Youth Anxiety: The Effect on the Individual and Family Factors Involved

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Abstract

In the exploration of anxiety disorders, it is important to note that anxiety disorders do not adhere to a particular age group but can affect any individual at any age. Obsessive Compulsive Disorder and Generalized Anxiety Disorder are two disorders that are commonly found in childhood and adolescence respectively. To understand how anxiety affects individuals, the understanding of family factor's effect on the afflicted is mandatory. Family factors such as alienation, disengagement, neglect, over protection, negative attachment, and even parental anxiety itself can affect the child or adolescent who had an anxiety disorder. To aid individuals with an anxiety disorder, Cognitive Behavioral Therapy should be administered by a therapist on a weekly or intensive basis. During and after therapy, parents should enforce the therapeutic homework assignments and effectively transport their child to the Cognitive Behavioral Therapy facility for a more positive treatment outlook.

Youth Anxiety: The Effect on the Individual and Family Factors Involved

How does a society react when confronted with stress, worry, or anxiety? Most individuals continue on with their lives taking these phenomena as common place in life. Others, almost fifty million in the United States (Dziegielewski, 2010, p. 325) are affected by these same phenomena in excess for which they are diagnosed with anxiety disorder. Of these affected individuals many will have an onset of an anxiety disorder as early as age thirteen (Dziegielewski, 2010). There are broad symptomologies for almost all types of anxiety; they include but are not limited to: anger, helplessness, fatigue, terror, distress, poor concentration, and dizziness (Dziegielewski, 2010). Some extreme responses to anxiety include panic attacks, obsessive-compulsive disorder, acute stress disorder, and generalized anxiety disorder

(Dziegielewski, 2010). While anxiety in general is used as an alarm system to warn individuals to prepare themselves for potential danger, individuals with an anxiety disorder view situations as more dangerous than they actually are (Woodruff-Borden, Morrow, Bourland, & Cambron, 2002). Anxiety disorders do not occur overnight, as there are many factors that contribute to the disorders. Rappe (2012) suggested that environmental factors such as low socioeconomic status may predict a later anxiety disorder. Woodruff-Borden et al. (2002) also suggest that vulnerable individuals who lack resources to help cope with life stressors are more at risk of an anxiety disorder than individuals who do have those resources. But seemingly the most important variable that affects youth with anxiety is their parental factors. An anxiety disorder can affect anyone, though this paper will focus on two anxiety disorders that commonly affect children and adolescents, the influence on these youth, and treatment strategies for aiding these afflicted persons.

Youth Anxiety

Obsessive-Compulsive Disorder

Childhood

As cited in Settipani, O'Neil, Podell, Beidas, and Kendall (2013, p. 9) anxiety disorders are "among the most common psychopathologies in children." Obsessive-compulsive disorder (OCD) is defined by Dziegielewski (2010, p. 331) as a "persistent and reoccurring obsessions (thoughts) and compulsion (behaviors) that are severe enough to be time consuming, and affect emotional, social, and occupational functioning." Children who score high on child behavioral inventories may have characteristics of sad, fearful, anxious, and withdrawn behaviors which puts them at an increased risk of anxiety (Jakobsen, Horwood, & Fergusson, 2012). If children acquire this anxiety disorder (OCD), it has been associated with a heightened risk for later

psychiatric problems (Piacentini, Bergman, Keller, & McCracken, 2003). Moreover, high child anxiety has also been associated with a greater risk of depression or further anxiety disorders (as cited in Jokobsen et al., 2012). While OCD may primarily affects the children, it also affects the children's parents. Obsessive-compulsive disorders symptoms not only place a burden afflicted children, but also on the children's families—for instance: having difficulties at bedtime, grooming rituals that may develop consistent tardiness to school, and OCD behavior associated with this anxiety disorder may exclude those children from going to public places with their parents. While OCD can also have an affect on the child's social ability and is correlated in having a negative effect on friend making (Piacentini et al., 2003). While parents may feel they have to employ a stronger sense of control over their child, it has been shown by Keely, Geffken, Ricketts, McNamara, and Storch (2011) that the most anxious children were those who reported the strongest parental control. It is also interesting to note that children who were "classified with these disorders were as infants, were categorized as anxiously/resistant children" (Warren, Huston, Egeland, & Sroufe, 1997, p. 641).

