

Anxiety and its Components and Treatment: Concerns as We Approach 2020

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Abstract

Anxiety is a psychological construct and condition that has been with us for many centuries. However, the forms of anxiety and the different elements of anxiety as well as the treatment of anxiety have changed over the years. This paper examines the overall, general, global realm of anxiety and explores some of the subdomains and tangential areas of anxiety as well as newer concerns in this realm. General issues regarding the treatment of anxiety are addressed. It is imperative for the practitioner to understand the various forms and types of anxiety and approach each form with understanding as well as caring and compassion.

Keywords: Anxiety; Anxiety Disorders

1. Introduction

Anxiety is part of the human condition. Men and women have experienced those emotions which have come to be labelled as “anxiety” for years. Currently, the Diagnostic and Statistical Manual-V includes a variety of “types” of maladies subsumed under the global heading of Anxiety. This paper will review some of these main areas- and also indicate tangential areas which need to be explored and examined by clinicians as they cause much consternation, in terms of their duration, frequency and intensity.

Anxiety Disorders are covered in the DSM-V from pages 189 to 233, and contains 1) Separation Anxiety Disorder (309.21) 2) Selective Mutism, (312.23) 3) Social Anxiety Disorder (Social Phobia) 300.23, 4) Panic Disorder (300.01) 5) Agoraphobia (300.22) and lastly Generalized Anxiety Disorder (300.02). Further, there are other minor conditions such as 1) Substance/Medication-Induced Anxiety Disorder 2) Anxiety Disorder due to another Medical Condition 9 (293.84), 3) Other Specified Anxiety Disorder (300.09 and Unspecified Anxiety Disorder (300.00). Generalized Anxiety Disorder is probably the most global “umbrella” term for the many realms of anxiety. This paper will address the global general issues regarding anxiety and then focus on some subtypes or tangential realms of anxiety. Some of these more minor realms are less accepted than others, however, the client experiences much the same feelings of anxiety and these realms should not be ignored- but

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rather treated with the care and compassion that the client deserves. Respect should be given to all clients or patients or students that present with signs and symptoms of anxiety and treatment options should be offered and progress monitored and later evaluated.

This paper will begin with an overall review of the global topic and discuss other lesser known domains and attempt to provide insight as to the nature of the disorder.

2. Overall Assessment of the Anxious Patient

In this section of the paper, some domains that bear examination regarding the anxious patient will be discussed. Often, certain realms are neglected which can provide a good deal of insight into the precipitating factors of anxiety and which lend clarity to the presenting problem of the patient.

1. **Medical History-** In many instances, the anxious patient may have had some type of medical problem, or may still be having some type of extreme medical problem which contributes to their feelings of anxiety. The skilled clinician will examine prior surgeries, accidents, and of course take a full complete medical history along with past medications that the patient may have been on, as well as current medications, as well as any "over the counter" pills that the patient is taking. All too often some patients are using recreational drugs in an effort to allay their anxiety or perhaps even alcohol or other substances. The client or patient may have been in chronic pain and lives in fear of that pain recurring (especially those with chronic migraine and back pain).
2. A detailed history of the presenting problem or antecedent event is often warranted. In some instances there have been multiple events (repeated child abuse) and in other instances an extreme event, which may not have been diagnosed as post-traumatic stress disorder, but certainly warrants investigation. In this day and age of school, and church and synagogue shootings, while a person may not have been directly involved or exposed to such events- they are often covered extensively on the television- and re-broadcast over and over again.
3. **Family History-** In many instances, it is imperative that the clinician investigate the "family crucible" as has been said in that the formative years may have been fraught with peril as well as anxiety. In some instances, there has been repeated child abuse and or neglect- and that abuse may have produced a child with a tendency toward anxious behavior. The family history, in some "family therapy" circles goes back many years and often it is found that there is a generational element to this anxiety- passed on from generation to generation.
4. **Legal History-** Some anxious individuals may have good reason to be anxious as they seem to have been chronically involved with the police and lawyers and the law and judges. In adolescence, the teenager gets involved with the wrong peer group, and becomes involved in car theft- and "joy riding" and thus begins a cycle of judicial involvement, and incarceration in some instances. Probation and parole follow and these "visits" are of course problematic.

