Dear Members,

Thank you to everyone who was able to attend ARCVic’s Open House, held on Wednesday 4th August 2004. It was great to catch up with members and friends of ARCVic and celebrate the setting up of our new home. Following our New Premises Appeal a few months ago, ARCVic received many very generous donations from members. All of these people have been thanked individually, but we would like to add another big thank you on behalf of the Committee of Management. Your generosity is deeply appreciated and will assist greatly with the setting up of our premises, and ensure that others have the opportunity to be helped.

We are pleased to welcome to our team of voluntary workers Jane Wilkins, Michelle Puttick and David Delaney, who will be joining ARCVic’s HelpLine as Telephone Counsellors after undergoing a training program over the next few weeks. Jane, Michelle and David all have a strong commitment to supporting people and families living with anxiety disorders, and bring to this role a range of relevant experience and knowledge from the health and disability areas. It will be great to have them working with us. We have had to limit the HelpLine hours over the past few months following Jeff’s resignation, and so we will be glad to be able to return to normal operating hours in the near future. Interestingly, despite the recent restrictions on HelpLine access, the number of calls to the HelpLine has increased significantly, with calls from people with anxiety disorders, and calls from professionals and services, almost doubling in the last three month period. This highlights the important role for a specialist community support service in meeting people’s needs for information and support, and in particular the increasing needs of mental health and health services and professionals for helpful information and support networks for clients, referral advice, recovery groups and specialist advice regarding individual client needs. While the demand for ARCVic’s assistance and specialist expertise has risen significantly over the past few years, particularly following the establishment of Primary Mental Health Teams, and beyondblue, ARCVic has received no recognition of this expansion of our role and increased pressure on our services by the State Government and Department of Human Services.

ARCVic continues to be involved with key research and service development projects in the anxiety disorders and mutual support/self help areas. An overview of the project undertaken as a partnership between The Network for Carers of People with Mental Illness and beyondblue – ‘The Needs and Experiences of Carers of People with High Prevalence Disorders’, is included in this Newsletter, as well as a summary of the research component which looked at the needs and experiences of carers of people with anxiety disorders. ARCVic is also a co-investigator on a project with A/Professor Michael Kyrios, Dept of Psychology, University of Melbourne, looking at models of collaboration between GP’s and psychologists in the treatment of OCD. Focus groups are currently being held to gain the perspective and views of people with OCD, and we thank all our members who are participating in these groups.

Thank you to Prue Lewis for accepting a part-time position of Assistant Editor of this Newsletter. As you can see she has done a great job with this edition, including commencement of a new ‘feature article’ series, which will present articles, written for this Newsletter, by Australian mental health professionals specialising in anxiety and obsessive compulsive disorders. Thank you to A/Professor Michael Kyrios, Sunil Bhar and Celia Hordern for writing our inaugural article for this series. In this Newsletter you will also find a questionnaire asking for your ideas, comments and suggestions about the Newsletter. We are very interested to know what you think is good, or needs improving in the Newsletter and will greatly appreciate your responses.

ARCVic’s Annual General Meeting will be held on Saturday 13th November, 2004. We decided to hold it on a Saturday this year as we thought it might be easier for more members to attend on that day. After the AGM we are going to celebrate our year’s achievements and enjoy a special afternoon tea party. We hope that many members will be able to attend this important occasion, and we look forward to meeting with you.

Regards,

John Geros, President & Kathryn I’Anson, Director

Introducing the new Assistant Editor

Hello everyone, my name is Prue Lewis and this is my first issue of the newsletter as Assistant Editor. I have been involved with ARCVic for the past 2½ years, initially on placement as part of my masters of clinical psychology degree, and then as a volunteer and consultant. I am a registered psychologist with a special interest in anxiety disorders. As an ARVCic helpline counsellor, I have spoken to many hundreds of people with anxiety disorders, especially OCD and panic attacks, as well as to the family and friends of people with an anxiety disorder, and many different kinds of health and community workers. I also facilitate the Managing Stress and Anxiety program at ARCVic. In this issue we have included an opportunity for you to “Have your say...” about the ARVCic newsletter. Responses to the survey will be considered when planning the future issues. Of course you are welcome to provide feedback and suggestions for the newsletter 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 Recovery Programs

Managing Stress & Anxiety

6 session group program
Commencing 30th October, 2004

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: $125.00
Facilitator: Prue Lewis, Psychologist, ARCVic Consultant

For further information or to register your interest in these programs contact ARCVic on 9886 9233 or 9886 9377

ARCWic Annual General Meeting

Saturday 13th November 2004
2.00 – 2.45 pm
at ARCVic, 42 High Street Road, Ashwood.

followed by

End of Year Afternoon Tea Party!
3.00 – 5.00 pm

Join us in celebrating ARCVic’s achievements this year. Meet with the staff, volunteers and the new Committee of Management.

Please register your intention to attend the AGM and the Afternoon Tea Party – phone the OfficeLine 03 9886 9233.

AGM Notices and Nomination Forms are enclosed with this Newsletter. Nominations for the Committee of Management are due by Friday 29th October 2004.

2005 Programs

- Social Anxiety Disorder Recovery Program
- Stress and Anxiety Management Group Program
- Family and Carer OCD Program
- Group Program for Young People with OCD and their parents/carers.

Dates and venues will be advised early in 2005. Registrations of interest are accepted at any time. Phone ARCVic 03 9886 9233.

New Family & Carers Support Group

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

The Group will be facilitated by David Delaney, ARCVic Volunteer (see David’s story about his experiences as a carer in the Opening Section of this Newsletter).

The venue and group meeting times are currently being organised. It is expected that the group will commence in February 2005. Please contact ARCVic on 03 9886 9377 or 03 9886 9233 to register your interest in this group.
WHAT IS COGNITIVE THEORY AND WHAT CAN IT TELL US ABOUT MANAGING OCD?

By Assoc. Professor Michael Kyrios (pictured), Sunil Bhar & Celia Hordern, University of Melbourne Psychology Clinic, Department of Psychology, University of Melbourne, Tel: 8344 5572. Written for the ARCVic Newsletter, September 2004.

Moderately effective treatments are available for Obsessive-Compulsive Disorder (OCD). Of the medication treatments, the serotonergic medications (SSRIs) are used most commonly, although a range of other options are also available. A number of psychological treatments are available, although behaviour therapy, cognitive therapy, and their combination have been shown to be the most effective for OCD. Studies have not generally supported differences between these treatments, except that medication treatments are more often associated with higher dropout and relapse rates. In other words, many individuals with OCD prefer not to continue with medication mainly because of side effects or relapse after medication is ceased. Problems with dropout are also seen sometimes in behaviour therapy where people with OCD are asked to undertake exposure work that they consider too difficult.

Furthermore, treatments are not always equally effective for all OCD subtypes. For instance, behaviour therapy may not be particularly effective on its own for people with OCD who present mainly with obsessions and few obvious compulsions. Treatment outcomes for people presenting predominantly with hoarding symptoms have not been as effective as those for people presenting with other OCD symptoms. There is also some inconsistency in the effectiveness of treatments for people with OCD who are also depressed. In the hope of developing better psychological treatments, psychologists have turned successfully to “cognitive” theory. For instance, our own research at the University of Melbourne Psychology Clinic using STOP Therapy (Systematic Treatment of Obsessive-compulsive Phenomena) has shown that people with OCD who present with depression or obsessional symptoms do just as well as non-depressed or mixed obsessional-compulsive symptoms. Furthermore, newer forms of cognitive therapy designed specifically for people with hoarding symptoms offer hope to individuals who have not responded previously to treatment.

While many people with OCD want to understand “cognitive” theories, they have found it difficult to access information that is easy to comprehend. We have put this article together in order to help fill this vacuum.

Cognitive Psychology
Cognitive psychology involves the study of our mental processes: (a) how we attend to various pieces of information from our environment; (b) how we see, process, and interpret that information; (c) the influence that our beliefs and assumptions have on how we process and interpret that information; (d) the influence that personality features (such as nervousness, perfectionism, etc.) have on how we process and interpret that information; (e) our memory abilities; (f) our intellectual abilities and ability to learn; (g) our ability to think, reason and make judgments; (h) the images that our mind conjures up; (i) the degree of confidence that we have in our learning, thinking, reasoning, judgments, and memory; (j) and other information processing mechanisms.

A number of areas of research in cognitive psychology can help us understand the processes that our mind uses to maintain, exacerbate and even cause OCD symptoms. Let's look at some of the more important research in some detail in order to develop a model that explains what we can do about OCD.

Normal intrusive thoughts
Many people are unaware of the sorts of thoughts and other intrusions (images, urges) experienced by others. We tend not to share all of our thoughts with others. Many people are also unaware of the fact that we need to have the capacity for “creative” thinking in order to survive as a species. Sometimes that means that the actual thoughts we have are bizarre and extreme, unrelated to what is going on around us, or feel inconsistent with the type of person we want to be. That’s just the way we’re wired as a species. Hence, it is not surprising that there is a high incidence of intrusive thoughts in people who do not have OCD or any other related difficulties. The type of thoughts that we see in such “non-clinical” groups and those with OCD do not differ. When comparing OCD and non-clinical groups, researchers have found that the form and content of intrusive cognitive phenomena (thoughts, images, and impulses) do not differ. However, non-clinical and OCD groups differ in the
frequency and intensity of intrusive thoughts. People with OCD have MORE intrusive thoughts, more INTENSE intrusive thoughts, become more DISTRESSED by their thoughts, try to CONTROL these thoughts more, and INTERPRET these thoughts more negatively than non-clinical groups. Hence, it is not surprising that people with OCD respond differently to their intrusive thoughts. It is these responses (usually in the form of compulsions and rituals) that maintain the intrusions, generating obsessions that persist.

**Thought suppression research**

Research with non-clinical groups has shown that attempts to suppress unwanted thoughts, although often successful in the short term, are associated with a delayed "rebound effect" (i.e., more of the suppressed thoughts after a period of time). A "rebound effect" can be likened to the increased bounce one sees in "super" balls, whereas squash balls tend to have no bounce at all.

This "rebound" effect, seen only after attempts at suppression of unwanted thoughts, can be explained by the following mental processes. Our mind automatically screens thoughts to make sure they do not involve "danger" or "threat" information. If suppressed thoughts are interpreted as involving danger, then they are returned to conscious awareness so that we can attend to the "danger". Our mind also keeps checking automatically to make sure that the suppressed thought has gone back to our conscious awareness. So, we can get two doses of the suppressed thought.

Certain thoughts are easier to suppress than others, and it may be that clinical groups are sensitive to specific types of thoughts. Furthermore, it is believed that the automatic mental checking also triggers off negative emotional reactions in those individuals with high expectations of success at thought suppression. So, if you expect to be able to suppress your unwanted thoughts, when you fail to do so, it is understandable that you become depressed and/or anxious.

In the case of OCD, intense attempts at thought suppression are related to the need to avoid certain themes (e.g., contamination, sexual impulses or imagery), with increased "rebound effects" resulting from: (i) the particularly intense attempts at thought suppression and (ii) the strong reactions of depression and/or anxiety from the lack of success at thought suppression. These are all related to the strong beliefs that many individuals with OCD have about thought control (more about this later).

A further complication involves the relationship between mood and intrusive thoughts. Negative mood (usually involving depression, guilt, anxiety) increases the frequency of negative intrusive thoughts and decreases the acceptability of such thoughts. Furthermore, negative mood reduces the effectiveness of efforts at thought suppression, particularly for negative thoughts. So, all-in-all, trying to AVOID intrusive distressing thoughts through suppression strategies DOES NOT WORK! In fact, it makes matters WORSE!!!

**Intrusive thoughts & mood**

As one might predict, people suffering from OCD are more anxious and depressed than non-clinical groups. Depressed mood is thought to prolong the duration of intrusive thoughts, while anxiety is thought to promote the frequency of such thoughts. As mentioned above, depression is also related to increased frequency, decreased acceptability, decreased dismissability, decreased controllability, & increased discomfort or distress of unwanted intrusive thoughts.

Anxiety also promotes the likelihood that an individual will act through a compulsion to reduce the distress associated with an intrusive thought. For instance, if one had an intrusive thought about contamination, one might try to reduce anxiety by washing one's hands. If one had an intrusive thought about someone being killed, someone with OCD might try to reduce distress by attempting to suppress the negative thought in order to stop the likelihood that one might carry out the thought.

Many OCD sufferers ask why, once they are depressed or anxious, they have difficulty thinking things through in a rational manner. Cognitive theory helps to explain what happens to our thinking once we are anxious or depressed. Very simply, when we are anxious, we have easier access to anxiety thoughts. When we are anxious, we have easiest access to anxious thoughts. As our brain designed to use the least amount of thinking energy, we tend to use the easiest thinking processes at our disposal. Our thinking usually matches our mood, so that we can focus on the situation that is making us anxious or depressed.

