

# C.A.L.M.

## Choices for **A**nxious **L**ifestyle **M**anagement

### A Publication Dedicated to Overcoming Anxiety Disorders

From the Anxiety Disorder Specialists at **ALTERNATIVE GROUP** of Redlands

Alternative Group is deeply committed to public education and health promotion. We embrace the principal that the benefits and assumptions underlying any treatment program should be clearly and publicly stated. Accordingly, these newsletters are part of an ongoing effort to promote understanding of our philosophy of treatment and to promote discussion of treatment issues.

#### IN THIS ISSUE

This issue of **C.A.L.M.** takes a look at panic attacks. “What’s Happening?” traces the experiences of the author in his own struggle with panic disorder through awareness, insight, and recovery. This issue also discusses basic facts about panic disorder and anxiety disorders in general, common symptoms, causes, treatment, and types of anxiety disorders.

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#### “WHAT’S HAPPENING?” Understanding Your Panic Disorder

by  
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#### I. My Personal Journey to an Understanding of Panic Attacks

It was late January, 1973. In Paris, the United States agreed to stop fighting in Vietnam. Liddy and McCord were found guilty in connection with Watergate. LBJ suddenly died of a heart attack. Ironically, his death came as the war that forced him out of office was coming to an end. Quite a start for a new year.

I remember reflecting on these events one cold and blustery winter day as I made my way across the University of Tennessee campus in Knoxville. I had been at UT for two years, dividing my time between being an Air Force captain serving as an Air Force R.O.T.C. instructor and a student pursuing a doctorate in counseling psychology.

As I approached the Volunteer Statue in the center of campus, something extraordinary happened, something I will never forget. It started as a cluster of strange sensations, and a

sense that something was terribly wrong.

It came on without warning. One moment, I was simply walking from one building to another, lost in thought, trying to sort out what seemed to be an increasingly complicated life. There was no shortage of worrisome thoughts, but most of that would have to wait. There was much I had to do. Deadlines had to be met. I had to “push on.” There would be more time for tying up loose ends later. For now, I had to move faster, get more done.

Suddenly, everything changed.

It was a strange sense of unreality. I felt disoriented. My heart was racing. My mouth felt like cotton. I couldn't think. I was lightheaded and felt unsteady. There didn't seem to be enough air. I felt cold and clammy but I was sweating. Most of all, I felt paralyzed. I struggled for understanding. What's happening to me? What should I do?

I sat down on the base of the statue, trying to sort it all out. My brain seemed frozen and I felt strange all over. I wondered if I should ask for help. Would anyone notice my distress? The sidewalk was full of students, but no one seemed to notice. How could that be? How could I feel such a loss of control without anyone seeing the signs?

Within a few minutes, the worst was over, leaving me confused and worried, unable to comprehend what had happened. I knew only that something strange and frightening had taken place, something totally outside of my understanding or experience. Would it happen again?

I wondered what I should do. Should I forget my original purpose and go back to my office? Should I go to the clinic? Should I go on to class and hope it -whatever “it” was- would not happen again? Suddenly, I had far more questions than answers and a new sense of urgency. I had to find out what had happened and keep it from happening again.

At last, I continued on to my 5:00 p.m. class, struggling to regain my composure. Once there, I sat through a lecture I scarcely heard, unable to let go of my uneasiness at what had happened and my dread of a reoccurrence. By the end of class, I had my second panic attack. I still had no idea what was happening or that it had a name. Something was seriously wrong!

During the next few days and weeks, the attacks continued. Increasingly distressed, I was ready for help. I was motivated. I wanted to find answers. I wanted it to stop.

A psychologist I knew told me she couldn't know what was happening to me. She told me she couldn't help me and referred me to a physician. The physician told me it was probably “stress” and prescribed Mellaril, a drug I promptly flushed after it made me feel even more disconnected from my body. Fellow doctoral students and several instructors shook their heads and told me they had no idea what was wrong. A friend suggested a vacation. No one mentioned “anxiety attack” or “panic attack.” That would've helped immensely if only I had some idea what was happening. The attacks

continued. I felt lost.

