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RELATIONSHIP BETWEEN PARENTING STYLE AND ANXIETY IN A SPANISH CHILDREN SAMPLE

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Abstract

The aim of this study is to ascertain whether there are any differences in the parenting practices experienced by two groups of children with, respectively, low-risk and high-risk scores for anxiety. A second objective is to determine which parenting variables are linked with the presence or absence of this kind of internalizing problem. From a sample of 550 subjects, we selected 180 children between 3 and 12 years of age who met a set of specific criteria as having either high risk scores (90 children) or low risk scores (90 children) for anxiety, according to the Behavior Assessment System for Children (BASC). After applying the Parent-Child Relationship Inventory (PCRI-M) to both parents, we carried out a binomial logistic regression analysis which resulted in a prediction model for 83.9% of the sample. The model was based on the following parenting variables: paternal involvement and support for autonomy, and maternal parental support, satisfaction with parenting, involvement, limit setting and role orientation. The paper also discusses the usefulness of our results for the planning of family intervention strategies. The information obtained has broad applications for interventions with families with anxious children, since parents' responses to the instruments used revealed patterns of behaviour that can be modified in both parents and children.

Keywords: anxiety; child rearing; parenting style; logistic models; limit setting.

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Introduction

González, Soriano and Navas (2013) define anxiety as instances of intense emotional strain associated with a child's fear of real or imaginary threats, accompanied by certain physiological symptoms such as sweaty palms, difficulty in breathing, palpitations, etc. In early childhood, this problem has generally been studied using classification systems such as the DSM-4-TR (APA, 2000), which focused specifically on three disorders that may occur in both young children and adolescents: separation anxiety, social anxiety and generalized anxiety. According to Echuburúa and Corral (2009), this classification system had shortcomings with regard to how the different forms of anxiety children are liable to suffer from are identified. In the DSM-5 (APA, 2013), therefore, anxiety disorders among children were not differentiated from other anxiety disorders experienced later in adult life, although González et al. (2013) have drawn attention to certain forms of anxiety which can be considered typical among school-age children, such as separation anxiety disorders (SAD) and school anxiety. Anxiety-related problems in children can also take other forms, such as social phobia, specific phobias, generalized anxiety disorder (GAD), obsessive–compulsive disorder and selective mutism (APA, 2013). That is way it is important preventing and addressing this problem during childhood.

Based on data supplied by the World Health Organization, Rando and Cano (2013) estimated that the incidence of anxiety disorders has increased from 6.20% in 2002 to 9.9% in 2007. A recent study showed that the incidence of anxiety disorders increases with child age, rising from 5.56% before 5 years of age to 12.32% between 6 and 12 and to 21.35% between 12 and 15 (Navarro-Pardo, Meléndez, Sales & Sancerni, 2012).

According to the DSM-5 (APA, 2013), prevalence rates for the different types of anxiety disorder among the child and youth population are: 19.3% specific phobia, 9.1% social phobia, 7.6% SAD and 2.2% GAD (Merikangas et al., 2010).

Given its internalizing nature, anxiety has no visible effect on the environment comparable to that of externalizing disorders. This renders it less perceptible and more difficult to detect (López, Alcántara, Fernández, Castro & López, 2010; Reynolds & Kamphaus, 2004). For Heredia (2014), evaluating anxiety in children is a more complex process than evaluating it in adults due to children's lack of autonomy in the early years of their lives, and because evaluation in itself is a constantly changing process. Difficulties in identifying this type of disorder in children may partly be due to the scarcity of suitable instruments of evaluation (Pedreira, 2000). One of the few standardized instruments that are available is the Behavior Assessment System for Children (BASC) (Reynolds & Kamphaus, 2004), an instrument that has been adapted for several countries, including Spain, and which can be used with young people between the ages of 3 and 18. Researchers into evaluation processes at these ages argue that information must be obtained

in the environment in which the problem occurs, and this instrument allows data to be submitted by parents and tutors, who it considers the principal source of information in the early years of a child's life.

Environmental factors, and above all those to do with their social background, greatly influence the development of anxiety disorders in children, and the social environment in which the child, their parents and their principal carers interact plays a crucial role.

