International Journal of Progressive Sciences and Technologies (IJPSAT)
ISSN: 2509-0119.

Vol. 33 No. 1 June 2022, pp. 619-627

Anxiety Disorder Affects The Mental Health Of Children During Puberty

Mirlinde Bilali[1], Arieta Hasani Alidema[1], Emire Bilalli[2]

[1] University for Business and Technology UBT, Pristina, Kosova
[2] Medical Faculty, Ss. Cyril and Methodius University

Abstract

Introduction. Developmental psychology focuses on exploring children's behavior at every moment of their lives, and the changes that occur from one period to another. Adolescence is associated with the onset of puberty, changes in social and emotional behavior, and the impact of vulnerability on social anxiety disorder. Anxiety is an emotional state that is felt with a feeling of pain, not tension, and with certain physiological phenomena such as effects on his heart rate, increased blood pressure and fatigue. period of development - puberty.

Purpose of the paper: To determine the impact of parental anxiety on the health of children during puberty

Material and methods: An analytical cross-sectional study was conducted. Use "Psychometric properties of the Screen for Child Anxiety Related Emotional Disorders" (SCARED) - a version for a child, and detect it in 4 domains (panic, separation anxiety, generalized anxiety and school phobia). The questionnaire consists of 41 questions, which we have to answer with one of the alternatives: Not true, somewhat true or very true. The Depression, Anxiety and Stress Scale (DASS) was used to determine anxiety, consisting of 42 questions that included three scales for self-assessment, personality symptoms, anxiety and stress. 2-5 questions with similar content, and assesses autonomic alertness, skeletal muscle effects, situational anxiety, and subjective experience with the effects of anxiety.

Results and discussion: A total of 600 respondents participated in the research, of whom 300 students (140 male and 160 female students) and their parents (198 males and 102 females). According to the results of the analysis of students' responses, 96 students were anxious or 32%, 130 children had significant somatic symptoms in terms of panic disorder or 43.3%, 119 (39.7%) children had general anxiety disorder, 149 (49.7%) presented with separation anxiety, 71 (23.7%) were with social anxiety disorder, and 87 (29%) students had signs of school anxiety. 14% (42) of parents thought that their child was anxious, 25.7% (77) had a child with significant somatic symptoms in terms of panic disorder, 7.7% (23) parents had a child with general anxiety disorder, 27.7% (83) parents considered that their child showed signs of separation anxiety, 18.3% (55) parents considered that their child had a social anxiety disorder, while 18.7% (56) parents stated that their child had school anxiety. According to the results of the DASS scale, the prevalence of depression in parents was 23.34% or 70 parents manifested depression; the prevalence of anxiety was 28.7% or 86 surveyed parents, while the prevalence of stress was 22% or 66 parents. A statistically significant difference was confirmed in the distribution of students without anxiety, with possible anxiety disorder, and with anxiety disorder, between parents with and without anxiety. Parental anxiety had no significant effect on the incidence of anxiety disorder in male children, but it had in female children. An overall score for anxiety disorder higher than 30 points, equivalent to a clinically convincing result for anxiety disorder, was recorded in 67.9% (38) of female children of anxious parents and 32.7% (34) of female children of non-anxious parents.

Discussion: Several researchers hypothesize that adolescent onset of depression may follow a different etiological course than depression that develops in childhood or adulthood. For adolescents, poor family functioning seems to "activate" the negative psychological impact of frequent, minor stress.

Conclusion: The results of the study showed a significant impact of parental anxiety on children's health.

Keywords – Anxiety, Parents, Children, Puberty, Influence.

Corresponding Author: Mirlinde Bilali

I. INTRODUCTION

The development of the individual can be observed because of progressive and relatively permanent changes in the neurological and physical structures, thought processes and behavior. Developmental psychology focuses on exploring children's behavior at every point in their lives, and the changes that occur from one period to another. (1)

When times are tough, it is normal for children and other family members to show strong reactions such as feelings of sadness, nervousness or confusion, sleep disturbances, physical reactions and fear of the unknown. Prolonged stress can lead to mental health problems and long-term consequences for the functioning and defense capacity of both children and caregivers.(2)

The family is a system that is constantly changing and evolving and going through different stages of development that require the ability to adopt new tasks and ways of adjustment.

