Read the below draft carefully. Then write a review of one page in which you answer all of the following 6 questions. Please be specific and provide details to support the claims you are making.

Peer Review Questions:

1. What is the **problem** that the writer is attempting to solve in this essay? Is the writer's description of this problem clear? Did you feel "hooked" as a reader?

2. Who is the writer's **target audience**? Does this seem like an appropriate audience for this particular subject? Explain.

3. Has the writer clearly explained his or her **solution** for the problem? Is enough evidence provided? Does the writer persuade you to believe that his/her solution is the best one for this issue?

4. Does the conclusion also function as a **call to action**, as per the assignment guidelines? Explain.

5. How well does the writer integrate outside material (sources)? What **other kinds of sources** could the writer consider from here?

6. **General:** Does the writer's essay seem to be unified? Is there a clear introduction, in which the reader is introduced to the issue and the thesis is presented? Do paragraphs have clear topic sentences/transitions? What about the mechanics (grammar, MLA)? Any suggestions there? Scan the paper for these basic organizational issues and offer advice/feedback.

Through the Looking Glass

Over the course of the past few weeks, I have learned about Social Anxiety Disorder (SAD). When I began my research, I didn't realize that I suffer from the disorder, and while it's true that I have reacted oddly in certain situations for years, I had no idea why these uncontrolled responses made me feel that I was different from everybody else. Even though my symptoms are mild and have not led to a clinical diagnosis, through the process of learning about the disorder, I have also learned which steps I can take to reduce my own anxiety. Though an outsider may not recognize it, one of the most obvious examples of my own case of SAD that I can give is when I nod my head repeatedly—as if in submission—when someone in authority is speaking to me (Roberts). This quirk of mine never really bothered me, but as I look back to an incident from

2006 that led me to the unemployment line, I can see where it undoubtedly bothers others[1]. In taking this unique opportunity to identify and reduce my own anxiety, I see there are only a few ways to be free from this burden. Although there are many clinical treatments and "self-help" resources available to a SAD patient, I am disappointed to find there is little effort made to educate those without anxiety about those of us with it. Perhaps I would still be in that walled office on the 17th floor of a San Jose sky rise if that particular manager had understood my nodding to be an uncontrolled response. It was my dream job, and my anxiety blew it for me.

During my research, I learned that there are three underlying causes of Social Anxiety Disorder. While one of the causes is genetic, the other two causes have, through exhaustive case studies, been linked in one form or another to environmental conditions (Terasawa, Roberts, Cicetti). In other words, we develop anxiety through direct involvement with people—some of whom may also have varying degrees of anxiety disorder.

In recent years, there has been a lot of focus on overall brain health as scientists are working diligently to discover the cause of and a cure for brain diseases such as Parkinson's and Alzheimer's. Because the ongoing studies focus on the same parts of the brain that control the emotional and visceral responses to anxiety, I'm confident that researchers will find a permanent

[1] At the time of the example incident in 2006, I knew that my nodding bothered my manager because she told me it did. She asked me why I nodded and I told her I didn't have an explanation. She told me that she thought I was nodding because I already knew what she was saying—as if in agreement—whereas I could only explain to her that no, I didn't already know what she was trying to tell me, but as far as I could tell, I was nodding only to acknowledge that I heard and understood what she was telling me.

treatment. Just last week, a team at Oregon Health & Science University reported they have cloned stem cells which "hold the promise of replacing cells damaged through injury or illness" and although the stem cell research is currently focused on "Diseases or conditions that might be treated through stem cell therapy [which] include Parkinson's disease," I also consider it a major step in finding a cure for Anxiety Disorder (OHSU). Unfortunately, until researchers discover a way to permanently correct a SAD patient's brain function either chemically or physically, we are left only with options to mitigate anxiety through either pharmacological (drugs) or psychiatric (talk) therapy.

Once a person has been diagnosed with Social Anxiety Disorder, there are two primary ways to ease the patient's response to stress. The first treatment is with a change to the body chemistry with medicines such as Inderal™ or Paxil™, and the second method includes Cognitive Behavior Therapy (CBT) that teaches "people with social anxiety…new ways of responding to situations that trigger fear and physical symptoms" (Hauser).