In this respect, parenting style, defined as the complex pattern of parental behavior and attitudes towards the child in daily interactions, is especially important (Darling & Steinberg, 1993). One of the best known theories in this field, consider parenting style a combination of two factors: responsiveness (involvement, acceptance, attention and warmth) and demandingness (vigilance, domination or severity) (Maccoby & Martin, 1983). Although different combinations of these dimensions generate well differentiated parenting styles, most parents have problems adapting to the child's stage of evolution: either they fail to use parenting practices appropriate to the child's age, or they are not consistent, adopting a democratic approach in some situations and being more authoritarian in others (Torío, Peña & Caro, 2008). The unpredictability of parental behavior may have negative consequences for the child in terms of anxiety (Ross & Wynne, 2010).

Several studies have underlined the extent to which parenting styles influence the incidence of anxiety in children (Ballespí, 2014; Chorpita, Brown & Barlow, 1998; Espinosa, 2009; Rando & Cano, 2013). Parents who exert excessive control over their children may cause fears to arise in them by depriving them of the opportunity to confront problems directly (Rando & Cano, 2013). One attitude and form of behavior that has been found to be most clearly related to anxiety is parental overprotection, i.e. excessive control of children's behavior by their parents (Affrunti & Ginsburg, 2012; Hirshfeld, Biederman, Brody, Faraone & Rosenbaum, 1997; Stubbe, Zahner, Goldstein & Leckman, 1993; Toro, 2014). This type of behavior limits a child's psychological autonomy and their freedom to act independently (Del Barrio, 2010; Hudson & Rapee, 1997; Siqueland, Kendall & Steinberg, 1996; Yap, Fowler, Reavley & Jorm, 2015), negatively affecting their personal competence (Chorpita, et al., 1998) and increasing their sense of vulnerability (Hudson & Rapee, 2000). Other relevant forms of parental behavior include stimulating or reinforcing responses to an aversive stimulus (Barrett, Rapee, Dadds & Ryan, 1996; Chorpita, Albano & Barlow, 1996; Dadds, Barrett, Rapee & Ryan, 1996), or reinforcing fearful behavior in a child by showing excessive interest in them (Spence, 1994). Parents' high expectations and emphasis on academic achievements may also cause anxiety in children (González et al., 2013).

According to Francis and Noël (2010), specific patterns of parental behavior may lead to a higher risk of inducing anxiety in offspring than the existence of certain types of disorder in the parents themselves. Children are more exposed to

anxiety when their parents' behavior is threatening, hostile or rejecting (Espinosa, 2009; Scher & Stein, 2003). Although the acceptance and rejection dimension appears principally to affect anxiety in younger children (Espinosa, 2009), the results of a meta-analysis by McLeod, Wood and Weisz (2007) suggest that anxiety variance is affected more by parental control than by parental rejection. A recent study by Pereira, Barros, Mendonça and Muris (2014) showed that factors like maternal anxiety and overprotection can in fact influence the incidence of cognitive and emotional imbalances in children. Maternal impatience with parenting has increased in recent years due to the incorporation of women into the labor market, changing roles among family members and higher maternal stress levels, which affect women's relationships with their families in general and with their children in particular (Heredia, 2014; Levai et al., 2018; Pérez-Padilla & Menéndez, 2016). The resulting family conflicts may lead to anxiety, as the children involved perceive a less affectionate attitude in their parents (Young et al., 2013).

Despite the discoveries mentioned above, few works have to date attempted to analyze the interactive effect produced jointly by paternal and maternal parenting styles on anxiety levels in their children, and little information is available about specific family profiles which may act as predictors for anxiety disorders. The fact that anxiety is considered the most common mental, emotional and behavioral disorder, even above depression, emphasizes a need for studies capable of analyzing the main variables involved in interaction between children and their parents and producing results which can be used to prevent and improve the situation of those suffering from this disorder.

The first objective in this study was therefore to ascertain whether there are differences in the parenting style experienced by two groups of children who obtain high and low risk scores, respectively, on the anxiety measurement instrument. The second objective was to determine which parenting variables are linked with the presence or absence of this kind of internalizing problem. In other words, we aimed to develop a model capable of predicting membership of a group with high anxiety scores or a group with low anxiety scores, based on certain parenting variables.

