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Anxiety Condition in Children

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Abstract – Three most common childhood anxiety disorders are social phobia (SP), generalized anxiety disorder (GAD), and separation anxiety disorder (SAD). The aim of the study was to emphazied most common anxiety conditon in children. The 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.

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.

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.

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 access or reading ability "seems to be variable on the social situation."

As a conclusion we can state that anxiety disorders in childhood and adolescence are common, often stable and present a risk for lifelong psychiatric disturbance. It is a cause for concern that, despite the existence of evidence-based interventions, the majority of children and young people with anxiety disorders do not access treatment.

Key words – Anxiety, Childrens, Disorder, Psychiatric Disturbance.

I. INTRODUCTION

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.

Three most common childhood anxiety disorders are social phobia (SP), generalized anxiety disorder (GAD), and separation anxiety disorder (SAD). 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

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(particularly depression). 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.

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 4 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 escapeavoidance behaviors like shyness or school refusal".

II. Literature Review

2.1 Anxiety and related disorders in children

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 6 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 7 of the belief that shy children subsequently 'outgrow' this condition" (p. 142).

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).

2.2 Cognitive-behavioral treatment

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). 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. 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).

III. Methodology

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 17 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?

IV. Results

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.

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.

V. Conclusion

Anxiety disorders in childhood and adolescence are common, often stable and present a risk for lifelong psychiatric disturbance. It is a cause for concern that, despite the existence of evidence-based interventions, the majority of children and young people with anxiety disorders do not access treatment. Numerous trials have now supported the effectiveness of CBT for childhood anxiety disorders, compared to a waitlist condition.

In recent years, a number of promising low-intensity CBT-based treatments have been developed and evaluated that offer a mechanism for increasing access to evidence-based treatment for children and young people with anxiety disorders. While there is some evidence for the effectiveness of SSRI medication, this is to be weighed up against the potential risk of harm in this age group, and the fact that so many questions concerning administration remain unanswered. In view of these concerns, recent guidelines state that pharmacological treatments should not be offered routinely to children and young people.

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