

ROLE OF THE FAMILY DETERMINANTS IN THE DEVELOPMENT OF ANXIETY DISORDERS IN CHILDREN AND ADOLESCENTS: A SYSTEMIC PERSPECTIVE

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ANXIETY DISORDERS AND THEIR RELATION TO THE FAMILY FACTORS

Results of some epidemiological studies show that anxiety disorders are among most prevalent of all mental disorders. An exact number of cases are difficult to determine for many people who suffer from anxiety disorders decide not to seek any treatment at all. Some of them meet health specialists who often don't recognize presenting symptoms as being caused by anxiety (Andrews et al. 1994). It is estimated that just in the USA more than 19 million people suffer from anxiety disorders, which include *panic disorder* (PD), *obsessive-compulsive disorder* (OCD), *generalized anxiety disorder* (GAD), *post-traumatic stress disorder* (PTSD), *social phobia* (SP) and *specific phobias* (DSM-IV, 1994). In fact, most of anxiety disorders are chronic with very low natural remission rates, although they have been considered as a mild and transient states. Patients who neglect treatment suffer from symptoms that are unremitting and usually grow progressively worse over time. Such persons are tormented by panic attacks, irrational thoughts and fears, compulsive behaviors and rituals, flashbacks, nightmares and frequent physical symptoms that frighten them. This is why people with anxiety disorders so often utilize emergency centers and other medical services. Because of the symptoms, their professional, social and family lives often are disrupted, and some them have to stay at home.

One of the difficulties in recognizing and managing an anxiety disorder is that it is frequently comorbid with other anxiety disorders or with depression, alcohol, and drug abuse or other mental disorders. In this regard an anxiety disorder is often overlooked when another disorder is also present. It happens because the anxiety disorders share much of their symptomatology with each other and with mood disorders, and this may lead professionals to over-diagnose some syndromes at the expense of underdiagnosing some of the less well-recognized syndromes. For example, the presence of chronic worry and tension may lead to a presumptive diagnosis of GAD unless follow-up questions establish the cause of the worry, which may then lead to a revised diagnosis of, for example, OCD or hypochondriasis.

The studies carried out previously established a prevalence of anxiety disorders in children and adolescents of 10-20 % with a slight predominance of females after puberty and a high comorbidity among anxiety disorders (Costello, Angold 1995). A vast number of these children also developed significant impairment in their psychosocial functioning. Recent studies also have tried to characterize risk factors for impairment and poor long-term prognosis in such cases. For instance, families of highly anxious children who consistently refused to go to school were also found to have difficulty actively managing their children's behavior. These kinds of findings suggest that helping parents to manage behavioral difficulties in their anxious children may improve the outcome of existing disorders. Environmental studies of risk factors for the early development of anxiety disorders have focused mostly on different aspects of the child-parent relationship. For example, parental modeling and high family conflict have been cited as familial factors that influence development of child anxiety (Muris et al. 1996, Rueter et al. 1999).

Some researchers have reported a significant association between parental rejection and over-control (meant as a tendency to restrict a child's autonomy) and childhood anxiety (Rapee 1997). It was also found that poorer coping abilities in anxious children were associated with maternal overprotective behaviors (Kortlander et al. 1997). In this case the maternal upbringing styles played a role of maintaining factor for anxious behavior in children. Another important factor, which is regarded as a predictor of anxiety disorders in children, is parent-child attachment. The role of this factor has been confirmed by Warren and others (1997) by a longitudinal study performed in a group of 172 adolescents who had previously been examined shortly after birth using an instrument for parental psychopathology and a special measurement for attachment. They have distinguished two subtypes of attachment. One subtype, which was termed as "anxious-resistant", consistently predicted the development of anxiety disorders. Children with another subtype, less severe, also developed anxiety disorders but at significantly lower rates. There is a number of studies on other important family factors, alas, a weak point of some researches in this area is that their methodology is based on self-reports from anxious persons concerning their experiences with parents. It raises the possibility of bias due to cognitive distortion associated with anxiety disorders.