Methodology

Participants

Pupils from infant and primary schools in Andalusia (Spain) were first analyzed in order to select a broad sample of participants from an average socioeconomic background. The study involved a sample made up of 180 subjects, divided into two groups. For the first group, 90 subjects were chosen with high-risk scores: that is to say, with T scores for anxiety higher than 60. 90 other subjects were then chosen, identical in terms of age, sex and school level but with T scores for anxiety lower than 40. These formed the low anxiety group.

Both groups comprised 46 boys and 44 girls of between 3 and 12 years of age, with average ages of 8.00 (SD= 2.756) in the high-risk group and 7.24 (SD=2.912) in the low-scoring group for anxiety. There were no significant differences between the two groups in relation to this variable, since t= -1.788 (p= 0.076). The children in each group were distributed as follows in terms of their school level: 33 from infant schools, 15 from the first and second levels of primary education, 20 from the third and fourth levels of primary education, and 22 from the fifth and sixth levels of primary education.

Instruments

To compile information, the following instruments were used an adaptation into Spanish of the "Behavior Assessment System for Children" (BASC) (Reynold & Kamphaus, 2004). The purpose of this system is to evaluate a wide range of pathological and adaptive dimensions using different sources of information (parents, teachers and children) and different methods (questionnaires, developmental history and observation). In this case, the questionnaires for parents were used. These questionnaires, which are divided into three levels according to age (3-6, 6-12, 12-18), have an internal consistency index of 0.70. Test-retest correlation (three month interval) was 0.85, 0.88 and 0.70 for the three levels of the questionnaire the parents completed. The internal consistency index for this sample was 0.74.

For this study, of the different scales included in this instrument, the anxiety scale was used. The instrument defines this scale as a measurement of "tendency to show fear or concern because of existing or unreal problems". The scale has internal consistency indexes of between 0.55 and 0.59, depending on the age of the subjects.

The scores obtained on any of the scales are transformed into T scores, which indicate the extent to which a particular score differs from the control group mean, thereby enabling comparisons to be made between subjects of different ages. These T scores can vary between 0 and 100, with a mean value of 50 and SD of 10. On the basis of the T scores, different levels are established: scores below 30 are considered very low, under 40 - low, between 40 and 60 - intermediate, over 60 - at risk, and over 70 - clinically significant.

The other instrument used was the PCRI-M parenting questionnaire by Roa and Del Barrio (2001), an adaptation of the Parent-Child Relationship Inventory (Gerard, 1994) which measures paternal and maternal parenting practices and attitudes using a direct score. It comprises 78 items with four response options (totally disagree, disagree, agree and strongly agree), grouped into seven scales. Higher scores on the different scales indicate greater agreement with the situation defined in each scale.

The seven scales are: (1) Social and emotional Support received by a mother or father; (2) Satisfaction with Parenting: satisfaction obtained by a parent

during parenthood; (3) Involvement: the level of a parent's interaction with and knowledge of the child; (4) Communication: the parent's perception regarding the effectiveness of communication with the child; (5) Limit Setting: the level of exigency in obedience of rules; (6) Autonomy: the ability to give the child independence; (7) Role Orientation: attitudes about the role played by each gender in parenting. A small social desirability scale is also included.

The internal consistency of the instrument for this sample, obtained using Cronbach's alpha coefficient, was 0.88. By scale, this coefficient ranged from 0.71 for the Support scale to 0.78 for the Satisfaction scale. For this sample, given the correlations between the different scales on the questionnaire, the questionnaire also showed good construct validity, especially in the most important parenting scales such as Involvement-Satisfaction with Parenting (0.51), Involvement-Communication (0.64), Limit Setting-Support (0.42), Limit Setting-Autonomy (0.44) and Satisfaction with Parenting-Limit Setting (0.37).