This is nature's way of making sure we stay focused on problems that are important to our survival. That's fine when you need to think about a situation that is realistically dangerous (e.g., your car is stuck in the middle of train tracks). But it's a disadvantage when you're thinking about unlikely dangers (e.g., becoming contaminated by touching a door knob). Unfortunately, our mind tends to continue thinking negatively when we need it to be flexible and take on new positive thinking. That's why it's hard work to change one's thinking. Nonetheless, a necessary part of managing OCD involves becoming aware of and changing one's thinking. The next section will discuss the beliefs, attitudes and thinking most closely associated with OCD.

**Beliefs about intrusive thoughts**

Various researchers have pointed to the importance of our interpretations of intrusive thoughts (i.e., what meanings we assign to intrusions). The meaning that we attach to intrusive thoughts can result in depression, anxiety and compulsive reactions. The meanings that we assign are obviously influenced by our underlying beliefs and attitudes.

When we have an intrusion, we decide whether it is important or not, we decide whether it means something about our ongoing activities, whether it reflects something about ourselves, our world, or our future. Depending on our appraisal, we will "hang on" to these intrusions for further processing or we "let go" of them.

The types of beliefs that people with OCD use to appraise intrusive thoughts include:

(a) an overdeveloped sense of responsibility. For instance, having experienced an intrusive thought, one might feel overly "responsible", either actively or passively, about the possibility of a threatening event occurring (eg, murder, death, contamination, etc.). The failure to prevent harm is considered the same as being responsible for harm happening. The failure to carry out
some sort of action to prevent a feared situation is considered the same as desiring the harm to occur. Commonly, OCD sufferers also report that just because something is unlikely to happen does not mean that they do not feel responsible for making sure it doesn't happen. Alternatively, having experienced an intrusive thought, one might feel "responsible" for thinking such "terrible things" and, hence, feel worthless.

(b) an oversatimation of danger or threat to the self or others. Usually, individuals who feel that there is a reasonable likelihood of a threatening event occurring want to take action to stop that possibility. However, individuals with OCD often overestimate the likelihood of danger in situations where threat is unlikely.

(c) an overdeveloped sense of the need to control mental and motor activities. As previously discussed, OCD sufferers commonly report the belief that they should exercise complete control over their thoughts. They also commonly believe that having a thought about doing something terrible is the same as performing the terrible action.

(d) the overimportance of thoughts. Many OCD sufferers pay too much attention to their thoughts, and place too much emphasis on their importance. As we know, everyone has weird thoughts, but OCD sufferers take these thoughts too seriously. Most individuals just let these thoughts go without needing to analyse, or act on them.

(e) an intolerance for uncertainty and ambiguity. All of us feel uncertain at times. However, OCD sufferers often report feeling more distressed during these uncertain times, and look for absolute evidence to confirm or disconfirm their beliefs.

(f) perfectionism: OCD sufferers tend to constantly demand high standards of themselves and believe that behaving in anything less than a faultless way will be unacceptable to themselves or others. If we appraise intrusions with such irrational beliefs, at least 2 types of self-talk result: (a) negative automatic thoughts (that result in negative moods, eg. depression & anxiety); or (b) "automatic action-oriented thoughts" (that lead to attempts to minimise the negative mood or the anticipated catastrophic or threatening.

In his cognitive-behavioural model of OCD, Salkovskis (1985) argued that the appraisal of intrusive thoughts results in negative automatic thoughts which, in turn, result in depression or anxiety. Negative automatic thoughts result from depression-generating beliefs about one's low self worth or the impossibility of ever changing anything (learned helplessness), and anxiety-generating beliefs about further short-term or longer-term threat. If the person regards themselves as "bad" for having had such thoughts, or become convinced that something bad will happen, then depression and anxiety will result.

Action-oriented thoughts concern plans for ongoing activity related to the original appraisal. Generally, individuals with OCD will want to take steps to control their thoughts and to prevent or eradicate the possibility of a negative outcome. These thoughts will lead to compulsive behaviours (e.g., thought suppression, washing, checking, praying, etc.). We know that thought suppression might lead to a rebound attendance to the thoughts, therefore making the thoughts even more salient and self-appraisals even more negative (eg. further evidence of failure, further evidence of helplessness).

Depression, in turn, might exacerbate one's OCD symptoms by increasing the prominence of certain unhelpful beliefs and by decreasing the efficiency of mental control strategies. Depression can also give rise to a further sense of disapproval, guilt and responsibility, which in turn can heighten OCD.

How we reward OCD

Avoidance of situations that make us anxious encourages further avoidance. Similarly reassurance seeking, passing on responsibility to others, and compulsive patterns are also rewarded. Some researchers emphasise that compulsions are reinforced through their anxiety reduction properties. In some people with OCD, while anxiety rises after an obsession has been triggered, the anxiety may reduce after a compulsive act (e.g., hand washing, checking). This reduction in anxiety acts as a reward, so that the next time anxiety rises, one is likely to act out the compulsion to get a quick reduction in that anxiety. In our own research, we found that carrying out compulsions does in fact decrease anxiety in the short term, but that this is short-lived and that anxiety rises again very soon. Carrying out compulsions does not reassure people that they are “safer” from perceived dangers. A further reinforcing process concerns the regulation of self image and integration of personality. Humans tend to behave in a manner which maintains their sense of self, even if that sense of self is not beneficial. It is often easier to behave in a manner in which we are accustomed, even if that manner is not useful.

Lessons to be learnt from the Cognitive Theory of OCD

The cognitive model of OCD attempts to explain the relationship between behaviour, feelings and what goes on in the mind. The model states that our beliefs influence the way we interpret or appraise our experience of various unwanted intrusions, situations or objects. We then respond on the basis of how we appraise these experiences. For instance, we are more likely to feel anxious and use compulsions if we appraise an intrusion as dangerous, needing to be controlled, or as a sign that we should take action to prevent a disastrous outcome. Therefore, understanding our thinking patterns is very important to understanding OCD. A range of beliefs is involved in the development of OCD, but these will differ from person to person and from situation to situation. Even two similar situations or intrusions can be associated with different appraisals. For instance, dirty clothes might be considered “contaminated” by someone with OCD, while dirty dishes might be not considered “contaminated” by that same person. Alternatively, someone with OCD will be distressed by aggressive urges, but someone else might be more concerned with forgetting the windows open when leaving home.

The identification of our appraisals in specific situations is important, and often possible through the use of diaries and monitoring sheets. Having identified one’s interpretations of intrusions, in order to overcome OCD, we need to change those appraisals and the compulsions associated with them in each OCD situation that we can identify. We need to practice rational appraisals in each OCD situation while allowing our anxiety to run out of steam. Only then can we re-program our mind to think more
reasonably, NOT to respond with anxiety automatically, and NOT to respond with compulsions. This is not a simple or easy process. The approach ought to be structured, well planned, and systematic in order to achieve maximum benefit. One needs to be motivated and consistent in one’s efforts to overcome the problem. Approaching the problem in an inconsistent manner tends to lead to poorer outcomes, and disappointment, frustration and hopelessness. With motivation and the help of a competent therapist, most of these problems can be dealt with and overcome. A program that is planned in conjunction with a therapist can be aimed at a level that one is more easily capable of mastering and sustaining, and the various steps can be graded to maximise one’s success.

Here is a quick way to remember some important lessons from Cognitive Theory:

CHARMS for YOU!

C onfidence in your ability to improve your skills over time
H old off from carrying out compulsions and rituals
A void avoidance and thought suppression
R ational thinking – think about your misinterpretations & challenge them
M aintain hope – positive change is possible
S elf acceptance and acceptance of intrusions as part of having a mind!

Far away there in the sunshine
are my highest aspirations.
I may not reach them,
but I can look up and see their beauty,
believe in them,
and follow where they lead.

Louisa May Alcott (1932-1888), Little Women (1869)

Don't have internet access....?

Website addresses are included where possible. ARCVic is mindful that not everyone has Internet access at home and so telephone numbers or postal details are included whenever available. Many local community libraries provide Internet access to members of the public.
Hormones: How do they affect anxiety in women?

by Margaret Altemus, M.D., Cornell University, New York. Article from the ADAA Reporter, the Anxiety Disorders Association of America, www.adaa.org. Reprinted with permission.

It is well known that, compared to men, women are more prone to develop anxiety disorders and depression. One factor that may contribute to the increase risk of anxiety in women is biology, particularly the constant fluctuations in reproductive hormones that women experience until after menopause.

What is known about hormones and how they can impact a woman’s life? Understanding the effects of hormones on anxiety disorders can help women have a more informed discussion of treatment and care with their health care providers.

Do monthly changes throughout the menstrual cycle affect anxiety disorders?

Research suggests that obsessive-compulsive disorder (OCD) seems to worsen premenstrually, but panic disorder does not. Not enough is known about the effects of the menstrual cycle on social anxiety, posttraumatic stress disorder (PTSD), phobias or generalised anxiety to suggest a relationship. Women with premenstrual mood disorder (PMD) may experience complete relief of anxiety symptoms during the first two weeks after onset of menses.

Will the symptoms related to my anxiety disorder be affected by pregnancy?

During pregnancy, levels of many hormones rise steadily. Unfortunately, little is known about how these hormone changes during pregnancy affect women with anxiety disorders. There is evidence that many women with panic-type anxiety have a reduction in panic symptoms during pregnancy. This may occur because progesterone—which rises greatly during pregnancy—has breakdown products that have effects similar to benzodiazepine medications like clonazepam and diazepam.

The hormones oxytocin and prolactin have been shown to have anti-anxiety effects in animals. These hormones may help reduce panic anxiety during pregnancy. However, other hormonal changes during pregnancy, e.g., possible increases in androgen hormones, may contribute to a worsening of OCD symptoms that some women experience. Although these hormone changes occur gradually during pregnancy, they reverse very suddenly after delivery. This abrupt drop likely contributes to postpartum worsening of anxiety and depression in some. Although pregnancy may provide some relief of panic-type anxiety, the risk of panic seems to increase after delivery. Women who continue to experience symptoms of anxiety during pregnancy should talk to their OB/GYN about treatments.

Will breastfeeding have beneficial affects on anxiety?

Breastfeeding may help prevent some of the sudden hormonal transitions that occur at the end of pregnancy since oxytocin and prolactin continue to be released. If the frequency of breastfeeding decreases gradually over time, the drop in oxytocin and prolactin for the mother will also be more gradual.

Studies have shown that women who breastfeed have reduced hormonal and nervous system reactions to acute stress. There have also been reports that breastfeeding may reduce anxiety symptoms for some women, but clearly other women continue to have anxiety. High levels of anxiety postpartum can make breastfeeding difficult because anxiety and stress suppress the release of oxytocin, a hormone needed for milk release.

How does menopause affect anxiety disorders?

After age 50, women are no longer at the same two-fold increase risk of developing an anxiety disorder. However there has been little study of the effects of menopause on anxiety or why women might experience this reduced risk. There seems to be variations among individuals in how perimenopause and menopause affect anxiety symptoms. During perimenopause, the three to seven year transition period between regular menstrual cycling and the last menstrual period, hormone levels can be very erratic, sometimes reaching levels much higher than those experienced before this period. This makes it difficult to figure out the role of hormones in any symptom changes during perimenopause. Women who do experience greater anxiety symptoms should talk with their health care provider.

Do hormonal medications affect anxiety disorders?

Symptoms related to anxiety disorders do not appear to improve or worsen with any type of hormonal contraception, e.g., birth control pills. Estrogen replacement after menopause has been shown to reduce hormonal and nervous system responses to stress. In addition, estrogen therapy has been shown to reduce symptoms of perimenopausal depression. These studies suggest that estrogen treatment may be helpful for anxiety during perimenopause or menopause, but no studies have examined the effect of estrogen or progesterone replacement on anxiety disorder symptoms.

What other hormones can affect anxiety disorders?

High levels of thyroid hormones can cause panic attacks, tremors, insomnia, palpitations, and other symptoms of anxiety. Overactivity of the thyroid gland, or hyperthyroidism, is a well-known cause of anxiety. Women are at greater risk of thyroid illness than men, partly because 10 to 20 percent of women have “anti-thyroid” antibodies circulating in their bloodstream that have the potential to cause hyperthyroidism. Usually, these antibodies do not cause a problem. However, if women do have anti-thyroid antibodies, postpartum is a time of increased risk for autoimmune hyperthyroidism. Women with thyroid conditions who have an anxiety disorder or exhibit symptoms of anxiety should discuss these with their doctor.

Although the details are still unclear on how hormones affect anxiety disorders in women, the early evidence does indicate that connections do exist. Further study in this area of anxiety disorder research will yield more answers over time. Until then, women at every stage of life should discuss their concerns with their OB/GYN and other health care providers to ensure proper treatment.