SYSTEMIC CHARACTERISTICS OF THE FAMILY

Although intrapsychic processes play an important role in the development of anxiety disorders, it has to be remembered that children exist as parts of family systems. Very often an adequate understanding of a child's psychopathology is possible only in the light of a full knowledge of the family system of which she or he is a part. In his simplistic definition of *a system* von Bertalanfy (1984) determines it as "*a complex of interacting elements*". The author states that systems theory can be used to describe both non-living and living systems, as, for instance, the family. Family professionals (e.g. sociologists, psychologists, family therapists) have derived from systems theory some principal ideas:

- families (and other social groups) are systems having specific properties which are more than the sum of properties of their parts,
- there are certain general rules which govern the operation of such systems,
- every system has a boundary, the properties of which are important in understanding how the system works,
 - boundaries are semi-permeable,
 - family systems tend to reach relatively, but not totally, steady state; growth and evolution are possible, indeed usual; change can occur, or be effected, in various ways,
 - communication and feedback mechanisms between the parts of the system are important in the functioning of the whole system,
 - events, such as behavior of individuals in the family, are better understood as examples of circular causality, rather than linear causality,
 - family systems, like other open systems, have the property of equifinality, that is the same final-point may be reached from a number of starting points,
 - family systems, like other open systems, appear to have a purpose,
 - systems are made up of subsystems and also are parts of suprasystems (Radochoński 1986).

According to those assumptions, within the family the subsystems will consist of various individuals or groups. There are boundaries between the various subsystems, e.g. marital, parental or child subsystems. Family, as a whole, belongs to suprasystems, which include the extended family, the neighborhood, the parish, the town, etc. Each family system has its specific structure and way of functioning. It also has its boundaries, which are less visible than in case of physical systems, though equally important. They mark divisions between different families and between subsystems within one family, e.g. between children and parents or between girls and boys. The boundaries influence the emotional processes, intimate distance and cooperation in joint actions carried out by family members.

There is interchange between family subsystems and their suprasystems, i.e. outside environment. The parts of the system interact in particular ways, which ensure stabilization of the whole system and, at the same time, enable change and growth in

its members. This is necessary for a healthy development each family member starting from birth through adolescence. The end of this process results in leaving home by a grown-up individual. The family becomes then an "empty nest" with parents only, who after some time go on retirement.

Another systemic characteristic of the family is circular causality, as opposed to linear one. It means that within the family system it is not always possible to see simple interdependence of events, as when event A causes event B and there is no further consequence (an example of linear causality). In fact the interdependence between events in the family is better understood when circular causality is applied. Circular causality operates when event A leads to event B, which afterwards effects event A, mostly through the mediation of events C, D, E, and even more (Radochoński 1987). Usually the circular processes appear in form of a "positive feedback loop" which, in many cases, favors development and maintaining of specific symptoms, e.g. fears, obsessions and behaviors typical for obsessive-compulsive disorder. In such cases the circular process had to be broken in order to stop and to prevent a patient from carrying out the symptoms. It could be achieved by change of some family rituals and habitual patterns of behavior in family members. In many families children are those members who perform difficult roles, which may result in developing a moderate or even a high level of anxiety.

FAMILY SITUATIONS AND ANXIETY IN CHILDREN

Anxiety in children arises not only in everyday stressful family situations, but also when a family runs into difficulties negotiating a particular stage of its developmental course. Such situations may provoke stress and anxiety in adult members as well, however their negative effect will focus mostly on children. Anxiety in children may arise in the following situations:

1. When a role played by the child is too strenuous and difficult to perform

Sometimes in situations of marital conflict the child may be called upon to play a role of peacemaker between the parents. It may intervene directly on behalf of one involved party but more often it tries to resolve the conflict by behaving "badly" in particular way. This may help to unite the parents in dealing with the child's "bad" behavior. While concentrating on the child's problem they are diverted from their own disagreement. Peacekeeping efforts of this kind usually are effective only temporarily. When the child perceives its subsequent efforts as useless ones, this can be anxiety-provoking and depressing to the child.

Another kind of situation is when the child plays the role of an ally of one family member (e.g. the mother) being in conflict with other members (e.g. the father). An extreme example is situation when the child has to protect mother who is physically attacked by the father. Very often its efforts will not be successful, since the child

seldom has the power and resources to provide complete protection to the mother. Usually it results in an intense stress and anxiety in the child.

2. When there is a conflict between the family system's needs and the developmental needs of the children

Healthy family systems require to develop and change over time in order to meet developing needs of its members, especially the children. Unfortunately family systems not always are functioning in ways which facilitate the children passing successfully through subsequent developmental stages. An example will be the family system which functions so as to infantilise the child, which can result in delay of its emotional development. Such dysfunctional family system pattern is when there is an over-close relationship between one parent and a child (usually between mother and child) and, at the same time, a relatively distant relationship between the two parents. The child who always has been overprotected, usually by an anxious mother, may find it difficult to cope with relationships and social functions outside the family, e.g. at school or in peer groups. This may lead to reluctance to go to school, with excessive anxiety associated with leaving home for school.

