

# Childhood anxiety: Occupational disruption

Ann Christie

## Abstract

The purpose of this paper is to demonstrate the effects of childhood anxiety on children's participation in occupations, their family of origin and extended family members from an occupational therapy point of view. A case history will outline the experience of a 12-year-old girl, the impact on her occupational, social and academic functioning and her family unit. Tools that were found to be useful in bringing about change are discussed, in particular the Sequentially Planned Integrative Counseling for Children model of intervention.

## Key words

Childhood, anxiety, occupational disruption, occupational therapy.

Christie, A. (2007). Childhood anxiety: Occupational disruption. *New Zealand Journal of Occupational Therapy*, 54(2), 31-39

Childhood anxiety is often unrecognised until a major depressive episode draws the attention of families. A child's presentation of mood differs somewhat from the adolescent or adult, with the disruption varying according to developmental ages and stages. Shyness, worry and nervousness may lead to internalised personal suffering for children. The effects of this can interfere with making friends, academic progress, family cohesion and activities, general happiness and self-esteem. Thus early recognition of childhood anxiety is critical in the prevention of long-term, debilitating problems in adolescence and adulthood such as depression, social isolation and even suicide.

The challenge of applying theory to practice is ongoing for occupational therapists who work in a multidisciplinary specialist area such as child adolescent and family mental health. The client includes the family/whānau as well the as child/adolescent. Due to the complex presentation of families/whānau it is important to develop collaborative partnerships with team members and to think eclectically when making decisions about assessment and intervention plans (Christie & Scaletti, 2000; Geldard & Geldard, 2002; Cronin Mosey, 1996). This way of working can assist the process of theory to practice, critical reflection and evaluative processes.

## Literature review

New Zealand studies from other disciplines indicate that anxiety is the most common disorder in children and adolescents (Anderson, Williams, McGee, et. al. 1987; Fergusson, Horwood & Lynskey, 1993; Hetrick, Proctor, & Merry, et. al., 2005; Merry, Hetrick, & McDowell, et. al., 2004; Watson, Clark, & Denny, et. al., 2003;). Theoretical foundations include literature from both occupational therapy and other disciplines.

A review of occupational therapy literature over the last 15 years reveals few models of practice designed for use within child, adolescent and family services (Cronin Mosey, 1996; Lougher,

2000; Creek, 2001). The available literature did not specifically focus on anxiety but rather on the role and a service delivery of occupational therapy. For instance, occupational therapy literature provides concepts of the psychosocial components of a family system (Humphry & Case-Smith, 1996), play theory in middle childhood (6-12yrs) (Florey & Green, 1997) and the development of play behaviours (Bundy, 1997; Cronin, 1996; Cronin Mosey, 1996; Hagedorn 1997; Law, Baum, & Dunn, 2005). Florey & Green (1997) also write about the problems of behaviour or emotions not always being noticeable until triggered by internal or external experiences.

Developmental theories which include the temperament (biological), emotional and social competency of a child within their environment (context) are of importance when developing intervention plans (Hetherington, Park & Locke, 2002) Attachment theory is also important (Fongay, 2002; James, 1994;) as attachment is seen as a prerequisite for successful socialisation. Scientifically, this theory shows how our earliest relationship with our mother influences later relationships in life.

Other useful therapeutic theories include narrative and family therapy (Freeman, Epston, & Lobovits, 1997; Goldenberg, & Goldenberg, 2004) to assist in externalizing the problem, getting to know the child, their identity and abilities. Family therapy

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also incorporates the family and extended family into the process. The elective model of Sequentially Planned Integrative Counselling for Children (Geldard & Geldard, 2002) allows the integration of occupational therapy applied frames of reference to focus on psychosocial dysfunction. Practice parameters for the assessment and treatment of children and adolescents with anxiety disorders (American Academy of Child and Adolescent Psychiatry, 1997) provided evidence based guidelines for intervention.

## Case study

This is the story of Maize, her family, and her road to recovery. Ultimately it is a celebration as she regains her ability to perform the occupational roles appropriate for a child making the transition to early adolescence. Names and place names have been changed to protect privacy.

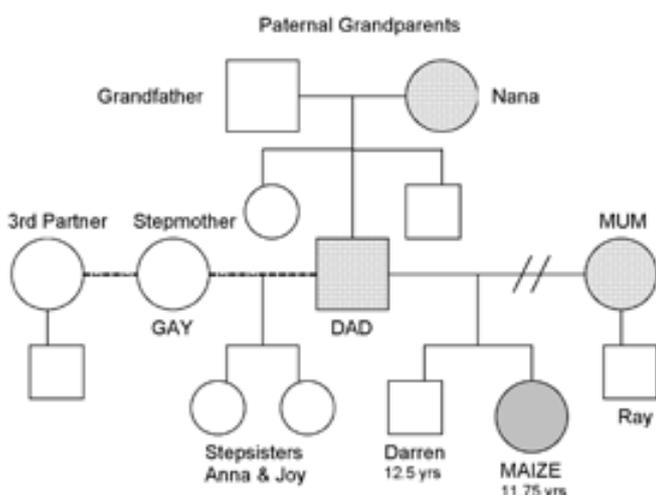
## Referral

Maize was eleven years old when her family first noticed something was wrong. She began by expressing a wish not to attend school. Several months later; she could not get out of bed to attend to daily functions or school. At this time, Maize was referred to the child, adolescent and family service where she was seen by the occupational therapist and a social worker for a child and family diagnostic and forensic interview (Sattler, 1998). The therapists involved used knowledge of child and adolescent development, family systems, DSM4 criteria (American Academy of Child and Adolescent Psychiatry, 2005) to identify and track the issues that were impacting on Maize's academic, social, emotional and occupational function. This was the start of her journey to recovery. However, her story started long before this event took place.

