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Comparison of Anxiety Disorders between Children with and without a Healthcare-Employed Parent

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ABSTRACT

Aims Healthcare professionals are exposed to highly stressful work environments and face numerous occupational challenges, which may adversely affect their family life. Parental occupational stress can influence children's psychological well-being; however, limited research has specifically examined anxiety disorders among children of healthcare workers. This study aimed to compare anxiety disorders in children with and without a parent employed in the healthcare sector.

Materials & Methods This causal-comparative study was performed on children and adolescents aged 10 to 18 years living in Rasht, Iran, in 2025, with and without a parent employed in the healthcare sector. Using purposive sampling, 60 participants were selected, including 30 children with a healthcare worker parent and 30 children whose parents were employed in non-healthcare occupations. Data were collected using the Screen for Child Anxiety Related Emotional Disorders. Data analysis was conducted using one-way analysis of variance with SPSS 27.

Findings Children with a parent employed in the healthcare sector showed significantly higher anxiety levels than children without such a parent. Specifically, total anxiety was higher (61.83±1.38 vs. 32.47±1.43; $p<0.001$), as were separation anxiety (13.08±0.45 vs. 8.49±1.06; $p<0.05$), generalized anxiety (15.73±0.71 vs. 10.01±0.67; $p<0.001$), and panic/somatic symptoms (19.71±1.37 vs. 11.24±0.87; $p<0.001$). In contrast, social anxiety and school phobia did not differ significantly between groups (both $p>0.05$). Overall, there was a between-group association between having a healthcare-employed parent and higher anxiety symptom severity.

Conclusion Children of healthcare workers experience higher levels of anxiety disorders compared to their peers.

Keywords Anxiety Disorders; Family; Child

CITATION LINKS

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Introduction

In contemporary societies, the number of working parents has been steadily increasing each year [1]. In Iran, although precise statistics are not available, economic and social conditions have led to a noticeable rise in the number of families in which both parents are employed [2]. Employment, while enhancing the family's financial capacity and being associated with increased self-esteem [3] and efficiency [4] for parents, may also have adverse consequences for children, including heightened feelings of loneliness [5, 6] and anxiety [7].

Among working parents, healthcare professionals represent a group that experiences particularly distinct family conditions due to the unique demands of their occupation [8]. Employment in professions directly related to human health and life is associated with elevated levels of occupational stress among healthcare workers [9]. Furthermore, shift work and night duties can contribute to increased occupational burnout in this population [10]. Exposure to such work-related stressors may also be stressful for the children of healthcare workers [11]. In line with this, existing research indicates a high prevalence of stress experiences and mental health problems among children of healthcare professionals [11, 12].

One of the major psychological problems faced by children of healthcare workers is anxiety disorders [13]. According to the fifth edition, text revision of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5-TR), anxiety disorders comprise a category of disorders in which excessive fear, apprehension, and worry play a central role [14]. Somatic symptoms of these disorders include sweating, palpitations, mild gastrointestinal discomfort, headaches, and chest tightness, while affective and cognitive symptoms encompass irritability, speech disturbances, rumination, confusion, and impaired concentration. Notably, individuals with anxiety disorders are at an increased risk of suicide [15]. This category includes separation anxiety disorder, selective mutism, specific phobias, panic disorder, agoraphobia, generalized anxiety disorder, social anxiety disorder, anxiety disorders due to medical conditions, and substance/medication-induced anxiety disorders [14].

Anxiety disorders are the most prevalent mental disorders worldwide, affecting approximately 34% of the global population [16]. These disorders often emerge during childhood or adolescence, and affected individuals frequently present with comorbid mental disorders such as depression [17], as well as physical conditions including cardiovascular disease, hyperthyroidism, asthma, and epilepsy [18]. The prevalence of anxiety disorders is approximately twice as high in women as in men [14]. Due to their high prevalence, chronic course, and frequent comorbidities, the World Health Organization has ranked anxiety disorders as the ninth leading cause of health-related disability worldwide [19]. In addition to severely impairing daily functioning and quality of life, anxiety disorders impose a substantial societal burden, accounting for 3.3% of the global burden of disease [16].

