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A Study Of Childhood Anxiety Disorders And Their Impact On The Development Of Anxiety Disorders In Adulthood

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A STUDY OF CHILDHOOD ANXIETY DISORDERS AND THEIR IMPACT ON

THE DEVELOPMENT OF ANXIETY DISORDERS IN ADULTHOOD

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Introduction

According to Children's Mental Health Ontario (CMHO), anxiety disorders remain some of the most common and least understood psychiatric conditions. Approximately one in ten people, especially females, and more than six percent of children suffer from an anxiety disorder (Spurgaitis, 2006). For youth, prevalence rates for anxiety disorders range from 12% to 20% (Gosch, Flannery-Shroeder, Mauro, & Compton, 2006). Too often, anxiety is viewed as a mental weakness or instability. These social stigmas can further discourage children with anxiety disorders and their parents from seeking help, which further perpetuates the problem. Anxiety disorders also cause a substantial burden for clients and their families, often leading to school absences, impaired relations with peers, and low self-esteem (Spurgaitis, 2006). Anxiety disorders also lead to impairment or disability in occupational, social, or interpersonal functioning (Principles of diagnosis and management of anxiety disorders, 2006). This study examines childhood anxiety disorders as well as their impact on the development of anxiety disorders in adulthood. Using qualitative measures, this study presents a few detailed, personal accounts of living with an anxiety disorder. It also compares, contrasts, and analyzes the effectiveness of different proposed treatment methods.

Literature Review

The three most common childhood anxiety disorders are social phobia (SP), generalized anxiety disorder (GAD), and separation anxiety disorder (SAD) (Gosch, Flannery-Shroeder, Mauro, & Compton, 2006). Anxiety disorders are characterized by certain key symptoms including excessive anxiety, fear, worry, avoidance, and

compulsive rituals (Principles of diagnosis and management of anxiety disorders, 2006).

Common risk factors include family history of anxiety (or other mental disorder);

personal history of anxiety in childhood or adolescence, including marked shyness;

stressful life event and/or traumatic event, including abuse; being female; and comorbid

psychiatric disorder (particularly depression) (Principles of diagnosis and management of

anxiety disorders, 2006). McLoone, Hudson, and Rapee (2006) claim that

epidemiological surveys show that females are approximately one and a half to two times

more likely to have an anxiety disorder than males.

It is important to recognize and acknowledge the discrepancy between the normal

human experience of anxiety and the symptoms of an anxiety disorder. According to

Gittelman (1986), "Anxiety is a normal part of being human; however, the

psychophysiological significance of these symptoms depends on their 1) severity and

disabling effect 2) persistence 3) age appropriateness 4) number 5) associated

symptomatology 6) usualness or bizarreness, and 7) family or peer group norms" (p. 76).

Kendall, Chansky, Kane, Kim, Kortlander, Ronan, Sessa, & Siqueland (1992, p.1)

recognize that many of the anxieties which children and adolescents experience are fairly

common and usually transitory, which is considered normal in development. They claim,

"Childhood anxiety becomes a concern when its severity or duration negatively infringes

on the child or those within the family and broader social network" (Kendall, Chansky,

Kane, Kim, Kortlander, Ronan, Sessa, & Siqueland, 1992, p. 1).

Some of the initial indicators of an anxiety disorder in a child are physical

symptoms and/or certain observable behaviors. Gittelman (1986) states, "Physical

symptoms that seem to have a particular connection with anxiety in children are

recurrent, nonlocalized abdominal pain, tics, and enuresis" (p. 75-76). Kendall, Chansky, Kane, Kim, Kortlander, Ronan, Sessa, & Siqueland (1992, p.1) suggest that other physical symptoms include perspiration, diffuse abdominal pain, flushed face, and trembling. Gittelman (1986) claims, "Behavioral manifestations that are common concomitants of anxiety are motor restlessness, anxious visage, compulsions, and escape-avoidance behaviors like shyness or school refusal" (p. 76).

The *Diagnostic and Statistical Manual of Mental Disorders (DSM)* provides mental health professionals with specific criteria for diagnosis. Klein (1989) states, "According to both DSM III and DSM III-R, the child must meet four of the following seven criteria: 1) unrealistic worry about future events, 2) preoccupation with the appropriateness of the individual's behavior in the past, 3) overconcern about competence in a variety of areas (e.g. academic, athletic, social), 4) excessive need for reassurance about a variety of worries, 5) somatic complaints, such as headaches or stomachaches, for which no physical basis can be established, 6) marked self-consciousness or susceptibility to embarrassment or humiliation, 7) marked feelings of tension or inability to relax. These symptoms must have persisted for at least six months" (p. 130).

The DSM-IV defines twelve types of anxiety disorders which affect the adult population, including panic disorders, phobias, Obsessive-compulsive Disorder (OCD), stress disorders, and Generalized Anxiety Disorder (GAD) ("Anxiety Disorders," 2006). The DSM-IV includes a criterion of severity with anxiety disorder diagnoses. For example, in order for the anxiety to be characterized as a disorder, it must be severe enough to interfere significantly with a person's occupational or educational functioning, social activities, or close relationships ("Anxiety Disorders," 2006).

