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PROBLEM-ORIENTED APPROACHES OF ANXIETY AND DEPRESSION IN FAMILY PRACTICE

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Abstract: **Background: according to the literature the prevalence of anxiety and depression remains high among family members which need to be approaches by the family doctors, thus Clinicians should be aware of the high rates of anxiety as well as depressive symptoms in family**
Objective: the aim of this study was to determine the prevalence, risk factors, and risk behaviors associated with depressive and anxiety symptoms and mostly approaches of anxiety and depression in family.
Methodology: We performed a systemic review study thorough US National Library of Medicine National Institutes of Health (Pubmed database) and we included all studies that contributed in discussion the factors and approaches of anxiety and depression in family.
Conclusion: The literature indicates that a broad array of parent and family factors are associated with risk for depression and anxiety mostly among youths

***Keywords*: Family medicine, anxiety, depression, family approached.**

I. INTRODUCTION

According to the National Institute of Mental Health, "Anxiety is a normal reaction to stress. It helps one deal with a tense situation in the office, study harder for an exam, and keep concentrated on an essential discourse. Thus, it helps one adapt. In any case, when uneasiness turns into an unreasonable, nonsensical fear of regular circumstances, it has turned into an impairing disorder."Anxiety issue have all the earmarks of being more basic in persons with chronic illnesses or crisis the overall population.[1] for example, Maguire et al., have found moderate to severe anxiety in 27% of a sample of breast cancer patients as compared to 14% in a control sample.[2] In addition to that, dr. Brandenberg et al. identified 28% of advanced melanoma patients as having anxiety compared to 15% of familial melanoma patients with no diseases.[3] Massie and Holland reported that anxiety accounted for 16% of requests for psychiatric consultations among inpatients.[4]

in 2002, a national group of experts was called to summarize and prioritize the state of research on risk and treatment for youth depression. Specifically, the National Institutes of Mental Health (NIMH) invited a workgroup of leaderships in the field of depression to clear up the condition of data about the risks for and treatment of depression, and to make proposals on where the field needs to center exploration attempts Costello et al., 2002.[5] Regarding risks for depression, the workgroup suggested further research into both family environment and inherited qualities. As dense by Costello and the NIMH workgroup, diverse pathways to depression are clear. The workgroup underlined the multidimensional way of depression, alongside the lack of exploration into the early pathways and communications that cause depression. In spite of the fact that examination has not recognized the greater part of the guardian or family environment considers that add to youth risk for depression and the instruments through which they operate, it is becoming clear that "there is a considerable familial component to unipolar depression" [5]

Comorbid anxiety with depression predicts poor results with a higher rate of treatment resistance than either issue happening alone. Cover of uneasiness and depression entangles finding and renders treatment challenges. A vital step in treatment of such comorbidity is careful and comprehensive diagnostic assessment. We attempt to explain various psychosocial approaches among population of comorbid anxiety and depression in family.

II. LITERATURE REVIEW

Finch et al, conducted research on youth population has recognized a few stressful occasions that can debilitate individual and family prosperity. These incorporate partition from family, presentation to traumatic occasions, segregation, loss of societal position, and changes in family principles and parts, and he found that introduction to viciousness was pervasiveand emphatically connected with nervousness and depressive indications. [17]

Erwin.B.A et al indicated in his study that comorbidity is associated with greater severity of social uneasiness issue. However, the differential impacts of comorbid state of mind and tension issue on manifestation severity or treatment result have not been explored. The creators assessed 69 persons with uncomplicated social tension issue, 39 persons with an extra uneasiness issue, and 33 persons with an extra state of mind issue. Those with comorbid temperament issue reported more prominent span of social tension than those with uncomplicated social nervousness issue. They were additionally judged, previously, then after the fact 12 weeks of comorbid conclusion. Conversely, persons with comorbid nervousness issue were evaluated as more disabled than those with no comorbid conclusion on just a solitary measure. Kind of comorbid diagnosis did not result in differential ratesof improvement of social anxiety disorder. [5]

Turner.S.M et al, in 2003 performed study that showed Anxiety disorders are familial, and although considerable evidence underpins the part of hereditary/natural parameters in their advancement, these alone don't completely clarify their etiology. In this study, the part of child rearing conduct as a conceivable variable in the transmission of nervousness from guardian to kid was analyzed. Utilizing meeting, self-report, and direct behavioral perception, practices of guardians with a tension issue were contrasted with those of guardians without an uneasiness issue on various measurements, however especially as for whether restless guardians effectively hindered their kids from participating in typical age suitable exercises. These practices were surveyed amid schedule activities and in a structured non-conflictual play task. Although anxious parents did not overtly restrict their child's behavior in either type of activity, they reported higher levels of distress when their children were engaged in these activities. Similarly, the "emotional climate" in families with an anxious parent differed significantly from families without an anxious parent. The results are discussed in terms of how parenting behaviors might influence the development of maladaptive anxiety via social learning and information transfer, and their heuristic implications.[15]

