Asian pearls

Relationship between personal, maternal, and familial factors with mental health problems in school-aged children in Aceh province, Indonesia

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A B S T R A C T

Recently, mental health problems (MHP) in school-aged children have become a global phenomenon. Yet, the number of children affected remains unclear in Indonesia, and the effects of mental health problems are of concern. The purpose of this study was to investigate the prevalence of MHP in school-aged children and its relationship to personal, maternal, and familial factors in Aceh province, Indonesia. Participants were 143 school-aged children with MHP and their mothers. They completed the Strengths and Difficulties Questionnaire, Social Competence Questionnaire, Brief Family Relationship Scale, Parental Stress Scale, Parent’s Report Questionnaire, and Indonesian Version of the Beck Depression Inventory-II. Mainly, children were rated to have emotional symptoms by their mothers (37.8%). Factors such as academic competence, family relationships, and maternal parenting stress are related to MHP. Given the high prevalence of school-aged children that have emotional symptoms, child psychiatric mental health nurses should give special attention to assist them during their school years. Moreover, nurses should aim to improve family relationships and reduce maternal parenting stress.

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1. Introduction

School-aged children with MHP are defined as 6–12-year old children with difficulties and/or disabilities in personal relationships, psychological development, playing, or learning, and children in distress and maladaptive behavior (Hockenberry and Wilson, 2009). The school-age period is a crucial time for children to develop MHP, because they begin school in a new environment, as well as having to achieve specific developmental tasks. Having new interactions with teachers and peers, they may encounter difficulties in fulfilling the expectations of their age to become successful school-aged children. Even though it is easier to be observed during this period, this situation may not be realized by parents; usually teachers will find an uncommon condition with a child when he or she is compared to other children in general (Yearwoodet al., 2012). MHP in school-aged children cannot be ignored, because it can develop into adolescence and adulthood and convey negative consequences, such as early substance use, smoking, bipolar disorder, and suicide, and criminal activities such as traffic and drunk driving offences, violence, damage to property, drug-related crimes, and pornography (Aebi et al., 2014; Biederman et al., 2008; Canosli et al., 2013; King et al., 2004). In addition, MHP in school-aged children has increased over the years and has become a global phenomenon (Centers for Disease Control and Prevention, 2013).

In the United States, the percent of children reported with MHP was 13–20% in during 1994–2011, and Asian countries seem to follow the same trend with 10–20% of children and adolescent’s suffering from MHP (Srinath et al., 2010). Unfortunately, the number of school-aged children with MHP in Indonesia remains unclear (Ministry of Women Empowerment and Child Protection of Indonesia, 2011). Nevertheless, the effects of these problems are of concern in Indonesia. It was reported that, many Indonesian school-aged children were involved in violence or legal system as abusers (43%). It has been reported that 32% of children experienced bullying at school, and the rate have tend to increase every year (Erlinda, 2014). In conclusion, the estimation of the number of school-aged children with MHP in Indonesia based on the estimation of the World Health Organization (WHO), is 10% of

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the child population in Indonesia (Mental Health Foundation, 2014). Therefore, approximately, 4.2 million school-aged children in Indonesia are suffering from MHP, and 100,000 school-aged children in Aceh province are estimated to have undetected and untreated MHP (Harwono, 2013).

Having been hit by massive earthquakes and a Tsunami attack in 2004, Aceh is listed as a province in Indonesia with the highest prevalence of mental health problems in the adult population. Research showed that the higher prevalence of MHP in the adult population related to the higher prevalence of MHP in the child population, and by conducting early detection and intervention; psychiatric nurses can prevent and minimize the impact and severity of MHP (Copeland et al., 2009). However, there is no prior research on MHP among school-aged children in Aceh province, Indonesia and how MHP is related to other factors.

In general, there are three factors influencing MHP in school-aged children; personal factors, parental factors, and familial factors. First, gender is a personal factor related to MHP in school-aged children. Males tend to show more behavioral problems, while emotional problems are most frequently exhibited by females. The risk of MHP in school-aged children also increases with age; older school-aged children have a higher risk for MHP compared to younger school-aged children (Bayer et al., 2011; Mendes et al., 2013). Additionally, many studies reported that social competence and academic competence related to MHP in school-aged children, in which such children exhibited low social and academic competence (Larsson and Frisk, 1999; Rolf, 1972).

Second, parental factors such as maternal parenting behavior, maternal parenting stress, and maternal depression have been frequently reported to be related to MHP in school-aged children. Furthermore, in school-aged children with MHP, the mothers had a higher risk for parenting stress and depression (Williford et al., 2010; Ngamkum, 2013; Van Loon et al., 2014). Research that examines aspects of mothers with MHP is important, because mothers spend more time with the children and many studies found that factors pertaining to the mother frequently related to MHP in school-aged children.