It is interesting to examine the possibility of genetic influence in childhood anxiety disorders. Klein (1989) claims, "An inherited disposition may interact adversely with certain environmental events, such as stressful life events or family interaction patterns and child-rearing practices" (p. 97). Morris & March (2004) found that "68% of mothers of SAD (Separation Anxiety Disorder) children had a lifetime diagnosis of an anxiety disorder, 53% had a lifetime diagnosis of major depression, and 47% had a current anxiety disorder diagnosis" (p. 175). Klein (1989) suggests that in addition to genetic predisposition, the mothers' anxious behaviors also contribute. Klein (1989) states:

> The mother-child relationship repeatedly has been implicated, on both theoretical and empirical grounds, as an etiologic factor in the development of separation anxiety disorder and school phobia. Generally, mothers are described as overprotective, having separation anxiety issues of their own, and reinforcing dependency and lack of autonomy in their children (p. 97).

A significant part of this study considered the impact that anxiety disorders in childhood have upon the development or persistence of anxiety disorders in adulthood. Gittelman (1986) indicates, "Abe (1972), who studied the long-term implications of childhood fears, concluded that 'childhood nervousness was predictive of anxiety symptoms in adulthood and that phobic adults were likely to have had some phobias in childhood.' However, many childhood phobias and anxiety symptoms do disappear with age" (p.70). She also found that about 50% of adult patients with agoraphobia and panic disorder have childhood histories of fearfulness, dependency, separation anxiety, school adjustment difficulties, and phobia (Gittelman, 1986, p. 68). McLoone, Hudson, and Rapee (2006) state, "Other studies have shown that almost half the children with an

anxiety disorder still met criteria for the disorder eight years after onset" (p. 221). They also suggest, "Adolescents with anxiety disorders face an increased risk of experiencing anxiety, depression, illicit drug dependence, and educational underachievement in early adulthood" (McLoone, Hudson, & Rapee, 2006, p. 221). Morris & March (2004) claim, "Retrospective studies suggest that some individuals with social phobia may overcome their condition, but this is not likely to occur if there is an early age of onset" (p. 147). They also suggest that "42% of children consistently rated as shy had anxiety problems in adolescence, as rated by behavior-problem checklists, in comparison with only 11% of children never rated as shy" (Morris & March, 2004, p. 147). McLoone, Hudson, and Rapee (2006) suggest that anxiety shifts from concrete specific fears to more abstract worries and interpersonal concerns as children mature. They claim, "Younger children tend to report higher levels of separation anxiety, whereas older children tend to report more social and generalized fears" (McLoone, Hudson, & Rapee, 2006, p. 220).

One of the most common childhood anxiety disorders is social phobia. According to Morris & March (2004), "Social phobia is a marked and persistent fear of social situations characterized by pervasive social inhibition and timidity" (p. 142). Social phobia (SP) causes a person to experience intense fear of being observed or of doing something horribly wrong in front of other people. These fears can be so extreme that people suffering from these phobias avoid objects or situations altogether, which significantly reduces their ability to lead a normal life (Spurgaitis, 2006). Until the past decade, social phobia in children was virtually ignored in the scientific literature. Morris & March (2004) claim, "Social phobia initially received very little attention from child researchers, possibly because fears in children are considered to be common and because

of the belief that shy children subsequently 'outgrow' this condition" (p. 142).   The

average age of onset is early to middle adolescence, but cases of social phobia have been

documented in children as young as age 8 (Morris & March, 2004, p. 142). Grover,

Hughes, Bergman, and Kingery (2006) state that children with social phobia are capable

of social interaction with familiar people but often cry, freeze or avoid social situations

with unfamiliar people. Morris & March (2004) suggest that the prevalence of social

phobia increases as children age and that the gender distribution for social phobia is

approximately equal (p. 143). They also state, "Prior to DSM-IV (American Psychiatric

Association, 1994), it was estimated that about 1% of the general child population

suffered from social phobia" (Morris & March, 2004, p. 142). Some physical observable

symptoms of social phobia include: heart palpitations (70.8%), shakiness (66.7%),

flushes and chills (62.5%), sweating (54.2%), and nausea (54.2%) (Morris & March,

2004, p. 145). Children with social phobia often exhibit behaviors such as poorer social

skills both in social actions and when reading in front of a small audience than do

nonanxious peers (Morris & March, 2004, p. 145). In addition, they claim that formal

speaking situations are the most universally feared. For the anxious child, the most

frequently distressful encounter is interpersonal conversation (Morris & March, 2004,

p.144).

Morris & March (2004) state:

> Those who are low on sociability may have little desire for and receive very little
> satisfaction from social interactions with others. When in social encounters, they
> may not interact but nonetheless show (or feel) very little emotional distress.
> Others may have a strong desire for social encounters but become so distressed
> when in the company of others that they are unable to engage in rewarding
> interpersonal interactions. These children, who profess a desire for social
> encounters but who become significantly distressed when doing so, may meet
> diagnostic criteria for social phobia (p. 141).

Children who are diagnosed with social phobia struggle with engaging in daily activities. Some of the functional impairments include depression, social isolation, loneliness and school refusal (Morris & March, 2004, p. 145). McLoone, Hudson, and Rapee (2006) suggest that while social phobia can be found in children, the onset peaks in early adolescence and remains stable across the lifespan. They claim, "Significant impairment as well as increased risk for school drop-out, substance use disorders and diminished employment opportunities have been associated with social phobia" (McLoone, Hudson, & Rapee, 2006, p. 222).