Moon.S.S et al, which he provide in his article a description of Separation Anxiety Disorder (SAD) and its diagnosis, and reviews evidence-based methods of assessment including clinical interviews, self-report scales, parent-teacher reports, behavioral observations, and self-monitoring in order to understand the child and the relevant social ecology and to provide the basis for formulating and evaluating social work intervention strategies.[7]

Hofmann.S.G stated concerning cognitive models of social phobia (social anxiety disorder) assume that individuals with social phobia experience anxiety in social circumstances to some extent since they overestimate the social expense connected with a possibly negative result of a social collaboration. Some feeling scholars, then again, indicate the view of control over anxiety-related side effects as a determinant of social anxiety. So as to inspect the relationship between saw passionate control (PEC), evaluated social cost (ESC), and subjective anxiety, the creators looked at three option basic condition models: Model 1 accepted that PEC and ESC autonomously anticipate social anxiety; Model 2 assumed that ESC partially mediates the relationship between PEC and anxiety, and Model 3 assumed that PEC partially mediates the relationship between ESC and anxiety. The authors recruited 144 participants with social phobia and administered self-report measures of estimated social cost, perceived anxiety control, and social anxiety. The results supported Model 3 and suggested that "costly" social situations are anxiety provoking in part because social phobic individuals perceive their anxiety symptoms as being out of control. [8]

Robichaud.M et al showed that negative problem orientation, a dysfunctional set of attitudes related to problem-solving ability, has been implicated as a process variable in several psychological disorders, notably depression and generalized anxiety disorder (GAD). The goal of this study was two-fold: (1) to further examine the construct validity of a new measure of negative problem orientation, the negative problem orientation questionnaire (NPOQ), through its relationship to conceptually similar variables, and (2) to investigate the specificity of negative problem orientation to worry, the cardinal feature of GAD, compared to depression. The sample consisted of 148 university students who completed six questionnaires, the NPOQ and measures of worry, depression, pessimism, self-mastery, and neuroticism. Multiple hierarchical regressions revealed that when entered in the last step following demographic information and personality variables (pessimism, self-mastery, and neuroticism), the NPOQ accounted for 5.6% of the variance in worry scores

compared to 1.6% of the variance in depression scores. It was concluded that the NPOQ shows evidence of construct validity, and that the process variable of negative problem orientation appears to have greater specificity to worry than depression. Implications for the understanding of worry and GAD are discussed. [9]

Hazlett-Stevens-H et al, conducted study which investigated whether generalized anxiety disorder (GAD) individuals rely on antecedent data to decipher vagueness and whether dependence on such going before signs perseveres without potential danger. Twenty-six GAD and 23 nonanxious control understudies played out a lexical choice assignment, utilizing homographs (i.e., words with various implications) as equivocal primes. Fifty-fifty the trials, a homograph prime that had both danger related, and additionally unbiased implications was trailed by an objective word identified with one of these two implications. What's more, each questionable prime was promptly gone before by a progression of four forerunner words that were either: (a) connected with the debilitating significance of the prime; (b) connected with the impartial importance of the prime; or (c) random to either importance of the homograph, and in addition the objective. Homographs for which both implications were unbiased in valence involved the other half of the trials. Effect size statistics suggested that GAD participants used the antecedent words to interpret the homograph primes with threat-related meanings, unlike their nonanxious counterparts ($p < 0.06$). When both meanings of the homograph prime were neutral in valence, the GAD group appeared deficient in the use of preceding information to interpret the ambiguous prime.[10]

Harb.G.C et al showed that the Interpersonal Sensitivity Measure (IPSM) was developed to assess hypersensitivity to interpersonal rejection, a suggested trait of depression-prone personality. Although studies of the IPSM and interpersonal rejection sensitivity have primarily been conducted in depressed populations, it is important to investigate interpersonal rejection sensitivity as a relevant construct in the assessment of social anxiety. This study examined the psychometric properties of the IPSM in treatment-seeking individuals with social anxiety disorder. The results of this investigation support the convergent and divergent validity and internal consistency of the IPSM in socially anxious individuals. An exploratory factor analysis of the scale was also conducted after the original factor and subscale structure was shown to be a poor fit for the present data. Three factors emerged (Interpersonal Worry and Dependency, Low Self-Esteem, and Unassertive Interpersonal Behavior), and 29 items were retained. Because they demonstrated negative factor loadings on Factor 2, it is suggested that the scoring for four items of the original IPSM be reversed. In summary, the revised IPSM assesses three aspects of interpersonal rejection sensitivity and appears to be a valid and reliable instrument for its assessment in social anxiety disorder. [11]

In a comprehensive and widely cited review by Goodman et al.1999, four mechanisms that may explain the complex transmission between mother and youth depression were presented: (1) genetics, (2) neuroregulation difficulties that impact affect regulation, (3) exposure to negative maternal affect and behaviors, and (4) stress and the environmental context within which the youth lives.[12]

III. Objectives

Depression and anxiety are substantial and largely unrecognized problem among population mostly young adolescents that warrants an increased need and opportunity for identification. Understanding differences in prevalence between males and females and among racial/ethnic groups may be important to the recognition and treatment of depression and anxiety in family medicine. Therefore the aim of this study comes to determine the prevalence, risk factors, and risk behaviors associated with depressive and anxiety symptoms through wide systemic review study of literature supported by evidence concerning the oriented approaches of anxiety and depression in family.

