Is there any way of monitoring compliance or response to medication?



Compliance (some people prefer the term 'adherence') is a key problem for any medication, particularly for psychological conditions of some chronicity. At least 50% of tablets are simply not taken. Reasons vary from simple forgetfulness, ambivalence about taking drugs, and unpleasant side-effects, to the sheer practicalities of running out of medication and thinking that the course is naturally completed. Checking on compliance may be seen as intrusive, but can be done in a supportive way. Asking about side-effects (tricyclics always have some kind of side-effect, for example a dry mouth), checking containers, if the patient brings them, or asking for someone to keep a diary (e.g. +2 to –2 in terms of a self-rating anxiety or depression scale) can all help. Monitoring drug levels would be ideal, and can be done if necessary. Unfortunately the ranges are quite variable (in terms of therapeutic serum levels) and it can be an expensive business.

In the end, saying to the patient 'I don't mind if you haven't, but I need to know because otherwise I don't know if the treatment is working' – that is to say a therapeutic alliance – may be the only way.

6.22 Are there any specific withdrawal syndromes associated with drug treatments?



Just as with alcohol or opiate withdrawal, there is a very distinctive benzodiazepine withdrawal state in up to a third of patients if they discontinue the drug suddenly. Symptoms are those of a severe anxiety state, with a considerable physical component such as sweats, tremors, palpitations and insomnia. Even hallucinations and confusional states have been reported, and a similar condition is associated with sudden discontinuation of short-acting SSRIs, such as paroxetine. In fact, varying degrees of restlessness, difficulty getting off to sleep and depersonalization are commonly associated with any sudden withdrawal of a drug that is

anxiolytic. Gradual discontinuation, over several months or more if need be, should be the rule.

6.23 Are medications effective in combination with psychological treatments?

There have been numerous studies showing that combined treatments, for example cognitive behavioural therapy with a tricyclic, or with an SSRI, is as good as or better than treatment with a single approach only. There is also evidence that the durability of treatment, that is a continuing remission in symptoms despite withdrawal of the treatment, is associated with psychological methods. By and large, therefore, if the resources are available, this should be the standard approach. Given the nature of anxiety, people's difficulties with somatizing, fears of having a more serious illness such as heart disease, and the stigma of being 'mad', explanation and reassurance on a regular basis are an absolute necessity. Furthermore, some patients will insist on something around 'counselling', while others hate the idea of 'talking treatments' and just simply want a pill to 'cure' them. Providing both should enhance the possibility of patients at least taking up one option.

6.24 How safe are anti-anxiety medications such as SSRIs or tricyclics if the patient is still drinking?



The combination of alcohol and any medication is an acknowledged problem, and patient leaflets usually suggest that alcohol should be avoided. The two major problems with alcohol are its tendency to block the effect of medications, especially SSRIs, and the possibility of medication enhancing the effects of alcohol. Thus, it is good practice to warn people that one glass of wine may have the effect of two or three, or might make them feel sick or dizzy, when they are on medication. By and large, though, these medications are relatively safe, and some patients may even find a reduction in craving for alcohol, if that is their problem. Clearly MAOIs and alcohol have a particular interaction (e.g. Chianti), and those prone to epileptic fits should be especially warned. If someone is abusing alcohol heavily, it is probably a waste of time, in reality, to try to 'cure' their depression or anxiety by going on prescribing antidepressants or tranquillizers.

6.25 Is there any indication for ECT in anxiety disorders?

If anything, generalized anxiety disorders and panics are a contraindication to using ECT. This is assuming there is no associated or underlying depressive illness, such as a severe agitated depression with obvious biological symptoms like weight loss, early-morning waking, marked self-blame and retardation. The main side-effect of ECT, namely short-term

memory loss, will merely enhance the sense of anxiety that patients feel because of their difficulties in concentrating and 'remembering things', anyway. Part of the criticism of ECT has derived from its inappropriate usage in just these types of patients whose 'depression' was really anxiety or panic.

6.26 What is the role of beta-blockers in treating anxiety symptoms?

Beta-blockers such as propranolol have been used successfully for some patients with a very 'physical' type of anxiety. They are particularly good for those worried about some kind of public performance, for example playing an instrument or having to look calm and collected and not shake or sweat. By interrupting the vicious cycle of anxiety causing bodily symptoms, such as palpitations and tremor, they make it possible for anxiety-prone people to put on a good front as well as actually feel better. Chronic use of such drugs has been tried, even at extraordinarily high doses (e.g. up to a gram or more of propranolol a day) but there is no evidence of real benefit.

6.27 What are the commonest causes for drugs not being effective?

The common reasons for treatment failure are not actually taking the medication (non-compliance or non-adherence), not taking a sufficient dosage, or not taking it for long enough (*see Box 6.3*). Overcoming such reluctance in some patients is extremely difficult; thus the need for education and psychological approaches. Yet even in the best-designed studies between a third and a half of patients simply do not get significantly better, particularly if they have long-standing illnesses. Some patients really are resistant to treatment, others simply adapt to a sick role, and a few, let us be frank, are financially better off on benefits. But such patients are the exception that proves the rule, that it is not nice being chronically anxious. Most people appropriately seek treatments for their conditions. New medications, and/or combinations of medications, are still required.

BOX 6.3 Reasons for medication being ineffective

- Non-compliance or irregular usage
- Discontinuing medication too soon (i.e. <3 months)
- Inappropriate dosage (usually *under*-dosage)
- Side-effects outweighing benefits
- Concomitant alcohol/illicit drug abuse
- Wrong diagnosis, thus inappropriate medication (e.g. antidepressants for a paranoid psychosis)

6.28 Are anxious or panic patients at particular risk of suicide or self-harm with medications?

In terms of suicide, the key factors of increased risk are older age, social isolation, male gender, alcohol or drug abuse, depressive illnesses at the more severe end, and availability of method. Tricyclics should therefore be avoided in such individuals, if they are being treated for anxiety symptoms.

