Dear Members,

Welcome to the first edition of our Newsletter for 2005. Our new Assistant Editor, Prue, has done a great job putting together a very interesting and informative newsletter, including our second feature article from a Melbourne-based psychologist, Rod Carne, who specialises in childhood and adolescent OCD and anxiety disorders. The article is aimed at parents of children with OCD, and is most pertinent at this time, as we are just about to commence our first OCD recovery program for young people and their parents. ARCVic was very excited to be successful in gaining a grant from Auseinet – the Australian Network for Promotion, Prevention and Early Intervention for Mental Health, to support the running of this program. This has enabled us to provide the program at a very low cost for families, and will ensure that the program outcomes will be promoted to the wider mental health sector. This we hope will assist with further support for the on-going development and availability of the program – a program which is desperately needed, according to the many parents that we have talked with in the last several weeks. These conversations have highlighted for us just how bad the situation is in terms of the availability of specialist public mental health services for adolescents with OCD – CBT based programs for young people with OCD and their parents are generally not available, with the exception of a limited individual treatment service in a few places. We think it is a travesty of our mental health system that the needs of young people with OCD are so blatantly ignored and that families are unable to access treatment, despite the severity and devastating impact of the disorder. All of the parents we talked to were desperate for help, and suffering themselves from exhaustion and stress from having to cope with the severe OCD symptoms of their child, together with the many major impacts on their child’s social and educational life, self-esteem and mood. Bullying at school was a common theme, with a number of the parents moving their children to different schools because of this. Most parents said that they had been unable to access any specialist help – and treatments consisted mostly of medication and counselling therapies. In most cases the treatments had minimal impact on the OCD, and in all cases there was little or no assistance provided to parents in how they should support and assist their child to deal with their OCD. These difficulties faced by parents and carers are consistent with the findings of our recent research on the needs of carers of people with anxiety disorders (a joint project with The Network for Carers of People with a Mental Illness and beyondblue), which included both carers of young people and carers of adults. We know these issues are well known to many of you who have been living with anxiety disorders for many years. My hope is that the research and programs which address these problems will bring some evidence and data to add weight to the cause, and will help us in our efforts to advocate for needed changes in the public mental health system.

There is a growing buzz of activity around our new ARCVic premises, as more volunteers are joining to assist our work, and new activities are being planned and organised. We were very pleased to welcome two new Committee members to our Committee of Management at the AGM at the end of last year – Paul Reid and Lois Van Dyk. Paul and Lois have both been involved with ARCVic for many years and bring considerable knowledge and experience to contribute to the management of ARCVic. Paul has also offered to take on the role of Library Officer, and is going to assist us to finish organising the set up of the library – so hopefully it won’t be long before we can start to make the library available to members. We are looking forward to a great year with many programs, activities and seminars – some are advertised in this Newsletter, and members will receive further notices when other events are finalised. Of special interest in the next couple of months is the seminar on stress management at ARCVic in May, presented by Prue Lewis, ARCVic Consultant Psychologist, and the 6th Conference for Carers of People with a Mental Illness – Talking Together, Working Together on the 8th–9th April, 2005 – see the program and registration brochure in this newsletter. You may also be interested in attending the Rally on Mental Health issues, being organised by the Victorian Mental Illness Awareness Council – see the notice under Mental Health News. This is a great opportunity to let the government know that there are many people who are concerned about the state of mental health services in Victoria.

Finally, on behalf of ARCVic, we would like to extend our sincere congratulations to Sunil Bhar, who successfully achieved his PhD and recently graduated. Sunil is a long term friend of ARCVic and, in his early days of study, showed his commitment to supporting and understanding people and families with OCD through his involvement in ARCVic and especially running one of our support groups for a couple of years. He has also presented at several of our seminars and conferences, and devoted his research to exploring aspects of self-identity and self-worth in the development and maintenance of OCD. Many of our members contributed to Sunil’s research, and I am sure they will be glad to know that his research has gained approval and will provide a strong foundation for continuing research in this important area. So, well done Dr Bhar! We look forward to hearing more of your research in the years to come.

Thank you again to all of our members, friends and supporters for your continued support, and we hope to see you at some of our events and activities during the year.

Regards,

Kathryn I’Anson
DIRECTOR

John Geros
PRESIDENT
Dear Members,

Thank you to the many readers who provided feedback via the newsletter survey included in the previous issue. We were delighted with the great response – both in terms of the number of people who responded, and also the overwhelmingly positive feedback about the newsletter. The survey results have confirmed that the newsletter is popular in its current format and content. However, we did learn that readers would like more information about depression, anxiety in general and stress. Information about disorders, newly published research and recovery skills were also of much interest. Further details about the survey responses are provided below.

Thank you also to the people who have contributed to the Opening Door in this issue. A special thank you to Jenny for her wonderful list of quotes. We welcome your contributions and suggestions at anytime. You can contact me at ARCVic by calling the helpline or office, or via email: arcmail@arcvic.com.au.

Kind regards,

Prue Lewis

ASSISTANT EDITOR.

**ARCVic Newsletter Survey Summary**

Thank you to all of our members who responded to our Newsletter survey included in the previous newsletter. A total of 54 people completed and returned the survey. Of these, 59% identified themselves as a person with an anxiety disorder, 17% were carers, family members or friends, and 24% were professionals or from organisations. Most people were located in the Melbourne metropolitan area, with a small number located in rural or regional Victoria, interstate and even overseas. Nearly all the topics included in the newsletter were of interest to the majority of readers, particularly information about disorders, new published research and recovery skills. The disorders of most interest were depression, OCD, social anxiety, GAD, and panic disorder. Other topics of high interest were anxiety in general and stress. People with anxiety disorders rated all the sections of the newsletter as “very helpful”, while carers, family members, friends, professionals and people from organisations rated most sections as “helpful”. In terms of how easy the information was to understand, most people responded “just right”. Similarly, most people indicated they thought the length of the newsletter was “just right”. We received many great suggestions for a new name for the newsletter. The ARCVic Committee of Management will consider these names at a forthcoming meeting. There were also many helpful suggestions about the Newsletter which we anticipate incorporating in future issues. Some of the suggestions and comments about the newsletter were:

- “I think the newsletter is a wonderful resource that is exceptionally well written and presented. Please keep up the good work.”
- “I find the ARCVic Newsletter very informative and professional”
- “More clever sayings and jokes”
- Congratulations on how good the newsletter is already. I suggest a short section giving information to “frequently asked questions” or similar.
- I believe the current format is very useful, informative and interesting. Any change which can enhance upon the current format, although difficult to imagine, is worthy of implementation. Whatever you do please continue the good work that you do!”
- We could have either a monthly or quarterly write up (report ) from the coordinators or facilitators of each of the existing support groups in Victoria.
- As a member/carer I find the newsletter a great help and gives me a greater understanding of the problem of OCD and hoarding.
- Thank you for your fantastic newsletter. I look forward to it and stop all other activities until I have read it through. It is warm, professional and educative. Well done.
- I enjoy reading it and put it out into my waiting room for clients to read - it is well recycled.
- As a psychologist I often refer clients to the newsletter, I think that it is user friendly and very readable for my clients.
**Managing Stress & Anxiety - Community Education Seminar**

*Saturday 2nd April, 10am - 12.30pm*

Gain an overview of the principles of managing everyday stress and anxiety.

**Venue:** ARCVic, Ashwood

**Fee:** $10 ARCVic Members, $15 Community

**Facilitator:** Prue Lewis, Psychologist, ARCVic Consultant

To register call the ARCVic Office Line on 03 9886 9233


**Managing Stress & Anxiety - Group Program**

*Commencing 7th May, 2005*

Learn stress and anxiety management skills to assist with managing stressful situations or environments at work, study or home. Gain a better understanding of triggers and signs of stress and anxiety. Learn to think more realistically. Develop relaxation skills. Discover new coping strategies. Identify your strengths. Address perfectionism. Enhance your life management skills – goal setting, problem solving, decision making and time management. Reduce worry. Understand how lifestyle changes can reduce stress and anxiety. Learn how to keep your progress going.

**Course Duration:** 6 sessions x 2.5 hours

**Time:** Saturdays, 10.00 am - 12.30 pm

**Venue:** ARCVic, Ashwood

**Fee:** $135.00

**Facilitator:** Prue Lewis, Psychologist, ARCVic Consultant


**OCD - Family & Carer Group Program**

Six week support & educational program for families and carers of people with OCD.

Commencing in June 2005. Contact ARCVic for program brochure and registration form.


**New Family & Carers Support Group**

For carers and families of people with panic disorder, agoraphobia, social anxiety disorder and generalised anxiety disorder.

Please contact ARCVic on 03 9886 9377 or 03 9886 9233 to register your interest in this group.


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**ARCVic RECOVERY PROGRAMS**

**OCD Recovery Program for young people with OCD (12-15yrs) & their parents**

*Commencing 17th March, 2005*

The program for young people aims to assist them to: understand the nature and symptoms of OCD and anxiety; develop knowledge and skills to manage OCD more effectively; learn alternative strategies for dealing with stress and anxiety; and work out a recovery plan.

The parent sessions include: learning about the nature and symptoms of OCD and anxiety, and factors affecting treatment and recovery; How to help your son or daughter implement their treatment and recovery plan; Learn practical ideas and strategies for providing effective help and support; Share and explore issues and ideas with other parents in similar situations.

**Course Duration:**
- 10 sessions x 1 hour (young people)
- 7 sessions x 1 hour (parents)

**Time:** Thursdays, 5.00 – 6.15 pm

**Location:** Burwood

**Fee:** $130.00

**Facilitators:** Iris I’Anson, Psychologist, ARCVic Consultant Psychologists.

**Australian Network for Promotion, Prevention and Early Intervention for Mental Health**

Supported by funding from Auseinet


**Social Anxiety Disorder Recovery Program**

*Commencing 8th April, 2005*

Gain a better understanding and knowledge of social anxiety; change unhelpful thoughts, beliefs and behaviours; identify patterns of behaviours and feelings that maintain social anxiety – and learn ways to establish new, more helpful patterns; develop skills to manage the physical anxiety responses; gradually face anxiety producing situations; improve social skills; overcome barriers to achieving your goals; enhance confidence in social situations.

**Course Duration:** 8 sessions x 2 hours

**Time:** Fridays, 10.00 am -12.00 pm

**Venue:** ARCVic, Ashwood

**Fee:** $150.00

**Facilitators:** Iris I’Anson, Psychologist, ARCVic Consultant, & Jessica Bernales, ARCVic Recovery Program Coordinator, Prob. Psychologist

**For further information or to register your interest in these programs contact ARCVic on 9886 9233 or 9886 9377**
We are a group of people with a common bond, sharing our troubles, experiences, understanding, strength and wisdom.

We listen, explore options, and express our feelings. We do not prescribe, diagnose, or give advice ... we suggest.

We are accepting and non-judgemental to group members.

We know what we share is confidential and that we have the right to remain anonymous if we choose.

We have the right to take part in any discussion or not.

We each have the right and opportunity to equal talking time and the right to remain silent.

It is important that we actively listen when someone is talking and avoid having side conversations.

We encourage "I" statements, so that everyone speaks in the first person.

We each share the responsibility for making the group work.

Having benefited from the help of others, we recognise the need for offering our help to others in the support group.

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Inner East Support Group

Coordinator - John Geros;


The Inner East Support Group meets at the Hawthorn Peppercorn Club on the first and third Thursday of each month at 7.30pm. A new format for the Group has been established for 2005. At the first Thursday meeting, the format will be small, mutual support groups, including a new people’s group, a regular’s group, a family and friends groups and a goal-focused group. At the third Thursday meeting, the format will be an open forum in a large group, which will focus on information sharing and discussion of topics raised in the meeting.

Family & Friends Support Group

This support group is convened by Bruce Hannan and meets on the first Thursday of each month, at the Peppercom Club in Hawthorn.

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South East Support Group

by Edwin Belfield, Coordinator

The South East Support Group meets at the Bayside - Bentleigh Community Centre, Gardners Road, East Bentleigh on the second Monday of each month, except on public holidays when the meeting is held on the Tuesday night. The meeting starts at 7.30 pm till 9.30 pm when we break for coffee and chat. Our group provides a supportive, caring and confidential place for sufferers and carers to talk about their problems, learn skills to help their recovery – such as different relaxation methods, basic cognitive behaviour therapy, building their confidence and self-esteem, networking with other sufferers etc. We have an average attendance of about 16 people each month.

In May 2004 the group celebrated its 10th Anniversary. A special night was enjoyed by all to celebrate this most significant milestone. Many thanks to Chris for the most scrumptious array of delicious food one could imagine and everyone else who helped make this a memorable night. Our special guests for the night were the President of the Anxiety Recovery Centre, Mr John Geros and his wife Jessica Bernales, who is the Administrative Officer at the Centre. Special thanks to the Anxiety Recovery Centre for supplying a beautiful anniversary cake for this occasion. Many thanks also to our group facilitators Dianne Anton and Terry Lack, for their dedication and wonderful help over the past years to achieve something we can all be very proud of, and hopefully look forward to another ten years.
Moonee Valley Anxiety & Depression Support Group

Andy Prodromidis, Coordinator & Frank Filardo, Assistant Facilitator

The Moonee Valley Anxiety & Depression Support Group had its first meeting in October 2003. The Group is jointly auspiced by ARCVic and the Inner West Primary Mental Health Team. Meetings are held at the Ascot Vale Neighbourhood Centre, Cnr Union Road and Munro Street, Ascot Vale, on the 4th Thursday of each month, 7.30 pm. The Group Coordinator is Andy Prodromidis (ARCVic Vice-President, Manager IWPMHT), and he is assisted by Frank Filardo (IWPMHT Consumer Consultant).

Thanks to Andy and Frank for their commitment and hard work in setting up and running this group.

Emerald Support Group

by Dianne Legge, Coordinator

Having served the needs of sufferers and carers in the district throughout the past three years, it is with some rejoicing that this splendid group now celebrates its third anniversary. Strong attendances, averaging 8-10 persons on a fortnightly basis, demonstrate effective acceptance of one another by those attending, together with being able to provide encouragement to others with like experiences.

Again, the group has benefited by having Dr Don Jefferys, AO, Clinical and Counselling Psychologist, address an “open” meeting. Such meetings are publicised in local newspapers, medical waiting rooms and community noticeboards. The group warmly appreciates the privilege of having such an encouraging, informative and helpful speaker.

The group’s “Fiftieth Meeting” was celebrated recently with a “pizza and coffee” night. It seemed a significant occasion and worthy of recognition. The continuing population growth in the district endorses the need for the group’s ongoing service and availability.

Albury-Wodonga Support Group

by Wendy Malcolm, Coordinator

Here we are in Albury Wodonga and it was the 10th Anniversary of the Support Group in October 2004 (more about this in the next annual report!). We are still plodding along, making a difference. Over the past three years the Group has received great support from the Wodonga Council. However, at the end of last year the Council notified us that we could no longer use their premises due to their requirements. So we had to move – the problems associated with finding another venue were numerous – causing much anxiety. We didn’t need that! After much to-ing and fro-ing, we have settled at a neighbourhood house (Trudewind Road) which meets our requirements, although it is a bit on the small side. The numbers of the Group are down a bit, but this is seen as a response to a lack of advertising and my absence for 4 months on an overseas holiday, which also impacted on the number of guest speakers at the meetings. There were some in the latter part of last year and up till May this year.

In partnership with Wodonga Regional Health, the Group ran a well-being therapy course for anxiety disorders. It was well received and successful. During my absence, the Group was run by an enthusiastic volunteer who ‘wants to make a difference’ and whose efforts were exceptional. A personal thank you to Janelle. She was ably assisted by Ann and the other members of the Group. Thanks to all concerned.

Social events have been down this year, although we had a night out at Christmas time at the Commercial Club in Albury.

John Walker remains on as our Patron. He relates well to people with mental illness and has an infectious sense of humour. It is anticipated that a BBQ will be held at John’s home prior to Christmas.

The Group remains a positive force in the lives of people suffering from anxiety disorders and depression in North East Victoria and region.

We plan to hold a second Forum in May 2006. Contrary to rumours, film of Wendy and Richard’s overseas holiday will not be part of the Forum!
Latrobe Valley Support Group

Catherine Ashford, Coordinator & Pearl Baker, Facilitator

The Moe-Narracan anxiety support group is held at the Latrobe Community Health Service in Moe. Group meetings run for 2 hours on a Monday morning once a fortnight, with, on average, six people in attendance. During each group session, individuals are able to share their personal experiences of living with an anxiety disorder, and support each other by sharing helpful ideas to improve their coping abilities. Group facilitators and other members provide information on local and metropolitan programs, services, and resources available to group members. The group continues to maintain a library of resources for members to access. The coordinator, Catherine Ashford has also made a valuable contribution to the group by initiating activities focusing on increasing self-awareness of individual’s experiences of anxiety, and introducing anxiety management strategies.

Special thanks goes to Dr Don Jefferys, who has again excelled in his commitment to the Moe-Narracan support group in 2004. He has volunteered his time and expertise to conduct five community seminars across the year. Dr Jefferys’ seminars not only raise community awareness of anxiety and related issues, but also reduce the stigma faced by group members living within a small rural community.

Another special thank you must go to the volunteer contribution of art therapist, Nola Rhodes. Nola has facilitated five art therapy sessions since the beginning of 2004. These sessions provide members with an opportunity to express their experiences and deal with anxiety through art. Art therapy has been a welcome addition to the group program, with lots of positive feedback from those who have participated.

Ballarat Support Group

Heather & Karen Pruis, Coordinators (to December 2003), Martin Smith, Coordinator

Following Heather and Karen’s departure from the Ballarat Support Group at the end of 2003, Martin Smith took over coordinating and running the group. The Group continued to meet on the first Wednesday of each month throughout 2004, however due to other commitments Martin is unable to continue running the group in 2005. Our thanks to Martin for doing a great job at keeping the group going for the year and providing support and assistance to group members.