Women’s Initiative at www.adaa.org.
Sleep is a basic human need at any age, as essential for good health as a proper diet and regular exercise. A good night’s sleep refuels the body’s energy, gives our active brains a rest, and puts us mentally in a better mood.

One of the greatest frustrations we all face at some point is not being able to fall asleep. We toss and turn, worry about the next day’s activities, look at the clock and count how many minutes we have left before morning. For many, though, insomnia is much more than a one-night annoyance. Insomnia is the clinical term for those who have trouble falling asleep, difficulty staying asleep, or waking too early in the morning. Caused by a multitude of physical and emotional problems, insomnia can be diagnosed as short-term or long-term, depending on when the patient feels that the loss of sleep is a problem.

Anxiety & Sleep
For individuals with an anxiety disorder, insomnia closes the loop on a vicious cycle of symptoms that can exacerbate these disorders. Many of the culprits that prey on anxiety sufferers — excessive stress, persistent worry, obsessive thoughts, gastrointestinal problems, and nightmares — also rob them of their precious sleep. In addition, certain antidepressants often prescribed for the treatment of an anxiety disorder can cause sleep difficulties.

Conversely, research has shown that chronic sleep problems are associated with an increased risk of anxiety, depression and reduced quality of life. Sleep disorders such as sleep apnoea, narcolepsy, and restless leg syndrome also interfere with good sleeping habits, thereby contributing to the possibility of mental impairment. The vicious cycle continues.

Whether sleeplessness creates the anxiety, or the disorder causes the insomnia, the risks of inadequate sleep go way beyond just being tired. Skipping the necessary hours of sleep can result in many negative consequences including, poor work or school performance, increased risk of injury, and poor health, as well as, impaired judgment and bad moods. In children, sleep disorders are linked to learning problems, slow growth, bed-wetting and high blood pressure.

Dos and Don’ts for Sleeping Soundly
The National Sleep Foundation (NSF) recommends an average of seven to nine hours of sleep each night for most adults and even more for children and adolescents. Yet nearly 25% of adults in America (47 million people) don’t even get the minimum amount of sleep they need to be fully alert the next day. To manage anxiety symptoms, and to ensure good health, make sleep a priority for you and your family. Here are some tips from the NSF to enjoying better sleep:

DON’T:
- Engage in stimulating activities right before going to sleep.
- Watch TV or use the computer before going to bed.
- Eat or drink before bedtime.
- Exercise within three hours before you want to fall asleep.
- Consume large amounts of caffeine, like soda and chocolate.
- Use nicotine products. Nicotine is a stimulant.

DO:
- Make time for sleep. Block out seven to nine hours for a full night of uninterrupted sleep.
- Establish a regular bedtime routine for children, which includes 15 to 30 minutes of calm, soothing activities.
- Set the stage for a good night’s sleep. Make sure your bedroom is cool, dark and quiet Get into bed only when you are sleepy. If you don’t fall asleep within 15 minutes, get out of bed, go to another room, and do something you find relaxing.
- Talk to your doctor if you have sleep problems. A doctor can discuss with you about the number of prescribed and herbal sleep remedies available.

Sweet dreams!
For more information about sleep and sleep disorders, visit the National Sleep Foundation at www.sleepfoundation.org.

Some Australian books about sleep
Insomnia: How to sleep easy, by Dr Leon Lack, Dr Helen Wright & Dr Helen Bearpark. The Australian Women’s Health Series, 2003. Sold at selected newsagencies.


What are the Differences Between Panic Disorder and Social Anxiety Disorder (Social Phobia)?


This is probably the most misunderstood subject in the area of the anxiety disorders. Most clinicians and therapists have not been adequately trained to understand or diagnose anxiety disorders in general -- and the clear-cut distinction between these two anxiety disorders is almost never understood.

Even normally reliable and scientific sources fail to make the correct distinctions in this area.

(As an additional note: Many people with any type of anxiety disorder are typically misdiagnosed as being "depressed". This occurs because anyone with an anxiety disorder, including panic and social anxiety, is naturally "depressed" over their anxiety and the significant impairment it causes in their daily lives.

Technically, it is more accurate to diagnose people with anxiety disorders as "dysthymic". The main point, however, is that it is the anxiety that causes the depression (dysthymia) and not the other way around. Once the anxiety shrinks and is overcome, the depression goes away with it.)

PANIC DISORDER

People with panic believe very strongly that the "attack" they experienced means that something is physically wrong with them.

For example, many people with panic disorder fear that they are having a heart attack, that they're about to lose control, or that they're going crazy. Other people with panic believe that because they can't catch their breath that they're suffocating, or that the dizziness, light headedness, and "unreal" feeling they experience means they have a terrible undiagnosed illness.

The person with a tightness around the head fears they have a brain tumor. The person with muscle spasms fears they're coming down with a muscular disease. Heart palpitations and/or skipped heartbeats "prove" that there's something wrong with the heart.

People can be checked, rechecked, and use the hospital emergency rooms repeatedly before it ever begins to get clear to them that what they are legitimately suffering from is anxiety, and not a physical, medical condition.

The central point is that people with panic fear that they have a physical, medical disease. Otherwise, what else could explain the suddenness and awfulness of that first panic attack? How could the mind have something to do with the horrible swirling emotions and feelings that overload the person during this traumatic and emotional attack?

A great many people who experience their first panic attack find their way to the hospital emergency room or go directly to their physician's office. They feel their life is in danger and they legitimately want a diagnosis to explain it. When doctors report that they can find nothing wrong with the person medically, it only heightens the person's anxiety. After all, something MUST BE WRONG or else how do you explain the horrific sensations and emotions they went through during the panic attack?

Unfortunately, many people are never told that they are experiencing anxiety, and that a panic attack could be the culprit.

Sometimes, especially when the panic occurs frequently and in many diverse places, the person feels more and more restricted as to where they can go and still be safe. When a person feels their "safety zone" is a limited area around their house, and they fear they'll have panic attacks as a result of getting too far away from this protection and safety, they may become agoraphobic.

SOCIAL ANXIETY DISORDER (Social Phobia)

People with social anxiety disorder do not believe that their anxiety is related to a medical or physical illness or disease. This type of anxiety occurs in most social situations, especially when the person feels on display or is the centre of attention.

The socially-anxious person has extremely high anxiety when they're put into a position to make small talk to a stranger or interact in a group. The anxiety becomes worse when the person fears that they are going to be singled out, ridiculed, criticized, embarrassed, or belittled. People with social anxiety find it to be a terrifying experience to interact with unfamiliar people, give any type of public presentation, or even be publicly noticed. For example, the office may be planning a birthday party for the socially-anxious person -- and instead of this being a pleasant and happy experience -- it will cause great anticipatory fear and dread -- because they will be on display......in front of all those people......and then they fear they will do something to make a fool of themselves......

The person with social anxiety is sometimes viewed as "quiet", "shy", "introverted", or "backward". They are continually concerned that other people will notice their anxiety and they will be humiliated and embarrassed as a result. Most people with social anxiety disorder hold down jobs that are well beneath their capabilities and capacities because they fear job interviews, working in a position where there is too much public contact, and being promoted to a position where they would have to supervise other people. When socially-anxious people isolate themselves as much as possible and are somehow enabled to stay at home and not work, their social contact can drift down to the immediate family or to absolutely no one at all.

Once a person avoids almost all social and public interactions we say the person has an extreme case of social anxiety disorder, more commonly called avoidant personality disorder. As you would expect, people with social anxiety disorder have an elevated rate of relationship difficulties, and substance abuse.

To escape the constant anxiety, many people with anxiety (both panic and social anxiety people) turn to the age-old, damaging anxiety reducers: alcohol and substance/drug abuse.
SYNOPSIS: DIFFERENCES

People with panic disorder experience a horrible anxiety attack accompanied by many physical symptoms that are originally interpreted as a physical, medical problem. Socially-anxious people experience horrible anxiety in social situations that lead them to stay away from other people because of the anxiety it causes. They see anxiety as a "fear" and do not believe it is caused by a physical, medical condition.

Panic and agoraphobic people are many times very social. In fact, the majority of panic people enjoy the company of talking and being with other people. This is nowhere more apparent than in a therapy group with other people who have panic and/or agoraphobia. The room is alive, active, open, friendly, and sometimes even noisy.

Contrast this picture with the life of socially-anxious people. Even though they are lonely and would like to be with other people and enjoy their company, the heightened anxiety this would cause overpowers the loneliness. Thus, the socially-anxious person stays alone. In a therapy group meeting of socially-anxious people, the room is fairly subdued, particularly during the first few sessions. Individuals are afraid of talking, drawing attention to themselves, and risking anticipated embarrassment.

Contrary to popular conception, people with social anxiety disorder do not develop agoraphobia. Agoraphobia results from the fear of panic attacks, not from the fear of social interactions. Likewise, people with panic disorder do not develop avoidant personality disorder. Avoidant personality disorder results from social anxiety as people continue to cut themselves off from most of the world because of the fear of social interactions and other people, not from the fear and dread of having a panic attack.

(Note: We, as a therapeutic and research community, are light years behind where we should be concerning the anxiety disorders. It is still prevalent within our own professional communities to dismiss the anxiety disorders as unimportant and not be able to make the clear-cut clinical distinctions that are apparent to those who specialize in this area.)

Also, contrary to current psychiatric/psychological nomenclature, people with social anxiety do not have "panic attacks". They experience extreme anxiety in social settings where they fear they will have to perform or be on display. It is not uncommon for socially-anxious people to use the terminology "I panicked". Again, however, the distinction here is that the person is not talking about the sensations leading to a physical pain or condition. They are referring to a very high level of anxiety and the adrenaline rush that accompanies it.

It is possible for a person to have concurrent symptoms from both of these anxiety disorders, although one or the other will usually be more prevalent. For example, a person with panic may also be socially-anxious concerning several different life situations, such as fear of public speaking and fear of being assertive. It is also possible for a person with one of the anxiety disorders to develop another disorder at a different period during the lifespan. People may also simultaneously suffer from several of the other anxiety problems, such as obsessive-compulsive disorder, post-traumatic stress, and/or generalized anxiety disorder.

It appears from the latest epidemiological data that social anxiety disorder is the most common of the anxiety disorders.

Lending credence to this data is that many socially-anxious people find it extremely difficult to seek help – going to therapy is a social event where the person is dealing with an authority figure on a 1:1 basis. Just the thought of this can create high levels of anxiety, and hold the person back from seeking help (even though they want it desperately).

Panic disorder with and without agoraphobia seems to be the second most common anxiety disorder.

The anxiety disorders as a whole continue to be the disorders that plague and afflict the largest number of people on the planet.....

The anxiety disorders as a whole continue to be the area in which the LEAST amount of research and clinical experience is available.....

The general public continues to hear more about the obscure psychological disorders that seem bizarre and strange, thus commanding a greater deal of media attention.....

And because of this mis-focus, people with anxiety disorders continue to be the losers.....

Please remember...each and every anxiety disorder is both treatable and can be conquered. No one needs to live their life with an ongoing anxiety disorder. Help IS available, but please seek out help carefully from professionals who have experience in treating anxiety disorders.

At present, the best help seems to exist in anxiety clinics whose practice focuses solely on these disorders. Ask questions of anyone you may potentially visit. Make sure they fully understand the problem that you want help to overcome. Don't let anyone tell you that panic, agoraphobia, social anxiety, or avoidant personality disorder cannot be overcome.

There are many of us who have suffered through the pain of an anxiety disorder first hand, and can vouch for the fact that it is possible that you can overcome anxiety, too. An experienced and knowledgeable therapist and a motivated client is all that is needed to gently move ahead and conquer the worst of your fears.
Exposure and ritual prevention (ERP) has been found to be very effective for treating obsessive compulsive disorder (OCD) over the last 35 years. We know that as many as 85% of people with OCD can be helped by using ERP. However, many OCD sufferers and their families are confused by some of the terminology associated with this technique. One very important term that confuses many is “habituation”. My goal in this brief article is to help clarify what this term means.

ERP is based on the principle of habituation. By nature, people habituate to negative things around them. In a sense, habituation means getting “used to” something we don’t like. For example, after being in a room for a period of time, we no longer hear the hum of a fan that we first found distracting. The sound does not go away; we just got used to the sound and, therefore, no longer perceived it. Another example of habituation we can all relate to is water temperature. When we first jump into water we may find that it is cold, but if we stay in it long enough we find that the water has “warmed up.” Again, the water hasn’t warmed up, we have just gotten used to it or habituated to it. If you were to get out of the water for a while and jump back in, you would find the water to be as “cold” as it was the first time. The process of habituation is normal and natural, and takes no effort on our part to occur.

So what does this have to do with anxiety and ERP? With respect to anxiety, habituation refers to the decrease or reduction in anxiety with nothing but the passing of time. This means that our anxiety about something we fear will eventually go down without doing anything but letting time pass.

