Surviving Anxiety

I've tried therapy, drugs, and booze. Here's how I came to terms with the nation's most common mental illness.

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I've finally settled on a pre-talk regimen that enables me to avoid the weeks of anticipatory misery that the approach of a public-speaking engagement would otherwise produce.

Let's say you're sitting in an audience and I'm at the lectern. Here's what I've likely done to prepare. Four hours or so ago, I took my first half milligram of Xanax. (I've learned that if I wait too long to take it, my fight-or-flight response kicks so far into overdrive that medication is not enough to yank it back.) Then, about an hour ago, I took my second half milligram of Xanax and perhaps 20 milligrams of Inderal. (I need the whole milligram of Xanax plus the Inderal, which is a blood-pressure medication, or beta-blocker, that dampens the response of the sympathetic nervous system, to keep my physiological responses to the anxious stimulus of standing in front of you—the sweating, trembling, nausea, burping, stomach cramps, and constriction in my throat and chest—from overwhelming me.) I likely washed those pills down with a shot of scotch or, more likely, vodka, the odor of which is less detectable on my breath. Even two Xanax and an Inderal are not enough to calm my racing thoughts and to keep my chest and throat from constricting to the point where I cannot speak; I need the alcohol to slow things down and to subdue the residual physiological eruptions that the drugs are inadequate to contain. In fact, I probably drank my second shot—yes, even though I might be speaking to you at, say, 9 in the morning—between 15 and 30 minutes ago, assuming the pre-talk proceedings allowed me a moment to sneak away for a quaff.

If the usual pattern has held, as I stand up here talking to you now, I've got some Xanax in one pocket (in case I felt the need to pop another one before being introduced) and a minibar-size bottle or two of vodka in the other. I have been known to take a discreet last-second swig while walking onstage—because even as I'm still experiencing the anxiety that makes me want to drink more, my inhibition has been lowered, and my judgment impaired, by the liquor and benzodiazepines I've already consumed. If I've managed to hit the sweet spot—that perfect combination of timing and dosage whereby the cognitive and psychomotor sedating effect of the drugs and alcohol balances out the physiological hyperarousal of the anxiety—then I'm probably doing okay up here: nervous but not miserable; a little fuzzy but still able to speak clearly; the anxiogenic effects of the situation (me, speaking in front of people) counteracted by the anxiolytic effects of what I've consumed. But if I've overshot on the medication—too much Xanax or liquor—I may seem to be loopy or slurring or otherwise impaired. And if I didn't self-medicate enough? Well, then, either I'm sweating profusely, with my voice quavering weakly and my attention folding in upon itself, or, more likely, I ran offstage before I got this far. I mean that literally: I've frozen, mortifyingly, onstage at public lectures and presentations before, and on several occasions I have been compelled to bolt from the stage.

Yes, I know. My method of dealing with my public-speaking anxiety is not healthy. It's dangerous. But it works. Only when I am sedated to near-stupefaction by a combination of benzodiazepines and alcohol do I feel (relatively) confident in my ability to speak in public effectively and without torment. As long as I know that I'll have access to my Xanax and liquor, I'll suffer only moderate anxiety for days before a speech, rather than sleepless dread for months.

I wish I could say that my anxiety is a recent development, or that it is limited to public speaking. It's not. My wedding was accompanied by sweating so torrential that it soaked through my clothes and by shakes so severe that I had to lean on my bride at the altar, so as not to collapse. At the birth of our first child, the nurses had to briefly stop ministering to my wife, who was in the throes of labor, to attend to me as I turned pale and keeled over. I've abandoned dates; walked out of exams; and had breakdowns during job interviews, plane flights, train trips, and car rides, and simply walking down the street. On ordinary days, doing ordinary things—reading a book, lying in bed, talking on the phone, sitting in a meeting, playing tennis—I have thousands of times been stricken by a pervasive sense of existential dread and been beset by nausea, vertigo, shaking, and a panoply of other physical symptoms. In these instances, I have sometimes been convinced that death, or something somehow worse, was imminent.

Even when not actively afflicted by such acute episodes, I am buffeted by worry: about my health and my family members' health; about finances; about work; about the rattle in my car and the dripping in my basement; about the encroachment of old age and the inevitability of death; about everything and nothing. Sometimes this worry gets transmuted into low-grade physical discomfort—stomachaches, headaches, dizziness, pains in my arms and legs—or a general malaise, as though I have mononucleosis or the flu. At various times, I have developed anxiety-induced difficulties breathing, swallowing, even walking; these difficulties then become obsessions, consuming all of my thinking.

I also suffer from a number of specific fears and phobias, in addition to my public-speaking phobia. To name a few: enclosed spaces (claustrophobia); heights (acrophobia); fainting (asthenophobia); being trapped far from home (a species of agoraphobia); germs (bacillophobia); cheese (turophobia); flying (aerophobia); vomiting (emetophobia); and, naturally, vomiting while flying (aeronausiphobia).

Anxiety has afflicted me all my life. When I was a child and my mother was attending law school at night, I spent evenings at home with a babysitter, abjectly terrified that my parents had died in a car crash or had abandoned me (the clinical term for this is *separation anxiety*); by age 7 I had worn grooves in the carpet of my bedroom with my relentless pacing, trying to will my parents to come home. During first grade, I spent nearly every afternoon for months in the school nurse's office, sick with psychosomatic headaches, begging to go home; by third grade, stomachaches had replaced the headaches, but my daily trudge to the infirmary remained the same. During high school, I would purposely lose tennis and squash matches to escape the agony of anxiety that competitive situations would provoke in me. On the one—the only—date I had in high school, when the young lady leaned in for a kiss during a romantic moment (we were outside, gazing at constellations through her telescope), I was overcome by anxiety and had to pull away for fear that I would vomit. My embarrassment was such that I stopped returning her phone calls.

In short, I have, since the age of about 2, been a twitchy bundle of phobias, fears, and neuroses. And I have, since the age of 10, when I was first taken to a mental hospital for evaluation and then referred to a psychiatrist for treatment, tried in various ways to overcome my anxiety.

Here's what I've tried: individual psychotherapy (three decades of it), family therapy, group therapy, cognitive-behavioral therapy, rational emotive behavior therapy, acceptance and commitment therapy, hypnosis, meditation, role-playing, interoceptive exposure therapy, in vivo exposure therapy, self-help workbooks, massage therapy, prayer, acupuncture, yoga, Stoic philosophy, and audiotapes I ordered off a late-night TV infomercial.

And medication. Lots of medication. Thorazine. Imipramine. Desipramine. Chlorpheniramine. Nardil. BuSpar. Prozac. Zoloft. Paxil. Wellbutrin. Effexor. Celexa. Lexapro. Cymbalta. Luvox. Trazodone. Levoxyl. Inderal. Tranxene. Serax. Centrax. St. John's wort. Zolpidem. Valium. Librium. Ativan. Xanax. Klonopin.

Also: beer, wine, gin, bourbon, vodka, and scotch.

Here's what's worked: nothing.

Actually, that's not entirely true. Some drugs have helped a little, for finite periods of time. Thorazine (an antipsychotic that used to be referred to as a "major tranquilizer") and imipramine (a tricyclic antidepressant) combined to help keep me out of the psychiatric hospital in the early 1980s, when I was in middle school and ravaged by anxiety. Desipramine, another tricyclic, got me through my early 20s. Paxil (a selective serotonin reuptake inhibitor, or SSRI) gave me about six months of significantly reduced anxiety in my late 20s before the fear broke through again. A double scotch plus a Xanax and a Dramamine can sometimes, when administered before takeoff, make flying tolerable. And two double scotches, when administered in quick enough succession, can obscure existential dread, making it seem fuzzier and further away.

