The family background of the anxiety-depressive disorder of 15 year old school boy

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Abstract

15 years old school boy of the third year of secondary school is treating as an outpatient patient since seven years. The boy was born in the family of two parents and three years younger sister. Both parents have university education. The mother is been treated for several years as a psychiatric outpatient patient with the diagnosis of pervasive delusional disorder. On the other side she played important role in the family functioning. The father of the boy was rather passive and not involved as much as the mother in supporting their children. The younger sister, has been treated as an outpatient patient for three years for anxiety disorders. For the moment she is well and is doing well at school. In the 7th year ofage the boy has started complaining for anxiety symptoms and persecutory feelings and lack of the sense of security in his class, because of the possible aggressive behavior of the other boys in the school and in the neighborhood. He felt also frightened by the possible following aggression of Germany against Poland. All those symptoms influenced substantially his social functioning, particularly the functioning in his peer group and in the school. He expressed many reactions of anxiety and depressive type. In the following years the threat of Germans was gradually reduced but very important was threat of the aggression of the other boys. From time to time the boy refused leaving his home. The last two years has changed substantially the social situation of the boy because of his rapid physical growth. So that his present physical condition is equal as the growth and strength of adult man. It has modified his position in the peer group, so that his contact with the rival boys became less anxious but the new compensating reactions appeared with the focusing on one school boy that was particularly aggressive in former years. This accumulation of emotions and impulsiveness that became important element of his social functioning make more and more difficult the coping with the conflict situation. They reflect among others specific family situation, his mother lived for many years with the feeling of the constant threat from her colleagues in the work place. From the other side his personality traits that can be compared to the personality structure of epileptoidal personality. This type of the personality is at present not included into the list of abnormal personalities of DSM and ICD, but clinical practice gives us a lot of data supporting our convenience that it is personality structure that should be diagnosed among other abnormal personality structures

Keywords: adolescent, anxiety, depression, family background

Streszczenie

Chłopiec lat 15 uczeń 3 klasy gimnazjum, leczony ambulatoryjnie psychiatrycznie od siedmiu lat. Rodzina składa się z obojga rodziców i młodszej o trzy lata siostry, rodzicie mają wyższe wykształcenie. Matka chłopca, od kilkunastu lat leczy się ambulatoryjnie psychiatrycznie z rozpoznaniem uporczywego zaburzenia urojeniowego, siostra chłopca, leczyła się ambulatoryjnie przez około trzy lata w związku z zaburzeniami lękowymi, aktualnie nie przejawia żadnych zaburzeń psychicznych. U chłopca w wieku siedmiu lat zaczęły się pojawiać lęki z poczuciem zagrożenia ze strony innych chłopców w klasie i w sąsiedztwie, okresowo był to przede wszystkim lęk przed Niemcami, którzy mogą napaść na Polskę. Poczucie zagrożenia w znacznym stopniu utrudniało mu funkcjonowanie społeczne, przejawiał on szereg reakcji adaptacyjnych. Okresowo Pacjent obawiał się wychodzić z domu. W ciągu kolejnych lat lęk przed Niemcami uległ znacznej redukcji. Ostatnie dwa lata zmieniły także sytuację społeczną chłopca w związku z jego szybkim rozwojem fizycznym, osiągnął on wzrost i siłę dorosłego mężczyzny, to zmodyfikowało jego pozycję w grupie rówieśniczej, jego kontakt z rywalizującymi z nim chłopcami stał się znacznie mniej lękowy, ale ujawniły się liczne reakcje kompensacyjne z koncentracją na jednym koledze ze strony którego doznał szeregu upokorzeń w poprzednich latach. Zaleganie treści afektywnych uniemożliwia mu radzenie sobie z sytuacjami konfliktowymi, jest wyrazem z jednej strony szczególnej rodzinnej sytuacji wychowawczej – matka przez szereg lat żyła w poczuciu stałego zagrożenia ze strony środowiska zawodowego, z drugiej zaś strony ujawniające się cechy osobowości epileptoidalnej. Osobowość ta nie jest wprawdzie włączona do międzynarodowych klasyfikacji, ale jej występowanie nie jest wcale rzadkie w obserwacjach klinicznych.