Gittelman (1986) states, "As is well known, anxiety can both elevate and disrupt cognitive and intellectual performance, according to the level of arousal attained and the spectrum within which optimal performance of a given function or task occurs. Inattention, distractibility, academic failure, and poor memory may all be manifestations of anxiety in children" (p. 76). Strauss and Last (1993) report a similar range of distressing situations in the school setting. School phobia is recognized as a dimension of social phobia (Morris & March, 2004, p. 143). Some of the distressing situations which Strauss and Last (1993) are referring to are described as specific behaviors performed in front of others, such as writing, eating, speaking, and more general conversational interactions. According to Strauss and Last (1993), the most common distressing event was an unstructured peer encounter (e.g. having to talk to another child), followed by taking tests, performing in front of others, and reading aloud)" (Morris & March, 2004, p. 143). Morris & March (2004) claim:

> School-refusal behavior, or school phobia, itself is not a separate diagnostic category, is a common associated clinical feature of children with SAD. The prevalence of school refusal behavior in the school age population is reported to

be approximately 5%. Rates of school absenteeism are much higher in some urban areas. Although early views were that SAD and school refusal were one and the same, not all children with school refusal behavior suffer from SAD, and not all children with SAD manifest school refusal behavior (p. 167).

Klein (1989) claims that school phobia has been shown to yield a higher prevalence rate in preadolescence and adolescence rather than early or middle childhood (p. 85).

Another one of the most common childhood anxiety disorders is Separation Anxiety Disorder (SAD). According to Morris & March (2004), separation anxiety disorder "is characterized by an unrealistic and excessive fear of separation from an attachment figure, usually the parent, which significantly interferes with daily activities and developmental tasks" (p. 164). In a sample of children referred to an anxiety disorders speciality clinic, SAD was the most prevalent disorder, with a rate of 33% (Morris & March, 2004). The DSM-IV defines this disorder as specific to children and as regarding separation from home or family that is excessive or inappropriate for the child's age. Separation anxiety can take the form of school avoidance ("Anxiety Disorders," 2006). Grover, Hughes, Bergman, and Kingery (2006) state that "an estimated 75% of children with SAD exhibit school refusal behavior" (p. 279). The age of onset of the typical SAD child is between seven and nine years (Grover, Hughes, Bergman, & Kingery, 2006). Some of the symptoms include tremendous worry that harm may come to a parent or themselves when separated, so that they might never be reunited again (Morris & March, 2004, p. 164). According to Kendall, Chansky, Kane, Kim, Kortlander, Ronan, Sessa, & Siqueland (1992), "Indicators of Separation Anxiety Disorder (SAD) include: call their mothers frequently from school or stop playing frequently to check on the parent, can't be left with a baby sitter because they protest so

strongly, worry frequently about mother's health, to the point of trying to be sure parent has taken medication, stands at the mailbox waiting, crying for the parent to return, and refuses to sleep over with friends or go to camp" (p. 4). Grover, Hughes, Bergman, and Kingery (2006) suggest other common behaviors of children with SAD, such as a reluctance to be alone, refusal to sleep alone, or reluctance to go to school. McLoone, Hudson, and Rapee (2006) claim, "Separation anxiety is most frequently observed at the start of the school day when the parent leaves the child at school" (p. 222).

Generalized anxiety disorder (GAD) can be characterized by uncontrollable and excessive worry occurring more days than not, about a number of everyday, ordinary experiences or activities and an intolerance for uncertainty. These feelings are often accompanied by physical symptoms, such as headaches or stomachaches (Principles of diagnosis and management of anxiety disorders, 2006). Grover, Hughes, Bergman, and Kingery (2006) provided other physical symptoms, including muscle tension, sleep difficulties, restlessness, and difficulties concentrating. They also claim that children with GAD report worries about school, family, friends, performance, and health (Grover, Hughes, Bergman, & Kingery, 2006). McLoone, Hudson, and Rapee (2006) suggest, "Children with generalized anxiety disorder are more likely to report being unable to sit still or relax, whereas parents are more likely to endorse symptoms of irritability and emotional upset" (p. 223). They also claim that children with generalized anxiety disorder often worry that their work in not of a high standard, are exceptionally punctual, are well-behaved and compliant, and even try to control their own peers in order to avoid reprimand (McLoone, Hudson, & Rapee, 2006).

Before treatment, it is necessary to assess and diagnose the anxiety disorder. McLoone, Hudson, and Rapee (2006) claim that the most commonly used clinical interview to determine an anxiety disorders in children is the Anxiety Disorders Interview Schedule for Children (ADIS), which is based on the criteria in the DSM-IV.

Cognitive-behavior therapy (CBT) is a widely accepted form of reducing anxiety disorders. Some of the components of this measure include education, problem-solving, exposure based approaches, cognitive approaches, emotion-regulation approaches, and relapse prevention (Principles of diagnosis and management of anxiety disorders, 2006). Grover, Hughes, Bergman, and Kingery (2006) suggest that modifications to cognitive-behavioral treatments be considered in order to tailor to specific anxiety diagnoses. They recommend imaginal exposure for generalized anxiety disorder (GAD), involvement of parents for separation anxiety disorder (SAD), and in vivo exposures for social phobia (SP). McLoone, Hudson, and Rapee (2006) state, "Empirical support from these studies suggests that between 50 to 80% of children who participated in the course of CBT were free of their primary anxiety diagnosis post treatment. CBT treatment benefits have been shown to remain stable over the long term with significant gains held for up to seven years post-treatment" (p. 228).