Social Anxiety Support Group

by Jessica Bernales, Coordinator

The Social Anxiety Support Group met in Armadale at 7.30pm on the last Wednesday of each month until November 2003 when our tenancy at Waora Community Mental Health Service finished and ARCVis moved to its new location in Ashwood. Support Group meetings resumed in February 2004 at a new time - the last Monday of the month at 7.30pm and a new venue – the Community Meeting Room, Ashburton Library. The Support Group continues to offer people living with Social Anxiety Disorder, their family and friends a safe and confidential setting to meet with others who share similar experiences. The Group aims to provide support to assist individuals with their recovery through increased understanding of their social anxiety, treatment options, applying self-help strategies, developing social connections and participating in social activities.

Thank you to our facilitators for their commitment and dedication over the past year - Dot Jacka, Fiona Cuthbert, and Jeff Pemberton. We were all very sad to say farewell to Dot in March due to an increased study and work load following her commencement of a PhD at Monash University, and Jeff in May when he accepted a teaching position in Japan. They are greatly missed and we wish them all the best in their new roles. Thank you to all who have attended over the last year and courageously shared their experiences, knowledge and wisdom, and inspired hope.
Support Group Statistics

Eleven Support Groups held a total of 192 meetings through the year (16 support group meetings were run each month).

The total number of attendances at the groups was 2054.

Group attendances included 1731 people with anxiety disorders (84%), 304 carers and family members (15%), and 19 students and professionals (1%). 325 people attended a group for the first time at some time during the year (18%). The gender of group participants was 1159 male (56%) and 895 female (44%).

Support Groups are located in the following regions (at June 2004): Eastern Metropolitan - (Ashburton, Hawthorn (2) - Inner East); Emerald – Outer East; Southern Metropolitan (Bentleigh; Dandenong (with ERMHA)), Western Metropolitan (Moonee Valley (with Inner West PMHT)); Gippsland (Moe - Narracan); Grampians (Ballarat), and Hume (Wodonga).

Community & Professional Education & Training

ARCVic organised or participated in 20 educational events from July ’03 to June ’04 with a total attendance of over 500 people.

Information Kits

ARCVic distributed 6584 information kits, packages and pamphlet sets. Of these 10% were for carers, 53% were for people with anxiety disorders, and 35% were for professionals and organisations.

Research & Projects

ARCVic assisted with 13 research projects on a variety of anxiety related topics including, OCD, hoarding, panic and carers.

OCD & Anxiety Helpline

ARCVic provided telephone helpline services to 4209 people with anxiety disorders (63% - Males 40%, Females 60%), carers, families and friends (19%), and the community (18%); and to 2728 professionals and workers from community, health and mental health agencies (39% of total calls).

48 telephone assessments were also undertaken.

A total of 6985 calls were dealt with by the HelpLine team, staff and volunteers.

ARCVic’s Volunteers

- Making a difference -

ARCVic’s team of volunteers consisted of 36 regular volunteers and a further 17 volunteers assisted with various projects and activities.

Volunteers worked a total of 5,915 hours (equivalent to 114 hours per week)

Out of these voluntary hours, 2,900 hours were worked by Support Group Coordinators and Facilitators (equivalent to 56 hours per week)

ARCVic’s Service Contacts were 11,159.

A HUGE THANK YOU to our Dedicated team of Exceptional Volunteers, from all of us at ARCVic for helping us to make a positive difference in the lives of people and families affected by anxiety disorders.
The role of parents in the recovery of children with OCD


Rod works in the Department of Child and Adolescent Psychiatry, Monash Medical Centre, as well as conducting private practice in Melbourne and Warragul. Rod has 20 years of experience in the area of child and adolescent mental health, with specialist knowledge and expertise in childhood anxiety disorders. Rod has extensive research and clinical experience in cognitive behavioural therapies for young people with OCD. Rod can be contacted on ph 9849 1709 or email rcarne@optusnet.com.au.

Readers of this newsletter will likely be aware that childhood obsessive compulsive disorder (OCD) is a relatively common psychological condition. Lifetime prevalence rates are estimated at between 1% and 3%. When OCD affects young people there is frequently associated disruption to academic performance, peer relationships and family function.

The OCD Expert Consensus Guidelines (March, J. et al., 1997) for treating childhood OCD recommend Cognitive Behaviour Therapy (CBT) as the first line treatment for all pre-pubertal children who present with primary OCD, and for adolescents with mild to moderate OCD. A recent large-scale study examining the efficacy of short-term CBT and/or medication (using a Selective Serotonin Reuptake Inhibitor (SSRI) -Sertraline) provided support also for the combination of an SSRI with CBT. There is a growing body of research evidence, therefore, supporting the effectiveness of CBT treatment for OCD, alone or in combination with SSRI medication. Notably, there is now also early evidence to indicate the benefit of cognitive behavioural family treatment of OCD (Barrett, et al, 2004).

The concept of a family approach to treatment reflects the clinical finding that alongside the heightened stress and anxiety experienced by affected children, OCD can be quite disruptive and upsetting for the family. Parents, in particular, may be drawn into a regular, tense involvement with their child in an attempt to satisfy obsessive-compulsive demands. Frequently, the heightened tension leads to anger and oppositional behaviour across family members.

Children under stress, given their early stage of development, naturally look to their parents for protection and reassurance. Parents, in turn, feel the press of responsibility to shield their children from threat, pain and distress. The sense of threat associated with a young person's experience of OCD naturally draws a family together, yet, in the context of significant anxiety, often at the expense of separate activity and independence. Accordingly, the balance between co-dependence and independence is extremely difficult for all to negotiate when a family member is in the grip of persistent doubt and anxiety. The relationship between children and parents necessarily becomes an integral part of the struggle to manage anxiety symptoms and, therefore, a relevant focus for initial and ongoing treatment.

The aim of this article is to consider the management of childhood OCD from the family's perspective, and in particular the parents' perspective. Specifically, to address several of the concerns parents have when their child develops obsessive-compulsive symptoms and the family is catapulted into a pattern of family interactions hitherto unknown.

Parental concern is reflected in questions such as, What caused the OCD?; Is it a result of our parenting?; What does our child need to help him/herself?; What can we do to provide support?; Why is he/she so oppositional and controlling?; How do we distinguish OCD from "bad" behaviour?; How long is this behaviour likely to continue?; What if he/she does not acknowledge the OCD and rejects treatment? What can we expect in the long term?

These are all legitimate and important questions, despite the fact answers are not always straightforward or even available. However, guidance with concerns such as these does shape the way forward for parents in attempting to provide support to their child in the battle with OCD. I will attempt in the paragraphs that follow to provide some further ideas and strategies for parents to consider in response to the questions posed above.

What causes OCD?

Evidence clearly points to the interaction of a number of factors, including genetic makeup, neuro-chemical changes, developmental demands, life events and available coping skills and resources. Frequently, a significant event, possibly a trauma or confronting experience, may be linked to the onset or escalation of obsessive compulsive symptoms. Such events are quite possibly a trigger to the more disruptive level of obsessive-compulsive behaviour, however, these events do not amount to a cause.

Practically, parents are often concerned to understand how they, or factors operating within the family, may be causing or at least contributing to their child's OCD. Certainly, family dynamics may become an important point of leverage in supporting the child who is learning to understand and manage OCD (This will be the subject of further discussion later). Again, however, family dynamics are insufficient to stand alone as a cause of OCD. It is
most accurate to embrace the concept that a complex interacting matrix of biological, psychological and interpersonal influences determine the experience of OCD.

What can my child be shown to help themselves?

It should be highlighted that it is the psychological perspective that is being described in this article. Each of the questions for consideration may be addressed from an alternative perspective - genetic, social, neuro-biological, medical etc. The psychological study of OCD does not explain all its elements and characteristics; however, is an important and useful point of entry, especially for parents wishing to understand their child’s predicament.

A primary aim of the psychological approach to treatment is to assist children better understand and respond to the experience of anxiety that accompanies OCD. At a psychological level, anxiety is understood as the experience of threat where there is no evident, realistic danger. The danger is always anticipated and exaggerated, rather than realistic. The term ‘fear’ is often used interchangeably with ‘anxiety’, yet is more accurately reserved for the experience of threat where there is indeed a realistic identifiable danger, such as coming across a venomous snake crossing a path.

While the emotional experience of anxiety and fear are very similar, it is helpful for children to appreciate the distinction and, further, to appreciate that the management of fear and anxiety is quite different. The appropriate response to fear is to take some immediate protective action, such as leaving the path to avoid a confrontation with the venomous snake. The treatment for anxiety, on the other hand, is to recognise the unrealistic and exaggerated sense of threat and not to treat the perceived danger as realistic. Recognising and differentiating that which is imaginary and that which is realistic is an important skill for the management of OCD. Of course, this is easier to say than implement, however, the skill remains a central focus for assisting children to subdue the persistent threat created by obsessive thoughts.

Why are such unlikely threats felt to be so pressing and intimidating? The answer to this question is complex and seemingly influenced by the interaction of several factors, as already stated. While it may be difficult to retrace a pathway to the origins of obsessive-compulsive behaviour, it is not difficult to appreciate why such unrealistic fears, and accompanying rituals, persist.

Extinguishing the threat of obsessive ideas is a tough assignment. The clarity and force with which these thoughts and images, which are often violent and bizarre, confront a young person lead obviously to great distress and confusion. Most youngsters do acknowledge the extremely low probability their obsessive thoughts will eventuate, and know they would never act on the more unacceptable thoughts and images that intrude on their thinking. Irrespective, in the face of such vivid obsession, to wilfully ignore the possibility seems unacceptable. On the other hand, to act on the obsession, even if the resultant action (ritual) does nothing to alter the likelihood of the unwanted outcome, works to alleviate the intimidation and threat posed by the obsession.

Because the obsessive threat does not then eventuate, the ritual action naturally comes to confer a security against the unwanted outcome (e.g., serious harm, illness). The action is appreciated for its capacity to remove, albeit temporarily, the intense discomfort accompanying the obsessive threat. Unfortunately, another outcome is that doubt and obsessive threats become more frequent and the child is now burdened with the sense that each obsessive thought must be acted upon.

It is notable also that young people who present with obsessional thinking and compulsive behaviour generally have high expectations of themselves and can be punishing if they believe they have not met their own or others expectations. They are inclined to be sensitive regarding others’ evaluations of their behaviour and find it difficult to satisfy their own expectations. This generally demanding and often punishing interpretation of events has often been idling away for some time as a precursor to the eruption of the more irrational and intimidating thoughts and expectations that characterize the OCD.

While the tormenting cycle of irrational, obsessive thought and compulsive ritual is a central focus of therapy, treatment will hopefully also operate to gradually contain the severity of expectation and relieve the generally punishing and stringent interpretation of day to day events these youngsters frequently bring with them when they present for therapy. Hopefully, their experience of the therapy will gradually encourage a somewhat kinder and more accepting evaluation of themselves, one which can more comfortably tolerate the inevitable likelihood of unintended error and unwanted lapses.

Such overall relief will enable children or adolescents to then more confidently allow themselves to “sit” with obsessive doubt and resist the urge to perform rituals until the anticipated threat of danger subsides. Preparedness to resist rituals places youngsters in a better position to gradually recover confidence in their ability to judge and accept the difference between a “realistic”, imminent danger and an imagined, improbable threat. As indicated earlier, developing this judgement is a crucial skill for the ongoing management of the anxiety that accompanies OCD. And the skill can develop best when the child is assisted to also gradually moderate the stringent outlook that idles in the background and makes the possibility of error or lapse in everyday activities seem dangerous and unacceptable.

How should parents respond to their son or daughters OCD?

I would suggest that parents are far better served directing their energies to the way everyday, realistic concerns are managed by their child than to become too involved in trying to subdue irrational, obsessive ideas and to prevent the performance of rituals. Parents can offer support to youngsters trying to resist rituals and assist with management of the secondary frustration, defection and oppositional behaviour that frequently accompany the experience of OCD (see later detail). This support will generally be more productive than becoming embroiled in the unrealistic maelstrom of obsessive thoughts and images, even though obsessions are seemingly the source of most distress. However, this said, it is frequently impossible, and not warranted, for parents to completely ignore repetitive behaviours and
requests for assistance completing rituals in the initial stages once OCD symptoms emerge.

Parents may find themselves involved with rituals in many ways. Often, for example, they are forced to repeatedly clean clothes in order to eliminate their child’s fear of contamination. Washing machines may operate several times a day. Other parents may need to field repeated questions intended to provide the child with reassurance in the face of troubling doubt. These requests are of the “Will this happen if...?” or “Promise me that this won’t happen...” type, where the parents’ assurance serves to eliminate, albeit briefly, the child’s sense of threat.

Sometimes, parents are recruited to assist in elaborate rituals to facilitate a separation, such as a child going to bed or leaving for school in the morning. For example, at night there may be a repeated exchange of “Love you’s” followed by some precise arrangement of bedclothes and an equally measured positioning of the bedroom door. A check under the bed or behind a wardrobe may also be required.

Parents usually feel torn as to whether they should go along with their child’s rituals or attempt to step back. The added anxiety and urgency that accompany times of separation, such as getting the child to sleep or off to school, can add to the pressure felt by all involved. Generally, it is more helpful to move toward less direct involvement, even at the cost of some increase in the child’s initial distress. At the outset, children frequently accuse parents of being mean and of deliberately subjecting them to a perceived danger. They may feel quite abandoned and rejected. There is little parents can do at these times to effectively eliminate their child’s distress. However, there are several interpretations of what is actually happening that will better assist the child.

First, it is important for parents to clarify that they do not share their child’s sense of threat. No parent wants to intentionally “train” children to anticipate threat and so parents can rightfully say that their unwillingness to respond to ritual is indeed a message that the threat is not warranted, rather than a sign their child is being set adrift. A parent is effectively saying, for example, that while the possibility somebody might die cannot be eliminated, it is not necessary to maintain constant vigilance against the possibility. Furthermore, if the child insists on doing so, even as response to the obsessive doubt, it is not something the parents wish to reinforce or encourage.

Second, children should be encouraged to recognize they do indeed have resources to withstand the anxiety that arises from their obsessive thoughts. Until they experience some relief through their own efforts to confront the threat, they will consider themselves helpless to do anything. They will always benefit by progressively taking ownership of their predicament and parents cannot contribute to this by any means other than to detach themselves somewhat when the child’s behaviour is exaggerated and unrealistic. Third, parents should present limits to outbursts children may display in the heat of their distress. This is an important aspect and I will discuss this in more detail in the section to follow.

In summary, an important guideline for family members, or others sufficiently involved to be offering support, is to progressively resist the pressure to participate in children’s rituals. However, realistically any refrain from assistance will need to proceed gradually and there are unlikely to be any rewards for parents who suddenly implement a total prohibition on all reassurance and assistance with ritual. Nonetheless, a child with OCD will benefit where the parents’ behaviour conveys both a challenge to the necessity to perform rituals and a willingness to tolerate the child’s initial floundering attempts to subdue their own anxiety.

How do parents assess whether behaviour is simply oppositional and defiant or a genuine feature of OCD? What about a child’s resort to aggressive outbursts?

It is common that children with OCD display quite oppositional and even aggressive behaviour, especially within the family home. Of course, this may escalate when parents are seen to be resisting the child’s urgent need for reassurance and assistance with rituals. Although defiant and aggressive behaviour are not usually highlighted in treatment protocols for OCD, such behaviour is often one of the biggest challenges, especially when considering OCD from the perspective of family.

It is probably not helpful to try to reliably separate OCD and acting out behaviour. The two are likely to be inextricably linked. Anxiety disorder can produce secondary oppositional, defiant and controlling behaviour. This is not to suggest that all youngsters with OCD display this feature. Rather, it is to highlight that the combination is quite common and should not give rise to doubt about the legitimacy of the OCD symptoms. There is a difference between the opposition that accompanies OCD and the symptoms of a behaviour disorder where acting out is a primary feature across all settings and over a prolonged period. However, because the distinction is important, parents may wish to discuss the significance of oppositional and defiant behaviour with their treating practitioner.

While aggression and defiance often feature in OCD, they do not alter a child’s accountability to family rules. This remains true even when extreme outbursts accompany the most acute obsessive-compulsive demands. However, accountability may need to be understood and implemented in a slightly modified way during the acute phase of the child’s encounter with OCD. This is inevitably a difficult territory for all to negotiate, however the difficulty also makes the ground fertile for developing the means to quell the most pressing aspects of OCD. There is a need to form a bridge between the principles that define normal parenting and a parent’s response when a child is in the irrational grip of OCD.

Reasonable rules and limits are a helpful starting point for developing this bridge. Normally, rules are valued and respected across all family members and this holds true in the context of the family where one member is battling with OCD. For example, three good rules for co-operative family living are:

1. No physical assault (biting, kicking, punching, scratching)
2. No destruction (Kicking walls, throwing plates etc)
3. No threatening, persistent verbal abuse

One may reasonably argue that not many more rules for general behaviour within the family are required, and it is better to put energy into the appreciation of these broad ground rules than to
impose too many strictures. (Parents may feel the need to impose limits to contain excessive rituals, such as water use, tissue use, etc, however this is a separate issue to be discussed later).

Family rules operate and are valued because they keep everyone safe from the possibility that other behaviour, such as physical force or coercion, will determine who has control within the family (control is not the same as authority). It is important that rules are upheld so as to demonstrate that control is limited, yet safeguarded for everyone, by the broad acceptance of family rules. This allows each person to focus on developing their own internal controls rather than to be continually on guard to protect themselves from control excesses by those around them. Parents have the authority to implement the system of rules that safeguards individual control.