Another type of family dysfunction is present when the parents try to put on the child responsibilities which are too great for its current age and level of emotional development. In such case the child is forced to grow-up prematurely. This pattern of behavior can happen in families where the parents are very much involved with each other or with outside activities (e.g. with professional career), and give their children insufficient affection and support. As a result the children may be left to fend for themselves and have to cope with life both within the family and outside it. It can also be anxiety-provoking for children because they face a pressure to grow-up too fast.

3. When children play some idiosyncratic roles within the family

Anxiety is also associated with various special roles which children play in some dysfunctional families. One of the idiosyncratic roles which are frequently played by children in the family system is that of "family scapegoat" (Minuchin 1974). The child who plays the role is appearing to be the person upon whom all the family problems and difficulties are projected. Usually the "scapegoated" child exhibits symptoms of serious disorders, e.g. psychosomatic disorders like asthma. The role of "scapegoat" is maintained in the family systems because its stability depends on having an "ill" child.

Second kind of idiosyncratic role is that of "parental" child. It exists in families where the parents give too much responsibility and power to a child. In some cases older children can take care of a parent, which leads to the inversion of family roles. When it happens, the child may become anxious and develop symptoms of various disorders, because it faces too heavy burden on its shoulders.

There is a special type of family systems which was described in the literature as “psychosomatic families” (Minuchin et al. 1978). In these families psychosomatic symptoms in one member, usually the child, comprise an important aspect of the way the family functions. In some cases there is a “primary” psychosomatic disorder in the child (e.g. asthma), but in many cases there is a disorder, described as a “secondary” one, in which there is no evidence of a physical predisposition. In such cases the child’s anxiety is expressed through psychosomatic symptoms. Minuchin and his colleagues (1978) have described the following characteristics of the “psychosomatic families”:

1. *Enmeshment*. A main characteristic of enmeshed families is that the subsystem boundaries are weak and easily crossed, and individual members don’t know their places in the system.

2. *Overprotectiveness*. In these families members represent a high level of protection and concern for each other. The overprotective attitude of parents can delay the development of personal autonomy and competence in their children.

3. *Rigidity*. This characteristic refers to the way these families try to maintain the family status quo. It is difficult for them to achieve growth and change which is required, for instance, when a child enters adolescence or leaves home. In these families ways of interacting, which are proper in case of younger children, cannot be abandoned in favor of those needed by adolescents. It results in rigid stability of family system, which is associated with the symptoms of disorders in some of its members.

4. *Lack of conflict resolution*. Rigidity of these families does not allow them to resolve conflicts and disagreements arising between individual members and subsystems. Unresolved conflicts contribute to the stress in these families and intensification of the symptoms.

According to Minuchin and his colleagues (1978) in psychosomatic families the child is in some way involved in a conflict between the parents. In certain cases the parents may unite in concern about the child, thus avoiding conflict, or marital conflict is changed into parental conflict over the child when it takes the side of one parent. Such processes can occur in many families and psychosomatic symptoms in children can be a way in which anxiety arising within the family system is overtly expressed.

DETERMINANTS OF THE CHILD’S ANXIOUS RESPONSE

It seems to be very interesting what makes that in a stressful family setting a child becomes anxious, rather than depressed or behaviorally disturbed? An important role in this process seem to play such constitutional factors like, for example, a

temperamental characteristics of an individual. Influence of these factors is partly responsible for significant differences among children, i.e. that some children are more anxiety-prone than others, while some may have a tendency to become depressed or behaviorally disturbed. Another important factor determining an anxious reaction in the child is general level of stress and anxiety in the family system. When it is high, it evokes intense states of anxiety. The influence of family system is crucial since we are dealing with circular processes within it rather than linear cause-and-effect relationships. In cases when the child's anxious state is part of a circular process by which the family's equilibrium is maintained, then anxiety will tend to persist and increase. The anxiety symptoms may be expressed overtly or they may be repressed and also, through the operation of mental defence mechanisms appear as phobic, obsessional, hysterical conversion of dissociative symptoms.

