Identifying and treating Agoraphobia

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Steve Trumble (00:00:00):

Welcome everybody and welcome to tonight's webinar on identifying and treating Agoraphobia. I think panic disorder might be better for the team on the webinar here, but anyway, it is Agoraphobia and we welcome all of the viewers who are watching the recording as well. Later on, MHPN would like to acknowledge the traditional custodians of the Land, sea, and waterways across Australia. Upon which our webinar presenters and participants are located, we wish to pay our respects to the elders past, present, and future for the memories, the traditions, the culture and hopes of Aboriginal and Torres Strait Islander Australia. So I'm Steve Trumble and I'll be facilitating tonight's session. I'm a GP by clinical background. I've been involved in health professional education for many years. The other panellists bios were disseminated with the webinar invitation, so in the interest of ensuring we cover as much content as possible during the webinar, we'll skip going over the bios in detail, but we are joined tonight by Caroline Johnson. Hello Caroline.

Assoc Prof Caroline Johnson (00:01:01):

Hi Steve.

Steve Trumble (00:01:03):

Now Caroline, as a fellow GP educator, what's one thing you think it is important for other mental health professionals to know about the GPS role in improving outcomes for people who are experiencing acrophobia?

Assoc Prof Caroline Johnson (00:01:16):

Well, the one thing I would emphasise is continuity of care. So the advantage that we have in general practise of seeing people over time and really helping them stay engaged in treatment and making sure that people get the kind of right dose and duration of therapy they need to recover from a condition like agoraphobia.

Steve Trumble (00:01:33):

Right. Alright. Thank you very much. Can only fully agree as a GP continuity is what it's all about. Peter McEvoy, welcome. Now, you've been working with the Centre for Clinical Interventions in Western Australia for a number of years. Can you share a bit more about the work you do with this organisation? Thanks,

Peter McEvoy (00:01:52):

Steve. I really wonderful to be with you. I've Centre for Clinical Interventions specialises in the treatment of anxiety disorders, affective disorders, so unipolar depression and bipolar disorder and eating disorders. So we offer cognitive behaviour therapy and we've been going for over 20 years now. So I've been working there all of that time except for four years at Crfa in Sydney in the early to mid two thousands.

Steve Trumble (00:02:22):

Great, thank you. And I'm sure that's where you worked most closely with Lisa Lampe. And now Lisa, we need to build a shrine to you. You have struggled enormously tonight with getting online, but you are here and we're very glad to have you here appropriately. You've been working with anxiety and OCD disorders for many years. What is it that's kept you engaged in that very challenging area of practise?

Lisa Lampe (00:02:44):

Look, it's the fact that people get better, but we have treatments that work. I love the collaborative nature of working with people and the fact that I learned from my patients and I can then pass that on to future patients. It's a wonderful circle of people getting better and all of us learning more,

Steve Trumble (00:03:05):

Right? Yeah, there's absolutely no question that feeling that you're achieving something is what keeps us going, doesn't it? So it's wonderful that motivates you. So we've got a great panel tonight, lots to talk about. We are using a new web player tonight, so I will just ask you to pay attention even if you've heard this bit before. But to interact with the webinar platform and to access the resources, there are a few options you can see there on the screen. To click the supporting resources button, you click that view supporting resources button under the video panel there. If you want to access the slides, the resources, the survey at the end, and also to get technical support should you need it, you can access the chat, which is at the top right, you can see a speech bubble up there and that's where you can click on that to get onto the chat room.

(00:03:57):

As I've mentioned, if you need technical support, you can click the dark button in the bottom right hand corner of your screen. We often find the webinar or if the webinar stops for people, it's usually an NBN issue rather than anything else. So please try refreshing your browser and if there's anything you have missed, this webcast is being recorded within the chat room. Please make sure that you are respectful of other participants and panellists and also keep comments on topic in the chat box. I can see there's lots going on in the chat box about people not being able to hear. You have to turn your volume up manually to be able to hear. So please make sure you've done that. And if your screen's frozen, sorry, please reload and you should be able to get back onto us. And Crystal's frozen as well. Crystal Lockhart, you can't hear me, but if everybody knows Crystal, send her a text.

(00:04:55):

Reload the URL. Now. Enough of that tonight, each panellist will give a short discipline specific presentation which will relate to the case which has been circulated. And then after that we'll have questions and answers between the panel, the aim and the learning outcomes are displayed. I won't

read through them because you can do that yourself, but basically it is all about learning about the comorbidities and most importantly, I for tonight, identifying treatments that work. We will move in now to the interdisciplinary presentations. We're starting off with poor old stellar. I must say it's probably one of the more florid case studies we've had in this series of webinars, but I always wanted to be a mills and burn novelist. So there we go. But anyway, plenty to talk about. Let's start with Caroline. Thanks very much.

Assoc Prof Caroline Johnson (00:05:54):

Thank you Steve, and thank you for having me here tonight. So I'm going to share the GP perspective and I think the first thing that we have to talk about GPS is we're the first point of call with respect to the health system. So it's very unlikely that Stella will walk in the door and just want help right away. Fact, we know from the 2007 national mental health survey that only one third of people who could benefit from help were actually accessing help. But the most important thing it found is of the two thirds of people who weren't accessing help, 85% of them said they had no need for help. So that's the world of the gp. People come to the GP about something or somebody else says to the gp, they're worried about someone. So it's a very different problem than when someone's already engaged in seeking help.

(00:06:37):

So the questions I have are what's Stella's developmental perspective? Is she going to come in with their mom dragging her in or her friends going to bring her in or is she going to present on her own? How willing is she given that she's anxious and struggling and staying at home, will she actually get help? And then there's all the other questions around what can happen to engage someone in care. And obviously when people are anxious, it's very hard to reassure them that even though there's a lot of barriers to accessing care, there's costs, there's appointment availability and everything else, it's worth accessing care. So the GPS role is often trying to make those barriers minimal and then also to think about having conversations with people about what's the right kind of therapy for that specific problem. And that's something that can be quite hard to do when there's time limitations, but I think it's really important and I often tell my GP colleagues to focus on what's the tipping point for the patient.

(00:07:31):

So often the point will be that their friends say this isn't good enough or their employment's at risk. Moving on to assessment, I guess the big thing to recognise here is the next slide please. The GP role is not so much about getting the diagnosis perfect, it's about making sure that you're not missing anything. So certainly in a very brief way, making sure that you're not missing any physical health problems and gps have little approaches to that. What's the most likely diagnosis? What are the red flag diagnosis I want to miss, and Lisa, we'll touch on a bit of a few of those things we consider and then this consideration of, well, does it matter what kind of anxiety Stella has? And I think it does matter because different types of anxiety respond to different types of therapy, but also there's more than just getting the diagnosis right?