Very often, the normal application of rules and limits will still serve to maintain reasonable cooperation in the circumstance of a child troubled by OCD. Nonetheless, parents of youngsters with OCD will no doubt be able to rectify instances where their son or daughter has seemingly discarded all respect for rules and all consideration of the rights of others. Significantly, however, the apparent “rebellion” that frequently accompanies the acute phase of OCD should be understood as a symptom of the child’s strain, anxiety and dejection. And, this is notwithstanding the fact a youngster’s reaction against family rights and rules can be very hostile, determined and replete with criticism of others. It should not, however, be read as a sign of their intent to reject the rules and the principles that underlie them.

As mentioned earlier, OCD often emerges in response to some particular stress or a strain operating at a particular stage of development. It may be that the way family interactions are operating forms part of that strain, and the symptom is therefore calling attention to the need to review the family dynamics for the sake of everyone, not just as a response to the young person with OCD.

The aim for parents therefore, in the face of an anxious child with OCD, is to encourage their child or adolescent back to a position where they are able to cope with rules, rather than deal with them as though they have abandoned rules for some other value. What does this mean in practical terms? It means that while young people with OCD should remain accountable to the rules, the crucial thing for parents is that they continue to uphold and present the child with the importance of the rule. This will incorporate the parents enduring respect for the rule in the way they themselves behave under pressure.

Accordingly, the authority residing with parents to uphold rules does not bind them to force their child or adolescent to comply with the “letter of the law”. The effort to enforce a given consequence (e.g., forgoing a favoured T.V show) may often result in drawn out, escalating control battles that intensify tension and rejection fears across family members. Much better, I would argue, in response to indiscretions by a child with OCD for parents to simply inform their defiant son/daughter that ‘closing their eyes’ to their infringement of the rule does not make the rule disappear. Sometimes, parents may feel compelled to then devise some further opportunity for the child to do something that will demonstrate the child’s acknowledgement of the rule – a consequence that the parent may more easily control, such as offering a lift to a friend’s place - although even this is not the vital component. Remember, there is no victory for a child in being unable to cope with a reasonable family rule. Parents need only reiterate the value of the rule and encourage their child that the panic driving their defiance is not necessary. Some message of optimism to indicate the parent has confidence the child will overcome their sense of threat, if and when such optimism is felt, will also be relevant and probably timely.

In a sense, an analogy may be drawn between the child’s sense of abandonment when parents do not uphold rituals and the parent’s sense of abandonment when their child does not uphold family rules. The treatment in both instances, in the context of a child with OCD, is not to panic that the threat of abandonment is realistic and to work gradually toward a more comfortable acceptance that the seeming rejection is more anticipated than real. However, all this is the territory for work undertaken together by the family and therapist to offset the more severe individual and family symptoms arising when a family member is affected by OCD.

How long will the OCD persist?

This is naturally difficult to predict and individual progress can vary widely. When OCD emerges during childhood symptoms may gradually remit, run an intermittent course or cause ongoing disruption. As indicated already, OCD generally does not occur in isolation. In up to 80% of cases (Barrett, et al, 2004) OCD is co-morbid with one or more other conditions, including anxiety disorder, depression, ADHD, Tourette’s Syndrome and learning difficulty. Delays in social skill development are a significant aspect of learning difficulty and such delay is associated with a more protracted course of the OCD symptomatology.

When children and adolescents are able to maintain a normal range of school, social and recreational activities the OCD is easier to manage. Many youngsters report that obsessive ideas are more likely to intrude when they are not doing anything, hence to be involved in a range of daily activities is helpful. Of course, children and adolescents benefit from the structure that surrounds their involvement in ongoing, organised activities. Indeed, whilst it is demanding for the family, parents should generally draw some encouragement from the frequent report that OCD symptoms are most intrusive at home and relatively absent, or at least better controlled, during daily activity. The more OCD symptoms, and other factors, force a retreat from everyday activities, and the longer the withdrawal process, the more at risk youngsters become for a decline into depressed mood and social isolation.

What if my son/daughter denies there is a problem and refuses help?

It is not surprising that there is a level of denial among many young people affected by OCD. Because they are well aware of the irrationality of their behaviour and the unrealistic nature of obsessive ideas, there is understandable reluctance to acknowledge the situation and to share the experience with
At some points, parents may be limited to modelling the positive approach they are trying to instil in their child, respecting the rather than on scientific findings specific to the treatment of OCD. Assessed presently on their general demonstrated effectiveness the efficacy of these treatments and their merit needs to be hypnotherapy and others. There is not a recognized literature on exercise, diet, various forms of psychotherapy, outward bound, alternative treatments such as acupuncture, naturopathy, Parents and others sometimes inquire about the merits of helping assume responsibility for youngsters’ treatment and recovery. Literature on OCD that is ‘reader-friendly”, such as the booklet, “The Secret Problem”, by Chris Wever and Neil Philips, may forge an opening. Parents may seek out information about the treatment approach to OCD so that some of their child’s fears about ‘therapy’ may be addressed with clear, practical guidelines. For example, the fear that treatment of the OCD will be taken out of their hands can be instructed by information about the collaborative nature of treatment. Young people should expect privacy, especially around the nature of obsessive thoughts and images, so long as their safety and immediate well-being are not compromised. Parents and caregivers are entitled to also expect some support and guidance in the management of their child’s OCD and this can generally be achieved without compromising family members’ confidentiality and right to individual consideration.

However, it remains the case that there will be some young people who remain steadfast in their rejection of intervention and therapy. In some cases, the withdrawal and isolation that complicate progress will be unpreventable. However, this does not mean the young person’s OCD is untreatable, just that parents and others involved will need to maintain a trial and error approach to possible openings and continue this inventiveness in the face of their child’s resistance and dejection. And yet, there is also that intuitively applied limit to the extent parents can helpfully assume responsibility for youngsters’ treatment and recovery.

Parents and others sometimes inquire about the merits of alternative treatments such as acupuncture, naturopathy, exercise, diet, various forms of psychotherapy, outward bound, hypnotherapy and others. There is not a recognized literature on the efficacy of these treatments and their merit needs to be assessed presently on their general demonstrated effectiveness rather than on scientific findings specific to the treatment of OCD. At some points, parents may be limited to modelling the positive approach they are trying to instil in their child, respecting the young person’s need to be given as much personal responsibility as possible and maintaining optimism in their son’s or daughter’s capacity to discover a way forward.

For those young people who do engage in a form of psychological treatment, the way forward may also be quite gradual. Time and patience will always be potential allies to young people in the therapeutic process, as will, undoubtedly, the respectful consideration and support of their caring parents.

References:

"The Secret Problem" by Chris Wever & Neil Philips

"OCD in children is explained in clear simple language. Cartoons are used to help children, teenagers and their parents understand the problem and its treatment.” To obtain a copy call or email ARCVic for an order form or visit the Shrink-Rap Press website at http://www.shrinkrap.com.au or call Shrink-Rap Press on ph. (02) 8765 0222 or email srpsales@geko.net.au. Cost: $16.50 per book + p&h.

OCD Recovery Program for young people with OCD (12-15yrs) & their parents

Commencing 17th March, 2005

The program for young people aims to assist them to: Understand the nature and symptoms of OCD and anxiety; Develop knowledge and skills to manage OCD more effectively; Learn alternative strategies for dealing with stress and anxiety; and Work out a recovery plan.

The parent sessions include: learning about the nature and symptoms of OCD and anxiety, and factors affecting treatment and recovery; How to help your son or daughter implement their treatment and recovery plan; Learn practical ideas and strategies for providing effective help and support; Share and explore issues and ideas with other parents in similar situations. See “Bulletin Board” in this issue for more information.
Recovery for mental health consumers is a personal and unique process; everyone with personal experience of mental health issues develops his/her own definition of recovery. It is living consciously and fully despite life’s burdens. There is not one model of recovery as it is a person-centred approach in which individual differences are considered and valued.

Whilst recovery is unique to each person there are common key factors. These include: Hope, Rights, Personal responsibility, Education, Self-advocacy, Mutual relationships and Support.

Consumers who are on a recovery journey are people who, in spite of symptoms, carve out a life for themselves. They have goals and they make choices to improve their situation with the right type of support. For recovery is ‘the expression of hope, the willingness to try and the discovery that you can do and be again’ (Deegan, 1996).

The promise of recovery is that it will lead to fuller lives. Recovery does not mean that you are cured nor does it mean that one is simply stabilised or maintained in the community.

In the National Mental Health Plan 2003-2008, recovery is defined as... ‘A personal process of changing one’s attitudes, values, feelings, goals, skills and/or roles. It is a way of living a satisfying, hopeful and contributing life. Recovery involves the development of new meaning and purpose as the person grows beyond the effects of psychiatric disability’. In my opinion, the National Mental Health Plan definition of recovery only goes so far.

Recovery is a process rather than an event. The consumer directs the recovery process – therefore consumer input is essential throughout the process. This complicated, uniquely individual process is not well captured by mental health policy. It is ironic that both consumers and researchers are striving to make sense of the same experience, but to date this has been primarily done in isolation from one another.

It is a common misunderstanding that recovery is the new word for rehabilitation. In actual fact the concept of recovery differs from that of rehabilitation in as-much as it emphasises that people are responsible for their own lives and that we can take a stand towards our disability and what is distressing to us’ (Deegan, 1996b).

Debates in Recovery

Recovery is not a new idea, though its recent prominence in mental health literature and policy may make it seem so. The people responsible for initiating the current dialogue are consumers.

Most of the literature on recovery for mental health consumers comes from the United States and has three main ideological sources. The first is the generic recovery or self-help movement exemplified by *The Power of Positive Thinking*, 12-step groups, co-dependency, self-help and new age philosophies. The second source is the mental health service user movement, and its underlying philosophy of human rights and self-determination. The third source is psychiatric rehabilitation with its focus on community integration and overcoming functional limitations.

The vision of recovery that comes out of the United States is more individualistic and mono-cultural than is appropriate for multicultural Australia.

We need to acknowledge cultural diversity and that a connection to one’s own culture is a key to recovery. Much of the literature focuses mainly on the individual’s process, without including the social, economic and political processes that also enable recovery. This approach therefore excludes the consideration the effect of the health system, environmental and social factors has on the consumer.

A philosophy of recovery provides a beacon of hope where, too often, people are told that mental illness means certain decline into unemployment, poverty and disability. In contrast, the philosophy of recovery focuses on health rather than illness and strengths/assets rather than problems.

The health system often disrupts the normalisation processes (that emphasise abilities and recovery) by continually introducing a ‘problem-saturated perspective’, which ‘services the illness’, rather than providing ‘the help one needs for getting on with life’ (Sullivan, 1994).

Two areas of discussion that require attention are the consideration of the social context in which recovery occurs and the range of roles consumers can play in the service system. Obviously the consumer must be in the driving seat of his/her own recovery but increasing literature now shows the benefits of consumers as deliverers of services as well. For example, roles such as peer support and peer counsellors, advocacy and providers of formal services.

Change and services

There is no way to predict who will recover and who won’t. Therefore, recovery services are grounded in the concept that people can recover from a mental illness if they are given sufficient opportunity to build skills and support. This has major ramifications for services for they must consider how this is reflected in their service provision. Services need also to be aware of their potential to enable and encourage consumer dependency.

Adopting recovery as the overall principle for the reform of mental health systems has ramifications such as the choice of services to be funded and how they are to be delivered.
As systems strive to create new initiatives consistent with this ‘new’ vision of recovery, new system standards are needed to guide the development of recovery-oriented mental health services.

Obvious benefits of a recovery definition for mental health services include:

- Reduced need for hospitalisation
- Increased possibility of positive outcomes
- As we normalise people’s feelings and symptoms, we build a more accepting, diverse culture
- Clinicians will enjoy the positive reinforcement of successful work experiences
- Cost effectiveness – at personal, family and community levels. Not discounting the obvious – the public purse.

The obvious benefits of recovery-focused services for consumers are too many to list here but can be summed up by saying that we regain a life and not just receive a prognosis.

### For the Future

Recovery is about hope and my hopes for the future of recovery are that services that will be led by consumers; services that enhance our autonomy, recognise us as whole human beings, expect our recovery and offer us a broad range of solutions and resources.

I hope that the general community and the mental health community will be a strong supporter of recovery. Finally, I hope for a world in which consumers become free and whole persons in wholesome relationships and gentle builders of free and whole communities.

### Bibliography


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### Comprehensive CBT for Trichotillomania

**By Nancy J. Keuthen, Ph.D., Chief Psychologist, OCD Clinic and Research Unit, and Co-Director, Trichotillomania Clinic, Massachusetts General Hospital and Harvard Medical School, Charlestown, MA. OCD Newsletter, Spring 2004, OC Foundation, USA. Reprinted with permission.**

In my experience, the treatment of trichotillomania (or “trich”) can be a challenging and, at times, frustrating endeavour for sufferers and professionals alike. Patients often approach treatment with considerable shame and apprehension given past histories of negative reactions from family (“You could stop if you only tried harder!”) and even from professionals (“Pulling out your hair reflects a wish to harm yourself”). Prior treatment failures are not uncommon, making it difficult for sufferers to embark on treatment for a second time. From the caregiver perspective, treaters face a paucity of research to illuminate the nature of trichotillomania and to help guide treatment. For many of us who spent years treating OCD before treating trichotillomania, we have been accustomed to the more robust CBT outcomes for OCD and can be humbled by the limitations we face in reducing the suffering of our trichotillomania patients.

So why then should trichotillomania sufferers pursue CBT? Despite my opening remarks, I firmly believe that CBT for trichotillomania is well worth the effort. A well-trained and experienced cognitive behaviour therapist can effectively reduce the patient’s shame, facilitate more constructive perspectives on the disorder, instruct in more functional coping strategies, encourage involvement of other sources of support, and help diminish associated avoidance.

I structure CBT as a collaborative process during which the patient and I work together to first uncover his or her “signature” pattern of pulling. I define my role as that of an educator and coach emphasizing the pivotal role of the patient in his or her recovery from trichotillomania. I introduce self-monitoring of symptoms as a method to establish baseline frequency, identify hair pulling patterns (habit-like pulling with decreased awareness or binge-like pulling accompanying intense emotional states), and develop early awareness. Training in early recognition of urges and associated triggers will provide the sufferer with the best chance of intervening more effectively in the future to control the pulling behaviour.

Although pulling frequency may diminish simply in response to monitoring assignments (a phenomenon called “behavioural reactivity”), lasting control over trichotillomania only occurs when solid CBT skills are acquired. I begin treatment (after brief psychoeducation on the nature of trichotillomania) by instructing patients in the essentials of Habit Reversal Training (HRT), a treatment package first popularized by Drs. Nathan Azrin and Gregory Nunn. In addition to awareness training, the essentials of HRT include identification of, and practice with, a competing response (i.e., a motor behaviour that is incompatible with hair pulling such as making a fist), as well as relaxation training. Along with HRT, I instruct patients in Stimulus Control procedures. Essentially, these are techniques that involve modifying the puller’s environment to enhance awareness or decrease opportunities to pull. For example, it can involve limiting pulling triggers (e.g., applying Band-Aids or wearing hats), providing cues to increase awareness (e.g., tying a ribbon on the steering wheel if pulling occurs while driving), or providing behavioural alternatives (e.g., playing with a Koosh ball or manipulating string or textured fabric).
While HRT and Stimulus Control techniques can significantly reduce symptoms, my experience has been that they do not sufficiently address pulling in reaction to strong emotions when greater numbers of hairs are extracted. To more effectively treat pulling that functions as a maladaptive way to control emotions, I have recently begun to incorporate techniques adopted from Dr. Marsha Linehan's Dialectical Behaviour Therapy (DBT). More specifically, I often use mind-fullness training to further enhance awareness of urges and behaviour, facilitate decentering from anxious thoughts, and promote acceptance-based perspectives. DBT techniques designed to help with emotion regulation (e.g., increasing positive emotions, "letting go" of emotional suffering, and reducing emotional vulnerability) are also effective. Lastly, I also implement DBT strategies to improve distress tolerance (e.g., self-soothing, distraction, "improving the moment," and identifying pros and cons).

Once hair pulling behaviour is significantly reduced through use of CBT skills, I instruct patients in relapse prevention strategies (modeled after the work of Dr. Alan Marlatt and colleagues in addiction research). I discuss the difference between "lapses" (temporary setbacks in hair pulling control) and "relapses" (loss of all gains with return to baseline functioning). Patients are asked to complete a matrix identifying all the short- and long-term pros and cons to pulling hair vs. controlling hair pulling. They are instructed to anticipate setbacks (especially early on in treatment), to preemptively identify high-risk situations, and to design effective behavioural strategies for coping with lapses. Lastly, I discuss with patients the importance of early intervention after setbacks to prevent the occurrence of more severe hair loss that, in turn, can further undermine one's motivation.

Finally, I'd like to suggest a few other treatment guidelines that I have found helpful in treating trichotillomania. First, I always discuss treatment expectations before I begin intervention. Appropriate expectations are defined as symptom control or management as opposed to a "cure." Unrealistic expectations often result in patients becoming frustrated and terminating treatment early. Second, I encourage patients to establish interim, short-term goals (e.g., routinely use stimulus control procedures when studying) to make the process of treating trichotillomania more manageable and less overwhelming. Third, I emphasize that one should focus more on one's compliance with self-monitoring and behavioural treatment strategies, rather than reductions in pulling frequency counts or hair regrowth. This is important for several reasons: trichotillomania is known to be a waxing and waning disorder; unanticipated life stressors may temporarily challenge one's ability to manage urges; different techniques may be more or less effective depending on the individual and their pattern of pulling. Also, hair re-growth can be delayed depending on the growth cycle during which the pulling occurred. And lastly, I routinely recommend the involvement of outside support systems when possible, whether family or support groups, to provide greater accountability and more frequent reinforcement to help sustain ongoing symptom management both during and after treatment.

Dr. Keuthen is author of the self-help book for trichotillomania "Help for Hair Pullers".