Everyone reacts differently. Some parents can immediately create a new home routine, some may struggle with balancing work and home responsibilities. Some children may feel deep sadness or anger, others may withdraw or act as if nothing is happening.(3)

Anxiety as a personality trait for him is a measure of individual differences in the tendency to anxiety, given the likelihood that the state of anxiety will be manifested in circumstances involving different levels of stress (4). In those parents who have more pronounced anxiety as a trait, most situations are assessed as threatening or dangerous and thus show a more frequent state of anxiety, as opposed to those with less pronounced anxiety as a trait (5).

Some research shows that increased parental anxiety can also increase a parent's willingness to express concern for their child. However, in other cases, due to the reduced ability to face unfavorable answers, parents will not express their concern, even though it exists (5).

Adolescence is associated with the onset of puberty, changes in social and emotional behavior, and increased vulnerability to social anxiety disorder.

The onset of adolescence roughly corresponds to the onset of puberty, which initiates drastic changes in hormone levels and a cascade of physical changes in the body and brain [6].

During adolescence, there are also dramatic changes in motivation, social behavior, and the rate of psychopathology, especially in girls. One of the most noticeable social changes during adolescence is the increased independence from parental personalities and the appropriate reliance on close friendships and romantic relationships with peers; by 7th grade, relationships with peers and parents become equally important to adolescents, and by 10th grade, relationships with peers become primary.

Stress is a non-specific consequence of any claim of the organism that exceeds the adaptive capacity of the organism itself and can also be understood as a situation that occurs in a situation of mismatch between the demands of the environment from the individual and his ability to respond to these requirements. Stress occurs when people feel that they cannot meet the demands of the environment, which can result in physiological, psychological and behavioral changes. (7)

Childhood and adolescence are the primary risk stages for the development of anxiety symptoms and syndromes, which can range from transient symptoms to completely debilitating anxiety disorders.

Anxiety is a pathological condition characterized by an irrational and overemphasized feeling of inner fear, fear which is accompanied by internal reactions that lead to hyperactivity of the autonomic nervous system and differs from fear which is a response to known causes. It is a diffuse, vague feeling of difficulty, which is accompanied by other bodily experiences (headache, etc.). Anxiety is experienced in everyday situations and is related to unfinished tasks that the person sets before themselves. Prolonged feelings of anxiety can lead to avoidance or adaptation using defensive psychological mechanisms or behavior and often the sources of anxiety go unnoticed. It is the result of frustration or stress, associated with awkward situations that are transmitted to other spheres of human life. (8)

Adolescence is a developmental period associated with significant physical, social, and psychological changes. It is also a period in which several psychiatric conditions, including depression and anxiety, are likely to begin. These observations have suggested that changes experienced in adolescence (for example, changes associated with puberty) may lead to vulnerabilities to the development of psychiatric conditions, rather than, or additionally, chronological age. (9)

Research shows that there is no age limit for the occurrence of anxiety and in this context the question arises how anxiety or this condition affects children, i.e., what consequences of psychosocial development and personality formation cause anxious parents in their children. Many studies have been devoted to the relationship between parents and children, i.e., the quality of parenting in relation to the disorder in children. Parents who show signs of depression, the environment that adversely affects the development of children in mental terms greatly affects the functioning of children and their psycho-physical health.