I have realized through my research that the pharmaceutical and psychotherapy industries have already cornered the market in treating anxiety disorders. Since Social Anxiety's formal classification as a disorder didn't come until 1994 and the most revealing discoveries didn't come until after 2005, the disorder as we understand it is still in its infancy. Since its recognition as a disorder, nearly all of the attention has been directed toward the SAD patient—the last person who wants the attention and the stigma. Many of the psychotherapy options suggest "interventions" to help the patient steer a mental detour around the "post event" analysis that sets him up for anxiety the next time he encounters a trigger (Price; Lewis-Morrarty; Helgadottir). In my opinion, little effort has been made to turn the mirror back on society to see which triggers could be removed—if only we could address the remainder of the population and not just the people

with social anxiety, then I feel we would be making progress to curb the number of new SAD diagnoses. What if the interventions could be addressed not to the SAD patient, but to the parent, the teacher, the supervisor—or anyone else in a position of authority?

Every year, employees must undergo a battery of mandatory training on how to address corruption in the workplace, sexual harassment, and various other topics that might be necessary for their jobs (e.g. Licenses and certifications). How hard would it be to include a reminder on how to recognize anxiety and take steps to enter a situation calmly? For adults and families, there are already tool-kits full of "self-help strategies" for a patient to use for managing their own anxiety (General; Home). In Jeff Szymanski's 2008 article for *ABC.com*, entitled "What Can Family Members Or Friends Do To Help Someone Manage Symptoms Of An Anxiety Disorder," he says:

> What I recommend to people is one of two options. One is that you kind of gently distract them away from things that make them anxious. So involve them in other activities that aren't anxiety-provoking, or get them to talk about things that aren't anxiety-provoking (Szymanski).

In my experience from 2006, it would have been helpful for someone to explain to the boss that her Obsessive Compulsive Disorder (OCD) that called for the perfectly-aligned pages to be stapled at a 45 degree angle, one inch from the top left corner was causing my anxiety. In my humble opinion, papers that were neatly stacked could be stapled in the top left corner, with little regard to the *exact position of the staple.* I was not doing the job *wrong,* I was just not able to meet her insane and micromanaged expectations.

If the solution for friends and family is as simple as Szymanski suggested, let's broaden the scope to include employers or other people of authority (e.g. Managers, professors, coaches).

We need to put more effort into writing tutorials or workshops for the general public and in turn, these lessons will help the person who is already SAD, but might even arrest the development of a SAD case tomorrow. I'm not suggesting that everyone becomes a therapist, but if the managers of anxious people knew a meeting may spark an anxious episode, they might want offer a piece of chocolate to the employee about twenty minutes before the discussion is scheduled (Martin). Additionally, it would be helpful for the employers to know that people respond differently to triggers, so the anxious employee might benefit from knowing the context of the meeting in advance, so paranoia doesn't get a chance to set in. In my case, it would be marvelous if my current *laissez-faire* manager would be reminded to reassure his anxious employee (me) that it's okay to clock in and out for lunch at a pace that feels natural instead of believing that the stamps must occur *exactly* an hour apart. Or, as in the case of my professor-student relationship, the professor could be coached to advise the students that although the assignments are due like clockwork, the graded works (constructive feedback) won't be available at regular intervals.

Only when the community of calm people realizes that the rate of diagnosed cases of Social Anxiety is increasing, will we be able to place the intervention squarely on the root cause (Cicetti; Twenge). Although the most revealing report on anxiety and its causes did not specifically list an authoritative figure as a cause for adult-onset anxiety, the studies do show how different life events contribute to a person's anxiety as they age. In 2000, J. M. Twenge published an article based on research that looks at the birth cohort (gender) to evaluate how gender roles make women more susceptible to anxiety than men. Twenge's study used a variety of indeces and reveals how anxiety increases with age, is different for men and women, and varies depending on which triggers are cued. (See Tables 1 and 2).

Table 1
Weighted Correlations Between Year of Scale Administration and College Students' Anxiety/Neuroticism Scores, 1952–1993