## Background information

Gathering information regarding Maize's developmental history, the family, the child and family's perception of the problem was the first important step. Appropriate assessments were administered and the whole family was invited including Dad, paternal grandmother (Nana) and Maize. Rapport building

Diagram 1: Family genogram



began as the group collaboratively put together a picture of the family genogram.

This process helped to trace Maize's family of origin. It revealed that she had been exposed to changes in family life at an early age. These changes impacted on her early psychosocial and emotional development and her ability to cope. During the changes, Maize's increasing anxiety remained unrecognized until her first major depressive episode drew the family's attention to her needs.

The original family constellation included father, mother, stepbrother and biological brother. Dad's first wife (Maize's biological mother) developed bipolar disorder shortly before the birth of Maize's older brother Darren. Maize was born 18 months later. Her mother took no medication believing it was unnecessary. Due to her mother's illness, Nana reported that she did not actually meet Maize until she was 3 years old. She described Maize's temperament as shy, withdrawn and watchful. She revealed Maize had a close relationship with her stepbrother Ray and biological brother Darren.

Following a series of manic episodes her mother was hospitalized. At five years of age Maize had to deal with her parent's marital separation and divorce, a move to the city, and her father suffering from depression. In between hospital admissions her mother requested and was given care of the children. This was unsuccessful, as the children were acting as caregivers to their mother, so once again they moved home and schools to live with Dad. Contact with mother and Nana was maintained by phone, email and school holiday visits.

When Maize was nine years old her dad remarried. Maize's concerns at this event were recorded in a letter. It was a sad letter telling of the effort it took to be a bridesmaid, knowing at the time the marriage was inevitable. Her feelings of powerlessness went unheard by her family.

During the first year of marriage the family had time to establish their relationships with Maize developing her role as stepdaughter. Then Anna was born, followed closely by Joy. Maize took on the role of the children's nursemaid in order to help and support her stepmother. This is not unusual within families when a child believes she needs to acquire status, and therefore some power, within the family group (Goldenberg, & Goldenberg, 2004). However, this was yet another role change for Maize so once again she felt displaced within the family. She later described this as feeling abandoned by both parents.

During her eleventh year she began complaining of body pains and headaches, and would often cry in the mornings before going to school. Her stepmother, busy with the little ones, had little patience with this behaviour. Dad was often called from work to come and pick up his daughter and take her to school. Surrounded by busy, frustrated adults, who did not understand, Maize had no way to express her feelings.

Over the next six months and prior to referral, further disruptions in the family's life impacted on Maize's psychological state. The second marriage broke up and her stepmother left home with the two girls. About this time Maize began to menstruate and this very personal, female experience was dealt with by Dad.

Again depressed, Dad then began another relationship. The family was in a state of crisis, each member coping with the changes in a parallel process rather than as a unit. Maize was in the midst of a family suffering enormous grief and loss with no female attachment figure. Finally she refused to attend school and this is when she was referred to the child adolescent mental health service.

So you might wonder why this historical background information so important. The relevance lies in discerning the impact of these life events and transitions on Maize's emotional and psychological development. The interview established that Maize had experienced a number of role changes, displacement within her family, transitions from homes and schools, and attachment issues of loss and grief. All this information was pertinent to developing an intervention plan that included the family.

**Assessment phase**

A variety of evidence based assessments were used by the multidisciplinary team to evaluate Maize's mental status and family functioning. Through the use of these assessments at the initial stage, team members gained a greater understanding of the degree of dysfunction impacting on Maize's everyday life. These assessments confirmed Maize's mood, level of anxiety, depression and trauma, a major childhood depressive episode, as well as extreme anxiety with frequent panic attacks and dissociation (see table 1). This information provided a baseline for occupational therapy programming.