In ERP we look for two types of anxiety habituation. First, there is “within trial” habituation or reduction of anxiety. A “trial” in ERP refers to an exposure assignment that you are attempting (e.g., touching a doorknob and not washing your hands). “Within trial” habituation is the reduction in anxiety you get while holding onto the doorknob over a period of time (e.g., your anxiety reduced from a 4 to a 2 using a 10-point scale in 10 minutes). You will get this anxiety reduction if you give yourself long enough without doing (e.g., washing your hands), thinking (e.g., thinking to yourself a prayer), or saying (e.g., asking if it is ok to touch a doorknob) anything. Your anxiety goes down with nothing more than the passage of time. The key to “within trial” habituation is to continue the exposure exercise long enough to experience this reduction in anxiety. Using the water temperature analogy again, you must stay in the water long enough so it can “warm up”. How long is long enough? It is different for different people; and it is different for different exercises. Most doctors would encourage you to do the exercise until you get at least a 50% decrease in your peak anxiety rating (i.e., when it was at its highest point during the trial, say from a 4 to a 2). Typically, the more challenging the exposure exercise is for you the longer it will take to experience “within trial” habituation.

The second type of habituation sought in ERP is “between trial” habituation. This refers to the reductions in the “peak” anxiety ratings you experience when you repeat the exposure exercise over and over again. The “within trial” reductions in anxiety that we have already discussed do not last long if the exposure exercise is not repeated. This means that if you saw your anxiety go from a 4 to a 2 in 10 minutes on a particular exercise and then waited a week before you did it again, you probably would get an anxiety rating of 4 to a 2 in 10 minutes again. The end result is nothing changes without repeating the exposure exercise in a time-intensive enough fashion. It’s like getting out of the water and not going back in until the next day. Chances are, it will feel as cold as it did the day before. It takes repetition to get you peak anxiety ratings to reduce from one trial to the next. With enough repetition you can get to the point where an exposure exercises will cause you minimal anxiety from the start of that exercise.

How many repetitions will it take before you experience minimal anxiety from an exercise? It is different for different people and different for different exercises.

“Between trial” habituation is really the effect of treatment. Rituals or compulsions give you the equivalent of “within trial” habituation. Compulsions work, and can work, to reduce anxiety quickly (e.g., driving anxiety from a 4 to a zero). Obviously, the problem is that they don’t help n the long run and every time someone is faced with that same situation they will have to ritualise again. Exposure without repetition is the same thing. It reduces anxiety at first; but if you don’t keep doing it, nothing good happens in the long run. ERP “beats” compulsions with the “between trial” reductions or habituation that occurs with repetition. In a sense, the goal of ERP is to replace the compulsions with the process of habituation as a means of reducing anxiety.

So, when doing ERP remember to do the exercise long enough to get “within trial” habituation, and repeat it enough times to get “between trial” habituation. Good luck!

**Editor’s note:** ERP is a form of treatment which focuses on changing behaviour. ERP can be an aspect of a Cognitive-Behaviour Therapy (CBT) program. That is, ERP isn’t an alternative to CBT but rather a component of it.
The Annual ANTs Convention

Introduction: ANTs are "automatic negative thoughts" that those of us with anxiety problems and depression have. We need to work very specifically and persistently to rid ourselves of these automatic negative thoughts -- not just temporarily but permanently. The following is an interesting parable concerning these "ANTS":

Overheard at the ANNUAL ANTs CONVENTION

Once a year, the ANTS from all around the world gather to visit each other and to show off how much each of them has grown bigger and bolder during the past year. The Annual ANTS Conventions are like sales meetings, whereby the ANT that has made the most "sales" or "commissions" by increasing peoples' automatic negative thoughts receives recognition, is greatly honoured, and highly praised.

The ANTS whole mission and goal in life is to fuel the negative thinking that leads to anxiety, panic, social phobia, agoraphobia, generalized anxiety, obsessive actions and compulsive behaviour and the related depression that goes along with anxiety.

So, at the convention, the ANTS discuss new methods and strategies to rip us down, tear our self-esteem to shreds, and make us feel completely hopeless and helpless about our anxiety. The ANT that comes up with the trickiest and most cunning plot to do this is always given a "special reward" and allowed to plague the people who have fully given in to ANTS thoughts so that their lives are ruined and totally filled with fear and anxiety. They are kept on a very short and tight leash by the ANTS masters.

Let's listen to some of this year's convention conversations:

Young ANT #1: "Hey, I've got another person convinced that he's no good, that he's not as important as other people, and who doesn't think he has any control over his own life. I've even got him scared to go out in public!"

Young ANT #2: "Ha! Another one of our victims trapped! I love it! (Clapping with glee.) What shall we give him? Panic attacks? Social anxiety? Obsessive-compulsive thoughts and behaviour? Agoraphobia? (A special gleam appears in the ANTS' eye:) Or maybe all of the above......"

Young ANT #1: "As long as he keeps believing us and giving in to us, we can give him as many problems as he'll take. Two problems are better than one, I always say......"

Young ANT #2: "Oh, man! I'm excited now! Maybe I'll win that award next year! I need to keep practicing my negative and irrational thinking and learn how to pass it on to others. Practice makes perfect, they always say......"

Young ANT #1 (snorting in pleasure): "But our victims never learn that practicing is important to change thoughts, do they? They start out practicing and being persistent, but they always quit before they really get any better. Then, we've got them trapped.

One more defeat makes them feel totally worthless and helpless and they give up!"

The young ANTS continue to chortle in evil glee.

Just then, an older and wiser ANT enters the picture and overhears the conversation between the two young, immature ANTS.

Older and Wiser ANT Voice #3:
"Stop your incessant bragging. You sound just like children! Don't you know that we derive our very existence from the lies we tell people that they believe? Every time you push too far there's a chance they'll get wise and then we will lose control. If the person ever fully realizes what we're doing to him, we're the ones who aren't going to have any power left......"

The younger ANTS shudder in horror at this statement.

ANTS #1: (slowly and meekly) "You mean like our friend, the Destroyer? When that woman he was working on got some help and realized what was happening to her, she practiced and practiced and practiced........." (ANTS #1 shudders violently at the thought).

ANTS #2: (hesitantly) "But what happened? What did this woman do anyway? And where is the Destroyer now?"

Older and Wiser ANT #3: "She realized what was happening to her, caught him at it, and used PEACEFUL, CALMING strategies and methods on him! And she wouldn't give up! Then she started "slow talk" and the "determination factor" and SHE ACTUALLY PRACTICED THESE ABOMINATIONS UNTIL THEY SANK DEEP DOWN INTO HER BRAIN AND BECAME AUTOMATIC! Older and Wiser ANT #3 begins perspiring, his heart beats faster, and he starts getting dizzy, "Oh, my God! I don't think I can go on.....!"

Finally, he pulled himself together and continued to speak in a very serious, low voice: "The Destroyer began to shrink and shrink, but the more he tried to bring back the anxiety, the fear, and the worry, the worse it got. She stood her ground, ignored him, and turned the other way. She refused to pay any attention to him. Finally, he had no toehold left, and he had to leave her. He ended up on the old insect farm for ruined and defeated ANTS: exhausted, defeated, and so very tiny and weak that he'll never leave the institution until he continues to shrink further and further and finally dies. That nasty, vicious anxiety woman killed the Destroyer for good just by changing her thinking habits and refusing to listen to him anymore."

(Older and wiser ANT #3 looks from immature ANT #1 to ANT #2, shaking his head).
"Are you two learning anything from this at all?"

**ANT #1:** (Scared, weak, trembling, and much more sober now).
"You mean, we have to be careful not to get caught. If our person realises what we’re up to and stops believing in what we tell them, then..... we’re.... we’re......"

**Older and Wiser ANT #3:**
"........DOOMED! You’ll spend the rest of your days on the dying ANTS farm with the Destroyer, feeling more and more miserable all the time, and continuing to shrivel up and shrink. The good news is that you won’t have to put up with the institution for very long. You’ll grow so small and tiny and insignificant that you’ll eventually just fade away into absolute nothingness. And no one will ever remember that you even existed.......

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**Procrastination: The time robber**


It’s a simple fact of life that most of us procrastinate. When there’s something that we don’t want to do, it’s amazing what our brains can come up with to avoid doing what needs to be done. It’s an ironic situation because we all realize that procrastination only makes us feel worse and continues to nag away at our mind to keep procrastination, that robber of our time, in check?

We need to learn some very specific strategies to deal effectively with this problem.

**Myth:** I might as well not even try.....I just can’t seem to motivate myself until someone “forces” me to get it done.

**Fact:** Many times it is too hard to do everything you need to do at once. The secret is to make a list of things that need to be done and then break the tasks up. For each task that you’ve broken up, you’ll have a beginning and an ending. The tasks should be broken into small enough pieces that you can always see the "light at the end of the tunnel".

The next key is just to start whether you feel like it or not. Use some self-talk to remind yourself you’ve got to get this done and you’re making a stab at it now. As the moments go by, you’ll begin to feel better and better. The secret here is not to wait until you “feel better” first before you start. You have to make the start first, and then the feelings of accomplishment and competence will follow after.

When you’ve finished with your first task, reward yourself. Read that magazine or watch that TV show. Go swimming. Do something positive to reward your effort and renew your mind.

**Myth:** That all sounds well and good. But I tried and I can’t even get started.

**Fact:** Maybe you’re having a hard time because you’re trying to jump in too fast. After you’ve been resting, watching TV, reading, or doing something relatively inactive, it IS harder to get going on a new task. The strategy here is to move toward the starting gate slowly. If you’ve been sitting or lying down, stand up, stretch, and do a short physical task, such as watering the flowers, vacuuming one room, or loading the dishwasher. While you’re doing this, determine in your mind you are going to start your first task just as soon as you finish.

**Question:** Aren’t you just talking about willpower?

**Answer:** In a way, yes. But, despite what some people think, EVERYONE has will power. The difference between those who procrastinate and those who don’t is that non-procrastinators have a specific strategy or system to help them through tasks that are not much fun.

Non-procrastinators get their mind in gear and then ACT. It is always a surprise how quickly things get done when they’ve been started. Many of us who have spent day after day procrastinating and feeling badly about it, are shocked to notice the difference a little movement in the right direction makes.

After you’ve finished each task, reward yourself. Some people finish that book, others go swimming, still others listen to music. The reward needs to be something you enjoy.

Perhaps now you can see the benefit of starting early when you have a new job to do. If you start early enough and don’t put everything off until the last minute, every day will be more enjoyable, you’ll feel like you’re accomplishing something (because you are), and you won’t have that nagging feeling that turns into depression as your deadline draws closer and closer and you haven’t even started yet. Don’t give in to the anxiety/procrastination monster: JUST DO IT AND YOU’LL FEEL BETTER.
Carers Week 2004 is October 17-23!

Background
Carers Week is a national awareness week held during October each year in Australia. The event was established to promote and raise awareness of the valuable role that carers play in our community and to generate discussion about carer issues. Carers Week also provides an opportunity for carers to come together, support one another and share ideas and information.

Theme and focus
The theme for Carers Week 2004 is – ‘Health & Well-being’ and the focus will be to:

♦ Raise awareness of the extra role that carers take on, and the health issues they may face
♦ Support carers to take action which positively enhances their own health and wellbeing

Carers Week also aims to:
♦ Heighten awareness of carers in the community

♦ Celebrate the work of carers and encourage carers to recognise themselves as carers
♦ Promote an awareness of the Commonwealth Carer Resource Centres and connect carers to these Centres
♦ Promote the services of the Commonwealth Carer Respite Centres
♦ Encourage carers to access the support and services which are available to them, and
♦ Support the promotion and distribution of information to carers

A direct result of raising general awareness is the self-identification of carers - ordinary Australians who find themselves in extraordinary circumstances. These people are the mums, dads, daughters, sons and other family members and friends who make sure that their loved ones maintain a quality of life despite disability, mental illness, chronic illness or frail age.

Through the active participation of key organisations such as Commonwealth Carer Respite Centres, Carer and Consumer Groups, Carer Support Groups, Carer and consumer service providers, government agencies, local council, hospitals, church groups and carers themselves, we can create a high profile event that will enable us to reach more carers, and in so doing help them to gain access to the information, support and advice they need.

Local/Regional Activities Guide
www.carersvic.org.au
Carers Victoria, Level 5, 130 Little Collins Street, Melbourne Victoria 3000
Telephone: 03 9650 9966, Freecall: 1800 242 636
Fax: 03 9650 8066, Email: cav@carersvic.org.au
Or your local Commonwealth Carer Respite Centre 1800 059 059 (this number will connect you to your local service).

Children of Parents with a Mental Illness (COPMI) Initiative

COPMI has recently released two new publications:

The Best For Me and My Baby
This booklet was developed with and for women with a mental health problem or mental illness - and their partners - who are thinking about having a baby, are new parents or are about to have a baby. It encourages health professionals and parents to work together to manage mental health during pregnancy and early parenthood and provides tips for parents and for supporting family and friends.

