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SHORT COMMUNICATION

PSYCHOPATHOLOGY AND ANXIETY PERCEPTION AMONGST PARENTS OF CHILDREN WITH

SCHOOL REFUSAL

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# INTRODUCTION

In keeping with society’s expectation concerning education and school attendance, most children attend school on a regular and voluntary basis. For some chil- dren there is difficulty in attending school plagued with emotional distress, especially anxiety and depression. Terms such as school phobia or separation anxiety may be used interchangeably but the term school refusal is preferable due to its descriptive and comprehensive nature1-6.

School refusal is noted in around 3-5% of most school going children across a varied age distribution and with no particular sexual dichotomy7-9. Various forms of anxiety have been implicated as a causative factor in school refusal by the child. These may range from sepa- ration anxiety to simple fears and phobias and at time panic and social phobia10-12. School refusal may be seen due to the presence of conduct disorder or oppositional defiant disorder on one hand and may be linked to ag- gressive peer groups, poor school climate, poor teach- ing and parent illiteracy with poverty on the other13-18.

Problems in family functioning have been high- lighted as a contributing factor to school refusal in vari- ous studies19-20. Parental emotional problems and insta- bility have also been implicated21. Harsh rearing prac- tices, avoidant and anxiety promoting behavior along with parental over protectiveness are the other factors put forward by some authors22. It has been noted fami- lies of children with school refusal are often rigid where no emotional freedom exists23. There have been few systematic studies on family functioning and parental psychopathology in children with school refusal24-26. These families are often ones where the family structure is ill defined and the parents often have incomplete per- sonality development27. Parents of children with school refusal have been found to be high on neuroticism and also report substantial marital discord in their lives28. Parents of children with school refusal have been diag- nosed as cases of simple or social phobia and panic disorder with agoraphobia to greater extent than the normal population29.

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The present study looks at psychopathology in parents of children with school refusal examining moth- ers and fathers separately. It also highlights the differ- ences between parents in perceiving the anxiety of their children. The clinical setting for the study was one in keeping with routine clinical practice in India.

# SUBJECTS AND METHODS

The subjects for the study were children with school refusal and their parents that presented to a pri- vate psychiatric clinic in Mumbai, India. All children be- longed to the age group 8-12 years and were studying in a non boarding full day school.

All the children in the study experienced consid- erable emotional distress in attending school due to various forms of anxiety on clinical assessment. All chil- dren had missed at least 10 days of school in the last month prior to presentation. This was the clinical criteria to select children with school refusal as it is not a DSM- IV / ICD diagnosis as yet. The cause of school refusal was not selected.

The children were not diagnosed as having any other psychiatric disorder and were not under psychiat- ric treatment in the past. This was ruled out on the basis of a clinical interview and history taking. This was im- portant to the study as many children with conduct disor- der or oppositional defiant disorder may exhibit school refusal as well. Such children were not selected for the study. Also in such cases the school refusal is more of truancy than actual school refusal related to anxiety or depressive causes.

All children had normal intelligence and no form of learning disability existed. This was ruled out by cur- rent and past academic performances and scrutiny of their notebooks and last exam papers for tell-tale signs of learning disability in their writing. None of the chil- dren had any major physical illness on routine medical examination.

The parents of child were selected on the basis that they were both staying with child and spent at least 3-4 hours with the child on a daily basis. The parents did not suffer from any psychiatric disorder and were not on any psychiatric treatment ever. The age group of the parents was between 30-50 years. All children and par- ents had a nuclear family constellation. Psychiatric dis- order in the parents was assessed by clinical assess-

ment and history taking with no formal assessment pro- cedure being used. We selected such a stringent sample as we did not wish to have many confounding factors affecting the rate of school refusal in the children. We accept that a selection bias could be present but we felt this was necessary in the demonstration of psychopa- thology and anxiety perception in an otherwise normal group of parents. This may be a limitation of our study. There was no specific reason for the age criteria of par- ents except to maintain uniformity. It was also noted and mandatory that the child was in the same school and place of residence for the last 5 years.