The prevalence of anxiety disorders among children and adolescents is particularly high. In this regard, Liu *et al.* [5], in a 30-year trend analysis from 1990 to 2019, report that globally, 932 million cases of anxiety disorders occurred among children and adolescents. In Iran, Ahmadi *et al.* [20] found that the prevalence of psychiatric disorders among children and adolescents is 35.5%, with anxiety disorders being the most prevalent (22.2%). Among anxiety disorders, separation anxiety disorder (8.7%) and generalized anxiety disorder (8.6%) are the most common.

Several studies have compared psychological functioning, particularly anxiety disorders, in children with and without working parents. For instance, Pourakbari and Mosayebi Dariani [21] report no significant differences in anxiety levels between elementary school children of employed and unemployed mothers. In contrast, Fili *et al.* [22] found that overall anxiety, fear of physical injury, and generalized anxiety are significantly higher among children of employed mothers compared to those with unemployed mothers. Similarly, Fadakar *et al.* [23], using family drawings, show that children of employed mothers exhibit more anxiety symptoms. In that study, boys with employed mothers are more likely to omit themselves and devalue the mother figure compared to boys with stay-at-home mothers.

Despite these findings, studies comparing the psychological status of children with and without parents employed in the healthcare sector are scarce. In this context, Sadeghian Dehkordi and Motaghi [24] demonstrate that anxiety scores are significantly higher among adolescent children of healthcare workers compared to those of administrative staff. Khorsandi *et al.* [25] examined the impact of parental occupational status on the mental health of healthcare workers' children during the COVID-19 pandemic and, based on a review of existing studies, concluded that these children experience substantial psychological pressure, including anxiety, depression, increased violence, and suicidal ideation. Moreover, Dörtkardeşler *et al.* [11] found that children of healthcare workers report higher levels of moderate to severe anxiety and more sleep problems compared to their peers without healthcare-worker parents.

Overall, healthcare worker parents face numerous challenges, including high occupational stress, work-family conflict, feelings of guilt, insufficient time for parent-child interaction, and reduced emotional connection with their children [8]. Consequently, their children are more likely to experience loneliness, concerns about their parents' health, and health-

related worries due to their parents' stressful working conditions and shift schedules [11]. Therefore, gaining a clearer understanding of the psychological status of this group may be beneficial for healthcare families, as well as health-related institutions in designing and implementing preventive programs. This study aimed to compare anxiety disorders in children with and without a parent employed in the healthcare sector.

Instrument and Methods

Design and participants

This descriptive, causal-comparative study was performed on children and adolescents aged 10 to 18 years living in Rasht, whose parents were either employed in the healthcare sector or engaged in non-healthcare occupations in 2025. Considering that the minimum sample size recommended for causal-comparative studies is 30 participants per group [26], a total of 60 participants were selected through purposive sampling. The sample included 30 children with at least one parent employed in the healthcare sector and 30 children whose parents were employed in non-healthcare occupations.

The inclusion criteria were willingness of both the child and parents to participate in the study, literacy (ability to read and write), and absence of diagnosed physical, psychiatric, or psychological disorders—except anxiety disorders—based on the children's medical and psychiatric records. The exclusion criterion was refusal or failure to complete the questionnaire.

Instrument

Screen for Child Anxiety Related Emotional Disorders (SCARED; Birmaher *et al.*, 1997)

The SCARED was developed by Birmaher *et al.* [27] and consists of 41 items designed to assess anxiety disorder symptoms in children and adolescents aged 8 to 18 years based on DSM-IV criteria. The questionnaire yields a total anxiety score and five subscales: generalized anxiety disorder (items 5, 7, 14, 21, 23, 28, 33, 35, 38), separation anxiety disorder (items 4, 8, 13, 16, 20, 25, 29, 31), social anxiety disorder (items 3, 10, 26, 32, 39–41), school phobia (items 2, 11, 17, 36), and panic disorder/somatic symptoms (items 1, 6, 9, 12, 15, 18, 19, 22, 24, 27, 30, 34, 38). Items are rated on a three-point Likert scale ranging from 0 (not true) to 2 (very true or often true). A total score above 25 indicates the presence of an anxiety disorder. In the original study by Birmaher *et al.* [27], five factors were extracted, with internal consistency coefficients ranging from 0.74 to 0.93 across subscales. Test-retest reliability ranged from 0.70 to 0.90, and discriminant validity was confirmed, with an agreement coefficient of r=0.20.

