

Parental Overprotection and Anxiety among Adolescents: A Correlational Study

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Abstract: Parental overprotection, which combines high control with low encouragement of autonomy, has been linked to anxiety in young people, but findings are mixed. This correlational, cross-sectional online survey examined whether adolescents' reports of parental overprotection were related to their anxiety. Participants were 86 school-going adolescents aged 13 to 18 years ($M = 15.58$, $SD = 1.60$; 43 girls, 40 boys, 3 who preferred not to say), recruited by convenience (snowball) sampling. They completed the brief current form of the Parental Bonding Instrument (overprotection = control minus autonomy items, averaged across mother and father) and the child version of the Screen for Child Anxiety Related Emotional Disorders (SCARED). Overprotection was not significantly related to anxiety, Spearman $\rho(82) = .09$, 95% CI $[-.13, .30]$, $p = .415$, and results were similar for mothers, fathers, and in sensitivity analyses. The study could detect only correlations of about .30 or larger, and the overprotection scores had low reliability, so the result is inconclusive. Anxiety scores were high: 79.1% scored at or above the SCARED cut-off of 25. Larger samples and more reliable measures are needed.

Keywords: parental overprotection, adolescent anxiety, Parental Bonding Instrument, SCARED, correlational study

1. Introduction

Adolescence is a period in which young people seek more independence while still relying on their parents. Parenting that is highly controlling and limits autonomy, usually called parental overprotection or, in some studies, helicopter parenting, has been proposed as a risk factor for anxiety [10, 15]. Attachment theory suggests that excessive control can foster insecurity and dependence [3], and self-determination theory proposes that restricting autonomy frustrates a basic psychological need and so increases distress [5].

2. Literature Survey

Meta-analytic evidence supports a small-to-moderate link. McLeod et al. [9] found a weighted mean association of $r = .25$ between parental control and child anxiety, and van der Bruggen et al. [16] reported that observed parental control was associated with child anxiety ($d = .58$) while noting that the direction of the link is unclear. Recent studies of adolescents point the same way: overprotective or helicopter parenting was related to higher anxiety [12, 13], including social anxiety in early adolescents [6]. Sadoughi [13], for example, studied 391 adolescents and found that helicopter parenting predicted higher trait anxiety ($\beta = .367$).

The evidence is not consistent, however. A systematic review of 38 studies found that five of ten studies of helicopter parenting reported a direct relationship with anxiety, whereas eleven of twelve studies of controlling parenting did [17]. Some studies find only indirect links, for example through perceived control or frustrated psychological needs [4, 13], or links for mothers but not fathers [8], and a study of undergraduates found helicopter parenting related to lower well-being but not directly to anxiety [14].

3. Problem Definition

Many of the studies above involved children, emerging adults, or different measures of parenting and anxiety, so

further evidence is needed on how school-going adolescents' own reports of parental overprotection relate to their anxiety. The present study examined this relationship with two standard self-report measures. The null hypothesis was that there is no significant relationship between parental overprotection and anxiety among adolescents.

4. Methodology

4.1 Participants and Procedure

A correlational, cross-sectional survey design was used. Adolescents aged 13 to 18 years who were attending school were recruited by convenience (snowball) sampling: the researcher shared a link to an online form through WhatsApp contacts and asked recipients to pass it on to eligible adolescents. The form was open from 23 to 25 October 2026 and received 105 responses. Thirteen respondents were screened out by the form (3 under 13 years, 8 aged 19 or older, and 2 not attending school), and 92 adolescents completed the questionnaires. Six of them reported a diagnosed psychological condition and were excluded, leaving a final sample of 86 adolescents (mean age = 15.58 years, $SD = 1.60$; 43 girls, 40 boys, and 3 who preferred not to say; 81.4% lived with both parents). Two adolescents reported no regular contact with either parent and had no overprotection score, so 84 were included in the main analysis. With $n = 84$, a correlation had to exceed $|.21|$ to be significant at the .05 level, and power was 80% for a correlation of about .30. The planned sample was about 20 to 40 adolescents, and data collection stopped when the form was closed, so the sample size was not set by a power calculation.

The form began with an information sheet and a consent question; adolescents who did not agree would have been taken to the end of the form (none declined). No names or email addresses were collected, participation was voluntary, and participants could stop at any time. Consent was obtained from the adolescents themselves; consent from parents was not sought.

