AnxietyNZ TRUST

ANXIETY DISORDERS INFO

Contents

Anxiety Disorders

Everyone knows what it's like to feel anxious – the butterflies in your stomach before a first date, the tension you feel when the boss is angry, and the way your heart pounds when you're in danger. Anxiety rouses you to action. It gears you up to face a threatening situation. It makes you study harder for that exam, and keeps you on your toes when you're making a speech. In general it helps you cope.

But if you have an anxiety disorder, this normally helpful emotion can do just the opposite – it can keep you from coping and can disrupt your daily life. Anxiety disorders are not just a case of 'nerves'. They are disabilities, often related to the biological make-up and life experiences of the individual. We now find they run in families, just like diabetes, asthma and other illnesses.

There are several types of anxiety disorders, each with its own distinct features. Those who suffer from anxiety disorders may feel anxious most of the time, without any apparent reason. The anxious feelings may be so uncomfortable that, to avoid them, they may stop some everyday activities. Others may have occasional bouts of anxiety so intense they become terrified and immobilized.

Anxiety disorders are the most common of all mental health difficulties. Many people misunderstand these disorders and think individuals should be able to overcome the symptoms by sheer willpower. Wishing the symptoms away does not work – but there are treatments that can help.

Agoraphobia

Is a condition where panic or anxiety attacks are followed by an avoidance of places where the panic attacks have occurred, or *could* occur.

What is agoraphobia?

What a strange name isn't it? Agora comes from the Greek word that means the market place and 'Phobos' was a terrifying Greek god. Thousands of years ago, to scare the enemy, banners depicting 'Phobos' (or the god of fear) were held up in time of war. Fear - or phobia was believed to be one of the worst punishments to be afflicted with. Some of the first documented cases of agoraphobia were about men who were too frightened to cross the market place. Today there are many more situations to be afraid of if one has agoraphobia. Agoraphobia (often thought to be a fear of open spaces) is also a fear of being closed in, or away from a safe place or person who makes you feel safe, 'if' the dreaded panic or phobic attack happens.

Although agoraphobia was common in the past, there were no lifts, motorways, aeroplanes, nor harbour bridges to be worried about. Modern living and technology created more situations where people who suffer from 'phobic fear' experience a feeling of terror at being 'locked in, or of not being able to escape quickly.

In early history few people could read or write and only a privileged few went to school. So there is little documentation of anxiety/panic attacks as a result of agoraphobia. During times of war there were cases of men suffering from a condition called "horseman's heart". It is thought now that these 'heart' attacks could be men suffering from panic attacks because they went away from their homes for a very long time.

Women often suffered with fainting attacks commonly called the 'vapours'. Perhaps these were in fact 'panic attacks' resulting out of the phobic fears they had about being closed in or away from the person they felt safe with. More recently the late Howard Hughes, well-known and respected aviator and millionaire industrialist bought himself a hotel and lived out his life in seclusion. According to historians he suffered from 'anxiety panic attacks' and a phobia of germs. Today he could have been helped with his problem.

Agoraphobia is an extremely common form of 'phobic fears'. In fact it is the single most common anxiety disorder. (The name used to describe all these disorders which have anxiety or fear as their main feature). It can start in childhood; it is extremely disabling and frightening. However on its own, it is the most easily helped.

If you suffer from Agoraphobia, there will be many places you will want to avoid because you are scared of 'phobic fears'. These thoughts and feelings are called avoidance. The avoidance occurs because you are afraid that you will feel the 'panic/anxiety attacks' when you are in a place, or situation, from which you cannot escape quickly, **or** when you have experienced 'panicky' feelings before in a similar situation.

You may feel terrified of having a panic/anxiety attack and try to avoid places and experiences such as:

- Going to school
- Being at school
- Going for holidays
- Meeting with friends
- Going out the door
- Thunder and lightning
- Going over bridges or into lifts,
- Going into classrooms or theatres
- When at school going out on the playing field
- Sports where you will be away from the school building
- The dentist, or hairdresser or any place where you feel restrained
- Being in bed on your own
- Having the light off
- The dark
- Walking to school
- Going on a bus
- Going in a car
- Going out in a yacht

If you live in the country… you may have different fears such as:

- Going to school on a bus.
- Waking in the night and thinking you are on your own.
- Having to stay in bed on your own whilst mum and dad milk the cows.
- Walking to a cowshed or paddock
- Doing any farm chores which take you away from home
- Thunder and lightening
- Noises

For more information visit www.anxiety.org.nz or call 0800 ANXIETY (0800 269 4389)

Alcohol & Drugs

When are they a problem?

The use of alcohol and other drugs is not uncommon among young people in New Zealand. Studies show that between 70-90% of young people have used at least one of these by the time they are 9.

Most will experiment and stop, or continue to use casually without significant problems. Some will use regularly, with heavy use leading to varying degrees of physical, emotional and social problems. Others develop a dependency that will be destructive to themselves and others for many years. Some will die or cause others to die.

It can be difficult however to determine when a person's usage will develop into a serious problem, therefore all use should be considered potentially dangerous.

Who is most at risk?

Some young people are more "at risk" than others and are more likely to develop alcohol and other drug-related problems. Highest on the list are those teenagers with a family history of substance abuse problems. Sometimes Social Phobia leads into alcoholism and substance abuse.

Those who begin to smoke or drink in their early teens are also at particularly high risk. There is some evidence that these substances are the "gateway drugs" which lead on to future heavier substance use.

When are substances a problem?

A young person's drinking or drug use should be viewed as problematic if:

1. As a result of their drinking/drug use they have regularly experienced any of the following things:
    - Had no money left for other things in life.
    - Given up things they used to be good at, like sports or hobbies.
    - Changed friends.
    - Dropped in their levels of performance (physically or academically).
    - Felt bad or guilty as a result of their drinking/ drug usage.
    - Failed at attempts to give up by their own efforts.
2. Do they regularly do any of the following things?
    - Turn up to school or work the day after 'using' and still feel 'hung over out of it' - maybe they don't bother turning up at all.
    - Get drunk or 'out of it' before or during school/work.
    - Drink and then do risky things like drive, go biking, skate, use machinery, or 'hang out' in potentially dangerous places.
    - Get into trouble with the police for doing things to get money to pay for alcohol/ drugs.

- Do stupid things when they are under the influence (things that you wouldn't normally do) like vandalism, assault or engaging in risky sexual behaviour.
- Have people 'on their case' about their usage e.g., parents, teachers, friends, or bosses.
- Partake in drinking/ drug taking to the point of intoxication.
- Display an inability to stop 'using' once they've started, getting drunk/ high when the intention was to only have a couple.

What are further warning signs?

Physical:	Lasting fatigue, repeated health complaints, red and dull eyes, or a steady cough.
	Complaining of blackouts or memory loss.
	Developing a tolerance, requiring more and more alcohol/drugs to achieve the same effect.
Emotional:	Personality changes, sudden mood changes, irresponsible behaviour, low self- esteem, depression, or general lack of interest.
	Using alcohol or drugs to cope with, or escape from, pressures or feelings of anger, sadness or frustration
Family:	Starting arguments, breaking rules, or withdrawing from family.
Social:	Having new friends who are less interested in standard home and school activities.
	Having 'scrapes' with the law.
	Changes to less conventional styles in dress and music.
	Drinking or taking drugs in order to feel comfortable with others socially.
	Drinking or using drugs when they are alone.

If any of these factors are present then the person's use of alcohol and/ or drugs should be viewed as a concern.

