us, a twenty-foot drop into frigid water in front of us. I felt very alive . . . when Johnny pushed me over the edge of the cliff.

What ledge is God asking you to jump off of right now?

God makes the call; we roll the dice; we make the move.

5. Changed Life

Every time someone says yes to God, the world changes a little bit. In the early days of the church, the legal authorities imprisoned Peter and John for teaching about Jesus. Although the authorities tried everything they could to intimidate Peter and John, they would not stop talking about God. We're told that "when they saw the courage of Peter and John and realized that they were unschooled, ordinary men, they were astonished and they took note that these men had been with Jesus."

Sometimes people say no. Every time you say no to God—you change a little. Your heart gets a little harder. Your spirit dies a little. Your addiction to comfort gets a little stronger.

It's Not the Size of the Risk That Counts

What counts as a significant risk for you will be a little different from anyone else in the world. Research makes it clear that some people have a strong genetic predisposition to anxiety.

Picture a bell-shaped curve: People on the far right are genetically predisposed to be risk takers. Their brains are not very sensitive to adrenaline and other stress modulators. They have a lot of a substance called GABA—gamma-aminobutyric acid. They require vast amounts of risk just to keep them from feeling bored. They are drawn to skydiving, bungee jumping, tightrope walking, alligator wrestling, and karaoke bars.

People in the middle of the curve are set up for an average amount of anxiety, while people on the far left are genetically predisposed to be risk avoiders. Their brains are extremely sensitive to adrenaline,

and they have low levels of GABA. They wrestle more with worry. They may feel more anxiety about going to a party where they will have to make small talk than persons on the right side of the curve feel when they are going to jump out of an airplane. Just because you're on the right side of this bell curve does not necessarily mean you have more faith! It could just mean you have more GABA.

And just because you're on the left side doesn't mean you're spiritually inferior to the thrill seeker. This is one of the reasons Jesus said, "Don't judge." Not even yourself. Only God sees into the brains and neurons and knows what raw material we all wrestle with. The goal is for you to take what counts as a risk for *you*, one step at time, starting with where you are.

God makes the call. We roll the dice. We make the move. We begin the adventure.

Where Proof Is Possible, Faith Is Impossible

I have had the chance to see dice-rolling faith up close and personal in my father. My dad lived in the same house in Rockford, Illinois, until he went away to college. His family was 100 percent Swedish, and Swedes are not an impulsive people. He became a CPA, and CPAs as a group are usually a little more sober-minded and prudent than, say, NASCAR drivers or professional lion tamers.

When Dad was fifty years old, he got a call asking if he would be interested in moving to California to join a church staff and help them in the area of finance and administration. It was a position consistent with his wiring. He asked a number of us to pray for him about this decision, and we all agreed it seemed like it could be a life-giving move. It was a difficult decision because he had spent his entire life in one community and in one profession, and to leave all that seemed crazy. He said no.

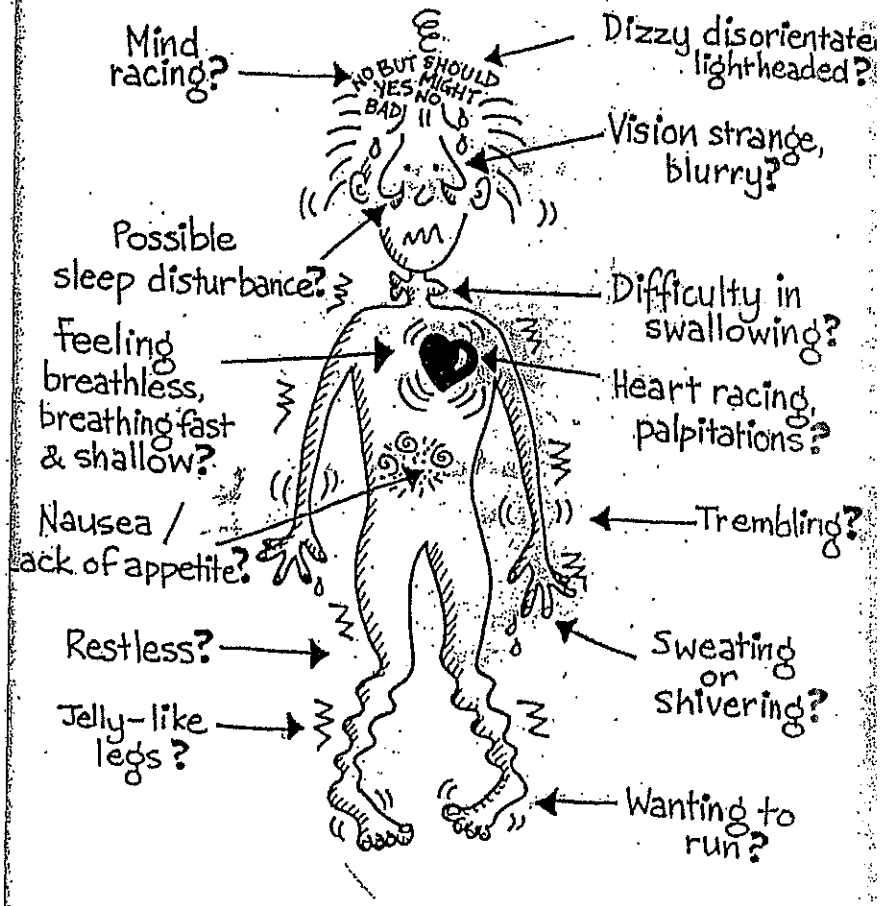
But he could not shake the sense that he had given the wrong answer. He had a restlessness in his spirit that he could not dismiss.

