Increased Symptoms of Posttraumatic Stress in School Students Soon After the Start of the COVID-19 Outbreak in China

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Research article

Keywords: Post-traumatic stress, COVID-19, school students, CRIES-13, stress, China

DOI: https://doi.org/10.21203/rs.3.rs-140073/v1
Abstract


Methods: We used the Children's Impact of Event Scale questionnaire (CRIES-13) to investigate the degree of Post-traumatic Stress (PTSD) symptoms caused by the pandemic in students selected from schools in Sichuan, Jiangsu, Henan, Yunnan, and Chongqing provinces of China.

Results: A total of 7769 students (3692 male and 4077 female), aged 8-18 years, were enrolled in the study, comprising 1214 in primary schools, 2799 in junior high schools and 3756 in senior high schools. A total of 1639 students (21.1%) had severe psychological stress reactions. A large proportion of senior high school students (23.3%) experienced severe psychological stress, and they had the highest median total CRIES-13 score. Female students were more likely to experience severe psychological stress and had higher median CRIES-13 total scores than males.

Conclusion: COVID-19 has placed psychological stresses on primary and secondary school students in China. These stresses are more likely to reach severe levels among female students and senior high school students.

Background

Studies have shown an increased incidence of post-traumatic stress in survivors of large-scale disasters [1–4]. Disasters can be defined as destructive occurrences that disrupt and overwhelm entire communities and affect millions worldwide in a given year [5]. Children who have experienced disasters are more vulnerable than adults to mental and psychological disorders, including post-traumatic stress disorder (PTSD) [6–8]. Disasters can severely affect their emotional status, resulting in stress reactions that are different from those experienced by adults [9, 10]. In addition, children may develop serious psychological and mental illnesses that occur sooner and last longer than those in adults [11–13].

In the 21st century, a number of infectious diseases have challenged global public health [14]. During the epidemic of severe acute respiratory syndrome in February 2003, many adult patients developed post-traumatic stress symptoms, PTSD, anxiety, depression, and other mental illnesses [15–18]. The current COVID-19 pandemic, caused by novel coronavirus SARS-CoV-2, constitutes a global public health disaster [19]. We are unaware of studies of whether and how the pandemic causes psychological stress on children.

Therefore, we investigated the prevalence of post-traumatic stress symptoms in primary and secondary school students from several provinces and regions in China at one month after the start of the COVID-19 outbreak. Our results may help elucidate the effects of the pandemic on the psychological health of children.

Methods

Subjects

Participants included students from several primary and secondary schools in Sichuan, Jiangsu, Henan, Yunnan, and Chongqing. We included a range of students, from those attending first grade of primary school (8 years) to those in the third grade of senior high school (18 years). Participants were stratified into primary school students (grades 1-6), junior high school students (grades 7-9), and senior high school students (grades 10-12). We excluded students with a history of substance abuse, those suffering from major physical and mental illnesses, including Axis I and Axis II disorders classified by the Diagnostic and Statistical Manual of Mental Disorders IV (DSM-IV) based on self-report, as well as those who could not understand the questionnaire.

The minimal sample size required for this study was calculated based on the typical sample size for questionnaire-based surveys of the occurrence of post-traumatic stress after disasters. Based on a PTSD prevalence of 32.2% in China after the outbreak of COVID-19 [19], we calculated a minimal sample of 2097 for a power of 0.8, type I error of 0.05 and allowable error of 0.02. We increased this by 10% to 2330 to compensate for missing or uncooperative participants. Ultimately, our sample was much larger (7769).

Measurement

Between 1 February 20 and 1 March 1 2020, approximately one month after the outbreak of the novel coronavirus infection in China, we collected demographic and psychopathological data from the participants using the Chinese versions of the General Situation Collection Sheet revised in 2010 and the Children's Revised Impact of Event Scale (CRIES) questionnaire [20]. The two questionnaires were distributed via WeChat, and their purpose and contents were explained to all participants. Questionnaires couldn't be submitted until they completed all questions.

