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Anxiety disorders are common and disabling. During their lifetimes, one out of every four Americans will fulfill diagnostic criteria for at least one anxiety disorder. Women are at increased risk for anxiety disorders, and developmental, societal, and reproductive factors are believed to contribute to the preponderance of this vulnerability. Anxiety disorder research in general is moving forward at a robust pace. However, research on sex differences in anxiety has lagged considerably, and little data are available to guide prevention, treatment, and public health policy efforts that are specifically focused on women and girls. The lack of information about the origins of sex differences in anxiety disorders is serious and needs to be rectified.

The Anxiety Disorders Association of America (ADAA) is the only national, nonprofit professional and consumer organization focused exclusively on the diagnosis, prevention, and treatment of anxiety disorders. In recognition of the need to advance the state of knowledge about anxiety disorders in women and girls, the Women’s Health Initiative of the ADAA sponsored a two-day conference on November 19-20, 2003 in Chantilly, Virginia. The objectives of this conference were to increase awareness of anxiety disorders in women and girls and to identify a research agenda that will further the recognition, prevention, and treatment of anxiety disorders in this population. The conference included basic and clinical researchers in psychiatry, psychology, women’s health, healthcare policy, and patient advocacy. Conference members listened to presentations and participated in workgroups that drafted position statements on research needs related to mechanisms of sex differences in anxiety disorders, clinical importance of sex differences, the relationship of anxiety disorders to the reproductive lifecycle and women’s health, and public health issues related to anxiety disorders in women. Workgroup leaders presented draft position statements that were considered and debated by all conference members. This position paper reflects the presentations and deliberations from the ADAA conference.
A large and compelling body of evidence from general population surveys confirms that each of the DSM IV anxiety disorders is more common in females than in males.\textsuperscript{1,3-6}

During their lifetimes, women are twice as likely as men to have panic disorder (5.0\% versus 2.0\%), agoraphobia (7.0\% versus 3.5\%), PTSD (10.4\% versus 5.0\%), or GAD (6.6\% versus 3.6\%).\textsuperscript{1,5} Social anxiety disorder (15.5\% versus 11.1\%) and OCD (3.1\% versus 2.0\%) also are more common in females than in males, but differences in prevalence rates are less pronounced.\textsuperscript{1,7}

**Morbidity**

The personal and societal burden of anxiety disorders is well-established. Anxiety disorders are strongly associated with comorbid depression, alcohol/drug abuse, functional impairment, poor quality of life, suicidality, and excessive utilization of healthcare resources.\textsuperscript{8-12} There is a small body of literature documenting sex differences in secondary comorbidities. Women with PTSD may be at increased risk of cocaine use and alcohol dependence compared with men with PTSD.\textsuperscript{13}

The secondary social consequences for women with anxiety disorders have been considered in the National Comorbidity Survey (NCS) database. Anxiety disorders are more common in females than in males who failed to complete high school (5.4\% versus 2.9\%) or college (3.0\% versus 1.9\%).\textsuperscript{14} Divorce rates for women with GAD, panic disorder, or social anxiety disorder are lower than in men with these disorders.\textsuperscript{15}

Anxiety disorders are associated with teenage pregnancy, but are weaker predictors of teenage parenthood than substance abuse disorders or conduct disorder.\textsuperscript{16}

Research is needed to address gaps in this body of research. For example, most studies examining anxiety-associated morbidity rely on cross-sectional or retrospective data, which are vulnerable to various biases. Prospective studies are needed. Because sex differences in anxiety...
prevalence emerge prior to adolescence, there is a particularly pressing need for prospective, longitudinal studies that follow boys and girls into adulthood. Findings from available prospective studies have noted a greater long-term morbidity in girls, relative to boys, with anxiety disorders, though not all studies note such sex differences.

