

Brief Report

Prevalence and Associated Factors of Emotional and Behavioural Difficulties during COVID-19 Pandemic in Children with Neurodevelopmental Disorders

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Abstract: Children and young people (CYP) with neurodevelopmental disorders (NDDs) may be particularly vulnerable to adverse mental health effects due to the COVID-19 pandemic. We conducted a cross-sectional U.K parent-reported study from 2nd April-2nd June 2020, using the Strengths & Difficulties Questionnaire. CYP with NDDs (n=371) compared to neurotypical controls, had a higher prevalence of emotional symptoms (42% vs 15%), conduct problems (28% vs 9%), and lower prosocial behaviours (54% vs 22%). Those with attention-deficit/hyperactivity disorder showed inflated conduct, and those with autism spectrum disorder exhibited decreased prosocial behaviours. Females with ASD had higher emotional symptoms compared to males.

Keywords: Autism Spectrum Disorder; Attention-deficit/hyperactivity disorder; Behavioural Neuroscience; Mental Health; COVID-19; Pandemic; Paediatric Neurology

1. Introduction

Children and young people (CYP) worldwide may be particularly vulnerable to the adverse mental health effects of lockdown, school closures, and physical distancing measures due to the COVID-19 pandemic [1,2]. Compared to neurotypical CYP, those with neurodevelopmental disorders (NDDs) such as autism spectrum disorder (ASD) and attention-deficit/hyperactivity disorder (ADHD), may be more vulnerable still. These CYP often struggle with changes in routine and restrictions to activity. It is imperative to understand the early mental health impacts across these common disorders to inform reasonable adjustments and interventions. Hence, we examined the prevalence of emotional and behavioural problems and associated factors for these symptoms in children with NDDs during the early stages of the COVID-19 pandemic.

2. Methods

We conducted a cross-sectional United Kingdom parent-reported study from 2nd April (10 days after the start of UK lockdown) to 2nd June 2020. We recruited a population-based convenience sample of children via social media and/or email lists disseminated via NDD charities and schools (King's College London Research Ethics Committee: LRU-19/20-15033). Using the Strengths & Difficulties Questionnaire, a standardized outcome measure used widely in observational studies with 25 items across 5 behavioural domains [3], we compared our data to previously published norms and a UK mental health cohort chosen due to similar characteristics [4,5]. We report descriptors, subscale mean scores (emotional, conduct, hyperactivity, peer, and prosocial), between-groups pairwise results after



adjustment for multiple comparisons, age, sex, and developmental level (general linear model multivariate procedure; IBM® SPSS v26.0), and effect sizes.

3. Results

Data for 453 children aged 4-15 years were analyzed (320 males; 70.6%). The neurodevelopmental diagnostic categories reported were: ASD (n=106), ADHD (n=183), and comorbid ASD+ADHD (n=82). CYP had an additional reported neurological diagnosis in 12% (n=3 cerebral palsy; 9 epilepsy; 10 genetic; 11 tic disorder; 12 developmental co-ordination disorder). Neurotypical CYP (n=82) show worse scores compared to norms on emotional symptoms and prosocial behaviour sub-scales (Table 1) [4]. Compared to neurotypical controls, children with NDDs had a higher prevalence of emotional symptoms (42% vs 15%; $\chi^2=21.0$, $p<0.001$), higher conduct problems (28% vs 9%; $\chi^2=13.2$, $p<0.001$), and lower prosocial behaviours (54% vs 22%; $\chi^2=22.5$, $p<0.001$). The emotional subscale was elevated across clinical groups (effect size 0.7-0.98); those with ADHD showed inflated conduct problems (effect size 1.12-1.17), and those with ASD exhibited decreased prosocial behaviours (effect size 0.97-1.06). Females with ASD had considerably higher emotional symptoms compared to males (mean [SD]= 7.2 [2.5] vs. 5.2 [2.8]; $t=4.7$, $p<0.001$). When compared to a pre-COVID-19 mental health cohort, our clinical sample scores reflect notably worse mental health in emotional symptoms, hyperactivity, and prosocial behaviour (Supplementary Table & Figures).

4. Discussion

These data suggest a high prevalence of emotional and behavioural difficulties in CYP, particularly with NDDs, during the early period of the COVID-19 pandemic. The comorbid ASD+ADHD group is particularly impaired with respect to conduct and prosocial behaviours. Females with ASD are particularly vulnerable to high emotional symptoms. The advantages of the method of recruitment include allowing population data to be collected in a short time and mitigating barriers imposed by the pandemic to community-based data collection. Limitations include cross-sectional data, and self-selected parent reports, which are potentially prone to selection bias. These data require replication in other studies, including those employing random sampling methods.