The presence of these factors does not necessarily mean that the person is an alcoholic or a drug addict. They are an indication that these substances are being abused or that they are having a negative impact on their life.

Some of the warning signs listed above can also indicate other problems. Parents may recognise signs of trouble but should not be expected to make a diagnosis. An effective way for them to show care and concern for their teenager is to honestly discuss the use and abuse of alcohol and drugs with them.

Getting Help:

Consulting a general practitioner to rule out physical warning signs is a good first step. This should often be followed or accompanied by a substance abuse counsellor.

Anorexia

Also called Anorexia Nervosa

What is Anorexia?

Anorexia is one of the eating disorders. It is a complex problem characterised by an obsession with food, weight and thinness. People with anorexia starve themselves, eating fewer calories than their bodies need to function.

Anorexia isn't just a problem with food or weight. It's an attempt by the person to use food to gain control in their life. Anorexia is an illness that usually occurs in teenage girls, but it can also occur in boys. Ninety percent of people with anorexia are female. Anorexia begins

most often between the ages of 11 and 19. It is estimated that anorexia effects 1-2% of teenage girls.

Why do people get Anorexia?

To understand why there has been an increase in the occurrence of anorexia, we must look at the social and cultural pressures placed on people today. The media, for example, equates beauty to thinness. We are barraged with the message that beauty, success, personal happiness and self worth are based on a thin shape.

In addition to this, there are several other factors that can place a person at risk of developing an eating disorder such as anorexia. These include:

- Stressful life situations accompanied by a lack of adequate coping skills
- Sensitivity to changes in life.
- Sensitivity to separation from family.
- Genetics and family history.
- Family dynamics
- Traumas relating to things that have happened in the past.

What are some of the warning signs of Anorexia?

Some warning signs of anorexia include the following:

- Deliberate self-starvation with weight loss.
- Fear of gaining weight.
- Refusal to eat.
- Denial of hunger.
- Constant exercising.
- Unusual behaviour towards food eg collecting recipes, preparing impressive meals for other people, or cutting their food into little pieces and then pushing it around their plate.
- A self-perception of being fat when the person is really too thin.
- Secretive about eating.
- Sensitivity to cold.
- Absent or irregular periods.
- Some people may engage in purging behaviours (vomiting, using laxatives).

What are the problems caused by Anorexia?

Females with anorexia usually stop having menstrual periods. Males may notice a reduced sex drive. They may also often get sick. They have a hard time concentrating and are always thinking about food. It is not true that people with anorexia are never hungry. Actually, they are always hungry. Feeling hunger gives them a feeling of control over their lives and their bodies. It makes them feel like they are good at something – they are good at losing weight. Anorexia can lead to harmful and potentially life threatening conditions including starvation, heat problems, brittle bones, and may affect females' future ability to have children. People with severe anorexia may be at risk of death from starvation.

Signs to watch out for:

Severe weight loss is always a cause for concern. It may, of course indicate that the person has a physical illness. In young people, in their early or late teens, it may suggest that they have developed anorexia. The person who does not wish to eat meals with the family, who seems to have become very interested in reading about or discussing diets, in cooking for and feeding others but not eating, and losing weight, may have developed anorexia. Other signs are that her periods may stop, exercise is taken excessively and mood may be very changeable. The person may complain about being 'fat', wear baggy clothes and feel cold.

What is the difference between Anorexia and Bulimia?

People with anorexia starve themselves, avoid high-calorie foods and exercise constantly. People with bulimia purge soon after eating. They often vomit and/or take laxatives or diuretics (water pills) to keep from gaining weight (NB people with Anorexia can also engage in purging although it is less common). People with bulimia don't usually lose as much weight as people with anorexia.

Treatment:

Treatment of anorexia nervosa is difficult and requires input from skilled counselling professionals. Anorexia is not the sort of problem that can just be ignored in the hope that it will go away or that the affected person will grow out of it.

This is a condition in which there are considerable variations in severity, making simple generalisations about treatment impossible. The return to eating often reveals the underlying issues behind the condition. People in the early stages of anorexia (less than six months or with just a small amount of weight loss) may be successfully treated without having to be admitted to hospital. But for successful treatment, the person must ideally want to change and have family and friends to help them.

People with more serious anorexia may need care in the hospital. Treatment involves more than changing the person's eating habits. People with anorexia often need counselling for a year or more so they can work on changing the feelings that are causing their eating problems. These feelings may be about their weight, their family problems, or their problems with self–esteem.

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Body Dysmorphic Disorder

What is Body Dysmorphic Disorder?

Body Dysmorphic Disorder is a type of anxiety disorder where a part of a person's physical features or attributes provoke intense anxiety and negative distorted beliefs about a part of their appearance. When others tell them they look fine or that the flaw isn't noticeable, people with BDD don't hear or believe it due to their preoccupation with their perceived flaw eg their skin is pale, their hair is too curly, their nose is too long.

This disorder is thought to be caused by a chemical imbalance in the brain, which may be genetically based. A person with a family history of generalised anxiety disorder or obsessive compulsive disorder is more prone to develop this type of problem. Also those coming from a family with an upward socio-economic status seen to be more at risk of developing this disorder.

Symptoms and Signs:

- Frequently comparing the appearance of the perceived defect with that of others.
- Frequently checking appearance of specific part in mirrors and other reflective surfaces.
- Camouflaging the perceived defect with clothing, makeup, hats, hands, or posture.
- Seeking surgery, dermatological treatment, or other medical treatment when doctors or other people have said that the flaws are minimal or nonexistent or that such treatment isn't necessary.
- Seeking reassurance about the flaw or attempting to convince others of its ugliness.
- Excessive grooming (for example, combing hair, shaving, removing or cutting hair, applying makeup)
- Avoiding mirrors.
- Frequently touching the perceived defect.
- Picking one's skin
- Measuring the disliked body part.
- Excessively reading about the perceived defective body part.
- Avoiding social situations in which the perceived defect might be exposed.
- Feeling anxious and self-conscious around other people because of the perceived defect.

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Compulsive Hoarding

Collecting is undertaken by all. What motivates collecting changes across the life span. In childhood items are collected for leisure or enrichment. In adulthood it is often for monetary reasons and, in old age may be for reasons of sentimentality. Collecting rarely leads to distress nor is the behaviour secret. The acquired items are considered valuable and may be discarded with minimal anxiety.

In contrast, compulsive hoarding leads to distress and dysfunction and is undertaken secretly; the items collected have minimal value and their disposal is resisted. Compulsive hoarding is disabling for the sufferer and can become an issue of public health.

Definition:

Compulsive hoarding is the acquisition of items that the hoarder has difficulty discarding. The hoarder is preoccupied with acquisition, has minimal insight into the purpose behind his behaviour and undertakes the hoarding in isolation. Hoarders find themselves acquiring items, considered valuable to them, while others see the acquisitions as of no value and are bewildered as to why the acquisitions occur. Hoarders lose the ability to differentiate between collecting for sentimentality, monetary or intrinsic reasons and acquire a greater number of items upon which they place significant value. Difficulty in organising the acquisitions is the norm, efforts to reorganise the acquisitions are resisted and touching of the objects is viewed as threatening. Compulsive hoarders deny they have a problem, resist intervention and become aggressive if intervention occurs.