IV. METHODOLOGY

The medical literature was searched and systemic review study has been performed for all previous studies on the approaches of anxiety and depression in family published before June 2016, through US National Library of Medicine National Institutes of Health (Pubmed database) database was searched using the medical subject headings *anxiety and depression in family and their approaches.* Also a review of reference lists from original research articles and several review articles; and a review of the authors' reference files. More than 15 studies were identified, all of which were published in English.

These articles were reviewed by the authors to determine whether they met a series of predetermined criteria for inclusion in our subsequent analysis.

V. RESULTS

Although the previous literature makes an important contribution to understanding how acculturative stress and immigrant generational differences contribute to anxiety and depression among families, study in 2006 which was performed by Dia.D.A et al, examines psychosocial functioning of siblings of children with an anxiety disorder. Parents with a child in treatment for an anxiety disorder were asked to complete the Child Behavioral Checklist for Ages 6-18 (CBCL/6-18) on that child's sibling and a brief demographic form. Data were collected on 65 siblings; parents reported that 8 (12%) of the siblings had clinical mental health diagnoses. Of the 57 siblings who did not have a diagnosis, 31 (54%) had scores on the CBCL/6-18 in the borderline or clinical range. A parent's having a psychiatric diagnosis and degrees of family interference were predictors of internalizing behaviors and total score in the sibling. Length of treatment was also predictive of the total score. Implications for treatment planning are discussed.[14]

Muris.P et al, examined the anxiety sensitivity construct in a large sample of normal Dutch adolescents age 13-16 years (n = 819). Children completed the Childhood Anxiety Sensitivity Index (CASI) and measures of trait anxiety, anxiety disorder symptoms and depression. Results showed that (1) anxiety sensitivity as indexed by the CASI seems to be a hierarchically organized construct with one higher-order factor (i.e., anxiety sensitivity) and three or four lower-order factors, (2) anxiety sensitivity and trait anxiety were strongly correlated, (3) anxiety sensitivity was substantially connected to symptoms of anxiety disorders (in particular panic disorder and agoraphobia) and depression, and (4) anxiety sensitivity and trait anxiety both accounted for unique proportions of the variance in anxiety disorder symptoms. Altogether these findings are in agreement with those of previous research in adult and child populations, and further support the notion that anxiety sensitivity should be viewed as a unique factor of anxiety vulnerability. [13]

Cortes-A-M et al, conducted longitudinal evaluation study that was aimed to determine if posttraumatic stress disorder (PTSD) symptomatology predicted later development of non-PTSD anxiety disorders in children and adolescents victimized by interpersonal trauma. Thirty-four children with a history of interpersonal trauma and no initial diagnosis of anxiety disorder participated in the study. Children were assessed at time one (T1) and then 12-18 months later at time two (T2). At T1, the Clinician Administered PTSD Scale for Children and Adolescents (CAP-CA) and the Schedule for Affective Disorders and Schizophrenia for School-Age Children-Present and Lifetime Version (K-SADS-PL) were used to evaluate children's PTSD symptoms and comorbid non-PTSD anxiety disorder diagnosis. At T2, the CAPS-CA and the K-SADS-PL were repeated. The diagnosis of PTSD and PTSD symptoms in children exposed to interpersonal trauma at T1, particularly the symptoms associated with avoidance and constricted emotional expression (criteria C) as well as physiological hyperarousal (criteria D), predicted the development of other anxiety disorders at T2. [6]

Study by Hickey.D of Twenty-nine couples in which one partner was depressed, result in 21 couples in which one partner had an anxiety disorder, and 26 nondistressed control couples were compared on measures of (1) quality of life, stress, and social support; (2) family functioning; (3) marital functioning; and (4) relationship attributions. The depressed group had significant difficulties in all four domains. In contrast, the control group showed minimal difficulties. The profile of the anxious group occupied an intermediate position between those of the other two groups, with some difficulties in all four domains, although these were less severe and pervasive than those of the depressed group. [16]

There was recent study by Franca Warmenhoven et al. 20012 in a focus group study in a sample of family physicians with varied practice locations and varying expertise in palliative care. In 4 focus group discussions with 22 family physicians, the physicians described the diagnostic and therapeutic process for depression in palliative care patients as a continuous and overlapping process. The family physicians reported that they regularly noticed a depressed mood, anxiety, sadness, and worry in palliative care patients, and generally felt competent to address these symptoms. They qualified emotional issues as understandable and appropriate in the process of accepting the end of life, and although they actively addressed these issues, they did not apply the medical concept of depression. They described difficulty in distinguishing normal from abnormal sadness.[18]

VI. CONCLUSION

The literature indicates that a broad array of parent and family factors are associated with risk for depression and anxiety mostly among youths, ranging from parental pathology to parental cognitive style to family emotional climate. Few studies have focused specifically on approaches to depression and anxiety in family medicine among youth and how their experiences contribute to their overall psychological well-being. This study was to determine the main oriented approaches of anxiety and depression in family and what are the main factors contributed in the stressors among family and risk of depression and anxiety.

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