It has previously been suggested that the onset of psychopathology and the increased levels of subclinical depression and anxiety may be explained by age, pubertal status (puberty), and pubertal timing (i.e., puberty). In terms of age, studies show an increase in age-dependent depressive symptoms in adolescence, while anxiety symptoms decrease in early adolescence (ages 10 to 13-14) and increase again from 14 years of age 15. Regarding puberty, multiple studies have shown that both pubertal status and puberty timing are associated with symptoms of depression and anxiety and with the onset of clinical depression and anxiety disorders. (9)

Research also confirms the link between children's well-being and good communication with parents, sharing and active participation of the child in making important family decisions. Such a link reduces the risk of psychosomatic and psychosocial problems and suicidal ideation in the long run. Positive relationships with parents, through care, support and recognition, play an important role in the attitudes and behavior of young people. Low family cohesion as well as frequent family conflicts are related to depressive mood, aggression and anxiety in adolescent children. (10)

The effect of the affect is seen in children regardless of the symptoms of the depressive disorder. Parents who have symptoms of depressive disorder are less likely to accept their children and have less support for their children.

When it comes to the psychosocial development of children and adolescents, family relationships, especially the relationship between parents and children, prove to be one of the most important factors. The role of parents in the development of children is emphasized in most theories, starting with Freud, Kohler, Burke, Vygotsky. Namely, all research shows that the relationship between parents and children is important for the successful socialization of children. Regulation of emotions and behavior are important for healthy development in the early period of children, who in interaction with the environment form emotions and deal with frustrations and stress. Parents in a state of stress do not adapt to the needs of the child and leave their emotions without support. (11)

The effects of puberty seem to communicate with gender; Although women experience depression and anxiety more often than men, these gender differences appear only after the onset of puberty. In addition, early puberty timing is associated with symptoms of depression and anxiety in women, while in men, late puberty timing is associated with disordered behavior and depressive symptoms [12].

Research results confirm that parental concern may be helpful in detecting disorders in children. Most research confirms a significant link between the type of concern and the later diagnosis: that the type of concern indicates the type of problem the child has.

II. AIM OF THE PAPER

To determine the impact of parental anxiety on the health of children during puberty.

III. MATERIAL AND METHODS

In this cross-sectional study, 150 high school students in the municipality of Gostivar were analyzed, as well as their parents. Two standardized questionnaires were used as a research tool. The Psychometric Properties of the Screen for Child Anxiety Related Emotional Disorders (SCARED) version was used to examine anxiety in children, and it measures anxiety in children in 4 domains (panic, separation anxiety, generalized anxiety, and school anxiety). phobia). The questionnaire consists of 41 questions, which should be answered with one of the alternatives: Not true, somewhat true or very true. The Depression, Anxiety, and Stress Scale (DASS), consisting of 42 questions that included three self-assessment scales designed to measure the negative emotional symptoms of depression, anxiety, and stress, was used to determine parental anxiety., divided into subscales of 2-5 questions with similar content, and it assesses autonomic alertness, the effects of skeletal muscle, situational anxiety, and subjective experience with the impact of anxiety.

IV. Statistical analysis

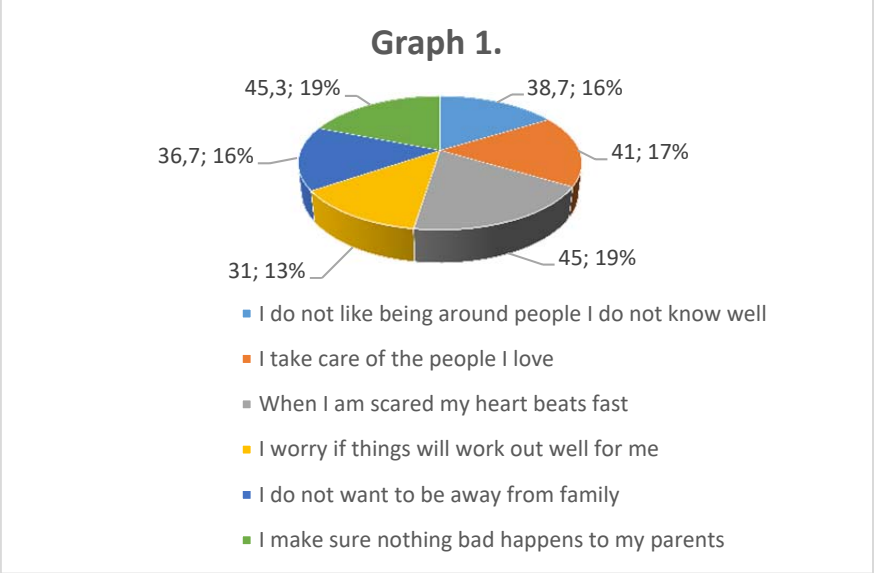
The data obtained from the survey were analyzed with the statistical program SPSS for Windows 23.0. All data of interest for the preparation of the paper are presented in tabular and graphic. The description of the data is made with relative and absolute numbers. Chi-square test was used to compare the answers of children from anxious and non-anxious parents. All those results are considered significant where the value of $p < 0.05$.