Diagnosis:

It is now widely acknowledged that compulsive hoarding is a symptom of OCD. It is, however, also a symptom of several other disorders, psychiatric and non-psychiatric. The most common reason given for hoarding is that the items 'may become handy one day' or 'the object belongs to me' or 'I do not want to be caught without' the hoarded item. Some signs and symptoms are:

- the acquisition of and failure to discard a large number of acquisitions that appear to be useless and of limited value.
- living spaces are sufficiently cluttered to preclude activities for which these spaces were designed.
- significant distress and impairment in functioning caused by the hoarding.

Items commonly hoarded include:

Magazines	Used cars	Junk mail	Boxes	Old clothes	Bottles
Notes or lists	Containers	Old receipts	Jewellery	Food items	Cosmetics
Gifts for others	Toiletries	Mechanical parts		School papers	Books

Compulsive hoarding of pets has long been recognised by animal care professionals.

Treatment:

Treatment of compulsive hoarding with pharmacotherapy or cognitive behavioural therapy has not been systematically studied. The results of pharmacological interventions are equivocal most having no or only a partial treatment response. The most common pharmacotherapy treatments have been the use of the tricyclic antidepressant Clomipramine and the serotonin reuptake inhibitors [SSRIs]. Factors that predict poor response to pharmacotherapy is the presence of comorbidity, particularly depression, the obsessive compulsive spectrum disorders and/or personality disorders.

Evidence using traditional behavioural therapy that emphasises response prevention is also equivocal in the treatment of compulsive hoarding.

More detailed info on compulsive hoarding:

Collecting is undertaken by all. What motivates collecting changes across the life span. In childhood items are collected for leisure or enrichment. In adulthood it is often for monetary reasons and, in old age, the collecting of items may be for reasons of sentimentality or security. Collecting rarely leads to distress or dysfunction nor is the behaviour undertaken secretly. The acquired items are considered valuable and may be discarded with minimal anxiety. In contrast, compulsive hoarding leads to distress and dysfunction and is undertaken secretly; the items collected inanimate or animate, have minimal value or purpose and their disposal is resisted. Compulsive hoarding, while recognised for centuries and occurring in all cultures, has attracted little empirical inquiry despite it being disabling for the sufferer and, at times, becoming an issue of public health.

Phenomenology:

Compulsive hoarding is the acquisition of items that the hoarder has difficulty discarding. The hoarder is preoccupied with acquisition, has minimal insight into the purpose behind his behaviour and undertakes the hoarding in isolation. Hoarders find themselves acquiring items, while considered valuable to them, others see the acquisitions as of no value and are bewildered as to why the acquisitions occur. Hoarders lose the ability to differentiate between collecting for sentimentality, monetary or intrinsic reasons and acquire a greater number of items upon which they place significant value. Difficulty in organising the acquisitions is the norm, efforts to reorganise the acquisitions are resisted and touching of the objects is viewed as threatening. Compulsive hoarders deny they have a problem, resist intervention and become aggressive if intervention occurs.

Diagnosis:

Compulsive hoarding is not defined in the 4th Diagnostic and Statistical Manual of Mental Disorders (DSM-IV). Reference to compulsive hoarding, however, is made in DSM-IV in context of obsessive compulsive personality disorder (OCPD) a disorder characterised by a preoccupation with orderliness, perfectionism, mental and interpersonal control at the expense of flexibility, openness and efficiency. Compulsive hoarding is defined in context of OCPD as the inability to discard worthless or worn out objects even though they have no sentimental value. Frost and Gross have questioned if those who do hoard have features of OCPD. The results show that compulsive hoarding is not necessarily consistent with a primary diagnosis of OCPD, but there is an overlap between hoarding with both OCPD and obsessive compulsive disorder (OCD). It is now widely acknowledged that compulsive hoarding is a symptom of OCD. It is, however, also a symptom of several other disorders, psychiatric and non-psychiatric. In the absence of a definition of compulsive hoarding, Frost and Hartl have suggested that compulsive hoarding may be viewed as

1. The acquisition of and failure to discard a large number of acquisitions that appear to be useless and of limited value.
2. Living spaces are sufficiently cluttered to preclude activities for which these spaces were designed.
3. Significant distress and impairment in functioning caused by the hoarding.

Prevalence:

There is uncertainty as to the prevalence of compulsive hoarding. To date no epidemiological studies have been completed. Evidence suggestive that compulsive hoarding may be more common than previously thought, stems from the recognition that this behaviour occurs in psychiatric disorders other than OCD and that it also occurs in non-psychiatric disorders including the dementias. Moreover, that those who hoard are secretive as to their behaviour, deny they have an illness and hence avoid treatment, add to the uncertainty as to how common is compulsive hoarding.

In an adult clinical study based upon 1000 adult patients with the diagnosis of OCD, it was shown that the incidence of those with hoarding compulsions was 18% · In a further study it was shown that 30% had obsessions and 28% had compulsions concerned with hoarding. In neither study was it stated if hoarding was the primary presenting feature of their OCD. In studies of children with OCD the incidence of hoarding was shown to be 11%. In various dementias 22% have hoarding compulsions.

OCD and compulsive hoarding:

Although compulsive hoarding has been recognised in psychiatric literature for some time, it has not been well studied as a symptom of OCD. Freud and the early psychoanalysts described the underlying mechanisms behind compulsive hoarding as stemming from anal character traits particularly when the hoarders had obsessional characteristics. The early psychoanalytical school concluded that hoarding took on the characteristics of a compulsion. More recent studies have suggested that hoarding begins in response to thoughts that the items collected might some day become useful but intrinsically collection of items becomes an end in itself.

It was perhaps Rachman and Hodgson in 1980 who first viewed compulsive hoarding as a symptom of OCD. Greenberg in 1987, provided the first phenomenological study of compulsive hoarding. He suggested that compulsive hoarders denied or minimised the significance of their behaviour. On confrontation they admitted their behaviour was excessive and irrational. Despite this admission, curtailment of their hoarding was not considered a viable solution. Although they had limited insight into their behaviour, there was an absence of other psychotic processes. An inability to resist the urge to hoard occurred in all subjects and all resisted the notion of treatment and the discarding of items. Greenberg also observed that compulsive hoarders initially collected and organised their hoard in groups but that over time, their organisation became disorganised. The items collected were varied; many items hoarded were others rejects.

Surprisingly there are only limited studies investigating compulsive hoarding as a symptom of OCD. Most with compulsive hoarding as their primary OCD symptom experience additional obsessions and compulsions. Other obsessions experienced include those concerned with symmetry, harm and violence, contamination and unacceptable urges. Additional compulsions include repeating, ordering, mental compulsions, washing and cleaning. The most frequent reason given for hoarding is the fear of discarding something that may be potentially needed in the future or that the item hoarded provided a feeling of security. Those who hoard, unlike those with OCD, do not resist the urge to collect, nor do they experience discomfort while collecting. On being forced to dispose of their acquisitions, anxiety and distress is experienced similar to those undertaking washing and checking rituals. The extent of the compulsive hoarding may be assessed by the space occupied.

Comorbidity:

Most who compulsively hoard have symptoms of OCD and additional psychopathology. Other comorbid illnesses shown to occur include major depression, dysthymia, panic disorder with agoraphobia, and hypochondriasis. OCD spectrum disorders also commonly co-occur; these include compulsive buying, pathological gambling and trichotillomania. Obsessive compulsive personality disorder is rarely diagnosed.

Items commonly hoarded

The items most commonly hoarded when the hoarding is seen as a symptom of OCD are listed in Table 3. To date no comparative study has been undertaken enquiring whether items hoarded reflect the nature of the underlying illness. Limited data suggests that there is similarities and differences across all illnesses.