To monitor intervention outcomes assessments such as the Childhood Depression Inventory (CDI) (Kovacs, 1992), March Anxiety Scale for Children (MASC) (March, 1997) and Body Mass Index (BMI) (World Health Organization, 1980) were used frequently (2-4 weekly). The Children's Global Assessment of Functioning Scale (CGAS) (Schaffer, et. al. 1983), Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA) (Gowers, et. al 1999), used both nationally and internationally as outcome measures are mandatory

Table 1: Assessments used:

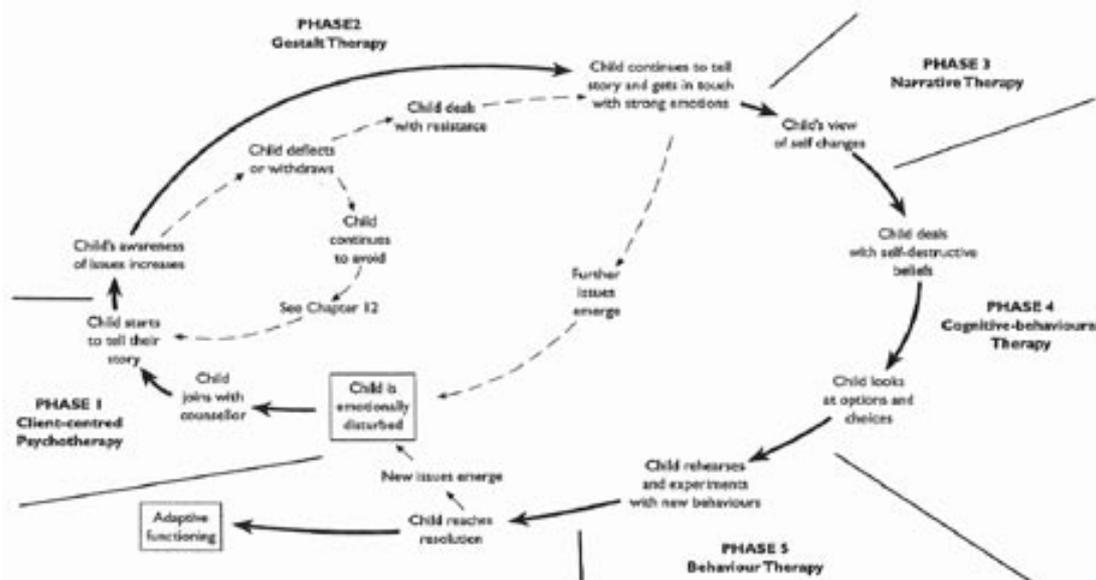
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- Childhood Depression Index, (CDI). Kovacs, (1999).
- Children's Global Functioning Scale (C-GAS). Schaffer et al., (1983).
- Clinical Forensic Interviewing of Children and Families. Sattler, (1998).
- Dissociative Features Profile, (DPF). Silberg, (1998).
- DSM-IV Diagnostic manual, (DSM-4). American Psychiatry Association, (1995).
- Health of the Nation Outcomes for Children and Adolescents (HoNOSCA). Gowers, et. al., (1999).
- March Anxiety Scale of Children, (MASC). March, (1997).
- Test of playfulness, (TOP). Bundy, (1997).
- Trauma Scale Checklist for Children, (TSCC). Briere, (1995).

assessments. The Trauma Scale Checklist for Children, (TSCC) (Briere, 1995) gave the degree of trauma and the Strengths and Difficulties Questionnaire (SDQ) (Goodman, et. al. 2000), an international evidence based assessment, was used to evaluate individual and group interventions.

**Occupational therapy assessments**

Sattler's (1998) guidelines for interviewing children with psychological disorders and children and families facing life stressors, were sufficiently flexible to encompass specific occupational therapy questionnaires concerning Maize's current occupational functioning and roles, i.e. attending to home and school routines, vocational and leisure pursuits, being a sibling, daughter, friend and school pupil. The Test of Playfulness (TOP) (Bundy, 1997) focused on play as a primary occupation of children (Hindmarsh-Hook, 2005). Used as an observation tool (without the video input) and questionnaire checklist, the TOP tracked Maize's return to play and playfulness to make sure it was appropriate to her child role.

Diagram 2: Sequentially Planned Integrative Counselling for Children (SPICC) (Geldard & Geldard, 2002)



## Intervention model

The intervention model chosen for its practicality, was the Sequentially Planned Integrative Counselling for Children (SPICC). Developed by Geldard and Geldard (2002) this eclectic model, which is based on a cyclic process, draws on and integrates theoretical concepts and practical strategies from well-established approaches that can be used as a method of producing therapeutic change and desired outcomes.

Of particular value was the way the model helped to address the resistance or avoidance behaviour that had arisen as a result of Maize's emotional pain. The elective components which consist of gestalt, behavioural and cognitive behaviour, narrative and family therapies, provided an evidence based system of intervention for complex presentations such as Maize. The SPICC model clearly demonstrated Maize's progress.

## Clinical presentation

Maize was a very bright child, a high achiever at school who loved researching ideas. She did not have a good repertoire of feelings literacy (Denham, 1999; Goleman, 2004; Hetherington, Park & Locke, 2002; Saarni, 1999) nor did her family. Throughout therapy she found it difficult to express how she felt. Learning that other children could experience the same symptoms was a revelation; she thought she was alone in her experience. Maize's physical symptoms were intense. Walking to and from school was a nightmare for her and a trial for both dad and Darren. Although recognizing Maize's distress, and trying to understand her, they both became irritated, frustrated and were unintentionally withdrawing their support.

