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Anxiety Disorders

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Abstract

Anxiety disorders are one of the most common childhood psychopathology. There are many anxiety disorders that plague youth including; separation anxiety disorder, panic disorders, obsessive-compulsive disorder, specific phobias, selective mutism, post-traumatic stress disorder and general anxiety disorder (GAD). There are specific diagnostic criteria and treatments for each of them that would take many pages to explain thoroughly; therefore, for the purpose of this monograph GAD will be diagnostically described but other anxiety disorders will be discussed throughout. Longitudinal data, information on assessment, contributory factors, interventions, popular non-validated techniques and a standard case study are discussed to help further understand anxiety disorders.

Definition and Classification

DSM IV Criteria

The diagnostic criteria for general anxiety disorder from the DSM-IV-TR is excessive anxiety and worry, occurring more days than not for at least 6 months, about a number of events or activities. The person finds it difficult to control the worry. The anxiety and worry are associated with three (or more) of the following six symptoms and children only require one of the following items; restlessness or feeling keyed up or on edge, being easily fatigued, difficulty concentrating or mind going blank, irritability, muscle tension and sleep disturbance. The focus of the anxiety and worry is not confined to features of an Axis I disorder. The anxiety, worry, or physical symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning. The disturbance is not due to the direct physiological effects of a substance or general medical condition and does not occur exclusively during a Mood Disorder, a Psychotic Disorder, or a Pervasive Developmental Disorder (DSM-IV-TR).

However, there are many important things to consider when making a diagnosis, especially with younger populations. First, anxiety disorders, particularly phobias, are developmentally linked and may be out grown. Also, anxiety is highly comorbid with behavioral disorders, depression, substance abuse and other anxiety disorders. Comorbidity rates range from 65-84% in epidemiological and clinical samples, respectively (Bird, Gould, & Staghezza, 1993; Albano, Chorpita, Barlow, 2003). Knowing the individuals comorbid diagnosis is important for course of clinical treatment and prognosis. Another thing to consider is whether there is an actual imposing threat, if so then the anxiety or phobia is a natural reaction, not a disorder. There are two types of anxieties, state and trait. State anxiety occurs in certain situations, were as trait anxiety is more of a personality trait that remains stable across situations (Cattell & Schier, 1961, 1963). All of these considerations are important but perhaps the most pertinent to keep in mind is that certain levels of anxiety are natural and often times beneficial for success in many facets of life. The anxiety must impair an individual in one or more parts of their life.

Educational Classification

Children's main two networks affected by anxiety disorders are school and friends. The government's educational laws recognize anxiety (they call it school phobia) as something that

can significantly interfere with school functioning; therefore, qualifying students for services under Section 504. This section requires a school to evaluate a student's need for accommodations to ultimately keep them in general education classrooms based on their disabilities. The evaluation is basically a gathering of information already completed by an outside source, usually a medical doctor (can be a psychologist). If the student's school phobia has been diagnosed by a doctor and significantly interferes with their school functioning then the school must develop and implement a plan for accommodations (TAESE, 2007).

The school phobia characteristics that interfere with school function are emotional reactions including somatic symptoms like stomachaches and headaches, panic attacks, crying, and behavioral avoidance (Beidel, Turner, & Morris, 1999). Moreover, this disorder has been linked to poor academic and social functioning. They may perform below their ability level, and the anxiety may interfere with recalling academic knowledge they already know (Ma, 1999).

Prevalence Rates

Research suggests that approximately 10-21% of children have clinically significant anxiety (Gurley, Cohen, Pine & Brook, 1996). Clinical samples have also seen prevalence rates as low as 3.7% and as high as 44.7% (Last, Perrin, Hersen, & Kazdin, 1992). Anxiety can negatively affect children's school performance and social relationships, as well as future emotional health (Beidel, 1991). Fortunately, throughout the years considerable research has found evidence-based procedures that decrease anxiety symptoms below clinically significant levels in many individuals. There are also many psychopharmacological treatments that are known to be effective tools in fighting anxiety. Diagnosing the disorder early and using effective treatments can lead to significantly better outcomes. However, many people who have early onset anxiety disorders in childhood can struggle with them their whole lives (Öst, 1987). More research on risk factors and prevention, as well as, more longitudinal and controlled treatment studies could help these individuals better understand and overcome their anxiety disorders (Perlmutter, 2000)

Longitudinal Study

A prospective study done by Pine, Cohen, Gurley, Brooks and Ma (1998), aimed to look at the link between adolescent and adult anxiety and depressive disorders. They looked at a sample of

776 young people living in upstate New York with clinical levels of anxiety. Through regression analysis they looked at longitudinal associations between clinically defined DSM anxiety or depressive disorders. The results suggest that adolescent anxiety or depressive disorders predicted about a 2-to-3-fold increase risk for the prospective adult disorder. Furthermore, there was evidence that some disorders like phobias, also including social phobia specifically predicted the recurrence of the same adult disorder. This however was not the case in all disorders. It is important to keep in mind that most adolescent disorders were no longer present in adulthood; nevertheless, most adult disorders were preceded by adolescent disorders.