The CRIES-13 measures symptoms of intrusion (4 items), avoidance (4 items), and arousal (5 new items). Answer item is set as "not at all", "rarely", "sometimes", and "often" [20, 21]. The CRIES-13 total score is used to judge the severity of the psychological impact caused by a traumatic event. A total score ≥ 30 is considered to indicate severe psychological stress [21–23].

Statistical analysis

All statistical analyses were performed using SPSS 25.0 (IBM, Armonk, NY, USA), and the significance level was set as \( \alpha = 0.05 \). We analyzed participant data and compared CRIES-13 scores across groups using the Chi-squared, Mann-Whitney U, and Kruskal-Wallis H tests. Post-hoc comparisons were conducted after adjusting the level of significance using Bonferroni correction.
We performed stepwise binary logistic regression using the forward likelihood ratio (LR) method in order to identify factors influencing perceived stress. We considered the influence of sex, age, grade, family structure, occupation of parents, past history of psychological illness (history of psychological consultations or use of psychotropic drug therapy), recent diagnosis of coronary disease, and exposure to coronavirus infection within the previous 30 days. Questions about infection exposure addressed the number of visits to Hubei province and surrounding areas, contact with patients diagnosed with COVID-19, incidence/occurrence of cold, fever, cough, nasal congestion, runny nose, sore throat, and diarrhea, and participation in large gatherings, such as dinner parties. Exposure was also assessed based on contact with family members who were doctors and frontline workers, as well as relatives within three generations who had been diagnosed with COVID-19 or were suspected of having coronary disease. We also included data on whether participants had received therapy against COVID-19, or had fever and other mild symptoms.

**Results**

**Demographic and clinical characteristics of subjects**

Our survey included a total of 7769 students (4077 female) from 5 different provinces in China (Table 1). All participants were between 8 and 18 years old (median 15 years), and were stratified into three groups based on their grade: primary school students (15.62%, median age 11 years), junior high school students (36.03%, median age 13 years), and senior high school students (48.35%, median age 16 years). In total, 24 participants (13 males and 11 females) were diagnosed with COVID-19, and 27 (16 males and 11 females) were suspected of being infected with the disease.
Table 1  
Demographic characteristics of school students, stratified by sex and grade