(00:08:20):

There's the formulation and thinking about what are the factors that, and again, people talk a bit more about formulation, but recognising that the GP formulation is often not done in a nice linear way from presentation to end. It's often bits of information that occur over time. Moving on to the next point, which is the management slide. I guess the big thing to emphasise here is the gps really work in what I

call a dimensional perspective. We don't really wait for someone to cross a categorical diagnostic line before we do stuff, although a lot of the systems we work in actually require us to. So for example, you're only eligible for a mental health treatment plan if you've got a diagnosis. But most of us in general practise land will be a bit pragmatic about that and say to patients, well if you're very close to crossing this line, we won't wait until you get sicker.

(00:09:04):

But there are implications for that around a person having a diagnosis. And in that respect it's really important to listen to the patient, what do they think is going on, even if you disagree with what they think is going on, you've got to have a conversation about what do you think caused the problem And spend a lot of time on having conversations about what the mental health professional's view is of what causes anxiety and what perpetuates it. Because getting that kind of shared understanding can really help prepare someone for therapy. And then there's of course the conversation around what type of therapy. And I'm not going to speak about that a lot now except to say the GP has a really important role in explaining to people with anxiety disorders that getting help is hard. I often use analogies like you don't expect someone to suddenly run a marathon if they're not training for it.

(00:09:48):

And to get help for anxiety, you really have to be prepared to commit to a bit of time and work. And my role as the GP is to sit with you on that journey. So moving on to how will we then work once we hand over the care to other professionals? And I guess the big thing here is gps do like to know from the health professionals we are referring to what their approach will be. I certainly spend a lot of time when I meet someone who says, I've had therapy before. It didn't help. I say, well, what exactly happened in therapy? Because then I can at least form a view of did they get an evidence-based therapy, did they get CBT or something else? And so for those of you who often interact with gps, please remember it's not that helpful to just say to Stella, go and see GP to get a plan.

(00:10:27):

If someone turns up with a 15 minute appointment, you're not going to get a very good quality plan with that approach. So thinking about how you're going to engage not just with the GP but also with the patient and the family. And then the last points I guess I want to make, which is my big area of interest, which is the last slide I'm going to talk to is the issue about recovery. And I think it is true what Lisa says, treatment for acrophobia does work, but people often have a lot of false starts because it's a difficult thing to do. And I see myself, the GP role, my own role very much is to save the person. I'm sticking with you on this journey, I want you to come back if it's not working or you want to drop out of therapy, that's your choice, but come and talk to me about it because this will come and go and you might have a few false starts. And I do think that that ability to monitor someone over time and look out for relapse and talk about relapse signals and finding out what did you do when treatment didn't help is really important in keeping people engaged for the longer term. So I think they're the main points from me. Steve.

Steve Trumble (00:11:24):

That's great. Thanks Carolyn. Thanks very much indeed. And so you would've probably given a diagnosis I guess to Stella in this case and she'd move on if you weren't going to do the counselling yourself to a

clinical psychologist or other suitable counsellor. And Pete McAvoy is going to give us that perspective now. Thanks Pete.

Peter McEvoy (00:11:45):

Great, thanks Steve. I feel like on behalf of all psychologists, I need to thank Caroline and all the GPS for all the amazing work they do before we see clients in helping to collaborate with the explanatory models and preparing them for therapy, which makes our job a lot easier. So when we first start to see a client, obviously we'll put together a problem list and really try to understand the impacts on the client's life from their problem. So in seller's case, if there's a history of panic attacks, then understanding their onset, any changes, persistence, frequency and intensity of those attacks. And I'll probably ask seller to give me a really detailed example of a time when she's experienced a panic attack or in terms of agoraphobia, just how she experiences that. I want to be pretty sure that a medical review has been completed and I'm assuming after someone has seen Caroline, that that has been completed.

(00:12:47):

And I can assume that there are no medical complications. And so psychological formulation of the problems is appropriate. I don't assess for co-occurring problems. So depression, social anxiety, and also the temporal relationship between those problems. So did the agoraphobia follow the social anxiety or come before and the depression as well because that tells us something about the relationship between the problems that Stella is presenting with and also guides what might be the treatment priority. Some of the low hanging fruit may be lifestyle factors that we might want to consider working on as well, but also protective factors that we may want to recruit to support Stella's recovery. As we work through therapy, we want to be aware of other interventions, particularly medications. If there are PRM medications like benzodiazepines, then that might really interfere with our progress. So we really need to know about that at the outset. And then we want to assess change as part of our assessment formulation. We might administer some psychometric measures with some of the beliefs, some of these scales as examples here that we also want to target and treatment and seek change in over the course of therapy. Next slide please.

(00:14:08):

We'll do an assessment of predisposing factors. We know that anxiety is highly heritable, so it tends to run in families, so there's going to be a genetic component most often. Also some environmental factors, so parenting or modelling of coping behaviours with anxiety that you might want to know about. And also significant life events. So any early experiences with trauma, separation, deaths of parents for example, and then temperamental factors. So non-specific temperamental factor. When I say nonspecific, I mean increases risk to a whole range of different mental disorders, things like neuroticism. But in terms of panic disorder and a phobia, anxiety sensitivity, a fear of those physical sensations, which may be a fear that physical sensations may lead to a medical catastrophe or a cognitive catastrophe in terms of losing one's mind or social catastrophe. So may lead to severe negative evaluation. For example, people who believe their anxiety may lead to those things are more likely to develop panic disorder and potentially a phobia. We can't change a lot of those predisposing factors that happened well in the past, but we can work on what's left behind. So some of the beliefs about self, others in the future and coping strategies as examples. Next slide please.

(00:15:35):

Moving on to case formulation. So I often think about the seven Ps when I'm formulating presenting a problem. We've already talked about predisposing factors we've talked about and then I get a sense of precipitating factors so we can break that into a distal precipitants. Those factors where there was a significant change in the rate or frequency or intensity of the acrophobia, what was happening around that time for the client, but also on a daily basis, more proximal triggers, what's triggering the avoidance or the anxiety every day for the client. And then the perpetuating factors, what keeps it going well, the cognitive content, the thoughts and the images that the client maybe has gone through their mind about what may occur if they don't avoid these situations helps us to establish a differential diagnosis about what might be driving that avoidance. As a clinician, we're aware that attentional biases, interpretation biases and memory biases may all be at play in the session as well.