COPING STATEMENTS

- This feeling isn't comfortable or pleasant, but I can accept it.
- I can be anxious and still deal with the situation.
- I can handle these symptoms or sensations
- This isn't an emergency. It is okay to think slowly about what I need to do.
- This isn't the worst thing that could happen.
- I'm going to go with this and wait for my anxiety to decrease.
- This is an opportunity for me to learn to cope with my fears.
- I'll just let my body do its thing. This will pass.
- I'll ride this through - I don't need to let this get to me.
- I deserve to feel okay right now.
- I can take all the time I need in order to let go and relax.
- There's no need to push myself. I can take as small a step forward as I choose.
- I've survived this before and I'll survive this time, too.
- I can do my coping strategies and allow this to pass.
- This anxiety won't hurt me - even if it doesn't feel good.
- This is just anxiety - I'm not going to let it get to me.
- Nothing serious is going to happen to me.
- Fighting and resisting this isn't going to help - so I'll let it pass.
- These are just thoughts - not reality.
- I don't need these thoughts - I can choose to think differently.
- This isn't dangerous.
- So what.

If you have picked up this book,
then you are probably experiencing
some very strange and frightening things . . .

DOES THIS LOOK FAMILIAR?



and overall, a feeling of fear and dread
that seems to come from nowhere?

Recipe for an "IT"

(Serves none)

4 truckloads of guilt
16 cups of shoulds
4 bags of perfectionism
12 busloads of criticism (self or outside)
10 barrels of low self-esteem
20 tonnes of negative thoughts
80 kilos of exaggeration
1 football field worth of worrying
Large pinch of sense of failure
1 period of insomnia*

Combine with any of the following:

1 major life change
1 or more relationship problem(s)
1 or more drug experience(s)
1 prolonged period of tension
1 set of gynaecological problems/hormonal changes
1 inability to relax
1 ridiculous work load
1 unhappy childhood
1 set of sexual problems
1 family member with Panic Disorder or Anxiety Condition
1 biological predisposition

**Ingredients may vary with each individual*

Allow mixture to simmer for most of a lifetime.

SO . . .

you have a **base**
of negative thoughts . . .

to which you **add**
a stressful situation . . .

followed by a **topping**
of physical sensations . . .

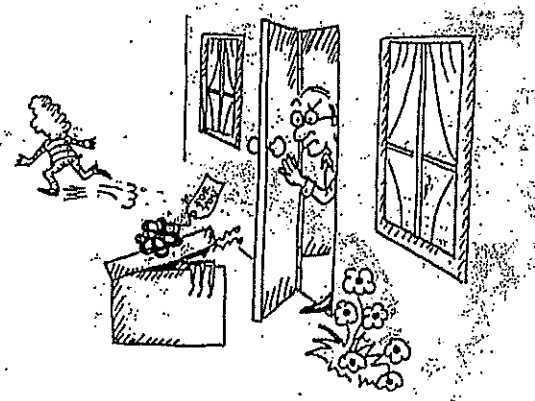
AND . . .