5. Sexual History- For some individuals a very difficult sexual experience may precipitate a very long series of difficult endeavors in the sexual realm, leading to performance anxiety which tends to permeate the life space of this individual. Obviously, this is going to differ for a male and a female- the female may have been sexually abuse or even molested or raped (in some cases repeatedly) and thus this realm is one of apprehension which permeates this individuals functioning. There is often a generalization to other aspects of the client's life, such as their interpersonal interactions with members of the opposite sex.
6. Social History- While some individuals are born shy, introverted, and withdrawn, this may contribute to their withdrawal. The family unit may be explored. The client may have been a first born or only child and on the other hand may have been the 6th in a series of 7 children.
7. Vocational /Occupational History- Depending on the age of the client, they may have had a very long stable job or career- or they may have had a number of menial, minimum wage jobs, and they have been chronically underemployed or perhaps have been optimally employed by an employer who continually expected perfection from the client. There may be a good deal of anxiety stemming from a narcissistic boss- or an overly demanding boss- or a boss that is very simply a loud, boisterous, demanding bully who will continually rant about the performance of his charges. In some instances, supervisors are martinets and harbor inordinate expectations.
8. There is always concern about suicidal ideation and homicidal thoughts and clinicians need to thoroughly evaluate all patients in this area. Most importantly to ascertain is if the person has a plan and if they have a history of previous attempts. Males and females tend to attempt suicide differently and thus probing is needed in an on-going or even beginning session.
9. Religious History- While the counselor should not mock or condemn any religion or religious practice- it may be important to examine the religious history and to ascertain if there are any religious or spiritual elements contributing to the person's anxiety. If the client holds rigidly to certain dogmas and feels that they are going to "burn in hell for all eternity" this could be a contributing factor to their anxiety.
10. Substance Abuse History- Some clients have a long history of using and abusing prescriptive drugs, as well as over the counter drugs, recreational drugs and various other stimulants. They may be using these as a way to cope with their anxiety, and they may also be over-eating or overindulging in certain foods to allay their anxiety.
11. Military History- For both males and females, it may be important and relevant to investigate if they have any military history and where they were deployed to, and to ascertain if there were any accidents, or major events that could be contributing factors. Many military personnel were seriously injured in combat but never received the acknowledgement or recognition that they deserve and many are now diagnosed with Post Traumatic Stress Disorder. Still others have had major difficulty readjusting to civilian life.

12. Obstetrical History- Overall, most deliveries are without major event, but for some women, these events are extended and problematic and post-delivery events can also instill some over-riding tension if there have been problems with delivery and a low Apgar score results. Low birth weight can also be of concern and for some individuals this is a serious event that can result in a good deal of on-going anxiety.

3. Subcomponents of the Assessment Process

In addition to the above, the clinician is keenly aware of a number of domains which bear examination:

1. Thought Processes- What are the outstanding thought processes of the patient? Are they rational, reasonable, realistic, logical, systematic or are a lot of tangential statements made that do not relate to the topic at hand. Often clients will make irrational statements or "act out" in a variety of unreasonable, unrealistic ways or will make statements that are "making a mountain out of a molehill" and they are catastrophizing instead of minimalizing.
2. Thought Content- What does the patient/client continually think of? Often the anxious person may be preoccupied with guns, bombs, bullets, hand grenades, and other weapons such as knives and karate sticks. Other individuals may reflect on funeral events- such as the eulogy, or the comments that people may make about them after they "leave this place". Some anxious individuals are preoccupied with revenge on a partner or employer- and how they would be vindictive in this regard.
3. Insight. It is imperative that the counselor investigate the degree of insight that the client has into their own condition. The client may not understand that they are "their own worst enemy" or that their preoccupation with crashing airplanes will not assist in their daily functioning. As a generalization, a good many individuals do not have much insight and understanding as to how they are contributing to their own demise and difficulties. They place themselves in untenable positions, often behaving unethically (or so they think) when in fact they are behaving illegally.
4. Judgment- Clients often present with bad judgments that have come back to cause their anxiety. They have borrowed money for college or car or career and are now faced with gargantuan debts. Their concern about their bills and debts takes emotional energy away from procuring another vocation or career. Often the choice of a mate or spouse or partner is fraught with peril- and results in ongoing anxiety as to how much the significant other is spending currently and how much the other is withdrawing from their bank account.
5. Speech- Quite simply, how one speaks can inform the counselor as to the amount and degree of anxiety, desperation, exasperation, and apprehension that a client is experiencing. How one communicates during the therapeutic hour is somewhat reflective of their communication style during the rest of the week. A client that speaks in short, staccato sentences, punctuated by acerbic vitriolic comments is providing some information as to their lifestyle and involvement with others.
6. General Knowledge. Clients often arrive at a therapist's office with little to no knowledge as to how the therapeutic relationship works or what is involved. A client who looks around for a couch to lie down on and free associate may