**Risk Factors**

Very little is known about antecedent risk factors for anxiety disorders in girls and women. Seminal findings from a female twin registry suggest that genetic factors are an important hazard for anxiety disorders in women. Familial environment also may contribute to increased risk, especially for GAD. Generalized anxiety disorder is of interest because of findings that it shares a common genetic pathway with major depression in women. An emerging literature offers compelling evidence that early life adversity, such as childhood sexual or physical abuse, predisposes to the development of anxiety disorders later in life. Women who were sexually abused as children appear to be at increased risk of adult-onset PTSD and panic disorder. Similarly, when assessed as adults, adolescent girls who had formerly been exposed to stress exhibit a greater risk for symptoms of GAD than adolescent boys.
**CLINICAL PRESENTATION**

Sex differences in the clinical presentation of anxiety disorders are recognized, and panic disorder is the best studied illness in this regard. Compared with men, panic disorder in women tends to be more severe and associated with higher rates of significant comorbidity, such as agoraphobia, GAD, and somatization disorder.\(^{26,27}\) Long-term follow-up data from the Harvard/Brown Anxiety Research Program (HARP) study confirm that remission rates for panic disorder and panic disorder with agoraphobia were similar for men and women. However, women with uncomplicated panic disorder experienced three-fold higher rates of relapse.\(^{28}\)

Posttraumatic stress disorder is a particularly salient disorder to consider in the context of sex differences. Rates of PTSD from the National Comorbidity Survey (NCS) are higher in women (20.4%) than in men (8.2%), and the nature of the traumatic event may account in part for increased risk for PTSD among women.\(^{29}\) Though assaultive violence is experienced more often by men than by women, rates of PTSD following a personal attack are 21.3% for women versus 1.8% for men. Men and women develop PTSD at approximately similar rates (ie, 65% and 46%, respectively) following exposure to a natural disaster (e.g., earthquake), which suggests that women who experience personal violence are more vulnerable to PTSD than are men.\(^{5}\) Moreover, women with PTSD are more likely to present with symptoms of numbing and avoidance, which is in contrast to men, who often exhibit irritability and difficulties with impulse control.\(^{30}\)

Compared with panic disorder and PTSD, less is known about sex differences in the clinical presentation of other anxiety disorders. Though the lifetime prevalence of social anxiety disorder in women (15.5%) is not markedly greater than in men (11.1%),\(^{1}\) genetic transmission may contribute to the increased risk in women.\(^{26}\) Women with social anxiety disorder also may be at increased risk of agoraphobia.\(^{26}\) The HARP study found that women with social anxiety disorder and a history of suicide attempts tend to have a particularly unremitting course of illness.\(^{28}\) Thus, limited data suggest that social anxiety disorder in women may be characterized by heritability, greater comorbidity, and a more severe illness course. Certain clinical domains of OCD exhibit sex differences, with females being more likely to exhibit cleaning/contamination or aggression/checking compulsions, comorbid depression or an eating disorder, and a less severe clinical course.\(^{26,31}\)
TREATMENT

There is a marked paucity of data about sex differences in treatment seeking for anxiety disorders. Clinical experience suggests that women are more likely to seek treatment for anxiety than men. However, it is believed that there are significant barriers to treatment for women. For example, women generally assume the bulk of childrearing responsibility, which may pose difficulties when seeking therapy if childcare is not available or affordable. Anxiety symptoms may not be recognized or accepted in girls because of gender-specific role expectations, which may normalize symptoms of worrying, shyness, or fear. Other barriers to treatment for women may include cost of therapy, lack of insurance for mental health care, stigma associated with a psychiatric diagnosis, and unavailable or inaccessible healthcare services.

Potential sex differences in anxiety disorder treatment response is an important area of consideration. However, to date, little attention has been paid to sex differences in treatment outcomes. There is some suggestion of sex differences for adults in response to treatment with the selective serotonin reuptake inhibitors (SSRIs), but this favors women. In an unpublished post-hoc analysis of a PTSD treatment trial, women who were treated with sertraline achieved greater improvement on PTSD symptom scores than men. Though sex differences for factors that are associated with pharmacokinetic and pharmacodynamic properties are recognized (e.g., fat composition, gastric emptying time, protein binding, cytochrome P450 enzyme activity), the contribution of these differences to medication response in the treatment of anxiety disorders is not known.

Posttraumatic stress disorder is a particularly salient disorder to consider in the context of sex differences.
**Research Priorities**

Descriptive studies of clinical and community samples:
- Describe course of anxiety disorders during reproductive transitions across the lifespan;
- Identify and elucidate sex-specific factors in the etiology and pathophysiology of anxiety disorder presentation, course, and treatment effects;
- Improve assessment, recognition, and diagnosis of anxiety disorders in young girls;
- Longitudinally assess gender-relevant vulnerability and resilience factors.

