Helping Students with Anxiety or Depressive Disorders: Guidelines and Strategies for School Mental Health Personnel

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Teaching Kids to Relax

It's best to let people explore several options and choose the one that is most beneficial to them. Both mental and physical techniques have been demonstrated to work equally well. It's hard to be both nervous and relaxed at the same time. If you can relax your mind, your body will relax. If you can relax your body, your mind will relax. People who learn to relax before and after events that cause fear can greatly reduce their anxious feelings.

Progressive Muscle Relaxation

Alternately tense and relax major muscle groups, working top down or bottom up. Tense each group for a full five seconds, then relax for 10-15 seconds and repeat. Major muscle groups include the forehead, eyes, jaws, neck, shoulders, upper back, biceps, forearms, hands, abdomen, groin, legs, hips, thighs, buttocks, calves and feet. Most people carry tenseness in a particular area: some people clench their jaw, for instance, while others tighten their neck and shoulder. People should emphasize the area that tends to give them trouble. Just like learning to play a game or instrument, practicing the technique over and over will develop the skill and increase confidence.

Controlled Breathing

Many people breathe shallowly when they're anxious. Such breathing causes the body to build up CO2 and in turn feeds the symptoms of anxiety. Controlled breathing works to relax the body by maintaining the proper balance of Oxygen and carbon dioxide. It takes about four minutes to restore the proper balance, hence when using this technique you should do it for at least that amount of time. It's best to inhale and exhale the same amount of time. It doesn't matter if you breathe through your nose or mouth. It sometimes helps to breathe with one hand on your stomach and one on your chest. When you breathe in, the hand on your stomach should move out. Breathe slowly to a count of 4 for each inhalation and exhalation, without taking big gulps of air. Note that aerobic activity of any kind would also have the same effect.

Imagery

Imagining scenes that are soothing and relaxing is an effective way to relax. The scene is not as important as how the image makes you feel. It may take a few tries for someone to find an image that is most relaxing to them. Sometimes it helps to think of a time when you felt most secure and relaxed and imagine that scene. Imagery works better when you include multiple senses. Imagine the sounds, the smells, the feel, etc. Younger children can draw a picture of their scene to help them remember to include all the senses. You can also have them dictate their own story and put it on tape or write it out for them.

Distraction

Distraction works to reduce anxiety by taking the focus off of the disturbing sensations or thoughts. Getting involved in another activity or thought will reduce symptoms of anxiety. It is important to practice distraction for at least four minutes before expecting a reduction in the unpleasant symptoms.

Script for Progressive Relaxation

Get comfortable in your position, and relax your shoulders, head, arms and legs (pause) Clench your fists as tight as you can. Hold them tight and feel the tension in your forearm. Now let go. Feel the tension drain from your arm and fingers, and notice the relaxation. Do it again. Clench your fists (pause). Hold them tight, and now relax. Notice the difference between tension and relaxation. Do it one more time on your own (pause).

Now bend your arms at the elbows and press your arms in tightly. Squeeze your biceps (pause). Tighten them as much as you can. Now let go. Feel the difference as the tension is released from your arms. Repeat it one more time – bend your elbows, squeeze your arms. Hold them tightly (pause). Then relax (pause).

Scrunch up your forehead as tight as you can. And relax (pause). Smooth out your forehead as much as you can, letting the energy drain down your face. Frown and feel the strain across your face. Frown as hard as you can. Now let go (pause). Feel the relaxation spread around your forehead, mouth and chin. Close your eyes, and squeeze them tightly. Pay attention to the tension you feel. Keep your eyes closed, and let them relax (pause). Keep them comfortably and gently closed.

Now clench your jaw. Bite hard (pause). Notice how it feels (pause). Now let go. Feel your lips part slightly as your mouth and jaw fully relax (pause). Press your tongue against the roof of your mouth. Push. Feel the strain on your tongue (pause). Relax (pause). Purse your lips, pressing them forward as tight as you can (pause). Now let go. Feel the tension draining from your forehead, eyes, jaw and tongue.

