## Podcast Transcript

# Let's Talk About Anxiety

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## Guest

### Sally K. Miller, PhD, AGACNP, AGPCNP, FNP-BC, PMHNP-BC, FAANP

- Certified as an adult-gerontology acute care, adult-gerontology primary care, family, and psychiatric-mental health nurse practitioner by the American Nurses Credentialing Center (ANCC), and a fellow of the American Association of Nurse Practitioners (AANP).
- Rural health with NextGen Family Care Clinic and iCarePsychiatry in Las Vegas, NV.
- Clinical professor at the Drexel University College of Nursing and Health Professions, Philadelphia, PA.
- APRN consultant/investigator to the Nevada State Board of Nursing.
- Presenter for the Fitzgerald Nurse Practitioner Certification Exam Review & Advanced Practice Update for family, adult-gerontology primary care, adult-gerontology acute care, and psychiatric-mental health, as well as teaches pathophysiology and pharmacology courses.
- Published in several nurse practitioner journals including the Journal of the American Academy of Nurse Practitioners, Biological Research for Nursing, Journal of Geriatric Physical Therapy, Journal of Primary Health Care, Journal of Correctional Health Care, and Advance for Nurse Practitioners.

## Host

### Jannah Amiel, MS, BSN, RN

- Visionary nurse leader with extensive clinical experience in high-acuity hospital settings. I
- Education expertise in pre- and post-licensure nursing education, and leading organizational teams in building and developing products and talent.
- The founder and nurse educator of an online bootcamp-style course experience that prepared pre-licensure nursing graduates pass the NCLEX-RN and enter the workforce.
- Currently the Sr. Director of Healthcare Curriculum at Colibri Group.

# Transcript

## Episode 1 – Let's Talk

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HOST, JANNAH AMIEL: Hello, everyone, and thanks for joining. I'm Jannah Amiel, nurse Jannah and I'm here with Dr. Sally Miller. Very excited today to have a conversation with one of the greatest nurses. I'm gonna pass it to Sally to introduce herself.

GUEST, SALLY K. MILLER: Well, good morning. As you said, my name is Sally Miller. I am a nurse practitioner, have been a nurse practitioner for almost 30 years now and currently I have a psych mental health practice here in Las Vegas. I have been a faculty member at universities, most currently Drexel University in Philadelphia, where I teach nurse practitioner students. I've been active in the professional community almost my whole career, currently a fellow of the American Academy or American Association of Nurse Practitioners, but mostly my primary love is clinical practice and teaching, so I get to do both. Also, I am a speaker with Fitzgerald Health and teach lots of the certification review and practice prep and a whole bunch of continuing education including psychopharmacology.

AMIEL: Fantastic, fantastic. So today, I wanted to talk about something that is happening in the nursing profession, right, not just in the nursing profession alone, but really within the healthcare workforce. And so Sally, and I had a conversation recently and this kind of sparked what we're doing now, right? What we're having the conversation about today and something that we know that we've definitely, I would say, are probably nodding our heads about is that in the last two years with COVID-19, right, with the pandemic and quite honestly, all the things that the pandemic has revealed, we're seeing an immense strain, right, on the health care system and not just that, but the people in the health care system, right? So, this is part of our conversation and so we're seeing an increase in the rates of anxiety diagnoses and panic disorders even.

There was a research study that showed that that doubled since 2020, when of course, right, we think about the pandemic. So, you recently shared Sally, when we were talking that you are seeing more nurses in your practice that were really, were coming in with these types of feelings, right? Something that I think that we're all feeling right now, the anxiety though, what is happening. And so I really wanted to have that conversation because it's like we're stating the obvious, we're having a lot of conversation across the board about things like burnout, we'll talk about things like stress and anxiety but we want to have this conversation because as a registered nurse, right, that hits close to home to hear really in real life, right?

Even though we talk about stress and anxiety and what's happening right now but in real life, like we really are struggling, and you really are seeing nurses in your practice and so I wanted to start off there. If you can just talk to us and kind of set the stage of, what have you been seeing in your practice lately since the start of the pandemic and as far as it relates to things like, you know, nurses coming in with anxiety and these types of manifestations.

MILLER: Anxiety is off the chart. In my practice, there are three distinct increases in the anxiety that I'm seeing. I mean, the first one, not just nurses, but in general, there are so many people that have anxiety disorders, one or more anxiety disorders, and had been in remission, had been well

controlled, functional, feeling good and then boom. When the pandemic started, within months, so many people that had been controlled, some for years, were on a medication regimen, seeing a therapist, but the control just immediately dropped. You know, there's a subset of anxiety disorders that is called "anxiety related to a health condition".

People with cancer, just for instance, or auto-immune diseases or any number of diseases that, you know, logically are anxiety producing, and they struggle with that and so are managing anxiety on top of that health condition. Then to have COVID emerge, which is a health threat in itself and of course, people with underlying disorders, people on cancer chemotherapy, people on immunosuppressants for all of those immune disorders like rheumatoid arthritis and lupus and even psoriasis and inflammatory bowel disease, they're especially vulnerable because of their medications that suppress [their] immune system. You know, if we had hours, I could tell you stories about patients who, it just devastated what was a controlled diagnosis, so there's that. The other thing is the new onset of anxiety disorders. I have seen people that had no history of a mental health diagnosis at all, you know, reached adulthood, middle age, even the later end of middle age whose anxiety now became so pervasive that they couldn't work, they had to come in and be seen and then the health care providers alone; nurses, nurse practitioners, therapists, psychologists, people who are helping other people manage their anxiety themselves developed anxiety symptoms to the extent that they really needed an intervention for it. So, across the chart.

