

Parent-Child Relationships in Children presenting with Somatic complaints: A Comparative Study

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Abstract

Introduction: Somatization account for disproportionately large number of visit to physicians and out-patient clinic. Many of the psychological problems present with pure somatic symptoms. The long term impact of Somatization is poor and results in compromised outcome in various areas. Children with faulty parent-child relationship are more prone to develop psychological problems and Somatization. Therefore, the present study was planned to assess the impact of parent child relationship on somatic presentation of children.

Aim and objective: To assess the relationship between parent-child relationship and somatic presentation in children.

Research design and methods: It was a cross-sectional, case-control study design. The study was conducted in Pt. B.D.Sharma, PGIMS, Rohtak, a tertiary care centre in northern India. The children of age between 9-14 years attending Paediatrics OPD with psychological and emotional problems formed the study group. They were referred to Department of Psychiatry for further evaluation. Thirty children who presented with somatic symptoms constituted the case group and thirty children with other psychological non somatic symptoms constituted the control group. The socio-demographic profile was taken on a specially designed proforma. The parent-child relationship was assessed by Children's Report of Parental Behaviour Inventory (CRPBI). The collected data was analysed statistically.

Results: We found that case group had significantly faultier parent-child relationship with both father and mother. Faulty father child relationship was associated with polysomatic and faulty mother child relationship was associated with monosomatic presentation.

Conclusion: Children presenting with somatic complaints should be properly evaluated for psychological stress due to faulty parent-child relationship.

Keywords: Parent-child relationship; Somatization; Faulty parenting

Introduction

Conversion disorder is by far the commonest form of somatoform disorder seen in children [1]. Children of low social competence tend to rely on somatic symptoms in the presence of stressful life events. The symptoms emerge that closely resemble a major medical or neurological condition, which is often temporally associated with a significant psychosocial stressor, and is not explainable by a psychophysiological mechanisms or principles. Psychological factors, particularly adverse family situations, have been implicated in the etiology of somatization disorders in children [2]. Secondary gain seems to be an important factor in symptom development and a common source of secondary gain may be found in family dynamics. Children with illness and disability become the focus for family attention and shift emphasis away from marital, financial or interpersonal issues.

It has long been proposed that the parent-child relationship is a major determinant of the child's development and eventual psychological health in adulthood. In the 1950s, Bowlby highlighted the adverse effects of maternal deprivation on child development, and

Ainsworth suggested that a stable parent-child relationship develops the child's ability to tolerate separation from the mother for long periods and with less distress [3,4]. Parents are instrumental in teaching children to move fluidly from distressed to a neutral state [5]. Parenting factors, maltreatment and faulty parent child relationship are likely to mediate children's risk of developing dissociative symptoms. Several studies based on this proposition have focused on the qualitative aspects of the parent-child relationship as a vulnerability factor in adult psychopathology, particularly depression [6-8]. A limited number of studies are there which assessed the association between parent-child relationship and Somatization in children in Indian set up. Therefore, present study was planned to assess the impact of parent-child relationship on somatic presentation of children.

Material and methods

Sample

The study was conducted in Pt B D Sharma, PGIMS, Rohtak, Haryana, a tertiary care centre in northern India. The children for the study were referred from Pediatrics OPD of the same institute. Children between 9-14 years of age consecutively attending the

Pediatrics OPD with psychological and emotional problems were referred to Department of Psychiatry. A total of 60 children constituted the sample and were divided into two groups. 30 children who presented with somatic symptoms and fulfilled the inclusion and exclusion criteria comprised the case group. 30 children who presented with non-somatic symptoms constituted the control group.

Case group

Inclusion criteria

- Age group 9-14 years.
- Children presenting with somatic symptoms.
- Parents who gave consent for the study.

