



Lifeline

anxiety disorder newsletter

A quarterly newsletter for people – and the families of people – who suffer from the panic brought about by fears, anxieties and phobias.

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Freud meets the amygdala...

Freud theorized that subconscious association of a harmless event, sight or sound with a previous trauma was the cause of renewed emotional reaction to the frightening event. In the case of post-traumatic stress disorder (PTSD), where everyday events which the victim can neither recognize nor identify trigger panic attacks, his theory appears to hold true.

Today, brain imaging is providing the means for researchers to study the processes involved in fearful and anxious reactions. Functional magnetic resonance imaging is being used to measure brain activity when seeing frightening pictures causes activity in the amygdala, the part of the brain processing emotion and fear. The brain proves to react to such negative images, even when they are so quickly shown that whether or not they were actually seen cannot be determined.

The use of neuro-imaging in studying the amygdala opens up the way to increased understanding of the causes of anxiety disorders – of finding out who is and who isn't susceptible to developing PTSD after experiencing trauma, of predicting who will and who won't be resistant to the various forms of therapy and, perhaps eventually, to even be able to diagnose a disorder. Researchers see it being put to use, in the near future, in evaluating progress during therapy and thereby determining, before more time and money is invested, whether it is beneficial to a particular individual or if something else should be tried.

Freud's investigations into the unconscious processing taking place in the brain were, of necessity, limited by the time it took for psychoanalysis to come up with useful information. Today, fast-tracking with neuro-imaging is set to uncover many more of the *whys* and *wherefores* of our fears and anxieties.

New uses for old medications

A drug approved for use as an antibiotic in the treatment of tuberculosis is proving to be helpful for people with social anxiety. The drug, D-cycloserine, has already proven to be effective for people in therapy for fear of heights. Harvard University's Massachusetts General Hospital, Boston University and Southern Methodist University have been conducting trials of the drug on volunteers with social phobia, randomly giving them D-cycloserine or a placebo once a week for five weeks in sessions in which the participants address, and get feedback from, a small audience. A month after the last session, the D-cycloserine group were reporting less social anxiety in day-to-day life compared to the placebo group and had healthier scores on three diagnostic tests. The study's leaders feel that the drug could be effectively in therapy for a wide range of anxiety disorders, including post-traumatic stress disorder and obsessive compulsive disorder.

Volunteers with PTSD taking part in a study of the use of the beta blocker, propranolol, for blocking out traumatic flashbacks at McGill University, found their symptoms to be less severe. The theory is that the intense memories in PTSD do not fade normally because of the abnormal amount of stress hormones released during the event so that when these stress hormones are released in the brain, blocking them results in the memories and associated emotions becoming less frightening.

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The current issue is always available for viewing or download from our website at: <http://www.designandcopy.ca/lifeline>.

Group therapy can some great advantages over going it alone

While we tend to perceive therapy as a one-on-one experience, in many circumstances group therapy can have greater benefit, opportunity to better understand the condition – access to a built-in support network and having the experience of being in a ‘safe’ social environment being just part of it.

For people who really feel that they are alone in having their condition and that nobody can possibly be going through what they are experiencing, therapy in a group setting is enlightening will help them to feel less isolated. They will quickly see that their personal condition, problems, situation, etc. are far more common than they ever thought possible and this will prove to be a huge step on the road to taking control of them.

In many cases the anxiety disorder prevents interaction with other people. A group therapy setting, then, is ideal when there is a need to recover or to develop social skills from scratch. While it may be difficult to take the first steps, the opportunity to learn to deal with feelings of fear and anxiety in a safe environment where being fearful is acceptable is one which will bring rewards for the effort made in taking those steps. Remember, most people usually *are* nervous before the first meeting – and that goes for first meetings beyond those of people dealing with anxiety disorders to those in everyday life – but their anxiety levels are generally way down by the end of the meeting. The group setting allows participants to practise assertiveness and manage fear, anxiety and panic, in the company of others, with the guidance of a trained therapist.

Group therapy falls, primarily, into two types, with the selection depending upon individual requirements.