Compulsive hoarding of pets has long been recognised by animal care professionals. It has only recently been acknowledged that they need psychiatric care. Compulsive hoarders of pets like others who compulsively hoard lack insight and deny they have a problem such that they are unable to see that often the animals are sick, dying or dead. Patronek has defined the compulsive hoarder of animals as someone who accumulates a large number of animals fails to provide minimal standards of nutrition, sanitation and veterinary care and fails to act on the deteriorating condition of the animals or the environment. They generally live alone, hoard cats and dogs and live in squalor. The hoarders view their behaviour as a consequence of an intense love of animals, the feeling that the animals are surrogate children, the belief that no-one else would or could take care of them and the fear that the animals would be euthanized.

Treatment:

Treatment of compulsive hoarding with pharmacotherapy or cognitive behavioural therapy has not been systematically studied. The results of pharmacological interventions are equivocal most having no or only a partial treatment response. When a second pharmacological treatment option is used, similar results have been shown. The most common pharmacotherapy treatments have been the use of the tricyclic antidepressant clomipramine and the serotonin reuptake inhibitors as listed in Table 3.

Factors that predict poor response to pharmacotherapy is the presence of comorbidity, particularly depression, the obsessive compulsive spectrum disorders and/or personality disorders.

Evidence using traditional behavioural therapy that emphasises response prevention is also equivocal in the treatment of compulsive hoarding.

Recently Frost and Hartl, however, developed a cognitive behavioural model of compulsive hoarding, which includes traditional behavioural therapy, as a preliminary step in developing an effective treatment programme. Their model developed from research suggesting that those who compulsively hoard have deficits in information processing, difficulties with emotional attachment to possessions, behavioural avoidance and erroneous beliefs about the nature and importance of possessions.

The deficits in information processing include indecisiveness, categorisation and memory impairment. Indecision has been shown to be a hallmark of compulsive hoarding; not only do hoarders experience difficulties in deciding what to save or discard and where to put it, they also have difficulties making decisions over routine affairs. Difficulties with categorisation/organisation stem from the suggestion that those who compulsively hoard have difficulties defining boundaries at a cognitive level, the boundaries invariably being limited so few items become included. Each acquisition may be given its own category and is thus unique. Moreover, as each item is unique it becomes difficult to decide that a class of objects is unimportant. Furthermore, as each item is unique, it cannot be categorised with similar objects and thus it becomes difficult to organise possessions. While it has been shown that those who compulsive hoard have no memory deficits when formally tested, they have less confidence in their memory believing that things must be saved less they be forgotten. Similarly if they consider the object is out of sight, it will be forgotten.

Those who hoard, hoard for sentimental and non-sentimental reasons, at times, there occurs extreme emotional attachment to acquisitions. Frost and Hartl suggest that those who hoard see their acquisitions as and extension of themselves with the hoarder feeling violated if the acquisitions are touched or moved.

Those who compulsively hoard, moreover, avoid the loss of acquisitions that they believe may be needed some day. With discarding minimised the compulsive hoarder prevents the distress associated with disposal, thus hoarding may be seen as avoiding or minimising decision-making.

Compulsive hoarding is a symptom of several psychiatric and non-psychiatric illnesses. To date, little is known of the phenomenology of this illness. Treatment studies suggest there occurs no or partial response to pharmacotherapy or cognitive behavioural therapy used alone or simultaneously. Significant distress and dysfunction is experienced by those who hoard arguing for more empirical studies into the illness that, for most, leads to impairment in functioning and, for some, the notification of public health officials who must act for the welfare of the individual and the community.

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Depression

Depression is not a fleeting sadness or 'the blues' but a pervasive and relentless sense of despair. A lack of interest in life accompanied by weight loss, loss of appetite, feelings of uselessness and sleep disturbance are some of the more common symptoms.

People with depression can't just 'snap-out of it'.

There can be an array of causes – it can be due to stresses in the home or at work, or it can just come out of the blue. A genetic predisposition and family history can be a major factor.

An official definition of depression:

- Two weeks of abnormal depressed mood
- Loss of interest and decreased energy
- Loss of confidence
- Excessive guilt
- Recurrent thoughts of death
- Poor concentration
- Agitation or retardation
- Sleep disturbance
- Change in appetite

Mild depression includes the first two symptoms and at least one other. Severe depression is the first two symptoms and at least five others.

People with depression experience many of the following for prolonged periods:

Sadness, lethargy, helplessness, hopelessness, worthlessness, difficulties with decisions, memory, concentration, loss of interest, energy, changes to sleep patterns – difficulty sleeping or staying awake, changes in weight – either in significant loss or gain in weight, relationship problems with partners, friends, family, colleagues, isolation and thoughts.

Treatment:

People suffering from depression should consult with their general practitioners; severe cases should obtain a referral to a psychiatrist and a clinical team.

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Generalised Anxiety Disorder (GAD)

Generalised anxiety disorder (GAD) is much more than the normal anxiety people experience day to day.

It is chronic and exaggerated worry and tension, even though nothing seems to provoke it. Having this disorder means always anticipating disaster, often worrying excessively about health, money, family, or work. Sometimes, though, the source of the worry is hard to pinpoint. Simply the thought of getting through the day provokes anxiety.

Symptoms and Signs:

People with GAD can't seem to shake their concerns, even though they usually realise that their anxiety is more intense than the situation warrants. People with GAD also seem unable to relax. They often have trouble falling or staying asleep. Their worries are accompanied by physical symptoms, especially trembling, twitching, muscle tension, headaches, irritability, sweating, or hot flushes. They may feel light-headed or out of breath. They may feel nauseated or have to go to the bathroom frequently or they might feel as though they have a lump in the throat.

Many individuals with GAD are startled more easily than other people. They tend to feel tired, have trouble concentrating and sometimes suffer depression.

Usually the impairment associated with GAD is mild and people with the disorder don't feel too restricted in social settings or on the job. Unlike many other anxiety disorders, people

with GAD don't characteristically avoid certain situations as a result of their feelings. However, if severe, GAD can be very debilitating, making it difficult to carry out even the most ordinary daily activities.

GAD comes on gradually and most often develops during childhood or adolescence, but can begin in adulthood too. It is suggested that as with other anxiety disorders GAD is a genetic illness/disorder. It is diagnosed when someone spends at least 6 months worrying excessively about a number of everyday problems.

Treatment:

Generalised anxiety is a treatable complaint and successful intervention may include both medication and cognitive-behavioural therapy. Other therapies are often used as in the case where people have had a severely dysfunctional childhood, loss of a family member and or other grief provoking episodes in their lives.

Diagnostic Criteria – Generalised Anxiety Disorder:

a) Excessive anxiety and worry (apprehensive expectation), occurring more days than not for at least six months, about a number of events or activities (such as work or school performance).

b) The person finds it difficult to control worry.

c) The anxiety and worry are associated with three (or more) of the following six symptoms (with at least some symptoms present for more days than not for the past six months):

   1) restlessness or feeling keyed up or on edge
   2) being easily fatigued
   3) difficulty in concentrating or mind going blank
   4) irritability
   5) muscle tension
   6) sleep disturbance (difficulty falling or staying asleep, or restless unsatisfying sleep)

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Obsessive Compulsive Disorder (OCD)

Obsessive-compulsive disorder (OCD) is one of the anxiety disorders. People who suffer from OCD become trapped in a pattern of repetitive thoughts and behaviours that are senseless and distressing and they find them extremely difficult to overcome. OCD occurs in a spectrum from mild to severe, but if severe and left untreated, can destroy a person's capacity to function at school, at work or even in the home.