But none of these treatments has fundamentally reduced the underlying anxiety that seems hardwired into my body and woven into my soul and that at times makes my life a misery.

My assortment of neuroses may be idiosyncratic, but my general condition is hardly unique. Anxiety and its associated disorders represent the most common form of officially classified mental illness in the United States today, more common even than depression and other mood disorders. According to the National Institute of Mental Health, some 40 million American adults, about one in six, are suffering from some kind of anxiety disorder at any given time; based on the most recent data from the Department of Health and Human Services, their treatment accounts for more than a quarter of all spending on mental-health care. Recent epidemiological data suggest that one in four of us can expect to be stricken by debilitating anxiety at some point in our lifetime. And it is debilitating: studies have compared the psychic and physical impairment tied to living with an anxiety disorder with the impairment tied to living with diabetes—both conditions are usually manageable, sometimes fatal, and always a pain to deal with. In 2012, Americans filled nearly 50 million prescriptions for just one antianxiety drug: alprazolam, the generic name for Xanax.

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And anxiety, of course, extends far beyond the population of the officially mentally ill. In a much-cited 1976 study, primary-care physicians reported that anxiety was one of the most frequent complaints driving patients to their offices—more frequent than the common cold. Almost everyone alive has at some point experienced the torments of anxiety—or of fear or of stress or of worry, which are distinct but related phenomena. (People who are unable to experience anxiety are, according to some theorists, more deeply pathological—and more dangerous to society—than those who experience it acutely or irrationally; they’re psychopaths.)

My life has, thankfully, lacked great tragedy or melodrama. I haven’t served any jail time. I haven’t been to rehab. I haven’t assaulted anyone or attempted suicide. I haven’t woken up naked in the middle of a field, sojourned in a crack house, or been fired from a job for erratic behavior. As psychopathologies go, mine has been—so far, most of the time, to outward appearances—quiet. Robert Downey Jr. will not be starring in the movie of my life. I am, as they say in the clinical literature, “high functioning” for someone with an anxiety disorder or other mental illness; I’m usually quite good at hiding it. This is a signature characteristic of the phobic personality: “the need and the ability,” as described in the self-help book *Your Phobia*, “to present a relatively placid, untroubled appearance to others, while suffering extreme distress on the inside.” To some people, I may seem calm. But if you could peer beneath the surface, you would see that I’m like a duck—paddling, paddling, paddling.

Stigma still attaches to mental illness. Anxiety is seen as weakness. In presenting my anxiety to the world by writing publicly about it, I’ve been told, I will be, in effect, “coming out.” The implication is that this will be liberating. We’ll see about that. But my hope is that readers who share this affliction, to whatever extent, will find some value in this account—not a cure for their anxiety, but perhaps some sense of the redemptive value of an often wretched condition, as well as evidence that they can cope and even thrive in spite of it. Most of all, I hope they—and by “they” I mean “many of you”—will find some solace in learning that they are not alone.

I struggle with emetophobia, a pathological fear of vomiting, but it’s been a while since I last vomited. More than a while, actually: as I type this, it’s been, to be precise, 35 years, two months, four days, 23 hours, and 34 minutes. Meaning that more than 83 percent of my days on Earth have transpired in the time since I last threw up, during the early evening of March 7, 1977, when I was 7 years old. I didn’t vomit in the 1980s. I didn’t vomit in the 1990s. I haven’t vomited in the new millennium. And needless to say, I hope to make it through the balance of my life without having that streak disrupted. (Naturally, I was reluctant even to type this paragraph, and particularly that last sentence, for fear of jinxing myself or inviting cosmic rebuke, and I am knocking on wood and offering up prayers to various gods and Fates as I write this.)

What this means is that I have spent, by rough calculation, at least 60 percent of my waking life thinking about and worrying about something that I have spent zero percent of the past three-plus decades doing. This is irrational.

And yet, an astonishing portion of my life is built around trying to evade vomiting and preparing for the eventuality that I might throw up. Some of my behavior is standard germophobic stuff: avoiding hospitals and public restrooms, giving wide berth to sick people, obsessively washing my hands, paying careful attention to the provenance of everything I eat.

But other behavior is more extreme, given the statistical unlikelihood of my vomiting at any given moment. I stash motion-sickness bags, purloined from airplanes, all over my home and office and car in case I’m suddenly overtaken by the need to vomit. I carry Pepto-Bismol and Dramamine and other antiemetic medications with me at all times. Like a general monitoring the enemy’s advance, I keep a detailed mental map of recorded incidences of norovirus (the most common strain of stomach virus) and other forms of gastroenteritis, using the Internet to track outbreaks in the United States and around the world. Such is the nature of my obsession that I can tell you at any given moment exactly which nursing homes in New Zealand, cruise ships in the Mediterranean, and elementary schools in Virginia are contending with outbreaks. Once, when I was lamenting to my father that there is no central clearinghouse for information about norovirus outbreaks the way there is for influenza, my wife interjected. “Yes, there is,” she said. We looked at her quizzically. “You,” she said.

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For several years, in my mid-30s, I worked with a psychologist in Boston, Dr. M., who had a practice at one of the city's academic medical centers. I had originally sought treatment for a number of phobias, but after several months of consultations, Dr. M. determined—as several other therapists, before and since, also have—that at the core of my other fears lay my fear of vomiting (for instance, I'm afraid of airplanes partly because I might get airsick), so she proposed we concentrate on that.

"Makes sense to me," I concurred.

She explained that we would try to apply the principles of what's known as exposure therapy toward extinguishing my emetophobia.

"There's only one way to do that properly," she said. "You need to confront the phobia head-on, to expose yourself to that which you fear the most."

Uh-oh.

"We have to make you throw up."

No. No way. Absolutely not.

She explained that a colleague had just successfully treated an emetophobe by giving her ipecac syrup, which induces vomiting. The patient, a female executive who had flown in from New York to be treated, had spent a week undergoing exposure therapy. Each day she would take ipecac administered by a nurse, vomit, and then process the experience with the therapist—"decatastrophizing" it, as the cognitive-behavioral therapists say. When she flew back to New York, Dr. M. reported, she was cured of her phobia.

I remained skeptical. Dr. M. gave me an article from an academic journal reporting on a clinical case of emetophobia successfully treated with this kind of exposure.

"This is just a single case," I said. "It's from 1979."

"There have been lots of others," she said, and reminded me again of her colleague's patient.

"I can't do it."

"You don't have to do anything you don't want to do," Dr. M. said. "I'll never force you to do anything. But the only way to overcome this phobia is to confront it. And the only way to confront it is to throw up."

We had many versions of this conversation over the course of several months. I trusted Dr. M., who was kind and smart. So one autumn day I surprised her by saying I was open to thinking about the idea. Gently, reassuringly, she talked me through how the process would work. She and the staff nurse would reserve a lab upstairs for my privacy and would be with me the whole time. I'd eat something, take the ipecac, and vomit in short order (and I would survive just fine, she said). Then we would work on "reframing my cognitions" about throwing up. I would learn that it wasn't something to be terrified of, and I'd be liberated.

She took me upstairs to meet the nurse. Nurse R. showed me the lab and told me that taking ipecac was a standard form of exposure therapy; she said she'd helped preside over a number of exposures for now-erstwhile emetophobes. "Just the other week, we had a guy in here," she said. "He was very nervous, but it worked out just fine."