4.2 Measures

Parental overprotection: The brief current form of the Parental Bonding Instrument (PBI-BC) [7], derived from the Parental Bonding Instrument [10], has eight items for each parent, rated 0 (*never*), 1 (*sometimes*), or 2 (*usually*). Overprotection was scored as the sum of the two control items minus the sum of the two autonomy items (range -4 to +4; higher scores indicate more overprotection), separately for the mother and the father, and averaged across both parents (the score of one parent was used when the other was missing). A parent's ratings were set to missing when the adolescent reported no regular contact with that parent. The form was meant to skip a parent's questions in this case, but the skip did not work, so these adolescents answered for that parent as well and their ratings were set to missing at scoring. Cronbach's α for the four items was low (mother, .33; father, .46). The control items were items 2 and 6 and the autonomy items were items 4 and 8; the item wording is the author's present-tense adaptation of the content described by Klimidis et al. [7]. The remaining four items (two care and two rejection) gave a care score (care minus rejection, range -4 to +4; $\alpha = .49$ for mothers and .35 for fathers), used only in exploratory analyses.

Anxiety: Anxiety was measured with the 41-item child version of the Screen for Child Anxiety Related Emotional Disorders (SCARED) [1, 2]. Items describe feelings over the last three months and are rated 0 (*not true or hardly ever true*) to 2 (*very true or often true*). The total score (0–82) was analysed, and a score of 25 or more was used as the cut-off that may indicate an anxiety disorder [1]. Internal consistency in this sample was high ($\alpha = .94$). The scale yields five subscales (panic/somatic, generalised anxiety, separation anxiety, social anxiety, and school avoidance), which were used only in exploratory analyses.

4.3 Data analysis

Overprotection scores departed from normality (Shapiro–Wilk $p < .001$), whereas SCARED total scores did not ($p = .623$). The null hypothesis was therefore tested with Spearman's rank correlation, and Pearson's r is reported for comparison. Tests were two-tailed with $\alpha = .05$, and

confidence intervals used Fisher's z transformation. Three sensitivity analyses (a) kept the ratings of parents with whom the adolescent reported no regular contact, (b) excluded the five adolescents who gave the same answer to every SCARED item, and (c) included the six adolescents with a diagnosis. Exploratory analyses covered the five SCARED subscales (Holm correction), care, gender, age, and a hierarchical regression.

5. Results and Discussion

5.1 Results

Descriptive statistics are in Table 1. SCARED scores were high ($M = 37.62$, $SD = 16.36$), and 68 of 86 adolescents (79.1%) scored at or above 25. Overprotection scores were low on average ($M = -0.60$, $SD = 1.31$): three-quarters of the scores were at or below zero, meaning that most adolescents rated their parents as giving at least as much autonomy as control. Overprotection scores for mothers and fathers were moderately correlated, $r = .42$ ($n = 74$).

Table 1: Descriptive statistics and reliability of the study variables

Variable	<i>n</i>	<i>M</i>	<i>SD</i>	Range	α
Overprotection, mother	83	-0.54	1.49	-4 to 3	0.33
Overprotection, father	75	-0.69	1.59	-4 to 2	0.46
Overprotection, average of parents	84	-0.60	1.31	-4 to 2	—
SCARED total score	86	37.62	16.36	1 to 82	0.94

Note. Overprotection = control items minus autonomy items (possible range -4 to +4). SCARED = Screen for Child Anxiety Related Emotional Disorders (possible range 0 to 82). α = Cronbach's alpha.

Overprotection was not significantly correlated with anxiety, $\rho(82) = .09$, 95% CI [-0.13, .30], $p = .415$ ($\rho^2 = .01$). The Pearson correlation was larger but also not significant, $r(82) = .19$, 95% CI [-0.02, .39], $p = .078$. The correlations for mothers and fathers were similarly small (Table 2), so the null hypothesis was not rejected. The result changed little in the sensitivity analyses (ρ from .09 to .11, all $p \geq .34$).

Table 2: Correlations between parental overprotection and SCARED total score

Analysis	<i>n</i>	ρ	95% CI	<i>p</i>	<i>r</i>	<i>p</i>
Main analysis (average of parents)	84	0.09	[-.13, .30]	0.415	0.19	0.078
Mother only	83	0.15	[-.07, .35]	0.185	0.21	0.055
Father only	75	0.11	[-.12, .33]	0.339	0.15	0.208
No-contact ratings kept	86	0.09	[-.13, .29]	0.429	0.18	0.089
Straight-line responders excluded	79	0.11	[-.12, .32]	0.342	0.21	0.062
Diagnosed adolescents included	89	0.1	[-.11, .30]	0.368	0.2	0.061

Note. ρ = Spearman correlation (main test); r = Pearson correlation. CI = confidence interval for ρ . All tests two-tailed; none was significant. The n of 89 in the last row is one fewer than 90 (84 + 6) because at least one of the six added adolescents had no overprotection score.