Panic manifests with somatic symptoms in younger children who are unable to express their emotional needs, and they often make up stories to help explain the experience. Rarely is the confabulation seen for what it is – a state of panic. Maize was convinced she had a heart condition and that she would die if someone did not help her. Frightened yet prompted by this strong belief, and independent of her family, she made several lone visits to community medical clinics for validation of her symptoms. Once she even enticed a caring lady from the local handicraft shop to accompany her on one of these trips. There was no cause for alarm but Maize's pain was very real and frightening for her. The family reported frequent crying 'jags' at home.

## Rapport building phase

During the rapport-building phase (Geldard & Geldard, 2003) and using assessment results, observations and activity-based interaction, some ideas of the possible internal processes occurring for Maize provided a guide for therapeutic exploration. For example, Maize identified her symptoms through a pictorial and narrative story on panic titled "Living with IT" (Aisbet, 1999). She used visual aids to show how climbing the hill from the car park to the service reception area, a walk of two minutes would take her 15 minutes. She was puzzled by the idea that her physical symptoms of rapid heart beats, piercing headaches, pain, dizziness and the sense of 'dying' were coming from her mind.

Maize cried her way through a box of tissues every session as she shared her story with someone who cared. Drawing was an expressive activity for her so a series of pastel drawings emerged along with the information about her occupational disruption. Many days were missed from school through 'pain', her marks had dropped, and her fear of failure to perform in front of class was strong. Friends and sports activities dropped off, she went nowhere on the weekends, spent excessive time in her bedroom away from the family and was irritable or tearful with her father and brothers. Household chores were non-existent. Later we discovered Maize had never been shown how to cook, clean or do household chores.

In addition to the somatic presentation came the almost obsessive belief in eating only 'heart ticked foods'. She worried about everyone, particularly her father's health. She was becoming thinner at each appointment. Visual referencing, linking pictures with thoughts and feelings assisted in making connections with the mind/body perception (Sloan-Manning, 2004; Taffel, 2004). The use of a children's large picture book of brain and body functions and the Heart Foundation food table for eating well was also helpful. In addition, making a large colourful paper 'worry' bag in which she could store all her concerns written on coloured squares of paper, helped to sort out which problem Maize did not need to own. As each worry was processed the bag became smaller while making progress toward the real issues behind the worry. In addition a 'vibrating cushion' acted as a sensory aid when learning breathing and relaxation techniques (Cronin Mosey, 1996).

With complex presentations such as Maize's it was important to be aware of transference issues (Geldard & Geldard, 2002). This was a young girl desperately looking to attach to someone (Fongay, 2002; James, 1994). The desire of the therapist 'to scoop her up and take her home' was a strong indicator of transference. Lack of awareness of this phenomenon may have inhibited therapy, or alternatively awareness may facilitate progress. The dilemma of who could become Maize's attachment figure in her family of origin was solved in the later stages of therapy by inviting the paternal grandmother to take part in the process.

## The Gestalt phase

Based on the concept that change occurs as a result of increased awareness the gestalt phase is where Maize began to explore the components affecting occupational performance. Here the relationship between the child's internal and external world is opened up for examination. This is a place where the child may begin to get in touch with strong emotions and issues. Maize became stuck, demonstrating avoidance behaviour three times when raised awareness of her somatic sensations, strong emotions and false beliefs occurred. Maize's mood became too low to move forward. Getting in touch with strong emotions was difficult and caused her to deflect and withdraw from interaction.

Knowing the literature indicates poor long-term outcomes (Cole, Peeke, Martin, et. al. 1998) if a child is allowed to stay in this state, it was decided to introduce sand tray therapy. Maize quickly became absorbed in this activity. It was less threatening

than talking, allowed her defences to soften and resistance to diminish (Labovitz-Boik & Goodwin, 2000). Her concerns began to surface without words, in the sand tray.

Reassessment using the CDI showed Maize's was still depressed and her ongoing weight loss was a concern. Following a multidisciplinary team review a psychiatric evaluation was undertaken. Maize was thought to exhibit signs of borderline anorexia and she was medicated for the ongoing depression. In addition, a decision was made for family therapy to run parallel to individual work and to include Nana in the therapy process as a substitute attachment figure (James, 1994). This idea was discussed at a family meeting which also included the paternal grandfather and Darren. Her biological mother was included by telephone as Maize had identified her as a person of trust but she was not well enough to join in physically. Her stepmother was excluded at Maize's request.

### Narrative therapy

Narrative therapy or story telling was used because it is a playful approach that externalizes the problem separating it from the person (Freeman, Epston, & Lobovits, 1997). Nana joined these therapeutic sessions and her commitment was such that she traveled many miles during the weekend to be there for the Monday morning sessions. Maize's need for a secure base was met by the increasing attachment to her Nana who welcomed this role.

