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Dans la genèse d'un trouble anxieux de l'enfant ; qu'on est-il des angoisses des parents ?

In the development of an anxiety disorder in a child, what role do the parents' anxieties play?

En el origen de un trastorno de ansiedad en el niño, ¿qué hay de las angustias de los padres?

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Résumé

Les enfants de parents anxieux présentent un risque nettement accru (jusqu'à cinq fois supérieur) de développer eux-mêmes des troubles anxieux, sous l'effet conjugué de facteurs génétiques et environnementaux. Nous rapportons le cas de Lilia, fillette de 7 ans adressée pour refus scolaire, chez qui le diagnostic de refus scolaire anxieux sur anxiété de séparation d'intensité sévère a été retenu à travers le cosleeping et les conduites d'évitement, un sentiment d'insécurité émotionnelle en l'absence de la maman. L'absence d'amélioration après huit semaines d'une prise en charge bien conduite basée sur une guidance parentale, une psychothérapie et un traitement médicamenteux a motivé la recherche de facteurs nourriciers de l'anxiété, révélant une histoire maternelle marquée par des psychotraumatisme sévères entretenant, et un style éducatif parental à la fois permissif et hyperprotecteur. L'initiation d'une thérapie maternelle individuelle a permis la reprise progressive de la scolarisation. Ce cas illustre les mécanismes de transmission transgénérationnelle des troubles anxieux et souligne la nécessité d'une approche thérapeutique intégrée, incluant les parents, pour assurer une rémission durable.

Mots-clés : anxiété de séparation ; refus scolaire ; transmission transgénérationnelle ; anxiété parentale ; psychotraumatisme.

Abstract

Children of anxious parents face a significantly higher risk—up to five times greater—of developing anxiety disorders themselves, due to a combination of genetic and environmental factors. We report the case of Lilia, a 7-year-old girl referred for school refusal. She was diagnosed with school refusal rooted in severe separation anxiety, manifested through co-sleeping, avoidant behaviors, and a sense of emotional insecurity in her mother's absence. A lack of improvement after eight weeks of well-conducted treatment—comprising parental guidance, psychotherapy, and medication—prompted an investigation into factors fueling the anxiety. This revealed a maternal history marked by severe psychological trauma, as well as a parenting style that was both permissive and overprotective. Initiating individual therapy for the mother facilitated the child's gradual return to school. This case illustrates the mechanisms of the transgenerational transmission of anxiety disorders and underscores the need for an integrated therapeutic approach—one that includes the parents—to ensure lasting remission.

Keywords: separation anxiety; school refusal; transgenerational transmission; parental anxiety; psychological trauma.

Resumen

Los hijos de padres con ansiedad presentan un riesgo notablemente mayor (hasta cinco veces superior) de desarrollar, a su vez, trastornos de ansiedad, debido a la combinación de factores genéticos y ambientales. Presentamos el caso de Lilia, una niña de 7 años derivada a consulta por rechazo escolar. Se estableció el diagnóstico de rechazo escolar de origen ansioso, vinculado a una ansiedad por separación de intensidad grave, manifestada a través del colecho, conductas de evitación y una sensación de inseguridad emocional ante la ausencia de la madre. La falta de mejoría tras ocho semanas de un abordaje terapéutico adecuado —que incluyó orientación a los padres, psicoterapia y tratamiento farmacológico— llevó a investigar los factores que alimentaban dicha ansiedad. Esto reveló una historia materna marcada por psicotraumas graves, así como un estilo de crianza caracterizado por ser, simultáneamente, permisivo e hiperprotector. El inicio de una terapia individual para la madre permitió la reincorporación progresiva de la niña a la escuela. Este caso ilustra los mecanismos de transmisión transgeneracional de los trastornos de ansiedad y subraya la necesidad de un enfoque terapéutico integral, que incluya a los padres, para garantizar una remisión duradera.

Palabras clave: ansiedad por separación; rechazo escolar; transmisión transgeneracional; ansiedad parental; psicotrauma.

Introduction

Children of anxious parents are at high risk (up to five times higher than the general population) of developing anxiety disorders, due to the interplay of genetic and environmental factors [13]. Patterns of intense attachment, parental overprotection and dysfunctional coping strategies play a key role in the development of anxiety in children.

Early intervention, including therapeutic approaches tailored to both children and their parents, is essential for preventing and treating anxiety and its long-term consequences.

The aim of this study is to understand and explore, based on a clinical case of school refusal, the complex interactions between parents' anxiety disorders and their impact on children's psychological and emotional development.

Clinical observation

Lilia, a 7-year-old girl, the eldest of two siblings, with no particular medical history, was referred by her paediatric service for assessment of a case of school refusal.

The interview reveals an anxious temperament, a parenting style that is both permissive and overprotective, and anxiety symptoms combining physical signs (abdominal pain, tachycardia), psychological symptoms (excessive distress when separation occurs or is anticipated (crying, panic, pleading)) and behavioural symptoms (avoidance), which became fully apparent during her time in Year 2 of primary school, leading to her dropping out of school.