Educational groups are used to teach participants relaxation methods, breathing exercises and cognitive skills all of which help reduce anxiety. They are generally short-term programs, usually four or six weeks long, after which individual sessions may be needed to help deal with particular problems or participants may move on to the second type of group.

The longer term process-oriented type of group therapy program involves participants getting to know each other in terms of providing support for

each other in overcoming their anxiety. Such a group can be of immense help to the individual participant, not only in coming to realize that other people are fearful and anxious, too, but in finding a supportive and empathetic environment where he/she can work towards the achievement of objectives in discussion with others, the trained therapist keeping such discussion relevant.

Combinations of the two group types provide for the inclusion of a teaching element then, as the participants master skills and come to know each other during the process, they discuss their situations and provide encouragement for each other in combatting anxiety triggering events. Cognitive-behavioural therapy groups work along these lines, helping participants to understand their thought processes and find ways to change or replace their negative thinking, and then to work at exposing themselves to their fear/panic/anxiety with that new cognition in place.

Group cognitive-behavioural therapy (CBT) is particularly effective for children with diagnosed anxiety disorders, both with and without the involvement of their parents, although, according to studies, those with very high social anxiety respond better to individual therapy at the outset and many move onto to a group format later.

When it comes to adults, group therapy tends to work better for women than for men; mainly because women are more used to sharing emotions. For men, this is much harder – especially for those in older generations who were brought up to be ‘men’, hiding fear, grief, insecurity, etc. Because they resist going, men are usually greatly outnumbered by women in the group setting which results in their finding it difficult to participate and tend to drop out. Male only groups may solve the problem for some, but for many, individual therapy is advisable as a first step to becoming more open to discussing their feelings before moving on to a group setting.

For many people, group therapy may prove to be the only way to recovery and, scary as it may appear when first presented, that possibility makes it worth the huge effort, not to mention finding the courage, needed to undertake this very successful method of treatment for anxiety disorders.

From one reader to another...

Volunteering

It's the last place you would expect to find me. But, Ruth was sure that I would enjoy serving at a soup kitchen with her. Talk about an uphill battle! Every element bothered me: the crowd of people waiting in line, the size of the big room in the parish center, and the many hours involved in cooking, serving, and cleaning up. But Ruth's enthusiasm kept me listening.

She countered all my objections with possible solutions. Each volunteer decided how much time and effort to contribute. I could leave whenever I wanted to leave – the 'gold standard' for someone with panic disorder. I talked about being in crowded spaces. She explained that the kitchen is a separate room. I could stand behind an opening where trays are passed to the guests. Of course, I would still be part of a 'crew' of twelve volunteers. Ruth gave me the phone number of her crew leader, Charlotte.

After Ruth left, I had a lively debate with myself. There was a lot of negative talk; some of it got ugly. Was I kidding myself? With all the obstacles, could I possibly be comfortable and calm? Somehow my wiser self whispered encouragement. I had nothing to lose by trying. Ruth had shown her belief in me. Now it was my turn. I phoned the crew leader. Charlotte had never heard of panic disorder, but she was very welcoming. She suggested that I could arrive just before serving time, and she agreed that I could leave any time. For security, she would walk me to my car. I couldn't ask for better support.

It was terribly hot the day of the dinner. I knew we would be serving freshly made meatloaf from several ovens. Feeling warm is a sign that my anxiety is increasing so I don't like to be in overheated rooms. I did what I could by wearing the coolest clothing possible.

As I entered the parish center, I glanced down the hallway. I could see there were lots of people waiting. I didn't want to focus on the actual number. When I entered the warm, but not unbearably hot kitchen, I was greeted by Charlotte, who introduced me to the friendly crew. Ruth couldn't be by my side because she would be in the big room pouring coffee.

After Charlotte and I had discussed the job she would give me, I took my place at the kitchen window where I would have to ask each person whether he wanted fruit or dessert. No food is wasted. I had trouble believing that I was actually there, moments away from the incoming tide of people.