Finally, after several weeks of torment, a professor said, "Oh, you're having anxiety attacks. I used to have those myself." Incredible relief! Just knowing it had a name and happened to other people - and it was something some people USED to have. At last there was hope.

I didn't know it at the time, but my future career as a psychotherapist was being shaped by my extreme distress in the first months of 1973. I began reading everything I could find on anxiety disorders in general and panic disorders in particular.

I began to see my panic disorder as the result of my learned beliefs and behaviors. My motto had always been, "When the going gets tough, the tough get going." Now I began to question my perfectionism and lack of self-nurturing, as well as my tendency to not complain or express anger. I began to see how I had relentlessly driven myself, ignoring needs and feelings that I would not let get in the way. A major realization was that an anxiety problem was something I was doing to myself. I became determined to learn and change. When the tough keep on going, and going, and **STILL** going, unlike the Energizer bunny, they begin to wear out and break down.

As a student counselor at the University Counseling Center, I began seeking work with anxiety problems as often as possible. I quickly discovered there was no shortage. Anxious students were easy to find. With insight and ongoing and persistent practice of new ways of thinking and behaving, my own bout with anxiety gradually subsided. By the end of the year, anxiety attacks were a thing of the past. I stopped fearing them. They have never returned.

When it was happening, it was awful! It is a level of discomfort almost impossible to comprehend if you have not been there, but for those readers who have not had an anxiety attack, I will try to explain. Imagine your car stalled at a busy intersection with an out-of-control cement truck, brakes squealing, skidding and careening toward you. Imagine your feelings. Your heart races, You break into a sweat. You fear you are about to die.

Now imagine having those same feelings except for one difference; there is no cement truck, no obvious threat, just the sense that something truly awful is happening. You feel faint; your chest hurts. Your legs tremble and feel as if they will not support you. You think you are having a heart attack. It is the same distress, but no real danger. It is really quite easy to see why so many panic disorder sufferers think they are going crazy or that something truly terrible is about to happen.

Imagine my response if someone had told me in the first months on 1973 that my disorder would someday be an asset. I would have been less than polite. I did not want a therapeutic asset - I wanted the problem gone and I wanted it gone NOW.

So guess what? The prediction would have been on target. My own struggle has helped

me immeasurably in helping others with anxiety disorders. Now I can say I honestly appreciate the lessons learned, the insights gained - but I will never forget how awful it seemed when it was happening. I suppose it is best I do not forget. I do not want to ever make the mistake of discounting or minimizing the distress of my clients. Too many of them have received no other help than being told, "It's all in your head," or worse yet, "It's a problem you'll always have. You will just have to live with it. Your only hope is medication."

## **II. Basic Facts**

The good news about anxiety attacks, confirmed by my own and others' experience, is that they are highly treatable. People do recover. Appropriate treatment brings relief to the majority of people who seek help for panic disorder and improvement is often seen in a matter of weeks. The bad news is that more than three quarters of those with serious anxiety problems never seek help. Those who do seek treatment may wait years before receiving a correct diagnosis and appropriate treatment. The following are some basic facts.

### **Anxiety Disorders in General**

- \* Anxiety disorder is the nation's most common psychiatric diagnosis (NIMH), but it takes an average of 8-12 years before correct diagnosis (Jerilyn Ross, President of Anxiety Disorders Association of America).
- \* 24% of the population will suffer from an anxiety disorder at some time in their lives (NIMH). During any six month period, about 9%, or 16 million people will suffer from an anxiety disorder.
- \* Women are twice as likely to suffer from an anxiety disorder as men (three times more likely to have panic disorder).
- \* According to recent studies, anxiety disorders cost the U.S. 46.6 billion in 1990, nearly one-third of the nation's total mental health bill of 147 billion. These dollars were not spent on effective treatments, but rather were lost due to social and economic costs, such as worker absenteeism, job loss, and alcohol or substance abuse.
- \* More than three quarters of those with serious anxiety problems never seek help.
- \* Up to 90% of all anxiety sufferers find relief once they seek professional help (NIMH).