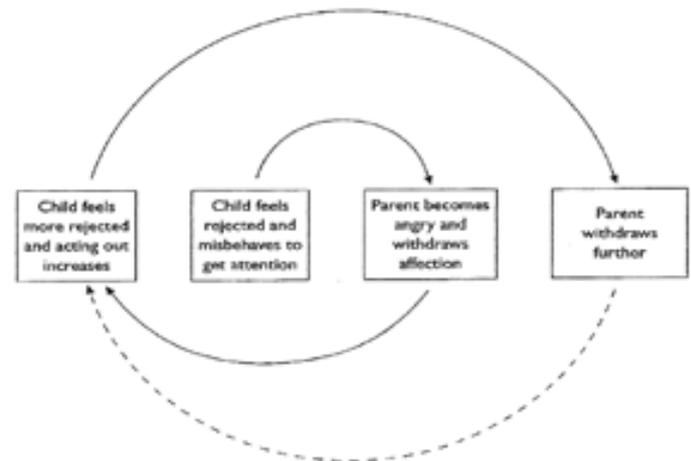
Story telling is familiar to every child and adult regardless of culture, tradition or circumstances (Burns, 2005; Fazio, 1997). Therapeutically it serves to assist resolution of a problem or issue. Maize's therapeutic journey included a life time-line journal. This activity focused on her strengths of drawing, and academic skills of research and writing. It assisted Maize in developing a different perspective of self, to improve her self-image and ultimately emotional competency (Goleman, 2004; Sarni, 1999). Additionally it provided a means to re-connect with key people in her family of origin as she looked for baby photos and interviewed family members about the important events in her life. Nana assisted in this process, making a connection with the family history in ways Maize had not been able to previously and learning about family experiences of which she had been unaware.

The story included the parallel processes of family movements, those major transitions that had impacted on the family unit (Goldenberg, & Goldenberg, 2004). Maize took the conscious and unconscious experiences of these transitions away with her. This is an important aspect of the therapeutic process because it enables the therapy to continue long after leaving the playroom and within the context of the family environment (Freeman, et. al., 1997; Labovitz-Boik, & Goodwin, 2000; Oaklander, 1988). Often when Maize returned, her therapy work in the playroom indicated she was functioning at a different stage of the therapeutic process so it was obvious Maize used her time between appointments to unconsciously process change. At these times it was very important for the team members to critically reflect on the techniques being used as a catalyst and to stay with the process and the child (Oaklander, 2006).

### Family therapy: A parallel process

Family therapy (Goldenberg, & Goldenberg, 2004; Scaletti, 1995) took place once a month. The family was informed that Maize might experience setbacks and they needed to be prepared. Frequently when change occurs, family members may unintentionally or unconsciously resist this change, creating a circular process (Geldard & Geldard, 2002) (see Diagram 3).

Diagram 3: Circular process (Geldard & Geldard, 2002)



Unknowingly this had happened previously and resulted in Maize refusing to go to school. Therefore Dad made the decision to terminate his relationship with the new partner as he realized this was impacting on his relationship with his daughter. Over the school holidays Nana's holiday programme was to feed Maize up, have fun, relax and keep her occupied. Nana taught her to sew and Maize was thrilled to receive a sewing machine as a present. Nonetheless the crying jags continued intermittently.

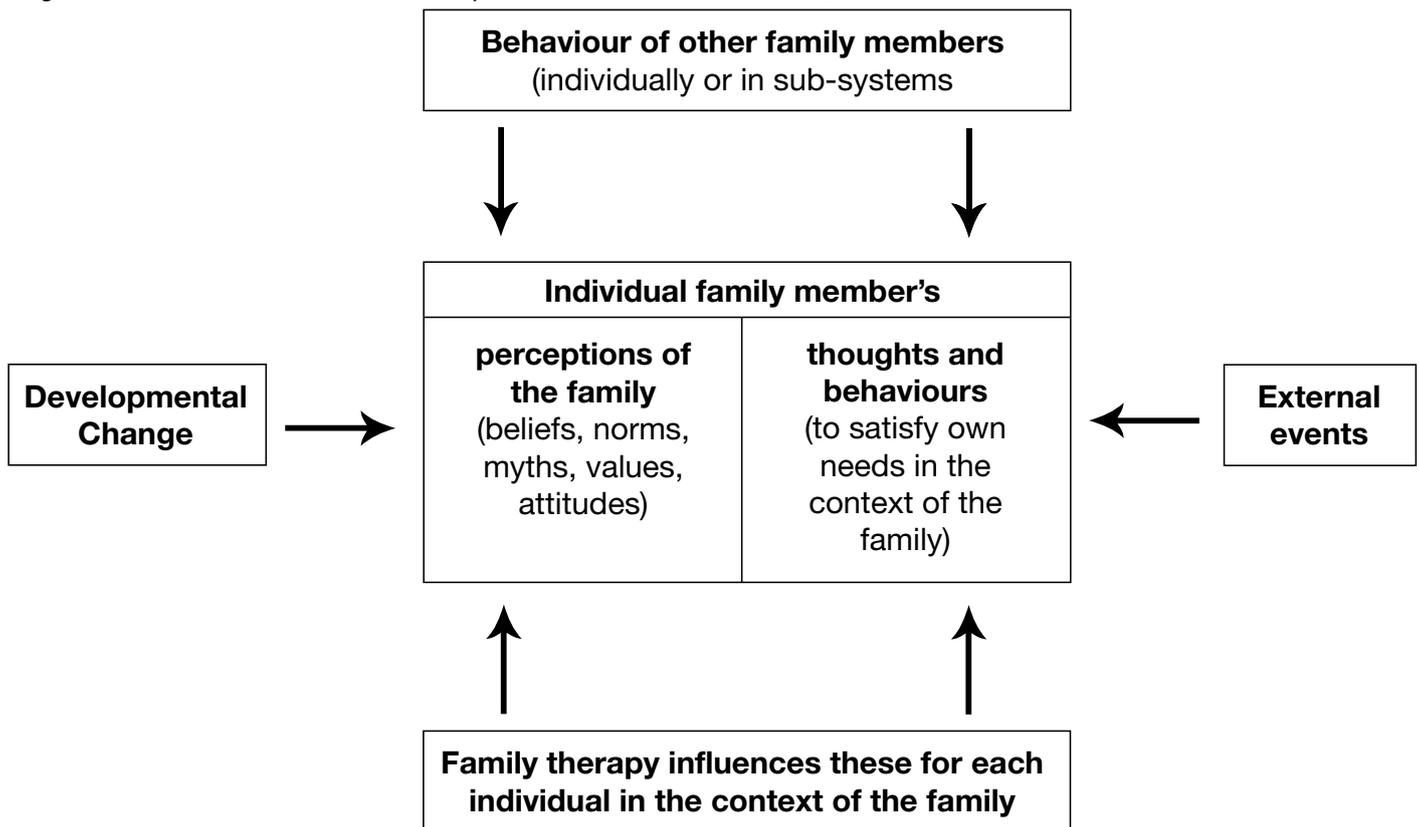
Historical encounters, which were raised in the journal, were often discussed in family therapy, giving Maize a deeper role in the family system (Solman, Atkinson, Milligan, et. al. 2002). This gave opportunities for all the family members to understand the impact of transitions on individual members and to develop conversations about them. Maize was surprisingly vocal in these meetings, more so than in the individual sessions.