Roll your head comfortably back and notice where the tension lies (pause). Now roll it to the left....and roll it gently to the right. Bring your head slowly forward and rest your chin on your chest. Feel the tension in the back of your neck. Now relax, letting your head return to a comfortable position (pause). Now lift your shoulders. Try to touch your ears with your shoulders. Press and hold (pause). Drop your shoulders and feel the tension release. Feel the release through your shoulders, neck, and arms. You feel more and more relaxed.
Give your whole body a chance to relax. Notice the heaviness of your body. Let your weight sink into the chair (floor). Take a deep breath and hold your breath (pause). Now exhale, and feel your chest loosen. Let all the air escape. Do this again, inhaling deeply and holding your breath, then easily releasing all the air. Repeat one more time (pause). Notice the tension draining from your body.

Now place one hand on your abdomen, tighten your stomach, and hold (pause). Relax (pause). Keeping your hand on your stomach, push your hand up with your abdominal muscles and hold (pause). Now let go. Notice the difference. Now arch your back without straining. Focus the tension in your lower back, tightening. Let go, and relax deeper and deeper (pause).

Tighten your buttocks and thighs. Press your heels down as hard as you can into the floor. Hold the tension (pause). Now relax. Curl your toes tightly. Feel the grip in your feet, ankles and lower calves (pause). Let go, and feel the energy moving in your feet. Now curl your toes up, toward the ceiling, and hold (pause). Relax again.

As you relax, notice that your body feels heavier and heavier. Feel the relaxation spread deeply through your calves... thighs...abdomen....back...arms...shoulders...and head. Let go some more (pause). Notice the feeling of looseness throughout your body (pause). I will count backward from five and as I do you will shift your attention from your body to your surroundings. Five, four, three...notice the presence of others around you, the sounds outside... two, one, open your eyes feeling refreshed and energized.

Everyone is afraid of something. Some people fear insects or high places, fear going to the dentist, speaking in front of others, or being in groups. Some things that make you feel nervous might cause other people to be very afraid. In the spaces below, record some of the situations that make you feel anxious or afraid.

I feel nervous when ____________________

I also feel nervous when ____________________

I feel afraid when ____________________

I also feel afraid when ____________________

I also feel afraid when ____________________

I also feel afraid when ____________________

I feel overwhelmed when ____________________

What Happens When You're Anxious?

Physical Reactions

Sweating palms
Tightness
Heart beating faster
Flushing
Light headed or dizzy

Thoughts

Thinking there's danger
Thinking you can't handle it
Believing you're on your own
Worries
Catastrophic thinking

Behaviors

Avoiding certain situations
Leaving when you start to feel afraid
Trying to control things

Feelings

Nervous
Irritable
Panicky
Afraid

How Scary Is It?

Goal: To determine how anxiety-provoking different situations are for a child.

Age: Best for children ages 5-8, though the activity might be useful for older youth who are very withdrawn, or who use limited speech.

Materials: Deck of Cards. 10 to 15 index cards on each of which is written a different anxiety provoking situation relevant to the child's fears (optional: Pictures of different kinds of situations instead of index cards)

Requirements: Child needs to be able to count and have at least some vocabulary to describe feelings of fearfulness.

Directions: Explain that you're going to play a game in which the child gets to rate how scary a situation is. Give the child ten to 20 playing cards from ace to ten, ace being the lowest. "I'll describe a situation, and you choose the card that tells how it is. If it's terrifying, you'd put down a ten, and if it doesn't even make you nervous, you could put down an ace or a two. Let's try one for practice."

Describe a situation or show a picture of an action that might cause fear in many people (e.g. a picture of a spider, or say, "A girl finds a spider on the wall of her room.") "How scary is that?" Respond to whatever number card the child pulls from her hand and places down next to the picture or index card. E.g. "You gave that a five. It's pretty scary", and wait for any elaborations the child might offer. If the child clearly doesn't understand the directions, give additional instructions, and do one or more examples.

