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Overanxious Disorder: An Examination of Developmental Differences

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Differences between a clinical sample of younger (ages 5 to 11) and older (ages 12 to 19) children meeting DSM-III criteria for overanxious disorder (OAD) were examined. Younger and older children were compared in terms of (1) the rates of OAD diagnoses occurring in the two age groups, (2) sociodemographic characteristics, (3) symptom expression, (4) association with other forms of maladjustment, and (5) self-reported anxiety and depression. The prevalence of OAD diagnoses and sociodemographic characteristics did not differ. Although younger and older OAD children showed similar rates of most specific DSM-III OAD symptoms, older children presented with a higher total number of overanxious symptoms than younger children. Older children more frequently exhibited a concurrent major depression or simple phobia, whereas younger OAD children more commonly had coexisting separation anxiety or attention deficit disorders. Older OAD children reported significantly higher levels of anxiety and depression on self-report measures. Findings indicated that the expression of OAD varies by developmental level.

There is evidence suggesting that the manifestation of anxiety disorders may differ across age groups in childhood and adolescence. To date, the empirical research primarily consists of data concerning age trends for specific types of subclinical fears or worries. In particular, differences in the number and kind of reported fears have been obtained for younger children versus adolescents (e.g., Jersild & Holmes, 1935; Lapouse & Monk, 1958).

In their review of the literature, Graziano, DeGiovanni, and Garcia (1979) noted that the number of reported fears generally declines from young

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childhood to adolescence (e.g., MacFarlane, Allen, & Honzik, 1954; Scherer & Nakamura, 1968). The percentage of children reporting one or more fears also appears to decrease with age (see Graziano et al., 1979). With regard to variations in types of fears according to age, there appear to be age-related decreases in reported fears of separation, animals, the dark, and imaginary creatures, and age-related increases in school and social anxieties (see Graziano et al., 1979).

Overall, research findings to date suggest that specific fears indeed are related to age in childhood and adolescence. Developmental differences for the subtypes of anxiety disorders of childhood and adolescence presented in the DSM-III (American Psychiatric Association, 1980), on the other hand, have only rarely been investigated (Francis, Last, & Strauss, 1987). This study focuses on one DSM-III anxiety disorder subtype not yet studied, overanxious disorder (OAD). OAD is characterized by pervasive anxiety that is not focused on a specific object or situation. Instead, those with OAD express excessive worries about multiple future and past events, an overconcern about performance or evaluation by others, an extreme need for reassurance by others, and marked self-consciousness. Additional features are somatic complaints for which no physical basis can be established and high levels of tension. OAD appears to be common in both childhood and adolescence, and children with this diagnosis frequently are referred for clinical outpatient services (Last, Hersen, Kazdin, Finkelstein, & Strauss, 1987); nonetheless, we know little regarding the assessment, course, and treatment of OAD.

This investigation provides a description of the manifestation of OAD in young chlidren versus adolescents. More specifically, we examine differences between younger children (ages 5 to 11) and adolescents (ages 12 to 19) with OAD by evaluating (1) prevalence of this disorder in the two age groups, (2) sociodemographic characteristics, (3) symptom expression, (4) association with other forms of maladjustment, and (5) self-reported anxiety and depression. Comparisons of younger children and adolescents with OAD will increase our understanding of the disorder and may have implications for treatment in the two age groups.

METHOD

Subjects

Subjects were 55 children and adolescents between the ages of 5 and 19 who were evaluated in the Child and Adolescent Anxiety Disorder Clinic at Western Psychiatric Institute and Clinic and who met DSM-III criteria for OAD. Cases of OAD were identified from among a total of 106 referrals

with anxiety disorders during the 26-month period between April 1984 and June 1986. OAD diagnoses were based on child and parent interviews using the Interview Schedule for Children (ISC; Kovacs, 1983a), a semistructured, symptom-oriented diagnostic interview.

Interdiagnostician agreement was determined by having a second clinician conduct separate parent and child interviews after a short time interval (morning–afternoon) following the initial evaluation. A total of 32 (58%) children in this sample were diagnosed independently by two clinicians as part of a larger reliability study (see Last et al., 1987). High interrater agreement for diagnoses of OAD (Kappa = .82) was found. Reliability also was calculated for all other DSM-III childhood disorders observed in the clinic sample. Kappa coefficients for these disorders ranged from .64 to 1.00, which exceeded the criterion of K = .60 recommended by Hartmann (1977).