Procedure

Following approval by the Ethics Committee of the University of Cordoba (Spain), which certified that the project complied with all internationally established principles and with specific national legislation, 6 randomly chosen infant and primary schools were contacted in the provinces of Cordoba and Jaen. Of the 6, 2 were located in provincial capitals and the other 4 were located in other towns and villages. Once the school management had given their consent, each tutor gave the pupils' families instructions on how to fill out the questionnaires. Each family received an envelope containing one copy of the BASC in P format (for fathers), in its different versions depending on their son's/daughter's age, and two copies of the PCRI, one for the father and one for the mother. The envelope with the completed questionnaires, sealed to ensure anonymity, had to be handed in within two weeks. Following this mass screening, 180 subjects were selected (for details, see the *Participants* section).

Data analysis

To evaluate the possible effect of parenting variables on anxiety, an ex-post-facto design was applied with a quasi-control group. A dichotomic variable was used as the dependent variable, derived from the T score obtained for *anxiety*. The two options for this variable were 0 for subjects with a low *anxiety* score, and 1 for subjects in the risk area. For this study, subjects were selected if their T score for *anxiety*, as reported by their parents, placed them above the risk level, and another group was chosen with low *anxiety* scores, equivalent to the first group in terms of gender and school level.

Binary logistic regression analysis was then performed. Based on the coefficients estimated by logistic regression for each of the variables, in accordance with its

probability of belonging to either level of the dependent variable, this process classified each subject into one of the two categories proposed.

Logistic regression enabled various models to be established. Since the main purpose of this analysis was to establish a model that predicts the dependent variable using the independent variables, the most efficient model was the one that predicted the highest percentage of correctly classified subjects with the lowest number of possible variables,. This model comprises an equation made up of estimated coefficients and the scores of the different variables, producing a final score of between 0 and 1, with a cut-off point of .5. Scores between .5 and 1 indicate the probability of obtaining a high score in *anxiety*; scores between 0 and .5 indicate the contrary.

To perform these analyses, the following predictive variables were taken into account, from both paternal and maternal perspectives: Support, Satisfaction with Parenting, Involvement, Communication, Limit Setting, Autonomy and Role Orientation.

Results

We first focused on ascertaining whether there were any differences in the parenting style experienced by two groups of children and determining which parenting variables were linked with the presence or absence of anxiety. On the *anxiety* scale, for possible T scores between 0 and 100, the risk group obtained a mean T score of 67.43 (SD= 5.923), ranging from 60 to 85, whereas the low *anxiety* group obtained a mean score of 35.88 (SD= 3.117), with a minimum of 26 and a maximum of 40.

With respect to paternal and maternal parenting style factors, an analysis of variance (ANOVA) was carried out to compare the mean scores obtained by the risk group and the low score group. As we can see in *Table 1*, the low score group had significantly higher mean scores on all factors.

Table 1. ANOVA between the two groups for parenting scales

	VARIABLES	Risk score	S.D.	Low score	S.D.	$F_{(1,178)}$
	Support	23.87	3.523	27.37	3.530	44.333**
	Satisfaction	34.20	3.822	37.24	3.110	34.355**
	Involvement	42.61	3.572	45.83	4.106	31.551**
Fathers	Communication	28.40	3.009	29.81	2.910	10.228**
	Limit setting	30.96	3.940	34.69	5.016	30.831**
	Autonomy	24.02	3.072	27.30	3.055	51.505**
	Role orientation	27.09	3.942	29.59	4.205	16.930**

Mothers	Support	21.78	3.509	26.52	3.852	74.628**
	Satisfaction	33.31	3.948	37.58	2.115	81.679**
	Involvement	43.77	3.690	46.88	3.031	38.196**
	Communication	29.10	3.402	30.36	2.999	6.897**
	Limit setting	29.56	4.329	34.74	4.494	62.235**
	Autonomy	23.72	3.315	27.33	3.229	54.800**
	Role orientation	27.18	3.612	30.56	3.757	37.805**
	** p<.05					

Secondly, we wanted to develop a model that would predict membership of a group with high anxiety scores or membership of another group with low anxiety scores, based on certain parenting variables. The two groups were subjected to a binary logistic regression analysis, and a prediction model (one of a number of different possible models) was established comprising the seven factors described in *Table 2*. This seven-factor model was selected since it predicts whether a subject will belong to one group or the other for a large percentage of the sample with a fairly small number of variables. The goodness-of-fit for the model was good, with a chi-square of 130.596 and seven degrees of freedom, statistically different from zero. The Cox & Snell R-square and the Nagelkerke R-square also had good values: .516 and .688, respectively. The Hosmer-Lemeshow test to evaluate correspondence between the real and predicted values of the dependent variable did not provide significant results, since $X^2= 3.168$ (p=.923).