We went back downstairs to Dr. M.'s office.

"Okay," I said. "I'll do it. Maybe."

Over the next few weeks, we'd keep scheduling the exposure—and then I'd show up on the appointed day and demur, saying I couldn't go through with it. I did this enough times that I shocked Dr. M. when, on an unseasonably warm Thursday in early December, I presented myself at her office for my regular appointment and said, "Okay. I'm ready."

The exercise was star-crossed from the beginning. Nurse R. was out of ipecac, so she had to run to the pharmacy to get some more while I waited for an hour in Dr. M.'s office. Then it turned out that the upstairs lab was booked, so the exposure would have to take place in a small public restroom in the basement. I was constantly on the verge of backing out.

What follows is an edited excerpt drawn from the dispassionate-as-possible account I wrote up afterward, on Dr. M.'s recommendation. (Writing an account of a traumatic event is a commonly prescribed way of trying to forestall post-traumatic stress disorder after a harrowing experience.) If you're emetophobic yourself, or even just a little squeamish, you might want to skip over it.

We met up with Nurse R. in the basement restroom. After some discussion, I took the ipecac.

Having passed the point of no return, I felt my anxiety surge considerably. I began to shake a little. Still, I was hopeful that sickness would strike quickly and be over fast and that I would discover that the experience was not as bad as I'd feared.

Dr. M. had attached a pulse-and-oxygen-level monitor to my finger. As we waited for the nausea to hit, she asked me to state my anxiety level on a scale of one to 10. "About a nine," I said.

By now I was starting to feel a little nauseated. Suddenly I was struck by heaving and I turned to the toilet. I retched twice—but nothing was coming up. I knelt on the floor and waited, still hoping the event would come quickly and then be over. The monitor on my finger felt like an encumbrance, so I took it off.

After a time, I heaved again, my diaphragm convulsing. Nurse R. explained that dry heaving precedes the main event. I was now desperate for this to be over.

The nausea began coming in intense waves, crashing over me and then receding. I kept feeling like I was going to vomit, but then I would heave noisily and nothing would come up. Several times I could actually feel my stomach convulse. But I would heave and … nothing would happen.

My sense of time at this point gets blurry. During each bout of retching, I would begin perspiring profusely, and once the nausea passed, I would be dripping with sweat. I felt faint, and I worried that I would pass out and vomit and aspirate and die. When I mentioned feeling light-headed, Nurse R. said that my color looked good. But I thought she and Dr. M. seemed slightly alarmed. This increased my anxiety—because if *they* were worried, then I should really be scared, I thought. (On the other hand, at some level I *wanted* to pass out, even if that meant dying.)

After about 40 minutes and several more bouts of retching, Dr. M. and Nurse R. suggested I take more ipecac. But I feared a second dose would subject me to worse nausea for a longer period of time. I worried that I might just keep dry heaving for hours or days. At some point, I switched from hoping that I would vomit quickly and be done with the ordeal to thinking that maybe I could fight the ipecac and simply wait for the nausea to wear off. I was exhausted, horribly nauseated, and utterly miserable. In between bouts of retching, I lay on the bathroom tiles, shaking.

A long period passed. Nurse R. and Dr. M. kept trying to convince me to take more ipecac, but by now I just wanted to avoid vomiting. I hadn't retched for a while, so I was surprised to be stricken by another bout of violent heaving. I could feel my stomach turning over, and I thought for sure that this time something would happen. It didn't. I choked down some secondary waves, and then the nausea eased significantly. This was the point when I began to feel hopeful that I would manage to escape the ordeal without throwing up.

Nurse R. seemed angry. "Man, you have more control than anyone I've ever seen," she said. (At one point, she asked peevishly whether I was resisting because I wasn't prepared to terminate therapy yet. Dr. M. interjected that this was clearly not the case—I'd taken the ipecac, for God's sake.) Eventually—several hours had now elapsed since I'd ingested the ipecac—Nurse R. left, saying she had never seen someone take ipecac and not vomit. [I've since read that up to 15 percent of people—a disproportionate number of them surely emetophobes—don't vomit from a single dose of ipecac.] After some

more time, and some more encouragement from Dr. M. to try to “complete the exposure,” we decided to “end the attempt.” I still felt nauseated, but less so than before. We talked briefly in her office, and then I left.

Driving home, I became extremely anxious that I would vomit and crash. I waited at red lights in terror.

When I got home, I crawled into bed and slept for several hours. I felt better when I woke up; the nausea was gone. But that night I had recurring nightmares of retching in the bathroom in the basement of the center.

The next morning I managed to get to work for a meeting—but then panic surged and I had to go home. For the next several days, I was too anxious to leave the house.

Dr. M. called the day after the ordeal to make sure I was okay. She clearly felt bad about having subjected me to such a horrible experience. Though I was traumatized, her sense of guilt was so palpable that I felt sympathetic toward her. At the end of the account I composed at her request, which was accurate as far as it went, I masked the emotional reality of what I thought (which was that the exposure had been an abject disaster and that Nurse R. was a fatuous bitch) with an antiseptic clinical tone. “Given my history, I was brave to take the ipecac,” I wrote.

I wish that I had vomited quickly. But the whole experience was traumatic, and my general anxiety levels—and my phobia of vomiting—are more intense than they were before the exposure. I also, however, recognize that, based on this experience in resisting the effects of the ipecac, my power to prevent myself from vomiting is quite strong.

Stronger, it seems, than Dr. M.’s. She told me she’d had to cancel all her afternoon appointments on the day of the exposure—watching me gag and fight with the ipecac had evidently made her so nauseated that she spent the afternoon at home, throwing up. I confess I took some perverse pleasure from the irony here—the ipecac *I* took made *someone else* vomit—but mainly I felt traumatized. It seems I’m not very good at getting over my phobias but quite good at making my therapists sick.

I continued seeing Dr. M. for a few more months—we “processed” the botched exposure and then, both of us wanting to forget the whole thing, turned from emetophobia to various other phobias and neuroses—but the sessions now had an elegiac, desultory feel. We both knew it was over.

Is pathological anxiety a medical illness, as Hippocrates and Aristotle and many modern psychopharmacologists would have it? Or is it a philosophical problem, as Plato and Spinoza and the cognitive-behavioral therapists would have it? Is it a psychological problem, a product of childhood trauma and sexual inhibition, as Freud and his acolytes once had it? Or is it a spiritual condition, as Søren Kierkegaard and his existentialist descendants claimed? Or, finally, is it—as W. H. Auden and David Riesman and Erich Fromm and Albert Camus and scores of modern commentators have declared—a cultural condition, a function of the times we live in and the structure of our society?

The truth is that anxiety is at once a function of biology and philosophy, body and mind, instinct and reason, personality and culture. Even as anxiety is experienced at a spiritual and psychological level, it is scientifically measurable at the molecular level and the physiological level. It is produced by nature and it is produced by nurture. It’s a psychological phenomenon and a sociological phenomenon. In computer terms, it’s both a hardware problem (I’m wired badly) and a software problem (I run faulty logic programs that make me think anxious thoughts). The origins of a temperament are many-faceted; emotional dispositions that seem to have a simple, single source—a bad gene, say, or a childhood trauma—may not. After all, who’s to say that Spinoza’s vaunted equanimity, though ostensibly a result of his philosophy of applying logical reasoning to irrational fear, wasn’t in fact a product of his biology? Mightn’t a genetically programmed low level of autonomic arousal have produced his serene philosophy, rather than the other way around?