Although OCD symptoms typically begin during the teenage years or early adulthood, recent research shows that some children develop the illness at earlier ages, even during the pre-school years. OCD affects more than 2 percent of the population at some stage and affects people of all ethnic groups. Males and females experience it equally.

Key Features of OCD:

Obsessions:

These are unwanted ideas or impulses that repeatedly well up in the mind of the person with OCD. Persistent fears that harm may come to self or a loved one, an unreasonable concern with becoming contaminated, or an excessive need to do things correctly or perfectly, are common. Again and again, the individual experiences a disturbing thought, such as, "My hands may be contaminated. I must wash them", "I may have left the gas on", or "I am going to injure somebody with my actions." These thoughts are intrusive, unpleasant, and produce a high degree of anxiety. Sometimes the obsessions are of a violent or a sexual nature, or concern illness.

Compulsions:

In response to their obsessions, many people with OCD resort to repetitive behaviours called compulsions. The most common of these are washing and checking. Other compulsive behaviours include counting (often while performing another compulsive action such as hand washing), repeating, hoarding, and endlessly re-arranging objects in an effort to keep them in precise alignment with each other. Repeating phrases or list making is also common. These behaviours generally are intended to ward off harm to the person with OCD or others. Some people with OCD have regimented rituals while others have rituals that are complex and changing. Performing rituals may give the person with OCD some relief from anxiety, but it is only temporary.

Insight:

People with OCD show a range of insight into the senselessness of their obsessions. Often they can recognise that their obsessions and compulsions are unrealistic (especially when they are not actually having an obsession). At other times they may be unsure about their fears or believe strongly in their validity.

Resistance:

Most people with OCD struggle to banish their unwanted, obsessive thoughts and to prevent themselves from engaging in compulsive behaviours. Many are able to keep their obsessive-compulsive symptoms under control during the hours when they are attending school or are at work. But over the months or years, resistance may weaken, and when this happens, OCD may become so severe that time-consuming rituals take over the sufferers' lives, making it impossible for them to continue outside the home.

OCD sufferers often attempt to hide their condition rather than seek help. Often they are successful in concealing the symptoms from friends or co-workers. An unfortunate consequence of this secrecy is that people with OCD usually do not receive professional help until years after the onset of the disorder. By that time, they may have learned to work their lives, (and family members' lives) around the rituals.

What causes OCD?

The old belief that OCD was the result of life experiences has been weakened before the growing evidence that biological factors are a primary contributor to the disorder. The fact that OCD patients respond well to specific medications that affect the neuro-transmitter serotonin suggests the disorder has a biological basis. For that reason, OCD is no longer attributed only to attitudes a patient learned in child-hood (for example, an inordinate emphasis on cleanliness, or a belief that certain thoughts are dangerous or unacceptable). Instead, the search for causes now focuses on the interaction of biological factors and environmental influences, as well as cognitive (thinking) processes.

OCD is sometimes accompanied by depression, eating disorders, substance abuse disorder, a personality disorder, attention deficit disorder, or another of the anxiety disorders. Co-existing disorders can make OCD more difficult to both diagnose and treat. People with OCD should not be confused with a much larger group of individuals who are sometimes called "compulsive" because they hold themselves to a high standard of performance and are perfectionists and very organised in their work or recreational activities. This type of "compulsiveness" often serves a valuable purpose, contributing to a person's self-esteem and success. In that respect, it differs from the life-wrecking obsessions and rituals of the person

with OCD. A person with OCD has obsessive and compulsive behaviours that are extreme enough to interfere with everyday life.

Treatment Options:

Research has shown that both pharmacological and behavioural treatments that can benefit the person with OCD.

Studies have shown that, for more than half of patients, medications relieve symptoms of OCD by diminishing the frequency and intensity of the obsessions and compulsions. Improvement usually takes at least three weeks or longer. Medication is only part of any solution as sufferers also have been shown to benefit from a particular form of therapy called behavioural therapy. Here the person with OCD works with a therapist to deliberately and voluntarily confront the feared object or idea, either directly or by imagination. At the same time they are strongly encouraged to refrain from ritualising. This is done within the structure provided by the therapist and any other identified support people.

Treatment is different for each person. One person may benefit significantly from behaviour therapy, while another will benefit from interventions with medication. Others may use both medication and behavioural therapy.

The individual affected, in consultation with the helping professional they are seeing should decide which approach to use.

For more information visit www.anxiety.org.nz or call 0800 ANXIETY (0800 269 4389)

Panic Attacks & Panic Disorder

Panic attacks and panic disorder belong to a cluster of illnesses/disorders known as anxiety disorders.

People who are affected by these conditions experience feelings of terror that strike suddenly and repeatedly with no warning. They normally cannot predict when an attack will occur. As a result many develop intense anxiety between episodes, worrying about when, and where, the next one will strike. In between times there is a persistent, lingering worry that another attack could come at any minute.

Symptoms:

Symptoms of a panic attack can be:

- Your heart pounds and you may feel sweaty, weak, faint, or dizzy, you may feel that you are going to lose control or act foolishly.
- Your hands may tingle or feel numb, and you might feel flushed or chilled.
- You may have chest pain or smothering sensations, a sense of unreality (depersonalisation) or fear of impending doom or loss of control.
- You will want to run or escape - normally people want to run to a safe person or place.

Whilst experiencing a panic or anxiety attack, you may genuinely believe you are having a heart attack or stroke, losing your mind, or on the verge of death. However, these are the symptoms of a panic attack and nothing else. Attacks can occur at any time, even during non-dream sleep. Most panic/anxiety attacks average a couple of minutes.

Who Experiences Panic Attacks?

Panic disorders can appear at any age.

Not everyone who experiences anxiety/panic attacks will develop panic disorder – for example, many people have one attack but never have another. For those who do have panic disorder, though, it's important to seek treatment. Untreated, the disorder can become very disabling.

Effects:

Some people's lives become greatly restricted. They avoid normal, everyday activities such as grocery shopping, driving, lifts, motorways, bridges, school, or in some cases even leaving the house.

Sometimes they may be able to confront a feared situation only if accompanied by a parent or other trusted person. For example, if a panic attack strikes while you are riding an elevator, you may develop a fear of elevators and perhaps start avoiding them.

Some people's lives become so restricted by the disorder it causes unemployment and loss of social and family life. This happens in about one-third of all people with panic disorder. In this case the condition is called **agoraphobia**.

Treatment:

Many people misunderstand this disorder and think individuals should be able to overcome the symptoms by sheer willpower. It is important to accept that people with panic disorders do not want to be like this. They cannot help their condition any more than a person suffering from diabetes can.

Studies have shown that treatment like cognitive-behavioural therapy, medication, or possibly a combination of the two helps people who suffer with panic disorder.

Cognitive-behavioural approaches teach people how to view the panic situations differently and demonstrate ways to reduce anxiety by using breathing exercises or techniques to re-focus attention. Another technique used in conjunction with cognitive-behavioural therapy, called exposure therapy, helps alleviate the phobias that may result from panic disorder. In exposure therapy, people are slowly exposed to the fearful situation until they become desensitised to it.

Some people find the greatest relief from panic disorder symptoms when they take certain specific medication for anxiety disorders. Such medications, combined with cognitive-behavioural therapy, reduce their frequency and severity.