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**Relationship Between Body Dysmorphic Disorder and Social Phobia: Two Very Debilitating Disorders**

Fugen Neziroglu, Ph.D., ABBP-Bio-Behavioural Institute Great Neck, NY Many Roberts, MA. Hofstra University Hempstead, NY. OCD Newsletter, Late Fall 2003, OC Foundation, USA. Reprinted with permission.

Body dysmorphic disorder (BDD) is characterized by an intense preoccupation with an imagined (or, if real, slight) bodily defect in a person with a normal appearance. Unfortunately for many professionals as well as for the general public, BDD is conceived of as a trivial or inconsequential disorder. This is far from the truth. BDD affects every aspect of one's life. The person is often very depressed due to his limitations. BDD involves the shell of the individual (the body); and, therefore, one cannot run away from it. You carry your body with you at all times. The perceived defect typically involves the face (e.g., vascular markings, asymmetrical eyebrows, color or shape of teeth, elongated chin, shape of nose, etc.), skin blemishes, size of various body parts, musculature, deformity of primary or secondary sex characteristics, etc. This preoccupation often leads to persistent checking behaviours (e.g., examining one's reflection in mirrors frequently or for lengthy time periods), camouflaging (e.g., attempting to hide the perceived defect from others by covering the facial "defect" with one's hair, or elaborately arranging one's clothing, covering mouth, etc.) and avoidance of social situations in which others might observe one's perceived flaw.

Understanding Body Dysmorphic Disorder

While BDD is currently categorized as a somatoform disorder, both theory and research suggest that BDD might be better conceptualized as an obsessive-compulsive (OC) spectrum disorder (Neziroglu & Yaryura-Tobias, 1993). This conceptualization was an outgrowth of similarity of symptoms between OCD and BDD and similar cognitive behavioural and pharmacological treatment response. However, recently there has been more evidence for the link between BDD and OCD based on a morphometric magnetic resonance imaging (MRI) study (Rauch, Phillips, Segal et al., 2003). The study involved comparing regional brain volumes in eight women with BDD and eight healthy participants. The BDD group exhibited a relative leftward shift in caudate asymmetry and greater total white matter versus the comparison group. These findings in regard to the caudate nucleus are consistent with both conceptualization of
BDD as an obsessive compulsive spectrum disorder, and the striatal topography model of OCD. Although the community prevalence rate of BDD is still a matter of debate, data seem to suggest that BDD affects approximately 2% of the general population (Rich, Rosen, Oroson, & Reiter, 1992). Moreover, reports from mental health settings suggest that BDD is present in 5% to 40% of those presenting with an Anxiety or Depressive disorder (American Psychiatric Association, 2000). Studies show that BDD appears to be distributed equally among men and women. Although it seems to usually develop during adolescence, BDD can arise anytime during the life cycle, occasionally manifesting itself after failed plastic surgery.

BDD is often comorbid with OCD, social phobia, major depressive disorder (Phillips, Gunderson, Mallya, McElroy, and Carter, 1998), and personality disorders. In fact, Perugi et al. (1997) claim that BDD is almost never experienced in isolation from other psychological disorders. One fairly recent study (given the slow development of the literature) suggests that OCD may be present in 94% of patients displaying BDD; (Neziroglu, McKay, Todaro, and Yaryura-Tobias, 1996). These authors further suggest that social phobia may be present in approximately 18% of BDD patients. While treatments for OCD have been applied to BDD, current treatments have not typically taken patients with both BDD and social phobia into account.

**Understanding Social Phobia**

Social phobia (SP) is a pattern of excessive concerns that typically are related to the fear of scrutiny by others and/or social interactions, as well as a habitual avoidance of social situations. Individuals with SP often miss important social occasions (e.g., weddings, business meetings, etc.) due to their concerns. Mattick and Clarke (1998) suggest that SP consists of two dimensions. The first is a fear of social scrutiny (i.e., an intense fear of what others might think about one’s presentation, style, appearance, etc.). The second dimension, according to Mattick and Clarke, is a fear of social interactions (e.g., feeling unable to properly carry on a conversation, a date, etc.). People suffering from SP may display difficulties in only one dimension or in both. BDD sufferers often display similar concerns, particularly in regard to social scrutiny.

**Distinctions Between BDD and Social Phobia**

As stated above, BDD and SP often present as comorbid conditions. Nevertheless, distinctions can be made between the identifying markers of each disorder. Although patients suffering from BDD and/or SP often verbalize similar concerns (e.g., "I'm not good enough," "Everyone will notice my deformity or inabilities."), some evidence has accumulated to distinguish between the two conditions. Both current research (e.g., Veale, Kinderman, Riley & Lambrou, 2003) and clinical experience seem to suggest that the core concerns of social phobics and patients with BDD differ. It is reasonable to suggest that patients displaying BDD are concerned with social scrutiny by others, particularly in regard to their "defect." However, BDD patients are more concerned with satisfying their own internal demands of "perfection" and "beauty" than they are of winning other people’s approval. This last statement may seem counter-intuitive to the family and friends of BDD sufferers, because BDD patients tend to often seek reassurance from others that their particular "defect(s)" are "OK" or "not too noticeable." Yet, such reassurance does little for the BDD sufferer, other than reinforce their future reassurance-seeking behaviour. That is, because the BDD sufferer is truly concerned about measuring up to his or her own ideal, no amount of reassurance from family or friends can ever be enough. Rather, reassurances by family or friends merely abate the BDD sufferer’s anxiety about his or her appearance for a short time and in the end leave him or her more likely to seek such assurances in the future. (Author's note: I have found a particularly effective response to reassurance-seeking questions about appearance to be, "You look like you did yesterday" and in response to further concerns, "You look exactly like you will tomorrow") If this does not work, you can always just tell the person that you will not reassure since it merely perpetuates the disorder and you want to help. Just a brief reminder: social phobia may appear as a condition comorbid with BDD.

**Treatment Approaches**

There have been many reports of successful treatments of BDD using pharmacological approaches (e.g., Fernando, 1988; Hollander, Liebowitz, Winchel, Klumker, & Klein, 1989; Phillips, McElroy, Keck et al, 1993; Phillips, Albertini, Rasmussen, 2002, etc.). Hollander et al (1989) report success in five patients using a variety of serotonin reuptake inhibitors (SSRIs). These authors particularly suggest clomipramine and fluoxetine as the treatments of choice for the pharmacological treatment of BDD. However, the direct mechanism(s) responsible for the amelioration of BDD symptoms has not yet been explicitly identified.

Cognitive-behavioural therapy (CBT) is suggested as a treatment of choice for BDD and body image dissatisfaction. An illustrative example of such an approach has been provided by Schmidt and Harrington (1995). They report the successful treatment of one BDD patient using a short-term cognitive-behavioural treatment program. The patient presented with concerns regarding hand-size, believing that he had exceptionally small hands. The patient, therefore, attempted to keep his hands concealed, especially around women, who he believed would assume that his small hands were indicative of his masculinity. Using nine sessions of a collaborative-empiricist cognitive therapy approach and behavioural homework assignments (e.g., comparing his hand-size with others), clinically significant success was achieved.

Similarly, a series of studies undertaken by Neziroglu and colleagues at the Bio-Behavioural Institute in Great Neck, NY, demonstrated effective results for the treatment of BDD using primarily exposure and response prevention (ERP) augmented with cognitive restructuring. Neziroglu and Yaryura-Tobias (1993) reported success in four out of five patients using such a method. Similar success has been demonstrated by Neziroglu, McKay, Todaro, and Yaryura-Tobias (1996), as well as McKay et al (1997). Moreover, Veale and colleagues (1996) reported similar success in a randomized wait-list control study using cognitive-behaviour therapy.
Group therapy has been suggested as a means of augmenting individual and psychopharmacologic therapy for BDD and body dissatisfaction (Rosen, Reiter, and Orosan, 1995; Rosen, Saltzberg, and Srebnik, 1989; Wilhelm, Otto, Lohr, and Deckersbach, 1999). We have found that groups are also helpful in reminding patients that they are not alone. In our current groups, it does not seem to matter that different people are affected by different aspects of their appearance. In OCD groups, there have traditionally been problems when there are vast differences in the symptoms. For a more in-depth review of treatment studies, the reader is referred to Neziroglu and Khemlani-Patel (2002; 2003).

Summary
BDD is a debilitating disorder characterized by preoccupations regarding perceived bodily anomalies and frequent checking behaviours (e.g., considerable grooming procedures, examination of defects, etc.). BDD often causes considerable distress to the sufferer and his or her family and friends and seems to be related to other OC spectrum disorders. Yet, effective treatments have been shown to exist, particularly a combination of pharmacological and behaviour therapy approaches. New treatments are being tested as this article is printed. With the correct therapeutic interventions, BDD sufferers can receive the best currently available treatments for their concerns.

“Every now and again take a good look at something not made with hands
– a mountain, a star, the turn of a stream.
There will come to you wisdom and patience and solace and, above all, the assurance that you are not alone in the world”

Sidney Lovett
Are you tired of doing things in a ritualistic manner? Yet, at the same time, do you feel you must listen to and do what the OCD is telling you to do? Are you frustrated with not being able to go out and do things that friends or family are doing because it might trigger an unwanted thought or urge? Do you feel you can't quite bring yourself to do an activity which might generate discomfort and anxiety? Do you dream about what you would like to accomplish in life, but feel trapped?

Treatment for OCD is not easy. However, it can get easier over time. Reducing the extent to which the OCD interferes in one's life involves behaviour therapy, specifically, exposure and response prevention (E&RP) treatment. Put simply, as with any type of fear, the way to reduce your fear is to face your fear. In OCD treatment, it is important to do response prevention, i.e., resist the urge to do what the OCD is telling you to do. Whether you employ a gradual exposure to triggering thoughts, images, situations, and activities or the more intensive "flooding exposure," with repeated practice, E&RP will reduce triggers that used to generate high levels of fear and anxiety to little or no anxiety (habituation). Treatment involves learning as much as you can about your particular types of obsessions. Learn the subtle and not so subtle rituals you do as a result of your obsessions. Are you avoiding doing things in life? In treatment, others can teach you what you need to do to reduce the OCD symptoms. But only you can decide when you are ready for this, where you can find the internal determination to fight it and when the time feels right to do this.

So, why challenge the OCD if you are feeling it's going to take too much effort? Why bother to face your fears of impending danger, disease or death to yourself or others? Why bother to take the risk of experiencing high levels of anxiety? Why risk experiencing the doubt and uncertainty that you feel might consume you? Because you deserve to have a better life than the one you have now with OCD.

OCD tells falsehoods and wants you to believe them. For example, it overestimates the potential for harm in a particular situation. Or, it tells you that, if you just do this one ritual or this brief avoidance, then the anxiety and stress will go away. That's an OCD trap. While you very well might feel better for a brief time after ritualizing or avoiding, these behaviours actually strengthen the OCD thoughts and fears and make them even more potent the next time they arise. By listening to what the OCD is saying, you are teaching your mind and your body that the only way to make your fear/anxiety/doubt subside is to do what the OCD is telling you to do. However, the real solution for reducing and eliminating fear permanently is to experience and ride through the anxiety, fear and doubt, while trying to minimize and eliminate avoidance and rituals. By doing this you are teaching your mind and body that the anxiety/fear can come down on its own over time without the OCD's false help. This is not pleasant or easy; so try not to get down on yourself if you try to resist and don't always succeed. It's the determination and persistent effort to resist that are important.

So why keep fighting the OCD? Because the rituals don't work! Your OCD may trick you into thinking that rituals are helping by offering a small measure of immediate relief; but, beware of this. There are flaws and exaggerations in what the OCD is telling you. Consider the person who washes excessively to avoid getting a disease. This person's family members and friends don't wash as much and as often and they don't catch the feared disease. So, why bother doing all that extra washing anyway? Or consider the other side of the coin. You wash and wash and you still get sick. What have you really gained by spending all that time, energy and effort trying to prevent something that you really don't have control over? Take a risk; we live in a dirty world.

The following is another situation where your OCD is giving you false information. For a long time, you have been ritualistically repeating an activity because you had a bad thought while performing that activity and you are concerned that not repeating it or not getting it right will cause something bad to happen to a friend or family member. A bad thing happens to a family member anyway. Does this mean you weren't doing your rituals often or completely enough? Or, does it just mean that, unfortunately, in this world, there are times when bad things really do happen to good people? Ask yourself if you are overly concerned about the welfare of others. Why should you spend so much energy and time trying to protect them when the rituals don't work anyway? Things happen in this world over which we have no control. Often, even the very ones you are trying to protect don't feel it's necessary to take these steps. Ironically, in order to get control over your life, you have to give up the need for control and give up the feeling of being in control with respect to your OCD.

You may be saying: "I don't want to risk it" or "If my fears could happen, then it wouldn't be worth taking even a remote chance."

Maybe the OCD is telling you, "I can't put my own wants and needs before the health and safety of others" or "It's too unbearable to experience this doubt." Yet, look how much the OCD has cost you. How much has it kept you from enjoying activities with friends and family? How has it impacted the quality of the relationships you do have? Think of the time and energy (both physical and emotional energy) you have put into trying to make sure that the improbable will not happen. Look how your OCD has interfered with your career and the enjoyment of pleasant activities. Consider how much time you have spent pondering what the OCD is telling you in order to reduce the feeling of doubt. And, you're paying this price just to get some fleeting relief. You are entitled to more in life.
What do you wish for in life? You deserve to give yourself a chance to have it. When you are reflecting on your life, will you feel that it was worth putting off challenging your OCD to avoid feeling anxious for such a short time? Seize the opportunity now. Focus on getting through one day at a time. Push yourself to engage in even small “behaviour therapy moments” as opportunities arise on a day-to-day basis. Take all the opportunities offered to you NOT to do what the OCD is telling you. Remind yourself that you don't have to eliminate the OCD all at once.

You can get to the same level of OCD symptom reduction by working on one area at a time or by gradually choosing to wage lots of smaller OCD battles throughout the day. Remember that a journey is accomplished one step at a time. A willingness to experience short-term emotional discomfort is the path to symptom reduction. Daily persistence in chipping away at OCD symptoms is crucial.

A better quality of life is worth going after. The things in life worth pursuing occasionally require some level of hard work. No one else can do this for you; you need to be your own best advocate to bring satisfaction into your life. This involves going after as many of your compulsions over time as possible. At the same time, look at what you can do to practice exposure and response prevention tasks every day.

What contributes to quality of life? It’s different for everyone. For some, it's the reward that comes with the enjoyment of each day's activities, whether these are rewarding solo activities or activities spent in the company of others at work or with family and friends. For others it's the feeling of accomplishing a task. OCD treatment is not just about symptom reduction. It's about getting back enjoyment in your life. Don't let the OCD keep you from pursuing what you want in life. Remember, no pain, no gain. You will need to experience the short-term emotional pain in order to experience the long term behavioural gain. No one else can do this for you. The determination needs to start with you. You didn't choose to have OCD, but you do have a choice in how you are going to respond to the obsessions. So, let go of the need to be in control, experience the doubt.....the potential benefits in your life are worth it!

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You may have to fight a battle more than once to win it.

Margaret Thatcher

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Panic Disorder: Physical (Somatic) Symptom-Shifting


A perplexing problem faced by most people with panic disorder is that the physical symptoms of panic tend to shift, or change, over time. Every person’s constellation of symptoms is slightly different, although many of the symptoms are the same. The confusing element is that, over time, and even during therapy, a person's physical symptoms may change.

This is many times frightening to the person who doesn’t understand what is happening to them. For example, as a part of panic disorder, a person may be plagued by feelings of nausea for a long period of time, enter into therapy, and as the panic attacks are gradually cut off, the nausea disappears -- only to be replaced by a headache that the person is afraid is a brain tumour.

What is really happening here is actually positive. Once the person fully and completely realizes the nausea is simply a symptom that the mind associates with fear and panic, the symptom disappears. In its place another symptom appears - whatever feels different or out of the ordinary. Then, the process begins again: The catastrophic misinterpretation - blowing a physical symptom way out of proportion - and then paying attention to it. And, as we know, the more attention you pay to these symptoms, the bigger they grow and the worse they get.

The person who understands that this will happen is two steps ahead of the game. Panic is very tricky - it will continue to plague you as long as you let it. In therapy, we learn quickly to expect this symptom shifting and then to realize that this is a positive event - a major symptom has gone away, and a new symptom has appeared. This new symptom is then identified for what it is, and we learn not to pay attention to it. Any of these “new” symptoms are, as a result, not as dramatic and intense. The shorter period of time it takes before you realize that a symptom has shifted and that panic is playing a trick on you, the quicker and easier the symptom will be to deal with and eradicate. Once the panic attacks are eliminated, and the symptom-shifting starts, a person is well on the way to recovery. Symptom-shifting is a positive element that, when viewed properly, indicates that you are on the road to recovery.
Strategies for reducing unhelpful worry

Adapted from Strategies for reducing chronic worry or rumination, by Anxiety And Stress Disorders Institute Of Maryland.

♦ Reframe worry thoughts as “cerebral flotsam and jetsam” or “mind junk” rather than important data that must be examined carefully. Distinguish “good” and “bad” worry whenever possible. Don’t be your own worst enemy by indulging yourself in worries and by rationalizing your continuing to do so.

♦ Learn to accept the presence of a worried thought without having to take it so seriously and without having to get rid of it.

♦ Ask yourself these questions when you’re stuck in worry mode:
  “What’s the evidence?”
  “Am I trying to control things that I can’t possibly control?”
  “Am I overestimating the risk the way I usually do?”
  “Will this even matter to me next year, next month or next week?”
  “On my death bed, will I regret not having worried more about this?”