Assessment

There are many ways to assess and diagnose childhood anxiety disorders. However, it is important to keep in mind that certain instruments are more appropriate for use in clinical trials, than in school settings. Behavioral rating scales, direct observations, functional behavior assessments and parent/child interviews are all useful tools in the diagnostic process.

The behavioral rating scales used in clinical settings and research include the Beck Anxiety Inventory (BAI), Revised Children's Manifest Anxiety Scale (RCMAS-2), Millon Adolescent Clinical Inventory (MACI), Child Behavior Checklist (CBCL), Multidimensional Anxiety Scale for Children (MASC), Social Anxiety Scale for Children-Revised (SASC-R), Social Anxiety Scale for Adolescents (SAS-A) and Social Phobia and Anxiety Inventory for Children (SPAI-C).

The BAI was produced to be a quick self-report measure that discriminates anxiety from depression. There is high internal validity and consistency among items, and was normed on a relatively large sample size. The age range is 17 and up and was made to be used in a clinical setting (Beck, 2009).

The RCMAS-2 measures the level and nature of anxiety experienced by children in a simple yes/no format. It is for ages 6 to 9 and takes only 10-15 minutes for the long version and 5 minutes for the short form. There is even a separate scale specifically for social anxiety. This rating scale is often used as a screening tool both in clinical and school settings (Reynolds & Richmond, 1978).

The MACI is not specifically for anxiety but has an Anxious Feelings domain in their Clinical Syndromes section. This assessment tool is good for clinical populations that may have many comorbid disorders. It was designed specifically for adolescents, ages 13-19 and takes about 25-30 minutes to give. It's 160 true/false questions and there is also a Spanish version (Million, Million, Davis & Grossman, 2009). The CBCL is also not specifically for anxiety but much like the MACI can be used to assess anxious feelings and even has a DSM oriented anxiety scale (Achenbach, 1991a).

The SASC-R and SAS-A are specifically for anxiety. They come in parent form or self-report form consisting of 22 questions, and take about 10 minutes to complete (La Greca & Stone, 1993). The SPAI-C is a more precise assessment tool for social phobia.

There are also a number of standardized interviews including the Anxiety Disorders Interview Schedule (ADIS-IV) that are often administered to the parents prior to clinical trials.

On the other hand, schools usually use the Behavior Assessment Scale for Children-II (BASC-II) or the Conners' Parent Rating Scales Revised: Long Version (CPRS-R:L) as a universal assessment tool for possible disorders or problem areas. They also may see how a student performs on an intelligence assessment, not only for the score but also as an opportunity to observe the student doing something that may make them anxious. Classroom observations are also necessary for a complete and thorough evaluation. Functional behavioral assessments are also done to find possible antecedents to the student's anxiety, as well as, to look at the consequences for the student after doing anxious behaviors (avoidance, physical symptoms, etc.). This is a key component for focusing the intervention and prevention process on the correct aspect of a child's life. Children can be anxious about many things, it's important to really hone in on what they are really worried about.

Possible Causes and Contributory Factors

There are many theories about how fears and anxieties are acquired; the main three are conditioning, modeling and verbal instruction. Through these pathways negative schemas are

formed; that in turn leads to negative thoughts and sometimes physiological responses such as sweating and stomachaches. Some of the major causes of these schemas are academic performance, situational variables in the family or at school, stress and pressure, perceived or real expectations by self or others, and degree of success in social and academic situations. Moreover, genetics could be a contributory factor due to the fact that anxiety disordered mothers are more likely to have children with anxiety (Last, Hersen, Kazdin, Francis, & Grubb, 1987).

A few theories explain in more detail how conditioning, modeling and verbal instruction interact to create fear responses. The two-factor theory believes that fear is learned through classical conditioning and is then maintained by continued conditioning. The stimulus is paired with an unpleasant reaction, which then leads to a feared response. Individuals will then avoid the feared stimulus, thus decreasing the fear response. In this scenario the behavior of avoidance is reinforced, this in turn strengthens the fear response (Mowrer, 1939,1947,1960). This however is a dated theory and the approach-withdrawal theory tried to address some of its limitations (Deplarto & McGlynn, 1984). The approach-withdrawal theory believes that the avoidance behavior is upheld by positive reinforcement rather than negative reinforcement. Avoidance of the feared stimuli increases relaxation in the individual; therefore, avoiding the stimuli or location. This is an important contribution because it explains why avoidance is maintained even when anxiety is missing. Social learning theory is another prominent hypothesis that was influential in the field of anxiety. Bandura believed that fears could be obtained through direct observations or modeling. He even takes it a step further in his self-efficacy theory and suggests that anxieties are linked to an individual's believed ability to confront a frightening situation or stimuli. These beliefs are influenced by direct experiences, modeling, and verbal persuasions (Bandura 1977, 1982).