V. Results

This part of the research presents the results obtained by processing and analyzing the answers from the completed questionnaires of 600 respondents, of which 300 students (140 males and 160 females) and their parents (198 males and 102 females) in the territory of municipality of Gostivar.

The structure of the answers that the children gave to the questions from the Questionnaire for Anxiety Disorders in Children - a version for children as the most true children accentuated the following questions: "I make sure that something bad does not happen to my parents" - 45.3% (136); "When I'm scared, my heart beats fast" - 45% (135); "I take care of the people I want - 41% (123); "I don't like being with people I don't know well" - 38.7% (116); "I do not want to be far from the family" - 36.7% (110), and "I care if things will work well for me" - 31% (93).

Graph 1. Graphic representation of the answers to certain questions from Questionnaire for anxiety disorders in children - a version for children



The average scores for the 5 questions from the Questionnaire for Anxiety Disorders in Children - version for children, which the students pointed out as the truest were: 1.14 ± 0.79, 1.06 ± 0.87, 1.26 ± 0, 76, 1.12 ± 0.77, and 1.18 ± 0.83, respectively.

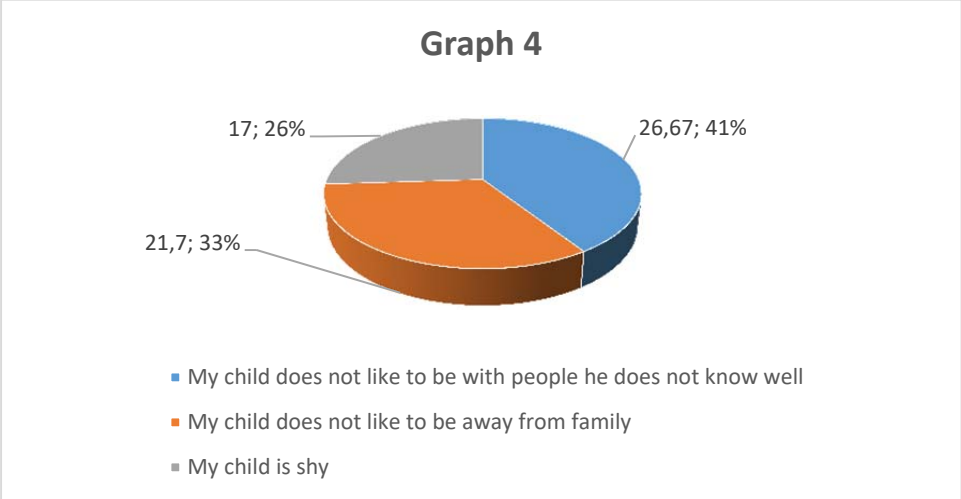
According to the results of the analysis of students' answers, 32% (96) of them were anxious; 43.3% (130) of the children had significant somatic symptoms in terms of panic disorder; 39.7% (119) of the children had generalized anxiety disorder; 49.7% (149) presented separation anxiety; 23.7% (71) had a social anxiety disorder, and 29% (87) of students had signs of school anxiety (Table 1).