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Total (n = 7769)</th>
<th>Sex</th>
<th>Grade</th>
<th>Z/x2</th>
<th>p</th>
<th>Primary (n = 906)</th>
<th>Junior High (n = 2799)</th>
<th>Senior High (n = 3756)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Male (n = 3692)</td>
<td>Female (n = 4077)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Median age (years)</td>
<td>15</td>
<td>15</td>
<td>15</td>
<td>-1.910</td>
<td>0.056*</td>
<td>11.00</td>
<td>13.00</td>
<td>16.00</td>
</tr>
<tr>
<td>Sex (Male/Female)</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>611/603</td>
<td>1420/1379</td>
<td>1661/2095</td>
</tr>
<tr>
<td>Grade (Primary school/Junior high school/Senior high school)</td>
<td>1214/2799/3756</td>
<td>160/451/1420/1661</td>
<td>148/455/1379/2095</td>
<td>32.324</td>
<td>0.000*</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family structure</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single parent</td>
<td>794</td>
<td>346</td>
<td>448</td>
<td>72</td>
<td>252</td>
<td>470</td>
<td></td>
<td></td>
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<tr>
<td>Two parents</td>
<td>2608</td>
<td>1339</td>
<td>1269</td>
<td>160</td>
<td>1064</td>
<td>1384</td>
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<td></td>
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<tr>
<td>Three-generation</td>
<td>2762</td>
<td>1350</td>
<td>1412</td>
<td>601</td>
<td>952</td>
<td>1209</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>1605</td>
<td>657</td>
<td>948</td>
<td>381</td>
<td>531</td>
<td>693</td>
<td></td>
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<tr>
<td>Occupation of parents</td>
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<td></td>
<td></td>
<td>34.448</td>
<td>0.000*</td>
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<td>Medical staff</td>
<td>160</td>
<td>86</td>
<td>74</td>
<td>7</td>
<td>108</td>
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<td>31</td>
<td>27</td>
<td>0</td>
<td>40</td>
<td>18</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Civil servant</td>
<td>287</td>
<td>151</td>
<td>136</td>
<td>7</td>
<td>164</td>
<td>116</td>
<td></td>
<td></td>
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<tr>
<td>Teacher</td>
<td>195</td>
<td>102</td>
<td>93</td>
<td>12</td>
<td>114</td>
<td>69</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Freelancer</td>
<td>1838</td>
<td>906</td>
<td>932</td>
<td>270</td>
<td>637</td>
<td>931</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Farmer</td>
<td>1073</td>
<td>477</td>
<td>596</td>
<td>349</td>
<td>185</td>
<td>539</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Researcher</td>
<td>12</td>
<td>8</td>
<td>4</td>
<td>0</td>
<td>8</td>
<td>4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Worker</td>
<td>1575</td>
<td>677</td>
<td>898</td>
<td>299</td>
<td>360</td>
<td>916</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self-employed</td>
<td>1586</td>
<td>797</td>
<td>789</td>
<td>166</td>
<td>761</td>
<td>659</td>
<td></td>
<td></td>
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<tr>
<td>Others</td>
<td>985</td>
<td>457</td>
<td>528</td>
<td>104</td>
<td>422</td>
<td>459</td>
<td></td>
<td></td>
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<tr>
<td>Family members</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Infected (Yes/No)</td>
<td>165/1604</td>
<td>70/3622</td>
<td>95/3982</td>
<td>1.757</td>
<td>0.185</td>
<td>9/1205</td>
<td>56/2743</td>
<td>100/3656</td>
</tr>
<tr>
<td>Doctor (Yes/No)</td>
<td>272/7497</td>
<td>145/3547</td>
<td>127/3950</td>
<td>3.785</td>
<td>0.052</td>
<td>14/1200</td>
<td>166/2633</td>
<td>92/3664</td>
</tr>
<tr>
<td>Frontline worker (Yes/No)</td>
<td>111/7658</td>
<td>51/3641</td>
<td>60/4017</td>
<td>0.112</td>
<td>0.738</td>
<td>18/1196</td>
<td>66/2733</td>
<td>27/3729</td>
</tr>
<tr>
<td>Respondent diagnosed with COVID-19</td>
<td>24/7745</td>
<td>13/3679</td>
<td>11/4066</td>
<td>0.426</td>
<td>0.514</td>
<td>6/1208</td>
<td>4/2795</td>
<td>14/3742</td>
</tr>
<tr>
<td>Respondent had contact with suspected COVID-19 patient (Yes/No)</td>
<td>27/7742</td>
<td>16/3676</td>
<td>11/4066</td>
<td>1.497</td>
<td>0.221</td>
<td>6/1208</td>
<td>4/2795</td>
<td>17/3739</td>
</tr>
<tr>
<td>Respondent received COVID-19 therapy (Yes/No)</td>
<td>157/7612</td>
<td>72/3620</td>
<td>85/3992</td>
<td>0.178</td>
<td>0.673</td>
<td>19/1195</td>
<td>34/2765</td>
<td>104/3652</td>
</tr>
</tbody>
</table>

We collected information about the family structure and occupation of the parents of all participants. A large proportion of participants lived in multi-generational households (35.6%) and in families with three individuals including the respondent (33.6%). Others had different family structures (20.7%) or lived with single parents (10.2%). The most frequent parental occupations were freelancers (23.7%), self-employed workers (20.4%), migrant workers (20.3%), and farmers (13.8%). A smaller proportion were medical workers (2.1%), police officers (0.7%), civil servants (3.7%), and teachers (2.5%). A total of 165 students had family members who had been diagnosed with COVID-19. Participants were also exposed to the virus via family members who were doctors (272 students) and frontline workers (111 students).

**Total CRIES-13 score**
The stress response of participants to the COVID-19 pandemic was measured based on CRIES-13 total score. A total of 1639 (21.1%) students experienced severe symptoms of psychological stress (total score ≥ 30; Table 2). These symptoms were more serious in senior high school students (23.3%) compared to primary students (20.3%) and junior high school students (18.4%) (χ² = 23.5, p < 0.001). A higher proportion of female students suffered severe psychological stress than male students (22.3% vs 19.7%; χ² = 8.03, p = 0.005).