♦ Identify any common cognitive distortions that fuel worry:
  All-or-nothing thinking
  Arbitrary inferences in ambiguous situations
  Personalization of events
  “Should” statements
  Distorted estimations of probability, risk and personal responsibility

♦ Strive to relinquish the need for control and certainty. The quest for both may seem irresistible and compelling at the moment, but, over time, it is entirely futile and merely perpetuates worry.

♦ Try using “scheduled worry” periods. Instead of indulging your worries by giving them your full attention whenever they intrude or by trying to avoid them, set up two or three 15-20 minute periods per day when you give your worries your complete attention. When worries intrude at other times during the day, try to defer them to your next scheduled worry period.

♦ Have a plan for action—not the “right plan” or the “perfect plan”—just a reasonable plan. What is the perceived threat to your vital interests? How are you vulnerable? Do you really have the facts? One can’t escape one’s own imagination or run away from what “could” happen. Arousal of the “fight or flight” response with no place to go leads to “freeze” (i.e., inhibition of action). Once you have a plan, don’t keep checking on it—store it. In general, some kind of action is usually preferable to spinning your wheels. Likewise, some kind of large muscle activity is usually better than thinking even more.

Worry gives a small thing a big shadow

(Swedish proverb)
There are many breathing exercises available. This one, “The Slow Breathing Exercise”, was published by the World Health Organisation and is widely used as a tool for managing stress and anxiety. The aim is to practice this exercise often enough so that you habitually breathe at 10-12 breaths per minute when at rest. This may assist with reducing the occurrence of hyperventilation (over breathing). Try counting your breaths for one minute prior and one minute after doing this exercise (one inhalation + one exhalation = 1 breath). If your “before” rate is much higher than 10 or 12, you should notice a reduction in the number of breaths per minute immediately after you have done the exercise. The main benefit from this exercise is the reduction in habitual breathing rate – it may be somewhat helpful when you are feeling very stressed or anxious, however when in these states you know how hard it is to remember and carry out such strategies.

1. Seat yourself comfortably in a chair.
2. Hold your breath for 5 seconds (do not take a deep breath)
3. When you get to 5, breathe out and say the word *relax* to yourself in a calm, soothing manner.
4. Breathe in and out slowly in a six second cycle. Breathe in for three seconds and out for three seconds. This will produce a breathing rate of 10 breaths per minute. Say the word *relax* to yourself every time you breathe out.
5. At the end of each minute (after 10 breaths) hold your breath again for 5 seconds and then continue breathing using the six second cycle.
6. Continue breathing in this way until all the symptoms of over breathing have gone.

The breathing rate in this exercise is for when you are not physically active. Don’t try to maintain the six second cycle if you are a doing physical activity for which you naturally need to breathe faster, for example, walking.

Stop the exercise if you feel too uncomfortable. If you have been breathing much faster than 10-12 breaths per minute, it will take practice to gradually be able to breathe at this slower rate.

The five secrets of effective communication


**LISTENING SKILLS**

1. **The Disarming Technique.** You find some truth in what the other person is saying, even if you feel convinced that what they’re saying is totally wrong, unreasonable, irrational, or unfair.
2. **Empathy.** You put yourself in the other person’s shoes and try to see the world through his or her eyes.
   - **Thought empathy:** You paraphrase the other person’s words.
   - **Feeling empathy:** You acknowledge how they’re probably feeling, given what they are saying to you.
3. **Inquiry:** You ask gentle, probing questions to learn more about what the other person is thinking and feeling.

**SELF-EXPRESSION SKILLS**

4. **"I feel" statements.** You express your feelings with "I feel" statements (such as "I feel upset") rather than with "you statements" (such as "You’re wrong!" or "You’re making me furious!").
5. **Stroking:** You find something genuinely positive to say to the other person, even in the heat of battle. This indicates that you respect the other person, even though you may be angry with each other.
Assessment of the published and unpublished data available for Advisory Committee. ADRAC has also sought advice from the updated 15 October 2004 have excluded severely depressed patients and have not In general clinical trials of SSRIs in children and adolescents however, an increase in some psychiatric adverse events (acts and ideation of suicide, self-harm, aggression, violence). During therapy with fluoxetine there was, decreased suicidal ideation compared with placebo by the end of the treatment period. During therapy with fluoxetine there was, however, an increase in some psychiatric adverse events (acts and ideation of suicide, self-harm, aggression, violence). In general clinical trials of SSRIs in children and adolescents have excluded severely depressed patients and have not adequately monitored participants for self-harm or suicide-related events. Other non-SSRI antidepressants have been subjected to even less scrutiny, and may be inefficacious and also associated with suicidality, as well as having other undesirable effects such as the toxicity in overdose of the tricyclics.

ADRC recommends:
1. Any use of SSRIs in children and adolescents with MDD and other psychiatric conditions should be undertaken only within the context of comprehensive management of the patient. Management should include careful monitoring for the emergence of suicidal ideation and behaviour which may particularly develop early in therapy, or if therapy is interrupted or irregular because of poor compliance. Cognitive behaviour therapy, if it is available, may enhance the outcome in MDD.
2. The choice of an SSRI for a child or adolescent with MDD or other psychiatric condition should be made only after taking into account the recent evaluations of clinical trial data and the Australian product information (PI). Prescribers should be aware that the marketers of fluvoxamine and sertraline (indicated for OCD) advise against use in children and adolescents with MDD, and of citalopram, escitalopram, paroxetine, venlafaxine and fluoxetine warn or caution against use in patients aged less than 18 years for any indication.
3. Children and adolescents being treated for MDD with an SSRI should not have their medication ceased abruptly. In addition, ADRAC asks that cases of emergent or worsening suicidal ideation or behaviour and self-harm in children or adolescents treated with an SSRI be reported to aid understanding of what might be an idiosyncratic response to the medication.

The Australian Adverse Drug Reactions Advisory Committee (ADRC) has reviewed data on the safety and efficacy of SSRIs* in the treatment of major depressive disorder (MDD) and other psychiatric disorders in children and adolescents. The data reviewed has included the US FDA analysis in collaboration with a group at Columbia University;† ADRAC has also consulted again with the Royal Australian and New Zealand College of Psychiatrists and the Royal Australasian College of Physicians. ADRAC has considered the recent evaluation by the UK Committee on Safety of Medicines (CSM) and the briefing papers provided recently to a US Food and Drug Administration (FDA) Advisory Committee. ADRAC has also sought advice from the Royal Australian and New Zealand College of Psychiatrists and the Royal Australasian College of Physicians Division of Paediatrics & Child Health.

None of the SSRIs, and indeed no antidepressant, is currently approved in Australia for the treatment of MDD in children and adolescents (persons aged less than 18 years). Fluoxetine, but none of the other SSRIs, is approved in the US for MDD in young people without a specified lower age limit. Two of the SSRIs, fluvoxamine and sertraline, are approved in Australia for children and adolescents with obsessive compulsive disorder (OCD).

Assessment of the published and unpublished data available for SSRI use in children and adolescents indicates that there is evidence of an increased risk of suicidality, including suicidal ideation, suicide attempts and self-harm events, associated with each of the SSRIs.† The strongest association has been found with paroxetine and venlafaxine, but sertraline, citalopram and fluoxetine have also been implicated, with fluoxetine possibly having the smallest risk.‡ There are very few data for fluvoxamine.

Increases in suicidal ideation and behaviour during the early stages of antidepressant treatment are well-known clinical phenomena in adults. It is clear that these events can occur in children and adolescents as well. While the size of the increase compared to placebo is small, around 2 to 3 patients per 100, the effect is stronger with some SSRIs than others in young people.

In a recent study,‡ at the completion of therapy fluoxetine was beneficial for the treatment of depression in adolescents with moderate to severe symptoms of MDD. Treatment with fluoxetine plus cognitive behaviour therapy was more beneficial and decreased suicidal ideation compared with placebo by the end of the treatment period. During therapy with fluoxetine there was, however, an increase in some psychiatric adverse events (acts and ideation of suicide, self-harm, aggression, violence).

In general clinical trials of SSRIs in children and adolescents have excluded severely depressed patients and have

Editor’s Note: If you have any questions or concerns about this information please speak to the prescribing doctor. In addition to this, information and advice may be obtained from Medicines Line 1300 888 763 and the Psychotropic Drug Advisory Service ph. 9389 2920 or email: C.Culhane@papyrus.mhri.edu.au.

Use of SSRI antidepressants in children and adolescents.
updated 15 October 2004

* The SSRI antidepressants included are citalopram, escitalopram, fluoxetine, fluvoxamine, paroxetine and sertraline, and the related medicine, venlafaxine.
† The FDA review also included mirtazapine which is not approved for use in children, bupropion which is not indicated as an antidepressant, and nefazodone which is no longer available in Australia.

22 Vol. 10, No. 4. March 2005 Newsletter : Anxiety Recovery Centre Victoria
SANE Report challenges political parties to ‘walk the walk’ on mental health...

A new report -‘SANE Mental Health Report 2004’- launched on the eve of the Federal election, reveals mental health services in crisis across Australia; stigma systemic in decision making at the highest political levels and no coherent national mental health strategy.

‘The SANE Mental Health Report 2004’ explores how well our mental health services are responding to the symptoms, disability and profound distress caused to individuals and families from mental illness.

It finds that politicians are quick to ‘talk the talk’ on mental health, the findings and recommendations of the report challenge them to ‘walk the walk’ - to dare to care about Australians affected by mental illness.

- **Summary report findings**
  - Mental health services are in crisis across Australia, barely able to cope with people experiencing acute episodes of illness.
  - Stigma is systemic in decision-making at the highest political levels with government leaders at both State and Federal level ensuring that services have had a low priority in policy-making and funding.
  - Retreat of the National Mental Health Strategy on many fronts with old-style psychiatric institutions still in place and prisons becoming de-facto psychiatric institutions.
  - No coherent strategy covering issues such as dual-diagnosis, rehabilitation and supported accommodation.
  - Vilification of people with a mental illness is not unlawful in any State or Territory, except Tasmania.

To obtain a copy of the report visit the SANE Australia website at www.sane.org, email: info@sane.org or ph: 9682 5933.

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**Government agrees to Mental Health Inquiry**

The Federal government has called for a wide-ranging Senate inquiry into the poor state of mental health services in Australia, including state-federal divisions over funding responsibility. It will investigate the lack of hospital and community care, chronic shortages in crisis services and the growing demand for care of the young, homeless and prisoners. Liberal senator John Tierney drafted the terms of reference for the Senate inquiry which is currently under review. He said that the government’s notice of motion to set up a select committee would be put to the Senate when it next sat on March 7, after it took submissions on the terms of reference from community and health groups. NSW Premier Bob Carr ways he welcomes the Federal government’s call for reform in the mental health sector and supports the inquiry which will investigate ways of reforming overlapping federal and state responsibilities for health. The inquiry comes amid rising concerns about the failure of governments to manage mental health issues in the community. The well publicised case of Cornelia Rau, the mentally-ill Australian resident who spent 10 months in immigration detention after authorities failed to recognise her mental illness, is currently undergoing a closed-door investigation. Mental Health Coordinating Council, NSW - Media Release – 22nd February 2005

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**Do you care about Mental Health?**

Do you want adequate Mental Health Services?

Do you think Mental Health Services deserve a fair share of the health budget?

Then lend your voice in the

**RALLY IN MARCH – Let politicians hear our voice**

- **on March 31st 2005**
- starting at 12.30 pm at the steps of Parliament House, Spring St, Melbourne.

**ALL WELCOME**

Join us for a barbeque in the Treasury Gardens afterwards.

Please RSVP for catering purposes to info@vmiac.com.au or phone (03) 9387 8317

organised by the Victorian Mental Illness Awareness Council
Australians are being urged to deal with their shock, disbelief and grief as news footage of the tsunami devastation hits home. The horrifying images of destruction, the stories survivors have told and the sheer numbers of deaths – tens of thousands – will have an emotional toll on Australians.

The Australian Psychological Society (APS) is urging Australians to seek help if they are experiencing emotional stress.

“It is not only those who have lost loved ones or who were firsthand witnesses who will be emotionally distressed. Television footage has brought the impact into all of our homes,” the President of the Australian Psychological Society, Ms Amanda Gordon, says.

“Tearfulness is normal with a crisis like this. However, other symptoms of shock and grief may include changes in sleep patterns, nightmares, fatigue, health problems, difficulty concentrating, excessive fear, anger and depression,” says Ms Gordon.

The experience of other horrific events such as 9/11 and Bali suggests that these and other symptoms may already be occurring, or may come on over the next few days and weeks. Australians are being warned to deal with the symptoms of stress effectively and immediately.

“The Bali bombings and 9/11 attacks showed us that those worst affected were those who watched television footage of the attacks over and over. Parents who allowed their children to sit glued to disaster footage has much more distressed children, and were themselves much more distressed for longer than those who limited their viewing.

“The most important thing is to talk to people, for talking is the healing medicine. When you talk to others, you will find that everyone's reaction is slightly different – we are all unique with unique responses to emotional pain,” explains Ms Gordon.

British clinical practice guidelines for depression, panic/agoraphobia, and GAD

The National Institute for Clinical Excellence (NICE), produces clinical guidelines for the treatment of a variety of illnesses by the National Health Service, UK. In December, 2004, NICE released the guidelines for depression, and for anxiety which includes panic disorder (with or without agoraphobia), and generalised anxiety disorder. There is one version for clinicians and one version for the public. Interestingly, two of the four “key priorities” for general management relate to the importance of information provision and encouraging attendance at self-help groups. The guidelines for OCD are due for release in September, 2005, and the PTSD guidelines in March 2005.

These current documents are available online at www.nice.org.uk (Click – “Our guidance”, “Clinical guidelines”, “Published guidelines”).

Australian and New Zealand Treatment Guides for Consumers and Carers

The Royal Australian and New Zealand College of Psychiatrists have published a series of clinical practice guidelines, and guides for consumers on various disorders including panic and agoraphobia, and depression. The purpose of these publication is to provide mental health practitioners, consumers, and carers with evidence-based information about particular mental illnesses and appropriate treatment options. Copies are available by visiting the RANZCP website at www.ranzcp.org/pubicarea/cpg.asp#cc.

Carer Counselling Program Victoria

The Carer Counselling Program Victoria is a statewide service especially for carers. The Carer Counselling Program provides short term counselling for carers. Accredited counsellors assist carers to cope with the pressures and stresses. They will also help carers understand the impact of the caring role on their own health and well-being. How it is provided: Face to face or on the telephone; individual or group; at our city site or at another service in your local area. Who is eligible? You are eligible if you are caring for someone who is frail and elderly; has dementia; a mental illness; a disability or complex needs; receives palliative care or exhibits challenging behaviour. You are also eligible if you have recently relinquished care - and the person you care for has been placed in residential care. Cost of service: Counselling costs have an emotional toll on Australians urged to deal with shock, disbelief and grief

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The Mental Health Research Institute of Victoria is currently undertaking a study to explore temperament and character traits in people with body dysmorphic disorder (BDD). BDD is defined as a preoccupation with an imagined or very slight defect in physical appearance, which causes significant distress to the individual. People who suffer from BDD dislike some aspect of how they look so much that they can’t stop thinking and worrying about it. Rather than being misconstrued and trivialised as socially unacceptable vanity, extreme preoccupation with bodily appearance has serious social implications, potentially affecting mental health and leading to, in some cases, depression, social isolation, occupational absenteeism, familial dysfunction and self-destructive behaviours.

Currently, treatment options are limited and research shows mixed outcomes for pharmacotherapy and psychological treatments. Recent studies exploring psychiatric disorders, including depression, bipolar and bulimia, have highlighted the existence of specific personality characteristics influencing treatment planning and provision.

This study aims to explore temperament and character traits in people with BDD in order to determine whether a relationship between personality and severe body image concerns exists. It is envisaged that findings from this study will provide valuable information on personality characteristics, which may influence treatment. Further, by understanding the relationship between BDD and personality, treatment can be specifically designed to reduce and alleviate the difficulties and concerns experienced by people with severe body image concerns.

It is envisaged that findings from this study will provide new and valuable information on personality characteristics, assisting with the development of more effective treatment options.

We are currently seeking referrals for the study. To be eligible to participate in the study, individuals must be 18 years of age and over and have a diagnosis of body dysmorphic disorder. Consent ing individuals will be invited to complete a personality inventory and participate in a clinical interview. Involvement in the study should take no more than two hours. Participants will be paid $30 for their time.

If you would like to make a referral, self-refer or require further information about the project, please contact Bernadette Jenner (03) 9388 1633. Details of the study will be forwarded to you by mail. All information provided will be kept confidential and secure and will only be disclosed with your permission or unless required by law. Only the researchers named below will have access to your information. Any written material, including publication material, will not contain any identifying information.

* Principal Investigators include Professor David Castle, Psychiatrist, Mental Health Research Institute; Bernadette Jenner, Psychologist, Mental Health Research Institute; Roberta Honigman, Social Worker, Mental Health Research Institute; Dr Robert Cloninger, Psychiatrist, St Louis University; Dr Paul Holman, Psychiatrist, Private Practice, Melbourne.

Monash University

The interpretation of ambiguous stimuli in people who panic

Specifically we are aiming to explore the differences in the way people interpret everyday events that seems to be associated with the ‘type’ of panic experienced (i.e. socially cued panic verses spontaneous uncued panic). Such research will assist in furthering an understanding of the nature of anxiety disorders and the similarities and differences between them.

Firstly you will be interviewed about various aspects of your emotional well-being over the telephone. This takes approximately 60 minutes.

Following this you will be asked to complete (within seven days) a series of questionnaires ‘online’. That is, the questionnaires are located at a web-site, and you complete and submit them via computer/internet. These questionnaires ask you about your experiences and feelings regarding anxiety and how you typically respond to certain situations or events. This takes approximately 60 minutes. Upon completion of all questionnaires you will be posted by registered mail a ‘Myer/Grace Bros’ voucher to the value of $30 as compensation for your time.