For children with GAD, clinicians are encouraged to introduce relaxation techniques early in treatment in order to alleviate physical symptoms. Some relaxation techniques include diaphragmatic breathing and progressive muscle techniques. Clinicians should encourage children to practice these techniques regularly as homework. Because clients with GAD do not experience anxiety about specific situations or objects, but rather shift their focus from one topic to another, it is essential that the client learns to

identify and challenge their thoughts about a range of situations. An important component of treatment for clients with GAD is the use of imaginal exercises. These techniques involve asking children to imagine anxiety-provoking situations while the therapist provides cues to facilitate the child's retrieval of their worrisome thoughts. Once the child has identified these thoughts, the next goal is to encourage them to challenge these worries and generate coping self-talk. Problem solving is also an important component. The child is encouraged to generate a list of possible solutions so that the therapist and child can evaluate and determine the most realistic and practical response to the worrisome situation (Grover, Hughes, Bergman, & Kingery, 2006).

Because most children with separation anxiety disorder (SAD) are at a young age, relaxation and breathing techniques should be adapted by using visual props, such as using balloons to show breathing and robots and dolls to show muscle tension and release. Cognitive restructuring techniques should also be simplified; for example, one could teach the child simple self-statements like, "Mom has always come back for me before." The clinician should be encouraged to work with the parents on extinction methods and positive reinforcement methods. Extinction methods involve ignoring when the child begs, cries, and/or throws a tantrum before separating from the parent. Positive reinforcement methods, on the other hand, involve praise, sticker charts, and rewards for the child's brave behavior. It is essential that parenting strategies are emphasized in treating children with SAD (Grover, Hughes, Bergman, & Kingery, 2006). Grover, Hughes, Bergman, and Kingery (2006) claim, "Over 63% of SAD children had a parent with clinical levels of anxiety" (p. 278). This statistic shows the importance of treating the parents as well as the child with SAD.

When working with children with social phobia (SP), the clinician may find it difficult to establish rapport. It is important to focus on the child's hobbies or interests in the initial phases. Clinicians should also focus on helping socially anxious children to generate coping thoughts for social performance. It is important for these children to work on lowering their perfectionist standards in their social performance; for example, a helpful self-statement may be, "It's okay if I have to pause to think of what to say next; the conversation doesn't have to be perfect" (Grover, Hughes, Bergman, & Kingery, 2006, p. 280). Social skills training is often necessary when working with children with social phobia. The clinician should use in-session role-play exercises or interactions with adults or peers. Certain vital social skills, such as introducing oneself, joining a group, and initiating conversation, should be taught as well. It is also important to encourage the child's parents to engage the child in social activities (Grover, Hughes, Bergman, & Kingery, 2006).

Gosch, Flannery-Shroeder, Mauro, and Compton (2006) suggest that anxious children might wish to learn how to initiate conversation with peers in the school lunchroom but are unable to due to their frequent use of avoidant problem-solving strategies. While the avoidance might be effective in reducing anxiety for a short period of time, it is an ineffective strategy for developing inter-personal skills (Gosch, Flannery-Shroeder, Mauro, & Compton, 2006). Klein (1989) claims that the two behavioral methods which are most frequently employed are graduated *in vivo* exposure and *in vivo* flooding (p. 71). *In vivo* flooding, which essentially consists of rapid forced reentry to school, has been described as the preferred treatment technique by a number of authors (Klein, 1989, p.71). According to Klein (1989), flooding has the advantage of a more

immediate return to school, while the graduated approach has the advantage of circumventing the dropout problem that often occurs when using flooding methods (p. 71).

A commonly used cognitive-behavioral treatment is the Coping Cat, which is a manual-based program that includes a therapist manual and child and adolescent ancillary workbooks. This treatment focuses on skill development and graded exposure to fearful situations. The skill development includes relaxation techniques, cognitive restructuring and problem solving (Grover, Hughes, Bergman, & Kingery, 2006). Other treatment programs are available in a school setting for children and adolescents, such as The Cool Kids Program, The Friends Program, and The Skills for Social and Academic Success Program (SASS). These programs are based on the principles of cognitive behavior therapy (McLoone, Hudson, & Rapee, 2006).