(00:16:36):

So the client is focusing their attention on the perception of threat. They might be interpreting fairly ambiguous information in their environment, consistently with their expectations of threat and therefore they're more likely to remember those examples of negative experiences at the expense of more benign or positive experiences. In terms of avoidance, we obviously want to know a lot about the sort of situations they're avoiding, the ways they're avoiding it, subtle and not so subtle ways, and how much more generalised that's becoming over time. Obviously there are emotions we want to assess and also physiological symptoms of anxiety, protective factors. As I mentioned before, we want to recruit these during our therapy and use those to really support the client's recovery. Think about potential obstacles to change from their past experience of therapy perhaps or whatever's happening in their life that might interfere with their progress. And we need to plan for contingencies around those.

(00:17:35):

And then obviously that all this leads to the treatment plan itself. Next slide please. So here's a formulation, a simple formulation we may bring together for Stella based on Clark's cognitive model of panic disorder. And I've adapted it here to take into consideration some of the features of agoraphobia. So we might have a trigger stimulus, internal stimulus of maybe physical sensations of anxiety or external situations. In Stella's case, crowded, noisy places, social situations, shops, university campuses, and she describes the buses as go on wheels. So bus is definitely a trigger of stimulus. There's some sort of perception of threat in these contexts which leads to that apprehension and the fight to flight response. So it'd be a lot of psychoeducation around what the fight or flight response is and how that manifests for Stella in terms of bodily sensations, how that leads to some sort of catastrophic interpretation of the sensations, but also the situations she talked about being dragged away for torture by her friends and sister I think in the case and feeling trapped like a rat in a box with no escape.

(00:18:44):

And I'd want to know if you were continue to be trapped, what then would happen? What are her predictions about that? So to prevent those catastrophes happening, she engages in a lot of avoidance of using emergency exits, escaping, avoiding, using more time at home, spending more time at home. And all this really serves to maintain that perception of threat and keep the cycle going. So really we want Stella to understand these cycles, see how it explains her past experience, her current experience, and how it also presents the change in an altered future. That's more positive. Next slide please. So in terms of the core components of treatment, a lot of psychoeducation during that individualised case formulation, we might engage some cognitive restructuring and thought challenging to modify that

perception of threat. And a lot of that challenging might happen through behavioural experiments where we're setting up experiments where we're directly testing some of her fears and that might involve interceptor exposure to the physical sensations, situational exposure in vivo exposure.

(00:19:50):

And while she's doing that, really abstaining from any subtle avoidance behaviours because those behaviours are going to stop her from really directly challenging her fears. We may introduce some arousal strategies. I don't often use those routinely because they can stop Stella from learning that her anxiety is not dangerous, it's not threatening, it's not going to lead to a catastrophe. So it really depends upon the function of the de arousal strategies. Is it just to dampen down some of the feelings or is it to try and prevent a catastrophe? If it's the latter, we really want to not use them when we're doing the behavioural experiments and then routinely outcome monitoring our outcome session by session to make sure our treatment's having an impact. That's great to Steve now.

Steve Trumble (00:20:37):

Thanks very much indeed. Wonderful. So just before we move on to Lisa, I just want to remind people to post questions if you have them. There are no questions as yet, which is unprecedented. I've just checked the system is working. So just remember you've got to put your mouse cursor down to the bottom of the image and hover over the three dots there and then that'll show ask a question, you click on that and ask a question. So we should be able to answer those when we get to that point in the presentations or in the webinar. So now Lisa, thank you very much. Let's hear the psychiatrist perspective.

Lisa Lampe (00:21:17):

Thank you. I guess generally by the time a patient comes to see a psychiatrist, often they're not making the sort of progress that the referring practitioner would've hoped for them to make. So I guess the first thing that we tend to think about is the diagnosis, right? So in this case I would take a close look at the history and there's a few little pointers that maybe we should consider some other things. There's a reference to being shy. So could this be social anxiety disorder and could that be the primary disorder or could it be a coexisting disorder? Noting that endorsing shyness is really pretty common and particularly in that age group, it wouldn't at all be unusual that entering a new social environment like university could cause a transient increase in shyness and social anxiety. Shyness is also particularly common in younger people and so it's not abnormal, but I would just be thinking in the back of my mind, okay, could this be social phobia?

(00:22:25):

Her key concerns appear to be physical symptoms. So that certainly makes panic and phobia more likely because social phobia is much more about worrying what people are going to think about me and there's a little bit of that, but it does look as though physical symptoms are more likely. And of course I would be wanting to think could a medical condition or treatment explain these symptoms? There's a little hint about alcohol use, so I'd certainly be wanting to explore that further and just checking what level and are any other substances involved? Next slide. So there's a few things to keep in mind diagnostically and first of all, panic attacks don't make it panic disorder. Panic attacks can actually be

seen in any anxiety disorder. So that of itself is not enough for us to say, okay, this is a panic disorder. I really would want to clarify with Stella what her main fears are.

(00:23:28):

So for example is the worst thing to her that somebody might think that she's bullish or looks odd or otherwise negatively evaluates her? Or is she much more worried about some terrible physical or mental outcome like Peter highlighted in his slide about losing it or being trapped and what would happen if she was trapped? What does she fear would happen? The associated avoidance certainly makes it phobic. So that means that if she's having the panic attacks it would be and the main fear is physical or perhaps going insane, then panic disorder and the associated avoidance would make it agoraphobia if she's avoiding because of those fears. And just noting that age is a very relevant factor when we're making a diagnosis because anxiety disorders usually present for the first time in the teens or twenties, it's highly unusual for a patient over 40 years to be presenting with anxiety for the first time, particularly panic or a phobia.

(00:24:40):

So that's a bit of a red flag. And the two most common things to think about in that case would be is it really a depression with prominent anxiety symptoms or is there in fact some organic cause, a medical condition or treatment? Next, we also would think about comorbidity as again as Pete referred to, if you've got one anxiety disorder, you're likely to have more. We always should think about major depression because there are some common genetic vulnerabilities between anxiety and depression or particularly for generalised anxiety disorder. But depression does come first in about 33% of cases in panic and agoraphobia, not so much in social anxiety disorder, which tends to come first. A number of medical conditions which are GP colleagues are very good at checking for. So I don't necessarily go into a lot of detail there, but just sort of tick the boxes and then we just need to check could it be size of medication possibly for some other medical condition or even psychotropic medication. Next slide.