Słowa kluczowe: młodzież, lęk, depresja, uwarunkowania rodzinne

The problem of depression and anxiety in adult population is widely known and recognized as one of the most important clinical and social issues of our time. The problem of anxiety and depression in children and adolescents are less known however not less important. We would like to present one of our adolescent outpatient patients to stress the importance of the family situation, early diagnosis and early start of the treatment. There are

many publications concerning above mentioned problems. Woodward and coworkers performed21-year longitudinal study of a birth cohort of 1,265 New Zealand children [1]. They suggest that adolescents with anxiety disorders are at an increased risk of later in live anxiety, depression, illicit drug dependence, and educational underachievement. Relations between the occurrence of depression in parents to the mental problems in their children was assessed by Weismann and all [2], they explored first onsets of suicide attempts and other psychiatric disorders in offspring of parents suffering from depression compare to offspring of healthy parents in 2-year longitudinal study. The results were very significant – "all the suicide attempts, first onsets of major depression and anxiety disorders were in offspring of depressed parents"[2], and subclinical manifestations of major depression at initial interview were persistent for 2 years, family risk factors like marital poor adjustment, parent child discord, low cohesion in the baseline were not associated with increased incidence of major depression or anxiety disorder. "Combining both retrospective and prospective data, the overall suicide attempt rate was 7.8% in the offspring of depressed parents as compared with 1.4% in the offspring of nondepressed parents. By age 20, over 50% of the offspring of depressed patients reported a major depression." [2]. The same relation between the mental illness in parent and risk of major depression and anxiety disorders – in their children was the main issue of analysis of Biederman and co 2007 [3] they assumed that the separation anxiety disorder significantly increased the risk for the subsequent development of specific phobia, agoraphobia, panic disorder, and major depression, even after parental panic and depression were covaried. Agoraphobia significantly increased the risk for subsequent generalized anxiety disorder. These findings suggest that separation anxiety disorder is a major antecedent disorder for the development of panic disorder and a wide range of other psychopathological outcomes, and that it increases the risk for subsequent psychopathology even among children already at high familial risk for anxiety or mood disorder. Masten and all [4] proved "Advantaged children were more competent, and with stress were less positively engaged in school, but were not likely to be disruptive." And what is particularly important : "Boys were less socially competent than girls and, when stress was high, appeared to be less protected by positive family qualities". According to Li X., Sundquist J. and Sunquist K. [5] hospital records analysis over forty years period showed that "The sibling risk was 2.26, which was independent of sex and age differences between siblings. The SIR was highest in siblings <20 years of age (2.83). Analysis of risk by subtype showed that having a sibling diagnosed with any anxiety disorder resulted in increased risks of a number of disorders; the highest increased risk was of social phobia (SIR 3.68, 95% confidence interval, 1.68-7.69)." [5]. The results supported the thesis that "Heritable effects likely play an important role in the cause of anxiety disorders". Another study of above mentioned authors and coworkers [6] tried to examine "Familial risks for depression among siblings based on hospitalizations in Sweden."[6]. In conclusion they assumed that "The significantly higher risk for siblings of depression patients than that for spouses suggests that heritable effects highlight familial susceptibility to this disease" [6]. The problem of genetics of depression in childhood and adolescence was the main problem investigated by Rice [7]. "Results from several family and twin studies suggest that an etiologic heterogeneity exists in depression in childhood and adolescence. Twin studies show that genetic influences on depression in young people may be indirect and work via effects on environmental risk exposure (gene-environment correlation) or genetic sensitivity to environmental risks (gene-environment interaction). Recent research on gene-environment interaction has examined the effect of specific functional genetic polymorphisms in conjunction with environmental stressors." [7]. Another study by Stevenson – Hinde and co. [8] is devoted to the many aspects of anxiety within families the authors proved that in a community sample of mothers anxiety levels were high, "Mothers' anxiety was not significantly related to age, education, or work status, but rather to mothers' and fathers' independent ratings of marital satisfaction and family functioning, and to fathers' own anxiety and depression. Fathers' anxiety was related not to their own views of marital satisfaction and family functioning, but rather to mothers' views and to maternal anxiety." [8]. The general study concerning vulnerability to depression in children and adolescents, was published by Purper-Ouakil and co. [9]. They stayed that "Psychopathology, in particular anxiety and disruptive disorders are well identified risk-factors for later depression. Subclinical depressive symptomatology, also termed "demoralization", also identifies high-risk populations, likely to become incident cases of depression. It is still unclear whether this condition is prodromal depression, a specific clinical entity or the expression of biological and/or cognitive vulnerability. Familial risk for depressive disorders involves both genetic and psychosocial factors. Marital discord, poor communication and dysfunctional parenting practices are often present in families with affective disorders and can be implicated in increased depressive vulnerability in the offspring. (…) High emotionality, defined as the tendency to become upset easily and intensely has been associated with an increased risk for subsequent major depression. (…)