In Iran, Palahang *et al.* [28] conducted an exploratory factor analysis using principal component analysis with varimax rotation, which resulted in the extraction of seven factors explaining 43% of the total variance. Internal consistency coefficients of the subscales ranged from 0.91 to 0.95 in the non-clinical sample and from 0.86 to 0.94 in the clinical sample, indicating satisfactory reliability.

Procedure

After obtaining official approval from Rahman Institute of Higher Education, the researcher visited Pars Hospital in Rasht. Following coordination with hospital management and receipt of research permission, participant recruitment was initiated. Among healthcare staff, those whose children expressed willingness to participate and whose parents provided informed consent were selected using purposive sampling in accordance with the study criteria, resulting in 30 participants. The comparison group, consisting of 30 children without parents employed in the healthcare sector, was also selected purposively from hospital visitors. Participants were assured that their responses would remain confidential, and written informed consent was obtained from parents prior to data collection.

Data analysis

Data analyses were conducted using one-way analysis of variance (ANOVA) and multivariate analysis of variance (MANOVA) in SPSS 27.

Findings

The mean age of participants was 9.34±2.14 in the group with a healthcare worker parent and 10.54±2.03 in the group without a healthcare worker parent. The mean scores of all anxiety-related parameters were higher among children with a parent employed in the healthcare sector compared to their counterparts (Table 1).

Table 1. Mean scores of anxiety disorders among children with and without a healthcare worker parent

Parameter	With healthcare-employed parent	Without healthcare-employed parent
Total anxiety score	61.83±1.38	32.47±1.43
Separation anxiety	13.08±0.45	8.49±1.06
Social anxiety	5.34±0.37	4.80±0.78
Generalized anxiety	15.73±0.71	10.01±0.67
School phobia	3.65±0.49	3.48±0.76
Panic/somatic symptoms	19.71±1.37	11.24±0.87

To examine group differences across the dependent parameters, MANOVA was conducted. Prior to conducting the analysis, statistical assumptions were evaluated. Normality of the data distribution was assessed using the Kolmogorov–Smirnov test; homogeneity of variances was examined using Levene's test; and homogeneity of the variance–covariance matrices was assessed using Box's M test; all were confirmed (p>0.05). All multivariate significance tests were statistically significant, supporting the appropriateness of conducting MANOVA. There was a statistically significant difference between children with and without a healthcare worker parent on at least one of the

dependent parameters (Hypothesis df=6, Error df=58, F=3.26): Wilks' Lambda=0.71 (p=0.001), Pillai's Trace=0.29 (p=0.001), Hotelling's Trace=0.41 (p=0.001), and Roy's Largest Root=0.41 (p=0.001).

A statistically significant difference was observed between the two groups in total anxiety scores (p<0.001), indicating that children with a parent employed in the healthcare sector differed in overall anxiety from children without a healthcare worker parent. In addition, a significant between-group difference was found for separation anxiety (p<0.05). No statistically significant between-group difference was found in social anxiety (p>0.05). However, a significant between-group difference was observed in generalized anxiety (p<0.001). No significant between-group difference was found for school phobia (p>0.05). Finally, the results revealed a statistically significant between-group difference in panic disorder/somatic symptoms (p<0.001; Table 2)

Table 2. Between-group comparison results of univariate analyses of variance assessing anxiety parameters (df=1 for all)

Parameter	Sum of squares	Mean square	F	p-Value
Total anxiety	281.37	281.37	14.20	0.001
Separation anxiety	183.17	183.17	1.98	0.020
Social anxiety	86.05	86.05	0.67	0.080
Generalized anxiety	196.44	196.44	2.08	0.001
School phobia	62.96	62.96	0.52	0.110
Panic/somatic symptoms	244.80	244.80	2.11	0.001

Discussion

This study compared anxiety disorders in children with and without a parent employed in the healthcare sector. Children with a parent employed in the healthcare sector exhibited significantly higher levels of overall anxiety compared to children whose parents were not employed in healthcare-related occupations. This result is consistent with previous studies conducted by Fadakar *et al.* [23], Sadeghian Dehkordi and Motaghi [24], Pourakbari and Mosayebi Dariani [21], Fili *et al.* [22], Khorsandi *et al.* [25], Şahin *et al.* [13], Adhikari [7], and Dörtkardeşler *et al.* [11].