The game is over when the child has used at least one card between ace and ten. You and the student can then arrange the cards, along with the situation they went with, in a row. This is your record or hierarchy of anxiety provoking situations for this student.

What Teachers Might Want to Know about Trauma

Nationally, it's estimated that 9% of young adults have been traumatized. Trauma can be defined as a negative event that lies outside the realm of usual human experience. It is something that overwhelms one's ability to cope. Disasters, sexual abuse, violence, life threatening illnesses, and even very bad accidents are examples of trauma. Trauma can negatively impact a child's development because it undermines the two foundation blocks on which healthy development rests - safety and trust. A child who has been traumatized often comes to believe, "the world is not safe" and may also believe, "people are not to be trusted". These two beliefs, if carried forward, can continually interfere with developmental tasks.

How do People Respond to Trauma?

An individual child's response to trauma is dependent upon several factors: the child's own biology, the response of significant others to the child's trauma, and the kind and duration of trauma. Trauma experts agree that severity increases in order of the following kinds of trauma:

Physical injury
Psychological injury
Combined physical and psychological injury
Sexual abuse

Note that sexual abuse is considered to be the single most traumatizing event that can happen to a person. Predictable trauma is less severe than unpredictable trauma, and trauma deliberately inflicted by a trusted person (e.g. watching your father hit your mother) is more severe than trauma that is not committed by a person (e.g. surviving a life threatening storm). In addition, the severity of the response to trauma increases with the duration. Acute, single episodes of trauma tend not to be as damaging as less acute, but chronic episodes. The most damaging is unpredictable, acutely chronic trauma, such as some kinds of sexual abuse.

We have known for several decades now that people respond to trauma in predictable ways. There is a pattern of behaviors that is a *normal response* to trauma. These behaviors are a defense, or coping mechanism that helps the individual to survive. There are individual differences, of course, but generally, people re-experience the traumatic event in one or more of the following ways:

They have recurrent disturbing thoughts or images
They have recurrent bad dreams
They sometimes feel like it's happening again
They feel very upset at exposure to some cue that reminds them of the event

Traumatized people also typically exhibit symptoms of anxiety. There may be sleep disturbances, hyperactivity, startle response, irritability or angry outbursts, difficulties with concentration, or hyper vigilance. People often report feelings of numbness after trauma. This is shown by:

Inability to remember some parts of the traumatic events
Feeling detached from others, alone
Difficulty expressing all emotions - restricted
Less interest in activities
Difficulty thinking about their future

People do not forget trauma. Traumatic events are typically encoded in the fight or flight pathways of the brain and are indelible. Experimental neurologists tell us that they will never go away. Teachers can tell kids that they will never forget what has happened, but the pain or discomfort can go away.

How does Trauma impact Learning?

In addition to its overriding influence on development, trauma changes the brain. Specifically, the *traumatized brain* is a *sensitized brain.* It is hyper-aroused. Chemically, we think trauma causes nerve cells to leak sodium, making the cell more likely to depolarize. The cell is more excitable because an immature or weak nervous system has limited ability to control arousal. There is evidence that the child's brain is more changed by trauma than the adult brain because the child's brain is more vulnerable.

This *arousal* is the core of the traumatic response.

For some children, trauma seems to not influence their classroom behavior or their learning, although their anxiety may make them more inefficient in their studying. For other children, the potential impact on learning is obvious. Children who are hyperactive, irritable, and having difficulty concentrating are going to have difficulty learning.

Why do some Children Seem to be able to Handle Trauma Better than Others?

Everyone has a potential breaking point. The unique biology of an individual contributes to their vulnerability or resilience. Vulnerability to trauma varies along a continuum. Also, prior trauma, *if resolved* seems to immunize children against later trauma, while *unresolved* prior trauma seems to sensitize the child even more to subsequent trauma.

Why is Early Intervention Important?

The part of the brain that encodes trauma does not mature until age 55. Early intervention can prevent the arousal from becoming permanent. In addition, early assistance to traumatized children can increase the chances that the stress they've experience will serve as inoculation against later stress and will decrease the negative influences of the trauma on their learning.

