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Research report

The Parental Overprotection Scale: Associations with child and parental anxiety

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ABSTRACT

Background: Parental overprotection has commonly been implicated in the development and maintenance of childhood anxiety disorders. Overprotection has been assessed using questionnaire and observational methods interchangeably; however, the extent to which these methods access the same construct has received little attention. Edwards et al. (2008, 2010) developed a promising parent-report measure of overprotection (OP) and reported that, with parents of pre-school children, the measure correlated with observational assessments and predicted changes in child anxiety symptoms. We aimed to validate the use of the OP measure with mothers of children in middle childhood, and examine its association with child and parental anxiety.
Methods: Mothers of 90 children (60 clinically anxious, 30 non-anxious) aged 7–12 years completed the measure and engaged in a series of mildly stressful tasks with their child.
Results: The internal reliability of the measure was good and scores correlated significantly with observations of maternal overprotection in a challenging puzzle task. Contrary to expectations, OP was not significantly associated with child anxiety status or symptoms, but was significantly associated with maternal anxiety symptoms.
Limitations: Participants were predominantly from affluent social groups and of non-minority status. Overprotection is a broad construct, the use of specific sub-dimensions of behavioural constructs may be preferable.
Conclusions: The findings support the use of the OP measure to assess parental overprotection among 7–12 year-old children; however, they suggest that parental responses may be more closely related to the degree of parental rather than child anxiety.

1. Introduction

Models of the development and maintenance of childhood anxiety disorders have commonly highlighted the central role of parental behaviours characterised by control and overprotection (Chorpita and Barlow, 1998; Murray et al., 2009; Rapee, 1997). These models have suggested that overprotective behaviours (in contrast to autonomy promotion) may convey to the child a sense that the world is dangerous, reinforce avoidance, and limit the child's opportunities to develop skills and confidence in managing potential challenges. Indeed, parental overprotection (and specifically a lack of autonomy granting) is the parenting dimension most consistently associated with child anxiety symptoms and disorders (e.g. McLeod et al., 2007; Van der Bruggen et al., 2008; Wood et al., 2003).

Parental overprotection has typically been assessed on the basis of parent or child reports on questionnaire measures, or by independent ratings of observed parent-child interactions. It has been suggested that questionnaire based methods may underestimate associations with child anxiety (McLeod et al., 2007), for example, due to social desirability effects. The extent to which these different methods of assessing parental overprotection tap into the same behavioural constructs has received little attention (Van der Bruggen et al., 2008; although there is some evidence of modest associations between parent responses to parenting vignettes and observational assessments; McShane and Hastings, 2009), and the validity of conclusions based on parenting questionnaires is unclear (McLeod et al., 2007). One questionnaire measure which has received sound empirical scrutiny is the Parental Overprotection (OP) measure. This is a 19 item parent report questionnaire developed by Edwards et al. (2008, 2010) to assess parenting behaviours that restrict a child's exposure to situations which the parent may perceive as being potentially

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threatening or harmful to the child. Notably, the responses given by parents of 3–5 year old children to this measure showed high levels of internal consistency, high levels of stability over time, and were found to correlate significantly with observer ratings of parental overprotective behaviours with their child in a physical threat task. Furthermore, both mothers' and fathers' scores on the OP measure were positively associated with change in child anxiety symptoms over a 12-month period (Edwards et al., 2010), suggesting that the measure also has good predictive validity.

The OP measure, therefore, is a potentially useful and efficient tool for the assessment of overprotective parenting behaviours; however, to date its use has been limited to preschool children from a community population. Given that the items included in the measure are likely to be applicable to older children (e.g. typical items include "I protect my child from his/her fears" and "I shelter my child from life's difficulties"), we were keen to examine its use in this context. We were also concerned to establish the utility of the measure in a clinical population. As studies of parenting in clinically anxious populations typically include children from about 7 years of age (Hudson and Rapee, 2001; Moore et al., 2004), our first aim was to evaluate the psychometric characteristics of the measure when completed by parents of 7–12 year old children.

Second, we set out to examine the association between OP scores and independent observations of parental behaviours; here we were interested to establish whether OP scores were specifically associated with observations of overprotective behaviours, and not other parental behaviours that have been found to be associated with child anxiety (i.e., those characterised by expressed anxiety or lack of positivity; McLeod et al., 2007; Wood et al., 2003).