For more information visit www.anxiety.org.nz or call 0800 ANXIETY (0800 269 4389)

Phobias

Phobias belong to a family of difficulties known as anxiety disorders.

Phobias occur in several forms. A specific phobia is a fear of a particular object or situation. Social phobia is a fear of being painfully embarrassed in a social setting. Agoraphobia, which often accompanies panic disorder, is a fear of being in any situation that might provoke a panic attack, or from which escape might be difficult if one occurred. People or children suffering with a phobia of germs may well have Obsessive, Compulsive Disorders. OCD.

Specific Phobias:

Many people experience specific phobias. Intense, irrational fears of certain things or situations – dogs, closed-in-places, heights, escalators, tunnels, motorway driving, water, flying, and injuries involving blood are a few of the more common ones.

Phobias aren't just extreme fear, they are irrational fear. You may be able to ski the world's tallest mountains with ease but panic going above the 10th floor of an office building.

People with phobias realise their fears are irrational, but often facing, or even thinking of facing the feared object or situation, brings on severe anxiety or a panic attack.

Treatment:

When phobias interfere with a person's life, treatment can help. Successful treatment usually involves cognitive-behavioural therapy, desensitisation or exposure therapy. This last involves gradually exposing sufferers to what frightens them until their fear begins to fade. 75% of people benefit significantly from this type of treatment. Relaxation and breathing exercises also help reduce anxiety symptoms.

Sometimes certain medications may be prescribed to help reduce anxiety symptoms before someone faces a phobic situation.

For more information visit www.anxiety.org.nz or call 0800 ANXIETY (0800 269 4389)

Post-Traumatic Stress Disorder (PTSD)

Post-Traumatic Stress Disorder (PTSD) is the development of characteristic symptoms following exposure to a traumatic event. The sufferer may have directly experienced the event, witnessed it, or simply learned about the event happening to someone close to them. Traumatic events may involve military combat, violent personal assault, kidnapping, terrorism, vehicular accidents, natural or manmade disasters, and being diagnosed with a life-threatening illness. The sufferer's typical response to the event is intense fear, helplessness or horror. The symptoms of PTSD cause significant distress and impairment of functioning, and last longer than one month in duration. PTSD is also commonly accompanied by other psychiatric conditions such as depression, alcohol/substance abuse, panic disorder and other anxiety disorders.

Persistent Symptoms of Post-Traumatic Stress Disorder:

- The re-experiencing of the traumatic event in the form of nightmares and intrusive recollections of the event.
- The avoidance of anything associated with the traumatic event. This may include thoughts, feelings, activities, situations, people or conversations.
- The numbing of general responsiveness to the external world. Examples include a lack of interest in previously enjoyed activities, feeling detached from other people, and a reduced ability to feel emotions.
- Increased arousal. This symptom may manifest itself in sleep disturbances, hyper-vigilance, an exaggerated startle response, irritability, anger, and lack of concentration.
- A sense of foreshortened future (the sufferer does not expect to have a normal life-span).

Treatment of Post-Traumatic Stress Disorder:

Post-Traumatic Stress Disorder is an extremely treatable problem. The most common treatment approaches involve a combination of:

- Education of the sufferer and their family members.
- Cognitive-behavioural therapy (including exposure therapy in a safe, controlled context).
- Medication to reduce the anxiety, depression and sleep problems frequently associated with PTSD.

- Support from family, friends and peers.

For more information visit www.anxiety.org.nz or call 0800 ANXIETY (0800 269 4389)

School Phobia

What is School Phobia?

School Phobia or School Avoidance is an intense fear of social situations where the sufferer feels that he or she will act in a way that will be humiliating or embarrassing and is a form of separation anxiety. Other symptoms of School Phobia are agoraphobia, social phobia, panic and / or generalised anxiety disorder (refer separate sheets).

Some of the phobic fears common with School Phobia:

- Walking into the classroom.
- Having to play sports and becoming a focus of others.
- Playing or acting in front of others.
- Speaking in front of others.
- Writing in front of others.
- Answering the phone.
- Unable to sign their name in front of others.
- Any situation that means the focus is on them.
- Imagining others are looking at them and are critical of their appearance.

Symptoms and Signs:

- Headaches, abdominal pain, fainting, nausea and vomiting.
- They may be impulsive, find it difficult to concentrate, lack self-confidence, cannot explain why school is so terrifying, worry often accompanied by diarrhoea.
- The child may be tired, exhausted and shaky.
- They will be apprehensive about new situations, insecure, tend to show off to compensate, crave sweet things.
- Hate to use school toilets, either because they are dirty or because he / she cannot go to toilet with other children nearby.
- Mentally sluggish, apprehensive, lacks initiative, poor physical stamina, clumsy, bad at games, hate being laughed at.

Treatment:

Children who suffer from School Phobia find relief from their symptoms when treated with cognitive-behavioural therapy, medications or a combination of the two. Therapy may involve learning to view social events differently eg school; being exposed to a seemingly threatening social situation in such a way that it becomes easier to face; and learning anxiety-reducing techniques, social skills, and relaxation techniques.

Self-Harming

What is Self-Harming?

Self-Harm is the practice of deliberately damaging body tissue as a way of coping with negative inner feelings.

It is an attempt to turn inner pain outward, therefore giving it a focus, which can be seen by the eye, and making it easier to deal with.

Self-harm includes those actions that result in an injury of some sort to the person by herself or himself. Other words commonly used to describe these actions are self-abuse, self-injury, self-inflicted injury, self-destructive behaviour and self-defeating behaviour. Self-abusive people may injure themselves directly or indirectly (eg "setting someone up" to do the injuring). Self-abuse varies greatly in frequency and severity from person to person. Estimates of the prevalence of self-harm range from between 0.4% and 10% of the population.

How do people Self-Harm?

The following are common ways that people self-harm:

- Cutting
- Skin picking/Scratching
- Wound Interference
- Hitting/punching
- Head Banging
- Bone Breaking

Why do people Self-Harm?

People self-harm for a number of different reasons however most typically it is a coping method used to deal with feelings that they don't feel capable of dealing with in any other way or they don't know how to deal with at all. Self-harm is in many ways an addiction. It is doubtful that they want to harm themselves but they feel they need to for whatever reason. Self-harming behaviour most commonly occurs for the first time between the ages of 10-16 years. It can be triggered by any one of a number of negative experiences or perceptions that a person may have eg:

- Abuse
- Bereavement
- Dislike of body or body shape

- Escape from emptiness, depression, feelings of unreality
- Low self-esteem

Some find the physical pain comforting, as it is temporarily distracting from their emotional pain. Others feel no pain whatsoever when harming themselves, instead they feel in control of what they are doing (this is often a way of compensating for the lack of control they experience with regard to how they are feeling).

Self-Harm & Suicide:

Self-Harm is often misinterpreted as a suicide attempt when usually nothing could be further from the truth. Most people who self-harm are interested in preserving their lives, not ending them.

However as self-harm is a symptom of a person in great distress there is a higher chance of those who self-harm going on to attempt or commit suicide at some stage.

Self-Harm & Shame:

People who self-harm are often ashamed of what they do and few 'come out' to others preferring to hide it from society to avoid being thought of as 'sick'. This is a great shame because often what someone who self-harms needs most is the support of their friends and families to deal with things.