### Table 2

**CRIES-13 scores of students, stratified by sex and grade**

<table>
<thead>
<tr>
<th></th>
<th>Total (n = 7769)</th>
<th>Male (n = 3692)</th>
<th>Female (n = 4077)</th>
<th>z/x²</th>
<th>p</th>
<th>Primary (n = 906)</th>
<th>Junior High (n = 2799)</th>
<th>Senior High (n = 3756)</th>
<th>H/x²</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Median scores</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>20</td>
<td>19</td>
<td>21</td>
<td>-5.739</td>
<td>0.000*</td>
<td>18.00</td>
<td>19.00</td>
<td>21.00</td>
<td>75.512</td>
<td>0.000*</td>
</tr>
<tr>
<td>Intrusion factor</td>
<td>8.00</td>
<td>7.00</td>
<td>8.00</td>
<td>-6.759</td>
<td>0.000*</td>
<td>6.00</td>
<td>8.00</td>
<td>8.00</td>
<td>104.141</td>
<td>0.000*</td>
</tr>
<tr>
<td>Avoidance factor</td>
<td>4.00</td>
<td>4.00</td>
<td>4.00</td>
<td>-3.146</td>
<td>0.002*</td>
<td>5.00</td>
<td>4.00</td>
<td>4.00</td>
<td>45.492</td>
<td>0.000*</td>
</tr>
<tr>
<td>Arousal factor</td>
<td>7.00</td>
<td>6.00</td>
<td>7.00</td>
<td>-8.563</td>
<td>0.000*</td>
<td>5.00</td>
<td>6.00</td>
<td>8.00</td>
<td>183.669</td>
<td>0.000*</td>
</tr>
<tr>
<td><strong>Distribution by total score, n (%)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt; 30</td>
<td>6130 (78.9)</td>
<td>2964 (80.3)</td>
<td>3166 (77.7)</td>
<td>8.030</td>
<td>0.005*</td>
<td>967 (79.7)</td>
<td>2283 (81.60)</td>
<td>2880 (76.70)</td>
<td>23.503</td>
<td>0.000*</td>
</tr>
<tr>
<td>≥ 30</td>
<td>1639 (21.1)</td>
<td>728 (19.7)</td>
<td>911 (22.3)</td>
<td></td>
<td></td>
<td>247 (20.3)</td>
<td>516 (18.40)</td>
<td>876 (23.30)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

To understand the degree of impact of COVID-19, we compared total CRIES-13 scores among primary school, junior high school, and senior high school student using the Kruskal-Wallis H test. We found a significant difference among the three groups (H = 75.512, p < 0.001; Table 2); median total CRIES-13 score was the highest for senior high school students (21), followed by the junior high school and primary students (18).

After adjusting the level of significance using Bonferroni correction, a post-hoc comparison found that total CRIES-13 scores were significantly lower for primary school students (Z = -7.469, adjusted p < 0.001) and junior high school students (Z = -6.616, adjusted p < 0.001) than for senior high school students. However, total scores were not significantly different between primary school and junior high school students (Z = -2.368, adjusted p = 0.054; Table 3). Across all three student groups, female students had higher total scores than males (median 21 vs 19; Z = -5.739, p < 0.001; Table 2).

### Table 3

**The post-hoc comparison of CRIES-13 scores by grade**

<table>
<thead>
<tr>
<th></th>
<th>Primary &amp; Senior High</th>
<th>Junior High &amp; Senior High</th>
<th>Primary &amp; Junior High</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>z</td>
<td>Adjusted p</td>
<td>z</td>
</tr>
<tr>
<td>Total</td>
<td>-7.469</td>
<td>0.000*</td>
<td>-6.616</td>
</tr>
<tr>
<td>Intrusion factor</td>
<td>-10.120</td>
<td>0.000*</td>
<td>-2.463</td>
</tr>
<tr>
<td>Avoidance factor</td>
<td>4.327</td>
<td>0.000*</td>
<td>-3.499</td>
</tr>
<tr>
<td>Arousal factor</td>
<td>-12.382</td>
<td>0.000*</td>
<td>-9.214</td>
</tr>
</tbody>
</table>