Measure or composite	Time span	Men		Women	
		Bivariate	w/controls	Bivariate	w/controls
Entire time period					
TMAS	1952–1993	.62*** (41)	.61*** (41)	.48*** (32)	.50*** (32)
EPI-N	1969–1991	.26* (25)	.31** (25)	.43*** (25)	.48*** (25)
EPQ-N	1973–1993	.65*** (22)	.76*** (22)	.65*** (23)	.89*** (23)
STAI	1968–1993	.65*** (60)	.49*** (60)	.45*** (54)	.37** (54)
Overall weighted average	1952–1993	.56*** (148)	.54*** (148)	.49*** (134)	.58*** (134)
Within-scale Z scores (All measures; TMAS adjusted)	1952–1993	.52*** (148)	.64*** (148)	.39*** (134)	.53*** (134)
Within time periods					
TMAS	1952–1967	.48** (29)	.48** (29)	.64*** (24)	.37** (24)
Overall weighted average (EPI, EPQ, & STAI)	1968–1993	.54*** (107)	.52*** (107)	.49*** (102)	.58*** (102)
Within-scale Z scores (EPI, EPQ, & STAI)	1968–1993	.53*** (107)	.43*** (107)	.48*** (102)	.44*** (102)

Note. TMAS = Taylor Manifest Anxiety Scale; EPI-N = Eysenck Personality Inventory Neuroticism; EPQ-N = Eysenck Personality Questionnaire Neuroticism; STAI = State-Trait Anxiety Inventory. *N* of groups is shown in parentheses. Correlations are weighted for sample size of study.
* $p < .05$. ** $p < .01$. *** $p < .001$.

Table 1: The increase of cases of anxiety over time, based on different types of tests, with respect to the gender of the patient (Twenge 1011).

Correlations Between Social Indicators and Z-Scored Scale Combinations of Women's Anxiety/Neuroticism Scores, Weighted for Sample Size, 1952–1993

Social indicator	10 years prior	5 years prior	Actual year	5 years after	10 years after
Overall threat					
Crime rate	.32**	.33***	.22*	.29**	.06
AIDS cases	.19	.27**	.39***	.47***	.24*
Worry about nuclear war	.04	.36***	−.16	−.49***	−.25*
Suicide rate, ages 15–24	.42***	.19	.21*	.04	.07
Women's LFPR	.42***	.41***	.38***	.32***	.31**
College degrees awarded to women	.19	.39***	.33***	.34***	.13
Index of social health (reverse)	−.34**	−.53***	−.26*	−.17	.07
Economic conditions					
Unemployment rate	.29**	.22*	.05	−.03	−.09
Percentage of children in poverty	−.04	.22*	.10	.09	−.07
Low social connectedness					
Divorce rate	.39***	.23*	.11	.11	.19
Percentage of people living alone	.35***	.36***	.32***	.28*	.17
Women's age at first marriage	.34***	.44***	.44***	.34***	.37***
Birth rate (reverse)	−.31***	−.15	−.19	−.14	−.29*
Trust (reverse)	−.18	−.33*	−.46***	−.15	.10
Regression with total scales					
Economic conditions	−.23	.31*	−.20	−.08	−.27
Social connectedness + other threats	.65***	.39**	.44***	.26	.15

Note. *n* varies from 54 to 134 because of missing indicators for some years. LFPR = Labor force participation rate.
* $p < .05$. ** $p < .01$ *** $p < .001$.

Table 2: Known causes of increased anxiety in women as they age (Twenge 1013).

Because all of my own examples occurred after my age of 35, I can absolutely contribute to any anxiety survey related to the effect of employer/employee relationships. Coincidentally, since SAD is genetic and is common among family members, I could also offer my parents and siblings for case-studies.

When Christina Brook concluded her 2008 report for the National Institute of Health, she wrote "We also discuss the need for research design improvements and considerations for future directions," but I can't be sure that she has taken *people in authority* into consideration (Brook). If we don't admit to ourselves that *people in authority* can constitute a real trigger for anxiety, we may not be able to keep the number of cases from spiraling out of control. While the tables from Twenge's studies show that the "Unemployment rate" causes anxiety, I believe the reason for the unemployment may have stemmed from an anxiety-triggered incident in the workplace (Twenge). I would like to see a study that ties anxiety to the unemployment cases, specifically as it relates to the anxiety-awareness level of the management. I believe anxiety and unemployment have a symbiotic relationship that needs to be considered more carefully.

Currently, the SAD patient is already burdened with anxiety as well as management of the symptoms, so take the pressure off of him/her. Let us not modify the effect of anxiety; let us modify the cause. With a comprehensive review of adult-onset SAD cases, it should be easy to distinguish which ones originated in the workplace and which ones could be avoided if only the boss knew the right steps to take. If cognitive based therapy is good enough to retrain the people with the brains that yield to social anxiety disorder, then with cognitive based therapy, it should also be a cinch to retrain the people whose brains function normally.

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