I don’t have to look far to find evidence of anxiety as a family trait. My great-grandfather Chester Hanford, for many years the dean of Harvard College, was in the late 1940s admitted to McLean Hospital, the famous mental institution in Belmont, Massachusetts, suffering from acute anxiety. The last 30 years of his life were often agonizing. Though medication and electroshock treatments would occasionally bring about remissions in his suffering, such respites were temporary, and in his darkest moments, in the 1960s, he was reduced to moaning in a fetal ball in his bedroom. Perhaps wearied by the responsibility of caring for him, his wife, my great-grandmother, a formidable and brilliant woman, died from an overdose of scotch and sleeping pills in 1969, a few months before I was born.

My mother, Chester's granddaughter, is, like me, an inveterate worrier, and, though she enjoyed a productive career as an attorney, she suffers from some of the same phobias and neuroses that I do. She assiduously avoids heights (glass elevators, chairlifts), and tends to avoid public speaking (when she has to talk publicly, she takes beta-blockers in advance) and risk taking of most kinds. Like me, she is mortally terrified of vomiting (and has not done so since 1974). As a young woman, she suffered from panic attacks. At her most anxious (or so my father, her ex-husband, says), her fears verged on paranoia: just after I was born, while suffering from postpartum depression, she became convinced that a serial killer in a yellow Volkswagen was watching our house. (Today, my mother and father, now divorced 15 years, disagree about the severity of the paranoia: my mother says it was negligible—and that, moreover, there really was a serial killer afoot at the time, a fact that research confirms.) My only sibling, a younger sister who is a successful cartoonist and editor, struggles with anxiety that is different from mine but nonetheless intense. She, too, has taken Celexa—and also Prozac and Wellbutrin and Klonopin and Nardil and Neurontin and BuSpar. None of them worked for her, and today she may be one of the few adult members of my mother's side of the family not currently taking a psychiatric medication.

On the evidence of just my mother's side of the family (and there is a separate complement of psychopathology coming down to me on the side of my father, a respected research physician who drank himself unconscious many nights throughout much of my later childhood), it is not outlandish to conclude that I possess what Sigmund Freud called "the hereditary taint," a genetic predisposition to anxiety and depression.

But these facts, by themselves, are not dispositive. In the 1920s, my great-grandparents had a young child who died of an infection. This was devastating to them. Perhaps this trauma, combined with the later trauma of having many of his students die in World War II, cracked something in my great-grandfather's psyche. Perhaps my mother, in turn, was made anxious by the fussy ministrations of her worrywart mother; the psychological term for this is *modeling*. And perhaps I, observing my mother's phobias, adopted them as my own.

Or maybe the generally unsettled nature of my childhood psychological environment—my mother's constant anxious buzzing; my father's alcoholic absence; their sometimes unhappy marriage, which would end in divorce—produced in me a comparably unsettled sensibility. Both my mother and father were well intentioned and loving, but between them, they combined overprotection and anger in a way that may have been particularly toxic for a child with an innately nervous temperament. On many occasions, my screaming bouts of nighttime panic would awaken the whole family, and my father would lie patiently with me, trying to calm me down enough to sleep. But sometimes, exhausted and frustrated, he would lash out at me physically. My mother dressed me until I was 9 or 10 years old; after that, she picked out my clothes for me every night until I was about 15. She ran my baths until I was in high school. Any time my sister and I were home while my parents were at work, we had the company of a babysitter. By the time I was a young teenager, this was getting a bit weird—as I realized the day I discovered, to our mutual discomfort, that the babysitter was my age (13). My mother did all of this out of genuine love and anxious concern. And I welcomed the excess of solicitude: it kept me swaddled in a comforting dependency. But our relationship helped deprive me of autonomy and a sense of self-efficacy.

Medication has more reliably soothed my anxiety than other forms of therapy have. Yet the case for medication is not at all clear-cut.

Still, in most respects my parents maintained a safe, loving, and stable suburban home; many people grow up in circumstances far more traumatic than mine and don't develop clinical anxiety. Ultimately, it's impossible to disentangle nature and nurture—my anxiety is surely the result of both, and of the interaction between the two. For instance, it's possible that my mother's anxiety while pregnant with me—having endured two miscarriages followed by difficulty getting pregnant again, she says her already high level of worry was inflamed by the fear that she wouldn't carry me to term—produced such hormonal Sturm und Drang in the womb that I was doomed to be born nervous. Research suggests that mothers who suffer stress while pregnant are more likely to produce anxious children. Thomas Hobbes, the political philosopher, was born prematurely when his mother, terrified by a rumor that the Spanish armada was advancing toward English shores, went into labor in April 1588. "Myself and fear were born twins," Hobbes wrote, and he attributed his own anxious temperament to the ambient turmoil of his gestation. Maybe Hobbes's view that a powerful state needs to protect citizens from the violence and torment they naturally inflict on one another (life, he famously said, is nasty, brutish, and short) had its origins in utero, as his mother's stress hormones washed through him.

Or do the roots of my anxiety lie even deeper and extend more broadly than the things I've experienced and the genes I've inherited—that is, in history and in culture? My father's parents were Jews who emigrated from Weimar Germany. My father's mother became a nastily anti-Semitic Jew—she renounced her Jewishness out of fear that she would someday be

persecuted for it. My sister and I were raised in the Episcopal Church, our Jewish background hidden from us until I was in high school. My father, for his part, has had a lifelong fascination with World War II, and specifically with the Nazis; he watched the 1973–74 television series *The World at War* again and again. In my memory, that program, with its stentorian music accompanying the Nazi advance on Paris, is the running soundtrack to my early childhood. Jews, of course, have millennia of experience in having reason to be scared—which perhaps explains why some studies have suggested that Jewish men are more likely to suffer from neuroses than are men in other groups.

My mother's cultural heritage, on the other hand, is heavily WASP; she is a proud *Mayflower* descendant who until recently subscribed to the notion that there is no emotion and no family issue that should not be suppressed.

Thus, me: a mixture of Jewish and WASP pathology—a neurotic and histrionic Jew suppressed inside a neurotic and repressed WASP. No wonder I'm anxious: I'm like Woody Allen trapped inside John Calvin.

Everyone knows that anxiety can cause gastrointestinal distress. (My friend Anne says that the most effective weight-loss program she ever tried was the Stressful-Divorce Diet.) But medical researchers have charted the connections in precise and systematic detail: as one's mental state changes, for instance, so does blood flow to and from the stomach. The gastrointestinal system is a concrete and direct register of one's psychology. In their 1943 landmark of psychosomatic research, *Human Gastric Function*, the physicians Stewart Wolf and Harold Wolff concluded that there was a strong inverse correlation between what they called "emotional security" and stomach discomfort.

That's certainly true in my case. Being anxious makes my stomach hurt and my bowels loosen. My stomach hurting and my bowels loosening makes me *more* anxious, which makes my stomach hurt more and my bowels even looser, and so nearly every trip of any significant distance from home ends up the same way: with me scurrying frantically from restroom to restroom on a kind of grand tour of the local latrines. For instance, I don't have terribly vivid recollections of the Vatican or the Colosseum or the Italian rail system. I do, however, have detailed memories of the public restrooms in the Vatican and at the Colosseum and in various Italian train stations in the winter of 2002. One day, I visited the Trevi Fountain—or, rather, my wife and her family visited the Trevi Fountain. I visited the restroom of a nearby *gelateria*, where a series of impatient Italians banged on the door while I bivouacked there. The next day, when the family drove to Pompeii, I gave up and stayed in bed, a reassuringly short distance from the bathroom.