In relation to OCD and childhood, it was also found by Warren et al. (1997) that there was an increased perception of fear and inhibited behaviors in children with anxiety compared to children without anxiety. This may be why 44% of the children in Piacentini et al. (2003, p. S63) study (n=151 children) reported problems at school because of OCD, and while in the same study, 48% of those children reported problems at home. In cases where children are overwhelmed with fear, inhibited behaviors may lead them to seclusion or alienation, which then leaves children to deal with stressful situations with little to no assistance from other individuals; this would in part decrease their ability to learn how to cope with these stressors (Woodruff-Borden et al., 2002).

Associated Factors

Many factors contribute to OCD and anxiety in general in children. One of the biggest factors mentioned throughout a multitude of studies (Settipani et al., 2013; Woodruff-Borden et al., 2002; Peris et al., 2012; Van Eijck et al., 2012) is the effect of the relationship between the children and their parents. Such factors as "marital distress between the children's parents and intrapersonal violence" (Rapee, 2012, p. 71) are correlated with childhood anxiety. Rapee (2012, p.69) also explains that there is a type of domino effect when it comes to children who suffer from an anxiety disorder. There is evidence that parents of anxious children are more likely to be anxious themselves, Rapee continues to explain that if a child's parents have an anxiety disorder there is a chance—four in six—of transferring that anxiety from parents to child. Woodruff-Borden et al. (2002) explain that children born to parents with an anxiety disorder are seven times more likely to have an anxiety disorder in later life. If anxiety is recognized within both the parent and child, there is a greater chance of disengagement between the two as can be seen in Woodruff-Borden et al. experiment. Woodruff-Borden et al. (2002), preformed an experiment including anxious children and their anxious parents; and non-anxious children and their parents. These couples were given an unsolvable puzzle and asked to complete it to view and compare the anxious and non-anxious couples. When the child-parent couple was introduced with this impossible task, a greater level of disengagement could be viewed toward the child from the anxious-parent compared to the non-anxious parent. This also ties into the statistic referred to before, where anxiety caused the child to withdrawal themselves leaving the child isolated without a proper way to cope with a stressful situation. The results of this experiment showed that when the anxious child parent couples are compared to the non-anxious child parent couples

there was an observable trait in which anxious parents acted more neglectfully toward their children.

It has also been shown that something as simple as overprotective parental behaviors may be positively correlated with anxiety symptoms and disorders; according to Rapee (2012) parent overprotection predicted child anxiety one year later. When viewing parent overprotection, it singles out mothers as the primary over protector in a family. In fact, children whose mothers were more protective had shown more signs of anxiousness (Rapee, 2012), and parents who overly inhibited children were more likely to have an anxiety disorder themselves (Woodruff-Borden et al., 2002). It has also been found that an insecure attachment to the parent, or the parent to the child, could also result in a form of an anxiety disorder; for the lack of attachment teaches the anxious child to internalize their problems (Woodruff-Borden et al., 2012). This attachment is decided during infancy, where parents either frequently rejected their children when the infant had looked for contact, or when caregivers had shown persistent anger and/or resistant behavior during child bearing, children raised in these conditions were characterized as "anxiously attached" (Warren et al., 1997) and in the longitudinal view, more at risk for anxiety symptoms and disorders.

Generalized Anxiety Disorder

Adolescents

Generalized anxiety disorder (GAD) is by far the most common anxiety disorder found in adolescents (Van Eijck, Branje, Hale, & Meeus, 2012). As defined by Dziegielewski, generalized anxiety disorder is the inability to control one's worrying, and is characterized by pronounced and excessive anxiety and worry about events and or activities. GAD is a concern to the social community of adolescence because adolescence is a vulnerable period for developing

psychosocial problems (Van Eijck et al., 2012). It is also believed that GAD could be a gateway to other anxiety disorders (cited in Van Eijck et al. 2012). It was once believed that GAD was more common in females due to their 'sensitivity', but this has been found to be not true, and males have been shown to be just as sensitive as females (Hale, Engles, & Meeus, 2006). GAD is more common in boys in early adolescence, while it is more common for girls in late adolescence (Hale et al. 2006), but overall GAD was reported more during middle adolescents for both sexes (Eijck et al., 2012). In Warren et al.'s (1997) study, out of 172 adolescents, 50% of the adolescents had at least one past or current anxiety disorder.