Morris & March (2004) claim, "Exposure-based treatments require that the child approach the anxiety-provoking situation in order to unlearn the fear response, thereby reducing anxiety" (p. 306). Some strategies include graduated exposure, systematic desensitization, flooding, contingency management, modeling, cognitive strategies, and the integrated cognitive-behavioral approach. (Morris & March, 2004, p. 306). They claim, "In graduated exposure, the child and the therapist generate a list of feared situations in a hierarchy, from least to most anxiety provoking. The child then approaches each situation sequentially, moving up the hierarchy as his or her anxiety level permits" (Morris & March, 2004, p. 306). It is essential to start with situations that produce only minimal anxiety so as to facilitate success. Flooding (or *in vivo*) involves repeated and prolonged exposure to the feared stimulus with the goal of extinguishing the anxiety

response. The child remains in the presence of the anxiety—provoking stimulus until his or her self-reported anxiety level diminishes. (Morris & March, 2004, p. 308). Contingency Management involves operant strategies such as positive reinforcement, shaping, extinction, and punishment. (Morris & March, 2004, p. 309). Modeling allows an anxious child to observe ways to approach and cope with a feared situation (Morris & March, 2004, p. 310). Studies show that children may learn anxious responses through observing behavior modeled by their parents (Gosch, Flannery-Shroeder, Mauro, & Compton, 2006). Cognitive strategies include techniques such as self-instruction training and altering maladaptive self-talk. (Morris & March, 2004, p. 311). The Integrated Cognitive Behavioral approach involves three goals for treatment: 1) the child learns to recognize experience, and cope with anxiety, 2) the child learns to reduce his or her level of anxiety, 3) the child learns to master developmentally appropriate, challenging, and difficult tasks (Morris & March, 2004, p. 313).

Other skills that are for coping with and managing anxiety in children: relaxation, imagery, correcting maladaptive talk, problem solving, and managing rewards (Kendall, Chansky, Kane, Kim, Kortlander, Ronan, Sessa, & Siqueland, 1992). They claim, "In relaxation training, major muscle groups of the body are progressively relaxed through systematic tension-release exercises. Anxious children and adolescents are not known for their ability to recognize cues for tension or for their skill in relaxing" (1992, p. 58). It is also beneficial to use imaginal activities to promote coping. Images are also helpful when teaching children how to tighten and relax specific muscle groups (Kendall, Chansky, Kane, Kim, Kortlander, Ronan, Sessa, & Siqueland, 1992, p. 59). They indicate that "addressing the self-talk of children during stressful situation can have positive effects on

their performance" (1992, p. 60). Instead of avoiding such emotionally arousing situations, children who experience anxiety need to consider what solutions to the problem are available (Kendall, Chansky, Kane, Kim, Kortlander, Ronan, Sessa, & Siqueland, 1992, p. 60).

Hypothesis

This study attempts to determine if a relationship exists between childhood anxiety disorders and their impact on the development of anxiety disorders in adolescence and adulthood. By comparing a group of personal accounts about living with an anxiety disorder, this study also seeks to assess which treatment methods seemed to be most effective for most people.

Methodology

Sample

The sample includes a small population of female, senior college students who have experienced any type of anxiety disorder during childhood or adolescence. Four women were selected for interviews. This selection was purposeful, as each of these women has already disclosed parts of their experiences and has already engaged in a trusting relationship with the author.

Data Collection

This study uses qualitative and exploratory methods to collect data. Specifically, individual interviews were conducted with the small sample of students who

have experienced an anxiety disorder. The interview questions are consistent for each

interview in order to provide an accurate comparison of symptoms and experiences with

treatment methods.

Sample of Interview Questions

1) Tell me about your experience with anxiety.

2) When did it start? Was it gradual or sudden?

3) What were your symptoms? Did you ever experience abdominal pains, restlessness, or compulsions? Did you experience unrealistic worry about future events, preoccupation with the appropriateness of your behavior in the past, overconcern about competence in a variety of areas (academic, athletic, social), excessive need for reassurance about worries, headaches or stomach aches for which there is no physical basis, self-consciousness or susceptibility to embarrassment or humiliation, feelings of tension or inability to relax?

4) Are you anxious over concrete, specific fears or more abstract worries?

5) Did any of your childhood or adolescent anxieties carry over into your adult life?

6) Do you think your anxiety is different from most people's experience of anxiety? How?

7) How did anxiety affect you in school, other social situations, or at home?

8) Did you get any help for your anxiety? What worked and what didn't? Did you have any problems with access to treatment (i.e. health care issues?) Did you work with a social worker, psychologist, etc? Do you feel that a stigma is attached to treatment?

9) Do you still have a problem with anxiety now? How does it affect you (i.e. home, school, social situations, job)?

10) Do your parents or any of your relatives have an anxiety disorder?

Data Analysis

In order to derive meaning from the data, one must compare the results of each individual interview with the entire sample. It is also necessary to refer to the literature and the DSM-IV to examine the similarities and differences in the symptoms and effectiveness of treatment types. It is also important to assess whether each individual's experience with anxiety in childhood or adolescence has carried over into their young adult life.

One prevailing pattern was evident in the onset of anxiety disorders relating to social situations. Out of the four females that were interviewed, three experienced anxiety relating to social situations. It seems that each of these three women considered themselves as always having a "shy personality trait," never being "really outgoing," or "naturally having a lot of nervous energy." Although they all stated different onsets of their anxiety disorders, they all admitted to feeling nervous or shy beginning in childhood. The time of onset that each person stated directly related to when each person realized that their experience with anxiety was different from other people around them. Another commonality between the women who experienced social anxiety was that home was always, as one woman stated, a "safe haven." One woman said that because she was never anxious at home, her parents were not aware of her anxiety issues.