HOUSETRAINING YOUR 'IT'

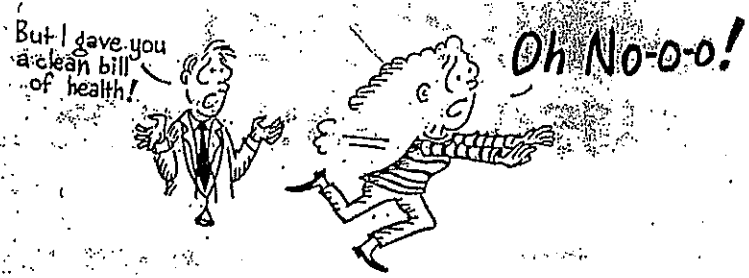
Step 1: ACCEPTANCE

Like him or not, your **'IT'** has moved in:
lock, stock and Panic Attack
That is the *present* reality.

It is difficult to accept this.
You don't want **'IT'**. You don't like **'IT'**.
In fact, you wouldn't wish **'IT'** on your worst enemy.

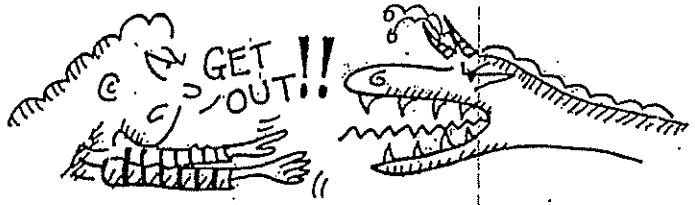


'No,' you think, 'there's been a mistake. **"IT"** is an exotic illness.' You have a check-up, just to prove it.



It's hard to live with **'IT'**
let alone accept **'IT'**.
You miss your old life, old self.
You grieve for the person you
think you've lost forever.

It's not fair! **'IT'** is not fair! You want **'IT'** gone. NOW!
You want your life back! How *dare* **'IT'** do this to you!
Go AWAY!

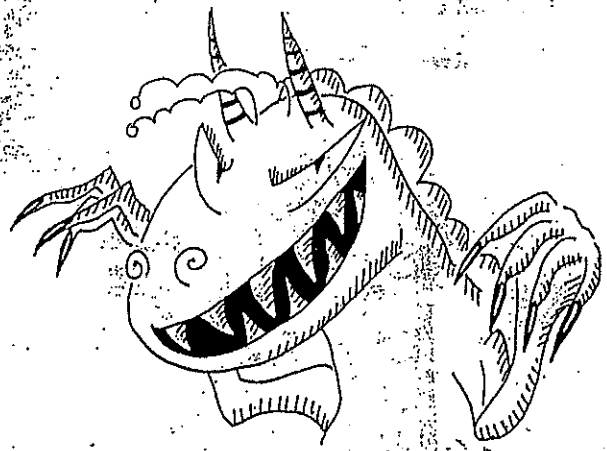


Guess what? He's still there.

WHY?

Because **'IT'** is shaped by **you** and **your** thoughts.
So, stop wishing and grieving and rebelling and
denying. Giving in does not mean giving up.
After all, **'IT'** is *anxiety*, nothing more than that!

Yes, he is **BIG** and **UGLY** and
TERRIFYING



But **YOU** designed him!

Acceptance does not mean that you have to *love* **'IT'**
or even *like* **'IT'**. In fact, right now, you *hate* **'IT'**.
Acceptance is somewhere in between such strong
emotions in a calm, central, neutral place.
You have **'IT'**, **'IT'** is unpleasant, but that's how **'IT'** is.
You *have* **'IT'**, in the same way as you *have* a bad
headache or you *have* a strong emotion.
It's the same as living with diabetes, for instance.
Let **'IT'** roll. **'IT'** is just something you live with . . .
FOR NOW.

Step 2:
BREATHING

'IT' is in full flight. He's having a field day. This is what you do:

STOP for a few seconds and observe your breathing. It is probably shallow, quick, and high up in your chest.

You may be doing an awful lot of sighing

or panting.

You are letting off too much carbon dioxide (CO_2). You are **hyperventilating** and this makes you feel weird and agitated.