Exclusion criteria

- Organic brain disease
- Autistic spectrum disorder
- Mental retardation
- Epilepsy
- Attention deficit hyperactivity disorder
- Psychotic disorders
- Any comorbid physical illness.
- Control group

Inclusion criteria

- Age between 9-14 years.
- Children presenting with psychological (non-somatic) symptoms.
- Parents who gave consent for the study.

Exclusion criteria

- Same as the case group.

Measures

The socio-demographic profile was taken on a specially designed proforma which included details regarding the education status, occupation of the parents as well as the family type.

Children's Report of Parental Behaviour Inventory (CRPBI): The adoption of Children's Report of Parental Behaviour Inventory (CRPBI) is given by Saxena Uma and Saxena N.K. It is useful in assessment of parent-child relationship, personality development, and children's home adjustment. It is a self-administering in case of literate subjects and can also be used as an interview schedule in case of illiterate ones. It can be administered individually, as well as in groups. It contains 108 items representing 18 different dimensions of perception. The validity and reliability of the test is 0.79 and 0.81 respectively [9].

Diagnostic and Statistical manual of Mental disorder fourth edition (DSM-IV): The psychiatric diagnosis was made according to DSM-IV with the use of specific criteria described for specific diagnosis [10].

Study design

Statistical analysis

Results

| CRPBI | Cases (n=30) | Controls (n=30) | T value | P value |
|-------------------------------|--------------|-----------------|---------|-----------|
| Dimensions | Mean ± SD | Mean ± SD | | |
| Acceptance | 24 ± 9.32 | 28.66 ± 5.07 | 2.63 | 0.009* |
| Child-centeredness | 22.6 ± 8.38 | 26.80 ± 4.56 | 2.69 | 0.009* |
| Possessiveness | 24 ± 9.32 | 28.66 ± 5.07 | 2.63 | 0.009* |
| Rejection | 16.84 ± 8.76 | 12.45 ± 4.76 | 2.7 | 0.009* |
| Control | 19.2 ± 1.86 | 18.26 ± 1.01 | 2.71 | 0.008* |
| Enforcement | 17.6 ± 5.59 | 14.8 ± 3.04 | 2.69 | 0.009* |
| Positive involvement | 23.00 ± 6.67 | 26.5 ± 3.8 | 2.99 | 0.004* |
| Intrusiveness | 16.20 ± 2.80 | 17.6 ± 1.52 | 2.69 | 0.009* |
| Control through guilt | 20.80 ± 1.86 | 17.83 ± 1.27 | 2.66 | 0.010* |
| Hostile control | 19.00 ± 2.33 | 17.83 ± 1.52 | 2.69 | 0.009* |
| Inconsistent discipline | 18.20 ± 2.80 | 19.6 ± 1.52 | 2.69 | 0.009* |
| Non-enforcement | 15.60 ± 3.72 | 17.46 ± 2.03 | 2.69 | 0.009* |
| Acceptance of individuation | 24.00 ± 9.32 | 28.67 ± 5.07 | 2.71 | 0.008* |
| Lack of discipline | 12.80 ± 1.86 | 13.73 ± 1.01 | 17.92 | 0.0001*** |
| Instilling persistent anxiety | 19.20 ± 1.86 | 18.26 ± 1.01 | 2.71 | 0.008* |
| Hostile detachment | 17.00 ± 6.70 | 14.53 ± 2.03 | 2.69 | 0.009* |
| Withdrawal of relation | 16.40 ± 3.73 | 14.53 ± 2.03 | 2.69 | 0.009* |
| Extreme autonomy | 22.40 ± 5.60 | 25.20 ± 3.04 | 2.76 | 0.007* |