AMIEL: Wow, and that's a good point. I never even thought about that, right? I think, right? You're totally right. We're all experiencing anxiety across the board in different ways, healthcare professional or not, but that was a fantastic point actually, about those who had it under control and now this kind of, like, new emergence and bringing that back. So, speaking of anxiety, right, I think we might have different ideas about what anxiety means. Like, how would we define that? What is anxiety?

MILLER: I'm so glad you asked that question because this is, it's just so critical to managing it appropriately. Anxiety gets thrown around, it gets thrown around as a symptom, you know, we toss around the diagnoses, even my peers in family practice and, you know, I did family practice for 25 years before I went into mental health as a specialty, and I was guilty of this too. We make a diagnosis of anxiety and just put it in a box called anxiety disorder and assume they're all the same thing and they're not and there are different types of anxiety. There are different anxiety disorders, and they get treated differently.

So, another one of my soap boxes that I always get on when given the opportunity is that very often the reason people don't respond to treatment the way we expect is because they don't actually have the thing that is being treated. So, to answer your question, anxiety as a word, you know, anxiety is a healthy, adaptive, physiologic response to a perceived threat or perceived stressor. I mean, it's biological. It emerges from what we call the lizard brain. You know, in mental health, we refer to the lizard brain and the wizard brain. The lizard brain is that primitive, subcortical, very basal brain that responds to stimuli that we don't even realize, you're not even aware it's happening. Whereas the wizard brain is the higher functioning cerebral cortex where we get to think about things and usually overthink things and process them and respond that way.

Anxiety comes from the lizard brain. Your brain will respond to a perceived threat before your higher centers even know that it's happening so as a protective mechanism, if you are, you know, walking down a very dark, unfamiliar street late at night, hopefully you're a little anxious. It's a protective mechanism. Anxiety increases the heart rate, it dilates the pupils, it heightens your sense

of smell, even your sense of touch. You know, we talk about the hair going up on the back of our neck or getting goosebumps, like we feel like something's wrong. We call it intuition but it's not. It's your lizard brain responding to very subtle things around you like a change in temperature or a change in scent that you don't consciously realize but your lizard brain does that know something's different and it's putting you on red alert so in that case, anxiety is protective and it's helpful and we want it. It heightens your focus; it heightens your awareness. That's a good thing.

When anxiety becomes maladaptive, when that response is either exaggerated to the circumstance or occurs for no obvious reason at all, then we call it a symptom. A maladaptive anxiety response is a symptom, it's an issue. If it begins to interfere with your ability to go through your day-to-day needs and day-to-day function, then it's a problem that needs to be addressed. Anxiety becomes an anxiety disorder when people meet diagnostic criteria for those anxiety disorders and it's a whole lot more than just having exaggerated anxiety. Anxiety disorders come in lots of flavors. It's an overarching term: there's Generalized Anxiety Disorder, there's panic disorder of their social anxiety, there's PTSD, there's separation anxiety, there's lots of different distinct anxiety disorders and they all have their own diagnostic criteria, and they all have treatments that may be different. It's not a universal bucket. So that's what I mean when I say we call somebody an anxiety disorder, you know, put them on an SSRI and then wonder why they don't get better. It's because we haven't really categorized them properly and treated them properly.

AMIEL: Yeah, that's actually a really good point and anxiety is a good thing, right, is what I'm hearing in some cases, right? Like you should be anxious right before you take your exam, that's probably a good thing.

You're feeling that fear. So okay, so when it becomes a problem, right, and I think that's where we're at now, right? I feel like we're not okay. When I think about nurses, right, and I think about healthcare workforce in that type of setting, right, and kind of what we're working on and saying that, if it's interfering daily, would you say that's the point where this isn't normal, right? You're talking about maladaptive that if I can't get through my day at work, if I can't do the tasks that I normally do, is that a point where you would say, "Well, this is not, that's not normal". Now, you really should see somebody.

MILLER: That is definitely not normal. I mean, that definitely requires intervention. Even if you do get through the day, but you do it at such a cost to your own psyche that you may get through the day but then you go home at night and it manifests as interactions with your family that are bad or that it's interfering in any meaningful way so that is actually a good point you bring up. Some people's anxiety is an anxiety attack, and it becomes very acute, and they can't get through the day. They're at work, they have what we call an anxiety attack and it's a problem right then and then there are those for whom it accumulates through the day, and they manage to get through it and then they go home.

We refer to social or occupational function. When a symptom interferes with social or occupational function then it's a problem, and so for some people, it interferes with their families and their social life and their other commitments. Either way, it's a problem.

AMIEL: And what are the differences? I think, like, what's the difference between someone who might be able to cope better, maybe with those feelings, and someone who really won't and that is a very maladaptive response that they have, and they are struggling in a much more significant way. Are there, like, risk factors that are different between those two, like, scenarios?

MILLER: There are. There are definitely people that have a physiologic predisposition to maladaptive anxiety. You know, at its basal level, there are pathways in the brain; there are neurotransmitters in the brain and if they are dysregulated, that's the term we use because in some cases, you have not enough neurotransmitter activity and in other cases, you have too much neurotransmitter activity. So even anxiety as a maladaptive symptom can manifest differently in different people depending on which neurotransmitters are affected, the nature of the imbalance, and then the pathway. We know that anxiety is a symptom and its sister, worry.