Within the family context, the picture is characterised by a 54-year-old father who is overprotective and permissive, and a hyperprotective mother who practises co-sleeping with her two children. The child's development has been marked by several aggravating factors: physical abuse by a teacher and the El Haouz earthquake.

The interview reveals no evidence to suggest a neurodevelopmental disorder or post-traumatic stress disorder. Lilia clearly expresses separation anxiety: fear that something might happen to her mother, fear of earthquakes, and fear of being left alone or sleeping alone. At school, her basic academic skills remain relatively intact and there are currently no signs of bullying.

After ruling out an organic aetiology, the diagnosis established is that of school refusal of an anxious nature, based on intense separation anxiety, associated with an inconsistent parenting style and perpetuating factors (previous bullying at school and the earthquake), without traumatic flashbacks, with a significant impact on school and family life and without comorbidity.

The intervention consisted of psychoeducation providing information on separation anxiety as a reaction of intense and disproportionate distress at the idea or prospect of being separated from attachment figures (the mother, in our case), which can be normal and form part of development; it is only referred to as a disorder when the intensity, duration and impact on daily life become excessive. Parents should validate the child's emotions without avoiding the issue; provide reassurance; manage their own anxiety; gradually encourage autonomy; adopt a reassuring parenting style, without being either permissive or violent; and take a gradual approach to co-sleeping.

Psychotherapy in which a safe space is created where Lilia can, through talking, play and drawing, express her fear and name her emotions ('I'm afraid my mum will die whilst I'm away'); followed by a gradual return to school, accompanied by a letter to the school explaining the necessary adjustments;

Given the severity of the symptoms, their duration and their impact, pharmacological treatment with 25 mg/day of sertraline was initially prescribed; this was well tolerated and improved her sleep. Subsequently, the dose was increased to 50 mg/day for four weeks, followed by a further increase to 100 mg of sertraline for another four weeks, without any improvement being observed. This therapeutic outcome led us to investigate the factors fuelling the anxiety, which directed our exploration towards the patient's family history.

Her maternal history is characterised by: the death of both parents, followed by adoption; child maltreatment; repeated sexual abuse by her adoptive father; and a rape at the age of 17 by an adult. As a result of these psychological traumas, the mother continues to sleep with her daughters and prevents her two girls from being left alone, even with their own father, which fuels a sense of emotional insecurity in Lilia. Individual therapy for the mother, of a psychiatric and psychological nature, was then initiated. This therapy enabled Lilia's gradual return to school and the start of a process of empowerment.

Discussion

This case illustrates the main mechanisms of the transgenerational transmission of anxiety disorders, which involve several interlinked factors: genetic predisposition, modelling (learning by observation), overprotective parenting, a stressful family environment and insecure attachment.

Anxiety disorders, including school refusal due to anxiety, have a well-established genetic component. This factor is present regardless of whether the anxiety is present in the mother or the father. It manifests itself primarily during childhood, but there is also evidence of its presence in infants and adolescents [Shaum].

A child may inherit biological predispositions to anxiety, in particular alterations in the neurobiological systems involved in stress management, such as the serotonin, GABA (gamma-aminobutyric acid) and dopamine circuits, which play a key role in emotional regulation.

Modelling involves the transmission of anxiety through the observation of parents' anxious reactions—whether behavioural, verbal or non-verbal—or through the reinforcement of behavioural inhibition in a shy temperament. This learning by imitation leads to the acquisition of avoidance or hypervigilance behaviours: in this way, children learn that anxiety is an appropriate response to uncertainty or danger, which reinforces their anxiety-related reactivity.

An overprotective parenting style is characterised by an excessive level of control and protection towards the child, which prevents them from coping independently with stressful or anxiety-provoking situations. This type of upbringing hinders the development of healthy coping strategies in the child, which in the long term reinforces their avoidance behaviours and anxiety [10].

Various environmental factors can trigger excessive activation of a child's stress system and increase their vulnerability to anxiety disorders, namely: family conflicts; significant life changes (divorce, moving house); unrealistic parental expectations; bullying; and psychological trauma (bereavement, divorce, abuse).

These stressful environments disrupt the child's emotional regulation and limit the development of appropriate coping strategies, thereby reinforcing avoidant behaviours and anxiety [6, 12].

An insecure attachment, particularly of the anxious or avoidant type, resulting from inconsistent or insensitive parental responses, also prevents the child from developing a sense of security in their relationships, which fosters anxious

behaviours in the face of uncertainty or separation [8].