Table 1: Children Report of Parental Behavioural Inventory (CRPBI) for assessing relationship between fathers with children in the study group

| CRPBI | Cases n=30 | Controls n=30 | T value | P value |
|------------|------------|---------------|---------|---------|
| Dimensions | Mean ± SD | Mean ± SD | | |

| | | | | | | |
|-------------------------------|---------------|---|---------------|---|------|-----------|
| Acceptance | 23.33 9.58 | ± | 28.66 5.07 | ± | 2.4 | 0.019* |
| Child-centeredness | 22 ± 8.63 | | 26.80 4.56 | ± | 2.41 | 0.019* |
| Possessiveness | 23.33 9.58 | ± | 28.66 5.07 | ± | 2.4 | 0.019* |
| Rejection | 17.46 9.01 | ± | 12.45 4.67 | ± | 2.41 | 0.019* |
| Control | 19.33 1.91 | ± | 18.26 1.01 | ± | 2.43 | 0.018* |
| Enforcement | 18.00 5.75 | ± | 14.80 3.04 | ± | 2.49 | 0.015* |
| Positive involvement | 22.05 7.19 | ± | 26.5 3.80 | ± | 2.41 | 0.019* |
| Intrusiveness | 16.00 2.87 | ± | 17.6 1.52 | ± | 2.4 | 0.019* |
| Control through guilt | 20.66 1.91 | ± | 21.73 1.01 | ± | 7.22 | 0.0001*** |
| Hostile control | 19.16 2.39 | ± | 17.83 1.26 | ± | 2.3 | 0.024* |
| Inconsistent discipline | 18.00 2.87 | ± | 19.6 1.52 | ± | 2.4 | 0.019* |
| Non-enforcement | 15.33 3.83 | ± | 17.46 2.02 | ± | 2.4 | 0.019* |
| Acceptance of individuation | 23.33 9.50 | ± | 28.66 5.07 | ± | 2.41 | 0.019* |
| Lack of discipline | 12.66 1.91 | ± | 19.73 1.01 | ± | 2.4 | 0.019* |
| Instilling persistent anxiety | 19.33 1.91 | ± | 18.26 1.01 | ± | 2.43 | 0.018* |
| Hostile detachment | 17.5 7.19 | ± | 13.5 ± 3.8 | | 1.93 | 0.058 |
| Withdrawal of relation | 16.66 3.83 | ± | 14.53 2.02 | ± | 2.41 | 0.019* |
| Extreme autonomy | 22 ± 5.57 | | 25.2 3.04 | ± | 2.4 | 0.019* |

Table 2: Children Report of Parental Behavioural Inventory (CRPBI) for assessing relationship between mothers with children in the study group

| Parent child relationship | Cases (n=30) | | Controls (n=30) | | P value | |
|---------------------------|---------------|---------|-----------------|---------|---------|--------|
| | Father | Mother | Father | Mother | Father | Mother |
| Faulty | 10 (33.33) | 9 (30) | 2 (6.67) | 3 (10) | 0.009** | 0.048* |
| Healthy | 20 (66.67) | 21 (70) | 28 (93.33) | 27 (90) | | |

Table 3: Parent child relationship of father and mother with their children in the study group.

Discussion

The present study is carried out in tertiary care centre in northern India as an attempt to assess the impact of parent-child relationship on somatic presentation in children in Indian set up. In the present study, the parents of children with somatic complaints were poorly educated and the trends support that Somatization was more associated with lower education [11-13]. In our study, parents of Somatizing children were mainly in lower occupations and even unemployed. Most of them belonged to rural areas, had larger family size and lower annual income. The reason for Somatization in children of these families might be diversion of attention by the parents, and to gain family attention children may produce somatic complaints. It was also reported that lower socioeconomic status have been associated with higher levels of Somatization symptoms in children [14-16]. Similarly, another study found an increased incidence of psychiatric disorders in children exposed to markedly adverse circumstances of family life, including difficult socio-economic conditions [17]. It has been suggested earlier that the psychological distress is ill understood by masses in the underdeveloped and developing countries, and reported that somatic symptoms are preferred mode of expression of psychological distress in agricultural, primitive societies, developing countries as well as weaker and depressed members of society like female and children. [18]

Our study found that monosomatic presentation was more common in children and the most common presentation was pseudoseizure. Garber stated that 50% of children report one somatic complaint, 15% four or more and 1% have as many as 12 symptoms. Our study supports the finding of the previous study, that majority of somatising children had monosomatic presentation [19]. Dissociative disorders, mainly presenting as pseudosiezuers and fainting spells, with or without co-morbid diagnosis were found to be high in clinic populations in India [20]. On contrary, Mullick et al found that polysomatic presentation was commoner (92%) than monosomatic presentation. They also found that children have significantly higher rate of abdominal pain and adolescents showed higher rate of headache [21].