(00:25:58):

We know some interesting things about the first panic attack. So DSM three or dsm, oh it's five now, sorry, always talks about coming out of the blue and the first attack may seem to come out of the blue and it seems to most often happen when somebody is away from home when they're intoxicated or withdrawing from substances or when they've recently had an illness or are going through a period of increased stress, but thereafter it's pretty rare that they come out of the blue. And one of the things that I or a clinical psychologist treating the patient will do is really help them learn what those triggers or cues are. Next slide.

(00:26:41):

It's also interesting you think about when panic attacks occur. So there's often a misapprehension amongst lay people that agoraphobia is the fear of the marketplace or the fear of open spaces, but really it's the fear of being anywhere where you wouldn't be able to escape or get help if you needed it. So people can get panic attacks when they're alone. They can get them when they're with friends and family, they can get them in their sleep and that tends to be particularly frightening for people. But the good news is it responds just as well to our usual treatments. So panic attacks can actually occur really in a range of situations, not just when people are away from home. Next slide.

(00:27:28):

Now the treatment algorithm, this was from the RANZ or it should say CP clinical practise guidelines. That's the College of Psychiatrists and these came out in 2018. These steps really are often done by the gp. So the GP makes a good global assessment and then because so many conditions in general practise, and Carolyn can tell me if I'm right or wrong about this, but they often spontaneously resolve. So the GP takes a watchful waiting approach but gets the patient to come back if symptoms haven't settled. And then we think about initial treatment based on severity. Next slide. And this is what we recommended in the guidelines that the mild anxiety, cognitive behaviour therapy is the treatment of choice and medication is often not required at all the moderate CBT or medication or both. But really we wouldn't recommend both. We think that one or the other is probably sufficient and even in moderate cases, CBT, if the patient can engage with it and get good quality, CBT is often sufficient. But when we start talking about severe anxiety disorders, then we are probably thinking about combining cognitive behaviour therapy and medication and just noting that if a patient is likely to need medication more than a few days, then it should be an antidepressant, not a benzodiazepine and not a beta blocker. And the other key point to keep in mind and for patients to know is it takes a lot longer for anxiety than it does for depression to see a response. So at least four to six weeks. Okay. I think that's it, isn't it?

Steve Trumble (00:29:16):

It's indeed. Thank you so much, Lisa. That's fabulous. And the questions have gone esque, which is great. There's been lots coming in now, so we've got plenty to talk about and we'll move into that phase of the webinar. Now the first question as I promised because she was the first cab off the rank was from Lynette Moody Moodly, and Lynette has asked at what point will it be useful to explore the causes of the anxiety or panic in addition to symptom management? So when do we go back to look at what's actually maybe underlying this rather than just treating symptoms? Lisa, it looks like you are up and it's hard for Lisa because she's using a Commodore 64 she found in the drawer. Hard to unmute there she goes.

Lisa Lampe (00:30:08):

Look, I just want to, I think emphasise what Pete said is that genetic factors are much stronger in anxiety than they are in many other disorders. And it's uncommon that there will be some cause like a traumatic incident or parenting experiences. So I often say to my patients, you didn't cause your child's anxiety except in so far as you passed on your genes. And so it's not something about parenting very often or a traumatic event. And I think that that's probably good news for parents, but where they need to help if they've got anxiety, which one or other parent or both usually do is show how to feel the fear and do it anyway. And I guess Pete might want to add something there as well.

Peter McEvoy (00:31:05):

I would agree with everything Lisa said. I guess we've talked about a bunch of potential causes of heterophobia and that's while we'd spend some time really trying to understand the content of the perceived threat that she's reporting and when it started around the onset, what was happening for her to really understand her interpretation of those contexts. And that will tell us a lot about how to treat it, how to respond to it using the principles that we've been talking about. If there is a history of trauma clients who grew up in very violent households for example, then it may be that we target that as well in treatment separately, but it won't necessarily mean we wouldn't also type acrophobia using the

approaches we've been talking about. But really that falls out of the assessment and the case formulation and that will guide the intervention rather than the other way around. And certainly diagnosis is one bit of information, but it's by far not the most important. Everything else in the case formulation is far more important.

Steve Trumble (00:32:22):

Great. Excellent. Thank you Peter. Now the next question we've got from Andy Williams who's been active in the chat box and as posed to her question in the question area, and it's actually a really important one, it's saying that we don't have anyone with lived experience on the panel primarily, and I was just wondering if there is anybody on the panel who could maybe give us some insight into how things might resolve for Stella. So what would she say about her experience if she or another person with lived experience was on the panel? I might ask you Caroline, because you are sort of in the front line of general practise, so next time you see Stella for something else, what do you think she'd be saying about her experience?

Assoc Prof Caroline Johnson (00:33:07):

Well I think it's a lovely segue from what Pete and Lisa were talking about before about which comes first, the trauma or the genes, the trauma, everything else. What I love about working in general practise with people over time is I noticed that their explanatory models about what's happening changes with time. And one of the richest things in general practise is because you see people little pieces as they're going through their therapeutic journey is you could just encourage them to reflect on that and talk about it. And so sometimes people really want to focus a lot on the bad things that have happened to them and then your role is to get them, make sure they feel heard, that somebody's really listened. I think that in itself is immensely therapeutic. And then maybe over time, particularly with a condition like agoraphobia of saying, well, it's all part of the journey is to say, well, I understand that these things happen to me and I understand the link between them and this condition that I have or my family history or whatever.

(00:34:02):

But then there's a kind of a leap they have to make of saying, well, I now have to do some things separate from that. I can't just be a victim of my past or my genes or whatever else I have to now do this and that lived experience. That's the bit I find most interesting. I think it's really hard for some people it's very unpleasant to do exposure, it's very challenging. And when the psychologists say to us, well no, don't give them beta blockers. And I think we all accept not to give benzodiazepines, but it's very tempting to say, well here's a little bit of beta blocker just to help you when you've got to do this. And so the experience of the person is often this one of knowing that they're being helped but often feeling like they're being abandoned because people are asking them to do things that make them feel worse. And I think that's a really important thing in general practise to have those conversations of saying, I know that's part of the journey, but it's worth investing the time because I can tell them lots of stories of people I know who have gone through that journey and gotten better. But Pete might want to add to that.

Steve Trumble (00:34:59):

Pete.