For subject classification, a mean percentage of 83.9% was obtained for correctly classified subjects, with small differences between the two groups: 84.4% for the risk group and 83.3% for the low score group. This model therefore offered a high level of sensitivity and specificity.

Table 2. Variables included in the model

VARIABLES	B	S.E.	Wald	d.f.	Sig.	Exp (B)	95% C.I. Exp (B)	
							Lower	Higher
Father's involvement	-.099	.065	2.293	1	.130	.906	.797	1.029
Father's autonomy	-.355	.096	13.546	1	.000	.701	.580	.847
Mother's support	-.141	.072	3.844	1	.050	.869	.754	1.000
Mother's satisfaction	-.338	.095	12.721	1	.000	.713	.593	.859
Mother's involvement	-.116	.088	1.746	1	.186	.890	.749	1.058

Mother's limit setting	-.100	.065	2.420	1	.120	.904	.797	1.026
Mother's role orientation	-.159	.070	5.115	1	.024	.853	.743	.979
Constant	42.002	7.328	32.851	1	.000	1.743E18		

One of the main advantages of logistic regression analysis is that it can be used to create an equation for classifying a subject in one of the conditions of the dependent variable, and also to reveal the probability of a high level of *anxiety* depending on the score obtained for one or more of the independent variables.

The equation is:

$$b_1 = 1/1+e^{-z}$$

where:

$$Z = B_0 + B_1(X_1) + B_2(X_2) + B_3(X_3) + B_n(X_n)$$

and:

Z= linear combination of variables.
B_0= estimated coefficient of the constant regression.
B_1= estimated coefficient for variable 1.
X_1= subject's score for variable 1.
b_1= probability of belonging to the risk group.
e= base of natural logarithms (2.718).

By transferring the data from the study to the equation described above, we get:

$Z = 42.002 + (-.099)(X_1) + (-.355)(X_2) + (-.141)(X_3) + (-.338)(X_4) + (-.116)(X_5) + (-.100)(X_6) + (-.159)(X_7)$

where:

X_1= father's score for involvement.
X_2= father's score for autonomy.
X_3= mother's score for support.
X_4= mother's score for satisfaction with parenting.
X_5= mother's score for involvement.

X_6= mother's score for limit setting.

X_7= mother's score for role orientation.

Finally, the result obtained for Z is transferred to the first equation to obtain the probability of b_1, *i.e.*, the probability of obtaining a risk score in anxiety.

For two randomly chosen subjects, one from the low score group (subject number 34) and the other from the risk group (subject number 156), the b_1

probability obtained for the first was .032 < 0.5. This subject was therefore correctly classified by the model as belonging to the low score group. The score obtained for the second was .947 > 0.5. This subject was therefore also correctly classified by the model, this time as belonging to the risk group. The classification of different subjects according to their probability of belonging to one group or the other is shown in Figure 1. Most of the subjects in the risk group had scores of between 0.5 and 1, while most of the subjects with low scores had scores of between 0 and 0.5.   Of particular note was the strong joint influence of the variables "maternal Satisfaction" and "paternal Autonomy" on the possibility of belonging to either the risk group or the low-score group, since when only these factors were inserted as the independent variables in the logistic regression analysis, 79.4% of the subjects were classified correctly.
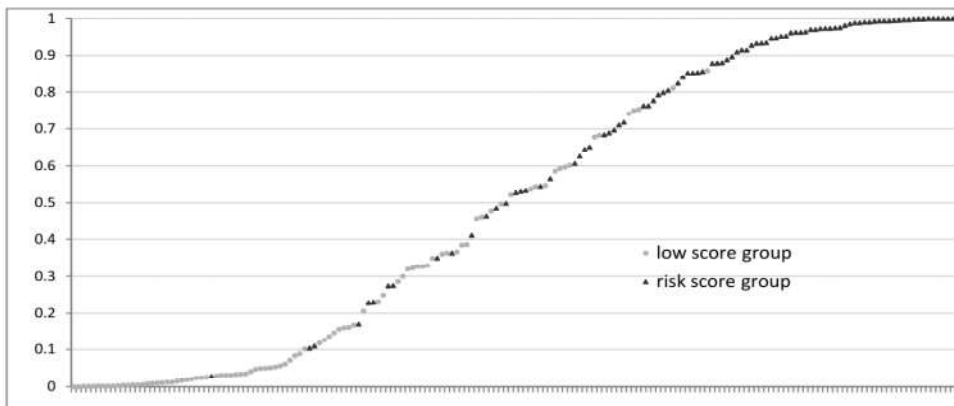