NOW — without lifting your shoulders, place your hand on your abdomen and take in a big, s-l-o-w breath till your abdomen *expands*. Hold it in.

Think *only* of your breathing.
It is the *most important* thing right now.

Now, let *all* the air out, very slowly, till your abdomen goes *in* again.

KEEP GOING

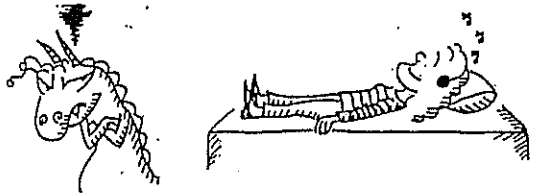
slowly, in ... and ... out, in ... and ... out.

'IT' is confused by this.

He thinks: 'Hang on, you're supposed to be *scared* and you're *relaxing*!!! You're *ignoring* me!!!'

Yes, you *are* ignoring **'IT'**. Breathing is the important thing right now. You are busy restoring your CO_2 level to normal. Keep going . . . in and out, in and out. This is *your* time. You can breathe anywhere, any time that **'IT'** decides to bite.

For added ammunition, find a comfortable,
quiet place to lie down.
Put on some soothing music or a relaxation tape
and continue with your breathing.
'IT' may hang around for a while, but he *hates*
this New Age stuff and he *hates* being ignored.
He'll head off and sulk.



He's persistent, though, so you must be, too. More so.
Do this as often as you need to.

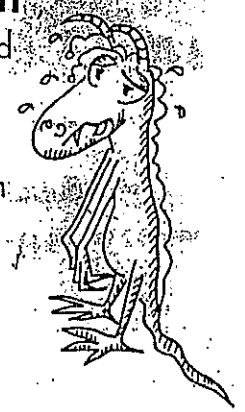
Step 3:
FLOATING PAST

In your mind, cast away your trembling, snarling,
biting **'IT'** on an island.

You are safely drifting past in a small boat.

'IT' is raging and roaring, but you are in your boat and
all you feel is distant ripples. This is not your concern
because you are just an observer, passively watching.
Let **'IT'** roar all **'IT'** likes. Remember, **'IT'** is just a
Panic Attack, nothing more sinister than that.

Step 4:
WAITING 'IT' OUT



In the early stages of your life with **'IT'**
the pain may seem to be endless and
always at an unbearable level.
'IT' is with you day after day,
and the claw of fear in your stomach
is *almost* constant.

ALMOST . . . but not totally.
In fact, even a formidable force
like **'IT'** gets tired from pummelling
you after a time.

If you were to make a graph, you would find that
the panic is not really constant, nor is it always at its
highest pitch.

There are even some **'IT'**-free periods in between!

Try charting your levels of panic on a scale of 1 to 10 and see how they actually fluctuate. **'IT'** is not *always* full-on. By deep breathing and floating, it is possible to wait for the worst moments to pass.

They always do.

Focus on that fact. Make it a chant.

Interestingly, if you were to *will* yourself to panic, you probably wouldn't. It is your *fear* of panic that makes it happen.

Return to Steps 1 to 4 as often as you need to. They will help you to accept that **'IT'** need not overwhelm you. You *can* control **'IT'**!

WELL DONE!

Now, move on.

'WALKIES' WITH 'IT'

Changing Attitudes

We know that drug use (especially marijuana & speed) by a person who has had psychosis is not healthy. It can prolong their symptoms, make them more prone to relapse, and can prolong their recovery.

How can we best help them to either reduce drug usage to a level that reduces harm, or to help them stop all together?

Our anxiety towards this issue can cause us to do things we wouldn't normally do. We don't want to see that person hurt or harmed and we may do things that damage the relationship we have with the person. We may also do thing's that does not allow the person to have their rights.

There is a need to continue to do things that continue to maintain healthy relationship with the person. That continues to allow you to have a voice in the issue and where necessary to set limits when the behaviour is having unacceptable limits on the family.

As parents and friends we are in it for the long haul. We are there because of our love and concern for the young person. We need to develop systems and strategies that assist them in the long run to home. We need to be prepared to provide support that allows the person to work through the issues.