Use of benzodiazepines, antidepressants, and pain killers in deliberate self-harm – an overdose – are typical, often combined with alcohol. While anxiety may be a component of such patients' problems, formalized disorders such as social phobia or panic syndrome – or other formal psychiatric diagnoses – normally constitute less than 10% of such cases. Social problems, difficult and/or abusive upbringings, borderline characteristics, limited impulse control and drug/alcohol abuse are much more relevant in such presentations.

6.29 Is there any role for major tranquilizers in anxiety management?

Phenothiazines such as perphenazine or chlorpromazine have significantly anxiety-relieving effects, and can be helpful in those especially at risk of benzodiazepine dependence. They are also helpful in patients with paranoid or other quasi-psychotic symptoms (e.g. ideas of reference) and can even be useful in those with borderline personality disorder. This seems to be via a lowering of internal arousal, leading to less resort to self-harming events. Whether some of the newer 'atypical' antipsychotics such as olanzapine or quetiapine will be similarly useful, on a practical basis, remains to be seen. Their use is probably best confined to more difficult or resistant problems, and advice about side-effects and long-term usage is well worth obtaining early.

6.30 Does medication for anxiety as often as not have to be for life?

Usually not. By definition anxiety disorders tend to fluctuate, in terms of both frequency and severity of symptoms, according to personal stresses, time of life and random factors. If treatment has been effective using an SSRI, tricyclic or MAOI (and usually that will take 2 or 3 months anyway), it should be continued for at least another 3–6 months. After that it will be up to the individual patients, their personal circumstances, and their view of the illness.

Once 'well', many patients do not like risking becoming 'unwell', and keeping them on long-term, low/medium-dose medication is safe and effective. Others want to keep trying to become drug-free, so as to feel they are not 'ill', so gradual withdrawal, while being monitored closely, every year or two, is worth attempting. Between a third and half of patients will

not relapse again, at least within the next 2–5 years, particularly if given the confidence of feeling they can deal with anxiety or panic attacks via self-relaxation or cognitive methods.

6.31 Has the community psychiatric nurse (CPN) a role in medications for anxiety?

Recent regulatory adjustments have now made it possible for CPNs to prescribe some medications. The standard antidepressants, whether SSRIs or tricyclics, as well as minor tranquillizers, can come under this protocol. Again, CPNs will need to take on extra training, in terms of understanding the uses of specific psychiatric medications, but this kind of nurse specialism is just what the NHS needs. Whether managing anxiety or depression, however, CPN-led mood clinics are now well-established in several centres.

PQ PATIENT QUESTIONS

6.32 I'm scared to take my medicine – can it hurt me? Is it addictive?

The cruel twist to being ill with anxiety is that it makes you frightened of anything and everything. In particular, any change or upset in a safe routine can easily bring on a panic attack, or the worry that you are going to start getting a panic attack. In this sense an anxious person is like a nervous climber clinging to a rock, too scared to move because he might slip. But of course, if he does not move, he will have to go on clinging to the rock and feeling frightened.

Taking medication – or embarking on any new treatment – is like this. People worry especially about feeling sick or fainting, or becoming sleepy or drowsy, so much so that they feel they will lose control. But this fear of losing control is half the problem. The thing to remember is that all medications have side-effects, but that they almost always disappear after several days. What they mean is that the medication is having an effect.

It may take time for prolonged anxiety relief, or for panic attacks to go away, but that probably means that the anxiety is being dealt with, not just blocked out. Anyway, conditions that have been bothering one for a while – months or years even – will always take time to respond. And remember, all medications are very, very safe, many having been used for several decades. They are safer than a number of over-the-counter drugs, like aspirin, paracetamol or even some antihistamines.

As for fears of addiction, these are also very common and very understandable. Not least because some people become anxious again when they stop their treatment, and this leads on to feeling shaky, and getting what even looks like a withdrawal state. Unfortunately these are usually signs of the illness coming back again, although stopping medication slowly, step

by step, should always be the cardinal rule. Real addictive drugs – like alcohol, nicotine or heroin – are addictive because you want more and more to get the effect. Also they dominate your life, so you want to take them all the time, and they do not make you feel better. Effective treatment medications – as outlined in this chapter – work at a standard dose, and go on working at the right dose for you, and you only need to take them once or twice a day. Most people also start to feel better from them, so they find they can start doing other things rather than worry about medications.

6.33 The medicine isn't helping. What can I do?

If your medication is not helping with anxiety then there is a lot that can be done. First of all, do you remember to take it regularly? Many people do not, but just missing out one or two doses a week can halve the effect, which needs to be consistent. You also need to be taking the right dosage, as high a one as possible that does not give you bad side-effects, for a good 2 or 3 months. Furthermore, if one type of medication does not help, go back to your doctor or specialist and see if you can start on another one. All the time of course you can be reading up on self-management, for example relaxation techniques, listening to an anxiety tape, or attending a local volunteers' group. Attending specialized counselling, anxiety-management groups, or cognitive behavioural or behavioural therapy is also available, and such treatments can be carried out at the same time as you are taking medication. The two do not clash with each other.

If your anxiety has really been going on for a number of years, continually or on and off, then it may be worthwhile trying to write down exactly what treatments you have had and what you have not had, so as to have a really useful chat with the doctor. Although your case records will have a detailed summary in them, taking stock of all that has been done, what has helped and what has not helped, can often show the way to finding the right treatment for you.