You know, worry and anxiety are not the same thing. Anxiety as a response or a symptom is the physiologic piece. It's that pounding heart, the sweaty palms, the shortness of breath, the tremulousness, whereas worry is that cognitive piece, that apprehensive expectation. The brain just, you know, separates on a thing and won't be quiet, won't turn off. There's different pathways. The worry piece is more pre-frontal, the physiologic anxiety is more of an amygdala, brainstem kind of phenomenon. So, the bottom line is there's all different abnormalities that may occur and some people have underlying dysregulation that when things are fine, doesn't rise to the level of a symptom. They might always be a little bit of a worrier, always something to check twice or whatever but it doesn't become a problem until they are faced with a significant stressor and of course, COVID-19 is just something that nobody in the world could ever have anticipated. I mean, a catastrophic, multi-modal stressor that's not going away and so people with that physiologic predisposition or tendency, that's definitely a risk factor for it.

AMIEL: Yeah, and what are you seeing? So, I'm curious in this way of, you know, like, are there any common manifestations first thinking about anxiety, right, that we think about that we should be looking out for in ourselves and in your scenario with your patients as well and I'm curious if there are things now that you're observing commonly. you know, that's floating to the surface as far as anxiety or anxiety diagnoses are concerned with your patients coming in at their common complaints and I'm wondering if these are things that in your opinion, do you think, is a direct, you know, kind of ripple effect of what's happened with COVID-19 and how that just like, touched everything?

MILLER: For sure, it's different depending on the population you're talking about. The people that already had an anxiety diagnosis, I mean, they're just decompensating. It just becomes a pervasive worry. They can't think of anything else. They don't get through the day. I mean, I've had people that were working that cannot, they just cannot go to work because they're so worried about being exposed to other people, what they will encounter. Every time they cough, I mean, they truly are panicked. You know, you and I, it's hard to appreciate, really, or understand how catastrophic that is to somebody. So, for that population, they just really appear to be decompensating. There's both the perseverative worry and anxiety attacks. I mean, just out of the blue, you know, anxiety attacks often are loss of control. They feel out of control and it's scary and they can't focus. So that's that population.

In the health care providers, it is also both. Healthcare providers have a tendency to push themselves to the limit. It is, you know, it's so interesting how, intellectually, we know a thing and then emotionally, we don't do a thing. And, you know, we as health care providers, we tell people all the time, whatever your symptom, don't wait until that whether it's pain migraine, chest pain, whatever, don't wait until the last minute. As soon as the problem begins to occur, we need to intervene whether it's take your medication or make an appointment as soon as the problem occurs because early assessment equals early intervention which equals best outcomes. That is a mantra in

nursing and healthcare, we all know it, don't wait to the last minute, and yet, health care providers, number one, they have this, the shoemaker's children has no shoes phenomenon.

We worry about everybody else, and we don't worry about ourselves, but it is also human nature to fear illness, disease, and loss of control. And I' finding that the healthcare workers, the nurses, the nurse practitioners, and the therapist because I feel like that's who I see most often. They feel as if they if they acknowledge their anxiety, and they acknowledge their worry, they are losing control, they're giving it up and so they won't acknowledge it. They just don't acknowledge it until they completely decompensate and cannot function and so for the healthcare providers, I would just encourage you strongly and it is hard, it is easier said than done.

Believe me, I'm a realist, if nothing else. There is a whole approach to healthcare and patient management called the transtheoretical model of change. I know that the nurses that are listening and the therapist and anyone else will know what I'm talking about. This is the Prochaska and DiClemente transtheoretical model of change and it speaks to the fact that the very first piece of chain, whatever it is, including recognizing you have an issue, the very first piece is called the pre-contemplative stage where we don't acknowledge it. It's not true, not us, you know, we aren't feeling this way and so that's the hardest nut to crack and I would just encourage everyone to recognize that we don't want to wait until we decompensate to seek care. So, if you find yourself thinking, "Oh, man, this was kind of rough", or "this was a bad day", or "this was a bad night, because of my bad day: maybe I should talk to somebody". If you're asking yourself, "maybe I should talk to somebody", the answer is yes, you should. I mean, you should right then. It doesn't always need a medication.

Not everybody with anxiety symptoms, or even for that matter, anxiety disorder needs drugs. It's not like a giving up, you know, I'm going to give up to chronic medication but anxiety as a symptom, often it's just a sister to loss of control and many times, there are non-pharmacologic ways, there are therapeutic interventions that help you regain that control and focus that control. So, the best advice I can say is if you find yourself saying, "Hmm, maybe. Is this a problem? Should I?" The answer is yes, it is a problem, and you should.

AMIEL: That's a good gut check and I think, you know, in my opinion, anyway, as a nurse, I imagine that there's got to be some type of stigma, right? We think we always say you have got to fill your cup first before you can fill somebody else's. But I think that the idea of, to your point, acknowledging that I'm not as whole as I think I should be, then I can't, I can't possibly take care of other people and so I wonder if that's a barrier too that you think and then that way to, you know, admitting it that something's wrong with me. That's what I feel like, then how can I take care of somebody else in that way?

MILLER: And you know, the other piece of that is it is also human nature to feel that if you plow through a symptom, you're doing well.  Again, you see that you see this with people after an MI. I mean, all the time, people with a migraine or pain or depression, if you can push through it, if I can keep doing what I need to do, then I am stronger. I am stronger than this thing and people feel good about that except that too is certainty.