### Factor scores on the CRIES-13

We observed significant differences among the three groups of students in intrusion (H = 103.14, p < 0.001), arousal (H = 183.669, p < 0.001), and avoidance factor scores (H = 45.492, p < 0.001) (Table 2). Post-hoc comparisons of the intrusion factor showed that junior high school students had higher scores than primary students (Z = -7.933, adjusted p < 0.001), while senior high school students had higher scores than primary students (Z = -10.120, adjusted p < 0.001) and junior high school students (Z = -2.463, adjusted p = 0.041; Table 3).

Pairwise comparison of the arousal factor showed that junior high school students had higher scores than primary students (Z = -5.200, adjusted p < 0.001), and senior high school students had higher scores than primary students (Z = 12.382, adjusted p < 0.001) and junior high school students (Z = 9.214, adjusted p < 0.001). In contrast, primary school students had higher avoidance factor scores than junior high school students (Z = 6.7, adjusted p < 0.001) and senior high school students (Z = 4.327, adjusted p < 0.001), and the scores of junior high school students were lower than those of senior high school students (Z = -3.499, adjusted p < 0.001; Table 3).

Across all three student groups, we found that female students had higher intrusion factor (Z = -6.76, p < 0.001) and arousal factor scores (Z = 3.15, p < 0.001) than males, but lower avoidance factor scores (Z = -3.15, p = 0.002; Table 2).

### Factors influencing individual stress response
We performed logistic regression to determine the factors affecting total CRIES-13 scores and stress responses. Our results showed that stress response was influenced by the sex of the participant (p = 0.024), school grade (p = 0.001), past history of psychological counseling (p = 0.001), exposure to infection via relatives (p = 0.009), and a recent diagnosis of COVID-19 (p = 0.006; Table 4). Individuals suffering from cold, fever, cough, nasal congestion, runny nose, sore throat, and diarrhea within 30 days of taking part in the survey also had a heightened stress response (p = 0.002).