52 sets of parents and children were screened and 43 met the inclusion criteria for the study. Of these 38 agreed to participate in the study and written informed valid consent was taken for the same after explaining to the parents, the nature and purpose of the study. Socio- demographic data and data with regard to variables for the study were collected using a semi-structured inter- view from both parents and children.

The study population was from diverse schools across Mumbai and included parents from all strata socio- economically. Hence they were a diverse group demo- graphically and represented the population of the area.

# INSTRUMENTS USED

The parents were administered the following tests –

1. *The Symptom Checklist – 90 (SCL-90)* – a comprehensive instrument used to assess general psychopathology and consists of 90 items as a self report scale which has been widely used in both normal and distressed populations. The items are divided into 9 sub scales that include various forms of psy- chopathology. The scales have a likert type scale of distress from 0 to 4. Scores are de- fined as General Symptom Index (GSI) with higher scores representing more psychopa- thology. Scores on each scale range from 0 to 0.99 (normal) while scores > 1 indicate psychopathology30.
2. *Spence Children Anxiety Scale (Parent Re- port) (SCAS-P)* – this is a self report question- naire with 39 items. It assesses various forms of anxiety in the child in 6 sub scales and a total score. The total score ranges from 0-

114. It has been used in a variety of clinical settings with reliability and validity being established across diverse populations31-34. This scale was chosen primarily as it gives a better description of the type of anxiety, a subjective experiences rather than a symp- tomatic approach. Parent and child versions were chosen for comparison as well as dual informants as in child psychology and psy- chiatry, it is well known that disagreements

in perception between parents and children occur35.

The children were administered the following scale –

*Spence Children’s Anxiety Scale (SCAS)* – this is a self report questionnaire made up of 39 items with a similar scoring pattern as in the parent report form.

Both parents and children were administered the tests on the same day. The Spence Scales had not been validated in India and hence no references for the same available.

# STATISTICAL ANALYSIS

The data was analyzed using the student t test with two tailed p values being obtained and p<0.05 being regarded as significant. The entire analysis was done by a qualified bio-statistician.

# RESULTS

No major differences were noted in the socio-de- mographic data of both parents. Mean ages of the fa- thers was 43.6 years and mothers was 39.4 years. Ma- jority of both parents were graduates and above (> 80%). 92% of the fathers were employed while 42% of mothers were housewives in keeping with Indian cultural stan- dards. Mean age of the children was 9.4 years.

On assessing the scores on the SCL-90 scale (table 1), it was found that mothers showed significantly greater scores on phobic anxiety (p = 0.0380), somatization (p

= 0.0134) and depression (p = 0.0059). Both parents had higher scores towards psychopathology on the anxi- ety, obsessive compulsive and general symptomatic in- dex scales. A high degree of interpersonal sensitivity and obsessiveness was noted in both groups depicting a lot about personality patterns of the parents.

On assessing the proportion of the scores on SCL- 90 (table 2), greater number of mothers gave abnormal scores on the somatization (p = 0.0001), depression (p

= 0.008) and phobic anxiety (0.0135) subscales. This was in keeping with the findings seen in table 1. Equal number of both parents had high scores on the general symptomatic index. A high degree of psychopathology was noted in the area of interpersonal sensitivity and general anxiety was noted in both mothers and fathers.

On comparing how the parents perceived their child’s anxiety, fathers perceived social phobia (p = 0.0160) and obsessive compulsive behavior (p = 0.0369) to a greater extent than their children who perceived separation anxiety in a larger manner (p = 0.0056) in table 3. Comparing the mothers and children, we found mothers perceived panic and agoraphobia significantly more (p = 0.0001) in table 4 while on all other scales there was no difference noted . Entire groups of fathers, mothers and children were compared to each other and individual children were not compared to what their parents perceived.