When your stomach governs your existence, it's hard not to be preoccupied with it. A few searing experiences—soiling yourself on an airplane, say, or on a date (and yes, I have done both)—will focus you passionately on your gastrointestinal tract. You need to devote effort to planning around it—because it will not plan around you.

Case in point: In the summer of 1997, while researching my first book, a biography of Sargent Shriver—who founded the Peace Corps for his brother-in-law John F. Kennedy—I spent part of the summer living with the extended Kennedy family on Cape Cod. One weekend, then-President Bill Clinton, who was vacationing on Martha's Vineyard, went sailing with Ted Kennedy, and I suspected that Hyannis Port, Massachusetts, where the Kennedys have their vacation homes, would be crawling with Secret Service agents. With some time to kill before dinner, I decided to walk around town to take in the scene.

Bad idea. As is so often the case for people with unruly, nervous bellies, it was at precisely the moment I passed beyond Easily-Accessible-Bathroom Range that my plumbing came unglued. While sprinting back to the house where I was staying, I was several times convinced I would not make it and—teeth gritted, sweating voluminously—was reduced to evaluating various bushes and storage sheds along the way for their potential as ersatz outhouses. Imagining what might ensue if a Secret Service agent were to happen upon me crouched in the shrubbery lent a kind of panicked, otherworldly strength to my efforts at self-possession.

As I approached the entrance, I was simultaneously reviewing the floor plan in my head (*Which of the many bathrooms in the mansion is closest to the front door?*) and praying that I wouldn't be fatally waylaid by a stray Kennedy or celebrity (as I recall, Arnold Schwarzenegger, Liza Minnelli, and the secretary of the Navy, among others, were visiting that weekend).

Fortunately, I made it into the house unaccosted. Then a quick calculation: *Can I make it all the way upstairs and down the hall to my suite in time? Or should I duck into the bathroom in the front hall?* Hearing footsteps above and fearing a protracted encounter, I opted for the latter and slipped into the bathroom, which was separated from the front hall by an anteroom and two separate doors. I scampered through the anteroom and flung myself onto the toilet.

My relief was extravagant and almost metaphysical.

But then I flushed and … something happened. My feet were getting wet. I looked down and saw to my horror that water was flowing out from the base of the toilet. Something seemed to have exploded. The floor—along with my shoes and pants—was covered in sewage. The water level was rising.

Could the flooding be stopped? Turning around, I removed the porcelain top of the toilet tank, scattering the flowers and potpourri that sat atop it, and frantically began fiddling with its innards. I tried things blindly, raising this and lowering that, jiggling this and wiggling that, fishing around in the water for something that might stem the swelling tide.

Somehow, whether of its own accord or as a result of my haphazard fiddling, the flooding slowed and then stopped. I surveyed the scene. My clothes were drenched and soiled. So was the bathroom rug. Without thinking, I slipped off my pants and boxer shorts, wrapped them in the waterlogged rug, and jammed the whole mess into the wastebasket, which I stashed in the cupboard under the sink. *Have to deal with this later*, I thought to myself.

It was at this unpropitious moment that the dinner bell rang, signaling that it was time to muster for cocktails in the living room.

Which was right across the hall from the bathroom.

Where I was standing ankle-deep in sewage.

I pulled some towels off the wall and dropped them on the ground to start sopping up some of the toilet water. I got down on my hands and knees and, unraveling the whole roll of toilet paper, began dabbing frenziedly at the water around me. It was like trying to dry a lake with a kitchen sponge.

What I was feeling at that point was not, strictly speaking, anxiety; rather, it was a resigned sense that the jig was up, that my humiliation would be complete and total. I'd soiled myself, destroyed the estate's septic system, and might soon be standing half naked before God knows how many members of the political and Hollywood elite.

In the distance, voices were moving closer. It occurred to me that I had two choices. I could hunker down in the bathroom, hiding and waiting out the cocktail party and dinner—at the risk of having to fend off anyone who might start knocking on the door—and use the time to try to clean up the wreckage before slipping up to my bedroom after everyone had gone to bed. Or I could try to make a break for it.

I took all the soiled towels and toilet paper and shoved them into the cupboard, then set about preparing my escape. I retrieved the least soiled towel (which was nonetheless dirty and sodden) and wrapped it gingerly around my waist. I crept to the door and listened for voices and footsteps, trying to gauge distance and speed of approach. Knowing I had scarcely any time before everyone converged on the center of the house, I slipped out of the bathroom and through the anteroom, sprint-walked across the hallway, and darted up the stairs. I hit the landing, made a hairpin turn, and headed up the next flight to the second floor—where I nearly ran headlong into John F. Kennedy Jr. and another man.

"Hi, Scott," Kennedy said. (I'd just met him for the first time the day before. "I'm John Kennedy," he had said when he extended his hand in introduction. *I know*, I had thought as I extended mine, thinking it funny that he had to pretend courteously that people might not know his name, despite the ubiquity of his face on the cover of checkout-counter magazines.)

"Uh, hi," I said, racking my brain for a plausible explanation for why I might be running through the house at cocktail hour with no pants on, drenched in sweat, swaddled in a soiled and reeking towel. But he and his friend appeared utterly unfazed—as though half-naked houseguests covered in their own excrement were common here—and walked past me down the stairs.

I scrambled down the hallway to my room, where I showered vigorously, changed, and tried to compose myself as best I could—which was not easy because I was still sweating terribly, right through my blazer, the result of anxiety, exertion, and summer humidity.

“Hi, Scott,” Kennedy said. He appeared unfazed—as though half-naked houseguests covered in their own excrement were common here.

If someone had snapped a photo of the scene at cocktails that evening, here’s what it would show: various celebrities and politicians and priests all glowing with grace and easy bonhomie as they mingle effortlessly on the veranda overlooking the Atlantic—while, just off to the side, a sweaty young writer stands awkwardly gulping gin and tonics and thinking about how far he is from fitting in with this illustrious crowd and about how not only is he not rich or famous or accomplished or particularly good-looking, but he cannot even control his own bowels and therefore is better suited for the company of animals or infants than of adults, let alone adults as luminous and significant as these.

The sweaty young writer is also worrying about what will happen when someone tries to use the hallway bathroom.

Late that night, after everyone had gone off to bed, I sneaked back down to the bathroom with a trash bag and paper towels and cleaning detergent I’d pilfered from the pantry. I couldn’t tell whether anyone had been there since I left, but I tried not to worry about that and concentrated on stuffing the soiled rug and towels and clothes and toilet paper I’d stashed under the sink into the trash bag. Then I used the paper towels to scrub the floor, and I put those into the trash bag as well.

Outside the kitchen, between the main house and an outbuilding, was a Dumpster. My plan was to dispose of everything there. Naturally, I was terrified of getting caught. What, exactly, would a houseguest be doing disposing of a large trash bag outside in the middle of the night? (I worried that there might still be Secret Service afoot, who might shoot me before allowing me to plant what looked like a bomb or a body in the Dumpster.) But what choice did I have? I slunk through the house and out to the Dumpster, where I deposited the trash bag. Then I went back upstairs to bed.

No one ever said anything to me about the hallway bathroom or about the missing rug and towels. But for the rest of the weekend, and on my subsequent visits there, I was convinced that various household-staff members were glaring at me and whispering. “That’s him,” I imagined they were saying in disgust. “The one who broke the toilet and ruined our towels. The one who can’t control his own bodily functions.”