Prevention and treatment studies:
- Conduct large-scale, longitudinal studies of early-onset anxiety disorders, stratified by sex, to determine impact of preventive and/or therapeutic interventions on illness course, comorbid conditions, and functional impairment. Focus on middle school and high school populations to measure effect of prevention/intervention on school performance, self-esteem, and other behavioral indicators;
- Conduct studies in high-risk populations, such as girls and women with histories of early-life adversity, pubertal girls with emergent low self-esteem, pregnant women with anxiety disorders;
- Identify mothers with anxiety disorders in primary care and pediatric healthcare settings in order to:
  - Enhance parenting skills;
  - Educate and intervene to improve diagnosis and treatment of mothers and prevent adverse sequelae in their children.
- Conduct effectiveness trials in women with anxiety disorders and secondary comorbidity (e.g., mood or anxiety disorders, substance use disorders) with a focus on female-specific functional outcomes.

Symptoms may not be recognized in girls because of gender-specific role expectations.
Mechanisms of Sex Differences in Anxiety Disorders

Despite documentation of sex differences in some anxiety disorders, there is little convincing evidence for any established mechanism underlying these differences.

In this context, mechanisms can be defined as any factor that can alter anxiety-related behavior. There is a remarkable paucity of established animal models that have investigated potential mechanisms underlying sex differences in anxiety. It is important for research on mechanisms of sex differences in anxiety disorders to focus on early development. Several questions are therefore relevant with regard to identifying research priorities. First, are there constitutional differences that predispose males and females to a differential expression or experience of anxiety that are subsequently amplified or suppressed by experience? Second, are there specific lifespan modulators that alter vulnerability to anxiety at different developmental stages that are separate from inborn risks for anxiety?

It is unlikely that a single mechanism or even a unique constellation of factors will account for sex differences in anxiety at all life stages. Examining several distinct stages in the life cycle during which sex differences occur could serve as starting points for the exploration of potential mechanisms. Anxiety symptoms as well as manifestations of anxiety, such as autonomic arousal, could be studied during childhood developmental epochs, including the neonatal and very early life period, pre-puberty, peri-puberty, and post-puberty adulthood. Findings could serve as starting points for the exploration of potential mechanisms that might account for sex-related differences.

Behavioral inhibition in infants and very young children is associated with anxiety later in life. There has been a suggestion that adolescent girls who were behaviorally inhibited as toddlers may be more prone to generalized social anxiety disorder than boys. However, studies of temperament in early life do not strongly support a role for sex differences in the relationship of behavioral inhibition to anxiety.
On the other hand, there is some evidence of sex differences in anxiety disorders and anxiety-like symptoms in pre-pubertal children. Obsessive compulsive disorder is more common in pre-pubertal males, but generally does not emerge in females until young adulthood.\textsuperscript{38} Separation anxiety disorder is twice as prevalent in girls as in boys.\textsuperscript{17} Elementary-school age girls are more likely to exhibit fearful behavior, whereas boys are more likely to exhibit impulsive and low helpfulness behaviors.\textsuperscript{39} In addition, negative affect is observed more often in girls than in boys.\textsuperscript{40} The development of first-episode panic attacks is more common in pubertal girls compared with boys.\textsuperscript{41,42} Mechanisms for these differences have not been elucidated.

There is a similar deficiency of data related to mechanisms for sex differences in adults with anxiety disorders, though some early findings might guide future research. Among adults, there is evidence for a sex-specific pattern of reactivity to socially threatening stimuli. For example, women who are exposed to assaultive trauma are more likely to develop PTSD than men.\textsuperscript{5,29} Brain imaging studies suggest that these differences may relate to divergence in amygdala or prefrontal cortex functioning of males compared to females.\textsuperscript{43} Anxiety symptoms may worsen during the late luteal phase of the menstrual cycle in some women.\textsuperscript{44} The literature suggests that panic disorder may be exacerbated or ameliorated during pregnancy or the postpartum period.\textsuperscript{45,46}
**RESEARCH PRIORITIES**

Studies of anxiety during periods of the life cycle associated with robust hormonal changes in women:
- Longitudinally assess changes in brain structure and function and in measurable behaviors focusing on vulnerable periods in the female life cycle;
- Investigate potential neurobiological changes associated with changes in sex hormones;
- Prospectively examine changes in women during adrenarche, gonadal puberty, menstrual cycle, pregnancy, post-partum, menopause, and hormone replacement therapy.