Peter McEvoy (00:35:00):

Yeah, thanks Caroline. Firstly, I guess I would say that there's no way I'd ever ask anyone to do something that they didn't believe would be helpful for them. And so the process from the very beginning needs to feel very collaborative and although we bring our expertise in terms of our understanding of theory and research and past clinical practise, the client is the expert in their life and their experience and it's a coming together of those expertise that are going to produce the best outcome. So if ever a client of mine felt like I was asking them to do that was terribly uncomfortable for fund or they didn't clearly see how it could help them, then I've not done my job well at all. So the client needs to understand what they're doing, why they're doing it, how is going to be helpful to them, why it's important.

(00:35:55):

And if they can't articulate that themselves and understand why it's important for them to do it, then we need to take a step back. And in terms of the individual lived experience of recovery, that is very individual and that needs to be us as clinicians really understanding where the client wants to get to and helping facilitate them to get there. It's not our agenda, it's not so some clients it's going to be these panic attacks are just really affecting my life and I really want to be able to do X, Y, and Z. Okay, so there are priorities X, Y, and Z. Let's work together to get there. Now a lot of the strategies we'll be working on in treatment are a means to an end. They may not be the ends themselves, it might be other aspects of the person's quality of life that really they want, they're coming to therapy for, but they need to understand how those means are going to get them there. And if they don't, we've not done our job well.

Lisa Lampe (00:36:54):

Okay. Can I add something Steve? I'm sorry. You go ahead

Steve Trumble (00:36:57):

Lisa, please.

Lisa Lampe (00:36:59):

In my experience, anxiety can be quite contagious from a therapist and I think sometimes treating clinicians offer medication partly because of their own anxiety. Pete's absolutely right. I want my patients to be their own therapist to understand why we would be asking 'em to do anything difficult and really negotiating it with them. A lot of therapists get anxious about a patient's anxiety and sometimes prescribing. I think it's a little bit more to treat the therapist's anxiety than the patients.

Steve Trumble (00:37:41):

Okay, we'll leave that one thing there because it's a really important point and obviously something we need to be very mindful of, but it has actually a couple of you have now mentioned exposure therapy and that was something that came up in the questions that were submitted before the webinar and it's

coming up a bit in the chat box as well. I'm just wondering, Pete, did you have any thoughts, any more thoughts about exposure therapy and it's role in agoraphobia?

Peter McEvoy (00:38:07):

Sure. Where to get the biggest bang for our buck in therapy and traditionally we might've used mainly behavioural rationale. So it's about habituation and just repeatedly going back in the situation to desensitising. But really in contemporary practise it's more a cognitive formulation. It's about what is your prediction specifically about. It might be about your anxiety, how intense it's going to get, how long it's going to stay up for. It might be about how other people respond to you in that situation. We really need to isolate very specifically the client's predictions in that situation and set up the circumstances where they can directly test those beliefs and find out once and for all how accurate they are. And we know we've done our job well when a client's walking back to the clinic, if we've gone out of the clinic to do an exposure shaking their head in disbelief, they're just so surprised that their fear did not come true.

(00:39:03):

That's when we know where we've really maximised what we call the expectancy violation, that difference between what they were predicting and what actually happened. And that's where the most powerful learning occurs. So before I mentioned I rarely use controlled breathing or relaxation in conjunction with exposure. I really would never do it. The reason is because it minimises that expectancy violation. There's always another explanation for why the client survived or why they could cope. It's only because I did the controlled breathing. But in fact, if we as therapists believe that anxiety is not dangerous, it's not harmful and it's tolerable, and actually I go into therapy knowing that my clients are far more capable and they believe themselves to be, then really what I need to do is create the circumstances for them to learn that about themselves and maximise that expectancy violation. So we don't need to control it, we don't need to minimise it.

(00:40:01):

We can just actually go and experience and ride the wave, come out the other side and learn something about how intense it gets, how quickly it passes and how the client is capable of tolerating it. Some of my biggest wins actually have been when clients have occasionally had panic attacks while we've done exposure exercises and they might have the belief now I've got to go home and rest for the rest of the day. And we test that belief. I remember a client who wanted to do that and would typically do that, but she decided instead to go into uni and test that out, came back to me next week and said, I could not believe how productive I was that afternoon. I thought I'd be shattered and couldn't achieve anything. And that was a huge turning point for her. The violation of her expectancy was so massive that she was just ran away with it and was doing amazing things. So there's a well designed behavioural experiment. We can always learn something about the probability of the fear coming true, the cost of it if it were to come true, and also the client's capability to cope if it comes true. So our job is to help the client learn those things about themselves.

Steve Trumble (00:41:10):

That's great, Peter. And to lift a quote out of the chat box from Daniel make the amygdala learns through experience, which probably sums up a lot of neuroscience in a few words. That's great. So thanks very much and lots of positive responses too for Lisa's comment on dealing with the counter

transference that we have to be very, very mindful of. So plenty to talk about still. And I'm actually going to go back to Lisa now because there's been a number of questions that have popped up in the chat and also more formally asking about comorbidities and overlap presentations, everything from autistic spectrum disorder, alcohol addiction, PTSD, depression, all of those sorts of things. And just wondering about how much we, I know we've already touched on it, but how much do we have to tease apart those comorbidities or do we rank order them in treatment or do we try and take more of a omnibus approach?

Lisa Lampe (00:42:10):

Comorbidities are extremely important because they're very common and I think it's important to be aware of them. Having said that, sometimes patients don't disclose all the detail until they trust us better or sometimes they've so much accommodated or learn to live with symptoms that doesn't occur to them to mention them. So sometimes it's something that we find out over time as we get to know the patient better, but it is really important to be aware of other symptom clusters if you like, that could be there. I'm a little bit cautious about thinking that we have to give a name to them all and diagnose 'em because in order to help an individual, we need that individual's problem list. So although I do a diagnostic exercise and I sometimes just have to be aware that there are some symptoms suggestive of PTSD or a SD or whatever it might be, without meeting a full hand.

(00:43:16):

And also I'm careful about putting a label that might stick and not be particularly helpful. So I'm cautious about making a lot of those diagnoses. But in terms of enumerating the problems that they're causing, difficulty sleeping, social anxiety, drinking too much or relying on substances, I think that's the way that we can then start to prioritise and individual's problems are and what ones are causing the most distress and impairment, and then think about strategies that we can use. So that's where the formulation, individualised formulation becomes very important. And then as we go along, okay, if it becomes clear that they meet criteria for another diagnosis, then we might share that with them because it can be helpful sometimes, I mean labels aren't all bad. Sometimes they help you look for more information or get in touch with support groups, for example, or for us as therapists to think about other treatments that might be helpful. I'll say it is important to think about a trauma history because as has been mentioned, exposure can be very confronting. So we do need to be mindful of the sorts of things that might be triggering for people, but that is all part of a comprehensive assessment. And as I say, I think gradually putting the pieces together over time.