Figure 1. Observed groups and probability prediction

Discussion and conclusions

The purpose of this study was to analyze which factors in the parenting practices and attitudes of fathers and mothers were linked to a higher or lower probability of obtaining a score in the risk area of the BASC in relation to anxiety.

With regard to the first of our stated objectives, we can conclude that differences do exist between the behaviour displayed by the parents of the two groups of children. Focusing on the comparison that was carried out using the ANOVA described above, all the variables considered could act as good predictors of anxiety, because very significant differences are obtained in all cases. We therefore agree with Roa and Del Barrio (2001) that high scores on the PCRI scales relate to a more appropriate parenting style which facilitates better adaptation in children.

Turning to the second objective proposed in this study, based on the parenting practice model suggested by Darling and Steinberg (1993), it is possible to identify family models or general patterns of parental behavior that would seem to be directly related with anxiety in children. Even accepting methodological limitations like small group sizes, wide age and cross-sectional ranges, and the use of questionnaires and behaviour reports taken from a single source of information, the results obtained reflect major differences between the two groups; for nine out of every ten subjects included in the sample, a combination of low scores in involvement and autonomy granted by the father, and support, satisfaction with parenting, involvement, limit setting, and role orientation on the part of the mother, significantly increased the probability of scoring in the high-risk area of the BASC for anxiety.

The model created included a number of significant variables, but it also had some variables which, although not significant, contributed greatly to its predictive ability, increasing the number of correctly classified subjects. One particularly relevant variable was the degree of autonomy granted by fathers. Here, as Rando and Cano (2013) showed, an excess of control and lack of autonomy can lead to the appearance of certain fears and anxiety, depriving sons/daughters of their freedom of expression (Yap et al., 2015). Another important variable was maternal satisfaction with parenting. This coincided with other studies in which anxiety predictors strongly linked with satisfaction, like acceptance-rejection, were identified (Espinosa, 2009). Some other variables in our study, like the amount of support perceived by mothers and role orientation, are quite innovative. These two aspects highlighted the importance of family support networks in the prediction of anxiety in children. The study showed the value of such support and orientation in the mother's role in bringing up children. Indeed, when this is not forthcoming (either from the father or from other members of the family), the mother may experience emotional unease or anxiety, which in turn may have negative consequences (like lack of affection for her offspring) and more easily trigger anxiety in her children (Toro, 2014).

We cannot ignore that these kinds of problems must be analyzed in terms of interaction, since, although the family situation described might be a precursor to anxiety, these problems in children can also destabilize the family dynamic, generating inappropriate patterns of interaction with the parents.

Conclusion

Although the method used did not allow us to establish causal relationships, the information obtained has broad applications for interventions with families with anxious children, since the parents' responses to the instruments used reveal patterns of behaviour that can be modified in both parents and children. For this purpose, clear rules could be established and enforced through daily monitoring

strategies regarding different tasks, improved parent-child communication and the involvement of all members of the family in different parenting tasks to help achieve a healthy work/life balance for both parents.

Further research could be conducted to provide information about certain as yet unclarified aspects, such as the possible differences between the most important variables in anxiety prediction for young children and adolescents. Moreover, this study opens up a broad new avenue of research in which other problems may also be addressed.

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