The process was cathartic for Maize she gained a better sense of belonging. Not only was medication lifting her mood, but therapy was enabling her to deal with her past issues through reconstruction of life events. These meetings dealt with the biological mother's illness, how it affected everyone. Reality versus family myth was exposed. Dad was able to address the issue of his recent separation from his second wife with his children. They had developed their own false beliefs about why it had happened that differed from reality and fact. By this stage in therapy, the family and Maize were starting to share their emotions and feelings, and this was important learning for all the family.

### Cognitive Behaviour Therapy (CBT)

As the year drew to a close, the transition to secondary school became an issue for Maize and her family. The excitement of buying a uniform, visiting the new school, working out transport

Diagram 4: Influences on individual family members (Geldard &amp; Geldard, 2002)



arrangements, meeting new peers and teachers had taken up much of her time, along with farewells at intermediate school. She seemed happy and appeared to be looking forward to this new adventure.

Then Maize began to withdraw again. She stopped writing her time-line journal, and reported that she was feeling angry thinking about the cause of this emotion. At this point CBT (Blomquist, 1996) was used to get in touch with her thoughts and behaviours. Together with Nana, strategies were developed on how to deal with this behaviour during the Christmas holidays. Contact was maintained by phone.

Clinical reasoning and experience indicated there was something missing in the time-line. So why did we believe this might be so? Maize was demonstrating the confusion, anger and fear that often relates to children who have been traumatized. The TSCC assessment results indicated this possibility; however therapy had not yet revealed what it might be. Maize's description of her feelings suggested she was entrapped (Giarratano, 2004). Using a CBT map called the Trauma Trap helped Maize to make sense of what was happening in her life in the present. The activity shows the interconnection between thoughts, moods, behaviours, reactions and environment; how they influence each other and how positive change can be brought about. Here again visualization proved to be strength and a motivator for Maize.