### **Panic Disorder Specifics**

- \* Panic disorder strikes between 3 and 6 million Americans, or as much as 5% of the adult American population (NIMH).
- \* Panic disorder patients use emergency service almost 13 times more often than non-psychiatric patients and nearly 3 times more often than patients with major depression (Markowitz, 1989).
- \* Panic disorder patients seek help from general practitioners about twice as often as the general population.
- \* Panic disorder patients use both general and psychiatric services 16 times more often

- than other psychiatric patients (Markowitz, 1989).
- \* 43%, especially those with agoraphobia, have lost their jobs or part of their income due to problems related to panic disorder.
  - \* 27% of panic disorder patients are financially dependent and/or receive welfare or disability benefits (Markowitz et. al., 1989).
  - \* Panic disorder patients are 7.5 times more likely to have troubled marriages than non-psychiatric patients (Markowitz et. al., 1989)
  - \* 30% or more of panic disorder sufferers also have depression serious enough to warrant treatment.
  - \* Panic disorder patients report more gastrointestinal symptoms than non-psychiatric patients (Lydiard et al., 1994).
  - \* Panic disorder patients tend to seek relief from anxiety in alcohol, drugs, and prescribed as well as non-prescribed medication (Cowley, 1992).
  - \* 31% of panic disorder patients have a diagnosis of alcohol or other substance abuse (Leoine et. al., 1993). Another study found alcohol abuse/dependence in 54% and drug abuse/dependence in 43% of the sample (Dick et. al., 1994).
  - \* 26.2% of the patients, especially men, have higher mortality from cardiovascular disease than would be expected from their age and sex (Coryell, 1984).
  - \* There is increased incidence of hypertension among panic disorder patients (Noyes et. al., 1980; Katon, 1984; Charney and Heninger, 1986), as well as increased baseline heart rate (Charney and Heninger, 1986; Neese et. al., 1984; Roth et. al., 1986; Chegnon et. al., 1993), which may put these patients at risk for cardiovascular disease.
  - \* An increased prevalence of 47% of respiratory disease in panic disorder patients has been reported (Zandbergen et. al., 1991).
  - \* Asthmatic patients include a higher prevalence of panic disorder (6.5%) and agoraphobia (13.1%) than that seen in the general population (2%) (Shavitt et. al., 1992).
  - \* People with panic disorder are 18 times more likely to have attempted or thought about suicide than people with no mental illness. (This is especially true when depression of substance abuse is present.) 20% of people with panic disorder and 12% of those with occasional panic attacks have attempted suicide (New England Journal of Medicine).
  - \* Panic disorder is highly treatable, with improvement often seen in 6 to 8 weeks. Appropriate treatment brings relief to 70 to 90% of people with panic disorder. Two year follow up studies have shown 81% of patients to be panic free (Barlow, Wolfe, and Master, 1994).

You can see that panic disorder is serious and, like stress in general, can harm your health over time. Do not be frightened by these facts. Panic attacks alone cannot harm you. The disturbing findings above apply mainly to untreated panic disorder and stress over a period of years. Remember, most panic disorder sufferers do not seek help. Those who do, usually get better.

The following sections examine what a panic attack is and what it is not. Further, they look at what happens during a panic attack. Let's demystify it and also dispel the myth that it is something that strikes you "out of the blue," unrelated to anything else

happening in your life.

The most important thing to know is that the biggest fears of those who have panic attacks - fear of having a heart attack, dying, or going crazy - DO NOT HAPPEN! In everything I have read, in over twenty-five years of experience treating anxiety disorders, I have never heard of these things happening to anyone. I know it is a terrible feeling, but the attack itself will not hurt you. It is only anxiety.

### **III. Symptoms**

You may be thinking, "If it is only anxiety, why do I feel so bad?" True, the symptoms are among the most distressing that you can experience, but they are only temporary and harmless.