ROLE OF THE FAMILY SYSTEM CONCEPT IN THE ASSESSMENT AND THERAPY OF ANXIOUS CHILDREN

There is no doubt that the family system to which a child belongs is an important determinant in influencing the way the child develops acute or chronic anxiety. This is why a mental health professional who deals with child, among other variables, should take into consideration also the family context. In addition to interviewing child and parents, assessment of the family system should always be carried out. There are some techniques for interviewing and assessing families described in the literature (Barker 1981). They provide us with results, which can be used in decision making process about the selection of effective mode of treatment. It is important to know whether treatment should address the whole family system or it should concentrate on the anxious child alone. However, family therapy should be applied when the following conditions are present:

1. There are visible serious problems in the functioning of family system.
2. The child presents the anxiety, which is obviously associated with the way the family is functioning. Family dysfunction has an explicit influence on symptoms the child shows.
3. The therapist has obtained consent of the family members about their participation in process of therapy.

One of fundamental assumptions of the family-systems theory predicates that anxiety, like other psychopathological symptoms, exists within interpersonal context, i.e. the child's family. Thus symptoms explicitly represent a certain dysfunction of family system. In this regard an important aspect of the system are relationships and patterns of interaction between its members. The individual (e.g. the child with symptoms of anxiety) is influenced by actions of family members and, in turn, in-

fluences them in a circular rather than a linear manner. As mentioned above, in family system causality is seen as a mutually causative sequence or a self-recursive cycle of events with no real beginning or end. In this concept therapy is primarily aimed at altering patterns of relating between family members. As an important treatment mode frequently used in dealing with anxious children, family therapy permits disturbed children to work through their problems with their parents and siblings. The therapist engages all members of the family in open discussions about their relationships and encourages them to review their respective role and expectations of one another. In many cases this approach can be effective in helping the anxious child to understand and feel more comfortable with the family. The family therapy is especially effective when the anxiety is related to misunderstandings among family members, the parents' inconsistent or inadequate management of the children and chronic tension in the family, brought about by conflicts in roles. For example, children who suffer because of avoidant or separation anxiety disorders do well in family therapy because they work on their problems in the presence of their major attachment objects (i.e. the parents). Most of anxious children improve when they have a better understanding of what is expected of them and when they are not faced with uncertainty of the inconsistent expectations of parents and siblings. Sometimes it happens that the parents refuse or cannot participate in the therapy sessions. In such circumstances a "sibling therapy" can be applied. During the sibling therapy sessions the therapist meets the children without the parents, helps them develop and strengthen the bonds between them, and teaches them how to be supportive to each other. This kind of treatment may be the most effective approach for anxious children in cases when parents are not providing the nurturance and guidance that these children need (Lewis 1986).

An example can be an anxious child with mysophobia (fear of dirt and contamination) and hand-washing rituals. The disordered behavior in child brings about that the mother remains overinvolved with the child's problems rather than dealing with her distancing husband. After some time the whole family is concentrated on the child's bizarre fears and habits of cleanliness. The child's symptoms usually gain him a great deal of attention and power in preventing his parents, especially the mother, from disciplining him. The mother might feel helpless in maintaining the discipline on a "sick" child, especially since his symptoms might serve to keep her husband more strongly tied to home than before. In this situation the father would react as being more protective and staying longer at home. His behavior would influence the wife, decreasing her feeling of insecurity and loneliness. This case shows how the symptoms in the child can perform a "homeostatic" function, thus pushing the family to evolve into a more functional system.

Anxious disorders in children almost always modify structural relationships within the family system. Quite frequently, one parent (usually the mother) will be regarded as more supportive than the other. It results in creating alliances and coalitions between some family members directed against others (e.g. mother-child coalitions).

tion against distancing father). Thus, the child may demonstrate a strong dependency to one parent and disrupted relationship with the other (e.g. with the father who does not approve the child's anxious behavior). These conflicted and emotion-based alliances tend to amplify difficulties already present both in the child and in the functioning of the family system. Problems such as these require a sensitive exploration of the parents' feeling about the child, the disorder and their role in the therapy process. In such instances family therapy may be of critical importance in the overall treatment not only of the children with anxiety, but also of the whole family system.