On April 13, 2004, at 2 o’clock in the afternoon, I, then 34 years old and working as a senior editor at *The Atlantic* and dreading the publication of my Sargent Shriver biography, presented myself at the nationally renowned Center for Anxiety and Related Disorders at Boston University. After meeting for several hours with a psychologist and two graduate students and filling out dozens of pages of questionnaires, I was given a principal diagnosis of “panic disorder with agoraphobia” and additional diagnoses of “specific phobia” and “social phobia.” The clinicians also noted in their report that my questionnaire answers indicated “mild levels of depression,” “strong levels of anxiety,” and “strong levels of worry.”

Why so many different diagnoses? And why were they different from the diagnoses of my youth (“phobic neurosis,” “overanxious reaction disorder of childhood”)? Had the nature of my anxiety changed so much? How can we make scientific or therapeutic progress if we can’t agree on what anxiety is?

Even Sigmund Freud, the inventor, more or less, of the modern idea of neurosis—a man for whom anxiety was a key, if not *the* key, foundational concept of his theory of psychopathology—contradicted himself over the course of his career. Early on, he said that anxiety arose from unexpressed sexual impulses (anxiety is to repressed libido, he wrote, “as vinegar is to wine”). Later in his career, he argued that anxiety primarily arose from unconscious psychic conflicts. Late in his life, in *The Problem of Anxiety*, Freud wrote: “It is almost disgraceful that after so much labor we should still find difficulty in conceiving of the most fundamental matters.”

Today, the American Psychiatric Association’s *Diagnostic and Statistical Manual* (now in its just-published fifth edition, *DSM-5*) defines hundreds of mental disorders, classifies them by type, and lists, in levels of detail that can seem both absurdly precise and completely random, the symptoms a patient must display (how many, how often, and with what severity) to receive any given psychiatric diagnosis. All of which lends the appearance of scientific validity to the diagnosing of an anxiety disorder. But the reality is that there is a large quotient of subjectivity here (both on the part of patients, in describing their symptoms, and of clinicians, in interpreting them). Studies in the 1950s found that when two psychiatrists evaluated the same patient, they gave the same *DSM* diagnosis only about 40 percent of the time. Rates of consistency have improved since then, but the diagnosis of many mental disorders remains, despite pretensions to the contrary, more art than science.

In the spring of 2004, such was my terror over the looming book tour that I sought help from multiple sources. I first went to a prominent Harvard psychopharmacologist. “You have an anxiety disorder,” he told me after taking my case history. “Fortunately, this is highly treatable. We just need to get you properly medicated.” When I gave him my standard objections to reliance on medication (worry about side effects, concerns about drug dependency, discomfort with the idea of taking pills that might affect my mind and change who I am), he resorted to the clichéd—but nonetheless potent—diabetes argument, which goes like this: “Your anxiety has a biological, physiological, and genetic basis; it is a medical illness, just like diabetes is. If you were a diabetic, you wouldn’t have such qualms about taking insulin, would you? And you wouldn’t see your diabetes as a moral failing, would you?” I’d had versions of this discussion with various psychiatrists many times over the years. I would try to resist whatever the latest drug was, feeling that this resistance was somehow noble or moral, that reliance on medication evinced weakness of character, that my anxiety was an integral and worthwhile component of who I am, and that there was redemption in suffering—until, inevitably, my anxiety would become so acute that I would be willing to try anything, including the new medication. So, as usual, I capitulated, and as the book tour drew closer, I began a course of benzodiazepines (Xanax during the day, Klonopin at night) and increased my dosage of Celexa, an antidepressant I was already taking.

But even drugged to the gills, I remained filled with dread about the book tour, so I went also to the Boston University center, and was ultimately referred to a young but highly regarded Stanford-trained psychologist who specialized in cognitive-behavioral therapy. “First thing we’ve got to do,” she said in one of my early sessions with her, “is to get you off these drugs.” A few sessions later, she offered to take my Xanax from me and lock it in a drawer in her desk. She opened the drawer to show me the bottles deposited there by some of her other patients, holding one up and shaking it for effect. The drugs, she said, were a crutch that prevented me from truly experiencing and thereby confronting my anxiety; if I didn’t expose myself to the raw experience of anxiety, I would never learn that I could cope with it on my own.

She had a point, I knew. But with the book tour approaching, my fear was that I might *not*, in fact, be able to cope with it.

I went back to the Harvard psychopharmacologist (let’s call him Dr. Harvard) and described the course of action the Stanford psychologist (let’s call her Dr. Stanford) had proposed. “You could try giving up the medication,” he said. “But your anxiety is clearly so deeply rooted in your biology that even mild stress provokes it. Only medication can control your biological reaction. And it may well be that your anxiety is so acute that the only way you’ll be able to get to the point where any kind of behavioral therapy can begin to be effective is by taking the edge off your physical symptoms with drugs.”

At my next session with Dr. Stanford, I told her I was afraid to give up my Xanax and related what Dr. Harvard had said to me. She looked betrayed. After that, I stopped telling her about my visits to Dr. Harvard. My continued consultations with him felt illicit.

Dr. Stanford was more pleasant to talk to than Dr. Harvard; she tried to understand what caused my anxiety and seemed to care about me as an individual. Dr. Harvard seemed to see me as more of a general type—an anxiety patient—to be treated with drugs. One day I read in the newspaper that he was administering antidepressants to gorillas at the local zoo. Dr. Harvard’s treatment of choice for the gorillas in question? SSRI antidepressants, the same class of medication he had prescribed for me.

I can’t say for certain whether the drugs worked for the gorillas. Reportedly, they did not. But could there be a more potent demonstration that Dr. Harvard’s approach to treatment was resolutely biological? For him, the content of any psychic distress—and certainly the meaning of it—mattered less than the fact of it: such distress, whether in a human or some other primate, was a medical-biological malfunction that could be fixed with drugs.

Not all therapists have such black-and-white views; many find room both for medication and for other kinds of therapy. Some cognitive-behavioral therapists, for instance, use certain drugs to enhance exposure therapy. And neuroscientists increasingly recognize the power of things like meditation and traditional talk therapy to render concrete structural changes in brain physiology that are every bit as “real” as the changes wrought by pills or electroshock therapy.

My own experience, of course, involves ample exposure to both drugs and other therapies, often in concert. Starting when I was 11, I saw the same psychiatrist once or twice a week for 25 years. Dr. L. was the psychiatrist who, when I was taken to McLean Hospital, administered my first Rorschach test. When I started therapy with him, he was approaching 50, tall and lanky, balding a little, with a beard in the classic Freudian style. Over the years, the beard came and went, and he lost more of his hair, which turned from brown to salt-and-pepper to white. Trained at Harvard in the 1950s and early 1960s, Dr. L. came

of professional age in the late stages of the psychoanalytic heyday, when Freudianism still dominated. When I first encountered him, he was a believer both in medication and in such Freudian concepts as neurosis and repression, the Oedipus complex and transference. Our first sessions, in the early 1980s, were filled with things like Rorschach tests and free association and discussions of early memories. Our last sessions, in the mid-2000s, were focused on role-playing and "energy work"; he also suggested during those latter years that I sign up for a special kind of yoga program, later alleged to be a brainwashing cult by some former members, though their claims were never proved.

Here's some of what we did in our sessions together over a quarter century: looked at picture books (1981); played backgammon (1982–85); played darts (1985–88); experimented sporadically with various cutting-edge psychotherapeutic methods of an increasingly New Age complexion, such as hypnotism, eye-movement desensitization and reprocessing, energy-systems therapy, and internal-family-systems therapy (1988–2004). During this period I also moved, in tandem with prevailing pharmacological trends, from one class of drugs to another, in often overlapping succession: from antipsychotics to benzodiazepines to tricyclic antidepressants to MAOI antidepressants to SSRI antidepressants back to benzodiazepines again. I was the beneficiary, or possibly the victim, of seemingly every passing fad in psychotherapy and psychopharmacology.