Studies of contextual or interpersonal factors that may affect anxiety:
- Describe features of interpersonal functioning during important periods of the life cycle, such as mother-infant attachment, weaning, school-based social relationships, dating, and transition to independent living, marriage, child-rearing, senescence, and retirement;
- Identify and track potentially pathogenic interpersonal experiences, including trauma, familial factors (e.g., violence, parental loss or conflict, sibling interactions), peer relationships (e.g., bullying, excessive shyness), and response to pubertal changes.

Studies of sex differences in cognitive and emotional processing in community samples and clinical populations:
- Incorporate neuroimaging techniques and experimental and self-report symptom and other psychological measures in epidemiological surveys;
- Focus on sex-specific mechanisms for threat appraisal, response to anxiogenic cues and capacity for emotion regulation across the lifespan.

Studies of sex differences in animal models of anxiety:
- Incorporate examination of sex differences into studies of fear and anxiety; stratify these studies by sex;
- Identify and validate sex-relevant contextual measures when studying anxiety in rodents;

Obsessive compulsive disorder is more common in pre-pubertal males, but generally does not emerge in females until young adulthood.
• Conduct non-human primate studies of sex differences in anxiety. Include integrative approaches to anxiety disorder studies:
  • Recognize that mechanisms underlying sex differences in anxiety are likely to be multi-determined;

• Support collaboration across the multiple domains associated with sex differences in anxiety disorders. Study anxiety in congenital syndromes (e.g., congenital adrenal hyperplasia, fragile X syndrome, androgen insensitivity syndrome) likely to elucidate sex-relevant mechanisms.
Reproductive Lifespan Issues

A woman’s reproductive life is characterized by marked fluctuations in levels of estrogen and progesterone, which have the potential to modulate anxiety.

However, effects of reproductive hormones on anxiety are complex, and this remains an understudied area with disappointing levels of collaboration between researchers interested in anxiety disorders and those studying reproductive functioning.

**Puberty**

Unlike anxiety disorders, depression is not prevalent in young children, and sex differences in depression do not occur until adolescence, at which point girls are twice as likely to have depression as boys. In contrast, anxiety disorders are prevalent in prepubertal children. There is an early female preponderance of some anxiety disorders, and the influence of pubertal status or hormonal factors on the prevalence of anxiety disorders in males and females remains unclear. Findings of sex differences in childhood anxiety disorders differ according to the disorder under study. Results from one large community sample of children with a variety of different anxiety disorders indicate that by age six, girls are twice as likely as boys to have developed an anxiety disorder and that the disorder will be more severe in girls than in boys. Separation anxiety disorder is more prevalent in girls. However, not all anxiety disorders are the same. For example, boys are more likely to first develop OCD before puberty than are girls, but after the age of 20, females are at higher risk of incident OCD than males.

**Premenstrual Dysphoric Disorder**

Some women with PMDD have co-morbid anxiety disorders, with social anxiety disorder and specific phobia being the most common. Existing mood and anxiety disorders often are exacerbated during the late luteal phase, and evidence for premenstrual worsening of symptoms has been
suggested by the findings of prospective and retrospective studies in women with GAD, panic disorder, OCD, or social anxiety disorder. Anxiety symptoms, such as fear, worry, or nervousness, are not consistently observed in PMDD, although there may be increased premenstrual vulnerability to a panic-like state characterized by anticipatory tension and irritability.

**Pregnancy**
Anxiety disorders represent a clinical challenge in the pregnant woman. However, again, too little is known about anxiety during pregnancy, the postpartum period, and lactation. There is evidence that stress responses are blunted during pregnancy, particularly in the third trimester. Yet little is known about the interaction of perinatal fluctuations in estrogen and progesterone levels and symptoms of anxiety disorders, or about the effect of pregnancy on efficacy of anxiolytic medications.

Increased anxiety symptoms during pregnancy have been documented in a study that employed the Spielberger State-Trait Anxiety Inventory. Emerging data also suggest that anxiety symptoms occurring during pregnancy may be associated with perinatal complications, such as preeclampsia, premature rupture of membranes, cesarean section, and fetal complications. In a study of pregnant women with PTSD, findings indicated increased risk of ectopic pregnancy, miscarriage, hyperemesis, preterm contractions, and excessive fetal growth. Such results have implications for perinatal

There is evidence that stress responses are blunted during pregnancy, particularly in the third trimester.
management, fetal outcome, and childhood development and warrant further study.