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A behavior-shaping plan was established that involved rewarding Carrie for playing or working independently from her mother, with the physical distance between them progressively increased (at home and at school). Both parents and school provided incentives for spending more and more time away from Mom. As an initial step, Carrie and her parents wrote up a menu of rewards that they all agreed on. Rewards included small treats, toys, special activities or privileges (e.g. watching a favorite video, staying up a half hour later, or getting to help Mom cook or play a game). The menu was posted on the refrigerator. The counselor arranged to teach Carrie some relaxation skills so she could reduce her anxious feelings. At a meeting with the school counselor, Carrie, Carrie's teacher, and Carrie's parents, a list was made of the behaviors they wanted to encourage in Carrie. Carrie earned points toward rewards when she was able to perform the task on the list. Everyone agreed to reward points on the day they were earned. If Carrie was unable to do a task and not earn a reward, she was simply encouraged to try again next time. Here is the list:

Things for Carrie to do at Home:

1. Play for five minutes in a room next to Mom, with Mom in sight.
2. Same as #1 but Mom out of sight and talking to Carrie.
3. Same as #2 but Mom two rooms away.
4. Same as #3 but three rooms away.
5. Same as #4 but Mom not talking.
6. Same as #5 but one floor away
7. Increase the time in #6 up to 30 minutes in five minute increments

Things for Carrie to do when she comes to School:

1. Carrie and Mom go to school together with Mom sitting near the back door.
2. Same as #1 but Mom stays near the door, and Carrie moves to chair 15 feet Away.
3. Same as #2 but Mom moves her chair outside the door in Carrie's view.
4. Same as #3 but Mom out of sight.
5. Mom stays in school, but remains in the library or front office.
6. Mom stays in car outside of school for 15 minutes, then drives home.

Things for Carrie to do when she is going to sleep:

1.
2.
3.
4.
5.
6.
7.

Research Updates on Treatments for Anxiety and Depression

Treating social phobia in adolescents

Adolescence is the period when social phobia usually begins. Some authorities believe that cognitive features play a central role in maintaining social phobia. They proposed that social phobics are excessively self-focused and inundated with negative self-images during social situations. Social phobics therefore do not accurately assess social situations. They believe others see them in the same negative light they view themselves. Social skills deficits are common among both adult and child social phobics, even as young as age 7. It's still not clear whether these deficits arise as a result of ongoing avoidant behavior (the individual does not get enough practice to develop good skills), or whether they're the result of interfering negative imagery.

Hirsch, C., Clark, D.M., Mathews, A., & Williams, R. (2003). Self-images play a causal role in social phobia. *Behaviour Research and Therapy, 41*, 909-921.

Hudson, J.L., & Rapee, R.M. (2000). The origins of social phobia. *Behavior Modification, 24,* 102-129.

Treatment of adolescent depression

There is some evidence of differential effects for treatment approaches. Specifically, CBT approaches seem to be more effective for boys than girls, interpersonal approaches seem to be helpful for individuals who are more oriented toward affiliation than toward achievement. There is ongoing debate about whether to focus on universal vs. selected or targeted approaches. There are benefits to both. Universal approaches avoid participation stigma and reach people with diverse risk factors. Also, there is less attrition in universal programs. Selective approaches, however, are associated with larger effect sizes.

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Stolberg, R.A., Clark, D.C., & Bongar, B., (2002). Epidemiology, assessment, and management of suicide in depressed patients. In I.H. Gotlib and C.L. Hammen (Eds.), *Handbook of Depression.* New York: Guilford Press.

HELPING MY SON CONFRONT OCD WAS NOT EASY

by Kim Wyre

I could hear the panic in my fourteen-year-old son's voice as he called, "Mom," from the bottom of the stairs. My instincts recognized trouble. I hurried down the stairs, irritated because this was the fourth day in a row that he had been progressively later and later for school.