#### The Symptoms Include:

- \* Racing or pounding heartbeat
- \* Chest pains
- \* Dizziness, lightheadedness, nausea
- \* Difficulty breathing
- \* Tingling or numbness in the hands
- \* Flashes or chills
- \* Dreamlike sensations or perceptual distortions
- \* Terror - a sense that something unimaginably horrible is about to occur and one is powerless to prevent it
- \* Fear of losing control and doing something embarrassing
- \* Fear of dying

Your symptoms may vary from this list. Usually, a panic attack lasts only a few minutes. Most who have one attack will have others. If you repeated attacks or feel extremely fearful of having another attack, you have a panic disorder.

A most difficult problem for panic disorder sufferers is getting the right diagnosis. Panic disorder is a great imposter, with symptoms similar to many physical ailments. Panic disorder symptoms can mimic symptoms of heart attacks, respiratory illness, thyroid diseases, and disorders of virtually every bodily system.

The first impulse for many people experiencing a panic attack is to rush to a hospital emergency room. Each day, thousands of panic disorder sufferers receive emergency treatment for what seems like a heart attack, chest pain, shortness of breath, sweating, rapid heart beat, and increased blood pressure. Some, after extensive evaluation and monitoring, will be correctly diagnosed as having panic disorder. Others, probably the majority of cases, may be misdiagnosed by professionals either unfamiliar with panic disorder or understandingly misled by the confusing symptoms.

Often, when no physical symptoms are found, patients are sent home with assurance that “it is just nerves.” Many patients spend years in and out of emergency rooms or being passed from doctor to doctor before someone recognizes that a real and highly treatable problem exists.

The biggest obstacle to recovery is the is the fear that attacks indicate a major physical illness. The most destructive thing you can do is hold tenaciously to the belief that something is wrong despite all reassurances to the contrary from professionals. Such continual worry about physical illness intensifies anxiety and even brings about the occurrence of panic attacks.

In rare cases, symptoms do indicate illness. Certainly illness may coexist with a panic disorder. Put your mind at ease by getting yourself checked out physically. We always recommend a thorough physical with a physician knowledgeable about anxiety disorders. When seeing a physician, follow the guidelines below.

1. Find a doctor you trust and can talk too, someone you believe will listen to you. If you do not know such a physician, ask friends and family for a recommendation.
2. Fully explain your concerns and your symptoms. Hold nothing back. If you think personal stress might be involved, tell your doctor.
3. Allow your physician to perform what ever evaluations or examinations he or she believes necessary to find the cause of your symptoms.
4. If a consultation with another physician or specialist is recommended, follow that advice. Be sure your primary care physician gets feedback from specialists.
5. If a physical problem is found, follow your doctor’s treatment recommendations.
6. If no physical cause is found for your panic attacks, see a licensed mental health professional who specializes in anxiety disorders and **STOP WORRYING ABOUT YOUR BODY! IT IS ONLY ANXIETY.**

#### **IV. Causes**

Fully exploring causes, including major theories about panic disorder, requires far more space than this article allows. What follow is purposely brief.

First, is a panic disorder a biological or psychological disorder? I tend to agree, in part, with William D. Kernodle, author of *Panic Disorder: The Medical Pont of View*, who states, “There is a substantial body of knowledge indicating that panic disorder is a physical disorder with psychological complications.”

I believe the opposite is also true. In other words, “panic disorder is a psychological disorder with physical complications.” Increasingly, health care professionals are tuning in to research supporting the idea of mind and body interaction. Certainly, your body can

affect your mental health. On the other hand, your mind can change your body. Your mind can make you sick. Your mind can also heal you. Both mind and body are part of the panic disorder picture. I will not get sidetracked by a debate between biology and psychology. Instead, I will briefly address both.

Let's look at biological factors. To begin with, it seems clear from twin studies that there may be a genetic component. Identical twins are more likely to both have panic disorder than is the case for fraternal twins (where one twin has panic disorder). Many studies of families have noted more than one member having panic disorder.

In other panic disorder studies, researchers have been able to create panic attacks using sodium lactate, carbon dioxide, and caffeine. It is important to note, however, that this finding applies only to people with panic disorder.