- Need to have a system of support for ourselves. A system that allows us the opportunity to explore issues and to let out our frustrations. We may need to break our own code of silence, and to have people that we can talk to. If the young person is not willing to go to D&A counselling then we may need to go so that we can sort through the issues.
- Need to be able to intelligently talk about drugs and their effects on people. Need to have knowledge about the various drugs. Their effects and side effects, reasons why people use drugs, how to help people stay stopped.....
- Need to be aware of our own standards on drug use. What is acceptable or not acceptable. Sometimes what we say and what we do can be incongruent.
- Continue to increase the likelihood that the young person will discuss and talk through issues with you.
    - Acknowledge and be prepared to talk about your own drug use and how it affected you.
    - Respect their need for privacy, don't go playing detective. Better to talk about any issues or changes in behaviour that you have concerning the person and whether they are using drugs.

If behaviour is beyond what is reasonable to put up with. Then a plan of what is acceptable behaviour and what are the consequences needs to be discussed openly. Involve health workers in this process. Calling police, destroying drugs or supporting the person to leave home maybe necessary. Possibilities need to be discussed in advance. Realise that experience is often the best teacher. Many people who manage well now, took a few years before they grew sick of relapsing and decided to do something about illness management.

COMTEMPLATION:

The person is beginning to weigh up the +ves and --ves of their lifestyle choices. And at this stage may not be committed to change. For many the consequences of their lifestyle may be having an effect on their relationships, finances, legal issues, health issues. There is a realisation that if they continue to head down this track that they may not gain life satisfaction. That they may indeed be sacrificing their dreams and goals.

The person may initiate conversations and arrange appointments with health workers for assistance.

Two questions that may prove helpful at this time are:

1) What are the +ve and --ve consequences of the persons lifestyle choices to this time. In doing this the person is able to make an informed decision about what the consequences are.

2) What are the persons dreams, goals for their lives
What lifestyle choices do they need to make in order to attain the above.
Allow time for the person to make a decision.
Acknowledge losses the person may have experienced; recognise and normalise grief reactions like denial, anger, guilt, shame, fear of recovery.
Understand that these are only part of the persons response

OTHER QUESTIONS:

What do you call the problem or condition you have to deal with?
How severe or life threatening do you think it is?
How long do you think it will last?
What should be done about it?
Who have you found to be helpful?
What do you fear most about the condition or its treatment?
Why did it happen to you?

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Understand that these are only part of the persons response

OTHER QUESTIONS:

What do you call the problem or condition you have to deal with?
How severe or life threatening do you think it is?
How long do you think it will last?
What should be done about it?
Who have you found to be helpful?
What do you fear most about the condition or its treatment?
Why did it happen to you?

Stages of change

James O. Prochaska and colleagues developed this model beginning in 1977 . The original model consisted of four variables: "preconditions for therapy," "processes of change," "content to be changed," and "therapeutic relationship". The model consists of two parts: "stages of change" and "processes of change".

An individual passes through five "stages of change" before he/she is considered to have successfully and permanently adopted a behaviour

1. ***Precontemplation*** - the individual does not exhibit the specified behaviour, and has not considered adopting the behavior
2. ***Contemplation*** - the individual is considering adopting the behaviour, but has not dedicated any effort towards enacting it or preparing to enact it
3. ***Preparation*** - the individual has started to gather information on the behaviour, with a view towards enacting it
4. ***Action*** - the individual has begun to enact the behaviour regularly, but has not continued doing so over a long period
5. ***Maintenance*** - once a behaviour has been regularly enacted for more than six months, the individual is said to have passed into the "maintenance" stage for that behaviour, and has therefore adopted that behaviour. (This is not, however, a "final" stage, after which the individual does not have to expend effort to maintain the behavior - a number of factors can propel an individual back into other stages of change.)

A sixth stage was later added to this model.

6. ***Transformation*** - At this "final" stage, the change in behaviour has become part of the person's normal behaviour.

Although the stages of change are often cited in the above order, this is not necessarily the order in which an individual will travel through the stages of change; any individual may lapse back into earlier stages, or may skip stages entirely.

Processes of change

- For movement from precontemplation to contemplation, the processes of "consciousness raising," "dramatic relief," and "environmental reevaluation" are emphasized.
- Between contemplation and preparation, "self-reevaluation" is emphasized.
- Between preparation and action, "self-liberation" is emphasized.
- Between action and maintenance, "reinforcement management," "helping relationships" and "counterconditioning," are emphasized.