have some general ideas about psychoanalysis but not really understand about desensitization or relaxation or biofeedback. Further, in terms of general knowledge of the world- the client may have never finished college and have only minimal knowledge of the zeitgeist or spirit of the times regarding counseling and mental health. Such individuals need to be reassured that mental illness is no longer a major stigma in the lives of many.

7. Cognitive Functioning. Directly or indirectly the counselor is going to informally or formally assess the cognitive functioning of their clients. Some clients understand "chain of events" and the fact that some events directly or indirectly cause emotional states. Other clients may have some sort of "magical thinking" believing that Publishers Clearinghouse will arrive on Monday with a check for one million dollars and all of their problems are going to be over. Some individuals with this "magical thinking" style will request hypnosis as a magical cure or solution to their anxiety. While some hypnosis may help with relaxation, further coping skills may be needed to help with global functioning.
8. Cooperation- As in all therapeutic endeavors- the counselor hopes that the client will cooperate, respond to questions, correctly assess their functioning and the duration, frequency and intensity of the anxiety or related condition (math anxiety, test anxiety).
9. Rapport and the relationship is obviously important in their matters. Anxious individuals MAY be quite anxious in terms of building a therapeutic relationship and some males may have difficulty with a female therapist or vice versa.
10. Attention and concentration may be areas that need to be specifically addressed as some research has shown that there are many adults with attention deficit disorder that have not been diagnosed, counseled or treated. Procuring the anxious patient's attention for the therapeutic hour is of utmost importance, and if the attention of the client wavers, the client perhaps has not had breakfast or lunch or could even conceivably be anemic or diabetic.

4. Realms needed to be Examined

Clinicians and counselors are often confronted with a wide variety of conditions in which the patient is experiencing some form of "anxiety". These will be summarily discussed.

4.1 Math anxiety

Much has been written over the years about the construct that we refer to as "math anxiety". Certainly for those who have been diagnosed with a learning disability in math, anxiety is an appropriate response. For whatever reason, the student has been having difficulty with arithmetic, has been failing classes in math, perhaps has been embarrassed by a teacher or has had their self-worth, self- esteem, impacted by their difficulties in math.

Other individuals, simply fear the emotions associated with math. They may have had a bad experience in elementary school with math, may have been berated by a math teacher or they may have had numerous papers and assignments returned to them with big red numbers reflecting their lack of learning in math.

Some individuals freeze up at the mention of balancing their check book and some college students live in fear of having to take statistics (often referred to on college campuses as “sadistics”).

Unfortunately, there is no global definition of “math anxiety” and while students may shiver and shake during a math test, they may be unable to get accommodations and modifications for their anxiety and may be required to take a number of math courses such as algebra, geometry and or trigonometry.

Luttenberger, Wimmer, and Paechter [1] have extensively reviewed the literature and the issues and concerns revolving around math anxiety and they have discussed the antecedents, outcomes and variables associated with math anxiety. They indicate that math anxiety is a different form of anxiety and indicate that much more research is needed into treatment issues and identification.

4.2 Test anxiety

Since evaluations and assessments have been with us for many years- the word test has become almost a universal evil. There are many different forms of tests- multiple choice, true- false, fill in the blank, matching column and essay and even oral tests. Currently many tests are administered on computer via the Internet and students are in fear of the computer “crashing”.

They may enter the testing situation with beads of sweat on their frontalis and perspire during the entire test, and some students may not be able to optimally function during the test, thus they are frequently not able to perform adequately.

Cannon, Rash, Gerwing, Bramble, Landine and Gerwing [2] have investigated the phenomenon of post-secondary educators perceptions of students test anxiety. Their research in Canada showed an awareness of test anxiety and some commitment to assisting students with test anxiety and they concluded with the recommendation that there be more information provided to faculty as to symptoms, signs and the availability of counseling services to address the issue of test anxiety.

4.3 Performance anxiety

Some clients function very well in the course of their lives- but when they are required to demonstrate their learning, issues arises. Musicians, singers, and of course athletes also have some sort of performance anxiety as they approach the task at hand. Any individual who has to speak on stage may have some concern about their performance as they approach their designated time.