## Resolution

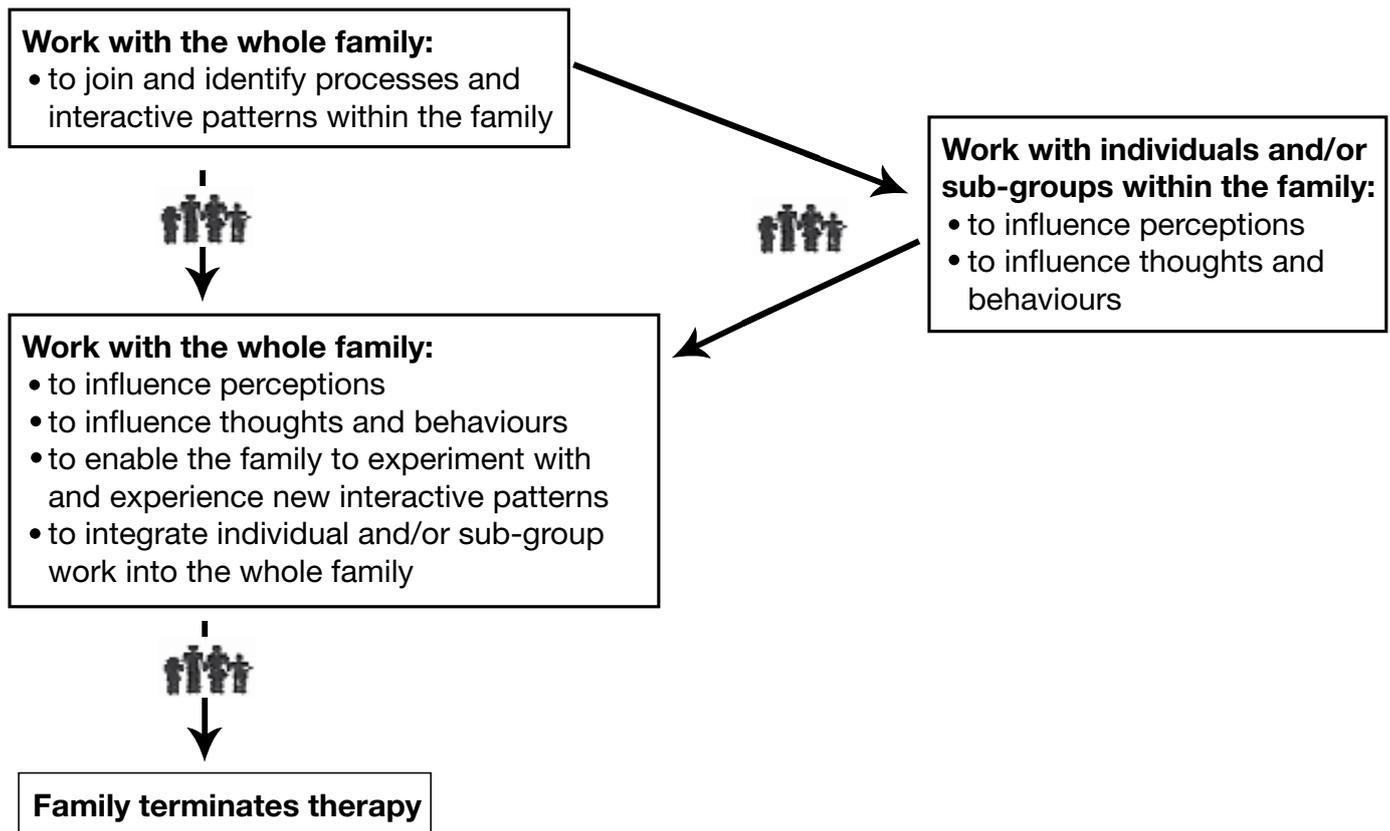
In the New Year, Maize reported that the transition to school went well, school was fun, that she had made some new friends and had 'heaps' of homework. About this time we

talked of reducing the medication. At the family meeting the grandparents discussed a two month trip to the UK. Dad was thinking of having friends to stay at Easter, a family who had children the same age as Maize and her brother. Shortly thereafter, we received an urgent call from Dad for an early morning session. During the weekend, Maize had revealed to Nana, to a close family friend and, finally to Dad, that she had experienced sexual abuse. The abuser was Dad's life-time friend, who was coming to stay over Easter. His wife was the twin sister of her stepmother Gay. This explained why the stepmother was never invited to the family meetings.

The relief experienced by Maize when her Dad believed her, was palpable. As required by service protocol, a notification of sexual abuse was made to the Child, Youth and Family Service (CYFS), a government-funded service that deals with these issues. At the next family meeting the aftermath of the family's reaction was addressed, shock, horror and feelings of a violation of trust. Some extended family members did not accept the allegations. However the family of origin held fast in their new found strength as a family unit, supporting Maize completely. Biological mother also expressed relief having wondered in the past about this man.

This incident, traumatic at the time, finally brought the whole family together. The two mothers stopped arguing and bickering, and according to one they all 'grew up'. Maize was happy in therapy. Medication was reduced with a view to stopping it completely in six months. In the final phase of therapy she was integrated into a young woman's group for stress management called 'Smashing Mountains'. This is a ten session peer group and it was reported that she was an active

Diagram 5 Impact of family therapy (Geldard &amp; Geldard, 2002)



Note:  represents change which occurs between sessions

participant. Following completion of the group sessions a final family meeting was held to celebrate the healing process and discharge from therapy.

### Critical reflection

While Geldard and Geldard (2002) maintain their SPICC model would generally consist of 6-10 sessions thus making it cost effective from a service point of view, they do recognise that a small percentage of children require long-term help. Such was the case with Maize given the complexities of the family dynamics, mental health issues and long term history of transitions and changes in her life. The authors suggest that sometimes children will go round the spiral more than once but all of the parts in the spiral do not need to be used in order to bring about change. Referring to the spiral to assist in the evaluation process of Maize was one of the most useful aspects. In effect this meant that decisions could be made regarding therapeutic changes, such as medication and family therapy. Intervention for Maize consisted of a series of 8 sessions with a 4-6 weekly breaks including school holidays. This enabled her to internalise the therapeutic process while enacting her occupational roles as daughter, grand daughter, sibling and friend. She began engaging in peer group occupations such as netball, friendships, shopping and achieved academic success. Generally SPICC was found to be a useful and effective model for Maize.