His thin, frail silhouette and the alarm in his voice remain etched in my memory forever. "Mom, I have too much to do. I can't come upstairs," he called. I was unprepared for the roller coaster I was about to ride, a track of ups and downs that were to take my son Hadley and me from the pain of helpless despair to the freedom of self-discovery. Other families that experience obsessive-compulsive disorder (OCD) can understand this journey.

Viewed by almost everyone as a model teenager, Hadley was a loving, kind, and conscientious son who easily maintained straight A's through all his years in school. He was sensitive, well liked by peers, and especially respected by adults. He followed the rules. As we look back now, some of the imprints of OCD seem visible, but the signs were subtle and easily confused with transitions through normal childhood stages.

An extraordinary coincidence led to his diagnosis. Hadley overheard our conversation with our closest friends who disclosed that their sixteen-year-old daughter had recently been diagnosed with OCD and talked about their family's painful struggles. In an enormous act of maturity and courage, Hadley recognized his own disorder and informed us of his worst fear . . . that he, too, had OCD.

OCD wears many faces and after several distressing evaluations, we discovered that Hadley's OCD was "extreme" on a continuum of mild, moderate, severe or extreme. OCD occupied Hadley's every waking thought and resulted in the lengthy time-consuming rituals he created in an attempt to relieve his horrific thoughts, worries and doubts.

The weeks following his diagnosis were filled with fear and agony for our family, as Hadley no longer hid his behavior from us. Our family sat at the dinner table sickened as we waited for Hadley to satisfy his overwhelming urge to wash his hands to a series of audible counting rituals in a voice that was not my son's. Frequently, after many attempts, he was unable to join us for meals. There were times when Hadley was unable to complete the memorized list of detailed rituals that allowed him to safely exit his room. He was unable to go to school, play his favorite sport, lacrosse, or even go to the bathroom. His world of functioning and coping rapidly crumbled before our eyes. He became thinner . . . his eyes grew deep and dark. And the depression that often accompanies OCD surfaced.

The onset of OCD requires a process of grieving that family members are deprived of expressing because this energy, needed to cradle our hearts and souls, must be harvested and channeled into managing OCD. Every facet of parents' lives feels invaded as they grow to

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understand this diagnosis. For parents, the road to their child's recovery is arduous, requiring vigilance, calm, and firmness. Until the disorder stabilizes, parents serve as a light in fearful darkness, a voice to an uneducated society, and a reality check to misinterpreted brain signals.

Hadley was constantly afraid. The umbilical pull to free him from the jaws of a mysterious predator was overwhelming. I was told not to give in to his requests because my actions could only temporarily ease his immediate suffering. Becoming educated about OCD, I found the desire to rescue my child kept surfacing, while at the same time I began to understand that my protection would only tighten the grip of the OCD chains.

At night as I watched him sleep, I wept at the role I was forced to play. He seemed too young and too unprepared to venture into this darkness alone. Children facing a serious illness reply on their parents to guide them and shield them. Where would I find the strength to trust my adolescent son to handle his conflict? This suffering wasn't his fault. I felt powerless, as though I were deserting him.

I learned with considerable pain that it is almost impossible to explain extreme OCD to others. The behaviors seem so bizarre. And because I was unable to disclose Hadley's diagnosis, I was not able to find the support and empathy I craved and felt I deserved. To protect him and myself, I found it safer to keep Hadley's OCD concealed. This led to isolation and further fueled our agony. I found myself envying the life-style of people free of OCD. I caught myself thinking, "If we had to face such a disastrous diagnosis, why couldn't it be more tangible like cancer or a traumatic injury? Then my friends would be able to comfort me as I had them when they faced crises in their lives." My family had to hide behind the stigma of mental illness.

Hadley's road to recovery was blazed by the support of our friends and their daughter. They shared their experiences and warned us of common pitfalls. We found an adolescent psychiatrist with experience treating OCD, who used Hadley's love of lacrosse as a vehicle for communication. "Hadley, when you're engaged in a face-off in mid-field, you are aware of the remote chance that the plane you hear overhead could come crashing down on you. It's possible . . . but the odds are minimal. As you undergo treatment, you will retrain your brain to ignore such small percentage worries." Eventually Hadley would create new pathways in his brain, actually altering chemistry, the doctor explained. It would require great strength and personal determination. In addition to these, Hadley brought other tools to the battle: knowledgeable family intervention and support, medication, and behavior modification. It would be laborious, painful and time-consuming, but remission was within his reach.