The feeling of isolation amongst those who self-harm is immense and this is often fuelled by the host of misconceptions and images which self-harm has been surrounded with. People who self-harm are often scared that when people find out they will 'disown' them and threaten to walk away if they don't stop.

Helping Someone Who Self-Harms:

The most important way in which others can help self-harmers is by listening and not judging them. It is often very hard to even try and contemplate why people would want to deliberately injure themselves. It is also important not to threaten or bully the self-harmer as usually this will do nothing more than isolate them further and probably stop them from confiding in you again.

Dealing with someone who self-harms can be very distressing and frustrating for all involved and it is 'ok' to seek help from others.

There are counselling approaches that can be used to help people who self-harm to learn better ways of coping with their negative feelings.

For more information visit www.anxiety.org.nz or call 0800 ANXIETY (0800 269 4389)

Social Phobia

Social phobia is an intense fear of social situations where the sufferer feels that he or she will act in a way that will be humiliating or embarrassing.

Social Phobia often runs in families and may be (co-morbid) accompanied by depression or alcoholism. Social phobia often begins around early adolescence or even younger. If you suffer from social phobia, you tend to think that other people are competent in public and that you are not. Small mistakes you make may seem to you much more exaggerated than they really are. The nature of a person with social phobia means that they will be hypersensitive and find criticism where it is not intended.

The act of blushing itself may seem painfully embarrassing, and the sufferer can feel as though all eyes are focused on them. They may be afraid of being with other people other than those closest to them. Or their fear may be more specific, such as feeling anxious about giving a speech, talking to a teacher or other authority figure, or general fear of social situations such as parties. More rarely it may involve other people, for instance when signing a cheque.

Although this condition is often thought of as shyness, the two are not the same. Shy people can be very uneasy around others, but they don't experience the extreme anxiety in anticipating a social situation, and they don't necessarily avoid circumstances that make them feel self-conscious. In contrast, people with social phobia aren't necessarily shy at all. They can be completely at ease with people most of the time, but particular situations, such as walking down an aisle in public or making a speech can give them intense anxiety. Social phobia disrupts normal life, interfering with career or social relationships. The dread of a social event can begin weeks in advance, and symptoms can be quite debilitating.

People with social phobia are aware that their feelings are irrational. Still, they experience a great deal of dread before facing the feared situation, and they may go out of their way to avoid it. Even if they manage to confront what they fear, they usually feel very anxious beforehand and are intensely uncomfortable throughout. Afterwards, the unpleasant feelings may linger, as they worry about how they may have been judged or what others may have thought or observed about them.

Treatment:

About 80 percent of people who suffer from social phobia find relief from their symptoms when treated with cognitive-behavioural therapy, medications or a combination of the two. Therapy may involve learning to view social events differently; being exposed to a seemingly threatening social situation in such a way that it becomes easier to face; and learning anxiety-reducing techniques, social skills, and relaxation techniques. Social Phobia seems to improve with a combination of one to one counselling and therapeutic groups.

For more information visit www.anxiety.org.nz or call 0800 ANXIETY (0800 269 4389)

Suicide

Suicide is an increasingly important issue in New Zealand. Youth suicide is of particular concern as New Zealand has one of the highest rates of youth suicide in the western world.

The factors linked to youth suicide are numerous and complex. Researchers are continuing to try and pinpoint exactly why people attempt suicide. It is known that suicidal behaviours occur as a response to situations that the person views as overwhelming. Some events that are associated with an increased risk include:

- Death or terminal illness of relative or friend.
- Divorce, separation, broken relationship, stress on family.
- Loss of health (real or imaginary).
- Loss of job, home, money, status, self-esteem, personal security.
- Depression.
- Alcohol or drug abuse.

Warning Signs:

There are a number of possible warning signs that you can look out for if you are concerned that someone you know may be considering taking their life.

- Noticeable changes in their mood or behaviour, eg acting violently, dangerously or recklessly. Also becoming withdrawn, anxious or apathetic.
- Using alcohol or drugs more than normal.
- Giving away their favourite possessions or tying up loose ends with people.
- Saying that they want to kill themselves or that life isn't worth living.
- Feeling depressed (or a sudden change in mood from depression to happiness).
- A sense of hopelessness about the future and that things will never get better.
- Feelings of worthlessness, shame, guilt, self-hatred, "no one cares".
- Getting into death images and music.
- Declining performance at school, work, or other activities.
- Declining interest in sex, friends, or activities previously enjoyed.
- Neglect of personal welfare, deteriorating physical appearance.
- Alterations in either sleeping or eating habits.
- Previous suicide attempts.
- Developing a suicide plan, acquiring the means, "rehearsal" behaviour, setting a time for the attempt.
- Making out a will.
- Inappropriately saying goodbye.
- Verbal behaviour that is ambiguous or indirect: "I'm going away on a real long trip.", "You won't have to worry about me any more.", I want to go to sleep and never wake up.", "I'm so depressed, I just can't go on.", "Does God punish suicides?", "Voices are telling me to do bad things.", requests for euthanasia information, inappropriate joking, stories or essays on morbid themes.

All suicide attempts should be taken seriously. About one-third of people who attempt suicide will repeat the attempt within one year, and about 10% of those who threaten suicide eventually do kill themselves.

Things you can do:

If you suspect that someone might be thinking about suicide, do not remain silent. Suicide is preventable, but you should act quickly.

- Ask them about it. Don't be afraid to say the word "suicide." Getting the word out in the open may help them realise that you understand how serious their feelings are. Ask open-ended questions if you can. Saying things like 'what does that mean to you?' will allow the person to speak more openly with you, and stop them from avoiding talking by just saying yes or no. Listen carefully. Do not dismiss their problems or get angry with them.
- Reassure them that you care. Remind him or her that no matter how awful their problems seem they can be worked out, and you are willing to help. Reassure them that their feelings are OK.
- Listen. Give the person every opportunity to unburden their troubles and vent their feelings. You don't need to say much, your voice and manner will show that you are concerned. Be patient and sympathetic. Avoid arguments and advice giving. Save your own story for another time. It is really important that you don't judge them.
- Don't agree to keep it secret. You should explain to the person that you want to help them and that this will involve getting advice and support from professional people who know how to help.
- Be honest. If their words or actions scare you, tell them. If you're worried or don't know what to do, say so. Don't be a cheerful phoney.
- Stick by them. Be prepared for them to be angry or withdrawn at times. If you try and help them they may try and push you away. Don't be put off, stick by them anyway.
- Be aware of the myths and misconceptions that surround suicide.
- Remove potentially harmful items from their environment, including, pills, guns, kitchen utensils and ropes, car keys etc.
- Seek professional help. Discuss the situation with your GP or another health professional that you trust. If possible help them find a counsellor who they can talk to. Offer to go with them if that will help.

Treatment for Suicide:

Suicidal feelings are usually a result of negative circumstances and/or as an outcome of conditions such as depression, anxiety or substance dependence. Treating these conditions is often the best way to address the suicidal feelings. These conditions are readily treatable with a combination of psychotherapy (a skilled form of counselling) and where necessary, medication.

For more information visit www.anxiety.org.nz or call 0800 ANXIETY (0800 269 4389)

Teen Depression

Every young person probably feels 'down in the dumps' from time to time when things appear to go wrong at school, home, with friends, teachers or family. Feelings that "when it rains, it pours" and that "life isn't fair" are not uncommon during these years. These feelings can be particularly evident when an adolescent is thinking about and testing values and priorities that exist around them in society. This sort of feeling is appropriate for this developmental stage and **on its own** isn't usually any cause for concern.