An important part of this study was to explore and compare the symptoms that these females experienced as a result of anxiety. Three of the four women interviewed have experienced abdominal pains. One distinction is that one woman experiences stomach aches after feeling anxious while the other two women experience the stomach aches during their anxiety attacks. Two of the four women expressed their experience

with compulsions. However, one of the women interviewed has also been diagnosed with Obsessive Compulsive Disorder (OCD). The other woman stated that she "compulsively cleans during the height of her anxiety."

Three out of the four women experience unrealistic worry about future events. One woman expressed that she was afraid of trying out for the softball team because of the possibility of not making the team. She noticed that other students around her never seemed as nervous as she did about trying out. Another woman experienced an unrealistic fear of passing out in class while sitting in a classroom. Only one woman, who is diagnosed with Social Phobia, expressed that she experienced preoccupation with past behavior. She states, "I would obsess over feeling stupid or silly for doing things."

Of the four women interviewed, three were over concerned about their competence in a variety of areas, such as in academics, athletics, or social situations. One woman expressed that she focused on academics because she did not usually have to be social in order to succeed. Academics lifted her self-esteem. One woman who also experiences anxiety in social situations states that the "heart of her anxiety is over concern about competence in athletics, social situations, and academics." Another woman, who did not experience anxiety as a result of social situations, also experienced being overly concerned with academics. She said that she was concerned with grades and overall achievement in life in high school. The one woman interviewed who did not experience anxiety as a result of concern for competence or achievement in academics had a specific fear of fainting in public. It seems that the women who expressed over concern about competence in certain areas experienced more abstract and general worries.

Two of the four women interviewed expressed excessively needing reassurance from others about their anxiety. Both of these women experienced anxiety about social situations. One woman said, "I always need to hear that I'll be fine from others." The woman who said that she does not need reassurance from others is the only woman who does not experience anxiety about social situations.

Three out of the four women interviewed suffer from headaches due to anxiety. One woman states that immediately after an anxiety attack she gets a headache. Two of the women experience migraines during the height of their anxiety. Both of these women have family members who also suffer from chronic migraines, and both women believe that there is a genetic link to experiencing chronic headaches and having a mental illness. All of the women who experience anxiety as a result of social situations feel susceptible to embarrassment or humiliation often. The only woman interviewed who does not experience feeling embarrassed or humiliated often is the woman whose anxiety is not related to social settings. All four of the women interviewed, regardless of what causes their anxiety, feel tension or inability to relax. Some other physical symptoms which these women experience include: feeling shaky, vomiting, teeth chattering, shortness of breath, heart racing, sweaty palms, tension in the jaw (TMJ), constant coughing, and tension in the face, back, and head muscles.

When asked if their anxiety concerns specific fears versus abstract worries, the four women responded differently. One woman who has been diagnosed with Generalized Anxiety Disorder expressed that she does not have specific phobias but that her anxiety is situational and stress-related. It was interesting that the woman who experienced the fear of fainting in public, which is specific, stated that her anxiety was

over abstract worries. Although her fear of fainting in public produced the most anxiety for her, this fear can also be attributed to feeling anxious in a variety of social settings, which is more abstract. Another woman expressed having abstract worries, as her worries cover a variety of areas, such as teaching, relationships, and fearing rejection.

One interesting connection between two women with very different anxiety disorders is their common fear of people becoming mad at them. One of these women does not consider her anxiety related to social situations; yet, her fear impacts her relationships with other people. This may be because she considers anxiety related to social situations as being shy.

A very significant part of this study was to assess whether anxiety disorders in childhood carry over into adulthood. Two of the four women stated that their anxiety has definitely carried over into their young adult lives. Both of these women experience anxiety in social situations. However, one of the women who did not state that her anxiety carried over from childhood also stated that her "overachievement issues stem from when she was little." The other woman who stated that her anxiety has not carried over from childhood experienced the height of her anxiety in high school. Since high school, though, she continues to experience the same worries and anxieties without her medication.

One of the women who stated that her anxiety from childhood has carried over into her young adult life explained that her Separation Anxiety during childhood became social anxiety or Social Phobia (SP) during adolescence and adulthood. She believes that because she had supportive parents, who pushed her into social situations, she learned how to force herself into uncomfortable social situations. She stated that without her

parents' support, she never would have moved away to college and experienced life outside her home.

The other woman who stated that her anxiety from childhood has carried over into her young adult life explained: "I remember that moving to a new town in first grade was a traumatic experience for me." She remembers feeling anxious about being in a new setting, and she could not concentrate on her academic work, which caused her to have low self-esteem in her academic ability. She was anxious about not fitting in and did not feel like she belonged. She stated that she became even more shy in high school. She expressed that she had always wanted to be social, but she would shut down often. She also stated that her anxiety around public speaking and speaking in front of groups carried over from childhood into adolescence and young adulthood. Now, she feels that her anxiety is always present but that some months are worse than others. She states that she feels a lot less anxious during the summer. She also expressed that working out alleviates much of her anxiety and stress.

One of the women who did not express that her anxiety was significant during her childhood expressed that her experience with anxiety in high school has definitely carried over into her young adult life. Like another woman who was interviewed, she too wanted to be social in high school but always felt afraid. With the help of the medication, Paxil, this woman states that her anxiety is now much more under control. She now participates in things that she would have backed away from in the past, such as studying abroad in a foreign country and being an activist.