Steve Trumble (00:44:46):

Well, in the question, sash has actually given us a particular symptom that ties in nicely to Stella going off on her sister's hens night, which is that again on differentials that your thoughts on avoidance of public places being driven primarily by fear of vomiting, induced by anxiety and escape not being possible, and the consequence, the feared consequences, judgement of others and embarrassment of being seen vomiting rather than the act of vomiting itself. Throwing it at the three of you here, what would be your first approach if Stella had come with that particular symptom? What would you focus on? Peter, you're like, you're nodding or vertically shaking your head. I'm not sure which cultural sign you're giving me.

Peter McEvoy (00:45:32):

Yeah, look, I'm happy to speak to this. So the primary perceived threat is what's going to probably guide our diagnostic assessment in this case. An important change I guess in DSM five was that didn't have to be panic disorder, didn't have to be present to be able to diagnose acrophobia. So that's a really important thing to keep in mind. ICD 10 already allowed them to be diagnosed separately. So the agoraphobia that Lisa defined earlier is really agnostic to what the fear actually is. But other than people being afraid of help not being available should they need it, so why do they need help that may differ across people? Is it a fear of falling? Is it a fear of panic attack? Is it a fear of something else? So that I guess is the first point. The second point in that example, we could be thinking for differential diagnosis and meta phobia, that fear of vomiting, but there's a social aspect to it in the fear of judgement from others.

(00:46:44):

If I were to vomit, I guess for differential for that, I'd be saying, well, is the social anxiety generalised beyond just the fear of vomiting? Is the person more broadly fearful of other people judging them negatively for other reasons as well that the symptoms of anxiety might be obvious to them that they might fall short of other people's expectations in some important way or some sort of rejection may issue because of the way they're behaving. So if that's more generalised, then I'd be thinking more social anxiety is part of the picture and maybe the vomiting is a consequence of that and then the social judgement . But if there's no generalisation of that fear of negative evaluation, then I might be thinking more AMO phobia as a specific phobia and maybe with agoraphobia as a fear of going out in case help isn't available should the person feel unwell and vomit.

(00:47:38):

But it could be that the avoidance is really driven again by the meta phobia itself. So again, your pace formulation should address that. The other point I'd make following on from Lisa's point and the question about co-occurring problems, we can take a very trans diagnostic perspective as well because a little secret is that all anxiety disorders are going to involve some perceived threat, some negative thought leading into some emotion of fear and anxiety, which leads to some sort of emotion driven behaviour, which is some sort of avoidant behaviour which then maintains the perceived threat. And that's the cycle we could plug into that simple formulation, really any anxiety disorder. So what do we want to achieve? We want clients to learn how to manage their thoughts more effectively so that they're more balanced and more accurate and more helpful to them. We want them to learn that they can cope with those emotions without having to avoid them.

(00:48:38):

So the emotions themselves are just scary as they used to be, and we want them to directly challenge their perceived threats as well by actively confronting those situations and learning that it's less probable their fears to come true, less costly, or they can cope better than they thought. So if we take those general principles, we can apply that to any of those anxiety disorders. So in this example, let's say well avoiding a social situation for fear of need evaluation, serving the same function as avoiding a situation for fear of vomiting, they're both avoidant functions. So if the client can really understand the function of their behaviour, they're doing the avoidance for good reasons, because they want to protect

themselves from threat, that's a really important point to validate that they're doing it because it has helped in the past and they believe it's helping them currently.

(00:49:28):

If we can help them to understand how those behaviours are acting the longer term maintaining the problem. So it's worthwhile experimenting with dropping them and learning that actually they can cope better is less probable and less catastrophic than they thought, and that can be applied to fear of vomiting, fear of negative evaluation or any other fear, then they're learning how to generalise those principles across their problems and it's going to be a much more efficient and effective way of treating their primary problem, but also their co-occurring problems and hopefully leave them less vulnerable to relapse down the track.

Steve Trumble (00:50:05):

Great, thank you very much. And actually I'm going to jump in and ask a question that anybody can respond to because it's got quite a lot of support in the chat box, which is about whether there could be sensory sensitivities going on in Stella's case here and the sorts of things that she's avoiding. Carolyn, I can see you nodding. I mean, presuming she's not vomiting and you're not taking a more physical approach, would you be wondering about autistic spectrum disorder if she was complaining of sensitivities like that?

Assoc Prof Caroline Johnson (00:50:35):

Yes. I mean this is something I certainly think in the last few years it's become easier to have conversations about because our patients are also much more informed about this and whether the pandemic helped people spend enough time on the internet to start asking these questions, which I think is a great thing that they're actually questioning it. And I have had a few patients who have had sort of physical fears that we thought were anxiety, and then they've raised the question themselves, is this a sensory problem? And I guess the challenge for me as a GP is then often the psychologist they're seeing who's trained in pure CBT says, well, this isn't really my area of expertise, go back to the GP and find someone else. And that can be really hard as a GP because you go, well, it is a slightly different thing than just sort of textbook CBT and how am I going to help the person?

(00:51:18):

And I do think if psychologists have expertise in this area, it would be really good if they highlight it on their website so that we know there are people who are comfortable dealing with those variations. Because it can be quite challenging for a patient when a therapist says, well, you've had your dose of CBT and I think you've got something else going on and I can't help. And there's a shortage of professionals to help in that area. So any sort of advice around who's comfortable offering that so that people don't end up just going around and around the sort of therapy circles and starting again, I think is really important. And then from the GP point of view, it's about being really compassionate and saying, yes, this is possible, but for most of us in general practise, even though those of us who are comfortable delivering simple CBT, we probably would want some extra help around those for all the things Lisa said about not using labels inappropriately and confusing people more.

Steve Trumble (00:52:09):

Yeah, I must say I never wrote the case thinking of Stella as being neurodivergent, but it's something that would be in your mind all of you I guess when you think meeting somebody with Stella's issues. Alright, so thanks so much for everything that's been said so far. There has been quite a lot of, or quite a few questions asked about other approaches to therapy and as Carolyn said, some people might not see CBT is always the frontline of treatment here, but question from Kay about the role of other counsellors in particular school counsellors or counsellors that Stella might have access to educationally at the university. Just wondering about how perhaps counsellors who are not particularly health professionals might be able to assist Stella with her problem.