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Motivational interviewing

MI was developed by clinical psychologists William R Miller,and Stephen Rollnick. It is a client-centered, semi-directive method of engaging intrinsic motivation to change behavior by developing discrepancy and exploring and resolving ambivalence within the client.

Motivational interviewing recognizes and accepts the fact that clients who need to make changes in their lives approach counseling at different levels of readiness to change their behavior. Some may never have thought of changing the behavior in question. Some may have thought about it but not taken steps to change it. Others, especially those voluntarily seeking counseling, may be actively trying to change their behavior and may have been doing so unsuccessfully for years.

Motivational interviewing is non-judgmental, non-confrontational and non-adversarial. The approach attempts to increase the client's awareness of the potential problems caused, consequences experienced, and risks faced as a result of the behavior in question. Alternately, therapists help clients envisage a better future, and become increasingly motivated to achieve it. Either way, the strategy seeks to help clients think differently about their behavior and ultimately to consider what might be gained through change.

Motivational interviewing is based upon five general principles:

1. ***Express empathy***, guides therapists to share with clients their understanding of the clients' perspective.
2. ***Develop discrepancy***, guides therapists to help clients appreciate the value of change by exploring the discrepancy between how clients want their lives to be vs. how they currently are (or between their deeply-held values and their day-to-day behavior).
3. ***Roll with resistance***, guides therapists to accept client reluctance to change as natural rather than pathological.
4. ***Support self-efficacy***, guides therapists to explicitly embrace client autonomy (even when clients choose to not change) and help clients move toward change successfully and with confidence.
5. ***Avoid argumentation*** (and direct confrontation). Arguments create resistance.

The main goals of motivational interviewing are to establish rapport, elicit change talk, and establish commitment language from the client.

PROs and CONs

	Changing my behaviour to……	Staying the same and not……
PROs		
CONs		

Margaret Hartstone and Amanda Burlock

Setting SMART Goals

CBT Goals
Simple and Specific: Stated in terms of what the person wants to achieve; eg. "I want to do the shopping by myself"
Measurable: Can be broken into steps and can be recorded.
Agreed: People agree this is a suitable goal.
Realistic: Person believes s/he has the ability to achieve this eventually.
Time scale: Goal seems achievable within the time.

Why might these <u>not</u> be SMART goals?	
"I just want to be happy."	
"I want to stop my kids arguing."	
"I don't want to feel embarrassed."	
"I want a girlfriend/boyfriend."	
"I want to stop all my tablets."	

Problem	Goal		✓/✗
		Simple and Specific	
		Measurable	
		Agreed	
		Realistic	
		Time scale	
		Simple and Specific	
		Measurable	
		Agreed	
		Realistic	
		Time scale	
		Simple and Specific	
		Measurable	
		Agreed	
		Realistic	
		Time scale	

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Graded Exposure

EXAMPLE

"My Goal is to do the weekly shopping alone"

Date	Task	SUDS (pre+post)		Comment
6/4	Stop car at deli and buy bread alone	9	7	Harder than I thought
7/4	Stop at car deli and buy milk alone	8	5	Calmed down quicker today
8/4	Walk to deli and buy bread alone	9	4	Scared - but I liked the walk back!
9/4	Walk to deli for milk alone	7	4	Getting easier now
11/4	Walk to deli for bread alone	5	3	Too easy
11/4	Stop car at supermarket for milk only, alone	8	7	Scary but not as bad as I expected.
12/4	Stop car at supermarket for apples	8	5	Also bought card and paper.

Next steps: more items, busier times, leave mobile phone home.....

My Goal is .....

I will persist until my anxiety has decreased to/by.....

Date	Task	anxiety (pre+post)		Comment

Next steps.....

.....

Margaret Hartstone and Amanda Burlock

Who should I see and what's the difference?

Counsellors & Psychotherapists

Counsellors and psychotherapists in Australia are self regulating professions. In other words anyone can claim to be a counsellor or psychotherapist regardless of whether they have any training or qualifications. It is in the publics own interest to only use a counsellor/psychotherapist who is registered with a recognised professional body such as the *Australian Counselling Association* (ACA) or *Psychotherapist and Counsellors Federation of Australia* (PACFA). Members of these associations meet professional standards of training and abide to a code of conduct and a complaints procedure. Non registered counsellors are not accountable to any government or professional body.