**Table 4**

<table>
<thead>
<tr>
<th>Variable</th>
<th>B</th>
<th>SE</th>
<th>Wald chi-square</th>
<th>OR (95% CI)</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex (Male/Female)</td>
<td>0.128</td>
<td>0.057</td>
<td>5.113</td>
<td>1.136 (1.017–1.270)</td>
<td>0.024*</td>
</tr>
<tr>
<td>Grade</td>
<td>13.860</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary</td>
<td>-0.146</td>
<td>0.083</td>
<td>3.073</td>
<td>0.864 (0.735–1.017)</td>
<td>0.080</td>
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<tr>
<td>Junior High</td>
<td>-0.234</td>
<td>0.064</td>
<td>13.200</td>
<td>0.940 (0.697–0.898)</td>
<td>0.000*</td>
</tr>
<tr>
<td>Occupation of parents</td>
<td>16.827</td>
<td></td>
<td></td>
<td></td>
<td>0.051</td>
</tr>
<tr>
<td>Medical staff</td>
<td>0.179</td>
<td>0.215</td>
<td>0.689</td>
<td>1.196 (0.784–1.824)</td>
<td>0.406</td>
</tr>
<tr>
<td>Police</td>
<td>0.280</td>
<td>0.327</td>
<td>0.732</td>
<td>1.323 (0.697–2.512)</td>
<td>0.392</td>
</tr>
<tr>
<td>Civil servant</td>
<td>0.171</td>
<td>0.169</td>
<td>1.029</td>
<td>1.186 (0.853–1.651)</td>
<td>0.310</td>
</tr>
<tr>
<td>Teacher</td>
<td>-0.396</td>
<td>0.230</td>
<td>2.957</td>
<td>0.673 (0.429–1.057)</td>
<td>0.085</td>
</tr>
<tr>
<td>Freelancer</td>
<td>0.183</td>
<td>0.100</td>
<td>3.341</td>
<td>1.201 (0.987–1.462)</td>
<td>0.068</td>
</tr>
<tr>
<td>Farmer</td>
<td>0.328</td>
<td>0.111</td>
<td>8.741</td>
<td>1.388 (1.117–1.725)</td>
<td>0.003*</td>
</tr>
<tr>
<td>Researcher</td>
<td>0.754</td>
<td>0.631</td>
<td>1.429</td>
<td>2.126 (0.617–7.325)</td>
<td>0.232</td>
</tr>
<tr>
<td>Worker</td>
<td>0.151</td>
<td>0.104</td>
<td>2.135</td>
<td>1.163 (0.950–1.425)</td>
<td>0.144</td>
</tr>
<tr>
<td>Self-employed</td>
<td>0.145</td>
<td>0.103</td>
<td>1.958</td>
<td>1.156 (0.944–1.415)</td>
<td>0.162</td>
</tr>
<tr>
<td>Psychological consultations (Yes/No)</td>
<td>0.646</td>
<td>0.131</td>
<td>24.389</td>
<td>1.908 (1.477–2.466)</td>
<td>0.000*</td>
</tr>
<tr>
<td>Relatives infected by COVID-19 (Yes/No)</td>
<td>0.451</td>
<td>0.173</td>
<td>6.779</td>
<td>1.570 (1.118–2.206)</td>
<td>0.009*</td>
</tr>
<tr>
<td>Respondent had contact with suspected COVID-19 patient (Yes/No)</td>
<td>-1.514</td>
<td>0.778</td>
<td>3.787</td>
<td>0.220 (0.048–2.206)</td>
<td>0.006*</td>
</tr>
<tr>
<td>Respondent diagnosed with COVID-19 (Yes/No)</td>
<td>1.937</td>
<td>0.703</td>
<td>7.594</td>
<td>1.570 (1.118–1.632)</td>
<td>0.006*</td>
</tr>
<tr>
<td>Respondent received COVID-19 therapy (Yes/No)</td>
<td>0.119</td>
<td>0.189</td>
<td>0.400</td>
<td>1.127 (0.778–1.632)</td>
<td>0.527</td>
</tr>
<tr>
<td>Respondent had cold, fever, cough etc. in the previous 30 days (Yes/No)</td>
<td>0.435</td>
<td>0.142</td>
<td>9.344</td>
<td>1.544 (1.169–2.040)</td>
<td>0.002*</td>
</tr>
</tbody>
</table>

**Discussion**

In this study, we examined the early effects of the COVID-19 pandemic on the mental and psychological health of 7769 school students in China using the CRIES-13. Based on total CRIES-13 scores, 1639 students (21.1%) experienced symptoms of severe psychological stress, indicating an urgent need to understand the impact of such events on the mental health of children and adolescents.

Women are more likely to experience acute stress reactions and to be at higher risk of PTSD than men [24–30]. In addition, women often show higher scores than men on the invasion and avoidance factors of the CRIES-13 [31, 32]. These sex differences are associated with age, suggesting that older individuals respond differently to stressful events than younger ones [31–37]. Consistent with these results, we found that the largest proportion of students experiencing severe psychological stress were in senior high school. Similarly, studies of children exposed to war violence found older children to be more vulnerable to stress [38]. However, a survey of 8236 US children in grades 4–12 at 6 months after the 9/11 attacks found that primary school students (grades 4–5) were at higher risk of post-traumatic stress symptoms than junior and senior high school students [39]. This discrepancy may reflect that different grades of students may have different degrees of stress disorder under the influence of different events. Future research should focus on more different events.

We found that senior high school students had higher scores on arousal and invasion factors on the CRIES-13, but primary school students had higher avoidance factor scores. This suggests that senior high school students are more likely to feel frightened or anxious, experience flashback reactions associated with the event, and manifest symptoms of arousal. The immaturity of the cognitive process in younger children can make them less susceptible to recurring intrusive thoughts and other cognitive impacts of trauma [40, 41]. A maladaptive cognitive style in adolescents and older children may compromise their ability to regulate emotions, rendering them more vulnerable to PTSD [42].