Assoc Prof Caroline Johnson (00:53:05):

Well, I mean I guess I could respond there. As a gp we often hear that people are going to see different types of help. And so that kind of conducting the orchestra of saying, well, let's make sure that different types of help don't confuse each other. If someone's having a dose of CBT, then you want them to stick on that path until we've decided whether it's going to help or not. So this is where school counsellors can often be really helpful in being that sort of empathic connection contact, but just being really mindful of not undermining therapeutic approaches and certainly not saying, oh, why are you trying that? It doesn't work because not really helpful once someone started something. And so I'm really grateful if people, my experience as a gp, people will often turn up and say, the counsellor said I should just come and see you and get this.

(00:53:48):

It's very rare for them to call or leave a message. And I'm very grateful when people do, I know it can be hard to get a hold of gps and we can find it hard to get a hold of school counsellors, but having a quick chat about our alignment I think can really help just so that everyone's on the same page. And I think a school counsellor can be hugely helpful, particularly when the family's not so engaged or they're a bit sceptical about the benefits or there's cultural issues that a traditional clinical psychologist might not have grasped so much in individual therapy. And I think that they do play a role there, but I think it has to be a team game, not individuals giving unsolicited advice

Steve Trumble (00:54:27):

Actually. Thanks Caroline. I'm actually going to go back because there's a question I've got and fortunately it's also been asked by Lisa, oh no, sorry, by Jess, which is about in Lisa's presentation, why is the presentation over 40 years of age a red flag? What in particular? And somebody else asked about menopause obviously a bit later than 40, but we're just curious about why in particular over 40 is a red flag?

Lisa Lampe (00:54:55):

Well, it's actuarial, for example, 90% of people who are going to get social anxiety disorder will have it by 30. So it's just saying when you hear hoof beats, think of horses not zebras, at least in Australia, knowing that a particular condition is much more common in a particular age group, that's all. So it doesn't mean you can't get anxiety for the first time over 40, but it's uncommon. So it means that I don't want to miss something. So I guess it's like chest pain, isn't it? If you're over 40 and you're getting chest pain, we are going to look a lot more carefully for a cardiac cause than in a 20-year-old presenting with

chest pain. I mean, we're not going to absolutely exclude a cardiac cause, but we're going to perhaps really be thinking of a much broader constellation of possibilities. So that's all. It's just about what we know from large scale population surveys about the ages at which people first get their anxiety.

Steve Trumble (00:56:05):

Alright, well that's useful alters our diagnostic suspicion I guess depending on the person who's in front of us at the time. Now we've only got time for a couple more questions and there have been a lot after a slow start, which is fantastic. But this one from Lisa, it is Lisa this time. Hope it's not you asking this Lisa, because it is, if I see a client being prescribed benzos or beta blockers, how can I respectfully suggest to the GP that antidepressants are actually the recommended medication? I wonder, well, let's see how you would like to be told Caroline?

Assoc Prof Caroline Johnson (00:56:44):

Yeah, so I guess every GP is different. I think the majority of gps who prescribe benzodiazepines and beta blockers are doing it because someone else has given it before and the patient said it's helpful. Or Lisa, they're anxious, they want to reduce distress and they're anxious to do something and do it quickly. So I think that maybe when I was a younger gp, there were a lot of benzos being thrown around haphazardly, but in my experience, it's much more that they've seen a psychiatrist or been given something in ED when they're distressed and then there's this kind of expectation of continuing it. So you shouldn't assume because a GP is prescribing it that they also think it's a great choice. That's the first thing. And I think the best way is when you write back to the GP saying, oh, we had a conversation, the patient and I about the limitations of benzodiazepines and beta blockers when you're doing therapy.

(00:57:33):

But I know it can be really difficult. We'd love to have a chat with you about your thoughts on this. I certainly, I know a lot of the times I've prescribed these drugs, it's because it's been continuing from someone else. And I have actually said to people, these are not a great idea. They're not going to cure your anxiety. They're just going to make the treatment take longer. But you've got to temper that also with people's need for immediate relief or the fact that they've had brief relief for some of these medications. So I think it is good to be respectful, but I think it's also good to not assume that GPS think it's a great idea to be using these drugs. And so having more of a collaborative conversation about how can we reduce that in the context of what we're trying to do in therapy would probably be more productive. I hope that helps because I think it can be intimidating, can't it?

Steve Trumble (00:58:19):

Yeah. Pete, are you going to say something about that?

Peter McEvoy (00:58:21):

Yeah. Just to inforce to Caroline that really the conversation for me would be with the client and talking to them about how it fits into their formulation, how they're using it, and what it's teaching them about their capacity to cope. Lisa said before that really we want to ourselves redundant and help the client to develop their own coping. So I have a conversation with them about when you take your benzodiazepine, does it help you to feel more or less confident with your ability to cope with your

anxiety? And if our goal here really is to help you develop that confidence so that you can then manage down the tracks if you don't have your benzos on you, and a lot of clients really don't want to be taking medication for the rest of their life either. So you might tap into that motivation, then you put it in your formulation as a safety behaviour and avoidant behaviour and help the client understand how in the term it may be having some impact of obliterating the anxiety symptoms, but in the longer term, undermining their coping self-efficacy.

(00:59:28):

So if we're working towards building that and at the same time they carrying and taking their benzos, then really we're working at the very different goals. And really there probably isn't much point in us proceeding with this approach. So I guess just again, handing over to the client to make that decision. Is building your Coke and self-efficacy something that you think is important to you? Or is it continuing to use the benzodiazepines whenever you feel some anxiety and leave the question open for them to answer? And if they're answering it that actually I've tried this for a long time, it's not working, then that gives you the opening to really undermine the potential benefits of making that change in. Then order to write that back into my letter to the GP that that's one of our therapeutic goals as to if not, stop using immediately, at least start reducing as part of the exposure programme.

Steve Trumble (01:00:26):

What do you think, Lisa?