Here the anxiety is very specialized- focusing on a specific time in their lives when they have to demonstrate skills that they may or may not have learned or mastered. Musicians and performers all have a certain degree of anxiety, although with some, it may be debilitating.

4.4 Anticipatory anxiety

Some individuals, have experienced a very difficult event and have experienced perhaps a wide range of emotions, but some in other instances may have experienced a massive amount of anticipatory anxiety- in that they are aware of a pending or

upcoming anxiety attack or are aware of an upcoming event which makes them nervous and thus they are anxious even before the event. Certainly this somewhat bizarre or strange- but occurs nevertheless.

4.5 Separation anxiety

Children quite often are remarked as having “separation anxiety” when they first arrive at kindergarten or elementary school. They will cling to parents or mother and have a good deal of difficulty leaving their parent or parents and will often cry and become sad and morose. Most overcome this through teacher distraction and reassurance over time. But for some teachers, and some parents, this remains problematic as the child may want to telephone home to hear the mother’s voice and this disrupts the educational process and takes time away from providing instruction to the other children.

4.6 Castration anxiety

This has been mentioned in the past, basically in a Freudian or psychoanalytic perspective. It may be mentioned in the literature and some may hold to its existence as a clinical entity, but it will not be discussed further here.

5. Standardized Test Anxiety and the Current Zeitgeist

Currently in the schools, there are a number of school districts that indicate that a teachers job is incumbent upon the performance of their students in their classes and that their jobs and positions and raises and promotions rely on the test scores. The students also are aware that some of these test scores may be relevant when they apply to college and thus are mightily concerned about doing well and demonstrating mastery. Some states have multiple testings during the school year, further exacerbating the problem.

On one hand, teachers have to teach test preparatory skills so that students do not begin to cry or seek out attention. Teachers are constantly worried about the performance of their students on these standardized tests, realizing that to some extent, the performance of their students is somewhat of a reflection on their teaching. Thus both teachers and students are impacted, to a greater or lesser extent by the relentless pursuit of excellence as demonstrated by this “high stakes testing” concept.

Teacher candidates now have to take various tests before they are certified by the state in which they teach. Apparently these “tests” are able to somehow assess and evaluate a teacher’s competence to motivate and encourage students and promote learning and to assess a teacher’s competence in working with a wide variety of students.

Social anxiety or Social phobia occurs when people are fearful of social situations in which they might feel embarrassed or judged. They typically feel nervous spending time in social settings, feeling self-conscious in front of others, and worry about being rejected by or offending others. Other common symptoms include having a difficult time making friends, avoiding social situations, worrying for days before a social event (anticipatory anxiety) and feeling shaky, sweaty or nauseous when spending time in a social setting. Some just feel very uncomfortable and uneasy.

A panic disorder is recurrent panic attacks that have symptoms such as sweating, trembling, shortness of breath or a feeling of choking, a rapid heart rate, and feelings of dread. Such attacks often happen without warning. People who experience

panic attacks often become fearful about when the next episode will occur, which can cause them to change or restrict their normal activities. This may be a common form of anxiety when helping athletes or students. Whereas phobias, are intense fears about certain things such as spiders or snakes, or situations like flying in airplanes that have heavy turbulence.

5.1 School shootings

Sadly, a number of schools have been the victims of what is now known as “school shootings”. These events began years ago with Columbine High School and continue to this day. Tangentially, there have been also synagogue shootings, church shootings and shootings at yoga and exercise facilities.

These shootings have resulted in some individuals having a type of “free floating” anxiety and apprehensiveness about going out to the local movie theatre (there have been shootings there also) or to a local grocery shop for milk, bread, cake or pie.

Children arrive at school somewhat upset, worried about whether such an event could occur at their local school and apprehensive as to whether their teacher would be able to save them or if their teacher would also be struck dead by a bullet.

Shaughnessy, Holin, Johnson & Cordova [3] have recently investigated some of the concerns relative to counseling survivors and their families following school shootings. At the current time, teachers report that their students are apprehensive about school shootings fearing that it could in fact happen in their school and that their teacher or principal may not be able to protect them.