PET scans have shown brain abnormalities in those with panic disorder and obsessive compulsive disorder. Additionally, the mere fact that anti-anxiety medication helps panic disorder indicates it has a biological base. In studies where sodium lactate or other substances were used to create panic attacks, those attacks were successfully blocked by medication, further demonstrating a biochemical basis.

It is possible that people with a panic disorder have a serotonin deficiency or that serotonin is not being used appropriately by the body. It is also possible that people with panic disorder have a noradrenergic system, particularly part of the brain called the Locus Coeruleus, that is more sensitive to stimulation.

Hyperventilation is often a factor. Breathing shallowly from your upper chest rather than from your diaphragm causes you to exhale too much carbon dioxide. Lowered levels of carbon dioxide in the blood and brain cause dizziness, heart palpitations, and more difficulty breathing. The result may be increased anxiety and feelings so similar to a panic attack that a full blown attack may be triggered. Those people who respond to stress with tense chest muscles and shallow breathing may set in motion a physical chain of events leading to a panic attack.

You can see from the above explanation of hyperventilation that it is not an either-or question, biology or psychology. In the hyperventilation example, you can see a clear interaction of mind and body. Let's take it a step further.

Stress cause your body to produce endorphins (hormones that have pain killing and tranquilizing abilities). When the stress ends, your body produces cholecystokinin (let's call it CCK) to counteract the endorphins. CCK can cause panic attacks. The more stress, the more you produce endorphins. The more endorphins, the more CCK. The more CCK, the more likely you will have panic attacks. Thus it seems likely that stress, particularly prolonged stress, can cause panic attacks.

IT would be easy to get into a "chicken or egg" debate at this point. Is it mind or body? Which comes first? Does one cause the other? Instead of looking for cause and effect, I

believe there is an interaction of both, with either causing changes in the other and vice versa. Exciting research from UCLA indicates that cognitive behavioral therapy, without medication, can positively change brain structure and brain chemistry in obsessive compulsive disorder patients. There is increasingly strong evidence that your mind can heal your body and that your psychological well-being can positively change body structure and chemistry. Of course, there is also no doubt bodily factors can adversely affect psychological well-being.

Let's look at psychological theories. According to learning and behavior theories, further attacks follow the initial spontaneous attack because of conditioning. The panic disorder sufferer learns to associate situations and places with anxiety. Phobic avoidance may develop as an attempt to head off additional attacks. Anxiety may also be conditioned to internal bodily cues, such as heart palpitations that in turn trigger a surge of fear and adrenaline. In this case, hypersensitivity to various bodily sensations may be experienced as a medical crisis. The resulting mobilization of the nervous system leads to rapidly escalating anxiety, more body sensation, and ultimately a panic attack.

Cognitive theories also focus on an individual's interpretations and beliefs about bodily signals. "Anticipatory anxiety," or fear of fearful feelings, may lead to avoidance behaviors and increasing anxiety, ultimately leading to a panic attack. In other words, if you are expecting a panic attack and worrying enough about it, you will probably create an attack. It is what is known as a "self-fulfilling prophecy." Additionally, life may become dominated by the need to avoid situations associated with a panic attack, leading to an increasingly constricted, empty, and difficult life.

Other theories focus on developmental factors, such as childhood separation anxiety, school phobia, or other childhood anxiety. Evidence indicates that many anxious adults were anxious children whose disorder went untreated or inappropriately treated. Also, children of parents with panic disorder are far more likely to develop fear, avoidance, and withdrawal in new or unfamiliar situations, setting themselves up for their own anxiety disorder.

Your parents may have often seemed worried about you and communicated their anxiety to you in countless ways. It may be that your parents were themselves anxious and worrisome about events that might have happened, but probably never did.

If your parents were anxious and worrisome, it would be quite normal for you to have learned to share their anxieties or be prone to develop an abundance of worries of your own. For example, mothers who get on and off a bathroom scale frequently, and with obvious distress, usually have daughters with fears and insecurities about food and weight.

Parenting may be a key factor in other ways. Many clients with panic disorder tell us that their parents were overprotective, overly strict, controlling, rejecting, critical, or just plain scary.