To evaluate developmental differences among OAD children, two groups were formed: (1) children younger than 12 years of age at the time of referral (n = 23), and (2) children 12 years of age and older at intake (n = 32). Preliminary analyses suggested that this age cutoff produced the most meaningful comparisons. The mean age was 8.0 years (SD = 1.64) for children in the younger group and 15.0 years (SD = 1.80) for children in the older group. Fifty-six percent of the younger and 62% of the older children were female. Almost all in both groups were Caucasian (< 12 years: 100% Caucasian; ≥ 12 years: 96.3% Caucasian). SES was determined by the Hollingshead (1975) Four-Factor Index of Social Class. Social class ratings were combined into two groups: (1) middle/upper socioeconomic level (I, II, III) and (2) lower socioeconomic level (IV, V). The majority of families in both the younger (69.6%) and older (71.9%) OAD groups were of middle/upper SES. The two age groups did not differ significantly in terms of the prevalence of OAD, sex ratio, racial composition, or SES.

Procedure

The two groups were compared on the following variables: OAD symptom ratings, concurrent diagnoses, and self-reported anxiety and depression.

OAD Symptom Ratings. Younger and older children were compared on the frequency (presence or absence) of individual overanxious symptoms. Clinician summary ratings of overanxious symptoms were based on individual parent and child interviews using the ISC. The ISC contains seven items that are rated on a dichotomous scale (yes or no) that directly correspond to each of the DSM-III diagnostic criteria for OAD. Ratings of "yes" indicate clinically significant symptomatology. Previous research has demonstrated high interrater reliability for anxiety symptom summary ratings using the ISC (Kovacs, 1983a). The percentage of both groups exhibiting each of the seven symptoms was determined and χ^2 tests were used to assess differences.

Concurrent Diagnoses. To evaluate comorbidity for both groups, children were assigned all DSM-III diagnoses for which they qualified on the basis of the ISC. The DSM-III hierarchical system and diagnostic exclusionary rules were not adhered to in order to obtain a comprehensive assessment of comorbidity, with the exception that diagnoses that could be subsumed under others were not given. The groups were compared on all concurrent diagnoses, including additional anxiety disorders, major depression, oppositional disorder, conduct disorder, and attention deficit disorder (ADD). Percentages of both groups demonstrating each of the coexisting diagnoses were calculated and χ^2 tests were used to evaluate differences.

Self-Report Inventories. Self-report measures were completed by children in both groups prior to their diagnostic inverviews: the State-Trait Anxiety Inventory for Children (STAIC; Spielberger, 1973), the Revised Children's Manifest Anxiety Scale (RCMAS; Reynolds & Richmond, 1978), the Fear Survey Schedule-Revised (FSSC-R; Ollendick, 1983), and the Children's Depression Inventory (CDI; Kovacs & Beck, 1977). All four have previously been shown to have adequate psychometric properties (Kovacs, 1983b; Ollendick, 1983; Reynolds & Richmond, 1979; Smucker, Craighead, Craighead, & Green, 1986; Spielberger, 1973).

The questionnaires were filled out without assistance with the exception of younger children, to whom each item was read aloud by a research assistant while the child marked the responses. Data are not available for all children in the two groups owing to the inability of very young children to provide responses on these measures and errors in completion of questionnaires. Clinicians assigning DSM-III diagnoses were blind to children's self-report ratings.

T tests were performed to assess mean differences. Correlations between age and scores were obtained to examine the relationship among these variables for the combined sample.

RESULTS

OAD Symptom Ratings

Table I shows comparisons of the groups on the presence of individual overanxious symptoms using the ISC. The older were significantly more likely than the younger children to express unrealistic concern about the appropriateness of past behavior. There were no significant differences between the two groups, however, in the rate at which they presented with any of the remaining six symptoms. All but one child in each group demonstrated unrealistic worries of future events.