As previously stated, these theories postulate ideas for how negative schemas or cognitive distortions are formed. Beck et. al (1985) and Kendall & MacDonald (1993) both believe that distorted thoughts are highly associated with anxiety (Chorpita, Albano, & Barlow, 1996). Furthermore, having a negative attributional style has been linked to a number of child psychopathologies including anxiety (Bell-Dolan, 1995). Along these same lines, "Anxiety sensitivity" (McNally & Reiss, 1985) has been studied as another contributing risk factor for

anxiety disorder individuals. “Anxiety sensitivity is the extent to which individuals believe that their own anxiety or anxiety-related sensations have harmful consequences.” (Chorpita & Southam-Gerow, 2006). There is some controversy over this but in the end studies have shown that children with clinical levels of anxiety tend to focus more on threatening stimuli (Vasey & McLeod, 2001); therefore, dwelling on negative thoughts that could influence their world schemas and forming a negative attributional style.

Genetics could also play a role in anxiety disorders. It has been found throughout the years that anxiety disordered mothers are more likely to have anxiety disordered offspring (Last, Hersen, Kazdin, Francis, & Grubb, 1987). This however is hard to prove because children living with their parents will directly observe and model their parents. Anxious parents exhibit anxious traits and those maybe vicariously learned by their children. On the other hand, it is quite possible that it is not one or the other but that both play a major role in shaping the child’s anxiety.

Interventions

A meta-analysis done by Silverman, Pina and Viswesvaran looked closely at evidenced based treatments for anxiety disorders among children. According to criteria by Nathan and Gorman (2002), they found a majority of the studies to be fairly rigorous to methodologically robust. However, Chambless et al. (1996) and Chambless and Hollon (1998) criteria yielded no well-established treatments and four probably efficacious treatments. Those treatments are Individual Cognitive Behavior Therapy (ICBT), Group Cognitive Behavior Therapy (GCBT), GCBT with Parents, GCBT for social phobia (SOP), and Social Effectiveness Training for children with SOP. There were no significant differences between individual and group treatments on recovery rates and reduction of anxiety symptoms, and other related symptoms. Moreover, parent involvement was not significantly more efficacious than non-parent involvement.

The probably efficacious treatments had at least two well-documented random clinical trails (RCT) that showed significant results. However, most of these treatments were studied by the same researchers in similar settings, to be well-established the results need to be replicated by other researchers and generalize to a different setting. Future research should target these treatments to see if they are well-established and best practice for youth.

Kendall (1994) first evaluated ICBT with random clinical trials (RCT), with 47 youth (9-13 years) who presented with anxiety disorders. The treatment included the IBCT treatment package and the behavioral component included in vivo exposures, relaxation training, and contingent reinforcement. The participants learned how to recognize distorted cognitions, come up with coping plans, and self-evaluate. At post-treatment, 64% of the individuals in the ICBT group no longer met criteria for an anxiety disorder, compared to only 5% in the waitlist group. Kendall (1996) also did two follow-up studies that showed that treatment gains were maintained and that successful outcomes at post-treatment were linked to less substance abuse.

Barrett (1998) evaluated GCBT using 60 youth ages 7-14 with anxiety disorders. He had two GCBT conditions, one with a parent-training component and one without. The program consisted of cognitive and behavioral strategies for youth, and the parent component taught parents how to manage their child's emotional outbursts, communication and problem solving. The treatment in both conditions yielded positive results with 64.8% no longer meeting criteria for their anxiety disorder compared to 25.2% in the waitlist condition. At a one-year follow-up treatment gains were maintained; moreover, other researchers were able to replicate the results. Spence et. al. (2000) found that GCBT is also effective for individuals with social phobia.

Beidel et al. (2000), studied Social Effectiveness Training for Children (SET-C) with youth 8-12 years old with a primary anxiety disorder of social phobia. At posttreatment, 67% in the SET-C group no longer met criteria for social phobia compared to 5% in the control group.

There are also multiple treatments that were found to be possibly efficacious ICBT with Parents, Emotive Imagery for darkness phobia, ICBT for school phobia and refusal, graded exposures plus either contingency management or self-control for phobic disorders, one-session behavioral exposure treatment for school phobia, FRIENDS, skills for academic and social success, school-based GCBT, and etc. All of these studies show great promise to someday finding the right treatment for each anxiety and phobia disorder. However, most of these studies have been done in clinical settings and it is hard to say whether the results would generalize to community settings.