The information provided by you will be coded to protect your privacy and kept confidential with ONLY the research team having access to it. Information collected from this study will only ever be reported in aggregate so no individuals may be identified.

David Austin (PhD candidate) and Professor Jeff Richards, Department of General Practice, Monash University, Phone: 8575 2246; Fax: 8575 2233, Email: David.Austin@med.monash.edu.au or Jeffrey.Richards@med.monash.edu.au
University of Wollongong

New study aims to improve understanding of brain activity in OCD

Research currently being conducted at the University of Wollongong is hoped to eventually lead to improved understanding and treatment of psychological problems such as Obsessive Compulsive Disorder and Panic Disorder. The research is focused on discovering how patterns of brain activity differ between people with Obsessive-Compulsive Disorder, those with Panic Disorder and people without a psychological disorder when they are thinking about emotional information. The research team has access to sophisticated technology including state-of-the-art EEG and event-related potential (ERP) equipment that measures brain electrical activity in new ways to help understand particularly how and why people with OCD seem especially sensitive to anxiety and guilt related themes in their environment, and the reasons why OCD sufferers have “sticky minds” and can’t let go of unwanted thoughts or images.

The research is being conducted as part of a PhD by Sue Thomas, a registered psychologist, under the supervision of Associate Professor Craig Gonsalvez & Dr Stuart Johnstone of the Department of Psychology, Faculty of Health and Behavioural Sciences.

In the past, Associate Prof. Gonsalvez has been the Director of the Anxiety Clinic at Westmead Hospital, has developed and has run out-, day- and in-patient treatment programs for OCD in Westmead & St. John of God Hospitals. He maintains close links with OCD support groups, has contributed articles to the Anxiety Disorders Alliance Newsletter, and presented lectures at OCD support group meetings. The current PhD thesis is one of several ventures by the University of Wollongong to contribute to OCD research. In December 2003, Dr. Shelley Bannon (supervised by Dr Gonsalvez) was awarded a PhD for her thesis, Executive function deficits in OCD: Episode or Trait Markers?

Ms Thomas, Dr. Gonsalvez, and their co-researchers are now calling for volunteers to help in the study. People required are:

- Adults (18 years plus)
- With a diagnosis of either Panic Disorder or Obsessive-Compulsive Disorder from a doctor or health professional
- Not having another serious current psychological condition (for example, major depression, drug or alcohol dependence)

Participants will usually come on two occasions to the University of Wollongong. On the first visit, they will be interviewed by a psychologist, and asked to complete a computerized interview and some questionnaires about their psychological symptoms.

On the second visit, brain activity, heart rate, and skin conductance (changes in perspiration levels on the fingers) will be measured while participants are looking at different types of words on a computer screen and performing simple tasks.

Brain electrical activity will be measured from a cap, which sits on the head and is fitted with a number of electrodes that record minute electrical changes as they occur within the brain. The procedure is non-invasive and should involve no discomfort.

While we cannot reimburse travel costs, light refreshments will be provided. All participants will be offered the option of receiving a summary of the projects results at its completion. In addition, participants will receive detailed written information regarding the purpose of the study, and contact numbers for the researchers should any further questions arise.

University of Melbourne

OCD-Related Research Projects

Obsessive Compulsive Disorder (OCD) is an anxiety disorder that often involves extreme reactions to particular intrusive thoughts, images, or urges, resulting in obsessive and compulsive symptoms.

Professor Mike Kyrios, Richard Moulding, Guy Doron and Dr. Sunil Bhar are conducting the following two research projects.

Project 1: Obsessive-Compulsive Disorder and Issues of Control

Project 2: Attachment and Internal Representations of World and Self in Obsessive-Compulsive Disorder.

We are seeking people to help us in these studies:

- Volunteers who are experiencing OCD.
- Volunteers who are experiencing other anxiety disorders.
- We are also seeking the participation of individuals without any psychological disorders.

In one study, we wish to focus on how people’s views about the need to control their thoughts and environment contribute to the maintenance of OCD and other anxiety disorders. In the second study, we are particularly interested in the way that individuals suffering from OCD and other anxiety disorders see themselves, their world and remember their early development.

Both these studies comprise of two parts. The first part includes undergoing a 40 min structured interview to confirm diagnosis. The second part comprises the completion of 9 questionnaires for each study.

If a participant decides to participate in both studies they will need to undergo ONLY one interview and complete ONLY 15 questionnaires.

The studies can be conducted either at the Anxiety Recovery Centre (ARCVic), or at the Royal Melbourne Hospital, Parkville. While we cannot reimburse travel costs, light refreshments will be provided. All participants will be offered the option of receiving a summary of the projects results at its completion. In addition, participants will receive detailed written information regarding the purpose of the study, and contact numbers for the researchers should any further questions arise.
The studies are expected to improve our understanding of thinking styles associated with OCD and other anxiety disorders. This will contribute to the improvement of treatment programs in the future.

Richard and Guy are undertaking a PhD in clinical psychology at the University of Melbourne, and they are involved in the treatment of anxiety, depression and OCD. Both have been living in Melbourne for five years, Richard having come from Perth, and Guy from overseas. Please contact us for any additional information regarding these projects, or if you’d like to volunteer.

Thank you in advance,
Richard Moulding, 8344 814, moulding@unimelb.edu.au
Guy Doron, 8344 6345, gdoron@unimelb.edu.au

University of Melbourne - Department of Psychology
An Investigation into Compulsive Buying (“Shopaholism”)

You are invited to participate in a research project into Compulsive Buying, a little studied but very disabling condition. Research from the United States (Black, 1996) shows that up to 1 in 12 persons are affected by this condition, presenting with symptoms such as: uncontrollable urges to shop; purchasing much more than intended with many of the items going unused; significant debts, family and occupational problems due to overspending; and feelings of guilt and shame because of binge buying. Our study will be the first in this area based on data from a local sample, and preliminary results suggest that Compulsive Buying is a serious problem in Australia. The aims of our study are to investigate and describe the psychological factors leading to compulsive buying behaviour and to delineate this disorder from other associated disorders (such as OCD and impulse control disorders) and normal behaviour. Based on this knowledge, we hope to develop more effective treatments for those suffering from the significant financial and emotional impact of this condition.

The study is conducted as part of a doctoral research program at the University of Melbourne, being undertaken by researchers of the University of Melbourne Psychology Clinic. With the aim of clearly understanding the distinctions and overlaps between compulsive buying disorder, OCD and normal behaviour, we require participants that a) experience the symptoms mentioned above, OR b) suffer from OCD, OR c) do not suffer from any psychiatric disorder.

Participation in our study involves filling out two series of questionnaires, which will be sent to your home address, and for a smaller number of participants it involves coming to the University of Melbourne Psychology Clinic (based at the Royal Melbourne Hospital) to perform 3 computer-based tasks simulating a shopping situation. Completing the first package of questionnaires, which enquires about your everyday behaviour, thoughts and emotions, should not take longer than 30 minutes and basically assesses your suitability for our study. The second package of questionnaires is similar in content and will be sent out once we have received and analysed the results of the first package. Completing this package of questionnaires should not take longer than 60 minutes. For those invited to participate in the computer simulated shopping tasks, which take approximately 60 minutes, there is a $20 reimbursement of travel costs.

This study has been approved by the ethics committees of the North Western Health Service as well as the University of Melbourne. We appreciate very much if you would choose to support us in this study, which we hope will be an interesting experience for those participating and will enable us to develop effective help for those affected by this poorly understood and trivialised disorder and their families. Please be reminded that if you choose to participate today, you can still withdraw from our study at any time and your withdrawal will not have any effects on the treatment or support you or your family member are currently receiving. For further information about this research project please contact Carl Zabel, Department of Psychology, The University of Melbourne, Tel (03) 8344 5572, Fax (03) 9349 4195, email c.zabel@pgrad.unimelb.edu.au.

Carl Zabel is a registered psychologist, currently undertaking a doctoral degree in Clinical Psychology in the Department of Psychology, University of Melbourne. Carl has worked with anxiety and depression related disorders in clinical settings in Australia and overseas. Paul McQueen is a probationary psychologist, who is also undertaking doctoral studies in Clinical Psychology at the University of Melbourne. Paul obtained his honour’s degree through research into cognitions in OCD. A/Professor Michael Kyrios, is the principal supervisor of this project and is a specialist in OCD and related disorders. He is a Senior Lecturer in the Department of Psychology at the University of Melbourne. References: Black, D.W. (1996). Compulsive buying: A review. Journal of Clinical Psychiatry, Vol. 57, pp. 50-54; Kyrios, M., Frost, R.O., & Steketee, g. (2004, in press). Cognitions in compulsive buying and acquisition. Cognitive Therapy & Research

Melbourne Neuropsychiatry Centre, Mental Health Research Institute-RMH, University of Melbourne, & Austin & Repatriation MC
Brain Imaging Study : Investigating the Anterior Cingulate Cortex in People with OCD

Previous research has demonstrated subtle differences in the ways in which thinking, memory and brain functions in OCD compared to controls and other disorders. Utilising brain scanning technology, Magnetic Resonance Imaging (MRI), this study looks at a part of the brain called the anterior cingulate cortex – a region particularly involved in emotion, motivation and thinking, areas which may be implicated in OCD and other psychiatric disorders such as schizophrenia. Whilst clearly the two disorders are not the same, we know that this part of the brain is involved in some way in both conditions. However, we are still unsure exactly how this part of the brain is involved in the behavioural difficulties people with OCD or schizophrenia experience. Therefore, by focussing on this brain region in both OCD and schizophrenia, it is hoped that the findings of this study will allow us to better understand the experiences of individuals suffering from schizophrenia or OCD, and develop more effective interventions.

This is a major National Health and Medical Research Council (NH&MRC) funded project being conducted by the Melbourne Neuropsychiatry Centre (Sunshine Hospital), Mental Health Research Institute, in collaboration with the Royal Melbourne Hospital and the Austin Repatriation Hospital.

Newsletter : Anxiety Recovery Centre Victoria, Vol.10, No. 4. March 2005
For this study, we are looking for males or females who: are between 18 and 45 years of age; right handed; have suffered from OCD for at least two years. The project requires attendance at three sessions. In the first session we will ask you some questions and conduct some tests that measure your memory and thinking. In the second session you will be asked to attend a brief session at a practise MRI scanner to help you understand and experience the MRI environment. In the third session we will ask you to lie inside an MRI scanner. While you are lying inside this scanner, we will collect information about the anatomy, function, and chemistry of your brain. The MRI scan is safe and does not involve any invasive procedures or use any radiation.

Participants will receive a picture of their brain, feedback on their test results, and six monthly newsletters informing them about how the project is going.

If you wish to participate or would like more information on the research, please contact Kerrie Clarke on 8345 0592, mobile: 0414 233 739, or by e-mail at kerrie.clarke@wh.org.au.

University of Melbourne & The Melbourne Clinic
A research study investigating compulsive hoarding, OCD and related anxiety disorders:
Volunteers needed with OCD, Social Anxiety Disorder or Panic Disorder

This study is being done as part of a doctoral research program at the University of Melbourne, being undertaken jointly by the University of Melbourne Psychology Clinic and the Melbourne Clinic. The project is investigating compulsive hoarding in comparison with OCD (without hoarding), Social Anxiety or Panic Disorder, and a community sample of people without any psychiatric symptoms. The project will investigate thinking patterns and abilities in people with and without compulsive hoarding problems. Previous research has shown that those with compulsive hoarding report difficulties in memory, concentration and and making decisions. The study will compare these types of difficulties across the different disorders. Participants will be asked to fill out a series of questionnaires about their experience of hoarding (if any), about their early childhood experiences, about making decisions, about their memory, and about their current emotional state . These questionnaires are not difficult to complete, there are no right or wrong answers, and they should be fun and enjoyable to do. If any difficulties are encountered, a break can be taken between sessions. The time involved is about 2.5 hours including an interview about other psychological issues and whether or not any rooms in your home are affected by clutter. We cannot say that there will be any direct benefit to you from your participation. Those who have compulsive hoarding symptoms will have the benefits of learning more about this condition and some will have the opportunity to participate in an intensive pilot treatment program. Those participating who do not have compulsive hoarding problems will also learn more about the condition, and have the awareness that they are contributing to the understanding for this difficult and poorly understood clinical problem. The time being given by you to this project is very much appreciated. For further information about this research project please contact Christopher Mogan, Head of Psychology Services, The Melbourne Clinic, Tel (03) 9420 1477, Fax (03) 99537 0103, email c.mogan@pgrad.unimelb.edu.au.

Christopher Mogan is undertaking this research project as a PhD candidate in the Department of Psychology, University of Melbourne. Christopher Mogan is an experienced clinician and Director of the Anxiety Disorders Unit, a Melbourne Clinic - University of Melbourne facility headed by Professor Schweitzer. Chris has specialised in the treatment of anxiety disorders since commencing in the unit in 1987. He has been involved in the treatment of compulsive hoarders through the anxiety disorders clinic. A/Professor Michael Kyrios, is the principal supervisor of this project and is a specialist in hoarding research. He is a Senior Lecturer in the Department of Psychology at the University of Melbourne. Professor Schweitzer is the co-supervisor. He holds the Healthscope Chair of Psychiatry at the University of Melbourne, and directs a research and teaching program at The Melbourne Clinic.

Monash University
Preventing panic

Panic Online is an interactive program that provides information about panic and anxiety as well as how to control the experience of panic sensations and how to change self-defeating thoughts. An online therapist contacts participants by email and guides them through the program as well as assisting them with other issues relevant to their disorder. The research team has received $200,000 from the National Health and Medical Research Council to evaluate how well the internet therapy works compared to face-to-face cognitive behavioural therapy and also to medication. Thirty Victorians have already gone through or are completing the 12-week program. Study participants are limited to Victoria because some people are randomly placed in the section of the study that requires face-to-face therapy.

Professor Richards says previous research by his group shows that Panic Online is better for controlling panic than other self-help procedures. "Some of the many treatment gains found among people who complete Panic Online include a significant reduction in the overall severity of panic disorder, fewer panic attacks, diminished anxiety about future panic attacks and increased confidence in dealing with them, in addition to overall reductions in anxiety and stress," he says. "If our study shows that Panic Online is as beneficial as face-to-face cognitive behavioural therapy or medication, then we can confidently recommend it to people who are unable or disinclined to enter face-to-face therapy." Monash University is seeking people with panic disorder to participate in this study. Participants take part in an interview to determine their eligibility, and then complete 12 weeks of therapy involving either Panic Online or face-to-face cognitive behavioural therapy with a psychologist, or medication administered by a psychiatrist. For further information, contact +61 3 8575 2246 or visit http://www.med.monash.edu.au/mentalhealth/paniconline/
Cognitive behaviour therapy for hypochondriasis: a randomised controlled trial


Hypochondriasis, a persistent, irrational fear or belief that one has a serious, undiagnosed medical illness, is a prevalent disorder affecting as many as 5% of medical outpatients. Similar to OCD, hypochondriasis involves obsessions and compulsions - obsessions about being ill and compulsions to check with others for either diagnosis and treatment or reassurance that one is not ill. Individual cognitive behaviour therapy (CBT) administered in six 90-minute sessions to 102 subjects with hypochondriasis, was compared to medical care as usual for 85 subjects. The CBT sessions focused on factors that cause patients to exaggerate bodily symptoms and misattribute them to serious disease. Subjects were assessed before and 6 and 12 months after completion of treatment. At the 12-month follow-up, CBT patients had significantly lower levels of hypochondriacal symptoms, beliefs, and health-related anxiety. They also had significantly less impairment of everyday functioning. Hypochondriacal attitudes and concerns improved more than occurrence of bodily symptoms did. This finding was expected as the treatment was intended to improve patient coping with symptoms rather than curing the disorder. This study supports the use of CBT for hypochondriasis to lessen patient fears and beliefs and improve coping.

Exposure and ritual prevention for obsessive-compulsive disorder: effects of intensive versus twice-weekly sessions.


Behaviour therapy by exposure and ritual prevention (ERP) is an effective treatment for OCD. Most treatment studies have used an intensive ERP schedule with daily sessions each week, a schedule that is often not possible in most clinic settings. Forty OCD patients received 15 sessions of ERP, 20 received daily treatment over 3 weeks and 20 received twice weekly therapy over 8 weeks. Results indicated that both programs were effective. The effect of therapy schedule was moderate, with a trend toward more improvement in the intensive group at post-treatment. No differences were found at a 3-month follow-up. Also of interest, some patients had additional mental disorders and histories of treatment failure. This study suggests that the benefits of ERP are not limited to highly selected research subjects.

Repeated checking causes memory distrust

Behaviour Research and Therapy, 41:301-316, 2003, M. van den Hout and M. Kindt

In OCD, individuals with checking problems check repeatedly in an effort to prevent harmful events. They tend not to check once or twice, but much more often. This study looked at why distrust in memory persists despite repeated checking. An interactive computer animation program was developed in which participants had to perform checking rituals on a virtual gas stove. Repeated checking of the virtual stoves resulted in recollections of the last check being less vivid and detailed, and the participants became less confident about their memories of the last check. The checking became more familiar with increased checking, the memory of the checking became less vivid and detailed and this reduced confidence in memory about whether the last check was done correctly. This study suggests an answer to the question "why memory distrust continues despite repeated checking?" Repetitive checking results in memory distrust; rather than reducing doubt, checking fosters doubt.
10 Simple Solutions to Panic

How to overcome panic attacks

Martin, A. & McCabe, R. 2004. USA

This concise, easy-to-read manual provides much needed guidance and assistance to anxiety sufferers in a ten step program.