Table I. Percentage of Younger versus Older Overanxious Children Exhibiting Each OAD DSM-III Diagnostic Criterion

Overanxious disorder symptoms on the Interview Schedule for Children	Age groups			
	<12 years (n = 23)	≥ 12 years (n = 32)	χ^2	$p <$
1. Unrealistic worry about future events	95.4	96.9	0.21	n.s.
2. Unrealistic concern about the appropriateness of past behavior	61.9	90.3	4.48	.05
3. Unrealistic concern about competence in one or more areas	76.2	71.9	0	n.s.
4. Somatic complaints for which no physical basis can be established	73.9	77.4	0	n.s.
5. Marked self-consciousness	73.9	78.1	0	n.s.
6. Excessive need for reassurance about a variety of concerns	74.2	83.9	0.11	n.s.
7. Marked feeling of tension or inability to relax	78.3	83.9	0.03	n.s.

An additional analysis was performed to compare the total number of OAD symptoms displayed by each child in the two age groups (a minimum of four symptoms are required for the diagnosis). An overall χ^2 revealed that there were significant differences in the number of symptoms shown by each group ($\chi^2 = 8.6$, $df = 3$, $p < .05$). A subsequent simple χ^2 analysis demonstrated that the older children (66%) presented with more than five sympoms significantly more often than the younger children (35%). In fact, 28% of older OAD children met all seven DSM-III criteria for the disorder, whereas only 4% of the younger group presented with all OAD symptoms ($\chi^2 = 3.61$, $p < .06$).

Concurrent DSM-III Diagnoses

Additional DSM-III diagnoses received by the two groups are summarized in Table II. Complex χ^2 analyses performed separately for concurrent anxiety disorders and other childhood disorders revealed significant differences between the two groups ($\chi^2 = 18.67$, $df = 6$, $p < .01$; $\chi^2 = 11.4$, $df = 3$, $p < .01$, respectively). Subsequent simple χ^2 tests showed that the younger children were significantly more likely to receive a concurrent diagnosis of separation anxiety disorder (SAD), whereas the older children more commonly had a concurrent diagnosis of simple phobia. Although χ^2 tests did not yield significant differences for agoraphobia and panic disorder, these diagnoses were present only in the older group.

Table II. Concurrent DSM-III Diagnoses for Younger versus Older Children with Overanxious Disorder[a]

DSM-III diagnoses	Age groups: <12 years (n = 23)	Age groups: ≥ 12 years (n = 32)	χ^2	$p <$
Anxiety disorders				
Separation anxiety disorder	69.6%	21.9%	10.63	.01
Avoidant disorder	13.0%	25.0%	0.56	n.s.
Simple phobia	8.7%	40.6%	5.36	.05
Social phobia	8.7%	9.4%	0.15	n.s.
Agoraphobia	0%	6.3%	0.24	n.s.
Panic disorder	0%	15.6%	2.29	n.s.
Obsessive-compulsive disorder	4.3%	9.4%	0.03	n.s.
Major depression	17.4%	46.9%	3.92	.05
Oppositional disorder	17.4%	6.3%	0.75	n.s.
Conduct disorder	8.7%	0%	0.94	n.s.
Attention deficit disorder	34.8%	9.4%	3.93	.05

[a]Yates's correction for continuity was applied when the frequency of any cell was less than 10.

Table II also shows that the groups differed significantly in coexisting major depression and ADD. Almost 50% of older children received a diagnosis of major depression, whereas less than 20% of the younger group met DSM-III criteria for this disorder. On the other hand, younger children were more likely to demonstrate an ADD than older.

Self-Report Inventories

Data from self-reports of anxiety and depression are presented in Table III. Older children demonstrated significantly more state and trait anxiety, greater worry and oversensitivity, and higher levels of depression than did the younger.

Owing to the possibility that the differing total number of OAD symptoms demonstrated by the two OAD age groups may have presented a confound for findings on self-report measures, additional analyses were conducted in which the number of OAD symptoms served as a covariate. Analyses of covariance again revealed that the older group received significantly higher scores on the state portion of the STAIC ($F(2, 37) = 8.23$, $p < .001$), the STAIC trait subscale ($F(2, 38) = 3.39$, $p < .05$), the worry/oversensitivity factor of the RCMAS ($F(2, 37) = 3.26$, $p < .05$), and the CDI ($F(2, 39) = 4.36$, $p < .05$) when the effect of symptom severity was statistically controlled.