Family Talk
Developed in partnership with families and young people, this booklet contains tips and information for parents with mental health problems, their children, other family members and support people. Topics include answering questions, discussing things as a family and planning for times when the parent may be unwell.

Also included are 'press out' cards for children and young people to use to record their important phone numbers.

To print your own copy go to “Downloads” at www.copmi.net.au. To order a hardcopy go to www.copmi.net.au/common/order_form.html. If you don’t have internet access call (08) 8161 6859.
Carers’ Network website launched!

http://www.carersnetwork.org/

Welcome to the Carers’ Network!

Who we are
The Network is the Victorian peak body of organisations and individuals that support carers of people with a mental illness.
It comprises
• Carers or former carers linked with carer groups
• Representatives of state-wide carer organisations with a significant carer focus
• Workers from carer support programs

What we aim to do
• Ensure state and federal governments recognise the role, contribution and needs of carers.
• Advocate for policy changes and improve services to address carer needs.
• Support carer involvement in the planning, delivery and evaluation of services for people with mental illness and their carers.
• Facilitate communication between carers and government.
• Establish partnerships between carers and service providers.
• Encourage research on best practice in carer support.

What this means for you
Carer issues are identified and worked on through monthly Network meetings and specific working groups. Carer issues and policy positions are taken to State and Federal government officers and Ministers via:
• Regular meetings with the Mental Health Branch
• Letters, submissions, deputations
• Liaison and representation on government committees

If you have an issue relating to our aims, please contact one of the member organisation representatives who will bring it to the Network. Alternatively, you can email us. You can be informed of the Network’s progress, working groups and research on carer issues through this website which is regularly updated, as well as through member organisations’ newsletters and carer meetings.

When should I contact the Network?
The Network only deals with carer issues on the large-scale, that is, working to address systemic problems for carers in mental health across Victoria, such as policy changes and improved services for all carers. It does not deal with carer issues on an individual basis. Below is a list of the organisations and the representatives who make up the Network. Use these contacts to discuss a systemic issue.

Representative
ARCVic’s current representative on the Network is Kathryn I’Anson. She can be contacted at:
ARCVic, 42 High Street Road, Ashwood, Vic, 3147.
Postal address: PO Box 358, Mt Waverley, Vic, 3149
Ph: (03) 9886 9233, Fax: 03 9886 9411
Email: arcmail@arcvic.com.au

For personal carer support, information or advocacy, it is better to call the OCD & Anxiety HelpLine: 03 9886 9377 (Mon to Thurs, 10.00 am to 4.00 pm).

Mental Health Week 2004 - Sunday October 10th - Saturday October 16th

The theme for Mental Health Week 2004 is "Mental Health: What do you know?". The additional message is "Social and Emotional Well Being", Mental Health Week aims to engage people all around Victoria in rural and urban areas, to create awareness of mental health matters and become involved in mental health community activities.

CALENDAR OF EVENTS
The calendar of events for Mental Health Week is available at the website of the Mental Health Foundation of Australia (Victoria), http://www.mentalhealthvic.org.au/mhw.asp, or call (03) 9427 0406.

‘It’s all right’

SANE Australia recently launched a new website specifically for young people called “It’s all right”.

“It’s all right” is a website where you can read the diaries of four fictional teenagers touched by mental illness. It also has fact-sheets and provides an online information and referral service on mental illness including schizophrenia, depression and anxiety disorders.

http://www.itsallright.org
**New Research Projects**

**Australian Research Projects**

**University of Melbourne - Department of Psychology**

*An Investigation into Compulsive Buying ("Shopaholism")*

“In the popular media, Compulsive Buying is often referred to as "retail therapy" reflecting a misconception that is associated solely with positive outcomes or occasional trivial negative effects. However, the clinical scenario suggests a more serious disorder.” (Kyrios, Frost & Steketee, 2004)

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:


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.

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.**

**Feedback from people with OCD who have already participated in this research project:**

"I was impressed with the organization of the project. At all times I was well informed, kept up-to-date and made to feel comfortable and welcome… It is difficult to discuss OCD with people outside of the health profession, and for me, this was one way of giving something back for the help and assistance I have received…I found the brain scans interesting to view, and was actually surprised (pleasantly) by some of the test results." “Michael”

“All those who ran the program were fantastic. I would gladly donate any future time for further research…My hope is that my very small contribution will slowly, one day help and benefit others who suffer from this soul destroying disease… It was great to feel a sense that being part in research somehow helped me move forward from so many years of suffering in silence, and even still to this day.” Adrian

“Interviewing and testing was well thought out, organised and handled in a non-judgemental, friendly manner. Transport, where required was very well handled and communication effective and open…The pictures, results and debriefing seemed thorough, and well thought out. In short, the feedback was very good.” C.N.

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.

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**University of Melbourne**

**Investigating the Treatment of Post Traumatic Stress Disorder**

Researchers at the University of Melbourne are currently conducting a study looking into the nature and treatment of trauma. This study will investigate the effectiveness of two treatment interventions and treatment change. Participation will involve an assessment interview and completion of questionnaires to determine whether the treatment offered through this study will be appropriate and beneficial. If the treatment will not be appropriate for potential participants a suitable referral will be offered. If the treatment is appropriate participants will be randomly allocated to one of the two treatment interventions. Treatment will involve meeting with a therapist on an individual basis, once a week for one or two hours, for approximately ten weeks. Treatment sessions will focus on past experiences of trauma and therapists in this research study have been trained in the application of specific treatment techniques. Following treatment participants will be reassessed and again after three months to assess the benefit of treatment over time. The University of Melbourne Human Ethics Committee and the Department of Justice Research Ethics Committee have approved this study. For further information please contact the research director Dr Grant Devilly on 03 8344 94 56 or to speak to officers of the University of Melbourne or Department of Justice who are not involved in the study, contact the Executive Officer, Human Research Ethics at the University of Melbourne on Tel: 03 8344 7507, Fax: 03 9347 6739; or the Department of Justice on Tel: 03 9651 6920.
**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.

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**Austin Hospital and Professorial Unit at The Melbourne Clinic**

**A double-blind, randomised, placebo-controlled relapse prevention trial with 10-20mg escitalopram in obsessive-compulsive disorder**

The purpose of this project is to evaluate a relatively new drug, called escitalopram, for the treatment of obsessive compulsive disorder (OCD). Escitalopram belongs to a group of medicines called selective serotonin reuptake inhibitors (SSRIs) that have been used extensively in the last decade mostly to treat depression, anxiety disorders and OCD. Escitalopram has already been given to approximately 1.7 million patients worldwide. Escitalopram is approved for the treatment of depression and panic disorders in most European countries and in the US for the treatment of depression. It is not currently approved for marketing in Australia. The aim of this study is to assess the long-term efficacy of escitalopram in OCD. Previous experience has shown that escitalopram is an effective, safe and well-tolerated antidepressant. It has also shown efficacy in clinical studies in social anxiety disorder and generalised anxiety disorder. Escitalopram is expected to be able to relieve the symptoms of OCD. Participation in this project will involve 2 treatment periods. It is a maximum of 45 weeks long, including 21 scheduled visits to your doctor plus a follow-up visit. To assess the long-term effect of escitalopram in this disorder it is necessary to have a placebo-controlled study, to evaluate the difference between the effects of a placebo (a non-active/dummy drug) and the drug. Therefore, all participants will be treated with escitalopram in the first period of the study, but in the second period participants will receive either escitalopram or placebo. Volunteers are being sought to participate in this study who have a current diagnosis of OCD and are aged between 18 and 65 years. People may not be eligible for inclusion in the study if other pharmacological treatments are being used or if another psychiatric disorder is the primary diagnosis. More detailed information about inclusion and exclusion criteria are available for the researchers. Volunteers will not be paid for participation in the trial, however travel costs can be reimbursed. All medical tests, examinations, psychiatric care and study medication will be provided at no cost.

The ethical aspects of this project have been approved by the Austin Health Human Research and Ethics Committee. The study is being sponsored internationally by H. Lundbeck A/S. This study is being undertaken by the Department of Psychiatry, Austin Hospital, and The Professorial Unit at The Melbourne Clinic. The Chief Investigator is Professor Graham Burrows; co-investigators are Dr James Olver, Dr Susanne Gyorki (The Austin Hospital), and Professor Isaac Schweitzer (The Melbourne Clinic). For further information contact Sophie Ignatidis, Research Coordinator, Department of Psychiatry, Austin Hospital on 03 9496 5404; or Bridget Bassilios or Ms KC Crowley, The Professorial Unit, The Melbourne Clinic on 03 9420 9255.

Ed.:The above information regarding this study was taken from the Participant Information Sheet for this study, provided by the Department of Psychiatry, Austin Hospital. Lundbeck is a pharmaceutical company specialising in psychiatry and neurology, and owns/produces the antidepressant (SSRI) escitalopram.
Monash University
Preventing panic

Panic disorder affects 25 out of every 1000 people, yet many of these people seek no help for their condition. Now, Monash researchers are developing online therapies in the

It is no secret that Australian actor Garry McDonald, noted for his roles as Norman Gunston and the long-suffering son in ABC TV's 'Mother and Son', has spent much of his life struggling to control panic disorder. Psychoanalyst Sigmund Freud and inventor Nikola Tesla are two other high-profile people who experienced panic attacks throughout their careers.

In 1999, a survey commissioned by the Commonwealth Department of Health and Aged Care into the mental health of Australians found that in any 12-month period, almost one in five people have one of the common mental disorders (anxiety, depressive or substance abuse disorders).

The survey also revealed that among the 9.7 per cent of people with anxiety disorders, which include panic disorder, only 28 per cent seek help.

This finding has led Professor Jeff Richards and psychologist colleagues Dr Britt Klein, Mr David Austin and Dr Marlies Alvarenga from Monash's School of Primary Health Care to find new ways of treating people who experience frequent and unexpected panic attacks.

Panic attacks can involve a sudden rush of fear or intense anxiety and physical symptoms such as racing heart, shortness of breath, light-headedness or nausea. When these attacks happen unexpectedly, the person has what is known as panic disorder. This disorder can be debilitating, causing people to remain in their homes or change their behaviour so they do not encounter any potentially anxiety-inducing situations (known as agoraphobia).

"Three-quarters of people with anxiety disorders don’t go anywhere for help. This is particularly a problem outside the major capital cities and also in the outer suburbs of metropolitan areas," Professor Richards says. "There are different reasons for this, but mostly it comes down to access and affordability.

"To address this problem and the mental health of the population in general, we have developed and are trialling an internet-based program called Panic Online for treating panic disorder."

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."

Action: 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/

“A ship in the harbour is safe, but that’s not what ships were built for.”

Grant M. Bright
The Experiences and Needs of Carers and Families Living with People with a High Prevalence Disorder (Anxiety, Eating and Depressive Disorders): A Qualitative Research Project

by Kathryn I’Anson, Member, The Network for Carers of People with a Mental Illness, Director, Anxiety Recovery Centre Victoria

This research project was undertaken by the Project Management Group in a partnership between The Network for Carers of People with a Mental Illness and beyondblue: the national depression initiative. The Project Management Group was chaired by John McGrath, Chair of The Network for Carers of People with a Mental Illness. The Project Management Group members were Karen Elford, Director, Eating Disorders Foundation of Victoria; Nicole Higiet, Senior Researcher, beyondblue; Kathryn I’Anson, Director, Anxiety Recovery Centre Victoria; Kim Johnson, Carer representative; Julie Nankervis, Policy Officer, Carers Victoria; and Marie Thompson, Research and Program Officer, beyondblue. Special advisors to the project were Dr Ross King, Senior Lecturer, School of Psychology, Deakin University, and Associate Professor Michael Kyrios, Department of Psychology, The University of Melbourne. The project was funded by beyondblue: the national depression initiative. The comprehensive data obtained through this project was made possible by 89 carers, who participated in the focus groups and interviews to share their stories, experiences and insights about living with a family member with a high prevalence disorder.

**Background**

This project was initiated by The Network for Carers of People with a Mental Illness in November 2001. The need to undertake research on carers of people with high prevalence disorders arose from The Network’s identification of a major gap in evidence-based knowledge in this area, and the consequences of this lack of knowledge on service provision and government policy—i.e., minimal or no availability of specialist public treatment and support services (for carers, families and consumers). Organisations that assisted carers of people with high prevalence disorders reported to The Network on the difficulties and distress experienced by carers and families, which were exacerbated by the lack of understanding and recognition of their needs by the community, services and government.

