



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.

VOLUME SIXTEEN, NUMBER FOUR

WINTER 2009-2010

ISSN 1499-6375 (Print)

ISSN 1499-6383 (On-line)

High blood lead levels associated with higher risk of panic disorder

Blood lead levels prove to be associated with a higher than average likelihood of having major depression and panic disorder, a University of Montreal and Harvard School of Public Health published study reports. Researchers examined 1,987 adults, in their twenties and thirties, who responded to the National Health and Nutrition Examination Survey (1999-2004) and subjected the participants to structured, diagnostic interviews to determine mental health diagnoses.

The results were determined after adjusting for such variables as education, poverty levels, smoking, gender and race. Participants with the highest blood lead levels were 4.9 times more likely than average to have panic disorder than participants with the lowest levels and 2.3 times more likely to have major depression.

The findings indicate that lead contributes to this risk of mental health problems at levels that are, currently, considered to be perfectly safe. While lead is known to be toxic to the nervous system, most research done in the past has involved either children, or adults exposed to high levels of the toxic metal in the workplace. This new study demonstrates the affect on the entire population and, taken in combination with the recent reports of behaviour problems in children with comparable low blood lead levels, the need to find ways to significantly reduce environmental exposure to lead becomes imperative.

Overweight adults have higher rates of psychiatric disorders

Overweight adults have higher rates of psychiatric disorders. A national health survey of over 40,000 Americans shows obese adults being as much as twice as likely to suffer from depression, anxiety and other mental health conditions compared to normal-weight adults. Even moderately overweight people prove to have higher rates of anxiety disorders. While the reasons for this cannot be substantiated, it is entirely possible that the links between weight and certain psychiatric disorders involve dealing with stress by overeating which becomes what the researchers term a *conditioned reinforcer* which can lead to even minor stress leading to overeating although biological or genetic factors also probably play a part.

Framework for mental health strategy

The Mental Health Commission of Canada has announced the framework for Canada's national strategy to address the mental health needs.

Entitled *Toward Recovery and WellBeing*, the document has evolved from the input of thousands of people across the country on opportunity for everyone to achieve and maintain the best possible mental health and wellbeing.

"This is a key step in developing a mental health system that puts people living with mental illness at its centre and has a clear focus on their ability to recover," says Michael Kirby, Chair of the Mental Health Commission of Canada. "It also promotes the mental health and wellbeing of everyone living in Canada."

The framework's seven goals will provide direction in creating a transformed mental health system where:

1. People of all ages living with mental health problems and illnesses are actively engaged and supported in their journey of recovery and wellbeing.
2. Mental health is promoted, and mental health problems and illnesses are prevented wherever possible.
3. The mental health system responds to the diverse needs of all people living in Canada.
4. The role of families in promoting wellbeing and providing care is recognized, and their needs are supported.
5. People have equitable and timely access to appropriate and effective programs, treatments, services and supports that are seamlessly integrated around their needs.
6. Actions are informed by the best evidence based on multiple sources of knowledge, outcomes are measured, and research is advanced.
7. People living with mental health problems and illnesses are fully included as valued members of society.

The Commission will work with different people and groups across the country, during the next two years, to develop the framework into a finalised mental health strategy.

The material included in this newsletter is for general information and discussion purposes only and in no way replaces clinically recommended treatment. Subscriptions are free, but a \$5.00 fee is required to cover the postage and handling costs of 4 quarterly issues per year.

The LIFELINE Anxiety Disorder Newsletter may be contacted, by mail, at 431 Victoria Street, Shelburne, Ontario L0N 1S4 Canada or, by email at lifeline@designandcopy.ca

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

Diagnoses of anxiety disorders may depend on the doctor's perceptions as much as on the symptoms. There has to be a better way.

Studies have shown that general practitioners tend to supplement DSM criteria for the various mental health disorders with their own preconceptions and judgment. This, naturally influences their perception, recall and diagnosis of the patient's condition.