A correlation matrix generated for age and all self-report measures for a total of 38 children is presented in Table IV. To reduce the probability

Table III. Mean Ratings for Children's Self-Report Measures of Anxiety and Depression

Self-report inventories	Age groups: <12 years (n = 14)	Age groups: ≥ 12 years (n = 26)	t value	$p <$
State-trait anxiety inventory for children:				
State subscale	29.6	39.3	3.46	.001
Trait subscale	35.7	42.4	2.18	.05
Children's manifest anxiety scale-revised:	13.6	15.8	0.86	n.s.
Subscale scores				
Physiological	4.9	3.9	1.13	n.s.
Worry/oversensitivity	5.0	7.2	2.14	.05
Fear/concentration	3.4	4.7	1.48	n.s.
Fear survey schedule for children-revised:				
Total score	134.9	136.1	0.12	n.s.
Children's depression inventory:				
Total score	7.88	14.5	2.54	.01

of Type I errors, the minimum probability value for testing the significance of correlations was established at $p = .01$. Consistent with between-group comparisons, age was significantly correlated with state and trait scores on the STAIC, the worry and oversensitivity subscale of the RCMAS, and the CDI. Of interest, scores on almost all self-report measures of anxiety and depression were significantly and highly interrelated in this OAD sample.

Table IV. Correlation Matrix of Age and Self-Report Measures[a]

	1	2	3	4	5	6	7	8	9
1. AGE	–								
2. STAIC1	.58[c]	–							
3. STAIC2	.44[b]	.80[c]	–						
4. FSSC-R	−.07	.41[b]	.52[c]	–					
5. RCMAS	.21	.70[c]	.79[c]	.72[c]	–				
6. PHYS	−.09	.34	.53[c]	.53[c]	.79[c]	–			
7. W/O	.40[b]	.75[c]	.75[c]	.66[c]	.89[c]	.49[b]	–		
8. F/C	.29	.72[c]	.78[c]	.62[c]	.92[c]	.61[c]	.79[c]	–	
9. CDI	.47[b]	.82[c]	.80[c]	.41[b]	.66[c]	.40[b]	.63[c]	.72[c]	–

[a]STAIC1 = State-Trait Anxiety Inventory for Children-State Subscale, STAIC2 = State-Trait Anxiety Inventory for Children-Trait Subscale, FSSC-R = Fear Survey Schedule for Children-Revised, RCMAS = Revised Children's Manifest Anxiety Scale, PHYS = physiological factor of RCMAS, W/O = worry/oversensitivity factor of RCMAS, F/C = fear, concentration factor of RCMAS, CDI = Children's Depression Inventory.
[b]$p < .01$.
[c]$p < .001$.

DISCUSSION

Age differences were found in clinic-referred children with OAD. Younger and older OAD children were dissimilar in (1) the number of overanxious symptoms displayed, (2) patterns of comorbidity, and (3) severity of self-reported anxiety and depression. More specifically, the majority (66%) of older children met most or all (6 or 7) diagnostic criteria for OAD, compared with only 35% of younger children. Older children more frequently exhibited a concurrent major depression or simple phobia, whereas the younger more commonly had coexisting SAD or ADD. Finally, older children were more likely to report high levels of anxiety and depression on various self-report measures.

Although several important differences were demonstrated in younger versus older OAD children, notable similarities also emerged. First, the prevalence of OAD diagnoses did not differ in the age groups in this clinic sample. In addition, the sex ratio, SES, and racial composition were not substantially different in the two groups. Moreover, the frequency of specific overanxious symptoms did not appear to change over the course of childhood. Of note, the hallmark for OAD was "unrealistic worry about future events" regardless of age, with all but one child in each of the two age groups having this specific symptom.

The meaning of differences found between the groups on self-report measures can be better understood by comparing their scores to normative data from prior studies (Reynolds & Paget, 1983; Smucker et al., 1986; Spielberger, 1973). When contrasted with children of similar ages, mean scores on the STAIC, the worry/oversensitivity subscale of the RCMAS, and the CDI for younger OAD children consistently were at or slightly below the mean for normative groups. On the other hand, mean scores for older OAD children were above the mean on all measures for older normative samples. In fact, mean self-ratings for the older children on the RCMAS worry/oversensitivity factor and on the CDI were approximately 1 standard deviation above the mean for normative groups. Of note, scores for both OAD groups on self-reported fears on the FSSC-R were comparable to mean scores provided for a normative sample of nonclinic children (Ollendick, Matson, & Helsel, 1985). Although interpretation of these observations is limited by the lack of direct comparability of prior normative samples with clinic children in this study, the comparisons are suggestive that older children did demonstrate elevated anxiety and depression, whereas younger OAD children were not deviant on these measures.