Many of the aspects of these intervention programs are used in the schools. School psychologists and school counselors use manuals like Coping Cats to form anxiety-reducing curriculum for the school setting. They can see children individually or in groups and should teach the students to identify negative self-talk, how to restructure their thoughts, relaxation techniques, emotional coping skills, ways to self-reinforce, contingency management, and problem-solving proficiencies (Kendall, Kane, et al., 1990). Furthermore, it is helpful to give parents information about anxiety because they may have some misconceptions about the disorder.

Medications are also used as a means of intervention for many anxiety disorders. Selective serotonin reuptake inhibitors (SSRIs) have been shown to be effective treatments for generalized anxiety, separation anxiety, social phobia, and especially effective for obsessive-compulsive disorder. Fluvoxamine, Fluoxetine and Sertraline have all been studied and shown to be more effective than the control sample (Pine et al., 2001, Birmaher et al., 2003, Compton et al., 2001).

Recently, prevention has come to the forefront in research due to current knowledge about risk factors. Dedicated prevention programs are programs that target children with subclinical levels of anxiety. They are being researched in two different populations, school-aged and preschool (Chorpita & Southam-Gerow, 2006). The few studies that look at dedicated prevention have results that are leaving many hopeful, indicating that if we intervene early rather than later problems stemming from anxiety disorders can be circumvented.

Popular Non-validated Techniques

There are many effective treatments for anxiety, but for some anxiety disorders like post-traumatic stress disorder (PTSD) there are no clear treatments; therefore, fad techniques are being utilized in their place. Dr. Francine Shapiro is the creator of eye movement desensitization and reprocessing (EMDR) a popular miracle treatment for PTSD. It has been used with adult trauma survivors, including war veterans, rape victims, accident survivors, and traumatized children and adults with severe anxiety or depression. The basic concept of EMDR is therapists have their patients vividly recall their experiences and help them gain a new understanding of the events, their emotions, and thoughts associated with them. While the patients are recalling their

distressing memories they are moving their eyes back-and-forth in a rhythmic pattern. Although therapeutic benefits have been reported, no long-term studies have been done to show that EMDR has long lasting effects. Also, 25-30% of individuals who undergo treatment report no clear benefits (PTSD, 2009).

Standard Case Study

A case study done by Krain, Hudson, Coles and Kendall (2002) at Temple University looked at the effectiveness of family cognitive-behavioral therapy (FCBT) in reducing anxiety for a young girl named Molly L. Molly is a 9-year-old girl diagnosed with separation anxiety disorder, general anxiety disorder and agoraphobia without panic disorder. Her anxiety had been getting worse over the past three years, and previous supportive and behavioral psychotherapies were showing little benefits. Moreover, her parents were worried that her anxiety would keep her from attending school the following fall. The Anxiety Disorder Interview Schedule Child and Parent version (ADISC/P), Children's Global Assessment Scale (CGAS), The Revised Children's Manifest Scale (RCMAS), Multidimensional Anxiety Scale for Children (MASC), and a battery of other questionnaires and checklists were administered to assess Molly's diagnosis and severity. A Family Assessment Device (FAD) was also administered to assess family functioning to determine certain contributory factors, as well as, what to focus on during treatment. Through these assessments with Molly and her parents it became apparent that family dysfunction was highly influential to her anxiety; therefore, FCBT was deemed the most appropriate therapy option.

The therapy was an 18-week FCBT program, where the primary goals were to reduce Molly's anxiety in difficult situations and improve coping skills. They taught her numerous coping strategies including identifying anxious feelings and thoughts, using different coping thoughts and actions, as well as, self-rating and rewards. The second half of the therapy utilized the FEAR plan and exposure therapy. The second goal was to improve family communication; homework assignments were assigned and the family was encouraged to express their feelings to one another. Molly responded well to treatment and even became comfortable trying new situations, like taking the bus.

The treatment was effective overall in reducing Molly's anxiety; however, therapy revealed a number of critical issues that were key factors in the successful implementation of

treatment. Foremost, Molly and her family harbored both angry and guilty feelings about her anxiety. Furthermore, she saw her anxiety as “abnormal”, and felt undeserved of praise for things her normal peers were doing. In addition, the entire family was confused and frustrated by Molly’s condition, and Molly felt completely misunderstood. All of these were integrated into the therapy sessions.

At follow-up Molly showed a decrease in severity in all three of her primary diagnoses. Moreover, scores on the FAD indicated that family functioning had drastically improved, most importantly in both communication and general overall functioning. These results indicate that FCBT could be an efficacious treatment for anxiety-disordered youth and their families who are struggling to cope.

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