More importantly from an occupational perspective, as Maize regained some of her functional roles she began to

demonstrate a return of temporal adaptation. The learned occupational performance role that happens in the final stages of recovery and is reported to be associated with psychosocial dysfunction (Cronin Mosey, 1996). This may include the return to normal daily life activities, organisation of time, the ability to adapt to changes in social roles such as the challenge of entering secondary school. It gave Maize the structure and capacity to organize and fulfil her social role as a family member, and adolescent school pupil. Administering the ToP assessment at this point indicated a full return to playfulness. In addition, the family began to appreciate the value and benefits of play along with the impact these skills had on Maize's life (Bundy, 2005).

Psychoeducation for caregivers and extended family is also part of the therapeutic role (Rapee, Wignall, Hudson, et. al. 2000). Gradually Dad, Darren and the grandparents came to understand the nature of Maize's behaviour. The family became more accepting of the treatment role of medication and why it was necessary to run parallel to other therapy interventions. Certainly Nana gained immense insight and appreciation of the impact of the historical encounters and therapeutic process toward recovery that included stable attachment figures. This information she shared, where appropriate, with the family or by encouraging Maize to express her emotional concerns more readily to her father while in family therapy. Biological mother was included in this education through telephone contact and written information. Inviting family members to participate in the therapeutic process increased their interaction skills, their

ability to resolve issues as a unit, confirm their occupational roles and to know that family interaction serves as a source of support and problem solving.

Maize is now in the adolescent phase of development. She has been exposed to a variety of coping tools for the future, has a caring supportive family with whom she now feels integrated, a substitute mother figure – Nana to whom she is closely attached while still being supported by her biological mother when she is well enough. Maize's socialisation with peers appeared to be appropriate.

## Discussion

Being raised with mental illness in the family can affect a child like Maize, and greatly impact on the ability to cope. Children are reported to be less sociable and more disturbed in their emotional regulation, and their mothers are more likely to be less sensitive to the child's emotional states (Cowling, 1999; Lancaster, 1999). Therefore it would seem Maize and her brothers were disadvantaged from an early age with their mother experiencing bipolar disorder and a father who was periodically depressed? Information about Maize's early upbringing was limited. Dad reported no problems; Nana reported information from the age of 3 years and mother, contacted by phone, thought the children's upbringing to be normal.

Maize's presentation suggested otherwise. She was experiencing major depression and anxiety alongside a history of grief and loss (Fongay, 2002). Moreover Maize was in the early pre-adolescent developmental stage of life (11-14yrs.) and, as suggested by Lancaster (1999), adolescents experiencing difficulties may worry that they will follow the parental pathway of illness. This was certainly true, as Maize was perceived to have a similar temperament (Turecki, 2003) to her biological mother. This highlights the need for professionals to be aware of the vulnerability of children whose parent(s) has mental health issues. Nevertheless Maize demonstrated an underlying resilience (Reivich & Shatte 2002). Throughout her therapy she showed a high level of cognitive performance; trust in her mother as a person of importance in her life, and the ability to be resourceful.

## Conclusion

One of the interesting aspects of anxiety is that there can be large variations in individuals' responses to stressful events. Researchers have identified the following risk factors: *genetic predisposition*, meaning that anxiety tends to run in families; *personal characteristics*, meaning that people who have low self-esteem and poor coping skills may be prone to anxiety disorders; and *biochemistry* where it is theorized that some people may have too many or too few neurotransmitters in the brain, causing the normal anxiety-producing pathways to overreact.

Recent studies indicate that children who experience difficulties with anxiety continue to experience problems in adolescence (depression) and early adulthood. Approximately 30%-50% of adult sufferers of anxiety disorders identified childhood symptoms and they performed less well in their academic and social life than other children, despite having

the ability to do well. If treatment is not sought, up to 50% of anxious children still experience severe difficulties two to eight years after their symptoms first appear, therefore anxiety is not just a fleeting period of childhood for some children. Research supports the effectiveness of treatment demonstrating that approximately 86% of children who participate in therapy, no longer experience anxiety that impacts on their life and are able to maintain these results for up to 6 years. Information such as this emphasizes the continuing need to recognise and intervene early for children with childhood anxiety.

## Post script

Since documenting this case history Maize, who is still at school, has returned for further intervention. This is not unexpected considering her occupational disruption took place over several years. Maize made the referral herself through the family GP as Dad was depressed, biological mother was in hospital, Nana and Grandpa were moving into retirement and her brother Darren had left school and home. She felt the need of further support and to put new strategies in place for the future.

Intervention included sessions within the community setting, learning how to cook, and setting up an adolescent mentor. The Centre Maize attended has an arrangement with Auckland University to take psychology interns on a one year placement. This gives the Centre, and thus Maize, access to a mentoring programme for young adolescents which is part of the psychology degree process. Maize, who chose not to have medication, was discharged approximately four months later.

## Acknowledgement

I wish to thank Maize, her family and extended family for giving their permission to use clinical information in this paper. Real names, places and personal details have been changed to ensure privacy

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