The family marshaled our forces to help Hadley. My husband and I, along with my sister, divided up the literature. We reviewed the data and collated the information, quickly establishing a sound base of knowledge. As a family we presented a united, educated force to lovingly encourage Hadley to practice the techniques he was being taught until they became familiar and comfortable. He saw a psychologist specializing in treating OCD who helped him systematically identify his fears and face them using exposure and response prevention.

Today, two-and-one-half years later, as a seventeen-year-old, Hadley has faced many fears and succeeded in many things. He takes pleasure in the responsibilities of driving, struggles over the ups and downs of teenage dating, and dedicates himself to academics. His choices seem balanced and he was named "Outstanding 11th Grade Male" in his school. Along with a 4.0 grade point average, he enters his senior year as president of the National Honor Society and first string on the varsity lacrosse team. He has many friends and a specially close relationship with his older sister. Continuing medication with no apparent side effects, he now realizes that the skills he developed as a result of facing OCD are offering an unexpected reward as he helps his adolescent friends with their personal struggles.

Hadley's remission results from his courage and the time he dedicated to understanding and learning from his OCD. As a family, we are closer and stronger because we all learned the benefits of taking risks and facing fears. Our lives are richer, freer and happier. The principles of challenging OCD are applicable and beneficial to everyone. We recognize that there will always be stress in our lives and we feel better prepared to manage it now.

Through the Anxiety Disorders Association, I now act as a resource contact for other parents facing the initial diagnosis of OCD in a child. I serve as Hadley's voice and a reminder that recovery is possible. We are very proud of Hadley and the way in which he fought to accept his disorder and grow in the face of adversity. We have all grown.

Kim Wyre and her family live in Silver Spring, Maryland.

TEEN CONQUERS OBSESSIVE-COMPULSIVE DISORDER

by Megan Washam

The first thing that struck me about OCD was what it stood for: Obsessive-Compulsive Disorder. I remember when I was first diagnosed that the name struck an incredible blow. I cried endlessly that night, sickened and devastated that I was "disordered."

From that point on, I felt a bit less human, a bit more like a specimen than a person. I felt diseased and scared, but more than anything else, I felt alone. My days and nights were tortured, and the same mind that gave birth to my personality and my being made my life a living hell. I don't think I lived a single minute without some influence of OCD, whether it was in the form of gripping fear or some sort of "ritual." I heard and understood all that my psychologist told me, yet deep down I felt that I was the exception, the one who would never recover, the one who would "go off the deep end."

Treatment was certainly difficult, to say the least, but it is responsible for giving me back my life. Every step took strength and courage, but every step also freed me from the grip of OCD. There are few things in life more difficult than facing and overcoming one's fears, and since this is the goal of OCD treatment, this process is obviously an incredible ordeal. The majority of my treatment consisted of confronting my fears; I made my own nooses, visited a graveyard, repeated bothersome words, and engaged in other such activities which numbed me to the ideas and feelings that had so terrified me beforehand. Anafranil served as a a sort of stabilizer while I underwent the treatment. This all took much trust: in my family, in my doctors, and most importantly, in myself.

I'm still bothered by a lot of the stigmas surrounding OCD, especially since they made me feel rather terrible about myself. I find my first fault with the name: OCD is not a disorder. I'm not "disordered." Neither is anyone else with OCD. We're certainly as normal as anyone else, not somehow tainted as the word "disorder" implies. Secondly, I'm offended by the narrow-mindedness of people with regard to OCD. At the mere mention of it, people assume that you wash your hands 24 hours a day. OCD is much more than hand-washing. Personally, I was very worried that I would commit suicide, and this is only one of many "obsessions" that drive OCD. Everyone who has OCD is a little different. We can't just be classified and stuck in a file under "hand-washers."