For instance, a preconception that severe depression leads to feelings of worthlessness may result in the doctor unconsciously looking for signs to confirm that this is, indeed, the case. Suspicion that a patient has suicidal thoughts may lead to recall of this being the case despite it never actually having been discussed.

This places the onus on the patient to be thoroughly explicit when describing his/her symptoms since missed or mistaken diagnoses can only lead to greater problems. Correct diagnosis calls for clear communication on both sides. General practitioners do not, as a rule, have the experience in diagnosing mental illnesses that psychiatrists and other specialists do. But they *are* the first port of call in getting treatment and you, the patient, must ensure that you are both on the same wavelength. Don't presume. Ensure that he/she has the all the details. If you suspect a bias, you'll need another opinion. This is not always possible so try to get it right the first time. It shouldn't be this way, but be aware that it often is the case.

Anxiety disorders are prevalent in general practice but the rate of recognition is low due to combinations of poor communication between doctor and patient, the general practitioner's limited knowledge, and possible bias, in regard to psychiatric disorders. Add to this, other factors such as the patient's inability to discuss the problem, due to fear of stigma, the competing demands on the doctor's time and limited referral possibilities. It becomes obvious, then, that there is a need for a chronic care system for anxiety disorders in general practice, such as those used in diabetes care and other chronic diseases.

Unfortunately in many, or even, in most cases at present, treatment in primary care consists of benzodiazepines and/or antidepressants. While effective, such drug therapy often results in discontinuation due to side effects, relapse when treatment ends, or addiction if it doesn't. The more effective cognitive-behavioural therapy (CBT) is difficult for primary care physicians to deliver due to both therapist training time and the time involved in its provision. Under collaborative management, it could become accessible.

In a collaborative approach, a care manager coordinates treatment, monitoring treatment response and actively following the patient's progress. This care manager works in close collaboration with the general practitioner and they are both assisted by a specialist. In terms of mental health disorders, either a mental health nurse or a psychologist

with training as a CBT facilitator, would act as care manager and a psychiatrist as the consultant specialist.

In this way, stepped care can be put in place. Stepped care is provided in three steps – guided self-help based on cognitive behavioural principles; CBT; antidepressant medication. Bibliotherapy becomes the first line treatment and medication is used as a last resort. The doctor no longer has to resort to drug therapy in the first instance, the specialist's expertise reaches more patients and, even the time spent on CBT is reduced by the education involved in the guided self-help or bibliotherapy before it commences.

The care manager coordinates treatment, provides the guided self-help and the CBT, and evaluates each step. The doctor prescribes medication and evaluates all progress with the care manager. Both the care manager and the doctor consult the psychiatrist about treatment decisions. Patient involvement is enhanced through monitoring by the care manager and relapse is prevented by monthly follow-up calls.

A three year study of a collaborative stepped care treatment program for patients with either panic disorder or general anxiety disorder is currently being undertaken in the Netherlands. Studies done in recent years in the United States demonstrate that collaborative care is more effective than traditional care but show no consensus on the costs involved. The addition of guided self-help in the program being undertaken in the Netherlands study is expected to reduce overall cost by eliminating the need for both steps two and three in some cases and reducing the cost of step two and eliminating step three in others.

Is laughter the antidote to anxiety?

Dr Vela Menon of the Faculty of Internal Medicine, International Medical University, Malaysia thinks it is.

Her theory is that when you laugh you cannot feel fear because your subconscious mind gets the message that there is no danger. A few minutes of practice regularly for 21 days will condition you to easy laughter. Then, whenever you feel anxiety, instead of subconsciously reinforcing it with the wrong message to your subconscious, imagine every part of your body laughing at itself for reacting to a false fight or flight response.

Keep doing this and your anxiety will eventually weaken to the point where you will have gained control over how your body reacts and never be in danger of a panic attack again. This flushing yourself with laughter technique can also be used to dispel inappropriate feelings of despair, guilt, and sadness.

Be happy.

From one reader to another...