1. Understand Your Panic and Fear
2. Make a Contract and Set Realistic Goals
3. Track Your Panic Symptoms
4. Replace Anxious Thinking with Realistic Thinking
5. Confront Places Where Your Panic Attacks Occur
6. Confront Your Physical Symptoms
7. Stop Playing it Safe - Eliminating Subtle Avoidance
8. Learn to Breathe Normally
9. Reduce Life Stress and Improve Your Health
10. Choose Medications That Work ($25.00)

My Life as Side Effect: Living with depression

Deitz, Milissa. 2004. AUS

Milissa Deitz is a Sydney-based author and journalist whose work has appeared in various magazines and newspapers. "Until only a few years ago," she writes, "I spent a fair amount of time wanting my existence to cease. I was like an accidental tourist on earth, suffering from a chronic illness called life." This book is a loose diary of Milissa Deitz’s depression and an honest account of her own journey towards diagnosis, acceptance and management of her illness. She also includes the testimonials of other sufferers, and interviews with medical professionals and information from support groups. ($22.00)

Coping with Blushing


Robert Edelmann’s popular book has been updated since its initial publication in 1990. Great strides have been made in the last decade regarding treatment. The appropriateness of surgery, for example, as a cure for blushing, and the effectiveness of psychological therapy. What has emerged is evidence that blushing is not necessarily to do with purely external signs that are visible to others, but seems more related to internal thoughts and evaluations. Edelmann’s self-help book seeks to reduce the individual’s fear of and concern about blushing, not to eliminate it, as empathy and sensitivity towards others can be a positive characteristic.

CONTENTS
- Embarrassment and blushing
- What is blushing?
- Who suffers?
- Coping with blushing
- Calming yourself down
- Re-evaluating and redirecting thoughts
- Developing Confidence
- Putting the package together and monitoring change
- Blushing: A personal account ($24.00)

Why Zebras Don’t Get Ulcers:
The acclaimed guide to stress, stress-related diseases, and coping

Sapolsky, Robert.1994/2004. USA

Robert Sapolsky's popular book is about the role of stress in making some of us more vulnerable to disease, and ways in which some of us cope with stressors. There are fascinating chapters on ageing and death, stress and depression, the effects of stress on memory, and what being poor has to do with health. It may sound depressing, yet Sapolsky’s good humour and fine literary style succeeds not only in interpreting technical material but also in convincing us that we have an enormous potential to protect ourselves from all the bad news. Most certainly all is not lost! ($30.00)

Freeing Your Child From Anxiety Powerful, practical solutions to overcome your child’s fears, worries and phobias

Chansky, Tamar. 2004. USA.

Tamar Chansky is the Director of The Children’s Centre for OCD and Anxiety in the USA. ‘Worry is a relentless exaggerator,’ writes Tamar Chansky, ‘and for anxious kids it is the default first reaction.’ To manage worry parents must challenge the credibility of a child’s automatic thoughts and cultivate a strong ‘second reaction’ - what the author calls ‘speed dialling that voice of reason’. The cognitive-behavioural therapy so outlined can be implemented easily at home, and Chansky argues that it is a powerful tool. Her well presented book presents parents with a ‘Master Plan’ (a set of six steps to implement in most anxiety situations), and a closer look at specific anxiety issues and situations. ($30.00)
More Than Nerves - Anxiety and Social Phobia in the Real World
by Rob Fischer, Ph.D.

As one of the more than 19 million people in the United States who suffer from an anxiety disorder, I can give a first-hand account of a condition that is, at best, poorly understood.

During the summer before my senior year in college, my mother died of lung cancer at the age of 57. As a rather private person, I dealt with this loss as I had most of my problems throughout adolescence: I repressed my grief and kept moving. I avoided talking about my mother's death and I continued my college work and social schedule as if nothing had happened. Some six months later, my repressed feelings showed physical manifestation. I developed ulcer-like symptoms that defied the abilities of professionals at campus student health to treat effectively. In addition to this "stomach pain," I developed a fear of being in group settings, particularly dining out. I came to fear the debacle of being nauseated in public and having to leave in a panic. The more I tried to force myself to stay, the greater the anxiety level and the perceived pain became. Frequently, I delayed eating until I could be in a safe environment. The result over time was a substantial weight loss, at one point taking me to a waifish 155 pounds on my 6'2" frame. After seeking additional professional help, first from a physician and then a clinical psychologist, I was diagnosed with generalized panic disorder with agoraphobia. Although this diagnosis troubled me greatly, it also provided a name for my condition. This confirmed for me that my phobia was real and that I was not alone in the symptoms I experienced.

With the ebb and flow of time, I had recurring bouts with my problem. I found it the most ironic of disorders - here I was, someone who had enjoyed groups and events, with a promising career involving frequent interpersonal interaction ahead of me, hamstrung with a phobia that caused me to detest groups, particularly functions involving a meal. I tried to deal with the situation proactively through talk therapy and some prescribed medication and, at times, out of frustration, through self-medication using alcohol. All the while, two internal voices coached me about the problem in. One voice offered comfort and tried to lessen the embarrassment of having to leave a social situation. The other derided me, minimized my feelings, and encouraged me to simply "suck it up." Each voice had a turn in being the more persuasive.

Now, over ten years later, there are but a few lasting remnants of my earlier phobia and anxiety. I still prefer to avoid crowded situations, though nothing like the aversion I previously experienced. I feel a small twinge of anxiety in restaurants as well as airport terminals and malls. I now recognize my symptoms earlier, before an episode occurs, and can take action to lessen the feelings of anxiety. In all, this condition that used to control much of my life has become a minor concern, but still a lasting reminder of earlier times. Much like a cancer patient in remission, I am forever watching for any signs of reemergence of the disease, especially around times of significant change, loss, or stress. I never claim to have beaten the anxiety disorder, rather, I seek to manage it through behavioral and cognitive strategies that work for me.
If you have experienced any of the symptoms I have described, I encourage you to openly talk about your feelings with those close to you and seek professional help immediately. If you worry, as I did, that medication could lead to a long-term dependence on a chemical solution to your disorder, this concern should not keep you from talking to your physician or counselor. Medication, if effective, can provide an anxiety-free window of opportunity in which you can work to address the issues underlying your disorder. If you know someone who experiences an anxiety disorder, I ask that you learn about the disease and provide support to this person, always in the most uncritical manner possible. Be aware that the disease rarely takes a linear path; it is likely that successes in certain situations will be followed by difficulties in others. Learn, along with your loved ones, to take a long view of the road to recovery and avoid unreasonable expectations for a quick cure. Anxiety disorders are manageable for the vast majority of those who suffer from them, but professional care and personal strategies are both imperatives for success.

Courage does not always roar.
Sometimes courage is the small, quiet voice at the end of the day saying, “I will try again tomorrow.”

The “Switch Off”
by Greg Byrne

I have been battling anxiety for many years. I have developed a technique I call “the switch off”. I have found this to be very helpful and so I would like to share this with other people struggling with anxiety.

Suppose you are at a shopping centre and you get an attack. A worrying thought comes into your head and causes a lot of problems. Did this thought come from something you saw in the shopping centre? Did it come from overhearing a conversation or seeing someone who reminded you of a past incident? Or did it come “out of the blue”?

Let me suggest that regardless of how it arose you were “ripe for it”. Possibly because of something to do with your serotonin levels, or whatever else causes your problem, you were susceptible to an attack and it would have come whether you were at that shopping centre or not.

Having an insight into what is happening can enable you to deal with this sort of problem. There is an old saying in this game that what you say to yourself is this: “I’m in no state to deal with this now so I’ll put it out of my head until I am”. That is all very well and good, but it’s easier said than done.

Remember the old advertisement about the lady’s hair spray? “It won’t happen overnight but it will happen”.

How many things in life are like that? I could mention sports training, weight loss, singing lessons, piano playing and so on. Perhaps I could mention giving up smoking or drinking.
This is a special kind of learning. If you learn biology, history or chemistry it's a matter of simply studying a textbook and learning off a lot of stuff so you can repeat it in an examination.

This is more like learning French where you have to DO IT. The only way to learn to translate into French is to PRACTICE doing a lot of sentences using the textbook examples. The only way to learn touch-typing is to practice it. So if you say that "I'll worry about this later" doesn't work for me, then I'm sure it doesn't, but it will work for you if you keep at it. Keep doing that for several weeks and eventually it will work.

I've got a slight variation of "I'll worry about this later on" business. I say, "This is an attack and has nothing to do with my situation now". So I put it out of my mind. What I do is SWITCH OFF. It's only a variation of the "I'll worry about this later" idea but some people might find it helpful. The idea of switching off may be helpful in that it is more dramatic. Once you turn off a light all you have is darkness and the light can't come back until you switch on again.

**IT'S NOT A 100% SOLUTION**

No it's not a 100% solution but it's a great help to me. The more you do it the better you'll become and in a few short months you will be much improved. This can make quite a difference to you and not only help you with abnormal anxiety related to your problem but even normal anxiety related to real problems that you should be anxious about. But remember if it is a real problem and requires practical action from you, make sure you take that action. So that if you should be anxious about being behind with studies or assignments make sure you do study and do your assignments.

I believe that everyone could benefit from this technique even if perfectly healthy. So many people get into such a state over mounting problems that they are almost incapable of effective action to deal with those problems. Dealing with practical problems requires calmness and determination to really get stuck into what has to be done.

**TWO ASPECTS TO IT**

If you have a worrying thought there are two aspects to my approach. The first is to recognise that the thought is not from any practical thing in your life now, and, in my view, is related to a lack of serotonin in the brain. That is the most crucial thing because it involves insight into what is really happening. If it is something related to serotonin then just SWITCH OFF. If it's a problem to switch off then get involved in your favourite hobby or if you are out at a shopping centre go and have a look at products you are very interested in such as say home theatre, computers or new dresses (if you are female). This will help with the switch off phase. The SWITCH OFF phase can only work if one recognises that the problem has no practical origin in one's life now.

**SUPPOSE I'VE DONE SOMETHING WRONG IN MY PAST LIFE**

None of us are perfect and we've all done things we aren't very proud of. Either you are going to apologise to that person you have wronged, or compensate him financially, or simply resolve never to do it again. But there is no point in getting into a flap about it. Before compensating anyone financially I suggest that you discuss it with someone you trust first. THEN PUT IT BEHIND YOU. The person you have wronged is probably no angel himself.

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**Would you like to share your story with others?**

The Opening Door is the section of the newsletter dedicated to featuring original works - stories, poems, book reviews, inspirational thoughts, and drawings by people with anxiety disorders of all ages and their family members.

You are most welcome to contribute your original works or ideas to The Opening Door. Many people who are unable to attend support groups find comfort and hope from reading stories by other people who experience anxiety disorders. The Opening Door also provides the opportunity for professionals, family members, carers and friends to gain a more empathic understanding of anxiety disorders and how they can help more effectively.

Your contribution can be published anonymously, however, we do need to receive details of your name, address and telephone number with your contribution.
Dear Editor,

This is an OCD sufferer’s reaction to a section in the article "What is cognitive theory and what can it tell us about managing OCD?" printed in the ARCVic Newsletter, October, 2004.

The paragraph heading (page 5) reads - “How we reward OCD”. Reward - what an inappropriate word to use in conjunction with compulsive acts or rituals. Compulsions are a curse – a tremendous, horrific force which floods mind and body immediately after an obsessive thought. They usually begin in a simple form but soon grow and grow, becoming more time consuming, elaborate and complicated.

The sufferer is in despair while performing a compulsive act, or mentally ritualising, or doing both at once - and in despair on completion, because of the realisation that the whole destructive process will soon occur again and again (and again).

Many sufferers spend all their waking hours ritualising - even though most are well aware of the irrationality and futility of it.

Compulsions make life an utter misery, occasionally bringing momentary relief, but at an enormous cost.

They never have been and never will be associated in my mind as a reward.

from Lois Van Dyk, OCD sufferer, carer & ARCVic member

A response to this Letter to the Editor from A/Professor Michael Kyrios

Dear Editor,

The letter writer eloquently describes the burden that compulsions place on the individual sufferer, and we also need to remember the burden that compulsions place on family, partners, friends and other carers.

According to current psychological models of OCD, when an intrusive thought or urge results in the acting out of a compulsion, two important processes occur: (a) firstly, there is an immediate decrease in the experience of discomfort. Our research with OCD groups and controls consistently confirms this observation. However, we also know from both research and sufferers’ experiences that the immediate decrease in discomfort is soon followed by increasing distress and a loss of one’s sense of control over intrusions and compulsions. Nonetheless, the immediate decrease in discomfort associated with the compulsion makes it more likely that subsequent experiences of intrusions will also be followed by compulsions. Hence, the decrease in discomfort "negatively reinforces" the compulsion. The word "reward" is the closest lay term to the technical term "reinforcement" used by psychologists and psychiatrists; (b) secondly, the acting out of a compulsion also reinforces the beliefs underlying the sufferer’s fears. For instance, if one feels personally responsible for doing something to prevent harm from happening to others, the acting out of the resulting compulsion strengthens or reinforces that belief. Again, the word "reward" is the closest lay term to the technical term “reinforcement.” Hence, use of the term "reward" is intended to describe the processes by which compulsions self-strengthen, and is not designed to describe some sort of satisfaction or recompense gained from the effort.

Regards,
Michael Kyrios
(A/Professor, Dept of Psychology, University of Melbourne)
<table>
<thead>
<tr>
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<th>Request Details</th>
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<tbody>
<tr>
<td>Anna</td>
<td>Interested in establishing contact with people who experience anxiety aged between 33 – 35 years. Anna is a creative person who enjoys sport, writing and drawing. (Code: #932)</td>
</tr>
<tr>
<td>Jessica</td>
<td>19 years of age and would like to write to other young people living with OCD. (Code: #933)</td>
</tr>
<tr>
<td>William</td>
<td>Would like to have contact with others living with OCD and who also may be affected by depression. He is 33 years of age and would appreciate contact with someone close to his age. (Code: #934)</td>
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<tr>
<td>Joanna</td>
<td>20 years of age and interested in corresponding with people living with body dysmorphic disorder and/or social anxiety. (Code: #935)</td>
</tr>
<tr>
<td>Simmy</td>
<td>Would like to have contact with people who have social anxiety. (Code: #936)</td>
</tr>
<tr>
<td>Hugh</td>
<td>22 years of age, would like to write to people around his age group who suffer from OCD and/or depression. (Code: #937)</td>
</tr>
<tr>
<td>Brett</td>
<td>33 years of age, interested in email contact with people who live with OCD and depression. Email Brett at <a href="mailto:brettbrett123@hotmail.com">brettbrett123@hotmail.com</a> (Code: #938)</td>
</tr>
<tr>
<td>Danielle</td>
<td>Is seeking to have contact (written, email or telephone), with other young adults aged in their early twenties who have generalised anxiety disorder. (Code: #939)</td>
</tr>
<tr>
<td>Doug</td>
<td>Would like contact via email with people up to 30 years of age who have OCD or other anxiety related illness. Email Doug at <a href="mailto:dlarma@hotmail.com">dlarma@hotmail.com</a> or send mail by post to PO Box 44 Meeniyan, Vic, 3956 (Code: #941)</td>
</tr>
<tr>
<td>Mandy</td>
<td>Would like written or telephone contact with people in their 40’s living with Social Anxiety. (Code: #942)</td>
</tr>
<tr>
<td>Edwina</td>
<td>24 years old and interested in writing to people living with Social Anxiety who are between 20 – 30 years of age. (Code: #943)</td>
</tr>
<tr>
<td>Janet</td>
<td>Would like to write to people who suffer social anxiety or anyone who feels lonely and depressed because of mental illness. Write to: Janet, PO Box 436, Golden Square, Vic, 3555</td>
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</table>

If you would like to respond to any of these requests please contact Jessica on the ARCVic Office Line 03 9886 9233 for further details, or send your name and address by mail to ‘Pen Pals’, ARCVic, PO Box 358, Mt Waverley, Vic, 3149, and indicate which person you are interested in contacting (by name and/or code number).

Note- each Pen Pal request will be published in three editions of the Newsletter, unless a notice to delete the Request is received from the person who initiated the Request. ARCVic does not accept responsibility for any outcome, resulting from any written or verbal correspondence entered into, in relation to these Requests.
**ARCVIC SOCIAL GROUP CALENDAR 2005**

**SATURDAY 19th MARCH**

**Melbourne Aquarium**

*Location:* Corner of Queens Wharf Road and Kings Way. Melway Map 1D Ref L1  
*Time:* 2.30 pm  
*Cost:* Adults - $23.00, Concession - $15.00. A group discount applies if 10 or more people book. Discounted prices are: Adults - $16.80, Concession - $11.20. Advance booking is required to receive a group discount otherwise normal prices will apply.  
*Parking:* Car parking is available at Secure Parking located directly opposite the Aquarium at 474 Flinders Street.  
*Public Transport:* Flinders Street Station is a 5 minute walk. Trams routes 48, 70, 75 and City Circle travel along Flinders Street with stops within walking distance of the Aquarium.  
*Please register for this event by Wednesday 16th March to assist us with booking in advance as we may be eligible for a Group Booking Discount if 10 or more people are interested in attending.*

**APRIL**

**Comedy Event - Short Film**

A Melbourne International Comedy Festival Event – Original short films will be screening as part of The Comedy Channel Short Film Festival. Details and venue to be confirmed in late March.  
Contact us on ☎ 9886 9233 for further information about this event.

**SUNDAY 15th MAY**

**Lunch**

**Boathouse Café - Maribyrnong River**

*Location:* The Boulevard, Maribyrnong Park, Moonee Ponds. Melway Map 28, Ref D 8  
*Time:* 1.00 pm  
*Cost:* Meals cost approximately between $8.00 - $14.00

*For further information or to register, contact the Social Group Coordinators, John or Jessica on 03 9886 9233. If you are attending a social event for the first time, please ring to organise meeting arrangements.*
Support for people and families living with anxiety disorders

ARCVic - Support Groups & Branches

Inner East
2 support group meetings each month.
Venue: The Peppercorn Club – 584 Glenferrie Road, Hawthorn. Time: 7:30pm – first Thursday of each month – mutual support groups; third Thursday of each month – open forum, large discussion group.