One thing we know about the human mind and body is if you try to suppress a normal response, it is going to find another way out. It's like a game of Whack a Mole. If I keep this from happening, that same energy is going to come out in some other way and it's usually maladaptive because it's not the way it's supposed to come out. So, if you just ignore your anxiety and push it down and push it down, it's going to find another way out and it's usually not going to be a good one.

AMIEL: Yeah, that's a great point and I think that sometimes we champion that and I'll say, even in healthcare, I'll speak just for nursing alone, sometimes we champion that push through, you know, attitude that it's great that you worked a bajillion shifts in a row and hours on a row and you really were feeling heavy in the weight of that and we sometimes champion that type of kind of behavior versus really protecting, you know, our own safety, our own mental health safety and so now that then brings me to burnout, right, and the same way that we talk about anxiety a lot, I feel like I'm hearing and experiencing amongst my own peers, right, their burnout and the anxiety and so that's bubbling up a lot to the surface and I'm wondering if you can talk a little bit about that and if you know, there's anything that you think how is that related between this burnout conversation that we hear a lot, that we talked about a lot, and anxiety.

MILLER: I think burnout is exactly that it leads to that maladaptive expression of anxiety. You know, burnout is, it really is more of a late term. It can apply to work or a relationship, you know, home life. I mean, by definition, burnout is that point you reach at which the thing that you are doing no longer provides that internal sense of accomplishment or identity, you know, whatever it is. So, in this case, in the case of nurses, because it's an excellent example, burnout is that place where you just keep doing it and going through the motions, but you just don't feel good about it. You don't feel like you're doing anything positive anymore. You question if you are an asset. I see nurses questioning if this is really what they want to do. Do they want to go into something entirely different because they start to feel like they just don't get that internal sense that they used to get. That's burnout. But then, there's an economical piece, you know. Not all nurses can afford to just stop being a nurse and so they plow on because they need to do it to pay the bills, etc.

So, like I said, I'm a realist. I understand that it's not possible for everybody to just stop working, if they feel burnout, but, there's a but there, you do have to do something because that will lead, I mean, that produces that vulnerable state at which if you have any underlying tendency to develop anxiety as a symptom, that's when it's going to happen. I mean, like every other symptom or every other physiologic abnormality, we can usually compensate to a point but when you lower your resistances, your compensatory mechanisms, they're useless and then this thing that you've been managing for so long suddenly becomes overwhelming.

So, I mean, the short answer to burnout and I have told so many nurses this in the office, you have just got to step back, and I know it's hard. If you can't resign, and I'm not even suggesting you should resign but if you've been on a COVID unit and you just can't do it anymore because of the emotional toll of watching people in the hospital with COVID. In the beginning, they were all on ventilators and so many people were dying because nobody knew what to do. Now, the approach to COVID has become a little bit different. By the time you are hospitalized and ventilated, I mean, ventilation really is the last step now, so those people are really, really sick and they need all sorts of support. They need emotional support; they need physical support. The nurses are worried about their own health. The family units need support in so many ways. So, of course, it's going to burn you out. You factor in the fact that there is such a staff shortage and so people are always being asked to work extra shifts and double shifts and six days a week and you know, the money is out there. They're being tempted with these enormous hourly rates to do it.

So, for younger people who are maybe building a career, and the finances are really important, they do it, and they do it and then suddenly, they get to that place where "I'm burnout". So maybe not stop it, but perhaps it's time to go to a non-COVID unit. For any nurse that wants to change his or her area of focus, right now you can do it. There is enough of a shortage that if you need to step

back from that COVID unit, go to a non-COVID unit and if you have to change employers, you can do that too because the need is out there If you've been working six 16-hour shifts a week, it's just time to take even a few shifts off or a day off and recharge a little bit.

So, when something produces this sort of symptom in your life, you just have to back up and manage it and there are definitely ways to do that without leaving your career or leaving your job and not being able to pay your bills and by the time I see them, they're asking for FMLA. They need to take weeks off, but they just have to either step back from the role or step back from the unit. It's not even all about COVID. There are nurses who work in the ICU, it's hugely stressful for them and they come home every night, and they have a headache and an upset stomach, and they fight with their significant others, and I tell them, this isn't hard to figure out. You have to get out of that unit, you have to go work somewhere in another unit. You just have to step back from it.

AMIEL: No, that's right and I read it in a research article last week, I believe. It was very recently, and it said something like two out of five nurses in the next two years said they plan to resign and in thinking about that on top of, right, the shortage that we're already anticipating happening is horrifying. One just that you know anybody in their profession that they chose to do would rather say "I wouldn't want to do this anymore, because this is so bad" and two, we know what those implications would be like, right on the other side if we really did have two out of five nurses leaving in the next two years. So that's really sound advice and sometimes it's so much easier said than done but I think it's important. It's important. We have to stop because the outcome right on the other end of not looks pretty bad.

MILLER: Change is hard. It is change is hard. That's why we have a transtheoretical model of change. It's hard and there are numerous steps but if your anxiety, the conversation we're having is about anxiety, if your anxiety is becoming so pervasive, then you just have to do something about it because it will, I mean, it will eventually lead to an emotional implosion and then you won't be able to work anyway. So better to make the change now while you have a choice about where you can go and how you can make those adjustments.

AMIEL: I agree. I agree. Is there anything that you would like to share with our audience about anxiety, about this conversation that we're having, or are therapists, anyone who's listening now even that we haven't spoken about, but you really want them to hear or to know.