Counsellors train in the "talking therapies" and are able to help with most personal issues such relationships, grief, stress etc. Counselling has been proven to be an effective therapy for most emotionally based issues. Counsellors generally do not perform diagnostic or testing services particularly for issues such as schizophrenia, bi-polar disorder or clinical depression; these are generally the realm of psychologists. Counsellors can also be known as Psychotherapists. There is no one agreed definition for psychotherapists. Traditionally psychotherapists have differentiated themselves from counsellors by claiming to work therapeutically at a greater depth with clients and over longer periods of time. They have also claimed to hold higher qualifications. Although this may have been the case many years ago this argument no longer stands.

Psychologists

The 'Psychologist' label refers to completion of a four-year Psychology degree plus two years supervision or postgraduate qualifications. In addition, specialisation involves the completion of a Masters or doctoral degree (PhD). The emphasis in Psychology is generally upon changing behaviour and thinking styles and developing improved strategies for dealing with problematic situations. Clients are encouraged to become proactive in setting and achieving their goals. Psychological distress is usually deemed to be social in origin and therefore able to be changed.

Medication:

Psychologists *CANNOT* prescribe medication as they are not medically qualified. Their treatments are based on changing behaviour without medication.

Appointments:

- No referral is necessary to see a Psychologist if you are willing to pay in full for services. Making an appointment is usually just a matter of finding someone with relevant experience.
- However, a referral IS necessary if you wish for Medicare to pay a portion of the fee. A referral from a GP to a Psychologist (who is registered with Medicare) can entitle you to rebates to 12 individual sessions (and 18 in some cases), as well as 12 group sessions per year. NOTE: Not all Psychologists are yet registered to provide these services.

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Psychiatrists

The 'Psychiatrist' label means the person is a qualified medical doctor who also has expertise in emotional problems and mental illness. This means they have completed a medical degree prior to specialising in Psychiatry, requiring at least 13 years total in training. As a result, most Psychiatrists adopt the 'disease' model, emphasising the biological origins of psychological distress. This model often gives rise to various 'chemical imbalance' theories of mental illness. Therefore, many treatments involve medication. However, this can be combined with other forms of therapy, such as Cognitive Behavioural Therapy (CBT).

Medication:

Psychiatrists *CAN* prescribe medication and are specifically trained for mental health problems.

Making an appointment:

In most instances you may need a doctor's referral to see a Psychiatrist, especially if you are to claim fees from Medicare.

Many psychiatric services are covered by Medicare. The rebate may differ between a public and private psychiatrist.

Qualifications:

In Australia, Psychiatrists are governed by *The Royal Australian and New Zealand College of Psychiatrists.*

Qualifications to look for:

- Are they a fellow of the *Royal Australian and New Zealand College of Psychiatrists (FRANZCP)* or of the *Royal College of Psychiatrists (FRCPsych)*?

Occupational Therapists
http://www.ausot.com.au

Social Workers
http://www.aasw.asn.au

Mental Health Nurses
http://www.acmhn.org

From: Anxiety Disorders Association of Victoria (http://www.adavic.org)

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INTERNET RESOURCES

- Clinical Research Unit for Anxiety and Depression
http://www.crufad.com/cru_index.htm
- The Anxiety Network International
http://www.anxietynetwork.com/index.html
- HealthInsite
http://www.healthinsite.gov.au
- The Anxiety and Panic Hub
http://www.panicattacks.com.au/
- National Institute of Mental Health
http://www.nimh.nih.gov/publicat/anxiety.cfm
- Obsessive-Compulsive Foundation
http://www.ocfoundation.org/
- Social Anxiety Institute
http://www.socialanxietyinstitute.org/
- MoodGym
http://www.moodgym.anu.edu.au/

COMMUNITY RESOURCES

Panic & Anxiety Disorders Association (PADA).
- Telephone: (08) 8297 7108 www.panicanxietydisorder.org.au
- 589 South Rd, Everard Park SA 5035 Mon – Thur 9:30am - 2:30pm

Obsessive-Compulsive Disorders Support Service Incorporated.
- 589 South Rd, Everard Park SA 5035 Telephone: (08) 8297 3063

SELF HELP BOOKS

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