Strohle, Gensichen & Domschke [4] have provided the most recent, most comprehensive review as to the diagnosis and treatment of anxiety disorders. They conclude that anxiety can in fact be treated and they have reviewed many of the treatment options (medication, biofeedback, relaxation, hypnosis, desensitization). Robinson [5] has indicated that “Generalized Anxiety Disorder is often precipitated by a psychosocial stressor. Buspirone appears to be less useful if benzodiazepines have been used recently....the dexamethasone suppression test (DST) is often positive in Generalized Anxiety Disorder ...and cardiac endocrine, and neurological illnesses are among the most common medical causes of anxiety disorders...and tolerance does not appear to develop to the anxiolytic effects of benzodiazepines; however, addiction is a long term concern” (p.83).

5.2 Counseling issues

Anxiety affects reportedly about 18% of US adults and 25% of adolescents aged 13 to 18 will experience anxiety according to the National Institute of Mental Health. Additionally, while treating this disorder there have been numerous additional issues regarding this population. Anxiety often follows with sleeplessness, depression, panic attacks, racing thoughts, headaches, or other physical issues. Although the anxiety disorders are similar it isn't rare to see in a counseling session a client with comorbidity within the anxiety disorders as well as depression and self-harm.

For example, a client who has obsessive compulsive disorder may also have panic disorders if their compulsion isn't mitigated. Also, an issue surrounding this population is that anxiety may be genetic, environmental or even situational, so it

may be difficult for the counselor to pinpoint the onset of what is causing the anxiety. Moreover, the use of drugs and alcohol pose a significant problem as well because the use of drugs and alcohol may turn into an addiction which won't help anyone who is anxious, so counselors have to get the clients off their preferred drug or drink while trying to minimize their anxiety riddled episodes.

Another counseling issue may involve multicultural issues as well. This may be problem if the client is unaware of a certain tradition and all it entails. For example, a client may not think it is normal to become anxious when going through a ceremony or festival, so the counselor may want to get to know that culture a little bit more so they're able to converse with the client that it is ok to be nervous for an event such as this. Counselor competence is crucial when treating anxiety because there are so many aspects and factors that could cause the disorder.

An issue a counselor may face while attending to a client appearing to have an anxiety disorder is an unwillingness to change. They may be apprehensive about treatment and be actually anxious as to what type of person they will be after treatment.

For example, there are many studies suggesting Cognitive Behavior Therapy may be a really good treatment to use, but if the client is unwilling to challenge their own thoughts, cognitions, attitudes, beliefs and philosophies and work towards a change within themselves to find out what is causing them to stress out so frantically, then change won't necessarily come.

Many times, when clients come in they talk about how their issues aren't real, or they express the simple idea that they "should just get over it".

Counselors should be aware of this when helping a client with anxiety because they shouldn't feel like their issues aren't important or real to them because they very much are. The counselor should attend to the client and get a better look at their world with anxiety.

A major part of the medical/health perspective is to give clients with anxiety medication to treat them. However, some counselors cannot prescribe medication so they have to be well versed in different coping strategies like breathing techniques, thought stopping techniques, relaxation, and meditation.

As with all counseling, it is imperative to form a therapeutic relationship. Rapport is essential and clear communication is imperative. Often clients will discuss their feelings and emotions while other clients will discuss their behaviors, which they believe lead to the anxiety. Other clients may report images of very dreadful situations- such as a plane crash or school shooting. These images may re-occur in daydreams or even nightmares.

6. Needed Research

The mental health of counselors, psychologists and psychiatrists is even of concern as they attempt to cope with the vast number of individuals seeking assistance with their legitimate concerns. In the past some concerns of patients presenting with "anxiety issues" have been ill founded. For example, a patient may have been concerned about defecating in a bathroom and being apprehensive as to what the person in the next stall might think of them. Obviously, this is ludicrous and preposterous-

but irrational, illogical, unreasonable, individuals think in certain irrational, unsystematic, illogical ways and require cognitive modification along the lines provided by Albert Ellis, [6] Ellis, Shaughnessy and Mahan [7] Aaron Beck, (Beck, Madewell and Shaughnessy [8] or Arnold A. Lazarus [9,10] Lazarus and Shaughnessy [11] and Donald Meichenbaum (Meichenbaum, Shaughnessy, & Haight) [12].

7. Summary and Conclusions

This paper has attempted to provide a broad overview of the topic of anxiety and its many related tangential issues. The paper has provided a framework for evaluation and future research also needs to examine the psychometric assessment of anxiety in its many forms and format. Treatment concerns were summararily addressed.

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