Medication has more reliably soothed my anxiety than various other forms of therapy have. (Without Thorazine and imipramine and Valium, I don't know that I could have gotten through seventh grade.) Yet the case for medication, I can also tell you, is complicated by drawbacks and side effects that range from sedation to weight gain to mania to headaches to digestive and urinary troubles to neuromuscular problems to dependency and addiction to, some say, brain damage—and that's leaving aside withdrawal symptoms that, in the case of many drugs, can be far worse than the side effects. While lots of people will testify that drugs have helped them, lots of other people will testify (and often do, in court filings and before Congress) that medication has ruined their lives. Though plenty of studies, and many individual experiences, suggest that drugs can be highly effective in treating anxiety, the benefits are at the very least not clear-cut.

Sigmund Freud relied heavily on drugs to manage his anxiety. Six of his earliest scientific papers described the benefits of cocaine, which he used regularly for at least a decade, beginning in the 1880s. Only after he prescribed the stimulant to a close friend who became fatally addicted did Freud's enthusiasm wane. Much of the history of modern psychopharmacology has the same ad hoc quality as Freud's experimentation with cocaine. Every one of the most commercially significant classes of antianxiety and antidepressant drugs of the past 60 years was discovered by accident or was originally developed for something completely unrelated to anxiety or depression: to treat tuberculosis, surgical shock, allergies; to use as an insecticide, a penicillin preservative, an industrial dye, a disinfectant, rocket fuel.

Prozac and other, similar selective serotonin reuptake inhibitors are currently the medications of choice for many psychiatrists, and have been for more than two decades. Given how completely SSRIs have saturated our culture and our environment, you might be surprised to learn that Eli Lilly, which held the U.S. patent for fluoxetine (the generic name for Prozac), killed the drug in development *seven times*, in part because of unconvincing test results. After examining the tepid outcomes of fluoxetine trials, as well as complaints about the drug's side effects, German regulators in 1984 concluded, "Considering the benefit and the risk, we think this preparation totally unsuitable for the treatment of depression." Early clinical trials of another SSRI, Paxil, were also failures.

I've been on one or another SSRI pretty much continuously for going on 20 years. Nevertheless, I can't say with complete conviction that these drugs have worked, at least for long—or that they've been worth the costs in terms of money, side effects, drug-switching traumas, and who knows what long-term effects on my brain.

After the initial flush of enthusiasm for SSRIs in the 1990s, some of the concerns about drug dependency and side effects that had attached to tranquilizers in the 1970s began clustering around antidepressants. "It is now clear," David Healy, a historian of psychopharmacology, wrote in 2003, "that the rates at which withdrawal problems have been reported" on paroxetine, the generic name for Paxil, "exceed the rates at which withdrawal problems have been reported on any other psychotropic drug ever."

Even leaving aside withdrawal effects, there is now a large pile of evidence suggesting—in line with those early studies of the ineffectiveness of Prozac and Paxil—that SSRIs may not work terribly well. In January 2010, almost exactly 20 years after hailing the arrival of SSRIs with its cover story "Prozac: A Breakthrough Drug for Depression," *Newsweek* published a cover story about the growing number of studies that suggested these and other antidepressants are barely more effective than sugar pills. A large-scale study from 2006 showed that only about a third of patients improved dramatically after a first cycle

of treatment with antidepressants. Even after three additional cycles, almost a third of patients who remained in the study had not reached remission. After reviewing a host of studies on antidepressant effectiveness, a paper in the *British Medical Journal* concluded that drugs in the SSRI class—including Prozac, Zoloft, and Paxil—"do not have a clinically meaningful advantage over placebo."

How can this be? Tens of millions of Americans—including me and many people I know—collectively consume billions of dollars' worth of SSRIs each year. Doesn't this suggest that these drugs are effective? Not necessarily. At the very least, this massive rate of SSRI consumption has not caused rates of self-reported depression to go down—and in fact all of this pill popping seems to correlate with substantially higher rates of depression. Meanwhile, the relationship between low serotonin levels and anxiety or depression (once, and to some extent still, the theoretical reason SSRIs, which boost serotonin, should work) now seems less straightforward than previously thought. George Ashcroft, who, as a research psychiatrist in Scotland in the 1950s, was one of the scientists responsible for promulgating the chemical-imbalance theory of mental illness, abandoned the theory when further research failed to support it. "We have hunted for big, simple neurochemical explanations for psychiatric disorders," Kenneth Kendler, a co-editor of *Psychological Medicine* and a psychiatry professor at Virginia Commonwealth University, conceded in 2005, "and have not found them."

Some drugs work on some people, but the reasons are murky, and the results sometimes fleeting. Of course, studies have generally not found the response rates to nonpharmacological forms of treatment to be better than the response rates to antidepressants or any other drugs. Some recent studies have found that the effects of cognitive-behavioral therapy are more enduring than drug treatment. But as a general rule of thumb across many types of therapy, patients tend to split pretty evenly among those who see long-term improvement, those who see only transient benefits, and those who see no improvement at all. (That's generally true of placebo treatments as well.) And so, just as I find it difficult to endorse most of these treatments, I am also reluctant to condemn them. Like medication, they clearly do help some patients. This is a fact I can vouch for personally.

On the Sunday in the autumn of 1995 when my mother announced to him that she might want a divorce, my father, desperate to save the marriage, and in a gesture that was completely out of character, acquiesced to emergency couple's counseling. When that didn't work, and my mother left him, he became unmoored, and soon began seeing Dr. L., my psychiatrist. For years before that, my father, despite footing the bill for my sister's and my shrinks, had disdained psychotherapy. "How was your wacko lesson?" he'd ask jeeringly after I'd had an appointment. He did this so often that the term became a part of the family's lingua franca, and eventually my sister and I were referring without irony to our wacko lessons. ("Mom, can you give me a ride to my wacko lesson on Wednesday?")

And yet, there he was, suddenly sharing a therapist with me. My own sessions with Dr. L. came to be dominated by the therapist's questions about his new star patient, my father. I couldn't blame Dr. L. for finding my father the more interesting patient. After all, while he'd been seeing me for more than 15 years, he'd been seeing my dad for only a few months. My dad entered therapy emotionally wrecked by his separation, profoundly shaken, and newly sober. He completed therapy less than two years later, happy, productive, remarried, and deemed (by himself and by Dr. L.) to be much more "self-actualized" and "authentic" than he had been before. He was in and out of therapy in 18 months. Whereas I was entering my 18th year of therapy with Dr. L. and was still as anxious as ever.

At some level, it is adaptive to be reasonably anxious. According to Charles Darwin (who himself seems to have suffered from crippling agoraphobia that left him intermittently housebound for years after his voyage on the *Beagle*), species that experience an appropriate amount of fear increase their chances of survival. We anxious people are less likely to remove ourselves from the gene pool by, say, frolicking on the edges of cliffs or becoming fighter pilots.

An influential study conducted 100 years ago by two Harvard psychologists, Robert M. Yerkes and John Dillingham Dodson, laid the foundation for the idea that moderate levels of anxiety *improve* performance: too much anxiety, obviously, and performance is impaired, but too *little* anxiety also impairs performance. "Without anxiety, little would be accomplished," David Barlow, the founder and director emeritus of the Center for Anxiety and Related Disorders at Boston University, has written.