Third, as a part of familial factors, family income and family environment in terms of relationships dimension has related to MHP in school-aged children. Low family income was reported as one of the stressors in the family of school-aged children with MHP (Beiser et al., 2002), while family environment, especially the relationship dimension, tended to be poor among family members with MHP (Sanguekulchaisri, 2013; Wuthironarit, 2013).

2. Methods

A study on school-aged children with MHP is important to provide new information about mental health problems, which would have utility for the development of appropriate promotion, prevention, and intervention methods. This study applied a cross-sectional correlational design. This study aimed to 1) describe the dimensions of MHP in school-aged children with MHP, and 2) investigate the selected factors, including gender, age, academic competence, social competence, family income, family relationship, maternal parenting stress, maternal parenting behavior, and maternal depression, as they relate to MHP in school-aged children in Aceh province, Indonesia. Informed consent was obtained from both children and mothers, and the mothers to sign the children’s informed consent.

2.1. Sample

There were two groups of participants in this study; school-aged children with mental health problems, and their mothers. The total number of participants needed was calculated by using Thorndike’s Formula (Thorndike, 1978). A total of 143 school-aged children with MHP and their mothers were selected to be participants in the study, and they were equally divided among nine elementary schools. Participants in the study fulfilled the following inclusion criteria; children ages 6–12 of either gender, under supervision of counseling teacher for having some problems at school, and score of at least 17 on the Strengths and Difficulties Questionnaire rated by the mother.

This study applied four steps of simple random sampling, including the selection of districts, sub-districts, elementary schools, and children (including their mothers). The selected elementary schools were SD No. 1 Syamtaliria Bayu, SD No. 5 Syamtaliria Bayu, MIN Punteut (Bayu sub-district, North Aceh district), SDN 3 Percontohan Peusangan, SDN 5 Peusangan, SDN 28 Peusangan (Peusangan sub-district, Bireuen district), SDN 4 Muara Dua, SDN 5 Muara Dua, and SDN 9 Muara dua (Muara Dua sub-district, Lhokseumawe district).

2.2. Instruments

The Strengths and Difficulties Questionnaire (SDQ) is one of the more frequently used instruments to measure MHP in children, as well as the Rutter Questionnaire, Child Behavior Checklist (CBCL), and Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA). However, the SDQ has several advantages, such as focusing on both strengths and difficulties and its ability to better measure inattention and hyperactivity dimensions of behavior. This instrument is also available in many languages translations (Goodman, 1997; Goodman and Scout, 1999; Mathai et al., 2003). Four dimensions of the SDQ, including emotional symptoms, conduct problems, hyperactivity and peer problems, were used to classify MHP in children. If the total score is at least 17, school-aged children are categorized as having MHP (Wille et al., 2008).

The Beck Depression Inventory-II (BDI-II) was used to measure maternal depression. The BDI-II consists of 21 items. For the Indonesian version of the BDI-II (Ginting et al., 2013), scale score ranges indicate the following levels of depression for the Indonesian population: 0–13 = normal, 14–17 = mild depression, 18–28 = moderate depression and 29–63 = severe depression.

The Social Competence Questionnaire (SCQ) was adapted from the Self-Perception Profile for Children by Harter (2012). The SCQ consists of six contradictory statements, and lower scores indicate lower social competence.

The Parent’s Report Questionnaire (PRQ) was used to measure maternal parenting behavior. The PRQ consists of 20 items from five behavioral dimensions of the mother’s parenting, which including respect for autonomy, control through guilt and anxiety, consistency, child centeredness, and parental temper and detachment. A high score in any dimension reflects positive parenting (Cohen et al., 1977).

Table 1

<table>
<thead>
<tr>
<th>Instruments</th>
<th>Cronbach’s Alpha</th>
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<tbody>
<tr>
<td></td>
<td>English version</td>
</tr>
<tr>
<td>SDQ</td>
<td>0.88 (Goodman, 1997)</td>
</tr>
<tr>
<td>BDI-II</td>
<td>0.73–0.96 (Kuhner et al., 2007)</td>
</tr>
<tr>
<td>SCQ</td>
<td>0.75–0.84 (Harter, 2012)</td>
</tr>
<tr>
<td>PR</td>
<td>0.67–0.90 (Cohen et al., 1977)</td>
</tr>
<tr>
<td>PSS</td>
<td>0.81 (Berry and Jones, 1995)</td>
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<tr>
<td>BFRS</td>
<td>0.88 (Fok et al., 2013)</td>
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* Pilot project.
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