In general, it appears that pregnancy is not protective against all anxiety disorders. However, results of studies that were mostly retrospective in design suggest that pregnancy has a variable effect on panic disorder and OCD. Of 215 pregnancies evaluated in one systematic review, 46 panic symptoms improved in 41% of women, and 38% experienced either new-onset panic disorder or exacerbation of existing illness. Similar findings of a variable effect of pregnancy on the course of anxiety have been reported for women with OCD.46

**Postpartum Period**

New mothers may be particularly vulnerable to anxiety disorders. Though study samples are small, it appears that panic disorder47,61,62 and OCD55,63,64 are exacerbated or emergent during the postpartum period in many women. Intrusive obsessions related to harming the newborn are common in women with postpartum OCD.59 The development of PTSD after childbirth has been observed to occur in 1.7% to 5.6% of women who experienced traumatic deliveries.65,66

**LACTATION**

Emerging data suggest that breastfeeding may offer some protection against postpartum anxiety by providing a gradual physiological transition from the pregnant to the non-pregnant state.67 Findings from animal studies demonstrate increased levels of the anxiolytic neurotransmitter, γ-aminobutyric acid (GABA), during lactation.68 In studies of new mothers, lactating women exhibited decreased hypothalamic-pituitary-adrenal (HPA) axis and adrenergic stress responses compared with bottle-feeding women.69,70 There is cross-sectional, naturalistic evidence that breastfeeding women have fewer anxiety symptoms compared with bottle-feeding women.71-73
Anxiety symptoms are anecdotally reported to be elevated in perimenopausal women, but there are no published data to confirm this. A validated 12-item menopausal symptom list has been developed that measures psychological, somatic, and vasomotor symptoms associated with the perimenopause, and studies of anxiety during this period are ongoing. Ovarian aging is a measurable parameter that can be detected a decade or more before the onset of menopause, which is encouraging with regard to the possibility of conducting longitudinal studies.

**Research Priorities**

**Studies of menarche and PMDD:**
- Document the incidence and course of anxiety disorders across menarche;
- Determine whether anxiety disorders comprise risk factors for infertility and/or functional amenorrhea;
- Examine the effect of menstruation onset, offset, and cycling (ie, menarche, normal menses, perimenopause) on symptoms of anxiety disorders;
- Understand the therapeutic mechanisms associated with PMDD treatment (e.g., rapid onset/offset of therapeutic response to SSRIs and interaction with anxiolytic neurosteroids).

**Studies of pregnancy, postpartum, and lactation:**
- Determine whether anxiety disorders, especially PTSD, are risk factors for hyperemesis gravidarum, preterm labor, and other pregnancy complications;
- Determine whether women with anxiety disorders are at risk for pregnancy loss, including miscarriage, stillbirth, and fetal reduction;
- Measure the severity, symptom profile, and fluctuations of anxiety during pregnancy and postpartum;
- Study the longitudinal course of anxiety disorders during pregnancy and postpartum (including lactation);
• Explore the possible existence of reproductive event-specific excessive anxiety responses (e.g., a pregnancy-related anxiety syndrome);
• Conduct treatment studies of women with perinatal anxiety disorders.

Studies of menarche and PMDD: Document the incidence and course of anxiety disorders across menarche.
Public Health Implications

The preponderance of anxiety disorders in women represents a public health concern of great importance.

Twenty-five percent of all adults will experience an anxiety disorder in their lifetime, and women bear a disproportionate share of this burden in terms of prevalence, disability, and treatment costs. The indirect costs associated with anxiety disorders, such as impaired vocational productivity and disrupted interpersonal functioning, may also be greater among women. Smoking, substance use, and other adverse health behaviors have a significant negative impact on women’s health and increase the cost burden of anxiety disorders. Because women are often primary caregivers, the costs of untreated and unrecognized anxiety disorders extend beyond individual women to their children, significant others, and extended families in ways that may not occur for men.

Barriers to the detection and effective treatment of anxiety disorders in women cross multiple domains and are related to stigma, unavailability of healthcare services, ethnic and cultural factors, and socioeconomic status. Access to treatment and parity are especially important issues for women. Medical and psychiatric comorbidity may be different in women than in men and may likely play an important role in the recognition and treatment of anxiety disorders. There may be differences in response to behavioral and pharmacological treatment interventions between men and women, or differences among women at different points in the reproductive cycle. Therefore, treatment studies need to be conducted and stratified by sex. Sexual functioning merits special attention as a health outcome associated with anxiety disorders.