As for me, I believe I fully recovered from OCD when I was entering ninth grade. It's been about two years now and my memories of OCD are fading. It's hard for me to believe now that I ever went through such an ordeal. Ironically, it was previously nearly impossible for me to believe that I might ever recover. It all seems so far behind me, such a piece of my distant past. Of course, I'll never forget OCD or the effects that it had on my life. It was truly a scary and downright wretched experience, but I overcame it. Though I have very few positive comments about OCD, I will say this: it renewed my faith in myself and the strength that I have within me.

I wish that when I had OCD I had been able to talk with people who had recovered. I needed to know that it could be done, that I wouldn't suffer for an interminable period. I also wanted to verify that people with OCD were normal people, people like me. I felt that I was weird, and that meeting these people would help convince me that I was not. They were the only ones who could ever truly understand me: my parents and doctors tried their best, but only others with OCD could know how I felt.

Now I wish to help those who are fighting the same battle I fought and won. OCD is a very difficult and individual struggle, but it can and WILL be overcome. I overcame OCD because I believed in myself and had faith, though it wasn't always easy. That's the absolute best way to combat OCD. Believe in yourself, for in time, you will look back on OCD, as I do now. It will be difficult for the road is rough. But you will succeed. Believe me. I know.

Megan Washam, 16, is entering her junior year in high school. She has lived all across the Untied States and is presently living in Virginia where she has been a cheerleader and played basketball, baseball, and softball. For four years, Megan has volunteered in a retirement home and become very special to both the residents and staff. She enjoys shopping with friends, poetry and writing, and plans to attend college to further her study of the humanities.

PANIC DISORDER AT FIVE: THE HARD ROAD TO HEALTH

by Kerry McKay

More of a hardship than belonging to a pariah group is being a pariah without a group. This has been the case for people with panic disorder, and for some this pariah status can begin at a very tender age.

I had my first anxiety attack when I was five and making my First Holy Communion. On cue, when the choir began singing "Let There Be Peace on Earth," it all crashed in on me at once — the thunder of the congregation singing, the thousands of beady eyes on me, the pungent smell of papal incense. But the worst part was when my five-year-old body went cold and tense and I realized that I was trapped — stuck in my place in line between Kathy Reilly and Claire O'Connor for more than an hour.

I sat with my nerves exposed, terrified that I would be sick and faint, soiling the slightly yellowed dress that had been my mother's when she made her Holy Communion. *Was it as awful for her as it is for me?* I wondered, wiggling my long skinny legs, studying the details of my shoes and praying for the clenching in my body to go away.

During the car ride home, I told my parents that I had been very nervous at the ceremony, and my father responded, "Not as bad as the girl who threw up," the disdain for the girl very apparent in his voice. My father's comment confused me, told me that everyone feels this anxiety. Because I didn't want my father to disapprove of me, I made it my goal not to reveal the turmoil inside me.

And I didn't, for the next 25 years. I learned to grow somewhat accustomed to the racing heart, sweating, nausea, smothering sensations, and all the other excruciating physical symptoms. They were my secret.

In high school I appeared to be a fairly normal, sensitive teenager, and the basketball I played kept my body fueled with endorphins. But there was still that unpredictable anxiety, that wave of high-pitched, counter-productive energy as if my blood vessels were chalkboards and the blood running through them was a sharp fingernail.

In college this wave hit me more often and more powerfully, sometimes two or three times a day. My throat would constrict and I would feel as if I couldn't get in air, fleeing to the bathroom because I would rather have been found dead on the bathroom floor than have passed out in a class. Whatever was creating these terrifying feelings inside of me was insidiously brilliant because it always took on a different plan of attack, always created a symptom not quite like the one that had struck before it, making it impossible for me to know with each attack if it would be THE one — the one that would kill me. Junior year I had to give up basketball and consequently, a partial scholarship, because my life was being consumed by my nerves. Eating in public became increasingly difficult. I didn't know how to tell my friends — these mellow, laid-

back, cool people — that my nerves had become so hideously acute for no apparent reason, that I couldn't relax. I experimented with self-medication: marijuana enabled me to swallow but also triggered the attacks, so it wasn't really a relief. Alcohol became my crutch.