Lisa Lampe (01:00:27):

Yeah, I think that with both this and the previous question about role counsellors, I think something that hasn't quite been mentioned is the patient's right to know what the evidence says so that they can make an informed decision. So there's a range of treatments available. They have varying levels of evidence as to their likelihood to affect long-term improvements in function. And I mean, I assume when something's been prescribed that there's a reason why that particular combination might've been prescribed. So I am careful when I was younger, I probably wasn't careful, but now I'm more experienced and I understand that prescribing decisions can be complex, but I do think that one of the important things is to share what the evidence tells us with the patient so that they then are in a better position to make an informed decision. And many, some patients won't like CBT or they won't want an antidepressant or they various, they won't want medication at all, but at least they then can make an informed decision if they know what the evidence tells us.

Steve Trumble (01:01:42):

That's great. And I think that conversation's really important. I would suggest that maybe in the chat, Deborah Fox has summed it up by saying it's a team game, clapping hands emoji. Well said, Dr. Caroline, a collaborative approach is great, which is really what everybody has said that getting that collaboration not only between health professionals but with the person themselves obviously, and finding out as a gp, getting some support in stopping something that I might not be totally happy with is a really good thing. So you feel like you're not alone in that therapeutic relationship. I'm afraid we've come to the end of our question time now, but this is the really important bit where we get each of our panellists to sum

up, summarise a few final words about their approach to people with acrophobia. So we'll go through the same order, I think, and start with Caroline. Thank you.

Assoc Prof Caroline Johnson (01:02:35):

Well, I'll start where I finished, where I started, which is remember the value of a continuous relationship with a gp. So encouraging people to have that ongoing support if you're working in the community with a gp, making sure they understand the advice you've given because the GP can really help you reinforce it because they will be seeing the person over time and they can certainly also revisit it when there's relapses in the future. So I think that's the main thing that collaboration and continuity.

Steve Trumble (01:03:03):

Right. Thank you. 30 seconds. Now we'll go to Pete. Your final thoughts.

Peter McEvoy (01:03:11):

Look, we've covered a lot of ground today and I think some of the take homes to me definitely about collaboration, definitely the client focus, definitely the importance of the comprehensive assessment and case formulation to really drive your treatment plan and using the approaches that are most effective and most efficient based on the evidence and helping to socialise the client to that, as Lisa was just saying, so that they can make a really informed decision. And again, just thanking my colleagues for all the amazing work they do, we just one psychologist, one cog in the wheel and all the work, Caroline and her colleagues do really pave the way for us. And Lisa and psychiatrists are so critical when we have complex cases to really provide that additional support. And the multidisciplinary team P workers can also be really important in a lot of context, but also, again, really focusing on the consumer's priorities and our role is to facilitate them to achieve that.

Steve Trumble (01:04:21):

Great, thank you. That's what MH PN is all about, the collaborative teamwork. So fabulous. Lisa, your final thoughts?

Lisa Lampe (01:04:28):

Yeah, look, collaboration, communication, teamwork. And then I'm going to echo something that Carolyn said right at the beginning, which was not giving up. That would be one thing I would say with patients too. I'm going to stick with you until we find a way through this thing. And I think if treatment doesn't seem to progressing, I think a good therapist will try to work out why is this patient not seem to be getting the benefit that we hoped and expected they would get? So all those things and sticking in there.

Steve Trumble (01:05:08):

Alright, well everybody's been exceptionally concise, which means I have a couple of minutes and people are leaving from the chat group. I can see. But one thing we didn't touch on, and it's one thing we agreed to talk about before we started the webinar, which is about the role of family and that for better or worse, Stella does have two sisters who are in her life. Just wondering in a couple of minutes,

what sort of words would you say to her family in supporting her in being treated with Acrophobia? What can they do to try and sustain the messaging in the home? Pete, it looks like you are ready. Or Lisa?

Peter McEvoy (01:05:48):

Yeah, I'm happy to speak first. At the point where Stella and I have worked through her and developed her individualised case formulation, so she really understands what's maintaining her problems and also what's most likely to be helpful for modifying those problems and breaking the vicious cycles. It'd be great to have a session or two with her family with Stella's consent and I've chat to seller before about the sort of things that we want to cover in that session. And then I'd be asking seller to articulate what she needs from them over time and how she wants them to respond when she's feeling anxious and when she's asking for reassurance or being very avoidant. So the critical thing is that seller really understands what's maintaining it, what needs to change, and then she asked for it in a way that the family can understand and then respond to it, maybe even put down a plan and she'd write down that plan.

(01:06:49):

When I feel like this or when I'm doing this, I would like you to do this to help support me. So everyone's on the same page. You've got that in writing. And that can change over time. Absolutely. But then the family have clear guidance, a clear way of how to help the client. The client is also asking for the sort of help that is unlikely to get their backup and get feeling angry and upset because that's not going to get anyone anywhere. So that, again, collaboration because actually collaboration and bringing the family into the room so that you can have that conversation with them. The family may need some of their own individual support because sometimes it's very difficult caring for someone, a loved one who's really going through a difficult time. So that may be another suggestion that we might make.

Steve Trumble (01:07:38):

Right. Thanks Pete. You've actually picked up on a comment from Susan cao, which is about making the client their own therapist in recovery, and the idea of equipping Stella with the ability to use her family members to do things that help her just sound so important. So I think that's a really good message and probably an excellent one for us to finish on. Number two, daughter's done tacos tonight, so finishing early is a bonus, but thank you all very much for what you've said. It's been absolutely fabulous tonight. You've been so generous with your thoughts and I think the audience have really appreciated what you've had to say. We do just have a few things to say, so please don't leave before we talk about these few things, which is about completing the exit survey, which is really important, getting the feedback we need from you.

(01:08:29):

So there is a banner above where we are at the moment or scan the QR code that will pop up at the end of the webinar. The recording's available. Those of you who had trouble connecting or hearing or with the screen freezing, there will be a perfect recording online for you to watch in a couple of days and even to share with some of your colleagues if you want to have something to discuss. The next webinar is coming up, fabulous one Tomorrow. Emerging Minds Navigating Cultural Differences, culturally Responsive Practise Supporting Families. So that's tomorrow at seven 15 and that will hopefully touch

on a few of the questions we had tonight that I couldn't get to about Cross-cultural difficulties. And then Wednesday the 10th of April, we have no, I can't Overcoming School Refusal again with some fruity case studies there. And also there's a new webinar, it's not on the slide you're looking at now, which is about, and again, it's important for tonight, supporting the mental health of a neurodivergent person with co-occurring autism and A DHD. So that's Wednesday the 26th of June, close to the winter solstice to look forward to there. Before I close, I'd like to acknowledge the lived experience of people and carers who have lived with mental illness in the past and those who continue to live with mental illness in the present. So thank you to everyone for your participation this evening and have a good evening. Good night.