Table 1

Psychopathology in the Parents based on SCL-90 scores

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **SCL-90 scales** | **Mothers (n = 38)** | **Fathers (n = 38)** | **t value** | **p value** |
|  | **Mean ± SD** | |  |  |
| Somatization | 1.03 ± 0.62 | 0.72 ± 0.42 | 2.5327 | *0.0134\** |
| Obsessive Compulsive | 1.32 ± 0.63 | 1.46 ± 0.78 | 0.8607 | 0.3922 |
| Interpersonal Sensitivity | 1.23 ± 0.59 | 1.16 ± 0.74 | 0.4559 | 0.6498 |
| Depression | 1.13 ± 0.66 | 0.78 ± 0.38 | 2.8380 | *0.0059\** |
| Anxiety | 1.96 ± 0.67 | 1.83 ± 0.71 | 0.8443 | 0.4012 |
| Anger Hostility | 0.43 ± 0.22 | 0.51 ± 0.36 | 1.1689 | 0.2492 |
| Phobic Anxiety | 1.15 ± 0.69 | 0.86 ± 0.49 | 2.1124 | *0.0380\** |
| Paranoia | 0.57 ± 0.38 | 0.59 ± 0.36 | 0.2355 | 0.8144 |
| Psychoticism | 0.54 ± 0.31 | 0.63 ± 0.44 | 1.0308 | 0.3060 |
| General Symptomatic Index (GSI) | 1.16 ± 0.68 | 1.09 ± 0.64 | 0.4621 | 0.6454 |

* Significant (p < 0.005) Paired t test used in the statistical analysis

Table 2

Ratio of the Scores of Parents on the SCL-90 scales

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Scale** |  | **Mothers (n = 38)** | **Fathers (n = 38)** | **X2(df = 1)** | **p value** |
| Somatization | Normal | 20 | 34 | 12.539 | *0.0001\** |
| Psychopath | 18 | 04 |
| Obs. Comp. | Normal | 24 | 19 | 7.143 | *0.007\** |
| Psychopath | 14 | 19 |
| Interpersonal | Normal | 26 | 25 | 0.0312 | 0.8624 |
| Psychopath | 12 | 13 |
| Depression | Normal | 18 | 26 | 6.854 | *0.008\** |
| Psychopath | 20 | 12 |
| Anxiety | Normal | 17 | 18 | 0.0234 | 0.8875 |
| Psychopath | 21 | 20 |
| Anger Hostility | Normal | 34 | 35 | 0.091 | 0.7641 |
| Psychopath | 04 | 03 |
| Phobic anxiety | Normal | 18 | 23 | 2.231 | *0.0135\** |
| Psychopath | 20 | 15 |
| Paranoia | Normal | 36 | 37 | 0.098 | 0.7646 |
| Psychopath | 02 | 01 |
| Psychoticism | Normal | 37 | 35 | 0.812 | 0.3682 |
| Psychopath | 01 | 03 |
| GSI | Normal | 25 | 24 | 0.0312 | 0.8624 |
| Psychopath | 13 | 14 |

* Significant (p < 0.005) Chi square test used in the statistical analysis.

Table 3

Children Versus Fathers Scores on Spence Children Anxiety Scale

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **SCAS Scales** | **Children N=38** | **Fathers N=38** | **t value** | **p value** |
|  | **Mean ± SD** | |  |  |
| Panic Agoraphobia | 13.8 ± 6.2 | 14.3 ± 4.2 | 0.4116 | 0.6818 |
| Separation Anxiety | 13.6 ± 7.7 | 9.6 ± 3.9 | 2.8568 | *0.0056\** |
| Physical Injury Fears | 7.8 ± 3.8 | 9.3 ± 4.3 | 1.6113 | 0.1141 |
| Social Phobia | 9.6 ± 4.2 | 12.4 ± 5.6 | 2.4658 | *0.0160\** |
| Obsessive Compulsive | 5.6 ± 3.1 | 7.4 ± 4.2 | 2.1256 | *0.0369\** |
| Generalized Anxiety/ Over-anxiety | 11.7 ± 6.8 | 13.4 ± 6.8 | 1.0897 | 0.2794 |
| Total Score | 66.3 ± 19.2 | 69.4 ± 21.6 | 0.6612 | 0.5105 |

* Significant.