Physician, Heal Thyself

I often do things that frighten me. It's part of my recovery from panic disorder. But this challenge was different because it was in the "scared witless" category. I was asked to speak at a school of medicine to explain anxiety disorder to the residents. Men and women who had completed four years of medical school, they were now practising medicine and treating patients under the guidance of a more experienced doctor. It was an opportunity to teach these young physicians how to recognize and assist people with various types of anxiety disorders. It was also a chance for me to really mess up.

Because anxiety disorder is so often misunderstood, it was important for me to speak. Each of the residents would see patients in the years ahead who would need a special type of medical cue. Maybe I could have a small impact on those future visits, those appointments where a person with a racing heart and clammy hands hoped for some relief, a little understanding. And the benefits weren't all in the distant future because these doctors could refer people to my anxiety support group now. We were meeting twice monthly in the same building where the residents were getting their training.

On the day of my speech I expected a good turnout because lunch was being provided for the residents. I had been invited to join them since I was speaking from 12:30-1:30 P.M. Of course I had quickly declined that free meal. People were still eating when I entered the room. The spatial arrangement was not phobic-friendly. I was expected to stand inside a "box" made by long tables in front of me, to my right, and to my left. Behind me was a blank wall. There was no podium, just an uninviting plastic chair. A few of the chairs at the tables were empty, but most were filled with twenty-something-year-olds looking intently at me. A few smiled, very few. I did not get a friendly greeting from these medical professionals. My subject was serious but I could have used a more encouraging atmosphere.

I launched right into my history of panic disorder by describing my first panic attack at age 24. My voice was quivering, but I remembered to speak up so they could hear me. My legs started to tremble. My face felt fire red. As I spoke about being housebound, my whole body began to shake. There was no way to hide my symptoms of anxiety even if I wanted to, in fact I raised my arms into the air so they could clearly see them moving. But I was in trouble, and I knew I could be losing this chance. I was literally losing my balance so I reached backward for the chair. I half grabbed and half fell into it.

Even though I had to sit down, I kept on talking. I explained that for many years I never left the house without



a panic attack. I told them that I didn't know if people had "half-blown" panic attacks, but I always had "full-blown" attacks. They found this remark funny. They smiled. I smiled. Until that moment, my anxiety had continued to increase; then it started to decrease. When I described my most recent panic attack, during a dental procedure, I was able to stand up and act out the incident. This time I waved by arms on purpose to illustrate how the dentist gestured while loudly telling me to relax. Everyone laughed. One doctor said. "That made it worse."

I didn't feel relieved for long. I had planned to spend the last thirty minutes answering questions. The first question hit me like a splash of cold water. A doctor described testing a male patient, ruling out various physical problems, and arriving at a diagnosis of panic disorder. The patient refused to admit that he was anxious and insisted on more tests. The doctor asked me, "How do I get him to accept having panic disorder?"

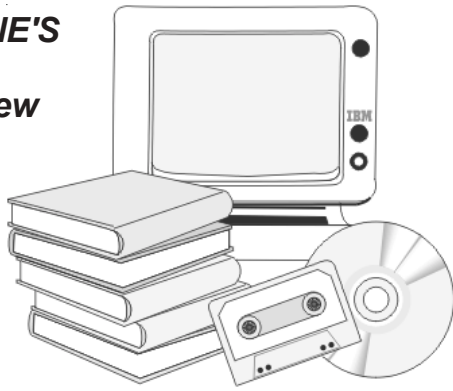
The questions that followed were just as challenging: What if my patient wakes up in the morning with a panic attack? Did an incident in your childhood cause your agoraphobia? Can my patient recover with no support from her family? I had knowledge from my experience and from what I had learned from others, but, naturally, I wasn't equipped to answer all of the questions. I did the best I could.

As I left the room, I felt kind of numb. I was not upset about showing so much anxiety during my speech because they had gotten a good demonstration of what to look for in their patients. I was proud of myself for not leaving in a rush when I was panicking. My reward would come when a person newly diagnosed with panic disorder joined my support group.

Colette Carner.

Colette may be contacted by writing to her c/o Lifeline, 431 Victoria Street, Shelburne, Ontario L0N 1S4 or lifeline@designandcopy.ca

LIFELINE'S Media Review



Here's the Deal: Don't Touch Me by Howie Mandel.
Bantam. November 24, 2009.