It is unclear whether the tendency for older children to have more symptoms is specific to OAD children or is a more general age-related trend for childhood disorders. Examination of results reported by Francis et al. (1987) suggests that this age difference is not in fact a general developmental

phenomenon. Francis and her colleagues showed that younger children (5–8 years) with SAD actually presented with more SAD symptoms than a middle SAD age group (9–12 years). Furthermore, the older age group (13–16 years) did not differ from younger or middle children in their rates of SAD symptomatology. Thus, the present findings seem to be specific to children with OAD.

There are several possible interpretations of the findings that older children displayed more overanxious symptoms and described themselves on average to be more anxious than the younger group. First, older children and adolescents may need to exhibit more extreme worrying and social anxieties, more distress, and/or more impairment to be considered sufficiently deviant to be referred for treatment. Thus, higher levels of worrying and anxiety may be necessary to be considered clinically meaningful in older children and to warrant referral. An alternative interpretation of the above findings is that older children may be more self-aware and better able to articulate their difficulties than younger children. One further possibility is that developmental changes in cognitive abilities may be responsible for the older group's higher rates of concerns about past behavior and events, thus contributing to increased symptomatology and higher levels of self-reported anxiety. Finally, it may merely be that older children have had symptoms over a longer period, which have resulted in more impairment over time. Longitudinal data for children with DSM-III diagnoses of OAD would help to elucidate this issue further.

The relationships that existed between OAD and other forms of psychopathology in younger versus older groups were noteworthy. It was not surprising that the younger OAD group more frequently had simultaneous problems with SAD than did the older group, on the basis of the prior Last et al. (1987) findings regarding the relationship between SAD and OAD. Nonetheless, the extent (approximately 70%) of the overlap of these two anxiety disorder subtypes in the younger group was remarkable.

The significant coexistence of OAD and ADD in younger children, relative to the older OAD group, was unexpected. Although previous investigations have demonstrated an association between anxiety and ADD without hyperactivity in nonreferred children in grades 2 through 5 (Lahey, Schaughency, Strauss, & Frame, 1984; Strauss, Frame, & Forehand, 1987), specific overlap with this anxiety disorder subtype has not yet been shown. The higher comorbidity of OAD and ADD in the younger group may be due to the general finding that the severity and number of attention deficit symptoms decline as children get older (cf. Barkley, 1981). One very different interpretation of these findings is that the differential diagnosis of OAD and ADD may be more difficult in younger children. That is, OAD children's preoccupation, worrying, and nervous mannerisms may be misinterpreted by parents and/or children as inattention to external stimuli, distractibility, and fidge-

tiness, or vice versa. As children get older, it may be easier to distinguish anxiety from attention difficulties. Examination of specific ADD criteria given to OAD chidren and study of the data concerning attention problems from more traditional sources (i.e., teachers) in future studies may help to explain this observed overlap.

Concurrent diagnoses of major depression in almost half of the older OAD group was striking. This high concordance rate is consistent with two previous reports demonstrating that older children with other types of anxiety problems also commonly display depressive features (Bernstein & Garfinkel, 1986; Kolvin, Berney, & Bhate, 1984). The presence of major depression in older OAD children underscores the importance of OAD in this age group. It would be of interest to determine the relative onset of these two disorders, which might have important implications for prevention and intervention.

In addition to examination of the coexistence of OAD groups with particular childhood categories, it is important to note the extent of overlap, overall, for this diagnostic group. Both younger and older OAD children showed a remarkable degree of concurrent anxiety and affective disorders in addition to their overanxious symptoms. This raises the question of the purity of this disorder in childhood and the need for distinction among anxiety disorder subtypes or perhaps even internalizing disorder subcategories (see Quay & LaGreca, 1986). Further investigation of family history, response to treatment, and other correlates associated with internalizing disorder subtypes is needed, however, before reaching conclusions regarding this important taxonomic issue.

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