Table 1. Results of the Anxiety Disorders, Panic Disorder, Generalized Anxiety Disorder, Separation Anxiety, Social Anxiety, and School Anxiety Scores from the Child Anxiety Disorder Questionnaire - Children's Version

CHILDREN	points	**n (%)**
≥ 25 Indicates Anxiety Disorder > 30 points indicates a clinically convincing result.	0 – 25	145 (48,33)
	26 – 30	**59 (19,67)**
	>30	**96 (32)**
Grade 7 indicates panic disorder or Significant Somatic Symptoms.	0 – 6	170 (56,67)
	≥ 7	**130 (43,33)**
Grade 9 may indicate Generalized Anxiety Disorder.	0 – 8	181 (60,33)
	≥ 9	**119 (39,67)**
Grade 5 may indicate Separation Anxiety SOC.	0 – 4	151 (50,33)
	≥ 5	**149 (49,67)**
A score of 8 for points 3, 10, 26, 32, 39, 40, 41 may indicate a Social Anxiety Disorder.	0 – 7	229 (76,33)
	≥ 8	**71 (23,67)**
A grade of 3 for items 2, 11, 17, 36 may indicate a Significant School Avoidance.	0 – 2	213 (71)
	≥ 3	**87 (29)**

The structure of the answers given by the parents to the questions from the Questionnaire for Anxiety Disorders in Children - a version for parents as the most true parents emphasized the following questions: "My child does not like to be with people he does not know well" - 26, 7% (80); "My child does not like to be away from family" - 21.7% (65), and "My child is shy" - 17% (51).

Graph 2. Graphic presentation of the answers to certain questions from the Questionnaire for anxiety disorders in children - version for parents



The average scores for the 3 questions in the Anxiety Disorders Questionnaire for Children - version for parents that were most often true were: 0.91 ± 0.6, 0.78 ± 0.8, and 0.78 ± 0.72, respectively.

According to the results of the analysis of the parents' answers, 14% (42) of the parents thought that their child was anxious; 25.7% (77) that their child has significant somatic symptoms in terms of panic disorder; 7.7% (23) of the parents have a child with generalized anxiety disorder; 27.7% (83) of the parents considered that their child showed signs of separation anxiety; 18.3% (55) of the parents thought that their child had a social anxiety disorder, while 18.7% (56) of the parents stated that their child had school anxiety (Table 2).

Table 2. Results of the subscales for anxiety disorder, panic disorder, generalized anxiety disorder, separation, social and school anxiety from the Childhood Anxiety Disorders Questionnaire - parent version

Parents	points	**n (%)**
≥ 25 points indicates Anxiety Disorder > 30 points indicates a clinically convincing result.	0 – 25	230 (76,67)
	26 – 30	**28 (9,33)**
	>30	**42 (14)**
Score 7 indicates Panic Disorder or Significant Somatic Symptoms.	0 – 6	223 (74,33)
	≥ 7	**77 (25,67)**
Grade 9 may indicate Generalized Anxiety Disorder.	0 – 8	277 (92,33)
	≥ 9	**23 (7,67)**
Grade 5 may indicate Separation Anxiety SOC.	0 – 4	217 (72,33)
	≥ 5	**83 (27,67)**
A score of 8 for points 3, 10, 26, 32, 39, 40, 41 may indicate a Social Anxiety Disorder.	0 – 7	245 (81,67)
	≥ 8	**55 (18,33)**
A score of 3 for points 2, 11, 17, 36 may indicate a Significant School Avoidance.	0 – 2	244 (81,33)
	≥ 3	**56 (18,67)**

According to the results of the DASS scale, the prevalence of depression in parents was 23.34%, i.e., 70 parents manifested depression; the prevalence of anxiety was 28.7%, ie 86 surveyed parents manifested anxiety disorder; while the prevalence of stress was 22%, ie 66 parents according to the answers to the questions recognized a stressful situation. Table 10 also presents the degree of these disorders in the surveyed parents, with 3% (9) of the parents presenting with a severe degree of depression; 10.7% (32) presented with severe anxiety; 1.3% (4) of the parents had a severe form of stress (Table 3).