Adolescents with GAD symptoms report higher rates of anxiety and withdrawn behavior when their parents were divorced, and also when these adolescents viewed displays of violence between their mother and fathers. These two variables were significantly associated with anxiety disorders in the adolescent (Rapee, 2012). When conflict rises in the household—even if it is minimal—it is possible that adolescents no longer see their relationship with their parents as positive due to their anxiety which adds to individual anxiety overall. These actions may be correlated with GAD symptoms because individuals with GAD tend to describe their relationships with their parents more negatively. That worrying correlated with GAD results in unrealistic perceptions, and they interpret their environment as more dangerous than it actually is (Eijck et al. 2012). In Rapee's (2012) longitudinal study, he followed 3,000 adolescents for 10 years and observed that greater overprotection was significantly and specifically associated with GAD.

Factors Involved

Anxiety causation is relatively similar for both children and adolescents; there are very few specified factors that pertain exclusively to the adolescent age group. One unique adolescent factor measured the perceived rejection from the parent to adolescent, such as over involvement, alienation, trust, and communication—these parental factors were cumulatively associated with GAD symptoms and disorders in adolescents (Hale et al., 2006). It is also understood, similar to children, that parental rejection was associated with insecure attachment and worry; which ultimately fuels anxiety symptomology (Hale et al., 2006). While another study suggests that a low quality attachment—actual or perceived—can cause the feeling of not being loved which can develop into a anxiety symptom of frequent worrying; which once again fuels anxiety symptoms (Van Ejck et al., 2012). While both children and adolescents seem to be negatively affected by these negative parental factors, there are positive parental factors that can promote a positive environment for these individuals suffering from anxiety.

Treatment

Cognitive Behavioral Therapy

While there are multiple ways to help treat anxiety disorders, the most common form of treatment is cognitive behavioral therapy (CBT). CBT has been a well-documented robust treatment for anxiety (Peris, Sugar, Bergman, Chang, Langley, & Piacentini, 2012) and when CBT is not enough, it is aided by the drug serotonin. CBT in most cases last about fourteen sessions, and can be delivered on a weekly format or an intensive format (more than one session per week) (Keely et al., 2011). In-Albon and Schneider (2007) have found CBT to be particularly effective in children who have an anxiety disorder. If an anxiety disorder is left untreated, the

individual has a significantly higher risk of developing chronic depression, substance use and abuse, and stronger anxiety symptoms later in life (Sulkowski, Joyce, & Storch, 2012). A positive treatment may ultimately promote attitudes within the individual, but the postivie outcome depends heavily on one important variable—the therapeutic alliance. The therapeutic alliance was a significant predictor of outcome in individuals seeking treatment for their anxiety (Keely et al., 2011). A positive therapeutic alliance can be seen in the first five sessions, as a visible reduction in anxiety symptoms occur (Keely et al., 2011). The therapeutic alliance helps in the treatment of anxiety disorder because the process of helping individuals takes a clinical skill, where therapists need to respond to individuals emotions in empathetic ways that communicate to the client that they are in a safe and supportive environment (Keely et al., 2011). Besides providing a secure and empathetic environment for the afflicted individual, therapists can teach anxiety prone clients how to sooth themselves and learn how to accept comfort from others (Warren et al., 1997). The therapeutic alliance is an important factor when considering CBT as a treatment strategy. CBT delivers the most positive clinical treatment of anxiety symptoms (Warren et al., 1997) but that is not the only factor that can predict the a positive outcome of treatment.

Positive Parental Factors

While so far it has been observed that parental factors have a disposition to promote anxiety symptoms, some varibles do the opposite. In fact it has been studied that there is evidence that reflect that several factors—family and partner relationships—can influence treatment outcome for both children and adolescents (Rapee, 2012). One such factor is the parent-child attachment, and it is suggested that a secure attachment in childhood and adolescences may reduce internalizing disorders and withdrawal symptoms associated with an

anxiety disorder (cited in Jakobsen, Horwood, & Fergusson, 2012) which in part may reduce anxiety symptoms as a whole.

When using CBT as a treatment for anxiety disorders the efforts to promote positive CBT focus not only on the individual but their family (Peris et al., 2012). For instance, if a parent is also suffering from a form of an anxiety disorder that child is expected to have a poorer outcome of treatment when using CBT (Settipani et al., 2013). Not only do parents play a role emotionally but they also play an important role in the in the actual form of treatment. Families as a whole are integral part in childhood and adolescent therapy; the parents of the individuals affected with an anxiety disorder facilitate the attendance of treatment and homework completion that complies with treatment (Peris et al., 2012).