Post-college, I kept plodding despite the anxiety. I got a solid entry-level position in one of the world's biggest publishing companies, and New York University admitted me into one of their graduate schools (with my company paying 85 percent of my tuition). I volunteered two evenings a week to try to pull myself out of what I believed to be just self-absorption.

When that didn't work, at the age of 22 I joined the Peace Corps, hoping that in living alone in Africa for two years I could face my fears and weird bodily symptoms and then coerce them into going away. I returned from my commitment two years later much more anxious than I had been when I joined, so I tried plan two: see a doctor.

I found a job in San Francisco replete with insurance benefits and within the next three years, I saw four psychotherapists, two nurse practitioners, four otolaryngologists, one psychologist, two massage therapists, a speech pathologist, two hypnotherapists, and two psychiatrists, and still I had no diagnosis.

When the doctors couldn't diagnose me, I decided to do some research myself and went to the medical school library at the University of California in San Francisco and spent an entire day poring through journals about swallowing difficulty — my most pronounced and debilitating symptom. The only positive thing I took away was learning that I wasn't alone, that there were other people who couldn't swallow, and that gave me the will to go on another day. That's how it was for four years. Each day I had to find a small incentive to live. I became agoraphobic, and sometimes things got so bad I was afraid to get up from the corner of my couch where I would huddle or sometimes gently rock in near catatonia because walking to another room seemed too risky.

Then in April of 1994, while in a bookstore, I discovered a book on depression and anxiety, which I read from cover to cover in two evenings. I had my diagnosis: primarily panic disorder complicated by a general anxiety disorder, post traumatic stress syndrome, obsessive compulsive behavior, and depression. There were names! There were other people like me! The attacks were real! I hadn't imagined or exaggerated them.

I became so angry with all of those who had doubted me and caused me to doubt myself for so long. I took a deep breath, told myself that self-hatred wasn't what I needed. Then I dialed the number of San Francisco's self-help hotline, speaking with the first person in my life who knew what I talking about when I said that couldn't go on any longer — that I was at war with something in my body and it was winning.

She gave me the name of a doctor who was a rehabilitation specialist who had, himself, lived for 30 years with this disorder, and having finally overcome it, now dedicated his time to helping others cure themselves. After listening to me for 15 minutes he said, "It sounds pretty clear to me that you have panic disorder." Thus began my process of recovery. In his cognitive/

behavioral therapy class and with the help of psychodynamic therapy along with medication, I have begun to reclaim my life.

Looking back, I wish many thing had been different. I wish that my parents had known of this help when I was a child. I wish that one of the doctors they took me to see when I was four and ill for two-and-a-half months with a mysterious stomach virus that left me swimming in my clothes on my very first day of kindergarten, had recommended a good child psychologist. I wish my parents had raised red flags at my extreme nervousness beginning at age five, or had taken me to see a well-informed psychiatrist when I started having nightmares a year later, nightmares that I was dying. I wish that they had sought professional help when, beginning at age eight, I kept a journal and at the end of each entry recorded how I feared I might die that night, or when in my teens I developed trichotillomania and would compulsively pull out my eyelashes and eyebrows. Most of all, I wish that I had had the guts and self-confidence it would have taken to make my cries for help more audible.

I confirm that panic disorder is real and debilitating, but that it is also treatable. It hasn't all gone away. I'm not miraculously fixed. For me, working at overcoming panic disorder has become a way of life in much the same way as the creeds of Alcoholics Anonymous become a way of life for many alcoholics. I live moment by moment and relish my ostensibly small, but, in actuality, tremendous victories. Yesterday, I sat calmly sipping herbal tea while chatting with a friend at a cafe near my work, Then I went home and ate a spaghetti dinner so big that afterwards I had to unbutton and partly unzip my jeans. Ahhh, it feels good to be healthy.

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