Third, we investigated whether OP scores discriminate between children with a current anxiety disorder and non-anxious children, and whether associations were specific to anxiety, and were not accounted for by common comorbid difficulties (depression and conduct problems). Also, in view of Edwards et al.'s (2010) report of significant associations between OP scores and parental negative affect (anxiety, depression and stress), we were concerned to examine the extent to which the association between OP scores and child anxiety was accounted for by overlapping associations between child anxiety and parental anxiety or depression. We therefore set out to examine the association between OP and child anxiety, taking into account parental anxiety and depression. Finally, in previous reports, cross-sectional and longitudinal associations between OP and child anxiety were based entirely on parent reported child anxiety, which is known to be influenced by parental emotional states (Bernstein et al., 2005; Kroes et al., 2003; Lagattuta et al., 2012); we therefore examined the relative association between OP and child anxiety as reported by both parent and child.

2. Method

2.1. Participants

A sample of 90 children (51 male and 39 female), aged 7–12 years (M=9.3, SD=1.4), and their primary caregiving mothers, took part in the study. Of these, 60 children met diagnostic criteria for a primary diagnosis of an anxiety disorder (see below) and 30 children formed a non-anxious comparison group. This sample provided sufficient power (0.95) to detect a medium effect size (based on Edwards et al. (2008)) using multiple regression with up to four predictors.

Children in the anxiety disorder group were recruited through referrals to the Berkshire Child Anxiety Clinic at the University of Reading by local health and education service personnel. Children were only included if they had a primary diagnosis of an anxiety disorder based on a structured diagnostic interview with children and mothers (ADIS-C/P; see below). Primary anxiety disorders of the group were as follows: Separation Anxiety Disorder (26.7%), Generalised Anxiety Disorder (26.7%), Social Phobia (20%), Specific Phobia (16.7%), Agoraphobia without Panic Disorder (5%), and Anxiety Disorder Not Otherwise Specified (5%). The mean number of anxiety disorder diagnoses was 2.6 (SD=1.2) and the mean number of any diagnoses was 3.1 (SD=1.6).

Control participants were volunteers, recruited through invitation letters, sent predominantly through local schools and after school clubs, specifically asking for children to form a non-anxious comparison group. Children were screened on the basis of child and mother report on the Spence Children's Anxiety Scale- child and parent versions (SCAS-C/P; see below). Where children scored above the normal range (i.e., in the 'borderline' or 'abnormal' categories) they were thanked and not invited for further inclusion in the study.

Inclusion criteria across both groups required that both children and mothers did not have a known significant intellectual impairment, Autistic Spectrum Disorder (ASD) (determined by being registered within local learning disability and social communication services) or severe major depressive disorder, psychosis, or substance/alcohol dependence. Primary caregiver mothers could be either biological or adoptive mothers.

As shown in Table 1, the anxious and non-anxious groups did not differ according to ethnicity, socio-economic status, child age or gender. As planned, the two groups did differ on child anxiety symptoms (SCAS-P/C), and, as expected, they also differed on low mood (SMFQ-C) and conduct problems (SDQ-P). The groups did not, however, differ significantly on maternal self-reported anxiety (DASS-A) or depression (DASS-D). The majority of children (89%) came from families of White British origin, and from families whose socio-economic status was classified as higher/professional (74%; National Statistics Socio-Economic Classification, NS-SEC; HMSO, 2005).

2.2. Measures

2.2.1. Parental Overprotection Measure

The parental overprotection measure (OP; Edwards et al., 2008) was used to measure mother self-reported overprotective behaviour. The OP consists of 19 items designed to assess parenting behaviours that restrict a child's exposure to perceived threat or harm, with items mainly having a behavioural or situation specific focus, rather than more general attitudes and beliefs (e.g. "When playing in the park I keep my child within a close distance of me" and "I protect my child from criticism"). Parents are asked to rate the extent to which the item represents their typical response of a 5 point scale ranging from 0 (not at all) to 4 (very much). The OP measure has previously been found to have high internal consistency (Cronbach's alpha=0.87), strong test–re-test reliability, and good construct and predictive validity when used with a community sample of parents of 3–5 year olds (Edwards et al., 2008).

For the current sample, the Cronbach's alpha of the OP scale was 0.89, indicating a high level of internal consistency. A similar internal consistency was found when looking at the anxious and control groups separately (α=0.90 and α=0.86 respectively). Frequency of responses across the five descriptors for each item was generally good, although for three items in the scale ("I would not allow my child to go out with family friends if I were not present", "I am reluctant for my child to play some sports for fear he/she might get hurt", and "I accompany my child on all outings"), 'never' was endorsed by the great majority of mothers (i.e., 80% or more). However, analyses indicated that the internal consistency of the scale would not be improved by the deletion of