The other woman who stated that her anxiety from childhood did not carry over into adolescence or adulthood expressed that the height of her anxiety happened in

college. However, she also states that her anxiety is now much more under control. She finds that having an agenda decreases stress. She also sets up and lays out her school bag the night before in order to decrease anxiety in the morning. She also tries to think of stressful things separately and deals with them one at a time.

It is also important to compare when these women recognized that their anxiety was different from other people's experience. A prevailing pattern that emerged is that each of these women did not recognize that their anxiety was a problem until high school or college. Even those women who experienced anxiety during childhood did not receive help until college. One of these women stated that in high school she knew her anxiety was different than others because they were not as nervous about trying out for sports teams. She stated that she also recognized that her younger brother never seemed as nervous as she did. However, it was not until college that she actually fully explored the issue. In a social work class, she did a research paper on Social Phobia (SP) and she began to think she might have an anxiety disorder.

Another woman that was interviewed stated that it was her freshman year in college when she first realized that she had a problem with anxiety in high school. In high school, she did not have to work as hard to get good grades. In college, she became so anxious about academic work that she had to write down every part of her entire day in an agenda. If she did not write down and set up an exact time for showering or eating in her agenda, she could not function. Also, whenever she went to the library, she would become so anxious that she could not breathe or concentrate and felt nauseous. She stated that she has not been back to the library since freshman year of college. In college,

she recognized that her anxiety was different from others because other people seemed to be able to handle stress better.

One woman expressed that she recognized that she had an anxiety disorder during high school. When two of her friends revealed that they too had anxiety issues, she began to see that she had similar experiences. She stated that they also had a fear of passing out in public places but that their coping mechanisms were different. Her two friends would vomit while she would have an anxiety attack. She knew that her experience with anxiety was not just a phase when she feared going to her high school graduation because of the crowd.

Another woman who was interviewed stated that she recognized her experience with anxiety was different than others in college as well. She felt more pressure to succeed than she had in high school, which heightened her anxiety.

For all four of the women interviewed, school produced a significant amount of anxiety. For one woman diagnosed with Social Phobia (SP), she went back into her old school records to see if anything indicated her having an anxiety disorder. She learned that she had been tested for learning problems and placed in a reading group. The results of the tests stated that her reading ability "seems to be variable on the social situation." She was frustrated and angered that teachers and school staff did not pay better attention to these results, as she might have been able to receive treatment earlier. She also learned from her mother that one of her elementary school teachers told her mother that she would not do well in middle school because she could not talk in class.

One woman who is diagnosed with Generalized Anxiety Disorder (GAD) expressed that taking tests in school caused her to have anxiety attacks. Another woman

that was interviewed who experienced anxiety as a result of social situations expressed that school was an anxiety-provoking and stressful experience. She would cut class in order to escape or relieve tension. Another woman with social anxiety explained that she would use the bathroom in school as her escape. Whenever she had an oral presentation, she would cut that class.

Other social settings that produce anxiety for two of the women include town fairs due to the crowds and group situations where one is expected to remain still or quiet.

In order to assess the effectiveness of treatment methods, the four women were asked about their experiences with getting help for their anxiety. Of the four women who were interviewed, only one had a positive experience with medication. Three out of the four women went to their family physicians to seek help for their anxiety. Of these three women, two also sought help from a psychologist. Of those who sought out counseling, they expressed that it was easy to access help from counselors through on-campus counseling centers. As for medications, one woman said it would take a month to start working, another woman said it would take a month to access because of her health care plan, and another woman said that it cost her family $150 dollars per month.

One woman saw a psychologist at a college counseling center who practiced cognitive behavior therapy. She was the only woman out of the four that were interviewed that engaged in cognitive therapy. She states that self-talk has helped her greatly with her anxiety. She asks herself questions, such as, "What am I worried about happening?" or "Am I afraid of rejection or saying the wrong thing?" She expressed that talking with her psychologist helped, as it validated her feelings. Yet, she also mentioned that seeing the psychologist on a weekly basis was emotionally draining, as she cried

during every session. She often felt embarrassed talking to the psychologist about her anxiety, and her reaction to embarrassment is to cry. She continues to practice techniques the psychologist taught her, such as self-talk, exposure to uncomfortable situations, and breathing exercises. Although her psychologist also recommended medication, her father was very opposed to this suggestion.

One woman who is diagnosed with Generalized Anxiety Disorder (GAD) decided to try medication. Her family physician prescribed her anti-depressants. Looking back, she wishes her physician had suggested therapy. She was on a very high dosage of anti-depressants during her sophomore year of college. She said that it made her depressed and tired and that she cried all the time. She decided to go off the medication for these reasons. She states that although medication did not work for her, self-talk has helped calm her down. This experience has influenced her decision to never try medication again.

Another woman who saw her physician for anxiety was prescribed Paxil. Unlike the other woman's physician, this woman's physician recommended both medication and counseling. After she began taking Paxil, she no longer experienced anxiety attacks. She attempted seeing a psychologist at a college counseling center, but the psychologist told her that since the medication was working, there was not much she could do to counsel her. She went once per week for a couple of months, but she felt that it was useless. She did not like feeling drained after talking with the psychologist. Her doctor and mother eventually suggested that she try going off the Paxil to see its effects. She said that she felt fine during the summer, but once school started, the anxiety issues came back.