MILLER: So, number one, not every anxiety symptom is an anxiety disorder. Not every anxiety symptom needs a drug. So before assigning those diagnoses, and putting people on the generic standard medications, either really just take a little extra time to accurately diagnose their anxiety. Is it a disorder or not, and then treat them appropriately.

Give you a real quick example. It's not a COVID example but a quick example from primary care. A patient came in asking for, she was anxious, very anxious, couldn't sleep, worried all the time, panic attacks, a classic anxiety type patient, and she was asking for medication for anxiety. So, the first thing you need to do is find out if there is a cause of anxiety or not. If there's no obvious cause, then it is largely biochemical, and medication is necessary and very effective.

But sometimes there is a distinct cause to that anxiety and all the medication in the world won't eliminate the cause. In this circumstance, this lady was in a relationship that was abusive and violent repeatedly and now she was beginning to worry about her children. So of course, she was anxious. This is a circumstance where anxiety, it wasn't a symptom, it was a very appropriate response to an

environment in which she lived where she felt threatened every day and night. So, the answer for somebody like that isn't, "Oh, here have a SSRI and let's see if you're better". The answer is to really work with this patient on how she can get out of that environment and I know not everybody can and not everybody can right away so it's a multimodal intervention here but my point is, whenever there is a cause of anxiety, you really have to identify that cause and work very hard to mitigate that cause in some way, not just write the prescription. Number one, identify if they actually have an anxiety disorder or not and then number two, if there is an identifiable cause, recognize that we have to work on trying to mitigate that cause.

AMIEL: Excellent. That's fantastic advice. A swim upstream: address the underlying cause, always, right? Awesome. Sally, I appreciate you so much for joining me today and having this amazing dialogue and necessary dialogue and thank you everyone for tuning in.

I'm Jannah Amiel and on behalf of myself and Dr. Miller, thank you for joining us. Goodbye for now.

(SOUNDBITE OF MUSIC)

## **Episode 2 –** Managing and Treating Anxiety

(SOUNDBITE OF MUSIC)

AMIEL: Hi and thanks for joining the mental health meetup. I'm Jannah Amiel. I'll be your host today for Episode two and joining me again is the great and amazing Dr. Sally Miller. So happy to have you again and last time we spoke, we spoke a little bit about things around anxiety and COVID and the pandemic and kind of what we're seeing so we're going to continue that conversation some more today but before I do that, Sally, do you want to introduce yourself to our audience?

MILLER: I will. Well, aside from being great and amazing which is tough to live up to, I will do my best. So, my name is Sally, and I am a psychiatric mental health nurse practitioner. I've been a nurse practitioner for almost 30 years and for the first 25 of them, worked in a variety of outpatient and inpatient settings from the more medical medicine, internal medicine perspective, I guess I could say, and then five years ago, focused in psychiatry, so that's where I've been for the last five years. I have been a speaker with Fitzgerald Health since 2001. So over 20 years with FHEA. I am a clinical professor at Drexel University in Philadelphia, and I am a fellow of American Academy of Nurse Practitioners but most importantly, a clinician and a teacher. Those are the things that I think are most important to me.

AMIEL: Fantastic. Awesome. So last time that we spoke, we spoke again about anxiety, right? We kind of set the stage for that, what is anxiety? What's going on? Why are we hearing about it so much and seeing about it so much, not just in the healthcare worker arena, right, like nurses and therapists in that way, but just the general public. So we talked a lot about that and I want to transition us into maybe talking about how to manage that personally and even as a practitioner or a provider who's taking care of patients and so one of the things that I wanted to ask and get your input on is if there's any type of best practice recommendations in the event that someone's having an acute episode. So, I'll give you an example. If you are working with a colleague, nurse, or another practitioner who you recognized was absolutely experiencing some real anxiety, they're having the symptoms, they might be having an acute episode, or maybe just a build-up of it. Are there things that we can do in that moment, to help like not kind of go over the edge, so to speak?

MILLER: There are. There are actually several best practices that are advocated and are really helpful. People just have to do them. You know, on a side note, in this, I do want to share with you that before going into mental health, like I said, I was internal medicine, very cut and dry. You know, my road has columns and lines, and I really wasn't a real believer in therapy and non-pharmacologic interventions and deep breathing and all this and you know. I'm not proud to say it now, but that just wasn't the way my brain worked, and I didn't know anything about it, and I didn't advocate for it. When I did my mental health post-masters, part of my clinical involved spending a certain number of hours with a therapist. Not learning how to be a therapist, heaven help us, because I have no skills when it comes to being a therapist, but learning what types of therapy there are, what types are best matched to certain things, and so that I could refer patients appropriately. I was paired with an excellent therapist; it turned around my whole appreciation for that discipline. So, when I suggest these things that I'm going to suggest, I'm sure that there are lots of nurses who are just like me thinking, "yeah, okay. Yeah, right". Number one, I will tell you that it's not going to help, but believe me, I mean, it really does, and you just have to try it. You know, we live in a pill society, and everyone seems to respond to a pill for everything and listen, there are pills that are necessary for some things, but not, not necessarily and not this. So, to come back to your question, if somebody is at work, or anywhere, if it's at the end of the day, they're at home, if you are having an acute anxiety episode or anxiety attack, what everyone will identify is the loss of control, the inability to focus that they try to, you know, they go through a trajectory, they try to think about something else, they pick up some mindless thing or task or turn on the TV. They try to rein themselves in and they can, and it just escalates.