A high and sustained level of public and professional awareness is needed if significant, emergent findings related to anxiety disorders in women and girls are to remain a priority for healthcare policy makers. Cost data must be collected so that the current and future economic burden of
Medical and psychiatric comorbidity may be different in women than in men and may likely play an important role in the recognition and treatment of anxiety disorders.

undiagnosed and inadequately treated anxiety disorders in girls and women can be documented and used to persuade policy makers of the importance of this issue. A broad-reaching public education campaign that features prominent and effective spokespersons and utilizes the full spectrum of mass media, including but not limited to television, print media, radio, schools, and the internet, will advance this agenda. Public awareness campaigns should reach a wide demographic with the message that anxiety disorders are real illnesses that are prevalent, disabling, recognizable, linked to suicide and substance abuse, and highly treatable.

Programs that increase awareness of anxiety disorders in women also must target healthcare providers. The anxiety disorders research community should increase their interaction with the Centers for Disease Control and Prevention by lobbying for inclusion of anxiety-related questions and diagnoses in behavioral risk factor surveillance data. In addition, the research community should lobby the National Institute of Child Health and Human Development to increase funding for studies of the role of anxiety disorders in healthy development and to include anxiety measures in their ongoing longitudinal study of pregnant women.
Clinicians and researchers need to increase their efforts to deliver scientific and continuing medical education presentations and publish original data and systematic reviews on the public health consequences of anxiety disorders in women and girls. Inclusion of measures of anxiety disorders and other mental illnesses in ongoing women’s health studies, such as the Nurses’ Health Study and the Women’s Health Initiative Study, will collect valuable data.

**Research Priorities**

- Access and re-analyze available datasets to determine sex differences in the onset, course, comorbidities, functional disability, and healthcare resource utilization for anxiety disorders in women and determine the gaps in the literature that merit further investigation. Though there are many studies of the epidemiology, biology, treatment, and healthcare resource utilization of anxiety disorders, the data has rarely been disaggregated by sex and comprehensively reviewed;
- Document the economic burden of anxiety disorders in women, including direct treatment-related costs and indirect costs associated with truncated education, poor occupational function, impaired role functioning and interpersonal relationships, and suicidal behavior;
- Study methods of effective case finding for anxiety disorders in girls and young women;
- Identify aspects of women’s unique biology that impact the treatment of anxiety disorders and affect associated health consequences;
- Study the relationship between anxiety disorders and illnesses that may be particularly common among women, such as fibromyalgia, chronic fatigue syndrome, irritable bowel syndrome, and multiple chemical sensitivity and document the costs associated with these conditions;

Programs that increase awareness of anxiety disorders in women also must target healthcare providers.
• Design and test economically feasible and sustainable public health models that prevent, detect, and treat anxiety disorders in women and increase access to care;

• Identify aspects of the patient, provider, healthcare system, and healthcare environment that are associated with best practices in the detection and treatment of anxiety disorders.
Conclusions

Despite a large and growing body of literature on anxiety disorders in general, the available data that specifically relates to women and girls falls short of informing aspects of diagnosis, treatment, and prevention that may entail sex differences.

The study of anxiety disorders in women is in its infancy. In response to the multiple unmet research needs, participants in this conference, which was sponsored by the Women’s Health Initiative of the ADAA, issued a call to action by outlining a research agenda that focuses on several key areas:

- Document the social costs and economic burden of anxiety disorders in women;
- Identify sex-specific developmental risk factors to understand the temporal development of anxiety disorders and to characterize vulnerability and resilience;
- Develop animal models of anxiety in females to better understand mechanisms of sex differences in anxiety disorders;
- Characterize fluctuations in anxiety symptoms and course of anxiety disorders during the reproductive life cycle (menarche, the menstrual cycle, childbearing events, and the perimenopause);
- Understand the bidirectional relationship between anxiety and reproductive functioning, including the potential role of anxiety as a moderator of reproductive life cycle events and the potential role of reproductive physiology in determining the course of anxiety disorders;
- Determine whether there is a unique clinical presentation of some anxiety disorders in girls and women and apply this knowledge to improved preventive and therapeutic interventions;
• Design and study ‘best practice’ models to optimize quality of care for girls and women with anxiety disorders;
• Develop effective educational campaigns that target the public and healthcare professionals;

Determine whether there is a unique clinical presentation of some anxiety disorders in girls and women.

• Foster collaboration between anxiety disorder and women’s health researchers and between the research community, clinicians, medical educators, patient advocates, healthcare policy makers, and insurers.
Anxiety Disorders in Women:

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