Another woman saw both a family physician and psychologist for her anxiety. She had a positive experience with her psychologist, as it reduced some of her anxiety. However, the psychologist did not use any cognitive behavior therapy or techniques. Looking back, she thinks that the psychologist was not all that professional. Yet, she stated that it had helped to talk to someone and that it boosted her self-confidence. Her family doctor prescribed her with medication, but she did not feel that it made a significant difference, so she went off it quickly.

It is evident from the data that genetics may influence anxiety disorders. One woman with Social Phobia (SP) expressed that she believes her father has an undiagnosed anxiety disorder. She stated that throughout her life, she has observed that he has never had any friends. She also said that he will not socialize outside the family. She explained that he now works at home, so he does not have any social contact or interactions outside the house. She said that her mother does all of the errands in the community because her father does not like doing them. Her father also feels awkward about having company at the house. She also mentioned that her father's mother had problems with anxiety. For instance, her grandmother moved her family almost every year because she never felt accepted or happy in any place she lived. She believes that the constant moving contributed to her father's anxiety, as he frequently had to make new friends and adapt to new situations. His mother would also threaten him, telling him that he could not come home until he had made a new friend that day. She believes that growing up observing her father's anxious behaviors probably produced some of her own anxiety issues; yet, she also mentioned that it may be a result of a genetic chemical imbalance.

The woman who is diagnosed with Generalized Anxiety Disorder (GAD) also stated that her mother, father, grandmother and great-grandmother all experience anxiety issues. The woman who had anxiety about fainting in public expressed that her mother had anxiety in college as well. However, she stated that her mother's anxiety was not nearly as severe. She also mentioned that other relatives on her mother's side display nervous behavior but none are diagnosed with anxiety disorders. She stated that her grandfather on her mother's side does not like going anywhere in public. Another woman who was interviewed revealed that her sister, mother, and maternal grandmother have histories of depression and chronic migraines. She believes that the mental illnesses could be linked. Her mother's sister is also very anxious. She stated that her father is restless and cannot sit still most of the time. Her father's mother also takes medication for anxiety.

Limitations of this study

The size of the sample was far too small to make any generalizations about these data. Because people with anxiety disorders often have difficulty discussing their experience with anxiety, it was difficult to find subjects to interview. Another aspect that must be addressed is the issue of the large undiagnosed population. The author also may have been biased, as she knew the participants on a personal level before conducting the interviews.

Implications for Social Work Practice, Policy, and Research

As one of the women who was interviewed suggested, it is necessary for social workers to educate teachers and school administrators about childhood anxiety disorders in order to treat the anxiety problem as quickly as possible. This woman's experience shows the importance of having more school social workers available in schools. Specifically, with children who experience Social Phobia or School Phobia, high absenteeism could result if the anxiety is not addressed and treated.

It is also necessary for social workers to become familiar with these behaviors and symptoms in order to determine when clients have an anxiety disorder. Social workers should be knowledgeable of cognitive therapy in order to increase their effectiveness in helping clients with anxiety disorders.

It is evident from the results of this study that medication is not easily accessible. One woman expressed that her medication cost her family $150 per month. Another woman mentioned that it takes Paxil a month to work, and another woman stated that because of her health care plan, it would take one month to receive the medication. Social workers must advocate for better integration of mental health and primary health care.

Further research should include prevention strategies and risk factors. Although progress has been made in researching and developing treatments for anxiety, there is not enough emphasis on preventative measures. It might also be interesting to further explore the genetic influence versus environmental causes of anxiety disorders.

References

Anxiety Disorders. (2006). Retrieved February 11, 2007, from
    http://www.healthatoz.com

Gittelman, R. (1986). *Anxiety disorders of childhood.* New York; London: Guilford
    Press.

Gosch, E., Flannery-Shroeder, E., Mauro, C. F., Compton, S. N. (2006) Principles of
    cognitive-behavioral therapy for anxiety. *Journal of Cognitive Psychotherapy: An
    International Quarterly, 20,* 247-262.

Grover, R. L., Hughes, A. A., Bergman, R. L., & Kingery, J. N. (2006). Treatment
    modifications based on childhood anxiety diagnosis: Demonstrating the flexibility
    in manualized treatment. *Journal of Cognitive Pyschotherapy: An International
    Quarterly, 20,* 275-286.

Kendall, P.C., Chansky, T.E., Kane, M.T., Kim, R.S., Kortlander, E., Ronan, K.R., Sessa,
    F.M., & Siqueland, L. (1992). *Anxiety disorders in youth.* Massachusetts: Allyn
    and Bacon.

Klein, R. G. (1989). *Anxiety disorders in children.* Newbury Park, California; London:
    Sage Publications.

McLoone, J., Hudson, J., & Rapee, R. (2006). Treating anxiety disorders in a school
    setting. *Education & Treatment of Children, 29,* 219-242.

Morris, T.L., & March, J.S. (2004). *Anxiety disorders in children and adolescents.* New
    York, New York: The Guilford Press.

Principles of diagnosis and management of anxiety disorders. (2006, July). *Canadian
    Journal of Psychiatry, 51,* p.9S-21S.

Spurgaitis, K. (2006) Children's anxiety disorders still prevalent: Your mental health.
    Cobourg Daily Star (Ontario), final edition, 7. Retrieved October 1, 2006, from
    LexisNexis database.