South East - Bentleigh
Venue: East Bentleigh Community Health Centre, Gardeners Road, East Bentleigh. Time: 7:30 pm, second Monday each month.

South East - Dandenong
Venue: ERMHA – ‘Aspirations’, 65 Robinson Street, Dandenong. Time: 2.00 pm – 4.00 pm, last Thursday each month.

Moonee Valley
Venue: Ascot Vale Neighbourhood Centre, Cnr Union Road & Munro Street, Ascot Vale. Time: 7.30 pm, fourth Thursday each month.

Wodonga
Venue: Trudewind Rd Neighbourhood House, Quirk Court, Wodonga. Time: 7.30 pm, 2nd & 4th Tuesdays each month. Enquiries: Wendy Malcolm 02 6059 4176 or 0418 698 401

Emerald
Venue: Salvation Army Hall – Cnr Como Street & Main Road, Emerald. Time: 7:30 pm, second & fourth Monday each month. Enquiries – Dianne Legge – 5968 4759.

La Trobe Valley
Venue: La Trobe Valley Community Health Centre, 42-44 Fowler Street, Moe. Time: 10.00 am, Mondays fortnightly. Enquiries – Catherine Ashford 5127 5555.

Families, Carers & Friends Support Group
A support group for families, carers and friends of people with an anxiety disorder. Venue: The Peppercorn Club – 584 Glenferrie Road, Hawthorn. Time: First Thursday of each month.

Parents Support Network
A support network for parents of children and adolescents with OCD. Ring 9886 9377 for more information.

Social Anxiety Disorder Support Group
A support group for people with Social Anxiety Disorder, families and friends. Venue: Community Meeting Room, Ashburton Library, Cnr High Street & Munro Avenue, Ashburton. Time: Last Monday each month, 7.30 pm.

Social Groups
Monthly social events, including dinners, bowling, picnics, cinema and so on. All ages welcome. See Social Group Calendar in this Newsletter.

OCD & Anxiety HelpLine
03 9886 9377
Monday - Thursday 10.00 am - 4.00 pm
Message Bank – 24 hours

NB. The Message Bank operates if the telephone counsellor is currently taking another call – this is to avoid callers constantly getting an engaged signal, and allows a message to be left. Please leave a message – the counsellors always attempt to return calls as soon as possible.

The HelpLine team provide counselling, information and referral advice to people with OCD and Anxiety Disorders, and their families.

Important Phone Numbers –

LifeLine 13 11 14
Suicide HelpLine 1300 651 251
CareRing 136 169
Kids Help Line 1800 55 1800
ParentLine 13 2289
Grief Line 9596 7799

Men’s Line Australia – 1300 78 99 78
Lifeline’s Just Ask – 1300 13 11 14 (rural mental health information service)
Medicines Line – 1300 888 763
SANE Helpline – 1800 688 382
Treatment Programs and Clinics for Anxiety Disorders

**Anxiety Recovery Centre Victoria**

**ANXIETY DISORDERS RECOVERY PROGRAMS**

42 High Street Road, Ashwood

ARCVic Recovery Programs are aimed at supporting participants to gain knowledge, skills and strategies that will assist them to recover from their anxiety disorder and achieve a better quality of life. The programs are conducted in a group setting. The sessions combine cognitive-behaviour therapy, anxiety management, relaxation training and self-help techniques. The focus of the programs is on anxiety symptoms and the range of other issues which affect recovery - self-esteem, social and conversation skills, relationship and communication difficulties, beliefs, and negative thinking.

Phone Jessica Bernales, Recovery Program Coordinator on 03 9886 9233 or 03 9886 9377 for further information.

**University of Melbourne**

**PSYCHOLOGY CLINIC**

The Psychology Clinic has moved to a new location in the University of Melbourne. Contact the Clinic on 03 8344 5572 for further details. The University of Melbourne Psychology Clinic specialises in the treatment of anxiety disorders and depression. The clinic operates on a fee-for-service basis (based on income). The Clinic provides assessments, individual and group cognitive-behaviour therapy. Admission requires referral from a doctor or other health professional.

**The Melbourne Clinic**

**ANXIETY DISORDERS (CBT) PROGRAM**

(Private Health Insurance Recommended)

Treatment programs available at the Melbourne Clinic are – Anxiety and Depression Program (inpatient), and Anxiety Day Programs. The Anxiety and Depression Program is a four week, live in program which focuses on assisting participants develop strategies to alleviate emotional distress and challenge unhelpful ways of thinking and behaving in a supportive environment. The Anxiety Disorders Day Programs are offered on an outpatient basis and are designed to provide intensive and proven treatment in the psychological management of anxiety. Specific treatment programs include - Social Anxiety Program, Panic and Agoraphobia Program, Obsessive Compulsive Disorder Program, and Anxiety Management Program. Treatment programs are conducted in a group format and are based on cognitive behavioural therapy. Clinical Director: Christopher Mogan. Coordinator: Kerryn Addison. Enquiries to Kerryn Addison – 9420 9225.

**Monash Medical Centre**

**OBSESSIVE COMPULSIVE DISORDER CLINIC - CHILDREN & ADOLESCENTS**

Department of Child and Adolescent Psychiatry, 246 Clayton Road, Clayton, 3168. Telephone: 03 9594 1300

A treatment program to help young people (8 - 18 years old) to more effectively manage OCD. Time-limited cognitive behavioural treatment either with or without medication; assessment, treatment and follow-up phases; includes the young person and his/her parents; cost-free; a research component focuses on the evaluation and efficacy of the treatment programme. For further information contact Rod Carne, Clinical Psychologist, on 9594 1300.

**PADA (Panic, Anxiety & Depression Assistance)**

**PANIC, ANXIETY DISORDERS & DEPRESSION TREATMENT SERVICE**

222 Burke Road, Glen Iris, 3146. Telephone: 03 9886 9400 Fax: 03 9886 0650 email: tranx@alphalink.com.au

Treatment programs include: education, relaxation training and breathing control, letting go of fear, changing fearful thinking and beliefs, building self-esteem, handling emotions, controlling panic attacks, assertiveness skills, supported gradual exposure. PADA does not use prescribed drugs in their treatment programs. Group programs are available for people with social anxiety disorder and panic disorder. Individual treatment is also available. For further information ring PADA/TRANX on 9886 9400.

**Wavecare Counselling Service**

**ANXIETY MANAGEMENT WORKSHOPS**

155 Coleman Parade, Glen Waverley, 3150. Telephone: 03 9560 6722

Regular Anxiety Management Workshops, including ‘Fighting Your Fears’ – 2 hour workshop for people with general anxiety, panic attacks, phobias and obsessive compulsive disorder; Assertiveness, Stress Management and Depression workshops. Individual treatment is also available. Contact Wavecare Counselling Service for details of coming programs.
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ARCVic Links

"Talk things through with WIRE"

Women’s Information provides free information, support and referrals to women across Victoria. WIRE services include a phone support service, a walk-in centre, training, education, and a comprehensive, searchable website. Across these services, WIRE aspires to be recognised for quality and consistency in informing, supporting, knowing and voicing the concerns of Victorian women.

WIRE is a service that women - all women - can access when they want options, reliable information and another sensitive and supportive woman to talk to.

At WIRE, they will take on anything. No problem is too big or too small. That being said, the most common issues women contact WIRE about are: family life and relationships, domestic violence, family and relationship issues, sexual harassment and assault, health and well-being (including such issues as depression, anxiety and isolation), intervention orders and family court issues, education and training, housing, finance.

Phone Support 1300 134 130, 9am to 5pm Monday to Friday; Walk In Centre 210 Lonsdale St, Melbourne, 10:30am to 5pm Monday to Friday; Visit: WIRE at www.wire.org.au

The Eating Disorders Foundation of Victoria (EDFV) is a non-profit association providing support those whose lives are affected by eating disorders, and to better inform the community about these disorders. The EDFV seeks to:

• respond to the needs of both people experiencing eating disorders and carers – recognising the impact of eating disorders beyond the individual
• provide information, knowledge, support and resources in order to encourage resilience and recovery and lessen the impact of the eating disorder on the quality of life of individuals and families
• advocate for systemic change for improved access to treatment facilities for sufferers of eating disorders, support for carers and for the reduction of the stigma associated with eating disorders and other mental illnesses
• raise awareness of eating disorders by means of general community education and specialist training for specific sectors
• promote the need for a focus on prevention, early intervention and health promotion.

1513 High Street, Glen Iris, Vic 3146, Australia Phone: (03) 9885 0318 Fax: (03) 9885 1153
Non-metro Victorian callers call 1300 550 236, e-mail: edfv@eatingdisorders.org.au, web: http://www.eatingdisorders.org.au
**Recovery Programs and Workshops**

**Commencing soon**

**Anxiety Disorders Recovery Programs - Anxiety Recovery Centre Victoria**

- OCD Recovery Program – commencing March, 2005
- Social Anxiety Recovery Program – commencing April, 2005
- Managing Stress & Anxiety Program – commencing May, 2005
- OCD Family & Carer Program – commencing June 2005

Further details see ‘Bulletin Board’, in this issue, or phone the Recovery Program Coordinator on 03 9886 9233.

**Relaxation and Meditation**

with Mary Chandler, Psychologist. Feeling anxious or stressed? Take some time to improve your general well being with deep body relaxation, guided visualisation and a variety of meditation techniques. 6 weeks. Fee $53, Seniors $51, Concession $49. Bulleen and Templestowe Community House (BATCH, 284 Thompsons Road, Lower Templestowe. Ph 9850 3687, or email batch@hotkey.net.au. http://home.vicnet.net.au/~batch

**Wellbeing Workshop Series**

with Mary Chandler, Psychologist. All sessions contain information and techniques for skill development, as well as time for discussion and questions. Session topics include anger, self-esteem, loss and grief, motivation, stress, happiness, and forgiveness. Fee $20 per session or book 4 or more for $17 per session. Concession: $18 per session or book 4 or more for $15 per session.

Bulleen and Templestowe Community House (BATCH, 284 Thompsons Road, Lower Templestowe. Ph 9850 3687, or email batch@hotkey.net.au. http://home.vicnet.net.au/~batch

**Box Hill Hospital Health Promotion Unit - Health for Life**

The Health Promotion Unit offers a variety of health education courses which aim to empower participants to better manage their health and wellbeing. Some of the courses are: Anger Management, Sleep Solutions, and Relaxation. For bookings or further information contact the Health Promotion Unit on 9895 4947 or email: health.promotion@boxhill.org.au.

**Conferences & Seminars**

**Anxiety and Depression Support Group for Women - Information Sessions - Keystone**

Information sessions are held on Fridays, 10.00 am – 12.00pm. Venue: Donvale Living and Learning Centre, 283 Springvale Road, Donvale.

Friday 4th March – Our Stories of Recovery.
Be inspired by stories of hope from women living with anxiety and depression. Speakers will share their wisdom and knowledge, and identify what has helped them on their journey of recovery. Women’s Health Week Event – Group open to all.

Friday 18th March – Beyond Blue video viewing.

Friday 1st April – Celebrating our Diversity. Bring along a plate of food from your culture to share with the group.

**Mood Disorders Support Group Community Education Seminars**

1st Wednesday of each month, Time: 7.30 pm. Venue: Mental Health Foundation House, 270 Church Street, Richmond, Victoria. Information and support for people experiencing mood disorders, their families and friends; for professionals and service providers, and all people interested in mental health promotion and illness prevention. Support group meetings are also held on the third Wednesday of each month. The group offers support and friendship to people experiencing mood disorders, their families and friends. Mood disorders include depression – unipolar and bipolar and general anxiety-depressive illness. Ph: 9427 0406; Email: mhfvic@pacific.net.au. Prior registration essential by phone, fax or email. Entry fee for speaker evening on first Wednesday of each month: Concession - $5.00; MHFA(V) Member - $15.00; Non-Members - $20.00. Support meetings on the 3rd Wednesday of the month are free. www.mentalhealthvic.org.au.
5th Annual Grampians Mental Health Conference - Mental Health and Wellbeing of Youth, Young Adults and their Families.
1st-2nd March, 2005. Ballarat Lodge, Ballarat. The conference is a joint initiative of Regional Mental Health Providers and the Department of Human Services. Keynote Speaker: Professor William McFarlane, Psychiatrist, Doctor and Director of Research, Department of Psychiatry, Maine Medical Centre, USA. Other presenters include Dr Warwick Brewer, Professor Patrick McGorry and Tony McHugh. Please direct enquires to Catherine Barnes at JK Personnel, ph. 5332 9955 or email: catherineb@jkperonnel.com.au.

28th National Conference - Australian Association for Cognitive and Behaviour Therapy.

8th–9th April, 2005. Crown Promenade, Melbourne. For carers, consumers and clinicians. The conference well provide up-to-date information and research on best practice, treatment and care, and approaches to rehabilitation and recovery. See enclosed conference brochure. www.carersnetwork.org/conferences

Friday 8 April is the CALD Carers day, featuring information for carers from Greek, Italian, Vietnamese, Turkish and Maltese backgrounds. This day will include:
- Testimonials from carers
- Ways to reduce conflict and support recovery
- Mental illness and substance use
- “Ask the doctor” sessions

On Saturday 9 April, the main conference will present information on:
- Training mental health professionals to work with families
- Guidelines for clinicians on working with families regarding confidentiality
- Optimising treatment outcomes in schizophrenia
- Mental illness and substance misuse issues
- The needs and experiences of people living with depression, eating disorders, and anxiety disorders: the carers' perspective
- Employment that works – The Social Firm
- Discussion of ways to reduce conflict and support recovery
- Update for carers on relevant, new initiatives.

The Network hopes that this will be a dynamic conference allowing for considerable interaction between participants and presenters with opportunities for delegates, exhibitors and sponsors to meet throughout the duration.

Peninsula Carer Council Inc - Public Forum
Launching the Peninsula Carer Council: a council of carers of people with a mental illness.
Keynote speaker – Maria Bohan, CEO, Carers Victoria. Master of ceremonies – Jeff Young, Program Manager, The Bouverie Centre, Flemington.
Wednesday 27th April, 2005 – 7 pm to 9 pm.
Brotherhood of St Laurence complex, High Street, Frankston. Melway B9, MAP 100a.
For further information contact Peninsula Carer Council on 5970 5024, or email info@peninsulacarercouncil.org.au.
### ARCVic Publications 7 Order Form

- **Nine, Ten, Do It Again: A Guide To Obsessive Compulsive Disorder.** By Kathryn I’Anson, Director, OCADF, 1997. 2nd Ed.
- **‘Speaking From Experience: Obsessive Compulsive Disorder’.** A video produced for people with OCD and their families. The video provides information about OCD from the perspective of six people who have lived with OCD for many years. The video includes segments on early signs of OCD, diagnosis and reaction, the symptoms of OCD, understanding OCD, other mental health issues, impact on life, family and relationships, telling other people, treatment, support and recovery. Produced by Speaking From Experience Pty Ltd with the assistance of the Anxiety Recovery Centre Victoria. (Duration 43 minutes).
- **‘Speaking From Experience: Depression’.** This video offers first hand accounts from six people about the impact depression has had on their lives. The video includes segments on: early signs, breaking down, diagnosis, defining depression, impact on lifestyle, suicidal tendencies, family and relationships, study and employment, professional support and other management techniques. Produced by Speaking From Experience Pty Ltd with the assistance of SANE Australia. (Duration 43 minutes).

**I wish to order:**

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<th>Product Description</th>
<th>Number of Copies</th>
<th>Price per Copy</th>
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<td>Nine, Ten, Do It Again: A Guide To Obsessive Compulsive Disorder.</td>
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<td>OCD &amp; Anxiety Disorders Information Package</td>
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<td>Social Anxiety Disorder: Theory &amp; Management</td>
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**TOTAL AMOUNT**

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**PAYMENT DETAILS**

- My cheque/money order for $………………….. made payable to ARCVic is enclosed.
- Please charge my credit card.
- Bankcard □ Visa □ Mastercard □ Amex □ Diners

**Card Number**

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Amount $……………… Expiry Date …/……

**Cardholder’s Name (caps)**

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**Signature**

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These persons, professionals, and organisations have been awarded a ‘Friend of the Foundation / Anxiety Recovery Centre Victoria certificate, in appreciation and recognition of significant and valued contributions (educational forums, articles, conference papers, donations, sponsorship, organisational services, provision of specialised professional services) which have supported the aims, services and development of the Anxiety Recovery Centre Victoria / Obsessive Compulsive & Anxiety Disorders Foundation Victoria.

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<td>Dr. David Ames</td>
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<td>Mr. Edwin Belfield</td>
<td>Prof. Michael Jenike</td>
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<td>Mr. Nigel Bennett</td>
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<td>Mr. Sunil Bhar</td>
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<td>Mr. Rod Carne</td>
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<td>Dr. Lisa Lampe</td>
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<td>Prof. Jonathan Davidson</td>
<td>Dr. David Leonard</td>
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<td>Mr. Robert Doyle MP</td>
<td>Mrs Wendy Malcolm</td>
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<td>Mr. Ian Farnbach</td>
<td>Dr. Peter Marriott</td>
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<td>Dr. Peter Farnbach</td>
<td>Mr. Campbell McComas</td>
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<td>Dr. Rosemary Fawns</td>
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<td>Ms. Evelyn Field</td>
<td>Professor Sandy McFarlane</td>
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<td>Mrs Judy Fraia</td>
<td>Mr. David McVilly</td>
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<td>Mr. John Geros</td>
<td>Mr. Chris Mogan</td>
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<td>Mrs Poppy Geros</td>
<td>Prof. Stuart Montgomery</td>
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<td>A/Prof. Phillip Morris</td>
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<td>Ms. Annie Hayball</td>
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