Adolescent Pressures:

There is some indication that adolescents experience more loneliness than other age groups. The position of the young person in today's society can contribute to a sense of meaninglessness, powerlessness and isolation. They are neither children nor adults. School failure can create a strong sense of rejection, a lack of meaning or challenge can create boredom or apathy, social expectations may be unrealistic, and conflicting messages from family and loved ones may magnify the struggle for independence.

The person is confronted with developmental changes in relationships with others. They seem to constantly be adjusting to the losing or breaking of one social relationship and the surfacing or formation of new ones.

Adolescence is often a period of complicated and demanding conflicts. Teens undergo a shake up physically, psychologically, emotionally and socially. They are vulnerable to being overwhelmed by the many changes and pressures brought to bear during this critical time.

Adolescent depression is not caused by a single incident or factor, but is usually associated with genetic vulnerability and ongoing environmental stresses such as described above.

Symptoms of Adolescent Depression:

Depression is an illness and is quite distinct from sadness or a depressed mood. The illness presents many of the same symptoms, but it varies in length of time and intensity. In adolescents it may be displayed socially and they may not be interested in 'once enjoyed' activities. When this occurs they should be assessed for the possibility of depression.

Symptoms to watch out for include:

On going sadness.	Fluctuation between apathy and talkativeness.
Anger and rage, verbal sarcasm and attack.	Overreacting to criticism.
Feelings of being unable to satisfy ideals.	Poor self- esteem
Loss of confidence.	Feelings of helplessness, hopelessness and guilt.

Intense ambivalence between dependence and independence.	Feelings of emptiness in life.
Restlessness and agitation.	Pessimism about the future.
Death wishes, suicidal thoughts, plans or attempts.	Rebellious refusal to work in class or co-operate in general.
Sleep disturbances.	Increased or decreased appetite, severe weight gain or loss.

A young person's depression is different from an adult's and it is sometimes more difficult to diagnose because:

- Adolescents do not always understand or cannot express feelings very well.
- Symptoms are often dismissed as "just growing up".
- The young person may not be aware of the concept of depression and may not be reporting anything wrong.
- There is strong tie between getting into trouble and feeling depressed. It is difficult to sort out if the teenager is depressed because of being in trouble, or in trouble because of being depressed.

Depression in adolescence can result in poor academic performance, truancy, delinquency, alcohol and drug abuse, disobedience, self- destructive behaviour, sexual promiscuity, rebelliousness, grief, running away, alienation, feelings of inferiority and loneliness.

Young people may attempt to escape depression and loneliness in a number of ways. Some poor and less helpful ways include:

- Denying a need for relationships and refusing to talk about how they feel.
- Denying that they are lonely or depressed
- Using alcohol or drugs to escape.
- Engaging in self- harming behaviour.

These strategies will only lead to new problems, deeper levels of despair and erosion of relationships with others.

Some better ways of coping include:

- Maintaining open and honest communications with those who are concerned
- Trying to maintain social relationships.
- Regular exercise, healthy food and adequate sleep.
- Challenging negative thinking when it is present.

Depression may get worse and last several months, or even several years, when not treated.

Treatment of Adolescent Depression:

Depression is a very treatable illness. Each individual's experience is different, so treatment must be flexible enough to realise these differences. The two most common ways of treating depression are with medication, psychotherapy (a skilled form of counselling), or a combination of both.

For many people, medication is useful in treating the symptoms. Only a doctor can describe antidepressant medication.

Psychotherapy is also effective in treating stress- related depression. In this treatment a person has the opportunity to explore events or feelings that are painful or troubling and which might have contributed to the depression. The role of the therapist is to look beyond the problem and explore these feelings.

It is important that an adolescent is surrounded by close friends and family who understand the depression. This support will give these teenagers an easier time than those who are isolated.

For more information visit www.anxiety.org.nz or call 0800 ANXIETY (0800 269 4389)

Trichotillomania

What is Trichotillomania?

Trichotillomania is the compulsive urge to pull one's own hair and sometimes that of others. Onset may occur in early childhood but is more often in adolescence and early adulthood. Usually one hair is plucked at a time from one or more sites on the body, most commonly the scalp, eyebrows, and eyelashes.

The hair pulling is usually carried out in secret and often occurs in specific environments such as watching television, driving, during telephone conversations and reading. Some sufferers discard the hair, others may chew or ingest the hair (Trichophagia).

Sufferers often deny their condition and avoid help, believing that this behaviour is unique to them, devoid of a name and beyond treatment. Accompanying complications such as anxiety, depression, substance abuse and compulsive overeating may also be in evidence.

Numerous theories have evolved concerning the cause of trichotillomania. It has been suggested that it is a pathological form of grooming behaviour, an anxiety reducing habit or the result of a neurotransmitter deficiency. Recent studies indicate that those with trichotillomania have elevated glucose metabolic activity in several brain regions, suggesting the condition is neurobiological.

Current treatments most commonly used include cognitive behavioural therapy and / or the use of pharmacological treatment. Behavioural techniques include awareness training, development of competing responses and relaxation exercises. Medications that effect neurotransmitter levels have been shown to be the most effective. Anafranil (clomipramine), Prozac (fluoxetine) and, most recently Zoloft (sertraline) have been used with varying levels of success.

Whilst trichotillomania has been recognised for over one hundred years it has, until recently, been hidden. It is believed that exposure through public discussion will encourage sufferers to seek treatment.

For more information visit www.anxiety.org.nz or call 0800 ANXIETY (0800 269 4389)

24/7 Anxiety Helpline

If you're feeling anxious and would like to talk to someone about anxiety relief - wherever you are in New Zealand - you can phone our free 24 hour Helpline:

0800 ANXIETY (0800 269 4389)

Our Helpline gives vital support to hundreds of people each month who experience all forms of anxiety, including Panic Attacks, Phobias and Obsessive Compulsive Disorders.

If you suffer from anxiety, or have an anxious relative or friend you'd like to help, please call us for support and information about anxiety and anxiety management strategies.

This service if completely confidential and free of charge. It is the only service of its type in New Zealand.

Who Can Ring the Helpline?

- Anyone who is struggling with ongoing stress, Anxiety, Panic Attacks, Obsessive Compulsive Disorders, Phobias, and associated issues.
- Concerned family members, loved ones, and supporters of anyone in an anxiety-related crisis.

What Do We Provide?

- We will listen and support you with empathy and unconditioned acceptance.
- We can take you through breathing and relaxation exercises that are really effective in minimising feelings of anxiety and panic.
- We can discuss practical strategies you can learn and apply whenever anxiety and panic starts to feel overwhelming.
- We will offer encouragement, education, and advice for anyone who is supporting someone struggling with anxiety.

Who Will I Be Talking To?

Our Helpline is staffed by specially trained and understanding volunteers. If you are experiencing anxiety or panic and don't know what to do, our Helpline staff are well equipped to walk and talk you through the experience.

Is This Really a 24/7 Service?

Yes it is! We operate all hours, every day of the year, including public holidays. However, please keep in mind that 12am-8am is reserved for severe anxiety situations only.

Whatever the hour, if the line is temporarily busy when you call, please try again a few minutes later and one of our volunteers will be available to take your call.

Please remember to call 111 in more urgent situations.

FOR FURTHER INFORMATION ABOUT THE ANXIETY HELPLINE
VISIT www.anxiety.org.nz or EMAIL helpline@anxiety.org.nz