Since beginning as a stand-up comedian at Toronto's Yuk Yuk's in 1978, Howie's career has included *Comedy Store* sets, 20 appearances on *The Tonight Show*, six years on the Emmy Award-winning drama, *St. Elsewhere*, talk show host and, currently, game show host. All despite serious obsessive compulsive disorder (OCD) as well as attention deficit hyperactivity disorder (ADHD). Now, at the peak of his career with *Deal Or No Deal*, Howie Mandel finds himself well-positioned to help shed the stigma attached to mental health disorders.

After the miserable season during his daytime talk show *The Howie Mandel Show* when he soaked his hands in a bucket of Purell under his desk after shaking hands with his guests, the fist bump became his trademark greeting on *Deal Or No Deal*. This, along with brand new makeup sponges every day, literally laundered money, avoiding hand rails helps Howie to manage his OCD.

He has recorded a public service announcement for anxiety disorders, testified on Capitol Hill, discussed OCD with fellow sufferer Howard Stern and talked about ADHD on *Regis and Kelly*. With the launch of the book and a concurrent ABC's 20/20 feature on his everyday life Howie Mandel is bringing high profile to the need to eliminate stigma.

Chameleon by Jordan Taylor Brown. Power of One.
September 18, 2009.

A novel about a thirteen-year-old girl living with social anxiety disorder written by fifteen-year-old Jordan Taylor Brown of Lakeland, Florida. Jordan has social anxiety disorder and wanted to help people understand this irrational fear of interacting with people. Using the voice of Chemille, the novel's protagonist, Jordan vividly describes the panic attacks and distress she experiences - erratically beating heart, swollen tongue, limp limbs and constant extreme stress. "As far as how she (Chemille) feels about certain things, or how she would react or the thought process, that's pretty much me," Jordan says. This is a book which all teenagers should read because it is they who can best help a contemporary with social phobia.

Mixed up amygdala connections may be the cause of General Anxiety Disorder

Stanford University of Medicine researchers studied the neural pathways going to and from subsections of the amygdala - the brain's emotion, memory and fear processing centre - to find the causes of general anxiety disorder (GAD).

Using functional magnetic resonance imaging (MRI) they scanned the brains of recruits with GAD, and participants who did not have the disorder, to measure changes in activity in different regions of the brain. Participants were instructed to just let their minds wander for eight minutes in the MRI scanner providing the researchers with enough material to determine which areas were connected.

In the non-GAD participants, they found the basolateral amygdala subregion to be linked primarily to regions associated with memory, emotional and cognitive functions and visual and auditory processing. The centromedial amygdala, at the top of the amygdala, was more connected with subcortical areas of the brain - the thalamus, which controls information flow throughout the brain and assists in regulating alertness, the brain stem, which regulates heart rate, breathing and release of neurotransmitters and the cerebellum, which controls motor coordination.

In the amygdalas of the participants with GAD, the basolateral amygdala proved to have more connections with centromedial area and the centromedial subregion with the basolateral targets. There was less connectivity in both amygdala regions to the region of the brain responsible for determining the importance of stimuli. The amygdala was also more connected to a cortical network providing cognitive control over emotion.

The researchers suggest that these differences would cause people with GAD to have difficulty in distinguishing between authentically worrying situations and mild annoyances. The obsessive worry would be explained by the cognitive control connection in that, because the disorder results in being overwhelmed by emotion and the belief that this will cause complete breakdown, distraction or avoidance is achieved by worrying.

Internet addiction in children

Depression, ADHD and social phobia were strong predictors of the development of an internet addiction in children. Depression and social phobia seem to be stronger predictors among girls and ADHD in boys. Researchers at Kaohsiung Medical University Hospital in Taiwan tracked the medical histories and internet use of 2,300 11-year-olds over two years and found that 11 percent developed an internet addiction. The Taiwan psychologists want to make parents aware of the risks children with the mental health disorders have in compounding their problem with addiction to the internet.