Children's vulnerability to mental health changes, especially for those with NDDs, should be considered when integrating them back into schools and daily life. The risk of second waves of COVID-19, and the reduction of social care, respite services and after school clubs pose further threats for families who have children with NDD. In addition, CYP with NDDs often have other neurological conditions that require management and are often impacted by mental health difficulties [1]. Whilst managing their own transitions back into new ways of working, clinicians, parents and teachers can likely expect increased mental health needs from CYP with NDDs which will require immediate support. A focus on wellbeing approaches with individualized transition planning may help ease reintegration. The pandemic risks widening inequalities for children, particularly in vulnerable groups. As such, this presents an opportunity to redress the imbalance and support children and families' wellbeing as we emerge into the 'new normal' world.

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Conflicts of Interest: The authors have no conflicts of interest to disclose.

Table 1. Strengths and Difficulties Questionnaire data for NDD clinical groups and controls during lockdown, and UK (pre-COVID-19) norms (n= 10298)[3].

SDQ Subscale	Diagnostic Category	Mean (SD)	95% CI	Effect size (Hedges' g) vs control (95% CI)	Pairwise comparisons for study groups† and summary t-test for controls vs UK norms
Emotional symptoms (0-10)	ASD	5.9 (2.8)	5.4-6.4	0.98 (0.67, 1.28)	ASD; ADHD; ASD+ADHD > control (p<0.01) Controls > norms t=3.9, p<0.001
	ADHD	5.1 (2.8)	4.7-5.5	0.70 (0.43, 0.97)	
	ASD+ADHD	5.5 (2.8)	4.9-6.2	0.84 (0.52, 1.16)	
	Control	3.1 (2.9)	2.5-3.8		
	UK norms	1.9 (2.0)			
Conduct problems (0-10)	ASD	3.1 (2.2)	2.7-3.6	0.52 (0.22, 0.81)	ADHD; ASD+ADHD > ASD > control (p<0.01) Control vs norms – t=1.5, p=0.1
	ADHD	4.6 (2.2)	4.3-4.9	1.17 (0.80, 1.45)	
	ASD+ADHD	4.5 (2.2)	4.0-5.0	1.12 (0.79, 1.44)	
	Control	2.0 (2.3)	1.5-2.5		
	UK norms	1.6 (1.7)			
Hyperactivity/inattention (0-10)	ASD	6.8 (2.0)	6.4-7.2	1.39 (1.06, 1.70)	ADHD; ASD+ADHD > ASD > control (p<0.01) Control vs norms – t=1.8, p=0.07
	ADHD	9.2 (2.0)	4.3-4.9	2.56 (2.21, 2.89)	
	ASD+ADHD	8.9 (2.0)	8.4-9.3	2.42 (2.01, 2.81)	
	Control	4.0 (2.1)	3.6-4.5		
	UK norms	3.5 (2.6)			
Peer relationships (0-10)	ASD	6.0 (2.2)	5.6-6.4	1.80 (1.45, 2.14)	ASD; ADHD; ASD+ADHD > control (p<0.01) Control vs norms – t=1.7, p=0.09
	ADHD	3.9 (2.3)	3.6-4.2	0.87 (0.60, 1.14)	
	ASD+ADHD	5.6 (2.2)	5.2-6.1	1.64 (1.28, 1.99)	
	Control	1.9 (2.3)	1.4-2.4		
	UK norms	1.5 (1.7)			
Prosocial behaviour	ASD	4.3 (2.4)	3.9-4.8	-1.06 (-1.37, -0.75)	ASD; ASD+ADHD < ADHD, control (p<0.01) ADHD < control (p=0.04)
	ADHD	6.1 (2.4)	5.7-6.4	-0.37 (-0.63, -0.11)	

(0-10)	ASD+ADHD	4.6 (2.4)	4.0-5.1	-0.97 (-1.29,-0.65)	Control < norms for t=5.91, p<0.001
	Control	7.0 (2.5)	6.4-7.5		
	UK norms	8.6 (1.6)			

† Bonferroni corrections for multiple comparisons, and corrected for developmental level, age, and sex. ASD= Autism Spectrum Disorder (M:F= 67:39; mean age= 10.4 [3.1] years); ADHD= Attention Deficit Hyperactivity Disorder (M:F 142:41; mean age= 10.4 [2.6] years); ASD+ADHD= comorbid ASD & ADHD (M:F= 62:20; mean age= 11.0 [2.7] years); controls=neurotypical children (M:F 49:33; mean age= 9.6 [3.5] years); Hedges' g: measure of effect size where values of 0.20, 0.50, and 0.80 equivalent to effect sizes as small, medium, or large; ns= non significant difference; t= t-test.

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