Several explanations may account for this finding. One plausible factor contributing to higher anxiety levels among children of healthcare workers is the elevated occupational stress experienced by their parents. Healthcare professionals are often required to work long and irregular shifts, including night duties and weekends [29]. Such work schedules may substantially reduce the amount of time parents spend with their children, potentially leading to feelings of loneliness, emotional neglect, and insecurity in children. Moreover, working in healthcare settings is inherently stressful due to frequent exposure to critically ill patients, mortality, resource shortages, and organizational pressures. These stressors can negatively affect parents' mental health, increasing irritability, emotional exhaustion, and reduced emotional availability, which may indirectly influence children's psychological well-being.

In addition, healthcare workers are at heightened risk of occupational burnout due to excessive workload and chronic psychological pressure [30, 31]. Burnout may limit parents' emotional energy and responsiveness, impairing their ability to engage in warm, supportive, and emotionally attuned interactions with their children. As a result, children's emotional needs may remain unmet, increasing their vulnerability to anxiety symptoms.

Another important factor is children's concern about their parents' safety and health. Children of healthcare workers may worry that their parents are exposed to infectious diseases and could transmit illnesses to family members—a concern that becomes particularly salient during outbreaks of contagious diseases, such as the COVID-19 pandemic [32]. Additionally, children may fear that their parents could be physically harmed in high-risk clinical environments, such as emergency departments or intensive care units. These persistent worries may contribute to heightened anxiety and hypervigilance. Irregular work schedules may also complicate the arrangement of consistent childcare. Difficulties in securing stable caregivers at different times of day and night may result in children frequently transitioning between caregivers, fostering feelings of instability, insecurity, and a lack of predictability. Furthermore, healthcare worker parents may experience guilt due to limited time with their children [33, 34]. Such guilt may manifest as overly strict parenting practices or, conversely, attempts to compensate through material rewards rather than emotional connection. Both patterns may interfere with effective parent-child communication and emotional bonding.

Chronic stress and fatigue may further hinder parents' ability to communicate effectively with their children. Parents may struggle to listen attentively, demonstrate empathy, or respond adequately to their children's emotional concerns. From a social learning perspective, children also learn coping strategies by observing their parents' responses to stress. Continuous exposure to parental anxiety, distress, or depressive symptoms may increase the likelihood that children adopt similar maladaptive coping patterns, thereby elevating their risk of developing anxiety-related problems.

Despite its contributions, the present study has several limitations. First, data were collected using self-report questionnaires, which may be subject to response bias or inaccurate reporting. Future research could benefit from incorporating additional data collection methods, such as clinical interviews, parent or teacher reports, and observational measures, to obtain a more comprehensive assessment. Second, the causal-comparative design does not allow for causal inferences, and the observed relationships may be influenced by

unmeasured confounding parameters. Experimental or longitudinal designs with greater control over potential confounders are recommended to clarify causal pathways between parental occupational status and child anxiety. Finally, the findings are limited to children and adolescents aged 10 to 18 years who reside in Rasht in 2025. Conducting similar studies with younger children, older adolescents, and samples from different cities or cultural contexts would enhance the generalizability of the results.

Our findings highlight the heightened vulnerability of children of healthcare workers to anxiety-related problems. Greater awareness of this population's psychological needs may assist families and healthcare institutions in developing targeted preventive and supportive interventions to promote children's mental health and resilience.

Conclusion

Children of healthcare workers experience higher levels of anxiety disorders compared to their peers, likely influenced by parental occupational stress and psychological burden.

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