The present study also found that somatising children had more disturbed relationship with their parents as compared to non somatising children and supports the previous research findings [22,23]. Negative life events reported by parents are associated with children's emotional and behavioural problems [17]. Our study found that somatising group of children had significantly higher scores on dimension of control, rejection, enforcement, withdrawal of relations, instilling persistent anxiety and hostile detachment. However, in the control group, there was significant higher scores on the dimensions of acceptance, child-centeredness, positive involvement and noneforcement. A longitudinal study, including 196 children of 5-6 years of age who were followed up six times reported that high level of psychological control exercised by mothers combined with high affection predicted increases in levels of both internal and external problem behaviours in children. In contrast, behavioural control exercised by mothers combined with low level of psychological control decreased children's external problem behavior [24]. Another study done on 276 high school normal sample found that perceived parental psychological pressure correlated positively with depersonalization and trait anxiety among the adolescents whereas perceived parental warmth was positively associated with active coping [25]. Dissociation was associated with parental rejection and inconsistency in applying discipline [26]. It was also observed that children with disorganised or

avoidant attachment styles in relating to their mothers were at higher risk of developing dissociation in adolescence [27]. The results of a recent study indicated that adolescents with somatisation disorder perceived their parents being significantly more rejecting and also reported more anxiety and depressive symptoms compared to normal controls. Hostility/aggression and indifferent/negligence in mothers were found as significant predictors of somatisation disorder [28]. It has been reported that somatisation subjects were exposed greater levels of emotional abuse, with more perpetrators and a greater frequency and duration of victimization, compared to non somatising subjects [29]. Somatoform disorders were likely to occur more frequently in children and adolescents who have been severely maltreated than in others [30].

Also, it was found that highly somatising children were at increased risk of major depression and likely to describe panic attacks at 4-year follow-up. There was an increased risk of substance abuse and dependence in highly somatising children [31]. Another study carried out in a community sample, reported that dissociation is a mediating factor between overprotective parenting and depressive symptoms in males. Among females, dissociation mediated the relationship between inconsistent parenting and depressive symptoms [32]. Thus, it is postulated that parental inconsistency, parent's own dissociation, faulty parent-child relation may increase children's risk of developing dissociative symptoms and behavioural problems. Therefore, it becomes important to assess somatising children properly for psychological stress due to interaction with parents.

The present study has assessed parent-child relationship in a better way as it used Children Report of Parental Behaviour Inventory which is having 108 items divided into eighteen different dimensions. Although, it supports the findings of previous studies that somatisation is more common in children having faulty relationship with parents, but have few limitations. It was a cross-sectional study. A longitudinal, interventional study may throw more light on assessment and management of children having somatic symptoms as majority of mental disorders presented to the doctor at primary health care settings in developing countries include somatic symptoms. It was a hospital based study, done in tertiary care centre. The sample size taken was small, so the results cannot be generalised to general population. The present study has also not assessed the parental psychopathology which may be an important factor in producing psychological problems in children.

Conclusion

Current study shows that majority of somatizing children had conversion disorder, while few has undifferentiated somatoform disorder, while few had undifferentiated somatoform disorder. The non-somatizing children were mainly having depressive and anxiety disorders. Somatizing children had significantly faultier parent-child relationship with both the parents. Thus, future research focusing parental factors, parenting practices and parent-child relationship promises to provide important insight for improving intervention and prevention programs to decrease children's risk of developing somatisation.

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