The performance of athletes, entertainers, executives, artisans, and students would suffer; creativity would diminish; crops might not be planted. And we would all achieve that idyllic state long sought after in our fast-paced society of whiling away our lives under a shade tree. This would be as deadly for the species as nuclear war.

Even if I can't fully recover from my anxiety, I've come to believe there may be some redeeming value in it.

Historical evidence suggests that anxiety can be allied to artistic and creative genius. The literary gifts of Emily Dickinson, for example, were inextricably bound up with her reclusiveness, which some say was a product of anxiety. (She was completely housebound after age 40.) Franz Kafka yoked his neurotic sensibility to his artistic sensibility; Woody Allen has done the same. Jerome Kagan, an eminent Harvard psychologist who has spent more than 50 years studying human temperament, argues that T. S. Eliot's anxiety and "high reactive" physiology helped make him a great poet. Eliot was, Kagan observes, a "shy, cautious, sensitive child"—but because he also had a supportive family, good schooling, and "unusual verbal abilities," Eliot was able to "exploit his temperamental preference for an introverted, solitary life."

Perhaps most famously, Marcel Proust transmuted his neurotic sensibility into art. Proust's father, Adrien, was a physician with a strong interest in nervous health and a co-author of an influential book called *The Hygiene of the Neurasthenic*. Marcel read his father's book, as well as books by many of the other leading nerve doctors of his day, and incorporated their work into his; his fiction and nonfiction are "saturated with the vocabulary of nervous dysfunction," as one historian has put it. For Proust, refinement of artistic sensibility was directly tied to a nervous disposition. Dean Simonton, a psychology professor at the University of California at Davis who has spent decades studying the psychology of genius, has written that "exceptional creativity" is often linked to psychopathology; it may be that the same cognitive or neurobiological mechanisms that predispose certain people to developing anxiety disorders also enhance creative thinking.

Many of history's most eminent scientists also suffered from anxiety or depression, or both. When Sir Isaac Newton invented calculus, he didn't publicize his work for 20 years—because, some conjecture, he was too anxious and depressed to tell anyone. (For more than five years after a nervous breakdown around 1678, when he was in his mid-30s, he rarely ventured far from his room at Cambridge.) Perhaps if Darwin had not been largely housebound by his anxiety for decades on end, he would never have been able to finish his work on evolution. Sigmund Freud's career was nearly derailed early on by his terrible anxiety and self-doubt; he overcame it, and once his reputation as a great man of science had been established, Freud and his acolytes sought to portray him as the eternally self-assured wise man. But his early letters reveal otherwise.

No, anxiety is not, by itself, going to make you a Nobel Prize–winning poet or a groundbreaking scientist. But if you harness your anxious temperament correctly, it might make you a better worker. Jerome Kagan says he hires only people with high-reactive temperaments as research assistants. "They're compulsive, they don't make errors," he told *The New York Times*. Other research supports Kagan's observation. A 2013 study in the *Academy of Management Journal*, for instance, found that neurotics contribute more to group projects than co-workers predict, while extroverts contribute less. And in 2005, researchers in the United Kingdom published a paper, "Can Worriers Be Winners?," reporting that financial managers high in anxiety tended to be the best, most effective money managers, as long as their worrying was accompanied by a high IQ.

My anxiety can be intolerable. But it is also, maybe, a gift—or at least the other side of a coin I ought to think twice about before trading in.

Unfortunately, the positive correlation between worrying and job performance disappeared when the worriers had a low IQ. But some evidence suggests that excessive worrying is itself allied to intelligence. Jeremy Coplan, the lead author of one study supporting that thesis, says anxiety is evolutionarily adaptive because "every so often there's a wild-card danger." When such a danger arises, anxious people are more likely to be prepared to survive. Coplan, a professor of psychiatry at the State University of New York Downstate Medical Center, has said that worrying can be a good trait in leaders—and that lack of worrying can be dangerous. If people in leadership positions are "incapable of seeing any danger, even when danger is imminent," they are likely, among other poor decisions, to "indicate to the general populace that there's no need to worry." (Some commentators have suggested, based on findings like Coplan's, that the main cause of the economic crash of 2008 was politicians and financiers who were either stupid or insufficiently anxious or both.) Studies on rhesus monkeys by Stephen Suomi, the chief of the Laboratory of Comparative Ethology at the National Institutes of Health, have found that when monkeys genetically predisposed to anxiety were taken early in life from their anxious mothers and given to unanxious mothers to be raised, a fascinating thing happened: these monkeys grew up to display less anxiety than peers with the same genetic markings—and many also, intriguingly, became the leader of their troop. This suggests that, under the right circumstances, some quotient of anxiety can equip you to be a leader.

As always, all of this comes with the proviso that anxiety is productive mainly when it is not so strong as to be debilitating. But if you are anxious, perhaps you can take heart from these findings.

I’ve come to understand that my own nervous disposition is perhaps an essential part of my being—and not just in ways that are bad. “I hate your anxiety,” my wife once said, “and I hate that it makes you unhappy. But what if there are things that I love about you that are connected to your anxiety?

“What if,” she asked, getting to the heart of the matter, “you’re cured of your anxiety and you become a total jerk?”

I suspect I might. Military pilots, by reputation, at least, are famously unanxious. And one small-scale study from the 1980s found that nine out of 10 separations and divorces among Air Force pilots were initiated by wives. Perhaps the two are linked. Low baseline levels of autonomic arousal (which can correspond to low levels of anxiety) have been tied not only to a need for adventure (flying a fighter plane, say), but also to a certain interpersonal obtuseness, a lack of sensitivity to social cues. It may be that my anxiety lends me an inhibition and a social sensitivity that make me more attuned to other people and a more tolerable spouse than I otherwise would be.

The notion of a connection between anxiety and morality long predates the findings of modern science or my wife’s intuition. Saint Augustine believed fear is adaptive because it helps people behave morally. The novelist Angela Carter has called anxiety “the beginning of conscience.” Some research into the determinants of criminal behavior suggest that criminals tend to be lower in anxiety than noncriminals. (On the other hand, different studies have found that high levels of anxiety, especially in youth, correlate with delinquent behavior.)

My anxiety can be intolerable. But it is also, maybe, a gift—or at least the other side of a coin I ought to think twice about before trading in. As often as anxiety has held me back—prevented me from traveling, or from seizing opportunities or taking certain risks—it has also unquestionably spurred me forward. “If a man were a beast or an angel, he would not be able to be in anxiety,” Søren Kierkegaard wrote in 1844. “Since he is a synthesis, he can be in anxiety, and the greater the anxiety, the greater the man.” I don’t know about that. But I do know that some of the things for which I am most thankful—the opportunity to help lead a respected magazine; a place, however peripheral, in shaping public debate; a peripatetic and curious sensibility; and whatever quotients of emotional intelligence and good judgment I possess—not only coexist with my condition but are in some meaningful way the product of it.

In his 1941 essay “The Wound and the Bow,” the literary critic Edmund Wilson writes of the Sophoclean hero Philoctetes, whose suppurating, never-healing snakebite wound on his foot is linked to a gift for unerring accuracy with his bow and arrow—his “malodorous disease” is inseparable from his “superhuman art” for marksmanship. I have always been drawn to this parable: in it lies, as the writer Jeanette Winterson has put it, “the nearness of the wound to the gift,” the insight that in weakness and shamefulness is also the potential for transcendence, heroism, or redemption. My anxiety remains an unhealed wound that, at times, holds me back and fills me with shame—but it may also be, at the same time, a source of strength and a bestower of certain blessings.