If you experienced excessive criticism, you may have learned to think far too much about what you did wrong and far too little about what you did right. The result might be that you learned to be pessimistic about your own abilities, expecting defeat and lack of success. You may have learned to be quite anxious about making mistakes or taking risks. You may also have had deep resentment that you were unable to express. Such resentment, if kept deep inside, often contributes to an anxiety disorder.

Extremely high standards and expectations may have presented you with impossible hurdles and blocked the development of confidence and self-esteem. You may have come to believe you had to meet parental expectations in order to be loved and accepted. Those perceived expectations may have been quite unrealistic, leaving you either very fearful of falling short or convinced that you simply could not measure up.

Like many families, your family may have been quite good at generating rules for every situation, rules that may not have been particularly consistent or meaningful, but certainly plentiful. Your need, like other children, was not for thousands of rules, but for a few rules that were fair, consistently applied, sensible, and meaningful. If rules were too numerous and confusing, the result may have been a growing sense of insecurity and the need to always be vigilant so as not to incur the wrath of parents. Or perhaps you were one of those children who rebelliously refused to follow any rules. Either way, substantial anxiety was generated, as well as doubts about your own competence and worthiness.

Your family may have been characterized by what we call “family mythology.” This refers to the need for some families to appear perfect to everyone, including themselves. It may not have been okay to talk about problems or have certain kinds of problems. You may have lived in dread of disappointing your family by having a difficulty that family members were not supposed to have. As a result, problems were not discussed, feelings were avoided, communication was superficial. The stage was set for adult difficulties and anxieties.

Adult events may also trigger an anxiety disorder. Many of our clients report significant life events during the last year. Events that involve major loss or threat often set a panic disorder in motion.

Finally, we see predisposing personality characteristics in many panic disorder clients. Some are nonassertive and have difficulty with anger and conflict. Others are shy, passive, or dependent. Anger is often the key. We frequently ask, “What do you do with your anger?” The reply from many of our panic disorder clients is that anger is unacceptable or a source of extreme discomfort. As our clients become more comfortable with anger and other emotions, their panic symptoms are usually dramatically reduced.

## **V. Treatment**

Appropriate treatment, as stated previously, can bring major relief to 70 to 90% of people with panic disorder, with improvement often seen in as few as 6 to 8 weeks.

Often, a combination of psychotherapy and medication is helpful. Many physicians prescribe drugs that selectively block pre-synaptic neuronal re-uptake of serotonin.

These "Selective Serotonin Re-uptake Inhibitors" (SSRI's) are fluoxetine (Prozac), sertraline (Zoloft), paroxetine (Paxil), fluvoxamine (Luvox), and venlafaxine (Effexor).

Both Prozac and Luvox have been found to reduce panic attacks and avoidance behavior. Prozac and Zoloft are frequently prescribed for panic disorder patients, as they have few side effects compared with other anti-panic drugs.

Benzodiazepines, such as Xanax, Ativan, Librium, Klonopin, Centrax, Serax, Tranxene, and Valium have an anti-anxiety calming effect. Xanax has a panic reducing quality. They are fast acting and usually well tolerated. On the other hand, they can be habit forming. Further, Xanax can cause a groggy feeling that can interfere with the new learning crucial to the recovery process.

We work with several caring psychiatrists who are knowledgeable and skillful when prescribing for anxiety disorders. They do not over prescribe, are alert to side effects, and are interested in helping patients reduce or eliminate medication when no longer needed. Many of our clients do not require medication and we generally do not suggest an evaluation for medication if they are making expected progress in overcoming their disorder.

Our therapy consists of both individual and group treatment. Many clients receive both. For some, group therapy has to wait until they have established some reduction in their anxiety, particularly anxiety about being around others or being in a new and strange situation. Once in group, however, their recovery accelerates in the company of others who are on the same journey. Group work provides a caring and encouraging support system from which each person learns from every other person's experience.

Whether therapy is individual or group, a varied and comprehensive approach to treatment is needed. We have found that lasting recovery is achieved when there are basic and comprehensive changes in habits, attitudes, and lifestyle. Our interventions address seven levels of contributing causes.