So, one of the really valuable best practices, techniques, and that a good therapist will suggest is trying in a very simple, straightforward, one-track way to refocusing yourself. So even if you're at work, and you just, it just gets there, and you just can't anymore. You just can't, you make sure the patient's safe. Right? If you're with the patient, you have to make sure they're safe. Grab another nurse. Everybody has at least one friend on a unit we like to think anyway, right? First, the patient is safe and then you just go into the lounge, the bathroom, anywhere, and just find a very specific thing to focus on.

One thing that many people don't realize is that you can use multiple senses for this. One thing that has been extremely valuable, and I get good feedback, when I finally convince someone to try it, is writing it down. Journaling is the contemporary term. Just start writing, write whatever, whatever is coming to mind, usually the thing that has you being anxious, just write. It doesn't have to be pretty; it doesn't have to be for publication. No one else ever has to see it. It can go in the shredder when you feel better but just channeling that nervous anxiety into a different modality for expression can be really helpful. Another thing to focus on is the sense of smell and the sense of touch. Some people find it really helpful to just get into that quiet, even if it's to get in your car, you know, whatever, get into that alone space, and aromatherapy.

Again, you know, there was a time when I would have thought "oh, yeah, right", but really like focusing your sense on a particular, you know, a relaxing, calming, there are many excellent ones to choose from out there and I think there's a whole business but get a scent that is calming or calms you and just focus on it for a little bit. Just close your eyes and focus on that scent. Another thing is sense of touch. If you are an animal person, and it's possible, like, it's at the end of the day, you're at home, just sit next to that animal, touch it, let it touch you, you know, stroke, just in some way, try to focus on a very particular outlet, capitalizing all the senses of your body and that can get people, you know, it's not a perfect cure but get them past that moment through that time. They just regain...

and if you can't do anything else, truly, breathing, just good old fashioned, deep breathing exercises, just focus on a breath on a count on some very specific thing to get you past that, so that you can then finish your day, do what you have to do, and then go home and decide if this is a one-time thing. Or maybe I should talk to somebody, which means yes, you should.

AMIEL: Right. Right. As you said, if you're having that thought, then it's a yes, absolutely. So that's really good advice and I feel like easy things that we can accomplish in the moment if we're starting to have those feelings. Now, so you mentioned that you've used some of these with your patients which is awesome and in episode one, we talked a lot about underlying causes, and just even swimming upstream to make sure that you're addressing what the cause is of you know, the issue that someone's experiencing or the manifestations they're experiencing. What is the... I wonder if you can talk to us about the kind of arc of a patient or individual, right, who is experiencing anxiety, or you're having these manifestations and you start with these first kind of non-pharmacologic techniques to help and they're helpful, or maybe they're not and then we transition to things like medications and things like that. What does that look like as far as taking care of a patient deciding you know what, now we have to get to the point that this is something you should be medicated for?

MILLER: So that is an excellent question, actually. And often the therapist calls us the meditators. They're the talker so we have this we have this dynamic back and forth relationship. So, one general principle is that if there is a clearly identifiable cause of anxiety, then the non-drug therapies should be first.

Unless it is just such a profound manifestation that they can't even you know, go out the door can't go to work and then it's usually a combination of therapies. But I mean, we see this all the time, people going through a bad divorce, you know, relationship is ending, a major financial upset. Maybe sometimes adolescents have had to move and it for them, it's traumatic. Like if there was any identifiable thing. Truly, the best practice is to work with a therapist on how to manage that thing and although you don't, I mean, meditators medicate. It's what we do. It's the discipline we know, and we just tend to do that but one of the most important aspects of prescribing is to know when it's appropriate and when it's not and so I have on numerous occasion, had a patient come to me expecting to be medicated and at the end of the interview, I'll tell them, this just isn't the answer for you. I mean, it happens every day.

In fact, I have a student working with me, precepting with me, a psych NP student, and last Wednesday, which was our clinic day, it seemed like every patient, I was advising them to see a therapist, we kind of laughed about it, because that's not usually the way it goes. And it's not the experience a psych NP student expects, but it was just the best thing to do for this certain number of patients. On the flip side, sometimes a patient will work with a therapist, and they just can't get the level of relief that they need to be able to go through their day to manage that social or occupational dysfunction and then we need to use medications.

The goal is always as a bridge. The goal is that the medications will be used with a timeframe in mind, you know, I always tell these patients, I don't want to have a long-term relationship with you. We want medications to help you just get to that place where you can be most receptive to the non-drug strategies that the therapist will work with you. So sometimes that happens if a therapist, typically we ask the patients to work with a therapist at least for a month, if they can, and they just feel like they're still not getting the level of remission they need, then we augment with medication therapy. On the other hand, sometimes there are patients for whom there is no identifiable cause.

And if there's not, then that more often than not, is primarily a biologic, a truly dysregulated neuro chemical concentration.

And then they are the people that will probably need medication for the long haul, like medication will be part of their world. Not forever. In psychiatry, one of the first things people ask you is, "Do I have to take this forever? Is this always going to be part of my life?" And the goal is that no, I mean, always the goal is no, but for the patient who really doesn't have any identifiable reason for the anxiety, it's just pervasive and part of their life, chances are that that is biochemical, and they will need medications for the long haul, to learn how to manage it.

Now, sometimes even those patients, once they get on medicines, they're just in the best, they're the best vessel, they're in the best place to work with a therapist. Sometimes a therapist really can help them learn strategies to manage their anxiety, so that sometimes we can trial taking off the medication. So, it is a continuum.

There's a trajectory, there's something for everybody.

AMIEL: Now, that makes sense. And what are some of those medications? What are some of the medications that you would use for a client like this?