Table 3. Frequency and degree of depression, anxiety and stress in parents - DASS scale

	Depression **n (%)**	**Anxiety** **n (%)**	**Stress** **n (%)**
Normal	230 (76,67)	214 (71,33)	234 (78)
Easy	21 (7)	17 (5,67)	26 (8,67)
Average	17 (5,67)	26 (8,67)	19 (6,33
Heavy	23 (7,67)	11 (3,67)	17 (5,67)
Very heavy	9 (3)	32 (10,67)	4 (1,33)

The results of the research showed that gender did not have a significant impact on the occurrence of depression, anxiety and stress in the parents of students (p = 0.074, p = 0.12, and p = 0.054, respectively). All three conditions were slightly more often manifested by students' mothers.

According to the given answers, depression was recognized in 29.4% (30) of the respondents, and in 20.2% (40) of the respondents; 34.3% (35) of the female respondents and 25.8% (51) of the male respondents were anxious; stress was manifested by 28.4% (29) of the respondents and 18.7% (37) of the respondents (Table 4).

Table 4. Frequency of depression, anxiety and stress depending on the gender of the parents

Parents gender	**Depression**		**Anxiety**		**Stress**	
	Have	**Does not have**	**have**	**does not have**	**have**	**does not have**
men	40 (20,20)	158 (79,80)	51 (25,76)	147 (74.24)	37 (18.69)	161 (81.31)
female	30 (29,41)	72 (70,59)	35 (34,31)	67 (65.69)	29 (28.43)	73 (71.57)
p value	X^2=3,2 p=0,074 ns		X^2=2,4 p=0,12 ns		X^2=3,7 p=0,054 ns	

No statistically significant difference was found in the degree of illness of the person, the degree of anxiety, and the degree of stress, depending on the sex of the information (p> 0.05).

Very severe form of women and anxiety of women through their answers a slight thing from gender - 4.9% (5) vs. 2% (4), and 13.7% (14) to 9.1% (18), consequently, while very severe stress was detected in 0.98% (1) of one study and 1.5% (3) of a male study.

The results of the study showed a significant effect of the anxiety of the results on the results of the children.

Statistically significant difference was confirmed in the distribution of students without anxiety, with possible anxiety disorder, and with anxiety disorder, between parents with and without anxiety (p <0.0001). Anxious parents more often than parents who did not manifest anxiety have children with possible anxiety disorder and with a convincing result for anxiety disorder - 22.1% (19) vs 18.7% (40), and 50% (43) vs 24.8% (53), consequently.

Anxiety in parents was significantly associated with panic disorder in children (p <0.0001), generalized anxiety disorder (p <0.001), separation anxiety (p <0.001), and social anxiety disorder (p <0.0001)., and was not significantly associated with school dropout (p = 0.25).

Anxious parents significantly more often than parents without anxiety had children with panic disorder - 61.6% (53) vs 36% (77), with generalized anxiety disorder - 51.2% (44) vs 35.05% (75), with separation anxiety - 63.95% (55) vs43.9% (94), and with social anxiety disorder - 41.9% (36) vs 16.35% (35).

VI. Discussion

Support is one of the basic things that motivates us to thrive in the environment in which we live. We receive the greatest support from our loved ones - family. The family is an important link in the chain of child development, and it is from the family that children receive the greatest support. Besides families with two parents, most of the young people (children) live with one parent. Studies show that these children are much more vulnerable. (13)

The reasons can be various, from: rejection and stigmatization from the environment, through the weak parenting capacities for independent upbringing of the child, to the insufficient support of the single parent, in the community and society. In these circumstances, young people often develop lower self-esteem, learn less, and suffer more from emotional problems.(14)

However, the relationship between parents and children also has an impact on the child's development. The role of the parent is quite important in this period, and according to research, the relationship between children and parents is important for

successful socialization of children. The child in this period has several different emotions and, in the attitude, or frustration of the parents these emotions can lead to suppression in themselves, so the parents in a state of stress are not adapted to the needs of the child and leave their emotions without support.(15)

Concern itself can affect the development of the child itself, too little worried or too worried parents can affect the psyche and behavior of the child, and thus can directly or indirectly affect the appearance of problems in children.