**These levels are:**

**\* Physical**

Physical health, physical sensations, breathing, muscle tension, nutrition, exercise, physiological imbalances, overreaction to physical symptoms, the need for medical expertise and possibly medication, and a need for substance abuse Treatment

**\* Emotional**

Suppressed feelings, particularly anger

\* **Behavioral**

Avoidance of fearful situations and emotions

\* **Cognitive**

Upsetting self-talk, erroneous beliefs, automatic negative thoughts

\* **Interpersonal**

Difficulty owning and communicating feelings and needs, difficulty with assertiveness, conflict, marital, or family stress, family of origin issues, history of abuse

\* **Whole self**

Self-esteem, ability to be self-nurturing, self-efficacy

\* **Existential/Spiritual**

Purpose, direction, finding meaning in one's life, spirituality

At this point, an example will illustrate what I mean by a comprehensive approach to treatment. The following case is typical of several clients we have seen over the past few years. The real name of the client is not used and confidentiality is protected by omission of any identifying information.

*Carol's life was increasingly constricted and filled with despair. She found herself so terrified and confused by her panic attacks that she was no longer able to focus on her work or relationships. The episodes seemed to come out of the blue, without warning. She responded to the attacks by becoming hypervigilant, afraid even to go to sleep, as she was sometimes awakened at night by terrifying sensations that had her believing she was dying. Day or night, attacks brought fear, heart palpitations, dizziness, and the constant dread of another attack. She was left exhausted and depressed, unable to enjoy even the simplest of past pleasures.*

*Finally, she had to seek help. Fortunately, her family physician was able to get her in right away due to a cancellation. Finding nothing obviously wrong, he nevertheless referred her to an internist for further tests. No physical basis was found for her symptoms. Her panic attacks could not be explained by possible medical problems such as hypoglycemia, hyperthyroidism, a calcium-magnesium deficiency, mitral valve prolapse, or inner ear disturbances. Carol, now diagnosed as having panic disorder, was referred to our center for specialized anxiety disorder treatment.*

*While every client is unique, there are also similarities. Carol seemed typical of so many clients that we have seen for panic disorder.*

*She was not very good at relaxing. Her breathing was shallow and rapid, especially while under increased stress. Even after initial introduction in diaphragmatic breathing,*

*she still found it extremely difficult and needed a great deal of daily practice.*

*Other health behaviors needed improvement. Carol drank several cups of coffee daily, did not exercise, and did not get enough sleep. She rarely took vacations and considered relaxing a “waste of time.”*

*Carol’s self-talk was mercilessly negative and self-critical. The daughter of anxious parents, she had grown up in a home where she had learned harsh perfectionist beliefs. She had a long list of “shoulds” and “musts” that were impossible to live by. No matter what she did, it never seemed to be good enough.*

*Carol was also prone to something called “awfulizing and catastrophizing.” Her symptoms provoked terror based on her fear that she was about to die, go crazy, or have a heart attack. At the very moment she felt the first sign of rising anxiety, she engaged in “scare talk,” saying to herself, “What if I am going to die? I can’t stand this. It’s getting worse. It must stop.” Of course, her symptoms immediately got worse.*

*Carol was anxiety prone in still another way. Eager to please and fearful of disappointing or offending anyone, Carol was markedly nonassertive. Believing she must please everyone, all the time, left her either depressed because someone was critical of her or anxious that she might disappoint them. Moreover, her need to avoid conflict or disapproval led her to stuff and stack anger and resentments. Years of denying her feelings had provided ample fuel for an anxiety disorder.*

Carol’s recovery program followed the comprehensive model described earlier. A summary of her recovery plan is as follows. Categories overlap.

### Physical

Carol learned and practiced diaphragmatic breathing, deep relaxation, and visualization. She began regular aerobic exercise to reduce anxiety and give her a sense of personal power. Nutritional improvements included elimination of caffeine, eating a healthier diet, and taking vitamin supplements (B complex, C, Calcium-magnesium). Carol was offered medication by her family physician, but declined, preferring instead to develop her own resources.