Conclusion

In observing the anxiety disorders most commonly found in children (OCD) and adolescence (GAD), it is imperative to note that these anxiety disorders do not conform only to these age groups, but can effect both children and adolescents. It is also important to note that anxiety disorders seem to extend from parental factors and environmental stressors; most importantly they are likely to extend from an anxiety disorder that the parent possesses themselves. If the individual is taken for treatment, they will most likely be treated with a form of CBT and if their case is severe, treatment will also employ the medication serotonin. It is important to note that a stable therapeutic relationship between the afflicted and therapist is greatly associated with a positive outcome of CBT. Parents should also be involved in the therapeutic process in making sure that individuals do assigned work and attend sessions. It is imperative that children or adolescents receive treatment for their anxiety as it is a growing

epidemic in the United States, and if left untreated, anxiety can lead to negative long term disorders/activities in the future.

References

Dziegielewski, S. F. (2010). DSM-IV-TR in action. Hoboken, N.J: Wiley & Sons.

Hale III, W.W., Engels, R., & Meeus, W. (2006). Adolescent's perceptions of parenting behaviors and its relationship to adolescent generalized anxiety disorder symptoms. *Journal of Adolescence, 29*, 407-417. doi: 10.1016/j.adolescence.2005.08.002

In-Albon, T., & Schneider, S. (2007). Psychotherapy of childhood anxiety disorders: A meta-analysis. *Psychotherapy Psychosomatics, 76*, 15-24. doi: 10.1159/000096361

Jakobsen, I. S., Horwood, L. J., & Fergusson, D. M. (2012). Childhood anxiety/withdrawal, adolescent parent-child attachment and later risk of depression and anxiety disorder. *J Journal of Child and Family Studies, 21*, 303-310. doi: 10.1007/s10826-011-9476-x

Keeley, M. L., Geffken, G. R., Ricketts, E., McNamara, H.J.P., & Storch, E. A. (2011). The therapeutic alliance in the cognitive behavioral treatment of pediatric obsessive-compulsive disorder. *Journal of Anxiety Disorders, 25*, 855-863. doi: 10.1016/j.janxdis.2011.03.017

Peris, T. S., Sugar, C. A., Berman, L., Chang, S., Langley, A., & Piacentini, J. (2012). Family factors predict treatment outcome for pediatric obsessive-compulsive disorder. *Journal of Consulting and Clinical Psychology, 80*, 255-263. doi: 10.1037/a0027084

Piacentini, J. R., Bergman, L., Keller, M., McCracken, J. (2003). Functional impairment in children and adolescents with obsessive-compulsive disorder. *Journal of child and adolescent psychopharmacology, 13*, 61-69. www.liebertpub.com/cap

Rapee, R. M. (2012). Family factors in the development and management of anxiety disorders. *Clinical Child Family Psychology Review, 15,* 69-80. doi: 10.1007/s10567-011-0106-3

Settipani, C. A., O'Neil, K. A., Podell, J. L., Rinad, B. S., & Kendall, P. C. (2013). Youth anxiety and parent factors over time: Directionality of change among youth treated for anxiety. *Journal of Clinical Child & Adolescent Psychology, 42*, 9-21. doi: 10.1080/15374416.2012.719459

Sulkowski, M .L., Joyce, D. K., & Storch, E. A. (2012). Treating childhood anxiety in schools: Service delivery in a response to intervention paradigm. *Journal of Child and Family Studies, 21,* 938-947. doi: 10.1007/s10826-011-9553-1

Van Eijck, F.E.A.M., Branje, S. J.T., Hale III, W.W., & Meeus, W.H.J. (2012). Longitudinal associations between perceived parent-adolescent attachment relationship quality and generalized anxiety disorder symptoms in adolescence. *Journal of Abnormal Child Psychology, 40,* 871-883. doi: 10.1007/s10802-012-9613-z

Warren, S. L., Huston, L., Egeland, B., & Sroufe, L. A. (1997). Child and adolescent anxiety disorders and early attachment. *Journal of the American Academy of Child and Adolescent Psychiatry, 36,* 637-644. http://www.jaacap.com/

Woodruff-Borden, J., Morrow, C., Bourland, S., & Cambron, S. (2002). The behavior of anzious parents: Examining mechanisms of transmission of anxiety from parent to child. *Journal of Clinical Child and Adolescent Psychology, 31,* 364-374. http://www.jaacap.c