According to a study on Anxiety and Depression in Children of Depressed Parents, it turns out that growing up with depressed parents can cause anxiety in the child and affect his development, and the dynamics of change in preventive intervention leads to the use of transdiagnostic interventions. Transdiagnostic interventions may be most effective if they are designed to optimize reductions in anxiety symptoms at the beginning of the intervention, in order to optimize subsequent reductions in depressive symptoms. Anxious parents more often than non-anxious parents have children with possible anxiety disorder and with a convincing result for the development of anxiety disorder in their children. This study highlights the importance of recognizing anxiety in children and parental anxiety about how anxiety affects children's health. (16)

VII. Conclusion

From this we can conclude that parents who express concern about certain aspects of their children's development also express higher levels of anxiety than parents who are not affected. Anxious parents are more likely to develop panic disorder in their children, which affects their pubertal development. Those parents who have anxiety need to monitor the activities of the children, but not too much so that the occurrence of anxiety disorder does not occur, and their pubertal development is not disturbed.

References

[1] Beesdo K, Knappe S, Pine DS. Anxiety and Anxiety Disorder in Children and Adolescents: Developmental Issues and Implications for DSM-5.Psychiatr Clin North Am, 2009.

[2] Deardorff J, Hayward C, Wilson KA, Bryson S, Hammer LD, Agras S. Puberty and gender interact to predict social anxiety symptoms in early adolescence. The Journal Of Adolescent Health: Official Publication Of The Society For Adolescent Medicine.

[3] Brown BB. Handbook of adolescent psychology. In: Lerner RM, Steinberg L, editors. Adolescents' relationships with peers. 2nd. Hoboken, NJ US: John Wiley & Sons Inc; 2004. pp. 363–394.

[4] Tronick E, Reck C. Infants of depressed mothers. Harvard review of psychiatry. 2009; 17 (2): 147-156.

[5] Bornstein (Ed.). Handbook of Parenting (2nd Ed.), Vol 3: Being and becoming a parent. 2008

[6] Sisk CL, Foster DL. The neural basis of puberty and adolescence. Nature Neuroscience. 2004;

[7] Cohler, B.J. Psychoanalysis and Parenthood. In: M.H. 2002.

[8] Davis N.M. Depression in children and adolescents. J School Nursing 2005; 21: 311-17

[9] Renske van der Cruijsen, Jennifer Murphy, Geoffrey Bird, Alexithymic traits can explain the association between puberty and symptoms of depression and anxiety in adolescent females, 2019 Jan 16, available at https://www.ncbi.nlm.nih.gov / pmc / articles / PMC6334924 /

[10] Tronick E, Reck C. Infants of depressed mothers. Harvard review of psychiatry. 2009; 17 (2): 147-156.

[11] Klein E i sur. Psychological medicine. Zagreb: Golden marketing; 1999.)

[12] Marković, J. The development of sociodemographic factors and the gradual order of functionalities with emotional problems and problems ranging from 4 to 11 years. Novom Sadu University, Faculty of Medicine, 2011.

[13] Bornstein (Ed.). Handbook of Parenting (2nd Ed.), Vol 3: Being and becoming a parent. 2008

[14] Tronick E. The neurobehavioral and social emotional development of infants and young children. New York: Norton, 2007.

[15] Rohde P, Lewinsohn PM, Klein DN, Seeley JR, Gau JM. Key characteristics of major depressive disorder occurring in childhood, adolescence, emerging adulthood, adulthood. Clinical Psychological Science: A Journal Of The Association For Psychological Science. 2013

[16] Audra K Langley, Avital Falk, Tara Peris, Joshua F Wiley, Philip C Kendall, Golda Ginsburg, et al, The child anxiety impact scale: examining parent- and child-reported impairment in child anxiety disorders, 2013 Aug 5. Available at https://pubmed.ncbi.nlm.nih.gov/23915200/