### Emotional/Interpersonal/Behavioral

Carol developed assertiveness skills and began expressing rather than suppressing feelings, particularly anger. She practiced talking about her emotions and wrote extensively in her journal. Carol learned that conflict avoidance and passivity were destructive not only to herself, but also to relationships. She learned verbal skills for dealing with conflict and for negotiating with others based upon a strong sense of personal rights.

### Cognitive/Whole Self

Carol learned corrective self-talk, a process for recognizing and changing self-defeating beliefs. Changed beliefs allowed her to approach life in a more optimistic and relaxed manner. She was able to eliminate “scare talk” and purposely reduce rather than unconsciously intensify anxiety. A more accepting, nurturing view of self led to increased self-esteem and satisfaction with life.

### Existential/Spiritual

With lowered anxiety, Carol began broadening her focus beyond work and her list of “shoulds” and “musts.” She began exploring her spirituality and developing interests based on her own unique beliefs and values, feeling free to pursue what seemed important to her. Supportive and calming self-talk allowed her to feel more free and expand her comfort zone. Life became more meaningful.

Your situation may differ from Carol’s. Your progress may be slower or faster. Through a comprehensive recovery program, together with hard work over a period of months, Carol was able to free herself from her panic disorder. Most important, she now has the skills to keep her anxiety from overwhelming her. Life is good now and Carol is able to enjoy it.

Our experience has shown us that a comprehensive approach, such as described in Carol’s case, is usually effective. An approach involving physician, therapist, and patient as treatment team members is ideal.

One last point. People recover. We have seen lots of recovery-but never without active involvement and practice. A major goal of the **C.A.L.M.** program is powerfully involving participants in their own recovery. You recover not by reading a book or listening to a lecture, but by trying out and practicing new behaviors and ways of thinking. Take responsibility for your recovery. Do the work, make the changes, and practice those new skills and attitudes until they become part of you. You will not be disappointed.

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## **Anxiety Disorders**

The following is a list of thirteen anxiety conditions with brief definitions.

**Panic Attack:** the sudden onset of intense apprehension, fearfulness, or terror. These feelings are often associated with impending doom. During these attacks, symptoms, such as shortness of breath, palpitations, chest pain or discomfort, choking or smothering sensations, feelings of unreality, or fear of losing control, are present.

**Agoraphobia:** anxiety about, or avoidance of, places or situations from which the escape might be difficult and/or embarrassing or in which help may not be available in the event of having a panic attack or overwhelming feelings of panic or panic-like

symptoms.

**Panic Disorder Without Agoraphobia:** characterized by recurrent, unexpected panic attacks about which there is persistent concern.

**Panic Disorder With Agoraphobia:** characterized by both recurrent, unexpected panic attacks and agoraphobia.

**Agoraphobia Without History of Panic Disorder:** is recognized by the presence of agoraphobia and panic-like symptoms without a history of unexpected panic attacks.

**Specific Phobia:** characterized by “clinically significant” anxiety provoked by exposure to a specific feared object or situation, usually leading to avoidance behavior.

**Social Phobia:** characterized by “clinically significant” anxiety provoked by exposure to certain types of social or performance situations, often leading to avoidance behavior.

**Obsessive Compulsive Disorder:** characterized by obsessions that create marked anxiety, distress, and/or compulsions that are the efforts to neutralize the anxiety.

**Post-traumatic Stress Disorder:** the re-experiencing of an extremely traumatic event accompanied by symptoms of increased arousal and by avoidance of stimuli associated with the trauma.

**Acute Stress Disorder:** has recognizable symptoms similar to those of post-traumatic stress disorder, but occurs immediately in the aftermath of an extremely traumatic event.

**Generalized Anxiety Disorder:** characterized by at least six months of persistent and excessive anxiety and worry.

**Anxiety Disorder Due to a General Medical Condition:** characterized by prominent symptoms of anxiety that are judged to be a direct physiological consequence of a general medical condition.

**Substance-Induced Anxiety Disorder:** recognized by prominent symptoms of anxiety that are judged to be a direct physiological consequence of drug abuse, a medication, or toxin exposure.

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