Based on the regression analysis, we found that the occurrence of cold-related symptoms within one month of participating in the survey significantly influenced stress response. Based on studies of the spread of various viruses, psychosocial factors are related to experimental exposure and infection rates. C-reactive protein (CRP) is an acute-phase reactant downstream of the pro-inflammatory cytokines released during influenza infection [43]. Studies have shown that a marker of peripheral inflammation, plasma CRP, may be prospectively associated with PTSD symptom emergence, suggesting that inflammation may predispose to PTSD [44]. On the other hand, the increasing number of patients and suspected cases, and the increasing number of outbreak affected provinces...
and countries have elicited public worry about becoming infected [45]. As we know, the most common symptoms associated with COVID-19 are fever, cough, dyspnea, expectoration, headache, and myalgia or fatigue [46]. This is similar to the symptoms of the common cold [47]. Particularly, the relevance of perceived threat for health and life and the experienced feelings of vulnerability as mediating factors [48]. It was reproted that mental health symptoms may have been common during the COVID-19 outbreak among the general population in China, especially among infected individuals, people with suspected infection, and people who might have contact with patients with COVID-19 [49]. This is consistent with our research results.

Although previous studies have explored the impact of the SARS epidemic on mental health, this is the first study addressing the psychological impact of COVID-19 on children and adolescents. Using a relatively large sample ranging widely in age, we were able to conduct a cross-sectional study of the mental and emotional status of students at one month after the outbreak began in China. There were no participants from Hubei province, which were subsequently identified as being caused by a novel coronavirus termed severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) [19]. However, this may have caused a bias since the participants were selected from schools in certain regions in China, resulting in findings that may not be generalizable across all children and adolescents. In addition, the survey involved substantially more high school students than primary school students. Even though the timing of the survey may help identify participants who require psychological and clinical intervention, the cross-sectional design meant that we could not assess how persistent the post-traumatic stress symptoms are.

Conclusions

In conclusion, our results showed that COVID-19 has placed psychological stresses on primary and secondary school students in China. These stresses are more likely to reach severe levels among female students and senior high school students.

Abbreviations

COVID-19/SARS-CoV-2: Coronavirus Disease 2019
CRIES-13: the Children's Impact of Event Scale questionnaire
PTSD: Post-Traumatic Stress Disorder
DSM-IV: the Diagnostic and Statistical Manual of Mental Disorders IV
SPSS: Statistical Product and Service Solutions
LR: likelihood ratio
CRP: C-reactive protein

Declarations

Ethics approval and consent to participate

This study was approved by the Ethics Committee of West China Hospital of Sichuan University. The research had been performed in accordance with the Declaration of Helsinki. Written informed consents had been attained from all the participants and their guardians based on the principle of self determination. The participants' rights were fully respected and preserved in the whole process of this study.

Consent for publication

Not applicable.

Availability of data and material

The data that support the findings of this study are available on request from the corresponding author (Li Yin, yli009@163.com). The data are not publicly available due to privacy or ethical restrictions.

Competing interests

The authors declare that they have no competing interests.

Funding

This work was supported by the National Nature Science Foundation of China (81801357), the Science and Technology Education Program of the Sichuan Province (2020JDKP0013, 2020YFS0259), and the Chengdu Key Technology R&D Program (2019-YF05-00284-SN). The above mentioned funding bodies had no further role in the study design, collection, analysis and interpretation of data, in the writing of the report; and in the decision to submit the paper for publication.

Authors' contributions
LY conceived and designed the experiments. HM X, HZ, LJ H, XL W, XW T, YP W, QQ X, PX, RQ J, JZ, FD, MY Y, DL, XJ L, CL Z, WJ W, LL, HM C, WC Z, HP Z, WW helped collect the data. HM X, HZ and LY wrote and revised the manuscript. All authors have read and approved the manuscript.

Acknowledgements

We would like to acknowledge the contribution of all of colleagues and volunteers for their support in this study.

References