We began to serve. As each person approached, I asked, "Sir, do you want a cup of peaches? Chocolate cake or apple pie?" The pace was incredible. Between 5:30 and 6:10 pm, we served seventy-five guests, then those who wanted seconds. Maybe you've seen the Lucille Ball episode where she is working at a candy factory and trying to keep up with the candies coming down the conveyor belt. It was kind of like that. I had to stand in one place, yet be in constant motion, placing plates on the trays and handing them out.

I never considered leaving during this hectic experience. I had to concentrate on what I was doing. I had wondered how I would manage facing a crowd. What I discovered is that I saw only one person at a time. This coping strategy came naturally to me as I did the job. I looked at each person as an individual. Although I was vaguely aware of the many table of six or eight diners, I gave them little attention.

I made it through. It would have been nice to stay and eat with the crew, but I was content to leave before the other volunteers. As we walked to my car, Charlotte thanked me for my help in the evening's work. It made me feel happy to be needed. She asked how it went for me. I told her I was exhausted, but that it went well. I would be back. I was grateful that other steps in my recovery from panic disorder had brought me to this place.

Colette Carner.

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When it's time to go to school...

A child or adolescent with at least three of the following symptoms has a level of separation anxiety disorder meeting *Diagnostic and Statistical Manual of Mental Disorders* (DSM) criteria for a diagnosable disorder:

- recurrent excessive distress when separation occurs, or is anticipated, from home, from someone or from something to which the child is attached.
- nightmares.
- school avoidance.
- complaints of physical ailments, e.g. nausea and stomachaches.
- problem continues for at least a month.
- problem causes significant distress and/or impairment.
- is not a problem that is part of another serious mental illness.
- problem appears suddenly or during/after a stressful event.

This fear of separation not only causes the child to refuse to go to school but, also, to miss simple childhood pleasures like staying over at friends' houses and going on school trips. Just making friends, in fact. Then, in the long term, the disorder will become more serious. Without treatment, the child will have academic problems and difficulty in making friends. He/she may go on to develop other anxiety disorders, agoraphobia and clinical depression as an adult, restricting both career and social aspirations.

Treatment is imperative and exactly what kind depends upon the child's condition. Often the kind of separation disorder which shows up when a child starts school can be treated simply through the support and encouragement of parents and teachers. In most cases today, parents are aware of the problem by the time a child enters kindergarten and have the advantage over previous generations when it was often the first time he/she experienced being in unfamiliar surroundings with strangers. Consequently, with help from the school, the child can probably be introduced to school and to the classroom prior to the first day, with additional assistance being provided on that day. This approach also applies to school phobia, or school

After the baby is born...

Postpartum depression is not one, but six mood disorders. It is really being used as an umbrella term, covering baby blues – which is hormonal and experienced, for a short time, by most new mothers, postpartum depression, anxiety disorder, obsessive-compulsive disorder, post-traumatic stress disorder and the very serious postpartum psychosis.

As many as half of new mothers with postpartum depression actually have postpartum anxiety disorder, usually panic disorder. They feel nervous and completely overwhelmed and experience panic attacks without actually realizing what is causing the racing heart and perspiring.

Postpartum obsessive-compulsive involves continually obsessing about things – cleanliness, for example, which manifests itself in the new mother compulsively washing her hands all the time and changing the baby's sheets several times a day – or in repetitive thoughts about keeping the baby safe from germs or accidents, etc., which can develop into being afraid to take the baby out.

The act of childbirth itself can result in post traumatic stress disorder with the new mother constantly reliving the experience. Long term, this can lead to fear of pregnancy, fear of sexual intercourse and all the problems which these particular fears can go on to cause

Other than baby blues which most healthy new mothers weather and quickly put behind them, all these conditions should be recognized and dealt with before they become serious. While postpartum psychosis is rare, it can develop from untreated postpartum depression. There is no need to feel guilty about it; the doctor knows that nobody is at fault. It is just something that happens and can be effectively treated.

refusal, when it first becomes apparent. Watch for anxiety which will, literally, make the child sick and pleas to stay home due to headaches and stomachaches – all problems which recede when the child is allowed to do so. If support and encouragement show no results and/or there is continuing difficulty, however, psychotherapy, cognitive behavioural therapy being the most effective form of treatment, will be needed and shouldn't be delayed.