MILLER: So, there are lots that are used with other medical conditions as well, or other psychiatric conditions and then there are a few that really are specific to anxiety. So, if we're talking about acute anxiety attacks, or a, you know, a more short-term phenomenon. So, the first thing we have is benzodiazepine which is kind of a dirty word these days. There is a high potential for abuse, it is addictive, the withdrawal can be physically very dangerous and so there is a real hesitancy to prescribe them and we should be very respectful of these medicines, because they can be dangerous, they can be addictive and so like every highly effective medication, there is a potential downside. It just seems like the more effective medication, the more the potential consequences of it. So, it's a risk benefit assessment, you have to decide risk benefit.

For some people, they really do need a benzodiazepine in the short-term just to get them through this week or this day or this thing or this something. Some people they tend to be nervous Nellies all life but they're fine, but they are absolutely terrified of getting on a plane terrified, have avoided it their whole life but now maybe their son or daughter or somebody is getting married, they have to fly across the country. They have to get on the plane. Give them a benzodiazepine. I mean, that's what it's for. They're probably not going to become addicted if they take one on the flight there and one of the flight back. Benzodiazepines really are pill-form alcohol. They directly suppress the sympathetic nervous system response. They suppress the racing heart. The impending like "I feel like I'm gonna die", the shortness of breath, the tremulousness, they suppress it like no other medication and so for someone suffering from panic attacks or very acute phenomenon, they really are the best option. They are not intended to be a long-term solution. Nobody ever intended for patients to take Xanax four times a day for the rest of their life, but for the short haul, it is helpful in the appropriately selected patient.

If you have concerns about abuse or misuse, well, then yes, we can't use that. We do have other options for short-term anxiety. They're not as effective. You know, you have to set those expectations with your patient but another commonly used drug for short-term anxiety is propranolol, marketed as Inderal. It's an old school beta blocker, meaning it blocks beta adrenergic

receptors, it blocks their response to epinephrine. So, epinephrine binds to a beta receptor and activates the sympathetic nervous system.

These drugs block that response and so they can help people. Sometimes we have people who, you know, don't need to be medicated every day. But perhaps they just got a promotion. And part of that promotion is that they have to lead a team meeting, you know, twice a month, and they are terrified. Public speaking, like, they almost didn't take the promotion because of that. This is someone for whom a dose of Inderal, an hour before that meeting, they can get through it. It may not be a glass pond. Again, it's about setting expectations with a patient, but they can do it, they can have their meeting, and they can have their promotion. And so, we have helped attenuate that social occupational response.

Another option sometimes that we will use as an antihistamine. You know, first generation antihistamine that crosses the blood brain barrier and can have some calming properties. Again, for the intermittent need when you don't want to use a benzodiazepine or maybe it's just not bad enough to use a benzodiazepine, you can use that as well. So, we do have these short-term, these options for the short term, isolated PRN use. And that's really the hierarchy: benzos at the top for the most profound, really disabling symptoms, beta blockers and antihistamines for those people that need help, but it doesn't quite rise to the level of the benzo or perhaps they have had a history of addictive disorder or substance use. And we just don't want to use a benzo. So that's the acute phase.

On the other side of the spectrum, people that truly do have anxiety disorders. And like I mentioned in the last episode, there is very different anxiety disorders, there's Generalized Anxiety Disorder, Social Anxiety Disorder, Panic Disorder, PTSD. So, for those for many, not all, but for most of them, we start off with the SSRI because they tend to be very well tolerated, they're safe. You don't get physically addicted to them in the sense that it's dangerous to stop them. And they're, they're well tolerated. So, they're a favorite among prescribers just because they're, they're safe.

An SSRI on a daily basis... now, it's important to recognize these are not meant for acute anxiety episodes. It's not like we say, "You're terrified of that plane, take an SSRI an hour before the flight", this will not help you. And whereas if they have anxiety on a consistent, you know, regular daily basis, these medications can be very helpful. There's a lot of SSRIs out there and most of our listeners are probably familiar with them. There's you know, fluoxetine, paroxetine, sertraline, citalopram, citalopram, fluvoxamine, and there's one for all occasions. And they all were originally designed as antidepressants, and they all help with depression. But they all also have unique little sidechain actions that the others may not have. And one of them is paroxetine, which is marketed as Paxil. And that really is the best SSRI in my humble opinion, when anxiety is the primary treatment target for people with generalized anxiety disorder, for instance, or long-term social anxiety. Paxil can be, I've had a lot of luck with that have been extremely successful in taking people whose generalized anxiety disorder was so pervasive that wouldn't get a driver's license or wouldn't get a job or didn't want to go back to school. And that medication on a daily basis allowed them to do that.

So, these aren't drugs that reverse your acute anxiety. These are drugs that over time help suppress it from manifesting. So, an SSRI would really be the first choice for people that don't respond to that.

The next level is, was called the SNRI or serotonin, norepinephrine reuptake inhibitor. So now you're involving another neurotransmitter that's implicit in anxiety, that would be the norepinephrine piece. And there are a couple of them on the market and they really are all equally efficacious for people that either don't respond to an appropriate trial of an SSRI or for some reason, don't want to take one but another one for anxiety that I really do appreciate the opportunity to mention here is called Buspirone or it's marketed as BuSpar. BuSpar is a medication that's not like any of the others we've discussed. It is a serotonin partial agonist. And it was designed for generalized anxiety disorder. It was designed for people that have generalized anxiety disorder, which is chronic and can be disabling. And for whom the SSRI, or the SNRI, just doesn't control symptoms.