A working group was established by The Network to develop a project design that would provide qualitative and quantitative data on the needs of carers and families of people with high prevalence disorders. The working group consisted of John McGrath, Julie Nankervis, Karen Elford and Kathryn I’Anson (convener). A research project and budget were developed and a funding proposal was submitted to beyondblue in January 2002. A funding grant was approved for the first part of the project—which would explore the needs and experiences of carers and families through focus groups and interviews. The aim was to provide qualitative data that would highlight the lived experience of caring for a person with a high prevalence disorder, and form a basis for developing a questionnaire for the quantitative study (part two of the project). A formal partnership between The Network and beyondblue was then established to conduct the project as a joint venture, and the Project Management Group was set up to develop and supervise the project.

**Rationale:**

Misperceptions and myths about the experience of people with high prevalence disorders are commonly held and mostly unquestioned by both professionals and the community. The impact and disability caused by anxiety, eating and depressive disorders on people have been trivialised by simplistic conceptual notions of these conditions—for example, that people with an anxiety disorder are the worried well, that people with depression simply need to pull themselves together and do something productive, and that people with anorexia nervosa are young girls led astray by peer pressure and fashion images.

There is now considerable scientific and clinical evidence of the marked difference between ‘normal’ feelings of anxiety, sadness and self-consciousness and the symptoms of the high prevalence disorders. However, these misconceptions have contributed to community and professional ignorance about these disorders and the cursory recognition given to high prevalence disorders by the mental health system, resulting in a major gap in the provision of treatment, support and crisis services for these people and their carers and families.

It is now well documented that the debilitating nature of chronic and severe anxiety, eating and depressive disorders contributes to loss of educational opportunities, employment and income for the individual affected, and increase family dysfunction. People with serious high prevalence disorders experience marked impairments in their ability to undertake many routine and life-sustaining activities. Sufferers are often housebound and isolated, and may be unable to perform major role obligations (go to work, care for children etc.). People with high prevalence disorders also have a high risk of developing other mental health problems.

It is apparent from anecdotal and clinical observations, that high prevalence disorders have a major impact on families. However, the needs and experiences of carers and families of people with high prevalence disorders are not well known or understood. There is little Australian or international research that has investigated the impact on carers. Consequently, the specific services and supports needed by carers and families living with anxiety, eating and depressive disorders have received minimal consideration in service development and health policy.

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1. The depression component of this project was incorporated into beyondblue’s national research agenda, and as such included focus groups from six Australian capital cities. The depression research was primarily conducted by Nicole Higiet and Marie Thompson, beyondblue, with input into the background papers from the Project Management Group. The eating and anxiety disorders components of the project investigated carer experiences only in Victoria (metropolitan and rural), and this research was undertaken by the Project Management Group (Nicole Higiet, Marie Thompson, Kathryn I’Anson, Jude Nankervis, Karen Elford and Kim Johnson, Chair—John McGrath).
Summary of Project:

The purpose of the project was to undertake an in-depth qualitative analysis of the needs and experiences of carers and families of people with high prevalence disorders (anxiety, eating and depressive disorders). The project aimed to achieve better recognition for carers and families of people with high prevalence disorders and to raise the awareness of the community, service providers and government about the nature of the caring role and its impact on carers and families.

A total of eighteen focus groups were conducted with the primary carers of people with anxiety, eating and depressive disorders. The focus groups for anxiety and eating disorders were held in rural and metropolitan Victoria. The focus groups for depression were held in six capital cities of Australia – Adelaide, Brisbane, Canberra, Melbourne, Perth and Sydney. Four in-depth interviews were undertaken in rural areas of Victoria with carers of people with depression, and eleven in-depth interviews were undertaken with carers of people with anxiety and eating disorders to provide a representative population sample. A total of 89 carers participated in the study.

Five open-ended questions were asked across the groups and interviews:

1) What were the first signs of something being wrong that you noticed?
2) What effect has the disorder had on you emotionally, physically, socially, financially?
3) What effect has the disorder had on your family life and family relationships?
4) What were the difficulties and barriers in obtaining help?
5) What do you need from health and mental health professionals and services that would help you in your caring role?

All focus groups and depth interviews were recorded, with permission given by participants, and transcriptions were made for thematic analysis. Results were analysed using the qualitative NUDIST thematic analysis program.

The research produced a wealth of qualitative data, providing a unique insight into the caring role and the impact of these disorders through the stories and descriptions related by carers and families.

Several papers were developed to present the research data. These papers included a series of background papers for each disorder that cover the impact on carers during various phases of the caring role – the detection and identification of the disorder, the experience of living with a person with the disorder, and the experience of accessing treatment and support. The background papers also include a literature review. These background papers form the basis for the development of other papers, including a research summary update and articles for journals and other publications.

The following papers from the research project have been published or are currently in press:

**Eating Disorders:**
- Background paper one: The Detection and Identification of Eating Disorders: ‘How did it get to this stage?’
- Background paper two: The Experience of Living with an Eating Disorder: The Carer’s Perspective
- Background paper three: Accessing Treatment and Support for a Person with an Eating Disorder and their Family.
- Literature Review
- Research Update: The Impact of Living with Eating Disorders – Carers’ Perspectives
- An article has been accepted for publication in The International Journal of Eating Disorders.

**Anxiety Disorders:**
- Background paper one: The Detection and Identification of Anxiety Disorders
- Background paper two: The Experience of Living with an Anxiety Disorder: The Carer’s Perspective
- Background paper three: Accessing Treatment and Support for a Person with an Anxiety Disorder and their Family.
- Literature Review
- Research Update: The Impact of Living with Anxiety Disorders – Carers’ Perspectives
- Articles are currently being developed for submission to professional journals.

**Depression:**
- Paper One: The Detection and Identification of Depression
- Paper Two: The Experience of Living with Depression: The Carer’s Perspective
- Paper Three: Accessing Treatment and Support for a Person with Depression and their Family.
- Literature Review
- Research Update: The Impact of Living with Depression – Carers’ Perspectives
- An article has been accepted for publication in the Medical Journal of Australia (in press).


The main findings established by the research were that carers and families of people with high prevalence disorders experience significant and comprehensive impacts. The research showed that people with these disorders often become highly dependent upon carers (spouses,
Anxiety disorders are the most common mental disorders affecting Australians. Estimates of the life-time prevalence of anxiety disorders range between 13% and 26%. This study focused specifically upon obsessive compulsive disorder, generalised anxiety disorder, social anxiety disorder and panic disorder. The onset of anxiety disorders is generally in late childhood or adolescence. The female to male ratio of the anxiety disorders is 2:1 for panic disorder and social anxiety disorder 2.5:1 in generalised anxiety disorder, and 1:1 in obsessive compulsive disorder (OCD).

Research Objectives
The research had four aims:
1. Explore the experience of living with a person with obsessive compulsive, generalised anxiety, social anxiety and panic disorder.
2. Understand the impact of this experience on primary carers and the family.
3. Identify factors contributing to the burden of care.
4. Highlight opportunities to improve the lives of those living with a family member with an anxiety disorder.

Methodology
Six focus groups (three groups each consisting of two sessions) and seven depth interviews were conducted with the primary carers of people with an anxiety disorder in both rural and metropolitan Victoria. The total number of participants was 24.

Research Findings
When analysing the results a number of consistent themes emerged from the data. As summarised in the following section, caring for a person with an anxiety disorder has a profound impact, not only on the person with the illness, but also upon the carer and family.

Barriers to identifying an anxiety disorder
Carers described behavioural, physical and/or psychological signs as early indicators of the presence of an anxiety disorder in a family member, yet mostly these signs were only recognised in hindsight a number of barriers prevented carers from noticing the development of the disorder at the time. These barriers included family members hiding their symptoms due to feelings of shame and fear, carers’ lack of awareness of anxiety disorder symptoms or misattributing the symptoms to a phase of adolescence, naughtiness, eccentricity or personality traits.

"Initially I thought she was different we didn’t know that a lot of things were classic signs of OCD."

Recognition of an anxiety disorder
There is a complex psychological response to the realisation that a family member has an anxiety disorder. Guilt, fear, sadness, grief, loss, shock and anger were common.

"I felt pretty terrible because I hadn’t recognised it."

"I was worried about his life mainly, and then mine. How would I cope during the time he needed me most?"
Family involvement in symptoms

In an attempt to alleviate the distress experienced by the person with the disorder, family members frequently actively engaged in, allowed and/or aided behaviours symptomatic of the disorder. As a result, carers reported that the symptoms of OCD become intrinsically intertwined into all aspects of living.

“You’re part of their illness. It’s your illness too, in a way.”

“With germs, I was afraid to sneeze. I’m not allowed to pick up the telephone without washing my hands, if I open doors, I have to use my foot. I have to climb over the fence to get into my own house.”

Accommodating and living with the symptoms of OCD impacts upon the quality of life of all family members. The symptoms control, dominate and infiltrate into most if not all areas of life.

“Abnormal becomes normal…. You adjust to the other person, mould yourself.”

“You’re on edge or there’s a volcano ready to erupt…there’s always this big uneasiness or tension.”

Carers of people with panic and/or generalised anxiety disorder feel constrained by the dependency of their family member. Their family member’s need for the carer to be in close proximity, to provide constant reassurance and undertake daily activities for them left many carers feeling trapped by their role.

“I can’t be with him 24 hours a day, and if something happened and I’m delayed, he will panic, he will massively panic over my delay. …It makes me feel a bit closed in.”

“I’m constantly running around to take her here and there.”

Impact on relationships

Caring for a person with an anxiety disorder was particularly demanding and placed considerable strain on spousal, family and social relationships. Over time, the impact of living with the symptoms became burdensome and hindered the progression of secure and balanced relationships. Furthermore intimacy and dynamics within the relationship were altered.

“I also have some grief in the sense that I missed out on a normal marriage. I’m more his mother than his wife. I’m the carer. There’s affection, but there’s no physical side to our marriage, it finished about three months after we got married.”

“It affects the whole family, because we’ve basically got to be on tenterhooks with him all the time.”

“I’m an extrovert I love people - and he was reluctant to go out with other people. He didn’t want to have other people in our home and to go out. And that became a burden.”

The financial impact

Living with a family member with an anxiety disorder impacted financially on the carer. Anxiety disorders sometimes debilitating the person to the extent that they are unable to work.

“I’ve been backing my daughter financially because she can’t work … and (I’ve been) paying whatever to get her by. She does budget but I have to help her get by on a very regular basis.”

Certain symptoms have a direct influence on family finances. For example in the case of OCD, throwing away of food or clothes due to fears of contamination. Over time, this disposal of “contaminated” items becomes costly, and thus has an impact upon the financial status of the family.

“And the waste of food, if he thinks it’s been touched and opened he won’t have it. Clothes I buy for him, sometimes they might just end up on the pile on the floor.”

Impact on psychological, emotional and physical

Carers became so intertwined with the disorder that their own needs and/or a life outside of their caring role became difficult for carers to consider and many described feeling trapped and defined by their role. Furthermore, carers were often overwhelmed by the all-encompassing unrelenting nature of the role and many experienced chronic stress, symptoms of depression and related physical complaints.

“Maybe this is my career or something.”

“The weight is on you and you do suffer from it (depression). You sort of wilt and get cranky. …the demands that are put on you, you do get that way.”

“On a physical level, how it affects you physically, how you feel, how your body feels, health wise and that … My body can actually feel it I don’t know, this weight comes all over me, I can actually feel it.”

Barriers to accessing treatment

Resistance from their family member, lack of information as to whom to approach for assistance, poor diagnostic skills amongst some health professionals and stigma were potential barriers to accessing treatment for a family member with an anxiety disorder.

“I was relieved when he had the diagnosis because at least we know what we’re dealing with. It’s unfortunate that it didn’t happen the year before - it would have saved a lot of suffering and heart ache.”

In the absence of intervention, carers assumed responsibility for their family member, leaving many feeling out of their depth, overwhelmed and unsupported.

“They leave the onus and the responsibility to us. And it’s a nightmare.”

Once services had been accessed, there were a number of factors which continued to hinder accessing effective, evidence-based intervention.

These barriers related to lack of inclusion of carers in the treatment process, the cost of treatment, ineffectual mental health professionals, proximity to services, and lack of services.

“Look I understand, I mean there’s confidentiality… I understand all that. But you know I think they need to take on board that you’re the one he’s seeing, with the information… and the person doesn’t describe things. A young man who is very proud doesn’t want to really describe all the issues”

“Psychiatrists should specialise like medical professionals do.”

Carers commonly considered effective treatment for their family as the most significant means of alleviating the strain they experienced in their role.
“What would make the difference is proper treatment. If they’d have had proper treatment back in the early days, the problems would alleviate themselves.”

The need for support

The overwhelming nature of the role of caring is compounded by the experience of accessing effective intervention for a family member. As a result, many carers were often feeling in need of support and understanding. In a number of cases this support was absent from usual support networks such as friends or family. Consequently, the majority of carers sought support through more formal channels such as via carer support groups.

“That I actually had a little bit of support there (at the support group)...was just wonderful, and to just be able to talk and say how I felt, and just get some reassurance and support. That was fantastic.”