In exploratory analyses, school avoidance had the strongest subscale correlation with overprotection ($\rho = .23$, $p = .032$), but it did not remain significant after Holm correction ($p = .159$); the other four subscales were not significant ($|\rho| \leq .20$, $p \geq .063$). Care was not significantly related to anxiety ($\rho = -.20$, $p = .065$). Adding overprotection to a regression that already included age and gender raised R^2 from .015 to .041,

a change that was not significant, $\Delta R^2 = .026$, $F(1, 77) = 2.10$, $p = .152$ ($n = 81$). Girls and boys did not differ in anxiety ($M = 35.30$ and 39.50), Welch $t(74.5) = -1.15$, $p = .252$, but girls reported lower overprotection than boys ($M = -0.94$ and -0.31), Mann–Whitney $U = 613.5$, $p = .049$, an uncorrected result that may be a chance finding.

5.2 Discussion

Adolescents' reports of parental overprotection were not significantly related to their anxiety, and the null hypothesis was not rejected. The correlation was positive, as theory predicts, but small ($\rho = .09$; $r = .19$), and the confidence intervals were wide enough to include both no relationship and a relationship close to the $r = .25$ reported for parental control in the meta-analysis by McLeod et al. [9]. The finding is therefore inconclusive rather than evidence that overprotection is unrelated to anxiety. It fits the mixed picture in the literature [17] and is closer to studies that found weak or indirect links [4, 14] than to those that found direct links.

Several features of the study may have limited the relationship that could be observed. The overprotection score rests on only four items per parent, and its reliability was low ($\alpha = .33$ and $.46$), which reduces observed correlations. Most scores were at or below zero, so there were few highly overprotected adolescents. Overprotection may also act through psychological needs and emotion regulation rather than directly [13], and these were not measured. The correlation was slightly larger for mothers ($\rho = .15$) than for fathers ($\rho = .11$), the same direction as in an earlier longitudinal study [8], but neither was significant and the difference was not tested.

Anxiety scores were high, with 79.1% at or above 25. The SCARED is a screening tool, and a score of 25 or more indicates the need for further assessment, not a diagnosis. The proportion is far above the pooled prevalence of anxiety disorders in children and adolescents (6.5%) [11], which suggests that adolescents who chose to take part, or the cut-off in this sample, over-represent anxiety. Careless responding may also have contributed, because the form was anonymous and unsupervised and five adolescents gave the same answer to every SCARED item, although excluding them changed the correlation little. The result should not be read as the prevalence of anxiety among adolescents.

6. Conclusion

In this sample, parental overprotection was not significantly related to adolescent anxiety. Because of low reliability of the overprotection scores and limited power, a small or moderate relationship cannot be ruled out. High anxiety screening scores suggest that adolescent anxiety deserves attention in schools whatever its causes.

7. Future Scope

The design was cross-sectional and correlational, so no causal conclusion can be drawn. Both measures were self-reported by the adolescents, the sample was small, and it was recruited online through personal contacts, so it is not representative and eligibility could not be checked, and the number of adolescents reached and the response rate are unknown. Diagnosis was identified by a single self-report question, the questionnaires were in English only, some SCARED items refer to parents and may overlap with perceptions of parenting, and no ethics committee approval was obtained (see Declarations). Many exploratory tests were run, so the two nominally significant exploratory results (school

avoidance before correction, and the gender difference in overprotection) may be chance findings. Future studies should use larger samples, longer parenting measures with adequate reliability, reports from parents as well as adolescents, and longitudinal designs that test indirect pathways.

Declarations

Ethics and consent: Participation was voluntary and anonymous, and each participant gave informed consent online before taking part. Consent from parents was not sought. No institutional ethics committee approval was obtained; the study was carried out as MSc project work under the guidance of a project guide, and no formal justification for not seeking parental consent was documented. The information sheet told participants that they could stop at any time and that it can help to talk to a trusted adult or their school counsellor if they felt upset; no helpline details were provided, and because responses were anonymous, individual scores could not be fed back to participants.

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Data availability: The anonymised dataset is available from the corresponding author on reasonable request.

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