Familial and individual vulnerability is likely to heighten the depressogenic impact of life events and psycho-social adversity." [9]. Another two studies are focused on the parental factors as predictors of anxiety of their children Festa and co. [10] stated that "higher levels of parental anxiety, rejection, and over control were related to higher levels of social anxiety. Higher levels of social support, acceptance, and validation were associated with lower levels social anxiety. The strongest predictors of social anxiety symptoms (…) were parental anxiety and friendship quality (i.e., validation from a peer)." [10]. The second study was of Bögels and co. [11] they stated that "Mothers might have the role of teaching social wariness to their low socially anxious children, whereas fathers may teach social confidence to socially anxious children." [11].

15 years old school boy of the third year of secondary school is treating as an outpatient patient since seven years. The boy was born in the family of two parents and three years younger sister. Both parents have university education. The mother is been treated for several years as a psychiatric outpatient patient with the diagnosis of pervasive delusional disorder. On the other side she played important role in the family functioning. The father of the boy was rather passive and not involved as much as the mother in supporting their children. The younger sister, has been treated as an outpatient patient for three years for anxiety disorders. For the moment she is well and is doing well at school. In the 7th year of age the boy has started complaining for anxiety symptoms and persecutory feelings and lack of the sense of security in his class, because of the possible aggressive behavior of the other boys in the school and in the neighborhood. He felt also frightened by the possible following aggression of Germany against Poland. All those symptoms influenced substantially his social functioning, particularly the functioning in his peer group and in the school. He expressed many reactions of anxiety and depressive type. In the following years the threat of Germans was gradually reduced but very important was threat of the aggression of the other boys. From time to time the boy refused leaving his home. The last two years has changed substantially the social situation of the boy because of his rapid physical growth. So that his present physical condition is equal as the growth and strength of adult man. It has modified his position in the peer group, so that his contact with the rival boys became less anxious but the new compensating reactions appeared with the focusing on one school boy that was particularly aggressive in former years. This accumulation of emotions and impulsiveness that became important element of his social functioning make more and more difficult the coping with the conflict situation. They reflect among others specific family situation, his mother lived for many years with the feeling of the constant threat from her colleagues in the work place. As we mentioned before the father of the boy was rather passive and the central role in the family played the mother and it corresponds among other with the statement of the Bógels [11] "Mothers might have the role of teaching social wariness to their low socially anxious children, whereas fathers may teach social confidence to socially anxious children."

From the other side his personality traits that can be compared to the personality structure that was after Franciszka Minkowska described as epileptoidal personality. This type of abnormal personality is characterized by specific psychological viscosity, explosiveness, susceptibility, vindictiveness, rigidity in terms of the tendency to keep emotional reactions and accompying intellectual context for a very long time. Their relations with other people often become egocentric, preceptorial, non- reflective, not flexible, egocentric and stubborn. Their explosiveness makes them sometimes aggressive and can complicate their family and social functioning [12]. Epileptoidal personality is according to a Kretschmer associated with the athletic constitution (body building). This type of the personality is at present not included into the list of abnormal personalities of DSM and ICD, but clinical practice gives us a lot of data supporting our convenience that it is personality structure that should be diagnosed among other abnormal personality structures [12]. Great majority of above described personality features can be seen in the personality of our patient and it is the reason of his difficulties in his former social functioning and after his situation was changed in his inability to left them behind. According to his emotional viscosity and keeping in memory all details of his humiliating events he is still concentrated on them and on the person of one of his colleagues that was particularly annoying him in the past. In the terms of transactional analysis he plays a game in the position of the victim and planning revenge. It makes the upbringing situation of the boy rather complex.

He needs long term psychotherapy which is the basic form of the treatment and also some pharmacological treatment to diminish his tension and explosiveness. In practice it is uneasy task because the boy lives in a distant part of our region and can visit our consulting room not often. Concluding we would like to stress that psychological and psychosocial situation of the boy in his preadolescent and adolescent period of time is dynamically changing and the psychotherapy should be reoriented according to it.

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