Whilst maternal overprotection takes centre stage, the father's contribution is equally decisive and complementary in this context. Lilia's father, aged 54, combines two characteristics whose importance is highlighted in the literature: a permissive parenting style and advanced paternal age. The permissive style, as defined by Baumrind, is characterised by a high level of emotional warmth combined with a low level of demands and control: the parent gives in to the child's requests, avoids conflict and does not impose limits or provide a stable framework. Long considered benign because of its affectionate nature, this style is now identified as a risk factor in its own right for internalising disorders. Kadoglou et al. point out that a permissive parenting style more than doubles the likelihood of anxiety disorders in pre-school children, and observe a similar trend in the case of paternal permissiveness [7]. The mechanism is twofold: on the one hand, the absence of a framework deprives the child of the predictable reference points needed to build a sense of security; on the other hand, permissiveness implicitly validates avoidance, as the child who refuses to face a situation that causes them anxiety never has to confront it. In Lilia's case, her refusal to go to school, her refusal to sleep alone and her continued co-sleeping have therefore never encountered a structuring boundary: each act of avoidance, by immediately alleviating her distress, has been negatively reinforced and perpetuated.

It is worth highlighting the particular relationship that exists within this family between maternal overprotection and paternal permissiveness. Far from counterbalancing one another, these two parenting styles complement each other in terms of avoidance: the mother, marked by her own psychological traumas, prevents separation; the permissive father, too, does not enforce it and fails to fulfil the role of a 'separating third party' who might have created a space for the child to become more independent. The resulting inconsistency in parenting, which oscillates between anxious control and a lack of boundaries, against a backdrop of experiences of bullying at school, corresponds precisely to the inconsistent parental responses described as leading to insecure attachment.

The father's advanced age (father's age ≥ 40 years at the time of birth) constitutes a second point of interest. It is associated with an increased risk of neurodevelopmental and psychiatric disorders in offspring, via de novo mutations, epigenetic alterations and age-related changes in gamete quality, which may contribute to the biological vulnerability to anxiety mentioned above [11, 14]. However, advanced paternal age , above all, introduces specific psychosocial dynamics—beyond the biological—that influence parenting style, attachment patterns and the child's emotional development [11]. An older father tends to adopt a more indulgent and less restrictive approach, often described as 'grandparent-like', with less physical availability for activities involving trial and exploration. In the case of Lilia, whose father was 47 when she was born, this dynamic may have reinforced the permissiveness observed.

Finally, it is worth raising the issue of anxiety about death: in families with elderly parents, existential concerns relating to the parent's mortality can affect the parent-child relationship and manifest themselves in the child through anxiety-related fears centred on loss [11]. However, Lilia's symptoms revolve precisely around the fear that something might happen to her mother; an anxiety about the loss of her attachment figure, triggered by the El Haouz earth-

quake. This aspect, often overlooked in assessments, deserves to be explored systematically and integrated into parental counselling.

Lilia's case exemplifies the interrelationship between these mechanisms and, above all, the decisive role of her mother's history in perpetuating the girl's anxiety. Recent literature on the intergenerational transmission of trauma sheds light precisely on the trajectory observed.

In the mother's case, the accumulation of traumatic experiences during childhood (adoption, maltreatment, repeated sexual abuse by her adoptive father and, subsequently, rape during adolescence) constitutes a set of early adversities (Adverse Childhood Experiences) which, as several longitudinal studies demonstrate, have an impact on the mental health of her offspring. These maternal adversities operate, in particular, through altered parental representations and insecure adult attachment, which have been identified as mediating pathways for transmission [18].

The most evident mechanism in this case is that of trauma-informed parenting. Field and colleagues have demonstrated that a parenting style characterised by role reversal mediates the relationship between maternal post-traumatic stress disorder and daughters' anxiety [5]. In Lilia's case, the continued practice of co-sleeping and the fact that the mother avoids any separation (to the extent of not leaving her daughters alone with their own father) reflect less an appropriate form of protection than a projection of the mother's own insecurity onto the child. The mother's emotional availability, described as a key mediator in the transmission of trauma, is disrupted: the mother's anxious vigilance constantly signals to the child that the world and separation are dangerous.

This dynamic is linked to the modelling mechanism and that of insecure attachment described above: Lilia learns, through direct observation of her mother's avoidance behaviours, that anxiety is the appropriate response to separation, and develops an anxious attachment in response to her parents' excessively worried reactions. The accumulation of traumatic events specific to the girl herself (abuse by a teacher, the El Haouz earthquake) triggered an already vulnerable stress response, which precipitated her refusal to attend school.

This interpretation retrospectively explains the failure of the initial treatment, which focused solely on the girl: whilst the maternal source of insec (the untreated trauma and the overprotective behaviours stemming from it) remained active, Lilia's symptoms could not subside. It was precisely the commencement of individual maternal therapy, centred on this care-related factor, that enabled improvement and the restoration of autonomy to begin, in line with evidence identifying the mother-child dyad as a priority therapeutic target in the transmission of trauma [18].

Conclusion

The transmission of anxiety disorders results from personal, genetic and environmental factors. As illustrated by Lilia's case, the failure of treatment focused solely on the child should prompt an investigation into the parental factors that fuel anxiety. An integrated therapeutic approach, which takes all these elements into account and includes, where necessary, treatment for the parents' psychotrauma, is essential to ensure lasting remission and the acquisition of long-term coping strategies.

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