Conclusions

Anxiety disorders have a profound impact upon the carer and family - from the early signs of development and the detection process through to the more severe debilitating stages of the disorder.

The nature of living with the disorder itself coupled with barriers to accessing treatment leaves carers feeling depleted, overwhelmed in their role and in desperate need of support.

The experiences and needs of carers and families appear largely unrecognised and/or ignored by health professionals, services and the wider community.

Recommendations

- Increase community awareness about anxiety disorders and the signs and symptoms associated with them.
- Increase community awareness and understanding about the significant impact anxiety disorders have not only the person who has the disorder, but also those who care for them.
- Recognise the needs of carers and provide support when they are dealing with the implications of an anxiety disorder and the profound impact the condition can have on the individual and family.
- Review health policy pertaining to anxiety disorders management practices and carers’ needs.
- Encourage health professionals to better understand and respond to carers’ needs and concerns, and to promote a more inclusive approach to treatment and management.
- Ensure that appropriate support services and networks for carers in metropolitan and rural areas are adequately funded, available and accessible.
- Educate and encourage health professionals to share information with carers about the disorder, its management, coping strategies, information about appropriate services, and eligibility for assistance including mutual support programs and financial entitlements.

For more information

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Mail: PO Box 6100, Hawthorn West, Vic 3122
beyondblue: the national depression initiative
www.beyondblue.org.au

For more information about anxiety disorders contact:
Anxiety Recovery Centre Victoria
aromaI@arcvic.com.au Ph 03 9886 9377
PO Box 358, Mt Waverley, VIC 3149

For more information about Carers Victoria contact:
cav@carersvic.org.au Ph. 03 9650 9966
Freecall: 1800 242 636 www.carersvic.org.au

To view the full papers go to the web-site of any of the participating organisations.

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The outcomes of this project would not have been possible without the many carers who contributed their stories and experiences to the project. On behalf of the researchers, Project Management Group, and the Anxiety Recovery Centre Victoria, I would like to extend my sincere appreciation to these carers for their honesty and generosity in sharing a wealth of experiences, memories and insights, which has allowed us to effectively portray the carer and family experience. Their stories will inspire the highest regard and respect for all carers who live with and care for people with anxiety disorders, and other mental disorders. We also hope they will inspire understanding and a commitment to support the carer’s need for care.

Kathryn I’Anson, Director, ARCVic

THANK YOU
Leading researchers discussed sleep disorders, anxiety and the role of GABA at the 2004 ADAA annual conference. Justine Kent, MD, a 2003 ADAA Junior Faculty Research Grant recipient, spoke about GABA and its effects on the brain. GABA, short for gamma-aminobutyric acid, is an amino acid that occurs naturally in the brain and acts as a neurotransmitter, a chemical that serves as a messenger in the brain. GABA helps neutralise the effects of glutamate, a brain chemical that causes excitement.

Dr Kent explained that an imbalance of GABA is thought to underlie pathological anxiety. Studies suggest that reductions in GABA can trigger the racing thoughts, anxiety, restlessness and insomnia that characterise many of the anxiety disorders (including panic disorder, generalised anxiety disorder and PTSD) and keep you up at night.

GABA seems to have an important role in sleep regulation and producing sleep from wake, Thomas Roth, Ph.D, Director for the Sleep Centre at Henry Ford Hospital, told the audience. If you wake a normal person up repeatedly during the night, they will fall back to sleep faster and faster with each disturbance. However, an insomniac cannot be woken up frequently; after the third time, they are up for good due to elevated levels of cortisol, a hormone released in the body during stressed or agitated states. Researchers are investigating how GABA affects cortisol with respect to sleep quality, not just sleep quantity.

Research into the relation of GABA, sleep disturbances and anxiety disorders is relatively new and may lead to new treatment for anxiety disorders. Philip T. Ninian, MD, Director of the Mood and anxiety Disorders program at Emory University, spoke about current treatments for anxiety disorders in conjunction with GABA and Tiagabine, a medication previously used to control seizures. SSRIs are widely used as the first line of treatment for anxiety disorders and benzodiazepines are also commonly prescribed for insomnia. While there are advantages to these pharmaceuticals, further research is needed to determine their efficacy and tolerability for these co-occurring disorders. Finally, a new generation of GABA-stimulating drugs in various stages of development appear promising for treating both conditions.

The following summaries come from the OCD Newsletter, OC Foundation. Reprinted with permission.

**Exposure and ritual prevention for OCD: effects of intensive versus twice-weekly sessions.**


Behaviour therapy by exposure and ritual prevention (ERP) is an effective treatment of OCD. Most treatment studies have used an intensive ERP schedule with daily sessions each week, a schedule that is often not possible in most clinical 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.

**Family approaches to treatment for obsessive compulsive disorder**


Drs. Steketee and Van Noppen review research on family aspects of OCD, focusing on issues that pertain to behavioural treatments for adults. There is evidence that family hostility, emotional over-involvement and criticism perceived by the patient can negatively affect behavioural treatment outcome. Family accommodation (assistig with or supporting rituals) predicted poorer family functioning and more severe OCD symptoms after behavioural treatment. Although not well researched, family education and supportive therapy are suggested to be useful for families and patients. Based on research findings, authors recommend psycheducational interventions for family members who are unfamiliar with OCD, who accommodate a patient’s symptoms and who tend to be critical and/or negative in their attitude. Therapists should use behavioural contracting in which family members agree on who does what with whom to limit rituals and family involvment. Therapists should discourage excessive behavioural and emotional involvement to ensure that patients take responsibility for therapy decisions. Family therapy may be needed to support relatives in dealing with frustrating patient behaviours and to encourage more positive family communication. Multifamily group therapy appears to be an efficient and cost-effective form for providing family behaviour therapy.
Mr. Worry A story about OCD
Niner, H., 2004. USA
Beautifully illustrated by Greg Swearingen, this hardback picturebook for children covers the topic of OCD in an honest, reassuring way. Kevin can’t get to sleep at night until he straightens his chair and the books on his desk. He checks for the light under his bed - a light he knows isn’t there. His mind gets ‘sweaty’ and he thinks he might be crazy. The boy sees a counsellor who works with him to manage his ‘Mr. Worry’. The support she gives him clarifies the situation and helps him to control his behaviour. For ages 5-10 years. ($32)

What To Do When You’re Scared & Worried
Crist, J., 2004. USA
This guide for children offers ‘Fear Chasers and Worry Erasers’ as well as other tools, including some written exercises, that kids can use to help get a handle on their fears. Part 2 focuses on the bigger worries - ones that are too hard to handle alone - like phobias, separation anxiety, generalized anxiety disorder, panic attacks, OCD and PTSD. Written by a child and family psychologist, the book handles these issues well and its snappy design will appeal to its young readers. Ages 10-15 years. ($22)

Writing to Heal: A guided journal for recovering from trauma and emotional upheaval
Pennebaker, J., 2004. USA
James Pennebaker is well-known for his book, ‘Opening Up: The Healing Power of Expressing Emotions’. His new book celebrates the benefits of emotional writing. A research psychologist, Pennebaker has studied the links between writing and health. He offers a series of writing techniques and exercises in a workbook style:
- Breaking mental blocks
- Appreciating the good in a sometimes bad world
- Constructing and editing your story
- Changing perspectives
- The power of fiction, poetry, dance and art. ($45)

Helping Your Child with OCD
A workbook for parents of children with obsessive-compulsive disorder
Fitzgibbons, L., & Pedrick, C., 2003. USA
This workbook offers helpful suggestions on a range of topics, including guidelines on how to interact with professionals working with your child, and worksheets to help keep track on what is going on. Aimed at parents of children aged 6-18 years, this book teaches treatment methods such as how to ‘boss back the OCD’, use positive self-talk, and develop a family plan. Both authors are cognitive-behavioural therapists. Cherry Pedrick is the co-author of ‘The OCD Workbook’ and ‘The Habit Control Workbook’.

Peaceful Mind:
Using mindfulness & cognitive behavioural psychology to overcome depression
McQuaid, J., & Carmona, P., 2004. USA
An important development in the psychological treatment of mood disorders has been the integration of mindfulness meditation and cognitive-behavioural psychology. By drawing on both these disciplines, people suffering from depression now have new tools for managing their mood problems. ‘Peaceful Mind’ describes in a clear manner how to practically apply these tools in daily life. ($32)

Books available from Open Leaves Bookshop, 79 Cardigan Street, Carlton, Vic., 3053.
Telephone 03 9347 2355
Fax 03 9347 1430
email openleaves@bigpond.com.
http://www.openleaves.com.au

Note – mail order is available – prices apply to Open Leaves Bookshop and may not reflect prices in other bookshops.
Reviews provided by Open Leaves Bookshop.
Dealing with Panic and Anxiety: A personal narrative.
by David Delaney, ARCVic

Anxiety amongst sufferers can be debilitating even when faced with activities of daily living. Going to the shops, paying bills or even going to the doctors can seem incredibly difficult. Relief only appears to come from avoidance and withdrawal from aspects of daily living. This often translates into depression, a common secondary effect of prolonged and untreated anxiety. The purpose of this story is not to provide ideas for how to treat anxiety or panic, but to possibly provide something more valuable. Hope!

Untreated anxiety can be manifested by symptoms such as phobias. Agoraphobia being one such common phobia. How can one walk into a shopping centre, filled with many potential threats, with any great confidence? Such occurrences that the rest of us take for granted. Clearly we have developed coping mechanisms that others haven’t.

Those that don’t have such coping mechanisms see most aspects of life as threatening. To an extent, I talk from personal experience. My Mum had developed agoraphobia over many years. This had a substantial effect on her relationships with family as she became increasingly reliant on us to provide support for her. Finally, after years of isolation, apart from family, Mum began exhibiting signs of Panic Attacks. Difficult to diagnose, as these often manifest themselves as physical symptoms such as shortness of breath and chest pains.

Diagnosis was the first of our problems, as it takes time to isolate the symptoms and appropriately diagnose. This came from exhaustive testing of all physiological signs to exclude other medical issues. Then a plan of attack needs to be put in place to not only deal with the current symptoms, but plan for the future. This can be difficult as the future is somewhat uncertain.

I found great allies in mental health professionals that helped me in the development and introduction of multi faceted methods to deal with Mum’s anxiety. This also takes a great deal of time as diagnosis of mental health issues can be somewhat difficult, leading to time taken to introduce appropriate therapy. Probably the key to my Mum’s success though, was my Mum’s real determination to improve the state of her life, and her courage here should be noted. Without it, she would never have allowed me to take her to shopping centres, sit in car parks, walk to the doors, come back to the car and repeat the exposure slowly increasing the intensity until Mum could see how far she had come. Coupled with some
relaxation exercises that Mum was taught, she slowly began to overcome her fears and the decreased anxiety lead to increased exposure to the world. Persistence and patience is the key, for both family and the person afflicted. Also, although I’m sure Mum would happily agree that she was not keen to gradually desensitize herself to her fears, trust in others such as family and those involved in her care provided some impetus toward management of her panic attacks.

I cannot appropriately write about 2 to 3 years of difficult times in such few words. Suffice to say, Mum is doing brilliantly now and recently told me how sometimes she is walking back from the shops and smiles to herself how good life is now. She asked why is that so? My answer was a lot of caring, persistence and courage got her through, as well as teamwork. Teamwork, planning and appropriate interventions; between Mum, family and the health care professionals. This comes from careful and considered diagnosis. Sometimes better days seem a long way off, but belief in the process, persistence and good support are so important to the outcome. Anxiety can have so many triggering events, but over-all seems to develop over a long period of time. Therefore, it seems logical that treatment is a long-term proposition. There is light at the end of the tunnel, although at times it seems as if that light is an oncoming train! It isn’t, and it is so important to set small goals. As I said, the purpose of this story is not to give a step by step approach of how to deal with anxiety or panic attacks, but just to say that no matter how long the process may take, there can be a happy ending. Just ask my Mum!

Growing beyond social anxiety

Never risking is never growing beyond fear or ridding myself of it. To confront a friend, dial a number, ask for a raise, change jobs or just...No...all of these can be acts of heroism, leaps into freedom. To do what others expect, so they’ll love me, is to play it safe. To throw imagination into the ring is an act of courage. But as I grow, I become more willing to venture out of my safe cocoon.

Pat Taylor.

Perfectionism and Pressure


I don’t have to be perfect. I won’t expect that of myself any longer. Nobody can be perfect, and besides, there is no “perfect” way of doing anything. I just do things and no longer try to do them perfectly. If I’m not doing something as good as I’d like, or I’m having problems because of anxiety, I will coolly and calmly accept it. By trying harder and pressuring myself more to do things in a precise and perfect way, I only make myself miserable, and I will actually hurt my
performance. I just do what I need to do, and realize there is no perfect way to do them, or no perfect way to feel. I accept it coolly and calmly if I have anxiety or if I don’t understand something. I don’t have to be perfect. I won’t expect that of myself any longer.