Effective treatment of anxiety disorders often requires family interventions in addition to interventions directed specifically toward the anxious child (e.g. individual cognitive-behavioral therapy or pharmacological therapy). During treatment process, regular family therapy sessions are scheduled to explore these issues and the family's capacity to cope with them. In its initial stages a psychoeducational approach is used and is sufficient in most cases. Anyway, not infrequently, unresolved core issues of power, dependency and intimacy emerge. Also, quite often, the affected child and his or her symptoms are the focal point around which these issues swirl. If such problems would go unnoticed, treatment directed toward the anxious child symptoms may be inadvertently sabotaged via missed appointments, treatment noncompliance or failure to improve.

FINAL REMARKS

Causal factors of the anxiety disorders related to the family are very complex and intertwined with other social factors. In fact family characteristics appear to predict emotional and behavioral development only in complex interactions with other factors, such as socioeconomic status, sources of support outside the family, and the child's age, sex and temperamental traits. Because of that the concept of risk factor is important here, i.e. the idea that in examining causal factors usually we are dealing with certain probabilities. It means that particular events or conditions may be factors increasing the probability that there will be a particular outcome for the child, such as an emotional (anxiety) disorder. When it happens that several risk factors occur together (e.g. parental mismanagement, poverty, child's difficult temperament and community violence), their effects are not merely additive but rather multiplicative. For instance, two of the mentioned factors occurring together more than double the probability that a child will develop a certain kind of psychopathology (e.g. an anxiety disorder). When a third factor is added, the chance of disorder is several times higher (Quinn, McDougal 1998). The notion of heightened risk, as opposed to simple cause-effect relationship, is important in all types of behavior disorders, not just anxiety disorders. From that point of view it's very important to know what happens in families with the heightened risk of emotional disorder. Although we can explain this problem in general terms, we cannot make sure predic-

tions of outcomes for individual children for two main reasons: 1. each child is affected individually by the family environment, 2. whether familial determinants are positive or negative for a child, and whether they reduce or heighten the child's risk of emotional disorders, depends on the processes involved. Those processes (e.g. coping strategies) determine how vulnerable or resilient a child will be. Stressful life experiences that occur within the family are always, in some way, related to the larger social environment in which family is functioning as a social group. That's why it is so important to consider both the interpersonal interactions and relationships that occur between the child and other family members and the external influences on the family that may affect those interactions.

REFERENCES

- Andrews G. et al. (1994). *The treatment of anxiety disorders*. New York, Cambridge University Press
- Barker P. (1981). *Basic family therapy*. St. Albans, Granada
- Bertalanffy von L. (1984). *Ogólna teoria systemów*. Warszawa, PWN
- Costello E.J., Angold A. (1995). *Epidemiology*. W: J.M. March (ed.), *Anxiety disorders in children and adolescents*. New York, Guilford, s. 109-124
- DSM-IV (1994). *Diagnostic Criteria from DSM-IV*. Washington, D.C., American Psychiatric Association
- Kortlander E. et al. (1997). *Maternal expectations and attributions about coping in anxious children*. *Journal of Anxiety Disorders*, 11, 297-315
- Lewis K.G. (1986). *Sibling therapy with multiproblem families*. *Journal of Marital and Family Therapy*, 12 (3), 291-300
- Minuchin S. (1974). *Families and family therapy*. Cambridge, MA, Harvard University Press
- Minuchin S., Rosman B.L., Baker I. (1978). *Psychosomatic families: Anorexia nervosa in context*. Cambridge, MA, Harvard University Press
- Muris P. et al. (1996). *The role of parental fearfulness and modeling in children's fear*. *Behav. Res. Therapy*, 34, 265-268
- Quinn K.P., McDougal J.L. (1998). *A mile wide and a mile deep: Comprehensive interventions for children and youth with emotional and behavioral disorders and their families*. *School Psychology Review*, 27, 191-203
- Radochoński M. (1986). *Rodzina jako system psychospołeczny*. *Problemy Rodziny*, 5, 13-21
- Radochoński M. (1987). *Choroba a rodzina*. Rzeszów, Wydawnictwo WSP
- Rapee R.M. (1997). *Potential role of childrearing practices in the development of anxiety and depression*. *Clinical Psychology Review*, 17, 47-67
- Rueter M.A. et al. (1999). *First onset of depressive or anxiety disorders predicted by the longitudinal history of internalizing symptoms and parent-adolescent disagreements*. *Archive of General Psychiatry*, 56, 726-732
- Warren S.L. et al. (1997). *Child and adolescent anxiety disorders and early attachment*. *Journal Am. Acad. Child Adolesc. Psychiatry*, 36, 637-644