Table 4

Children Versus Mothers Scores on Spence Children Anxiety Scale

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **SCAS Scales** | **Children N=38** | **Mothers N = 38** | **t value** | **p value** |
|  | **Mean ± SD** | |  |  |
| Panic Agoraphobia | 13.8 ± 6.2 | 19.6 ± 5.1 | 4.4536 | *0.0001\** |
| Separation Anxiety | 13.6 ± 7.7 | 13.2 ± 4.7 | 0.2733 | 0.7854 |
| Physical Injury Fears | 7.8 ± 3.8 | 7.2 ± 4.1 | 0.6616 | 0.5103 |
| Social Phobia | 9.6 ± 4.2 | 10.2 ± 5.8 | 0.5165 | 0.6070 |
| Obsessive Compulsive | 5.6 ± 3.1 | 6.3 ± 5.8 | 0.6561 | 0.5138 |
| Generalized Anxiety/ Over-anxiety | 11.7 ± 6.8 | 12.6 ± 7.1 | 0.5643 | 0.5742 |
| Total Score | 66.3 ± 19.2 | 74.2 ± 23.3 | 1.8130 | 0.1111 |

*\* Significant.*

# DISCUSSION

School refusal is commonest between children of the age 6-12 years10. Our sample represented that age group. Most of the parents in our study were graduates and relatively well educated. This could probably mean that this group of parents had higher expectations from their children and this pressure may at times contribute to school refusal.

Anxiety from mothers is often passed on to the child and he may be brought up in an environment that is anxious with fears being inculcated in him. The child may thus have a propensity towards school refusal26. Mothers with unexpressed anxiety and depression are likely to express somatic symptoms. This may serve as a

model for the children to express somatic symptoms and exhibit school refusal36-38. A depressed mother may voice thoughts about suicide in front of the child and cause separation anxiety. She may also show neglect for the child. This may in turn cause the child to reciprocate in the form of school refusal25. These factors are in keeping with the psychopathology noted in mothers of children with school refusal in our study.

Fathers in the study showed higher perception of social phobia and obsessive compulsive anxiety. We hypothesize that this may be in keeping with their own anxious and obsessive temperaments which they try and project onto their children20. We could also say that fathers probably misinterpreted the anxieties of their children. Mothers perceived panic and agoraphobia to

a greater extent. This panic in mothers exhibits their temperament which begets further anxiety in the chil- dren. Lack of differences between scores on mothers and children on all other scales indicates that mothers understood their children better and also perceived their child’s anxiety in the right manner. Using parental psy- chopathology and anxiety perception in family based interventions for school refusal is important for a com- plete solution to the problem39.

# LIMITATIONS

A number of limitations exist with respect to the present study. First would be the small sample size of the study. It is not possible to generalize these findings to larger groups. This was a clinic referred sample and not a community based sample. We have been rigid in our inclusion and exclusion criteria and thus had a group of parents devoid of non anxiety co-morbid psychiatric pathology as well any major psychiatric disorder. The converse is true in a majority of cases with school refusal. The lack of structured clinical interviews in the assessment and ruling out of psychiatric disorders is another caveat. As mentioned earlier a selection bias and lack of validated scales may be another con- straint.

# CONCLUSIONS

Parental psychopathology may be an important factor in school refusal as shown in our study. Many a times the parents may project their psychopathology onto their children which may lead to various psychiatric prob- lems in the child. Parents often think for their children without realizing what is in their child’s mind. The differ- ences in anxiety perception between children and their parents is an indication of the same. It is not surprising that school refusal causes much distress to the child, parents and school personnel alike. It is not understood whether nature or nurture causes school refusal, or whether parental psychopathology has genetic effect to it. Studies do not confirm whether exposure to this psy- chopathology in the growing stages of the child leads to school refusal. The heterogeneity of school refusal and variable family dynamics involved, warrant further re- search and larger studies across diverse cultures and in both home and school settings. It is important for all those involved with school refusal to realize that it is a vexing problem where the treatment has to involve both the child and his parents.

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