Some people's symptoms are just that bad, and the SSRI won't do it. Buspirone on a daily basis, used appropriately as prescribed, can have an unbelievable impact on suppressing chronic anxiety. Now out in the world, both of mental health and in primary care, this medication has a reputation. It's not a bad one, it's people think it doesn't work. I've heard my own peers in psychiatry say, "Oh, it doesn't help. I don't use it. It's useless. It doesn't do anything" and it's because they're using it inappropriately. I mean, one of the basic rules of pharmacotherapy is don't ask a medication to do what it can't do. Don't ask them to do what it's not designed for. Because BuSpar was originally designed as an alternative to a daily benzodiazepine for people with really significant anxiety. It just evolved into trying to use it instead of a benzo for everything. And it's not.

So again, if you're terrified to get on that plane, BuSpar an hour before the flight is not going to help you. But if you have generalized anxiety disorder, that is really chronic and disabling and doesn't respond to the SSRI or the SNRI, BuSpar can have a huge impact. Without exaggeration, I'm not being dramatic. I have seen it save people's lives. I had one patient whose anxiety was just so pervasive. I mean, she was cachectic, she had a body mass index down to under 15. I mean, she wasn't eating, she wasn't sleeping, I am convinced she would have died. And we used we, me and my personalities, we used BuSpar. And I mean, it saved her Now, people with anxiety like that, they're never going to be just all "Don't worry, be happy". I mean, anxiety is always going to be a part of their world. That really is their biological makeup, but we can markedly improve it and improve that experience of daily life they have. So those are the medications. I mean, and there are people I feel compelled to say, few and far between, and we try everything else first. But there are those with panic disorder, where their life is characterized by unanticipated and unprovoked panic attack, and unexpected, they never know where and sometimes people do need to be on a benzodiazepine chronically, but thankfully, it's a very small subset of the population.

AMIEL: Yeah, that's excellent information. I learned a lot about those medications. And you said something about patients maybe not wanting to, right, so if it does, in fact, get to the point that medication therapy really is the answer for this patient in order for them, you know, to cope and to be able to live with this appropriately right, in their life. And they don't want to take a medication, right, I imagine that would be a barrier to you know, their own success. Right? And what can NPs do? Therapists? I mean, how do you help to break that down?

MILLER: It is, it is a huge issue. People refer to them as crazy pills, you know, I don't want to take crazy pills, I don't want to be on this stuff. People worry about it being on their record. Because there is such an articulation between or I guess I should say, among the pharmacists, the pharmacies, the insurance companies, and the prescribers. You know, there are these collective databases now where when I get a new patient, if it's a controlled substance, especially, I have to query a database, and I can see what else they're on. If I have a patient who transfers to me from another provider, or maybe they have an existing primary care provider, when I go into my

prescribing software, I can see everything that they're on. So, some people worry that others will have access to the fact that they're on a mental health medication, and they worry about how it could impact insurability, employability, they worry about driver's license, in some states where people want to have a concealed carry permit. They worry about the eligibility for that.

And these, you know, I understand these are not entirely unreasonable fears. I mean, the correct answer here is that there are privacy laws. I mean, we have HIPAA, this information should not be shared. But on a practical level, I do understand the concerns about it getting out. What I do tell if that's the problem, I do tell people, I have never ever seen it happen, where some unauthorized or some ancillary entity has access to their record and inhibited in any way. So, I understand the fear.

But in 29 years of prescribing, I have never seen it come to pass. So, I, as you know, as best I can, I try to reassure them about that. The stigma about taking any crazy med or mental health medication, you know, we all have different personalities and the way we approach patients, and I tend to be very down to earth, and point out that number one, they're in my office, there's a problem. I mean, obviously, they have a real problem, they want help, or they wouldn't be in my office in the first place. And that they can feel enormously better if they take these medications. I do reassure them that I don't prescribe indiscriminately, and I don't. And so there are those that do you know, there are some mental health offices where that's what they do, you know, they turn out the meds, you know, in all fairness to them.

That's what we know. And that's what we're taught. So of course, we think that is the answer. But I feel strongly that it isn't always and so I, I really don't prescribe unless I think it's the thing to do. And I will tell people if I don't have anything to offer them. So, I try to give them that assurance that I wouldn't suggest it if I didn't think it was really going to be helpful to them.

And then finally, the last two things that sometimes really seem to help are that number one, the plan isn't for the rest of your life. The plan is to help you bridge through finding a better way to manage these things and then, of course, the last example that sometimes will hit home is this, I mean, this is a biological phenomenon. You have hypertension, and you take medicines to lower blood pressure, do you think twice about that? If you have an overactive gut, you take medications to slow that down, you know, if your heart is pumping too fast or beating too fast, and you take medicines for that, do you see anything wrong with that? In this circumstance, you have an imbalance of chemicals that are making you feel this way. And we can normalize that. So, I really don't see it as any different than treating any other biological anomaly that can decrease health.

AMIEL: Such a good point, Sally. Thank you so much for that. Thank you for that. And, again, I appreciate you joining me today for this amazing dialogue as we continue to talk about all things mental health, anxiety, and more. So, thank you again, Sally, for joining me. And thank you everyone for tuning in. We hope you'll join us for another discussion and talk about how we can put this into our practice for ourselves and for our patients. I'm Jannah Amiel. On behalf of myself and Dr. Sally Miller, thank you so much for joining us. Goodbye.

(SOUNDBITE OF MUSIC)