There is only pressure in a situation if I put it on myself. Nothing is that important. It’s all small stuff. If others disapprove -- who cares? There is no pressure because there is no exact right way to do things. I repeat, there is no exact right way to do things. There is no pressure because there is nothing I have to do in a given situation.

I can do whatever I want. I can always do whatever I want. Whatever the consequences, they won’t be that bad. There is no pressure because I can accept it if someone judges me to be nervous. There is no precise way to do things. I repeat, there is no exact right way to do things. Since there is not a precise way to do things, there is no pressure.

However, whenever I do something or however I act is OK. If I don’t do something a certain way, the consequences will always be something I can deal with. There is no pressure because I can do whatever I want. There is nothing I have to do. There is no exact right thing to do. There is no pressure because whatever I do, nothing bad is going to happen.

There is no pressure because other people’s opinions do not determine how I feel about myself or whether I am a worthy human being. If I want, I can just accept things peacefully and stare blankly into space and say nothing. There is no pressure because I don’t have to be perfect. I won’t expect that of myself any longer.

I am putting a great deal of pressure on myself by analysing every situation for the perfect way to do it. Remember, analysis = paralysis. When I feel pressured, I’m going to stop thinking and just do it. There is no universal perfect way of doing it, so whatever I do will be acceptable. If after doing something, I think I could have done a better job, I’m just going to say to myself, “Well, I learned something here, and this knowledge will help me do a better job next time. It’s OK. I don’t have to be perfect. I am satisfied with my efforts.”

My self esteem is not determined by how I perform at a certain task or whether others judge me as being intelligent, competent, fun to be around, or good-looking. There is no pressure because I can accept it if someone judges me to be nervous. If someone judges me as a failure in a certain regard, I will be able to accept it, because I don’t need their approval to sustain my self esteem. My opinion of whether or not my work is good is more important than theirs. My opinion about whether my attitude is good is more important than anyone else’s. My comfort with how I carry myself and what I do is more important than anyone else’s. And there is no pressure because as a human being I have the right not to have to justify what I do.

I can accept the fact that sometimes I am nervous and anxious. Just because I don’t feel perfect, and sometimes experience more anxiety feelings than other people, doesn’t mean that I am less valuable as a person or that I should feel ashamed. I have some tough feelings to deal with but I will keep using the techniques I am learning with cool, calm, confident, peaceful determination. I will do things for my own enjoyment and growth and not for other people.

Thus there is no pressure, because if other people look down on my performance, looks, or the way I conduct myself, I can still be happy because I am doing things for my own personal satisfaction, not for other people’s. I have the rights as a human being to say “I
don’t know,” “I’m not good at this task,” “no”, or “I don’t care”. I’m going to avoid using words like “should”, “must”, “can’t”, and “have to,” because they make situations very rigid and pressuring. I will avoid worrying thoughts like “what if ____?” I will do whatever makes me happy. The more I try to pressure myself into doing a perfect job, the more problems I cause for myself and paradoxically the more my performance suffers.

Pressuring thoughts are ANTs thoughts. Pressure is a lying ANT because no matter how I perform, things will be OK. I don’t have to be perfect. I won’t expect that of myself anymore. I won’t pressure myself anymore. I have nothing to prove to anyone else or to myself. Thus, I won’t pressure myself anymore. There is nothing I have to do. Anything I do is OK.

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.

Please send your contributions for consideration for inclusion in the newsletter to The Assistant Editor, ARCVic, PO Box 358, Mt Waverley, Vic, 3149, or email: arcmail@arcvic.com.au.
**Pen Pal Network**

<table>
<thead>
<tr>
<th>Janet 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</th>
<th>A 21 year old man would like contact with other young people living with social anxiety. (#930)</th>
<th>Stephanie is 10 years of age. She would like to write to a young person between 8-12 years of age who has OCD. (#931)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anna is 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. (#932)</td>
<td>Jessica is 19 years of age and she would like to write to other young people living with OCD. (#933)</td>
<td>William would like to have contact with people 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. (#934)</td>
</tr>
<tr>
<td>Joanna is 20 years of age and she is interested in corresponding with people living with body dysmorphic disorder and/or social anxiety. (#935)</td>
<td>Simmy would like to have contact with people who have social anxiety. (#936)</td>
<td>Hugh, 22 years of age, would like to write to people around his age group who suffer from OCD and/or depression. (#937)</td>
</tr>
<tr>
<td>Brett, 33 years of age, is 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> (#938)</td>
<td>Danielle is seeking to have contact (written, email or telephone), with other young adults aged in their early twenties who have generalised anxiety disorder. (#939)</td>
<td>A 16 year old young man would like to write to others living with OCD (#940)</td>
</tr>
</tbody>
</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.

Although the world is full of suffering, it is also full of the overcoming of it.

*Helen Keller (1880 – 1968)*
ARCVIC
SOCIAL GROUP CALENDAR
2004

SATURDAY 30th OCTOBER
Meet for Coffee
Join us for a tea, coffee, and a sweet or savoury bite to eat.
Location: Gloria Jean’s Coffee, 797 Burke Road Camberwell. Melway Map 45 Ref J 12
Time: 5.30 pm       Cost will vary depending on drink/food selection

SATURDAY 27th NOVEMBER
Movie Night
Venue and time to be confirmed.
Contact Jessica for further details.

SATURDAY 18th DECEMBER
Event to be Confirmed
You decide, lunch or dinner at your favourite eatery!
Contact us with your suggestions by ☎ 9886 9233; email arcmail@arcvic.com.au or post PO Box 358 Mount Waverley Vic 3149, before 30th November and event arrangements will be finalised in the first week of December.
Please make sure your name and contact details are clearly stated in your telephone message or correspondence so that we can get in touch with you.

*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 Peppercom Club – 584 Glenferrie Road, Hawthorn. Time: 7.30pm – first and third Thursday each month.

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.

Ballarat
Venue: 137 Albert Street, Ballarat. Time: 7.30 pm, first Wednesday each month.

Wodonga
Venue: Tradewind 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 Peppercom 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 22 89
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. Register now for the Managing Stress & Anxiety Program commencing in late October.

University of Melbourne
PSYCHOLOGY CLINIC
9th Floor, Charles Connilber Building, Royal Melbourne Hospital, Flemington Road, Parkville, 3050. Telephone: 03 8344 5572

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 and Anxiety Disorders Assistance)
PANIC & ANXIETY DISORDERS 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.
PaNDa is a Victorian, statewide, not-for-profit association which works for women and their families affected by antenatal and postnatal mood disorders. Formed in 1985 and restructured in 2000, PaNDa offers confidential support, education and information to callers.

PaNDa’s support network is run by dedicated staff and trained volunteers, some of whom have experienced PND or psychosis.

**PaNDa Offers:**
- Telephone support and information for sufferers and families, provided by staff and volunteers.
- Resources and referral information.
- Information on supports in your area.
- Information, education and training seminars for professionals and community groups.
- Literature on antenatal and postnatal depression and psychosis.
- Staff and volunteers as guest speakers.
- Community information displays.
- Regular newsletters to members.

**PaNDa Administration and Support Line:**
Phone: (03) 9428 4600
Fax: (03) 9428 2400, Email: panda@vicnet.net.au, Office hours are 9:30am - 4:30pm, Monday to Thursday.

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**What is GROW?**

GROW is weekly meetings of small groups of people who have experienced depression, anxiety or other mental or emotional distress who come together to help each other deal with the challenges of life. Many people come to GROW while struggling with the loss of a job, a loved one or a relationship.

*It can be extraordinarily liberating and affirming to share problems with others who are encouraging and accepting, and facing similar issues!* Over two million people in Australia experience a mental illness each year. Changing thinking and behaviour patterns while sharing thoughts and feelings with understanding people is considered a very effective way to treat mental and emotional distress. This is GROW’s approach based on 50 years experience.

A voluntary organisation, GROW began in Sydney in 1957. It now has groups throughout Australia and overseas. GROW is partially funded by each of the States and Territories.

GROW VIC: 29 Erasmus St, Surrey Hills, VIC 3127, ph. 03 9890 9846 or 1800 604 066, email: growvic@alphalink.com.au website: http://www.grow.net.au/
Recovery Programs and Workshops
Commencing soon

Anxiety Disorders Recovery Programs - Anxiety Recovery Centre Victoria

Managing Stress & Anxiety Program – Commencing Saturday 30th October, 2004

Further details see ‘Bulletin Board’, page 2 in this Newsletter, or phone the Recovery Program Coordinator on 03 9886 9233.

Keystone’s Anxiety and Depression Support Group for Women, Donvale
- Activities in October, November, & December include:
  - What is Bipolar Mood Disorder?,
  - Low cost entertainment and shopping ideas,
  - “Power games”,
  - Pampering Day,
  - Good foods for mind & body,
  - the Christmas Party.
These events alternate with Coffee and Chat mornings. Friday’s 10am to 12pm. Donvale Living and Learning Centre, Donvale. Please call group facilitators if you are interested in attending: Vivian Mason or Catherine Neil at Keystone, ph 8841 3014, Wed, Thurs, Fri.

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 well-being. 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.

Carers’ Pampering Day, Geelong
As part of Carers Week 2004, the Commonwealth Carer Respite Centre (Barwon South West) is holding a day of pampering. Activities include massage, reflexology, lunch, refreshments and mutual support in a caring and nurturing atmosphere. Geelong Conference Centre, 21st October, 10am – 3pm. Bookings essential. Call the Carer Respite Centre on 1800 059 059. Bookings are limited.

Carers’ Pamper & De-Stress Day, Shepparton
A day of fun and relaxation. Carers can enjoy a massage, manicure an other techniques for relaxing. You will also be treated to a 3 course luncheon and refreshments throughout the day. Sheparton RSL, 21st October 10am-4pm. Bookings essential. Call the Carer Respite Centre on 1800 059 059. Bookings are limited.

Carers’ Morning Tea - carers living in the Port Phillip, Stonnington, Glen Eira, Kingston and Bayside areas.
20th October at Florian Reception Centre. Bookings essential. Contact ph. 9276 6439 and leave your details.

Friendship with oneself is all-important, because without it one cannot be friends with anyone else in the world.

Eleanor Roosevelt (1884-1962)
**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.*

A series of seminars about depression and related topics have been arranged for 2004 -

**3rd November** – Recent Developments in the Treatments of Bipolar Disorder – Professor Michael Berk, University of Melbourne

**1st December** – Beyond the Tinsel of Christmas – Associate Professor Kate Moore, Deakin University

Entry is by gold coin donation. Prior registration is essential. Enquiries and registration: 03 9427 0406

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.

**Beyond diagnosis: Life as a carer - A conference for rural carers of people with a mental illness.**

October 30th, 2004. 9.15am to 4.00pm. Platinum Room, Foundry Arms Hotel, High Street, Golden Square, Bendigo.

Guest speakers include: John McGrath – Board Director of beyondblue: the national depression initiative and Chair of the Network of Carers of People with a Mental Illness. Prof. David Castles – mental Health Research Institute. Dr Liz Lewis – private psychiatrist, Bendigo.

A range of interactive workshops will include maintaining emotional well-being, keeping well, tai chi, journaling and naturopathy.

Cost $10 carers, $15 workers. Includes lunch, morning tea and resources.

To register or for more information contact Fiona Smart or Mark Mathews, St Luke’s, Bendigo, ph. 5448 1100. Tickets must be purchased by October 22nd.

**Rural Mental Health Carer Conference**

“*Strength in the Wilderness*”

A joint initiative of The Network of Carers of People with a Mental Illness, Sage Hill Carer Services Warrnambool & Carers’ Choice Grampians Region

Friday 12th November, 2004 (9:30am - 4:30pm)

Colonial Motor Inn, Grampians Road, Halls Gap

Key Presenters:

Dr Warrick Brewer (ORYGEN Youth Health) “Impact of Mental Illness on cognitive behaviour and research about Mental Illness and sense of smell”,

Dr Craig Hassed (GP & Senior Lecturer, Author of “Know Thyself”) “Coping with change and looking after yourself”,

Christine Culhane (Pharmacist at the Mental Health Research Institute) “Overview of new medications for the treatment of Mental Illness, and question time”.

Afternoon interactive sessions will include health checks, massages, relaxation, poetry and music workshops, as well as information sessions regarding Centrelink, Respite, Public Trustee, Guardianship Board, Employment and “The Kit”.

Registration fees: Single $30 (Concession $20), Double $50 (Concession $40).

Contact: Peter McMahon (Sage Hill) (03) 5561 5261 or Nola Kervarec (Carers’ Choice) (03) 5333 7104
ARCVic Publications 7 Order Form

- ‘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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Number of Copies ………….$@$10.00 each $…………………..

☐ OCD & Anxiety Disorders Information Package
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☐ ‘Speaking from Experience: Depression’
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